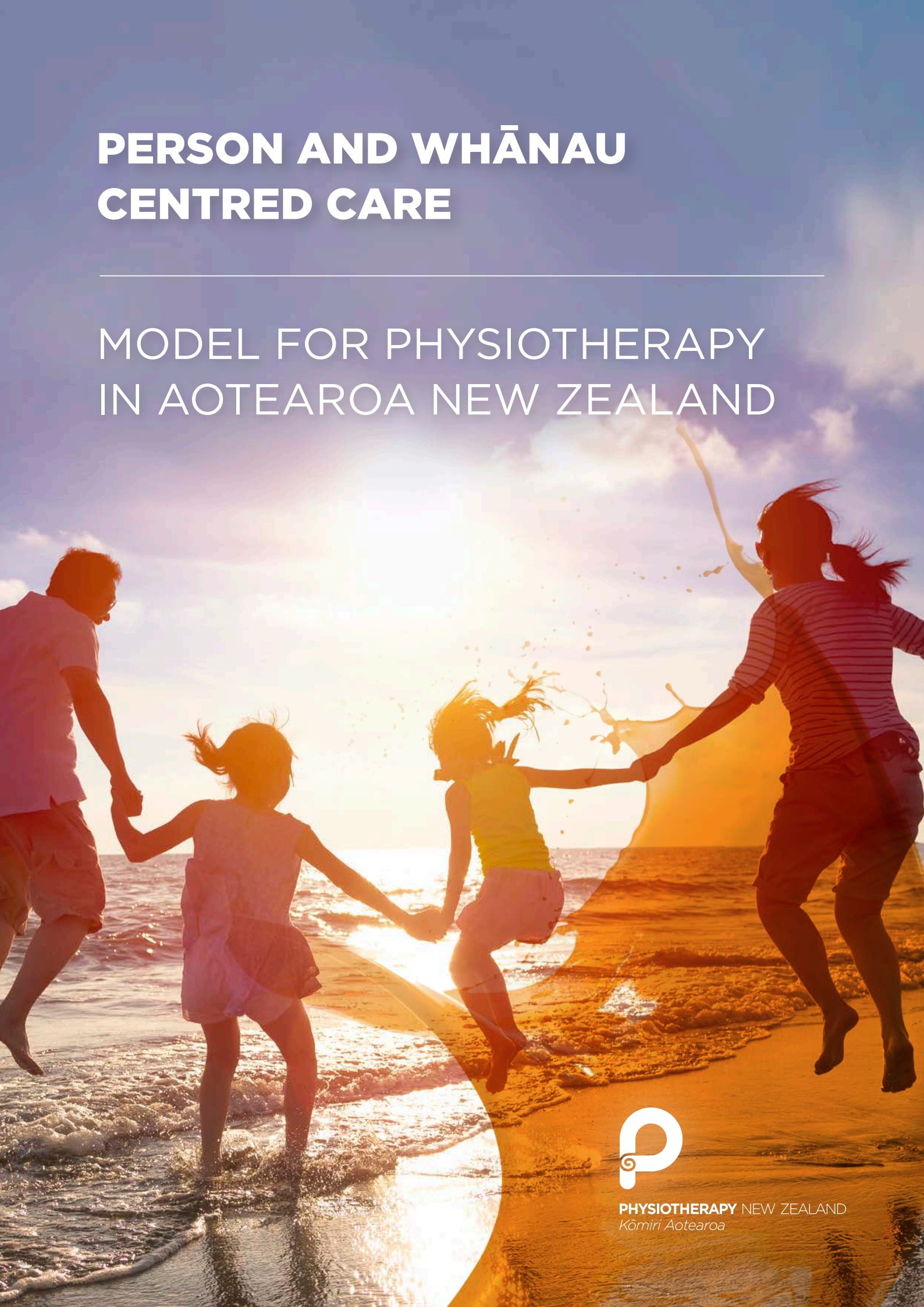
PERSON AND WHĀNAU CENTRED CARE

MODEL FOR PHYSIOTHERAPY IN AOTEAROA NEW ZEALAND



PHYSIOTHERAPY NEW ZEALAND
Kōmiri Aotearoa

CONTENTS

INTRODUCTION

Person and whānau centred care is collaborative healthcare focused on meeting the needs, values, and desired outcomes of individuals and whānau. This document presents a definition and model of person and whānau centred care for physiotherapy in Aotearoa New Zealand.

The model consists of:

- a set of values that underpin person and whānau centred care
- a set of defined behaviours through which those values are enacted
- system-level components, which may not be under the direct control of each physiotherapist, but that all physiotherapists should influence as they are able.

A selection of stories from people who have received physiotherapy care that illustrate what different behaviours 'look like' in practice have been provided.

