CARE PLANNING

Rasheed Meeran, HOLY CROSS HOSPITAL

AIM

- The aim of the workshop is to ensure you are able to use a systematic approach to clinical risk assessment and care planning that is user friendly and compliant with regulatory requirements

OBJECTIVES

- By the end of the workshop participants will be able to:
  - Complete a clinical risk assessment
  - Write a care plan that is clear and comprehensive
  - Provide supervision to other relevant staff to achieve competence and confidence in writing and using care plans
  - Create an awareness of the care pathways available at Holy Cross Hospital

HOLY CROSS HOSPITAL

CARE PATHWAY 1 – ADMISSION (Rehabilitation)

The pathway has 6 stages:

Stage 1 – Pre admission

- Initial enquiry and referral received and discussed by multidisciplinary team (MDT)
- Establish whether admission for rehabilitation or long term care
- Pre admission assessment to gain further information, identify needs and risks, ensure they can be met by Holy Cross Hospital, identify need for special equipment and prepare report for funding authorities
- Team discussion and decision on admission
- Visit to Holy Cross by patient and/or family
- Gain approval for funding* Confirm with CCG patient is being admitted for Rehabilitation (Intensive or Slow stream)

Stage 2- Admission

Day 1

Admission procedures completed by RN

- Patient seen by doctor
- Basic care planning completed to ensure safety

Day 2

- Multi-disciplinary team meeting to identify patient's needs and specific risks related to care
- Agree a care plan and team members responsible for documenting it

Stage 3 – At 2 weeks

Goal setting

Completion of appropriate outcome measures (NPDS, NPTDA, RCS) and smart Goals set

Specific assessments by each discipline (as appropriate) completed including:

- Medical and nursing including medication review
- Physiotherapy
- Occupational therapy
- Speech and language therapy (dysphagia assessment by day 2 if patient has oral diet)
- Neuropsychology
- Dietitian

Stage 4 – 4 weeks after admission Formal case discussion

Multi- disciplinary team case review to:

- Share assessment results
- Review and amend care plan
- Prepare initial report

Stage 5 – Patient and family meeting (6 weeks after admission)

Formal meeting with patient (if able) and family involving multi-disciplinary team to discuss results of assessments, progress and future plans. There are opportunities for questions.

Stage 6 – Re-assessment and review

Continuous process (Usually 3-monthly funding blocks), timescales for formal reviews are defined according to patient's needs and changing condition. If continuing Rehabilitation, continue 2 weekly goals (or other interval as appropriate) and monthly reports.

HOLY CROSS HOSPITAL

CARE PATHWAY 2 – TRANSFER FROM REHABILITATION TO LONG TERM CARE PACKAGE

Planning

Patient assessed as reaching potential in rehabilitation

- Repeat Rehabilitation Complexity Scale assessment
- MDT meet to ascertain ongoing needs and plan of care
- Change plan on trial basis for 3 months and monitor effects
- Reverse to original plan if patient shows signs of deterioration
- Agree recommendations

3 months

Evaluation

- MDT meet to discuss effects of changed plan and agree recommendations

High maintenance package

- Requires highly specialist nursing e.g. tracheostomy, ventilator dependent, behaviour management, frequent seizures
- Regular medical input
- More than 2 therapy disciplines required to be actively involved
- Requires specialised equipment e.g. electronic assistive technology, ventilator

Low maintenance package

- Requires intervention from a registered nurse e.g. monitoring, medication, enteral feeding, dysphagia management, dressings
- Monitoring by medical staff
- 2 or less therapy disciplines actively involved
- No needs for specialist equipment

- Meet with family to provide information , listen to concerns

3 months

- In consultation with family and PCT make a decision on whether the patient's needs can be properly met elsewhere e.g. nearer the family home
- If decision is to transfer elsewhere – move to pathway 3

HOLY CROSS HOSPITAL

CARE PATHWAY 1 – ADMISSION (Long term care)

The pathway has 6 stages:

Stage 1 – Pre admission

- Initial enquiry and referral received and discussed by multidisciplinary team (MDT)
- Establish whether admission for rehabilitation or long term care
- Pre admission assessment to gain further information, identify needs and risks, ensure they can be met by Holy Cross Hospital, identify need for special equipment and prepare report for funding authorities
- Team discussion and decision on admission
- Visit to Holy Cross by patient and/or family
- Gain approval for funding * confirm with CCG that admission is for long term care
- Arrange admission date

