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Person-Centred Care Planning Change Package Dementia in Hospitals

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Improvement Hub

Enabling health and social care improvement

Introduction

Welcome to the person-centred care planning change package

The aim of the person-centred care planning change package is to provide you with evidence-based guidance to support the delivery of person-centred care for people with dementia in hospital settings. A change package consists of a number of high-level outcomes supported by activities that when implemented, bring about improvement. It brings together what is known about best practices and processes based on evidence from literature, research, and the experiences of others.

Why have we developed this change package?

This change package is for hospital teams participating in the dementia in hospitals collaborative. It will support teams to use quality improvement methods to improve person-centred care planning in their service.

What is included in this change package?

- Driver diagram
- Change ideas
- Guides, tools and signposts to examples of good practice
- Information on the evidence base. The change package is also supported by an evidence summary.
- Guidance to support measurement

Project aim

Setting a project aim

All quality improvement projects should have an aim that is **S**pecific, **T**ime bound, **A**ligned to the NHS board's objectives and **N**umeric (STAN). The aim for the hospital collaborative is**:**

By April 2023, the hospital care of 95% of people in the ward will be informed by a personalised care plan which reflects their strengths, needs, wishes and choices. The person-centred approach will support the prevention and management of stress and distress.

Driver diagram

Our aim is:

Aim

By April 2023, the hospital care of 95% of people in the ward will be informed by a personalised care plan which reflects their strengths, needs, wishes and choices. The person-centred approach will support the prevention and management of stress and distress.

Which will require:

Primary Drivers

Care Plans are completed and documented for all people in the ward

Care Plans are co-produced with involvement of the person, their family and carers

Staff feel competent and supported to use person-centred approaches and are using them to inform practice

So we need to ensure:

Secondary Drivers

There are effective processes for care planning and documentation

Recommended guidance and tools are used

Patients, families and carers are meaningfully involved in the process

Workforce capability in inclusion and involvement

Workforce capability in personalising care and support

The hospitals collaborative driver diagram above visually presents the parts of the system that need to change to deliver the aim. It is used to help the team identify the actions required to successfully deliver improvements.

Driver diagram and change ideas

Understanding driver diagrams

The primary drivers are the key components of the system that need to change to deliver the aim. The secondary drivers are the processes that influence the primary drivers. Changing the processes outlined in the secondary drivers should change the primary drivers and deliver the aim.

Change ideas

Change ideas are specific practical changes the project team can make to change the processes in the secondary drivers.

The following pages provide a list of change ideas for person-centred care planning. They are grouped by the primary driver that they influence. Project teams should select change ideas to implement. A range of change ideas will be needed to ensure there are changes to all primary drivers.

This change package does not contain an exhaustive list of change ideas. Project teams can also generate their own change ideas that will help drive change in the secondary drivers. One way of generating ideas is to use the question “How might we?” For example, “How might we engage relatives and carers more meaningfully?”

Primary drivers

Primary Drivers

Care Plans are completed and documented for all people in the ward

Care Plans are co-produced with involvement of the person, their family and carers

Staff feel competent and supported to use person-centred approaches and are using them to inform practice

This section contains the quick read guides, organised under each of the **three primary drivers**.

Each guide outlines the description, rationale, evidence and examples of good practice with links to change ideas and tools that you may find useful.

The guides demonstrate how the change ideas and tools can support you in achieving the aim that the care of people in your ward will be informed by a personalised care plan which reflects their strengths, needs, wishes and choices.

Completed care plans – change ideas

Primary Driver

Care plans are completed and documented for all people in the ward

Secondary Drivers

There are effective processes for care planning and documentation

Recommended guidance and tools are used

Change Ideas

Develop care planning documentation

Use the Essential 5 bundle to develop care plans

Introduce audit process for care plans

Use ward rounds and huddles for communication of key information

Use Mental Welfare Commission guidance

Completed care plans – evidence and examples

Why is it important?

Effective processes are important to ensure that care plans and documentation are completed and reviewed appropriately and that the multi-disciplinary team can contribute to person centred care planning. This includes transition points such as admission and discharge. Effective processes such as ward rounds, huddles and family meetings also support good communication between staff, patients, carers and family members. The use of guidance such as the Mental Welfare Commission can support teams to develop effective processes to complete person-centred care plans.

