Adult Mental Health Services
Bradgate Unit

Multi-disciplinary Care Planning Guidelines

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The following have contributed to the new care plan format and its guidance:

Mohammed Abbas, Consultant Psychiatrist
Gemma Ablewhite, Improvement Facilitator
Mohammed Al-Uzri, Consultant Psychiatrist
Claire Armitage, Lead Nurse
Mariam Benaris, Consultant Psychiatrist
Jane Capes, Senior Matron
Rachael Carroll, Ward Matron
Sharon Clay, Deputy Ward Matron and Practice Development Nurse
Liz Compton, Senior Matron
Tessa Doherty, Occupational Therapist
Rachael Eldessouky, Ward Matron
Cormac Ffrench, Staff Nurse
Antonia Garfoot, Senior Infection Control Nurse
Lynn Gibson, Service User Consultant
Hayley Huddlestone, Staff Nurse
Vicky McNulty, Deputy Ward Matron
Mandy Littleford, Occupational Therapist
Jo Lock, Acting Ward Matron
Kelly Jackson, Staff Nurse
Anita Kilroy-Findley, Nurse Specialist, Tissue Viability
Chris Meakin, Consultant Psychiatrist
Sui Neale, Acting Ward Matron
Louise Short, Ward Matron
Denise Smith, Staff Nurse
Adam Somauroo, Deputy Ward Matron
Rob Stocking, Consultant Psychiatrist
Toral Thomas, Consultant Psychiatrist
Astyn Tinkler, Staff Nurse
Adrian Vann, Consultant Psychiatrist
Joy Ward, Staff Nurse
Rebecca Woods, Occupational Therapist

Acknowledgement

Original art work by Anita Patel
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1. Introduction to care planning at the Bradgate Unit

These guidelines have been produced as a resource to assist staff to use the new care plan format. Care plans play an important part in the work of mental health staff, not only as a legal record of care given, but also as a key therapeutic tool for engaging service users and carers in planning and meeting care goals. This document aims to help staff to use the new multi-disciplinary care plans.

As underpinning principles, the new care plans aim to:

- Integrate care and treatment plans for all disciplines, to ensure that all team members are aware of and working towards a unified plan that addresses all areas of need
- Strengthen patient collaboration and involvement in the assessment, care planning and review process.
- Ensure that there are robust links between the risk assessment and the resulting care plans.
- Develop the relationship between the care plan, the daily review and the weekly ward round to ensure a safe and streamlined process.
- Be clinically meaningful and help in delivering care.
- Provide quick access to information and help in tracking decisions.
- Add value to, and integrate, the patient journey through the use of a simple and understandable approach.

The care plans have been produced within the Bradgate Unit by a group comprising service user representation, senior and ward nurses, occupational therapists and medics. Various care planning models have been looked at and the format has evolved in the light of feedback received. Some elements of the format have been adapted from Coventry and Warwickshire Partnership NHS Trust, whose care plans were brought back by nurses following a recent benchmarking visit.

In addition, the new approach proposes a mental health, physical health and social needs model which will be referred to as MPS. This model will link the different assessments and interventions as well as the paperwork.

The documentation format comprises:

- **My care plan**: this puts the patient perspective at the centre of the care process and its aim is to identify what the patient wants to achieve from the admission. It is to be done by the patient with the help of the named nurse or a delegated colleague. Objectives from this will feed into the MDT care plan and the care delivery plans.
• The MDT care plan: this care plan will be the point of reference for all decisions or interventions during an inpatient admission. It is designed to address the different needs of patients which have been identified as part of the case summary/formulation and Summary of needs documents.

• The MPS Needs Summary document: this should be completed during the first MDT meeting following admission. It summarises the patient needs across the three domains – mental, physical and social (MPS)

• Care Delivery Plans: these are more detailed multi-disciplinary plans which outline how the care will be delivered. Each patient must have one care delivery plan (CDP) which is the mental health care delivery plan and this will come to the MDT for discussion. Other CDPs should be developed only on an as needed basis.

• Weekly Evaluation Form: the green form used for weekly evaluation has been modified to fit with this model.

Core care plans will no longer be used by nursing staff. To assist staff to write individualised, evidence based care plans of a consistent high standard, the care planning good practice guidance will include model care plans and prompts for care plans on a range of topics.

See section four for more information about how the new format works in practice.
2. What is a care plan?