The model has been developed to support and enhance the physiotherapy profession, and to build physiotherapists' capability, knowledge and understanding. Demonstrating the values and enacting the behaviours described in the model will enhance physiotherapists' professional practice and ability to improve health outcomes. In contrast, centring care on the needs of the healthcare system or the professionals within the system perpetuates health inequities and contributes to poor health outcomes. Incorporating person and whānau centred care into practice will also assist physiotherapists' adherence to the requirements that apply to physiotherapy in Aotearoa New Zealand as aspects of the model directly align with the *Physiotherapy Standards framework*[1] and other parts of the regulatory framework, including the *Code of Health and Disability Services Consumers' Rights.*[2]

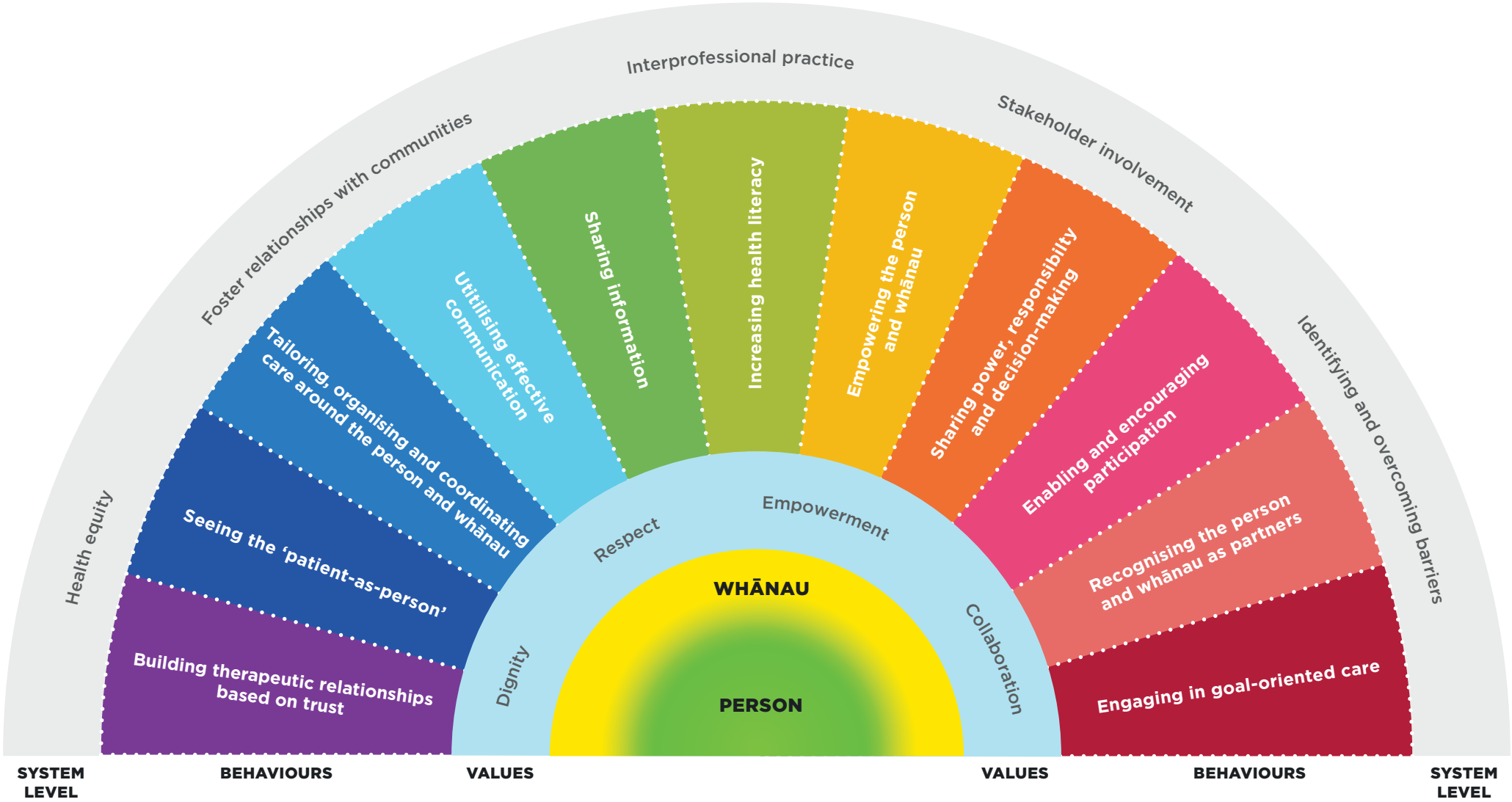
The intended audience for this document are physiotherapists within Aotearoa New Zealand, those offering continuing professional development to physiotherapists, physiotherapy students, and others associated with the profession.

Supporting resources and further information to assist physiotherapists to enhance their practice in terms of developing and strengthening these competencies are available on the Physiotherapy New Zealand website.

