Web-appendix 4

Data Extraction Table – Person-centered rehabilitation content
<table>
<thead>
<tr>
<th>Title</th>
<th>Category</th>
<th>Topical synthesis of each article’s extracted data</th>
<th>Textual data extracted (quotations)</th>
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</thead>
<tbody>
<tr>
<td>Turner-Stokes L, Ashford S, Esquenazi A, et al. A comprehensive person-centered approach to adult spastic paresis: a consensus-based framework. European journal of physical and rehabilitation medicine. 2018;54(4):605-617.</td>
<td>1</td>
<td><strong>Meaningful outcome and priorities accounted for</strong>&lt;br&gt;Active engagement into care and self-management&lt;br&gt;Involved into goal-setting and care evaluation - their objectives are of critical importance in guiding all clinical decisions.</td>
<td>Treatment interventions for spastic paresis should be centered on as far as reasonable on the patient’s own priorities for treatment.&lt;br&gt;The value gained from understanding health outcomes from the patient’s perspective (i.e. patient reported outcomes [PROs]) is increasingly acknowledged, and in many countries PRO data are now a requirement for commissioning and reimbursement of medical treatment.&lt;br&gt;The patient should be at the heart of all care, and their objectives are of critical importance in guiding all clinical decisions.&lt;br&gt;Treatment for spastic paresis should be centered on as far as reasonable on the patient’s priorities for treatment.&lt;br&gt;Goal setting, negotiation and formal recording of SMART goals (agreed between the team, patient and/or their family carer) should be an integral part of all spasticity management programmes.&lt;br&gt;Patients (and/or their family carer) should be involved in the evaluation of goal achievement.</td>
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Goal attainment scaling should be recorded alongside other standardized measures in the evaluation of outcome.

When planning interventions for spastic paresis, the team should consider the patient and their family’s capacity for self-rehabilitation, as well as ways to enhance this approach.


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<tr>
<th>Stage</th>
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<td>1</td>
<td>SDM requires considering patients’ individual circumstances, values, and preferences, which are key components of PERSONCENTERED CARE. SDM includes eliciting patients’ preferences and promoting engagement. Three-stages approach: Preparing for collaboration; Exchange Information on</td>
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<td>SDM requires clinicians to consider patients’ individual circumstances, values, and preferences, which are also key components of evidence-based practice and patient-centered care. Institutional mission statements honoring patient-centered care may be reinforced by clinicians and team performance appraisals that reward behaviors of eliciting patients’ preferences and promoting engagement</td>
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<td>Stage 1: preparing for collaboration: invite patients to participate; Determine decision(s) to be made; Negotiate priorities.</td>
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<td>Stage 2: Exchange Information on Options: Identify patient knowledge, concern and options; Value the expertise of the patient and the PT;</td>
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<td>Options (e.g. valuing the expertise/experience of the person); Affirm and Implement decisions, all with sub-steps.</td>
<td>Outline options with benefits and risks; Deliberation about the patient and PT about the options; Clarify and correct perceptions about the options; Determine congruence between patient priorities and available options.</td>
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<td>Promoted for example with: Health literacy precautions; teach-back; Motivational Interviewing; Decisions Aids, Patient Reported Outcomes measures.</td>
<td>Stage 3: Affirm and implement decision: PT summarizes the plan; Confirm congruence with patient priorities &amp; goals; Patient summarizes the plan &amp; relates concerns &amp; confidence about the plan; Document decision-making process &amp; plan; Document implementation &amp; outcomes of the plan.</td>
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<td>Barriers to implementation include: beliefs that costs too many time; understaffing / high case/work loads turning practitioners too busy to elicit and listen; staff turn over and lack of continued, knowledgeable relationships;</td>
<td>It is a process that both the person under care and the provider bring into their skills, knowledge and/or experiences.</td>
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| Strategies that support SDM include: Health literacy precautions (simplifying verbal and written communication and making physical and virtual environments easier to navigate, so patients are more informed and better able to participate in their health decision making and follow-through.). Teach-back. Teach-back is one of many active listening techniques that support SDM deliberations, patient education, and patient-clinician therapeutic alliance. (“I want to see whether or not 4
| reimbursement on number of visits. | not I’ve done a good job explaining this information to you. Please tell me what you heard me say.” In addition to helping clinicians check patient comprehension, teach-back helps engage patients and affirm their role in care.). Motivation Interviewing (e.g. to addresses patients’ readiness to consider and implement changes by identifying and mobilizing their intrinsic values and goals), Decision aids (DAs) (tools that help patients acquire knowledge about their health conditions and treatment options, and consider that information in light of their values, resources, and preferences). They can take the form of online calculators, checklists, videos of patients discussing how their values affect their health decisions, decks of cards with outcome options, or other media). Patient-reported outcome measures (PROMs) (assess patients’ views on the status and functional impacts of their health conditions)

Barriers to: “Clinicians may believe that they do not have time to practice SDM, even though clinic visit observations have shown that SDM does not substantially increase the visit length. Understaffing may hamper SDM (an environmental resource TDF domain), as patients report limiting discussions with busy clinicians rushing between patients. High staff turnover is a barrier for patients and
clinicians, who view staff continuity as important to building relationships and SDM.

At the system level, reimbursement and productivity metrics based on numbers of visits, rather than on longer-term patient outcomes and satisfaction, may reduce incentives for provider organizations to implement and sustain SDM and patient-centered care.

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| Micro-doings of Person-centered care in everyday rehabilitation work – micro-translation, i.e. a person- and context-sensitive one, of core principles into practice; Notion of tinkering as a useful concept for approaching person centered care - Uncertainty, humility, and doubt in one’s expertise – leading to continual, ethical questioning of what to do and what is best (or good / Person-centered care) at each moment of care. Attends to the “personhood” of all engaged in clinical | Focus on the “micro-doings of Person-centered care in everyday rehabilitation work.

Moves care from a limited biomedical, disease-focused approach to a broader humanistic one.

PERSON-CENTERED CARE has become important for ideological reasons as well as for ethical ones.

Notion of tinkering as a useful concept for approaching person centered care”. “Uncertainty, humility, and doubt in one’s expertise are inherent to tinkering, which involves a continual questioning of what to do, what is best, and what is person centered care within each moment of care.

Determinations of what constitutes good, better, or best rehabilitation practices are inevitably questions of ethics.

Person-centered care is promoted as good practice in rehabilitation because it provides a framework for attending to the personhood of all engaged in clinical encounters. |
<table>
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<th>encounters, including the practitioners – the subjectivity of all those involved</th>
<th>Post-critical analyses suggest that multiple interacting forces, conditions, assumptions, and actions intersect in shaping each rehabilitation encounter such that what constitutes good care or person-centered care cannot be determined in advance.</th>
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<td>Although general agreement on core principles, everyday PERSON-CENTERED CARE practices are difficult to prescribe and need to consider the multiple interacting forces, including other practice demands.</td>
<td>Tinkering” is a potentially useful approach that involves a continual questioning of what to do, what is best, and what is Person-centered care within each moment of care.</td>
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<td>Good PERSON-CENTERED CARE cannot be determined in advance or fully standardized, but set in context of the multiple forces (care logics, professional expectations, internalized</td>
<td>Person centered care is one of a group of closely related “centred” approaches to care (e.g., patient/client, family, woman, child) which appeal to theories of interaction as psychosocial and ethical goods [6]. While there are important and contested differences between each of these approaches, they have in common an appeal to attend to the needs, preferences, and circumstances of individuals receiving health care or other services.</td>
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<td>Differences [in conceptualization] can be a source of productive care practices when understood and specified for local needs, conditions, and preferences. This open-ended approach is perhaps a welcomed response to the proliferation of calls to standardize PERSON-CENTERED CARE.</td>
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responsibilities, institutional imperatives, conventions, policies, etc.) in practice.

Standardized, script-form of thinking and acting curtail flexibility and creativity needed for PCR – objectify and homogenize care practices.

Not a “checklist” or “put-on-paper” approach to otherwise profound/sensitive/emotional or person-specific issues that otherwise arise as personally significant.

“Ticking boxes” and other “on paper” requirements,

We identified instances of what we saw as both “good” and “bad” care moments and/or PERSON-CENTERED CARE across the data. We did not always agree. Moreover, we noted that the same practices had different effects in different contexts, or had multiple effects within the same care event.

While (some) scripts are necessary to organize care processes, strict adherence to scripts and the demands of standardization could problematically objectify and homogenize care and people.

[scripts are] written and unwritten rehabilitation texts and conventions such as outcome measures, forms, charting, standards, funding policies, practice patterns, and best practice principles. These scripts reflect and reproduce particular dominant logics, discourses, and understandings embedded in rehabilitation. We noted how scripts interwove with bodies, shaping gestures and behaviors and operating to curtail possibilities for spontaneity, risk taking, creativity and flexibility. Scripts acted as more than guides, they were embodied in the everyday work of both practitioners and patients, and tended to reinforce rather than reimagine particular subject positions and approaches to care.
including requirements for PERSON-CENTERED CARE, can be done for their own sake and paradoxically work for care to be mostly “transactional” and essentially devoid of the “personal” – or what actually makes it person-centered.

The measures, goals and other ‘person-centred tools’ act as possible mechanisms for enacting PERSON-CENTERED CARE or not.

Not everyone, even experts, agree on what is “good” and “bad” PERSON-CENTERED CARE practice for each context and occasion.

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<th>The event however unfolds as a checklist approach to what may be profound issues for Irene: anxiety, mobility, living well.</th>
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<td>Even when patients directly identify “their” goals, the goal is never a simple or direct representation of their wants and preferences. Rather, the goal is produced in the event in relation to how questions are framed, previous interactions, what each actor presumes is possible, what patients think practitioners want to hear, what lines of discussion are encouraged or discouraged, etc.</td>
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<td>The text suggested that her clinical service required her to complete outcome measures, record and assess goals, and presumably carry a full caseload. No doubt, the service instigated these practices to improve care, through standardization, creating reliable “objective” evidence, and to ensure care was person-centered. Paradoxically, however, the patient and practitioner as persons became lost in the processes, and instead what was made to matter was the completion of the measures and goals for their own sake. Thus, in this encounter, practice was “transactional” and largely devoid of the personal [30].</td>
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“Benevolent” manipulations, apart from (harsh) coercion, can be part of PERSON-CENTERED CARE. Exploring the reasons behind a dissent and determining if they can be addressed may be, in many cases, a defensible approach to negotiating a possible compromise.

Persuasion takes many forms including empathy, listening and encouragement, and does not need to be intentionally aimed at (only) compliance or engagement, even though

The measures and goals act as possible mechanisms for enacting PERSON-CENTERED CARE or not, and can also be set aside even when protocols “require” their use. Not only care practices, but persons and personhood materialize by what is possible at this time, within this timeframe, in the context of this service, and within these persons’ perceptions of possibilities. PERSON-CENTERED CARE is thus inevitably an act of micro-translation that extends beyond an isolated consideration of the interpersonal, the institutional, or the socio-structural. PERSON-CENTERED CARE emerges through the entangling of the multiple in particular times and places.

Coercion is associated with hard versions of paternalism and is intended to override personal autonomy to protect an individual from harm. Persuasion (and education) are consistent with softer forms, intended to help individuals make choices that practitioners view as better or best. The language is different, but in practice, these distinctions are harder to make [36]. Well-meaning efforts to educate are risky in that they are often also, with or without intentionality, acts of manipulation oriented to securing compliance. Well-meaning, so we call them “benevolent” manipulations.
it may get there (secondarily).

Temper the persuasion with humility – and it requires tinkering: diligent reflection and uncertainty (i.e. one ‘defensible’ approach may not fit all. Key is ascertaining if, when and how to convey this flexibility.

If persuasion is part of PERSON-CENTERED CARE, it entail knowing how and when to push, and when to ease off. This soft paternalism may have place if for the sake of the person’s truly own goals and motivations.

The practitioners’ assuredness and impatience felt misguided, made us uncomfortable, and we easily agreed was not how we understood PERSON-CENTERED CARE.

Care encounters thus materialize the subjectivities of all involved in ways that might be intended or not, welcomed or not. Said differently, PERSON-CENTERED CARE and other practices shape the personhood of all persons in the encounter, not only the “patient” [2,30].

As a team, we discussed that AnnaRN’s approach felt more like PERSON-CENTERED CARE, but was still nevertheless an attempt to persuade, to manipulate benevolently. Both practitioners repeatedly sidestepped James’ stated refusals. Whether or not this approach is consistent with PERSON-CENTERED CARE is debatable. Exploring the reasons behind a dissent and determining if they can be addressed may be, in many cases, a defensible approach to negotiating a possible compromise.
| PERSON-CENTERED CARE is risky/uncertain, subject to failure, and has to be continuously adapted in the moment. Professionals should not fully trust themselves, i.e., trust they know, trust they are right, trust they don’t need to change or adapt own views as times goes by and circumstances change. Tinkering refers to a flexible approach to care that adapts to the situation at hand. Involves a delicate balance between pushing and releasing. | The encounter suggested to us that PERSON-CENTERED CARE is risky, subject to failure, and has to be continuously adapted in the moment. The ongoing challenge for practitioners might be understood as a question of how to temper persuasion (“This will make the patient’s life better and they will thank me. I know, I am an expert”), with humility (“I only know so much, need to apply it to this person’s situation, and there may be another way of thinking/doing in this case”). Such an approach requires diligent reflection, uncertainty and, as we discuss below, “tinkering”. Such an approach requires diligent reflection, uncertainty and, as we discuss below, “tinkering”. It means recognizing one might not be right, or that an approach that works in some situations may not work in others, and ascertaining if, when and how to convey this flexibility to the recipients of care. Broadly speaking, tinkering refers to a flexible approach to care that adapts to the situation at hand. |
Uncertainty, humility, doubt in one's expertise, and risking failure are inherent to tinkering which involves a continual questioning of what to do, what is best, and what is PERSON-CENTERED CARE within each context.

Being attentive to and interpreting person's responses, including bodily, emotional, etc, to adapt further action accordingly, while with an eye on everyone's safety at the same time. A dance, in which one part responds to another.

Interpreting Tony's anxiety from bodily and verbal gestures, and modifying her approach in response to his anxiety (from motivating to soothing).

Persuasion takes many forms including empathy, listening and encouragement, and does not need to be intentionally aimed at (only) compliance. Compliance may be produced nevertheless.

If persuasion can be conceived of as consistent with PERSON-CENTERED CARE, then it is expressed at least in part through “knowing” when to push, how to push, and when to ease off. PERSON-CENTERED CARE as tinkering is a dance in which each partner responds to the other.

We might say that these forms of soft paternalism are justified when they serve a patient's goals. The risk is that patients may not still/want
| Co-production: the person undergoing care is not merely objectified as a body that needs treatment, but neither was he an autonomous subject making free choices and fully taking care routes completely on his/her own. Extraordinary PERSON-CENTERED CARE can occur at very ordinary actions and interactions. It is nothing grand but rather, infinitely small, nimble, and cumulative through micro-acts of care. | the same goal, want a break, may not want this particular intervention, may not immediately know what they want, and/or may change their minds. We might thus suggest that the person-centered practitioner approaches tinkering by reading the body, responding to the situations, listening to others, interpreting expressions of doubt, and all the while keeping an eye on everyone’s safety. Gareth, who is not a clinician and had not previously observed such an encounter, was moved by the intensity of this event. (…) Gareth’s reaction helped us to remember that quotidian practices are extraordinary in their ordinariness, that good care happens all the time. We all agreed that there was a lot going on in this encounter. Three bodies, equipment, expectations, endpoints, and emotions came together to produce standing (and anxiety, and soothing, and learning, and PERSON-CENTERED CARE). She sensed, without asking, that a limit had been reached. To ask more of Tony would have been to “lose” him. |
Tinkering in the event was thus pushing and releasing in a delicate balance.

PERSON-CENTERED CARE was co-produced within care events. Tony was not merely objectified as a body that needed to stand, but neither was he an autonomous subject making free choices.

What we all agree on, however, is that PERSON-CENTERED CARE is mostly nothing grand but rather, infinitely small, nimble, and cumulative through micro-acts of care.

In some of our team’s initial conversations, the notion of the importance of establishing and maintaining trust emerged as crucial to PERSON-CENTERED CARE. However, we considered that PERSON-CENTERED CARE might be better served by professionals encouraging people not to trust them. That is, it is important to question each other, to question oneself, to question the scripts that state what one should do or what is “best” practice.

Enemark Larsen A, Rasmussen B, Christensen JR.

1

The therapists need true commitment with PERSON-CENTERED CARE, needs willingness to share power, The active participation of clients is an important aspect of rehabilitation quality as conceptualized in client-centred Practice (CCP). A recommended outcome measure for enhancing CCP is the Canadian Occupational Performance Measure (COPM).

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<th>needs communication skills such as active listening, and needs not to be undermined by a prevailing biomedical paradigm of service and care. The Canadian Occupational Performance Measure (COPM) is a tool recommended for enhancing PERSON-CENTERED CARE, and can do so under certain circumstances. Under those circumstances, its use can enhance client’s awareness of own need (i.e. self-perception/awareness), therapist knowledge of client’s perspectives hopes and a collaborative/</th>
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<td>The scoping review found that the use of the COPM seemed to enhance CCP and that certain conditions were necessary for the COPM interview to have this desired effect. The Use of the COPM Seemed to Enhance the clients’ awareness of their self-perceived needs (…) seemed to facilitate a process of self-awareness. The Use of the COPM Helped with Forming a Partnership and Making Collaborative Goals. Environmental and Therapeutic Factors Seemed to Affect If a COPM Interview Enhanced CCP. This review showed that the OTs’ commitments to CCP, their willingness and ability to share power with the client, and the environment in which the rehabilitation occurred were important factors determining whether the COPM interview would positively affect CCP. Environmental factors affected the possibility of conducting a COPM interview as the OTs were reluctant to perform a COPM interview if the focus was on physical functions, that is, in settings where a medical paradigm was dominant [15, 19–21].</td>
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The COPM Interview Requires Advanced Communication Skills. Effective communication skills appeared to be vital to the successful use of the COPM and the enhancement of CCP. Corresponding findings have been reported in other studies on CCP, which describe a focus on interviewing skills, for example, the ability to listen actively, communicate in an appropriate language, and share information that aligns with the clients’ needs [4–7, 20, 21, 38, 39].

The review found that the use of the COPM seems to enhance CCP, specifically by improving awareness of client perspectives, wishes and hopes for the future, thereby reinforcing a partnership with collaborative goalsetting. However, to use the COPM interview to enhance CCP, professional communication skills, power sharing, and an institutional commitment are required.

| Devan H, Hale L, Hempel D, Saipe B, Perry MA. What Works and Does Not Work in a Self-Management | 1 | Shared decision making and guided problem-solving, to improve self-efficacy and facilitate self-management of chronic condition. | As person-centered communication forms an integral aspect of Person-centered care and shared decision making, our review findings indicate the need for better communication across all stakeholders (ie, patients, clinicians, family, and friends) to positively support self-efficacy of self-management strategies.79 |
| Prescott S, Fleming J, Doig E. Goal setting approaches and principles used in rehabilitation for people | Collaboration tied to but not synonymous with PC (person-centeredness) – even though the process can | Client-centredness and collaboration featured as the most frequent principles that underpin goal setting approaches (…). Although collaboration appears to be synonymous with client-centred goal setting approaches, it should be noted that goal setting approaches can be collaborative, but the resultant goals may not be client-centred, |
| --- | Communication skills: empathic understanding, acknowledgement and reassurance | For clinicians, upskilling person-centered practice and communication skills should be encouraged. Clinicians need to acknowledge the patient's chronic efforts to manage symptoms, some of which might be erratic, and recognize the extraordinary struggle required for ongoing control. This acknowledgement and empathy will help to foster trust and deepen the therapeutic alliance. Shared decision making to elicit patient preferences, beliefs, and attitudes as well as discussing the risks and benefits of proposed treatment plans. 81,82 Decision aids 83 would be worthwhile given the promising evidence to support person-centered communication, patient satisfaction, and improved health outcomes. 84 Clinicians involved in the management of chronic pain need to be cognizant of the importance of person-centeredness by means of shared decision making and guided problem solving to facilitate ongoing self-management. |
be collaborative, resultant goals may not be PC.  
PC goal setting targets motivation and goal-directed behavior.

Families often consulted, especially when significant cognitive and communication impairments are present (difficult to implement PC goal-setting) – yet, matter to clinical judgement in whether it facilitates or hinders the process for the client. Further approaches to engage patients with these difficulties are needed.

that is, not relevant to or important to the client (…) when examining studies that specifically compared client-centred, collaborative goal setting with traditional goal setting approaches, results are inconclusive in terms of effectiveness.

Effective client-centred goal setting may also be enhanced by the adoption of approaches which target increased motivation to achieve goals and the development of independent goal-directed behaviour.

Families are often consulted to enhance the goal setting process, to gain an understanding of client values when significant cognitive and communication impairments are present, to enable the client to feel supported and to facilitate the delivery of education regarding the rehabilitation process [31, 32, 37, 51].(…) A therapist must, therefore, employ clinical judgement to determine whether family involvement will either facilitate or inhibit the goal setting process for the individual client.

Similar to previous reviews, this review found that therapists report that client-centred goal setting can be difficult to implement especially when cognitive and communication impairments are present, such as impaired self-awareness and impaired memory [34, 36, 37, 46, 51]. Another barrier related to the feasibility of a client-centred approach is
| Njelesani J, Teachman G, Durocher E, Hamdani Y, Phelan SK. Thinking critically about client-centred practice | Time taken to plan goals is an implementation barrier. Philosophical shifts, increased time in terms of training and organizational change to move from traditional treatment approaches towards approaches that enable increased client involvement are needed | the amount of time taken to plan goals [34]. (...) Implementation of a client-centred approach in the clinical setting may involve philosophical shifts, increased time in terms of training and organizational change to move from traditional treatment approaches towards approaches that enable increased client involvement.

None of the included evaluation studies that used client-centred goal setting methods set out to determine the extent to which the approach was client-centred. In order to evaluate client-centred goal setting, tools which allow one to measure the client-centred-ness of goals are needed (...) Furthermore, given the reported challenges (i.e. cognitive impairment, impaired self-awareness and communication impairment) for implementing client-centred goal setting with people with ABI in clinical practice, further studies are required to explore the strategies or techniques which facilitate client-centred goal setting in this population. | Opening up discussions with patients and their families regarding the positive value unreflexive pursuit of “normal” occupations, which are value-laden with judgments and social expectations for becoming or being an independent, self-sufficient, and productive person, may draw attention away from our pursuit of being client-centred. Being cognizant of the ways that normalization of occupational possibilities... |

| Critical reflexivity can help therapists, together with clients, embrace individual differences and envision possibilities for occupations that would be missed altogether in the pursuit of "normal". Providing opportunities for dialogue with clients to reflect on and consider a range of occupational possibilities is an important first step in this process. |
|---|---|
| may influence our clients and ourselves through critical reflexivity is one step towards critically reflexive client-centred practice. We suggest ways that client-centred practice might include roles for occupational therapists to take a lead in opening up discussions with clients about a wide range of occupations and encouraging a more open mind about occupations that may be possible and feasible. (…)perspectives are highly influenced by social values and beliefs about what occupations are “normal” and socially expected. This in turn influences what is considered “meaningful”. There is a risk that client-centred practice is simplified and conflated by the belief that if clients participate in goal-setting, then the outcomes will likely be more achievable and meaningful. Little attention has been paid to how terms such as “meaningful” are interpreted, or how certain occupations have come to be “meaningful” for individuals. This approach may involve giving more consideration to how occupational therapists can work to consider clients’ unique sets of needs, capabilities, and resources (i.e. being client-centred) to enable them to consider and try out alternative occupational possibilities in all categories of occupation throughout the life span. Providing opportunities for dialogue with clients to reflect on and consider a |
‘Only’ participation in goal setting, without critical reflection and opportunities for dialogue, does not grant that goals and outcomes to be truly meaningful.

There is a risk that client-centred practice is simplified and conflated by the belief that if clients participate in goal-setting, then the outcomes will likely be more achievable and meaningful. Little attention has been paid to how terms such as “meaningful” are interpreted, or how certain occupations have come to range of occupational possibilities is an important first step in this process.

We suggest that engaging in critical reflexivity can help therapists, together with clients, embrace individual differences and envision possibilities for occupations that would be missed altogether in the pursuit of “normal”. Being client-centred involves opening up discussion with clients and their families regarding the positive value of alternative occupational possibilities that are available in the world. Opening up such spaces for discussion with clients will not only enhance our client-centred practice but also the participation of clients in their communities.
| Page | Nguyen T, Baptiste S. Innovative practice: exploring acculturation theory to advance rehabilitation from pediatric to adult "cultures" of care. Disability and rehabilitation. 2015;37(5):456-463 | 1 | Thus acculturation theory can facilitate culturally competent care by examining multiple aspects of a patients’ transition experience beyond their medical condition, within an acculturation reasoning. Acculturation theory can provide insight into how patients are experiencing a change in environments, which can in turn inform client-centred practice. Acculturation theory can help clinicians become more client-centred by embracing partnership, reinforcing clearly the expertise of the patient and family in understanding and translating the complexities of their own lives and the need for understanding the options for care and services that exist to enable them to make educated decisions and choices. Thus acculturation theory can facilitate culturally competent care by encouraging professionals to examine multiple aspects of a patients’ transition experience beyond their medical condition. Acculturation process as the cultural, psycho- logical, and behavioural changes that individuals experience when they make the transition into a new culture. |
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| 1 | Engagement is co-constructed and accounts for a relational process in the therapeutic dyad, not solely the patient. |

| 2 | Conceptualizing engagement as a co-constructed process may help clinicians be more aware of their role in patient engagement and sees the responsibility to engage shift from the patient to the therapeutic dyad. |

| 3 | Engagement includes a relational process. |

| 4 | Our review suggests engagement to be multi-dimensional, comprising both a co-constructed process and a patient state. While engagement is commonly considered a patient behavior, the review findings suggest clinicians play a pivotal role in patient engagement. |

| 5 | Conceptualizing engagement as a co-constructed process may help clinicians be more aware of their role in patient engagement and sees the responsibility to engage shift from the patient to the therapeutic dyad. |

| 6 | Engagement includes a relational process. |

| 7 | The patient may move toward a state of engagement, but they may at times also move away from this state[43] (...). Viewing engagement as a process, not just a static behavior, could challenge how clinicians view and work with the so-called “disengaged” patient. Disengagement (or failure to engage) is commonly portrayed as a patient “problem” and responsibility. This ignores the role of the healthcare provider, therapeutic process or environment in disengagement[62]. |
| Whalley Hammell KR. | 1 | Viewing engagement as a process and asking, “how can we facilitate engagement?” may promote a more reflective, relational approach to working with such patients. It raises the possibility that “full” engagement (incorporating collaboration, contribution, active participation and emotional investment) could be seen as the desired endpoint. |

| | | Critical thinking enables occupational therapists to reflect on their own inequitable access to privilege and power, and reduces the potential for the profession to re-inscribe dominant ideologies that devalue disabled people and justify their inequitable opportunities. Because critical thinking demands a readiness to restructure one’s thinking, and decreases the risk of acting on faulty assumptions, it is an essential component of client-centred practice. Critical thinking is an intellectually engaged process of thinking about thinking: of examining assumptions and beliefs and the taken-for-granted knowledge that is assumed to be – or that one holds to be – “true”. |

| Client-centred occupational therapy: the importance of critical perspectives. Scandinavian journal of occupational therapy. 2015;22(4):237-243 | PC requires critical thinking not to act on faulty assumptions and to have notions of inequitable access to privilege and power. Because critical thinking demands a readiness to restructure one’s thinking, and decreases the risk of acting on faulty assumptions, it is an essential component of client-centred practice. |
|---|
| 1 | Common elements: respect for values, beliefs, experience and contexts; collaboration and shared decision-making; open communication and information sharing; Support for self-management; Inclusion of family. |
| | Other components: Access to care; coordination of care across time and settings. Hope and understanding of what is possible. |
| | One element that client centeredness may add to patient-centered care is the notion of hope and belief in possibilities; occupational therapy’s concept of understanding what is possible is not an explicit part of patient-centered care. (…)how to acknowledge and address the hopes of patients and their loved ones (…)For example, in rehabilitation, patients often have to reconcile the incompatibility of their physical or mental capacity with their perceptions of themselves in the past or in the future (Wood, Connelly, & Maly, 2010). As they explore new roles and possibilities, hope may promote optimum achievement (…)methods build on and are steeped in hope for “living life to its fullest.” |
| Common elements: respect for values, beliefs, experience and contexts; collaboration and shared decision-making; open communication and information sharing; Support for self-management; Inclusion of family. |
| Shared decision-making |
| Inclusion of family |
| Access to care and coordination |
| Exploring and driving Hope, inclusively by new roles and possibilities. |
| Need to work on aligning physical and mental (in)capacities with perceived self, of the past and future. |
| Need for PC to be shared across professions, for |
example fostered through inter-professional education.

The occupational therapy profession must explore the most effective methods to train future practitioners not only in how to practice client-centered occupational therapy but also in how to work on interprofessional teams that promote patient-centered care. Because emphasis on completing certain aspects of training outside of practice silos is becoming more common in health care education, and because patient centeredness cuts across professions, interprofessional training in patient-centered practice is a possible future direction for occupational therapy education.


1  PERSON-CENTERED CARE happens not only when the therapist has values and competency for a PERSON-CENTERED CARE practice but also when the context of health system is aligned with that philosophy.

The natural environment of the patient allows for PERSON-CENTERED CARE. The values of respect, autonomy, choice, and control appear to be the basis for CCP.

The client is viewed from a strengths perspective and as an active participant in the therapy process.

The therapist collaborates, facilitates, enables, and negotiates with the client to guide the therapy process in general. In order to bring the client into the decision-making process the therapists share information, power and responsibility for therapy with the clients (8-10).

Enacting CCP depends on the therapist embodying the values, philosophy, and attributes of CCP and the client’s ability and willingness to collaborate in the therapy process. It also hinges on the
CARE, more than unfamiliar healthcare settings.
Client-centred practice is best embodied by occupation-focused interventions in the natural environment of everyday living.
Person-centered as strength-based, collaborative and respectful practice which enables choice, autonomy and control
congruence of the philosophy (with) those of the context and systems of health services.

It may be simplistic to think that practice is either client-centered or not and perhaps envisioning CCP along a continuum is more appropriate.
Client-centred practice is best embodied by occupation-focused interventions in the natural environment of everyday living. Providing services that are impairment-focused in unfamiliar settings is not a good fit for client-centred practice.

| Jesus TS, Hoenig H. Postacute rehabilitation quality of care: toward a shared conceptual framework. Archives of physical medicine and | 1 | Responsive to needs, values, perspectives, or personal factors of each person. Pertinent relatives included. | the rehabilitation process needs to be patient centric (eg, responsive to needs, values, perspectives, or personal factors of each patient),1,74 and (3) quality metrics need to cover the whole continuum of patient care. When we refer to patients and patient centeredness in the PAC-rehab quality framework, it should be extended to include pertinent family/caregivers. |
In addition, patients have active roles in rehabilitation quality of care. Patients are coproducers of their own rehabilitation process and outcomes (eg, through an active involvement into care decisions, engagement with care activities), a role which can be fostered by providers (eg, through shared decision-making, training on self-management). Second, patients can be actively involved in quality measurement and improvement activities, or even in developing the underlying rehabilitation evidence both by participating in research studies and helping to guide the studies themselves (eg, see the Patient Centered Outcomes Research Institute at www.pcori.org). Increasingly, patients are engaged in the development of outcomes measures, new intervention models, shaping mechanisms for the public-reporting of quality information, reporting on gaps in quality of care, defining the aspects of health care they value the most, and participating in quality improvement committees.

| Fleming-Castaldy RP. A macro perspective for client-centred practice in curricula: Critique | Beyond the client–therapist dyad to consider the larger (macro) practice setting and societal influences that have | A macro perspective for client-centred practice inclusive of disability rights and social justice is required. |
move beyond the client–therapist dyad to consider the larger practice setting and societal influences that have an impact on client-centred practice.

