Final report

November 2017

Innovating for Improvement

Embedding A Bio-Psycho Social Model Of Care In An Older Persons Inpatient Service

Leicestershire Partnership NHS Trust

The Health Foundation

About the project

Project title:

Embedding A Bio-Psycho Social Model Of Care In An Older Persons Inpatient Service

Lead organisation:

Leicestershire Partnership NHS Trust

Partner organisation(s):

NA

Project lead(s):

Dr Samantha Hamer

Contents

Part 1: Abstract

This project was designed to have a Project Worker to embed a biopsychosocial model called the Enriched Model (EM) of dementia care on organic assessment wards. Previous training showed a decrease in incidents, but this was not sustained. The Project Worker's principle role was to:

- Work directly with patients on 1 to 1 observations, modelling behaviour and translating previous training into practice
- Promote collaborative MDT working and ensure dissemination of information following assessments
- Support existing training and ensure new training takes the EM into consideration
- Value and support staff alongside leading and managing change on the wards

We evidenced:

- Improvements in staff knowledge and practice, being able to articulate application and actions rather than just tokenistic statements.
- Raised standards of care evidenced through Personal Enhancer and Personal Detractor observations.
- Increased engagement with EM not achieved by training alone, and a real desire from staff to continue with it.
- Cost saving projection of £32k over the course of a year and ongoing initiatives regarding reduction in Level 1 observation.
- Improved staff morale and potentially retention through their enthusiasm and engagement with EM way of working.

Challenges have been around engagement of managers who felt that roll out was slow, done in isolation, expectations of the role weren't clearly defined and recruitment to the role put pressure on existing staffing problems.

Enablers came in the form of a dedicated steering group, good governance data and enthusiasm from healthcare support workers on the ward.

Continuation of the role is being discussed with service managers currently.

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Part 2: Progress and outcomes

The intended outcomes were:

	Outcome	Measurement/data source
1	Identification of barriers, good practice or risks with staff using the model	Project Worker reflective diary and analysis using Kotter and Bridges's model of change
2	Evidence of use of EM in practice on the wards	Observation by Person Centred Care Group to measure Personal Enhancers and Personal Detractors pre and post Project Worker
3	Improvement in staff knowledge of Personal Enhancers and Personal Detractors and the EM	Staff knowledge questionnaire pre and post Project Worker and focus groups with staff 10 months into the project
4	Reduction in incidents including falls, violence and aggression	Analysis of monthly governance data
5	Reduced use of 1 to 1 observations	Number of days patients remain on 1 to 1 during the admission and the number of 1 to 1 shifts on each ward (recorded on handover sheets)
6	Evidence of use of the EM being translated into patient care plans	Review of care plans by Project Worker and staff from person centred care group
7	Decreased length of stay as a direct result of being able to find suitable placements for patients due to reduction in challenging behaviour and use of 1 to 1	Analysis of delayed discharges
8	Reduction in individual behaviour incidents following involvement from Project Worker and care plans being implemented	Comparison of individual behaviour incidents in patients who have received involvement from Project Worker
9	Reduction in staff sickness	Monthly reports from HR
10	Development of cases for "story telling" to spread knowledge around the outcomes and benefits from the project	Collection of information regarding individual patients and their carers involved in the project, by the Project Worker

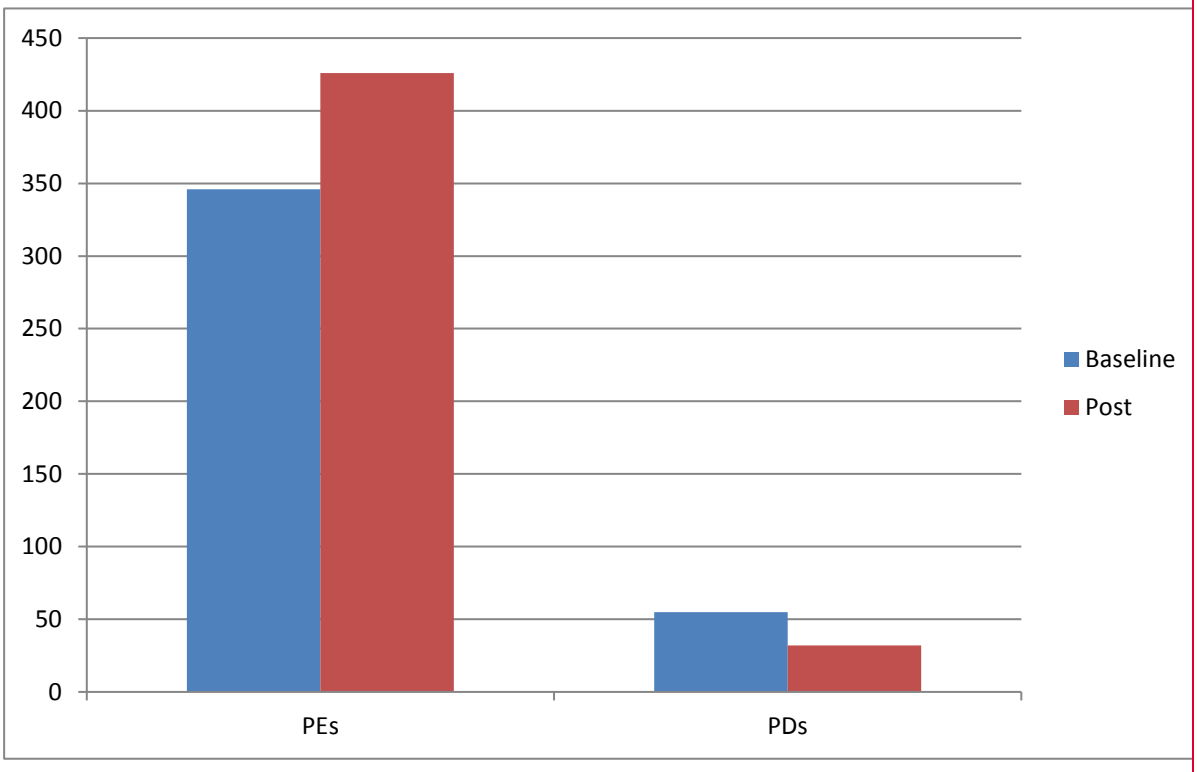
Outcome 1:

Use of the reflective diary highlighted the following changes in good practice:

- Increased use of “Who am I?” document
- Better use of ABC charts
- Established the level 1 support tool with progression from modelling and advising, to partial completion by staff, to staff independently completing, to staff suggesting application of the model would be helpful for other patients (not on level 1).
- Increased use of grab bags and focused activities.
- Collaborative working across disciplines
- Staff response to “Thank you” cards

Outcome 2:

Using the EM, staff behaviours identifed on interaction with patients can be classified as Personal Enhancers (PEs) and Personal Detractors (PDs) and these are an indicator of the quality of care in a setting and relate to the patient’s wellbeing. Observers from the Person Centred Care Group, who were independent of the project, observed interactions between staff and patients over 2 lots of 3 hour periods on both wards, prior to the Project Worker starting and 8 months afterwards.
Over both wards, the number of PEs increased and the number of PDs decreased.



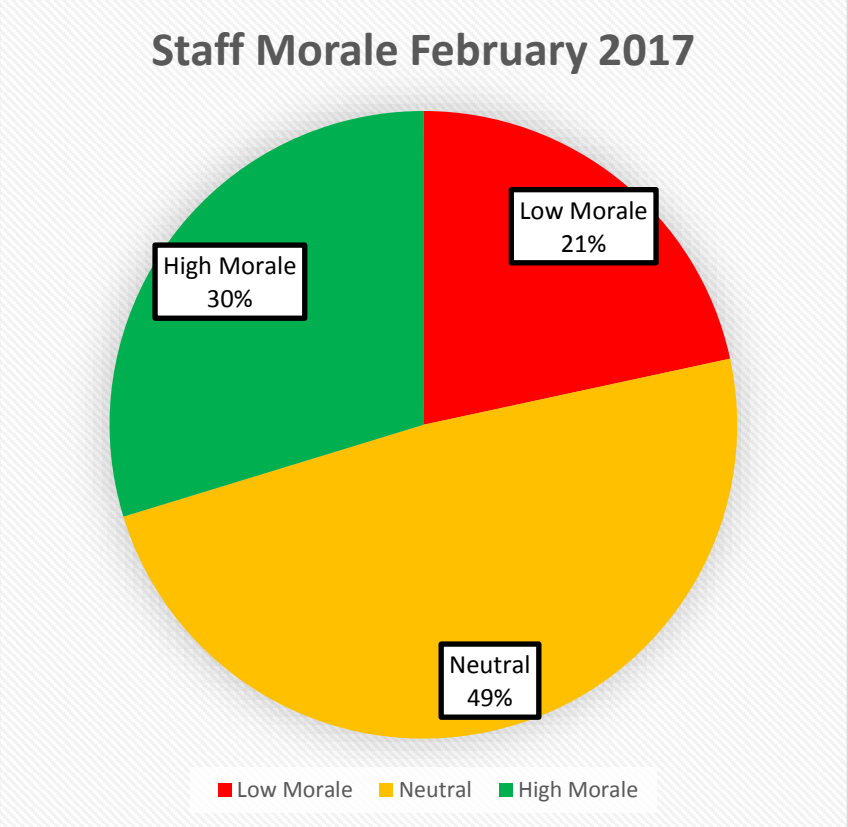
The PDs were also grouped according to severity. The severity of PDs also shifted into the milder end of the range ie from 7 to 2 severe/very severe:

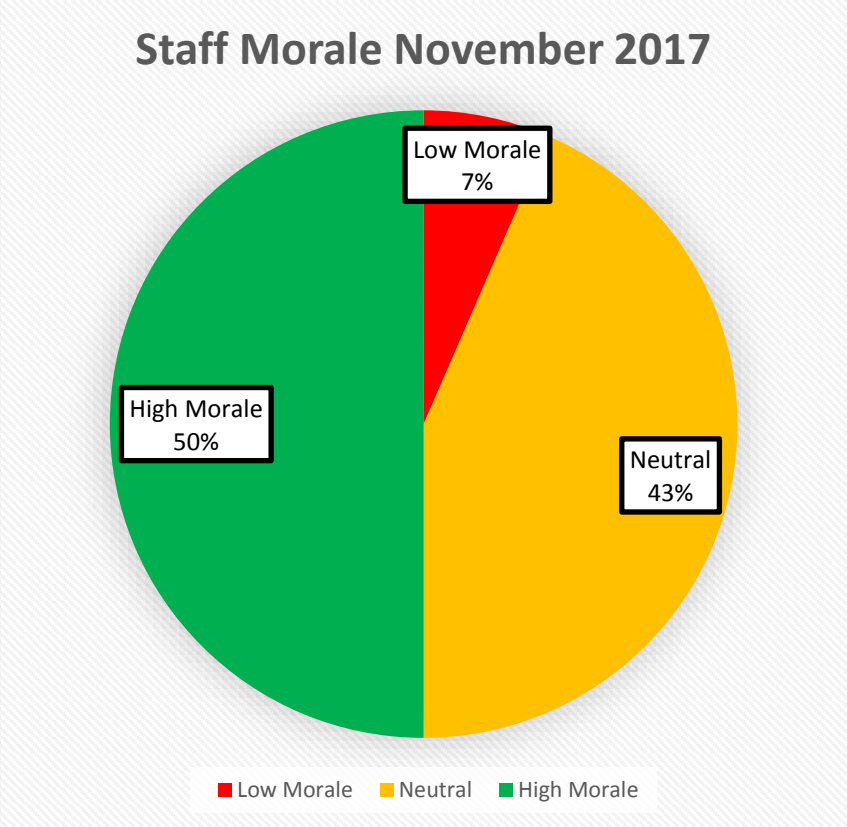
Severity code	Baseline		Post intervention	
	Wakerley	Coleman	Wakerley	Coleman
Mild	0	1	1	6
Moderate	4	16	3	13
Severe	2	3	1	1
Very severe	0	2	0	0

Outcome 3:
Responses to a staff knowledge questionnaire were analysed using Grounded Theory (Charmaz 2006). Over 500 responses were coded and validity of themes established.
Themes suggested a tentative categorisation of staffs' status in the process of change and were characterized as:
DISENGAGED: not relating to patient, task focused, no engagement with model, passive narrative
DEVELOPING: acknowledgement of the model, demonstrating a response to the patient needs, some therapeutic use of self-questioning narrative
ENGAGED: applying the model, being personally committed, overriding constraints to apply the model, proactive narrative
Analysis demonstrated that after the project:

- More staff felt that Person Centred Care was evident
- Staff were more engaged with improving person centred care
- The Project Worker post itself helped to shift staff to higher engagement with EM

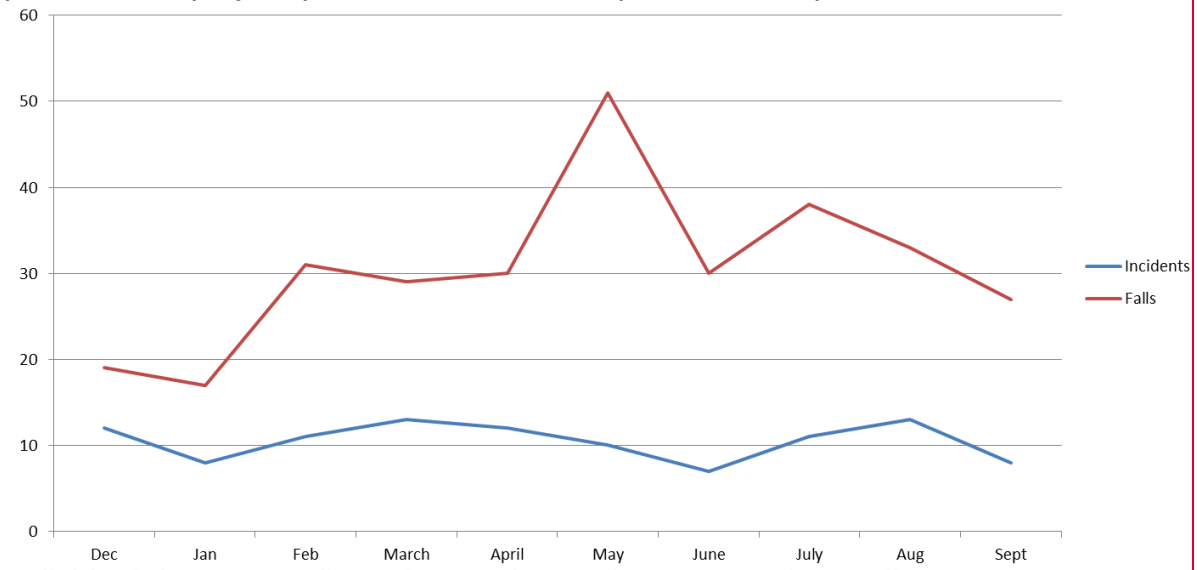
Analysis of feedback from the focus groups demonstrated that staff felt their skills were being recognised and that this was a better way of working with patients, and corresponds with an increase in staff morale:





Feedback from matrons and the deputy head of service demonstrated the difficulties in staff enagement at this level and is useful for future rounds to be aware of.

