Southern Health NHS
NHS Foundation Trust

My Wellbeing Guidance v1.0

Documentation Details	
Document reference:	Community Care Wellbeing Plan v0.1
Title:	OpenRiO My Wellbeing plan
Summary:	This document defines trust expectations and requirements for adults services staff using the RiO electronic patient record system
Owned by:	Southern Health NHS Foundation Trust
Authors:	Dr Abigail Barkham, Gill Turner, Mark Surtees
Approved by:	
Date approved:	DRAFT
Next review date:	July 2015 (to incorporate single assessment functionality)
Document location:	TO BE UPDATED

Date yyyy-mm	Version	Author	Summary of Changes
2016-03	0.1	Dr Abigail Barkham	Creation
2016-04	0.1	Hannah Aitken	

Reviewed and approved by: Members of the Trust Clinical Informatics Steering Group:	
Name	Title

Table of Contents

1. Document Status

This is a document created by Dr Abigail Barkham which outlines the reasons for the ‘My Wellbeing Plan.

2. Introduction

RiO Community is the primary health record for Southern Health Foundation NHS Trust (the Trust) Adult Services with the exception of MSK services, RAU Petersfield, Andover and Gosport who use RiO for appointments and appointment out-coming only.

The My Wellbeing Plan provides a framework for Trust staff to follow when using RiO. Staff delivering care to patients where a business arrangement is in place may be given access to read and contribute to the patient record and must be provided with access to the plan

The SOP (Standard Operating Procedures) must be read along this document and in conjunction with additional Service Specific Guidance which can be found on the Southern Health website.

Failure to comply with the Standard Operating Procedures may result in disciplinary action being taken against the employee

2.1. Purpose

The purpose of this document sets out a Divisional wide statement and vision on how Southern Health NHS Foundation Trust (SHFT) plans to support the well-being planning process for service users referred to SHFT community care. This document will give guidance to managers and teams on how ISD expects staff within practice settings to carry out a wellbeing plan.

The mission of the ISD is to promote improved health, wellbeing and independence of the populations it serves. This will be achieved by delivering good quality-focussed, integrated health care that enable patients to be in control of the care they receive where possible. Other drivers exist that provides us with the evidence that a robust assessment and care plan is imperative in order to plan and execute an excellent standard and quality of care. Within the field of frailty care this is evidenced through British Geriatrician Society (2014)

2.2. Glossary of Terms

Term	Definition
Wellbeing plan	A plan that is completed with the service user and family following a holistic assessment. The plan considers all aspects of the service user's goals and management planning. It ensures that a person's concerns or problems are identified to enable them to be addressed and as a consequence goals set.
Single assessment process	This process enables an integrated approach to assessment using one document to serve a multiple of professions with the outcome of one assessment process for the service users.
Service User	A person that comes into the care of ISD

3. Background

There is a growing evidence base that has emerged around the interplay between physical, social and mental morbidity (DoH 2011a, 2013a, British Geriatric Society, 2014)) and the potential to radically improve outcomes by addressing these needs in an integrated way. Key areas also impact upon this evidence base;

- There have been significant advances in the capability of health and social care organisations / systems to measure and report on care outcomes. This information will play an increasingly important role in enabling informed patient choice.
- Safety and quality of NHS care: A succession of public inquiries (e.g. Mid Staffordshire (Francis, R 2013) Winterbourne View) relating to failures in the duty of care of health and social care providers, particularly to vulnerable patients and service users, have rightfully pushed the safety and quality of care right to the very top of the agenda.
- The Five Year Forward view (DoH 2014): Improvements in relation to people's health and wellbeing, funding and efficiency and care quality will only be attained with the relevant shift in the use of technology and creation of sustainable care models.

It is the expectation in the ISD that in the future we will be looking to achieve a single assessment process that will incorporate Health and Social care enabling a trusting partnership to be developed in each other's assessment. The ultimate aim for the single assessment process is to ensure that our service users only need to offer their assessment details to one professional through a shared document. Following on from the single assessment process a well-being plan will be generated with the service user. The aim and purpose of a well-being plan is to provide the service user / patient / carer / family with a plan of their health and social care needs post assessment. The My Wellbeing plan should reflect current needs, areas of risk/ challenge and future recovery plans. It will include realistic specific, measurable and timely goals agreed with the service user/ patient / family.

It will have a focus on humanisation of health care Todres et. Al. (2009), Borbosi et. Al. (2012), Todres, Galvin, Dahlberg (2014) Humanisation is a conceptual framework that articulates what we mean by the term "humanisation" as a value base for guiding care. This provides eight philosophically informed dimensions of humanisation, which together, form a framework that constitutes a comprehensive value base for considering.

