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## **Cover Page**

Assessing needs and planning care (at a glance clinical series)

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2500 words inclusive

## **Assessing needs and planning care**

### **(at a glance series)**

#### **Assessing people's needs and planning effective care**

The role of the nurses cannot be underestimated in the care of the patient in healthcare settings. More pressure had been placed on registered nurses, since the inception of the COVID 19 pandemic, which left the world in an unprecedented state. The Nursing and Midwifery Council (NMC, 2018) published the 'Future Nurse' standards of proficiency guidelines. Denoting its centrality to nursing practice. 'Assessing needs and planning care' is the third of seven areas of proficiency, which the NMC terms 'platforms'. The importance of person-centred care and evidence-based nursing intervention was emphasised (NMC, 2018) as pivotal for an effective assessment and planning of care. The NMC further highlighted that the nurse should understand the necessity to assess each patient's capacity to make their own decisions, and to allow the opportunity to give and withdraw consent. An assessment is a form of a dialogue between a client and the practitioner where they discuss the needs of the former to promote their wellbeing and what they expect to happen in their daily life (NICE, 2021). Nursing assessments involve collecting data from the patient and analysing those data to identify their needs. These needs are sometimes categorised as problems.

Planning care employs different strategies to resolve the identified needs from the assessment that is performed. Ideally, those strategies will include selection of appropriate evidence-based nursing interventions. The patient's needs and wishes should be prioritised when planning care, and the individual must be involved in the decision-making process to ensure a person-centred approach. The planned care

must consider the patient's conditions, personal attributes, and choices. It is worth noting that the principles of care planning are transferable between the hospital, home and care home settings. The NMC (2015) Code, Section 2, highlighted the importance of partnership working with patients for effective delivery of high-quality care and involving them in their care, including empowering the patients by allowing them to make their own decisions. The patient should be viewed holistically. Therefore, the physical, psychological, social and spiritual aspects of an individual's life are considered important and cannot be separated. Also, intrinsic factors of a patient's condition often influence their adherence to advice/treatment. Therefore, understanding their non-concordance and tailoring treatment/recommendations can be personalised to improve the quality of care delivered.

Brooker (2007) developed the acronym VIPS to address some confusion about what should or should not be perceived as person-centred care. 'V' is a value base that affirms the value of human beings irrespective of their age and cognitive ability; this is the commencement of individualised care. 'I' is individualised care that considers every individual's distinctiveness and holism. 'P' is about seeing the world from the patient's perspective; this is enabled by taking into account the patient's point of view in the care they receive from healthcare professionals. 'S' is about enabling a social environment that facilitates resolution of the patient's psychological needs, including their mental, emotional, and spiritual needs. Healthcare professionals should endeavour to involve the patient in their choice and decision making as much as possible and use various methods to achieve this (Lloyd, 2010). Nurses must assume that a patient has the capacity to make their own decision unless proven otherwise (DOH, 2005).

## Care planning

Planning care is essential in the delivery of appropriate nursing care to the clients. Following the assessment of the patient 's needs, the next stage is to 'plan care' to address the actual and potential problems that were identified. This helps to prioritise the client's needs and assists in setting person-centred goals. The planned care will change as the patient's needs change and as we identify new needs. Care planning assists professionals in communicating the patients (NICE, 2021; DOH, 2012) care to others, thus enabling continuity of care. Communication may be verbal but will always involve documentation in any of a variety of formats including computerised, handwritten or pre-printed care plans.

It is essential to consider your consultation style while developing a care plan in order to reduce paternalism. Collaborative consultation encourages the patients to participate in their care, which improves rapport, while the paternal consultative approach, involving minimisation of the individual's part in and responsibility for their own care needs may compromise care outcomes and concordance (Leach, 2010). Collaborative/partnership consultation styles enable the practitioner to adopt a person centred approach and involve them in their care. This could be achieved by asking a question like 'we have different types of treatment approaches that could be considered, so what are your preferences' as opposed to a paternal consultation style where you say, 'I am going to prescribe a certain treatment for you'.

