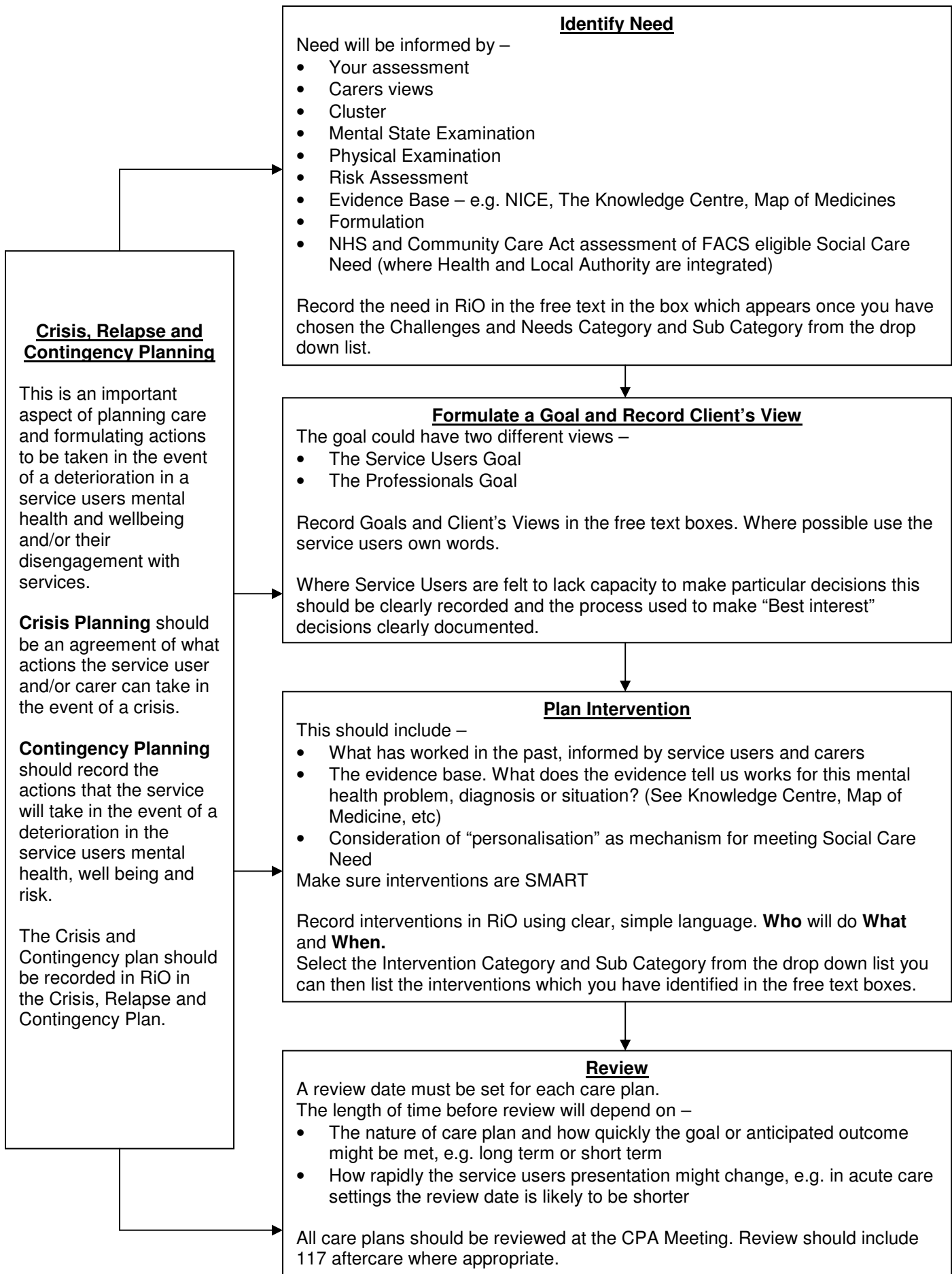


Care Planning Good Practice Guide

Quick Reference Flow Chart



Care Planning Good Practice Guide

Introduction

This guidance is aimed at staff from any professional group who are involved in the care planning process. This document aims to give a better understanding of:

- the care plan in the context of meeting the needs of the different groups involved
- levels of collaboration
- communication between professionals

The Recovery Model is core to the implementation of the Care Programme Approach in AWP and the four stages of the CPA process of Assessment, Planning, Implementation and Evaluation. The care plan is a key opportunity for professionals to work in collaboration with service users in implementing the CPA, (DoH, 2008).

