

Using the Chapelhow Framework to deliver patient care

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Abstract

The aim of this article is to discuss two of the Chapelhow enablers: communication and managing risk. These can be the difference between a therapeutic relationship with the patient or an incident due to the patient becoming agitated. The author would suggest that more work needs to be done on the impact gender can have on communication, such as male care providers upon female patients, and the potential associated risk and how this can be reduced with risk management.

Keywords

Chapelhow enablers, Communication, Gender, Risk Management, Positive Risk

Please cite this article as:

Arnold, J. (2017) Using the Chapelhow Framework to deliver patient care. *Links to Health and Social Care* Vol 2 (2), pp. 3-15



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Introduction

This article will reflect on the care given to a patient who has been detained under the Mental Health Act 1983 (amended 2007) using the framework by Chapelhow et al. (2005), who identified several enablers considered to be fundamental in delivering expert care. These include assessment, communication, documentation, managing risk, professional decision making and managing uncertainty. For the purposes of this article the focus will be placed on communication and risk management.

Communication is fundamental to patient care as there can be no caring or therapeutic relationship without it (Morrissey and Callaghan 2011). Indeed, it is only by obtaining a patient's perspective on what they hope to achieve throughout their care as well as engaging with other care-providers and professional bodies within a multi-disciplinary team (MDT) that we can hope to provide person-centred holistic care. Meanwhile risk management proves essential in the provision of care and according to Gilbert, Adams and Buckingham (2011) particularly significant for those within a secure mental health setting as personalised risk management plans are put into place to facilitate recovery as well as ensuring that safety is paramount. Higgins et al. (2016) found that it was only through proper risk management that care can be truly person-centred.

These two enablers will be applied to a reflection on the care given to a patient residing in an adult forensic psychiatric medium secure unit. To ensure the individual's confidentiality is maintained as outlined by the Nursing and Midwifery Council Code of Conduct (NMC 2015), the subject of the case study shall be referred to using the pseudonym Toni. Toni has given verbal consent for her personal case details to be

used as part of a student's coursework.

Toni is a 25-year-old woman who has been detained under the *Mental Health Act* 1983 (amended 2007) and has been residing in a medium secure setting. Previously she has had numerous violent altercations with the public and police force and has been volatile with staff and peers on the ward when experiencing a manic episode, with little regard for the consequences. Subsequently, Toni often suffers from prolonged periods of depression and anxiety due to her psychotic state. According to the International Statistical Classification of Diseases and Related Health Problems, these are all indications of her dual diagnosis of bi polar and borderline personality disorder (World Health Organization 1993). Under details of her section, Toni was required to utilise therapeutic interventions to aid in her recovery of mental health as well as her overall wellbeing. In the situation already discussed the MDT were utilising one to one therapeutic nursing sessions where Toni could openly express her feelings including any negative thoughts she was experiencing.

Communication

Within nursing practice, communication is a broad term and involves utilising an individual's knowledge, information, and ideas to exchange either in the form of speaking, listening, reading, or writing and can also include non – verbal communication (Eadie et al. 2006). Verbal communication was used during one-to-one sessions to help Toni to become more self-aware and improve her insight into her illness. During these therapy sessions, the primary goal was to ensure that Toni felt included in the decisions involving her care and was able to openly discuss her mental wellbeing and overall health because as Marbley et al. (2015) note, this is often key to an individual's

recovery. The trusting therapeutic relationship and effective communication individuals had with Toni during this one-to-one session proved instrumental in ensuring that she felt comfortable enough with care providers to openly disclose the fact she had been experiencing hallucinations. Subsequently, this enabled further effective communication between Toni's care providers and the wider MDT to provide a clearer understanding of where she was in her recovery pathway and the care interventions needed for further progression.

One potential issue that arose during these sessions was the impact that gender differences between Toni and her carers could have on the effectiveness of her one-to-one therapy. This concern was supported by a study by Dysvik and Sommerseth (2010), who found that within the mental health sector, women can come across as more caring and empathetic than men which may enable the patient to talk more openly with female members of staff. Eadie et al. (2006) noted the significance of empathy in the development of the underpinning relationship and feelings of trust a patient has with nursing providers and, as such, it is possible that female patients might experience difficulties in disclosing information to male carers as they may struggle to find an empathetic common ground with them (Dysvik and Sommerseth 2010).