A care plan is the document that identifies the care to be given – it’s a record of needs, actions and responsibilities, which can be used and understood by patients, families and other agencies as appropriate.

**Overarching principles and values of the care plan**

- The care plan must guide the work of other team members and be a basis for quality, continuity of care and risk management.
- The care plan must be central to patient care, involving service users and carers and building on strengths as well as focusing on needs.
- It’s a legal document, and the author is professionally accountable for the care they have planned, and for upholding professional standards such as record keeping and code of conduct.
- Interventions must reflect current evidence and best practice.
- The care plan must be reviewed on a weekly basis.
- The care plan must be holistic – covering mental and physical health and social care needs where appropriate.

**Who is the care plan for?**

The care plan is a collaborative process between the team and the patient that details what work will be done together to reach the specified and agreed goals. The care plan must reflect the service user’s needs and wishes, and is both about the more immediate concerns of safety and care, and progress towards recovery. The care plan should aim to give the service user control over their life by achieving the identified goals.
3. How to write a care plan

There is no single approach to writing a care plan, however, most care plans follow a similar format based on a simple process.

For example, the stages of the nursing process are Assess, Plan, Implement and Evaluate, and similarly the occupational therapy process is Assess, Treatment Plan, Implement and Evaluate.

Assess

The assessment process involves gathering information and completing assessment tools, for example the interagency assessment and Morgan Risk. Assessment is an ongoing and dynamic process, particularly in an acute environment where risks can change very quickly.

The overall aim of assessment is to initiate a therapeutic relationship with the patient and develop an understanding of problems and needs, which will enable the team to move to the next stage: planning.

Plan

Patients will be admitted to the ward with a range of problems, and it will be necessary to prioritise these for the period of the admission.

The goals of the admission 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 patients 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 service user, i.e. a patient centred outcome.

Goals must be SMART:

- Specific,
- Measurable
- Achievable
- Realistic
- Time bound

Objectives are often used in care planning – these may be steps towards a goal or components of goals.
Implement

Interventions are the actions that will be implemented in order to achieve the goals. Once the goals are agreed, the interventions can be identified: what do staff need to do to achieve the goals? The interventions should be patient centred, achievable, evidence based and orientated to improved health and independence.

<table>
<thead>
<tr>
<th>Interventions must be specific and individualised ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>× Establish a one-to-one</td>
</tr>
<tr>
<td>× Assess mental state</td>
</tr>
<tr>
<td>× Ensure good dietary intake</td>
</tr>
</tbody>
</table>

Evaluate

Evaluation must take place weekly as a minimum 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 ongoing 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. Evaluation must be completed prior to the weekly ward round or multi-disciplinary review where it will be discussed by the team.

Patient and carer collaboration

The patient should (wherever possible) be involved in the decisions about when, where and with whom information about them is going to be shared and used. The patient should be able to involve the relatives and friends they rely on for support in their assessment.

Care plans must be developed and reviewed with the collaboration of the patient (and/or carer, as appropriate) wherever possible. If the patient does not wish, or is not able, to be involved in the development of the care plan, the reason for this must be documented along with a date on which this will be revisited and reviewed.

Care plans must be written in simple, jargon free language to allow easy patient access. A copy of the care plan is given to the patient (if the patient is able to keep it safely and securely), and also to their carer if the patient agrees.
4. How to use the Bradgate Unit care plan forms

The care plans are divided as follows:

**The patient perspective (My Care plan):** this is to identify what the patient wants to achieve from the admission. It is to be done by the patient with the help of the named nurse. Objectives from this could feed into the MDT care plan and the care delivery plans.

**The MDT Care Plan:** this care plan will be the point of reference for all decisions or interventions during an inpatient admission. It is designed to address the different needs of patients which have been identified as part of the case summary/formulation and Summary of Needs documents.

The **Summary of Needs** document, should be completed during the first MDT meeting following admission. It summarises the patient needs across the three MPS domains, i.e. M: Mental health needs, P: Physical health needs and S: Social needs.

The MPS model links the different assessments and interventions as well as the paperwork. The mental health needs cover three areas: M1: symptoms/ diagnoses, M2: psychological themes and M3: risks. This is to ensure a comprehensive assessment of needs especially psychological themes. Decision and interventions documented in the MDT care plan will be linked to other documentation in order to have quick access to more details.