## **Stages of care planning**

Care planning is the third stage of the nursing process (NMC, 2018; Toney-Butler and Thayer, 2021). Care planning involves assessing patients' needs, identifying the problems, setting goals, developing evidence-based interventions, and evaluating the outcomes (Matthews, 2010). This involves a high level of critical thinking, decision making and problem-solving skills. It is important to note that a care plan can be prescriptive; this is done after the patient has been assessed by prescribing the nursing actions (Hogston and Simpson, 2002) or collaborative involving the multidisciplinary team. There are situations when there are divergences in what the nurse sees as a priority in patients' needs compared to what the patients want. Cases like this require the nurse to use their clinical judgement to prescribe what is best for the patient. **The care plan could still be done in conjunction with the patient even they don't agree by explaining to them the reasons for the decision and acknowledging that it is not their preferred choice**, e.g., a patient with a high risk of self-harm being put on intermittent 15min observation. In other situations, the care plan needs to be collaboratively agreed upon with the service user (NHS England, 2016).

## **Identifying Problems**

Nurses need to identify the patient's problems/needs and arrange them in the order of priority with the patients agreement. It is safe to classify the needs as High, Intermediate, and Low to set the goals right.

## **Goals**

The goal gives a cue to the expected outcome that could resolve the problems/needs, and this should be patient-centred. There could be short-term achievable goals within a short period and long-term goals set for the patient, which could take days, weeks,

or months to accomplish. Nurses must think S.M.A.R.T. by setting goals that are **Specific, Measurable, Achievable, Realistic, Timeframe** (Revello and Fields, 2015: NurseChoice, 2018).

## **Intervention**

Interventions are nursing actions/procedures or treatments built on clinical judgment and knowledge performed by nurses to meet the needs of the patients. This should be evidence-based and indicate when, who and how often it will be carried out (Hogston and Simpson, 2002). Nursing interventions are the actual implementation of the actions scheduled to assist the patient in improving their health condition. They should aim to meet the goals set at the previous stage. There are three classifications of intervention, as stated by Brooks (2019). These are those independently initiated by the nurses, those that are dependent on a physician or on other healthcare professionals, and the interdependent, which rely on the experience, skills, and knowledge of multiple professionals.

Independent nursing interventions are planned and actioned by nurses autonomously (NMC, 2018). They do not require the direction of any other healthcare professionals, while other healthcare professionals usually direct dependent ones. However, the nurses must determine the appropriateness of those 'orders' before carrying them out because they are still accountable for the 'orders', such as administering prescribed medication (NMC, 2018). Due to developments in the nursing profession, some advanced nurse practitioners like nurse prescribers can prescribe interventions that fall into dependent interventions. Interdependent interventions are usually collaborative care plans reviewed in multidisciplinary (MDT) meetings and must be

agreed upon by all the parties involved. Both the goals and intervention must be communicated to all that care for the patient in a timely manner.

## **Evaluation**

This is the stage when the planned intervention is evaluated to assess if it has been achieved or not. This can be an ongoing process, and the intervention should specify the frequency of the evaluation and the timeframe. If the initial goal becomes unachievable, the nurse will be required to reassess the patients need.

## **Benefits of care planning**

The DOH (2011) highlighted that care planning aims to improve quality care and outcomes by respecting individual wishes and enabling patients to acknowledge the ownership of their condition and influencing outcomes. Health Care Professionals (HCP) should engage individuals in decision making and facilitate their taking control of their health by agreeing on common goals to improve outcomes; this will, in turn, reduce demand on health services, for example fewer GP appointments and emergency admissions. Furthermore, promotion of the self-management of long term conditions can slow progression of the illness. The HCP and patient coming together to agree on common goals will improve outcomes.

Care planning empowers patients to care for themselves when they are self-managing and do not have an HCP to call on. This became evident during the pandemic when patients often had to go for more extended periods between appointments with HCPs. Care planning has really come into its own in community care because it improves patients compliance to their treatment and other care needs without healthcare professionals input. This benefits HCP and the NHS organisation as it increases job satisfaction, efficacy savings and quality of care for the patients (DOH, 2011).

## **Nursing Considerations**

- The patient should know the reason for the assessment
- The assessment should be flexible and adaptable to the needs of the individual,
- The patient must be fully involved and their dignity, independence, and interests should be paramount.
- They can bring someone with them if preferred
- Appropriate language and terminologies should be used
- The diversity of the individual client, their beliefs, values, culture, and their circumstances should be considered.
- It is essential to consider the patient's gender, sexuality, ethnicity, disability and religion in the assessment.
- Be prepared to listen to their personal history and life story
- The whole family's needs should be considered, inclusive of the patient and the carers; remember 'holistic care'.
- Cost-effectiveness is another factor of consideration

## **Model of Care**

Model of care explains the way health services are delivered to enable best practice.