Therefore, as a male university student being present during the therapy sessions of a female patient it was noted that potentially Toni might withhold certain information. It was important to build a therapeutic rapport with Toni prior to the one-to-one session. This was done by engaging Toni in conversation involving common topics of interest

such as music, films and the news which had enabled her to feel comfortable conversing with male care providers. Furthermore, Toni chose to have one-to-one therapy and she indicated that she preferred talking to the male members of staff as she felt the female nurses tended to be too emotionally involved in her care.

The issue of confidentiality regarding the content of Toni's one-to-one therapy was mentioned at the beginning of each session. Toni understood that if she indicated either verbally or physically any serious intention to harm herself or others, staff would be professionally obliged to pass it on to other members of the MDT in accordance with local safeguarding policy (Safeguarding Adults Board 2015). Elger, Handtke and Wangmo (2015) discovered a potential issue in communication here when they recognised that mental health professionals sometimes struggled to determine the circumstances in which they should pass on information as well as what information they could/could not share. Issues such as suicidal plans and abuse being suffered emotionally, physically, and financially need to be reported in accordance with local safeguarding procedures (Safeguarding Adults Board 2015), as these have a major impact upon an individual's holistic health. Toni did not reveal suicidal plans or an abusive history in her discussion about the hallucinations she had recently been experiencing. Toni was involved and communicated with accordingly, particularly when other healthcare professionals needed to be involved so that her care plan could be updated.

Stensrud et al. (2014) found that as well as having the ability to *explore* the emotions of

the individuals under their care, it was equally important that care providers learned to respond empathetically to what the patient was disclosing. Therefore, although it was important to communicate the medical knowledge that Toni was suffering hallucinations to the relevant professionals within the MDT after the one-to-one session ended, it was equally important to consider the present circumstance and continue to listen to Toni as she revealed the personal impacts the hallucinations had on her feelings and reassure her that there was nothing wrong with her somatically (Stensrud et al. 2014). This aspect of communication is proven to be of the utmost importance within the mental health sector especially, given that people with a mental health history have a higher number of somatic complaints than those without mental health issues (Kekkonen et al. 2015).

Furthermore, Stensrud et al (2014) revealed that to listen and reassure patients effectively, staff should have the skills and access to explore other therapeutic resources. For instance, when Toni mentioned she started to feel anxious when other patients on the ward became unsettled resulting in shouting for prolonged periods of time. She was offered the use of an MP3 player to distract her from these noise levels. The use of a low stimulus room gave her some solace and a way to cope with these daily stressors on her mental wellbeing. This approach was based on a study by Brown, Rutherford and Crawford (2015) who found that music could be utilised in this way. By discussing this as an option with Toni without needing to have the decision reviewed by a third party first, we not only succeeded in reassuring Toni but also secured a level of trust and communication that underpinned our therapeutic relationship with her.

Gilbert, Adams and Buckingham (2011) discovered that choice of language was also a significant factor in effective communication within the mental health setting and when conversing with a patient in a one-to-one setting. Staff must respect boundaries and comply with pre-written care plans detailing what topics or specific words to avoid, as they may be classed as a trigger for some individuals. It is a staff member's duty to ensure that they manage the risks of Toni becoming agitated and distressed and are aware of the ways communication can be used when in the one-to-one therapeutic sessions. It was included in Toni's care plan that subjects relating to her biological family and questions that may probe into the psychological abuse that she suffered as an adolescent should be avoided.

Risk Management

A study by Briner and Manser (2013) revealed that the ability to put clinical risk management plans into practice was fundamental in reducing instances of patient self-harm. Although this was a qualitative piece of research, relying on testimonies of nursing professionals over quantitative data, it does seem reasonable to assume that any actions that may reduce risk to the patient would increase their safety. However, there is still a lot of debate concerning what constitutes effective risk management of patient and staff safety and how this may directly impact on the individual's progress towards recovery. Nolan and Quinn (2012) concluded that staff should be in the position, with support of their organisation, to effectively manage risk. They must assess whether constraining a patient's rights and autonomy is the best way for individuals to recover in long term inpatient settings on a case by case basis. They also

suggested that staff should be taking positive action and interpreting risk for the benefit of patients and their recovery.

