NIPEC

Northern Ireland Practice and Education Council For Nursing and Midwifery

Recording Care Project Strand 1

Literature Reviews: Care Planning

Published by the Northern Ireland Practice and Education
Council for Nursing and Midwifery (NIPEC)

Produced October 2014

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1.0 Introduction

The purpose of this paper is to discuss and identify key themes arising from a literature review pertaining to care planning, to inform discussion between key stakeholders as they develop a way forward to improve the quality of care planning within the nursing profession in Northern Ireland.

2.0 Background

2.1 Care planning has had a long history since the days when Florence Nightingale first put pen to paper. Nursing research relative to care planning has demonstrated a tension between using a preferred model to articulate care that is planned and the reality of practice in any clinical environment[1]. It is now 34 years since Roper, Logan and Tierney[i] first penned their model of care which many nursing care plans are underpinned by. Integrated Care Pathways have been in use and under discussion for quite some time also, referred as a method of linking up all the professions into one record and incorporating evidence based guidelines into practice whilst providing individualised person centred care[2].

2.2 The nursing process[2] promoted the principles of assess, plan implement and evaluate as a way of nursing patients and clients. Combining the nursing process with the activities of daily living resulted in a record which was termed the ‘nursing care plan’. The use of a problem solving approach to planning care now results in documentation which can be lengthy, particularly for those clinical areas which use standardised care plans[3, 4]. These lengthy documents can prove difficult for staff to use, with challenges that include; time to have a detailed conversation with patients/clients, provision of tailored information and written advice and appropriate time to apply evidence based care[5].

2.3 From a patient/ client perspective the difficulties arising from separate clinical noting by professions, can be grouped into issues around

communication, namely: similar questions are asked of the person repeatedly in the same episode of care by different personnel[2], problematic communication between professions[6&7]; duplication of information which may lead to inaccuracy[1]; physiotherapy/ specialist notes held separately which creates difficulties in Emergency Departments/ out of hours with vital pieces of care or history missing from the case note[1].

2.4 Within the five Health and Social Care trusts in Northern Ireland, there are many different forms of care plans. It is recognised that there are many complex issues in relation to care planning[8]. Nursing requires a clear and accurate record of the planned, delivered and evaluated care, which can demonstrate that it is individualised and person-centred to meet the needs of the patient[9].

3.0 Purpose of Review

3.1 This review will examine the themes arising from recent literature (2003 – 2014) relative to care planning. Attention has been paid to the relevance of involving patients in their care from the outset, of multidisciplinary collaboration in providing individualised person centered care, and, continuing education for all health care professionals to inform discussion between key stakeholders as they develop a way forward for care planning within Northern Ireland.

4.0 Methodology

4.1 Databases were searched through the interface Health on the Net Northern Ireland (HONNI). A number of searches were performed in three databases: British Nursing Index (BNI), Bio Med Reference database (BM) and Cumulative Index to Nursing and Allied Health Literature (CINAHL) with the following key search words: nursing care, patient care plans, nursing care plans, advance care planning individualised care plans. This search was limited to 11 years which gave a total of 371 abstracts.

4.2 Abstracts were scanned for relevancy and selected papers printed giving a total of 35 papers of which 29 were relevant. The main

discussion points within the selected 29 papers were summarised and logged for thematic analysis (Appendix A). Summaries were then examined, main themes recorded and tallied for frequency (Appendix B). Of the 9 main themes identified, 5 occurred at a frequency of 3 or above and will be discussed in the body of this paper.

5.0 Main Discussion

5.1 *Involving patients and families in the care planning process*

5.1.1 Nurses have long been keepers of the patient/client care plan. Care planning is a process which offers people active involvement in deciding, agreeing and owning how their condition(s) will be managed[8]. Historical evidence would suggest patients being *'informed of care,'* rather than being involved in the process of agreeing their care[10].

5.1.2 A study conducted in Australia[10], demonstrated that were effective care plans had been implemented it was with the interaction of patients and families. Such empowerment means a change in the roles and responsibilities that have traditionally been assumed. Vision for care planning is one of a, *'dynamic road map, held/owned by the individual in whatever setting which is regularly evaluated, and reviewed with the patients and their clinical/Mutli-disciplinary team (MD[T]).'*[11]

5.1.3 Patients need to move from being passive recipients of care to partners in care. At the heart of this move is the care planning process and the care plan. This encourages ownership of quality improvement in collaboration with other professions which results in sustained improvement of standards of record keeping[12].

5.1.4 To move our health economy to one of empowerment we must move away from a, *'didactic or paternalistic care provision model.'* To achieve this vision there is a definite need for incorporation of the wishes of patients/clients and their families in the care plan[13].

5.2 *Reflection on care planning*

5.2.1 This issue was raised in six papers, where the suggestion was made that there was a need for on-going reflection within organisations for nursing staff/MDT in relation to care planning being deemed necessary in order for staff to remain knowledgeable about the care planning process. Reflection and reflective practice has become a key issue for nursing. The NMC has stipulated that reflection is a competence that now needs to be demonstrated in order to gain entry onto the register as a Mental Health Nurse from September 2011. This has meant that reflection has become a competence in which staff must become proficient. It is also recognised that there are skills and personal attributes required for reflection, and that staff are often unsure how they can gain the skills required[14].

