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In this article...

- Person-centred care for older people with mental ill health
- Development of a tool to check wellbeing in older people
- The tool led to better care in a mental health residential unit

Author
Nicola L Wheeler is a trainee clinical psychologist at Plymouth University, and formerly an assistant clinical and research psychologist at Birmingham and Solihull Mental Health NHS Foundation Trust; Rachael L Gardner is a senior occupational therapist in mental health services for older people at Birmingham and Solihull Mental Health NHS Foundation Trust.

Abstract

After recognising that care for older people could be more person-centred and have a broader focus on the person’s holistic wellbeing, a mental health unit for older people introduced individual wellbeing reviews in which staff discuss a different resident each week. The aim is to collate information on individual needs and preferences in order to strengthen the care-planning process and help staff provide holistic, person-centred care. This article reports on how the wellbeing reviews work and how a dynamic tool supporting the sharing of information was developed. The wellbeing reviews and tool not only benefit residents, but also empower staff and give them opportunities to develop their skills and knowledge.

In old age, dementia can challenge wellbeing by reducing the personal and social resources individuals need to manage difficult situations. Care providers looking after older people, especially those with dementia, therefore need to focus on wellbeing (Bradford Dementia Group, 2008). This article discusses the approach taken to improve the wellbeing of residents in a continuing care mental health unit at Birmingham and Solihull Mental Health NHS Foundation Trust, and describes the development of a person-centred care-planning tool to help staff meet residents’ holistic wellbeing needs. A case study illustrates how the tool is used to tailor care to individuals.

Residents with complex needs
The Bradford Dementia Group (2008) defines ‘wellbeing’ as how a person is managing in their everyday life – what is happening to and around them, and considering the natural ups and downs they may experience (Diener and Larson, 1993). It advises that dementia can challenge a person’s wellbeing, impacting on the resources (personal and social) they need to manage and overcome difficult situations.

Care workers of people with dementia need to offer support to maximise their wellbeing. As multidisciplinary healthcare professionals, we appreciate wellbeing is affected by numerous factors including an individual’s mental and physical health, his/her context and circumstances, the environment (physical and social), and opportunities and resources to engage in meaningful occupations (Bradford Dementia Group, 2008).

Our unit provides residential care for up to 19 older people with a range of long-term mental health difficulties, both organic and functional, including psychotic episodes, severe depression, complex trauma and dementia. Our residents have complex needs and sometimes display behaviours that can be challenging for staff. Many have come to live on the unit because local nursing homes have been unable to manage their care and meet their needs.

The wellbeing and care-planning tool benefits patients and staff
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Innovation

Staff working on our unit traditionally addressed residents’ wellbeing from a medical perspective, with limited input from psychology and occupational therapy. In 2008, the unit started offering psychology and occupational therapy input to its residents. In 2009, we embarked on a culture shift to start thinking about wellbeing holistically and raise staff’s awareness of its importance in promoting good mental health (Department of Health, 2009).

National dementia guidance emphasises the importance of person-centred care (National Institute for Health and Care Excellence, 2006), so we wanted to ensure this was happening on our unit. We particularly wanted to consider residents’ relationships with staff and others, recognising how these can affect wellbeing (NICE, 2006). We therefore decided to introduce resident wellbeing reviews (Wheeler and Johnson, 2010).

Introducing wellbeing reviews

The wellbeing reviews, facilitated by psychology and occupational therapy, ensure unit staff (nurses, healthcare assistants, management, housekeeper, activities coordinator) have a dedicated, one-hour weekly time slot to focus on a resident’s wellbeing. The number of staff and mix of professions vary for each review (Wheeler and Johnson, 2010); healthcare assistants and nurses are always present alongside the facilitators; other members of staff attend according to availability and whether they have information to share about the resident.

The aims are to:

- Embed person-centred care into the unit’s culture by increasing staff understanding of the approach and how they can use it in their practice;
- Empower staff to learn more about indicators of wellbeing and ill-being;
- Prompt staff to reflect on a resident’s behaviours that they might find challenging by considering the resident’s personhood, life history (including cultural and religious identities), physical health (including undetected pain), mental health, psychosocial factors and physical environment;
- Generate actions or solutions to improve care and promote residents’ wellbeing, including reducing behaviours perceived as challenging.

After one full review cycle (that is, after each of the 19 residents have been reviewed once), a new cycle starts. In subsequent reviews, in addition to thinking about the resident’s current wellbeing, the team also discusses actions from the previous reviews.

Improving the reviews

When we analysed the first reports, we noted that discussions frequently focused on aspects of care that staff struggled with; for example, managing behaviours perceived as challenging, or managing personal care at times of conflict or when a resident was in distress. Staff appreciated thinking about these issues together and generating actions to tackle them. They found that review discussions enhanced their personal knowledge, perspectives and practice (Wheeler and Johnson, 2010).