4. Expectations

The ISD expects all clinicians to complete a comprehensive holistic assessment within 24 hours of admission to the ICT. Holistic assessment can make a big difference to people's experience of care;

- It can help them to realise their concerns are worthy of consideration and not unusual
- It can open up the door to discussion and bring attention to sources of help that may not be required there and then but may need at some point later.
- It allows people to discuss their concerns or issues at an earlier stage before they reach more serious proportions.
- It enables realistic goals to be set.
- It enables safe and effective discharge planning through effective well-being planning.

It is expected that through a full holistic assessment of needs a robust wellbeing plan can be completed with the service users and its implementation will lead to a more productive way of encouraging self-management. It is always expected and important that the goals set through holistic assessment are realistic and discussed in full with the service user.

It is expected that all staff will be fully competent to complete a holistic assessment in line with the SHFT skills and competency framework (2016 version). The well-being plan will have a focus on humanisation of health care Todres et. Al. (2009), Borbosi et. AL. (2012), Todres, Galvin, Dahlberg (2014) Humanisation is a conceptual framework that articulates what we mean by the term "humanisation" is a value base for guiding care. This together, form a framework that constitutes a comprehensive value base for considering both the potentially humanising and de-humanising elements in caring systems and interactions.

5. Purpose and Aims

"The mission of the ISD is to promote improved health, well-being and independence of the populations it serves. This will be achieved by delivering good quality quality-focussed, integrated health and social care services that enable patients to be in control of the care they receive wherever possible. Other drivers exist that provides us with the evidence that a robust assessment is imperative in order to plan and execute an excellent standard and quality of care."

Along with the wellbeing plan that will be produced following holistic assessment, it will have a focus on humanisation of health care Todres et. Al. (2009), Borbosi et. AL. (2012), Todres, Galvin, Dahlberg (2014)

The ultimate aim will be for a single assessment process that examples excellent integrated working and trust in each other's core assessment competencies. The single assessment process will provide one point of assessment for all health and social care practitioners to complete. This will have the added benefit for the service user who will in turn only need to express their current situation with one health or social care professional. The holistic assessment will aim to have the potential for each profession to build on with regard to their professional requirements.

The 'My Wellbeing Plan' will be based around the service users / patients' goals and the actions required to meet these goals the risk they may hold and the future plans for rehabilitation, re enablement and recovery.. Actions will represent those of the service user and of the health and social care professionals and wider network involved with the patients care pathway.

6. Scope

A wellbeing plan will exist for all service users / patients' receiving care from Southern Health NHS Foundation Trust and shared with partners where appropriate.

The integrated plan will be the service users' well-being plan. As a wellbeing plan the document will be held by the service user / patient. The well-being plan will aim to provide the service user, patient, family, health and social care professionals, SCAS and primary care with a plan that meets the ongoing need, crisis and recovery plans. It will be the aim for the plan to be shared across all agencies but belong to the service user / patient.

7. Definitions

The wellbeing plan is a multi-professional document that holds the full consideration all aspects of a person's needs, ensuring they are seen as a whole. It is a plan that is completed with the service user and family following a holistic assessment. The plan considers all aspects of the service users' goals and management planning. It ensures that a person's concerns or problems are identified to enable them to be addressed and as a consequence goals set.

8. Rationale

The wellbeing plan will aim to provide the service user, patient, family, health and social care professionals, SCAS and primary care with a comprehensive assessment. As a consequence care can be planned in partnership with the service user and family resulting in a wellbeing plan that is useful, supportive, and realistic and recovery focussed.