Integrated services are a care model that is multifaceted and coordinates the care required of a patient all together to meet their needs. This is a patient-centred care provided by a number of different health and social care professionals across providers to reduce duplication, confusion, delay and gap in services (Monitor, 2015).

The care plan is an integral part of integrated services as it enables the creation of shared care plans that map different care processes. This becomes a point of

reference for various providers involved in the care of the patients (WHO, 2016: Curry and Ham, 2010).

### **Care pathways**

Care pathways, also known as critical pathways, clinical pathways, integrated care pathways, care paths and care maps, are a specific patient journey that dictates the care to be given or process to be followed for a particular condition or needs. This evidence-based care process is established by considering expert opinions for better health outcomes at a lower cost (Centre for Policy on Ageing, 2014). Care pathways are often developed at local levels and good at meeting local needs. They are also known to improve cross setting collaborations. Clinical pathways aimed to provide effective healthcare appropriate for the patient group of conditions, thereby reducing hospital stays, leading to cost-effective healthcare (Kozier et al., 2008).

### **Care clustering and Payment by Results – PBR**

Care clustering is a generally needed assessment tool intended to rate a patient's care need based on specific scales. They are the framework used to plan and organise mental health services, including the care and support given to individuals to allocate them into clusters. One of the care clustering tools is the Health of the Nations Outcome Scales (**HoNOS**) (Wing et al., 1998; NHS England, 2016/17; Yeomans, 2014). Payment by Results (PBR) was used to authenticate care cluster allocation in mental health in that clusters become the common currency for pricing and payment of mental health services (DOH, 2013). Therefore, nurses need to consider cost-effectiveness during care planning to consider the availability of funding for the patient and how much funding is available. Mental health clustering should happen at the

initial completion of assessments, during scheduled reassessment and at any reassessment following a significant change in the patient's needs.

### **Importance of Record keeping**

Accurate record-keeping plays an essential role in assessing needs and planning care. This complies with the NMC who says that record keeping is fundamental to nursing practice (NMC, 2015), and records must be accurate and precise. Professionals should be aware of the need for legal accountability while writing records as these become legal documents that could be tendered in the law court (Dimond, 2005). Record is not only limited to patients record but includes all records that are related to your range of practice. The person that you are caring for should be included in the record-keeping process, and they should be asked to sign the plan of care if they have the capacity to do so (NMC, 2010). It is good practice to make an entry in the care documentation if the individual service users cannot sign or agree to their planned care and state the reason for this (Butterworth, 2012). Care plans can be documented in an Electronic Health/Patient Record Systems (EHRs) like RIO with NHS approved suppliers like Allscripts, Cerner, DXC, IMS Maxims, Nervecentre, Meditech, TPP and System C (NHS, 2019).

### **Importance of assessment and planning care to Policy and NMC guidelines**

- You must be compliant with the NMC guidelines for record and record-keeping
- Adhere to the organisation policy on record and record-keeping e.g., NHS Trust policy

- Follow the NHS Trust Care Programme Approach (CPA) policy
- Collaborate with all concerned in the care planning process.

### **What does a good and a bad care plan look like?**

There are some critical factors to consider when writing a focused person-centred care plan. One of these is to clearly document in detail the needs of the patient using the patient's language whenever possible, e.g., 'Mr D, likes to dress smart every morning but has been finding it difficult to make the choice of clothing to wear'. The documented goal/aim of the care plan should consider the SMART acronym. Therefore, the aim should be specific by targeting an issue that could be measured which is achievable and realistic, while indicating the time that this could be achieved. For example, 'Mr D, you would like to be able to make your own choice of clothes to wear every day with the support of staff'. The intervention must specify how the goal/aim will be achieved, including who will be responsible for implementing each task. This could be the staff nurse on duty, team nurse, team leader, the nurse in charge and/or the patient (please put the patient's name). Evaluation should be carried out regularly and documented; this should conform with the specified time speculated in the intervention. Evaluation should be done whenever there are actions performed regarding each intervention detailing the progress of the patient's problem/needs. An example of a poor way of writing a problem could be 'Mr D is unable to dress by himself and the aim is 'Mr D will appear to dress smartly'.

## Useful Questions

- What should you aim to do when care planning?
- Who should you involve and why?
- Who's care plan is it anyway?
- Is it acceptable to destroy care plans or other records?
- When should they be reviewed?
- Should the patient have a copy?

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