ASSESSING, PLANNING & MONITORING CARE *FOR* NURSING ASSOCIATES

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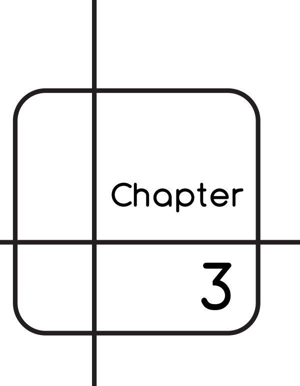

Bio-psycho-social healthcare assessment

Lisa-Marie Rowe

NMC *STANDARDS FOR PROFICIENCY FOR NURSING ASSOCIATES*

This chapter will address the following platforms and proficiencies:

Platform 1: Being an accountable practitioner

1.1 understand and act in accordance with the Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates, and fulfil all registration requirements.

1.11 reflect on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs, and preferences, taking account of any need for adjustments.

Platform 2: Promoting health and preventing ill health

2.6 understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours, and lifestyle choices to mental, physical, and behavioural health outcomes.

Platform 3: Provide and monitor care

3.3 recognise and apply knowledge of commonly encountered mental, physical, behavioural, and cognitive health conditions when delivering care.

3.19 demonstrate an understanding of co-morbidities and the demands of meeting people's holistic needs when prioritising care.

Platform 6: Contributing to integrated care

6.1 understand the roles of the different providers of health and care. Demonstrate the ability to work collaboratively and in partnership with professionals from different agencies in interdisciplinary teams.

6.2 understand and explore the challenges of providing safe nursing care for people with complex co-morbidities and complex care needs.

6.3 demonstrate an understanding of the complexities of providing mental, cognitive, behavioural, and physical care needs across a wide range of integrated care settings.

Chapter aims

After reading this chapter you will:

- Be able to explain the theory and principles of the bio-psycho-social model.
- Understand how a person's bio-psycho-social needs can affect one another.
- Understand how the bio-psycho-social model supports a person-centred approach.
- Recognise the importance of inter-disciplinary working to meet the bio-psycho-social needs of an individual.

Introduction

This chapter will explore how an individual's biological, psychological and social needs are intertwined and affect a person's overall health and well-being.

It will encourage the reader to consider the impact of different needs upon one another and how this affects the delivery of care. It will explain how the bio-psycho-social model emerged over time and how the model can be used within all specialities of nursing to deliver person-centred care.

Historical overview

For centuries, clinicians disregarded the influence of psychological and sociological factors upon health. It was considered that poor health was caused by a biological fault rather than the result of psychological and social factors such as poor living conditions for example. The emphasis was on diagnosing and treating an illness rather than treating a person based upon their individual state of health and well-being.

In 1942, the Beveridge report was presented to parliament. The report aimed to eradicate the five 'Great Evils' which were said to plague society: Want, Disease, Ignorance, Squalor, and Idleness. Although not implemented until after the Second World War the report led to the introduction of:

- A social security system which acted as a safety net for those who were elderly, unwell, or on maternity leave;
- The introduction of the National Health Service (NHS) which was to be free at the point of delivery to all;
- Improved access to education, including adult education;
- Improved living conditions through the building of council housing;
- The creation of more jobs.

The formation of the Welfare State was celebrated as accessible to all from 'cradle to the grave'. Beveridge was approaching welfare by tackling both the physical and the social needs of the population and moving away from the biomedical approach.

In 1977, Engel wrote about the correlation between an individual's biological, psychological, and social (BPS) needs. Engel's BPS model (see Figure 3.1) moved away from ritualised or paternalistic care and towards patient-centred care where it was recognised that biological, social, and psychological factors all affect one another and a person's overall health and well-being. This emphasised a more holistic approach to health rather than a biomedical approach to illness.