5.2.2 An exploratory study conducted in 2014 used reflection as its medium. The results showed that participants were able to collaborate effectively and identify shared perceptions within the work place. Following the workshops three key themes emerged through which reflection might be promoted within organisations: effective leadership, culture change and professional and personal development for staff[15]. There is also the need for senior management and clinicians in supporting staff to reflect as crucial, specifying; development of an educational programme that should be tailored to maximise responses from ward staff respecting the time constraints placed on them, time to share case studies of patients who had completed their care plan, and time to reflect on the outcomes for those patients. This would result in staff relating the discussion to their clinical practice[16].

5.2.3 The nurse's ability to document patient/client status, problems and progress was also seen as an important issue in patient

safety. Many nurses have been taught to write as much as possible, operating under a philosophy if ‘it wasn’t recorded it wasn’t done’, rather than accurately reflecting the status of the patient/client and their ongoing treatment or care. Many nurses when pressed understood that care planning should be a collaborative process underpinned by the principles of partnership working and empowering the patient/client. However, they found difficulty in promoting this ethos when care within organisations remained target driven. This was at odds with the aim of patient centred care[17]. Relinquishing some of the responsibility health professionals feel for patients/clients could help in applying the principles of partnership working in practice, however adequate systems of education, reflection, support and follow up with staff would be required if this was to become a reality[13].

5.2.4 NMC (2008),’*the skills of planning care are not to be undervalued......,’* they must be skilfully planned, implemented and evaluated by competent practitioners[18]. Phillips[12] agreed with the NMC, stating that; ‘*for care plans to work, skills expressed as competencies were required for the health professional. Any such skills were crucial if the care planning process was to result in partnership with the patient.’* O’Leary’s[19] theory for obtaining a better knowledge structure within organisations rests on ensuring effective communication processes are in place and that effective teams work with a shared mental model of care. This presents as an organised knowledge structure of the relationship between the tasks facing the team and how the team members will interact. A number of methods enabling knowledge transfer related to care planning were identified including:

i) MDT rounds or MDT focus groups

ii) Staff updating programmes

iii) Facilitation

iv) Case study reviews

v) Reflection sessions

Without a shared understanding of the plan of care, team members would be unable to engage[19].

5.3 *Multidisciplinary care plans*

5.3.1 Modern health care is complex and there has long been recognition that the management of long term conditions in particular, is dependent on an active negotiated care plan[11]. In in order to maximise clinical outcomes multi-professional staff require a joint perspective on management and care issues, working flexibly together and in collaboration with one another. The outcomes and experiences for people are dependent on the MDT. MDT care planning therefore should promote shared decision making[8].

5.3.2 A systematic review of 55 randomised controlled trials conducted over 25 years concluded that shared decision making was effective and popular with patients. Patients want their clinical teams not to just give information but to also take part in decisions. Shared decision making is becoming the new standard and the patient/client care plan is at the heart of this process.

5.3.4 *'Patient safety and inefficiencies in care occur when information fails to cross effectively between professions, whereas sharing of information with patients/clients continually is more effective.[21]'* Further conjecture suggested that nurses engaged in direct clinical care often viewed care planning as holding little or no value to patient/client care and that care plans were created and maintained within silos with minimal cross over to other disciplines, moreover they were usually initiated and

resolved from care setting to care setting offering no assistance in the continuity of care between care givers and venues.

5.3.5 Care planning is everyone`s business, a care package designed to meet the individuals needs[13]. Authors are agreed that the process is one of collaboration and joint working underpinned with the principles of person centeredness and partnership working. This means Care planning becomes an action rather than an end product. '*Care Plans must be individualised, negotiated and representative of the care required, to do this we must embrace multi-professional collaboration.'* Care planning needs to be delivered within a conscious sympathetic health care system[9].

5.4 *Organisational investment*

5.4.1 At a time of economic downturn, investment in time to complete care plans is even more important given the cost effectiveness to service if they are constructed and executed appropriately. A complex programme of change requiring organisational processes to be redesigned is needed and the commencement of a cultural shift among the MDT that care planning is everyone's business. To achieve the best outcomes organisational systems and effective commissioning approaches must be in place and working together[22].

5.4.2 Understanding new techniques for organisation of care is a practical and conceptual problem. Various models and theories exist but they show little by way of the theory and characteristics that explain their implementation[22]. A systematic review completed by May and interpreted using the Normalisation Process Theory (NPT), recognised some of the barriers to the implementation of care planning as;

i) Behaviours of senior leaders,

ii) Negative effects of documentation e.g. too much paperwork,

iii) Culture and belief systems of professionals,

iv) Partnerships between professionals,

v) Wider commitment from the organisation,

vi) Understanding of the process,

vii) Operationalisation under pressure,

viii) Implementation and embedding and accountability

5.4.3 In discussing the way forward in working with staff. Literature cited that any new way of working should be presented in a workable form with consideration given to the impact of implementation through e.g. additional work, additional demands for change that can lead to resistance from potential users. Furthermore it was acknowledged that staff sometimes struggled to understand the real evidential value of the need to change a process. It was identified that engagement of the MDT through collaboration in small group learning sessions was the most beneficial in adopting new processes as it allowed them to talk about practical issues, and develop strategies in groups[22].

