# Chapter 15

## Person and Family Centred Care

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*'Can you see me? All of me? Probably not. No one ever really has.'*

*~Jeffrey Eugenides*

## History and Context of Person Centredness

Person-centredness (PC) has historical roots dating back to Florence Nightingale, who emphasised the patient's experience over the illness itself. Psychologist Carl Rogers (1961) significantly contributed to PC theory in the 1940s, advocating for a client-centred approach grounded in respect for individual potential and resourcefulness. Over time, PC spread across healthcare disciplines, inspiring a more holistic model of care delivery known as Patient-Centred Care (PCC), which gained prominence in the late 1960s. Initiatives like the Picker-Commonwealth Programme of 1987 defined key dimensions of PCC, such as respect, coordination, communication and emotional support. Similarly, South Africa's Batho Pele principles (Department of Public Service and Administration 1997), which was launched in 1997, aligned with PC values, emphasising public service improvement through access, transparency and respect.

By 2000, PC become globally recognised, with the World Health Organisation advocating for person-centred health systems. Subsequent academic work, including Mead and Bower's five-dimensional PC framework, further defined its practical aspects: biopsychosocial care,

shared responsibility, therapeutic alliances, and the recognition of both patient and provider as individuals (Mead and Bower 2000).

## Person and Family Centred Care (P/FCC)

Although related, Person Centred Care and Family Centred Care are not conceptually the same. Both focus on the person; however, there are key differences. PCC is focused on the person, as an individual, seeking care, while FCC is focused on the family system of the person seeking care (Coyne, Holmström and Söderbäck 2018). See Table 15.1. below for the description and foundations of P/FCC.

**Table 15.1: Description and foundations of P/FCC**

| | Description | Foundations |
|---|---|---|
| Family-Centred Care | FCC is a philosophy of care that fundamentally supports and respects the family's participation in their child's care through a partnership approach. It involves shared healthcare decision-making between the family and the healthcare provider. | The family is both the focus and the unit of care. FCC is based on the belief that child and family well-being are best achieved when the service system supports the family's ability to meet the needs of their child. Partnership among families, children and healthcare providers is a core component of FCC (Coyne, Holström and Söderbäck 2018). |

| | Description | Foundations |
|---|---|---|
| Person-Centred Care | PCC is a holistic approach to care that is respectful and individualised. It allows for the negotiation of care and offers choice through a therapeutic relationship in which the person receiving care is empowered to participate in healthcare decisions to the extent they desire (Institute for Patient- and Family-Centered Care 2023). | The person's needs and goals should be the focus of care, rather than paternalistic and biomedically oriented healthcare. This requires organisational vision and commitment, effective leadership, motivation to change, feedback and organisational learning, shared governance and appropriate personal qualities among staff (Institute of Medicine 2011). Collaboration within the team and competencies such as leadership, clinical excellence and critical thinking are also required. |

In paediatric care, FCC values enable and prioritise the contribution of parents/caregivers of the children receiving care, as they are considered expert partners concerning their child's health and holistic needs. Both PCC and FCC are important to ensure that the child and their family unit are collaboratively considered within decision-making. Some scholars also highlight the need for CCC, where the voice of the child, their assent and their safety should be taken into consideration in healthcare decision making, planning and outcomes (Coyne Holmström and Söderbäck 2018).

Informed Consent: This is a legal and ethical requirement by means of which a parent or legal guardian provides permission for a child to undergo medical evaluation or treatment. The parent or guardian must be given sufficient information about the purpose, risks, benefits and alternatives of the proposed intervention, and they must voluntarily agree, without coercion (Beauchamp and Childress 2019). In paediatric settings, children generally cannot provide legally binding consent due to their developmental stage, so the responsibility lies with the parent or guardian.

Assent: This is the child's agreement to participate in healthcare decisions or interventions, appropriate to their age, maturity and understanding. While it does not replace legal consent, it respects the child's developing autonomy and encourages engagement in their own care (American Academy of Pediatrics 1995). Assent involves explaining procedures in age-appropriate language, checking that the child understands and ensuring that they are willing to proceed.

