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Personalised Care Planning

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Aims

- By the end of this session, you will:
  - Understand the principles of care planning
  - Understand your responsibilities under the NMC
  - Be able to create a personalised care plan

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Comprehensive Model of Personalised Care
https://www.youtube.com/watch?v=RXOd-7rn6so

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Personalised care planning

- Personalised care and support planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation.
- The process recognises the person's skills and strengths, as well as their experiences and the things that matter the most to them. It addresses the things that are not working in the person's life and identifies outcomes or goals and actions to resolve these

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There is no set template for what a personalised care and support plan should look like, but it should reflect the following:

- A way of capturing and recording conversations, decisions and agreed outcomes or goals in a way that makes sense to the person.
- Should be proportionate, flexible and coordinated and adaptable to a person's health condition, situation and care and support needs.
- Should include a description of the person, what matters to them and all the necessary elements that would make the plan achievable and effective.

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How to implement a personalised care plan

Assessment:

1. Is important to understanding the individual's health status, preferences, and goals.
2. Different types of assessments, such as medical, psychosocial, and cultural assessments.

Setting Goals:

1. Importance of setting realistic and achievable goals in collaboration with the individual.
2. Health-related goals should be included in a personalized care plan.

Developing the Plan:

1. Collaborative nature of personalized care planning, involving both healthcare professionals and patients and carers.
2. The plan should address physical, emotional, and social aspects of care.

Implementation:

1. Practical steps involved in carrying out the care plan, including coordination among healthcare team members.
2. Potential challenges and how they can be overcome.

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MH – which is more person centred?

Problem	Actions	Clients View
Mental Health: XX suffers from paranoid schizophrenia and depression. She experiences frequent auditory command hallucinations	Primary nurse will form a therapeutic relationship and offer 1:1 interactions per shift. To explore coping strategies Monitor mental health	XX will work with MDT and comply with treatment offered
Mental Health: I hear voices, telling me to hurt myself, at times I get so low and miserable. I feel people are after me, wanting to harm me, so I stay in to avoid people	I will speak to my primary nurse and I will try to use distraction techniques when I hear the voices e.g. listening to music using ear phones, reading newspapers, going for a walk.	I want to feel well and will try to work with my primary nurse and work out what helps me to feel better

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ACS – which is more person centred?

Problem	Actions	Clients View
Maintain good foot health. XX is unable to cut her toenails and needs to see podiatrist every 6 weeks	XX will visit podiatrist every 6 weeks to have toenails cut at clinic To have appropriate footwear	I agree with treatment plan
I don't want my toe nails to get too long so that it hurts my foot when I am walking	I will try to keep my appointments every 6 weeks and not miss any	If it is too difficult to make the appointment I will try to call beforehand to make other arrangements

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Which one is more personalised

Goal	Interventions	Clients View
Patient has diabetes To monitor and optimise health whilst preventing deterioration To identify health related diseases, taking into account, high risk groups including age, gender and ethnicity To achieve outcomes as per local national guidance frameworks or care pathway ie: NICE	Identify modifiable risk factors and provide health promotion ie Weight, smoking, diet and exercise Nurse to manage patient in consultation with GP and Specialist Nurse Adopt a continuous assessment approach in accordance with relevant guidance	To agree to self manage
I have diabetes and would like to understand and manage it better	I will listen to advice re how to manage my diabetes, and understand importance of diet and exercise I will be able to recognise symptoms of low and blood sugar levels I will try to make sure I attend all healthcare appointments so that I get the care I need at the right time	I feel happy with the plan we have discussed and want to manage my diabetes as independently as I can

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How to make a measurable goal

Confirmation (I have demonstrated)	Range (over time or episodes)	Action (that I can deal with)	Problem (my problems)	Test (even when I'm tested)
"I have proved I can	consistently	control	my temper	even when I'm provoked"
"I have the skills to	-	manage	my finances"	
"I have proved I can	over 12 episodes of home leave	avoid	substance misuse	even when I'm with people I used to take drugs with"

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Key considerations

- Reflect the patients cultural and ethnic background as well as their race, economic. Disadvantage, age, religions/ spirituality and disability
- Consider the role of any family/ carers who are involved
- Consider safeguarding concerns
- Include crisis and contingency arrangements
- Acknowledge areas of difference and disagreement
- Identify any unmet needs
- Give a date of the next planned review
- Communication aids - for example, pictures, symbols, large print, Braille, hearing loops.

