



## CLINICAL LEAD AND TRAINING DIRECTORS' NEWSLETTER JUNE 2024 - Theme; Care Planning



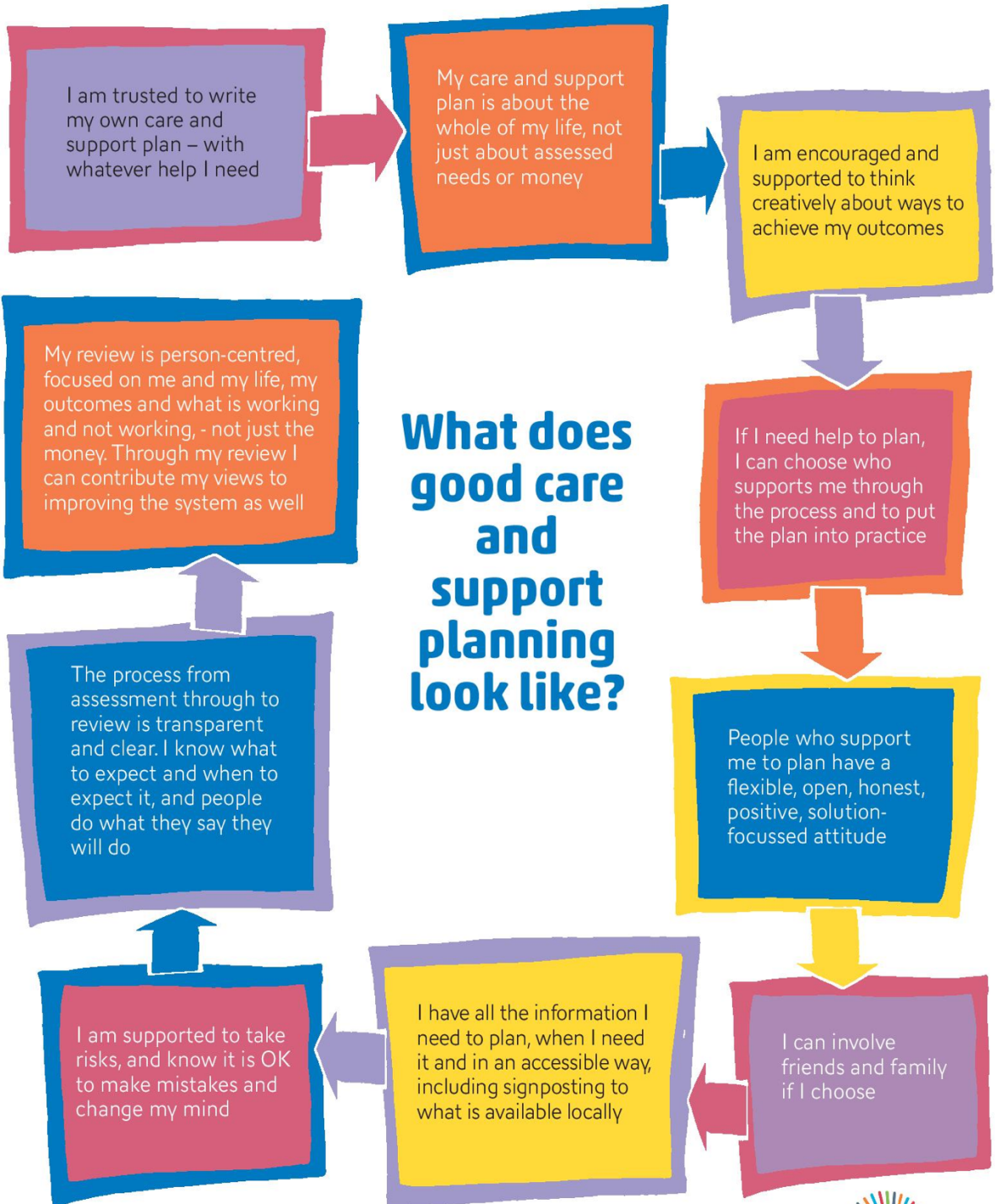
A nursing care plan provides direction on the type of care the individual/family/community may need. The main focus of a care plan is to facilitate standardised, evidence-based, and holistic care.