Whaka paohotia oku painga kia ngaro oku ngoikoretanga

Highlight my strengths and my weaknesses will disappear

Photo taken at the 2016 Kapa Haka Kura Tuarua Te Hāro o te Kāhu National Competition, and used with permission from He Waka Kōtuia Trust ©



VISUAL REPRESENTATION OF MODEL

[Diagram shows the person and whānau centred care model. The person is located at the centre, with the whānau wrapping around the person. Values wrap around the whānau. Behaviours radiate out from the values. System-level components are located around the outside of the behaviours.]

KEY CONCEPTS

Person and whānau centred care is collaborative healthcare that is focused on meeting the needs, values, and desired outcomes of the person and whānau.

The person is the individual who has a therapeutic or professional relationship with a physiotherapist.

Whānau is a concept that applies to many cultures and ethnicities. Whānau are those to whom the person relates in terms of shared experiences, values and beliefs. The people and relationships that comprise a person's whānau may be lifelong, or time-limited and specific to the person's life circumstances. These relationships are not necessarily reliant on kinship ties.

This model recognises that whānau is a core value of many people, particularly those who belong to communalist cultures. The embodiment and expression of this value will vary between individuals.

VALUES

Person and whānau centred care is underpinned by the values of dignity, respect, empowerment, and collaboration.

DIGNITY / Rangatira, Rangatiratanga

Dignity is the inherent value and worth of each person and whānau.[3,4] Physiotherapists treat all people with dignity by acknowledging and upholding their value and worth.

RESPECT / Aroha, Arohatia, Manāki, Manākitanga

Respect is giving each person and whānau proper attention and consideration, and holding them in due regard.[5] Physiotherapists afford all those with whom they interact appropriate care and attention, aiming to enhance personal and whānau mana in all interactions.

EMPOWERMENT / Manamotuhake

Empowerment is the process of supporting and enabling individuals, whānau, and communities, to take control of their own health needs, and become stronger and more confident in doing so.[6]

COLLABORATION / Rangapū, Tō Rangapū

Collaboration is the process of individuals, whānau, and health professionals, working together in partnership to achieve a common purpose.[6]

BEHAVIOURS

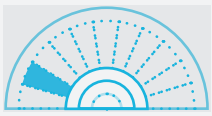
Person and whānau centred care is demonstrated through the following behaviours. Although presented as separate behaviours, there is significant crossover and overlap between these. The order in which these are presented relates to the visual representation of the model; the order does not indicate relative importance or priority. Each story presented describes an example of what the behaviour 'looks like' in practice. These experiences were shared by physiotherapy consumers.

BUILDING THERAPEUTIC RELATIONSHIPS BASED ON TRUST

Relationship-building involves[7]:

- developing and maintaining rapport and trust with the person and whānau;
- honest and open engagement with the person and whānau;
- genuine interest in the person and their whānau, exploring their values and interests, and taking the time to understand what they find meaningful and important;
- developing an open and inclusive 'space' in which the person and whānau feel safe;
- acting with integrity in all interactions with and concerning the person and whānau.

> *"Our mum has dementia and the physiotherapist developed a great rapport with her which was a significant factor in her recovery and optimising her mobility. Mum is very musical and creative and the physiotherapist went the extra mile with incorporating these interests with his therapies to make it work for her."*



SEEING THE 'PATIENT-AS-PERSON'

Seeing the 'patient' as a person involves:

- **Recognising the individual as a whole person**, and seeing the total picture of their preferences, abilities, potential, wellbeing, and wider social and cultural background (as opposed to focusing just on the individual's condition or symptoms). Acknowledging the uniqueness of each person is fundamental. A central orienting question for practitioners to ask themselves is "Who is this person and what do they need from me today?" [7,8]
- **Recognising the specific external and situational influences** on the person's health and wellbeing (e.g., their stressors, work life, broader determinants of health, et cetera), that these factors can also influence a person's decision making related to health, and that these influences may change, while being flexible in response to these changes.
- **Positively responding to diversity** in others:
    - suspending judgement;
    - being inclusive in one's attitude and behaviour, and responding appropriately to people in all of their diversity;
    - behaving in a culturally competent, safe, appropriate, and responsive manner for each person and their whānau;
    - valuing functional diversity of physical, sensory, and cognitive abilities.
- **Being aware of your own culture, values, and philosophy of care**, and the influence of these on your relationship with the person and whānau:
    - reflecting on and understanding your own culture, values, and beliefs, and those of physiotherapy and your clinical setting;
    - reflecting on and developing an understanding of unconscious bias, and how you as an individual unconsciously react to those who are different from you.[9]