5.5 *Core skills*

5.5.1 Quality of care, efficiency outcomes, hospital pressures and competing priorities to provide, have placed nurses under growing pressure not least in the area of care planning. Addressing the core skills of nurses to complete care plans was a theme considered in a number of the selected papers, and was irrespective of whether the discussion focussed on one profession or multi-professions[12]. Therefore before addressing any of the core skills of care planning it is important to distinguish between, a care plan which is a static entity, a record of the care planning process whilst care planning is the dynamic, and involves the patient/client and the health professional in an open and honest change of dialogue[12]. Some of the skills particular to care planning were addressed in a longitudinal study by Juve-Edina[23], nursing assessment was used to represent patient's problems within the care plan and reflect the

nurse's judgements on patient status. Furthermore, nursing assessment provided the basis for the selection of nursing interventions to achieve outcomes for which the nurse was accountable. Care planning should follow a process namely one of, collaboration with families which will allow for early anticipation of problems and collaboration with other professionals[24]. Care planning skills should include holistic assessment, accurate understanding of disease pathology, knowledge of risk factors and understanding of issues that affect the patient/client and the family[25]. Given the plethora of skills required care planning skills should include appropriate construct, identification of problems, and delivery of evidence based care whilst providing an account of the patient's journey[9].

5.5.2 Terminology across the selected literature is broadly reflective of three main axis: assessment, diagnosis and intervention. These three represent patient/client health status, problems, situations and responses for which nurses are accountable. Interventions and actions are performed and clinical findings are assessed on this basis[23]. To accomplish this three main axis approach there is a need for a committed, skilled and adequately resourced MDT working with patients, Commissioners, managers, clinicians and patients/clients working together to achieve the desired outcomes, and making the finances fit according to patients need and not the other way around[8].

5.5.3 The care planning process could be compared to negotiating a contract resulting in the care plan document laying down both parties' responsibilities[12]. Therefore care planning should:

- be person centred
- identify optimal health outcomes linked to assessment of need
- demonstrate active patient involvement in decision making through a partnership approach
- enable sharing of information across the MDT

- ensure effective evaluation which will demonstrate quality outcomes

Care plans must follow a process in collaboration with patients/ clients and families, allowing for anticipation of problems[24].

6.0 Conclusion

6.1 From this literature review it is clear that there are many, diverse factors which influence care planning within nursing and the wider health service, most of which may be addressed appropriately in a manner, which the evidence suggests, and will lead to quality improvement. It is noteworthy that relatively few of the papers selected included the redesign of documentation per se, in fact most of the discussions concentrated on aspects of quality improvement. The key areas of, determining what is documented, skills required to care plan, inclusion of the patient in the planning of their care, the process and time spent care planning, organisational responsibilities and a multi disciplinary approach. These factors appear to have the most influence over the process and quality of care planning.

6.2 In order to inform discussion regarding the way forward for care planning within Northern Ireland the following key issues are offered for consideration by senior nursing and midwifery colleagues:

1. The priority or ranked importance of the 5 issues identified
2. The influence these issues have relative to the intended purpose of improving the quality of the care plan to be included within the Regional Person-Centred Nursing Assessment and Plan of Care Record.
3. The need for a multi professional approach to care planning involving the patient/client, during designing, for inclusion within the Regional Person-Centred Nursing Assessment and Plan of Care Record.
4. The need for an appropriate evaluation framework of any new approach developed in relation to care planning across the region.

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Appendix A
Table of Document Summaries

Document	Summary
Adriana.L, Chavez.P, Prachee.S, Andrea. A, Anderson.J.E, Jernigan.C, Ravi.V. (2014) Tool To Expedite The Development Of Treatment Plans. Lippincott Williams & Wilins, p 70 – 75.	A quality improvement project to reduce time between new patients initial visits and the finalization of their treatment plans
Baker. D. (2014) Planning Care For Service Users Who Have A Deteriorating Condition. Art And Science. 17, 2, p 30-33	Implementing CPs must follow a process in collaboration with families this allows for anticipation of problems. Part of the nurses role to support individuals to maintain, regain and learn skills, support from other professionals is usually needed. Collaboration maximises the likelihood of goal achievement. Need for nurses to know what equipment and resources are available as they plan the care with the patient.
Beasely, C. (2009). Supported Self Care And Care Planning For Patients With Long-Term Conditions. British Journal Of Community Nursing. 14, 9, p 394 – 397.	Outlines the policy imperative for long term condition care planning. 'care planning forms a vital part of the self-care agenda' p 394 Reference to information prescriptions. Mention of five self-care pillars: skills and knowledge training, tools and self-monitoring devices, healthy lifestyle choices, support networks.
Booth. A (2012) Benefits Of An Individual Asthma Action Plan. Practice Nursing, 23, 12, p 594-602.	Strong evidence which suggests that personalised asthma action plans improve patient quality of life, reduce the risk of exacerbation and prevent hospital admissions. A personalised action plan contains written information which is individual to a person with asthma – they should help people with asthma to detect early signs of worsening asthma and provide information to help them to make changes in treatment in order to prevent an asthma exacerbation. Providing education to patients without writing the advice down may prove of little value. It is helpful to have two or three action points with no more than four. Use of a traffic light system is common in many action plans. Detailed plans contain further information, the causes, the triggers, medication etc. Use of the SMART approach (Barnes 2007). Education required implementing this properly. Patient preference may assist the health professional in determining what kind of plan to choose. Challenges: the time to have detailed conversations with people. Providing tailored information and written advice. Need to press for appropriate amounts of time in order to apply EBC. For asthma Clinical Management Guidelines (NHS Yorkshire and Humber 2010) suggest 20 minutes. A challenge for commissioning groups is to determine how much time should be built in and devoted to EB interventions and personalised action plans. Personalised care plans allow people to react