The importance of good quality care planning which involves service users as much as possible in decision making long been recognised, (Sainsbury, 1998; Duncan, et al, 2010). The implementation of this process has been suggested as being deficient, (Jansson, et al, 2011).

Key factors in successful care planning are co-operation, collaboration and communication, (Hall, et al, 2008). These three factors are important not only in the relationship between the health professional and the service user but also between health professionals and other agencies, (Hall, et al, 2008).

The Role of the Care Plan

Collaboration

Best practice in care planning is to directly involve the service user. Where the service user is willing and has capacity to engage in the process of care planning they should be encouraged to do so, this includes the documenting of the plan. In these circumstances the wording of the care plan should be in the 1st person where appropriate using the words of the service user to describe problems, strengths, interventions and goals.

Some of our service users have less understanding and acceptance of their mental health difficulties and may be less likely to engage collaboratively with the care planning process.

Nonetheless it is important that we maximise likelihood of engagement by ensuring that where possible we use the language of the service user, that we avoid jargon and abbreviations and that we are clear, simple and precise in our explanations of interventions.

Carers are also important to consider in the care planning process. Carers have a key role in providing and supporting interventions and their involvement and agreed responsibilities should be incorporated.

Co-operation

Co-operation between agencies is vital in providing a seamless service and minimising risk. The CPA process and therefore the formulation of a care plan should enhance collaborative working between professionals and different agencies. A clear understanding of what everyone role in delivering care is an important part of the care planning process.

Communication

The written care plan is a means of communication. This includes communication of the agreed problems or unmet needs identified during the assessment process, the agreed interventions, the goals, the time frames and means of review.

In order for this communication to be effective the written care plan must contain enough detail so that it can be understood by all those with whom it will be shared, including the service user and, where appropriate, their carer.

A core role of the written care plan is to communicate with the service user. The care plan can be a means of involving and engaging the service user empowering them to take an active role in their own care. Wherever possible a copy of the care plan should be given to the service user and where appropriate their carer.

There will be times when a service user may refuse a copy of their care plan. This along with the reasons why, should be documented in the care plan itself.

Multi-disciplinary working can be greatly enhanced by effective care planning. The care plan should act as a clear statement of who is doing what and when in order to meet a specific identified need. Therefore one role of the care plan can be to communicate between professionals. The care plan is also a means of communicating a plan which all staff working shifts in a ward environment need to be aware of.

Writing a Care Plan

The principles of writing a good quality care plan remain the same regardless of whether you are using a piece of paper or RiO. The core parts of the care plan are problem or need, goal, intervention and review.

SMART Care Planning

All care plans should adhere to the SMART Approach. They should be:

Specific
Measureable
Achievable

Realistic
Time framed

Good quality care plans should outline the approach to be taken to meet a specific need which has been identified during the assessment process. The goals or expected outcomes should be realistic and achievable whilst still inspiring hope. If the goal identified by the service user appears initially unachievable rather than not addressing the goal it may be more supportive to break this down into the first steps towards the goal. In order to know if the interventions outlined are effective the care plan needs to be measurable and therefore a review date needs to be set.

This approach is outlined further by addressing each part of a care plan individually:

Needs

The care planning process starts by identifying the service users needs. The need is also sometimes referred to as the problem. Needs can also be turned around and recorded as strengths instead. The approach you use will depend on the purpose the care plan, who it is predominately written for, and the service user themselves.