Indeed, as Reddington (2017) revealed risk management is often a 'grey area' especially when the factor of positive risk is considered, as many healthcare professionals find themselves bound by the standards and regulations of the NMC (2015). When undertaking risk assessments consideration needs to be given to the most effective recovery pathway for the individual patient. For example, as Toni has a history of becoming violent when she has misunderstood something or has become agitated due to her confusion leading her to assault a member of staff, it would be reasonable and within NMC guidelines (2015) to have Toni escorted by two members of staff when in a closed space both for her own protection and the safety of her care providers based on the assessment of this risk. On the other hand, the progress Toni had made throughout her one-to-one sessions meant that we took the positive risk to continue using these therapy sessions without noticeable restrictions.

Of course these positive risks are not undertaken lightly and still involve a lot of careful planning and risk management strategies to ensure that this takes place in the safest environment possible (NHS Foundation Trust, 2015). For instance, when in a one-to-one session with Toni, the low stimulus room was used to help maintain a level of calm and reduce anxiety levels. In addition, the seating in the room was laid out so that the staff member was situated closest to the door facing Toni who was strategically sitting with her back towards the wall. This seating arrangement significantly reduced the risk

of Toni causing harm to herself or a staff member as the door was always accessible. Whilst the door remained closed to maintain a level of privacy and confidentiality, both Toni and the staff member could be viewed through a clear window by other professionals which prevented the opportunity for behaviour to become dangerously aggressive in accordance with local guidance and policies (Safeguarding Adult Board 2015).

It was important that assessments were carried out often to highlight any new risks to the patient and her overall wellbeing and subsequently manage them accordingly (NHS Foundation Trust 2015). These routine assessments allow for changes to be made to a patient's care plan which may also have the positive implication of allowing staff members to identify a new positive risk that may aid in the recovery of the individual. Toni's care plan included risk assessments that were reviewed routinely on a four-week basis in accordance with hospital policies which allow the MDT to monitor her recovery progress and adjust her plan where necessary. For example, when Toni was first admitted to the ward she could not participate in one-to-one therapy due to her spontaneous outbursts of violent behaviour, which posed a high risk to her own safety as well as the physical safety of staff. However, as time progressed and more risk assessments were carried out, the MDT decided that Toni had displayed more self-control and was participating enough to be offered the positive risk of one-to-one therapy sessions within her care plan to aid her recovery further.

Conclusion

After reflecting on Toni's care in the context of both communication and risk

management, it has been demonstrated that these two enablers are key to providing a holistic and person-centred approach to care, specifically but not exclusively within a mental health setting (Chapelhow et al. (2005). It has been demonstrated that effective communication is fundamental within the care system between the patient and care provider and also within a MDT. It has also been shown that communication is a very broad term and encompasses the effective use of other enablers such as the founding of relationships, choice of language and listening (Elgar et al. 2015), which have enabled Toni to take an active part in her recovery process and care planning.

Furthermore, effective risk management alongside the ability to take positive risks, identified by Nolan and Quinn (2012), is equally important in providing a holistic care approach. This was an integral aspect of Toni's care plan as the strategically planned environment of the one-to-one sessions ensured that her progress was in line with her recovery pathway. These therapy sessions not only proved useful in allowing staff an insight into Toni's mental state but simultaneously allowed her to gain an understanding of her illness. This increased self-awareness could undoubtedly have a positive impact for Toni's long-term care plans and may reduce the risk of violent outbursts that she displayed during her earlier years within a residential care setting.

Equally, it is important to note that research into these enablers is constantly evolving. The potential negative consequences that the issue of gender differences can have on the effectiveness of communication, highlighted by Dysvik and Sommerseth (2010), should be further researched to ensure that the upholding of a professional boundary does not prevent the finding and utilising of an empathetic "middle ground" particularly

between male care providers and female patients. Meanwhile, further research into the 'grey area' of risk management, as highlighted by Reddington (2017), could prove significant in seeking further improvement in patient treatments particularly if built upon research by Nolan and Quinn (2012), which highlights the importance of including the patient and their opinions on what 'positive risks' they feel comfortable with. This highlights the intrinsic interlinking nature of the enablers in delivering patient-centred care, the importance of which, as highlighted in the reflection on Toni's one-to-one sessions, should not be underestimated.

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