	to changing circumstances. Personal self care and professional care are linked. The key element is making it personal or individualised and questioning technique and review. Action Plans need to be used and reviewed if they are to have a sustainable effect, changes should be reflected within the plan if it is too effective in the long term. (Ring et al 2007). Evaluation – is the plan agreed having the desired effect, is the condition under control. Need for a joined up approach – patient, nurse, Dr, MDT, Consistency, supplying the patient with a copy and a copy in the medical notes. Galvanising out IT experts to produce the plan so that it can be stored and coded and printed out for patient to take away. Shared action planning is of greater benefit. Care planning apps providing information about a particular condition. Conclusion: Enabling and empowering patients to manage their condition should help to improve quality of life and reduce the risk of attack. Providing education, advice and goal setting should be synonymous with routine management. Plans should be evidence based and individualised.
Cardwell, P. (2011) Is Care Planning Still Relevant In The 21st Century? *British Journal Of Nursing*. 20(21), p 1378 – 1382.	Calls into question the relevance of developing and possessing cps due to preponderance of pre-printed cps. Contends that to deliver individualised care nurses need to be able to understand how to care plan. Need to include self care in plans of care to empower the person (children's based article – aimed at educating parents). Discussion on evolution of assess plan implement evaluate to include a nursing diagnosis which is an outcome of the assessment stage. The process is described as continuous. Mentions a number of models related to children's settings – accepts the RLT is the most widely used. Care plan presented is similar to what would be used in NI – task orientated with some person centeredness.
Casey L. K, Mangione-Smith. R, Britto. M.T. (2014) Individualised Plans Of Care To Improve Outcomes Among Children And Adults With Chronic Illness A Systematic Review. Care Management Journals. 15, 1, p 11-25.	ICP are developed to improve care coordination but their association with improved outcomes is unknown. Information is sparse. More evaluation is required as to who should be involved in their developed and what they should include and how often they should be updated. Care co-ordination requires substantial investment of personnel and infrastructure. Literature is sparse and generally of low quality. IPC are used in a MDT approach most commonly and patients with more complex illnesses tend to benefit the most from this approach. ICP are associated with improvements in satisfaction, function status, symptom management ED use hospitalisation and mortality in various study contexts and patient populations.

Clarke, N. M. (2014) A Person-Centred Enquiry Into The Teaching And Learning Experiences Of Reflection And Reflective Practice – Part One. Nurse Education Today. 34, p1219 – 1224.	Reflection and reflective practice has become a key issue for curriculum development within nurse education. The NMC linked the demonstration of reflective skills to clinical competence to gain entrance onto the professional register. NMC stipulated that reflection is a competence that needs to be demonstrated in order to gain entry onto the register as Mental health Nurse for all new pre-registration nursing programmes from September 2011. A requirement of health regulating bodies such as the NMC has meant that reflection has become a curriculum element in order to ensure that nurses are able to meet the competencies that pertain to reflective practice. Participants recognised there are skills and personal attributes required for reflection, but that they are unsure how to actually apply these definitions in practice and gain the skills required. That teaching methods utilised were perceived as the reason behind this. Furthermore this research emphasised the need for reflection to be an integral part of teaching and should not be perceived as something of an add on.
Clarke, T., Kelleher, M. and Fairbrother, G. (2010). Starting a care improvement journey: focusing on the essentials of bedside nursing care in an Australian teaching hospital. Journal of clinical nursing. 19, p1812 – 1820.	Acknowledgement that a focus which does not have foundations in an assessment and planning methodology leads to task based care. Poor planning practice inevitably leads to poor communication and problems around patient management. Audit tools need to identify poor assessment, poor structure and a lack of planning in nursing documents. Project was based largely on improving assessment, EWS and communication processes. On further reading it seemed to focus largely on the appropriateness of the cps and the frequency of evaluation/interventions. A review of clinical incidents was taken forward also following poor audit results – 6 domains for attention were identified – 5 from the audit scores, and a further group discussion agreed 8. Care outcomes were described as standard statements for each domain- personal care, documentation and communication, promoting self-management, medications administration, privacy and dignity etc. Despite education and awareness sessions, record keeping continued to prove a problem. Decision to take forward and emancipator PD approach to improve care planning and record keeping.