9. Instruction / Explanation / Rationale & References

No.	Instruction	Explanation / Rationale / References
1.	An initial assessment of patient care will be completed by a trained member of staff. The response time to referral will depend on patient need identified by referrer and also triage pathways that exist within the service.	A full assessment in partnership with the service user and/or carer will aim to shape the ongoing wellness plan. Individual practitioners are responsible for ensuring that they are working in a recovery orientated way
2.	For the service user/carer/family to identify the pertinent goals that they would wish to be the aim of the plan	The service user needs to be at the centre of the care plan. By identifying and recording their goals as paramount then actions can be agreed as to how to achieve these goals in the wellness plan. Triggers will be agreed to show when the plan is not meeting the goals agreed and clinical supervision will be implemented for the health care professional to offer senior clinical advice
3.	All care plans are expected to be: • Up to date • Reflect the person's own assessment of their situation and priorities • Be written in simple personal and meaningful language for the service user/family/carer • Be created in partnership with the service user/family/carer • Have clearly identified goals and actions • Have clearly accessible contingency / crisis plans • Have clearly stated review dates • Be given to the service user	The interaction that is held will facilitate the development of a care plan that will impact on the outcome for the service user / patient and the length of need for services. Focussed on the patients working strengths the well-being plan will address the obstacles and issues that the person is faced with but from a different vantage point that is hopeful and individually created. Humanisation of the care pathway which means to form a framework that constitutes a comprehensive value base for considering both the potentially humanising and de-humanising elements in care systems and interactions
4.	Staff skills and competency in creating a wellbeing plan will need to be assessed in practice. In particular relation to their habitation, re-enablement and recovery, self-management and well-being aspect of the plan. Applying SMART goals	Training maybe required assisting staff in completing the wellbeing plan. In view of the need for a wellbeing crisis recovery plan and self-management focussed plan, staff may require further training in well-being recovery and disease self-management. The wellbeing plan will need to be part of the staff skills and competency training to enable the well-

		ness plan to reflect a self-management focus and for staff to be confident in completing this in all areas of care.
5.	The wellbeing plan will be uploaded onto the RiO system for viewing by all health professionals	For all health professionals to view the wellbeing plan in light of the new opportunities through OpenRiO
6.	The wellbeing plan will remain in the service users' home. It will be shared with al agencies identified within the plan	To ensure that the plan is shared with all relevant agencies for communication around crisis management
7.	A key worker will be identified as the most appropriate individual to lead with the wellness plan in partnership with the service user. The key worker will be responsible for the coordination of the times review.	Each individual will have a key worker allocated that best represents their care needs at that point in time. The key working will work with the service user to update and refresh to well-ness plan as required and agreed
8.	Section 1 of the wellbeing plan. **My details**	This section required the demographic details of the service users. It will identify the key worker involved and a review date
9.	Section 2 of the wellbeing plan. **This is me**	This section will outline the social, family, job, personality, home, lifestyle, social and leisure activities etc. It will also outline the past and current health issues for the service user. It should aim to assist the health professional in understanding the service user and is the service users opportunity to describe themselves and what is important to them.
10.	Section 3 of the wellbeing plan. **What keeps me well and what support I need to become well?**	This section will aim for the service user to identify what keep them well and also what is required to keep them well. A set of goals will be established that we be articulated in the service users terms i.e. I would like to sit out in my chair and see the garden each day. Plan will be actioned in how to reach this goal and who will be involved to achieve this function
11.	Section 4 of the wellbeing plan. **What is normal for me?**	This section will outline what is 'normal' for the service users'. This section will also be used as UCP planning for SCAS. It will identify what could go wrong and how the service user and family can mitigate this. A set of observation to be completed and also reviewed should clinical signs change

12.	Section 5 of the wellbeing plan. **My choices**	This section will outline what the service users' wants in the case of an emergency and also what risk medications the service user may be on. This section again will aim to replace UCP details for SCAS and will need updating if clinical indicators change
13.	Section 6 of the wellbeing plan. **My care services**	This section will outline any care services that are involved for this service users' including health, social and voluntary care

10. Guidance on completing the form

My Key Worker: **Their telephone no.**

Assessment date: Review date:

Date printed:

Section 1

My Details	**My GP Details**	**My Key People** (Community Team, social care, etc)
Surname: **TEST**	GP Name:	Role:
First Name:	Practice Name:	Phone:
Date of Birth:	Practice Code:	Role:
NHS no:	Phone number:	Phone:
AIS no:	Direct number:	Role:
Landline no:		Phone:
Mobile no:		

Address. Key safe (if appropriate)	**Principal Carer / Next of Kin** Name Address: Tel. Number

My other important contacts:

Adult Services Out of Hours	**0845 603 4555**	Older persons Mental Health	**via GP**
Health Out of Hours	**111**	Legal representative	

Section 2

This is me **(pen picture, inc. family, job, personality, home, lifestyle, social and leisure activities etc.)**

My name is ……..and I live at home with my husband …... I have a cat called Honey. I like to go out into Winchester shopping with my husband but this has been difficult recently as I am having difficulty mobilising. My husband ….does all the shopping and cooking at the moment. …..also manages the washing. I would like to stay at home and do not like going into hospital.

These are the long term conditions I live with and also a summary of medical input I have needed in the past (Current issues and past medi

I have Heart Failure (2015) ; I wear a pad as I do not always know when I am going to the toilet.

