

# Evaluating the facilitation of client centred care plan



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Developing care plans to be agreed by older patients and/or their carers has become common practice (Cegala et al. 2000). As outlined in *The Essence of Care* (Department of Health, 2001b); patients care plans should be integrated, multidisciplinary and accessible to the patient.

Due to a common fault of assessments being duplicated with no coherent approach across health and social care service (Department of Health, 2001a, p24), the Single Assessment Approach (SAP) in conjunction with the Care Programme Approach (CPA) was published to cater for the person centred approach in caring for individuals of an older age with depression, dementia and other mental health problems (Department of Health, 2002).

Much publicised literature emphasises the need of developing a person centred approach in regards to care plans, and as of now, it is deemed standard practice within health and social care professional frameworks. The aim of person centred care, as emphasised by Kitwood (1997), is to break the traditional, ritualised approach to care, to ensure that each person is cared for in an individualised manner (Neno et al, 2007).

The majority of relevant literature including Kitwood (1997), Morton (1999) and Stokes (2000) all emphasis the need for family, friend, carer and other third party involvement during the initial assessment process of client care, to develop a care plan based around the clients needs, interests, demands and wants. They also suggest that it would be poor practice to not consider such third party involvement in trying to achieve person centred care. They also take the assumption that as long as these third parties are present to advocate the client's history, behaviour and needs, and that the facilitating

team member follows an effective framework, then person centred care should be attainable. However, if no such third parties are available, and the client has only ever received care via a biomedical model approach, and not a bio-psychosocial model, and has no interest or understanding in engaging or identifying care requirements, then facilitating patient centred care can become a very difficult process.

It was whilst on a six week clinical placement as a student mental health nurse, that these factors were observed. The following account, with supportive literal evidence, will support the difficulty in attaining a person centred approach to care.

To adhere to the laws of confidentiality, as stated in The Code of Professional Conduct (NMC, 2008), the client's identity will be changed to that of a pseudonym. Furthermore, no reference to the location of client, service, or family members will be identified.

### **The clinical setting**

The Dementia Day Hospital is a community based facility that specialises in the diagnosis of Dementia based illness's, and the continuing observation, assessment and Multi-Disciplinary Team (MDT) involvement, of those diagnosed, or awaiting diagnosis of dementia. It must be noted that dementia is a loosely used umbrella term to describe a range of brain disorders that are usually progressive, irreversible and eventually fatal (Redfearn & Ross, 2006). Examples of brain disorders that result in the term dementia are Alzheimer's disease, Vascular Dementia, Fronto-Temporal Dementia, and Dementia with Lewy bodies.

The day hospital is open Monday to Thursday for clients who have been diagnosed, or awaiting possible diagnosis, to attend. The main purpose of this day facility is to assess a clients aspects of daily living (ADL's), neuropsychological state, behavioural aspects, risk assessment, mental capacity, cognitive functioning, titration of medication and development of any person centred care plans to prevent early admission into institutionalised care (Department of Health, 2001a). The day centre also bridges the gap between hospital and primary care services (Ames & Hastie, 1995). It also offers carer(s) brief respite for the day. The continuing attendance also offers the MDT early insight into any needs, wants and demands of the client and carer(s).

On a Friday, the day hospital runs as a Memory Clinic. This service enables clients from the community, or hospital wards, to be assessed for any potential brain disorders. The clients are referred by their personal General Practitioner (G. P.) if suspected to be suffering with any memory/cognitive problems. The memory clinic provides a full person centred approach to assessment by means of medical screening and history, personal biography and insights into the client's relationships, beliefs and attitudes (Page, 2003). As part of the assessment a family member, friend, or other close third party, is asked to accompany the client to provide relevant information in regards to the client's activities of daily living, and neuropsychiatric thoughts/behaviour. This helps to obtain information in regards to all involved with the clients care.

## Reflection of care

Mr B is a 76 year old gentleman, who had been newly referred to the day hospital. He had been diagnosed with suspected dementia of the Alzheimer's type, and was also suffering from depression. The focus of Mr B's attendance at the day hospital was to a, assess his rate of cognitive decline, b, assess his aspects of daily living (ADL's) and needs, and c, encourage social interaction in hope of relieving him of his depressive symptoms. Gottfries (2001) points out that half of those suffering from dementia will present with depressive symptoms at some stage. The fact that depressive symptoms mirror a large proportion of dementia symptoms (Manthorpe & Illiffe, 2006), meant that the Psychiatric Consultant wanted to be sure he was not misdiagnosing, and hence Mr B's referral for continuing assessment.