Cotrill. R (2013) Guideline Directed Wound Care: A Patient With A Post Kidney Transplant Surgical Site Infection. Journal Of Wound Care. April, 22, 4, p214 – 216.	Example of how best practice guidelines can be used to guide care: Patient with post of site infection. Diagnosis of infection made, dressing changes performed three times per week to decrease unnecessary pain and to ensure efficient use of health care resources. Wound healed after 3 months. Recommendations: complete holistic assessment is key to gathering information. An accurate understanding of wound aetiology and history to understand why healing is delayed. This allows for creation of a treatment plan to eliminate or reduce factors that may affect wound healing. Understanding these issues and including the family is of primary importance.
Elsherif, M. and Noble, H. (2011). Management Of COPD Using The Roper-Logan-Tierney Framework. British Journal Of Nursing, 20, 1, p 29 – 33.	Article written by nursing students to demonstrate the process used for one particular patient. Very academic piece which had no mention of patient involvement in the care planning process – didactic approach.
Heermann Langford.L.K, Tinker.M.S, Martial.M.A. (2010) A New Life For The Care Plan. Nursing Management, December, p 22 – 24.	Health Information Technology for Economic and Clinical Health (HITECH) act electronic health record (EHR) incentive programme. This legislation calls for healthcare providers to meet a set of minimum requirements using a certified EHR. The programme lays out an overall plan that incentivises hospitals and providers to implement, adopt and meaningfully use an EHR. Nurses have long been keepers of the in- patient care plan. The Joint Commission requires the care plan to contain the identified care needs and treatment goals, the strategy to meet those needs and goals and any progress toward meeting the goals. It also required the CP to be regularly evaluated and revised as needed. However nurses at the bedside often view CP as holding little or no value to direct patient care. CPs are created and maintained within each clinical disciplines silo with minimal cross over to other disciplines. Additionally CPs are usually initiated and resolved from care setting to care setting offering no assistance in the continuity of care between care givers and venues. Lack of cross over contributes to inefficiencies on care and decreased patient safety. Another challenge is that CPs isn't part of care delivery workflows therefore they necessitate extra work for clinicians to create, modify and maintain to meet regulatory and accreditation requirements. Dobay defines a MDT CP as 'written by each discipline independent of the rest of the care team.' Von Gunten,' working sequentially with the medical record (it being the chief means of communication).

	Working across and sharing knowledge across functional domains can be difficult and is recognised as a major challenge. Domain specific knowledge is localised and embedded into the practice of that area. Sharing of information about and with patients continually is the most effective. Common elements of a MDT Care Plan: - Problem lists - Targeted outcomes - Actions and interventions essential to achieving targeted goals and outcomes - Evaluation of progress toward meeting the set goals Maintaining one problem list and managing one medication list and one allergy list between care givers is the ultimate goal of PCC. Each discipline then applies its unique skills and knowledge toward assisting the patient to meet those goals and is aware of efforts being made by the other disciplines. There can be concern – i.e. one discipline cluttering another, or making lists so long they impeded work flow.
Holmic, P. (2009). Patient-Centred Care Planning. Practice Nursing. 20, 1, p18 – 23.	Reference to work around diabetes care planning again. Reference to inclusion of person in care in their plan of care.
Juve-Edina.M.E, (2013) What Patients' Problems Do Nurses E-Chart? Longitudinal Study To Evaluate The Usability Of An Interface Terminology. International Journal Of Nursing Studies, 50, p1698-1710.	The nurse's ability to document patient status, problems and progress is an important issue in patient safety. ATIC terminology is used in the electronic nursing care planning. Quality of care, efficiency outcomes and challenged hospitals has placed nurses under growing pressure. Levinson (2010) lack of adequate assessment of the patients status, inadequate monitoring of the patients progress and poor communication among clinicians account for almost 70% of SAIs within the hospital setting. Accurate nursing documentation may help increasing the efficiency of clinical and management decision making in the context of growing demands of information along with the widespread use of EHR. EHRs are expected to increase patient safety, reduce medical errors improve efficiency and reduce costs. We currently use nursing diagnosis to represent patients' problems in charting the care planning in patient records to reflect the nurse's judgements on patient status. Nursing diagnosis provide the basis for the selection of nursing interventions to achieve outcomes for which the nurse is accountable. It is nursing judgement on the patient, actual or potential health problems, represented by a concise statement, based on the analysis of objective or subjective assessment data for which the nurse can prescribe care. Increasing evidence showing that existing classification systems such as NANDA 1 classification are not able to represent the kind of nursing data commonly recorded in patient's charts in sufficient detail, they only partially cover patients problems identified.

	Terminology has three main axes: assessment, diagnosis and interventions to represent patient health status, problems, situations and response for which nurses are accountable, the interventions and actions they perform and the clinical findings they assess. Definition of Nursing diagnosis: “A nursing diagnosis is a clinical judgement – or the conclusion of several judgements – on the health status of an individual and the actual or potential consequences and reactions within the different dimensions of the individual and in the context of their environment and particular experience and within the scope of professional nursing accountability, including shared responsibility with the care beneficiaries and with other healthcare providers. Hypothesis: Nurse’s clinical expertise may play a role in the final judgements stated and documented. Novice nurses are more symptom focused, they need to use a greater number of diagnoses and more general concepts to explain a situation while expert nurses are more focused on the problem outcome, being able to synthesise and accurately identify specific diagnosis and outcomes to be managed and prevented. Describing how many nursing diagnoses a patient’s care plan should contain should not be considered as an indicator of nursing intensity, patient complexity or severity of situation.
May .C ., Sibley. A ., and Hunt.K. (2013) The Nursing Work Of Hospital-Based Clinical Practice Guideline Implementation: An Explanatory Systemic Review Using Normalisation Process Theory. International Journal Of Nursing Studies. 51, p 289-299.	Systematic review using the Normalisation Process Theory. Key words: Clinical guidelines, implementation, nursing work, systematic review, qualitative synthesis review, practice theory. Little by way of practice theory that characterises and explains implementation processes themselves. Clinical guidelines provide a consistent approach to quality improvement in healthcare settings. Barriers: behaviours of opinion leaders, negative effects of documentation systems and electronic health records, the culture and belief systems of professional, the state of partnerships between them and wider commitment from organisations.
O’Donoghue. D. (2010) Achieving Quality: The Need For A Multi-Professional Approach. Journal Of Renal Nursing. May, 3, 3, p 110-114.	Modern health care is complex. The way clinical teams work together and interact impacts on patient experience and outcomes. During the patient journey patients encounter various professionals. To maximise clinical outcomes multi-professional staff require a joint perspective on management and care issues, work flexibly and in collaboration. (National Renal Workforce Planning Group 2002). The outcomes and experiences for people are dependent on meaningful engagement with patients, carers and families and high-quality preparation for their chosen modality. This needs a committed, skilled and adequately resourced multi-professional team working with patients. Commissioners, managers, clinicians and patients need to work together to ensure the model of care achieves the experience and outcomes we all desire and then make the finances fit according to the