Consent vs Assent: The key difference between these two concepts is that informed consent is legal authorisation provided by the parent or guardian, whereas assent is an ethical practice that acknowledges and encourages the child's developing autonomy and willingness. In practice, involving children through assent can improve co-operation, reduce anxiety and foster a long-term positive attitude toward healthcare.

***What is the anticipated impact of P/FCC in hearing healthcare?***

Audiology is a profession with a focus on the diagnosis and management of hearing loss (HL), which has lifelong limitations and restrictions on communication, functional health and overall quality of life. Management of HL globally has been marred with challenges, and chief among them is low patient adherence to hearing health interventions such as hearing aid (HA) use, as well as the impersonal, acute and one-size-fits-all approach to audiological rehabilitation. This indicates alignment with a 'biomedically focused, device-centred, and clinician-led' (Convery et al. 2019) management approach instead of P/FCC (Figure 15.1). In the traditional biomedical approach to health and hearing care, there is a top-down approach from the care provider to the patient. The focus is on diagnosing the condition and providing a 'quick' cure (for example, prescribing HAs to treat HL), where the health professional is seen as the expert who directs treatment and goal setting. Research has shown that the 'biomedically focused, device-centred' audiology service approach is failing up to 83% of those affected by HL and, in South Africa, up to 85%, because of the lack of access to hearing amplification devices (Orji et al. 2020; Hlayisi and Ramma 2019). In recent South African research on factors influencing PCC, audiologists and speech-language pathologists (53.9% of respondents) identified linguistic and cultural differences between the health professional and patient as one of the top barriers against PCC (Mahomed-Asmail et al. 2025). Leplege et al. (2007) have long posited that, in agreement with PCC and FCC principles, rehabilitative interventions should tackle the difficulties considered most relevant by the person with the disability.