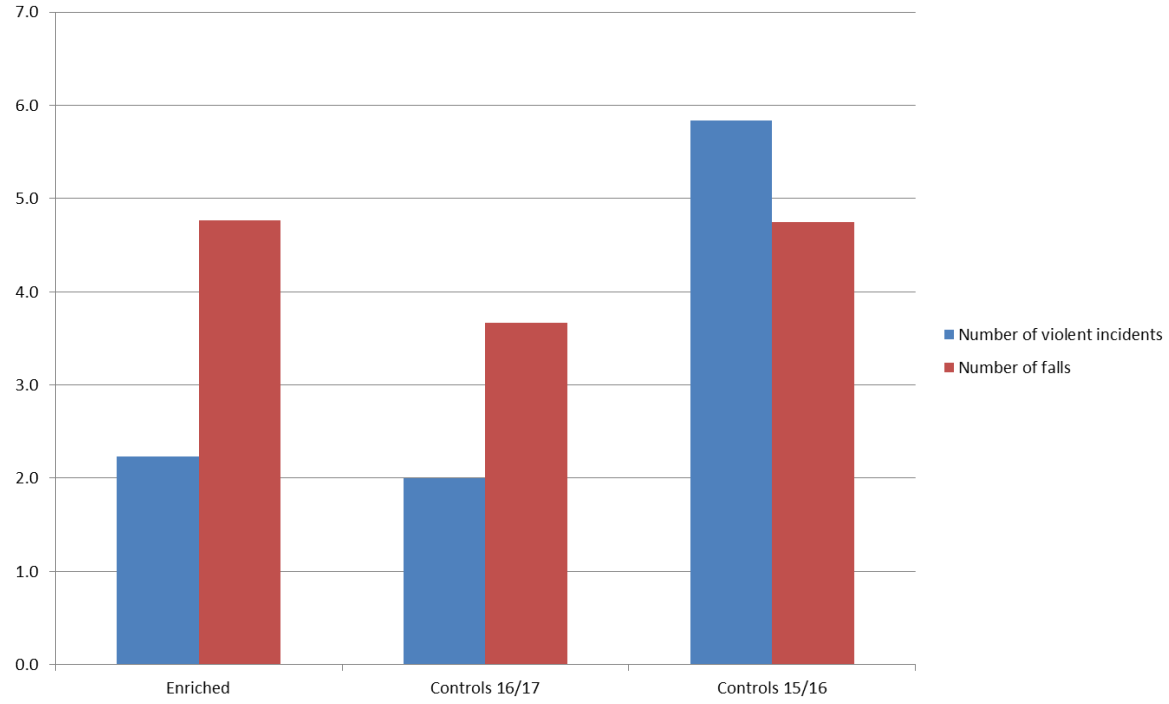
Outcome 4:
Governance data was analysed to look for patterns or changes during the project. Analysis of falls and violent incidents did not show any relevant changes over the period of the project (December 2016 to September 2017).



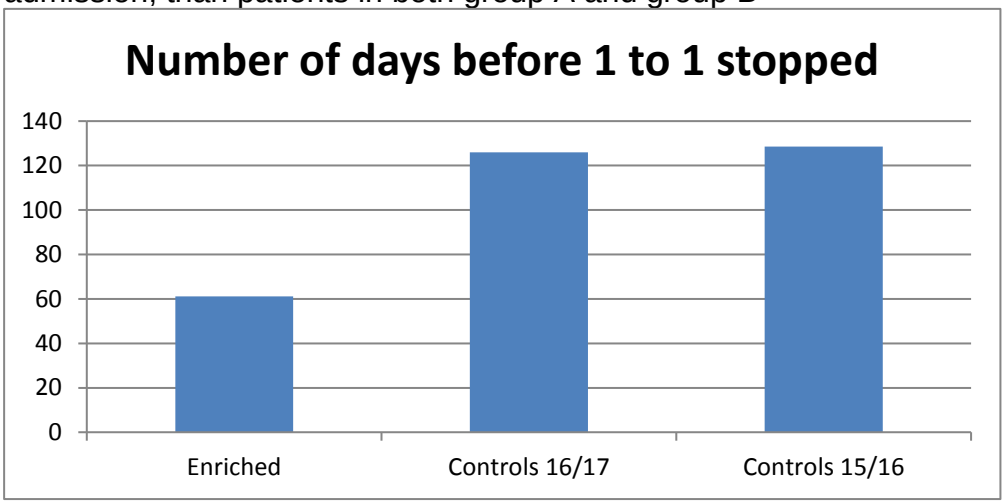
Individual data was collected for patients who were put into 3 different groups:

- admitted between January 2015 and April 2016 (n = 12), staff trained but model not embedded (control group A)
- admitted after December 2016 to date (n = 12), but not subject to direct involvement from project worker (control group B)
- admitted after Jan 2017 to date (n = 17) and subject to involvement from project worker (patient group C)

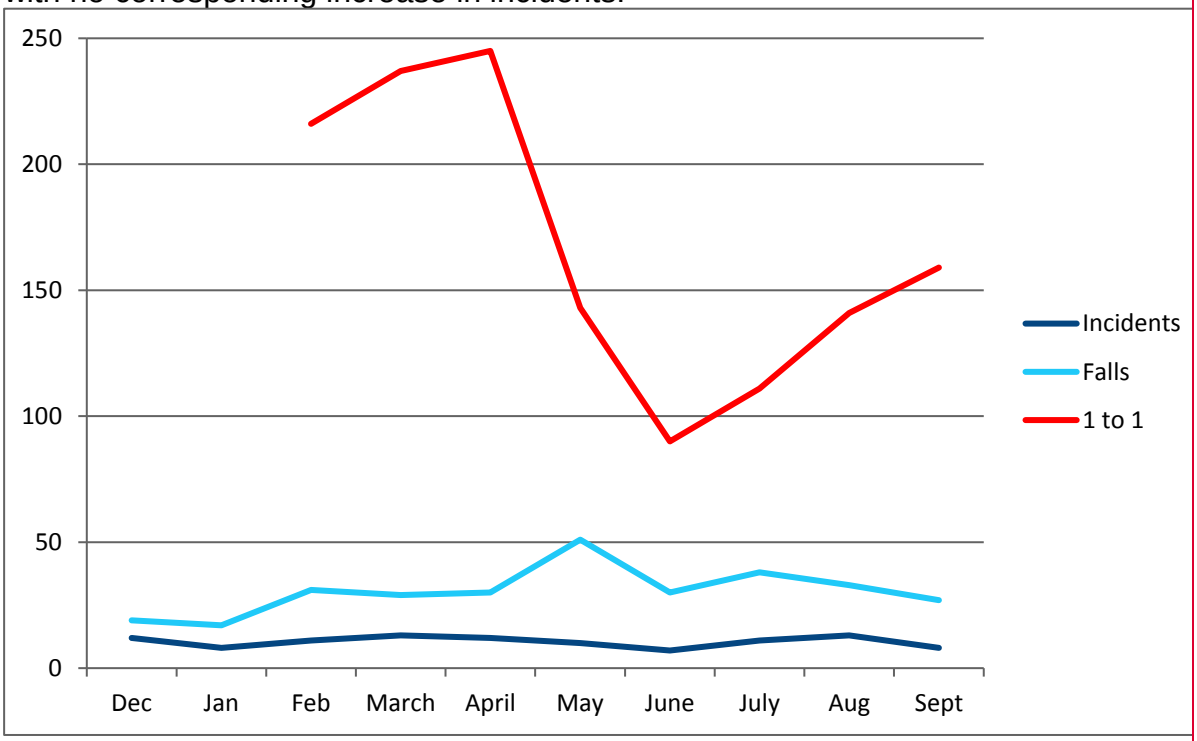
There was no difference in the number of falls per patient in any of the groups. Both groups B and C had less violent incidents per patient compared to patients in group A, who had been admitted prior to the project starting.



Outcome 5:
The project appears to have had a significant impact on the 1 to 1 shifts. The patients in group C, who had direct input from the Project Worker, on average, spent around 70 days less on 1 to 1 observations during the course of their admission, than patients in both group A and group B



The number of 1 to1 shifts required across each ward also fell during the project, with no corresponding increase in incidents.



When compared to the same 8 months during the previous year, the total number of 1 to 1 shifts was 165 less during the 8 month period of the project. Over a 12 month period, this would equate to £31,930 saving in Bank Band 2 spend.

Outcomes 7 and 9:
There was no demonstrable change in length of stay or staff sickness during the course of the project.

Outcomes 6 and 8:
We were unable to reliably measure changes in the quality of care plans, and the individual data for incidences has yet to be analysed.

Outcome 10:
The Project Worker has collected individual patient stories to help dissemination and spread using examples.

Please see paper in Appendix 1 with more indepth analysis of the information discussed above.

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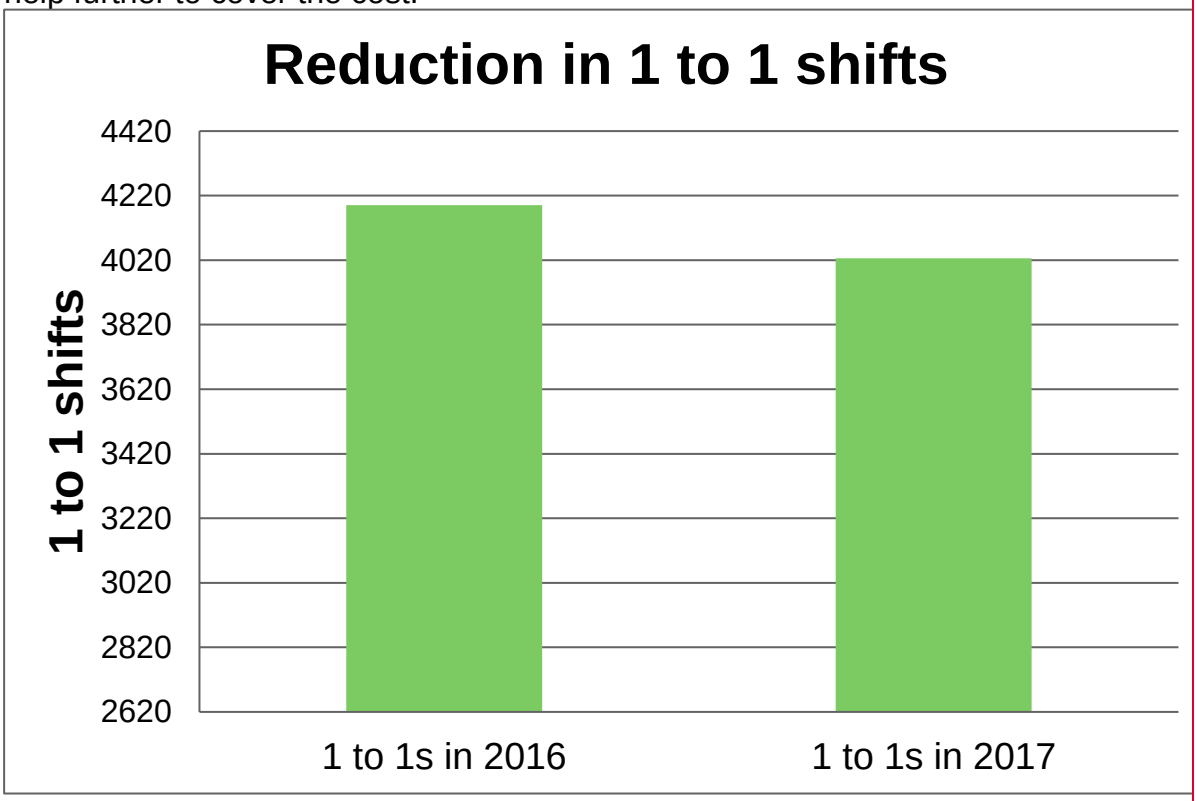
Part 3: Cost impact

The inpatient organic assessment wards in Leicestershire Partnership NHS Trust are commissioned under a block contract.
The service would cost a Band 6 mental health practitioner at £50,185, and would need to find this amount to continue to provide the Project Worker.
The number of 1 to 1 shifts fell significantly during the period of the project, and on comparison, there were 165 fewer 1 to 1 shifts, during the same 8 month period during the previous year.
Number of 1 to 1 shifts over 8 month project is 165 less than the previous year.
This could be extrapolated to 248 fewer shifts over a 12 month period.
The breakdown of shifts would include:

- 118 weekday shifts at a cost of £90.00 per shift (£10,620 total)
- 48 weekend shifts at a cost of £150.00 per shift (£7,200 total)
- 83 night shifts at a cost of £170.00 per shift (£14,110 total)

Total cost of 248 shifts with the breakdown as above is £31,930.
This would not cover the cost of an ongoing Project Worker, but not all patients on 1 to 1 observations were part of the current project, and including all of them may help further to cover the cost.



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Part 4: Learning from your project

We are very pleased that we achieved our primary project aim, to embed the Enriched Model of care on the wards, and that we have clear evidence of a positive shift in staff engagement with the model and associated changes in practice. We have also seen a reduction in the number of Level 1's required on the ward with no increase in adverse incidents.

The enablers to the project were:

- A dedicated steering group working collaboratively throughout to review and direct progress, with shared responsibility for completion of tasks due to the individuals having clear commitment to the project and different levels of experience. It helped to have a multidisciplinary steering group consisting of nursing, medical, OT and psychology input, which meant that we could engage with staff across a range of disciplines. The different members of the group also had a range of leadership experience which helped to identify and address barriers as they arose. We were able to share these challenges and recognising that this was a Quality Improvement project, rather than research, were able to adapt to learning throughout the project and make changes as needed.

- The appointment of a nurse as the mental health practitioner in the role of project worker, which helped to engage the majority of the workforce, who are in the nursing profession.

- Good baseline and ongoing governance data, which was surprisingly reliable and easy to access.

- The individual supervision of the project worker to help develop the role and manage barriers.

- The highlight reports helped to keep us to deadlines and provide a structure for reviewing progress.

- The support and input from our consultant (Richard Edgeworth), reviewing our outcomes, ensuring our measurements were realistic and booking reviews with us to ensure we had targets and deadlines as well as sharing some of the challenges with us.

The aspects that didn't work as planned, or proved difficult were:

- Resistance from some managers who had to deal with a perceived loss of a Band 6 nurse, with a lack of understanding of the project worker role. Although they were invited to be part of the steering group, and individual conversations were held to address this, earlier work on this may have been

beneficial. The project worker ended up having to provide work schedules and activity logs to demonstrate the work that she was doing to managers.

- The project worker having to understand the changes to role while working in the same environment. This was helped by individual supervision and support from the steering group to define the role and provide protection from being pulled back into the numbers. A simple thing, like having a different colour uniform, was not allowed due to existing policy around this.

- Our lack of familiarity with and use of communications to share the project's progress, such as blogs.

Feedback that surprised us consisted of both positive and negative feedback:

- We were surprised at just how positive the reaction was from Band 2 healthcare support workers and the depth of enthusiasm for this change in practice.

- Also, how far reaching the involvement of the Enriched Model could be, including other teams outside of the hospital (Care Home In Reach), MAPA training to use the principles of the model, interest from the acute hospital and the reaction of student nurses. These teams were impressed by what we were doing and were keen to understand how we were working and how they may be able to look at using the EM themselves, or help patients in their environements to benefit from it.

- We received anecdotal negative feedback from the head of service, which was so far from the positive feedback of frontline staff, that this also took us by surprise, but was addressed by presenting our final analysis of the project to our local Clinical Network meeting and the Clinical Governance forum.

Our specific learning on introducing and sustaining innovations in the NHS includes:

- The project team needs to have an ongoing commitment and this needs to be matched by middle managers, as well as the Trust Boards. Better engagement with this level of management would have been one of the things done differently prior to the project starting.

- The project worker needed persistence and the ability to keep going back over and over again until change was evidenced. This particularly applied to correct use of documentation, until there was a shift in the way staff were thinking from " we don't have time for this" to "there isn't always enough time, but this is the way we work now and it's better for our patients".

- The need for clearly defined outcomes and realistic ways of measuring these, in order for evaluation to be successful. Initially, we wanted to demonstrate how the project worker had embedded the EM on the ward, by evidencing improved quality in care plans that referred to the EM. Looking into this further, we were unable to find a reliable way to measure the quality of care plans at baseline, or ways of demonstrating an improvement in the quality of care plans and so decided that this would not be a good use of our time and resources.