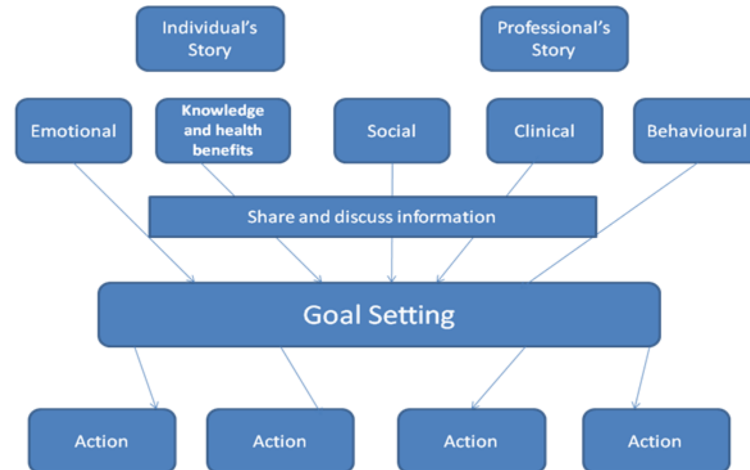
	patients need and not the other way around. MDT care should promote shared decision making. Systematic review of 55 randomised controlled trials conducted over 25 years concluded that shared decision making was effective and popular with patients. Clinicians are often poor at even eliciting never mind acting on the patient's agenda. Kon 2010 argues that patients want their clinical teams not just to give information, but to also take part in decisions. Shared decision making is becoming the new standard but to many it remains unclear as to what that means. Decisions need to be made in a manner consistent with the patient's wishes.
O'Leary, K.J. (2010). Patterns Of Nurse – Physician Communication And Agreement On The Plan Of Care. *Quality And Safety In Health Care*. 19: p195 – 199.	Ineffective communication between health professionals highlighted as root cause for medical 'mishaps'. Study interviewed patient's nurses and doctors on a US medical ward using semi structured questions. Lack of agreement in diagnosis evident – nurses sometimes being unaware of clinical findings.
Philips, J. (?) Care Planning: More Than Meets The Eye. *British Journal Of Community Nursing*. 15, p 1.	Acknowledges that care planning requires core skills in terms of competence – related to planning actual care and recording it. Care planning needs to support the patient to be in control of their own health. To enable them to be an active partner in care and not passive. Fundamental to this process is the activity of goal setting and problem solving. Goals need to be mutually agreed and realistic. Advocates the employment of a self care approach and creation of small achievable steps. Exploration of self management techniques may be helpful and questioning. Skills for health 2008 competencies for self care mentioned.
Poder.U, Fogelberg-Dahm. M, Wadensten.B. (2011) Implementation Of A Multi-Professional Standardized Care Plan In Electronic Health Records For The Care Of Stroke Patients. Journal Of Nursing Management, 19, p 810-819.	Aim: comparing staff opinions about standardised care plans. Majority of nurses agreed that EB-SCP were useful and facilitated their work. However there was no change before and after implementation with regard to opinions about standardised care plans, self reported documentation habits or time spent on documentation. Conclusion: EB-SCP seems to be useful in patient care and improves perceived knowledge about EB guidelines. For nurse managers introducing EB-SCP may improve the pre-requisites for promoting high quality EBP in multi-professional care. What is a standardised care plan? It describes the care to be provided and contains a diagnostic cluster, collaborative problems and interventions, it should be up to date evidence based knowledge (p811). Most nurses felt SCP helped increase their ability to provide high quality basic care.