### **What is a plan of care**

A plan that describes in an easy, accessible way the needs of the person, their views, preferences and choices, the resources available, and actions by members of the care team, (including the service user and carer) to meet those needs. It should be put together and agreed with the person through the process of care planning and review.

**Process in personalised care and support planning-** this is the overall process of personalised care and support planning. A good personalised care and support planning process will mean that the person: has the time and support to develop their plan in a safe and reflective space

Care plans are important they provide direction for individualized care of the client. A care plan flows from each patient's unique list of diagnoses and should be organized by the individual's specific needs. Continuity of care. The care plan is a means of communicating and organizing the actions of a constantly changing nursing staff.



Developed by the National Co-production Advisory Group for Think Act Local Personal and Coalition for Collaborative Care

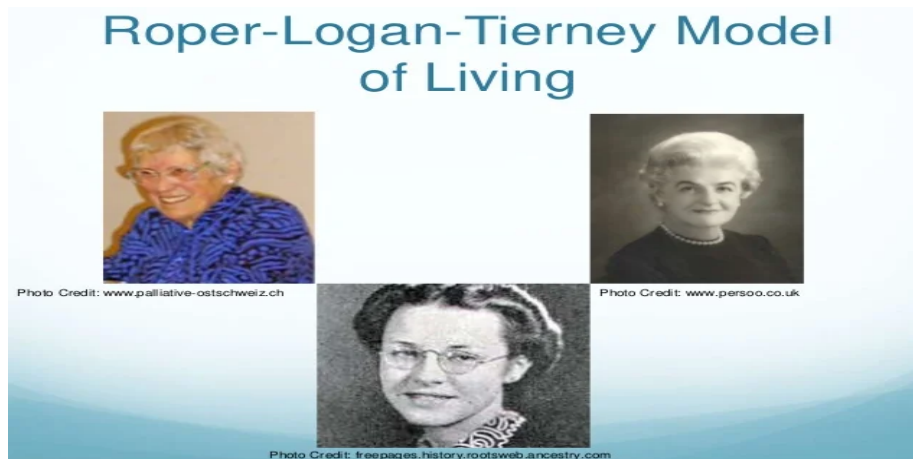


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## **Roper Logan and Tierney Model of Reflection**

The Roper Logan model was named after the author of the model, Nancy Roper, Logan and Tierney. It was first developed in 1980 based upon the work by Nancy Roper in 1976. The model is based on the 12 activities of living in order to live.



The purpose of the Roper Logan theory is as an assessment used throughout the patient's care. As a nurse you should use the model to assess the patient's relative independence and potential for independence in the activities of daily living. The patient's independence is looked at on a continuum that ranges from complete dependence to complete independence. This helps to determine what interventions will lead to increased independence as well as what ongoing support is needed to offset any dependency that still exists.

## **The 12 Activities of Daily Living**

Roper states that the twelve activities of daily living should be viewed "As a cognitive approach to the assessment and care of the patient, not on paper as a list of boxes, but in the nurse's approach to and organization of her care," and that nurses deepen their understanding of the model and its application. The patient should be assessed on admission, and his or her dependence and independence should be reviewed throughout the care plan and evaluation. By looking at changes in the dependence-independence continuum, the nurse can see whether the patient is improving or not, and make changes to the care provided based on the evidence presented.



## Roper-Logan-Tierney

### The 12 activities of living listed in the Roper-Logan-Tierney Model of Nursing

#### are:

1. Maintaining a safe environment
2. Communication
3. Breathing
4. Eating and drinking
5. Elimination
6. Washing and dressing
7. Controlling temperature
8. Mobilization
9. Working and playing
10. Expressing sexuality
11. Sleeping
12. Death
13. Factors influencing activities of living- Medication





The Roper Logan model also considers the five factors listed below, these are the factors which make the model holistic, Roper believes that failure to consider these factors means that the resulting assessment is both incomplete and flawed. Therefore, it is recommended that nurses make use of the model through promoting an understanding of these factors as an element of the model.

**The following variables are factors that impact on the individual and affect their levels of dependence/independence.**

**Biological:** The biological factor addresses the impact of the overall health, of current injury and illness, and the scope of the patient's anatomy and physiology.