Stage 2- Admission

Day 1

Admission procedures completed by RN

- Patient seen by doctor
- Basic care planning completed to ensure safety

Day 2 (Usually Tuesday)

- Multi-disciplinary team meeting to identify patient's needs and specific risks related to care
- Agree a care plan and team members responsible for documenting it

Stage 3 – At 4 weeks

Goal setting

Completion of Rehabilitation Complexity Scale Assessment

Specific assessments by each discipline (as appropriate) completed including:

- Medical and nursing including medication review
- Physiotherapy
- Occupational therapy
- Speech and language therapy (dysphagia assessment by day 2 if patient has oral diet)
- Neuropsychology
- Dietician

Stage 4 – Formal case discussion

Multi- disciplinary team case review to:

- Share assessment results
- Review and amend care plan
- Prepare initial report

Stage 5 – Patient and family meeting (6 weeks after admission)

Formal meeting with patient (if able) and family involving multi-disciplinary team to discuss results of assessments, progress and future plans. There are opportunities for questions.

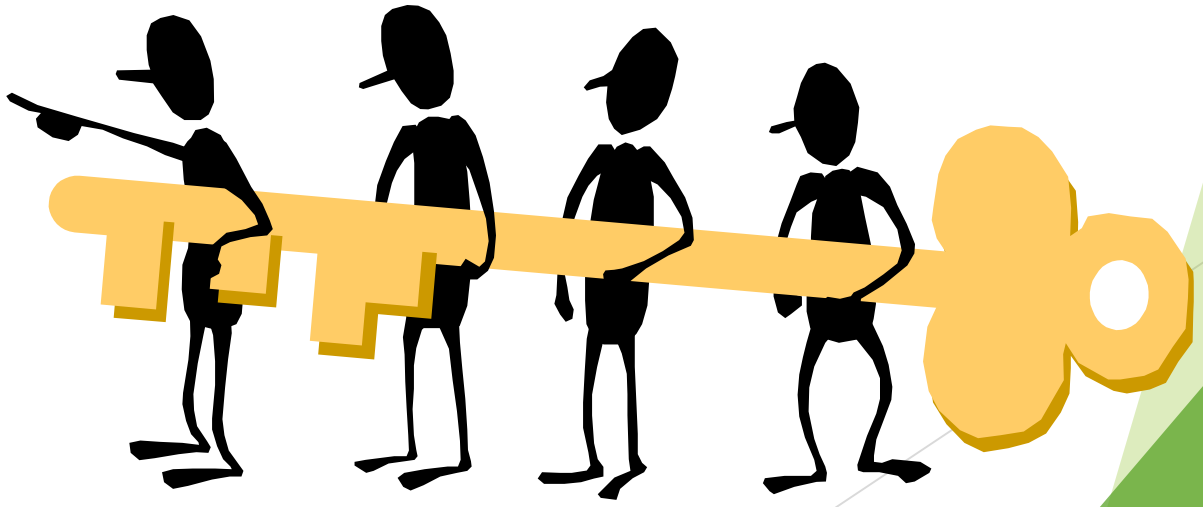
Stage 6 – Re-assessment and review

Continuous process, timescales for formal reviews are defined according to patient's needs and changing condition.

Rehabilitation patients - move to care pathway 2 if patient has reached full potential

QUESTIONS TO ASK?
Work in groups to consider:

- What is a care plan?
- Why do we have care plans?
- What information should a care plan contain?
- Who should be involved in compiling a care plan?



YOU MIGHT HAVE SAID

- A document which fully describes the care of an individual patient
- Care plans ensure consistency of care – provided they are accurate, well written, up to date and used
- Detailed information on clinical risks and all aspects of a patient's care
- MDT, patient, family

CARE PLAN MODELS

- Many models available
- Best known are:
  - Roper, Logan and Tierney – based on activities of daily living
  - Orem – based on self care
  - Maslow's Hierarchy of Needs – based on prioritising needs in order most important to patient
- Most models based on theory and difficult to adapt to practical situation
- Best models are those developed locally involving by team delivering care. Benefits include:
  - Team understand them
  - Sense of ownership
  - Familiar language more likely to be used

SYSTEMATIC APPROACH

- Assessment
- Planning
- Intervention
- Evaluating

Key points to note

- All staff are advised to look at the care plan before performing procedures for a patient – IT IS THE MAIN REFERENCE DOCUMENT!!!!
- You are allocated a care plan
- You are responsible as the 'registered professional'
- You are required to review the care plan every month before the 7th of each month
- Any changes MUST be documented and is 'your' responsibility
- Any litigation or review will look into who was responsible and if they highlighted the changes, risks and the management plan accurately