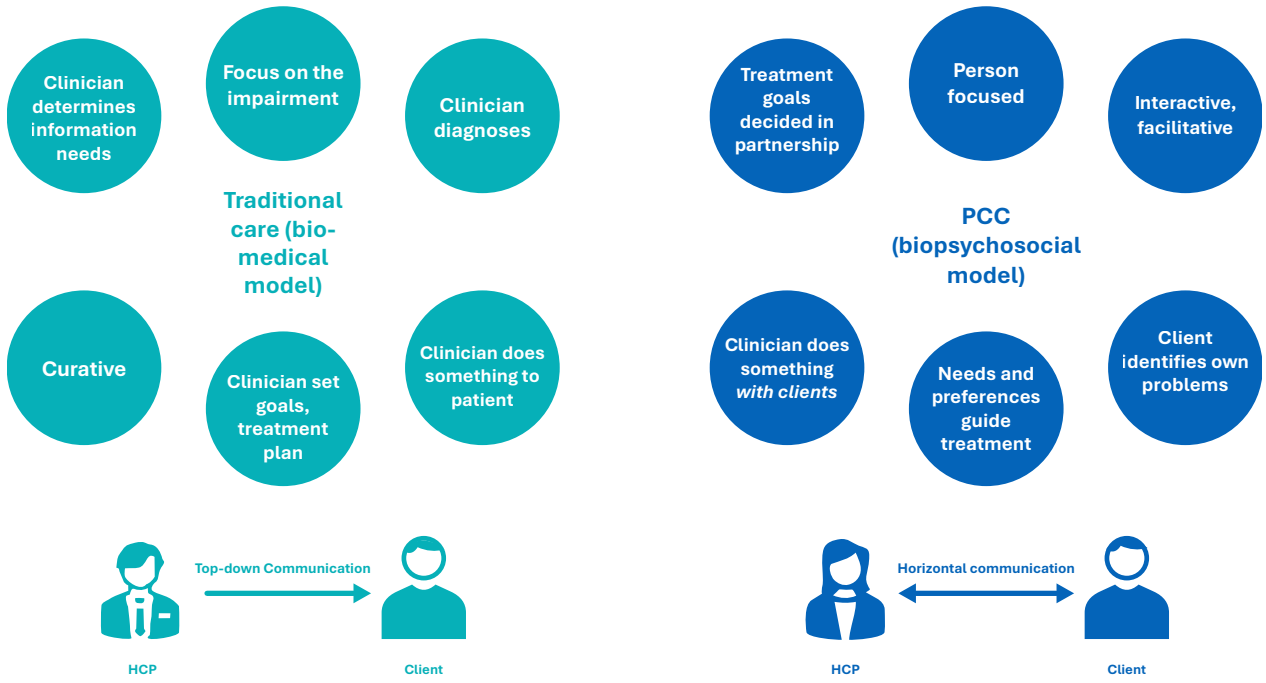



**Figure 15.1: Differences between a PCC and traditional, biomedical care approach**

## Proposed Strategies for Implementation of P/FCC in Audiology

In audiology, P/FCC implementation has been propelled mostly by the Ida institute, a Danish non-profit organisation that was established to focus on the human side of HL management (Kirkwood 2008). The Ida Institute was driven to global importance by a collective of experts from ethics, audiology, anthropology, education and social responsibility backgrounds (Kirkwood 2008). Over time, the Ida Institute has, with its partner experts in hearing care, curriculum development, research and clinical practice, put together various tools to operationalise P/FCC in audiology. Most of their tools were developed to make the key aspects of P/FCC tangible and has resulted in what they term ‘the six elements of PCC’. Parallels can be drawn between these principles and the seven PCC dimensions of by the Picker-Commonwealth programme, the eight Batho Pele principles and Mead and Bower’s five dimensions of PC. The principles include:

1) Active listening
2) Open-ended questions and reflective conversations
3) Empathy
4) Involvement of family and friends
5) Shared goal setting
6) Decision making, and understanding of individual preferences

Practical clinical applications of each P/FCC element are described below with suggested tools (paper-based) to facilitate and enable implementation. Some of these tools are freely available on the IDA website (*www.idainstitute.com/tools*) for clinicians, students and families. While the use of these tools is not essential, doing so could be useful in getting the process started. It is important that P/FCC should be understood as an overarching approach to hearing healthcare that informs all interactions with the child, person or family rather than being reduced to a discrete tool, technique or isolated component of a hearing care appointment.

***Elements of P/FCC and clinical applications***

a) Active listening

It is crucial for HHPs to pay full attention to the person speaking during a consultation to determine their needs, values and preferences. In paediatric sessions, active listening can be applied across all aspects of care, for example, whenever a parent or caregiver shares their concerns, gives feedback or asks a question. Active listening includes paying attention to verbal and non-verbal cues of the parents and/or caregivers, as well as the child. It is important that active listening strategies be used when communicating with the child to ensure that they are involved in clinical discussions, decisions and goalsetting where possible and in an age-appropriate manner. See Table 15.2 for some practical examples.

b) Open-ended questions and reflective conversations

HHPs should ask questions that encourage detailed responses. This helps with identifying emotions, experiences, needs and so much more than a list of symptoms. Open-ended questions may seem unstructured at first, but asking one open-ended question can frequently provide more information than several closed-ended questions. Reflective conversations are often facilitated through open narratives that build a relationship. In paediatric hearing care,

the child and family will most likely meet with the HHP over an extended period of time, so it is important to have continued investment in understanding each other. The purpose of open-ended and reflective conversations is to encourage the child and family to 'hear' their own thoughts, to let them know that the clinician is trying to understand and to encourage them to keep talking.

c) Empathy

An empathic HHP can help the person or family feel understood and seen, and build a therapeutic relationship. There are three types of empathy that may be useful to apply as a clinician in paediatric care, and include the following:

- Cognitive empathy: This is the ability to mentally understand another person's perspective/experience and impacted aspects of life. Here, a clinician is advised to be non-judgmental and open-minded, and have the capacity to engage others through their lens (Areas of difference, such as culture, religion, traditions, practices and beliefs, test cognitive empathy).
- Emotive empathy: This is the ability to feel with another person through active listening, reflective conversation and openness to engage emotions in clinical settings.
- Empathic action: This involves putting empathy into action. For example, an HHP can put empathy into action by showing compassion and holding space silently so that the parent of child they are assisting can feel heard.