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Family and carer involvement

Why is family and carer involvement important?
How can we involve them?

- Families and carers can play a vital part in keeping their relative or friend well. They often know the people they care for better than anyone else and this knowledge can be useful in planning care with patients.
- Their involvement can take many forms and can be anything from getting copies of letters about appointments to full involvement in planning and reviewing care.

All informal carers who provide regular support for a patient are entitled to an assessment of their own needs

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Carers Views

- A short video on the lived experience of carers
- Life Beyond the Cubicle is an exciting Making Families Count project that has produced learning materials which aim to educate and update staff on the importance of involving families wherever possible during mental health crises to improve patient care, avoid harm and reduce deaths.
- This an e-learning available on the Oxleas Learning Centre (The Fish)

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Activity – Lets care plan!

Activity: Pair Up and Create a Care Plan

1. **Please get into pairs**
   - Work with a partner to discuss and share ideas
2. **Identify a need of your partners**
   - Discuss and choose a specific care need
3. **Develop a Care Plan**
   - Write a care plan addressing the identified need.
   - Ensure it reflects person-centered care principles.
   - Set realistic and measurable goals
4. **Be Prepared to Share**
   - You'll have the opportunity to present your care plan to the group.

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nmc Nursing & Midwifery Council

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What does the NMC code say

- The NMC emphasizes the importance of person-centred care and collaborative care planning. Nurses are expected to work in partnership with individuals, their families, and other healthcare professionals to develop and implement care plans that meet the unique needs of each patient.

1. **Person-Centred Care:** The care plan should be centred around the individual's needs, preferences, and goals. Nurses should involve patients in the decision-making process and respect their autonomy.
2. **Collaboration:** Nurses are encouraged to collaborate with other healthcare professionals, patients, and their families to ensure a holistic and coordinated approach to care.
3. **Assessment and Documentation:** Thorough assessment of the patient's health status, including physical, emotional, and social aspects, is crucial. Documentation of the care plan, including goals, interventions, and evaluations, is essential for continuity of care and communication among the healthcare team.
4. **Communication:** Effective communication with patients, families, and colleagues is essential for successful care planning. This includes clear and accurate documentation as well as verbal communication.
5. **Evidence-Based Practice:** Care plans should be based on the best available evidence and should be regularly reviewed and updated as the patient's condition or circumstances change.

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Example one - **Fitness to practise referral**

Failure to preserve patient safety

- Failed to prepare / ensure there was an appropriate care plan in place following the patient's admission to the X ward
- Failed to conduct /ensure that appropriate risk assessments were conducted during the patient's admission to X ward

Example two – **NMC hearing**

- Failed to ensure that Patient X's care plans were sufficient for his needs in that you:
  a) failed to ensure that the care plans were of an acceptable standard;
  b) failed to ensure that Patient X's family were sufficiently involved in Patient X's care plans and / or care planning

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Roles of Nurse and Nurse Associates

Nursing associate 6 platforms	Registered nurse 7 platforms
Be an accountable professional	Be an accountable professional
Promoting health and preventing ill health	Promoting health and preventing ill health
Provide and monitor care	Provide and evaluate care
Working in teams	Leading and managing nursing care and working in teams
Improving safety and quality of care	Improving safety and quality of care
Contributing to integrated care	Coordinating care
	Assessing needs and planning care

NMC Nursing & Midwifery Council

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Care planning documents – Oxleas

- There is a range of care planning documents that are used across different teams in Oxleas, however the principles remain the same.

1. My Care Plan
2. Care plan library Inpatient Management
3. WAA Acute Inpt/LD Day Service Care Plan
4. Intermediate Care Units – My Care Plan
5. Dialog+
6. SystmOne for prisons
7. Oxcare

Don't get hooked up by the format. All care plans will have:

- Problem/need
- Goal
- Interventions
- Service user views
- Evaluation

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Top tips

What's been helpful for you when care planning?

- Don’t use professional jargon. Use language the patient understands
- Use patients own words and phrases where possible
- Make sure the patient feels that they own the care plan by developing it together

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Resources

- The Ox Care planning (The Ox)
- NHS England » Personalised care and support planning

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