'Culture' is "a dynamic system of rules – explicit and implicit – established by groups to ensure survival, involving attitudes, values, beliefs, norms, behaviours, shared by a group, but harboured differently by each [person] within the group".[10 (p. 24)] Culture varies between individuals within the same group and over time. Cultural competence and safety involves acknowledgement of your own culture as different from those of your patients and their whānau, so as not to impose your own cultural beliefs and practices onto them.[11]

> *"I will always always always remember the way you [the physio] took the time to build rapport with [my daughter, aged 1½]. And SAW HER as a person. Not as "just a toddler" or "patient". How you talked to her and ASKED her before you touched her."*

TAILORING, ORGANISING, AND COORDINATING CARE AROUND THE PERSON AND WHĀNAU

People and whānau have unique needs and values. Tailoring, organising and coordinating care around people and whānau involves:

- empathy and compassion;
- suspending judgement;
- appreciating the person's and whānau perspectives, instead of making assumptions regarding their needs and wants;
- consideration of access to care, delivery of care, resource availability, provision of adequate time for care, optimising the use of person and whānau time, and working in the environment that best suits the person and whānau;
- utilising relevant frameworks of care. This involves:
    - selecting and negotiating frameworks appropriate for the person, whānau, and situation. Examples include the International Classification of Functioning, Disability and Health[12] and Māori models of health, such as Te Whare Tapa Whā,[13] and Te Wheke;[14]
    - learning with, from, and about interprofessional colleagues to enable effective collaboration and teamwork;[15]
    - consideration of whether you are the right therapist, or yours is the right discipline, to best meet the needs of the person and whānau;
    - ensuring that you are aware of the various services and organisations that are available within the community that may meet the needs of the person and whānau.

Coordinating care around the person and whānau extends to the collaboration with other healthcare professionals, advocating for the needs of people, whānau and communities, and assisting people and whānau to navigate the health care system.

> *"From the first phone conversation organising the very first appointment, our family needs have been considered with the offer of home visits should we find it difficult to make it into the physiotherapist's place of work. In a similar vein, once my daughter and I began attending speech language therapy appointments, these were combined successfully with physiotherapy appointments, thus reducing the number of visits we needed to make to the hospital and increasing the value (to us) of those visits we did make."*

UTILISING EFFECTIVE COMMUNICATION

Effective communication comprises all of the components of verbal communication, body language, and the content of the message communicated, as well as active listening, connecting and engaging. It involves:

- spending time talking with, and understanding, the person's and whānau views, values, needs, and wishes – and valuing the time spent exploring these;
- actively seeking person and whānau perspectives, taking time to listen (listen more – talk less), and ensuring that you gain an accurate understanding of these;
- ensuring explanations and demonstrations given are understood. This may involve using appropriate resources (e.g., interpreters, picture books, videos) to optimise communication;
- healthy and respectful conflict resolution, if and when conflict arises.

> *"The physiotherapist took time to show me all the exercises and if I didn't get it right she used a different way of explaining to help me understand it better. She never hurried me or seemed to be in a rush. She always made me feel safe and made sure I didn't trip or fall over equipment."*

SHARING INFORMATION

Information is shared between the physiotherapist and the person, whānau, and other professionals involved in the person's care, as appropriate. Sharing information is a two-way process, involving both giving and receiving information.

Giving information involves:

- the provision of complete, accurate, unbiased information in a timely manner and in an accessible, appropriate and understandable format;
- checking with the other parties to ensure that they have received and correctly interpreted the message.

Receiving information involves:

- actively seeking, and being receptive to and valuing information from the person and their whānau, and other health care professionals;
- checking back with the other party, ensuring that you understand this information correctly;
- creating an environment in which people and their whānau are comfortable sharing information relevant to their presentation and care.

Sharing information is closely related to utilizing effective communication. As such, it involves using appropriate resources (e.g., interpreters) to enable information sharing to be effective.

> *"Immediately following my stroke, while still in hospital, the physiotherapists who worked with me always invited my husband to attend sessions. While always talking to me directly, they shared their professional knowledge with him. This meant that my husband was able to help me practise skills and exercises in our own time which was of great benefit to me."*

INCREASING HEALTH LITERACY

Supporting the person and whānau to increase their levels of health literacy is a key enabler for self-management and participation. This involves:

- exploring how the person and whānau understand health, and what information would support this;
- exploring the ability of the person and whānau to access and understand information and services which are important for improving or managing their health, or for making better informed decisions affecting their health;
- collaboratively developing strategies to improve these abilities.

> *"Our physio helped us be able to connect with other whānau that were facing the same journey as us. It gave us a safe platform to discuss our experiences."*

EMPOWERING THE PERSON AND WHĀNAU

Empowering individuals and whānau involves supporting people to recognise, develop, and enhance their own strengths, abilities, and confidence, to enable them to live an independent and fulfilling life. Empowering the person and whānau enables self-management and autonomy, and can be aided through engagement with consumers, whānau, family, work places and communities.