The MDT care plan includes sections to address these needs in a systematic way as shown below:

<table>
<thead>
<tr>
<th>Needs</th>
<th>MDT sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>M: mental</td>
<td>M1 Symptoms and diagnoses</td>
</tr>
<tr>
<td></td>
<td>M2 Psychological themes</td>
</tr>
<tr>
<td></td>
<td>M3 Risks</td>
</tr>
<tr>
<td>P: Physical</td>
<td>P</td>
</tr>
<tr>
<td>S: social</td>
<td>S</td>
</tr>
</tbody>
</table>

**Care delivery plans:** these are more detailed plans which outline how the care will be delivered. Although most of these will be nursing plans, other professionals can develop care delivery plans (CDPs). Each patient should have one care delivery plan which is the mental health care delivery plan or CDP1. This form should come to the MDT for discussion.

Other CDPs should be developed only on an as needed basis. The CDP should be numbered and linked to the MDT care plan. This will reduce significantly the number of care plans written by nurses and any care plan written will have a specific purpose and would be linked to the patient needs and the actual care.
**Weekly Evaluation Form:** The current green form used for weekly evaluation has been modified to fit with this model. The decisions sections have been removed as decisions will be documented in the MDT care plan. The weekly evaluation form contains 4 sections: Patient and family views, Pre-MDT nursing summary, Pre-MDT medical summary and MDT summary. Each section should cover the MPS domains.

Nurses and doctors are expected to review the MDT plan when they do their summary and can come up with suggestions. Nurses will need to review the care delivery plans as part of their pre-MDT summary and discuss it with patient and update the CDP if necessary. Therefore, this form will replace the previous weekly evaluation of care plans.

**Case Example:**

A woman with a diagnosis of borderline personality disorder with severe anxiety symptoms and depressive symptoms was admitted following an overdose. She was transferred from A&E after being found medically fit. She had been taking Citalopram for the last two years with some effect on reducing the depressive symptoms. She is currently living with her mother as she has lost her accommodation. In the day following admission, she was reviewed in the MDT meeting. The needs summary could look like this:

| M: Mental | M1: Diagnosis, symptoms groups | Borderline personality disorder  
|          |                              | Severe anxiety symptoms  
|          |                              | Depressive symptoms  
|          |                              | Recent overdose  
|          | M2: Psychological themes: maladaptive personality traits, coping skills | Maladaptive personality traits as part of borderline personality disorder including low self-esteem, emotional instability, poor coping skill, self-harming behaviour, intense relationships  
|          | M3: Risks | Risk of self-harm  
|          |          | Moderate risk of suicide, mainly accidental  
|          |          | Risk of vulnerability  
| P: Physical | No needs |  
| S: Social | Accommodation | No accommodation currently, lives with mother  
|          | Discharge planning | Does have a CPN and open to outpatients consultant  
|          |          |  

**MPS Needs Summary**
The **MDT Care plan** for this patient could look like this (this covers approximately the first two weeks of the admission):

**Medication section:** On admission, the patient was on Citalopram 30mg. This was continued. At the first MDT meeting after admission, she was started on a one week course of Lorazepam. After one week, in the second weekly evaluation (WE2) anxiety reduced significantly and this was reduced and stopped.

The care plan section could look like this:

**Medication**

<table>
<thead>
<tr>
<th>Goal/ Need/ rationale (dated)</th>
<th>Action, Decisions (Dated and by whom)</th>
<th>Outcome (dated) Include benefit and side effects</th>
<th>Leaflet offered (O), Given(G)</th>
<th>Consent</th>
<th>Where to find more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric medication on admission 1/2/14 Dr X</td>
<td>Citalopram 30 mg OD</td>
<td>Already on medication</td>
<td>yes</td>
<td>Admission notes 1/2/14</td>
<td></td>
</tr>
<tr>
<td>Severe anxiety symptoms 1/2/14 Dr X</td>
<td>One week course of Lorazepam 0.5 mg tds</td>
<td>Reasonable effect 8/2/14</td>
<td>G</td>
<td>Yes</td>
<td>Needs summary OR 1/2/14</td>
</tr>
<tr>
<td>Reduced level of anxiety 8/2/14</td>
<td>Reduce and stop Lorazepam in one week</td>
<td>N/A</td>
<td>yes</td>
<td>WE2</td>
<td></td>
</tr>
</tbody>
</table>
### Psychological treatment