Mr B's wife had passed away 4 years previously, and it was at this point that he had started to feel very low and isolated. He had no close family or friends, and relied on his wife to cook, clean, organise, etc. The fact that Mr B had always been a relatively quiet and private man meant that he struggled to ask neighbours or distant relatives for any help. It was this aspect that made the team concerned in regards to his ADL's, and if he was managing to meet them. Baldwin et al (2002) points out that male gender of an elderly age, living in isolation after a recent bereavement, are deemed a high risk to depression.

As a result of Mr B living alone, he had been assigned a Community Psychiatric Nurse (CPN) and a Social Worker. It was this multidisciplinary team, in conjunction with his attendance at the day hospital, which would collaboratively attain what help, further services, etc, Mr B would need to <https://assignbuster.com/evaluating-the-facilitation-of-client-centred-care-plan/>

help him to continue living in the community, and avoid any future hospital admission.

As a result of Mr B's initial dementia assessment, he had obtained a score of 23 out of 30 in the Mini-Mental State Examination (MMSE) (Folstein et al. 1975), which is a cognitive test that allows an indication of a person's cognitive functioning. This suggested that Mr B had a mild level of cognitive impairment. Although the MMSE is widely used as an aid to determining cognitive function, it does have its negative points. Miller (2003) argues that it has a lack of sensitivity towards mild cognitive impairment; whilst Kitwood (1997) points out that it has no way of determining a person's previous levels of cognition, related to their levels of education and skills that they developed through life.

Unfortunately, nobody accompanied Mr B to his initial assessment, and as a result very limited information in regards to his neuropsychological/behavioural condition was obtained. As a result, the team had no indications of whether he was experiencing any hallucinations, delirium, obsessive behaviour, "wandering" etc (McKeith & Fairbairn 2001). Mr B had also stated during his assessment; that although his wife did most of the cooking, cleaning, etc, he was managing to meet his ADL's fine. However, this information could not be confirmed. In order to try and obtain this information, Mr B would be observed at the day hospital for 6-8 weeks in order to gather any relevant information. Though, it was assumed that any hallucinations may not surface through the day, as they are often more prevalent in the evening and night-time (Allen & Burns 1995).

As of yet, Mr B had no personal care plan in place whilst he would attend the day hospital. In order to implement a plan of care, a bio-psychosocial assessment of the client needs to be attained (O'Carroll & Park, 2007). The importance of mental health nurses possessing the skills to conduct a comprehensive assessment of mental health problems is a key competency, as identified in *The Capable Practitioner* (SCMH, 2001). As Norman & Ryrie (2009) point out, assessment permeates all aspects of nursing care, and is the cornerstone of mental health nursing.

The Care Programme Approach for Mental Health Service Users (CPA) (2003), in conjunction with, the National Service Framework for Older People in Wales (2006), is a unified assessment and care plan policy that incorporates holistic assessment and care of a client. This is the assessment form used to facilitate a care plan, and one that runs systematically throughout this specific trust. The CPA allows multi-agency involvement to work collaboratively in achieving a more person centred plan of care (Harrison et al, 2004).

As it was Mr B's first day of attendance, it was suggested that a member of the team could ask Mr B to accompany them into a private room, to conduct an assessment of strengths and weaknesses that could be incorporated into the care plan. After team discussion, it was decided that Mr B should be allowed to familiarise himself with the environment, thus allowing the team to observe any behavioural characteristics displayed by him. It was believed that this would also help in recognising any interests and dislikes that Mr B had in terms of the facility.

As a means of observation, it was suggested by the student to use a Dementia Care Mapping (DCM) approach (Kitwood & Bredin, 1993). DCM is highlighted by many researchers such as Brooker et al (1998), Martin & Younger (2000), and Fox (1995), as an observational tool that can improve care practices and the communication and empowerment of patients. Kitwood (1992) states; that much of the decline in dementia sufferers is deemed to be a consequence of the social and environmental situation experienced. By using DCM at 5 minute intervals, a more person centred approach of well-being or ill-being can be attained.

As part of the structured day at the day hospital, a few group activities are incorporated into the clients' daily care. These include Reality Orientation Therapy, Reminiscence Therapy, Validation Therapy and physically involved games such as skittles, bean-bag toss, etc. By observing Mr B's interaction and participation within these group settings, it was believed a more informative collection of interests could be implemented into a potential plan of care.

It was observed that during the reality orientation therapy, clients met the session with mixed responses. Due to varying levels of cognitive impairment, some clients appeared to find it beneficial as it validated their awareness of the day, season, year, etc (Brooker 2001). However, it was observed that some clients appeared very frustrated that they did not know the day, date, etc. This negative aspect is observed by Naldrett (2007) who acknowledges that; when someone is confused, it can be very challenging to have someone pointing out that ' you' have the wrong idea of the time, or the place ' you' are in.