**Physiological:** The psychological factor addresses the impact of emotion, cognition, spiritual beliefs, and the ability to understand. According to Roper, this is about "knowing, thinking, hoping, feeling and believing."

**Socio-cultural:** The sociocultural factor is the impact of society and culture as experienced by the individual patient. This includes expectations and values based on class and status, and culture within the sociocultural factor relates to the beliefs, expectations, and values held by the individual patient for him or herself, as well as by others pertaining to independence in and ability to carry out the activities of daily living.

**Environmental:** The model recommends consideration of not only the impact of the environment on the activities of daily living but also the impact of the individual's ALs on the environment.

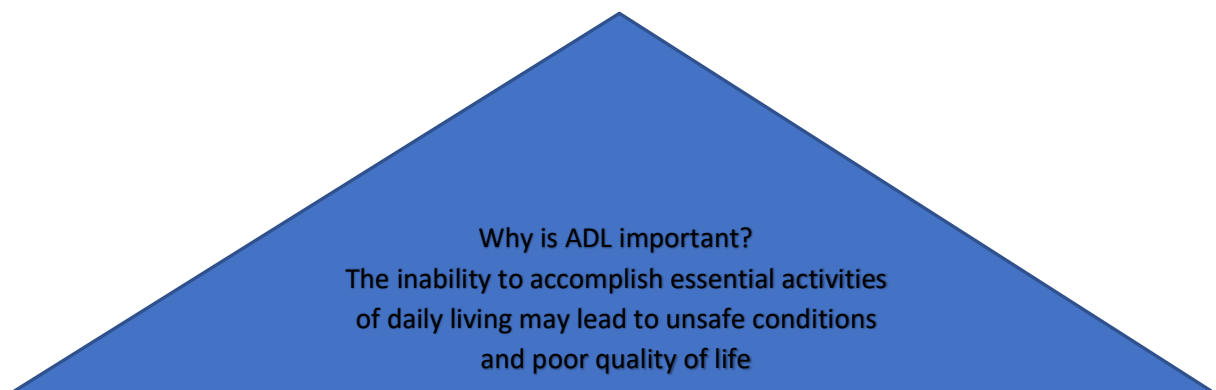
**Politico-economic:** this is the impact of government, politics, and the economy on ALs. Issues such as funding, government policies and programs, state of war or violent conflict, availability and access to benefits, political reforms and government targets, interest rates, and availability of funding (both public and private) all are considered under this factor.



## Evaluation of the Roper, Logan and Tierney Model

The Roper, Logan and Tierney model is widely used in nursing practice in both the UK and Ireland. The patient is assessed on his or her or her ability to perform the 12 activities of living in relation to his position on the lifespan, and his or her level on the dependence/independence continuum and aims in care are identified. The goals of the care plan are mutually agreed between the nurse and patient and the family. Finally, evaluation of care determines whether or not the goals of care have been achieved, or if they need to be revised. The model provides a systematic and logical means of delivering care, encouraging team participation leading to primary care and continuity of care.

Activities of daily living, also known as ADLs, involve routine self-care activities we normally perform independently. However, people with chronic illnesses, injuries, or debilitating health conditions such as dementia often need everyday assistance with basic tasks and activities of daily life



### **A care plan is...**

- 1) The written record of a plan of action negotiated with the person to meet their health and social needs
- 2) Something which sets out who is doing what, when, and why (outlines aims, actions and responsibilities)
- 3) A tool to support the safety of the service user and others
- 4) A plan which can be used and understood in a crisis by service users, their families and carers and other agencies, as well as colleagues
- 5) A plan which people feel they own



6) Based on a thorough assessment of need

7) Produced in partnership with all those concerned

8) Coordinated by the most appropriate person, such as a Care Coordinator or lead professional

9) Produced in the most appropriate forum

10) Shared effectively with those who are part of it

### Care Planning Standards

Standards for care planning come from a number of sources, but the national CCA standard is:

“A Care Plan is a written record of the agreed care and treatment plan for an individual” (Care Standards Handbook CCA 2014)