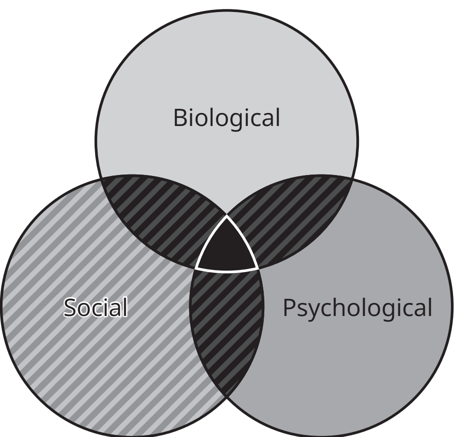

Figure 3.1 The bio-psycho-social (BPS) model (Engel, 1977)

The BPS model states that multiple factors produce multiple effects upon a person's health. A definition of health provided by the World Health Organization (WHO) Constitution (2024) states: 'Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'.

Activity 3.1 Reflection

Consider when you have felt unwell.

- What were your physical symptoms?
- How did it make you feel psychologically?
- How did being unwell affect you socially?
- What made you feel better?

It is likely that medication was not the only method of making you feel better.

As this activity is based on your own observation, there is no outline answer at the end of the chapter.

The BPS model provides a humanistic approach whereby no person's illness is reduced to one contributory factor. It allows healthcare professionals to obtain a clear picture of an individual and what is important to them. The BPS model encourages healthcare professionals to consider an individual's circumstances and the impact of these upon their overall health. In turn this aids diagnosis as the patient relays information which could provide details of contributing factors to their ill health. Therefore, we need to recognise the person as a whole-being. This is known as holism.

Housing

Housing is a clear example of how social status can affect biological and psychological health. Poor housing can affect people in several ways:

- Respiratory conditions such as Asthma
- Cardiovascular conditions
- An increase in accidental injury
- Mental Health conditions
- Overcrowding
- Infectious diseases including tuberculosis, influenza, and diarrhoea.

The World Health Organization (2018).

Equally, where a person lives can affect them biologically, psychologically, and socially. Table 3.1 shows some differences between urban and rural areas.

Table 3.1 Differences between urban and rural areas

Urban area	Rural area
High density population	Low density population
Access to public transport	Poor/infrequent public transport
Easy access to shops and supermarkets	Limited access to shops and supermarkets
Limited green space	Access to green space
Inhalation of fumes/pollution	Cleaner air
Access to specialised health care	Sense of community
Greater employability opportunities	Fewer job opportunities

Case study 3.1: Joan Part 1

Joan is 74 years old and lives in a cottage in a very rural area. She is recently widowed and has type 2 diabetes, hypertension, and osteoarthritis. Her husband used to drive so they could access their groceries, the doctors, chemist and attend Church. This was especially useful as the nearest shop is a 15-minute drive away. Since she has been living alone; her daughter has set up a supermarket delivery for her mum. As Joan finds it hard to stand for long periods to cook, they have ordered frozen microwave meals.

Activity 3.2 Critical thinking

Joan's bio-psycho-social needs have been separated in the list above. However, these do affect one another.

Draw and add the needs into the BPS model from Figure 3.1. How do they affect each other? For example, you may identify how Joan's diet may affect her hypertension and type 2 diabetes.

Biopsychosocial model: Joan's needs

Biological needs (The 'bio' circle) These factors relate to Joan's physical health, genetics and bodily functions.

Type 2 diabetes, Osteoarthritis and Hypertension: These chronic conditions require ongoing monitoring, medication management and a controlled diet.

Psychological needs (The 'psycho' circle): These factors encompass Joan's mental health, emotions and coping mechanisms.

- **Grief:** As a recent widow, she is dealing with the emotional and mental toll of losing her husband.
- **Coping with change:** She must adapt to a new lifestyle that includes living alone and experiencing loneliness.

Social needs (The 'social' circle): These factors include Joan's social environment, relationships and external circumstances.

- **Social isolation:** Her rural location and inability to drive mean she is cut off from her community, including her church and social network.
- **Lack of transportation:** The loss of her husband's driving means she can no longer access services or social outings on her own.
- **Loss of a caregiver:** Her husband was a critical support system, and his absence leaves a major gap in her daily care and companionships.