	EBC a great challenge: common barriers: characteristics of the organisation, insufficient time for nurses to implement new ideas (the most frequent barrier), and lack of authority to change patient procedures found in 49% of the studies. Poor supportive leadership for the importance of EBC and the time that it takes. EBSCP should be complemented with individual care plans, training staff both in care and in the technical aspects of using EBSCP in for e.g., an EHCR Nearly half of the staff reported lack of knowledge of the publication describing EB nursing in stroke care. Opinions about standardised care plans: Majority felt SCP helped their ability to provide high quality basic care for all patients and that quality standards are a pre requisite for ensuring SCP are of a high quality. Documentation needed to be as time efficient as possible without jeopardising quality of care. Harris (1990) and Lee et al (2002) point out that SCP could entail a risk of neglecting patient's individual needs. The reason for not always following the nursing process when recording patient care may depend on inadequate education in documentation issues, lack of support from the organisation or the high workload on the unit.
Smith.D, Carey.E (2013) Person-Centred Care Planning For Clients With Complex Needs. Art And Science. December, 16, 10, p 20 - 23.	Article focuses on person centred plans gives an example of a daily bathroom regime p22 for someone with complex needs
Smith, S., Gentleman, M., Loads, D., and Pullin, S., (2014) An Exploration Of A Restorative Space: A Creative Approach To Reflection For Nurse Lecturer's Focused On Experiences Of Compassion In The Workplace. Nurse Education Today. 34, p 1225 – 1231.	Study undertaken as part of a larger programme of research: the Leadership in Compassionate Care Programme. A series of four reflective workshops were provided and used the medium of collage as a process for reflection. Participant's identified the approach as a demonstration of effective collaboration and identifying shared perceptions and experiences in regard to compassion in the work place. Three key themes were identified by participants during the analysis process: leadership, culture and professional and personal development. Participants specifically identified the need for interactive forums where lecturers could express ideas, share projects and innovations and take the lead in generating different ways of working, teaching and learning opportunities.
Stott, N. (2011). Improving Care Planning Practice In Oncology Nursing Practice. *Nursing Standard.* 25, 42, p 33 – 39.	PD project within 27 bedded oncology ward in Scotland. General ethos of improvement. Audit of why care plans (CPs) were not being used. Results showed that existing online portfolio of CPs did not contain enough detail, not easily accessible and no clear structure. Literature review was undertaken to inform the process – significant finding was that care planning needed to be based on the needs assessment. Other elements were patient

	involvement and evidence based care planning. Also demonstrated lack of information around the effective design and layout of CPs. Lee (2005) content should include diagnosis or nursing problem, nursing goal, evidence of implementation and evaluation. Nursing action was also highlighted for inclusion – Canale (2004). Lee (2005) suggested that an efficient CP system, using standardised CPs allows nurses more time to dedicate to patients. Consulted with patients also. Questionnaires designed for nursing and medical staff. Both different in design. Results fed back - time was an issue so the system to be introduced should ensure time was used efficiently. Pilot care plan devised to trial – used sign off system for daily use rather than evaluative statements. Intensive support offered preceding the pilot and fir first week – awareness sessions completed and ongoing training with both day and night staff. Despite interventions the use of the single care plan tailed off in the final weeks of the pilot. There were some halo effects – for those who were using the CPs they began to CP better in other areas of nursing diagnosis. Recs: future study further facilitated, nurse education concentrating on CP-ing, focus groups with patients to see how to best integrate their opinions in CPs, further consultation with nurses.
Tan, H.M., Lee, S.F., O'Connor, M.M., Peters, L., Komesaroff, P.A. (2013). A Case Study Approach To Investigating End-Of-Life Decision Making In An Acute Health Service. Australian Health Review. 37, p 93 – 97.	Raises issues of involvement and potential for budgets to be impacted – also unrealistic expectations for patients regarding treatment pathways for palliative care. Evidence of 'informing' of care rather than being involved in the process. Study demonstrated that where effective care plans had been implemented it was with the interaction of patients and families. Evidence existed that care plans were often not read from one shift to the next. Conclusion was that further work was required in this area to ensure effectiveness.
Taylor.C, Cummings.R, Mcgilly.C. (2012) Holistic Needs Assessment Following Colorectal Cancer Treatment. Gastrointestinal Nursing, November, 10, 9, p 42-49.	Assessments not always well co-ordinated and do not necessarily occur at key points in the patients care pathway. Nurses role to stimulate an assessment conversation, support the individual and their identity and prioritise their health and care needs. Patients may need some help to think through their needs and realise their concerns. HNA should be a guided conversation ideally structured by the use of an assessment tool – choice is variable. The choice will depend on the patient population and personal preferences. Must have an assessment tool to ensure consistency. Avoid unnecessary repeated

	assessments. When to do the assessment/review: Around the time of diagnosis/commencement of treatment Completion of the primary treatment plan New episodes of disease recurrence Point of recognition of incurability Point of crisis If the patient requests it Any agreed actions must reflect the patient's priorities. Avoidance of repetition Effective assessment hinges on the provision of appropriate education and training for HSC professionals
Thomas, S. (2009) Will The Year Of Care Improve Care Planning? *British Journal Of Neuroscience Nursing*. Vol 5, 10, p 478 – 479.	Recognition that the management of long term conditions is dependent on an active negotiated care plan. Reference to the work on diabetes from previously referenced paper.
Thompson-Hill, J., Hookey, C. Salt, E. and O'Neill, T. (2009) The Supportive Care Plan: To Improve Communication In End-Of-Life Care. International Journal Of Palliative Nursing. 15, 5, p 250 – 254.	Development of a patient held record and plan of care which provides a framework for initiating discussions and making the plans and wishes of each individual patient known to all HCP involved in their care. Use of this document demonstrated a more inclusive discussion ongoing with people in end of life care.
Tsang. F. L, (2014) Nurse Prediction Prevention And Management On Post-Operative Delirium In Geriatric Patients With Hip Fracture: The Development Of A Protocol To Guide Care. International Journal Of Orthopaedic And Trauma Nursing. 18, p 23-34.	National Institute for Health and Clinical Excellence introduced a guideline for the management of delirium in 2010. Aim- a protocol with a nursing care plan referenced from an international guideline. Using known risk factors associated with post op delirium and preventative interventions were adopted to develop the protocol and nursing care plan. Care plan was adapted for staff to implement in their local area. Delirium a common complication in older adult's rates between 9 and 65% .Paper describes the incidence of post op delirium and to describe the development of a practice protocol for nurses to use to identify and monitor those patients at risk of developing post op delirium. An accurate and timely assessment using a strategic protocol is of paramount importance to detect patients with delirium and to provide appropriate interventions. The protocol guides practice and has been widely welcomed and implemented by staff. Many nurses using protocols see it as a means of providing evidence based care. Nurses commonly use checklists to guide their clinical care for patients with box ticking. Similarly a well defined protocol with specific care interactions prescribed in various circumstances can be developed to help nurses. The counter argument this could lead to restricted decision making and a reduction in independent thinking. Flynn and Sinclair (2005)