Another important aspect to consider as an empathic HHP is building rapport. Building rapport in paediatric care involves developing a trusting and collaborative relationship with both the child and their family, fostering open communication and a sense of safety (Brown, Mulhern and Hardy 2020). Rapport serves as the foundation for person- and family-centred care, where children and families are active participants in decision making and management (Kuhlthau et al. 2011). Rapport is achieved through empathy, respect and active listening, enabling understanding of the child's needs and the family's concerns (Levett-Jones, Cant and Lapkin 2017). Coyne, Holmström and Söderbäck (2018) describe some of the steps that can be used in practice:

- Adapting communication to the child's developmental level
- Using play or non-threatening interactions to reduce anxiety
- Validating the experiences of caregivers

Establishing rapport is vital for the HHP to enhance co-operation during clinical encounters and to strengthen intervention adherence, which is critical for long-term health and developmental outcomes in paediatric care.

d) Involvement of the parents and family

In paediatric care, it is important that decisions be made in collaboration with both the caregiver and/or parents and child (where appropriate). The contribution and participation of the family in paediatric hearing care is advantageous for continuity of care, compliance and overall long-term success. The HHP can encourage involvement of the family and siblings of the child by:

- Inviting the family and siblings to appointments with the intention to involve them in the session by encouraging the siblings to provide feedback and make observations about play and encouraging each member of the family to take on roles and responsibilities, such as: for the dad or co-parent to make notes for home activities, for the mom to fill out the questionnaire.
- Adding pre-planned tasks for family participation during appointments:

    - Pre-planning certain tasks for each family member to place family at ease and guide their participation at appointments. For example, during assessments, one parent can be tasked with the role of play audiometry response reinforcer (Chapter 5). This will enable their active participation during assessment and place the child at ease inside a booth with a familiar face. Furthermore, a sibling can be tasked with bringing a familiar toy that can be used during play audiometry.
    - Discussing Third-Party disability which describes the functional difficulties and psychosocial challenges that may be experienced by the parents and siblings as a consequence of a family member's health condition, despite not having the impairment themselves (Scarinci, Worrall and Hickson 2008). In the context of paediatric HL, parents and siblings may experience emotional distress, social withdrawal, financial strain, and increased caregiving responsibilities, all of which can negatively impact their quality of life (Scarinci, Worrall and Hickson 2009). For example, parents often report heightened stress related to communication breakdowns, hearing device management and educational or healthcare systems navigation (Hétu 1996). Recognising third-party disability in paediatric audiology is essential,

as the well-being of family members directly influences the child's developmental and rehabilitative outcomes. Integrating counselling, education and psychosocial support during an appointment can helps mitigate third-party disability and strengthen the overall effectiveness of intervention.

e) Shared goal setting and decision making

HHPs can facilitate collaborative goal setting and develop a care plan based on the individual's needs and preferences as well as those of their family. Applying shared decision-making and prioritising individualisation can seem tricky to balance. Some practical tips to consider are:

- Understand the child and family context.
  - Ask about the child's daily routines, communication environment and family priorities.
  - Consider cultural, linguistic and lifestyle factors that may affect hearing care choices.
- Present options clearly and collaboratively.
  - Explain intervention choices (for example, the use of HAs and therapy strategies) in age-appropriate language for the child and accessible terms for caregivers.
  - Discuss the benefits, risks and realistic outcomes of each option.
  - Tailor strategies to the individual.
  - Adjust therapy techniques to the child's attention span, learning style and communication abilities.
  - Modify follow-up plans and home strategies based on family feedback and observed progress.
- Encourage ongoing collaboration.
  - Encourage caregivers to share observations, concerns and successes.
  - Revisit goals regularly to ensure care continues to meet the evolving needs of the child and family.

Successful application of shared goal setting is linked with active and attentive listening to the needs of the child and family. Furthermore, the goals should follow a solution-based approach in line with the shared concerns, needs and preferences. It is also important to take note of the power dynamics in decision-making and establishing equal decision-making

capacity. Moreover, it is crucial to understand that in paediatric care the goals can shift and evolve as the child develops. Some key aspects to consider in facilitating shared goal setting and decision making include:

- Create an enabling space for all to contribute their goals.
- Be clear about how goals will be prioritised, for example, where there is a difference of opinions and ideas.
- Remember that the HHP's role as the knowledge bearer clinically is to guide the parent or caregiver, who, in turn, is the knowledge bearer in the child's life. Therefore, the goals that are set should interweave these two worlds.
- Be mindful of the ethical considerations for and differences between consent and assent, where appropriate.