Learning activities to foster the development of a macro perspective for client-centred practice (…) below I share select exemplars from the literature and my teaching methods.


Encourages: 1) Shared control and decision-making – entails involvement and partnership; 2) consideration of the patient as a whole person and individual preferences within social contexts.

Complex cases: disagreement about the acceptable levels of risk and discharge plans for patients after traumatic brain injury

Being patient centered, the model encourages (1) shared control of consultations, decisions about interventions, and management of the health problems with the patient and (2) understanding the patient as a whole person who has individual preferences situated within social contexts.

Common sources of ethical challenge relating to negotiation of expectations; goals and roles between clinicians, patients, and families; and issues of risk and capacity.

Complex cases including situations involving challenging family relationships compounded by disagreement about the acceptable levels of risk and discharge plans for patients after traumatic brain injury that involved the potential of harm for the self and others"... "the
that involved the potential of harm for the self and others compounded by challenging family relationships.

Jargon free and simple language as much as possible.

Neutral perspective on who the users are. However, with attention to inappropriately imposing healthcare provider or family views over that of the patient.

Process outlined in an ethics analysis model can be used in team meetings (... and) incorporated in family meetings to guide shared decision making.

Patient-centered care has influenced the PCEAM-R in at least three ways. Questions and prompts included in the model (1) emphasize a shared involvement (partnership) of patients and health professionals in managing patients’ health care; (2) imply an understanding of the patient as a whole person and social being, embedded in a range of relationships of care and interdependence, and having preferences that are informed by his/ her social context; and (3) were written (as much as the authors were able) with jargon-free, simple language that takes a neutral perspective on who the users of the model are (perhaps the patient, the health professional[s], or both).

These influences of patient-centered care may be particularly relevant in a rehabilitation context, in which patients transition between community and institutional contexts and in which relationships of caregiving are often long-term and include both professional and informal carers.
| Hammell KR. Client-centred occupational therapy in Canada: refocusing on core values. Canadian journal of occupational therapy Revue canadienne d'ergotherapie. 2013;80(3):141-149 | 1 | Core philosophy of respect for clients (i.e. treat clients with respect and who make them feel listened to, cared for, and valued) — over and beyond enabling skills. Respect for: clients, their strengths, experience, knowledge, moral right to make choices for their lives. Fostering respectful, supportive relationships. | Striving for consensus is consistent with the patient-centered care approach and includes attention to inappropriately imposing healthcare provider or family views over that of the patient. |

| Hammell KR. Client-centred practice in occupational therapy: critical reflections. | 1 | Egalitarian principle – reducing power inequalities. Enabling and strengths-based approach, not | Client-centred practice is fundamentally about respect—for clients; for their strengths, experience, and knowledge; for their moral right to make choices concerning their lives—and about fostering respectful, supportive relationships with clients.

The Canadian occupational therapy profession has amended its definition of client-centred practice to focus on therapists' enabling skills rather than on a philosophy of respect for clients. Evidence suggests that clients value occupational therapists who treat them with respect and who make them feel listened to, cared for, and valued. Client-centred practice is characterized as being egalitarian and undertaken by therapists who strive to reduce power inequalities, who listen to clients, help clients to make choices and decisions about their lives, who are neither authoritarian nor judgemental, do not tell their
<p>| Scandinavian journal of occupational therapy. 2013;20(3):174-181 | prescriptive, tailored to personal circumstances and values, and respectful of personhood and client choice. Services accessible and fit the context which the person lives. More rhetoric than reality clients what to do, and who work on behalf of, for, and with clients towards those goals that are of importance to clients such that interventions are responsive to individuals rather than their “conditions” (17,18,21,22,24,26,27). Client-centred practice recognizes the autonomy of individuals, the need for client choice in making decisions (…), the strengths clients (…)ensure that services are accessible and fit the context in which a client lives.[(5),p.253] Evidence suggests that the profession does not adhere consistently to its espoused client-centred ethic in all its practices and that the concept of client-centred practice in occupational therapy ought to be subjected to considerable critical reflection. |
| Papadimitriou C, Carpenter C. Client-centered practice in spinal cord injury rehabilitation: a field guide. CARF, 2013. | Requires Reflective Practice, including relationship with client; Acknowledge persons' strengths, abilities and see them as experts in living with a disability, and try to To achieve client-centeredness in practice we recommend: Consistently engage in reflecting on your practice; Acknowledge client experiences and knowledges of their abilities as expertise; Be determined and think out of the box; Develop self-care strategies to avoid burnout; |</p>
<table>
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<tr>
<th>Ward CD. Is patient-centred care a good thing? <em>Clinical</em></th>
<th>1</th>
<th>Rehabilitation would integrate 'carers' within rehabilitation's ethical and therapeutic system by</th>
<th>If disablement is not to be seen as the problem of one individual then problems in rehabilitation must be 'owned' not solely by a single patient but also by other people implicated in a situation. It follows that</th>
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<td>understand/learn from that and related narratives. Openness, mindfulness (e.g. to think out of the box Communication skills. Active strategies to avoid burnout Team collaboration and expand work even to beyond professional boundaries and work environment – in advocating for and developing peer-support systems</td>
<td>Collaborate with other rehabilitation disciplines to meet the needs of your client. Actively engage patient advocates and develop peer-support systems.</td>
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<td>rehabilitation. 2012;26(1):3-9.</td>
<td>'patient-centred care', where a professional directs assessments and interventions towards one person, has shortcomings in rehabilitation. A human systems model, shifting the focus of rehabilitation towards relationships, enables rehabilitation problems to be seen as provisional and context-dependent. Rehabilitation practitioners (...) would integrate 'carers' within rehabilitation's ethical and therapeutic system. By adopting a relational or systemic approach rather than an individually focused one, rehabilitation practitioners would be better able to understand and respond to clients in their ecological contexts. Significant persons such as carers and family members would no longer be regarded merely as concerned bystanders but as integral parts of the complex ethical and therapeutic systems on which good rehabilitation outcomes depend. Only a minority (of people) appear to have chosen to exclude others from their quests for self-determination. Early perceptions of multiple sclerosis were cocreated, so the articulation of future problems will continue to have a relational context.</td>
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<td>adopting a relational or systemic approach rather than an individually focused one. Rehabilitation practitioners would be better able to understand and respond to clients in their ecological contexts. Significant persons such as carers and family members would no longer be regarded merely as concerned bystanders but as integral part of the rehabilitation process and outcomes.</td>
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| Phelan SK.  
Constructions of disability: a call for critical reflexivity in occupational therapy.  
Canadian journal of occupational therapy  
Revue canadienne d'ergotherapie.  
2011;78(3):164-172 | 1 | PERSON-CENTERED CARE needs to expand beyond a focus on the individual and that considers broader social structures | As a profession, perhaps it is time to rethink and elaborate our understandings of client-centred practice in a way that expands beyond a focus on the individual and that considers broader social structures. |

Seminars in speech and language.  
2010;31(2):81-89 | 1 | Genuine compassion – open hearts and minds, which can expose to personal vulnerabilities.  
Known principles, from Mead and Bower, applied: A biopsychosocial perspective; The client as a person; Shared power and responsibility; A therapeutic | Really listening to our clients, really understanding what it is like for people to live with a communication disability, and being willing to step into their lives with genuine compassion require that we open our hearts as well as our minds. But it exposes us to our own vulnerabilities and needs as well.  
Mead and Bower's five dimensions:  
A biopsychosocial perspective; The client as a person; Shared power and responsibility; A therapeutic alliance; Recognizing the clinician as a person |

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<th>Table 1</th>
<th>Domains of client-centred rehabilitation at client and organisational level</th>
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<td>1</td>
<td>Domains at client level:</td>
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<td>Client participation in decision-making and goal-setting</td>
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<td></td>
<td>Client-centred education (information is timely and appropriate)</td>
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<td></td>
<td>Evaluation of outcomes from the client’s perspective, not just from the perspective of the rehabilitation professionals</td>
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<td>Family involvement and support</td>
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<td></td>
<td>Coordination and continuity of care (clients often feel isolated and abandoned after discharge from rehabilitation)</td>
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Domains of client-centred rehabilitation are at the client and organisational level.

Client: has information, participate in decision-making, outcomes evaluated from the client’s perspective, family involvement and support, care continuity, emotional support – listened and treated with respect; physical comfort.

Organization: client involved in service planning; programmes are evaluated from the clients’ perspective and organizations respond to

alliance; Recognizing the clinician as a person
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<th>Client’s feedback; Access; Interdisciplinary and coordination also with other services; organizational support for client-centered care</th>
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<td>Staff roles that facilitate client-centered care: such as “contact person” designated patient advocate/ombudsman, or designated staff who addresses equity issues.</td>
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<td>Measurement needs to occur for QI purposes.</td>
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<tr>
<td>Measures of client centredness at both client and organisational as part of a province-wide quality improvement</td>
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<tr>
<th>Emotional support (clients feel they are being listened to and treated with respect and dignity)</th>
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<tr>
<td>Physical comfort (recognition and management of pain)</td>
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<tr>
<td>Domains at organisational level</td>
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<tr>
<td>Client involvement in service planning</td>
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<td>Evaluation of the programmes and services from the clients’ perspective</td>
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<td>Organisational response to client feedback</td>
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<td>Accessibility</td>
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<td>Interdisciplinary approach</td>
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<tr>
<td>Coordination and continuity with community services</td>
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<tr>
<td>Organisational support for client-centred care</td>
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</tbody>
</table>
The existence of specific staff roles that facilitate client-centred care (e.g. patient advocate/ombudsman, designated contact person assigned to each client and family, or designated staff who addresses equity issues).

It is important for organisations to utilise measures of client centredness that can be used for discriminative and evaluative purposes so that quality of care can be monitored within and between programmes.

In Ontario, measures of client centredness at both client and organisational level have been developed and are being used as part of a province-wide quality improvement initiative.

<p>| MacLeod R, McPherson KM. Care and compassion: part of person-centred rehabilitation, inappropriate response or a forgotten art? | PC requires a compassionate perspective: active regard for another’s welfare and deep understanding of the person’s misfortune or suffering. | Compassionate perspective is what could guide truly person-centred, empathetic and collaborative care. The virtue of compassion is a trait combining an attitude of active regard for another’s welfare with an imaginative awareness and emotional response of deep understanding, tenderness and discomfort at the other person’s misfortune or suffering. It is expressed in acts of |</p>
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<tr>
<th>Leplege A, Gzil F, Cammelli M, Lefeve C, Pachoud B, Ville I.</th>
<th>Individualized, flexible and adjustable approach, not one-fits-all: different persons, different ‘disabilities’, different rehabilitation. Recognition of emotional needs and emotional support provision for the specific person-centredness means addressing the person’s specific and holistic properties: One should understand the uniqueness of people as opposed to: (i) The assumption that all people with one kind of disability will automatically have similar needs (…). A person-centred approach is an individualized, tailored approach and not a routine or standardized group approach (…). it is necessary to have some flexibility and the capacity to adjust to their changing needs rather than a systemic adherence to a rigid policy. In that sense, person-centredness means:</th>
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<tr>
<td>This can entail transforming person-centredness into relationship-centredness Notion of personhood.</td>
<td>beneficence that attempt to prevent and alleviate the suffering of the other person [29]. Indeed, some have suggested that rather than using the term person-centred, we should focus on relationship-centredness [49]. The very title ‘person-centred rehabilitation’ can at times seem to be a sound-bite or catch phrase, but more appropriately is a reminder that at the centre of everything we do is a person: someone who is a member of a family that sits somewhere within a community and all of those people will always be impacted on by the presence of illness or disability.</td>
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<td>Context, history and experience of that person.</td>
<td>To tailor interventions for specific individual and evolving needs versus ‘one size fits all’ programs.</td>
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<td>It is important to register the interdependence between the person and his or her friends and family, to understand the importance of peer support, to provide family members with emotional support, to give them information about the client’s condition and treatment, to offer ongoing help with care giving; and to involve families in goal setting and decision-making.</td>
<td>One should see disability through the person’s eyes, recognise emotional needs and concerns, and learn how to manage and deal with the emotional challenges related to a chronic condition. Furthermore, people with impairment do not all react to their impairment or to interventions in the same way. Thus, one should listen to the person with empathy, pay attention to the person’s thoughts and enter into the person’s world (…) person-centredness means that the individual’s subjective experience, personal history and emotions should all be taken into account (versus relying solely on objective data).</td>
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<td>Addressing issues of everyday life that matter to people.</td>
<td>Lastly: Individuals are social beings. Therefore, the entire context of the rehabilitation process and the person’s unique environment must be taken into account: so it is important then to register the interdependence between the person and his or her friends and family, to understand the importance of peer support, to provide family members with emotional support, to give them information about the client’s condition and treatment, to offer ongoing help with care giving; and to involve families in goal setting and decision-making (…).</td>
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Active participants in the rehabilitation process (versus objects of care).

Interventions should have a subjectively perceived significance: person is an expert in him/her-self: recognition of the person-hood of disabled people.

PERSON-CENTERED CARE is anti-reductionist: it is the opposite of: Too uniform; too analytical; too theoretical; too negative; and too directive. It is a multi-dimensional concept

Strengths-based approach approach, without pity, condescension or stigma

| person-centredness means: to adopt an ecological view as opposed to the more focused point of view of a clinical caregiver.
Person-centredness means addressing the person’s difficulties in everyday life:
Person-centredness surely means that interventions should focus on daily-living activities and address real-life difficulties.(
Person-centredness means that interventions should first and foremost reflect the person’s needs (versus third party interests).(
Person-centredness signifies acknowledging the environmental origin of difficulties (versus stigmatizing the persons).
Person-centredness means the person as an expert: Participation and empowerment
Person-centredness means: Disabled persons should be active participants in the rehabilitation process (versus objects of care).(
Person-centredness signifies improving participation in social relationships, home life, education, work and economic life (versus only addressing impairments and activity limitations) (...)
Person-centredness means that: Interventions should have a subjectively perceived significance and be evaluated by appropriate instruments (i.e., meaningful and relevant to the client) versus |

|
outcomes based on measures of isolated impairments and disabilities. In this sense, person-centredness means: respect of patients’ values, preferences and expressed needs (versus paternalism).

Disabled persons are experts about their own situation and needs. At the heart of this conceptual definition is recognition of the person-hood of disabled people.

Person-centredness means respect the person ‘behind’ the impairment or the disease:

Disabled persons are sometimes regarded with pity or condescension and even stigmatized. It is therefore important to remind ourselves that disability is a ‘normal’ part of life. People often possess strengths and capabilities person-centredness means the need for a more positive perspective from disability to abilities and from handicaps to participation (versus defectology).

From a general standpoint, the notion of person-centredness represents anti-reductionism. (…) it criticizes an approach towards disability and disabled persons, which tends to be: Too uniform; too analytical; too theoretical; too negative; and too directive.
Thus, person-centredness encompasses multiple meanings that cannot be summed up under one notion. In other words, it is a multi-dimensional concept.

Not only does person-centredness cover different ideas but each of the ideas it expresses can give rise to a large variety of interpretations. No consensus can be found, whether about its meaning or about its implication.

| Gzil F, Lefeve C, Cammelli M, Pachoud B, Ravaud JF, Leplege A. Why is rehabilitation not yet fully person-centred and should it be more person-centred? Disability and rehabilitation. 2007;29(20-21):1616-1624 | 1 | Analyse person-centered rehabilitation within the paradigms that gave origin to the concept, and analysis of the pros and cons (e.g. issue of autonomy not fully within reach) of the application of person-centered to rehabilitation. Need to find common ground: the highest possible level of autonomy may be the personal goal of many | Client-centred rehabilitation encompasses much more than goal-setting and decision-making between individual clients and professionals’ [2, p. 1411]. (See also Cott et al. [24] in this issue.) Is person-centredness really, as usually constructed, the way forward for rehabilitation? The response to this question is far from being obvious. Person-centredness has undoubtedly helped rehabilitation to improve in moving towards more of a strengths based approach, but is it the response required to address the difficulties rehabilitation currently encounters? For rehabilitation, person-centredness may be as much a problem as it is a solution. |
patients, but it cannot be the ultimate goal of the rehabilitation process which takes place in a rehabilitation setting because of the many components and aspects of autonomy that are out of reach of professional intervention.

Speaks of PERSON-CENTERED CARE as a strengths based approach.

Person-centredness thus generated practices that are more respectful of individuals’ needs, particularities and preferences.

From an ethical point of view, person-centredness allowed rehabilitation to acknowledge that disabled persons are full fledged citizens and persons, that they not only have needs but also thoughts, emotions and that even though they come across difficulties, they possess a certain quantity of abilities. Person-centredness thus generated practices that are more respectful of individuals’ needs, particularities and preferences. It facilitated disabled persons’ voice to be heard, their expertise and competence to be acknowledged.

From a technical and pragmatic point of view, person-centredness made it possible to break with the medical discourse monopoly on disability and allowed to acknowledge there was a time for care, which was distinct from the time for medicine. It also allowed acknowledging that individuals were not isolated, that they are social beings who need the presence of people around them, people who must be trained and informed about their needs. Person-centredness also enhanced professional acknowledgement that disabled persons were individuals (and individuals who were different from one another) whose needs and strengths were variable in time. Therefore, person-centredness probably led (or may lead) to improvement in intervention effectiveness/efficiency.
…On the negative side… although in principle there should not be any contradiction between person-centredness and scientificity, in practice it is extremely difficult to reconcile person-centredness and traditional approaches to scientific rigour.”

Whilst the notion of person-centredness has an ancient pedigree, its application in rehabilitation raises a number of relatively poorly understood theoretical and practical issues. This becomes particularly manifest when we consider the notion of autonomy. Even though disabled persons have every right to self-determination (as does any individual who possesses an intact decisional competence), the specificities relevant to the disability situation must be taken into account. As observed by Catz et al. [18] ‘the highest possible level of autonomy may be the personal goal of many patients, but it cannot be the ultimate goal of the rehabilitation process which takes place in a rehabilitation setting’ because of the many components and aspects of autonomy that are out of reach of professional intervention.

The current concept of rehabilitation is at least as syncretic1 as the notion of person-centredness. It combines several paradigms belonging to chronic diseases and disability…. there is no
contradiction in principle between person-centredness and medicine, nor is there any between person-centredness and rehabilitation. Again, much depends on how we define person centredness.

In order to understand (and eventually to comply with) the injunction for ‘more person-centredness in rehabilitation, researchers seem to have hesitated between two interpretations. The first is that one of the ideas involved in the notion of person centredness has to be favoured and taken in the strongest sense of the term. The other is that ‘more person-centredness’ requires us to go past the apparent opposition between the different ideas implied by the notion of person centredness (See Leplege et al. [19] in this issue) and try to work out some kind of synthesis.


1 Service delivery as chronic disease management, with outcomes meaningful to clients. Need to pay attention to the transition from the non-disabled to the disabled self.

Models of rehabilitation service delivery need to move to a chronic disease management model that incorporates outcomes that are meaningful to clients, and not the assumed needs or outcomes as defined by rehabilitation professionals.

Little attention to the transition from the non-disabled to the disabled self.
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<td>Life narrative approach as an option in order to better understand each person’s experience. Meaning, importance, satisfaction, and choice have an impact on participation: the ICF does not attach notion of meaning.</td>
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<td>To deliver client-centered care, physiotherapists need to identify the patients' individual treatment goals. Iterative user-centered design was conducted in co-creation with the physiotherapists and patients, in three phases. Their needs and preferences were identified by means of group meetings and questionnaires. A theoretical goal-setting framework and elements of shared decision making were integrated into the new-called, Patient-Specific Goal-setting method. The new goal-setting method contributes to a more</td>
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<td>Client-centred notions of meaning, importance, satisfaction, and choice have an impact on participation in life in the community. The ICF does not attempt to attach the notion of meaning to participation. Other authors suggest training health professionals to adopt a life narrative approach when working with people following stroke in order to better understand each person’s experience[16].</td>
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<td>2007;29(20-21):1566-1574</td>
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| Client-centred attitude on the part of the therapist. | structured approach to goal setting and enables patient participation and goal-oriented physiotherapy.  
Based on the selected problematic activities, individual treatment goals are set jointly by patient and physiotherapist, after which a shared decision is made about the treatment plan, and the treatment goals can be evaluated after treatment. The follow through of treatment goals at each and every treatment session, is of main importance in this goal-setting method.  
During the development process, it became clear that the new version of the instrument could not be applied separately, but was to be fully integrated in the physiotherapy process.  
[It was required a] client-centered attitude on the part of the physiotherapist. | Haley KL, Cunningham KT, Barry J, de Riesthal M. Collaborative Goals for Communicative Life 2 | Collaborative goal-setting approach – challenging in aphasia.  
Collaborative goal setting is at the heart of person-centered rehabilitation but can be challenging, particularly in the area of aphasia. |
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<td>Strengths-based goal setting, encouraging consideration of possibilities and priorities rather than listing problems or limitations.</td>
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<td>Growing familiarity with the case</td>
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<td>Withholding of clinician input for a growing familiarity with the particular person.</td>
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<tr>
<td>The FOURC model approaches planning from a position of strength by encouraging clients to consider possibilities and priorities rather than listing problems and limitations</td>
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<td>Collaborative goal-setting is not a one-off procedure – melding within (other) care activities…. ongoing and interactive development over the course of therapy to expand and refine the plan.</td>
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<td>Instead of asking about complaints, we ask questions such as the following: Who are your communication partners? What is important to you? How can you grow? What resources can you pull from?</td>
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<td>Client-driven intervention selection and confidence</td>
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<td>Although the FOURC model can help the collaborating client–clinician team to identify meaningful goals by the end of the first session, effective intervention planning is always distributed over many sessions. The planning begins at the time of the initial evaluation and continues throughout the rehabilitation program, melding with intervention strategies, further assessments, observations, and conversations to become an integral component of a comprehensive aphasia rehabilitation program.</td>
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| Four integral qualities of the FOURC model: (a) coordination of diverse interventions toward a shared communication goal in order to unite
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<th>building activities to address psychological aspects of aphasia rehabilitation.</th>
<th>expectations and promote generalization-driven action, (b) strategic guidance of client initiation and withholding of clinician input to promote an expectation of mutual contribution, (c) ongoing and interactive development over the course of therapy to expand and refine the plan, and (d) client-driven intervention selection and confidence building activities to address psychological aspects of aphasia rehabilitation.</th>
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Even though the supervised sessions are group-based, each patient will follow his or her own individualised, patient-centred, exercise programme. |
Fu VWY, Weatherall M, McNaughton H. The Taking Charge After Stroke (TaCAS) study protocol: a multicentre, investigator-blinded, randomised controlled trial comparing the effect of a single Take Charge session, two Take Charge sessions and control intervention on health-related quality of life 12 months after stroke for non-Maori, non-Pacific adult New Zealanders discharged to community living. BMJ open. 2017;7(5):e016512.

| 2 | Time to listen emphasized – and to allow express hopes, fears and priorities. Gentle reflection on person’s own thoughts, attempting to avoid shaping patient’s goals. Discourage to suggest goals – focus in what the person wants rather than what providers perceive doable. Structured workbook with heading for patients to write down goals and intermediate steps. Ongoing process they can later review. Identity “who I really am” is the first heading. Others are |
| Research clinicians are trained to encourage participants to ask and answer their own questions, and to form their own ideas. Time spent listening to participants is emphasised, in particular allowing them to consider and express their hopes, fears and priorities. By gently reflecting the participant’s own thoughts, the TCS attempts to avoid shaping the patient’s goals, a process that can occur in therapist-led goal-setting. Research clinicians are discouraged from suggesting goals so that the focus remains on what the participant wants, rather than what is perceived to be doable. Using a structured workbook allows participants to write down any forthcoming goals and intermediate steps, and to see this as an ongoing process that they can review in their own time; in essence, ‘Taking Charge’ of their own recovery. The intervention takes between 60 and 80 min to complete. The headings within the workbook include Who I Really Am, Hopes and Aspirations, Main Fears, My Best Day, Physical Needs, Communication, Emotional Issues, Information Needs, Financial Issues, My Support Network and Stroke Prevention. |
| Korner M, Becker S, Dinius J, Muller C, Zimmermann L, Rundel M. A patient-centred team-coaching concept for medical rehabilitation. Journal of interprofessional care. 2018;32(1):123-126. | Hopes and aspirations, main fears, best day, physical needs, communication & Emotional issues, Support Network & Prevention Taking charge, empowered, enabled in own recovery. | We understand patient-centredness as a core principle for healthcare that is characterized by a collaborative patient–provider relationship including the patient’s perspective in different stages of the decision-making process during his treatment. We, therefore, especially focus on the role of teamwork for an effective patient-centered treatment, as mentioned in the integrative model of patient-centredness (Scholl, Zill, Härter, & Dirmaier, 2014). Benefits of interprofessional teamwork for patient-centredness have been demonstrated in a former study, where different aspects of collaboration were predictors of aspects of patient-centredness when using a structural equation modelling approach (Quaschning, Körner,
Interprofessional teamwork can be a determinant of PC, and benefit from coaching & Wirtz, 2013). Training or coaching can help to improve teamwork and subsequently patient-centredness. We see coaching as an intervention that focuses on tasks, performance, processes, and cooperation.

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<td>Explore lived experience, rendered in contexts of relevance, through a reflective, interpretative dialogue. Towards making sense of their illness situation. Providers’ empathy (understand situations from the patients’ perspectives). Helping framing disturbances in context, and create a new order to their lives</td>
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<tr>
<td>The overarching aim of Hermes was to explore patients’ lived experience, as embodied beings, of their illness, revealing its central aspects, as well as exploring how people render those experiences meaningful in their contexts of relevance. These were to be explored through a reflective, interpretive dialogue between the patients and the nurses. Hermes aimed at helping patients as interpretative beings to interpret, understand, and make sense of their illness situations, as well as helping nurses understand those situations from the patients’ perspectives. In accordance with the existentials of embodiment and attunement, the structure of Hermes aimed at facilitating patients in describing their embodied being, helping them in framing these disturbances as an important aspect of their illness experiences and as being a major concern to them.</td>
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Hermes aimed at helping people in framing and reframing those disruptions through rehabilitation as well as viewing them holistically and in context. By so doing, the aim was eventually to help people make sense of (as distinct from merely accepting) the illness situation through therapeutic rehabilitation practices, by establishing a new order to their lives, involving the creation of more spaces for attending to the world and their life projects according to their desires.

Hermes aimed at facilitating the exploration of patients’ lived experiences of physical illness through language and reflective interpretative dialogue, as well as their significance (that is the severity of the disruption of the illness on daily life).

Asking patients to address the severity of the disturbing impact of illness on a verbal scale was intended to provide insight into how well the patients were attuned to these disturbances.

Dialogues with the nurses revealed that interviews conducted via Hermes, and/or the subsequent reading of them, substantially
| Christie J, Macmillan M, Currie C, Matthews-Smith G. Developing person-centred practice in hip fracture care for older people. Nursing standard (Royal College of Nursing (Great Britain) : 1987. 2016;31(16-18):47-57 | 2 | Narrative, real-life examples at each stage of recovery help the focus on PC care. Quality Improvement processes required Organizational Leadership: facilitative and participatory Toward a collaborative experience Culture for unified, integrated care, not fragmented, fully independent/isolated. | increased their insight and understanding of the patients’ perceived situations, as aimed for. Reflecting on excerpts from patient and caregivers’ real-life examples at each stage of their recovery following hip fracture, maintained the person-centred focus of the research and highlighted experiences that had not previously been heard or understood. Quality Improvement Processes, Enabling and Sustaining Change and Learning and Development are the vehicles for developing person-centred practice. The culture and context evolve from a fragmented, specialist, independent and isolated to a shared vision, dialogue and then unified, integrated care culture. The leadership style evolves from one directive to one facilitative and participatory. Movement toward a collaborative experience, beyond a multi-professional experience and persons’ experience. |

| 2 | Using known guidelines for communication, a client-centered assessment tool was adapted to facilitate a client-centered OT assessment for people with aphasia. |

The aphasia-friendly COPM consists of a ring binder folder. There are 42 pages with 150 laminated pictures, accompanied by clear, concise text, and key points in bold.

The pictures and text used in the aphasia COPM are based on principles for communication with clients with aphasia, which include using simple language, with no jargon or complex words; using short simple sentences; giving clear chunks of information; using bold, clear, large font, at least 14 point; avoiding italics or underlining; and using clear colour contrast (Rose et al., 2003; Social Care Institute for Excellence, 2008).

The flashcards used to support rating performance and satisfaction were adapted for aphasia, by including a visual image at each end of the scale in addition to the numerical values. Yes/No (‘yes’ and thumb up, ‘no’ and thumb down) picture cues were used to help with decision-making. Picture prompts were used to explain complex ideas, such as time before and after stroke, realistic goals and barriers to achieving goals.
| Lund A, Michelet M, Kjeken I, Wyller TB, Sveen U. Development of a person-centred lifestyle intervention for older adults following a stroke or transient ischaemic attack. Scandinavian journal of occupational therapy. 2012;19(2):140-149 | 2 | Right to decide and the right not to decide. Group and project leaders discussed how to apply person-centredness in the intervention, acknowledging the exact application might vary across contexts/situations. Active invitation to reflect and explore their meaningful occupations. | Use of the aphasia-friendly COPM enabled rehabilitation goals to be established, which differed to the goal identified by the referrer. Utilization of the Canadian Occupational Performance Measure (COPM) results in groups is described to demonstrate the person-centred process of developing and tailoring the intervention content. The group leaders and the project leader met once a month and discussed how to apply person-centredness in the intervention. Participants were invited to reflect on and explore their meaningful occupations during their daily lives and this prepared them for the following group intervention. The themes in the groups were addressed through performance of occupations and experienced by the participants in their real-life context. This contributed to the development of a truly occupation-based and person-centred programme, which possibly increased its potential for enhancing participants' social participation and well-being in line with their interests, needs, and desires.” |
The Canadian Occupational Performance Measure (COPM) was used for the individual needs evaluations to describe the qualitative and the quantitative aspects of occupational performance (18,19,33).

As demonstrated by Peoples et al. (41), to find the balance between the right to decide and the right not to decide is of importance for people who have had stroke or TIA in their experiences of rehabilitation where they are struggling to regain power and control in their lives. The participants might not always be ready to assume responsibility even though the group leaders (occupational therapists) may want them to. This is an ongoing challenge related to person-centred intervention.

| Hersh D, Worrall L, Howe T, Sherratt S, Davidson B. SMARTER goal setting in aphasia rehabilitation. Aphasiology. 2012;26(2):220-233 | 2 | The concepts in the acronym SMARTER (shared, monitored, accessible, relevant, transparent, evolving, and relationship-centred) can increase collaboration in goal setting without losing the advantages of the concepts. | SMART is an acronym guiding the nature of rehabilitation goals themselves, whereas SMARTER guides a collaborative goal setting process. S: shared - decision making, even though “not all patients necessarily want to assume such a responsibility”. “In the Goals in Aphasia Project most people with aphasia and family members wanted to be involved in decisions about therapy and discuss what was possible within the constraints of the service they were receiving. Speech |
In SMART (specific, measurable, achievable, realistic, and time-bound).

A specific, achievable, measurable goal could be negotiated (shared) with a client (with information in an aphasia-friendly formats) and family in the context of a strong relationship, where the goal is clearly relevant and motivating, where there are transparent links between that goal, broader goals, and therapy tasks, and where that goal could be monitored and re-negotiated over time.

Pathologists also intended to share goal setting to the extent that they usually asked clients what they wanted to do and tried to work towards functional outcomes, tailoring therapy to relevant aspects of people’s lives.” Within a shared approach effort is made to prepare clients, including families and significant others, about what is on offer and what choices exist. It is not enough for shared goal setting simply to ask people what they want to work on or to invite them into a meeting (…) clients need to be orientated as if to a new job.” “There should be regular opportunities to attend meetings, supported as required by aphasia-friendly materials using a range of media (Rose et al., 2009).

The term shared incorporates effective interprofessional collaboration in order to address the holistic nature of people’s goals. Interestingly, findings from our study suggest that the influence of SMART sometimes constrained the sharing of information between team members. One speech pathologist said: “I document what I can measure. And what I can report on objectively.” This meant that goals that were vague, intangible, or difficult to measure, often ones related to emotional adjustment or social confidence, were left as implicit, were not recorded and therefore were not valued.
Overall increased focus on a relationship-centred care.