Joan's bio-psycho-social needs can be separated as follows:

Biological needs:

- Type 2 diabetes
- Hypertension
- Osteoarthritis

Psychological needs:

- Recently widowed
- Daughter lives far away
- Pain from osteoarthritis

Social needs:

- Socially isolated – difficulty in accessing doctors, chemist and Church
- Groceries delivered weekly (ready meals have high salt and sugar content).

Intersections of needs (The overlapping sections)

Joan's situation demonstrates how these domains do not exist in isolation but constantly influence each other.

Biological and social overlap

- **Groceries:** Her rural location (social) combined with her limited mobility and health issues (biological) prevent her from driving to get groceries. This is mitigated by her daughter arranging delivery, but it is a direct result of the intersection of her needs.

(Continued)

- **Healthcare access:** Her physical conditions (biological) are managed in a more challenging way due to her remote location and lack of transport (social), requiring arrangements for chemist and doctor visits.
- **Dietary needs:** The inability to easily get fresh groceries (social) can impact her ability to manage her diabetes through diet (biological).
- **Reduced mobility:** The physical effects of her conditions limit her ability to perform daily tasks and leave her home.
- **Cardiovascular risks:** Long-term social isolation and loneliness are associated with a higher risk of heart disease, high blood pressure and stroke. Inflammation promoted by isolation can accelerate the buildup of plaque in arteries.

Biological and psychological overlap

Cooking difficulty: Osteoarthritis pain (biological) makes it hard for her to cook for long periods, which can lead to stress and frustration (psychological).

Illness and grief: The stress of grieving (psychological) can worsen her physical health conditions, such as hypertension (biological). The isolation and grief can also make it harder for her to manage her diabetes effectively.

Weakened immune function: Chronic stress and elevated inflammation can suppress immune system function link to diabetes also.

Psychological and social overlap

- **Grief:** Companionship and support from family and social connections is recognised to help people in the grieving process.
- **Mental health disorders:** Social isolation is both a risk factor for and a consequence of mental health issues. It is strongly linked with increased rates of anxiety, depression and post-traumatic stress disorder (PTSD).

Biological, psychological and social overlap

Holistic well-being: The combined effect of all these factors on Joan's overall well-being is clear. The death of her husband created social isolation and grief (social and psychological), which affects her ability to manage her chronic health conditions (biological). The solutions, like food delivery from her daughter, help manage the logistical social needs but don't fully address the mental or physical challenges.

Type two diabetes can affect all BPS needs including stress, anxiety and depression, social stigma, poor social-economic status, age, genetics, obesity and other comorbidities. For example, Joan's poor mobility due to pain will affect her ability to exercise and to maintain a healthy weight.

- Hypertension: biopsychosocial considerations for hypertension include biological factors like genetics, hormone imbalances and physiological responses to stress, which can elevate blood pressure. Social isolation is a psychological stressor that affects hypertension by activating the sympathetic nervous system. An increase in the stress hormone cortisol can damage tissues and increase inflammation over time.

The bio-psycho-social model and person-centred care

The BPS model is closely aligned to person-centred care. Person-centred care relies on effective communication and creating a therapeutic relationship. Once a therapeutic relationship is established, the healthcare professional can find out about the person's individual needs and preferences. A nursing associate is expected to 'work in partnership with people, to encourage shared decision-making, in order to support individuals, their families and carers to manage their own care when appropriate' (NMC, 2018).

Delivering person-centred care also encourages autonomy and the person's right to self-determination. Working in partnership with people 'creates better patient outcomes and costs less to health and care systems' (NHS England, 2024). Person-centred care also encourages people to take responsibility to maintain and improve their health. Rather than care being provided for them or done to them, they are in control and central to all decision-making – a concept supported in 'no decision about me, without me' (Coulter and Collins, 2011).

What is important to a person and what they prioritise can be different to factors prioritised by healthcare professionals. The NHS Long Term Plan (2019) recognised this and aimed for people to have autonomy and control over their own individual care. Healthcare professionals must respect a person's ability to make unwise decisions (MCA, 2005) and record a person's decisions and choices – 'write accurate, clear, legible records and documentation' (NMC, 2018).