f) Understanding individual preferences

HHPs are encouraged to recognise and respect the unique needs and desires of the child (where applicable) as well as of their families. Individualisation of hearing care depends on the HHP's ability to identify the unique needs and particularities of the child and the family. Determining their needs and preferences is an ongoing and critical aspect of P/FCC. Individual preferences should be considered in conjunction with all other aspects, as previously discussed, that need customisation. Practical tools that may assist patients and their family/caregivers in this regard include:

- The Communication Rings (a tool to help identify the social network of the child and family, and to assess how HL may affect relationships, that is, 'who I communicate with', available from https://idainstitute.com/tools/communication-partners--communication-rings.
- Living Well (a tool to help identify the most important communication situations and strategies to optimise communication in these situations, that is, 'where I communicate', available from https://idainstitute.com/learning-hall.
- Question prompt lists for parents (Available from *chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/http://www.heartolearn.org/tutorials/transcripts/QPL_Parents_ENGLISH.pdf)*

**Table 15.2: Elements of PCC and practical examples for implementation**

| Element of PCC | Examples of implementation | Tools |
|---|---|---|
| Active listening | Verbal cues to indicate full attention:<br>• Inviting the person to say more, that is, 'Tell me more about that/please elaborate on …'<br>• Acknowledging what they are saying through paraphrasing, asking clarifying questions and reflecting emotion and affirmation:<br>- *Paraphrasing*: 'Just to make sure I understand, you're saying your child doesn't respond to soft sounds at home?' Reflecting emotion: 'You mentioned that you've had to push quite hard to get a referral — that must have been exhausting.'<br>-*Clarifying*: To the parent: 'Can I just pause to check — I think I heard you say the school has noticed issues in the classroom too?' To the child: 'You're saying that your HAs are okay at school, but they feel 'itchy' after a while?'<br>• Where appropriate, expressing appreciation for the sharing of vulnerable or personal information. This can be useful to build rapport, for example, 'thank you for sharing that with me, I value your trust.'<br>• Acknowledging body language and emotions. This could include statements such as 'I see you are tensing up/I see you are feeling sad.'<br>• Responding with soft affirmations, such as 'Mmm,' 'I see…'<br>• Taking brief notes and explaining why, for example, ' I'm just writing this down so I don't miss anything — it's important.'<br><br>Non-verbal cues to indicate full attention:<br>• Maintaining eye contact with the person speaking or facing the child when they are engaging.<br>• Nodding gently or using facial expressions that show engagement.<br>• Using warm, open body language, for example, arms relaxed, slight forward lean.<br>• Minimising distractions during case history/counselling, for example, making notes or records afterwards, if possible.<br>• Pausing and giving time for both parent and child to speak — avoid interrupting. | |

| Element of PCC | Examples of implementation | Tools |
|---|---|---|
| Open-ended questions and reflective conversations | • *Asking What/When/Why/How questions*. These give context to and show the impact of the symptoms. Examples include 'Can you tell me When you feel most impacted by XYZ in your normal day?', 'How does XYZ affect your day-to-day activities?', 'Why do you think XYZ is a concern for you?'<br>• *Asking for real life examples* which provides details on lived experiences. This could include 'Can you share the most recent incident of this?', 'When do you first remember noticing this?', 'What can you give as a real-life basic example of this?'<br>• Facilitating reflective conversations and interactions between the HHP and the child and parents by:<br>- Asking the parent/child to tell you how they got to you today.<br>- Summarising what the person is saying and asking them to confirm that you have understood them.<br>- At the end of the session, asking them how they feel about everything shared.<br>• Other practical ways to offer reflective comments that can strengthen connections include:<br>- *Reflecting feelings* such as 'Sounds can feel too loud sometimes, can't they?' or 'It sounds like noisy places aren't your favourite.'<br>- *Acknowledging perspective*, which could include 'You've done a great job telling me what it's like for you.' Or 'You're trying really hard to hear in school - that must take a lot of focus!'<br>- *Building confidence* by using phrases such as 'I can see how much you've learned about your hearing already.' or 'You're the expert on what works best for you!' | a) Living Well and<br>b) Motivation Tools |