Within a shared approach effort is made to prepare clients, including families and significant others, about what is on offer and what choices exist. It is not enough for shared goal setting simply to ask people what they want to work on or to invite them into a meeting.

goals that were vague, intangible, or difficult to measure, often ones related to emotional adjustment or social confidence, were left as implicit, were not

M – Monitored “rather than rather than measured”. monitored denotes continuous evaluation, often as part of therapy itself (…) Monitoring highlights the value of regularly discussing improvement or lack of it, updating on progress towards agreed goals, and making evaluation a part of therapy. The second issue is that measurement of change on therapy goals does not have to be numerically based.”

A- Accessible “Information needs to be in an aphasia-friendly format, whether that involves extra time, a total communication approach, supported conversation, or careful adaptations to goal setting documents or contracts (Rose, Worrall, Hickson, & Hoffmann, 2011).”

R- Relevant “relevant to people’s lives.” For therapy to feel relevant for clients, the goal-setting process needs to be shared and worked through together. It would be useful to have a supported in-depth interview where possible. Ideally people with aphasia in residential rehabilitation would have an opportunity to do this in their real-life context; that is, we suggest a home visit with a speech pathologist as part of the goal-setting exchange, just as occupational therapists carry out home visits prior to discharge. This would allow both clients and
recorded and therefore were not valued.

Monitoring highlights the value of regularly discussing improvement or lack of it, updating on progress towards agreed goals, and making evaluation a part of therapy. The second issue is that measurement of change on therapy goals does not have to be numerically based.

clinicians to judge priorities for therapy from a broader life context rather than only from the results of particular assessments”

T – Transparent “major area of breakdown in collaborative goal setting is clarifying the links (rationales) between these steps, to each other, to the broader goal, and to therapy activities”. “Some speech pathology participants suggested creative ways to achieve this such as using goals lists; visualisation, metaphor and analogy to explain sub-goals (steps, ladders, journey, bite-sized chunks); making sub-goals “outcome oriented”; using hierarchies of everyday activities; encouraging clients to prioritise or rate tasks for importance; and seeking regular feedback.”

E – Evolving. “The term evolving emphasises the need to revise and revisit goals regularly but also incorporates a process of explaining to clients, even early on, that they can ask to change therapy direction, that therapy goals are not set in stone, and that recovery is very individual.”

R- Relationship-centred “the importance of relationship particularly because, in aphasia therapy, communication is both the focus of
therapy and the vehicle for its delivery.(…) We suggest that the relationship, sometimes described by speech pathologists as “rapport”, is core to this and takes priority before formal goal setting and prior to formal assessment where possible.”

People with aphasia and their families often feel confused or excluded by the goal-setting process and that professional tendencies to prioritise SMART goals are perpetuating this situation. We suggest that the concepts in the acronym SMARTER (shared, monitored, accessible, relevant, transparent, evolving, and relationship-centred) need to be highlighted for clinicians as a way to increase collaboration in goal setting without losing the advantages of the concepts in SMART (specific, measurable, achievable, realistic, and time-bound). For example, a specific, achievable, measurable goal could be negotiated with a client and family in the context of a strong relationship, where the goal is clearly relevant and motivating, where there are transparent links between that goal, broader goals, and therapy tasks, and where that goal could be openly re-negotiated.”

McGilton KS, Davis A, Mahomed N, et al. An inpatient rehabilitation PERSON-CENTERED CARE model with a component of individualized Patient-Centred Rehabilitation Model – inclusive of people with Cognitive Impairment (PCRM-CI). Our model is the first to include the following 5 components: rehabilitation management; dementia
<table>
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<th>model of care targeting patients with cognitive impairment. BMC geriatrics. 2012;12:21</th>
<th>family support and education, nonetheless with standard elements such as a brochure, booklet to prepare for going home and additional written aids with information and resources available. The model allowed that people with Cognitive impairments were treated instead of deemed ineligible for admission.</th>
<th>management; delirium prevention and management; staff education and support; and family/significant other support and education. Individualized family support and education will be provided by the team and will be reinforced on admission to the unit with a brochure which includes the goals of the rehabilitation program. Additional written aids will be given to family members including: information on delirium, resources available once the patient is home, and a discharge booklet to prepare for going home&quot; In most rehabilitation facilities, CI makes patients ineligible for admission to rehabilitation (…) the PCRM-CI model can improve the mobility and functional outcomes of clients with CI.</th>
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<tr>
<td>Terry G, Kayes N. Person centered care in neurorehabilitation: a secondary analysis. Disability and rehabilitation. 2019:1-10</td>
<td>Human approach to rehabilitation care; culture of care where care and compassion are prioritized; “knowing the patient” rather than protocol-driven process.</td>
<td>Cultures of care are central to enhancing person-centered practice.” “healthcare cultures where care and compassion are prioritized. Each theme cohered around a central organizing concept – or the key idea than underpins the thematic explanation of the data [29]: (1) That patient experience and needs should always be understood in terms of their difficult new reality; (2) the need for a relational orientation in</td>
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Understanding, reassuring and “guiding” the person through the new difficulties and reality, and how they are perceived, after a disrupting life event (e.g. disability onset; return home with residual disabilities).

Relational orientation in care - within the notion of therapeutic/supportive relationship/alliance, achieved through: Willingness to spend time with; willingness to engage with the person as a person; willingness to be responsive and adapt – rather than categorizing for protocol-driven process.

care; (3) the importance of treating trust as a currency; and, (4) efficacy in rehabilitation is co-constructed, and enabled by the efforts of clinicians.

It was the orientation by clinicians toward simple tasks that highlighted how different their bodies and lives had become. Goal setting was often described as depressing or disempowering as a consequence, with broader long-term hopes deferred for their immediate clinical needs.

Practitioners viewed positively by participants, were described as guides through the difficult new reality, giving clear information about the severity of their condition, pathways to provide improvement, and warnings about the limits and constraints their condition placed on them. Understanding the centrality of a patient’s difficult new reality did not mean practitioners assumed that the patient was vulnerable or incapacitated [13]. What seemed essential was a sense that these guides both understood the wider terrain of the difficult new reality, but also the individual needs of those attempting to navigate it. More personalized, engaged care of patients was always described in terms
Trust is a key component of the relational orientation in care, has a “protective” effect and can be lost, gained or transferred to beyond the dyad relationship, including for the next level of care.

The “bond” can be constructed rapidly, even in acute-based settings – e.g. putting the persons at ease and giving patients the sense that their unique/person needs matter, and they are not just another “number”.

Practitioners as a person and reciprocity – sharing of the self, not full professional

of the relational orientation of a practitioner, even above their skills or knowledge.

Relational orientation in care: The second theme we constructed spoke directly to the notion of the therapeutic relationship [39] and its creative and generative scaffolding of rehabilitation [40]. Within the dataset, participants spoke of ‘success’ with a patient as moving beyond a set of tasks (and sometimes even initial clinical outcomes), treating the relationship between patient and clinician as the priority. The therapeutic alliance was understood not simply as a welcome addition to rehabilitation, but as the basis of it. As with theme one, examples of what “the “bond” was consistently constructed as something that could be established quickly, and gave momentum to progress – even in the highly transitory space of acute wards.

Giving patients a sense that their needs were important, that their difficult new reality had been recognized. In contrast, being treated as just another number, seemingly without consideration for their unique needs could have the opposite effect.
<table>
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<tr>
<th>Detachment or “low key” approach, can be positive to engender trust and reciprocity.</th>
<th>Where relational practice was constructed as legitimate rehabilitation work, this appeared to contribute to a more human approach to care. This was described as inevitably leading toward client engagement and participation in clinical decision making.</th>
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<td>Enabling notions of (self-)efficacy as competent people, of self-worth and confidence in themselves, i.e. empowered in the context of a relational autonomy, and enabling to gain sense of progress and outcomes as they occur.</td>
<td>Practitioners described positively by participants appeared to engage with patients beyond the task or program, motivating them through the relationship built up between them. Being “low key” or simply relying on expertise over relationship (e.g., “it’s just a job for you”) was described by many as barrier to care being experienced positively. Depth of relationship (or perception of such) was constructed by participants as providing the potential to enable greater engagement, engender motivation, and support a willingness to participate in tasks that seemed difficult or mundane, and promote confidence to do more than the patient thought possible.</td>
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<td>Engagement seen as a product of a supportive relationship.</td>
<td>First, a willingness to spend time with clients, building a relationship as part of the ‘duty’ of care. Second, a willingness to engage with the person as a person, irrespective of whether outcomes follow a ‘normative’ pathway to independence. Third, a willingness to be</td>
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responsive and adapt to the individuals in their care, not attempting to quickly categorize them or force them into a protocol driven process.

One of the key components of relational care - trust.” “Trust as something that persists beyond dyadic arrangements, and can be gained, lost, or transferred to other practitioners and contexts. It also reflected talk of trust’s protective effects, and its ability to ‘purchase’ hope and confidence.

Good professionals were often described using terms such as putting clients at ease, or making them feel relaxed.

Knowledge about a practitioner, their history, their skills, and their personhood, all shaped the way a patient experienced care. Although most participants spoke about the relationship being professional rather than personal, an increasing awareness of how a clinician worked, and the experience and knowledge they could use to guide clients, helped engender trust.” “need for more dynamic and fluid conceptualization that allows for reciprocity in sharing of self as a therapeutic tool in its own right [46].
Within many accounts, the 'contagiousness of trust' was considered a mitigating effect throughout care. Those clinicians that went outside “usual practice” and attempted to bridge gaps in care not only garnered trust for themselves, but also seemed to contribute their trustworthiness to others within their teams, and to the next line of professionals in a patient’s care.

This perspective constructs the role of therapists and significant others as enhancing or enabling efficacy, or a sense of autonomy, the patient may not have, or feel capable of, especially at the beginning of the rehabilitation process. In this way the concept seems to be closely affiliated with (...) relational autonomy.

Confidence expressed in their practitioner and their practitioner in them, enabled greater confidence in themselves and their capabilities:

There was still a focus on empowerment, and increasing self-efficacy in daily living tasks within Elsa and other’s stories.
Engagement in this account was viewed as a product of the supportive relationship Myrtle had with her occupational therapist, enabling her to gain a sense of progress in her outcomes.

Clearly the level to which this sort of support is appropriate will depend on the individual patient, and thus needs to be a product of the relationship, and knowing the patient, rather than protocol driven [53].


| 3 | Respectful; Individualized; Empowering; Holistic, including spiritual needs. | Reviewed the attributes of PERSON-CENTERED CARE included: Individualized; Respectful; Empowering; Holistic. Most interventions included in this review focused only on a specific attribute, mostly individualized for personal needs and preferences in developing a shared decision-making and goal-setting process, but hardly implemented a holistic–biomedical, psychosocial, and spiritual–approach, which is the most fundamental attribute of Person-centered care (Lines et al., 2015; Zhao et al., 2016). |

Tistad M, Flink M, Ytterberg C, et al. Resource use of healthcare services 1 year after stroke: a

| 3 | Activating / activated patients may have less or changed healthcare-seeking behaviors and healthcare utilization. | (Patients) experienced that the intervention enabled them to feel as owners of their own rehabilitation process.32 33 This suggests that the effect of the CADL intervention on healthcare usage might be related to a changed healthcare-seeking behaviour of an activated patient. Similar results |

Team-based PERSON-CENTERED CARE: whole PERSON-CENTERED CARE come from the whole rehabilitation team, not from a single profession or professional.

have also been found in other settings, showing an inverse association between patient activation (knowledge, skills and confidence) and healthcare usage, that is, patients with higher levels of activation had lower healthcare usage.33

As rehabilitation after stroke should be team based34–36 and the OT is only one among several professions in the team, it might be questioned as to what extent the care and rehabilitation as a whole was client-centred. In order to provide client-centred care and rehabilitation, embracing all the clients’ needs, priorities and values, future interventions should involve the entire team in a shared approach to explore how such a team-based intervention could affect healthcare usage.

We conclude that the provision of a client-centred occupational therapy ADL interventions after stroke did not appear to prolong the LOS, nor did it increase the number of contacts with outpatient healthcare services during the first year after stroke. Client-centred services may thus be implemented even though more evidence on the effect on client and family outcomes and resource use through a full powered RCT with economic evaluation is warranted.
| Prescott S, Doig E, Fleming J, Weir N. Goal statements in brain injury rehabilitation: A cohort study of client-centredness and relationship with goal outcome. Brain Impairment. 2019:1-14. | 3 | ‘Specific’ goals, as opposed to more general goal statements, were perceived to be less person-centred.  

Goal setting documentation and structured endeavor did not enhance or did detract perceptions on their person-centredness, and can be more of a service-oriented activity (e.g. not necessarily fully carried out in the client’s presence) than a client-centered one.  

Time needed to elicit what is important and meaningful to patients. | ‘Specific’ goals were perceived to be significantly less client-centred, which is an interesting finding contrary to our hypothesis.”  

“For example, when goals are broken down to be very specific, clients may perceive that they do not reflect what is important and meaningful to them”  

Collectively, the findings suggest that documentation of goal statements that are measurable, non-jargonistic, participation-focused, recalled by the client and include a time frame as well as the client’s name is more for the purpose of objective measurement by the service.  

The hypothesis that goals that were recalled would be more client-centred was not supported.  

Overall, the findings from this study indicate that rehabilitation goals focussed on the essence
of what is important and meaningful to the individual are associated with significantly greater improvements in performance and satisfaction.

Spending time with individual clients to elicit and understand what is important and meaningful for them should be prioritised in goal setting. Furthermore, given that time spent writing goals using standard criteria does not appear to benefit clients, it may be beneficial to use indirect therapy time to operationalise and document goals for measurement purposes, as opposed to doing this in the client’s presence.

In order to improve rehabilitation outcomes, it is recommended that clinicians spend sufficient time with clients to elicit what is important and meaningful to them.

When documenting goals for clients, more general goal statements that are not highly specific appear to have greater meaning and importance for clients.
| Gustavsson M, Guidetti S, Eriksson G, von Koch L, Ytterberg C. | **3** | Home environment (client’s real-world) as one more prone to PERSON-CENTERED CARE. | Stroke severity may be of less importance for outcome in perceived impact of stroke on participation when receiving an enhanced client-centred intervention. Thus, a client-centred approach may be particularly important for those with moderate to severe stroke. |
| Factors affecting outcome in participation one year after stroke: A secondary analysis of a randomized controlled trial. Journal of rehabilitation medicine. 2019;51(3):160-166 | | Within the in-patient setting, more explicit PERSON-CENTERED CARE behaviors or conditions need to overcome the ‘disadvantage’ of the setting for PERSON-CENTERED CARE. | The difference in outcome with regard to context of rehabilitation was found only in the control group. This result might reflect that the home environment itself induces a more client-centred approach, i.e. the needs are more easily identified by the client and supported by the therapist in the client’s real-life world, as has been suggested in previous studies (29, 30). It is plausible that, in the context of the home environment, the difference in client-centred behaviour between the occupational therapists who used an enhanced client-centred approach and those who delivered usual rehabilitation was too small or non-existent, whereas there was a difference in client-centeredness within the in-patient rehabilitation in the hospital between occupational therapists who used the client-centred approach and those who delivered usual rehabilitation. |
| | | Those with moderate to higher levels of severity benefiting more from a PERSON-CENTERED CARE approach in perceived disability impact. | This leads us to propose that, in contrast to the inpatient hospital environment, the home environment empowers the client and, as a |
consequence, facilitates the team members in adopting a more client-centred approach. Receiving rehabilitation in one's home environment has previously been shown to contribute to individualization of the rehabilitation, and increased patient participation in goal-setting and participation in everyday life (31, 32). Furthermore, multi-professional teams providing rehabilitation in the clients’ homes described that the context enabled them to propose strategies to assist the clients to manage daily life (32). In addition, the home environment has been reported to make the clients aware of their limitations and to facilitate identification of difficulties in ADL that they wanted to address. It also allowed the clients to become partners in the rehabilitation process, in goal-setting and in planning their rehabilitation (33). Rehabilitation at home after stroke is recommended in the Swedish national guidelines for stroke care for those with mild to moderate stroke (1). Based on this study, providing an enhanced client-centred approach could be beneficial for those receiving rehabilitation at home, although it might be even more important for those receiving rehabilitation at an in-patient unit.

| Hedman A, Eriksson G, von Koch L, Guidetti S. | 3 | PERSON-CENTERED CARE was not better or | For the people with stroke, this five-year follow-up – as well as previous 3- and 12-month followups10,11 – could detect no better or |
| Five-year follow-up of a cluster-randomized controlled trial of a client-centred activities of daily living intervention for people with stroke. Clinical rehabilitation. 2019;33(2):262-276 | worse for the long-term outcomes, either functional autonomy, perceived social participation or life satisfaction. Cultivating person’s ownership for the rehabilitation process. Allowing significant others’ own needs to be accounted for and addressed. | worse effects of the client-centred ADL intervention compared to usual ADL interventions, neither for the primary outcome perceived participation nor for secondary outcomes such as independence in ADL and life satisfaction. This was the case both for group comparisons at year five and for the comparison of changes between three months and five years. The assumption that adaptive behavioural changes as a result of the client-centred ADL intervention would occur with delay – and eventually lead to a more favourable outcome regarding participation in everyday life – could not be verified. However, at year five, better outcomes were found for significant others of those with stroke who received the client-centred ADL intervention regarding mean depression score, as well as the proportion with signs of depression according to the \( \geq 8 \) cut-off on the Hospital Anxiety and Depression Scale. At year five, significant others in the client-centred ADL intervention group had significantly lower depression scores, and a smaller proportion of them showed signs of depression based on the |
recommended clinical cut-off compared to significant others in the usual ADL interventions group. In fact, no significant others in the client-centred ADL intervention group showed signs of depression based on this cut-off at year five, while more than one-fifth of the significant others in the usual ADL interventions group did. This is an interesting finding, as the client-centred ADL intervention was not specifically designed to meet the needs of the significant others.

Qualitative findings from the first year of the same trial suggested that the client-centred ADL intervention seemed to enable the significant others gradually to find ways to meet their own needs. Furthermore, a significant within-group change regarding the caregiver burden factor ‘General strain’ was observed in the 12-month follow-up among the significant others in the client-centred ADL intervention group. Thus, the group differences regarding signs of depression identified in the present five-year follow-up study may relate to a development that started already during the first year among the significant others of those with stroke who received client-centred ADL intervention.

Experiences in the context of receiving the client-centred ADL intervention identified in earlier qualitative studies, for example,
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<th>Authors</th>
<th>Year</th>
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<th>Methods</th>
<th>Results</th>
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<tr>
<td>Eriksson C, Eriksson G, Johansson U, Guidetti S.</td>
<td>2019</td>
<td>Occupational therapists' perceptions of implementing a client-centered intervention in close collaboration with researchers: A mixed methods study.</td>
<td>Co-implementation: Implementation of a (novel) PERSON-CENTERED CARE interventions needs to promote interaction of those being trained with the underlying research and research team, allowing space and room for discussions and reflections. Management supportive of implementation</td>
<td>Over 70% of the OTs benefitted from reading and discussing articles in the workshop; 60% had faith in the intervention; 69% reported usability of the intervention. High level of support from managers was reported, but less from team members. The workshop context with facilitation and access to evidence, supportive organizations and teams, sufficient interaction with researchers and satisfying self-image were successful key factors. There is a need of space and room for discussions and reflections over time to be able to do the translation of research-based knowledge based on the clinician's previous experience and knowledge.</td>
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<td>Ross EF, Haidet P.</td>
<td></td>
<td>Attitudes of physical care: Didactic educational</td>
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<td>Our data revealed a positive difference in student attitudes toward patient-centered care and the prioritization of psychosocial tasks</td>
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<td>therapy students toward patient-centered care, before and after a course in psychosocial aspects of care. Patient education and counseling. 2011;85(3):529-532</td>
<td>experience devoted to psychosocial aspects of patient care can improve PERSON-CENTERED CARE attitudes in students. Psychosocial aspects of care require values identification, self-knowledge Exploration: Cultural competency, communication, motivational interviewing skills, knowledge of Narrative medicine, and competencies to manage issues such Loss and grief, sexuality, and burnout. following a curriculum focused on the psychosocial aspects of care. The strong consistency of student attitudes prior to the course suggests that the attitudes of the students were affected by this educational intervention. This attitude shift implies that educational programs may be effective in developing patient-centeredness in physical therapy students. Qualitative data suggest that students found the course beneficial in learning about themselves, their classmates and the concepts of patient-centered communication. It shows positive effects on student attitudes toward patient-centered care after a discrete, focused didactic educational experience devoted to psychosocial aspects of patient care. The components of this course could be replicated in physical therapy and medical educational programs to enhance the patient-centered attitudes of the graduates. Psychosocial aspects of care course contents:</td>
<td>Values identification and self-knowledge Exploration</td>
<td></td>
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| Larsen AE, Adamsen HN, Boots S, Delkus ECG, Pedersen LL, Christensen JR. A | 3 | Egalitarian Danish culture might have influenced a high perception and value on Danish occupational therapists perceive to practice client-centred practice (CCP) and appear to have adopted the beliefs, theory and ideals of CCP, perhaps influenced by the egalitarian Danish culture. | Cultural competency  
Death and Dying  
Loss and grief  
Narrative medicine  
Healthcare Communication  
Sexuality issues  
Motivational interviewing  
prevention of burnout  
Assertiveness. |
| survey on client-centered practice among danish occupational therapists. Scandinavian journal of occupational therapy. 2019;26(5):356-370 | PERSON-CENTERED CARE. | The following two factors were positively correlated with CCP: the occupational therapists performed self-directed work, which may have enabled them to use assessments that allowed their intervention to follow the clients' priorities, and that they were educated in CCP. The identified hindrances to CCP were having fixed standards, which was negatively correlated with the respondents' perceived level of CCP, and having too little time per client, which was negatively correlated with their satisfaction with their CCP. These societal challenges indicate that the rules and regulations in Denmark established in occupational therapist departments contradict CCP. Sufficient time to ensure self-directed collaboration with the client and an interdisciplinary commitment to CCP appear to be important for facilitating CCP in occupational therapy practice. Therefore, Danish occupational therapists should strive to have working conditions that contribute to the vision of patient involvement in Danish healthcare, leading to the positive effects of client satisfaction, client participation and more effective interventions. | Requisites/ Determinants: Self-directed work – intervention and assessment allowed to follow clients' priorities vs. having fixed standards and having too little time per client. Organizational / System factors on working conditions: Sufficient time to ensure PERSON-CENTERED CARE and to a interdisciplinary team commitment to PERSON-CENTERED CARE. |
|---|---|
| Course on narrative reasoning, to understand the individual’s unique lived experience, improve students’ perspective of PERSON-CENTERED CARE. Students however admit that difficulties in implementation may arise |
| Students attending the narrative reasoning course (…) recognized that the achieved competencies could help them to act and interact differently with their patients. Consequently, they perceived that their focus of reasoning shifted towards the patient. They seemed to have integrated the patient-centred model of practice in their professional core values and beliefs. They also become aware of the difficulties or resistances to the implementation of this model of practice. However, they assumed to be committed to change the actual context of practice. |

Narrative reasoning, defined as a reasoning strategy where the health professional is engaged in apprehending and understanding of the unique living experience of an individual (Edwards, Jones, Carr, and Jensen, 2004), has been presented as a core component of the health professionals’ competencies towards a patient-centred model of practice (Edwards et al, 2004; Kumagai, 2008). Through narrative reasoning, clinicians are committed to the apprehension and understanding of patients’ “stories”, illness experiences, meaning perspectives, contexts, beliefs and cultures (Edwards, Jones, Carr, and Jensen, 2004; Loftus, 2006; Mattingly and Fleming, 1994).
| Burau V, Carstensen K, Lou S, Kuhlmann E. Professional groups driving change toward patient-centred care: interprofessional working in stroke rehabilitation in Denmark. BMC health services research. 2017;17(1):662 |
|---|---|---|
| The study identified supportive factors and contexts of patient-centred care: Professional groups expressed highly positive professional interest in reorganised stroke rehabilitation concerning patients, professional practice and intersectoral relations; individual professional and collective interprofessional interests strongly coincided. The corresponding strategies were driven by a shared goal of providing needs-based care for patients. Individual professionals worked independently and on behalf of the team. There was also a degree of skills transfer as individual team members screened patients on behalf of other professional groups. interprofessional, early discharge teams in stroke rehabilitation in Denmark was conducted with focus on day-to-day coordination of care tasks and the professional groups’ interests and strategies. |
| PERSON-CENTERED CARE is facilitated by: |
| - Needs-based, interprofessional reorganization of early discharge teams – continuity and coordination of care |
| - Teams’ shared goal for needs-based care. Individual professionals worked independently and on behalf of the team. A degree of skills transfer as individual team members screened patients on behalf of other professional groups |
| - Professionals working both independently and in behalf |
Rose A, Rosewilliam S, Soundy A. Shared decision making within goal setting in rehabilitation settings: A systematic review. Patient education and counseling. 2017;100(1):65-75

| 3 | Full PERSON-CENTERED CARE or Shared Decision-Making approach to goal setting was rare. Patient preferences for involvement in goal-setting must be accounted for. Benefits of involvement included increased confidence and ownership, perceived control over the situation, increased motivation to achieve goals. Apart from affective/cognitive outcomes, effects on | The literature showed various levels of patient involvement existing within goal-setting however few teams adopted an entirely patient-centred approach. Only two studies reported an entirely patient-centred goal-setting process with clear evidence for SDM. The other studies were largely therapist-led with minimal evidence of SDM. It appears critical that a healthcare professional seeks a patient’s preference for involvement in decision-making before goal-setting commences. Patients reported a wide variety of benefits from taking part in decisions about their goals including increased confidence and a sense of ownership over the decision-making process and subsequently perceived control over their situation. This could consequently have a positive impact on the patient’s rehabilitation, increasing their motivation to achieve the goals that were set. |
functional outcomes had conflicting results. Further education in SDM for both patients and clinicians – the latter weren’t confident about having the skills.

The literature supported this by demonstrating that patients, who were more involved in the goal-setting process, had greater improvements in their function [11,43]. Further to this similar results have been identified from review-based research [48] investigating the patient–clinician interaction. The findings suggested that when SDM was used during an interaction it led to improvements in affective-cognitive outcomes (e.g. satisfaction, confidence, knowledge). However, improvement in health outcomes was not found [48]. The latter finding was in contrast to the present results that associated SDM with improvements in patient functional scores.

Evidence suggests the use of SDM within goal-setting can have a variety of benefits including increased confidence and a sense of ownership. Consequently, this can have a positive impact on the patient’s rehabilitation, increasing their motivation to achieve their goals. However, at present research suggests that both clinicians and patients require further education about this approach. Clinicians felt they did not have the necessary skills to involve patients in decisions about their goals. Whereas patients felt they lacked knowledge in
| Körner M, Luzay L, Plewnia A, et al. A cluster-randomized controlled study to evaluate a team coaching concept for improving teamwork and patient-centeredness in rehabilitation teams. | 3 | Interprofessional teamwork is an element likely contributing to Person-centered care. Hypothesis one, that the TCC will improve interprofessional teamwork in medical rehabilitation, was partly supported for some dimensions of teamwork. Hypothesis two, which states that the team intervention concept can enhance the external participation aspect of patient-centeredness, could not be confirmed by the results of the patient survey. (Staff) changes or improvements might have been too small or too specific to be recognizable by patients or that it would require more time for patients to notice effects. | relation to goal-setting, the rehabilitation process and their condition and consequently felt disempowered to participate. To enhance the use of SDM within goal-setting in rehabilitation it is likely both clinicians and patients will require further education on this approach. Limited time per patient may also impact on the SDM interaction as patients may not feel that they are known enough by the clinician or do not trust them. |
1) to listen thoroughly to the patient's narrative to include his or her experience, resources and needs in the treatment and care process.  
2) co-creation of goals and milestones agreed upon by both the patient (together with relatives if needed).  
3) safeguarded the care process by documentation of the | In addition to usual care, the intervention group received PERSON-CENTERED CARE according to the PERSON-CENTERED CARE framework, containing three routines for guiding of a PERSON-CENTERED CARE process to initiate, integrate and safeguard person-centred care in daily clinical practice [10]. The PERSON-CENTERED CARE teams were specially trained through lectures, seminars and workshops on how to apply the intervention. Moreover, booster sessions were held with the PERSON-CENTERED CARE teams during the study period to share experiences and maintain a continuing application of PERSON-CENTERED CARE. The first routine was to listen thoroughly to the patient's narrative to include his or her experience, resources and needs in the treatment and care process. The second routine focused on co-creation of goals and milestones agreed upon by both the patient (together with relatives if needed) and the health care professionals. The third routine safeguarded the care process by documentation of the PERSON-CENTERED CARE health plan, a shared document that comprised the |
| PERSON-CENTERED CARE health plan, a shared document that comprised the patient's beliefs, resources and needs together with medical expertise. Routines were implemented and systematically followed-up throughout predefined milestones, such as service arrangements including follow-up and continuity in primary care. Fully implemented gPERSON-CENTERED CARE implies long-term effects, particularly in patients with low socioeconomic status, as reflected in improved general self-efficacy combined with return to work or a previous activity level without jeopardising clinical outcomes. | In the present study these routines were implemented and systematically followed-up throughout predefined milestones: • A personal narrative that guided a jointly developed PERSON-CENTERED CARE health plan at the hospital within 48 h after randomisation • Scheduled to a follow-up meeting at four weeks post-discharge to a specially trained cardiologist and an RN at the outpatient clinic • Assigned to and scheduled for a follow-up meeting within eight weeks to one of five designated primary care centre teams with a specially trained PERSON-CENTERED CARE team (physician and RN). These results suggest that a fully implemented gPERSON-CENTERED CARE implies long-term effects, particularly in patients with low socioeconomic status, as reflected in improved general self-efficacy combined with return to work or a previous activity level without jeopardising clinical outcomes. |
patients with low socioeconomic status, as reflected in improved general self-efficacy combined with return to work or a previous activity level without jeopardising clinical outcomes

| Dockens AL, Bellon-Harn ML, Manchaiah V. Preferences to Patient-Centeredness in Pre-Service Speech and Hearing Sciences Students: A Cross-Sectional Study. Journal of audiology & otology. 2016;20(2):73-79 |  | Results indicate a high preference to patient-centeredness in pre-service speech and hearing sciences students in USA. Wahlqvist, et al. [5] reported no decline of patient-centered attitudes across the curriculum, which is consistent with this study. This suggests that established values are maintained and supported as undergraduate students progress in years. a difference between subscales of sharing and caring was found with the caring subscale not as positive as the sharing subscale. It is suggested that patientcentered caring is related to empathy that develops over experience and time.

Although undergraduate students show high preference for PERSON-CENTERED CARE, the subscale related to empathy had lower values: experiential learning opportunities might be created | 3 |
Since direct experience is not as common in undergraduate education as it is graduate education, the potential for experiential growth in empathy is limited. Findings of this study suggest a need for inclusion of coursework and experience that support development of empathy.

<table>
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<th>Shared decision-making and partnership (initiating, working, safeguarding and maintaining the partnership). Seeking engagement and active involvement of patients and families. Increased self-efficacy. Seeing the patient as a person with needs as well as resources (strengths) and of a person-centred dialogue as a basis for engaging patients as actively involved partners</th>
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An approach to PERSON-CENTERED CARE has been operationalised and tested by the Gothenburg Centre for Person-Centred Care (GPCC) [9,10]. In this approach (henceforth gPCC) the patient narrative is the point of departure, which forms the basis for a partnership between the patient and health care professionals, which in turn is formalised, documented and implemented in a jointly developed gPCC plan [9]. Congruent with the principles of shared decision-making, a fundamental aim of the gPCC approach is to engage and empower patients as active partners in their care. Self-efficacy, defined as a person’s belief that he/she is able to successfully execute behaviours necessary to achieve desired goals [11], has been proposed as a central concept in gPCC [12]. Increasing self-efficacy and active patient involvement are decisive factors to improve outcomes [12,13].

