Care Planning Guidance

July 2017

Wessex CCGs in partnership with PaCT

Fareham and Gosport and South Eastern Hampshire Clinical Commissioning Groups

West Hampshire Clinical Commissioning Group

This guidance has been developed to support health and social care staff who are involved in the care planning process.

Care planning is at the heart of the health and social care therapeutic process and should be developed in partnership with the service user, and wherever possible his or her carer. It is recognised that there may be considerable variation between care plans as there is no single correct way to write one, but there are important common points to cover regardless of the client group.

This document provides some guidance for what to include and how to structure a care plan that is helpful for both staff and service users.

Key principles of care planning:

- Involving service users and carers in care planning – people significant to the person
- Building on strengths as well as focusing on needs
- Making the care plan central to a person's care
- Ensuring the care plan is holistic – covering health and social care needs
- Sets out clear goals and support interventions
- Describes in an easy, accessible way the support needed to be provided

What does care planning involve?

- Gathering and sharing stories – views of all concerned including the resident, their family/carers and professionals
- A systematic review of the areas of need, what people can do for themselves, outcomes people want to achieve as well as areas of need.
- Needs to promote independence/empowerment where possible, thinking about re-enablement model
- Exploring and discussing information – to work out what is most important
- Goal setting – what do we want to achieve?
- Action planning – What are we going to do? Who is responsible? When will it be reviewed?
- Risk Management – how do we make care as safe as possible
- Mental Capacity Act (MCA, 2005) principles

A care plan is:

- A record of needs, actions and responsibilities, outcomes important to the person, so that it tells you about the person – their likes and dislikes and how they wish to be supported
- A tool for managing risk
- A plan which can be used and understood by service users, families, carers and professionals
- Something which people who use the service feel they own

- Based on a thorough assessment of need
- A multi-professional, multi-agency endeavour
- Co-ordinated by the most appropriate person, e.g. a key worker
- Shared with those that are part of it
- The written record of a plan of action, negotiated with the person to meet their physical/mental health and social care needs
- A legal document the author is professionally accountable for the care they have planned

A care plan is not:

- A bureaucratic exercise
- A wish list but is a plan of agreed elements of care
- A risk assessment

Risk Assessments:

Risk assessments are NOT a care plan – a risk assessment is a tool to help you identify the need for a specific care plan. Risk assessments should always be accompanied by a plan of action based on the information you have learnt as a result of conducting the risk assessment. Sometimes a risk assessment can be used to identify and evidence that there is no risk, in this instance there needs to be no specific plan. However please remember risks need to be re-assessed and the plan maybe when you will do this.

How to write a care plan:

A care plan should be written with the person or significant other/advocate who knows the preferences of the person the plan is for. A sense of ownership by all those concerned is vital in making the plan translate into reality which can be promoted by:

- Using people's own words and phrases and involving them in the writing of the plan
- Recognising that care plans exist for the benefit of the person
- Using the person's lasting power of attorney (LPOA) for health and welfare (if applicable)

In practice, it may be useful to write:

- the care plan as 'I need', to encourage the service user to think about what he/she needs
- statements of action that are instructional and able to be followed in your absence
- interventions that relate directly to the needs and goals

To make text more inviting to read, use:

- Short sentences – in general no more than 15-20 words long
- Present and active tenses, where possible, for example, 'your appointment is on…' not 'your appointment has been made for…'
- Bulleted or numbered points to divide up complicated information
- Small blocks of text. Do not use long paragraphs – divide them up using headings and new paragraphs
- White space makes the information easier to read
- Large bold font emphasizes text. Avoid UPPER CASE letters, italics, and underlining as they make the text more difficult to read. WRITING IN CAPITALS READS AS IF YOU'RE SHOUTING.
- The font size should be between 12 point (minimum) and 14 point. However, if you are providing information for elderly people, or those with sight difficulties, you should always use at least 14 point.
- Typed information should usually be in Ariel font
- Handwritten plans should be in simple text (not joined up writing) to avoid mis-interpretation
- Avoid abbreviations unless stating at the beginning of the document what the abbreviations refer to
- Consider the use of pictures and images to meet the communication needs of the person

Most care plans follow a similar format based on a simple process. The four stages of the process are:

Assess, Plan, Implement and Evaluate:

Assess: The assessment process involves gathering information and completing various assessment tools, for example the Waterlow Pressure Ulcer risk tool and is an on-going and dynamic process. The overall aim of assessment is to initiate a therapeutic relationship with the resident and develop an understanding of problems and needs, which will enable the team to move to the next stage (planning). The assessment will also include what they can do for themselves or what they want to try and achieve.

A clinical assessment should have physical, psychological, emotional, spiritual, social and cultural dimensions. Risk assessments are formulated and implemented from the assessment process and form an integral part of the care plan.

The written assessment and identification of client needs must include identifying areas such as (not an exhaustive list):

Allergies
Medication

Infection risks
Pressure ulcer & skin integrity risks
Nutritional risks
Resident handling needs
Falls risk

Plan: Residents may be admitted to the home with a range of problems, and it will be necessary to prioritise these. The goals of the care should be agreed by the multi-disciplinary team based on the patient's perspective, resources available and management of identified risk. The process of setting goals can be therapeutic, particularly if they are the result of a collaborative process between staff and residents and as they can help to clarify complex problems and indicate a commitment to change.

What is a goal? Goals convey what it is that is to be achieved and the desired outcome for the health gain for the client – i.e. a patient centred outcome.