- You need to have good quality baseline data and the ability to easily collect other data throughout the project.

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Part 5: Sustainability and spread

Will the intervention be sustained beyond the funding period?

The role of the project worker itself will not be funded after the period of the project. This is due to lack of financial resource within the service, to sustain this individual role. Since the presentation of the evaluation of the project at Clinical Network and the Clinical Governance forums, the evidence has produced positive change and recognition from managers who were previously negative about the impact of the project.

There is therefore a clear desire and commitment to maintain the changes that have been embedded by the project and there are ongoing discussions with the Lead Nurse, Inpatient Matron and ward staff on how the role of the project worker can be shared and delegated to existing members of staff. The project has definitely inspired frontline staff and service managers are keen to continue to support them and promote this way of working.

The project worker does have some time now to work on the sustainability of the project and will do this by engaging with existing Band 5, 6 and 7 nursing staff to ensure that:

- they take responsibility for ensuring that patients on level 1 observations are reviewed and put forward for case reviews.
- they model the appropriate behaviour for other members of staff.
- They take information into handovers and safety huddles . Safety huddles were set up during the time of the project, but as a result of it. The aim is to identify and manage risks during each shift on the ward. The project worker ensured that the safety huddles were run with the Enriched Model in mind.
- the named nurse ensures the “Who am I?”, level 1 support tool and ABC charts are completed and used effectively.

The psychology staff will ensure that the case reviews are conducted and information from them is disseminated appropriately.

There needs to be ongoing recognition of staff skills.

It will be the role of the existing Person Centred Care Group to monitor this, repeating observation of PEs and PDs and ensuring that the Enriched Model is considered when new staff training is introduced.

What interest and recognition have you had on your innovation?

We have been working closely with the Trust trainers for the Management and Prevention of Aggression. This training was radically reviewed at the same time the project started and is now presented as Dementia Capable Care. Trainers have attended case reviews we have developed vignettes to support the new training.

We have had interest from other parts of Mental Health Services for Older People in Leicestershire Partnership NHS Trust, such as the In Reach Team, who help to prevent admissions from care homes, which are predominantly due to challenging behaviour. They have previously used formulations based on the Newcastle Model, but wish to look at the Enriched Model to help with consistency for patient care.

We have been approached by commissioners regarding the care of people with dementia within acute hospital settings. There are difficulties in managing distressed behaviours, particular during crisis admissions and these patients often end up inappropriately placed, on level 1 observations with staff who lack confidence in their skills to manage this. We are looking at a further quality improvement project putting the Enriched Model into practice in this specialised environment with the aim of reducing level 1's and improving placements into care homes. We have started exchanging ideas with Acute Hospital dementia leads and facilitated exchange visits of band 5 staff.

Do you plan to spread this innovation beyond the Innovating for Improvement award site?

We will be releasing an article in the Trust newsletter in December sharing the success of the project within the organisation.

The project worker attended the National Dementia Congress in November. As an alumni student of Bradford University she has shared our progress with the Lead of dementia studies who expressed interest in further updates.

She had opportunity to discuss submitting a paper for publication in the Journal of Dementia Care (Hawker Publishing Ltd) and Jessica Kingsley Publications are interested in developing a book on the project and guidance for other services to look at implementing the model. The project would be replicable in other dementia inpatient units that have access to mental health practitioners and psychology staff to run the case reviews. It may also be useful in care homes if they could also access these professionals.

We have intentions of submitting papers to other professional journals and are currently exploring other avenues.

The Leicestershire Partnership NHS Celebrating Excellence awards have opened for nominations and we are applying for the Excellence in Innovation or Research

award. We are also applying for the Health Service Journal awards and investigating other local and national innovation awards.

We need some further time to develop a published book, and time to attend conferences to present our project.

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Appendix 1: Resources and appendices

Initial paper on the project, presented to Mental Health Services for Older People's Clinical Governance meeting on 13/11 2017:

Embedding the Enriched Model of Dementia Care on organic inpatient wards.

Introduction

In 2014 MHSOP provided training for staff on The Enriched Model of Care, which was provided by Hazel May (external consultant). The Enriched Model is based on Professor Kitwood's work on personhood and the training was a progression on Dementia Care Mapping and the Bradford Wellbeing Profile which the service had used in its development of Person Centred Care.

During the period of training, incident numbers fell on the wards, but once the period of training finished, the numbers increased again. This suggested that the training was not embedded into practice on the wards.

In 2015, the MHSOP Clinical Network promoted a bid to the Health Foundation, to run a project that would look at embedding the Enriched Model of Care into clinical practice on the wards. Out of 320 bids, we were in the successful 20 that were funded by the Health Foundation. The funding was predominantly for the role of a Project Worker (Band 6 Mental Health Practitioner) to work with staff and patients on the ward to embed the model.

The project was run by a steering group, who were guided by a consultant assigned by the Health Foundation. The consultant was able to support and challenge the steering group, helping to define outcomes and how to measure these. The steering group has provided bi-monthly update reports to the Health Foundation and is producing the Final Report at present, which will be presented in poster format at the Health Foundation conference in February 2018.

Method

The role of the project worker did evolve over the time of the project in response to varying needs of patients and staff on the wards. The primary role was to:

- Prioritise patients on level 1 observations, reviewing care plans for these patients, ensuring that they were discussed in case reviews, promoting behaviours seen to help these patients with staff working directly with them.
- Modelling behaviour for staff to continue with patients, helping to translate the previous training into practice, using graded learning.
- Leading and managing change on the wards.
- Valuing and developing staff involved in care on the wards and introducing tools to support them e.g key fob information cards, 1 to 1 support tool, use of thank you cards and acknowledgement of good practice, encouraging Band 2 HCSWs to stop referring to themselves as "unqualified".
- Supporting the existing training for staff on the Enriched Model of Care by the CELS.
- Promoting collaborative MDT working through case reviews, ward rounds and handovers.
- Ensuring dissemination by following through on documentation and ward process across a variety of setting (case review, RiO, safety huddles, ward round, handovers)

The Project Worker also ensured the consideration of the Enriched Model of Care in other service developments on the wards by being involved in newly implemented "Safety Huddles" and liaising with the trainer for new MAPA training (Dementia Capable Care) that was rolled out during the time of the project. The Project Worker has also supported

staff who have been taking part in training from Worcester using ideas from the Enriched Model.
The Project Worker has also looked at improved use of existing tools and paperwork such as the "Who am I?" document, ABC charts, and Level 1 charts.
Case reviews, chaired by a psychologist, had been taking place on the wards since the initial Enriched Model training, but there had been a lapse in the frequency and regularity of these due to changes in psychology staffing. The Project Worker was able to help co-ordinate the reviews along with the Psychology Assistant, identifying appropriate patients on the wards and making sure the right people were in the reviews and gathering appropriate information prior to the review taking place.
During the first 8 months of the Project Worker being present on the wards, case reviews were held for 22 people, providing formulations and action plans. 20 of these patients also had update reviews to adapt plans as appropriate. The Project Worker helped to translate the actions plans into clinical practice.
91 staff attended with a total figure of 249 attendances, showing that some staff attended more than once. All therapy staff and 47% of nursing staff (all bands) have attended at least one review. There has also been attendance from some regular Bank Health Care Support Workers (HCSW), medical staff, nursing students, the MAPA trainer and In Reach staff.

Results

The intended outcomes and measurements of these were:

	Outcome	Measurement/data source
1	Identification of barriers, good practice or risks with staff use of the model	Project Worker reflective diary and analysis using Kotter and Bridges's model of change
2	Evidence of use of the Enriched Model in practice on the wards	Observation by staff from person centred care group to measure Personal Enhancers and Personal Detractors pre and post Project Worker
3	Improvement in staff knowledge with regards to Personal Enhancers and Personal Detractors and the Enriched model of dementia care	Staff knowledge questionnaire pre and post Project Worker and focus groups with staff at 10 months into the project
4	Reduction in incidents including falls, violence and aggression	Analysis of monthly governance data reports
5	Reduced use of 1 to 1 observations	Number of days patients remain on 1 to 1 during the admission and the number of 1 to 1 shifts on each ward (recorded on handover sheets)
6	Evidence of the use of the Enriched Model of care being translated into patient care plans	Review of care plans by Project Worker and staff from person centred care group
7	Decreased length of stay as a direct result of being able to find suitable placements for patients due to reduction in challenging behaviour and use of 1 to 1	Analysis of delayed discharges
8	Reduction in individual behaviour incidents following involvement from Project Worker and care plans being implemented	Comparison of individual behaviour incidents in patients who have received involvement from Project Worker
9	Reduction in staff sickness	Monthly reports from HR
10	Development of cases for "story telling" to spread knowledge around	Collection of information regarding individual patients and their carers

	the outcomes and benefits from the project	involved in the project, by the Project Worker

We have analysis for all outcomes except numbers 6 and 8. We were unable to find a way of reliably measuring change in care plans. The reduction in individual's behavioural incidents has also not been analysed yet, but will be done shortly.

Outcome 1:

Analysis of the reflective diary, staff knowledge questionnaires and focus group data shows the following;

Narrative shift from "Fred's aggressive" to "Fred's distressed" reflecting change in staff ideas and actions regarding managing patient behaviour

Multi-stream dissemination across ward settings, meetings and documentation (previously just RiO)

Consistent evidence across questionnaires and focus groups of change in staff views and application of model resulting in different approach to care

Level 1 support tool and Who am I document; at baseline 0/8 completed, progression from modelling and advising, to partial completion by staff to staff independently completing to staff suggesting application of the model would be helpful for other patients (not on level 1). "Who am I?" documents now present at every case review (used for formulation).

Positive examples of use of the Enriched Model evidenced through increased number of 'thank you' cards issued (record kept of change in care)

Outcome 2:

Personal Enhancers (PEs) and Personal Detractors (PDs) are an indicator of the quality of care in a setting and can relate to the patient's wellbeing as meeting the patient's psychological needs. There is a greater likelihood of behaviour that challenges when a patients social/psychological needs are not supported. Observers from the Person Centred Care Group, who were independent of the project, observed interactions between staff and patients on the wards over 2 lots of 3 hour periods on both wards, prior to the Project Worker starting and 8 months after the Project Worker had started on the wards. Over both wards, the number of PEs increased and the number of PDs decreased (see Table 1).

Table 1

Social Psychological need	Coleman Ward				Wakerley Ward			
	PE pre	PE post	PD pre	PD post	PE pre	PE post	PD pre	PD post
COMFORT	86	99	12	11	47	38	2	
IDENTITY	8	12	5	2	8	13	1	
ATTACHMENT	8	11	2	1	18	22	1	
OCCUPATION	69	67	10	5	59	108	10	
INCLUSION	11	29	4	8	32	27	8	
Total PEs/PDs	182	218	33	27	164	208	22	

Using established analysis methods, the PDs were also grouped according to severity. Table 2 shows the reduction in the number of severe and very severe PDs and demonstrates that as well as the number of PDs has decreased, the remaining PDs that were observed have also shifted into the milder end of the range ie down from 7 to 2 severe/very severe. Examples of these would be:

At baseline:

- Jerking wheelchair to new location with no communication or explanation, walking off leaving patient distressed
- Intimidation, staff members laughing at patient not including
- Jerking patient by arm into a seat walking away leaving patient in distress
- Poking finger into patient's face, speaking aggressively using intimidating speech

To post intervention

- Not making eye contact, staff repeatedly saying “get up, get up”, patient becoming agitated
- Patient eating lunch, LAMP, translator and staff member standing over patient, patient becoming agitated

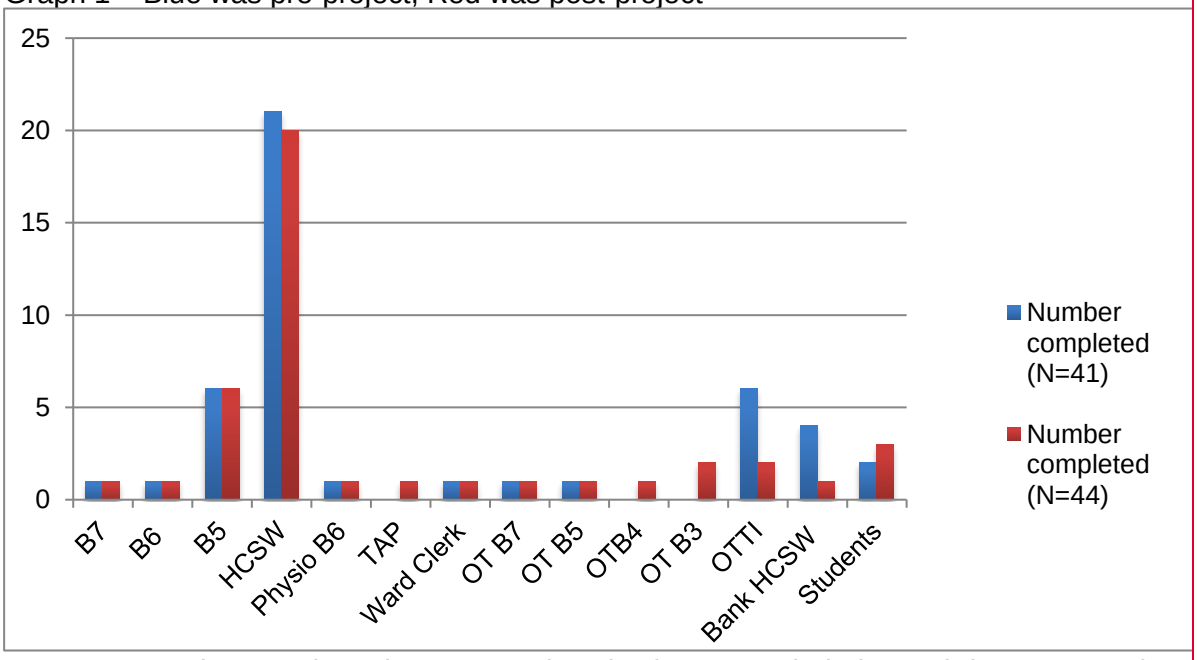
Table 2

Severity code	Baseline		Post intervention	
	Wakerley	Coleman	Wakerley	Coleman
Mild	0	1	1	6
Moderate	4	16	3	13
Severe	2	3	1	1
Very severe	0	2	0	0

Outcome 3:

The Staff Knowledge Questionnaire was completed by ward staff prior to the Project Worker starting and again after 8 months of her being on the wards. It was completed by staff across different disciplines and grades (see Graph 1).

Graph 1 – Blue was pre-project, Red was post-project



Responses to the questionnaire were analysed using Grounded Theory (Charmaz 2006) whereby themes emerge from available data. Over 500 responses were coded and validity of themes were established across both data sets and independently checked. The themes were consistent between baseline and post intervention. Additional themes emerged post intervention in keeping with staff development.

Themes also suggested a tentative model for staff’s status in the process of change and were characterized as:

DISENGAGED: not relating to patient, task focused, no engagement with model, passive narrative

DEVELOPING: acknowledgement of the model, demonstrating a response to the patient needs, some therapeutic use of self-questioning narrative

ENGAGED: applying the model, being personally committed, overriding constraints to apply the model, proactive narrative

The Post questionnaires demonstrated various changes:

1. More staff felt that Person Centred Care (PCC)was evident on the wards, with themes shifting from barriers to putting PCC into practice (Limited application, Limited understanding, Impact of bank staff, Demanding environment, Time and staffing as a barrier, Need to improve) to themes suggesting engagement with the Enriched Model (Being responsive and acting on observations, Practical use of the model, Recognition of developing practice, Importance of staff skills, Understanding the patient, Knowing my own limitations, Client needs and impact of time of day).