I get breathless and have a condition called cor pulmonale (2014)

I also have osteoarthritis (2008)

I have had depression in the past (2005)

I have hypothyroidism (2003)

Section 3

What keeps me well and what support I need to become well?

(milestones, goals, physical and psychological, envi

I need help with my washing and dressing and will need care to help me changing my pads when they are wet.

I need help from therapy as I am having trouble mobilising.

I also need help with getting a chair in place that allows me to sit properly and ensures that I don't get breakdown of my pressure ulcers.

I need to take my inhalers (Salbutamol, Fluticortasone) to help with my breathing.

I also need to take my water tablets (Bumetanide 2mg twice a day) to make sure that I don't get breathless.

This is my plan (it needs to include my physical wellbeing, daily living, personal care, environment, mobility and		
What are my individual goals? Identified needs	**How can I manage & maintain these goals & my wellness?**	**Who is helping me with this?**
I want to stay in my own home.	Improve my mobility. Improve my ability to stand with and take some steps with the WZF in the house. I need help with standing. I need two people to stand me and prompt me to push up from the chair arms and use my frame. At the moment I can only stand for 1 or 2 minutes and then I have to sit down again. If I take my water tablets I will have more breath to take some steps.	[redacted] Physio ERS@H team/[redacted]
	To reduce my breathlessness so that I can mobilise better. 1. For the Health professional to review by breathing and advise if further treatment required. 2. To make sure that I take my nebulisers to assist in helping my breathing better. 3. For [redacted] to help me with my medication remind me to take it and to use my inhalers. 4. I must take my water tablets in the morning and at lunchtime or else I will become more breathless and this could stop me from walking as far as I want too. 5. I will need to keep a good look at my weight weekly the health professionals will help with this.	[redacted] Consultant Nurse ERS@H team and GP[redacted]
	To have more help in washing and dressing me and also helping me change my pad. I am waiting for more carers to come in and help me with my pad change. To remember to use the cream on my skin if [redacted] is helping with my personal care. I am thinking about having a catheter but at the moment I am not keen on this.	Care agency/ SW/ ERS@H team/[redacted]
	I am not eating very much at the moment. I have nutritional drinks and I try to have 1 or 2 a day. I need help from [redacted] to get these for me. [redacted] does all the shopping but he will need some help with this and also some ideas about how he can be helped with this. I know that the nurses and physiotherapist and occupational therapist will need to check on my weight and also my eating.	[redacted]

I want to be able to go to Winchester	At the moment I can only sit in my chair and I am not able to get to bed. I need to try and change my position in the chair at regular hourly intervals. If I can I will try and stand every 1 or 2 hours. I have a chair cushion but at the moment this is not comfortable. I have pads for my elbows that ben will help me with to make sure they are in place. The nurses will review my pressure areas and sore skin	Carers/ERS@H team

Section 4

What is normal for me? **(usual health and what can I do)**
At the moment it is normal for me to need 2 to help stand me. It is normal at the moment for me only to stand for 1 or 2 minutes at a time and then I need to sit back down again. It is normal at the moment for me to sleep in my chair as I cannot get back into bed and I can't mobilise to my bedroom. It is normal for me at the moment to have trouble with incontinence. I am waiting for an increased package of care to help me with my care It is normal for me at the moment to have a reduced appetite. I have nutritional supplements at home. cooks for me and shops for me, I sometimes need help with this.

What I need to do if my needs change?	
What could go wrong? (risks, change in health)	**What will need to be done / What will I do; who will I contact?** (include relevant phone numbers)
I could fall at home	I will need picking up from the floor and assessing by the paramedic. I do not want to go to hospital.
I could get more breathless	I can use my blue inhaler, I can call the GP. I must take the water tablets twice a day.
I could get chest pain	I can call the ambulance service or the GP

Normal Observations			
Pulse	74	Blood glucose range	4-6mmols
Respiratory rate	24	Peak flow	Not measured
Blood pressure	96/45	Weight	76kg
O_2 Saturation	This can range from 77-85% in air this is normal for [redacted]		

Section 5

What I want to happen in an emergency (Advice for ambulance crews and out of hours doctors who might need			
I don't want to go to hospital			
Medication emergency carers need to know about (not a full medication list)			
Warfarin	No	Immune suppressants	No
Steroids & recent use	No	Insulin	No

My Choices.			
DNACPR form completed:	No	Do I have an End of Life Plan agreed:	No
Where is it?		(If yes please summarise in emergency care box above)	
Do I have an advance directive in place?	No	Lasting Power of Attorney for Welfare and / or Finance in place?	LPA for welfare Yes / No LPA for finance Yes / No
Where is it?			

