1. Introduction

This guidance has been developed to support clinical staff in the assessment and care planning process.

Assessment and Care planning is at the heart of the clinical and 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 due to the diverse services and there is no single correct way to write one, but there are important common points to cover regardless of team, ward or client group.

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

This guidance aims to:

- Meet professional, local and national standards
- Outline aims, actions and responsibilities of assessment and care planning
- Risk Management – how do we make care as safe as possible
- Goal setting – what do we want to achieve
- Be accessible to everyone who is part of the care planning process
2. What is a care plan?

A care plan is the document that identifies the care to be given – it is 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 is 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.
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 various assessment tools, for example the interagency assessment and Morgan Risk. Assessment is an on-going 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. The initial assessment can identify further specialist assessments required to meet people’s needs, e.g. depression assessment.

Plan

Patients will be admitted to the ward / team with a range of problems, and it will be necessary to prioritise these for the period of the admission. 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 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**
- **Attainable**
- **Realistic**
- **Time bound**

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

Assessment is a systematic, deliberate and interactive process that underpins every aspect of care. It is the process by which clinical staff and service user together identify needs and concerns and is seen as the cornerstone to personalised care. It is the only way that the uniqueness of each service user can be recognised and considered in the care process. (Royal Marsden 2011)

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 use of assessment tools enables a standardized approach to be used within a particular care setting. This can facilitate the evaluation of clinical interventions and clinical care. Perhaps more importantly, assessment tools encourage service users to engage in their care and provide a vehicle to allow staff to record the patients experience more effectively.

The first written assessment and identification of the service users immediate needs must begin on admission to the service and as part of that assessment must include identifying any: E.g.

- Allergies
- Medication,
- Infection risk
- Pressure ulcer risk – Waterlow
- Nutritional Risks
- Patient handling needs
- Morgan Risk Assessment
- Falls risk
5. Content of Care Plans

For all service users 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 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 Care

The assessment has provided a focus for planning and implementation of care that is effective and evidence-based. The process should consist of

1. Identifying clinical outcomes
2. Determine the immediate priorities and recognise what clinical invention is required and what referrals are required to other health and social care professionals.
3. To identify the anticipated outcome for the service user, using measurable “verbs” that describe patient behaviour or need and what the service user says facilitates the evaluations of the outcomes.
4. To determine what care interventions are required and what action will prevent or manage the service users’ needs, so that outcomes may be achieved
5. To document the care plan for the service user in an accessible format, in order for all other team members to be involved in the care of the individual
Measurable Verbs (use these to be specific)

Examples of measurable and non-measurable verbs for use in outcome statements

- State, Verbalise, communicate, list, describe, identify
- Demonstrate, perform
- Will lose, will gain, has an absence of
- Walk, stand, sit

Non-measurable Verbs (do not use)

- Know
- Understand
- Think
- Feel
6. Evaluate Care

Evaluating Care

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 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 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. Evaluation must be completed prior ward rounds or multi-disciplinary review where it will be discussed by the team
7. Legal Issues

Implement Care

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 the Professional Bodies and Trust Policy Standards of record keeping

“If it is not recorded it did not happen”
8. The Care Quality Commission Essential Standards of Quality and Safety

Outcome 4 – Care and Welfare of people who use services

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 called the Essential Standards. There are 16 Essential Standards associated with the provision of safe, quality care.

Each standard is defined by the CQC as an ‘Outcome’. The CQC inspect Trusts against compliance with ‘outcomes of care’ because these are the standards all staff are expected to deliver to all of the people who use their services.

The CQC frequently inspect services for evidence against;

Outcome 4; Care and welfare of people who use services.

People should get safe and appropriate care that meets their needs and supported their rights.

Question: How can you ensure that care plans demonstrate compliance with this legal requirement?

- 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


NMC (2009) Record keeping guidance for nurses and midwives

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

The Royal Marsden Hospital Manual of Clinical Nursing Procedures (student Ed 2011)

The Royal Marsden Hospital Manual of Clinical Procedures 2005 Ed)

http://www.hpc-uk.org/


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Writing good Care Plans Derbyshire Healthcare NHS 2012

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