> *"Knowing that I couldn't read print but could see colour, two physiotherapist students made a long programme and a short programme, each with a different coloured case. Since then, these exercises have been down-loaded onto my cell phone and Booksense* so that I have an accessible set of exercises which I can listen to and work through no matter where I am."*

SHARING POWER, RESPONSIBILITY, AND DECISION-MAKING

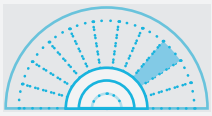
Integral to the notion of partnership is the sharing of power and control. It involves:

- recognising where power and control sits within relationships, and understanding when and how these should be shared;
- reflecting on the nature of power relationships (including cultural) that are present within the therapeutic setting and relationship. For those who belong to the dominant culture within the context, it also involves reflection on, and challenging of, any stereotyped views of minority cultures that you may hold or that might exist within that setting.[11] This is also integral to cultural competence and safety;
- sharing decision-making with the person, and whānau as appropriate, including being adaptable and accommodating to support decision-making for those with different abilities or decision-making processes, and not judging the decisions made;
- enabling people and whānau to be in a position to assume responsibility and share in the decision-making;
- providing complete information about all possible options to enable the person and whānau to determine the relative value of these;
- recognising and respecting that some people may not wish to fully assume power within the relationship at a certain point in time, while avoiding making assumptions about this. It is important to ascertain individuals' and whānau wishes on an ongoing basis.

> *"The physio team visited and spent time explaining and answering all our questions, enabling us to feel confident in our decision-making."*

* Booksense is a portable electronic Digital Accessible Information System device with multiple functionalities including text-to-speech output.

ENABLING AND ENCOURAGING PARTICIPATION

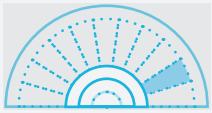


Enabling participation involves supporting the person and whānau to develop the knowledge, skills and confidence that they need to fully participate in the partnership and therapeutic process.

Encouraging participation is about supporting individuals and whānau to engage and be actively involved in the therapeutic process and partnership. It may also involve working with the person, their whānau, community or workplace, to develop further supportive resources and structures. Supportive environments have been found to enhance people's participation and self-management, and support health improvements.[16]

> *"The physiotherapist was so attentive to my own views, ideas, experiences and observations (as the mother of the patient), which definitely contributed positively to my level of participation and involvement in appointments. This means I felt it worthwhile to observe my child carefully and prepare for appointments; I also acted on the advice and guidance given by the physiotherapist because I was confident that it came as a result of a communion between the physiotherapist's expertise and experience and my knowledge of my own child."*

RECOGNISING THE PERSON AND WHĀNAU AS PARTNERS



The essence of partnership is recognising the person, whānau, and practitioners as equal partners with different expertise. It involves:

- recognising that people, whānau, and practitioners bring their own perspectives, values, expertise, needs and desired outcomes to the relationship;
- valuing the person and whānau perspectives and expertise (including their lived experience of their condition);
- incorporating and valuing person and whānau values, interests, and expressed wishes into the treatment plan and care;
- seeing the person and whānau as colleagues within practice and educators;
- working with the person and whānau to provide the best outcomes for all parties.

> *"The centre of conversations during physiotherapy appointments was what our family's experience and perception of our child's development had been. The physiotherapist offered advice and guidance (not instructions - note the difference!) after careful listening and observation and was encouraging at all times regarding the strategies developed within our family for supporting our daughter's specific needs."*

ENGAGING IN GOAL-ORIENTED CARE

Integral to goal-oriented care is collaborative goal-setting, where goals that are meaningful to the person and whānau are collaboratively negotiated and agreed. Negotiation is fundamental to this process. Goal-oriented care focuses on these explicit objectives, encouraging achievement of the highest possible level of health as defined by that person, and including "the ability to adapt and to self-manage, in the face of social, physical and emotional challenges".[17 (p. 1)] Progress against the goals is regularly and jointly monitored and evaluated, and progress and achievement are recognised and celebrated.

> *"Our physios have always focused on goals which is [a habit that is] now ingrained in my daughter's life since her [brain] injury. Her first goal was learning to walk again. Now her goal is to swim in the Paralympics."*

SYSTEM-LEVEL COMPONENTS

The person and whānau centred care model also recognises a number of system-level components. These are components that may not be under the direct control of the physiotherapist, but nonetheless, impact on the care of people and should be actively considered by physiotherapists. Physiotherapists and others within the wider community are encouraged to reflect on these, and influence them wherever possible.