#### National Standards for care plans include:

- The Care Quality Commission’s (CQC) ‘Essential Standards of Quality and Safety’, Outcome 4: Care and welfare of people who use services: People should get safe and appropriate care that meets their needs and supports their rights.
- CQC Fundamental standards include: care and treatment must be appropriate and reflect service users' needs and preferences.
- NICE Quality Standard for service user experience in adult mental health People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.
- Mental Health Act 1983 Code of Practice
- Department of Health (2007) Best Practice in Managing Risk
- Department of Health (2008) Refocusing the Care Programme Approach
- Professional standards
- National and Local Policy and Procedure



## Person-centered planning



Person-centered planning should be at the heart of professional practice. Identifying needs and preferences and helping people to articulate these involve:

- Values including: respect; honesty; and dignity
- Listening and communication skills
- Assessment skills in a wide variety of areas
- Understanding issues of capacity and consent
- The right tools, resources or skills to support the person.

You might ask someone:

- What is important to you?
- What do you hope to do, and what prevents you?
- What works well, and who supports you?
- What do you want to change?
- How would you like your support to work?
- What would you like to do next?

The CCA standard for service user involvement and choice is:

“People who use services will be treated with respect as partners in planning care, and their recovery and wellbeing supported” (Care Standards Handbook CCA 2014)

**The fundamental standards from the CQC include:**

**Person-centred care:** Treatment that is tailored to the service user and meets their needs and preferences.

**Guidance:** Providers must do everything reasonably practicable to make sure that people who use the service receive person-centered care and treatment that is appropriate, meets their needs, and reflects their personal preferences, whatever they might be.





Planning to improve your well-being could focus on the 5 Ways to

Wellbeing:

**Connect - Be active - Be mindful - Keep learning - Give to others**

Think of a health issue you would like to manage better, or use an example from someone you know:

How a care plan is put together can have a major impact on how much the plan is owned by the person whose plan it is, and hence how effective the care plan is.

A care plan that is written by one person alone in an office may include all the key elements, but is not likely to be as effective in practice as one which is written in partnership with the person and others who are part of the plan.

A sense of ownership by all those concerned (and in particular the person themselves) is vital in making the plan translate into reality. This can be improved by:

1. Using people's own words and phrases (familiar and comfortable language, which avoids jargon and abbreviations)
2. Using goals, aims, and outcomes identified by the person
3. Recognising that care plans exist for the benefit of the service user, and should be based around the needs of that person, not on the services available
4. Understanding that people with long term conditions may be at different stages on their journey, which may affect how much control they are able to take
5. Ensuring the person feels that they own the plan, through developing, agreeing and writing the care plan as much as possible, including the opportunity to review the plan to ensure it is understandable, and to have a copy as soon as possible
6. Producing the plan in a format and style that the person is comfortable with, and can use



## 7. Being flexible in the approach to the involvement of those who have a stake in the plan

### **Care plans should include:**

- Why are we doing this?
- What are we planning to achieve?
- How are we going to do it?
- Who will do it?
- Where will it be done?
- When will it be done by?

The care plan should also:

- Focus on people's strengths and wishes
- Include the person's role in the plan
- Reflect the individuals cultural and ethnic background as well as their gender, sexuality, race, economic disadvantage, age, religion/spirituality, and disability
- Consider the role of any family or carers who are involved
- Include action and outcomes in all relevant aspects of an individual's life
- Consider any safeguarding issues for children or vulnerable adults
- Consider safety issues
- Include crisis and contingency arrangements
- Give the date of the next planned review
- Cover transfer details if appropriate
- Identify any unmet needs
- Acknowledge areas of difference or disagreement.



## Safety planning

Safety planning and risk management are an essential part of care planning, and should be woven into the care plan. This should be based on a sound assessment of safety issues and risks to the person, their family and others.

Safety plans should:

- Be formulated collaboratively with the service user and their carer(s)
- Avoid professional jargon and use language the service user understands; use their own words where possible
- Be clearly and effectively communicated to all concerned

## Person-centred safety planning

Person-centred safety planning is a fundamental process within a care plan. The Care Programme Approach process involves identifying specific actions based on an individual's needs, considering safety and risk issues. All the needs of the individual should be reflected in a care plan, including all those relating to risk.