ASSESSMENT

- Based on assessing clinical risks and patient needs
- Ideally both are assessed – if a risk is present then a need is too
- Pro-active approach
- Ensures early detection of risks
- Ensures allocation of resources and implementation of interventions to manage/minimise risks

STATEMENT, PROBLEM or RISK

- Statement – declaration of facts
- Problem – situation that needs addressing
- Risk – potential harm that could arise or in other words consequence of not addressing problems

ASSESSMENT

- Summary sheet of areas of risk acts as contents page for detailed care plan
- Summary sheet is completed on first day of admission by marking a Y (yes) or N (no) in correct box
- Individual more detailed sheets completed for each section marked Y
- Standardised assessment tools used for nutrition, moving & handling and tissue viability
- Other sections use standard risk assessment
- Timescale for completion of detailed sheets depends on level of risk
- Whole team approach used with different disciplines taking lead responsibility for relevant areas
- Initial assessment rated if no action is taken

GENERIC CLINICAL RISK ASSESSMENT

Name	DOB
Risk no	
Description of risks (if no action taken) number each identified risk	

Date	Risk no	High	Medium	Low	Signature

WHAT IS A RISK?

- Potential to cause harm/suffering
- For example:

Risk to a patient with a tracheostomy is not having a tracheostomy but potential harm from tracheostomy or failure of it to maintain airway for example due to:

- Occlusion
- Decannulation
- Infection
- Haemorrhage
- Tube change failure

RATING RISK

- Simple rating system of:
  - High
  - Medium
  - Low

- REMEMBER you are rating risks as if no care plan is in place

PLANNING

- Pro-active approach
- Think through each identified risk
- What needs to be put in place to minimise the risk to an acceptable level?
- Plan and document actions to take if the worst happened e.g. tracheostomy tube occlusion

INTERVENTION

- What interventions may be necessary to minimise risk
- For example - changing a tracheostomy inner tube before suction and/or at least every 2 hours will reduce risk of occlusion
- We need to bear in mind interventions carry risks
- For example – changing a tracheostomy tube is risky – what do we have in place to minimise those risks e.g. procedures, competency framework, regular training etc.

Other risks

- Related to the task, equipment etc are listed and managed as part of Health and Safety committee or the management team

EVALUATION

- Once plan of care outlining intervention is in place we need to assess risk based on implementation of plan
- This is the 'managed risk'
- For example – tracheostomy is at high risk of occlusion if no plan in place but with plan in place most patients would be at low risk

Managed risk – please rate with care plan in place

Review date	Risk no	High	Medium	Low	Signature

GROUP WORK

- Risk, problem or statement?
- Work together and decide if what is written on each slip is a problem, a statement or a risk
- Place each slip on to the relevant pile
- Discussion

GROUP WORK

- Agree on a patient
- Select 1 area of risk
- Complete the risk assessment and write the plan of care for each selected area

Group work

- Review the care plan with a view to
  - Are the right professionals involved in related areas
  - Review the format of the care plans
  - Review the quality of the care plans

WHAT HAPPENS NEXT? Communication

- Care plans discussed with patient and /or family
- Document discussion on front sheet and ask patient/family member to sign
- All staff to be made aware of detail in care plan and take time to read
- Any changes – discuss at handover and include in communication book and weekly ward newsletter

- ANY OTHER IDEAS?

WHAT HAPPENS NEXT - evaluation

- Evaluation
  - Once plan is drafted:
    - Do risks change at different times of the day or at night?
    - Should actions differ at different times?
    - Night staff to review, may be necessary to do separate plan for day and night
  - Re assess managed risks every months and document with date in appropriate place
  - Re assess and re-write if patient changes or management strategy changes
  - Review and re-write care plans every 6-12 months as minimum standard for long term patients

ANY OTHER IDEAS?

Future

- Electronic patient records are being looked at
- Will make life much easier for
  - Setting up reminders
  - Auditing
  - Sharing with patients and families

SUMMARY

- Written care plans are a valuable tool to ensure systematic comprehensive care provided they are written well and include information required - like a ‘recipe’ for care
- Care plans should be individualised and demonstrate potential risks to patients as well as actions to minimise risks
- Care plans that are used properly provide evidence of care needed and provided