With each review cycle we sought to improve their usefulness. We felt that the initial cycles had major drawbacks: while the discussions yielded a wealth of information and empowered staff to think about how to promote wellbeing, the emphasis was on us as facilitators to ensure discussions were accurately recorded and actioned. Immediately after the review, we completed a report summary of staff and using these observations to supplement the review discussion; when possible, we spoke directly with residents about their wellbeing, empowering them to think about possible solutions for themselves. However, this placed emphasis on the indicators we identified, creating a power imbalance between us and the staff. Our aim was to take a reflective practice stance, enabling staff to openly discuss issues and concerns; however, creating the profile before the review seemed to disempower them and negatively affect their understanding and subsequent actions. As a result, we decided the Bradford Wellbeing Profile was not the right tool.

Developing a new tool

We researched a number of wellbeing measures – generic, older people-focused, dementia-specific – but found nothing suitable. We sought advice from a psychology colleague, Andrew Papadopoulos, who is particularly interested in the wellbeing of older people; he helped us identify what we wanted from a wellbeing measure. We were aware that we, as multidiscipli-

“Our aim was to take a reflective practice stance, enabling staff to openly discuss issues and concerns”

nary professionals, contributed to the reviews we facilitated, and recognised that our unique contribution lay in:

- Our understanding of biopsychosocial factors and how these affect residents;
- Our use of person-centred, more positive language;
- The way we formulated residents’ behaviours and distress as expressions of unmet needs.

After concluding that no existing measure met our requirements, we set about devising our own tool, which would:

- Meet NICE (2006) dementia guidance and apply the principles of person-centred care by paying particular attention to respect, dignity and people’s life history; individualising activities; be sensitive to religious, spiritual and cultural identity; and understand behaviours that challenge as a way of expressing unmet need;
- Respect residents’ individuality and diversity by documenting individual preferences;
- Maximise clinical utility for staff and improve their knowledge and skills;
- Reduce facilitators’ administrative burden.

Our Person-centred Wellbeing Care Planning Tool (PWCPT) does all the above.
Focus of the wellbeing review:
- How staff could help Mrs Parker feel more settled in her new home
- Staff’s difficulties in facilitating her personal care

Main points highlighted during review discussions:
- Two members of staff were needed to provide Mrs Parker’s personal care, as she would hit and shout. During the discussions, one staff member reported finding out that Mrs Parker preferred pink flannels and having her baths in the evening, which settled her for bedtime. The fact that she had been given her baths in the morning was thought to explain why she would often be unsettled, and had been observed trying to get into the bath, around bedtime. This information was shared with all present and documented in the ‘actions’
- Staff acknowledged that Mrs Parker had always been a housewife and liked to have a sense of purpose. She appeared to enjoy helping with tasks around the unit, such as laying the table. This was to be encouraged
- Mrs Parker liked talking about her family and flowers. Her family had told staff that she had always been a keen gardener. These topics could be used by staff to engage with her
- Mrs Parker did not appear to interact with other residents, and staff were concerned about her isolation outside family visits. They suggested asking her about her hobbies/interests, so they could help her engage in group activities and talk to residents with similar interests
- Staff shared Mrs Parker’s food and drink preferences and her related routines, so these could be respected by all
- Mrs Parker had hearing difficulties. Staff acknowledged they must speak clearly, gain her attention before speaking and ensure she was wearing her hearing aids

It can be downloaded at nursingtimes.net/wellbeingtool. The category questions, taken mainly from DEMQOL and DEMQOL proxy (Parker et al, 2007), encourage staff to think about the relevance of each category for the resident and help them identify priorities for improvement. In the ‘formulation’ column, staff document how they understand residents’ behaviours and what unmet needs (arising, for example, from discomfort, pain, fear or distress) these behaviours might reflect.

When devising the tool and determining its terminology, we drew on a range of existing evidence-based wellbeing measures and models, including those of Papadopoulos et al (2011), Bradford Dementia Group (2008), Parker et al (2007), Tennant et al (2007), Logsdon et al (1999), Kitwood (1997) and Kitwood and Bredin (1992). Staff at the residential unit, and other professionals and carers who have used the PWCPT, particularly like its categories, especially Kitwood’s (1997) hope, comfort and identity. They feel these categories allow them to obtain a detailed biopsychosocial understanding of individual residents and their needs, unlike other care planning tools, which focus mainly on care tasks.

Using the tool in practice
During wellbeing reviews, one facilitator leads the discussion while the other completes the PWCPT. Staff are asked to identify the wellbeing categories they think are the most pertinent for the resident, and these are considered first. The discussion then goes on to cover the remaining categories. All suggestions of how to improve wellbeing are documented in the ‘possible ways to enhance wellbeing’ column of the tool, and discussed in order to reach a collective decision about which ones seem most relevant or practical to try first; these are then recorded in the ‘actions’ column. The other suggestions remain in the ‘possible ways to enhance wellbeing’ column so they can be revisited at future reviews.

Specific staff members are tasked with implementing the actions that have been collectively agreed upon. In the weeks between reviews, staff add comments and observations to the tool in preparation for the next review. This can include new information, feedback about action points and hypotheses about what might be happening to the resident. The PWCPT therefore becomes an evolving document, as everyone is encouraged to contribute.