“Best Practice in Managing Risk” (Department of Health, 2007) describes best practice in safety planning. The guidance identifies positive risk management, a collaborative approach building on strengths/resources and the roles of services and individuals as key to an effective safety management plan. Safety plans should incorporate actions which support the individual's needs and priorities alongside minimising risks to the individual or others.

The language used is important. For the person to retain ownership avoid the use of professional jargon. The term “risk management” can potentially create an obstacle to working together. Discussions about staying safe



and how the organisation or individual can support with this can be more constructive and collaborative (Morgan, 2013).

### **Crisis and contingency plans**

Crisis and contingency plans must be based on the individual circumstances of the person, however, where there are no risks identified, contact information may be sufficient. This should always include 24 hours a day 7 day a week contacts detail.

Crisis plans should set out the action to be taken if the service user becomes very ill, or their health is deteriorating rapidly.

The plan should include:

- Who the service user responds best to and how to contact them
- Previous strategies that have been successful in similar situations
- Early warning signs and specific relapse indicators
- The responsibilities of all members of the care team. This should include the service user; the family (with their agreement) and the community

**Contingency plans** should help to prevent a crisis developing when, at short notice, the coordinator is not available, or part of the care plan cannot be provided. The person's health may be affected by the problem, but is not the cause of it.



The plan must include:

- Information about who to contact if the coordinator is not available
- A contingency for any key elements of the care plan

### **Involving carers and families**

Carers and families can play a vital part in keeping their relative or friend well. In working with carers and families it is important to be clear about the views of the person being supported about their involvement, and what



information can and should be shared. Involvement in care planning can take many forms, and can be anything from getting copies of letters about appointments to full involvement in planning and reviewing care.

The Triangle of Care: Carers Included (2010) has six key standards that outline the approach that mental health services should take:

- 1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
- 2) Staff are 'carer aware' and trained in carer engagement strategies.
- 3) Policy and practice protocols re: confidentiality and sharing information, are in place.
- 4) Defined post(s) responsible for carers are in place.
- 5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
- 6) A range of carer support services is available.

### **Carers Support Plans**

All informal carers who provide regular support for someone are entitled to an assessment of their caring, physical and mental health needs, and a support plan to meet the needs identified.

This may include (depending on the needs identified):

- Information, including where and how to access services, both during office hours and in a crisis
- Action to meet defined contingencies
- What will be provided to meet the carers identified mental and physical health needs



- Advice on income, housing, educational and employment matters
- Arrangements for short term breaks and respite
- Arrangements for social support, including access to carers support groups
- Information about appeals or complaints procedures

### Writing good care plans

It is important to give some thought to the content and style of the care plan, as well as the process of putting it together. We often use statements such as 'monitor health' or 'monitor medication' with no indication about what precise aspects of someone's health should be monitored, or how these should be monitored.

As a minimum, the care planning discussion should include:

- Agreeing the person's own goals (e.g. I want to lose weight, stop smoking, get out more, get a job, manage the voices better)
- Providing information that is timely, relevant, and accessible
- Supporting individuals to take an active role in their own health
- Agreeing any actions or treatments, and who is responsible for them
- Agreeing a timely review date

In practice, it may be useful to write...

- The care plan as 'I need', to encourage the service user to own the care plan
- Clear outcomes that are person-centred
- Interventions that relate directly to the needs and goals
- Actions that include the person's own responsibilities
- Statements of action that are instructional and able to be followed in your absence
- Care plans in partnership with the person whose plan it is, in language they are comfortable with.



## Accessibility and communication

Until a care plan has been effectively communicated with the people who need to see it, it remains only a plan. A care plan found only in the record (whether paper or electronic) will not work very well. Think about the language of the care plan. Use of words such as 'refrain', 'comply' or 'non-compliant' can set a tone that doesn't necessarily reflect the person's experience of the needs that have been identified, and technical terminology can exclude people. However, simply sending out a written care plan in English on paper may not be enough, and some of the recipients may not be able to access this. Issues to consider include:



The level of literacy



The age of the person: children and young people may respond more to a visual approach



The language the person is most comfortable speaking (e.g. Welsh)



Sensory impairments and disabilities



Cognitive impairment.