| Element of PCC | Examples of implementation | Tools |
|---|---|---|
| Empathy | Some practical ways to express emotive empathy to caregivers/parents include the following statements:<br>- *When they're feeling worried*, 'It's completely understandable to feel anxious when something doesn't seem quite right with your child.' or 'This is a lot to take in — many parents feel the same way when they hear this for the first time.'<br>- *When they have had a long journey*, 'It sounds like you've been trying to get help for a while — that must have been exhausting.' or 'You've been through a lot just to get to this point. I really admire your persistence.'<br>- *When they express guilt*, 'It's very normal to question yourself — but please know this isn't your fault.' or 'You care deeply about your child, and that comes through in everything you're doing.'<br>- *When they are unsure*, 'It's okay to feel unsure — this is a big decision, and we'll take it one step at a time.' or 'You don't have to have all the answers today — we're here to support you through it.'<br><br>Practical ways to apply empathic action when interacting with the child include the following;<br>- *When they are nervous or shy*, 'It's totally okay to feel a little nervous — lots of kids feel that way when they come here.' or 'You're being really brave just by coming in today.'<br>- *When frustrated*, 'That must feel really frustrating when you can't hear things clearly.' or 'It makes sense that you don't like loud sounds — they can be really uncomfortable.'<br>- *When engaged*, 'You've done such a great job today — I can tell you've been trying really hard.' or 'You're really good at telling me what works for you — that's so helpful!' | |
| Involvement of the family | • Actively seek input and participation from each member through asking open ended questions like 'What would YOU like to add/contribute?' or 'How can YOU best support in this?' | a) My Hearing Explained<br>b) The Communication Rings |

| Element of PCC | Examples of implementation | Tools |
|---|---|---|
| Shared goal setting and decision making | *Clear, person-centred communication*<br>• Use everyday language to explain test results and hearing conditions, for example 'This graph shows how soft or loud a sound needs to be for your child to hear.'<br>• Explain pros and cons of each option in the family's context: 'One option is HAs, which can help with soft speech in quiet and noisy places. Another option is monitoring for now, depending on how things go at home or school.'<br>• Use visuals or handouts when helpful: 'Here's a simple chart that compares the options — we can go through it together.'<br><br>*Eliciting parent values and priorities*<br>• Acknowledge lived experience by making statements such as: 'You know your child best — what have you noticed works well for them?'<br>• Summarise what the parent has said, for example 'So, you're saying you'd like to explore options that don't feel too overwhelming for your child right now?'<br>• Reflect both facts and emotions, for example 'It sounds like you're feeling a bit torn — you want to support your child but also want to make sure they're not uncomfortable with the solution.'<br><br>*Involve the child (when appropriate)*<br>• Include the child's voice in age-appropriate ways such as 'You've said it's hard to hear your teacher — what would help make that easier?' or 'Let's look at some colours and styles of HAs. Which ones do you like?'<br>• Empower the child in choosing or using technology where possible.<br><br>*Giving space to decide*<br>• *Allow time to process*, for example, 'You don't have to decide today. I can give you some information to take home, and we can talk more at the next visit.'<br>• *Offer follow-up support*, such as 'If more questions come up, just call or email — we're here to support you.' | a) The Goal-sharing for Partners Strategy (GPS)<br>b) Partner Journey<br>c) My Turn to Talk for Parents |

| Element of PCC | Examples of implementation | Tools |
|---|---|---|
| Understanding individual preferences | *Structured Conversations with Caregivers*<br>• Ask open-ended questions about the family's routines, values, and goals for their child.<br>Example: 'What activities does your child enjoy most at home or school?' or 'What is your main priority for your child's hearing this year?'<br>Discuss past experiences with healthcare or devices to identify preferences or concerns.<br>*Observation of the Child in Natural Settings*<br>• Watch the child interact in play or during routine tasks to notice communication style, attention span, and responsiveness. Example: Observe how the child reacts to background noise or group settings to guide hearing device recommendations.<br>*Use of Visual Aids and Choice Boards*<br>• Present options (HAs, therapy activities, or communication strategies) using pictures or models so children and parents can indicate preferences. Example: Let a child choose between two colourful HA styles or select which therapy game they want to try first.<br>*Incorporating Questionnaires or Preference Scales*<br>• Use short forms to capture caregiver priorities and child comfort levels with devices or therapy approaches. Example: A Likert-scale sheet asking parents how important aesthetics, comfort, or durability are in hearing devices.<br>*Collaboration with Other Professionals*<br>• Consult teachers, speech therapists, or early intervention specialists who observe the child in different contexts. Example: Ask the teacher how the child participates in classroom discussions to guide amplification choices. | a) My World<br>b) My Hearing Explained<br>c) Living Well for Teens and Tweens<br>d) The people I talk to |