Barriers to implementing person-centred care include:

- Fears of litigation;
- Accountability;
- The ability of staff to make decisions regarding capacity;
- Patients being labelled as 'non-compliant';
- Time;
- Communication difficulties;
- Power imbalances;
- Institutionalisation.

Protected characteristics and the bio-psycho-social model

Person-centred care must consider protected characteristics, a person's views and wishes and how these may impact upon care provision. Nursing associates are required to:

1.11 *Reflect on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments* (NMC, 2018).

Under the Equality Act (2010) it is unlawful to discriminate against someone because of a protected characteristic. The Act specifies that the advancement of equality relies upon:

- Removing or minimising disadvantage suffered by people due to their protected characteristics;
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people;

- Encouraging people from protected groups to participate in public life or in activities where their participation is disproportionately low.

Therefore, it is important to recognise that those with protected characteristics are generally more likely to experience specific BPS needs. Some examples are provided below.

- Age – older persons are more likely to experience multi-co-morbidities, be socially isolated and experience loneliness.
- Disability – people with a disability may find difficulties in accessing services, there may be poor public transport provision and barriers to employment.
- Gender reassignment – there is a higher prevalence of anxiety and depression in persons awaiting gender reassignment surgery.
- Marriage and civil partnership – the absence or presence of marriage/civil partnership can affect a person's financial and social status, and their sense of emotional well-being.
- Pregnancy and maternity – social factors can affect maternal health and perinatal outcomes as well as infant mortality.
- Race – people of different races can be more likely to encounter certain medical conditions, such as sickle cell anaemia or diabetes.
- Religion or faith – people who follow a specific diet may struggle to access specific suppliers according to their social environment. They may require prayer breaks at work and follow religious rites of passage which affect employability.
- Sex – different genders may experience different BPS needs. A female may struggle from menopausal symptoms, whilst a male is at higher risk of heart disease and has a shorter life expectancy.
- Sexual orientation – people who identify as LGBTQ + may face social prejudice and isolation and are more likely to experience poor mental health.

A programme of educational resources on personalised care and population health can be found at: www.gov.uk/government/collections/all-our-health-personalised-care-and-population-health.

Social prescribing

Social prescribing was a key component of NHS England's 'Comprehensive Model for Personalised Care' (NHSE, 2019). Within primary care, social prescribing is being used to manage long-term conditions using the BPS model. Social prescribing comes in number of different forms from walking groups, knitting meetings to support groups. Benefits of social prescribing include:

- Enabling a social connection for those that may be experiencing loneliness;
- Providing physical benefits;
- Tackling social vulnerability;
- Educational opportunities including peer support;
- Emotional well-being;
- Creating communities;
- Challenging health inequalities;
- Improving mental health;
- Reducing pressure on the NHS.

Case study 3.2: Joan part 2

Joan is becoming increasingly lonely; she has lost her appetite as it is just not appealing to eat on her own. She is socially isolated and spends long period sat in her armchair, her daughter rings a couple times a week, but she is very busy. Joan has not been able to collect her prescription so is not taking her medication. Some days she does not get dressed or eat more than a couple of rich tea biscuits; she feels like she wants to die. Her skin is beginning to feel sore on her bottom.

From the description the following physical nursing needs can be identified.

- Joan is malnourished. Action – MUST assessment, referral to dietician, dietary supplements.
- Joan is not taking her medications for pain, hypertension, and type 2 diabetes. Action – organise delivery of medications.
- Joan is not mobilising regularly, placing her at risk of pressure damage and disuse atrophy. Action – complete a pressure damage risk assessment, provide pressure relieving equipment, barrier creams, and encourage exercise.

When completing nursing care, it is important that the nursing associate also considers Joan's psycho-social needs. Patients may have different priorities in regard to their overall health and well-being. Nursing associates should ask patients what is important to them.