HEALTH EQUITY

Significant differences exist in the health and health outcomes of different groups of people, linked to their socioeconomic status, ethnicity, gender, sexuality, and geographic location.[18] Differences that are unnecessary, unwarranted, unfair, unjust, and avoidable are health inequities.[19] Health equity does not mean that the health care or services provided to all groups are uniform or the same. Instead, it means that approaches and services are tailored to different groups to enable them to get the same outcomes; health equity is about equity of health outcomes. Equitable approaches consider the impact of avoidable differences and aim to minimise the impact of these.[9] Principles aimed at enhancing health equity should be considered in the development of all interventions and actions at all levels within the health sector. Improving health equity assists provision of person and whānau centred care, and vice versa.[6]

FOSTER RELATIONSHIPS WITH COMMUNITIES

Fostering relationships with communities encourages community engagement and participation in health initiatives. Community engagement and participation can improve health outcomes, provide support networks to members, help communities to identify and understand factors that contribute to certain health issues, and raise awareness of preventative and other health care options. Time and ongoing commitment are required to build strong relationships between health care providers (professionals and managers) and community members. The strength of these relationships helps determine the effectiveness of community engagement and participation.

INTERPROFESSIONAL PRACTICE

Interprofessional practice optimises the use of multiple skills sets (including those of professionals, patients and whānau) to provide well-coordinated, high-quality, person and whānau-centred care.[20] Higher levels of collaboration are needed when health needs are complex and individuals receiving care require diverse skills.[21] Interprofessional practice requires effective communication, a clear understanding of roles and team dynamics, shared leadership and an ability to effectively resolve conflict.[20,21] Interprofessional practice is supported by team members learning with, from and about each other.[15]

STAKEHOLDER INVOLVEMENT IN PRACTICE MANAGEMENT, SERVICE DESIGN, AND POLICY

Individuals and whānau are key stakeholders in healthcare. It is important that all stakeholders (including those with lived experience) are involved in the co-design, development, delivery, monitoring, and evaluation of healthcare and health services. Stakeholder input into practice management, service design, quality improvement, and policy is encouraged whenever possible. There are a number of ways that people's input can be gained, including consultation via focus groups or questionnaires, or the involvement of 'consumer representatives' on steering committees or working groups. It can also include ongoing measures such as providing channels through which individuals and whānau can give feedback, (e.g., comment boxes).

IDENTIFYING AND OVERCOMING BARRIERS

There are many potential barriers to individuals and whānau receiving optimal care. Barriers can include the attitudes of healthcare providers and/or funders,[22] the attitudes of individuals and/or whānau members, adherence to a biomedical paradigm, and expectations of those involved. Other barriers that may exist include the time available for physiotherapy sessions (or the timing of those sessions), the space available in consultation rooms for whānau members, the models of service delivery implemented, access to the healthcare services required, cost, and the healthcare system itself.[22] Explicit identification and planning is required to enable the management or removal of these barriers.

REGULATORY CONTEXT

The person and whānau centred care model endorses the regulated requirements to which physiotherapists and physiotherapy practices must adhere in Aotearoa New Zealand, and the component behaviours are integral to many of these requirements. These include the *Physiotherapy practice thresholds in Australia and Aotearoa New Zealand (2015),*[23] the *Physiotherapy Standards,*[24] *the Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct,*[25] as outlined in the *Physiotherapy Standards framework 2018,*[1] and the *Code of Health and Disability Services Consumers' Rights.*[2] The model complies with all applicable legislation that governs physiotherapy practice, including the Health Practitioners Competence Assurance Act 2003,[26] the Privacy Act 1993,[27] the New Zealand Bill of Rights Act 1990,[28] and the Health and Disability Commissioner Act 1994.[29] The model coheres with the strategic themes and areas for action of the *New Zealand Health Strategy 2016*[30,31] and *He Korowai Oranga*[32] (New Zealand's Māori Health Strategy), and aligns with many of the characteristics of Whānau Ora.[33] The model and component behaviours also align with a number of the strategic objectives in Physiotherapy New Zealand's *Strategy 2016-2020.*[34]

MODEL DEVELOPMENT

This model and supporting definitions has been prepared as part of the PNZ Professional Development Committee's Person and Whānau Centred Care work stream (work stream leads, Ben Darlow and Karen Evison). It has been informed by input from consumers, members of the work stream's reference group, and existing literature. The development process has included initial literature review,[6,23,35-46] the development and analysis of vignettes provided by consumers and physiotherapists demonstrating the presence or absence of elements of person and whānau centred care, initial model development, stakeholder consultation, further literature review,[8,22,47-62] subsequent model redesign, and further extensive stakeholder consultation. The Professional Development Committee are grateful to all those who have provided input to the model, including members of the reference group: Martine Abel, Amelia Buick, Dawn Birrell, Karen Elliott, Ben Hinchcliff, Lynda Kirkman, Dave Nicholls, Meredith Perry, Jess Radovanovich, Madeleine Sands, Di Scott, Ashley Simmons, Erin Swan; Tae Ora Tinana; consumers who have generously shared stories.

