NHS Tayside

Mental Health Nursing

Standards for Person Centred Care Planning

Implemented May 2019
Review May 2020

FOREWORD

I am delighted to endorse the Mental Health Nursing Standards for Person Centred Care Planning developed for use across our Mental Health services in Tayside.

Person Centred Care Planning is a fundamental role for Mental Health Nurses and these Standards recognise the importance of working in partnership with people to engender hope, opportunity and promote recovery. The Standards recognise the diversity and uniqueness of individuals and ensure that what matters to the person is a key consideration within their care plan.

I would like to thank all the Mental Health Nurses who have been involved in the development of the Standards through the Care Planning Collaborative and the Care Plan Audit Tool Short Life Working Group. In particular, Jenny MacDonald, Senior Nurse Practice Development for her leadership in the development of the Standards.

Gillian Costello
Nurse Director
30th April 2019

INTRODUCTION

Description & Scope of the Standards

The Mental Health Nursing Standards for Person Centred Care Planning provides a framework to support the development of person centred care plans and will enable a consistently high quality approach to care planning for nurses working in all mental health settings within NHS Tayside.

A nursing care plan is a therapeutic tool that identifies, in collaboration with the person for whom care is being provided, the detailed plan of nursing care agreed with them and where possible with their carer's. The care plan is a dynamic document that follows on from a comprehensive assessment and formulation of the persons needs. It focuses on their individuality, describing explicit interventions that are central to care delivery.

The care plan ensures continuity of care and effective communication across and between the multidisciplinary team who are providing the care.

The care plan will be **reviewed** at a frequency determined by the person's needs, with **goals** and **interventions** updated as changes occur to provide a timely, accurate and detailed record of interventions in place and the progress made.

The scope of these Standards is to include the care plans of all Mental Health Nurses across the range of Mental Health services in Tayside.

Why the Standards were developed

In response to local and national Mental Welfare Commission reports the NHS Tayside Mental Health Professional Nursing Forum identified care planning as priority area in need of improvement.

How the Standards were developed

A Short Life Working Group was set up in 2017 to develop a care planning audit tool for Mental Health Nurses. This group comprised of representatives from all Mental Health settings, both community and inpatient. A literature search was completed for recently published local or national documents, best practice and Standards relating to person centred care planning. An audit tool was produced and thereafter draft person centred care planning Standards were developed, widely tested, reviewed and refined. In January 2019 the Standards underwent a consultation process.

How the Standards will be used

The Person Centred Care Planning Audit tool will be used to audit 5 patients' care plans at least monthly.

5 care plans will be selected at random on a monthly basis and compliance reported to the relevant Quality Improvement or Governance groups and committees.

In response to audit results, each area will identify areas of good practice and areas for improvement. Action plans will be developed, shared and implemented following each audit cycle.

This is in addition to the NHS Tayside Nursing Records Policy audit.

Use of Terminology

The Person Centred Care Planning Standards use the terms "person" and "carer". The decision was made to use these terms during the consultation process.

	STANDARD	GUIDANCE
1	Every person has a written care plan reflecting, where applicable, their individual: • Mental Health and Wellbeing needs • Physical Healthcare needs • Activities of Daily Living • Discharge needs	EMIS documentation: • Holistic Mental Health Assessment • Clinical Risk Assessment • Physical Assessment • Care Plan • Discharge Plan
2	What is important to the person is identified within the care plan.	Exploring the person's values and beliefs and developing care from what is important to them is essential to person centred care planning. If unable to identify what is important to the person's recovery then carers if possible, with the person's consent, should be consulted.
3	Symptoms relating to the person's mental and physical health care needs are explicit within the care plan.	Describe the impact of these symptoms on the person's mental and physical health using easily understood language.
4	SMART goals are agreed with the person: • Specific • Measureable • Achievable • Relevant • Time framed	Identify which goals are of priority to the person Goals will be determined with the person. Where this is not possible, with the person's consent, carers should be consulted.

