

Walking With Purpose Clinical Guidance

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Clinical Conversations using the COM-B Method



C – capability – Psychological - Skill (An ability of proficiency acquired through practice) or **knowledge** (An awareness of the existence of something) or **memory, attention and decision process** (Ability to retain information, focus on aspects of the environment and choose between two or more alternatives) or **behavioural regulation** (Behavioural, cognitive and/or emotional skills for managing or changing behaviour)

O – opportunity – physical - environmental context and resources (Aspects of a person’s situation or environment that discourage or encourage the behaviour) or **behavioural cueing** (Processes by which behaviour is triggered from either the external environment, the performance of another behaviour, or from disappearing in consciousness Or social - social influences (those interpersonal processes that can cause oneself to change ones thoughts , feelings or behaviours) or norms (The attitudes held and behaviours exhibited by other people within a social group) or subjective norms (One’s perceptions of what most other people within a social group believe and do) or social learning/imitation (A process by which thoughts, feelings and motivational states observed in others are internalised and replicated without the need for conscious awareness

M – motivation – reflective - attitude towards the behaviour (The general evaluations of the behaviour on a scale ranging from negative to positive)or **beliefs about capability** (Beliefs about one’s ability to successfully carry out a behaviour)or **beliefs about consequences** (Beliefs about the consequences of a behaviour (i.e.. perceptions about what will be achieved and/or lost by undertaking a behaviour, as well as the probability that a behaviour will lead to a specific outcome)or **feedback process** (Processes through which current behaviour is compared against a particular standard)or **goals** (Mental representations of outcomes or end states that an individual wants to achieve)or **intention** (A conscious decision to perform a behaviour or a resolve to act in a certain way)or **motivation** (Processes relating to the impetus that gives purpose or direction to behaviour and operates at a conscious or unconscious level)or **values** (Moral, social or aesthetic principles accepted by an individual or society as a guide to what is good, desirable or important)or **needs** (Deficit of something required for survival, wellbeing or personal fulfilment) or **self image** (One’s conception and evaluation of oneself, including psychological and physical characteristics, qualities and skills)or **perceived susceptibility/vulnerability** (Perceptions of the likelihood that one is vulnerable to a threat)or **general attitudes/beliefs** (Evaluations of an object, person, group, issue or concept on a scale ranging from negative to positive)or **social/professional role and identity** or **optimism**) or **automatic – emotion** (A complex reaction pattern involving experiential, behavioural, and physiological elements) or **reinforcement**(Processes by which the frequency or probability of response is increased through a dependent relationship or contingency with a stimulus or circumstance)

C – capability – psychological (skill or knowledge or memory, attention and decision process or behavioural regulation)

O – opportunity – physical (environmental context and resources or behavioural cueing) or **social** (social influences or norms or subjective norms or social learning/imitation)

M – motivation – reflective (attitude towards the behaviour or beliefs about capability or beliefs about consequences or feedback process or goals or intention or motivation or values or needs or self image or perceived susceptibility/vulnerability or general attitudes/beliefs or social/professional role and identity or optimism) or **automatic** (emotion or reinforcement)

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East, West, Central, Mental Health & LD Themes



- Safe IPC Environment - Central
- 1. Patients need to be able to walk around however there can be concerns with other patients and invading their space. This needs to be managed with the MDT including a more visible presence from the IPC team
- Domain: **Capability - Knowledge**
- Reason: the IPC team don't always have the knowledge and information to know where the patients who walk with purpose are. Likewise, staff don't always know if the patients being transferred are going to walk with purpose
- Behaviour Change Technique: **Provide information, instructions and give feedback** - heat map, better communication, transfer documentation?

Guidance Vs Algorithm



MM17 DELIRIUM MANAGEMENT IN ADULTS IN ACUTE AND LONG TERM CARE SETTINGS

Delirium Management for Adults

History of acute confusion and/or Drowsiness - THINK DELIRIUM!

Clinical suspicion of delirium or assessment tool positive (e.g. 4AT or CAM)

AVOID

- **Bed moves**
- **Unnecessary interventions**
- **Hypoxia**
- **Dehydration**
- **Constipation**
- **Catheterisation**

THIS PATHWAY DOES NOT relate to alcohol or substance misuse: Refer to NICE.