A key consideration when recording need is to try to do this in a way which promotes maximum engagement from the service user. Therefore recording the need as “Jill has a diagnosis of paranoid schizophrenia” is unlikely to promote engagement if Jill is either unaware of her diagnosis or if she disagrees with this. The diagnosis or symptoms are not a need in themselves but the experience of the service user living with them may be. So, instead we could say “Jill finds it difficult to sleep as she is disturbed by the sound of voices in her room. Jill is unsure of where the voices come from”. If appropriate the use of the 1st person can also help ownership of the care plan and empower service users in taking action in managing their own care.

When considering needs it is important that we recognise key needs according to the cluster and presentation. Needs can be identified by linking to the Knowledge Centre or to other resources such as the Map of Medicine. Linking care plans with these resources will also ensure that they have a clear evidence base.

Where Health and Local Authority services are integrated it is important to understand that the assessment should also consider Social Care Needs within the framework of the NHS and Community Care Act. Guidance should be followed to consider whether these needs are “FACS Eligible”. The assessment of Social Care “need” is separate from the identification of a “resource” to meet this need. For example, service users do not “need to be in a Residential Care Home”. Instead, the exact nature of the need should be carefully assessed and then thought should be given as to how best to creatively meet that need.

Different approaches can help to identify needs. The use of collaborative approaches such as the Recovery Star can help to identify area of need which the service user agrees with and can also help with phrasing the need.

Any areas of risk identified in the risk assessment must be clearly identified in a care plan.

Sometimes there are needs which professionals identify which will be difficult to share with service users, such as needs around capacity or safeguarding and risk to others. However despite the difficulty in directly addressing these as needs with our service users it would be negligent not to plan care which addresses them. All efforts should be made to phrase the need in a way in which it can be sensitively shared and discussed with the service user in a culture of openness and collaboration. However if this is not possible then a plan of care should still be recorded and the reasons for this not being shared with the service user should be clearly documented in the care plan, for example where covert medication is being administered.

When recording this in RiO the need or problem which has been identified can be written free text in the box which appears once you have selected 'new problem/need'. Once you have recorded the problem/need you will also need to select the most appropriate category for this from the drop down boxes 'Challenges and Needs Category' and 'Challenges and Needs Subcategory' from the drop down list.

Goals

The goal can be defined in a number of ways. The service user may have goals that they hope or expect that the interventions will help them to achieve. This may be directly related to management of symptoms and experiences of mental health problems or may be more socially inclusive and holistic. For instance the goal or expected outcome of attending a supported activity may be to make friends and socialise for the service user, however for the professional involved the outcomes might be more that an activity will provide regular structure to someone's day and increase their sense of self esteem and self worth. Providing there is a way of measuring the success of both this difference should not be a problem and both goals can be recorded.

It is important that the goal is measurable and therefore a way of reviewing the effectiveness of the care plan is identified. The type of outcome will depend again on the purpose of the care plan and it is important to consider this when recording. If the service user has little or no engagement in the care planning process then it may be that the expected outcomes are ones which will be observed by those around them, be they professionals or family or carers.

Goals are recorded in RiO by again selecting the need you wish to address then recording free text in the box labelled 'Goals'. The goals should be a direct description in clear simple language of what measurable outcomes will be seen as a result of the interventions.

Interventions

Interventions can be informed in a number of different ways. Firstly, what has worked well for the service user in the past. It is important to recognise what effective coping mechanisms and approaches service users may have used before. It may be that these can be enhanced. Interventions should not just

include what professionals will do but also what service users can do themselves and what carers can do to support them.

Secondly the evidence base, what does the evidence say works in certain presentations. This information can be found quickly and easily using resources such as the Knowledge Centre and the Map of Medicines. When describing the interventions it is important to remember SMART care planning. The interventions must be specific. It is not enough to record that “The Intensive Team will visit daily”, the interventions should outline the purpose of the visit, what approaches will be used and this should all be informed by the evidence base.

This gives the service user a clear understanding of what will happen and how this will be achieved. It is important that interventions are clearly measurable. It is also important to ensure that the frequency of the intervention is recorded.

A balance sometimes needs to be struck between the wishes of the service user and what the evidence tells us about the appropriateness of an intervention.