Case study 3.3: Joan part 3

Joan explains that she would like to be able to visit her husband's grave on their wedding anniversary. Joan's ability to achieve this goal relies on her being nutritionally stable, having controlled pain and being able to mobilise safely. Joan's GP surgery arranges for her prescription to be delivered. Joan is referred to the social prescribing team in her GP practice. Sue a local befriender begins to visit Joan. Joan enjoys the company with a cup of tea. After a few weeks Joan asks her daughter to add some 'treats' to her shopping list for when Sue visits. Joan begins to get dressed. Over time, Joan feels more confident in her mobility and Sue takes her shopping for her groceries. Joan begins to eat better; she gets stronger and feels able to socialise. She is able to visit her husband's grave.

Although social prescribing was not a traditional medical intervention, it did create positive bio-psycho-social outcomes for Joan. A model created by Moody (2009) (see Figures 3.2 and 3.3) depicts this well.

Integrated assessment

Domain	Areas to consider
Social environment	• Main carer & carer network • Next of kin & wider family • Friends & community • Preferred methods of interaction
Physical environment	• Think from the skin outwards • Clothing & footwear • Main daily living areas • Beyond the doorstep & transport
Systems of care	• Health & social care integration • Sharing information & care records • Respite & carer support • Funding & benefits
Psychological status	• Recognised conditions or symptoms • Motivation & confidence • Emotional wellbeing • Spiritual & cultural fulfilment
Multimorbidity	• Treatment burden of multiple long term conditions • Physical & mental health • Vision, hearing, dentition, continence • Strength & mobility
Acute health events	• Frailty syndromes: delirium, falls, immobility, incontinence, medication side-effects • Planned acute care (e.g. surgery)

Figure 3.2 The frailty fulcrum model

The frailty fulcrum model identifies several factors within a person's life:

- Social environment
- Physical environment
- Psychological status
- Multimorbidity (long-term conditions)
- Acute health events
- Systems of care

The model places these factors upon a scale ranging from Resilience to Vulnerability (see Figure 3.3). A person's long-term condition cannot be reversed and is likely to be placed on the vulnerability side of the scale. If other factors are not considered it is likely that they will slide down towards vulnerability too.

However, the model demonstrates how by moving some of the other factors towards the resilience end of the scale the scales may be able to balance and in turn improve a person's overall quality of life.

This model may be used by nursing associates to 'demonstrate an understanding of co-morbidities and the demands of meeting people's holistic needs when prioritising care' (NMC, 2018).

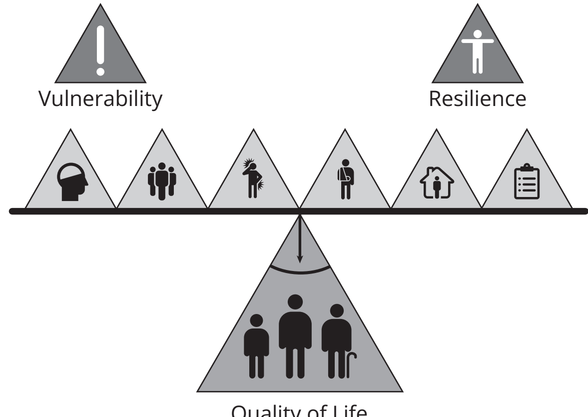

Figure 3.3 Factors that impact a person's quality of life

The role of the nursing associate in providing bio-psycho-social care

Nursing associates are well placed to provide bio-psycho-social care. The inclusion of the four domains of nursing within the qualification aids the application of the BPS model.

As we have established, a person's needs are rarely confined to only biological, psychological, or social. Healthcare professionals working in different settings need to be able to provide care for all patients. For example, people who have a learning disability will access the same healthcare settings as someone without a learning disability and therefore staff need to have the knowledge, skills, and behaviours to provide high-quality patient-centred care.

By meeting the standards of proficiency for Nursing Associates (NMC, 2018) and completing practice experience in all domains and in a range of settings, nursing associates can use their transferable knowledge accordingly.

