Dementia care 3: evaluating the effects of wellbeing reviews on residents and staff

Wellbeing is now considered a crucial aspect of mental health. A continuing needs unit introduced a programme of reviews to improve quality of care.

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**ABSTRACT**


**Background**

This third in a three part series on dementia describes a pilot of weekly wellbeing reviews to discuss individual residents’ needs on a continuing care unit. Part 1 focused on communication and part 2 examined different approaches to care.

**Aim**

To evaluate the effects of wellbeing reviews on residents and staff.

**Method**

A pilot cycle of reviews (one review per resident) was carried out, and reports and comments from the reviews analysed.

**Results**

Staff appreciated being able to reflect on and discuss a single resident in depth.

**Conclusion**

Wellbeing reviews are a valuable addition to medically based ward rounds, with benefits for staff and residents.

**Background**

Ward rounds are a long standing practice intended to enhance quality of care (Manias and Street, 2000). However, as many older people now live on continuing needs units, their needs must be addressed holistically. These units care for people with long term mental health needs – both organic, such as dementia, and functional, such as anxiety and depression – that are too complex or challenging for nursing homes to manage.

Chenoweth et al (2009) emphasised the importance of person centred care, as they found it reduced agitation in people with dementia. Kitwood (1994) said that caring for people with dementia using a person centred approach should include addressing their neurological impairment, social environment and psychology, general health, personality and biography. The need to address these factors shows that the standard, medically orientated ward round is not sufficient for residents in a continuing needs unit. In addition, the National Audit Office (2007) found deficiencies in the use of person centred care in its care homes audit.

Many care homes and health professionals think they are practising person centred care, but Brooker (2004) pointed out that it has no universally agreed definition. However, it includes respecting dignity and addressing a person’s “social, emotional and occupational needs” (Bruce et al, 2002). Brooker (2004) divided person centred care into four main elements, called VIPs: V = “a value base that asserts the absolute value of all human lives”; I = “an individualised approach”; P = adopting the “perspective of the resident”; S = “providing a social environment that supports psychological needs”.

The need to use a person centred approach led to multidisciplinary team reviews of resident wellbeing being introduced on our continuing needs unit.

**What is wellbeing?**

Ensuring client wellbeing has become an increasing focus for mental health services, and is an important element of “good mental health” (Department of Health, 2009). However, the term is not well defined or understood.

For the purposes of the reviews, we adopted Bradford Dementia Group’s (2008) terminology: “wellbeing” is identified through signs that residents are “engaging with the world around them and experiencing positive feelings”; “illbeing” is recognised if residents are “withdrawing or disengaging from the world around them and experiencing negative feelings”.

**AIM AND METHOD**

Resident wellbeing reviews

A programme of reviews was introduced in March 2009 to ensure the wellbeing of residents and care staff. They were mainly set up by the psychology department and facilitated by psychologists and occupational therapists, but care staff and other members of the MDT were invited to attend.

The programme consisted of a protected one hour slot set aside specifically for the reviews and any staff member wishing to attend could do so. Each week was allocated to a different resident, allowing an in depth person centred discussion about them. Staff were asked to focus on that resident and address her/his specific wellbeing needs. They prepared and listened to an account of the resident’s journey to the unit, reflected on and discussed current indicators of wellbeing; any negative care practices, and generate any suggestions for improving residents’ wellbeing. The main aims were to:

- Allow care staff to explore and discuss current indicators of wellbeing;
- Identify signs of illbeing;
- Develop/embed person centred care planning and language into the unit’s culture;
- Remain focused on actions and solutions.

At the end of each review, the main action points and issues were summarised in the resident’s notes and staff communication book (a notebook for conveying messages among the team). Care plans were reviewed so staff could implement recommendations arising from the review. This ensured a record was kept of care practices and interventions discussed, so these could be monitored and reviewed in the next cycle of reviews.
Process analysis
The facilitators completed a process report immediately after each review. These documented the number of people who attended the review and their profession; staff concerns about the resident and their wellbeing; suggestions for improving their care; staff reflections about the review; reflections on group process themes and dynamics; and anything staff had learnt.

Once one cycle of reviews had been completed (one review per resident) the process reports and staff comments were analysed qualitatively using Braun and Clarke’s (2006) approach. Data was also quantified based on the frequency of discussion of an item during the cycle; for example, the number of times staff raised behaviour issues as challenging was recorded.