All gPCC professionals had received training in the theory and
in their own care – fostered by formal training. Booster sessions with tutoring and case examples to assure adherence. Implemented at the continuity of care: hospital, outpatient and primary care practice of gPCC [9,10] through lectures, seminars and workshops and were given practice in how to formulate and execute gPCC plans. Training emphasised the importance of seeing the patient as a person with needs as well as resources and of a person-centred dialogue as a basis for engaging patients as actively involved partners in their own care. Four three-hour booster sessions with tutoring and case examples were provided during the study period to ensure adherence to the gPCC approach. In the gPCC-intervention group the partnership (initiating, working, safeguarding and maintaining the partnership) between the patient and health care professionals [9] was emphasised at all three health care levels (i.e. hospital, outpatient and primary care).

the gPCC approach improved patients’ self-efficacy without causing worsening clinical events. Our findings emphasise the importance of establishing a partnership where patients, physicians, RNs and other health care professionals collaborate as a team through a co-created gPCC plan that is initiated in-hospital and formalised and maintained in primary care.

Feldthusen C, Dean E, Forsblad-d'Elia H, 3 Partnership building and includes sharing of to devise a mutually agreed self-care plan that guided the participant in managing his or her fatigue and to effectively do so over time. The
Mannerkorpi K. Effects of Person-Centered Physical Therapy on Fatigue-Related Variables in Persons With Rheumatoid Arthritis: A Randomized Controlled Trial. Archives of physical medicine and rehabilitation. 2016;97(1):26-36

Information, deliberation, and decision-making between patient and practitioner. Mutually agreed plan, guided self-management and enables to do it effectively over time. Focus on tailoring exercise and balancing life activities - role to coach and support each participant according to own resources, context, will, personal factors and environmental factors - beyond needs Person's preferences accounted in the scheduling of follow-up meetings.

Intervention was initiated with an individual person-centered meeting. A self-care plan was jointly developed and focused on tailoring health-enhancing physical activity and balancing life activities. The physical therapist's role was to support and coach each participant in developing a self-care plan, according to his or her resources, context, will, and needs, and to tailor physical activity and specific exercises according to his or her disease specific, personal, and environmental needs. Follow-up meetings and phone contacts were scheduled according to each person's preferences.

The same physical therapist, experienced and specialized in RA management and Person-centered care, conducted the intervention. Person-centered care focuses on partnership building and includes sharing of information, deliberation, and decision-making between patient and practitioner. Person-centered physical therapy that focuses on health-enhancing physical activity and balancing activities in daily life in persons with RA was shown to reduce general fatigue.
Someone with both technical and PERSON-CENTERED CARE experience was needed to employ the approach.

General fatigue was reduced.

| Fors A, Gyllensten H, Swedberg K, Ekman I. Effectiveness of person-centred care after acute coronary syndrome in relation to educational level: Subgroup analysis of a two-armed randomised controlled trial. International journal of | 3 | Partnership and deep dialogue from the scratch, shared decision-making, co-creation of a plan, eventually revised collaboratively. Plans addressed resources and possibilities, obstacles and agreed upon priorities, including needs for support. | PERSON-CENTERED CARE intervention emphasising the patient as a partner across the three health care levels. First, a thoroughly performed dialogue at admission to hospital (within the first 24 h after randomisation) laid the foundation for co-creation of a PERSON-CENTERED CARE health plan between the patient and health care professionals. A shared decision making process for a PERSON-CENTERED CARE health implementation plan was performed involving the patient, physician and RN. The PERSON-CENTERED CARE health plan served as a basis for a discussion about the patient's general medical condition and was eventually revised collaboratively (...) These plans addressed each |
Follow-up visits, referrals and discharge notes scheduled and shaped collaboratively. Patients and the PERSON-CENTERED CARE team could schedule additional visits at their discretion, if necessary. Patients with low education clearly benefited

patient's resources, possibilities and obstacles to achieve agreed priorities and post-discharge goals, including the need of support from family, friends and health care professionals. (..) Moreover, referrals and discharge notes were shared by health care professionals and the patient. Follow-up visits at the outpatient clinics and primary care units were scheduled together with the PERSON-CENTERED CARE team (…) If necessary, additional visits with the PERSON-CENTERED CARE team were conducted at the discretion of the patient and PERSON-CENTERED CARE team.

We found that combining PERSON-CENTERED CARE with usual care after ACS compared with usual care alone resulted in a significantly improved composite score in patients with low education at the six-month follow-up, as assessed by the combination of better general self-efficacy, return to work or prior activity and no readmissions to hospital was necessary. The present analysis shows that the PERSON-CENTERED CARE intervention was particularly effective in patients with low education.

| Papadimitriou C, Cott C. Client-centred | 3 | Enabling – clients to live meaningful, fulfilling lives. | CC in rehabilitation means enabling clients to live meaningful, fulfilling lives in their communities [6]. Client-centred practice (CCP) has been |
practices and work in inpatient rehabilitation teams: results from four case studies. Disability and rehabilitation. 2015;37(13):1135-1143

Collaboration, respect, empowerment, and recognized their experiences and knowledge.

Organizational, client and provider factors – beyond client-provider communication, affect CC.

CC is not a “one size fits all”. It is affected by organizational policies, team characteristics and culture.

Client-centred practice (CCP) is influenced by client, provider and organizational factors. CCP is not just about client–provider communication. How inter-professional teams work together is an important aspect of CCP.

Among team members:
Shared knowledge, shared goals and mutual respect influence team members'

Shared knowledge, shared goals and mutual respect characterize the relationships among members in a team. These three dimensions influence, and are influenced by, the nature of team members' communication and the organizational structures and culture in which they take place.
| Muller I, Kirby S, Yardley L. The therapeutic relationship in telephone-delivered support for people undertaking rehabilitation: a mixed-methods interaction analysis. Disability and rehabilitation. 2015;37(12):1060-1065 | Communication, PC, and are influenced by organizational structures, policies and culture. How inter-professional teams work together is an important aspect of CCP. Effective teamwork does not automatically lead to enhanced client-centredness. Strategies are needed that ensure teamwork does not merely perpetuate the health professionals’ control of the patient or that decisions are the “right” decisions from the health care professionals’ perspectives. | Responsive to needs and preferences Interaction focused on socio-emotional and physical elements apart from biomedical agenda. High person-centeredness associated with stronger therapeutic relationship. Person-centredness is the degree to which people are at the centre of their care and refers to how responsive the support is to people’s needs and preferences. It was calculated as the ratio of all codes relating to socio-emotional and psychosocial elements of the exchange divided by codes that further the bio-medical agenda. This research found person-centredness during telephone support sessions to be related to the therapeutic relationship. Participants whose telephone support sessions were more person-centred were more likely to report a stronger relationship with their therapist. This supports previous research that views the development of a therapeutic relationship as a fundamental requirement for medical |
Therapeutic relationship as requirement for Person-centered care and importance of person-centered communication right from the scratch.

Friendly chatting about personal matters – beyond therapeutic ones.

Empathetic encouragement and reassurance.

therapy to be considered as truly person-centred [37], and highlights the importance of person-centred communication from as early as the first appointment.

The main differences were that high person-centred sessions typically included friendly chatting about personal matters unrelated to dizziness and rehabilitation.

High person-centred sessions also typically contained therapist encouragement to persevere with the rehabilitation and reassurance that the exercises were safe and would not cause harm.


The intervention did not impact in the target measures: issues of operationalization, implementation and research design might not be ruled out.

<Reports to the CADL intervention extracted for other paper also included>

Our hypothesis, that a client-centred ADL intervention would have an effect on participation superior to that of the usual ADL interventions during the first year after a stroke, could thus not be confirmed in the present study. However, the lack of differences in outcomes aligns with the conclusions of a recent systematic review of RCTs examining patient-centred interventions, which has shown that the beneficial
Interventions are challenging to implement and evaluate, following the difficulty to operationalize effects in favour of patient-centred care or rehabilitation were reported mainly in the areas of patient satisfaction and perceived quality of care (3).

The notions of patient-, person- and client-centred care or rehabilitation and similar terms are frequently used interchangeably, and this is also the approach acknowledged in Swedish healthcare legislation (25). There is, however, no consensus regarding how the concept should be operationalized in clinical trials (3) (…) We nevertheless might have failed to identify the specific principles of the CADL and the ways the intervention relates to outcome.”

In conclusion, the results of this study showed no differences in changes in perceived participation, but there was a trend towards a positive clinically meaningful change for the CADL in perceived participation during the first year after stroke.

The client-centred rehabilitation approach is challenging to implement and evaluate through RCT approaches alone.

Flink M, Bertilsson AS, Johansson U, Guidetti 3 Finding common goals: the continuous process from <Reports to the CADL intervention extracted for other paper also included>

| Setting the initial goals to deciding how goals are to be achieved and following them up, not only setting them up. Concepts of sharing power, listening/communicating, partnership, choice and hope were reflected. Unintended consequences: Documentation improvements were made in the main target, but detrimental to others also important, such as family and emotional support. | Finding common goals has a broader application, covering the continuous process from setting the initial goals to deciding how goals are to be achieved and following them up. Client-centeredness in occupational therapy has been linked to the concepts of sharing power, listening/communicating, partnership, choice and hope.7 These concepts are related to the aspects that make up the components Finding common goals for rehabilitation and Information and responsiveness in this paper. Training in client-centeredness enhances the documentation on finding common goals, i.e. on goal setting, how to reach goals and follow-up on goals. Training in client-centeredness enhances the documentation of clients’ participation in finding common goals for rehabilitation. Interestingly, documentation of the aspects of Information and responsiveness were not more present in the intervention group, and occupational therapists in control group documented significantly more on the clients’ families and emotional support.” |
The results could also indicate a negative effect of the training, being that the occupational therapists focused explicitly on finding common goals and hence omitted other important perspectives such as that of family and emotional support.


| 3 | Practitioners and patients: story telling toward sharing (practice) experiences and improving a person-centered practice – from both carers and patients; share experiences while hearing other’s. Participatory collaborative process enabled the multidisciplinary group to see the whole patient journey, to share understandings, and to become a team. | Participants provided evidence in the form of a story of their experience in practice and their understanding of safe, effective, person-centred hip fracture care. Story-telling enabled participants to share their experience whilst hearing the experience of others. The patients and carers participated in semistructured interviews to tell their stories of the journey from injury through to getting home. Clinical leaders reflected on excerpts. Reflecting on excerpts from the patients’ and carers’ stories of each stage of the journey to recovery following hip fracture continued the person-centred focus and highlighted some of the difficulties experienced in the journey to recovery following hip fracture. The implementation of this participatory collaborative process enabled the multidisciplinary group to see the whole patient journey, to share understandings, and to become a team. |

| 3 | A PERSON-CENTERED CARE intervention (previous paper also included - “Effects of person-centred care in patients with chronic heart failure: the PERSON-CENTERED CARE-HF study”) Partnership at different layers: starting with patient narratives, evolving to co-creation of plan, and then shared decision making. Maintaining the partnership, inclusively through sharing of documents and plan update. Partnership and plan initiated in-hospital and formalised | Care planning and decision making were performed collaboratively by patients and health care professionals according to the gPERSON-CENTERED CARE approach [9]. The importance of seeing the patient as a person with needs as well as resources and of a person-centred dialogue as a basis for engaging patients as actively involved partners in their own care.” In the gPERSON-CENTERED CARE-intervention group the partnership (initiating, working, safeguarding and maintaining the partnership) between the patient and health care professionals [9] was emphasised at all three health care levels (i.e. hospital, outpatient and primary care). Stages: Initiating the partnership. Patient narrative; co-creation of plan Working the partnership: shared decision making Safeguarding the partnership: sharing documents (…) Maintain the partnership: update the plan. |
| Wallace MA, Kendall MB. Transitional rehabilitation goals for people with spinal cord injury: looking beyond | 3 | Transitional rehabilitation services that look beyond the hospital walls - entail a client-centeredness in mind; are therefore not entrenched | Client- or patient-centred care is considered a key paradigm in community rehabilitation and therefore is integral in assisting individuals to transition from hospital to home environments. Goals can reflect ambitions as well as possible or realistic achievements for individuals in this stage of their rehabilitation journey. Consideration |
the hospital walls. Disability and rehabilitation. 2014;36(8):642-650

Client involvement in goal setting

Goals can reflect ambitions as well as possible or realistic achievements for individuals

and inclusion of both is important for client-centred care [7] and both were identified across the goal domains within the typology developed from the current findings, highlighting their relevance for transitional rehabilitation. Client involvement in goal setting has been suggested to be currently limited by expert ideals and organisational factors [25].

While this may still be present in transitional rehabilitation settings, the current findings suggest that these contextual factors may have less impact than they would in a hospital setting because new services such as transitional rehabilitation are developed with client-centred practice in mind and are therefore not entrenched in preconceptions about what peoples goals should be. Therefore, goals were identified that were relevant to the life contexts of the clients.

| Bertilsson AS, Ranner M, von Koch L, et al. A client-centred ADL intervention: three-month follow-up of a randomized controlled trial. Scandinavian | 3 | Linking past experiences in everyday life to future horizons. | The CADL intervention integrated the principles of client-centred practice (17) and the person’s unique lived experiences for goal setting and collaboration during the rehabilitation process. A basic assumption for the CADL was that people develop skills and knowledge by having experiences linking their past experiences in everyday life (2) to their future horizons. CADL included nine steps (31,32) and significant others were invited to participate during the |
Understanding the person's life-world experiences.

Not only ability and goals but perceptions of ability and wanted goals are clarified.

Partnership in identifying strategies

Significant others involved

Approach that aims to establish a relationship based on the person's lived experiences as the point of departure for rehabilitation will require more time than the usual rehabilitation procedure, regardless of rehabilitation rehabilitation process. The first step of the CADL was to create a relationship between the OT and the person with stroke, which was seen as a prerequisite for understanding the person's life-world experiences. Next, the OT observed the client performing an activity and then together they evaluated the performance in order to clarify the client's ability and perceptions of his/her ability. By using the Canadian Occupational Performance Measure (38), the client identified three Goals for activities he/she wanted and needed to perform. (…) the client performed the activity ranked as the first goal to discover and identify difficulties in reaching the goal. Thereafter, the client and the OT together identified specific strategies that would enable successful performance of the chosen activity. Different strategies were used for problem solving, e.g. implementing new ways of performing ADL; modifying the environmental demands.

The CADL had beneficial effects on self-rated emotional well-being three months after the intervention started but that there were no other differences in effects for people with stroke or their significant others compared with UADL. Longer follow-ups are, thus, required to monitor plausible advantages in outcomes of a client-centred approach.
Furthermore, it is conceivable that a client-centred approach that aims to establish a relationship based on the person’s lived experiences as the point of departure for rehabilitation will require more time than the usual rehabilitation procedure, regardless of rehabilitation context.


| 3 | More intensive diagnostic evaluation and a less intensive treatment. Issue/danger of expecting patients to “get rehabilitated” Requirements for shared exploration, understanding and decisions may lead to that extensive diagnostic evaluation. | Client-centred therapy resulted in a more intensive diagnostic evaluation and a less intensive treatment, as compared to usual care therapy. A possible explanation for the shift away from treatment can be found in the theoretical foundations of client-centred therapy. The origin of client-centred therapy can be found in approaches that focus on enabling individuals to find solutions in a nondirective manner (16). These collaborative approaches supposedly empower and provide an opportunity for clients to find their own path to improvement (6). Thus, client-centred theory suggests that if clients are enabled and empowered, they can ‘treat’ themselves. However, the shift away from treatment in combination with the poor functional outcome in our trial suggest that clients receiving client-centred therapy are less able to follow their path to functional improvement compared to usual care. |
A possible explanation for the more intensive diagnostic evaluation can be found in the high diagnostic requirements of client-centred therapy. Client-centred therapy requires shared decision making and setting goals as well as the exploration of the therapists’ and the clients’ needs, perspectives, expectations, strengths, frames of reference, and the societal and practice context (12). It also requires the involvement of the client in the decision-making process and in setting goals. Implementing client-centred practice can be a challenge for the therapists and the clients. The implementation can also be influenced by contextual and systems variables.

In our trial, the therapists were extensively trained in the principles of client-centred practice and they were facilitated in implementing it in their practice teams. We found a clear contrast in outcomes between both intervention groups. The overall adherence to the interventions and the contrast between both randomisation-groups seemed to be a success since the client-centredness was in favour of the client-centred therapists and in favour of the patients that received the client-centred intervention (10). Nevertheless, the therapists indicated that it was not easy to actually implement client-centred therapy and to change their way of working. Others have also suggested that health
Professions experience educational barriers in implementing client-centred therapy (3, 17, 18). It seems that, despite intensive training, client-centred therapy poses a challenge for therapists' diagnostic skills, leading to a long and intensive diagnostic phase.

Our results might lead one to conclude that client-centred therapy should be abandoned: the results of our trial are not supporting the application of client-centred therapy. On the other hand, one can also argue that it is important to take the client's point of view and preferences into account in planning treatment. Apparently, the assumption that enabled clients can follow their own path towards improvement should be revised.

| McGilton KS, Davis AM, Naglie G, et al. Evaluation of patient-centered rehabilitation model targeting older persons with a hip fracture, including those with cognitive impairment. | 3 | Interactional strategies and techniques to compensate for a patient’s loss of cognitive function. Focus on Abilities or Strengths | The REAP model, a person-centered approach to care for complex older adults that helps compensate for a patient’s loss of cognitive reserve [16]. The REAP model has four components: (a) Relate well, which equips staff with interactional strategies and techniques to compensate for a patient’s loss of cognitive function (e.g., using one-step commands if necessary) [17]; (b) modification of the Environment [18] to accommodate and enable a patient’s changing cognitive abilities (e.g., HCPs are taught to control the daily activity schedule so as not to over- or under-stimulate the patient); (c) emphasis on... |
Personhood, gaining more knowledge of a person’s life to motivate the person during rehabilitation and care provision.

Appropriate implementation measures (e.g. initial debriefing, raising and addressing staff’s concerns, experienced facilitator of the approach) contributed to the effective implementation of the approach.

Patients with cognitive rehabilitation were included into the rehabilitation program, with expected positive outcomes.

Abilities-focused care [19], during which HCPs focus on a patient’s retained abilities and compensate when necessary (e.g., the ability to initiate activities may be threatened because of CI, so HCPs are taught to follow the steps of asking, cueing, and demonstrating before doing the activity for the patient); and (d) the concept of Personhood [20], which refers to gaining more knowledge of a person’s life to motivate the person during rehabilitation and care provision.

Implementing a new model of care involves negotiating and developing shared understandings about the beliefs, risks, and advantages of the new over the old approach [27]. A one-day workshop was delivered to all staff providing care on the unit. Given the potential of staff to feel threatened by this change, all efforts were made to make the workshop interactive.

To address staff concerns, a gradual admission of post-hip fracture patients with CI was implemented.

Perhaps the most useful strategy employed during the workshop was involving HCPs from the initial pilot site where the PCRM-CI model of...
care was first introduced and preliminary evidence of the model’s effect was found [28]. Staff from that site discussed their first-hand experiences of patients with CI who had been successfully rehabilitated when staff used the components of the REAP model within the context of the overall approach to care in the PCRM-CI model. They also admitted their pre-existing fears and disbelief about being able to rehabilitate this population and explained how, over time and with the help of the REAP model, their preconceived ideas were transformed into a more positive and accepting perspective.

Despite positive feedback from staff about the workshop, education alone may not change practice, as it does not close the gap between knowing and doing [29]. To increase the likelihood of successful implementation of the PCRM-CI, the APN acted as a facilitator to help staff understand the importance of making a change, what was needed to change, and the process for effectively making the change.

Current study afforded preliminary evidence that providing additional education, support, and clinical resources (e.g., an APN with expertise in gerontology) in existing community rehabilitation units can increase the proportion of patients who return home post-discharge. While
many patients with cognitive impairment continue to be denied access to inpatient rehabilitation post-hip fracture in many countries, implementing the PCRMI-CI is a viable option for enhancing access and care for those patients requiring active rehabilitation services post-hip fracture."


Some worst outcomes were achieved, presumably by excessive time dedicated to the client-centred assessment process.

The client-centered approach diverged substantially from the usual

Interventions in MS were performed according to a structured client-centred process model (CPPF) [12].

The CPPF is congruent with the Canadian model of occupational performance and engagement and the Canadian model of client-centred enablement (CMCE). The CMCE is a visual metaphor for client-centred enablement [12].

This client-centred framework describes eight action points (…) (enter/initiate) (…) where a collaborative decision is made to either engage in or terminate the therapy. At the second action point the therapist and patient set the stage by determining how they work together, by clarifying expectations and assumptions and by identifying priority issues and possible goals. Subsequently action point three concerns the assessment or evaluation (…). Action point four (agree on...
| OT practice; meaning it is not a usual practice. | Objectives and plan) involves the therapist and the patient to establish goals and agree on the objectives and plan of intervention. The fifth action is to implement the plan with patient participation and power-sharing. Action point six includes monitoring and modifying by ongoing evaluation to determine if the used strategies are meeting the objectives. In the seventh action point the outcome of the plan is evaluated (…) The process concludes (…) when the therapist and patient come to a collaborative decision to either pursue other objectives or conclude the therapeutic relationship[14].

Since client-centred practice is often considered as an important component of OT one can question whether the contrast between the client-centred intervention and the usual care therapy was evident.

Compared to usual care therapy, client-centred practice according to a structured client-centred process framework had no impact on the primary outcomes (i.e. disability, participation and autonomy). Secondary outcomes and PP analyses showed negative effects on functional outcomes compared to the usual care. A potential explanation is that more time is spent on the consultation process and less time on actual treatment. If this is indeed the case then the |
Implementation of client-centred practice should be adjusted towards a more balanced therapy with more attention to treatment in order to achieve positive functional results.

| Béliveau J. Middle managers' role in transferring person-centered management and care. The Service Industries Journal. 2013;33(13-14):1345-1362 | 3 | Middle managers need to have an active role on transferring PC management and care approaches, but they need to have capacity, cultural stance or beliefs otherwise might remain passive disseminators. There is a need for behavioral exemplarity. Strategies might otherwise be perceived as artificial or superficial. | When middle managers lack the capacity (e.g. own beliefs or cultural stance) to absorb the approach proposed, they will play a very passive role in disseminating this approach to the personnel. Conversely, when middle managers have the requisite capacity to absorb the person-centered approach, they are likely to use various strategies to disseminate this approach among unit employees more actively. The main lesson drawn from this study concerns the importance of behavioral exemplarity in knowledge transfer. Middle managers' behavioral exemplarity thus emerges as a sine qua non condition for dissemination strategies initiated by middle managers as part of the transfer of a person-centered approach to be considered credible. If this condition is not met, the strategies may be perceived as superficial and even as artificial. |
| Bright FA, Boland P, Rutherford SJ, Kayes NM, McPherson KM. Implementing a client- | 3 | "Being with" rather than "doing to" through listening in order to get to know, to | The primary way that client-centred practice was operationalised was through listening in order to get to know, to uncover and to understand what was meaningful. Four strategies were identified: utilizing mindful listening, allowing time, supporting clients to prioritise what is


uncover and to understand what is meaningful. Strategies: mindful listening, allowing time, supporting clients to prioritize what is meaningful and viewing the therapists’ role differently. meaningful and viewing the therapists’ role differently. It was advocated that therapists might start from the point of "being with" rather than "doing to".

Applicability of Client-centered strategies at the macro, meso and micro-system environments. OTs feel fewer opportunities and less well prepared to influence client-centred processes in meso and macro level environments. Focus group discussion suggested a new conceptualization of the Client-centred Strategies Framework in which the strategy categories could be perceived as influencing client-centred approaches at three levels: micro, meso, and macro environments (Figure 7).

Personal reflection and client-centred processes primarily influence the micro level of the therapist and the relationship between the therapist and the individual client or family. Practice setting strategies primarily influence the meso level of the environment in which occupational therapy practice occurs. Community organizing and coalition advocacy/ political action primarily influence the macro level of the
### Personal reflection and client-centred processes

Personal reflection and client-centred processes primarily influence the micro level of the therapist and the relationship between the therapist and the individual client or family.

- The survey results and subsequent focus group discussions suggested that occupational therapists feel comfortable with and well prepared to implement client-centred strategies at micro level environments; they feel that they have fewer opportunities and are less well prepared in terms of knowledge and skills to influence client-centred processes in meso and macro level environments.

### Therapeutic relationship as key part of PERSON-CENTERED CARE

- Active listening, empathy and a climate of acceptance and value regarding expectations and/or underlying factors.

- Therapeutic relationship facilitated by unconditional acceptance, non-judgmental interactions, empathetic

### Person-centered care has emerged as a key principle in the provision of health and rehabilitation services. To implement this approach, health professionals must strive to develop a person-centered therapeutic relationship.

- Barriers and facilitators to the therapeutic relationship “on aspects that are attributable to the physiotherapist, to themselves and to the environment where treatment takes place.

- Patients in this study acknowledged that the professional’s negativity and insecurity hampered the therapeutic relationship, whereas when they demonstrated confidence and trust in themselves, the opposite effect was reported.

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| conversations, authenticity (truthful) – without hiding emotions, as a mean to build trust. | Physiotherapists who engaged in empathetic conversations were able to create an atmosphere where patients felt free to express their problems and fears (Carey, Kelly, Mansell, and Tai, 2012; Derksen et al, 2016). Regarding authenticity, the ability for physiotherapists to speak truthfully to others and be true to their own character, without hiding their emotions or wishes, whether positive or negative, facilitates communication, as patients have greater trust in people who seem to have a certain congruence between what they say, what they do and how they portray themselves. Patients seem to assign special importance to nonverbal expression, as this is perceived as either a facilitator or an obstacle. The participants reported that they were more honest and open with physiotherapists who exhibited unconditional acceptance and were non-judgmental. Inappropriate expectations regarding the physiotherapist, the treatment or the results were expressed as being a barrier for the patient regarding the establishment of a good therapeutic relationship. |
| No mixed-messages (contradictory information) from different providers: all staff informing patients of their status must have their messages congruent / coordinated; otherwise distrust arises. | Privacy of the physical space for enabling non-divided attention and secure, trustful environment |
| Non-verbal, authentic behavior. | |
It is necessary to establish a context in which the patient's expectations regarding their treatment options are valued, using active listening, empathy and acceptance.

Patients perceive that when all the professionals in charge of informing them of their status are coordinated, this becomes a facilitator of the therapeutic relationship. Contradictory information, on the other hand, can lead to the patient losing trust in the physiotherapist, disrupting the relationship as “a successful and sustainable relationship must be built upon a base of trust and reciprocity. (Collett, 2013)

The characteristics of the physical space are also important, and must provide the necessary privacy in order to establish a relationship of trust and confidence, facilitating individualized attention, which is central to person-centered care (Kitson, Marshall, Bassett, and Zeitz, 2013), and where the patient can feel listened to, understood and considered.

Lloyd A, Bannigan K, Sugavanam T, Freeman J. Experiences of stroke

PC goal setting is uncommon

Person-centered goal setting is possible but often does not occur. Practitioners need to listen to the person and know “who they are” – there is a need for an individualized approach to goal setting.
survivors, their families and unpaid carers in goal setting within stroke rehabilitation: a systematic review of qualitative evidence. JBI database of systematic reviews and implementation reports. 2018;16(6):1418-1453.

| Individualized/tailored approach to goal setting; Knowing the person – listening to them and finding more about who they are; Practitioners set the tone for PC goal setting or lack thereof; Hope and momentum – importance of supporting that, including through goal-setting; Acknowledge and adapt to the person’s desired intention to be involved in goal-setting. | Practitioners had the potential to shape the context of goal setting in both positive and negative ways; they wanted practitioners to listen to them and find out more about who they really were. A positive and engaging therapeutic relationship seemed to foster more of the same, whereas a relationship where practitioner and stroke survivor goals were not aligned led to discontentment, resignation and sometimes to the stroke survivors keeping their own goals secret. Recovery after stroke is ongoing and unpredictable (…) leading to challenges in goal-setting. They experience person-centered goal setting as both possible and rewarding, but as often not occurring, with barriers outweighing facilitators. The practitioners working with stroke survivors are perceived as having a powerful role, which can positively or negatively shape the goal setting, and thus the rehabilitation experience. Stroke survivors express a need for goal setting to be tailored to individual needs and preferences and, for that to happen, practitioners need to take the time to listen well. Recovery after stroke is perceived as an ongoing, natural but unpredictable process, to which stroke survivors... |
respond in different ways. However, there appears to be a shared experience of the importance of maintaining hope and a forward momentum in recovery, and that goal setting could serve as a useful tool to support this if used well.

Acknowledge and adapt to a stroke survivor ability and desire to be involved in goal setting.


4

Transparency a central theme – with good communication to add awareness.

Goal setting processes, including integration of goals and goal evaluation, adds to awareness and (self-)determination.

Goals linked to everyday life.

Transparency seemed to be important for creating a rehabilitation situation that enabled the clients to discover and actively engage in their own rehabilitation.

Participants expressed that by having good communication with the OTs and by using different strategies they became more aware of their everyday life situation.

One characteristic that was expressed by all of the participants was how goal-setting and working to achieve goals contributed in different ways to awareness and determination.

These findings have implications for occupational therapy and other health professional interventions by showing how clients’ involvement
| Enabling agency, ownership and self-determination, accepting responsibility/accountability for the intervention, and taking control over one’s life. Sharing experiences – patients and providers with one another, adding to transparency. | in their “goal-setting process” (e.g., including goal-setting, integration of goals, and goal evaluation) seems to be necessary in order for them to follow their progress and help them to integrate and connect their goals to their everyday life.

Furthermore, the experience of transparency also seemed to be important to enable change and to support the participant’s sense of agency and ownership of daily activities and rehabilitation after their stroke. It also allowed an experience of agency and an attitude of accepting responsibility for the intervention and for taking control of how it developed.

Therapists performing the CADL described how they and their clients were sharing experiences with each other, which seemed to enable experiences of agency in daily activities for the clients. This might suggest that the therapists sharing with their clients contributed to transparency for both the clients and the therapists, where they both could see and understand the therapeutic process. It is conceivable that sharing and transparency represent the essence and meaning of |
| Kidd MO, Bond CH, Bell ML. Patients’ perspectives of patient-centredness as important in musculoskeletal physiotherapy interactions: a qualitative study. Physiotherapy. 2011;97(2):154-162 | 4 | Patient-provider interaction is key for PERSON-CENTERED CARE. Therapeutic relationship based on: ability to communicate; confidence; knowledge, expertise and professionalism; empathy; ability to relate; and transparency of progress and outcome. PPC categories not isolated but providing a composite picture of PERSON-CENTERED CARE. | the CADL and are necessary conditions for client-centredness in rehabilitation after stroke. Physiotherapists would do well to consider the value that patients place on aspects of the clinical interaction. In particular, clinician/patient interactions that place the patient at the centre of the therapeutic relationship are based on: the ability to communicate; confidence; knowledge, expertise and professionalism; an understanding of people and an ability to relate; and transparency of progress and outcome. According to this study, a clinician that fulfils a combination of these dimensions places the patient at the centre of the healthcare experience. Five categories of characteristics relating to patient-centred physiotherapy were generated from the data: the ability to communicate; confidence; knowledge and professionalism; an understanding of people and an ability to relate; and transparency of progress and outcome. These categories did not tend to occur in isolation, but formed a composite picture of patient-centred physiotherapy from the patient’s }
Communication: listening, paraphrasing, explaining, reassuring and ensuring understanding. Clear and transparent communication about instructions, information and progress when talking about other aspects of care.

Confidence in the physiotherapist was dependent on good communication.

Perspective (...) most participants emphasised concepts relating to the ability to communicate, such as listening, paraphrasing, explaining, reassuring and ensuring understanding. However, patients additionally focused on the role of clear and transparent communication about instructions, information and progress when talking about other aspects of care (... ) although communication underpins patient-centred care in physiotherapy [19], no single dimension of patient-centred physiotherapy exists without its reliance on the other dimensions.