A Nursing Associate needs to be able to utilise a range of communication tools to ensure bio-psycho-social care and to promote a person's autonomy. Example may include;

- A 'This is me' document which informs the reader of information that a person with dementia may not be able to communicate. This may include culture or religion, routines, family relations, or even how they like their tea.
- 'My Healthcare Passport'. This document provides healthcare professionals with information about a person's learning disability, how they communicate, routines, medications, allergies, long-term conditions, and anybody who should be involved in care planning.
- An advanced care plan. An advanced care plan is a document that a person has completed in anticipation of a time when they are unable to make decisions for themselves. The plan sets out their treatment preferences such as if they wish to receive cardio-pulmonary resuscitation or intravenous anti-biotics.

Separate disciplines

The separation of mental health, child, learning disability, and adult nursing disciplines within the training of nurses and in the delivery of care has arguably reinforced the belief that these

are separate components of a person's health and well-being. Nursing associates are trained to work in all four disciplines and as such are well placed to bridge the gap between disciplines by utilising the BPS model. Student nursing associates (SNAs) regularly report how they can utilise transferable skills from different placement areas back to their base placement as well as sharing their experience with staff whilst on placement.

Child

Nursing associates must 'understand the importance of early years and childhood experiences and the possible impact on life choices, mental, physical and behavioural health and well-being' (NMC, 2018).

The social-cultural environment that a child lives within directly impacts upon their health. There are significant differences between children from different social economic backgrounds.

Children from a higher social economic background are more likely to play sports, eat a balanced and varied diet and be exposed to cultural experiences. Whilst children from a lower social economic background are more likely to live in a cold and damp home, eat cheap nutritionally poor foods, suffer from illness, and have poor mental health (RCPCH, 2024).

The children's health of today is the adult's health of the future. Childhood trauma and sustained levels of stress are linked to symptoms such as poor cognitive development and mental health challenges such as depression and addiction. Whilst Adverse Childhood Experiences (ACEs) have been found to directly correlate with the presence of the disease process in adulthood (Felitti, 2002), with the more ACEs experienced the higher the risk of diseases such as cancer, auto-immune conditions, and cardiac disease.

In 2018, The World Health Organization, UNICEF and The World Bank collaboratively produced the Nurturing Care Framework which identifies the components required to aid childhood development:

- The promotion of health
- A stable, safe environment
- Optimal nutrition.
- Protection from threats
- Opportunity for learning
- Affection.

These continue to be as fundamental as a child develops through adolescence with one in seven children aged 10–19 globally experiencing a mental health disorder (WHO, 2024). During adolescence children experience not only physical and emotional changes they also begin to experience different social pressures such as social inclusion, social stigma, discrimination, gender identity, and are more likely to partake in risk-taking behaviours.

Mental health

Nursing associates are required to 'demonstrate an understanding of co-morbidities and the demands of meeting people's holistic needs when prioritising care' (NMC, 2018). They are encouraged to take a person-centred approach and recognise the impact BPS needs have upon one another.

Engel's (1977) BPS model reasoned that mind and body are so intertwined that they cannot be differentiated in matters of health. Poor mental health increases the risk of long-term conditions such as cardiovascular disease, stroke and Irritable Bowel Syndrome. Similarly, the presence of a long-term condition can increase a person's risk of experiencing poor mental health. For example, a patient who has Chronic Pulmonary Obstructive Disease (COPD) is three times more likely to experience depression. This can be attributed several factors such as:

- Anxiety around being able to breathe;
- Fears surrounding death and their mortality;
- An increase in dependency;
- A change in perception of oneself.

As a nursing associate when caring for a patient with mental health needs it is important to recognise the potential side effects of medications and how they may affect the person. Some common medications used in mental health are listed below some potential side effects have been identified (not exhaustive).

Activity 3.3 Reflection

Consider how the side effects in Table 3.2 may affect a person's BPS needs.

This activity does not have a model answer.