THIS PATHWAY IS NOT OPPOSITIVE, there is a full delirium pathway available on the network (MM17)

Act on acute, severe causes, e.g. sepsis, hypoxia, hypoglycaemia, medication intoxication

The patient's capacity to consent to treatment should be assessed, if they lack capacity they should be treated under the Mental Capacity Act in the patient's best interest (with a consideration of this). This must be documented in the notes, with a Mental Capacity assessment and best interest decision form (available on the network). The clinical team should take a collateral history to identify underlying causes (specifically include history of cognitive impairment, alcohol use, and recent medication changes) relatives should be informed of the diagnosis of delirium and how it is being managed. Identify pre-morbid social support and potential for proactive discharge planning as prolonged hospital admission is not beneficial.

Assess with local tool and record baseline cognitive function (4AT/4, 4AT-10)

Do a full physical examination including detailed neurological examination.

Do not forget dehydration & constipation - Very common and frequently missed causes of delirium

DOCUMENT DIAGNOSIS OF DELIRIUM & SUSPECTED CAUSES.

Medication Review

Review fully appropriateness of medication

Any drugs recently started/stoppped /dose changes to medication?

Compliance/Concordance issues with medication?

N.B. anticholinergics & sedatives

Consider potential causative medications: Opioids, Benzodiazepines / anxiolytics / anticholinergics / antihypertensives (especially if hypotension) / corticosteroids / antiepileptics / antipsychotics / antidepressants / antiparkinsonians / antiemetics

Avoid abrupt withdrawal of drugs with dependence potential or possible discontinuation syndrome.

Investigations

Dictated by the history and examination findings

U&E / LFT / FBC / Glucose / CRP / Calcium

Drug/toxic tests

ECG

Chest X-ray

Spinal / Urinary / stool Culture (as appropriate)

CT Brain if antiepileptic (URGENT), head injury

Neurological signs or persistent symptoms

N.B. Not all delirium is caused by UTI!

Optimise Management of Co-morbidity

The aim of recovery of delirium

For example:

- Respiratory disease
- Diabetes mellitus
- Cardiac disease / heart failure
- Thyroid disease
- Parkinson's Disease
- Cerebrovascular disease

There are often multiple causes of delirium but in up to 30% cases no cause is found.

Environmental & General Measures

Use Daily Prevention of Delirium 10 Chart for environmental rounding / Use Delirium 10

1. Hydration. Regularly prompt to take fluids and eat food
2. Mental stimulation. Engage regularly in conversation to re-orientate and check the patient is at a comfortable temperature.
3. Orientation. Avoid moving within/between wards, enhance orientation, encourage early mobilisation
4. Sleep. Reducing noise to a minimum during sleep periods. Encourage daytime activity/wakefulness
5. Eating. Encourage eating and ensure dentures are properly fitted
6. Sensory aids. Ensure hearing and visual aids are available, working and fitted correctly
7. Medication. Should be reviewed to identify any potentially causative or contributing to delirium
8. Breathing. Ensure oxygen is provided if needed for breathing difficulties.
9. Pain. Monitor, including non-verbal signs and treat, use PAINAD tool if unable to communicate pain
10. Infection. Treat infections appropriately and promptly. Avoid unnecessary urinary catheterisation

Medical & Nursing Management

Treat underlying causes:

Infection/sepsis, urinary retention, constipation, hypoxaemia, pain, dehydration, hypoxia, hypoglycaemia, hyponatraemia

Ensure O2 saturation > 90% (except in COPD - type 2 respiratory failure)

Assess and monitor pain

Consider swallow screening

Explain diagnosis to patient & carer and provide information leaflet

Use Butterfly scheme (dementia)

Use Delirium 10 pathway

Treatment of Delirium Symptoms

Relax visiting times, encourage family to reassure & support care

Refractive delirium is common in older patients.