#### M2: PSYCHOLOGICAL, MENTAL HEALTH & RECOVERY

<table>
<thead>
<tr>
<th>Goal/ Need/ rationale (dated)</th>
<th>Action, Decisions (Dated and by whom)</th>
<th>Outcome (dated)</th>
<th>Where to find more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor coping strategy and self-harming behaviour 1/2/14 Nurse Y</td>
<td>Named nurse to do a care plan using self-help material for both areas. 1/2/14 Nurse Y</td>
<td>CDP was developed Nurse Y 4/2/14</td>
<td>WE1 CDP2</td>
</tr>
</tbody>
</table>

### Risks

#### M3: RISKS, OBSERVATION LEVEL, LEAVES AND MHA

<table>
<thead>
<tr>
<th>Rationale and risks</th>
<th>Action, Decisions (Dated and by whom)</th>
<th>Observation level</th>
<th>Leaves</th>
<th>Where to find more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>New admission, risk of self-harm 1/2/14, Nurse Y</td>
<td>Observation level agreed 1/2/14</td>
<td>Level2 10</td>
<td>No leaves</td>
<td>Admission notes</td>
</tr>
<tr>
<td>Risk reduced significantly 8/2/14, Dr X</td>
<td>Reduce observation level</td>
<td>3</td>
<td>Escorted hospital grounds</td>
<td>WE2</td>
</tr>
</tbody>
</table>
### Physical Care

<table>
<thead>
<tr>
<th>PHYSICAL CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal/ Need/ rationale (dated)</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>To check physical health on admission</td>
</tr>
</tbody>
</table>

### Social Care and Discharge Planning

<table>
<thead>
<tr>
<th>SOCIAL CARE &amp; DISCHARGE PLANNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation needs? Yes…No. Open to psychiatric services Yes No Covering CMHT or Team……Name…………….Consultant… Name …… CPN.. Name …….. S/W….. Name …… Other……….. CPA status on admission: CPA Non –CPA CPA status on discharge CPA Non-CPA .. Need OPC follow up Y N, within how many weeks………………</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal/ Need/ rationale (dated)</th>
<th>Action, Decisions (Dated and by whom)</th>
<th>Outcome( dated)</th>
<th>Where to find more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs accommodation 1/2/14, Dr X</td>
<td>Refer to Inreach 1/2/14, Dr X</td>
<td>Referral done, 2/2/14, Nurse Y</td>
<td>Needs summary Correspondence 2/2/14</td>
</tr>
<tr>
<td>Needs monitoring on discharge 1/2/14, Dr X</td>
<td>Nurse to invite CPN for MDT meeting 1/2/14, Dr X</td>
<td>CPN invited Nurse Y, 2/2/14</td>
<td>OR 1/2/14</td>
</tr>
<tr>
<td>Needs supporting letters for accommodation 5/2/14, Dr X</td>
<td>Consultant to write supporting letter Dr X, 5/2/14</td>
<td>Letter done, Dr X, 6/2/12</td>
<td>Correspondence</td>
</tr>
</tbody>
</table>
An example of a Care Delivery Plan could look like this:

<table>
<thead>
<tr>
<th>No.</th>
<th>Plan of Care</th>
<th>Discontinuation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What actions people need to do</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>OT to spend time with X to assist her to find out what activities are available</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Create a weekly timetable together with OT</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Support X to plan her time when going on leave: meet with OT prior to leave and devise timetable of activities for home</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Plan activities that X would like to do in the future: meet with OT and complete an Interest Checklist</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Find out which of the identified activities X can engage in within her local area; meet with OT to search for appropriate opportunities</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Engage in activities on the ward initially to build up X’s confidence</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Learn some anxiety management techniques X can use: meet with OT to do this</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Begin to practise using anxiety management techniques</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Attend groups within the OT department</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Attend photography group in order to engage in activity within X’s local community with support</td>
<td></td>
</tr>
</tbody>
</table>

4.1 Filing instructions

Care plan documentation must be filed in the following order:

- MPS Needs Summary
- MDT Care Plan
- My Care Plan (patient’s care perspective)
- Care Delivery Plans (MPS)
  1. Mental
  2. Physical
  3. Social
- MDT Care Plan Evaluation (green forms)
5. What if I need more help with care planning?

The Learning and Development Department offers care planning training, and Bradgate Unit staff have been involved in the development of the course content.

Senior Matrons will be spending time on the wards on a regular basis supporting staff with care plan development and evaluation. If you would like any support, speak to your Ward Matron or Senior Matron at any time.