Evidence, examples of practice and education

The guidance to support this rationale is based on best practice and examples of this can be seen in:

- Personalised care planning for adults with chronic or long terms conditions
- Shared decision making in realistic medicine. What works.
- Mental Welfare Commission. Person-centred care plans. Good practice guide.
- Life story work

Tools

- What matters to you?
- Essential 5 Bundle guidance

Co-produced care plans – change ideas

Primary Driver

Care Plans are coproduced with involvement of the person, their family and carers

Secondary Driver

Patients, families and carers are meaningfully involved in the process

Change Ideas

- Use the Getting to Know Me (GTKM) document as a tool to support person-centred care delivery.
- Introduce IT approaches e.g. e-mailing documents such as GTKM to families to complete
- Introduce secure email for families to send in information e.g. photographs or biographical information
- Include families and carers in review meetings
- Provide iPads to support virtual visiting
- Person-centred / flexible visiting
- Develop life story work

Co-produced care plans- evidence and examples

Why is it important?

The involvement of patients, families and carers is essential for effective person-centred care planning to take place. The views and wishes of the person with dementia form a key part of the care plan through the use of good conversations. Additional information from families and carers is also important, especially if the person with dementia has difficulty communicating their wishes.

Evidence, examples of practice and education

The guidance to support this rationale is based on best practice and examples of this can be seen in:

- A comprehensive systematic review of visitation models in adult critical care units within the context of patient- and family-centred care
- Mental Welfare Commission. Person-centred care plans. Good practice guide.
- A systematic review of evidence on the links between patient experience and clinical safety and effectiveness
- The Patient Feedback Response Framework
- An evaluation of a near real-time survey for improving patients' experiences of the relational aspects of care
- Person-centred/flexible visiting (Pre-Covid clip)
- Carers and confidentiality – good practice guide
- Care plans: how people with lived experience and their friends and family want to be involved

Tools

- Care Opinion
- Care Experience Improvement Model
- Getting to Know Me (GTKM)
- Life Story work

Informed practice – change Ideas

Primary Driver

Staff feel competent and supported to use person centred approaches and are using them to inform practice

Secondary Drivers

Workforce capabilities in personalising care and support

Workforce capabilities in inclusion and involvement

Change Ideas

Involve a wider range of staff in care planning

Train key staff in person-centred approaches as per MWC guidance

Person-centred conversation skills

Develop ward observation skills

Training on identifying needs and opportunities

Use delirium decision support tool

Develop skills to capture narrative in real time using the Care Experience Improvement Model

Informed practice – evidence and examples

Why is it important?

Training and support is necessary to develop a culture of person centred care. The pace and routine of busy hospital wards can be a barrier to a person centred approached, so staff require time to develop their knowledge and practical skills in this area. This includes time to have good quality conversations with patients, their carers and relatives and to use in care planning. Ongoing support from managers is required to allow staff to undertake necessary training and to support a person centred approach in the day to day care of the ward.

Evidence, examples of practice and education

The guidance to support this rationale is based on best practice and examples of this can be seen in:

- Promoting Excellence Framework
- NES online dementia resources
- SIGN Guideline 86. Management of patients with dementia
- SIGN Guideline 157. Risk reduction and management of delirium
- Carers and confidentiality – good practice guide

Tools

- Personal outcomes discussions
- Care Experience Improvement Model
- Delirium decision support tool
- Mental Welfare Commission. Person-centred care plans. Good practice guide.

Measurement

Measurement is an essential part of improvement as it helps the project team understand if the changes they are making are leading to improved care. Below you will see an outline of three types of measures used in improvement and a link to the measurement framework.

Outcome measures

Outcome measures are used to understand if the changes are resulting in improvements towards the aim.

Process measures

Process measures demonstrate that change ideas are improving the underlying processes that contribute towards a person-centred approach.

Balancing measures

Balancing measures are used to determine if the changes are affecting things elsewhere in the system (unintended consequences).

More detailed information and the collaborative measures can be found in the measurement framework.

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