# Practical Application of Person- and Family-Centred Care (P/FCC) across Developmental Stages

### *Preschool-aged children with amplification*

At this age, family input and early learning settings are central to the child's development. Parent observations, combined with input from early childhood educators and clinicians, provide a holistic view of the child's listening, language and participation across daily routines. These observations help guide both device management and intervention strategies in ways that are meaningful to the family. Some examples of these checklists and questionnaires include:

- LittleEARS Auditory Questionnaire (parent-reported auditory behaviours in infants/toddlers), available at *https://hearlife.org/data/en/med-el/LittleEARS_Auditory_Questionnaire.pdf*
- Infant-Toddler Meaningful Auditory Integration Scale (IT-MAIS) (structured parent interview about spontaneous listening behaviours), available at *https://www.unm.edu/~lkrulik/it-mais.pdf*
- Auditory Skills Checklist (tracking early auditory milestones in everyday contexts), available at *https://www.chchearing.org/wp-content/uploads/2018/09/Auditory-Skills-Checklist.pdf*
- Ages and Stages Questionnaire (ASQ-3) (parent developmental screening tool with items relevant to communication and social engagement), available at *https://agesandstages.com/products-pricing/asq3/*
- Parent coaching strategies (clinician-guided observation and support for embedding listening and communication practice into daily play and routines)

### *School-aged children with amplification*

The practical application of P/FCC can be found in the management of a school-age child with hearing amplification. Classroom observation by the audiologist, combined with observation checklists from parents, educators, and the child, can provide valuable input about a child's performance in the school and home setting, and offer a more holistic perspective about the impact that a CI has on the life of the child and family. Some examples of these checklists and questionnaires include:

- Managing Listening Conditions Checklist (observations of the educator and/or child)
- Observational Record of Behaviour of Deaf or Hard of Hearing Students by audiologist observation (Landrud and Anderson 2011)
- Teacher Evaluation of Aural/Oral Performance in Children (TEACH), available at *https://www.outcomes.nal.gov.au/teach*
- Parent Evaluation of Aural/Oral Performance in Children (PEACH), available at https://www.outcomes.nal.gov.au/peach
- Quality of Life (QoL) Cochlear Implant Questionnaire, available at *https://pubmed.ncbi.nlm.nih.gov/33974778/*
- Vanderbilt Fatigue Scales (child, parent and teacher versions), available at *https://www.vumc.org/vfs/pediatric-scales-and-user-guide*

***Adolescents with amplification***

The practical application of P/FCC for adolescents should focus on supporting both the young person's growing independence and the family's role in scaffolding self-advocacy skills. At this stage, P/FCC involves engaging the adolescent as an active decision-maker while ensuring parents, educators and clinicians work together to address academic, social and emotional needs. Examples of strategies include:

- Self-Advocacy Checklist for Teens with Hearing Loss (student self-report of advocacy and independence skills), available at *https://successforkidswithhearingloss.com/product/self-advocacy-checklist-for-teens/*
- Listening Inventory for Education – Revised (LIFE-R) (student and teacher questionnaires about listening effort and classroom participation), available at Listening Inventory for Education – Revised (LIFE-R)
- Vanderbilt Fatigue Scales – Adolescent version (student and parent report of listening-related fatigue), available at *https://www.vumc.org/vfs/pediatric-scales-and-user-guide*

## Conclusion

This chapter aimed to equip the HHP with fundamental knowledge of P/FCC theory and guide the practical application of PCC principles throughout every appointment in the hearing care journey. When these principles are routinely incorporated into everyday consultations, the benefits of patient-centred healthcare are realised for both patients, families, clinicians and health systems alike.

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