6. References


NMC (2009) Record keeping guidance for nurses and midwives

Royal College of Psychiatrists (2007) Accreditation for Acute Inpatient Mental Health Services (AIMS)

Tunmore, R and Thomas, B (2000), Nursing care plans in acute mental health nursing, Mental Health Practice, November Vol 4 No 3 32-37

Acknowledgement

Coventry and Warwickshire Partnership NHS Trust (2013), ‘My care plan’
Appendix

Care planning guidelines and prompts

With the exception of Trust-wide evidence based core care plans, for example tissue viability, core care plans will no longer be used by nursing staff.

To assist staff to write individualised, evidence based care plans of a consistent high standard, the following prompts for care plans on a range of topics may be helpful.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission care plan</td>
<td>17</td>
</tr>
<tr>
<td>Blood borne virus</td>
<td>17</td>
</tr>
<tr>
<td>Clozapine</td>
<td>18</td>
</tr>
<tr>
<td>Discharge</td>
<td>18</td>
</tr>
<tr>
<td>Lithium</td>
<td>19</td>
</tr>
<tr>
<td>Mental health</td>
<td>20</td>
</tr>
<tr>
<td>Outbreak of infection</td>
<td>21</td>
</tr>
<tr>
<td>Pressure Ulcer Prevention</td>
<td>21</td>
</tr>
<tr>
<td>Recovery</td>
<td>23</td>
</tr>
<tr>
<td>Relatives’ and friends’ involvement and support</td>
<td>24</td>
</tr>
<tr>
<td>Risk and Observation</td>
<td>25</td>
</tr>
<tr>
<td>Sexually disinhibited behaviour</td>
<td>25</td>
</tr>
</tbody>
</table>
### Admission care plan

<table>
<thead>
<tr>
<th>Needs</th>
<th>Outline reason for admission and circumstances (e.g. informal, MHA section, detox etc.). Highlight main problems and needs and key risks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>To be cared for by the MDT within a safe environment whilst a holistic assessment of his/her healthcare needs is undertaken.</td>
</tr>
<tr>
<td>Care Plan</td>
<td>Welcome and orientate to the ward, give ward leaflet and information as needed. Establish a rapport with the patient and his or her family. Complete meet and greet and obtain, and give phone no. and information. Named nurse to be introduced. Observe and document sleep pattern, dietary and fluid intake using 72 hour monitoring form. Observe and document any signs of acute mental illness, mood level or any psychotic phenomena. Observation level to be agreed between nurses and medical team. For a full care plan to be completed in next 72 hours. With patient’s permission liaise with other disciplines involved in care. Named nurse to spend time with patient and allow him/her to express any anxieties/problems. To give prescribed medication, to observe for efficacy, adverse effects and concordance. To liaise with medical team and update them on progress as and when required.</td>
</tr>
<tr>
<td>Patient’s views</td>
<td>Patient’s view of the admission, including goals, preferences, anxieties etc.</td>
</tr>
</tbody>
</table>

### Blood Borne Virus

<table>
<thead>
<tr>
<th>Needs</th>
<th>To reduce or stop the transmission of infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>To promote compliance with the infection control policy To ensure good communication between healthcare professionals</td>
</tr>
<tr>
<td>Care Plan</td>
<td>Main BBV of concern are Hepatitis B,C &amp; D and HIV causing AIDS Inform Infection Control Team for advice. Follow standard precautions chapter in the IC Policy. These being: Hand Hygiene PPE</td>
</tr>
<tr>
<td>Sharps disposal</td>
<td></td>
</tr>
<tr>
<td>Waste disposal</td>
<td></td>
</tr>
<tr>
<td>Linen handling</td>
<td></td>
</tr>
<tr>
<td>Blood and body fluid spillage procedure</td>
<td></td>
</tr>
<tr>
<td>Specimen handling</td>
<td></td>
</tr>
<tr>
<td>Decontamination of equipment</td>
<td></td>
</tr>
</tbody>
</table>

### Patient’s views

#### Clozapine

**Needs**  
Patient has been prescribed Clozapine as a result of being unresponsive/intolerant of conventional neuroleptics

**Goals**  
To allow medication to build up over a period of 14-21 days to prescribed therapeutic dosage  
To improve and maintain mental state ensuring that they are educated on the benefits and side effects of clozapine

**Care Plan**  
Prior to starting treatment patient must receive a white blood count. Results must be normal before proceeding  
Patient will need regular monitoring. Blood tests weekly for 18 weeks then every 2 weeks for the first year.  
If white blood cell results come through as red, Clozapine must be stopped and medical staff informed. If amber contact medics. An immediate differential blood count must be obtained if infection develops  
Monitor response to treatment daily. Recording side effect. Contact medics if hyperthermic, sweating or tachycardic. Review weekly in MDT  
Administer tablets according to regime  
Regular BP monitoring and temp every hour for six hours then BP daily for first week until reviewed by medic.