The case study in Box 1 summarises a review discussion for a fictional resident, Gwen Parker (this is a clinical case example, which has been devised for illustrative purposes and does not contain any confidential information about any of our residents). A completed tool for Mrs Parker can be found at nursingtimes.net/wellbeingtool. It shows how information is documented and how the PWCPT can be amended as new information is obtained and further discussions take place. It also shows how staff were able to develop a shared understanding of Mrs Parker and her preferences from their observations and discussions with the resident and her family. The tool allowed staff to document a wealth of information under broad categories (many of which are not routinely covered in care plans), as well as to identify what additional information would help them to better understand Mrs Parker.

Advantages of the tool
We collected feedback from staff informally during the review discussions and in conversations about care planning, as well as formally via an anonymous questionnaire. We found that staff appreciated the tool’s “ease of use”, stating its categories and accompanying descriptions helped them “understand more about wellbeing in a broader sense”. The PWCPT offers an in-depth biopsychosocial understanding of the resident while “still addressing all important aspects of care tasks/duties”. Staff liked its “very practical” focus, feeling it made care planning “much easier”, as the category descriptions give guidance on what information to record, while the multidisciplinary discussions generate ideas and actions.

Previously, staff had perceived care-planning duties and paperwork as onerous; these were usually the responsibility of a nurse, while other staff members had no opportunity to contribute. All staff need an in-depth understanding of each resident. The review process and tool help them appreciate the importance of incidental pieces of information in building a holistic picture of residents, as well as the
Innovation

Innovation

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home. It could become an important
care planning in the
residents.

The PWCPT was originally created to facil-
ments and care plans for patients, and
planning, generate richer assess-
from colleagues or talking to residents’
flow, enabling staff to discuss how they might
data, for example, by

Following the review, the completed
tool is placed at the front of residents’
notes, where it is “readily accessible” and
can be “easily referred to”, which elimi-
nates the need for additional notes or care
plan actions. It provides a “good overview/
summary” of information about each resi-
dent. DEMQOL questions enable staff to
give a quantitative judgement about well-
being so this can be monitored over time.

During reviews, our multidisciplinary
perspective helps staff to better under-
stand challenging behaviours and reframe
them as expressions of unmet needs. The
team discusses how different staff mem-
bers manage challenging situations,
sharing expertise and best practice. For
example, in Mrs Parker’s case (see Box 1),
finding out and sharing that she prefers to
take a bath in the evening made a signifi-
cant difference: morning baths, which had
been creating stressful situations for her
and the staff, no longer took place.

Other ways of using the tool

The PWCPT was originally created to facil-
itate wellbeing reviews, but the way staff
have used it to document information sug-
gests that it may have other uses. Having
spoken to NHS and care professionals, we
are aware that existing care plans are often
limited – none being really fit for purpose,
holistic and person-centred. We have
begun to discuss how the PWCPT – a
readily accessible, evolving document –
could be used in other settings.

In more permanent settings, such as
care or nursing homes, we anticipate the
tool could be used as originally intended;
that is, completed through facilitated mul-
disciplinary discussions, with the com-
pleted tool becoming the care plan. This
avoids one staff member being responsible
for reviewing and updating information
for all residents.

Relatives and home-based care staff
could use the tool for care planning in the
home. It could become an important
resource, held by the family and/or
home-care staff, to be shared with other
health professionals, such as staff in hos-
pitals or respite settings when required.

Recently, we have been considering the
use of the tool in assessment units and
inpatient settings. Its usefulness lies in
its ability to record information from dif-
ferent sources. All staff, regardless of
level or professional background, can
record their observations and thoughts,
which is essential for a high-quality, in-
depth assessment.

Improved access to information tech-
nology within healthcare means the tool
can be accessed on tablets and uploaded
to electronic records, therefore preventing
information from being ‘missed’, ‘lost in
progress’ or stored on inaccessible elec-
tronic care plans. We suggest that an indi-
vidualised tool is created for each patient
or resident, and saved on a tablet or com-
puter accessible on the ward in a practical
location (for example, the desktop), so that
it is easily accessible for staff to check or
add information. At the end of a shift, the
tool can be uploaded to electronic care
records, for example, care notes or Rio, so
that there is an up-to-date version stored
in the patient/resident’s notes. Thus, the
tool is a dynamic, constantly changing
document that helps ensure care planning
is timely and meets the person’s changing
needs.

Information collected through the tool
can then be reviewed in care meetings or in
wellbeing or care reviews; as part of team
formulations, meetings or discussions,
and when thinking about or finalising the
next steps in a patient’s care. It can also be
shared with appropriate services/organisa-
tions at discharge, ensuring appropriate
support is put in place.

Conclusion

We are delighted by the positive feedback
about the PWCPT and are keen to share it.
The tool can be modified to reflect the
needs of a specific care environment, and
we are happy to help with this. We hope it
helps other services and settings improve
care planning, generate richer assess-
mens and care plans for patients, and
increase staff’s job satisfaction. MT

The authors welcome comments about
the Person-centred Wellbeing Care
Planning Tool and any suggestions
regarding its future development.

Organisations or services interested in
using it are welcome to contact the
authors via email (nwheeler@nhs.net),
explaining who they are and for what
purpose(s) they intend to use the tool.

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