Goals can be seen as challenging for staff, either because they seem unrealistic, or that supporting them is outside of their role. However, it is an important part of care planning to identify ways in which the team may support that goal.

For example an individual may want to go to the toilet unaided this may be unrealistic but it could be agreed or a compromise reached that they are left in privacy for part of the time. Understanding the rationale behind the goal may be because they don't want to bother anyone, understanding this may be that the compromise be they are offered assistance at certain key points in the day so they don't need to ask for assistance.

Goals must be SMART:
Specific
Measurable
Attainable
Realistic
Time Bound

For all clients, a care plan should include:

- Aims – why are we doing this?
- Outcomes – What are we planning to achieve?
- Actions – How are we going to do it?
- Responsibilities – Who will do it?
- Environment – where and when will it take place?
- Time – when will it be done by?

- Personalisation – any needs/preferences relating to race/culture, economic disadvantage, gender, age, religion/spirituality disability or sexuality?
- How was the person involved in care planning?
- Was capacity and consent considered?
- Safeguarding – risks, capacity, vulnerability, crisis and contingency arrangements?
- Previous history – any unmet needs?
- Date of next planned review

Implement: The assessment has provided a focus for planning and implementation of care that is effective (best possible outcome for residents) and evidence-based. The multi-disciplinary care team will determine the immediate priorities and recognise when clinical intervention and what referrals to other health and social care professions is required.

Evaluate: Effective evaluation of care requires the staff member to critically analyse the service user's health status to determine whether the service users' condition is stable, has deteriorated or improved.

Involving the service user, their family or advocates will facilitate the decision making. The frequency of the evaluation will depend upon the individuals care; however regularly evaluation review dates need to be included in the care plan:

- Clinical care e.g. nursing, therapy should be evaluated using measurable outcomes on a regular basis and interventions adjusted accordingly.

- Progress towards achieving outcomes should be recorded in a concise and precise manner

- Personalise, use service users own words if appropriate

- State what care you have given, planned or any variation. Comment e.g. "pressure area care given skin slightly red on sacrum"

- Amend the care plan if circumstances have changed

- Discontinue care plans if the goal(s) have been reached Evaluation must take place as per local guidelines and must focus on all elements of the care plan, i.e. the assessment; goals, interventions and the achievement of goals must be reviewed.

Evaluation involves considering if it is appropriate to continue with the current plan of care or try something different, and it will need to involve an element of on-going assessment (and, at times, re-assessment).

The evaluation must demonstrate patient involvement and, if this is not possible, a rationale and a plan for engaging the patient must be given. Amend the care plan if circumstances have changed, and discontinue it if the goals have been reached or the interventions need to change significantly.

Discontinued care plans must be clearly marked as discontinued by crossing through with a single line and 'discontinued' written across with the date. The date of discontinuation must also be entered on the care plan index.

Document your evaluation and actions taken on the evaluation form.

Record Keeping - Record keeping is a fundamental aspect of clinical care and clinical records must be:

- Factual , consistent and accurate
- Be written as soon as possible after the event
- Be written and recorded clearly and in such a manner that the text cannot be erased
- Have any alterations or additions clearly dated, timed and signed in such a way that the original entry can still be read clearly
- Be accurately timed and signed with a signature printed alongside the first entry
- Be readable when photocopied - Be written when possible with the service user involvement

Please refer to your professional body (NMC for Registered Nurses) or work place policy for standards of record keeping. ***Remember – 'If it is not recorded, it did not happen'***

CQC Fundamental Standards

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. The CQC's main aim is to ensure that the care provided by hospitals, services provided in the community, dentists, GP's and care homes meet with regulatory requirements based on fundamental standards.

The CQC have regulations associated with the provision of safe, quality care.
To regulate a service the CQC inspect and monitor in accordance with five key lines of enquiry, these lines of enquiry serve as prompts for CQC inspectors.
Key Lines of Enquiry (KLOE's) are:
Safe: you are protected from abuse and avoidable harm.

Effective: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.

Caring: staff involve and treat you with compassion, kindness, dignity and respect.

Responsive: services are organised so that they meet your needs.

Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Question: How can you ensure that care plans demonstrate compliance with the fundamental standards?

• Ensure you involve the service user in their care plan – it's all about them – personalise it to ensure that care is centred around their preferences

• Service users should understand, agree and consent to their care and treatment plan. They should have enough information to make informed choices

• If capacity is an issue, involve family, carers, relatives in the care plan

• Risk assessments balancing safety and effectiveness should inform the care and treatment plan

• When a patients clinical/ social/ psychological/ risk factors change presentation changes – or when a risk assessment is completed – Update the care plan

• Where communication is an issue – ensure that the care plan has outlined the most effective method of communication – this may be the use of communication passports, the use of translators, to ensure that service users understanding and personal preferences are being adequately addressed

• Care plans should consider their immediate and long term needs for needs, preferences and diversity

• Ensure that the care plans are reviewed regularly

• Make sure that service users know who to speak to about their plan of care and how to contact them.

References & acknowledgements:

The Care Quality Commission Essential Standards of quality and safety;
http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers
http://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards

Derbyshire Healthcare NHS Foundation Trust (2012) Writing Good Care Plans, a good practice guide

Leicestershire Partnership NHS Trust (2013) Care planning. A good practice guide.

NMC (2009) Standards of record keeping for nurses and midwives

http://www.skillsforhealth.org.uk/