Consider additional staff

Treat psychiatric symptoms if distressing, if patient's symptoms threaten their safety or the safety of others, use low dose of one medication (start low - go slow method) and review every 24 hours

Medications for aggression/significant distress:

Risperidone 250 to 500 micrograms orally as PRN dose. If necessary, repeat after 30 minutes up to maximum 2mg / 24hours

OR

Olanzapine 2.5mg orally as PRN dose. If necessary, repeat after 30 minutes up to maximum 1mg / 24hours

OR

Haloperidol 500 micrograms as PRN dose. If necessary repeat after 2 hours to maximum max 2mg/24h

Do not use antipsychotics in Parkinson's or Lewy Body Dementia. If antipsychotics are contraindicated use Lorazepam 500 micrograms - long oral/IV (max 2mg/24h)

Triggers for referral to Liaison Psychiatry

- Unresolved delirium (significant symptoms) after 7 days or more
- Severe agitation or distress not responding to standard measures above
- Doubt about diagnosis
- If detention under the Mental Health Act is being considered

Delirium must be included on discharge summaries

Delirium can last for up to 6 months and patients may not return to their cognitive baseline but the patient does NOT need to be an inpatient until complete recovery

If the patient does not return to their cognitive baseline after 3 to 6 months following discharge, this may need follow up.

SCUM Delirium Guidelines Approved Nov 18, Updated 2019

Acknowledgement: This pathway was adapted from the Scottish Delirium Association pathway Version 2.0.

Using other resources



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The final guidance



Walking with purpose could be an expression of unmet needs



Remember:

Provide person centred activities, and involve the carers

Communicate and support the other patients on the ward

Keep [patient status boards](#) updated

Capture daily acuity score on the roster system to determine staffing required especially around [evening/sundowning](#)

A patient walking with purpose could be at a greater risk of infection to themselves and others

The priority on admission is MDT review and ongoing patient and family/carer(s)

Is this a new presentation? Act on any physical causes – rule out delirium following [delirium guidance](#), consider [alcohol withdrawal](#) or [Acquired Brain Injury \(ABI\)](#)

Alcohol liaison details [can be found here](#) for all areas or are contactable by bleep

If the person has a [diagnosis of dementia](#), [use the inpatient pathway](#), encouraging hand washing and single use items. Check if they are open to a community mental health or substance misuse team

If the patient requires a mental capacity assessment, remember the assessment is decision and time specific. [Mental Capacity form](#) to be completed. Is a [DOLS](#) referral required - consider treatment, risks and safeguards (contact [psychiatric liaison](#) for support if this is needed)

Remember:

The [wellbeing](#) of staff and wider team matters

Aim for the correct skill mix

Be confident, raise concerns, and ask for help. You are [not expected](#) to be an expert in everything!

Raise [training](#) needs with your manager and look [here](#)

[The management of dementia \(BPSD\) guidelines including medication can be found here](#)

Supportive Patient Care - consider:

Life story documents including this is me, who I am, what matters

Developing person centred care plans

Using preferred language and facilitating spiritual and cultural needs

MDT Support – consider:

Dementia healthcare support worker/activities coordinator to facilitate meaningful activities

Medical review including [neurological symptoms](#) and [managing pain](#)

Assessing medication with [pharmacy support](#) for contra indications

Carer (including paid carers)/Family Support/[John's Campaign](#) – consider:

Using a patient hospital passport

[This is me](#) or [who I am](#) and [what matters](#) to be completed with patient and family

Engaging family, carers and friends – initiate early and regular contact according to preferences to gain and retrieve information about clinical condition/presentation

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Supportive Patient Care - consider:

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Using preferred language and facilitating spiritual and cultural needs

Access to communicate with family, such as RITA/[iPad](#)

Music – access to radio/headphones

Utilising the [butterfly scheme](#) if appropriate

MDT Support – consider:

Dementia healthcare support worker/activities coordinator to facilitate meaningful activities

Medical review including [neurological symptoms](#) and [managing pain](#)

Assessing medication with [pharmacy support](#) for contra indications

Clinical assessment with physio and occupational therapy to determine placing of the patients including mobility needs & ADL's

SALT for communication assessment

Referring to [advocacy](#)

Carer (including paid carers)/Family Support/[John's Campaign](#) – consider:

Using a patient hospital passport

[This is me](#) or [who I am](#) and [what matters](#) to be completed with patient and family

Engaging family, carers and friends – initiate early and regular contact according to preferences to gain and retrieve information about clinical condition/presentation

Encouraging contact online, phone, face-to-face – invitation for meal times

Asking family to bring in any meaningful items [i.e.](#) photo, music

Carer/family review of care plan with patient's permission or as advocates

Using the [Herbert Protocol](#)

To provide a supportive and safe environment, consider

Joint risk assessment with infection control and prevention team (IPC) /champions including an individualised ward/department environmental plan and the infection risk of patients, staff and visitors

Therapeutic space being utilised – following IPC guidance

Physical environment – noise, lighting, flooring, signage, any obstructions/obstacles

Liaising with the housekeeper and domestic staff for an all staff enhanced ward-cleaning rota

If in doubt shout – who is here to help, advise and escalate?