Table 3.2 Drugs and potential side effects (BNF, 2024)

Drug	Potential side effects
Lithium	Thyroid disorders
	Mild cognitive and memory impairment
Mirtazapine	Increased appetite, joint pain, confusion, and changes to bowel habits
Sodium Valproate	Abdominal pain, alopecia, anaemia, and weight gain
Olanzapine	Hyperglycaemia, hypotension parkinsonisms, and weight gain

Learning disability

There are approximately 1.3 million people in England with a learning disability (LD) (Public Health England, 2023). People with learning disabilities have the same right to have their biological, psychological and social needs met than any other person. However, people with learning disabilities are more likely to:

- Have poorer physical health. And more likely to die up to 20 years earlier than a person without a LD. Forty-two per cent of deaths of people with a learning disability were avoidable (LeDeR, 2023);
- Have poorer mental health. Forty per cent of all people with a LD are said to have a mental health condition (NICE, 2016);
- Be living in poverty;
- Experience discrimination.

Learning Disability (LD) Nurses are registered with the NMC as their own speciality. The role has been recognised for over 100 years. LD nurses work with individuals who have a learning disability to meet their BPS needs. However, the Royal College of Nursing (RCN, 2024) have revealed that the number of LD nurses has fallen from 5,553 some 15 years ago to 3,095 in 2024. The reduction in LD nurses leaves a deficit in provision.

All areas and specialities within the health service provide care for people with learning disabilities. Therefore, it is imperative that all nursing associates have experience of learning disability nursing and recognise the most significant factors to be conscious of when providing, monitoring and delivering care (NMC, 2023) whilst also recognising the person as an individual.

Activity 3.4 Reflection

Consider your place of work. What adaptations do you have in place for a people with a learning disability?

- Do you have easy read patient information?
- How can appointments be accessed?
- How may you introduce the environment?
- What sensory considerations are there?

As this activity is based on your own observation, there is no outline answer at the end of the chapter.

Nursing associates need to be able to recognise and accommodate sensory impairments. Every person with autism is an individual and presumptions should not be made due to a diagnosis. However, it is important to be aware of sensory considerations.

- People with autism can have an altered responsivity to pain. They can be hyposensitive or hypersensitive to pain.
- Children with autism can have a heightened sense of smell.
- People with autism can have a taste sensitivity. They may only like a particular brand or type of food and can recognise when there is a difference. They may struggle to take oral medications.
- Some sounds can be particularly overwhelming for people with autism. The call bells on a ward, the sounds of machines and the telephone ringing can all add to a person with autism's discomfort.
- Some textures maybe uncomfortable for a person with autism, this may be the bedding or hospital gown for example.
- Some people with autism have an avoidance to touch – examinations, observations, and clinical investigations may be difficult for a person with autism.

Public Health England (2023) provide guidance on communicating with people with a learning difficulty to promote their autonomy and health literacy. Please note that this is supportive guidance and does not replace a patient centered approach. Nursing Associates need to be able to adapt their communication style to meet the needs of the individual.

- Always speak directly to the person, unless advised not to do so.
- Use plain English, short sentences and do not use medical jargon and acronyms.
- Ask if they have a hospital passport – this may include information on their preferred method of communicating with others.
- Use visual aids such as photographs, objects, or gestures to support your words, and make use of supplementary NHS YouTube videos.

- Ask if they use any alternative forms of communication, such as Makaton (signs and speech), Talking Mats (symbols), Beyond Words (wordless picture books) or symbol-based images, like Widgit – if you are not able to use their tools, ask if they have someone with them who can assist.
- When writing, make it accessible to the individual – this may mean using larger, easy-to-read text to explain what you wish to say and easy read appointment letters (the NIHR website has advice on accessible health information).
- Talk and listen to the person's carer, friend or supporting professional, without excluding the individual.
- Give the person time (ideally seven seconds) to process what you have said before they respond.
- Check understanding, both yours and the person's, by asking open questions.
- Pay attention to body language and facial expressions.
- Consider the environment – noisy or loud environments with lots of activity are not conducive to effective communication.
- Show any equipment or machines that might be used and explain any noise that the machines may make to pre-empt any problems.
- Offer to follow up verbal discussions with a written note or a voice or video recording.