It is also essential that the care plan is legible, and typed or printed plans are to be preferred wherever possible. Consider the need to use:

- ✓ Manual or sign languages or communication methods such as British
- ✓ Sign Language (BSL), Makaton, Braille etc.
- ✓ Simplified language or larger size type
- ✓ Symbols or pictures
- ✓ CDs or DVDs
- ✓ Translation into languages other than English.



The care plan must be sent to everyone who plays a part in it, and made available to people who do not regularly play a part in it but may need access in a crisis, by making sure it is held in an accessible way. The Accessible Information Standard (NHS England) gives more information



### **Choice and capacity**

Occasionally service users may not want to (or are unable to) be fully involved in their care plan. The reasons for this may be to do with their capacity, their level of insight, communication difficulties, or their personal choice.

General principles to support involvement would include:

- ✓ Use innovative ways of developing and explaining care plans, e.g. pictures, recordings
- ✓ Revisit their capacity and choice on a regular basis
- ✓ Involve their carer or family, in their agreement
- ✓ Remember that people may lack capacity in some areas but may have the capacity in other areas
- ✓ Do not assume that they will not understand their care plan (or At least some parts of it)
- ✓ Write an engagement plan, detailing how you plan to engage them within the care planning process
- ✓ Try to engage them in alternative environments or activities
- ✓ Involve other professionals within your team or partner agencies, who may have a different approach or different skills
- ✓ If they don't wish to be involved in planning or review, hold a review in their absence and ensure there is a robust and clear plan that supports engagement as much as possible.





## Capacity and care planning

The principles of the Mental Capacity Act should also inform our approach to care planning, starting with the presumption of capacity; that every adult has the right to make his or her own decisions and must be assumed “The use of mechanisms such as advanced decisions to refuse treatment and the making of Lasting Powers of Attorney for health and welfare decisions under the Mental Capacity Act can be extremely useful in planning future care.” Welsh Assembly Government 2010 The Mental Health (Wales) Measure to have capacity to do so unless it is proved otherwise. Individuals being supported to make their own decisions and being given all practicable help to reach their own decisions, and that just because a person makes what might seem an unwise decision, they should not be treated as lacking in capacity to make that decision.

If there are concerns about the service user’s capacity to participate in the care planning process the care team should consider:

- Has the individual (and their carers) had all the relevant information they need to make a particular decision?
- If they have a choice, have they been given information on all the alternatives?
- Have they made an Advance Decision or Advance Statement, or is there a Lasting Power of Attorney?
- Has the information been explained or presented in a way that is easy for the person to understand (for example, by using simple language or visual aids)?
- Have different methods of communication been explored if required, including nonverbal communication?
- Could anyone else help with communication (for example, a family member, support worker, interpreter, speech and language therapist or advocate)?
- Are there particular times of day when the person’s understanding is better?
- Are there particular locations where they may feel more at ease?
- Could the decision be put off to see whether the person can make the decision at a later time when circumstances are right for them?



- Can anyone else help or support the person to make choices or express a view?

### Writing care Plan

1. Problem or need
2. Outcome
3. Nursing Action
4. Evaluation monthly to be done.
5. Care needs a summary to be completed within 72 hours of admission and followed by a care plan to be completed within one week.
6. Any changes in health condition to be reviewed/changed on the spot.



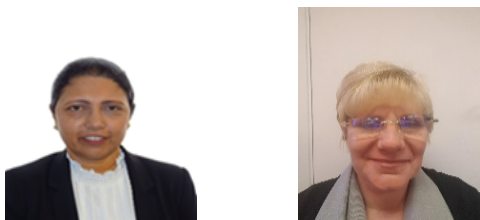


### ASSOCIATED DOCUMENTS (MOBIZIO):

- ✓ SU- Maintaining comfort and safety Care Plan
- ✓ SU- Risk assessment and management
- ✓ SU- Pre-assessment
- ✓ SU- Evaluation
- ✓ SU- MCA1 form
- ✓ SU- My involvement and consent
- ✓ SU- Deprivation of Liberty Checklist
- ✓ SU- DOLS progress notes

### ASSOCIATED AUDITS (ACCESS CARE COMPLIANCE):

- ✓ Provider Quality Audit
- ✓ Care plan Audit



Shiny Joe (RGN) & Sarah Jones (RNLD)  
Clinical Lead & Training Directors