Interventions are recorded in RiO by selecting the need you wish to address. Once you have selected the most appropriate ‘Intervention Category’ and ‘Intervention Sub Category’ from the drop down lists you can then add the interventions which you have identified under ‘Activities’. Again it is important that these interventions link directly to the identified need and are recorded in clear simple language which makes it easy to understand exactly who will do what and when.

“Personalisation” should be considered as a flexible mechanism for intervening to meet Social Care Need.

Clients View

Service User involvement is key to formulating meaningful care plans. Whilst the service user should be involved in every aspect of care planning and therefore their view should be included throughout it may be that there are statements that the service user wishes to make relating to the identified need or interventions.

This area of the care plan gives an opportunity to record the service users views in the first person. It can also make a record of whether the service user disagrees with the need/interventions and why.

Once the care plan is no longer required the actual end date should be completed in order to prevent the care plans remaining current indefinitely. Community care plans should not be ended simply because someone is admitted to hospital however they should be reviewed and amended if necessary.

In situations where it is considered that, at this point in time, the service user does not have capacity to make decisions about their care then the procedures outlined in the Mental Capacity Act and associated guidance should be followed. Staff in collaboration with carers, family and other relevant

parties may need to make “Best Interest “ decisions about the most appropriate care plan..

Crisis, Relapse and Contingency Planning

An important aspect of planning care is formulating actions to be taken in the event of a deterioration in a service users mental health and wellbeing and/or their disengagement with services. This should be done, where ever possible, before a crisis occurs enabling the service user, their carer and care co-ordinator to work together in the formulation of a plan. The aim of the plan is to support service users and carers to have an active role in staying well but also clearly communicating the safety net should contingency plans need to be put into action.

A crisis plan is service user led and will detail what actions they or their carer can take in the event of a crisis. A crisis will be defined differently by each service user and will be informed by their personality, coping style and resources and how much support is available from close personal relationships at that time. What constitutes a crisis for one person may not be the same for another.

Crisis plans should always include the detail of who to contact, including out of hours.

Crisis plans will ideally be written in collaboration with service users and their carers. Where possible staff should support the service user to construct the crisis plan enabling it to be written in the first person.

Crisis plans are recorded in RiO in the Crisis, Relapse and Contingency Plan under Crisis Plan.

Where the service user cares for any dependent children the crisis and contingency plan should include who will be caring for the children if the service user experiences a mental health crisis.

This is recorded in RiO in the Crisis, Relapse and Contingency Plan under Who will be Caring for any Dependent Children.

Additionally crisis and contingency plans need to detail the agreed signs and symptoms that the service users mental health is deteriorating. This should ideally be agreed with the service user and carer and recorded using language which is clear, concise and meaningful to all involved. It should also be clear enough to be understood by others who may not have met the service user before but may be involved in their care in a crisis.

This is recorded in RiO in the Crisis, Relapse and Contingency Plan under Relapse Indicators/Warning Signs.

A contingency plan outlines the actions that staff and the service will take in response to a deterioration in a service users mental health, wellbeing and/or risks. It will detail specific actions to be taken in the event of disengagement, DNA and/or non-concordance with agreed treatment plans.

Contingency plans should also include the requirements of any valid advance directive.

Contingency plans are recorded in RiO in the Crisis, Relapse and Contingency Plan under Contingency Plan.

Care Plan Checklist

<u>Care Planning Standard</u>	<u>Yes/No</u>
The Care Plan has a clearly identified need or problem	
The need is phrased in a way which encourages maximum engagement from the service user	
The need is specific	
The Care Plan identifies specific interventions which will address the need	
It is clear from the intervention who will do what and when	
The interventions are measureable e.g. how will you know if the interventions have addressed the need	
The Care Plan has a specific goal	
The Service User's view of the care plan is recorded	
There is a clear means of measuring the success of the care plan against the goal	
There is a Crisis Plan in place which outlines what the service user and their carer can do in the event of a deterioration of their mental health	
There is a Contingency Plan in place which outlines what the service and health professionals will do in the event of a deterioration of the service users mental health	

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