### Patient’s views

#### Discharge

**Needs**  
…………….. has been admitted due to *(enter brief summary of reason for admission.)*

**Goals**  
Barriers to discharge
(List identified needs and risks e.g. mental state, community support, accommodation and physical health needs, harm to self/others)

<table>
<thead>
<tr>
<th>Care Plan</th>
<th>In collaboration with …………….. and the MDT, identify and work towards a timely and appropriate discharge date. Specific discharge goals Identify individual goals for each barrier to discharge (e.g. stabilize mental state and reduction in the agreed risks to enable a safe and successful discharge). 1. Ensure that a full and ongoing assessment of the patient’s needs and risks is completed. 2. If further needs and risks are identified during the admission then ensure that the discharge care plan is updated. 3. For each identified barrier to discharge ensure that an individual care plan is completed. 4. There must be the following core care components of the discharge care plan mental state, risk, carer issues, community support, accommodation and physical health needs. 5. List the key relatives, friends or other agencies who are to be involved when planning discharge 6. List the key people who the patient needs to be referred to. 7. Ensure that each barrier to discharge is evaluated and the care plan is updated on a minimum of a weekly basis. 8. Anticipated date of discharge to be included (this must be reviewed and amended weekly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s views</td>
<td>Patient’s views to be sought on each barrier of the discharge plan and documented at each review</td>
</tr>
</tbody>
</table>

| Lithium |
|---|---|
| Needs | Patient has been prescribed Lithium to help stabilise mood or to increase the effect of antidepressant medication in severe depression. |
| Goals | To improve and maintain ……………… mental state. To be safely maintained on lithium. |
| Care Plan | Prior to starting treatment, patient must receive a blood test to check it is safe to take lithium. When patient has started treatment they will have regular blood tests as recommended by consultant to ascertain therapeutic level in the blood. Level to be between 0.6-1.0mmol. Ensure medical team register patient on lithium register. Patient to be given information leaflet giving explanation of lithium and its effects and side effects. Observe for following side effects: • Tremor |
- Stomach upset
- Passing a lot of urine
- Feeling very thirsty/dry mouth

Inform Consultant/SHO of above, if stomach upset lasts more than a day lithium may need to be omitted.

Less common side effects:
- Weight gain
- Oedema
- Hypothyroidism
- Skin rashes

Signs of toxicity:
- Blurred vision
- Drowsiness/feeling sleepy/sluggish
- Confusion/slurred speech
- Increased thirst/passing more urine
- Dizziness/vomiting
- Unsteadiness on feet
- Severe tremor/twitching
- Clumsiness

Discuss with doctor immediately. May need to omit lithium.

| Patient’s views | Encourage the patient to voice their views about the treatment, and document. |

---

### Mental health

<table>
<thead>
<tr>
<th>Needs</th>
<th>Outline reason for admission and circumstances (e.g. informal, MHA section, detox etc.). Highlight main problems and needs and key risks.</th>
</tr>
</thead>
</table>

| Goals | To be cared for by the MDT within a safe environment whilst a holistic assessment of his/her healthcare needs is undertaken.  
To establish an effective medication regime that will allow him/her to return to the community.  
To assist patient to develop an understanding of his/her illness and work towards recovery. |

| Care Plan | To develop a therapeutic relationship to build trust and to facilitate a successful discharge from hospital.  
To provide reassurance and support on the ward.  
To administer prescribed medication and to observe for any side effects and document these observations as appropriate.  
To promote concordance with the prescribed medication regime and to encourage patient to limit or stop their illicit substance use.  
Outline factors that can lead to a deterioration in mental state, and the symptoms and problems that can present. How should this be managed? |
### Patient’s views

Patient’s view of the admission, including goals, preferences, anxieties etc.

### N.B.

A mental health care delivery plan must be in place for every patient.