REFERENCES

1. Physiotherapy Board. Physiotherapy Standards framework 2018. Wellington, N.Z.: Physiotherapy Board; 2018.
2. Health and Disability Commissioner. The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996. Wellington, N.Z.: Health and Disability Commission; 1996.
3. Hicks D. What is the real meaning of dignity? Sussex Publishers, LLC, 2013. (Accessed 6 December, 2017, at https://www.psychologytoday.com/blog/dignity/201304/what-is-the-real-meaning-dignity-0.)
4. United Nations. Universal Declaration of Human Rights: United Nations; 1948.
5. Dillon RS. Respect. The Stanford Encyclopedia of Philosophy. Stanford University: Center for the Study of Language and Information; 2014.
6. World Health Organisation. People-centred and integrated health services: an overview of the evidence (interim report). Geneva, Switzerland: WHO; 2015.
7. Mudge S, Kayes N, Sezier A, et al. Getting evidence into practice: enhancing clinical care for people with long-term neurological conditions. 5th Annual NHMRC Symposium on Research Translation. Melbourne; 2016.
8. Mudge S, Kayes N, Sezier A, et al. Living Well Toolkit Clinician's Resource. Clinician's Resource. Auckland, N.Z.: Centre for Person Centred Research, Auckland University of Technology; 2016.
9. Poynter M, Hamblin R, Shuker C, Cincotta J. Quality improvement: no quality without equity?: Health Quality & Safety Commission New Zealand; 2017.
10. Matsumoto D. Culture, context, and behaviour. Journal of Personality 2007;75:1285-319.
11. Hughes F, Gray N. Cultural safety and the health of adolescents. BMJ 2003;327:457.
12. World Health Organisation. ICF Checklist for International Classification of Functioning, Disability and Health. Geneva, Switzerland: WHO; 2003.
13. Durie M. Te Whare Tapa Whā. Ministry of Health, 1994. (Accessed 21 December, 2017, at https://www.health.govt.nz/system/files/documents/pages/maori_health_model_tewhare.pdf.)
14. Pere RTR. Te Wheke. Ministry of Health, 1997. (Accessed 21 December, 2017, at https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-wheke.)
15. World Health Organisation. Framework for action on interprofessional education and collaborative practice. Geneva, Switzerland: WHO; 2010.
16. World Health Organisation. The Ottawa Charter for Health Promotion. Geneva, Switzerland: WHO; 1986.
17. Huber M, Knottnerus JA, Green L, et al. How should we define health? BMJ 2011;343:3.
18. Ministry of Health. A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health. Wellington, N.Z.: Ministry of Health; 2004.
19. Whitehead M. The concepts and principles of equity and health. Health Promot Int 1991;6:217-28.
20. Canadian Interprofessional Health Collaborative. A national interprofessional competency framework. Vancouver, Canada: College of Health Disciplines, University of British Columbia; 2010.
21. Oandasan I, Baker G, Barker K, et al. Teamwork in healthcare: promoting effective teamwork in healthcare in Canada. Ottawa, Canada: Canadian Health Services Research Foundation; 2006.
22. Anderson A, Mills C, Eggleton K. Whānau perceptions and experiences of acute rheumatic fever diagnosis for Māori in Northland, New Zealand. N Z Med J 2017;130:80-8.
23. Physiotherapy Board of Australia, Physiotherapy Board. Physiotherapy practice thresholds in Australia & Aotearoa New Zealand. Physiotherapy Board of Australia & Physiotherapy Board; 2015.

24. Physiotherapy Board. Physiotherapy Standards. Wellington, N.Z.: Physiotherapy Board; 2018.

25. Physiotherapy New Zealand, Physiotherapy Board. Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct with commentary. Wellington, N.Z.: Physiotherapy New Zealand & Physiotherapy Board; 2018.

26. Health Practitioners Competence Assurance Act 2003. New Zealand 2003.

27. Privacy Act 1993. New Zealand 1993.

28. New Zealand Bill of Rights Act 1990. New Zealand 1990.

29. Health and Disability Commissioner Act 1994. New Zealand 1994.

30. Minister of Health. New Zealand Health Strategy: Future direction. Wellington, N.Z.: Ministry of Health; 2016.

31. Minister of Health. New Zealand Health Strategy: Roadmap of actions 2016. Wellington, N.Z.: Ministry of Health; 2016.

32. Ministry of Health. He Korowai Oranga. Wellington, N.Z.: Ministry of Health; 2017.

33. Te Puni Kōkiri. The Whānau Ora Outcomes Framework: Empowering whānau into the future. Wellington, N.Z.: Te Puni Kōkiri; 2016.

34. Physiotherapy New Zealand. Physiotherapy New Zealand Strategy 2016-2020. Wellington, N.Z.: Physiotherapy New Zealand; 2016.