Section 6			
Summary of Care Services			
Provider	**Start date**	**End date (if applicable)**	**No. of weeks**

Who was involved in creating this plan:

I am happy with its content and I am happy for it to be shared with others involved in my care

Signature: Date:

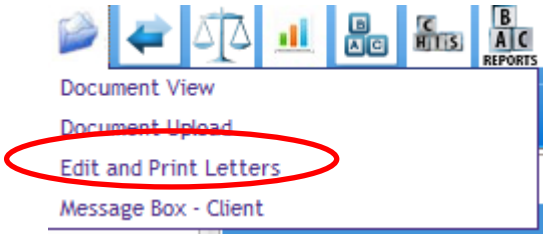
11. Step by step instructions

My Wellbeing Plan

Guidance

The My Wellbeing Plan has been designed in order to help the patient have more of a say in how their care is taken forward and what their aims are. It will be the property of the patient but will allow those external services to know what has been occurring should they have the need to enter the patient's home.

Once you have logged into RiO and you wish to complete the 'Wellbeing Plan', go to the Clinical Documents as indicated below, Select 'Edit and Print Letters' as indicated below:



Then complete the client search as it requests.

Select 'All-My Wellbeing Plan' from the Letter Type drop down and click 'create' at bottom of page.

The letter will open up as a word document. Certain sections will pull through automatically such as **Section 1** –

- My details (patient)
- My GP details

Unfortunately 'My Key People' section will need to be completed manually. These can be copied and pasted from Assessment forms if they are being used by the service.

Section 2

This section is about the patient and a summary of any long term conditions.

Section 3

This section talks about goals, both physical and psychological and what the patient feels will make them achieve these.

Section 4

This is about what is normal for the patient and what the patient would do if something went wrong.

Section 5

This is about what the patient would like done in an emergency, who to contact etc.

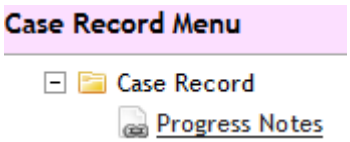
Section 6

This is a summary of the Care Services involved with the patient's care.

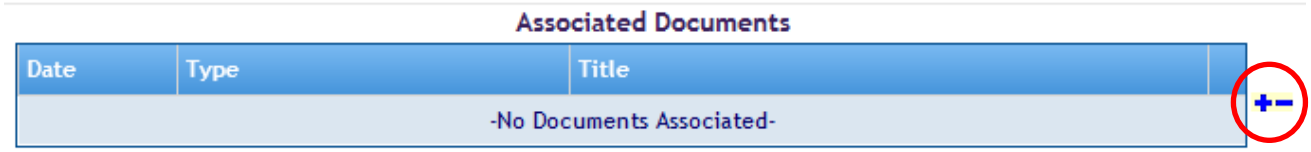
Once the letter is complete, it can be uploaded saved onto your teams shared drive. Please follow this naming convention when saving. Patient Surname - Initial, NHS no., Date of assessment, Version number.

A progress note needs to be added to the patient's record once uploaded and in future if any changes to the Wellbeing Plan take place.

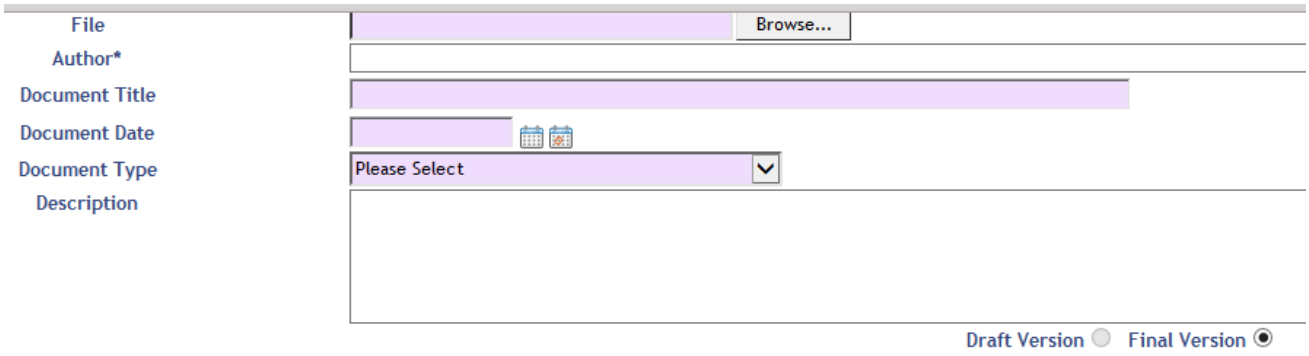
To add a progress note and upload the associated document to the note, follow the instructions below:



