Clinical Toolkit: CARE PLANNING

Why has this guidance been developed?

To provide practitioners with information regarding the development of care plans following assessment and formulation of a persons needs.

Who is it meant for?

All clinical practitioners who are required to undertake or participate in the development of a care plans as part of their routine practice. This includes anyone who provides front line assessment, care co-ordination, primary nursing and key working. It is a useful resource for trainees, but remember that all students and other learners must only undertake such work only with the supervision of a registered practitioner.

Does it contain everything I need to know?

This guidance covers the basics of care planning. Whilst we have tried to give guidance on how to write a care plan, each care plan will be written differently depending on the person for whom it is written. This includes if it is written in the first or third person, how the needs, goals and interventions are phrased and how prescriptive the interventions are.

What does it contain?

The guidance gives description of the central areas of a care plan, principles of collaboration with the person you are working with, and how and where the care plan should be documented in RiO.

Where should I record the care plan?

The care plan should be recorded in the Care Planning, CPA and Reviews section of RiO, in Care Planning. You should use this care plan regardless of if the person you are working with is assessed as CPA or Non-CPA.

The Care Planning form requires you to complete the following sections:

- Challenges and Needs – including selecting categories
- Intervention Categories
- Goals
- Activities
- Client's view
- Authorised by
- Main person responsible
- Planned/actual start date
- Anticipate end date

How should I record the care plan?

You should also refer to the more detailed guidance document here:
Good Practice Guide to Care Planning

A brief description of each section of the care plan follows:

Identify Need

Need will be informed by –

- Your assessment
- Carer's views
- Cluster
- Mental state examination
- Physical examination
- Risk assessment
- Evidence base – e.g. NICE, The Knowledge Centre, Map of Medicines
- Formulation
- NHS and Community Care Act assessment of FACS eligible Social Care Need (where Health and Local Authority are integrated)

Record the need in RiO in the free text in the box which appears once you have chosen the Challenges and Needs Category and Sub Category from the drop down list.

Formulate a Goal and Record Client's View

The goal could have two different views –

- The individual's goal
- The professional's goal
- The carer's goal

Record goals and client's views in the free text boxes. Where possible use the persons own words.

Where individuals are felt to lack capacity to make particular decisions this should be clearly recorded and the process used to make "Best interest" decisions clearly documented.

Plan Intervention

This should include –

- What has worked in the past, informed by the individual and their carer(s)
- The evidence base. What does the evidence tell us works for this mental health problem, diagnosis or situation?
- Consideration of "personalisation" as mechanism for meeting Social Care Need

Make sure interventions are SMART

Record interventions in RiO using clear, simple language. **Who** will do **What** and **When.**
Select the Intervention Category and Sub Category from the drop down list you can then list the interventions which you have identified in the free text boxes.

Review

A review date must be set for each care plan.
The length of time before review will depend on –

- The nature of care plan and how quickly the goal or anticipated outcome might be met, e.g. long term or short term
- How rapidly the persons presentation might change, e.g. in acute care settings the review date is likely to be shorter

What information supports this guidance?

You should access further information from the following sources:

1. Your clinical/professional supervisor and/or line manager.
2. Your professional organisation – eg: Royal College of Psychiatrists, RCN, BAOT/COT etc. – and check whether they have published guidance for their members.
3. The NICE Guidelines Service User Experience in Adult Mental Health, you can access it here
4. Guidance issued in 2008 on refocusing CPA Refocusing the Care Programme Approach
5. Derbyshire Healthcare Core Care Standards Core Care Standards
6. Refer to other tools in the Clinical Toolkit

When was this guidance produced?

It was developed throughout 2013 and approved for use on 09/12/2013

When will it be reviewed?

On a three yearly cycle (2016), or earlier if necessary

Who developed this guidance?

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