Table 3

Disengaged	Developing	Engaged
Basic care not patient focused	Acknowledgement of model	Applying the Enriched Model
Focus on own skills	Working to a professional standard	Confidence in using the Enriched Model
Barriers	Use of the "Who am I"	Relating to the individual
	Knowing the individual	Person first, ward second
	Some responsive working with individuals	Focus on patient's abilities
	Some therapeutic use of self	Responding in the moment
		Therapeutic use of self
		Disseminating the Enriched Model
		Empathic working
		Personally committed

Table 4

	Disengaged	Developing	Engaged
Pre	37%	41%	22%
Post	19%	31%	50%

Tables 3 and 4 show the themes that emerged when staff were asked "What are you proud of relating to Person Centred Care?" and the shift from disengaged to engaged.

2. When asked "How would you like to improve Person Centred Care?" the responses in the Post questionnaire showed applying the Enriched Model as the

most recurrent answer (see Chart 1).

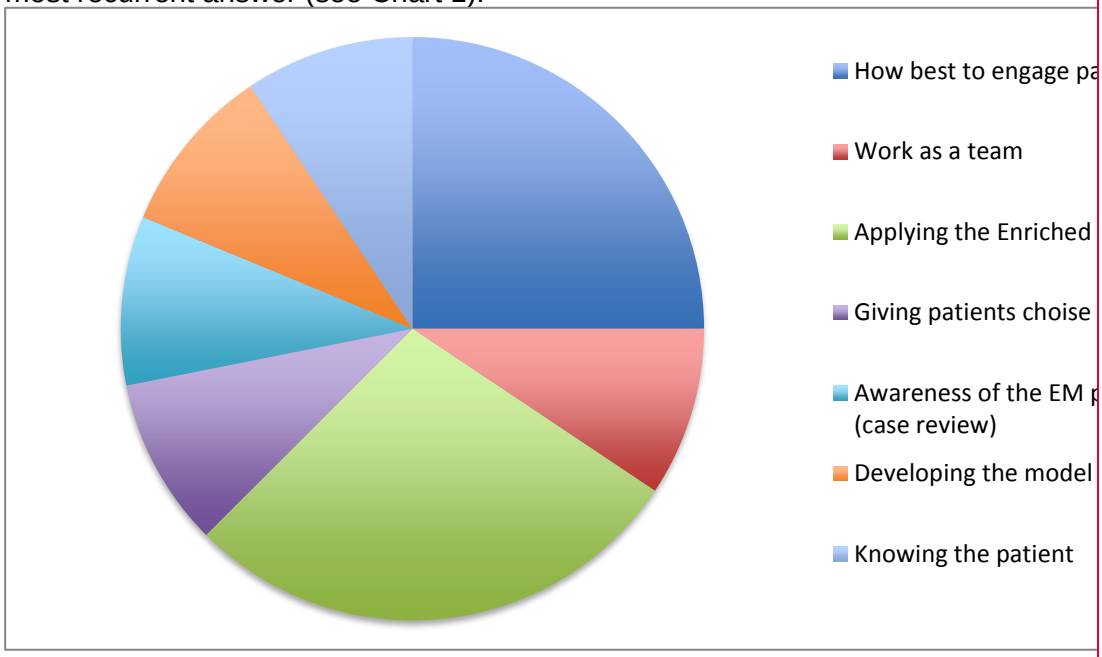


Chart 1

3. Training on the Enriched Model and Case Reviews were already in place before the project started, and 64% of staff felt that the training did change their understanding of dementia. However, with the Project Worker in post, the responses to the questionnaire demonstrated a shift towards greater engagement with the model (see Table 5)

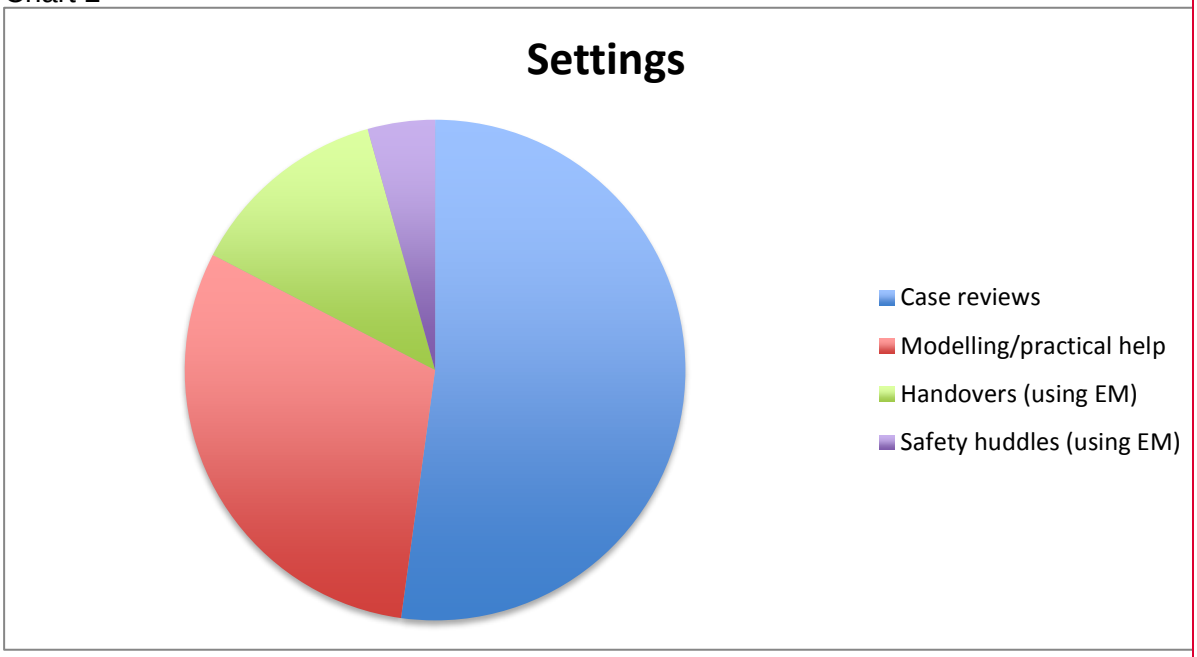
	Disengaged	Developing	Engaged
Pre	11%	50%	39%
Post	5%	39%	55%
	Perceived as burden	Gaining knowledge	Planned interventions
	Rejection -"No like to think I have a good	Prioritising patient needs	Collaborative working
		Reflection on practice	Confidence
			Develop model further
			Promoting patient experience
			Enhancing care
			Evidencing care

Table 5

After the presentation of interim findings at MHSOP Clinical Network, we were asked to get further feedback from staff. Staff were asked 2 questions. 15 slips were returned: Coleman 3, Wakerley 7, Therapy staff 5.

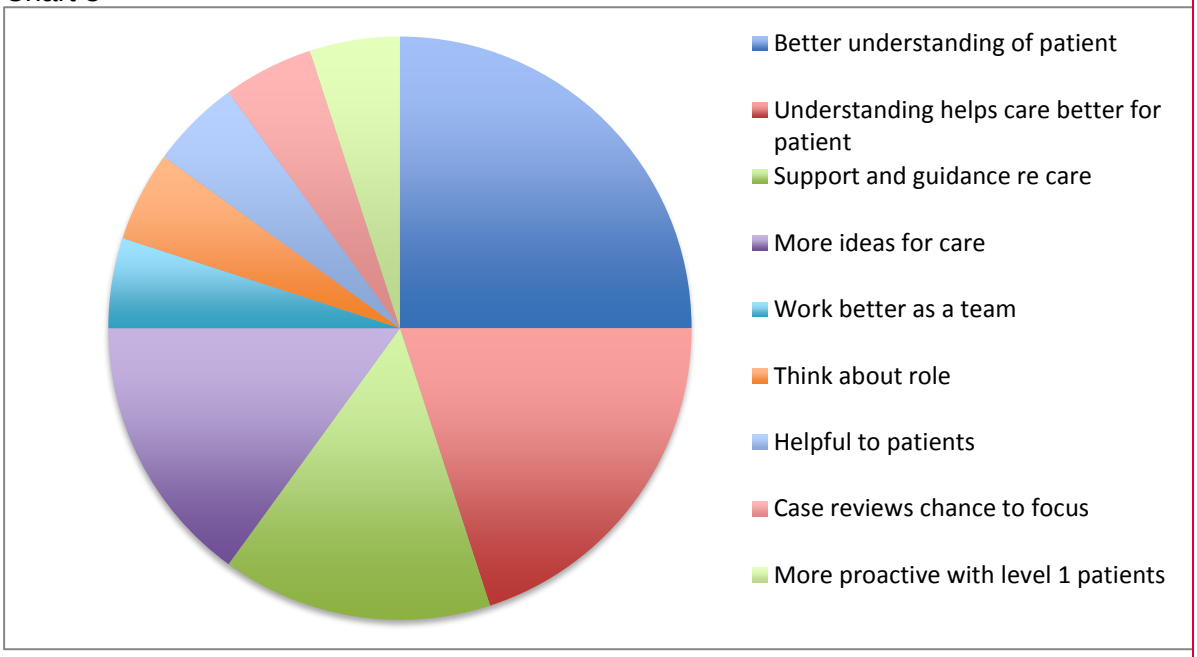
What contact have you had with Kate (Project Worker) whilst she has been rolling out the Enriched Model?

Chart 2



Do you think the EM is helpful and if so why?

Chart 3



Focus groups were also ran on both wards using the Morgan and Kruger (1998) method to develop questions and moderate responses.

Three male staff members attended on Coleman; 2 HCSWs and 1 trainee assistant practitioner.

Four female staff attended on Wakerley (all HCSW).

Both groups were asked the following questions, which generated example responses below:

1. Has working with the Enriched Model been useful and how have you noticed that?

"Case reviews most important, a chance for everyone to share…**to be able to pass on our knowledge and be heard (previously lost) and valued.**"

"Everyone having the same understanding, working from the same place"

"Different now; in the past the person was the illness, **now with the Enriched Model we look at the person behind the illness**"
"It's a big change for some staff"
"**We need to be pushed more to use the EM**"
"**It's how we work now but hard when we struggle with staffing**"
"**Better than the old way, the more you know the better you can help**"
"Think more about personality, mine and the patient's"
"We have always had ABC charts but not used them properly. It's better for myself and for the patient**. Understanding more (using the EM) means you can spot triggers or patterns because you know the person**"
"We can work in a more holistic way because we're thinking about more than just their dementia"
"It helps knowing the Enriched Model to use the new discharge checklist"
"We're better with personal care because we understand we need to talk to the patient about what we are doing and show them respect" – example given of very private, ex professional career patient previously resistant to personal care responding more positively using the enriched model.(Example given by staff member previously task focused)
"Joint working has been good."
"**Finally some respect for our skills**, what we know about the patient or their family is being listened to, is being noticed"
"(using the EM) it's better for the patient and my shift goes by quicker!"

2. Why do you think it's important to work in this way?

"If I was a patient I would want them to know me, that I'm more than the illness"
"The more you know and understand the quicker you can help them feel better"
"Start with the person and their stories"
"Care and compassion are better than any drug"
The staff were also asked to rate their morale pre and post project, and some of the comments from the focus groups suggest that the project has an impact on the improvement seen in Chart 4:

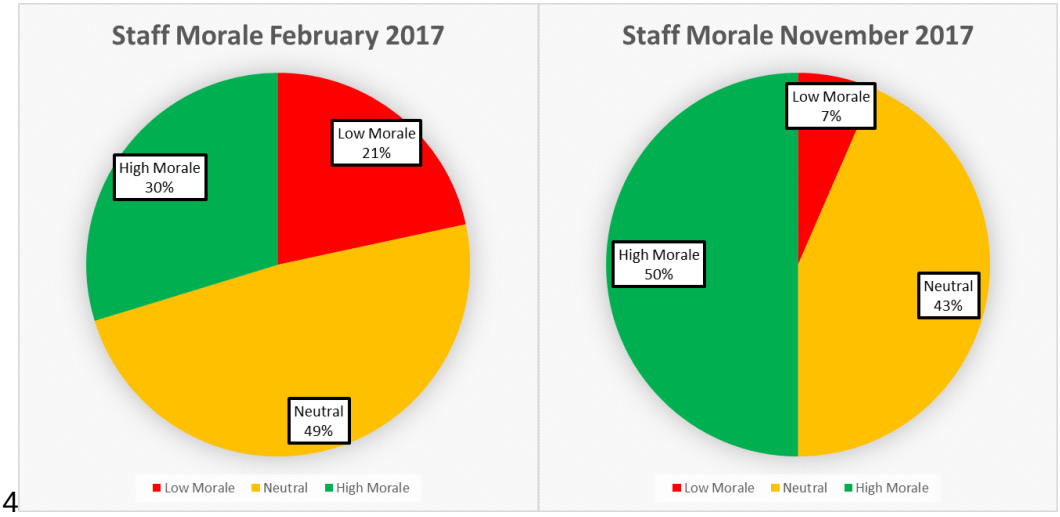


Chart 4

Ward matrons, inpatient matron and deputy head of service and a consultant psychiatrist were also interviewed for feedback and were asked the following questions, with responses:

1. Do you think staff have found the EM useful?

Problems with the way it was rolled out with a slow start
More could have been done to disseminate using link nurses
I've not seen any working alongside staff (modelling)

It has not been mentioned by staff in supervision and not seen modelling on the ward so it's difficult to comment
Not seen modelling or advising in practice
We're not seeing the EM language in care plans the way we do with safeguarding
Expectations of the role have not been met and involvement in incidents has had to be prompted
Tension between the Health Foundation contract and the needs of the service acknowledged
Staff benefit from the case reviews and definitely relate to the model
Very much so, I've been to 3 case reviews, regarding 2 of my patients and a review session
My impression is positive, rather than scrabble for information staff are analytical and develop a real understanding about the patient
It's useful to have the HCSW present as they often know things about the patient that qualified staff may not be aware of
Makes staff think more about the reasons for behaviour
Junior doctors often lose sight of those factors at admission that are relevant to patient issues; families come back with the same concerns
To take it forward elements of the EM need to be combined with the Ward Round, analysis of behaviour and how best to respond using that information

2. Do you think it's important to work in this way?

It's unfortunate that the roll out has been in isolation
There have been missed opportunities to discuss the project at New Ways of Working / Matrons meetings and Governance meetings
It's a big benefit for the patient
It influences staff understanding which improves the patient experience
It's very important for staff to have a range of approaches in their toolkit and has to help
Very committed to the model to enhance staffs timely and proactive response to patient needs
Need to move away from silo working to integrated practice across professional groups on the wards
It's raising standards of care on the wards
It's focused on individual patient needs and not generic
Gives a more helpful view of our work for students
Timing of case reviews should be within 2-4 weeks of admission rather than defaulting to long term cases
In the long term the Enriched Model should be incorporated with Ward Round

Outcome 4:

Monthly governance data was analysed to look for any patterns or changes during the course of the project. Analysis of falls and violent incidents did not show any significant changes over the period of the project (see Chart 5). Individual data was collected for patients who were put into 3 different groups:

- patients admitted in between January 2015 to December 2016 (n = 12), staff trained but model not embedded (control group A)
- patients admitted after January 2017 to date (n = 12), but not subject to direct involvement from project worker (control group B)
- patients admitted after Jan 2017 to date (n = 17) and subject to involvement from project worker (patient group C)

There was no real difference in the number of falls per patient in any of the groups. Both groups B and C had less violent incidents per patient compare to patients in group A, who had been admitted prior to the project starting (see Chart 6 December 2016 to September 2017))