RESULTS
Our continuing needs unit is a 19 bed unit for men and women with severe and enduring mental health problems, including functional problems but predominantly dementia. The majority of residents also have physical health problems. It took 22 weeks to complete the cycle (three sessions were rescheduled).

Attendance varied from four to eight members of staff, with an average of 6.5 staff. Attendees were mainly nurses (including students) and healthcare assistants (Fig 1). A member of the psychology department attended all reviews, while the activities coordinator and OT staff both attended 13 (68%) and management attended 14 (74%). Both the “user voice” representative for older adults (a trust employee who represents service users and family supporters) and the trust’s risk adviser attended one review.

Doctors and physiotherapists did not attend, although reviews were open to all members of the MDT.

Review content
Reviews began by exploring staff opinions on residents’ wellbeing needs. Those that staff struggled to manage were discussed most:

- Challenging behaviour: aggression, agitation or inappropriate sexual behaviour; identifying reasons/triggers (previous and current); staff feeling afraid to intervene.
- Psychologically orientated: loss of role; lack of personal items; attachment needs; low mood; effects of institutionalisation; residents looking sad/distressed; lack of understanding about residents and their social history; recognising residents’ need for space/time alone.
- Communication: difficulty engaging residents in conversation; their limited communication; verbal abuse or racism towards staff; issues with English not being residents’ first language.
- Personal care: mainly on continence; residents’ dislike of receiving personal care.
- Stimulation: residents’ dislike of noise; showing institutionalised behaviours; a preference for certain types of stimulation.
- Family related issues: family understanding/view of residents’ health; encouraging family visits.
- Staff issues: feeling frustrated/useless; dynamics between different staff roles.
- Other: issues with eating and drinking; falls/mobility concerns; sleep problems.

Staff concerns about residents’ wellbeing were:

- Person centred care: needing to engage with residents to increase interaction; staff needing to enhance understanding about residents and their social history; for example by increasing family involvement in care and personalising of bedrooms.
- Behaviours perceived as challenging: the impact of residents’ behaviour on others and the risk of either of them being hurt; suicide risk; triggers for challenging behaviour; ways to de-escalate challenging situations.
- General wellbeing: residents’ need for stimulation; the link between physical and mental health; families’ wellbeing; effect of incontinence on socialisation; no signs of illbeing identified.
- General care: promoting good sleep; improving approaches to personal care; finding appropriate care strategies; issues with eating and drinking.
- Empowerment: needing to reduce residents’ distress; improving quality of life; encouraging independence; improving mobility/reducing risk of falls.

Staff reflections on what they had learnt during the reviews were:

- Enhanced knowledge and understanding of residents; increased awareness/recognising the need to increase knowledge about residents and their social history, likes and dislikes; more understanding of residents and their behaviours; needing to engage/interact more with them; needing to offer choices; needing to ensure care is holistic.
- Care practices: how to recognise when residents are settled and safe; acknowledging when positive/good care is already in place; ways to improve care; involving family in care planning, and allowing staff to have input into this by discussing a resident’s care at length and sharing any concerns.
- Recognising possible triggers/reasons for challenging behaviours and identifying the need for training on methods to de-escalate incidents of challenging behaviour.
- Increased knowledge and understanding about dementia: different types of dementia; its effect on relationships; difficulties of caring for a younger resident with the condition; effects of institutionalisation and stereotyped behaviours displayed; the need to be more sensitive to residents’ emotions and to address conflicts between nursing care and patient advocacy.
- Negative learning: this focused on the difficulty of caring for residents whose behaviour challenged staff, and staff acknowledgement that residents felt to be irritating are often ignored.

Finally, staff discussed interventions that were already in place to improve wellbeing, and generated action points/strategies to improve quality of life:

- Stimulation: increasing the time for activities; enhancing communication and interaction; undertaking life story/memory box activities; increasing one to one activity time; providing care in residents’ own rooms rather than a lounge; using multisensory...
stimulation; providing outings, and increasing the use of doll therapy (therapeutic benefits seen in people with dementia having a doll/cuddly animal to be responsible for, care for and interact with);

- For individual residents: acknowledging a need for space/privacy; finding out more information about a particular resident; acknowledging a dislike of noise; learning about individual likes and dislikes; encouraging individuals to participate in choices/decisions; personalising rooms; needing to validate feelings of distress; asking MDT colleagues to assist with care;
- Health and care: needs for psychological assessment, medication review or pain assessment;
- For staff: the need to reflect on residents’ feelings; need to record incidents of behaviour seen as challenging; making the effort to include family in care planning and information gathering; developing strategies to improve the experience of personal care; learning different ways to de-escalate incidents of perceived challenging behaviour; being more observant about residents’ responsiveness to stimuli, promoting good sleep hygiene, and needing to monitor wellbeing.