Case study 3.2: Ben

Ben is 12 and has autism, tonight is a Thursday, and he normally watches Darts. However, he has been admitted to hospital because of acute abdominal pain. He is in a side room and his mum is staying with him. However, Ben is becoming increasingly anxious. Ben is holding his ears and rocking back and forth.

It is important to note that every person with autism is an individual and presumptions should not be made due to a diagnosis. However, the examples below aim to highlight some sensory considerations that maybe experienced by a person who has Autism in an inpatient setting.

People with Autism could have a heightened sense of smell.

Activity 3.5 Discussion

Discuss potential bio-psycho-social factors that may be affecting Ben. Consider how you could use a person-centred approach when delivering Ben's care.

This activity does not have a model answer.

The spiritual model

A limitation of the bio-psycho-social model is the absence of a recognition of a person's spiritual needs. Holistic care involves caring for a person's overall wellbeing including their

spirituality. There are a range of definitions of what is spirituality. This is because spirituality means different things to different people. Some people may link the concept of spirituality to their religion or faith whilst others may use it to describe a connection to something cosmic or divine in nature. Spirituality is linked to personal growth and wellbeing and may be demonstrated through pray, mindfulness or a connection with nature. Some individuals will not describe themselves as spiritual and may instead refer to themselves as an Atheist or Agnostic; nevertheless, a holistic approach to overall wellbeing is required.

Due to the diversity in the spiritual needs of individuals, as nursing associates it is important to be able to *'Reflect on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments'* (NMC, 2018).

Patients are likely to rely on their spirituality to help them cope with periods of ill health or when needing to adapt to significant life changes. The concept of spiritual care within nursing practice has been attributed to Battey (2009). However, history illustrates how nursing has always been linked to spiritual and religious care with the nursing role frequently being referred as a 'calling'.

Understanding the theory

The Spiritual Nursing Care Theory Model created by Bangcola (2021) depicts how a person's spirituality is integral to holism and just as essential as any other need. The theoretical framework is composed of four components:

1. Spiritual nursing care
2. The nurse's spiritual competency
3. The cultural background of the patient
4. The patient's spiritual needs.

Within clinical practice, nursing associates need to be able to provide care that recognises a person's spirituality. A healthcare professional is not expected to know all cultural, religious, values and beliefs but they are expected to utilise effective communication with the person to find out their needs. When a person is unable to communicate their spiritual needs, healthcare professionals should liaise with their families. There may be differences within different cultures or religions, so it is always better to ask, rather than presume what a person needs.

The HOPE assessment tool was established by Anandarajah and Hight in 2001.

HOPE stands for.

H- Hope. What are your sources of hope, strength, and comfort? Thinking back to the challenging times in your life, what or who has helped you cope and get through these times?

O- Organised Religion. Are you part of a spiritual or religious community? If so, does being part of this community help you? In what ways? Does it help you? How? What spiritual practices or beliefs help you?

P- Personal spiritual practice. (Prayer, Meditation, Scripture, Worship, Music, Art, Nature, etc.) How do you feel you're doing spiritually? How is it with your soul?

E- Effects on your Care. As your nurse, what can I do to help honour your spiritual/religious needs? As you face this challenge in your life, how can your religious community, (or health care team or other resources) help honour your spiritual/religious needs?

Other spiritual considerations include.

- Dietary needs;
- The gender of the healthcare professional providing care;
- The availability of space for pray and/or meditation;
- Washing facilities;
- The use of eye contact;
- Language;
- The role of family members;
- Last rites;
- Clothes and personal presentation.

Chapter summary

Providing person-centred care which encompasses a person's bio-psycho-social and spiritual needs is a rewarding experience. Building a therapeutic relationship with patients and their families enables you to meet their individual holistic needs and encompasses overall health and wellbeing. Going forward you are encouraged to replace 'what is the matter with you?' with 'what matters to you?'

> *'the good physician treats the disease; the great physician treats the patient who has the disease'*
>
> William Osler, 1849–1919.