Chart 5

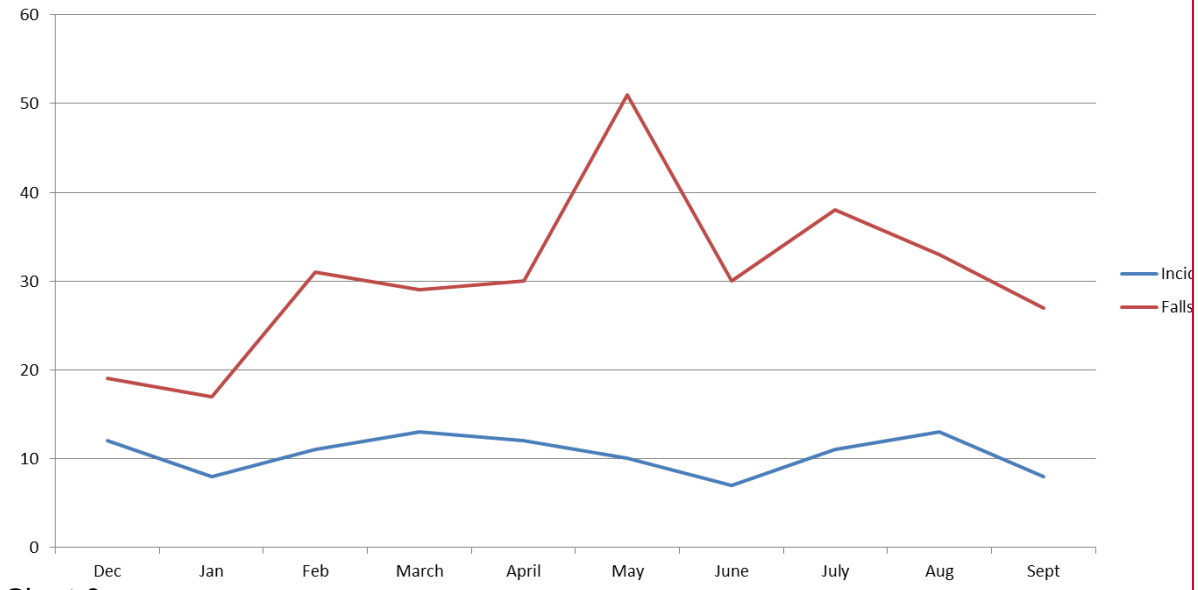
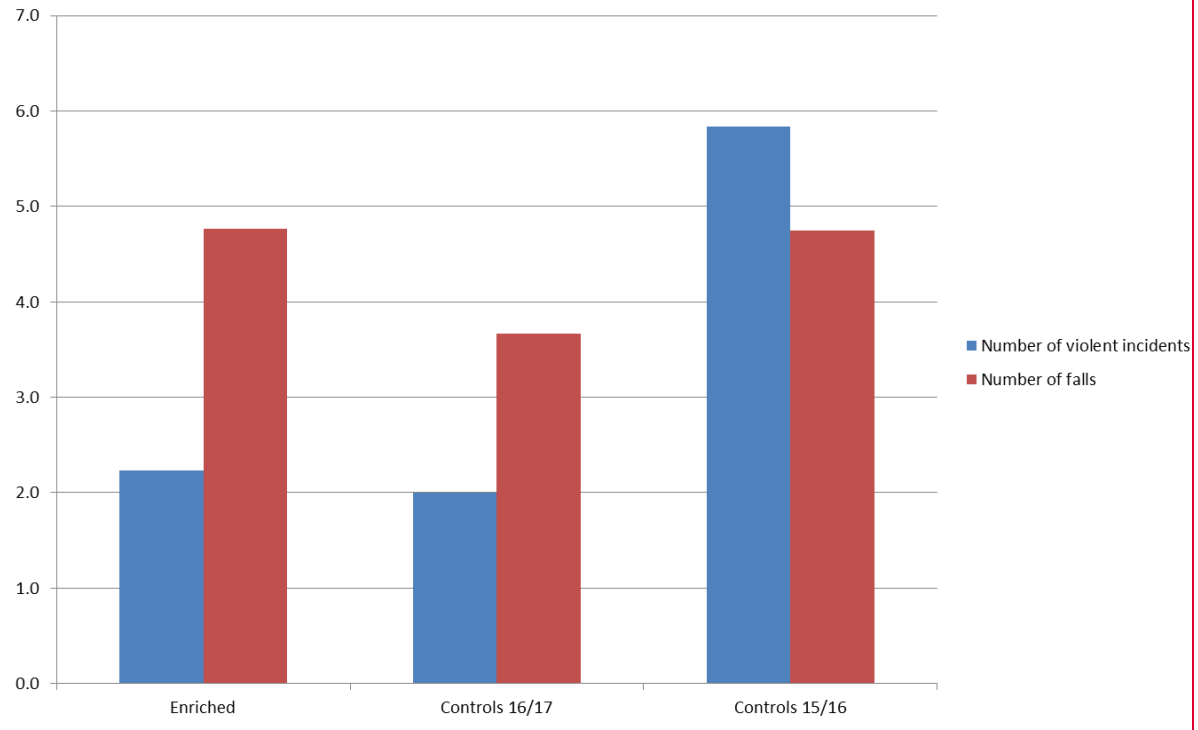


Chart 6

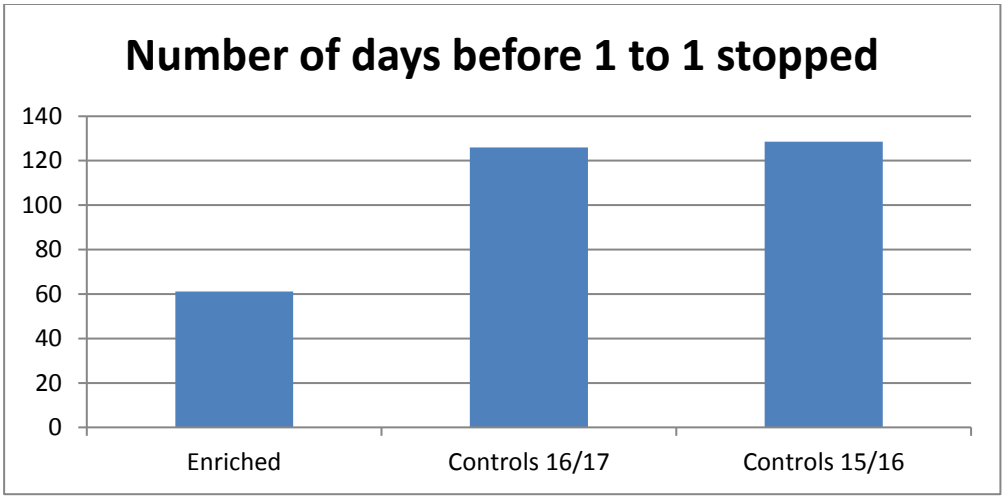


Outcome 5:

In order to look at whether the project had an impact on the number of 1 to 1 observations, the average number of days that patients in each group spent on 1 to 1 observations was calculated. The total number of 1 to 1 shifts that occurred during the course of the project was also plotted and analysed.

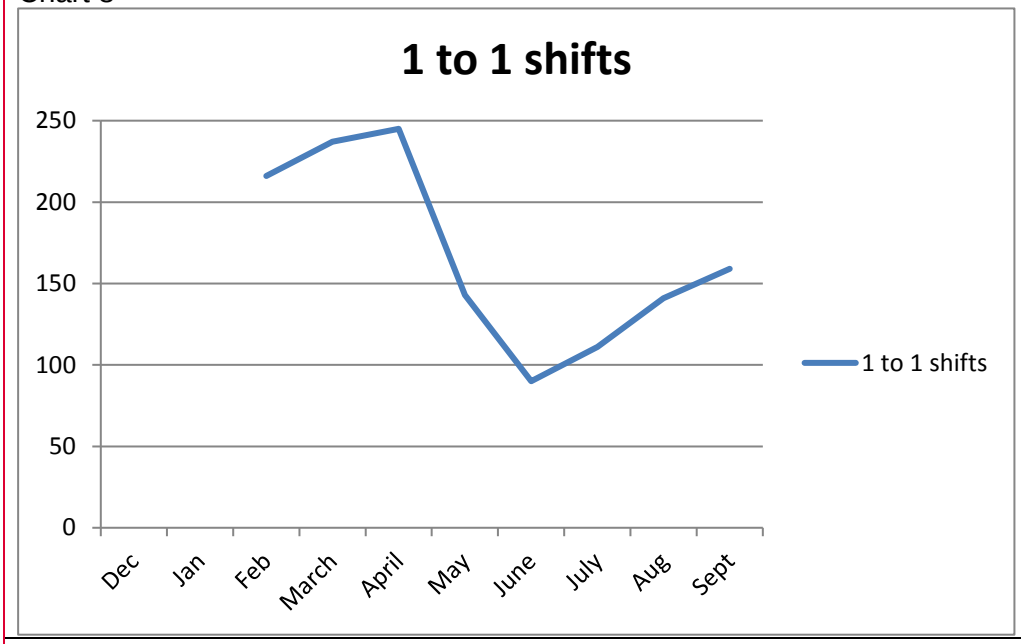
The patients in group C, who had direct input from the Project Worker, on average, spent around 70 days less on 1 to 1 observations during the course of their admission, than patients in both group A and group B (see Chart 7).

Chart 7



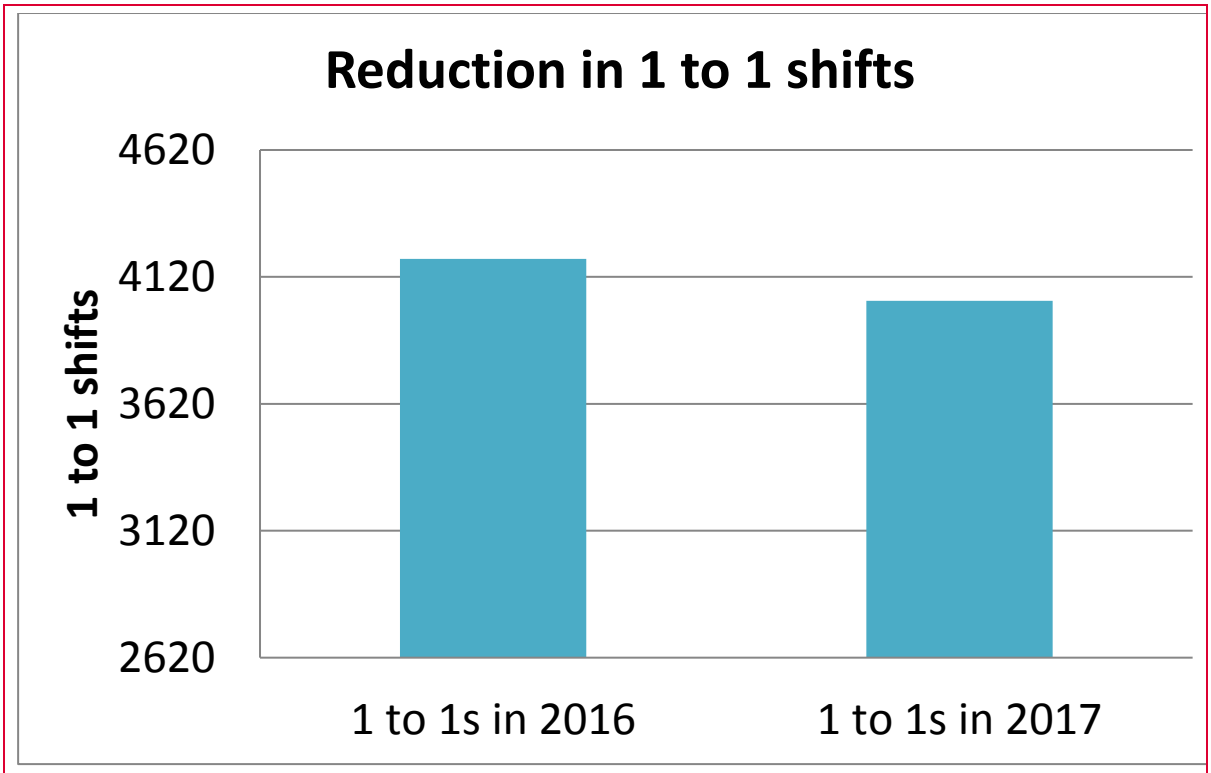
A reduction in the total number of 1 to 1 shifts required across both wards was also seen during the course of the project (see Chart 8).

Chart 8



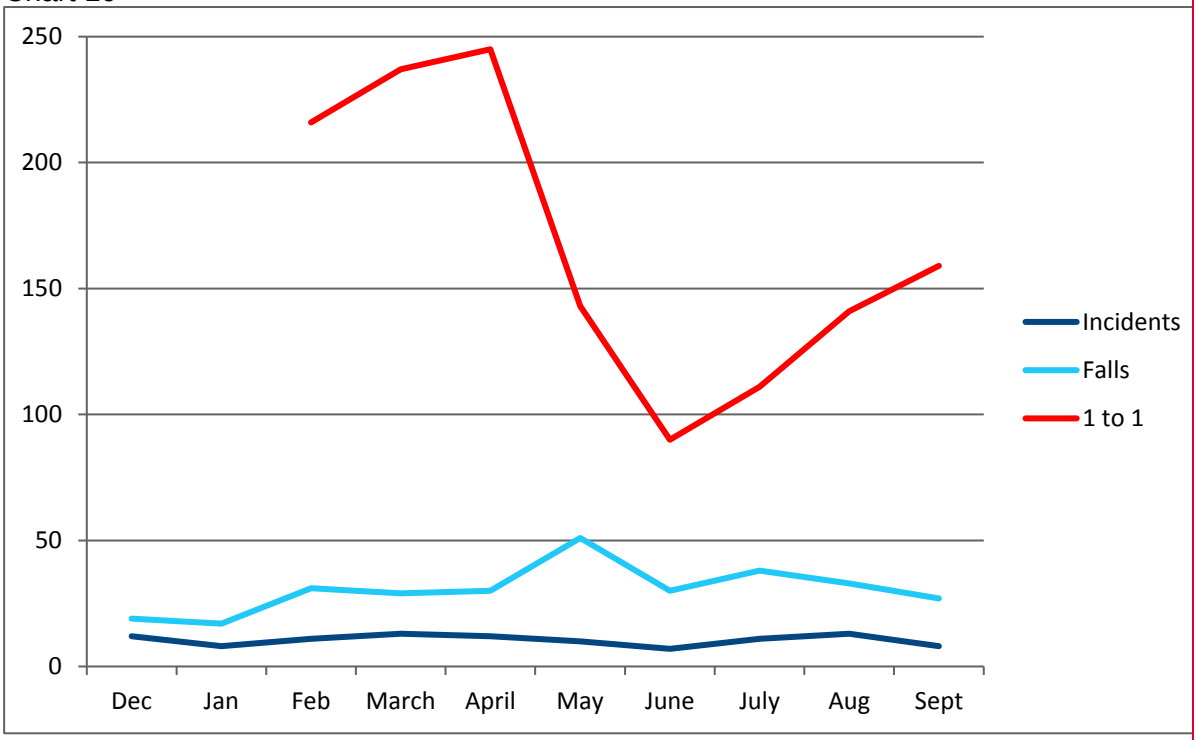
And, when compared to the same 8 months during the previous year, the total number of 1 to 1 shifts was 165 less than the 8 month period of the project (see Chart 9). Over a 12 month period, this would equate to £31,930 saving in Bank Band 2 spend.

Chart 9



Importantly, even with the reduction in 1 to 1 shifts, the numbers of incidents and falls have not increased, demonstrating that safety has been maintained despite this (see Chart 10).

Chart 10



Outcome 6:

We were unable to find a way of reliably measuring the changes in quality of care plans and with advice from the Health Foundation consultant we have not pursued this.