Although previous literature does not mention confidence per se as a component of patient-centred care, to some patients, confidence in the physiotherapist was dependent on good communication (…) Many of the concepts strongly reflected Mead and Bower’s dimensions of patient-centredness including a professional view of the ‘patient-as-person’ [34, p. 1088]

Stewart et al. called this relationship ‘the common ground’ [36,p. 444]; the space in which, rather than abdicating control to the patient, clinicians use their understanding to respond to the unique needs of the patient.
<table>
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<tr>
<td>Creating a diverse, encouraging, and educational physical rehabilitation experience. Benefits include: motivation, hope, improved self-confidence, and acceptance. Challenges to be identified and addressed include comparisons (with other and the previous self), negative emotions, recovery expectations, and slow progress. Need for support from health care professionals, family, and friends, as well other</td>
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<tr>
<td>Creating a diverse, encouraging, and educational physical rehabilitation experience with supportive staff who focus on communication and person-centred care. Benefits to people with spinal cord injuries, including motivation, hope, improved self-confidence, and acceptance. Challenges identified during physical rehabilitation for people with spinal cord injuries, such as comparisons, negative emotions, recovery expectations, and slow progress, should be addressed by healthcare professionals to ensure person-centred care. They also struggled to cope with life and bodily changes they were experiencing, and had difficulty with comparing themselves to their previous self or others with SCI Need for support from health care professionals, family, and friends, as well other</td>
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<td>Issue of control, including the fight for it and the process of regaining it that can occur during physical rehabilitation.</td>
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<td>people with spinal cord injuries.</td>
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<tr>
<td>Issue of control, including the fight for it and the process of regaining it.</td>
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<td>Partients feedback should always be sought and incorporated in order to identify and resolve any specific issues with programme structure.</td>
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<td>Working together with healthcare professionals as a team is important, and participants enjoyed being treated as an equal member in decision making about their own care.</td>
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<td>understanding and accepting new abilities was also represented as the importance of reconnecting the past and the future.</td>
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Regaining control could be a conscious decision made at some point after SCI, a by-product of reengaging in meaningful activities, or having the ability to live independently in the community.

Acting in a positive, respectful manner and working together with participants, as well as encouraging independence and thinking about the future.

Understanding and accepting new abilities was also represented as the

| In order for person-centred care to be implemented most effectively, the concerns of participants must be heard and addressed. Open and honest communication with participants about their concerns, especially with regards to the process of recovery after SCI and their individual expected outcomes. |
importance of reconnecting the past and the future.

In order for person-centred care to be implemented most effectively, the concerns of participants must be heard and Addressed.

Open and honest communication with participants about their concerns, especially with regards to the process of recovery and expected outcomes.

<p>| Hansen AO, Kristensen HK, Cederlund R, Lauridsen HH, Tromborg H. Client- | 4 | Individualization, inclusively in the information provision – relevant to life situations, Persons want information about alternative solutions, despite restrictions, and they want to participate in decision making, which would render the rehabilitation more relevant to their life situations and personalities. |
| centred practice from the perspective of Danish patients with hand-related disorders. Disability and rehabilitation. 2018;40(13):1542-1552 | personal factors and preferences. Information and education, even about alternative solutions – toward enablement. Participation in goal setting in the degree and way they wish, even implicit. Evaluation outcomes from the person’s perspective. Emotional support: listened to by all health professionals, if their hope for the future were included in the rehabilitation and if their emotional feelings were | Enabling occupation (…) was found to be essential and it was added as a domain. Information and education were considered essential. Participants in our study pointed out they want individual tailored information and education and that they wanted information, not only concerning the injury and restrictions, but also about what alternatives they had and how to handle everyday life. As a result, we suggest that a questionnaire evaluating client-centredness should provide items, both about whether the required information had been given, but also whether it was timely and relevant in relation to the patient’s life situation at the time. Most of the participants described that they had not participated in a formal goal setting session, whereas a few had set up goals with the OT or they felt that goals were implicit. Our findings suggest that it is crucial that a questionnaire evaluating client-centredness with outpatients allow patients to express whether they participated in the |</p>
<table>
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<th>addressed and taken serious.</th>
<th>rehabilitation to the extent that they wished, and not merely whether they participated or not.</th>
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<tr>
<td>Value of having continuity with the same therapist.</td>
<td>Evaluation of outcomes from the patient's perspective</td>
</tr>
<tr>
<td>Continuity of care between the ward and clinic, involving communication.</td>
<td>Emotional support: items about being listened to by all health professionals, if their hope for the future were included in the rehabilitation and if their emotional feelings were addressed and taken serious.</td>
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<tr>
<td>Importance of significant others, for some people.</td>
<td>Coordination and continuity: The participants in this study were mostly treated by the same OT during the course of their rehabilitation, and they valued this.</td>
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<td>The participants’ experiences of coordination between wards varied, but they all agreed about the importance of fast and efficient communication between the referring ward and the outpatient clinic.</td>
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<td></td>
<td>Family involvement: The possibility of having family members or important others involved in rehabilitation as a support was important for most participants, although only a few made use of it.</td>
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| 4 | Person as individual, with unique and holistic needs. Getting to know the person (providing opportunity to talk and to be heard); Helping, when necessary, in coordinating services, with personalization, flexibility, and availability of needs-based services. Connection and Partnership as key issues. Recognizing the client as an expert. Sharing informing, also of available resources. | Core elements of designing and delivering services in a person-centered way validated by persons with disabilities:

Understanding clients and meeting their individual needs: Getting to know the person (providing opportunity to talk and to be heard);
Assessing needs holistically Personalization, flexibility, and availability of needs-based services; Helping, when necessary, in coordinating services.

Connecting and partnering with clients: Professional training and competencies (e.g., how to build trusting relationships, create connection, improve communication skills) Compliance with ethical principles and values, respecting differences and demonstrating this to clients; Adequate facilities (private and comfortable service environment); Policies supportive of the service process (sufficient time to attend to clients and resources to meet clients’ needs, manageable caseload size).

Providing appropriate and adequate information (in an understandable manner, oral and written) about the following: Diagnosis, treatment,
| Providing appropriate and adequate information (in an understandable manner, oral and written) about the following: Diagnosis, treatment, medications, and prognosis; Available services (social, employment, disability unions, etc.) Clients’ rights and responsibilities; Self-help and support groups. |
| Private and comfortable environment |
| Sufficient time – manageable caseload size. |
| Addressing issues of power and empowerment – |
| medications, and prognosis; Available services (social, employment, disability unions, etc.) Clients’ rights and responsibilities; Self-help and support groups. |
| Addressing issues of power and empowerment: Fostering equality with clients; Recognizing the client as an expert; empowering clients, helping them increase their self-efficacy and take more control of their lives; Involving clients in planning and decision-making processes, sharing responsibilities with them. |
| Mastering skills such as active listening, motivational interviewing, and client empowerment to assist clients in meeting their rehabilitation goals. |
| Freeman C, Cassidy B, Hay-Smith EJC. | Private, safe space for sexual / intimacy issues. Reconfiguration of hospital space needs attention. Uninterrupted, private, autonomous, safe space where couples can be alone together is essential to support relationship maintenance, and to enable intimacy, including sexual intimacy. Even so, an outreach service with a focus on expressions of sexual intimacy is needed for couples who chose not to address sexual intimacy during acute inpatient rehabilitation. | A lack of privacy in the inpatient rehabilitation environment was keenly felt by the couples as they sought to be alone together. Reconfiguration of hospital space needs urgent attention. Uninterrupted, private, autonomous, safe space where couples can be alone together is essential to support relationship maintenance, and to enable intimacy, including sexual intimacy. Even so, an outreach service with a focus on expressions of sexual intimacy is needed for couples who chose not to address sexual intimacy during acute inpatient rehabilitation. A six months post-discharge program could incorporate intimacy in its holistic form and include a therapist with skills in facilitating family relationships and intimacy. |
couples who chose not to address sexual intimacy during acute inpatient rehabilitation.  

Continuity of care – home as a place to (further) address intimacy issues by skilled professional.

Individual who has sustained the injury and the partner are a singular entity—a ‘couple’. Thinking the client is within a couple, within a family.

Clinically, recognition that the individual who has sustained the injury has a partner, and with that partner they are a singular entity—a ‘couple’—needs to be embedded within the construct of care for health professionals. This requires moving beyond thinking the ‘client’ in client-centered health care is the person with a SCI to thinking the client is within a couple, within a family. In New Zealand, this has parallels with ‘whanau centered’ (family centered) practice.

Walder K, Molineux M. Re-establishing an occupational identity after stroke – a

Re-establishing an occupational identity through connecting the life story according to the past,

The theoretical framework described in this study can be used by therapists to explore how individuals form and maintain connections across the domains of self, reality and others, to create a client-
<table>
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<tr>
<td>theoretical model based on survivor experience. British Journal of</td>
<td>present reality and future reality. Connecting with reality meant confronting the impact on daily life and one’s unfolding life story according to three realities: past reality, the reality of the stroke and future reality.</td>
</tr>
<tr>
<td>Occupational Therapy. 2017;80(10):620-630</td>
<td>focused understanding of the experience of re-establishing an occupational identity. Connecting with reality meant confronting the impact on daily life and one’s unfolding life story according to three realities: past reality, the reality of the stroke and future reality.</td>
</tr>
<tr>
<td>Alanko T, Karhula M, Kroger T, Piirainen A, Nikander R. Rehabilitate</td>
<td>Outcomes of PERSON-CENTERED CARE: person felt respected, valued and listened to. They trusted professionals and self-efficacy is empowered.</td>
</tr>
<tr>
<td>es perspective on goal setting in rehabilitation - a phenomenological</td>
<td>When professionals committed to working in a patient-centred manner, the rehabilitees felt respected and they trusted professionals and thus their self-efficacy was empowered. The rehabilitees felt that they were valued, respected, and listened to. The interaction between rehabilitees and professionals was open and</td>
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<td><strong>Equal participation in goal-setting. Motivated to achieve the self-determined goals.</strong></td>
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<td>The rehabilitees wanted to set large-scale and far-reaching goals, whereas the professionals and relatives preferred shorter term goals which were more achievable for rehabilitation interventions.</td>
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<td>Relatives’ support was valued but their participation in goal-setting sometimes generates contradictory feelings with respect to autonomy</td>
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**equal and rehabilitees felt they could participate in the decision making related to their own, meaningful goals for rehabilitation.**

Professionals should be recommended to remove obstacles that restrain patient’s participation in the goal setting situation. A client-centred approach can facilitate rehabilitees motivation and engagement in goal setting, which may support achieving successful rehabilitation goals. Professionals should be recommended to recognize patients with changed health and offer psychosocial support for those in need to improve their participation in rehabilitation process.

The rehabilitees wanted to set large-scale and far-reaching goals, whereas the professionals and relatives preferred shorter term goals which were more achievable for rehabilitation interventions. Similar findings were found in previous studies where poor collaboration between a patient and professionals involved persuasion from the professionals side and where there were differences between the rehabilitee and professionals in perceptions of goal setting.
| Van de Velde D, Devisch I, De Vriendt P. | Psychosocial issues increasingly relevant at a second stage of the rehabilitation process. That is subjectively determined – requires individualization and skill to identify that timing. Less formal methods for goal-setting more likely capable of being truly PC. More informal communication leads to a more valid image of the | The result of this study indicates that all rehabilitees experienced trust in their relatives emotional, informational support, encouragement, and concrete help in the goal setting situation. Nevertheless, there were also rehabilitees who had contradictory feelings towards their relatives participation in the goal setting situation because the relatives restricted the rehabilitees autonomy. A client-centred approach entails a shift from focusing on recovering from short-term neurological issues to the long-term consequences of the disease. The professional must make this shift in reasoning at a specific and highly subjective client-defined moment during rehabilitation. Identifying this moment could strengthen the client-centred approach. Client-centred practice is most likely to be successful when client is susceptible to discuss is psychosocial issues and finding this moment is a challenge for the professional. To be effective in client-centred practice, the clients expect from the professional to be an authority with regard to biomedical issues and to be partner with regard to psycho-social issues. | 4 |
An informal method provides the professional with more fruitful information to plan a client-centred therapy programme tailored to the clients' needs. Using formal methods for goal setting do not necessarily cover all the information needed for a client-centred therapy programme. Rather, using informal methods could lead to a more valid image of the client. Results indicate that more informal communication leads to a more valid image of the client. An informal method provides the professional with more fruitful information to plan a client-centred therapy programme tailored to the clients' needs. ‘Being with’ clients might be more important than ‘doing to’ them and shifting from ‘what can I do for this person’ to ‘who is this person and what does he need’ may be necessary to promote a client-centred approach. This is how Bright et al. described in their ethnographic study how client-centred practice should be operationalised.[27]


Therapeutic relationship and trust as foundational, inclusively for client engagement. Working partnership between the client and the therapist and attributed clear roles to both. The framework presents an understanding of client-centred practice as a person-centred process of engagement founded on the establishment of a therapeutic relationship between the client and therapist in particular the participants emphasized the importance of therapists acknowledging the trauma associated with brain injury and being sensitive to the emotional impact of this trauma.
| the client and the therapist in this relationship. |
| Positive relationship experiences with therapists. |
| Importance of therapists acknowledging the trauma associated with the disabling condition and being sensitive to the emotional impact. |
| Felt valued and cared for as an individual. |
| Provides opportunity for clients to reconstruct a positive sense of self post-injury as a capable and valued person. |

The research participants in this study sought out relationships with therapists in which they felt valued and cared for as an individual and in which the therapist gave them hope for the future. The participants found the emotional connection that developed between the client and the therapist was central to developing trust in the therapist.

While the client–therapist relationship was identified as the foundation of client-centred practice, it was also seen to be pivotal to the active engagement of clients in therapy. The research participants described the process of clients engaging in therapy as the working partnership between the client and the therapist and attributed clear roles to both the client and the therapist in this relationship.

The participants in this study identified engagement in client-centred practice as an opportunity for clients to reconstruct a positive sense of self post-injury as a capable and valued person. They described feeling valued and affirmed as a person through positive relationship experiences with therapists.
Foreign language issues: Difficulties in communication caused by language discordance quickly emerged as the primary barrier to patient-centered care.

Lauren (patient) was unfamiliar with the translation services available to her as an English-speaking clinician working with a non-English speaking patient. She later expressed frustration with the facilities process for requesting translation services.

Specifically, completing required facility procedures did not guarantee interpreter availability. Furthermore, a lack of exposure to strategies for caring for diverse populations in her educational curriculum left Lauren with many questions about how to best engage with interpreters, leading her to conclude that she could not build a successful relationship with José when an additional person was present.

The lack of trained interpreters and reliance on ad hoc and untrained volunteer interpreters resulted in ethical missteps, role confusion, safety concerns, and breaches of privacy and confidentiality. The interpreter’s: (a) lived experience as a patient of the facility; (b) lack of formal training as an interpreter; (c) lack of formal assessment of fluency; and (d) unfamiliarity with medical terminology, the ethical
implications of interpretation, or clinical boundaries posed significant threats to high-quality care. The quality, type, and amount of information that was exchanged during each clinical encounter decreased, affecting treatment effectiveness, rapport, and trust. Patient preferences and goals were not established, the important contribution of occupational therapy was not recognized, and caregiver needs were not addressed.

Employment of volunteer interpreters in our case was a cost-effective way to meet the high demand for interpretation services and respond to patient needs. Although the use of interpreter services may increase costs in the short term, practitioners and institutions are encouraged to consider the positive outcomes of language access services on areas such as service utilization, quality and safety of health care, and patient satisfaction.

Communication in the presence of language discordance is only one factor to consider in the delivery of patient-centered care to diverse patient populations and in the complex interactions within patient–provider–caregiver triads.
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<td>4</td>
<td>PC includes both the right to decide and not to decide. Requires assessing client's readiness for power-sharing. The synthesis revealed key experience issues related to coping with a new situation; informational needs; physical and non-physical needs; being personally valued and treated with respect.</td>
<td>(The synthesis revealed issues related to) Coping with a new situation; informational needs; Physical and non-physical needs; Being personally valued and treated with respect; Collaboration with health professionals; and assuming responsibility and seizing control. The review also showed that the participants’ experiences were diverse, reflecting the dynamic nature of client participation. Enabling empowerment is a matter of constantly weighing contrasting issues against each other, e.g. the right to decide versus the right not to decide (Figure 1), and that autonomy and paternalism can be equal aspects of client-centred stroke rehabilitation. This challenges some of the current descriptions of client-centred occupational therapy, which are based on equal collaboration e.g. through non-paternalistic partnership approaches (41–43). Autonomy refers to the individual’s right to decide for him/herself (44). This fundamental right cannot be questioned, but the fundamental right not to decide and to decline participation in the decision-making process must equally be acknowledged. The ability to address this complexity calls for conscious and critical awareness of how best to</td>
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enable client participation in collaborative decision-making, e.g. how shared decision-making and paternalism is being administered.

Not all clients are ready to assume power and responsibility even though therapists may want them to (47). The findings suggest a need for a greater understanding of how occupational therapists are able to evaluate how and when clients are able to assume power and responsibility. This is supported by current occupational therapy theory (42,48). However, more research is needed to provide knowledge on how occupational therapists may assess, evaluate, and enable clients’ readiness and need for power-sharing.

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<tr>
<td>Participants value a patient-centred holistic approach to care. Therapeutic alliance, psychological, emotional and education support helped the participants to feel more</td>
<td>Participants value a patient-centred holistic approach to care. Alongside the value of physical improvement, the importance of the therapeutic alliance and the value of psychological, emotional and educational support helped the participants to feel more empowered in their own recovery.</td>
</tr>
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</table>
Empowered in their own recovery.

Gap in the way patients and professionals see goals: patients more in terms of overriding recovery and hope for continuous improvement for the own life context; professionals more in terms of measurable, timed goals.

No one-size-fits-all approach to goal setting: different types of patients respond best to different types of goal setting.

Professionals need to communicate fully with patients to gain an understanding of their

Stroke patients think about goals very differently from health professionals.

The participants in this study tended to have vague or broadly worded goals rather than specific goals, which is the preference of health professionals.

Individual patients have diverse ideas about goals within the context of the uncertainty of stroke, their life as a whole and recovery after formal rehabilitation is completed.

Patient uncertainty (about their condition, their potential for recovery, and rehabilitation processes in general) plays a large part in the difficulties patients have when engaging in goal selection.

We suggest that health professionals also need to receive training in what the experience of stroke is like for patients, both psychologically and physically, and how this affects their perspectives on engagement and (…) rehabilitation planning.
experiences of stroke, uncertainties regarding recovery, and wider views on goals. They may need training on that.

Patients view rehabilitation not as a discrete event, but as part of their whole life history.

Hope: patients do not need to know how things will improve in order to be hopeful that they might nevertheless get better.

Patients had an overriding desire to maintain a forward momentum towards

(Patients’) view of stroke recovery has no set endpoint and no specific goal other than to continually improve. In other words, stroke patients view rehabilitation not as a discrete event, but as part of their whole life history.

Our findings support this notion (of hope) with patients not needing to know how things will improve in order to be hopeful that they might nevertheless get better.

Our study also demonstrates how diverse patients’ thinking can be regarding goal setting in stroke rehabilitation.

Rather than assuming one approach to goal setting (such as the SMART approach) will meet the needs of all stroke patients, there should be a move towards methods that identify which types of patients respond best to which types of goal setting.

Patient-centred goal setting is considered an ideal part of modern rehabilitation, but cannot be addressed by one-size-fits-all clinical processes.
maximising their recovery and quality of life

(Patients had an) overriding desire to maintain a forward momentum towards maximising their recovery and quality of life after stroke.

To meet these diverse needs, health professionals need to communicate fully with patients to gain an understanding of their experiences of stroke and wider views on goals.


Focus on person-centered services accessed by people in rural / remote areas.

Service delivery options in that context might start with person-centered questions, followed then by flexible/responsive to changes (regarding any changes) in person’s and their carer’s needs and circumstances.

Rural and remote person-centred approach (…) The approach, that builds on existing rural therapy service delivery options, is person-centred and place-based.

The starting point for these strategies is the person-centred questions “What does this person or family want?” And “What would make a good life for the person?”

Making choices and deciding on the appropriate action to implement these choices is potentially empowering for people with a disability and their support network members [20].”

“A person-centred approach is an evolving process that is integral to providing therapy support, continues across the person’s life course,
and is responsive to the person and their carer’s changing needs and circumstances."


| 4 | goal setting for stroke patients was more clinician-centred, system centred or population-centred rather than being patient-centred. Low-level evidence supports the enhancement of psychosocial constructs and outcomes. Concept valuable mostly in philosophical arguments. Patient’s goals focused on psychosocial constructs and participation levels. | This study reviewed the literature to map the nature and extent of the application of the patient-centred goal setting practice in current stroke rehabilitation and found that this was uncommon, despite recommendations that this be common practice.7,9,66,67 Despite indications that patients could and wanted to be involved in the process43,45,48,55 goal setting for stroke patients was more clinician-centred, system centred or population-centred rather than being patient-centred in the various aspects of stroke rehabilitation.68 As a result, it was not possible to map the nature of this process in an explicit way. However, this review has identified significant barriers to patient-centred goal setting practice and methods that can be used to incorporate patient-centred goal-setting practice. The review identified low-level evidence supporting the claim that patient-centred goal setting practice may have a positive impact on psychological outcomes. The benefits can include improved self-efficacy, sense of autonomy, 48 self-assurance,69 motivation,48,70 reduced anxiety46 and empowerment leading to greater competent
Implementation varied across professionals – others than OTs had little implementation. Most literature came from OT due the philosophical roots of the profession.

The health system was often blamed by the structured focus, formal assessments and allowing thus for few explorations of preferences and potential; not known whether that is the genuine reason.

Person-centered goal setting needs to be actively supported, not just asking for patient's goals. Providers participation in rehabilitation efforts.47,48 There was no evidence indicating that patient-centred goal setting in patients who could participate in the process caused harm to stroke patients or the service providers.

It appears that the recommendation that goal planning involving the patient-centredness concept is valuable is based rather on philosophical arguments.

goal setting among professionals there seems to be a reported disparity (i.e. 40% of physicians (total numbers unspecified)49 and 80% (n¼9) of occupational therapists43 adopted it). The other therapists and nurses were of the view that they were quite limited in its adoption in their practice.15,48,51,54,59 However, this reported adoption should be interpreted with caution, considering the perceptual and practice gaps wherein what the professionals perceived and reported was not on par with what they actually applied in practice.43
can explore high order goals and facilitate a graded decision-making

Balance between flexible, open-ended assessment on measuring experiential goals and formal, structured approaches for setting and measuring them: personalized yet valid approach to evaluation of goal setting.

Providers must enable patients to actively perform the person-centred goal setting process. Only if all attempts to engage the patient fails, providers can act in the patient’s presumed preferences and potential.74 This may result in reduced opportunities to develop trust regarding the patients’ competence.75 It is important

| Patients’ goals included psychological and social perspectives and were mostly aimed at improving participation levels. |
| The high volume of occupational therapy literature relevant to the patient-centredness concept uncovered by the review is probably due to the influence of the governing ideologies of the profession.72,73 Moreover, the role of occupational therapists in the interface between hospital and community warrants a patient-centred approach. Patient-centredness has also been imbued into the occupational therapy professional culture as a part of educational training better than in other health professions.73 Hence the patient-centred practice principles from the discipline of occupational therapy could be used as a model to enable other professions to develop patient-centred goal-setting practices. |
best interests – with conflicts with family interests potentially arising.

to explore whether the system restrictions genuinely play such a major role.

Exploration of the higher order values (values that are core to any desire or need) that determine goals instead of simply questioning for their goals can be a better approach to determining patient-oriented interventions. Yet another proposed strategy from the literature is graded decision making, i.e., decision making suitable to the patient's degree of involvement at different points in time resulting in appropriately set goals which may reduce patients' passivity and improve participation.

Measuring qualitative outcomes based on patients' experiential goals can pose challenges for which an open-ended flexible approach catering to personally meaningful goals has been suggested. On the other hand, advocates of formalized patient-centred goal exploration condemn such informal interviewing as ineffective and suggest the use of tools like life goals questionnaire, goal attainment scaling, and the Canadian Occupational Performance Measure. Training and cost issues associated with the Canadian Occupational Performance Measure and issues of neglecting
important but immeasurable goals and instead setting unchallenging goals associated with goal attainment scaling (GAS) need to be contemplated.81 Measurement based on the patient-centred qualitative measures complemented with currently used quantitative outcome measures could be the means to a personalized yet valid approach to evaluation of goal setting.

It is worth noting that all patients capable of participating do not necessarily participate, with some handing over decision-making responsibilities to the health professionals. Judging the emotional engagement with the goal discussion can point to the level of involvement of the patient and give directions for the professional to pursue.82,83 Professionals need to educate patients about the concept and the process of patient-centred goal setting, provide clear information regarding the condition, its prognosis and time course in order to inculcate realistic expectations.5,83 Time, facilitatory environment, open communication and sensitivity to personal factors and situations are essential to establish a special therapeutic relationship involving trust.18,53,69 These strategies may facilitate behavioural change84 and improve participation in goal setting.12 If all
efforts to be inclusive of patients within the goal-setting process fail then the assumed best interests of the patient might be considered. However, this leads to a major ethical dilemma for professionals in rehabilitation practice, especially when conflicts arise with the family in the process of setting goals for the patient.

<p>| Peoples H, Satink T, Steultjens E. Stroke survivors’ experiences of rehabilitation: a systematic review of qualitative studies. Scandinavian journal of occupational therapy. 2011;18(3):163-171 | 4 | Enabling empowerment is constantly weighing contrasting issues against each other, e.g. as the right to decide or not decide. This is the individual versus the relational aspect of power and empowerment. With regards to the latter, there is an emphasis on client participation, partnership and shared decision-making. The review showed that stroke survivors’ experiences reflected individual and relational aspects of power and empowerment...Enabling empowerment is a matter of constantly weighing contrasting issues against each other, e.g. the right to decide versus the right not to decide… can be equal aspects of client-centred stroke rehabilitation. This challenges some of the current definitions of client-centred occupational therapy that emphasize partnership approaches based on active client participation and shared decision-making” |
| Wain HR, Kneebone, II, Billings J. Patient experience of neurologic Staff explaining their rationales to patient and providing opportunities for them to say how the felt and | 4 | Participants felt they were directing and leading their rehabilitation experience and received an individualistic and holistic approach to their care. This theme also included patients’ views on the therapeutic |</p>
<table>
<thead>
<tr>
<th>Rehabilitation: A Qualitative Investigation. Archives of Physical Medicine and Rehabilitation. 2008;89(7):1366-1371</th>
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<td>the chance to discuss was greatly valued, even when staff members disagree with each other.</td>
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<tr>
<td>OWNERSHIP: A strong sense of involvement in the rehabilitation process was portrayed by most participants. Opinions were sought, targets discussed, and opportunities given to guide and direct the experience. Most participants expressed the idea that this was their time and chance to be themselves.</td>
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<tr>
<td>Positive: &quot;(staff) sometimes agreed and sometimes disagreed and told me why, which was great&quot;. Although staff and patients did not always agree, the opportunity to say how one felt and the chance to discuss this was greatly valued.</td>
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<td>Personal Value: did not feel like &quot;a number . . . you’re a person&quot;.</td>
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<tr>
<td>Positive: The whole rehabilitation experience, therapy, information provision, and daily interactions strengthened participants' beliefs that they were recognized as unique individuals: &quot;...it wasn’t everybody’s</td>
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<td>Patients dislike when staff mostly “try to convince them”. It limits (feeling of) involvement and control. (Ownership issue)</td>
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<td>Interpersonal relations among patients and staff (supportive network and sense of community within the rehabilitation setting); atmosphere and the extent to which this facilitated and supported a patient-centered approach.</td>
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<td>One patient described his case conference as an opportunity for staff to “try and convince me...”. These feelings of limited involvement and control in one’s care led to a negative view of rehabilitation.</td>
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pleasurable experiences: laugh and joking with you) and among patients and even previous patients (companionship, share of information and perspective with those with the same symptoms and worries – inclusively there was a barbecue) are among the requirements for a Holistic Approach.

Others are that psychologic gains, although important to the participants, were not always recognized by the unit: “they were saying they were making empirical measurements and there is no change, there is no goal to see how they managed in the bath, it might be but, I felt that they wanted to see how I managed in the bath”. Negative: despondent with his goal-setting experience, and did not feel that this addressed his needs, nor was person-centered.

HOLISTIC APPROACH: multidimensional approach to patients’ care and well-being. This included aspects of rehabilitation such as relations with staff and patients, therapy received, and the benefits derived from therapy. Interpersonal relations featured strongly in all participants’ accounts. They supported the holistic approach to patients’ care... creating a supportive network and sense of community within the rehabilitation setting. Relations with other patients in the context of companionship: “They had a barbecue for patients last Friday.... had all the old patients come back”. This was an opportunity to share experiences and information by meeting people who were going through the same experiences such as people who "have the same symptoms or worries". Daily interactions with staff were very pleasurable experiences. These involved “nice people, laugh and joke with you”. Participants enjoyed the relaxed approach taken by staff because it helped the patients to be themselves. The staff also ensured participants felt welcome, and installed a sense of security,
| Improvement, umm, and I’m saying there is but you can’t measure it. (Holistic approach) | Trust, and comfort within them. Negative: psychologic gains, although important to the participants, were not always recognized by the unit: “they were saying they were making empirical measurements and there is no change, there is no improvement, umm, and I’m saying there is but you can’t measure it”.

Sense of a noninstitutionalized, accommodating environment was installed in participants from their first contact with the unit, from a generally welcoming approach of staff, supported and enhanced the therapeutic ambience: place for a newspaper, puzzles, crosswords... garden, café, for relaxing and spend enjoyable time (THERAPEUTIC ATMOSPHERE) | THERAPEUTIC ATMOSPHERE: “second home” and “holiday camp” as they felt relaxed and at ease. This sense of a noninstitutionalized, accommodating environment was installed in participants from their first contact with the unit. An explanation of what was involved or through the general welcoming approach of staff. The relation among members of staff supported and enhanced the therapeutic ambience of the unit. Do—“it’s the only time I actually have time to read a newspaper, when I go in there, so that’s lovely”... “puzzles, or crosswords, that sort of thing... I’ve always done it at home”. Most participants benefited from their free time because it provided a multidimensional approach to their care. Descriptions of the ward emphasized its small size, which created a welcoming, “nonthreatening” environment. The garden, sitting room, and café, were also greatly appreciated because they provided space away from the ward to relax and spend time with visitors and other patients..... |
| Amati M, Grignoli N, Rubinelli S, Amann J, Zanini C. The role of hope for health professionals in rehabilitation: A qualitative study on unfavorable prognosis communication. PloS one. 2019;14(10):e0224394 | 5 | Encouraging hope but avoiding false or unrealistic hopes according to prognosis; it is a mean to empowering patients.  
Tailoring is needed to communicate the (unfavorable) prognosis, to avoid frustration and demotivation.  
Communication of prognosis not too late and not to soon – would vary by person; needs person’s readiness which | Health professionals perceive hope in rehabilitation as a double-edged sword. Three main strategies were identified to maintain hope while avoiding false hope: 1) giving space for self-evaluation; 2) tailoring the communication of prognostic information; and 3) supporting the patient in dealing with the prognosis. These strategies are particularly suitable when HPs consider that patients might not be ready to accept the prognosis, due to their expectations for recovery.  
Giving space for self-evaluation. Giving space for self-evaluation can be very useful in preparing the patient for the communication of the prognosis. As formulated by a participant, one of the tasks of rehabilitation is to help patients slowly adjust hope to reality, by letting them cognitively digest their new limitations. (Table 4, Q9) In order to do so, the HPs reported giving patients the time to experience their limitations and then involving them in the evaluation of their situation. (Table 4, Q10) This awareness should, on the one hand, facilitate the acceptance of the prognosis and, on the other, limit false hope. | Discussion: These 4 themes interacted with each other to create a patient-centered experience, from staff installing feelings of control and a sense of respect in patients, to the organization of the unit, which facilitated a holistic and individual approach to rehabilitation. |
needs to be assessed/understood.

When uncertainty exists, a more concrete prognosis can be delayed. It also allows time for the person to process the situation. Indeed, space for self-evaluation must be provided.

Setting and achieving short-term realistic goals can focus on and motivate for the improvements and may provide opportunities for a greater awareness of the condition.