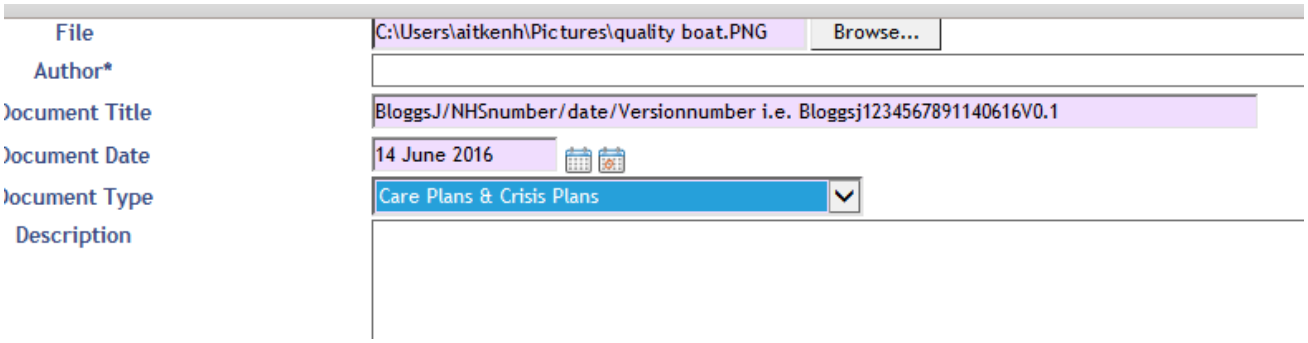
Click on progress note and at the bottom of the next page is a note in blue 'Add New Note', click on this – the next screen will be where you type your progress note. Before you tick 'validate this note' look at the bottom of the page for the following:



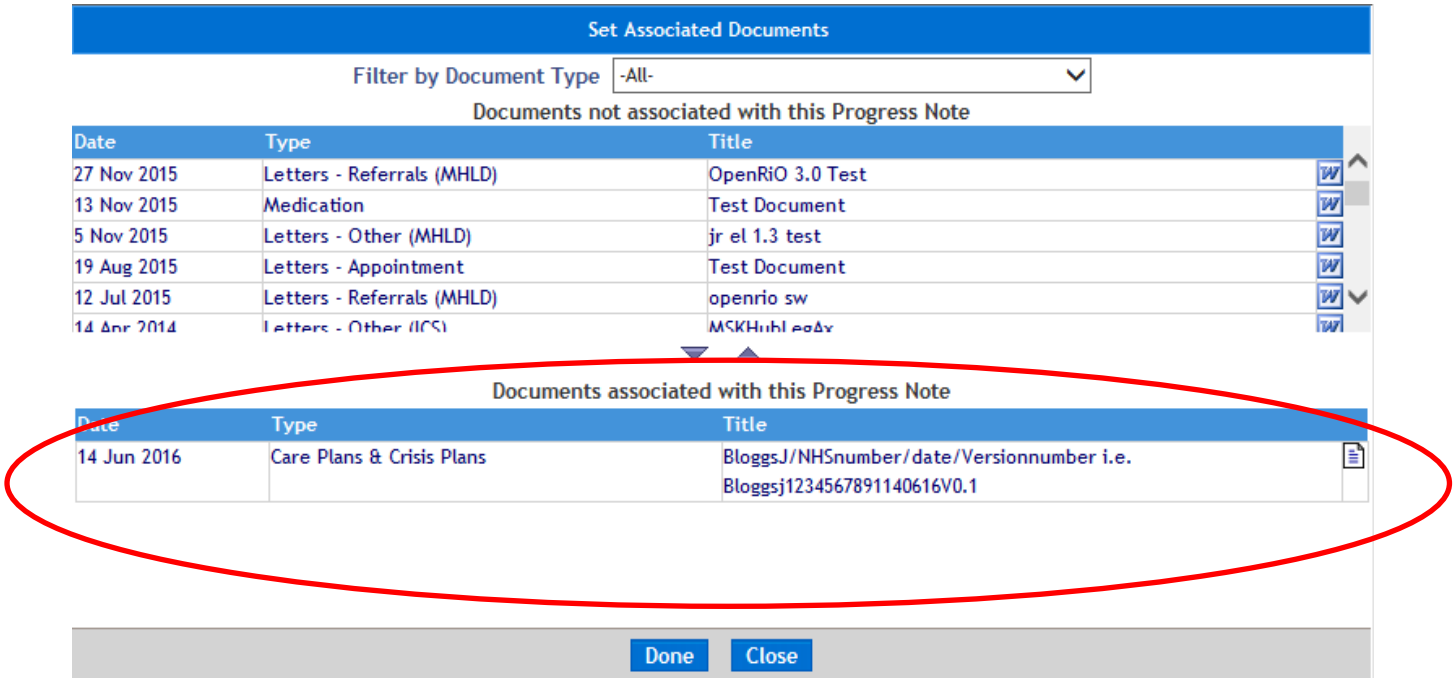
There are no documents associated with this person at the moment but if you click on the plus sign to the right of the box, as indicated. The next box that appears in the middle of the screen has 'Upload New Document', click on this and the following will appear



