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Care Planning in Long-Stay Care of the Older Person

Abstract This paper aims to reassure staff of the benefits of care planning.

Introduction

Every time that the author walks into a different long-stay care of the older person unit it is found that the staff are struggling with care plan introduction. Healthcare professionals are constantly looking for clarification on the subject. So what is it that frightens many healthcare professionals about care plans? And why are there problems surrounding their implementation? How can we educate student nurses on the importance of care planning if we fail to provide accurate and consistent documentation practices across our sites?

Care planning has its roots in the nursing process which dates back to the 1970's. It involves assessment, planning, implementation, evaluation and documentation. The irony is that all healthcare professionals automatically carry out this process in their everyday work and yet when asked to document this in a care plan it immediately becomes a monster! So what is a care plan? "It is a written, structured, plan of action for patient care based on holistic assessment of patient need, identification of specific patient problems and the development of a plan of action for their resolution" (Mason, 1999: 380). The professionalisation of nursing demands systematic approaches to healthcare. The care given is reflected in the care plan thus demonstrating this level of

professionalism as it clearly shows how care is approached in a rational, evidence based and holistic manner. The written plan is thus goal-orientated, efficient, effective & individualised. However healthcare professionals have difficulty writing these plans of care (Chavasse, 1981, Norton, 1981 & Roberts, 1982).

Barriers

Lack of relevant education may be viewed as a barrier to care plan introduction. The healthcare professional needs to possess requisite skills, knowledge and experience. Very often care plan introduction is expected by management and professional bodies but the educational resources and facilitative support may not be provided for same thus staff struggle in the swampy lowlands as they blindly attempt care plan introduction. Skill mix and re-organisation of the work schedule to enable time for documentation are also barriers to successful care plan introduction. One of the biggest offenders that the author has observed is when staff are not involved in the care plan design. Very often care plans which are working well in other sites are introduced without evaluation of their appropriateness and thus inevitably they sink like the titanic. Staff can't understand how if the care plan works well somewhere else why it will not work in their area. The answer is simple: it is unsuitable to their care environment, patient profile and services available. If care plans are to be successful a bottom-up approach is called for whereby all staff are involved in designing, piloting and evaluating the documentation. This approach will lead to a user-friendly document which staff will embrace with pride. This user-friendliness will enable the care plan to be kept active and not just left in a folder on a shelf gathering dust. Keeping care plans active will enable healthcare professionals to see their benefits rather than viewing them as another piece of documentation that just needs filling out. Mason (1999) supports this by offering that two important factors are involved in successful care plan introduction: being clinically driven and local ownership. O'Connell et al (2000) argues that few care plans have been able to reveal the current context of care being provided to a patient, were not informative, not specific, out-of-date and not easy to read or understand. Qamar (1990) supports this by reporting that pre-printed care plans are taken off the shelf, the patients name is applied, the nurse's signature is applied and the document is then ignored. Mason (1999) found that these pre-printed care plans with tick boxes hinder individualized care by discouraging freedom for each nurse to approach assessment in their own unique way.

The UKCC (1993) outlined the need to reduce documentation to a minimum, avoiding duplication and collation of unnecessary information. This duplication can be eroded if care plans are kept active and not left sitting in the patients file. If the care plan and the daily notes are kept together one will complement the other. They should be used simultaneously thus reducing the need to repeat information. All care should be visible at a glance and one should not have to sift through repetitious pages detailing the same information. The author has observed in many sites that assessment tools are completed on admission and then all of the same information is replicated within the care plan. Thus it is no wonder that healthcare professionals rebel against the extra paperwork that care plans sometimes entail. Surely the assessment tools are already part of the care plan and repetition is not necessary. The Waterlow scale, FRASE scale, mini-nutritional assessment chart etc are thoroughly devised and accredited, so why do we feel the need to repeat the information contained within them? Siegal & Fischer (1981) described the care plans which they reviewed as being unsystematic, fragmented, often illegible, not valid and with poor readability.

The Future

The population is ageing and recent media attention has directed healthcare professionals to focus on the standard and quality of care provided in long-stay care of the older person units. As current healthcare practices evolve and as the focus of health care shifts to recognising the importance of person-centred care then a re-invention of the care-plan for older peoples services is required. Mason (1999) offers that this move should not be confined to being based on a nursing model. Mason (1999) also argues that new and imaginative designs should be encouraged which are developed at ward level, tailored to meet the needs of the client and should involve minimum documentation. Healthcare professionals often write care plans which relate to their needs as practitioners rather than focusing on the patients needs (McMahon, 1988). Several authors have written about the need to shift current healthcare practices from routinised and ritualistic care to person-centred and relationship centred care. It is argued that if a care plan is to be realistic then the healthcare professional needs to establish a relationship with the resident in order to fully understand their needs.

McCormack (2001) aimed to develop this theory and offered from his work that there are four concepts underpinning person-centred nursing. These are: being in relation, being in a social world, being in place and being with self. The explanation of these terms includes; the relationship between the nurse and the patient, knowing the person's social world and devising life-plans for them, the working environment and its systems which may promote or hinder person-centred practice and finally knowing the patient and their values. This reflects Curtin & Flaherty's (1982) belief that the foundation of the nurse-patient relationship is based on a mutual humanity of the participants with its nature rooted in the determination of the patients human needs & the nurses response to them. The "senses framework" was introduced by Nolan et al (2001) and believes that experiencing a "sense" of security, belonging, continuity, purpose, achievement and significance are key in creating a caring environment.

McCormack (2001) supports this by saying that the expert gerontological nurse tries to give the patient as many opportunities as possible to exercise freedom of choice, to express opinions, to make decisions, to talk while the nurse really listens and to have the opportunity to express their authentic self in a negotiated partnership with the nurse. However, many healthcare professionals fear sharing care and control with the patient believing that they may have neither the desire or the knowledge to fully orchestrate their own health care. Sharing information with patients empowers them to make rational decisions about their own health. Patients can become active participants rather than passive recipients of healthcare. Evidence suggests that patients who actively participate in their own care have more favourable clinical outcomes (Kaplan et al, 1989 & Greenfield et al, 1985).

In the past healthcare for older people has focused on meeting the residents physical needs such as washing, dressing, eating, toileting etc. but the future of older person care directs healthcare professionals to focus on these needs combined with the residents social needs. Community nursing units by their very name imply that they exist as part of a community but the reality is that they often operate in isolation with little outside involvement. Ruddle et al (1997) quoted one of the residents as saying "losing contact with one's friends and neighbourhood is a big problem" and it was further found that an important concern was the standard of care that they could expect to receive and the level of independence they could maintain in the unit. When

older people realise that they are no longer part of their human world, they experience despair (RCN, 1993).

Thus the future of care planning for older people demands a need to move from the medical model of care to the social model of care. The author has developed a care plan in collaboration with two long-stay care of the older person units in the West of Ireland. It focuses on both McCormack's (2001) and Nolan's et al (2001) work and is based on New Zealand's domains of assessment for older people. These domains are identified as the issues of most importance to older people and are: personal care, safety, food, social participation, daily life and acute episodes. The success of this care plan reflects the earlier recommendations:

- A bottom-up approach
- Collaboration and inclusion of all team members
- Education
- Piloting on a small number of residents initially and celebrating small wins
- User friendly
- No repetition
- No jargon – easy to read and understand
- Freedom of the healthcare professional enabled through limited use of a tick boxes
- Inclusion of the resident in the care plan essential due to its design

Thus the author concludes with the positive motivational fact that successful care planning is possible.

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