Providing support and hope when poor prognosis are

Tailoring the communication of prognostic information. The HPs reported that tailoring the communication of the prognosis is helpful in fostering or maintaining patients’ hope, and limiting negative reactions (e.g. frustration, demotivation). In order to do so, the HPs mentioned the importance of collaborative constructing an understanding of the patient as well as of tailoring the timing and the format of the communication (…). The interviewees also suggested that HPs tailor their communication to patient “readiness”, namely discuss the prognosis when the patient is ready and willing to listen to this information. (Table 4, Q16) According to our participants, the “right moment” could, therefore, vary from patient to patient and is determined on the basis of an assessment of the patient’s condition and situation. (Table 4, Q17) When the prognosis is particularly uncertain, some HPs deemed it acceptable to delay its communication, if this could help the patients preserve hope and motivation for rehabilitation. Uncertainty, indeed, was framed by some HPs as an opportunity to gain time: instead of revealing the prognosis at once, they reported communicating it step-by-step, so as to give the patients time to reach awareness of their situation. (Table 4, Q18) As a general rule, one participant suggested that the best moment to communicate the prognosis is neither at the beginning nor at the end.
conveyed – e.g. with hints of hope and achievements. of the hospital stay, but in the middle. In this way, it is possible to support the patient towards acceptance of the prognosis during the time remaining before discharge. (Table 4, Q19).

Supporting the patient in dealing with the prognosis. Three supportive strategies can be used during and after communication of the prognosis: setting realistic goals, focusing on improvements, monitoring patient reaction for offering support.

by reaching goals, patients saw the improvements, gained awareness of their own capacities and became motivated to invest in their rehabilitation program. This approach of setting small and realistic goals not only supports motivation but, according to one participant, it avoids wasting energy by focusing on unrealistic or long-term goals.

Providers pointed for combining communication of the prognosis with a hint of hope, a perspective for the future despite the low likelihood of a complete recovery.

Empowering patients in what they can realistically hope for is instrumental in linking perceptions and reality.

Burridge LH, Foster M, Jones R, Geraghty T, Atresh S. Nurses' Introduction of new electronic documentation systems implies disruptions

The three themes were (1) discovering how eMR fits in a specialty setting, (2) making eMR work through adaptability, and (3) realizing the impact of eMR inclusion in the nurse–patient relationship.
| van der Veen DJ, Dopp CME, Siemonsma PC, Nijhuis-van der Sanden MWG, de Swart BJM, Steultjens EM. Factors influencing the implementation of Home-Based Stroke Rehabilitation: Professionals' perspective. PloS one. 2019;14(7):e022022 | 5 | Institution-based treatment can be too standardized, leaving little room for client-centered treatment and caregivers involvement, while the less rigid structure of HBSR makes it easier to adapt the rehabilitation process to the needs and preferences of clients and caregivers. | Participants reported that Home-Based Stroke Rehabilitation (HBSR) can be efficient and effective to most clients because it facilitates client- and caregiver-centered rehabilitation within the clients’ own environment. Participants characterized institution-based treatment to be standardized, leaving little room for client-centered treatment and caregivers involvement. Meanwhile, participants reported that the less rigid structure of HBSR makes it easier to adapt the rehabilitation process to the needs and preferences of clients and caregivers. Also, participants reported some advantages of treating clients within their own environment. | Perspectives of Person-Centered Spinal Cord Injury Rehabilitation in a Digital Hospital. Rehabilitation nursing : the official journal of the Association of Rehabilitation Nurses. 2019 ;45(5):263-270 | in the workflow and adaptive changes of providers for the person-practitioner interactions to remain Person-centered care | The eMR introduction triggered compensatory practices to manage the complexities and shortcomings of electronic documentation. Nurses adapted routines and reoriented workflows to preserve the Person-centered care. |
At client's home, professionals are like guests, which strengthens the client's position.

One of them concerns the professional being a guest in the clients' home. According to participants this can strengthen the client's position. Participants experience this can facilitate a stronger voice of clients and caregivers in reporting their needs and wishes regarding the rehabilitation process.

Our study reveals that professionals view the more flexible structure of HBSR, compared to institution-based rehabilitation, to facilitate client- and caregiver-centered treatment.


Individualized approach for a singular person (vulnerable, irrational, in constant movement, searching for meaning) - beyond the individualized care for the unique patient's characteristics (e.g. seeking compliance, rationality, and self-management).

This article has sought to shed light on the concept of the individual patient inherent in patient-centred care.

The "person" at the centre of care was not essentialised in terms of biological mechanisms, but rather considered as a vulnerable, irrational and moving self. By contrast, the second storyline focused on goal-oriented interventions aimed at restoring the patient to health. Here, the person in the centre of the treatment was shaped according to model narratives about "the successful patient"; the empowered, rational, choosing and self-managing individual. As such, the findings revealed two conflicting concepts of the individual patient inherent in patient-centred care. On the one hand, the patient is seen as being a person in constant movement, and on the other, they are captured by...
more standardised terms designed to focus on a more stable notion of outcome of illness. Therefore, our study suggests that the therapists’ will to recognise the individual in patient-centred care had a counterpart involving a marginalisation of the singular.

One storyline focused on an open-ended, singular healing process and a search for meaning and sharing. The “person” in the centre of care in this storyline was seen as a vulnerable, relational, and embodied self in constant movement. The second storyline, on the other hand, was governed by treatment goals, the aim of restoring the patient’s physical condition, and returning the patient back to work. Here, the patient as a person was shaped by the production of idealised images of “the successful patient”—a rational, compliant and self-managing individual.

Dorfler E, Kulnik ST. Despite communication and cognitive impairment - person-centred goal-setting after stroke: a

Person-centered goal-setting is a mean toward fostering autonomy in decisions for care and life.

The underlying assumption of the present study was that it is the responsibility of health professionals to enable participation in goal-setting despite communication and/or cognitive impairment.
Enabling participation in goal-setting for those with communication and/or cognitive impairment; providers have the responsibility to do so.

Continuing to offer opportunities for participation in goal-setting as the process unfolds.

Knowing the person and leaving one’s (practitioners’) values aside.

Apart from regular communication strategies and sufficient time, clinicians use different strategies for

Participants talked about remaining flexible and continuing to offer clients opportunities for participation as the rehabilitation process unfolded.

The importance of a flexible, evolving and individual practice, maintaining an open attitude, and leaving one’s own values, preferences, attitudes and notions of “normality” behind to get to know the client.

Various communication strategies (using simple language and communication aids, changing slowly between different topics, repeating, confirming understanding, summarizing essential points) [28,47,48], and the point that sufficient time needs to be made available, to achieve mutual understanding and build a trusting client-therapist relationship [20,28,30,47,48]. Additionally, our study suggests that clinicians do not distinguish between goal-setting strategies for clients with either communication or cognitive impairments, because these often overlap and each client has different needs. Instead, clinicians draw from a repertoire of strategies to best meet the individual client’s needs.
different persons than different patients.

Empathy and clarity when exploring means toward adding self-awareness, such as reflecting on performance.

Exploring personal motivation behind each goal.

“Relaxing” wording of goals, not a formulaic application of goal criteria.

Sometimes, one needs to rely on relatives, but patients have a “final say”

| Different persons than different patients. | Experiential, observational, audio and video feedback, as well as constructive feedback and structured experiences were described to gain self-awareness” “Important to this is, as the participants of the current study described, that clients are supported with empathy and clarity when reflecting on the performance of the activity.

The experiences of participants in this study suggested that identifying personal motivation behind the desired goal can increase the “success rate” of lasting goals.

Participants described a “relaxed” wording of goals, which refers to rejecting a formulaic application of all SMART criteria.

Enable client autonomy, and to support clients in making their own decisions within rehabilitation and life in general.

While interviewees asserted that it was principally possible to involve clients with communication/cognitive impairment in goalsetting, it was also acknowledged that at times this may not be the case and decisions may need to be supported through involving clients’ relatives. |
Although the client was thought to have the “final say”, it was considered important that relatives agree with or shape the client’s goals, especially when they are required to participate in or enable activities.

<table>
<thead>
<tr>
<th>Morera-Balaguer J, Botella-Rico JM, Martinez-Gonzalez MC, Medina-Mirapeix F, Rodriguez-Nogueira O.</th>
<th>Personal/private space available - improve the layout of the rehabilitation gyms</th>
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<td>5</td>
<td>Professional’s own negative states can cause barriers to the patient-centered relationship.</td>
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<td>Need to improve Communication skills, self-awareness and emotional regulation.</td>
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<td></td>
<td>Therapeutic patient-centred relationship not only depends on the personal qualities of the professional, but also on the patient’s attitudes and the characteristics of the context, including the organization and team coordination.</td>
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<td></td>
<td>Physical therapists themselves understand that to establish close relationship based on trust, it is important to have personal space available, in which the patient can feel accepted and listened to. [Negative mood from the professionals and/or avoiding other noticing it] eventually cause barriers to the patient-centered relationship.</td>
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<td></td>
<td>This study indicate that the therapeutic relationship is understood as being an important aspect worth considering, although more linked towards the patients’ contextual factors and needs than towards the practice of the profession.</td>
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Brazilian journal of Physical therapists’ perceptions and experiences about barriers and facilitators of therapeutic patient-centred relationships during outpatient rehabilitation: a qualitative study.
<table>
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<tr>
<th>physical therapy. 2018;22(6):484-492</th>
<th>Improve the layout of the rehabilitation gyms, as well as the coordination of all team members. Lack of training in communication skills (…) are barriers. Improvement of self-awareness, emotional regulation and communication skills could facilitate the understanding of the patients’ contextual factors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescott S, Fleming J, Doig E. Rehabilitation goal setting with community dwelling adults with acquired brain injury: a theoretical framework derived from clinicians' reflections on practice. Disability and rehabilitation. 2018;40(20):2388-2399</td>
<td>5 Clients with impaired self-awareness need additional support – structured communication and meta-cognitive strategies. For clients with emotional distress, clinicians provide additional time and intervention directed at new identity development. A theoretical framework was developed to explain how clinicians support clients to actively engage in goal setting in routine practice. The framework incorporates three phases: a needs identification phase, a goal operationalisation phase, and an intervention phase. Contextual factors, including personal and environmental influences, also affect how clinicians and clients engage in this process. Factors include Clinical Skills and Beliefs (e.g. regarding Client-centered intervention), Service Factors (multi- vs inter-disciplinary approach; clinical vs naturalistic setting; time available: prescriptive vs flexible); Power dynamics in Family; pre-injury factors and funding variables.</td>
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Rapport - entailing collaboration and partnership is key in the process. Acknowledging additional goals identified by clients to provide hope and convey that the client has been listened to and understood. Organizations need to be flexible in allow time for and recognize value in PERSON-CENTERED CARE. A clinician reported that intervention targeting client-centred goals was constrained by insurers. By contrast the publicly-funded community service valued

Clinicians use additional strategies to support clients with impaired self-awareness. These include structured communication and metacognitive strategies to operationalise goals. For clients with emotional distress, clinicians provide additional time and intervention directed at new identity development.

Building rapport is a core strategy to engage clients with brain injury in goal setting. The development of client-centred goals therefore relies on rapport being built through use of multiple strategies and a collaborative approach which focuses on partnership.

- Clients with self-awareness impairment benefit from additional metacognitive strategies to participate in goal setting.

Additional strategies are incorporated to engage clients in this process. In particular, clients with cognitive and communication impairment, especially self-awareness impairment, may benefit from structured communication and metacognitive strategies to formulate goals.
| client-centredness at an organisational level. | Whereas clients with emotional distress may need additional time and intervention directed at helping them to develop a new sense of identity.  
Community-based settings can be more prone to or value more PERSON-CENTERED CARE. Funding models can harness.  
Clinicians employed an informal approach to PERSON-CENTERED CARE goal-setting.  
Whereas clients with emotional distress may need additional time and intervention directed at helping them to develop a new sense of identity.  
Clients with emotional distress may need additional time for new identity development.  
Clinicians identified the importance of acknowledging these additional goals identified by clients to provide hope and convey that the client has been listened to and understood.  
A clinician reported that intervention targeting client-centred goals was constrained by insurers. By contrast the publicly-funded community service valued client-centredness at an organisational level.  
Clinicians in this study typically employed an informal approach to goal setting, which is consistent with previous reviews of goal setting practice [27,29–31]. |
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<td>organisations require a flexible approach towards the allocation of time for goal setting.</td>
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<td>Ohman A, Keisu BI, Enberg B.</td>
<td>Team social cohesion, professionalism, and patient-centeredness: Gendered care work, with special reference to elderly care - a mixed methods study. BMC health services research. 2017;17(1):381</td>
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<td>Mudge S, Stretton C, Kayes N.</td>
<td>Are physiotherapists comfortable with person-centred practice? An autoethnographic insight. Disability and Partnership – sharing rather than exerting power, implying recognition that person’s capabilities are often underestimated. Avoiding own (emotional) discomfort in handling with</td>
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A second key feature of person-centred practice is a commitment to work in partnership with patients, sharing rather than exerting power [5]. Our findings suggest that if we are to truly work in a person-centred way, we need to recognise that we often underestimate the capabilities of patients and we need to value the knowledge that only
the patient has, namely expertise about their needs, preferences and life situation.

Explicitly distinguishing when expressed goals are ‘future aspirations’ (i.e. ‘hope-as-a-want’) and when they are expectations related to treatment outcomes (i.e. ‘hope-as-an-expectation’) may be helpful during goal negotiation.

| Lloyd A, Roberts AR, Freeman JA. 'Finding a balance' in involving patients in goal setting early after stroke: a physiotherapy perspective. Physiotherapy research international : the journal for researchers and clinicians in physical therapy. 2014;19(3):147-157 | 5 | Patient-centered not the same as patient-directed. Patients don’t always want to be closely involved – especially early after a major disabling event. Collaborative goal setting deemed complex, challenging and requiring effort – training is required. | Our provisional grounded theory suggests that a patient-centred approach is not the same as a patient-directed approach. The physiotherapists perceived that patients did not always want to be closely involved in making decisions — especially early after stroke. So, where a patient has low desire for decisional control (i.e. not patient-directed), their rehabilitation may still be both patient-centred and collaborative. Arguably, this approach is truly collaborative because it adapts to the patient’s desire and ability to engage and be involved in decisions. Collaborative goal setting between physiotherapists and patients early after stroke was considered by physiotherapists as challenging, complex, multi-faceted and requiring significant effort. Ongoing training |
Collaborative goal setting potentially exist along a continuum. There is, therefore, a need for flexibility and fluidity in goal setting approach adapting to the needs of individuals, situations and purposes. It was considered important to pay attention to the client’s right to interact directly with the therapist even if a dominant relative was present during a meeting. The therapists also emphasized that it was up to the client to decide whether he or she wanted to interact with the therapists in a client-centred process. In this way, the clients had the power to influence how a client-centred approach was being effectuated.

Client-related obstacles (for a PERSON-CENTERED CARE approach) were functional limitations such as loss of speech, or visual and hearing impairments. For example, loss of speech combined with reduced perception sometimes required the use of communication tools.
toward rehabilitation engagement. Communication strategy on education: give the client hints rather than detailed instructions.

devices, representing a challenge in complex situations. In such cases, much attention had to be placed on the assistive device instead of on the personal interaction with the therapist.

Psychological problems could influence the client’s motivation to interact in a negative way. According to the therapists, such lack of motivation could be caused by sudden awareness of ageing, lack of consciousness of how to manage the situation or the struggle to cope with something that earlier was easy to do.

Strategy told by the therapists was to give the client hints rather than detailed instructions.

Our results reflect the dimension personal reflection” of the Client-centred Strategies Framework. The fact that the therapists suggested different strategies shows that they have ambitions in this direction, signalising readiness for change.

| Schmitt J, Akroyd K, Akroyd L. Perceptions of physiotherapy students of a person- | 5 | Principles of patient empowerment; patient education / information provision; patient seen as a | The principles which students considered significant included: patient empowerment; information and education of the patient; regarding the patient as a person; tailoring of rehabilitation; and the therapeutic relationship. No single principle was considered to be of greater |
centred approach in rehabilitation.

Person; therapeutic relationship and tailoring of rehabilitation (individualization of the care approach). Principles were all seen equally important.

Students did not see smooth transition between services as important. Students may have views of PERSON-CENTERED CARE more aligned with professionals' than patients'.

Importance than others by the participants. Views between student and service users differed on a number of dimensions.

On the subject of co-ordination and smooth transition between services, service users view this as an important aspect while physiotherapy students do not. The concept of the patient as a person is considered an important aspect of a person-centred approach by students, yet this is not seen as a particular issue for service users (by the literature), possibly because they make the assumption that this will be a given. On the principle of information sharing and education, service user and student views coincided and, whereas students view patient empowerment as a significant part of person-centred rehabilitation, service users do not perceive this in the same way. The latter are more likely to discuss their involvement in decision-making rather than seeing themselves as empowered in the process. It appears that the perceptions of the physiotherapy students are more closely aligned to the principles of a person-centred approach in rehabilitation as defined by health care professionals rather than as defined by service users.
The constant re-creation of meaning is what, in large part, relationships are about. Philosophically, there is ‘no meaning without context’.

A conversation would set the scene for a joint understanding of future problems and a joint negotiation of future risks and uncertainties. Such conversations should be (and often are) at the very heart of rehabilitation processes.


| Levack WM, Siegert RJ, Dean SG, McPherson KM. Goal planning for adults with acquired brain injury: how clinicians talk about involving family. Brain injury. 2009;23(3):192-202 | 5 | While family members are considered valuable contributors to the goal-planning process, they were also seen as potential barriers. Clinicians described restricting the involvement of family members in situations where such involvement was thought not to be in the best interests of the patient (as perceived by the clinician). Furthermore, these findings suggested that by-and-large the clinicians considered the patient to be the focus of goal-planning. The involvement of family members in goal-planning was only considered important insofar as it contributed to this focus. Planning rehabilitation to achieve goals for families rather than for individuals with brain injury appeared to not be within the scope of usual practice for the clinicians involved in this study. This orientation | While family members were often considered valuable contributors to the goal-planning process, they were also seen as potential barriers to the negotiation of goals between clinicians and patients and to the development of patient–clinician relationships. The clinicians thus described restricting the involvement of family members in situations where such involvement was thought not to be in the best interests of the patient (as perceived by the clinician). Furthermore, these findings suggested that by-and-large the clinicians considered the patient to be the focus of goal-planning. The involvement of family members in goal-planning was only considered important insofar as it contributed to this focus. Planning rehabilitation to achieve goals for families rather than for individuals with brain injury appeared to not be within the scope of usual practice for the clinicians involved in this study. This orientation |
| Moats G. Discharge decision-making, enabling occupations, and client-centred practice. Canadian journal of occupational therapy Revue canadienne d’ergotherapie. 2007;74(2):91-101 | 5 | interests of the patient (as perceived by the clinician). towards patient-centred (as opposed to family-centred) goals is reflective of much of the literature on goal-planning in adult rehabilitation”  
<other issues are for a whole family approach to rehabilitation; so were not extracted> | Discharge decision-making: therapist try to balance safety and autonomy issues.  
clients are sometimes intimidated, coerced, or excluded from the decision-making.  
Non-cognitively impaired, non-dependent people shall have client-defined decision-making. Negotiated decision-making otherwise. | Results suggest that therapists try to balance the sometimes competing issues of safety and autonomy. Client-defined decision-making is not satisfactory when clients are frail, cognitively impaired, or putting others at risk. Therapists and other professionals are often able to negotiate with the client and the family. However, clients are sometimes intimidated, coerced, or excluded from the decision-making.  
A new client-centred Negotiated Model of Decision-Making for use with older people is proposed, based on the following principles:  
1. Client-defined decision-making processes are suitable for use with non-cognitively impaired, non-dependent people.  
2. Negotiated decision-making processes are suitable and can be client-centred when clients are cognitively impaired, dependent on others, or putting others at risk. |
3. Negotiated decision-making processes give balanced attention to both safety and autonomy.
4. Enabling the engagement of older people in meaningful occupations is a central focus of the decision-making process.
5. Decision-making processes can be negotiated and client-centred:
   a. If the client’s wishes are considered and the client is included in the process.
   b. If processes are not characterized by ageist assumptions, professional dominance, coercion and/or intimidation.
   c. If the family considers the wishes of the person, when the family is regarded as the “client” and/or acts as proxy decision-maker.


| 6 | Person-centredness warrants measurement, through routine collection of patients experience-based data. Client participation in decision-making and goal-setting; | Person-centredness is an important characteristic of effective rehabilitation service delivery that warrants measurement. Routine collection of rehabilitation specific patient experience questionnaires by facilities providing medical rehabilitation could enhance opportunities for assessing factors critical to the provision of person-centered rehabilitation care. Both sub-scale and item level responses to the modified Client-Centered Rehabilitation Questionnaire provide detailed feedback to
| Melin J, Arestedt K. The Patient Participation in Rehabilitation Questionnaire (PPRQ): psychometric evaluation and revision for use in neurological rehabilitation. Disability 6 | Client-centered education; Outcome evaluation from client’s perspective; Family involvement; Emotional support & Physical support; Continuity/coordination of care | Patients must be given the opportunity to participate (in care planning, decision-making), in the degree and timing they want. Respect and integrity; Information and Knowledge; | Scales: ‘respect and integrity’ (6 items); ‘planning and decision-making’ (4 items); ‘information and knowledge’ (4 items); ‘motivation and encouragement’ (5 items); and ‘involvement of family’ (4 items). The PPRQ appears to adequately assess central aspects of participation in care and rehabilitation from the perspective of patients with spinal cord injury. |
For the patients to participate in the rehabilitation process they must be given opportunities to use their resources.

Thus, the staff must provide such conditions for participation. For example, respect for the patient’s unique needs, wants and preferences for care acknowledges the patient’s capacity to make decisions about his or her own rehabilitation. However, it must be recognized that the extent to which patients choose to participate is dependent on their vitality and condition, and that their ability and desire to participate may change over time and from situation to situation. Receiving and understanding information about one’s condition are necessary to make progress in SCI rehabilitation; although the information must be given at the ‘right’ time for each patient. The experience ratings reflect patients’ perceptions of the degree to which they are given opportunities to participate.

The seven scales of the CCRQ suggested by Cott et al. could not be replicated in the factor analysis in the large sample of German medical rehabilitation patients. Three alternative scales were identified, namely “Decision-making/communication”, “Self-management/empowerment”, and “Psychosocial well-being”. This
| Questionnaire (CCRQ) in a large sample of German rehabilitation patients. Clinical rehabilitation. 2017;31(7):926-935 | Empowerment. | structure was successfully verified in confirmatory analysis. It revealed convincing goodness-of-fit indices. Furthermore, the scales demonstrated good reliability as well as validity. |
| | Psychosocial well-being – mental/cognitive and affective/emotional well-being. | The CCRQ-aspect of “family involvement” was not included in our analysis, as the associated items had a low acceptance rate and therefore were only meaningful for a subsample of our study population. |
| | PERSON-CENTERED CARE Dimensions high-correlated. | The resulting 15 of the original 33 items could be assigned to the three scales as follows: The “Decision-making/communication” scale contains two items on shared decision-making (Items 1 and 16) as well as three items on individuality in decision-making (Items 5, 9, and 15). This means that decision-making is considered in the context of individuality and patients’ particular needs. The “Self-management/empowerment” scale focuses on establishing the prerequisites for shared decision-making (Items 3, 25, and 26) as well as on enabling patients to engage in health-promoting behaviors after they are discharged (Items 10, 22, and 24). The “Psychosocial well-being” scale measures both general well-being (Item 30) and aspects of mental-cognitive well-being (Item 21). Items 28 and 31 additionally |
measure emotional well-being and the consideration of affect and emotion in the context of the provider-patient relationship.

The high correlations of the sub-dimensions are also in accordance with the theory of patient-centeredness. Shared decision-making and self-management/empowerment are regarded as complementary concepts with shared elements, such as shared responsibility and the development of a trustful, respectful partnership. Shared decision-making is often considered a prerequisite of self-management/empowerment, but simultaneously, empowerment can enable patients to actively participate in decision-making processes as equals and hence can be considered a prerequisite of shared decision-making. Nevertheless, the existence of a second-order construct proved not to be a reasonable alternative model in the study sample.


Focus on measuring and optimizing rehabilitation experience across providers. Organizational, resources and physical environment

Empirical research and psychometric testing of question panels that gather data from across all service providers in a system would help to develop a valid, reliable, and parsimonious set of universal questions that are capable of providing feedback on the performance of a system, and not just individual providers.
# Across the Care Continuum. Part II: Key Dimensions

*Archives of physical medicine and rehabilitation.* 2016;97(1):121-130

| Aspects of the care experience, including convenience, comfort, cost, atmosphere, office staff attentiveness and overall courtesy, respect and friendliness. Information, partnership, engagement, family involvement and communication. Relationship, inspiring hope/confidence, and continuity of care (with the same therapist; having previous, relevant information) | Six categories: Rehabilitative care ecosystem, client and informal caregiver engagement, patient and health care provider relation, pain and functional status, group and individual identity, and open ended.  

Rehabilitative care ecosystem: interplay between the environment in which the rehabilitative care is delivered and the patient experiencing it. This includes both the physical environment and resources and issues that can be described as operational or policy related.  

Ecosystem exemplar items included acceptable cost (…), the waiting area is comfortable (…) convenient parking (…) I had to wait a long time to get my first appointment for treatment (…), calm and relaxing atmosphere in physical therapy rooms, and office staff is attentive to my needs (…). Perceptions of safety are not only confined to conditions in the physical environment, but also to the skill and knowledge of providers delivering the care. They are able to instill trust and confidence in vulnerable clients that they know what they are doing. Feedback on service quality often reflects patients’ desire for improvements in courtesy, friendliness, and respect. |
| Personalized attention and care. | Client and informal caregiver engagement:  
Information (…) I received the information that I needed when I wanted it (…). Engage (…) I felt as though the staff and I were partners in the whole process of care (…). Family (…) whether they were involved in treatment discussions. (…) Communication skills (…) I learned what I needed to know in order to manage my condition at home. (…) Goal setting (…) did you have the opportunity to discuss the goals of your rehabilitation after discharge?  

Patient and health care provider relation:  
listened carefully; seemed interested in me as a person; my therapist gave me encouragement and praise; (hope…) therapist gave me confidence I was going to get better and I expected the treatment would get me better.  
Continuity of care describes care that is experienced as unified, coherent, and connected over time across the health care system.  
62,63 Patients’ experience is clearly affected by the level of care continuity, which in turn is affected by such issues as disciplinary silos between professions, lack of follow-up (…) lack of investment in electronic medical records may result in necessary background information arriving after, instead of before, a referral appointment. |
|---|---|
The Beattie et al study of 1502 outpatients receiving physical therapy found that in the operational practice of scheduling patients with whichever therapist is available, rather than with a single therapist of their choice, the patients were 3 times less likely to say that their experience was optimal. “therapist seemed not to have enough information on previous physiotherapy treatment, and received contradictory information from therapist and physician”

Pain and functional status:
my physical pain was controlled as well as possible, (…), I achieved the treatment goal set by my therapist and I (…), and I received enough help in my daily routine (…).

Group and individual identity:
the treatment was tailored to my needs (…) and, in the negative, employees in these firms cannot be expected to give customers personal attention (…).

Open ended
The final theme offers a suggestion for patient experience measurement methodology. The opportunity for patients to express their experience in an open and flexible manner is important to the overall understanding of patient experience. Open ended questions are particularly important where survey length is reduced, thereby balancing the possibility of omitting a key question against the positively impact response rate. Do you have any additional comments you would like to share? Overall impression of rehabilitation institution?

Analysis of the responses to these open-ended questions that allow for more detailed descriptions may also reveal early signs of unanticipated trends that require closer scrutiny.

| Heinemann AW, LaVela SL, Etingen B, et al. Perceptions of Person-Centered Care Following Spinal Cord Injury. Archives of Physical Medicine and Rehabilitation. 2006;87(3):306-314. | 6 | Organizational culture to organize care around the needs of patients. follow-up/coordination/continuity had the lowest SCIMS users and nonusers differed on perceptions of chronic illness care (largely the goal-setting and tailoring component), which were more favorable for Model System users than nonusers. This SCIMS facility strives to organize care around the needs of patients and nurtures a culture that supports the accountability and productivity of its employees. |
scores, is of less control of facilities in itself. Systemic incorporation of PERSON-CENTERED CARE principles is needed. This sample with SCI reported the lowest scores in the area of follow-up/coordination. Care coordination requires the cooperation of other providers, which is only partly under the control of SCIMS facilities, particularly for patients who receive care elsewhere. Until person-centered principles are incorporated more widely, it seems likely that this aspect of patient care will be challenging to achieve.

Patients with continuing SCIMS facility contact reported a higher level of PERSON-CENTERED CARE, primarily reflecting goal setting and tailoring, than patients not receiving services recently from the SCIMS facility.

The sample reported a relatively high level of PERSON-CENTERED CARE compared with ambulatory care samples with less severe conditions.

| Medina-Mirapeix F, Del Bano-Aledo ME, Martinez-Paya JJ, Lillo-Navarro MC, Escolar-Reina P. Development | Experiences affected by the professionals’ attitudes and behaviors (e.g. emotional support, sensitivity to patient’s changes). | Items: Providing information and education, sensitivity to patient’s changes, emotional support (…).

2 major conceptual domains (…) experiences related to professionals’ attitudes and behaviors. |
and validity of the questionnaire of patients' experiences in postacute outpatient physical therapy settings. Physical therapy. 2015;95(5):767-777

| Teale EA, Young JB. A Patient Reported Experience Measure (PREM) for use by older people in community services. Age and ageing. 2015;44(4):667-672 | 6 | Dignity, staff have sufficient information, information provision and questions answered, confidence in staff building, involvement in discharge decision, home circumstances considered. The more focused (operationalized) the questions are, the better they reveal suboptimal experiences. | Items:  
Staff have sufficient information  
Involvement in goal setting  
Questions answered  
Confidence in staff  
Involved in discharge decisions  
Home circumstances considered  
Information provided for family  
Treated with dignity  
The overall experience on the (…) focused questions relating to the experience of involvement with decision processes (treatment decisions, discharge planning and goal setting) was weaker. |
| Doig E, Prescott S, Fleming J, Cornwell P, Kuipers P. Development and construct validation of the Client-Centredness of Goal Setting (C-COGS) scale. Scandinavian journal of occupational therapy. 2015;22(4):302-310. | 6 | Goals meaningfulness, relevancy and ownership for clients wanting to work on. Participation in goal planning and decision-making. | The C-COGS scale was developed to evaluate one aspect of client-centred practice: client-centred goal planning. The C-COGS scale was designed to be administered soon after setting rehabilitation goals, to evaluate, from the client’s perspective, the client-centredness of the process and the goals.

(“The goals are what I want to work on”) is the only rating in the alignment subscale that is included in the total C-COGS score as it relates to client-centredness (i.e. the client’s perceived desire to work on the goals).

The Participation subscale measures the client’s perceived participation in goal planning and decision making on goals, as well as the extent of involvement and inclusion in goal planning.

The Goals subscale measures the meaningfulness, relevance, and ownership of the individual goals as well as the client’s motivation to work towards them.

The goal subscale can also be used to prioritize rehabilitation goals according to the client’s reported importance, meaning, relevance, and motivation ratings, after goals are planned. |
and re-administered over time to assess changes in priorities to tailor rehabilitation accordingly. The average goal meaningfulness, importance, motivation, and ownership scores across goals can also be generated and may provide insights into where goal-planning practice changes may need to be considered.