	STANDARD	GUIDANCE
5	Specific, unique, evidence based interventions for physical, mental health and psycho-social needs are agreed with the person.	Interventions will : • Be unique to their individual needs • Identify risk of deteriorating factors • Evidence triggers for deterioration • Evidence self help/coping strategies • Evidence past supportive measures • Be strengths based not problem focused • Identify barriers to engagement • Identify therapeutic interventions and/or activities • Be based on current needs Consider the use of ratified rating scales.
6	The care plan will demonstrate involvement of the person	Roles and responsibilities that have been agreed with the person will be recorded. Working in partnership with the person to promote engagement. Respect person's who do not want / are unable to be involved – and record reasons for this and date for review.

	STANDARD	GUIDANCE
7	The care plan will evidence carer involvement where applicable.	Carer's roles and responsibilities will be clearly defined, with the person's consent.
8	The care plan will evidence collaborative working with multidisciplinary /agency involvement.	Their roles and responsibilities will be clearly defined.
9	The care plan will evidence the use of the Mandatory Data Set. (This standard is applicable from April 2020)	The Mandatory Data Set is the agreed patient outcome measure for use within Mental Health Services in NHS Tayside. Evidences the person's progress against the agreed interventions. Informs the next stage of care.
10	The care plan will evidence a date for review at a minimum frequency that complies with local agreement.	Consider: • Is there progress towards the goals? • Are the interventions working, do they need to change • Use of rating scales to support review
11	The person and carer, with consent, are offered a copy of the care plan.	Evidences collaborative / partnership working.

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ACKNOWLEDGEMENTS

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With special thanks to Rachel Milne, Wendy Tait & Kirsty Spence for their commitment to the development of these Standards

Appendix 1 – Person Centred Care Planning Audit Tool

Patients CHI

Care Plan Standard		Yes	No	N/A	Comments
Standard 1	Does the care plan identify relevant & current needs, specific to the patient, using the following headings?				
	• Mental Health & Wellbeing				
	• Physical Health				
	• Activities of Daily Living				
	• Discharge				
Standard 2	Does the care plan identify what is important to the patient?				
Standard 3	Does the care plan identify relevant symptoms?				
	• Relating to mental health				
	• Relating to physical health				
Standard 4	Do the identified goals follow the SMART criteria? Specific, Measureable, Achievable, Realistic, Time framed				
	• Mental Health & Wellbeing				
	• Physical Health				
	• Activities of Daily Living				
	• Discharge				

Appendix 1 – Person Centred Care Planning Audit Tool

Care Plan Standard		Yes	No	N/A	Comments
Standard 5	Interventions that have been agreed with the person will :				
	• Be unique to them as an individual				
	• Identify risk of deteriorating factors				
	• Evidence triggers for deterioration				
	• Evidence self help/coping strategies				
	• Evidence past supportive measures				
	• Be strengths based and not problem focused				
	• Identify barriers to engagement				
	• Identify therapeutic interventions and/or activities				
	• Be based on current needs				
Standard 6	Does the care plan evidence patient participation? (If not are the reasons recorded?				
Standard 7	Does the care plan evidence relative/carer involvement?				
Standard 8	Does the care plan evidence multidisciplinary/agency involvement?				

Appendix 1 – Person Centred Care Planning Audit Tool

Care Plan Standard		Yes	No	N/A	Comments
Standard 9	Has the Mandatory Data Set been adhered to? (Applicable from April 2020)				
Standard 10	Does the care plan evidence a date for review at a minimum frequency that complies with the local agreement?				
	• Is there evidence of progress towards goals?				
	• Is there evidence that interventions are working?				
	• Have interventions been reviewed and updated?				
	• Has a review date been agreed & projected forward as per local agreement?				
Standard 11	Has the patient been given a copy of the care plan?				
	• If not, are reasons recorded				
	Has the relative/carer been given a copy of the care plan?				
	• If not are reasons recorded				

Audit Compliance

Number of Yes & N/A Answers
_____ X 100

Number of Questions = 31
Overall Compliance = %

Completed by..... **Date.....**