Once completed the form should resemble this



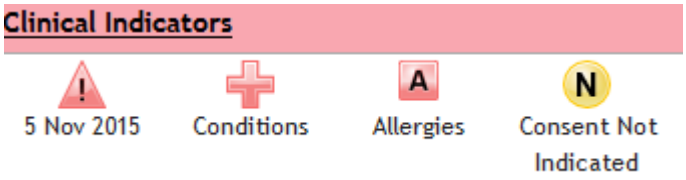
Click upload document at bottom of page and this screen will appear



You can now see that this document is associated with the progress note, click done. You are now able to validate your note and click 'Save Changes' . This process is now complete.

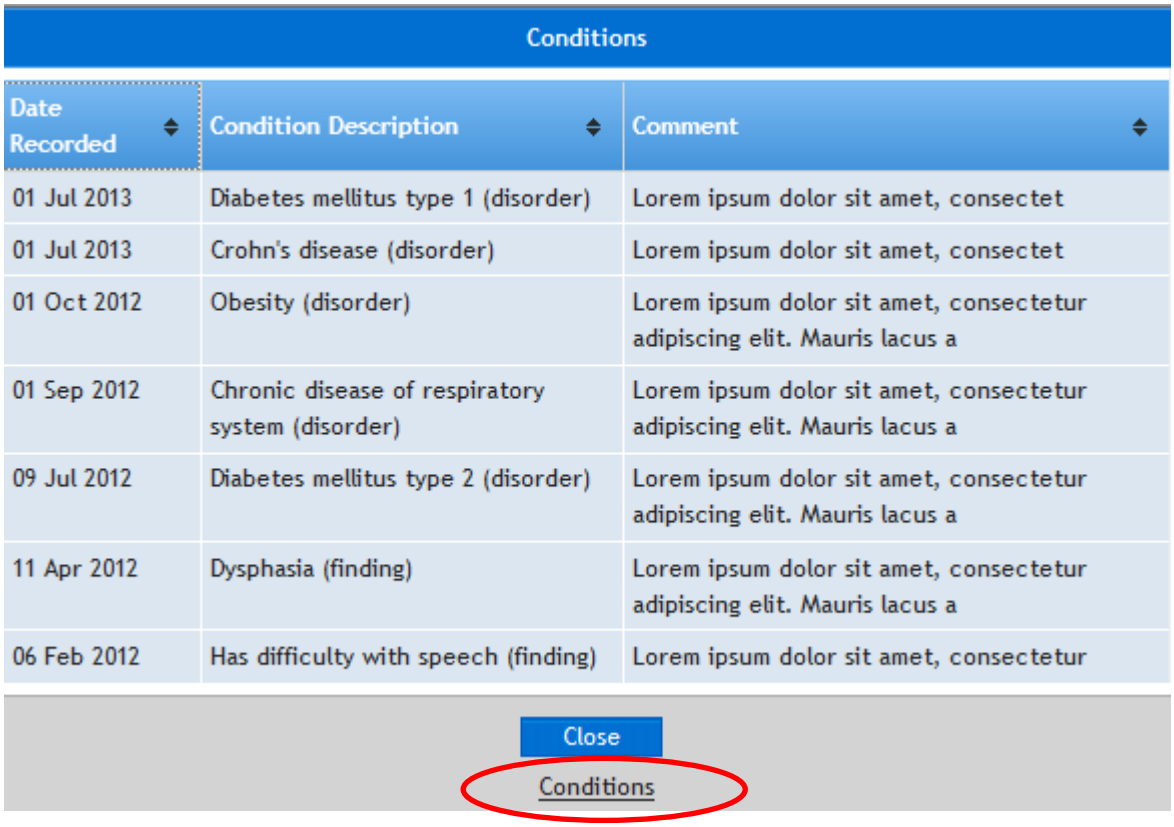
A condition to the patient's record needs to be complete. Please add the Frailty condition along with the comment 'My Wellbeing Plan complete'. (Steps provided to add condition).