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Unfortunately, Mr B's participation in this session was very limited, though regards to not knowing anyone, being in a new environment, and suffering from depression, has to be taken into account.

Upon reflection of using the DCM tool during this group activity, it became apparent that it may not be the best assessment approach to use with a client entering a new environment. Adams (1996) highlights the fact, that DCM can be very subjective based upon the mappers skill, and the patients anxiety and mood levels prior to the mapping itself. The students personal opinion is that; for DCM to work effectively, it must assume that the person being observed wakes up in the same frame of mind, daily. Otherwise a care plan could be ammended ineffectively, just because a client has lost interest in an activity due to having an " off day". However, DCM did appear to work effectively with those clients that had been integrated into the day hospital successfully.

Mr B showed no interest in any of the group sessions, and was observed to become more withdrawn. Bromley (1990) and Bee (1998) agree that disengaging from group, and society, is a common norm within individuals of an elderly age. As a result the team decided that a differing form of therapeutic intervention was necessary. Identifying when an intervention is necessary is highlighted as a required capability in Best Practice Competencies and Capabilities for Pre-registration Mental Health Nurses in England (DH, 2006) and The Capable Practitioner (SCMH, 2001).

As an opportunity to build a therapeutic relationship between staff and client, and obtain any relevant information in regards to his future plan of

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care, Mr B was asked by a team member if he would object to a private conversation. He was also asked consent for the student to attend (NMC, 2008), to which he gave. In order to assess a client, a therapeutic relationship between the caregiver and the client needs to be implemented as soon as possible. Peplau (1991) informs us that; the therapeutic relationship is the central element in the nursing process.

The student observed that during the process of conversation between Mr B and the nurse, communication between both appeared cognitively structured, at least more so than Mr B's MMSE would suggest. Mr B appeared to be more relaxed within a smaller, isolated setting, and more willing to communicate. Norman & Ryrie (2009) point out that some people enjoy talking communally, whereas others who are shy and anxious may benefit from a more private, structured, and formal interview. The nurse always validated Mr B's answers during conversation, thus allowing the client to feel heard and respected in terms of his personal choice, belief's, independence and self worth (Feil, 1992).

Whilst asking Mr B what aspects of care he would like incorporated into his care plan, he replied that he had no desire to follow a care plan, as he doubted that his continuing attendance at the day hospital would be met. He stated that the facility felt like a kindergarten, that was both patronizing and stigmatizing, and that he did not need to be here as he was not suffering from dementia, just slight forgetfulness. Jones & Miesen (2004) point out that; persons in the early stages of Alzheimer's dementia may use denial in a hope to prevent the full impact of the illness from entering their conscious awareness.

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The nurse continued to emphasise why Mr B's continual attendance at the day hospital would benefit his continuity of care, and help provide him with any future services and needs (Welsh Assembly Government, 2003; NICE, 2006), but Mr B appeared very forthright in his views to cease attendance. As a result of Mr B having mental capacity (Department of Health, 2005; Department of health, 2008), the day hospital team were not at liberty of detaining Mr B for continuing care.

Throughout the remainder of the day, the team tried to engage Mr B with numerous interventions and activities, in the hope that he may change his mind in regards to his future attendance. However, Mr B still remained disengaged with the care provided and continued his intent to cease attending in the future.

Unfortunately, Mr B did carry out his intentions to cease attending the day hospital. This left the team feeling frustrated, as they had hoped that upon reflection, Mr B would recognise the benefits of care that the day hospital provided. Fortunately, Mr B had continued support provided to him via means of a personally assigned CPN and Social Worker. He accepted input from these services, but did not want to be incorporated into a day care facility. As a CPA had been put in place, it meant that continuing care could be assessed throughout all required MDT's. However, this continuing care, in terms of a care plan effect, continued upon a more biomedical approach as opposed to a bio-psychosocial/person centred care model.

## **Conclusion**

It has been highlighted that person centred care in regards to facilitating a client's care plan, should be the primary focus upon addressing what needs, interventions and desired outcomes the client has. However, this approach can be time consuming, frustrating and unfruitful if a client suffering with dementia, especially at an early stage, refuses any interaction, intervention and goal setting aims. A person should always be allowed to have their independence, dignity, choice and belief's respected, as is the primary focus of person centred care, and as a result of this, client care can be very difficult to facilitate. Upon reflection of the situation experienced, it may have been more desirable for members of the day hospital facility to have visited the client at home on several occasions, to initiate a therapeutic relationship in a less formal, less stigmatizing and more relaxed/familiar environment. This may have then encouraged the client to accept the care being offered.