	suggest protocols shouldn`t encroach on nursing autonomy but should increase confidence. Standardised care protocols can help nurses to develop and take on new tasks and develop skills beyond the traditional scope of practice e.g. prescribing, diagnosing etc. Nurses can increase their autonomy and take a lead role in managing patient care. Protocol based care incorporating nursing care plans can provide comprehensive care for post op delirium management with hip fracture. Disadvantage no management protocol can be adopted independently for clinical use in a different clinical practice context they can only be developed for a local situation. (bit like Siobhan's care plan)RAMP Care Plan Risk Assessment and Management for Post Op......... Risk factors are captured to inform the care plan. What are the associated risk factors of the presenting problem? Preventative strategies are required to manage patients having associated risk factors. Strategies to provide preventive interventions require a proactive multi-factorial approach with a humanistic, compassionate approach to patient management if reversible risk factors are to be treated. Nurses need to orientate the patient at least four times daily and record the statement, 'patient orientated.' In the nursing care report. This also addresses some other areas such as fall prevention. Recognise the need, staff education, patient education and education for families and carers.

Walker, M.T, (2009) Adopting Year Of Care Planning. Practice Nursing. 20, 1, p 571 – 574.	Discussion on the rise of type 2 diabetes and necessity for care planning to be with the individual. National Service Framework identifies using an agreed 'shared care plan in an appropriate format and language'. Recognition that to move toward a health economy of self management and empowerment we must move away from a didactic or paternalistic care provision model. definition: Care planning is a process which offers people active involvement in deciding, agreeing and owning how their condition(s) will be managed. It is intended to be a process of collaborative care and joint working, underpinned by the principles of person centeredness and partnership working. (Healthcare Commission, 2007). Identifies that care plans are a part of policy direction for long terms conditions. Model used is:  5 A's of care planning referred to: Egan Counselling Glasgow: Assess, Advise, Agree, Assist, Arrange. Also UK model – Gather, Explore/discuss, set goals, action plan, review.

Wassermann, L.S. (2008) Respectful Death: A Model For End-Of-Life Care. Clinical Journal Of Oncology Nursing. 12, 4, p 621 – 626.	Establishment of a therapeutic relationship. Need for incorporating the wishes of patients and their families in the care plan. Need for the timing of conversations around EOL care.
Wong, M. (2010) The Role Of An Integrated Care Pathway In A Nurse-Led Dyspepsia Clinic. Gastrointestinal Nursing, April, 8, 3, p 26-30.	Reference to integrated care pathways (ICP) in the care of patients with dyspepsia. ICP is a structured multi-disciplinary care plan with detailed essential processes in the care of a patient who has a specific condition. Translation of national guidelines into local protocols and application to clinical care. Promotion of organised and efficient patient care. ICP encourages multidisciplinary communication. Internationally recognised. ICP offers patients time and opportunity for discussion about their condition during the consultation. Nurse can monitor and supervise drug use, diet info and lifestyle. Cost effective can free up consultant time, drug costs and health prevention. Can identify malignancy early. In using ICP clinical judgement is required at all times. Nurse is able to provide individualised and focused patient care. Can gather information via direct patient questioning. ICP assures good quality of care which is anchored in a standardised care process specific to the condition. Nurse can address lifestyle questions e.g. smoking, alcohol, healthy eating.

Appendix B

Themes from Selected Papers.

Theme	Summary of theme	Inclusion in papers
Care Plans need to involve patients and families	Care Plans should make the plans and the wishes of each individual and/or their family clear to all health care professionals and communicated effectively	7
Nurses require time to reflect on their care planning practice	Nurses require time to reflect on their care planning practice. To deliver individualised care nurses need to understand how to care plan and what is expected of them	9
Care Plans work best when they are multidisciplinary focused	How clinical teams interact with each other affects patient experience and outcomes. To maximise outcomes for the patient health care professional staff require a joint perspective on the management and care issues associated with their patients	6
Organisations need to invest time in care planning	Organisations need to determine how much time can be built in supporting development of nursing skill in care planning , providing education and making it easier for staff to understand the care planning process	4
Care Planning requires core skills	For care planning to work, core skills are required for the nurse. Competency in care planning is crucial if partnership with the patient is to take place	3
Standardised Care Plans allow nurses more time to dedicate to patients	Standardised Care plans may increase nursing autonomy and confidence and help nurses to develop and take on new tasks and skills beyond their scope of practice	2
Practice Development approaches are useful in improving care planning	Discussed in paper	2
Pre and post Registration Training must be included in any change to care planning	Pre and Post registration training require updates and training in any agreed method of care planning	1
Integrated Care Pathways work best in patients who have diagnosed specific conditions	Integrated Care Pathways promotes organised, efficient patient care and encourages multi-disciplinary communication. Information is gathered via the patient and care is anchored in an evidence base specific to the patient's condition	1