35. Addiction Practitioners' Association Aotearoa-New Zealand. Addiction Intervention Competency Framework: a competency framework for professionals specialising in problem gambling, alcohol and other drug and smoking cessation intervention. Wellington, N.Z.: dapaanz; 2011.

36. Ahmad N, Ellins J, Krelle H, Lawrie M. Person-centred care: from ideas to action. London, U.K.: The Health Foundation; 2014.

37. Blair W. Person-Centred/Whānau-Focused Nursing Framework. In: Williams A, ed; 2015:5.

38. Boon A. Excellence through patient and family centred care: literature review. Tauranga, N.Z.: Bay of Plenty District Health Board; 2012.

39. Centre for Parent and Child Support. Family Partnership Model. (Accessed 25 September 2015, at http://www.cpcs.org.uk/index.php?page=about-family-partnership-model.)

40. Clendon J. Patient centred professionalism: the New Zealand context. In: Williams A, ed; 2015.

41. Davis H, Day C. Current Family Partnership Model. London, U.K.: Centre for Parent and Child Support; 2007.

42. Foot C, Gilburt H, Dunn P, et al. People in control of their own health and care: The state of involvement. London: The King's Fund; 2014.

43. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. Social Science & Medicine 2000;51:1087-110.

44. Pharmaceutical Society of New Zealand. Enhance 2.0. Wellington, N.Z.: Pharmaceutical Society of New Zealand; 2015.

45. Royal New Zealand College of General Practitioners. Aiming for Excellence - The RNZCGP standard for New Zealand general practice. Wellington, N.Z.: RNZCGP; 2016.

46. The Health Foundation. Person-centred care made simple. London, U.K.: The Health Foundation; 2014.

47. CanChild Centre for Childhood Disability Research. Family Centred Service Sheets. McMaster University. (Accessed 23 November, 2015, at https://www.canchild.ca/en/research-in-practice/family-centred-service.)

48. Elder H. Te Waka Oranga: Bringing indigenous knowledge forward. In: Kathryn McPherson, Barbara E. Gibson, Leplege A, eds. Rethinking Rehabilitation - theory and practice. London: CRC Press; 2015:227-43.

49. Fernandez CA. Whakawhirinakitanga ahua: Exploring a Māori model of health service delivery: Massey University; 2015.

50. Harding E, Wait S, Scrutton J. The state of play in person-centred care: a pragmatic review of how person-centred care is defined, applied and measured. London, U.K.: The Health Policy Partnership; 2015.

51. King G, King S, Law M, Kertoy M, Rosenbaum P, Hurley P. Family-Centred Service in Ontario: A "best practice" approach for children with disabilities and their families. Hamilton, Ontario: CanChild Centre for Childhood Disability Research, McMaster University; 2002.

52. Manthei M. Positively Me - a guide to assertive behaviour. Auckland, N.Z.: Reed Publishing; 1998.

53. Mudge S, Sezier A, Payne D, Kersten P, Kayes, N. Developing and putting into practice a Living Well Toolkit: a pilot study drawing on Normalisation Process Theory. New Zealand Rehabilitation Association Conference. Christchurch, N.Z.; 2017.

54. Mudge S, Stretton C, Kayes N. Are physiotherapists comfortable with person-centred practice? An autoethnographic insight. Disabil Rehabil 2014;36:457-63.

55. O'Halloran PD, Shields N, Blackstock F, Wintle E, Taylor NF. Motivational interviewing increases physical activity and self-efficacy in people living in the community after hip fracture: a randomised controlled trial. Clin Rehabil 2016;30:1108-19.

56. O'Keeffe M, Kayes NM, Cummins C, McPherson K. What matters most to Māori? Forming therapeutic relationship in neurorehabilitation. Linking the chain: Physiotherapy New Zealand Conference. Auckland, N.Z.: Physiotherapy New Zealand; 2014:117.

57. Rose A, Rosewilliam S, Soundy A. Shared decision making within goal setting in rehabilitation settings: A systematic review. Patient Educ Couns 2017;100:65-75.

58. Rosewilliam S, Roskell CA, Pandyan AD. A systematic review and synthesis of the quantitative and qualitative evidence behind patient-centred goal setting in stroke rehabilitation. Clin Rehabil 2011;25:501-14.

59. 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. Clin Rehabil 2016;30:508-19.

60. Starfield B. Is patient-centred care the same as person-focused care? The Permanente J 2011;15:63-9.

61. Tertiary Education Commission. Learning progressions for adult literacy. Wellington, N.Z.: Tertiary Education Commission; 2008.

62. Waters S, Edmondson SJ, Yates PJ, Gucciardi DF. Identification of factors influencing patient satisfaction with orthopaedic outpatient clinic consultation: a qualitative study. Man Ther 2016;25:48-55.

Authors

Authors: Ben Darlow and Anna Williams, on behalf of the Professional Development Committee.

Year of publication: 2018