- Engage with your [IPC colleagues](#) [early](#), whilst awaiting infection screen/test lab results, including roaming staff
- They are here to work with you to help and [advise](#) and to maintain patient safety
- Other colleagues available for help - senior colleagues, senior staff, clinical site manager, [dementia nurse consultants](#) (in hours), psychiatric liaison, doctors, family for support.
- Bronze on call, IPC and psychiatric liaison are available out of hours/on call through switchboard
- The [safeguarding](#) team
- Document all decisions and actions

Leadership team; what can you do to help?

Remember to [listen](#) to your staff concerns, provide compassionate leadership to foster person centeredness

Look – undertake a timely review/clinical visit – in person or via phone

Ask – what do staff/family feel will help the situation?

Action – accept staff professional judgement as valid. Identify available resources, review and respond to the risk assessment – feedback to the staff and further escalate if needed

Remember:

Ensure patient has sensory aids – glasses, hearing aids [etc.](#) may need assessment

Walking with purpose needs to be [identified](#) on transfer and discharge documentation

Referral forms for Psychiatric Liaison and contact details for all areas [are found here](#)

Our Learning Disabilities Liaison nurse page is [here](#)

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Feedback



Questions for feedback

Thank you for supporting the Walking With Purpose (WWP) Project as an early-adopter ward. We now need constructive feedback on its use so that we can evaluate it and refine its implementation across the Health Board.

Please answer the questions below as fully as you can. We are seeking feedback from a variety of team members including anyone who may have used the guidance e.g regular nursing staff, AHPs, students, bank staff, but we **only need one survey completed per ward**. Therefore, we'd be very grateful if you could engage your colleagues on the ward and combine their views into a single response. For completeness, please list here the roles (not names) of the colleagues whose feedback has been sought:

Ward/Hospital name:

Respondent's roles:

Section 1. Capability

- 1.1 To what degree are staff capable of accessing the guidance?
- 1.2 To what degree are staff capable of understanding the guidance?
- 1.3 To what degree does the guidance support staff to take action to reduce IPC risk?

The screenshot shows a feedback form on a purple background. The form is titled "Feedback for Walking with Purpose Guidance" and includes several questions and text input fields. Each input field has a heart icon, a comment icon, and an "Add comment" button. The questions are:

- Has this been useful for supporting patients?
very simple to view & easy to understand, provides all the key points
yes, very informative and put together well. it was easy to understand and helped on the ward.
- In what situation/s did you find it useful?
It allowed the team a framework to understand the patient & gain the information required for personal centered care. Particularly those patients who did not have families to readily provide the information.
It gave us information to look at and check the details such as This is me, and getting to know the patients as individuals, personal centered care.
- Has this been useful for supporting staff? Which staff groups have you found it useful for? i.e students/bank staff etc
new staff members new to the specialty, been a useful guide
Its been very useful as new staff members and students can follow it easily to see what they can achieve. And what forms they will need to complete the task required.
- Has this been useful for supporting patients/carers/visitors?
allows key questions to be asked, plus providing advice by us to the families
Yes again with the information on this form they can see what advice they can be given eg This is me and using the butterfly scheme, and who to go to for advice.
- Would it be useful to support planning care for patients?
yes
yes I think it would
- If this hasn't been used, is there any reason why not?
I think a paper copy would be more beneficial as people can look at it better. and close up, we could also go over it with relatives and staff and discuss the details a lot better then if it was on a computer.
- Is this document better as a paper copy or electronic?
same as comment below - paper copy as the access to the computer is not always readily available
- Any other comments?