The findings indicate substantial construct validity of the C-COGS scale, based on correlation with measures of self perceived goal importance (17) and therapeutic alliance including therapist listening and inclusion as a partner in goal planning and decision-making (35).

| Kneebone, II, Hull SL, McGurk R, Cropley M. | 6 | 4 key themes that expanded the concept of PERSON-CENTERED CARE: ownership, personal value, holistic approach, and therapeutic atmosphere. These 4 themes are the same of (emerge from) a previous qualitative study also included in this review. | The draft of the questionnaire had the "superordinate theme- person-centredness. That included 4 key themes that expanded the concept: ownership, personal value, holistic approach, and therapeutic atmosphere."... "A successful rehabilitation environment involves fostering independence, choice, and control."...."Future work with a larger sample might enable its factor structure to be identified, providing validation of the mapping onto the themes established in prior qualitative work" |

Elements of therapeutic atmosphere:
| Bamm EL, Rosenbaum P, Stratford P.  
| Validation of the measure of processes of care for adults: a measure of client-centred care. | 6 | Enabling and Partnership domain focuses on patients’ and families’ involvement in their care process, particularly in decision-making (e.g. provide opportunities for you to make | Domains:  
| | | |  
| | | | Enabling and partnership; Providing general information; Providing specific information; Coordinated and comprehensive care; Respectful and supportive care.  
| | | | The Enabling and Partnership domain focuses on patients’ and families’ involvement in their care process, particularly in decision- |
| Lawford BJ, Delany C, Bennell KL, Bills C, 3 & 4 | Therapists felt that their pre-training skills and habits | Although physical therapists found training overwhelming initially as they realized the limitations of their current knowledge and clinical |
were not enough for delivering a person-centered approach.

Hence, therapists felt overwhelmed at the beginning of the instruction. Therapists become more confident with the approach over time, especially when provided with practical training with real patients. practice, they felt more confident and able to provide Person-centered care to people with knee osteoarthritis by the end of training. Training in structured person-centered methodology that provides opportunity for skills practice with patients using a restructured consultation framework can change physical therapists' beliefs about their roles when managing patients.

After the first 2 training days, therapists felt overwhelmed as they realized the limitations of their current knowledge and skills. They were anxious about applying a restructured consultation framework that required them to deviate from their usual communication and consultation style. This manifested as a loss of confidence from pretraining. Once provided the opportunity to practice with real patients, therapists then gained confidence over time. Post-training, therapists believed they had a deeper knowledge about how to provide care that was person-centered. The experiences of therapists in our study suggest that facilitation and/or encouragement of deliberate practice of skills with real patients is an important component of training that influences successful uptake and implementation of the new knowledge provided.
Physical therapists in our study believed that the training covered new concepts that had not previously been taught in their undergraduate training, which probably contributed to their feelings of being overwhelmed and out of their comfort zone initially.

Our findings have a number of important implications for the design of Person-centered care training programs. Therapists felt overwhelmed by the first 2 training days, experiencing difficulties with the volume of content being delivered, as well as the new terminology and/or ideas presented. This experience suggests that training programs may benefit by reducing the amount of new information, at least initially, or by extending the number of initial training days to allow more time to review concepts and minimize feelings of being overwhelmed.

| Prescott S, Fleming J, Doig E. Refining a clinical practice framework to engage clients with brain injury in goal setting. Australian occupational | Get to knowing and understanding the person; Valuing clients’ own expertise. | Valuing the client’s expertise and checking they are happy to proceed in a certain way. So, I feel like this has been a really good time for me to get to know you and to understand a bit more about where you’re coming from. |
|therapy journal.  
2019;33(3):564-574| 3 & 4| Providers need basic understanding of SDM before engaging in goal setting; Providing information on options available and the decision process; Assuring privacy, inclusively in ward, for taking shared decisions. SDM involves showing respect and listening to patients, and using communication skills: e.g. paraphrasing, seeking explanation for patient’s views| Importance of all staff having a basic understanding of SDM before they engage in goal-setting with patients.  
(Privacy is) more easily controlled in the community i.e. in a private room or in their own homes which may be why patients were able to engage in decision-making more easily in the current study. If staff can provide a quiet, private room for goal-setting to take place patients should find it easier to engage in decision-making on a ward.  
A key facilitator to SDM highlighted in this study was for staff to show they are listening to patients.  
Good listening skills by paraphrasing and seeking explanation for patient’s views. If staff repeated back to patients what they had interpreted, then patients knew they were being understood. Soundy et al [30] expanded on these listening skills to include being sensitive to the patient’s emotional needs, taking the patient seriously and making the patient feel respected. By staff using these skills patients are more likely to engage in the SDM and consequently retain what
| van Seben R, Smorenburg SM, Buurman BM. A qualitative study of patient-centered goal-setting in geriatric rehabilitation: patient and professional perspectives. Clinical rehabilitation. 2019;33(1):128-140 | views; interpreting patient’s views and seeking correction on the interpretation. SDM involves responsiveness to emotional issues. was discussed. As a result, their motivation is likely to improve, including their participation in the rehabilitation process.

One important barrier stressed in this study was patients not being given an explanation of goal-setting or rehabilitation options available. Healthcare professionals should be providing this information. |

| 4 & 5 | Discharge-oriented rehabilitation process, focused on basic self-care activities, can be a barrier to person-centered goal setting. Patients' goals and focus may change over time, through the rehabilitation process – which might be adaptable. With regard to the working method of the multidisciplinary team, professionals seem to think providing a client-centered goal-setting process is important. However, according to the professionals, during inpatient rehabilitation, older individuals are often unable to formulate goals, or they set unrealistic goals. Importantly, the rehabilitation process revolves around getting patients ready for discharge, resulting in goals that are related to discharge, for example, being able to perform basic self-care activities. “This study has generated insight into how rehabilitation goals of older patients change over time.” |
| Burridge L, Foster M, Jones R, Geraghty T, Atresh S. Person-centred care in a digital hospital: observations and perspectives from a specialist rehabilitation setting. Australian health review : a publication of the Australian Hospital Association. 2018;42(5):529-535 | 5 & 6 | Technology, such as eMR, can bring challenges to person-centered care: e.g. providers can rely on eMR than asking patients, rely on looking at screens rather than to people, extra documentation can take time from the interaction with patients. Challenges can be overcome as long as a commitment to person-centeredness exists, persists and practices/systems are adaptable. | The focus groups highlighted nurses’ concerns that interactions with inpatients had been displaced by time-intensive eMR documentation. In particular, person-centredness seemed elusive, undermining the quality of the practitioner–patient relationship. The perception was that practitioners generally now resorted to patients’ records for information more readily than to patients themselves.”

“Tensions between eMR and personcentredness in day-to-day practice were resolved in context through the less visible work of frontline practitioners’ emergent discretionary actions, highlighting their persistence, adaptability and commitment to person-centredness in the digital environment. Unexpected challenges of technological change, such as loss of informal communications, may resolve gradually as people and contextual factors influence and improve eMR use.”

Nurses were also concerned about the intrusion of technology into patient encounters, and what this signified for their patients, because ‘you’re looking at the screen instead of looking at your patient’ (NP). They opted for discretionary use of eMRs to maintain person-centredness.” |
“The generic eMR seemed inconsistent with person-centredness in ways that were not easily adaptable. For example, patients had formerly held a copy of their goal plan as ‘it puts the patient in control of their own rehab and goals’ (AHP), but this plan could not now be directly printed from eMR documentation for patients before planning meetings. In the inpatient setting, using eMRs had subtly changed how practitioners communicated with one another and with patients. Some nurse participants noticed that eMRs reinforced the power differential and distance between practitioners and patients:”

“This theme reveals some practitioners’ uneasiness about technology taking precedence and imposing extra documentation. This dilutes practitioner–patient relationships and tailored care in long-term rehabilitation. Nurses in particular resist the intrusion of eMR into the relational basis of PERSON-CENTERED CARE, and give precedence to their patients’ specialised needs.”

<p>| Siegert RJ, Ward T, Levack WM, McPherson KM. A Good Lives Model of clinical and community | 1 &amp; 2 | Rehabilitation (not that of minor injuries) might strive for people to have Good Lives - access to all (or at least a range) of the primary goods even though individuals can legitimately vary in the way they weight or rank them. | A fulfilling life will most probably require access to all (or at least a range) of the primary goods even though individuals can legitimately vary in the way they weight or rank them. |</p>
<table>
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<tr>
<th>Rehabilitation. Disability and rehabilitation. 2007;29(20-21):1604-1615</th>
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<td>goods in life even though individuals can legitimately vary in the way they weight or rank them. Individuals are not inherently or naturally good in an ethical sense. The (re-)construction of a meaningful and adaptive narrative identity involves orientating individuals to the range of primary goods and providing them with the resources to secure better lives in ways that are personally satisfying and socially acceptable - often involving the reconstruction of the self.</td>
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<td>There is no assumption in the GLM that individuals are inherently or naturally good in an ethical sense. Rather, the presumption is that (... humans) are more likely to function well if they have access to the various types of goods. Example of a practice: The construction of a meaningful and adaptive narrative identity (e.g., after a severe traumatic brain injury or spinal cord injury) involves orientating individuals to the range of primary goods and providing them with the resources to secure better lives in ways that are personally satisfying and socially acceptable. It will often entail the holistic reconstruction of the 'self.' The GLM emphasizes an overarching construct of personal identity and its relationship to an individuals’ understanding of what constitutes a good life (...) it is not enough to simply equip individuals with skills of daily living, it is essential that they also provide patients with opportunities to reconstruct their identity, developing one that gives them a sense of meaning and fulfillment (...) treatment plan be explicitly (...) take into account the individual's strengths, primary goods, and relevant environment; specifying exactly what</td>
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Requires (re-)construct of personal identity and its relationship to an individuals’ understanding of what constitutes a good life – for a sense of meaning and fulfillment.

A “good life plan” for achieving patient’s life goals is overarching guide for rehabilitation – containing all the primary goods and means of achieving them that match the individual’s history, abilities, preferences and social milieu. Barriers might be anticipated, strengths and competencies and resources are required to achieve these goods. An important aspect of this process is respecting the individual’s capacity to make certain decisions for himself/herself, and in this sense, accepting his or her status as an autonomous individual.

A GLM of rehabilitation assumes that a central task for client and therapist is the development of a good life plan. A good life plan (GLP) is a plan that contains all the primary goods and means of achieving them that match the individual’s history, abilities, preferences and social milieu. The key task (...) will be anticipating the major (...) barriers to achieving the plan and equipping the individual with the necessary internal skills and external resources to implement their own GLP (...) each client should have their own individual GLP and that this plan should form the overarching, integrative framework for that person’s rehabilitation (...) long-term goals have tended to focus on issues relating to secondary goods (e.g., ‘to return home’, ‘to walk again’, ‘to return to work’) rather than on primary goods. More compatible with a GLP would be the approach to rehabilitation planning that have included some consideration of a patient’s’ life goals (...) through determining which primary goods are most highly valued by a patient
internal skills, and external resources reinforced.

A key process will be working collaboratively with the client to clarify their own goals, life priorities and their aims for rehabilitation within the context of a past, present and future. In particular, it is essential to understand how a client prioritizes and operationalizes the primary human goods described earlier in this paper.

It would therefore seem crucial (if rehabilitation is to be person-centred rather than problem-centred), for the assessment of impairment, risk and vulnerability to be balanced with an assessment of the individual’s strengths, goals, and conception of the good life (...) asking them to choose their priorities has been tried and found ineffective. In our experience, such a task has been approached as it was a test rather than an opportunity for self-exploration. Rather, an open ended interview, where the assessor’s intentions and the rationale for the interview is made transparent with opportunity for discussion rather than one way ‘reporting’ has seemed more successful.
individual’s strengths, goals, and conception of the good life.

STRATEGIES:
Asking people to simply prioritize wastes the opportunity for self-exploration. Rather, an open-ended interview, where with transparent opportunity for discussion rather than one way ‘reporting’ has seemed more successful.

Series of increasingly detailed questions about the things (i.e. activities, situations, experiences) individuals value in their lives and what they put their energies. And finally metaphorical "questions about ‘possible selves’.

Two approaches "the first is to note (infer) what kind of goals were most evident in their general life functioning. The second assessment strategy is to ask a series of increasingly detailed questions about the things (i.e. activities, situations, experiences) individuals value in their lives and what they put their energies. And finally metaphorical "questions about ‘possible selves’.

We are not advocating the Good Lives Model for rehabilitation of minor or straightforward injuries (...) it prompts some useful questions about how ‘person’ centred rehabilitation can actually be without a clear identification of what it is for each person to have a good life.
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<td>No agreed definition of PERSON-CENTERED CARE in physical therapy. Implementation reflects the lack of operationalization of the term.</td>
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<td>With the inter-professional team regarding how physical therapists view PERSON-CENTERED CARE is essential, given that by some definitions, physical therapists cannot be completely patient centered without systematically involving health professional colleagues.</td>
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<td>An agreed definition and means of operationalizing PERSON-CENTERED CARE across professions as well as within a single profession, such as physical therapy, are lacking. Our findings support that physical therapists may believe they are practicing care that is patient centered without necessarily understanding the implications of the term. Conversely, many physical therapists may be practicing PERSON-CENTERED CARE without necessarily terming it as such.</td>
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<tr>
<td>Name: Pikkarainen A, Vahasantanen K, Paloniemi S, Etelapelto</td>
<td>Rehabilitation readiness (and capacity to set meaningful goals) must be actively</td>
<td>On the basis of our findings, implications for the development of person-centred gerontological rehabilitation can be formulated. The findings showed that most of the rehabilitees were not capable of</td>
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<td>fostered initially through genuine cooperation, and not assumed to be present or not. Time and opportunities must be given for people analyse their life course, analyse their life situations with personal life goals and personal interests, and, step by step, set their own meaningful rehabilitation goals. That may require exploring life in retrospect or teleologically: from the present to the past, and how they have come to this moment, to set goals and setting goals for the rehabilitation process in their first sessions. Therefore, we emphasize that older adults need sensitive, tentative, and preliminary time to construct their rehabilitation readiness (44,45) before setting goals for their forthcoming Rehabilitation. There also needs to be an informative discussion between the rehabilitee and a counsellor so that the process can begin with genuine cooperation. During this time, older rehabilitees can identify their capacity as agents of their own life course, analyse their life situations with personal life goals and personal interests, and, step by step, set their own meaningful rehabilitation goals for a certain temporal orientation in the future. Generally, in rehabilitation the perspective of professionals is automatically causal and prospective, from the present to the future. This study revealed that older rehabilitees can hold a contrary perspective.</td>
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They mainly describe their lives in a retrospective or teleological way: from the present to the past, and how they have come to this moment. This conflict of perspectives could be the main obstacle in providing effective, person-centred services, because it interferes with cooperation and makes motivating older rehabilitees more challenging.

Based on the findings, we propose that an agency based approach for gerontological rehabilitation is needed so that it can be seen as a person-centred practice. This approach means that older rehabilitees are able to take an active and meaningful role during the whole rehabilitation process, for which their temporal orientation and life-course agency are taken into account and supported when designing content, methods, durations, and timetables.

Particular features of agency such as autonomy, control of one’s own life, and fulfilment of values and beliefs in different individual settings and cultural groupings must be taken account as part of the rehabilitation process (22).
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<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Year</th>
<th>Volume</th>
<th>Issue</th>
<th>Pages</th>
<th>Summary</th>
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<tbody>
<tr>
<td>DiLollo A, Favreau C.</td>
<td>Person-centered care and speech and language therapy. Seminars in speech and language.</td>
<td>2010</td>
<td>31</td>
<td>(2)</td>
<td>90-97</td>
<td>Task-oriented performance assessment (of student clinicians) may hinder PERSON-CENTERED CARE. As such, supervisors may be more task oriented during their exchanges than PERSON-CENTERED CARE centered. Our expectation that first year clinicians would provide less PERSON-CENTERED CARE was not observed: no difference was found between novice and more experienced student clinicians. All the student clinicians tended to be more person-centered during the opening and middle segments of their interactions than at the closing segment. This trend appeared to be a reflection of the students being highly focused at the end of sessions on completing tasks, reviewing what had been done during the session, and instructing the client on homework assignments. The way in which students’ clinical performance is graded may promote a more “task-centred” approach.</td>
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<tr>
<th>Patient invited to set own personal functional goals within a shared decision-making, with step outlined:</th>
<th>It includes, among a myriad other (structured) steps: 5) Shared decision-making in defining the patient’s goals is ensured by the following steps</th>
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<td>(a) Elicit the patient’s views on the degree of involvement in decision-making</td>
<td>(a) Elicit the patient’s views on the degree of involvement in decision-making</td>
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<td>(b) Patient and doctor jointly set functional goals based on consensus</td>
<td>(b) Patient and doctor jointly set functional goals based on consensus</td>
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<tr>
<td>(c) The physician translates these goals into target scores on the corresponding items of the functional instruments.</td>
<td>(c) The physician translates these goals into target scores on the corresponding items of the functional instruments.</td>
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</table>

Both patients and professionals expressed a need for patient-centred goal setting. Patients indicated that goals were mainly set by the professional and that a rehabilitation plan was either not presented or its content was not clear to them. In contrast, the professionals regarded CFGS as patient-centred and potentially helpful in facilitating the goal-setting process. Nevertheless, the professionals indicated having difficulty with the implementation of the intervention.

Patient-centred goal setting supported by functional measurements was not feasible in its present form which confirms the evidence from the literature that is difficult to perform patient-centred goal setting in clinical practice.
The collaboration ended up to be provider-centric. Providers found implementation challenging. Implementation was therefore not successful.

Professionals recognized they tended to fall back on old routines. Patients did not notice the Patient-centeredness of the method. Training for the whole team was recommended to enhance implementation.

Patients want to be involved although that varied by patient: a flexible and individual-based goal-setting approach. CFGS incorporates this flexible approach to goal setting explicitly in the fifth step.

Implementation:

There were several indications that CFGS was not successfully implemented. First, the professionals indicated that there was a tendency to fall back on old routines that differed from CFGS. In particular, the professionals stated that CFGS was not always systematically and accurately executed as intended. Finally, the patients had not noticed the intended patient-centredness of CFGS.

Professional findings

The professionals emphasized the relevance of patient-centred goal setting in geriatric rehabilitation. They regarded CFGS as patient centred and potentially helpful in facilitating the goal-setting process. The use of the functional instrument was considered particularly supportive in setting and evaluating rehabilitation goals. Nevertheless, the professionals found the implementation of the intervention difficult. 

The professionals had several suggestions that could enhance the feasibility of CFGS. The first suggestion was to train the entire team.
The patients in the current study expressed that they wanted to be actively involved in the goal-setting process, as well as be informed about the progress of their rehabilitation [6]. However, the extent to which they wanted to be involved differed. This supports a flexible and individual-based goal-setting procedure rather than a more one-size-fits-all approach.

Becker S, Korner M, Muller C, Lippenberger C, Rundel M, Zimmermann L. Development and pilot testing of an interprofessional patient-centered team training programme in medical rehabilitation clinics in Germany: a process of finding and agreeing upon a common goal for all professions, having all the information need to reach the goal is accessible for every team member. The process of defining goals, setting deadlines and following them in order to Interprofessional teamwork is considered to be a key component of patient-centred treatment in healthcare, and especially in the rehabilitation sector. All the information needed to reach the rehabilitation goal is accessible for every team member. The process of finding and agreeing upon a common goal for all professions and improving the processes within the team with regard to that goal was mostly successful. This underpins the idea that a
<p>| process evaluation. BMC medical education. 2017;17(1):120 | reach those goals is considered a vital component of participative team interventions. | common goal is the crucial element in a team [47] and the process of defining goals, setting deadlines and following them in order to reach those goals is considered a vital component of participative team interventions [25, 48]. |
| Larsson H, Blomqvist K. From a diagnostic and particular approach to a person-centred approach: a development project. Journal of clinical nursing. 2015;24(3-4):465-474 | Focus on the whole person, not just the patient/disease. Focus on the whole person and his/her perspective is a foundation for patients to take active part of their care. Work as a mean to understand the patient experience of the symptom. | The person-centred pain care focuses on the whole person not just hurting body parts, disorders, symptoms or diagnosis. Person-centred care is also about building a foundation for making the patient actively take part in their own care, and not just be passive recipients of professional care. The expressed needs of the patient are equally important to the needs and treatments observed and prescribed by the staff (McCormack et al. 2010). The pain assessment form became a way for the staff to initiate a conversation with the patient, and a tool for understanding the patient’s experience of the pain, that is, to work in a person-centred manner. |
| Rochette A, Racine E, Lefebvre H, Lacombe J, Bastien J, Tellier M. Ethical issues relating to the inclusion of 4 &amp; 5 | Relatives are mostly perceived as caregivers by providers, not truly as clients as are patients. | Our results suggest that the predominant role for relatives is still that of a caregiver, despite the well-expressed needs of all stakeholders. None of the three groups of participants perceived relatives truly as clients. |</p>
<table>
<thead>
<tr>
<th>Relatives as clients in the post-stroke rehabilitation process as perceived by patients, relatives and health professionals.</th>
<th>Gustafsson L, Fleming J, Cornwell P, Worrall L, Brauer S. STRENGTH and the Health Care Team: Changing Interprofessional and Client-Centered Practices. Topics in stroke rehabilitation.</th>
<th>One day a week at home intertwined with the inpatient rehab promoted that the client, carer and therapists to collaboratively develop goals for the therapy within the client’s home and social environment in preparation for discharge.</th>
<th>To enhance client-centered preparation for transition to home by allowing the client, carer and therapists to collaboratively develop goals for the therapy within the client’s home and social environment in preparation for discharge (…) an alternative to early supported” Clients not yet cleared for discharge, spend one day off every week within their home with support of the therapy team, for some or all the time. Findings demonstrate that the environmental context for rehabilitation can impact on interprofessional team functioning, collaborative goal setting and client-centred practice.</th>
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<td>Kontos PC, Miller KL, Gilbert JE, et al.</td>
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<td>Improving client-centered brain injury rehabilitation through research-based theater.</td>
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<td>Qualitative health research.</td>
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<td>2012;22(12):1612-1632</td>
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<td>Avoiding medical jargon to improve client’s understanding and participation.</td>
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<tr>
<td>Appreciation for clients’ needs for emotional expression and sexual intimacy.</td>
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<tr>
<td>Increased involvement of family caregivers.</td>
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<tr>
<td>Making patients informed of different rationales for care staff may have.</td>
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Timely for stroke rehabilitation teams to consider alternate models of service delivery (…) as a means for increasing the shared focus for rehabilitation with clients and carers.

Influencing practice through the avoidance of medical jargon to improve clients’ understanding and participation in treatment; newfound appreciation for clients’ needs for emotional expression and sexual intimacy; increased involvement of family caregivers; and avoidance of staff discussions as if clients were unaware. These findings suggest that research-based drama can effect reflexivity, empathy, and practice change to facilitate a client-centered culture of practice in brain injury rehabilitation.
| 2 & 3 | Focus on a “partnership stance” and in the role of “eliciting patient narratives”. Tentative plan drawn by care provider was then discussed with the patient and finalized, when agreement was reached. “working the partnership”: patients encourage to be as active as possible and own ratings used for shared decision-making. | At admission, a comprehensive narrative was obtained from the patient, including information regarding everyday life prior to and during the worsening of their condition, symptoms, and his/her motivation/goals. The patient narrative was summarized in an assessment protocol to provide easily accessible and comprehensive understanding of how the patient’s situation and symptoms impact on daily life. Tentative PERSON-CENTERED CARE plan was then drawn up by the care provider, which included planned investigations, treatment goals, and length of stay. The PERSON-CENTERED CARE plan was discussed with the patient and finalized, when an agreement was reached. | Ekman I, Wolf A, Olsson LE, et al. Effects of person-centred care in patients with chronic heart failure: the PCC-HF study. European heart journal. 2012;33(9):1112-1119 | Research-based drama can affect reflexivity, empathy, and practice change to facilitate a client-centered culture of practice. |
| The PERSON-CENTERED CARE intervention was planned jointly by patient representatives, staff physicians, registered nurses, and other care professions in collaboration with the research team. | Second element: “Working the partnership: patients were encouraged to be as active as possible (...) Patients rated their symptoms of dyspnea and fatigue on a daily basis (...) and that was used to "promoting shared decision-making.  

The PERSON-CENTERED CARE intervention was planned jointly by patient representatives, staff physicians, registered nurses, and other care professions in collaboration with the research team.  

Our intention was to establish a working consensus to facilitate and safeguard the implementation of PERSON-CENTERED CARE in the designated hospital wards. Nevertheless, only 60% of the patients received the entire PERSON-CENTERED CARE intervention according to the protocol. The protocol nonadherence in this study reflects the challenges of instituting wide-ranging changes in daily hospital practice not only to care routines but also to approaches to care. |
<table>
<thead>
<tr>
<th>Guidetti S, Ytterberg C.</th>
<th>The 40% non-adherence reflects the challenges of instituting wide-ranging changes in hospital care routines and care approaches.</th>
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<tbody>
<tr>
<td>A randomised controlled trial of a client-centred self-care intervention after stroke: a longitudinal pilot study. Disability and rehabilitation. 2011;33(6):494-503</td>
<td>2 &amp; 3 No difference in the intended activity outcome, use of services or caregiver's burden at 12 months after the pilot test. Client-centered interventions also target caregiver burden</td>
</tr>
<tr>
<td>Ylvisaker M, McPherson K, Kayes N, Pellett E. Metaphoric identity mapping: facilitating goal setting</td>
<td>2 &amp; 3, 4, 5 Collaborative process: to facilitate the construction of a possible self – compelling for the client, with realistic goals and action leading to them.</td>
</tr>
</tbody>
</table>
Therapeutic relationship to be established a priori of the meaningful, actionable goals. It helps in overcoming barriers to goals and to become engaged in rehabilitation.

Clinicians without training in person-centered services and counseling procedures fell higher difficulty and discomfort in applying the approach.

Pre-service and in-service training might be required (inclusively for “mind shift”). Additionally, as team members, they might be

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<th>Metaphoric identity mapping:</th>
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<td>A: Establishing a respectful therapeutic relationship with the individual;</td>
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<td>B: Helping individuals to set meaningful goals for themselves and secondarily identify the action strategies/tactics needed to achieve the goals;</td>
</tr>
<tr>
<td>C: Helping individuals to overcome chronic obstacles to achieving important goals and to become actively engaged in rehabilitation;</td>
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<tr>
<td>D: Facilitating “deep” changes in identity through a long-term psychotherapeutic process.</td>
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All clients and clinicians found identity mapping to be an acceptable process and also useful for deriving meaningful rehabilitation goals. Both clients and clinicians saw client-centred goals as important. Cognitive impairments posed obstacles to this goal-setting intervention and mandated creative compensations. And finally, identity-related goal-setting appeared to require a “mind shift” for some clinicians and demanded clinical skills not uniformly distributed among rehabilitation professionals.

Those clinicians with training in person-centred services and counseling procedures experienced considerably less difficulty and discomfort, even though the specific procedures were new to them.
backed by those with higher competence in person-centered services and counselling/psychologically-oriented capacity.

Sometimes understood as out of clinician’s scope of practice, even though all clients and clinicians found identity mapping to be an acceptable process and also useful for deriving meaningful rehabilitation goals and both clients and clinicians saw client-centred goals as important.

Cognitive impairments posed obstacles to this goal-setting.

<table>
<thead>
<tr>
<th>All rehabilitation professionals must be competent in engaging clients in meaningful goal setting (…) preservice or in-service training in all of the rehabilitation professions should be designed to ensure competence in implementing such interventions. In particular, clinicians should be competent in collaborating with their clients in constructing an organised, well-elaborated, and compelling description of a possible self-capable of supporting the active pursuit of meaningful and achievable goals.</th>
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<td>In addition, when clinicians work as members of intervention teams, those with less competence in delivering person-centred services and using psychologically oriented procedures should collaborate actively with team members with greater competence as they engage the client in identity exploration and reconstruction. This collaboration also addresses the concern of some professionals that metaphoric identity mapping may be outside of their scope of practice.</td>
</tr>
<tr>
<td>Kurz AE, Saint-Louis N, Burke JP, Stineman MG. Exploring the personal reality of disability and recovery: a tool for empowering the rehabilitation process. Qualitative health research. 2008;18(1):90-105</td>
</tr>
</tbody>
</table>
through the imaginary choice-making and story-telling processes.

The following account is altogether representative:
“Giving patients the power to understand and express their own rehabilitation desires and preferred outcomes and to convey their personal illness narratives fostered deeper communication and trust. It inspired and informed clinical staff and family members in caring for these patients. In addition, patients gained insight into rehabilitation, forging deeper connections and greater levels of understanding successful acceptance of new identities that incorporate their disability.

Rehabilitation may be critical not only for rebuilding physical strength and abilities but also for intercepting self-destructive thought processes and facilitating positive emotional progress when facing life-altering disabilities. (…) We see RPE as a means toward encouraging renewed self-concept during a critical time of disability acceptance. In addition, it is a technique that allows individuals to share their illness experiences, the impact of stress, their views of disability, and personal motivations with health care professionals, thereby empowering patients and strengthening patient-caregiver communication.

Intervention – Recovery Preference Exploration (RPE): A computerized procedure in which patients, through a choice-making task, show how they would want to recover across specified sets of activities, imagining complete initial dependency in all activities. The procedure produces utilities (i.e. Strength of preference for achieving a particular outcome) for each activity and narratives uncovering the contexts.
among the patients, clinicians, and family members.

that shape patients’ natural attitudes and beliefs about disability.

Giving patients the power to understand and express their own rehabilitation desires and preferred outcomes and to convey their personal illness narratives fostered deeper communication and trust. It inspired and informed clinical staff and family members in caring for these patients. In addition, patients gained insight into rehabilitation, forging deeper connections and greater levels of understanding among the patients, clinicians, and family members. By providing a more comprehensive and humanistic view of the patient, staff were better able to make complex medical decisions and appropriately advise patients.

The two patients’ concepts of actual disability experiences were reshaped through the imaginary choice-making and story-telling processes. (...) Life was disrupted by illness severe enough to require medical intervention and to limit participation in life situations that were previously meaningful. Discussions of this disruption uncovered the idiosyncratic life contexts that determined each patient’s attitudes and feelings and shaped hopes for future recovery. The recovery preferences indicated by the patients presented in this article and their
associated explanatory narratives are rich with clinically useful information expressed through qualitative narrative and quantitative recovery preference choices.

The procedure gives patients the authority to describe their personal values.

| Baumann M, Peck S, Collins C, Eades G. | 2 & 4 | Based on what patients valued and did not value about the initial program design in the pilot, the Rogerian concept of PERSON-CENTERED CARE was adopted as that to be instructed to those delivering the arts program. Comfortable, non-judgmental environment, demonstrate genuineness, empathy and unconditional positive regard towards patients, whilst Based on the learning from the pilot (which highlighted what patients valued and did not value about the initial programme design) the underpinning concept of person-centredness was reinforced in the development of the guide. It was agreed that the programme should adopt a Rogerian [29] “personcentred” approach to the development of a relationship between artists and patients and to the selection and delivery of arts activity. Artists, therefore, were encouraged to create a comfortable, non-judgmental environment, demonstrate genuineness, empathy and unconditional positive regard towards patients, whilst using a nondirective, collaborative approach (eliciting and responding to patients’ artistic and/or personal interests and history). As might be expected from a person-centred intervention, benefits varied across the sample, but the most commonly mentioned positive aspects of participation included the experiences of: pleasure and... |

The meaning and value of taking part in a person-centred arts programme to hospital-based stroke patients: findings from a qualitative study. Disability and rehabilitation. 2013;35(3):244-256
using a nondirective, collaborative approach.

A series of benefits on dimensions of mental well-being and occupational engagement emerged from the art program with a PERSON-CENTERED CARE stance.

<table>
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<tr>
<th>Blickem C, Priyadharshini E.</th>
<th>Taking time to understand the patient-carer context before solutions were devised.</th>
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<tbody>
<tr>
<td>Patient narratives: the potential for &quot;patient-centred&quot; interprofessional learning? Journal of interprofessional care. 2007;21(6):619-632</td>
<td>Some patients are uneasy with breaking out the most traditional relationship with doctors.</td>
</tr>
</tbody>
</table>

enjoyment, a sense of connection with the artists, mental stimulation, learning and creativity, engagement in purposeful occupation and relief from boredom, and reconnection with valued aspects of the self. These experiences of participation contrast strongly with the acute and chronic distress associated with stroke, impairment, and spending long periods of time in hospital.

Education of stroke patients and their carers about being more active in their own care needed to pay close attention to their particular views and needs regarding discharge and care arrangements. For us, it highlighted the importance of taking time to understand the patient-carer context before solutions were devised.