Action points were identified for each resident. These were documented in their notes and care plan to ensure implementation and follow up, and so their effectiveness/suitability could be reviewed in the next cycle. All staff were made aware of the action points via the staff communication book.

**DISCUSSION**

Staff were extremely positive about the reviews, and appreciated the “opportunity to have an in depth reflection and discussion about a single resident”. Facilitators noted that: “Once staff began talking, they felt more able to contribute and offer their opinions.” The reviews allowed staff valuable time to think about the care of residents they found easy to care for. These residents were often not given “the same attention” as those with behaviours seen as challenging, as they did not require the same amount or level of care. Staff found it useful to begin each review with a summary about the resident to focus on their care. This was adopted at each review and prepared by different staff.

Staff considered it important for the group facilitator to allow a few moments for them to reflect and empathise with the resident when their social history/story was recalled at the start, as often this resulted in “palpable sadness in the room”.

**Compassion was often increased when staff began to acknowledge reasons why residents may display certain behaviours” and these were put in context. As discussions could focus on problems and a “sense of resignation noted in the room that nothing would change”, it was important for the facilitator to encourage “a shift in conversation to more solution focused ideas”.

At several reviews, staff commented on the potential benefits of a wellbeing group for them, especially when they needed to “offload” or “vent their frustrations”. This led to staff wellbeing groups being implemented. Bruce et al (2002) note that staff need support to acquire and use the special understanding and skills to give person-centred care, so training was also discussed at the reviews. Staff identified areas where training was needed, including stress management and ways to de-escalate situations, which are being addressed by the unit’s management.

**Obstacles**

This initial cycle was not without problems. On three occasions, reviews were cancelled because staff were too busy. The facilitators felt that managers’ presence was at times a distraction.

Medical and physiotherapy team staff did not attend any of the initial cycle of reviews, as some sessions started late, start times need to be addressed in the next cycle. Several sessions ran over the time slot, so ways to summarise and end sessions need to be found.

As some sessions started late, start times need to be addressed in the next cycle. Several sessions ran over the time slot, so ways to summarise and end sessions need to be found. It is also important for the group facilitator to ensure that staff focus on the resident and, if necessary, redirect them so they “don’t go off on tangents”.

Medical and physiotherapy team staff did not attend any of the initial cycle of reviews, and this could be a target for improvement.

**Future reviews**

In the second cycle of reviews, which began in January 2010, we have used the opportunity to review and evaluate previously identified needs and interventions/strategies.

As the first cycle was a pilot, no measures/scales were used. However, we are now piloting the use of a wellbeing measure, the Bradford Well-Being Profile (Bradford Dementia Group, 2008), and this to suggest possible action points to be discussed in the reviews. This echoes the instructions of the Bradford Dementia Group (2008), which said that “a discussion of social and emotional needs and how to meet them” should follow the creation of a wellbeing profile (a set list of positive and negative indicators to consider).

As these profiles rely on staff completing them by observing residents to monitor wellbeing, as well as requiring them to gain residents’ views, they will draw staff attention to possible psychosocial and environmental indicators, and enhance interaction with residents.

Also, in this second cycle, the importance of residents having the opportunity to discuss their general wellbeing and suggest topics to be discussed at their reviews was acknowledged. As Perrin and May (2000) said, “empowerment of people with dementia, and allowing them to construct their own solutions” is crucial to person-centred care. To ensure residents’ views are considered, wherever possible the facilitator talks to them to establish any needs before their reviews. While some residents have communication problems, every effort is made to establish their views and, if appropriate, those of their families.

**CONCLUSION**

Overall, the resident wellbeing reviews were a success and a valuable addition to the standard medically orientated ward rounds.

We are continuing to implement them because of their perceived benefits for both residents and care staff.

**REFERENCES**