Search for client via case record and click on conditions as indicated below:



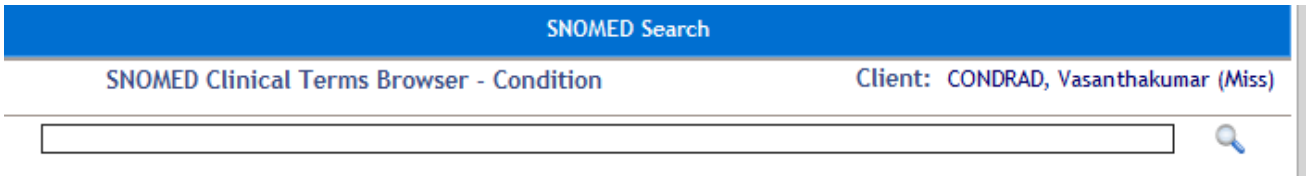
When you click on the red cross (Conditions) the following box will appear showing you what existing conditions the patient has.

If the patient does not have a condition assigned, there will not be a red cross icon. You will instead have to access via the case record menu by clicking the Conditions/Diagnosis folder and then selecting conditions.

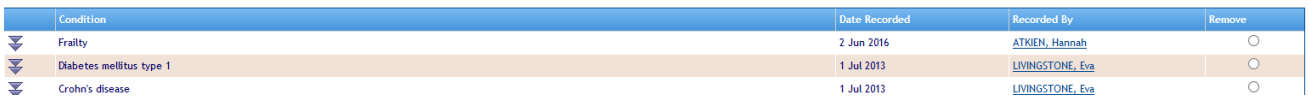


To add a condition click on Conditions at the bottom of the page, a larger box will appear and at the bottom of the page you are able to either 'Add' or 'Remove' another condition, click add and the following box will appear

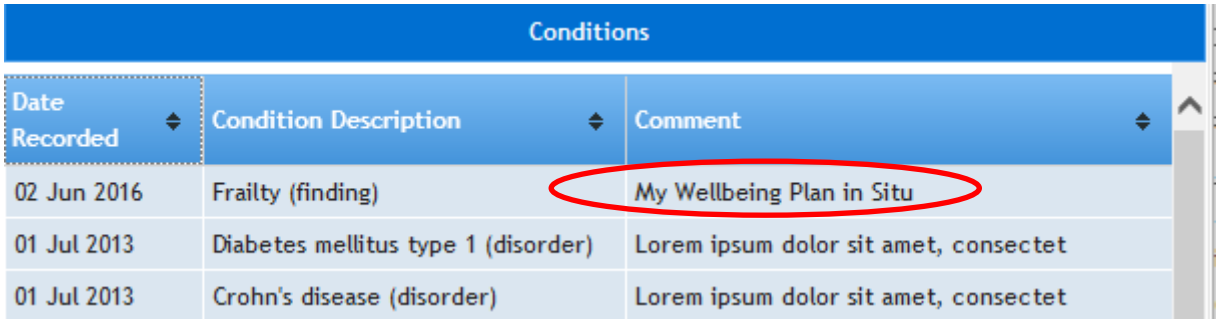
Click on the green cross and you will do a 'SNOMED' search, type 'Frailty' in the box and click on the magnifying glass



Search result will come up with a number of options, just pick the single word 'Frailty' and at the bottom of the page, click 'Add to client's record' – a new screen will appear with the words Condition Frailty and then the green cross (as above). In the comment box, you must type the words '**My Wellbeing Plan in Situ'** then click save at the bottom of the page. This box will then appear indicating the condition frailty has been added



When you return to the case record screen and click on ‘Conditions’, you will see the following box and clearly be able to see the comment, the patient has a ‘Wellbeing Plan in Situ’



Conditions

Date Recorded	Condition Description	Comment
02 Jun 2016	Frailty (finding)	My Wellbeing Plan in Situ
01 Jul 2013	Diabetes mellitus type 1 (disorder)	Lorem ipsum dolor sit amet, consectet
01 Jul 2013	Crohn's disease (disorder)	Lorem ipsum dolor sit amet, consectet

Please **ensure** all the comments remain the same as this will be used for reporting purposes.

If any future changes to the wellbeing plan are required, you can amend the version saved on the shared drive. This will require a new version number. Once saved you can then upload onto OpenRiO.