

# Promoting Healthy and Active Ageing

## Lesson 08

# Person-, Family-, and Community-Centered Care Approaches and Coordination Across Care Settings

# Intended Learning Outcomes

- Describe the principles of person-, family-, and community-centered care.
- Analyze the importance of care coordination across different care settings for older adults.
- Apply examples of nursing strategies that support person-centered care at individual, family, and community levels.

- As populations age, the demand for integrated, holistic, and compassionate care grows.
- Traditional health services often focus on diseases, but older adults have complex needs that go beyond physical health.
- Care should be person-centered, family-centered, and community-centered, ensuring dignity, independence, and quality of life.
- Nurses play a critical role in advocating, coordinating, and delivering this care across diverse settings.

# Person-Centered Care

An approach that places the individual at the heart of decision-making, respecting their values, preferences, and unique needs.

- **Core Principles**

- Respect and dignity
- Autonomy and self-determination
- Shared decision-making
- Holistic care (physical, psychological, social, spiritual)

- **Benefits**

- Greater satisfaction and trust
- Improved adherence to treatment
- Better quality of life

- **Nursing Role**

- Advocate for patients' choices
- Involve older adults in goal-setting and care planning
- Provide information in accessible ways (consider sensory decline, health literacy)

# Person-Centered Care: example

An older woman with arthritis is given options: physical therapy at home or community center. The nurse ensures she chooses based on her comfort and mobility.

# Family Centered Care

Recognizes the family **as partners in care** and acknowledges their vital role in supporting the older adult.

- **Core Principles**

- Collaboration and partnership
- Open, respectful communication
- Empowerment of family caregivers
- Support for caregiver wellbeing

- **Benefits**

- Reduced caregiver burden
- Enhanced continuity of care
- Improved outcomes for the older adult

- **Nursing Role**

- Assess caregiver stress and coping
- Provide education (e.g., insulin administration, wound care)
- Offer counseling and refer to support services
- Involve family in decision-making and care planning

# Family Centered Care: Example

A nurse teaches the son of a stroke patient how to perform safe transfers and links him with a caregiver support group.

# Community Centered Care

Care that involves and empowers communities to support the health and wellbeing of older adults.

- **Core Principles**

- Inclusion and participation
- Strengthening community resources
- Age-friendly environments

- **Benefits**

- Reduced isolation
- Increased social participation
- Better access to services

- **Nursing Role**

- Conduct outreach programs (screening, health promotion)
- Connect older adults with elder clubs, religious groups, or NGOs
- Advocate for elder-friendly infrastructure (safe roads, public toilets, transport)

# Community Centered Care: Example

A nurse organizes a fall-prevention workshop with the local PHM and community-dwelling older adults, encouraging physical activity and home safety.

# Coordination Across Care Settings

The process of ensuring smooth transitions and continuity of care across hospitals, homes, primary care, and long-term facilities.

## Challenges

- Fragmented services
- Lack of communication between providers
- Repeated admissions and medication errors

## Strategies

- Comprehensive discharge planning
- Use of case managers or nurse coordinators
- Multidisciplinary teamwork (MDT)
- Standardized care pathways

## Nursing Role

- Act as a “bridge” between hospital, home, and community services
- Provide clear handover information
- Ensure follow-up and monitoring after discharge

# An Example

A patient discharged after pneumonia is followed up at home by the community health nurse, who checks adherence to medications, assesses home safety, and arranges physiotherapy.

Mr. Senanayake, 80, with COPD and diabetes, has just been discharged after pneumonia. He lives with his wife, who is overwhelmed managing his medications. Their home is not elder-friendly, and they are socially isolated.

1. What are person-centered interventions for Mr. Senanayake?
2. How can his wife be supported in family-centered care?
3. What community-centered resources could be mobilized?
4. How can nurses coordinate care across hospital, home, and community?

# Case Discussion

Mr. Rajan, a 78-year-old retired farmer, was admitted to hospital with pneumonia. He has a history of hypertension and mild osteoarthritis. After 8 days of inpatient treatment with antibiotics and oxygen therapy, his condition stabilizes and he is discharged home.

## Hospital Discharge Plan:

- Prescribed oral antibiotics, antihypertensive medication, and nutritional supplements.
- Referred for physiotherapy to rebuild strength after prolonged bed rest.
- Advised to monitor blood pressure and watch for signs of recurrent infection.
- Provided discharge summary to family caregiver.

# Case discussion (*cont.*)

## Community Follow-Up:

A community health nurse visits Mr. Rajan at home one week after discharge. Following are her key actions.

- Medication adherence: checks if prescriptions are being taken correctly; discovers he occasionally forgets his evening dose.
- Home safety: identifies cluttered living room and absence of bathroom grab rails; discusses fall-prevention modifications with family.
- Rehabilitation: arranges outpatient physiotherapy sessions at the nearby health center.
- Family education: teaches daughter to recognize early warning signs of pneumonia recurrence (fever, breathlessness, chest pain).

## Key Coordination Points:

- Clear communication between hospital → primary care → community health services.
- Early follow-up prevents readmission and supports recovery.
- Nurse acts as bridge ensuring continuity of care across settings.

1. Identify the coordination roles of the nurse in this case.
2. What could go wrong if there was no follow-up at home after discharge?
3. Suggest strategies to strengthen hospital–community communication.
4. Discuss how this approach supports patient independence, family confidence, and quality of life.
5. Create a care plan for Mr. Rajan focusing on medication, home safety, and rehabilitation.



## Further Reading

- WHO (2016). Framework on Integrated, People-Centred Health Services.
- McCormack, B. & McCance, T. (2017). *Person-Centred Practice in Nursing and Health Care*.

Thank  
you