---

## Outbreak of infection

### Needs

To reduce or stop the transmission of infection

### Goals

- To promote compliance with the infection control policy
- To ensure good communication between healthcare professionals

### Care Plan

Inform Infection Control Team 0116 2227223. Patients information will be needed, DOB, Medication, Hospital Number.
Isolate affected patients if possible, if not en suite will need an allocated toilet/commode.
Do not transfer affected patients to other wards/healthcare facilities.
Collect stool sample, not vomit.
If clinical procedures/contact are necessary PPE must be worn.
Discard **all** PPE **prior** to leaving the room.
Ensure soaps/sanitisers are available.
Ensure room/area/ward cleaning is increased.
Warning signs need to be on entrances.
Remove all uncovered foods, fruit, sweets etc.

### Patient’s views

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## Pressure Ulcer Prevention

### Needs

The patient is at risk of developing a pressure ulcer due to poor mobility/low mood causing apathy/episodes of catatonia/physical disease process/titration of sedating medication with opioid prescription/ Waterlow of >15

### Goals

To minimise the risk of developing a pressure ulcer by applying the relevant elements of SSKIN

### Care Plan

1. Explain all procedures and rationale to maximise concordance, independence and to obtain informed consent where possible. Provide SSKIN leaflet and allow an opportunity to discuss. Date provided and discussed………………………………..
**Skin**

2. Complete Waterlow risk assessment within 6 hours of admission documenting any areas of concern i.e. non-blanching tissue on pressure points. Initiate SSKIN documentation if score is >15, poor mobility and/or existing pressure ulcer

3. Visually check any identified ‘at risk’ areas or ask if the patient has any ‘sore’ areas they would allow you to check /blanch test and document result daily on SSKIN
   Specify any ’at risk’ areas

4. Repeat Waterlow risk assessment weekly for >15, monthly for <15 or more frequently if there is a mental/physical deterioration

**Surface**

5. Assess the need for pressure reducing/relieving equipment considering Waterlow score, level of mobility and any other contributing risk identified in the holistic assessment. Contact tissue viability nurse if advice is required

6. Equipment issued after checking it is fit for purpose;
   mattress…………………… cushion…………………… heel
device…………………… other………………
   Ligature risk assessment for air mattress completed; yes/no/not applicable
   Equipment declined yes/no (delete as appropriate). Record rationale if declined

7. Where possible ensure chair is correct height/width/depth to reduce risk of friction and shear forces

8. When elevating legs ensure heels are protected

**Keep moving**

9. Patient should be encouraged to change their own position where possible following advice/education from staff

10. If unsure about ability to reposition due to mood level or functional limitation, staff will baseline their independent movement for 24 hours using the ‘keep moving’ section of SSKIN

11. If unable to reposition themselves independently staff must implement 24 hour repositioning utilising the ‘keep moving’ section of SSKIN

**Incontinence**

12. Patient has excess moisture on their skin due to incontinence / sweat / pyrexia - this is to be managed using a barrier film/cream, fans/damp cloths

**Nutrition**

13. Note patient’s nutritional score and approach to management

14. Where it is not possible to implement an element of SSKIN this must be recorded on the reverse of the chart using the given code descriptors
Patient’s views to be sought and documented at each review

References

<table>
<thead>
<tr>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Needs</strong></td>
</tr>
<tr>
<td><strong>Goals</strong></td>
</tr>
</tbody>
</table>
| **Care Plan** | 1. Establish if the patient has an Advance Directive or Wellness Recovery Action Plan (WRAP), and if so where can it be found?  
2. Named nurse to spend time with the patient on a one-to-one to discuss recovery and how it may help him/her. Agree use of a tool if appropriate, e.g. Recovery Star, WRAP or MOHOST.  
3. Offer the patient support and encouragement to participate in a recovery group or individual recovery session either on the ward or at the Glenvale Day Unit.  
4. Identified member of staff to spend time with the patient assisting him/her to identify:  
  - What steps can you take which will help with your recovery?  
  - What may cause a setback? (think about events, people, places, anniversaries, time of year etc.)  
  - What might you or others notice when you are becoming unwell?  
  - What can you or others do to help? And who to contact?  
  - What risks can you identify and how can you keep yourself safe?  
  - What are your aims for the future, and what lifestyle changes |
could you make that will help?