Outcome 7:

There was no demonstrable effect on length of stay (LOS) or delayed discharges. Analysis did show however that in many cases, the anecdotal belief that we were unable to find placements for challenging patients was false and that actually, the whole process has numerous steps, all with multiple delays between these steps that cumulatively add up to delays.

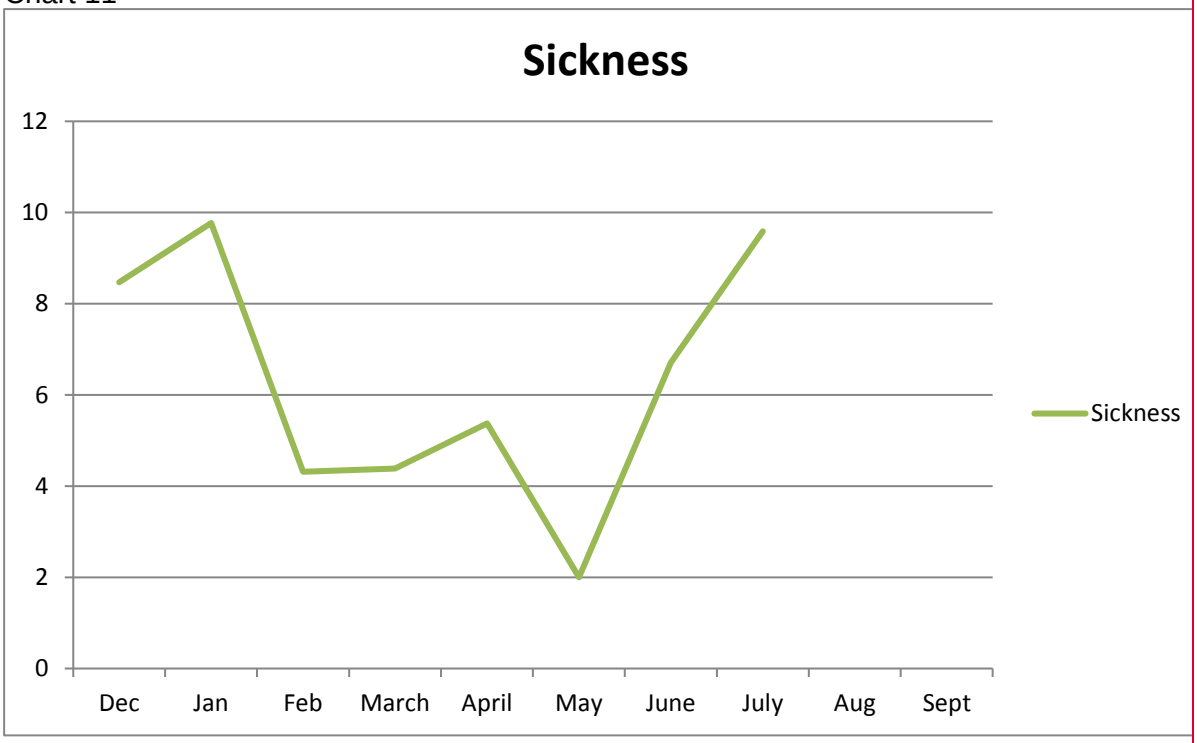
Outcome 8:

This data analysis is not available for this report, but can be produced with the data collected already.

Outcome 9:

Despite an improvement in staff morale, data so far does not suggest any impact on staff sickness levels (see Chart 11), but I have yet to receive figures for August and September.

Chart 11



Outcome 10:

We do have examples of patient stories to share, that demonstrate some of the changes effected by the project, but have not included them in this paper.

Summary

We have evidenced;

- A change in staff knowledge being able to articulate application and actions rather than just tokenistic statements ("I gained a better understanding of the reasons behind behaviour changes associated with dementia and possible ways to managed them" vs. "It made me aware of patient needs").
- Raised standards of care evidenced through PD / PE observations.
- Increased engagement with the model that was not achieved by training alone, and a real desire from staff to continue with it.
- A cost saving with a projection of £32k over the course of a year and ongoing initiatives regarding reduction in Level 1 observation.
- A contribution to staff well-being and potentially retention through their stated enthusiasm and engagement with the Enriched Model way of working

Moving forward

Learning from the feedback we have received alongside the outcomes that were evaluated, for the remainder of the project, we would like to:

- Engage the Band 5,6,7 and 8 staff with the project, as it has been targeted mainly at Band2 staff so far. Presenting results at the matron's meeting and the Project Worker working more directly with Band 5 and 6's on the wards.
- Meet with the MDT to discuss how to promote and integrate the model into ward rounds.
- Look at how the model can assist on discharge planning and passing information to care homes.
- Meet with In Reach to consider how to disseminate within the service.
- Consider dissemination on a wider level.
- Ongoing evaluation.

Options for the future

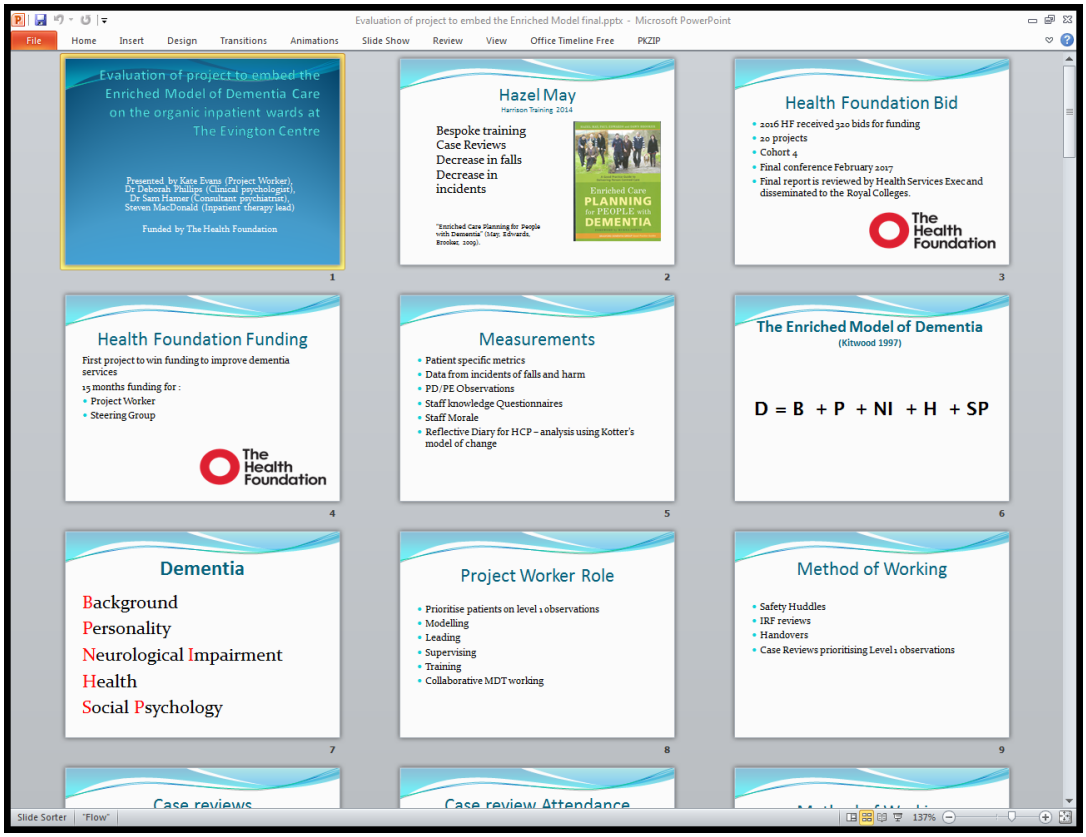
1. Return to pre-project status, with ongoing training for staff, but no Project Worker. The engagement with the model may be maintained by existing staff.
2. Service to continue to fund the Project Worker, to maintain the engagement and promotion of the model. Cost pressure will be an issue.
3. Management team to look at other models of maintaining the engagement of staff in the Enriched Model. For further discussion.

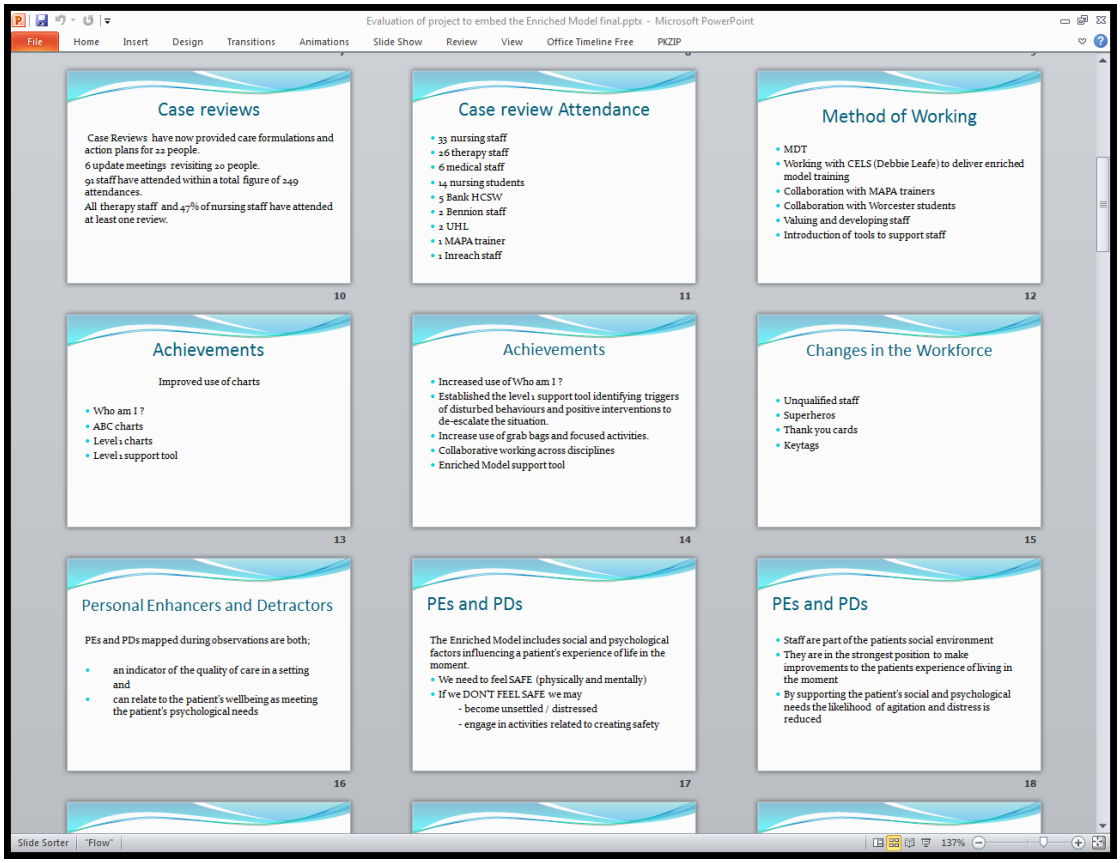
Anonymised Case Review example:

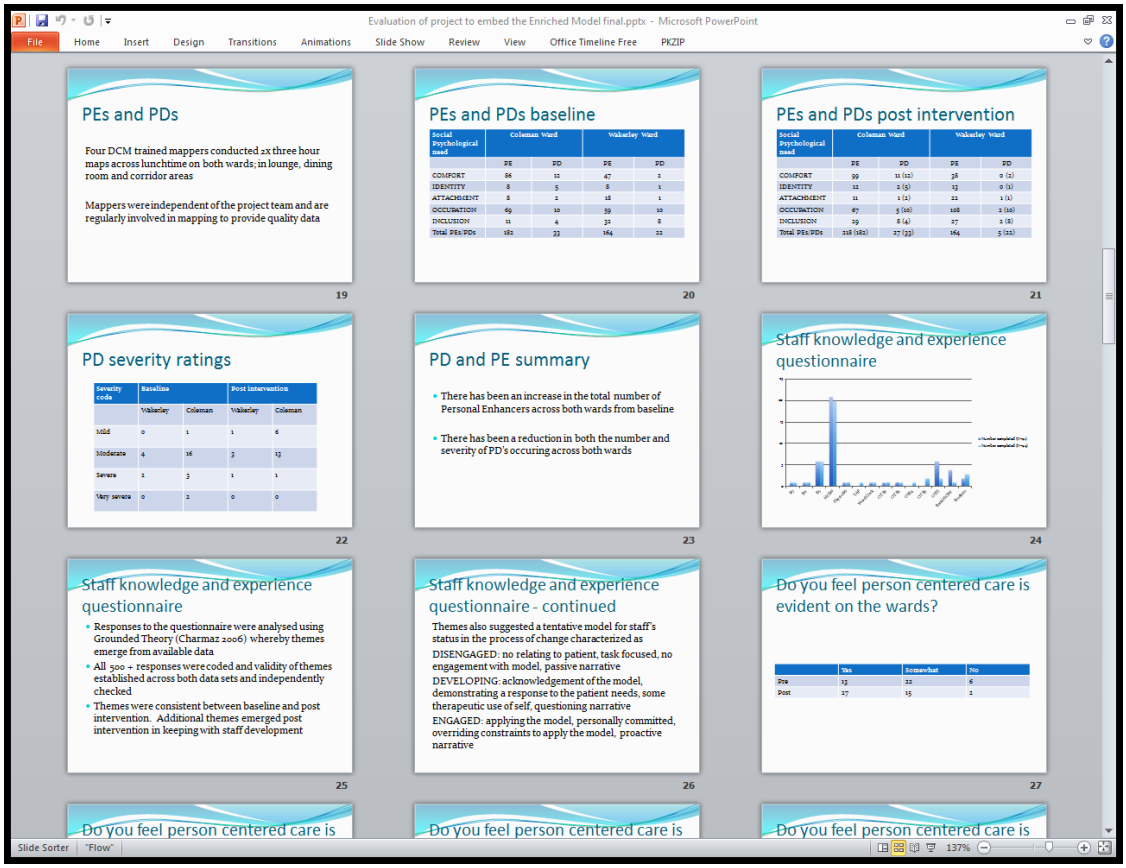
Enriched model summary

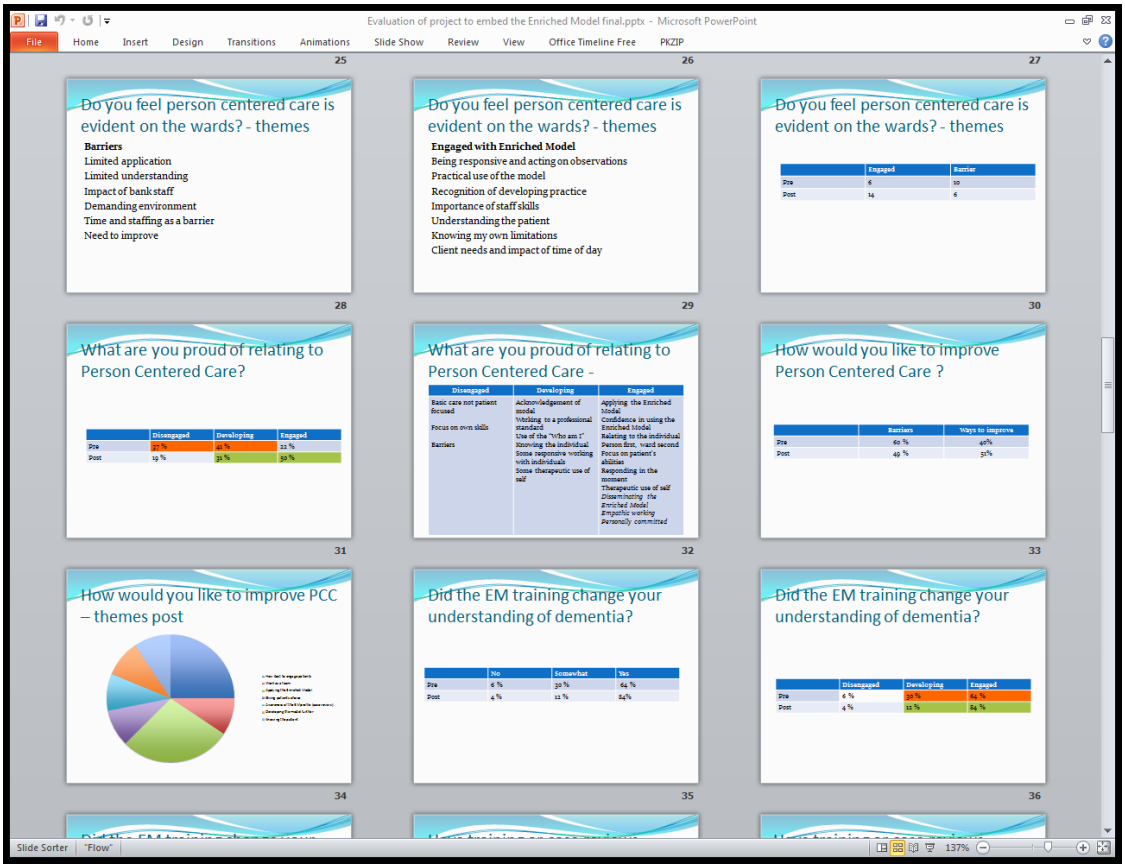
- A summary of the Enriched Model of Dementia Case Review which was held on the 27th of March for Patient B has been uploaded as a document onto RiO.
- This includes considering Patient B's background, personality, health, neurological impairments and social psychology. From this, some points to consider during care planning have been identified.
- The action points identified from the discussion were:
- Listening to audiobooks may be something Patient B would enjoy and may serve to calm him when agitated. Perhaps starting with listening to an audiobook on the CD player in his room and if this works well to invest in headphones for Patient B.
- To review level one observation level as staff report Patient B seems significantly more settled than when he arrived, especially in the morning. Not being on a 1-1 potentially gives us more of an opportunity to observe his interactional capabilities and how he meets his own needs.
- To continue a high level of engagement with Patient B as the level 1 observations reduce.
- Given Patient B's hearing difficulties and his visual problems, considering alternative methods of sensory engagement may be beneficial, which may include access to a guitar, visual material to do with travelling or his time in the RAF.
- Therapy staff to liaise with the in-reach team and the care home Patient B was previously in to ascertain what was in their sensory room that helped to calm Patient B.
- Sanaa to speak to Patient B's son, M, to engage him in a more practical way and to maintain a link to include him in Patient B's care. Offer M the opportunity to meet with the medical staff without having to come onto the ward. Try to get some photographs and some more specific information which will reflect the specificity of Patient B's interests with a view to creating a memory box.

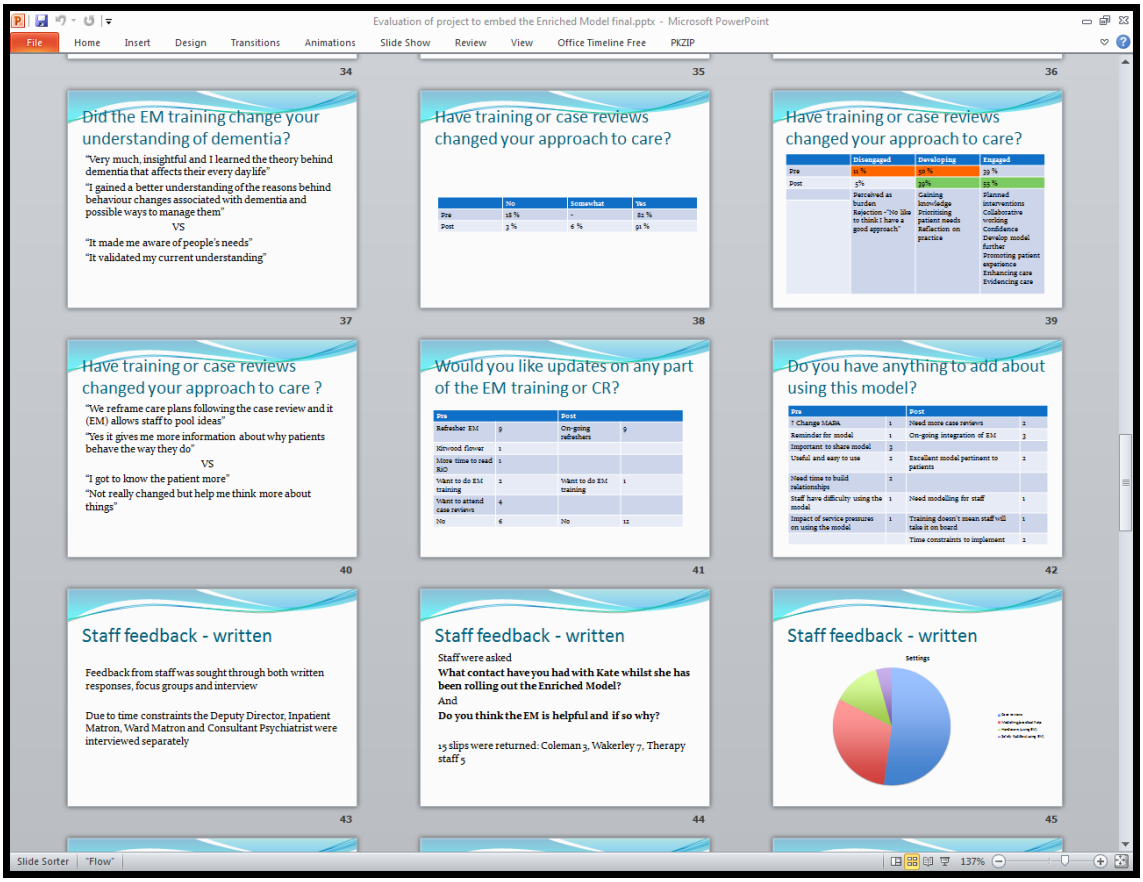
Power point presentation delivered to Mental Health Services for Older People's Clinical Network on 07/11/2017:

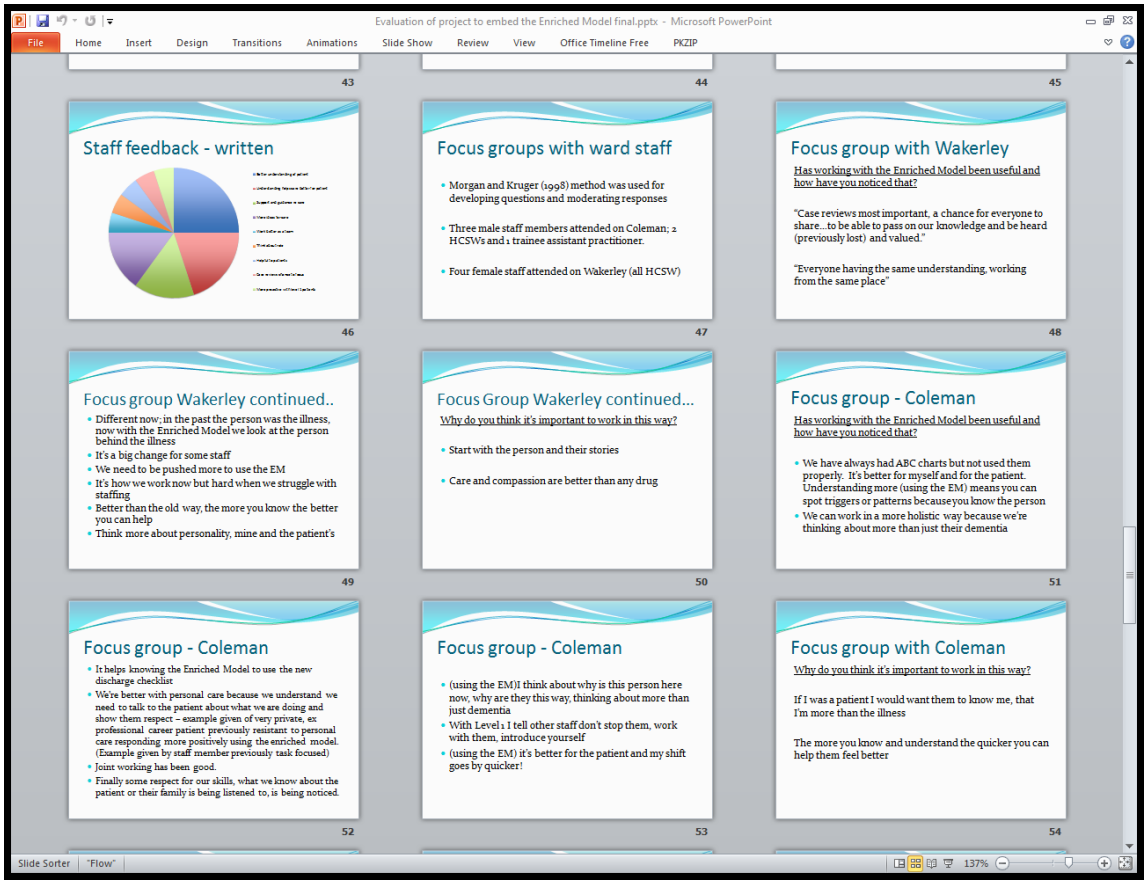


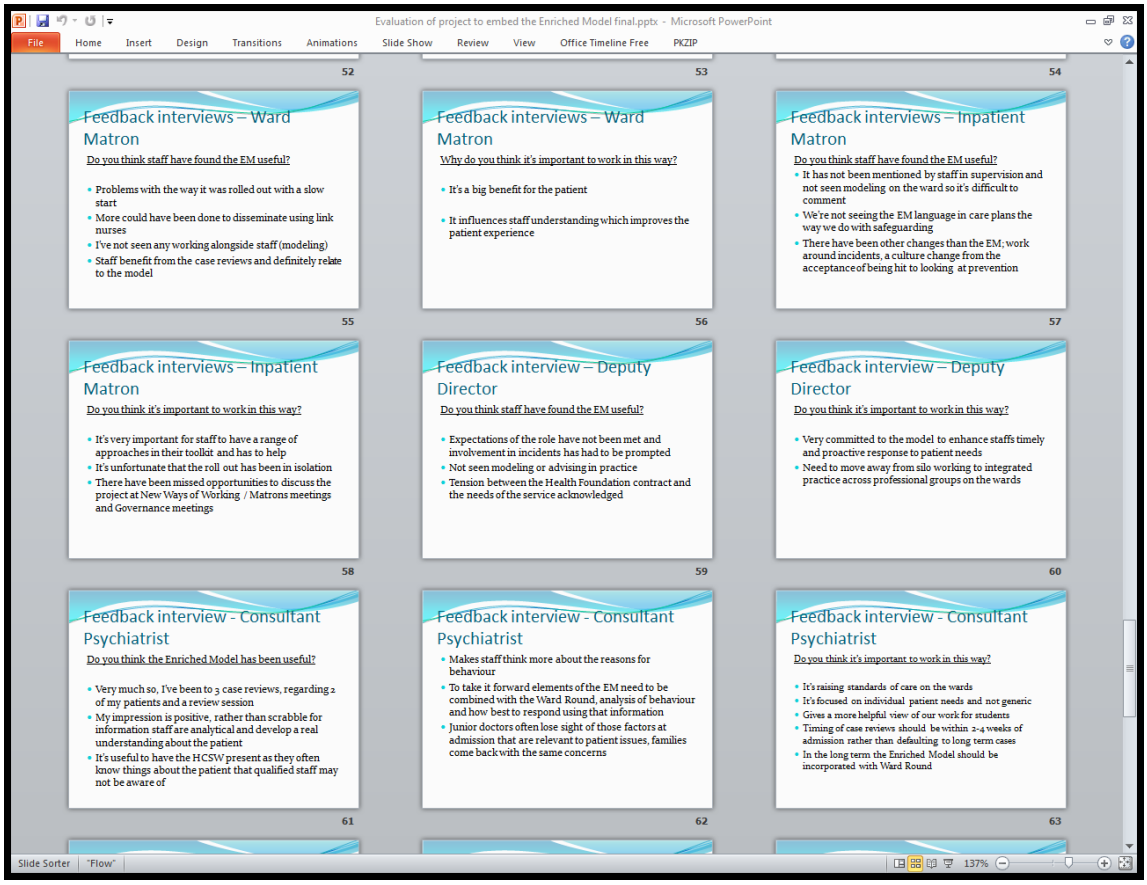

Evaluation of project to embed the Enriched Model final.pptx - Microsoft PowerPoint
Case reviews
Case Reviews have now provided care formulations and action plans for 22 people.
6 update meetings revisiting 20 people.
91 staff have attended within a total figure of 249 attendances.
All therapy staff and 47% of nursing staff have attended at least one review.
10
Case review Attendance
33 nursing staff
26 therapy staff
6 medical staff
14 nursing students
5 Bank HCSW
2 Bennion staff
2 UHL
1 MAPA trainer
1 Inreach staff
11
Method of Working
MDT
Working with CELS (Debbie Leafe) to deliver enriched model training
Collaboration with MAPA trainers
Collaboration with Worcester students
Valuing and developing staff
Introduction of tools to support staff
12
Achievements
Improved use of charts
Who am I ?
ABC charts
Level 1 charts
Level 1 support tool
13
Achievements
Increased use of Who am I ?
Established the level 1 support tool identifying triggers of disturbed behaviours and positive interventions to de-escalate the situation.
Increase use of grab bags and focused activities.
Collaborative working across disciplines
Enriched Model support tool
14
Changes in the Workforce
Unqualified staff
Superheros
Thank you cards
Keytags
15
Personal Enhancers and Detractors
PEs and PDs mapped during observations are both;
an indicator of the quality of care in a setting and
can relate to the patient's wellbeing as meeting the patient's psychological needs
16
PEs and PDs
The Enriched Model includes social and psychological factors influencing a patient's experience of life in the moment.
We need to feel SAFE (physically and mentally)
If we DON'T FEEL SAFE we may
- become unsettled / distressed
- engage in activities related to creating safety
17
PEs and PDs
Staff are part of the patients social environment
They are in the strongest position to make improvements to the patients experience of living in the moment
By supporting the patient's social and psychological needs the likelihood of agitation and distress is reduced
18
Slide Sorter
"Flow"
137%