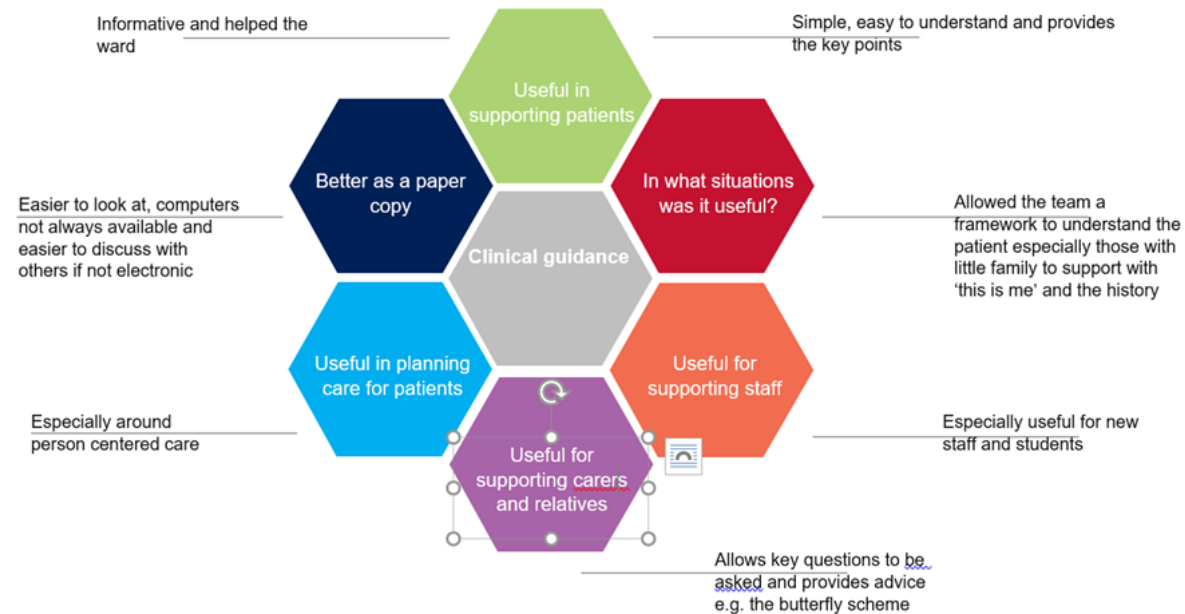
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Results and Analysis



Walking With Purpose



Thematic analysis of data

Wards displaying the data in a paper format

Having the guidance electronically via email or whatsapp groups

Discussion of the guidance at safety briefs and ward rounds

Staff already implementing the guidance prior to its release

Bank and agency staff using the guidance

Guidance being too busy/wordy

Managing WWP as an MDT approach

Helpful interactive links

Not had enough time to fully utilise the guidance

Competing demands of the ward

DSW supporting the guidance and already carrying out

Good links with IP can Psych liaison already in place

Guidance may fit better in a ward with less patients who WWP



Reflections



- Lessons Learnt –
- 1. At time, within the Bevan Exemplar programme it felt like everyone else knew what was going on and were more advanced in their project and learning regarding change/improvement/project management
- 2. Some information was hard to understand and follow. I needed to read around the topic and really focus on the presentation and discussion which led to a reduction in confidence!
- 3. Getting used to working in a group but just over teams and not in person was difficult at times, especially with people I had never met
- 4. I was able to make some great contacts from the programme and found particular projects that I could advise and collaborate on. I was able to give a perspective from BCUHB but also from my own work and experience. Likewise, I was able to receive support from others
- 5. It would be even better to do something similar in the future and relate back to this experience. I would be able to know how long certain things take, whom to contact for support and the approach to take which would hopefully make projects in the future smoother.
- 6. As part of our internal task and finish group working on walking with purpose, I felt very proud to initially change language and attitudes. The group was called 'wandering patients' to begin with which is not terminology that is used. It was also nice to have respect from colleagues given my experience in older person's mental health and my recent completion of the dementia masters.
- 7. I was then reliant on others for support with developing guidance/policy and presenting information. The other members had worked previously on quality improvement, transforming care and change which was new to myself.
- 8. We also had people with great experience in research and development within our task and finish group. It was a shame that others in the WWP group weren't able to be more part of the Bevan exemplar programme due to work commitments and the pandemic
- 9. It was hard for us as a team to continue the momentum if we had had a long period in between meetings and different members felt different areas needed to be a priority base don their background. There was also members of the group who changed jobs including myself which made things hard to complete with competing demands
- The collaboration as a whole has been incredibly helpful and will support our future plans to gain more feedback from other wards and to eventually publish onto the intranet to use in day to day practice

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