We also became aware that the notion of “patient-centred” care was more problematic than it first appeared. First, some patients and carers had differing perspectives regarding discharge even amongst themselves.
De-personalized patient narratives (arising from interviews with actual patients from the staff) and subsequent discussion workshops with the staff can provide a valuable mean for teams to discuss PERSON-CENTERED CARE processes – and other subjects beyond.

Doctors were among those who weren’t available to attend the PERSON-CENTERED CARE workshop.

The differences in perspectives between patients and carers disturbed our early hopes of an easily identifiable “patient-centred” process.

(Come patients) felt uneasy about breaking out of the more traditional professional-patient relationship: You don’t ask questions. You put yourself in the care of the doctor. You know he is doing his best to get the patient well. (Female patient, 69)

The patient narratives we hoped, would encourage an empathetic response from the reader that may be different from their everyday professional response. The idea was “to optimise the opportunity of the reader to gain an experiential understanding of the case”

The narratives were thus a composite of many stories and therefore, were neither fully fact nor fully fiction but situated in the realm of plausibility.

The patients in the stories ended up bearing little resemblance to actual patients (which we desired), but they still provided an opportunity to communicate issues.
that were difficult to put across using conventional methods of social science reportage.

The purpose of the narratives was to de-personalize the critique contained in the interview extracts and to offer the necessary distance for reflection, and bearing staff sensibilities in mind, they consciously related a variety of experiences, some more positive than others. Perhaps because the stories were written in the first person and read like a real patient’s experience, the criticisms implicit in them seemed more palatable.

They were not structured to provide any closure to the reader, in keeping with the slow and unpredictable nature of stroke recovery and also served the purpose of focusing on patients/carer experiences and institutional processes rather than on endings.

We constructed 6 patient or carer narratives, each approximately 800 to 1500 words in length, designed to give a sense of patient life based on the range of issues that emerged in the interviews.
With the exception of doctors and speech and language therapists, most other professionals on the ward were available to participate in the workshops (…)

discussing the patient/carer narratives seemed to allow professionals the distance to reflect on them without responding negatively to the critique contained in them. But we were most intrigued by the way the narratives also highlighted the hitherto unnoticed privilege of medical and institutional power.

The narratives began to work in ways that exceeded the initial role we had envisaged for them. Perhaps the lack of closure and the ambiguities contained in the narratives allowed for such opportunities. One of our key intentions in composing and sharing the patient narratives, was to de-personalize patient critique while at the same time conveying the essence of patient experience and allowing professionals the necessary distance for critical reflection. This critical distance was made possible by introducing an element of fiction and anonymity to what would otherwise be bold, critical patient statements that could, in some cases, be traced back to the patient. The other intention was to offer professionals a break from the normality of
everyday routine, by presenting a different, perhaps even startling perspective.

| Ranner M, von Koch L, Guidetti S, Tham K. Client-centred ADL intervention after stroke: Occupational therapists' experiences. Scandinavian journal of occupational therapy. 2016;23(2):81-90 | 3 & 5 | Collaboration with their clients, and strive to use their empathetic understanding of the clients’ lived experience throughout the whole intervention process in order to enable the clients’ ownership in daily activities after stroke. The continuity of sharing seems to be the key to a gradual increase in agency, and this approach could preferably be applied by inter-professional teams including the client and significant others. The core category sharing for agency in daily activities revealed the importance of sharing during the intervention process in order to enable agency in daily activities. The metaphor ‘enabling the client’s transfer over to the driver’s seat – shifting place’ was used during the analysis to focus on the purpose and the meaning of enabling a change during the intervention process. The metaphor made it visible that the OTs strove to support their clients to ‘shift seats’ with them in order to take the ownership of where to ‘drive’ in the context of daily activities. The findings on how the OTs supported their clients to take
| Enabling the client’s transfer over to the driver’s seat – shifting place’ was used during the analysis to focus on the purpose and the meaning of enabling a change during the intervention process. | Enabling the client’s transfer over to the driver’s seat – shifting place’ was used during the analysis to focus on the purpose and the meaning of enabling a change during the intervention process. Ownership is in line with how client-centred practice is framed by Townsend and Polatajko,[8] and Law, Baptiste and Mills.[3] Furthermore, the findings showed that sharing experiences appeared to promote the clients’ involvement in the rehabilitation process and helped them feel safe when ‘making things happen through their own actions’, which has previously been identified by Bergström[36] as a characteristic of agency. To create a sharing situation seemed to be a prerequisite for enabling change during the intervention process. This is in line with how the therapeutic relationship has been described as essential for the therapeutic process in occupational therapy and a ‘catalyst for change’. [37]  
  
In the present study, the process of ‘sharing to enable agency in daily activities’ seemed to take time. Previous studies have described therapists’ experiences of rehabilitation as time-consuming, [24,43] and lack of time as a barrier to achieve a patient-centred framework, [39] but have also described time as a resource. [23] The findings of the present study indicated that the intervention process had to take time, ‘the time it takes’[30] if a positive change was to happen. Thus a clinical implication might be that the intervention sessions could be spread out over a longer period to give the clients |

| 3 & 5 | Action required by individual clinicians (need to be more collaborative), whole team and the organizational environment and culture – all of them might perceive themselves more patient-centered than actually practiced. Need for increased self-awareness and PERSON-CENTERED CARE skills – even when rapport was achieved the quality of patient engagement varied substantially. | Organizations and clinicians may overestimate the degree to which their goal setting is patient-centered, even when they believe they prioritize this approach. Three factors were important: degree of clinician–patient collaboration, the environment where goal setting occurred and clinician self-awareness. Some actions require the investment of a whole team, others direction from management while there is still much that individual clinicians can do to improve client centered practice. By implementing strategies that relate to the collaboration between patients and clinicians as well as the environment in which they take place, the goals of rehabilitation patients should become more known, adopted and achieved. Clinician working in rehabilitation has a greater influence than the patient on goals developed. It was heard that sometimes patients were |
Among the team, one skilled person might be accountable for the PERSON-CENTERED CARE goal-setting (also for efficiency and not providing unneeded patient burden), and the team must have mechanisms for goals to be known across the team.

Lack of PERSON-CENTERED CARE skills included communications breakdowns by lack of active listening, responsiveness and summary of goals.

Being mindful of the influence of power relationships, expectations not even invited to participate in goal setting, or their views were simply ignored.

Clinicians attempt to engage patients in goal-setting discussions, but the quality of these discussions, the degree of patient influence and communication of those goals back to the patient and on to the treating team varied substantially across the sample.

when goal-setting discussions are conducted by various individuals within a multidisciplinary team, it can be challenging for the patient to know to which clinician to direct their goal. Patients should not have to decode the roles and responsibilities of the multidisciplinary team. Instead, it should be made clear to the patient on admission with whom they can discuss their goals, and the multidisciplinary team should have communication mechanisms to ensure those goals are made known within the treating team.

A clear practical implication from our work is the potential for greater efficiency and improved patient centeredness when one suitably skilled team member completes an in-depth goal-setting discussion.
and workplace culture is required for effective self-awareness and then PERSON-CENTERED CARE practices with the patient, rather than the multiple goal-setting discussions that currently occur in the studied service.

Reducing the impact of negative environmental factors requires the engagement of whole organizations and rehabilitation teams and is facilitated by an organizational culture that shows respect for diverse values and choices.

Clinicians in our study were skilled at making connections with patients and using banter to develop a rapport; however, they were less adept at carefully listening and responding appropriately to what the patients actually said.

A further communication breakdown noted in this study was the failure of most clinicians to provide any sort of goal summary statement to clearly indicate the outcomes of the goal-setting discussion.

The success or otherwise of the goal-setting interviews analyzed seemed in large part to be dependent on the clinician’s level of self-awareness.
Being mindful of the influence of power relationships, expectations and workplace culture is necessary in order for the clinician to balance competing interests in goal setting.8

A particular problem noted in this study was a mismatch between clinicians’ knowledge of client-centered practice and the way they actually conducted goal-setting interviews with clients.

Leach E, Cornwell P, Fleming J, Haines T. Patient centered goal-setting in a subacute rehabilitation setting. Disability and rehabilitation. 2010;32(2):159-172

Three approaches to goal-setting were identified: therapist controlled, therapist led and patient centred.

Therapists described difficulties in setting goals agreed to by patient, family and therapist. As such, ensuring a shared understanding of was seen as an imperative.

PERSON-CENTERED CARE approach was not the most common. Therapist often led, although they recognize the PERSON-

The therapist-led approach predominated, characterized by the therapist guiding the collaboration between therapist and patient with respect to goals for rehabilitation.

A patient centered approach allows the patient to identify and prioritise their goals for therapy and lead the process of goal-setting [10]. However other considerations within a patient centered approach include involvement of family members in the goal-setting process, educating the patient and family on the goal-setting process, life post-injury and realistic goals and negotiating relevant goals for therapy [33].
| CENTERED CARE can lead to increased motivation. | Many therapists described difficulties in setting goals agreed to by patient, family and therapist. As such, ensuring a shared understanding of these terms was seen as imperative to the therapists. |
| Barriers for PERSON-CENTERED CARE pointed were: lack of time, engaging those with communication/cognitive and awareness impairments, issues of unrealistic/unachievable goals. | The most commonly reported advantage of adopting a patient centered approach was its effects on increased patient motivation. |
| Strategies to overcome these difficulties included modifying communication and using education to overcome differences in knowledge and understanding of the goal- | A prominent barrier was the reduced capacity of individuals with stroke to participate in a communication exchange concerning their future. This was relevant to patients who presented with expressive deficits due to aphasia and also, patients who presented with reduced insight. |
| | Therapists commented that patients would often present goals that were unachievable or unrealistic considering their point on the rehabilitation continuum. |
| | Therapists indicated that they did not have the time needed to embrace a true patient centered approach whereby they consulted |
The barriers to a patient centered goal-setting approach outweighed the facilitators and revolved around patients’ reduced capacity to participate and inability to offer realistic goals. Strategies to overcome these difficulties included modifying communication and using education to overcome differences in knowledge and understanding of the goal-setting process between therapist and patient.

| Hiller A, Guillemin M, Delany C. Exploring healthcare communication models in private physiotherapy practice. Patient education and counseling. 2015;98(10):1222-1228 | setting process between therapist and patient. with family members and facilitated discussion outlining the process of goal-setting. | Subtle use of touch and casual conversation implicitly communicate competence and care, representative of a patient-centred mode PERSON-CENTERED CARE is not predominant - a ‘practitioner-centred’ model is. The communication occurring in the private practice physiotherapy treatment encounter is predominantly representative of a ‘practitioner-centred’ model. However, the subtle use of touch and casual conversation implicitly communicate competence and care, representative of a patient-centred model. Physiotherapists do not explicitly draw from theories of communication to inform their practice. In the private practice setting observed communication was structured, focused on physical aspects and led by the physio-therapist, these features represented a predominantly practitioner-centred approach to communication. Additionally, aspects of patient-centred
Physiotherapists did not explicitly draw from theories of communication to inform their practice, relying instead on their own experience and intuitive assessment of patients’ needs. Further training on the above, including for realizing what is sometimes implicitly used into practice, communication and empathy were evident through touch and the use of casual conversation. Therefore, the communication occurring in the time-limited private practice physiotherapy treatment encounter is predominantly representative of a practitioner–centred model of communication punctuated by the subtle use of touch and casual conversation to implicitly communicate competence and care. However, physiotherapists did not explicitly draw from theories of communication to inform their practice, relying instead on their own experience and intuitive assessment of patients’ needs.

Currently, the use of touch and casual conversation are significant elements of patient-centred communication in physiotherapy that appear purposeful, yet are implicit.

Further research to theorise physiotherapy-based clinical communication may help in progressing education to be related to explicit and empirically based communicative aspects of practice. In addition, understanding theories of communicative practice developed from empirical research should enhance professional self-awareness, which is a fundamental element of patient-centred care.
Physiotherapists may benefit from further education to achieve patient-centred communication. Equally, the incorporation of casual conversation and the use of touch into theory of physiotherapy patient-centred communication would highlight these specific skills that physiotherapists already utilize in practice.

| Parker DM. An exploration of client-centred practice in occupational therapy: perspectives and impact. University of Birmingham, 2013. | 3 & 5 | Respect; treated as equals – no power differentials. Partnership – although challenging (e.g. in negotiating goals). | Clients’ perspective of client-centred practice was the value they placed on the attitude and behaviour of the therapist, communicating respect and treating them as equals. Therapists valued partnership but were challenged in establishing a relationship with the client and failed to negotiate goals with them. Using a client-centred outcomes measure (the COPM) reinforced partnership, demonstrated joint goal setting and evaluated client satisfaction. Communication, use of language and documentation should be client centred and reflect the client’s needs. |

<p>| Bamm EL, Rosenbaum P, Wilkins S, Stratford P, Mahlberg N. Exploring Client-Centered Care | 3, 4 &amp; 5 | Partnerships and the whole team, including patients and families, having mutual goals and understating of outcomes. | The central category from both clients’ and HCPs’ perspective was the importance of the whole team having mutual goals and understanding of the outcomes. |</p>
<table>
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<tr>
<th>Experiences in In-Patient Rehabilitation Settings. Global qualitative nursing research. 2015;2: 2333393615582036.</th>
<th>Not all clients want to be active in the day-to-day decision-making – and that must be respected, but all participants reflected on the importance of working toward goals that were meaningful and important for the client. Poor client’s health literacy underscored as one factor capable of preventing people from active participation in care decision-making. Clinicians fostered control of patient’s over the situation by: education and information, joint problem solving.</th>
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<td>To help clients get some control over their situation, clinicians employed different strategies, including education and information provision, joint problem solving, weekend passes, and focusing on achievements. All clinicians described the patient and family as central members of the rehabilitation team. However, they would have liked the clients to be more proactive in seeking information, asking questions and participating in decision making. Most clients were happy with their role during their rehabilitation. Although they felt that they were listened to, and free to ask questions, they did not perceive themselves capable of making medical decisions. The main barriers to implementation of CCC identified by all participants were poor health literacy, lack of time, understaffing, and organizational culture. Poor health literacy affects clients’ ability to participate actively in their care by preventing them from asking questions and making decisions. The current work suggest that clinicians have a clear understanding of the principles of CCC and are working in partnerships with the clients.</td>
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solving, weekend passes and focus on achievements. to achieve their goals. Regardless of age, all participants reflected on the importance of working toward goals that were meaningful and important for the client. However, some clients tend to have passive attitudes to day-to-day decisions and their preferences should be respected and supported. Clients rely on a support group that includes family, friends, staff, and family physicians. Efficient communication among all the parties is paramount.

We need to encourage and educate clients to become motivated, well-informed, proactive participants in their care. Health education should begin as early as the school years to empower clients to participate in planning and decision making about their care.

| Levack WM, Dean SG, Siegert RJ, McPherson KM. Navigating patient-centered goal setting in inpatient stroke rehabilitation: how clinicians control the process to meet perceived professional | Therapists’ own difficulties to manage unpredictable goals – then back to more familiar, privileged professional goals, or what they deem to be achievable – or professional obligation (e.g. to ensure patients are as independent as possible with personal | The borderlands of ‘patient-centered’ goal setting: The challenge with patient-centered goal setting was that when patients (or their family) were asked to state what they wanted to achieve in rehabilitation, their answers were at times unexpected or not aligned with the type of goals that the clinicians themselves believed should be the focus of rehabilitation. Such conversations had the potential to become unpredictable, carrying a sense of risk that patients or family members might raise topics that were awkward or time consuming for the clinicians to address. When interactional |
responsibilities. Patient education and counseling. 2011;85(2):206-213

care) and the need to be responsive to financial and organizational imperatives (e.g. to discharge people as quickly as possible to independent community living).

Wonders about whether a 'patient-centered' approach is even possible in inpatient stroke rehabilitation when considering predominant funding and health system models.

A truly 'patient-centered' approach to rehabilitation may require a significant shift in the way clinicians think about goal setting and dilemmas like this arose, the clinicians employed strategies to navigate their way through conversations, back towards more familiar (i.e. privileged) goals.

The clinicians had not been sufficiently 'patient-centered' in their selection of which goals to work on. However, it would appear from this study that in inpatient rehabilitation other factors exist that compete with and limit the capacity for clinicians to be 'patient-centered', even when this approach is desired by clinicians themselves. (...Barnard et al.'s found that...) Inevitably written goals focused on what clinicians deemed to be 'achievable' within the scope of services they provided.

Other drivers, notably the need to fulfill perceptions of professional obligation (e.g. to ensure patients are as independent as possible with personal care) and the need to be responsive to financial and organizational imperatives (e.g. to discharge people as quickly as possible to independent community living), appear to have greater influence over clinical decisions than any need to address what might be genuinely important in the lives of the people receiving a rehabilitation service.
rehabilitation. Clinicians would need to be open to the possibility that anything a patient or family member introduces during goal setting sessions should at least be considered for discussion, even outside of the deemed ‘realistic’ and of traditional professional scope of practice.

This paper has introduced the notion of the privileging of certain goals in inpatient rehabilitation, and has presented a substantive theory explaining how these privileged goals create interactional dilemma for clinicians when they do not align with the objectives, attitudes and perceived capacity of patients and their family. The privileging of goals was seen to be driven to a large degree by financial and organizational factors. This raises questions about whether a ‘patient-centered’ approach is even possible in inpatient stroke rehabilitation when considering predominant funding and health system models.

If rehabilitation teams wish to promote a more ‘patient-centered’ approach to goal setting, they will need to ensure they identify and address barriers to the engagement in goals deemed important to patients and their family.

However, a truly ‘patient-centered’ approach to rehabilitation may require a significant shift in the way clinicians think about goal setting and rehabilitation. Clinicians would need to be open to the possibility that anything a patient or family member introduces during goal setting sessions should at least be considered for discussion. This might
require clinicians to consider topics outside the traditional scope of inpatient rehabilitation. It may also require clinicians to consider goals that they deem to be 'unrealistic'.

| Rosewilliam S, Sintler C, Pandyan AD, Skelton J, Roskell CA. Is the practice of goal-setting for patients in acute stroke care patient-centred and what factors influence this? A qualitative study. Clinical rehabilitation. 2016;30(5):508-519 | 3, 4 & 5 | Goal-setting practices were not much patient-centered: emotional and social issues were overlooked. Incongruencies existed between patients and professionals (and among professionals) in setting, communicating and prioritising goals. Therapeutic relationships (considered a key element of PERSON-CENTERED CARE) were dysfunctional. | Limited patient-centredness in goal-setting was evident through incongruities in goal-setting and dysfunctional therapeutic relationships. The study indicated that goal-setting practices were not very patient-centred locally, with emotional and social issues being overlooked. Goal-setting was not consistently patient-centred as evidenced by a) incongruities between patients and professionals in setting, communicating and prioritising of goals and b) dysfunctional therapeutic relationships. The factors that influenced patient-centred goal-setting were both professional and patient beliefs and attributes, work-culture, practice model, limitations in knowledge and systems that disempowered both professionals and patients. Findings relevant to the limited adoption of patient-centred principles in goal-setting in local practice are: a) Incongruities between patient and... |
Professionals might be caught in the conflict between their value of being more patient-centred and conforming to the biomedical paradigm, defensive and reactive care/organizational/work culture.

To change professionals' behaviour, the assumption that they are already patient-centred has to be challenged.

Organisations should encourage staff to adopt patient-centred practices using supportive strategies, as professionals were professionals in setting, communicating and prioritising of goals.(…);

b) Dysfunctional therapeutic relationship

Patient-related and system-related factors that influenced patient-centredness in goal-setting were (…): Patient disempowerment; (…) Proactive patient and family.

Professional-related factors that influenced patient-centredness in goal-setting were: (…) Work culture within the acute bio-medical model; (…) Professionals’ beliefs, knowledge and context of practice.

key dimension of patient-centredness, i.e. good working relationship between patient and professional.

Professionals might be caught in the conflict between their value of being more patient-centred and conforming to the defensive and reactive NHS culture.25 In addition to the culture within the NHS organisation, priorities of the organisation such as focusing on early discharge and safety were found to be non-conducive to patient-centred goal-setting.
| disempowered and lacked autonomy in adopting patient-centred practice. Staff needs to feel psychologically safe and confident could enable individual’s behavioural change towards a more patient-centred approach. | Our study identified similar trends it also identified that professionals were disempowered and lacked autonomy in adopting patient-centred practice indicating a need to empower and support behavioural change in individual staff. To alter professionals’ behaviour, the assumption that they are already patient-centred has to be challenged. Thereafter supportive strategies for a professional to feel psychologically safe and confident could enable individual’s behavioural change towards a more patient-centred approach. Organisations should encourage staff to adopt patient-centred practices using supportive strategies. |

| Patient being involved in decision-making was considered a matter of both person-centeredness and quality of care. Partnership had an overarching role, not only for | Partnership was identified as the core category with continuity of rehabilitation and patient-centred approach as its dimensions. Themes in the patient-centred approach were Biopsychosocial understanding and Professionalism. Main finding of this study was that the patient-centered approach formed by the biopsychosocial model and professionalism contributed substantially to achieve quality in rehabilitation for adults with fractures. |

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<tr>
<td>PERSON-CENTERED CARE. Interpersonal relationship means that therapist and patient reached a common understanding about the nature of the problem and the therapeutic means. Importance of psychological and social understanding of the problems faced by the patients; they perceived they were getting assistance to manage the situation, which increased their sense of control.</td>
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<td>The category of professionalism provided four subcategories, which interacted closely. They were interpersonal relationship, patient education, therapeutic means and perceived control. Interpersonal relationship means that therapist and patient reached a common understanding about the nature of the problem and the therapeutic means. Both patients and therapists considered the quality to be good when the therapist involved the patient in the decision-making process. In the category of biopsychosocial understanding, the two most important subcategories identified were perceived control and return to work. The therapists highlighted the importance of psychological and social understanding of the problems faced by the patients. As a consequence of this understanding, patients perceived that they were getting assistance to manage the situation, which increased their sense of control.</td>
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The present study indicates that partnership and patient-centred approach mitigated the consequences of the injury and helped the patients to cope with the situation.

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Contradictions in client-centred discharge planning: through the lens of relational autonomy.  

Background: While client-centred practice has received wide support, it remains difficult to apply in many practice settings. Identified barriers include constraints on time, resources, and services imposed by healthcare policies. Healthcare professionals’ prioritizing of client safety over (other) interests that clients may name may further restrict the application of client-centred practice. Discharge planning is one area where such considerations can conflict.

Client-centred practice was not promoted in discharge planning processes in the research setting.” Healthcare professionals interpreted client-centred practice to require abiding by client wishes, as long as this was safe; furthermore prioritizing safety took precedence over other considerations in discharge planning.

In the study setting, healthcare professionals’ understandings of client-centred practice were narrowly construed as upholding client preferences in so far as doing so was deemed to be safe according to the healthcare team – not aligned with the client-centered literature.  

Practice guided by relational approaches can enhance clients’ capacities to participate in collaborative decision-making by creating opportunities for shared decision-making and active involvement in the planning process. This approach ensures that clients are actively engaged in setting their discharge goals, aligning with their preferences and values, and fostering a sense of ownership over the decision-making process.  

Healthcare professionals’ understandings of client-centred practice were narrowly construed as upholding client preferences in so far as doing so was deemed to be safe according to the healthcare team – not aligned with the client-centered literature.
conditions that promote the enactment and recognition of their autonomy.

In situations where individual choices are constrained by external forces, opportunities for engagement in occupations can be impeded or coerced. So, enabling that equal opportunities exist might be promoted.

preferences in so far as doing so was deemed to be safe according to the healthcare team. Such a limited application does not achieve the intended aims of client-centred practice described in the literature.

We argue that relational autonomy theory is not only aligned with more robust descriptions of client-centred practice, but also has the potential to promote practice that reconciles concerns for client safety with aims to uphold client preferences. Practice guided by relational approaches can enhance clients’ capacities to participate in collaborative decision-making by creating conditions that promote the enactment and recognition of their autonomy.

On a broader scale, relational autonomy theory encourages the examination of social, political, and institutional structures and consideration of the influence these may have on individuals’ autonomy, identities, perspectives, strengths, and capabilities (29,30). This examination extends to the intersection of social, political, and institutional structures that can, at times, set up situations of occupational injustice (34). The failure of healthcare professionals to politicize their actions in the interest of social justice has been highlighted as a barrier to client-centred practice (34,49). The
application of a relational autonomy lens to practice could help to identify overarching social, political, and institutional structures that are intersecting to constrain client or therapists’ autonomy and create situations of injustice. Doing so could promote a discussion of how policies and practices could be reoriented away from institutionally driven values (50) or therapist-centred care (2) to better enable approaches that foster client autonomy, promote social and occupational justice, and better align with tenets of client-centred practice (34,37).

At the heart of client-centred practice is a presumption of respect for the autonomy of clients, yet little literature in the field problematizes how the enactment of respect for autonomy in practice occurs; the results of this study point to conditions that preclude or trump its enablement. Relational autonomy theory recognizes that not everyone has equal opportunity for autonomous decision-making and action, that autonomous action is mediated through relational, social, cultural, economic, contextual, situational, and political dimensions, and that power circulates in its enactment (29,30,33). In this way theories of relational autonomy offer a means of more deeply examining how autonomous
decision-making and actions of individual or groups of clients are enabled or constrained, and draw attention to circumstances that promote (in)justice for particular groups or individuals. For example, in situations where individual choices are constrained by external forces, opportunities for engagement in occupations can be impeded or coerced, which can result in occupational injustice and can have an impact on individual health and well-being(34). Theories of relational autonomy thereby contribute a critical perspective to the aim of respecting autonomy and imply a duty to promote justice as central to client-centred practice.

| Wijma AJ, Blettermann AN, Clark JR, et al. | 4 & 5 | Patient-physiotherapist interactions have a centralized role, including physiotherapists’ characteristics. PERSON-CENTERED CARE entails a treatment in which the patient is supported and empowered. | Patient-physiotherapist interactions and physiotherapists’ characteristics placed at the model centre. This review identified 14 articles from qualitative studies investigating patient centeredness in physiotherapy. From these studies, a synthesis of interrelated themes (individuality, communication, education, goal setting, support, social characteristics of a patient-centered physiotherapist, a confident physiotherapist, knowledge and skills of a physiotherapist in patient centeredness). |
| Individualized treatment and PERSON-CENTERED CARE goals | Patient centeredness in physiotherapy entails the characteristics of offering an individualized treatment, continuous communication (verbal and non-verbal), education during all aspects of treatment, working with patient-defined goals, a treatment in which the patient is supported and empowered, and a physiotherapist with patient-centered social skills, confidence, and knowledge. |
| Continuous communication and patient education (clear and lay speech – avoid jargon). | “Individuality” concerns specific patient-tailored education, communication, and treatment. “Communication” is the need for a continuous individualized dialogue with patients in clear and lay speech. |
| A therapist with patient-centered social skills, confidence, and knowledge is required. | “Education” primarily involves advice about the problem, diagnosis, treatment, and treatment course. |
|  | “Goal setting” is used by physiotherapists to activate and motivate patients, however, was not spontaneously mentioned by patients. |
|  | “Support” from the physiotherapist is seen as a mixture of individuality, equality of responsibility, understanding, reassuring, and empowerment. “The social characteristics,” “confidence,” and “skills |
“and knowledge” of a patient-centered physiotherapist are personal skills and encompass for instance: being able to relate to the patient, confident body language, up to date knowledge, and teaching skills. This theme can be used to create awareness among physiotherapists and offers the opportunity to physiotherapists to reflect upon whether their attitude and behavior are patient centered.

| Plant SE, Tyson SF, Kirk S, Parsons J. What are the barriers and facilitators to goal-setting during rehabilitation for stroke and other acquired brain injuries? A systematic review and meta-synthesis. Clinical rehabilitation. 2016;30(9):921-930 | 3, 4 & 5 | Flexible PERSON-CENTERED CARE approach to goal-setting, tailored to individual patients’ needs and preferences, which may change with time. Thus, PERSON-CENTERED CARE in goal-setting must be sensitive to the rehabilitation-stage in addition to individual person | Importantly, we identified that, contrary to the received wisdom that a patient-centred approach is an essential and desirable element of effective goalsetting, we found, in the early stages of rehabilitation patients often expect a therapist-led approach. The two previous systematic reviews of the effects of goal-setting also identified differing perspectives between patients and staff and the need for education. Like the current review, they noted that a patient-centred approach to goal-setting was not always welcomed by patients or staff, particularly during the early stages of rehabilitation which typically occurs while an in-patient. |
preferences for a goal-setting approach.

When the persons had returned home and had some experience of ‘their life after stroke’, they became more able to identify priorities and willing/able to compromise with goal-setting and action planning.

It may be that, for some patients at least, in-patient rehabilitation is a transition phase from a medical to biopsychosocial model. In-patient rehabilitation typically occurs during the acute and sub-acute phases of recovery, when relatively rapid recovery can occur, so a short-term focus may appropriate.

It is also a time when impairments may be improving and patients are just beginning to regain activities, so, again, goals regarding impairments and basic activities of daily living may be most appropriate. Furthermore, an emphasis on participation during in-patient rehabilitation may be inappropriate as the patient has not yet had opportunity to explore his/her capabilities and priorities in their own environment.

The results of the current review suggest that a more flexible approach is needed. There are points, particularly early in the rehabilitation process when a clinician-led, impairment-based medical model may suit some patients better and thus may be more effective. The results of this review and others6,7 highlight that the main problem with goal-setting is that both patients and clinicians struggle to identify and negotiate goals.18,31-34 This difficulty may be because patient-
centred goal-setting is not ‘fit-for-purpose’ for all stages of rehabilitation and for all patients.

The clear message from the current review is that the process of goal-setting needs to be tailored to individual patients’ needs and preferences, which may change with time. Although some patients were critical of their experience of goal-setting in the early stages of rehabilitation, others noted that once they had returned home and had some experience of ‘their life after stroke’, they became more able to identify priorities and willing/able to compromise their hopes and ambitions. It may be at this point that a patient-centred approach is most acceptable and effective.

Zimmermann L, Konrad A, Muller C, Rundel M, Korner M. Patient perspectives of patient-centeredness in medical rehabilitation. Patient education and

Patients evaluated the indicators of patient-centeredness very differently between centers. (…) For instance, with a total of 67 positive statements out of 80, patient-centeredness was rated much more favorably by patients at Center 1 than by those at Center 3.

Apparently, patients feel that patient participation is implemented quite differently at the centers, and the question is which organizational center-specific or patient-specific factors contribute to this difference in
counseling.  
2014;96(1):98-105

<table>
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<tr>
<th>dimension of patient-centeredness.</th>
<th>Time for reciprocal communication is essential.</th>
<th>assessment – at least from the patients’ perspective. One challenge for rehabilitation centers is to optimize patient-centeredness in the rehabilitation process. Therefore, inter-professional teamwork can also be seen as a factor promoting the implementation of patient-centeredness [37,38] and also using a client-centered goal formulation or clinical pathways as tools.</th>
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<tr>
<td>Asking patients via interview or questionnaire about their experiences, goals and treatment planning as well as implementing their treatment times more flexibly into the rehabilitation process.</td>
<td>The focus groups particularly highlighted the significance of relevant “interaction” from the patients’ view, with a total of 132 statements. Most statements were made on this aspect, thereby confirming that patients consider it a particularly important indicator of patient-centeredness. The provider–patient “interaction and relationship” is rated very positively when compared to the other dimensions of patient-centeredness, with 115 positive statements, but distinct between-center differences exist in this area as well (compare Centers 1 and 3).</td>
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<td>The focus group patients very frequently determined patient-centeredness by referring to provider–patient interaction and user participation. Therefore, this can be considered a very central dimension of patient-centeredness, supporting the results of other</td>
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248
The assessments of individual indicators of patient-centeredness and their implementation at the centers vary widely between centers. Improvements to patient-centeredness could be made by asking patients via interview or questionnaire about their experiences, goals and treatment planning as well as implementing their treatment times more flexibly into the rehabilitation process. It is essential that the patients are integrated more in patient care. Time for reciprocal communication and feedback between medical staff and the patient is essential for successful treatment.