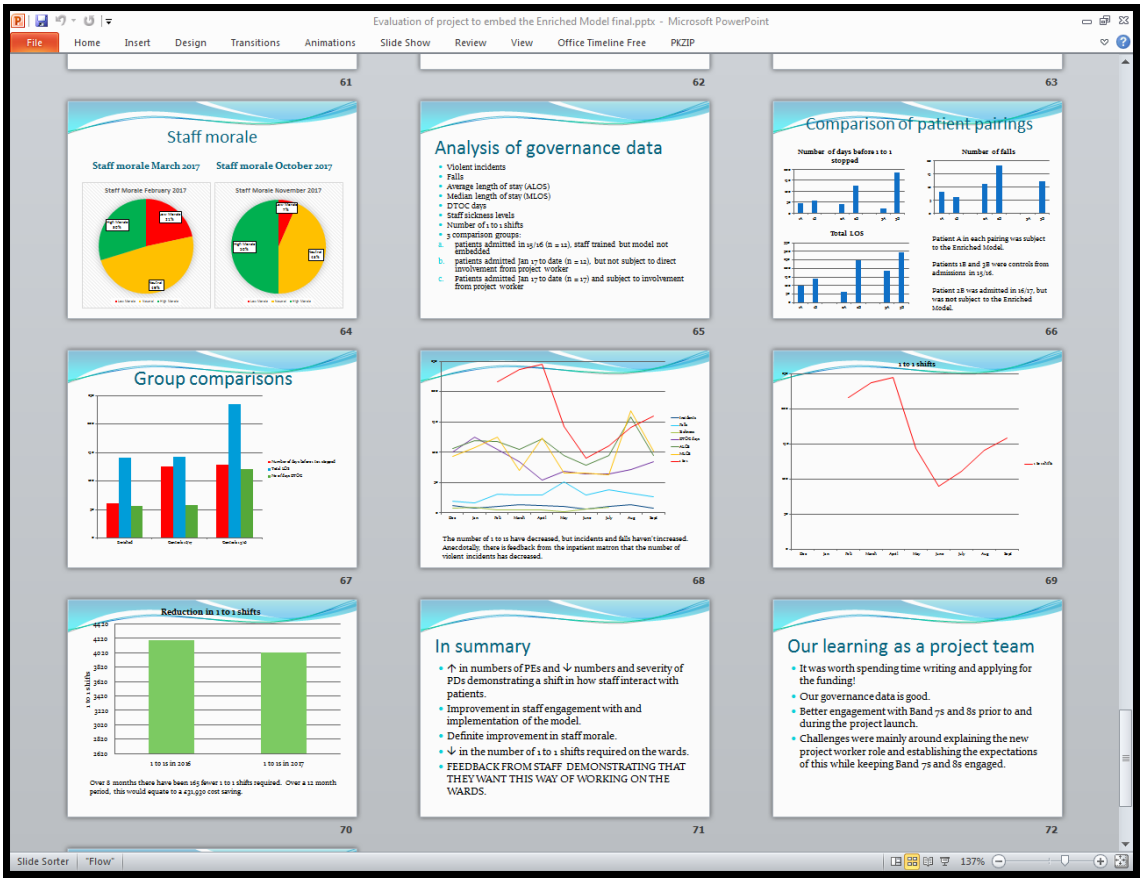

Evaluation of project to embed the Enriched Model final.pptx - Microsoft PowerPoint
PEs and PDs
Four DCM trained mappers conducted 2x three hour maps across lunchtime on both wards; in lounge, dining room and corridor areas
Mappers were independent of the project team and are regularly involved in mapping to provide quality data
19
PEs and PDs baseline
20
PEs and PDs post intervention
21
PD severity ratings
22
PD and PE summary
There has been an increase in the total number of Personal Enhancers across both wards from baseline
There has been a reduction in both the number and severity of PD's occuring across both wards
23
Staff knowledge and experience questionnaire
24
Staff knowledge and experience questionnaire
Responses to the questionnaire were analysed using Grounded Theory (Charmaz 2006) whereby themes emerge from available data
All 500 + responses were coded and validity of themes established across both data sets and independently checked
Themes were consistent between baseline and post intervention. Additional themes emerged post intervention in keeping with staff development
25
Staff knowledge and experience questionnaire - continued
Themes also suggested a tentative model for staff's status in the process of change characterized as
DISENGAGED: no relating to patient, task focused, no engagement with model, passive narrative
DEVELOPING: acknowledgement of the model, demonstrating a response to the patient needs, some therapeutic use of self, questioning narrative
ENGAGED: applying the model, personally committed, overriding constraints to apply the model, proactive narrative
26
Do you feel person centered care is evident on the wards?
27
Do you feel person centered care is
Do you feel person centered care is
Do you feel person centered care is
Slide Sorter
"Flow"
137%


Evaluation of project to embed the Enriched Model final.pptx - Microsoft PowerPoint
25
Do you feel person centered care is evident on the wards? - themes
Barriers
Limited application
Limited understanding
Impact of bank staff
Demanding environment
Time and staffing as a barrier
Need to improve
26
Do you feel person centered care is evident on the wards? - themes
Engaged with Enriched Model
Being responsive and acting on observations
Practical use of the model
Recognition of developing practice
Importance of staff skills
Understanding the patient
Knowing my own limitations
Client needs and impact of time of day
27
Do you feel person centered care is evident on the wards? - themes
28
What are you proud of relating to Person Centered Care?
29
What are you proud of relating to Person Centered Care -
30
How would you like to improve Person Centered Care ?
31
How would you like to improve PCC – themes post
32
Did the EM training change your understanding of dementia?
33
Did the EM training change your understanding of dementia?
34
35
36


Evaluation of project to embed the Enriched Model final.pptx - Microsoft PowerPoint
34
35
36
Did the EM training change your understanding of dementia?
"Very much, insightful and I learned the theory behind dementia that affects their every day life"
"I gained a better understanding of the reasons behind behaviour changes associated with dementia and possible ways to manage them"
VS
"It made me aware of people's needs"
"It validated my current understanding"
37
Have training or case reviews changed your approach to care?
38
Have training or case reviews changed your approach to care?
39
Have training or case reviews changed your approach to care ?
"We reframe care plans following the case review and it (EM) allows staff to pool ideas"
"Yes it gives me more information about why patients behave the way they do"
VS
"I got to know the patient more"
"Not really changed but help me think more about things"
40
Would you like updates on any part of the EM training or CR?
41
Do you have anything to add about using this model?
42
Staff feedback - written
Feedback from staff was sought through both written responses, focus groups and interview
Due to time constraints the Deputy Director, Inpatient Matron, Ward Matron and Consultant Psychiatrist were interviewed separately
43
Staff feedback - written
Staff were asked
What contact have you had with Kate whilst she has been rolling out the Enriched Model?
And
Do you think the EM is helpful and if so why?
15 slips were returned: Coleman 3, Wakerley 7, Therapy staff 5
44
Staff feedback - written
45


Evaluation of project to embed the Enriched Model final.pptx - Microsoft PowerPoint
File Home Insert Design Transitions Animations Slide Show Review View Office Timeline Free PKZIP
43
44
45
Staff feedback - written
46
Focus groups with ward staff
Morgan and Kruger (1998) method was used for developing questions and moderating responses
Three male staff members attended on Coleman; 2 HCSWs and 1 trainee assistant practitioner.
Four female staff attended on Wakerley (all HCSW)
47
Focus group with Wakerley
Has working with the Enriched Model been useful and how have you noticed that?
"Case reviews most important, a chance for everyone to share...to be able to pass on our knowledge and be heard (previously lost) and valued."
"Everyone having the same understanding, working from the same place"
48
Focus group Wakerley continued..
Different now; in the past the person was the illness, now with the Enriched Model we look at the person behind the illness
It's a big change for some staff
We need to be pushed more to use the EM
It's how we work now but hard when we struggle with staffing
Better than the old way, the more you know the better you can help
Think more about personality, mine and the patient's
49
Focus Group Wakerley continued...
Why do you think it's important to work in this way?
Start with the person and their stories
Care and compassion are better than any drug
50
Focus group - Coleman
Has working with the Enriched Model been useful and how have you noticed that?
We have always had ABC charts but not used them properly. It's better for myself and for the patient. Understanding more (using the EM) means you can spot triggers or patterns because you know the person
We can work in a more holistic way because we're thinking about more than just their dementia
51
Focus group - Coleman
It helps knowing the Enriched Model to use the new discharge checklist
We're better with personal care because we understand we need to talk to the patient about what we are doing and show them respect – example given of very private, ex professional career patient previously resistant to personal care responding more positively using the enriched model. (Example given by staff member previously task focused)
Joint working has been good.
Finally some respect for our skills, what we know about the patient or their family is being listened to, is being noticed.
52
Focus group - Coleman
(using the EM)I think about why is this person here now, why are they this way, thinking about more than just dementia
With Level 1 I tell other staff don't stop them, work with them, introduce yourself
(using the EM) it's better for the patient and my shift goes by quicker!
53
Focus group with Coleman
Why do you think it's important to work in this way?
If I was a patient I would want them to know me, that I'm more than the illness
The more you know and understand the quicker you can help them feel better
54
Slide Sorter "Flow" 137%


Evaluation of project to embed the Enriched Model final.pptx - Microsoft PowerPoint
File Home Insert Design Transitions Animations Slide Show Review View Office Timeline Free PKZIP
52
53
54
Feedback interviews – Ward Matron
Do you think staff have found the EM useful?
Problems with the way it was rolled out with a slow start
More could have been done to disseminate using link nurses
I've not seen any working alongside staff (modeling)
Staff benefit from the case reviews and definitely relate to the model
55
Feedback interviews – Ward Matron
Why do you think it's important to work in this way?
It's a big benefit for the patient
It influences staff understanding which improves the patient experience
56
Feedback interviews – Inpatient Matron
Do you think staff have found the EM useful?
It has not been mentioned by staff in supervision and not seen modeling on the ward so it's difficult to comment
We're not seeing the EM language in care plans the way we do with safeguarding
There have been other changes than the EM; work around incidents, a culture change from the acceptance of being hit to looking at prevention
57
Feedback interviews – Inpatient Matron
Do you think it's important to work in this way?
It's very important for staff to have a range of approaches in their toolkit and has to help
It's unfortunate that the roll out has been in isolation
There have been missed opportunities to discuss the project at New Ways of Working / Matrons meetings and Governance meetings
58
Feedback interview – Deputy Director
Do you think staff have found the EM useful?
Expectations of the role have not been met and involvement in incidents has had to be prompted
Not seen modeling or advising in practice
Tension between the Health Foundation contract and the needs of the service acknowledged
59
Feedback interview – Deputy Director
Do you think it's important to work in this way?
Very committed to the model to enhance staffs timely and proactive response to patient needs
Need to move away from silo working to integrated practice across professional groups on the wards
60
Feedback interview - Consultant Psychiatrist
Do you think the Enriched Model has been useful?
Very much so, I've been to 3 case reviews, regarding 2 of my patients and a review session
My impression is positive, rather than scrabble for information staff are analytical and develop a real understanding about the patient
It's useful to have the HCSW present as they often know things about the patient that qualified staff may not be aware of
61
Feedback interview - Consultant Psychiatrist
Makes staff think more about the reasons for behaviour
To take it forward elements of the EM need to be combined with the Ward Round, analysis of behaviour and how best to respond using that information
Junior doctors often lose sight of those factors at admission that are relevant to patient issues, families come back with the same concerns
62
Feedback interview - Consultant Psychiatrist
Do you think it's important to work in this way?
It's raising standards of care on the wards
It's focused on individual patient needs and not generic
Gives a more helpful view of our work for students
Timing of case reviews should be within 2-4 weeks of admission rather than defaulting to long term cases
In the long term the Enriched Model should be incorporated with Ward Round
63
Slide Sorter "Flow" 137%



Email from publisher:

From: Andrew James [andrew.james@jkp.com]
Sent: 15 November 2017 14:56
To: Evans Kathleen
Subject: Dementia Congress Follow up

Dear Kathleen,
It was lovely to meet with you at the congress last week, thanks for taking the time to talk.
I wanted to follow up and say I'd be very interested in developing a book project with you on change management and embedding training in the workforce and I've attached our proposal form here and put some information below about how publishing with us works and the next steps if you do want to pursue this.

For any project we consider, we need to base this on an assessment of a book proposal. The proposal should outline your vision for the project on what you are setting out to achieve with this book. It's always best to provide as much detail as possible in the proposal – especially chapter summaries, detail on the competition and how your book will sit alongside this and also the market and who the book is specifically for – as this will help speed up the process. I would strongly advise thinking carefully about the core market and who you envision the book being written for and tailoring your proposal with that audience in mind. For the competition, it's good to be detailed here too and consider how your book would complement existing titles but also how your book will significantly differ ie maybe your book will provide a very practical approach whereas existing books are more theoretical. I'd also add as much about your own platform in terms of social media presence or if you've written before etc.

Book proposals are provisional so we wouldn't expect all the writing to be firmed up and we would expect the ideas/focus to adapt throughout the writing process. We usually expect a manuscript to be submitted 12 – 18 months after the contract is signed and for proposals, there is no deadline for submitting these. I would also be able to look through a draft proposal and discuss possible book ideas in more detail.

We offer our authors a royalty on sales of the book (both paperback and eBook) and the initial offer is usually in the region of 8% - 10% with a potential riser based on numbers of copies sold (eg 8% rising to 10% after 5000 copies sold). We have offices in the UK & US and we have global distribution so the book would be available and sold worldwide. Our sales team would pitch the book to bookshops, wholesalers, organisations/associations and it would be stocked online via all major 3rd party outlets such as Amazon. We have a publicity and marketing team who would want to use your networks to help push the book and we would source reviews and press (such as interviews, blog posts, op eds) and we would promote the book via our social media accounts, catalogues and at conferences.

Do let me know if you have any questions.
Best wishes
Andrew

Senior Commissioning Editor
Jessica Kingsley *Publishers* – 30 years of books that make a difference 1987-2017
73 Collier Street, London, N1 9BE
andrew.james@jkp.com www.jkp.com
Tel: +44 (0) 20 7833 2307 Fax: +44 (0) 20 7837 2917

Level 1 support tool:

Care-plan summary sheet and prompt sheet for patients on Level 1 safe and Therapeutic Observations

This sheet is to be used to equip the member of staff doing Level 1 observations with quick prompts to help observations to be done safely and therapeutically.

This edition is a training aid with red print prompting the details to consider. Staff are asked to make entries identifying needs and what they expect colleagues to do to help the individual

Communication
how does person communicate? Mostly verbally/ non-verbally, are communication aids required? Do they respond to mime or body language ?

Psychological / emotional
How does the person interact with others? Are they looking for a familiar person ? Are they in a work pattern or family role ? Are they seeking reassurance ?

Nutrition
Does person manage full meals/cutlery ? Encourage frequent snacks, any choking risk? Do they sit for a meal or are they distracted / need prompts / physical assistance ?

Skin integrity Waterlow score: Any pressure area problems/ vascular problems/ wound care ?
Continence Any incontinence aids? Frequency of toileting times. What assistance / prompts do they need
Breathing Any problems with angina, breathlessness?
Drug therapies and medication does person accept meds readily / covert meds?
Altered states of consciousness / sleep Any history of seizures / TIAs / unresponsive episodes ? What is their sleep pattern ?. Does the person get out of bed immediately or lie in bed before getting up
General physical health summarise key problem areas the person may have
Mobility eg. Does person have a walking aid or need assistance ? is he/she a high falls risk
The 1:1 focus is on reducing and enhancing well being through safe and therapeutic observations:
At the start of the observation period: **Introduce yourself – explain who you are and why you will be observing the person for the next hour (eg. Hello, my name is…. Shall we do this (insert activity here) for the next hour or so…)** **Make yourself aware of the summary risks/care-plan on the reverse of this sheet.** **Make yourself aware of those things that the person enjoys doing** **Remember that the person has a right to not be involved in activities for the next hour…the important thing is that they are offered to him/her.** **If you have any concerns about the person, let the other staff know immediately.** **Make sure that you know what is on the person's 'Who-am-I' document**
Triggers note down the triggers that can lead to the person becoming frustrated eg noise / others invading their space / inability to communicate needs /time of day ?
Therapeutic interventions

note down those things that the person enjoys to do of a therapeutic nature
What can be done, therapeutically, to reduce the person's level of distress? How will this reflect in the person's behaviour? At what point do staff need to anticipate and defuse a problem ? what cues might they see ? Note down what tends to work best for the person.

Record if the therapeutic intervention(s) make a difference?

Photo of key fobs used:


Dementia
Background
Personality
Neurological Impairment
Health
Personal Detractors
&
Personal Enhancers
COMFORT
ATTACHMENT
ACKNOWLEDGEMENT : Recognising the participant as unique and valuing them as an individual
OCCUPATION
DISEMPOWERMENT : Not allowing a participant to use the abilities that they do have
IMPOSITION : Forcing a participant to do something, or denying them choice
IDENTITY
Superhero
Social Psychology
Our approach