**Patient’s views**

*Patient’s views to be sought and documented at each review*

<table>
<thead>
<tr>
<th>Relatives’ and friends’ involvement and support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Needs</strong></td>
</tr>
<tr>
<td>What needs does the patient have for carer involvement? (e.g. family support, involvement in decisions, post-discharge support)</td>
</tr>
<tr>
<td>What needs does the carer have? (whilst patient is in hospital and post-discharge)</td>
</tr>
<tr>
<td>Document the level of care and support needed if known</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
</tr>
<tr>
<td>With the patient’s permission, to develop a relationship with carers in order to enable them to be involved and supported throughout the patient’s hospital stay.</td>
</tr>
<tr>
<td><strong>Care Plan</strong></td>
</tr>
<tr>
<td>To provide carers with support and information regarding their treatment to enable informed choice and decision making.</td>
</tr>
<tr>
<td>Nursing staff to determine how they would like their carers to be involved and ensure this is fully documented on inter-agency assessment and evaluated on a regular basis.</td>
</tr>
<tr>
<td>Client confidentiality must be respected at all times, however; this needs to be balanced with ensuring the safety and welfare of the client and others.</td>
</tr>
<tr>
<td>Nursing staff to respect wishes regarding carer involvement and ensure that client confidentiality is maintained at all times dependent on a full risk assessment. <em>(Any risks identified towards family and others must be discussed with the MDT and a management plan must be put in place.)</em></td>
</tr>
<tr>
<td>Nursing staff to fully involve carers in the admission and assessment process and allow the opportunity to discuss issues with the MDT where appropriate.</td>
</tr>
<tr>
<td>Nursing staff to spend time with carers to determine their level of involvement and ensure this is fully documented in the MDT notes.</td>
</tr>
<tr>
<td>Carers to be contacted on a regular basis to obtain their views regarding current mental health and progress during admission.</td>
</tr>
<tr>
<td>Feedback to be obtained following any periods of leave.</td>
</tr>
<tr>
<td>All contact with family to be fully documented in the MDT notes.</td>
</tr>
<tr>
<td>Nursing staff to provide carer with support and reassurance offering them the opportunity to discuss any concerns they may have.</td>
</tr>
<tr>
<td>Undertaking an educational role, when necessary, to assist them to understand his/her mental health problems.</td>
</tr>
<tr>
<td>Nursing staff to ensure that relatives/carers have access to information about independent advocacy services and carer support networks.</td>
</tr>
</tbody>
</table>

**Patient’s**
### Risk and Observation

#### Needs
The patient has been assessed for risk and the following areas identified:
The patient has been placed on nursing observations due to the following risks:

#### Goals
The goal of this shared plan of care is to minimise identified risks, and to assist the patient in maintaining his/her safety needs, and also the safety of others.

#### Care Plan
1. Identify risk through completion of Morgan Risk assessment Tool 1 and 1b (if not completed by CRHT) and discuss with the patient to ascertain his/her view and accuracy of risks described.
2. The following actions are to be taken to manage the identified risks:
   3. Nursing staff will carry out observations according to the level prescribed.
   4. Nursing staff to keep the patient informed of their level of observation and give time to discuss this and ask questions.
   5. The level of observation should be reviewed at the daily ward review.

#### Patient’s views
*Patient’s views to be sought and documented at each review*

### Sexually Disinhibited Behaviour

#### Needs
Patient is exhibiting sexually disinhibited behaviour which may lead to him/her or others being at potential risk
Presenting behaviours:

#### Goals
To assist patient in identifying and maintaining appropriate behaviour
To minimise any potential or actual risk in order to ensure the safety of patient and others
To work with patient to promote and safeguard their well being
To protect patient’s dignity and vulnerability
To carry out a full risk assessment of presenting behaviour identifying actual/potential risk and discuss with MDT

#### Care Plan
Where appropriate liaise with carers to corroborate assessment, plus with patient’s consent involve carers in the plan of care consulting with them regularly
<table>
<thead>
<tr>
<th>Patient’s views</th>
</tr>
</thead>
</table>

To observe and document non-verbal behaviour with attention to
- personal space
- body posture
- Inappropriate/removal of clothing

To observe and document verbal communication
- verbal suggestiveness
- provocative language

For patient to be nursed on level [insert] observations
A clear management plan should be formulated with the MDT and be documented in the healthcare record
If appropriate to be moved into a side room so to reduce any potential risk to self and others
Nursing staff to be aware of any gender issues and should therefore not isolate themselves with the patient
Staff to be aware of any relationships or other vulnerable individuals that may be affected by patient’s behaviour