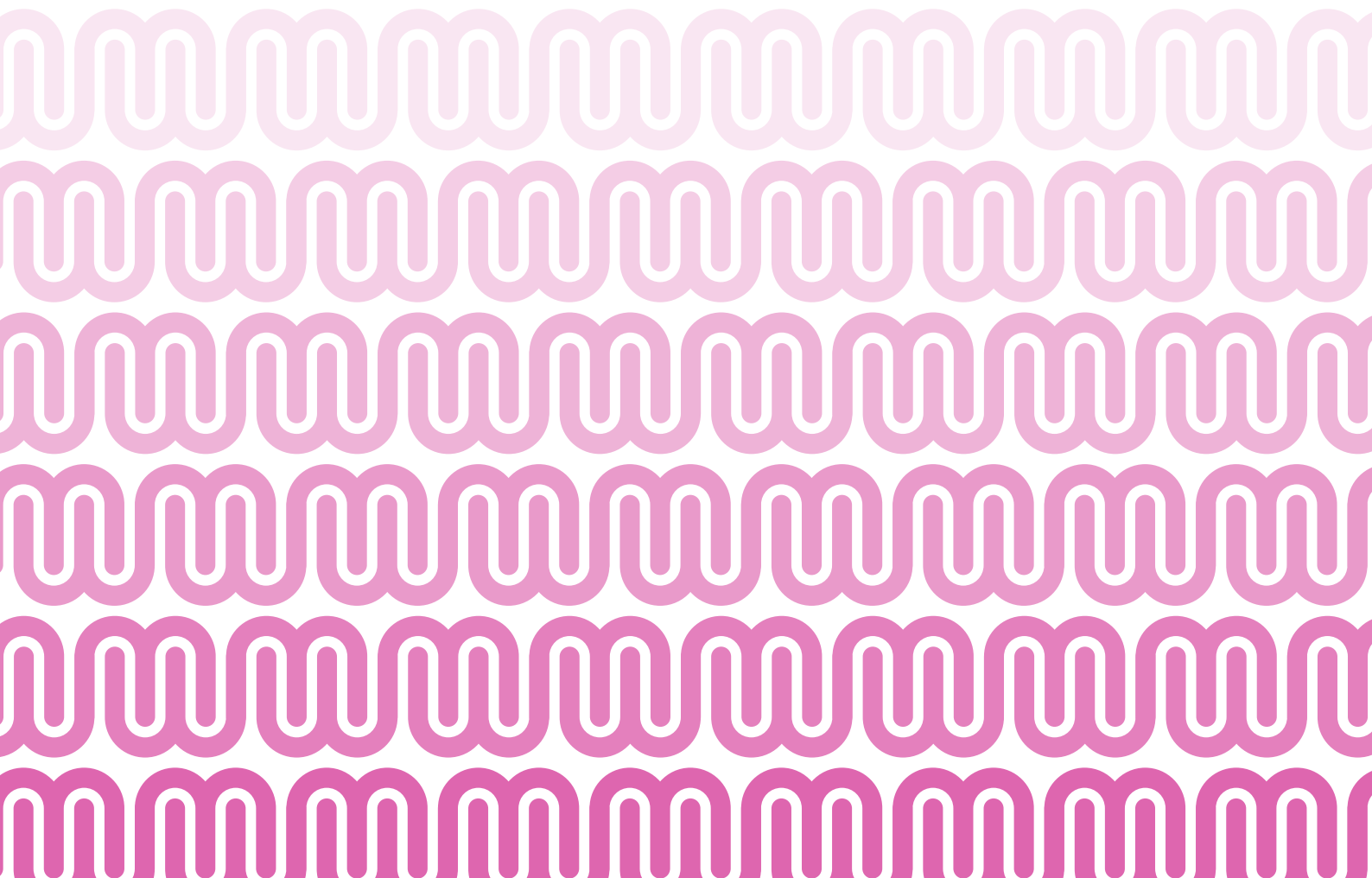




mental welfare
commission for scotland

Good practice guide



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

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What is a care plan and why are they important?

Everyone using mental health, dementia and learning disability services has the right to a care plan which is personal to them. They also have the right to be involved in developing their care plan, to know what is in their care plan, and to be involved in reviewing their care plan¹.

A care plan describes the care, treatment and interventions that a person should receive, to ensure that they get the right care at the right time. It is a written record of needs (either electronic or paper-based), actions and responsibilities, which can be used and understood by individuals receiving care, their relatives/carers and others as appropriate. The care plan is based on a 'template' which defines the areas the care plan covers. Some templates are very simple and focus on the essentials of care, e.g. mobility and nutrition, while others can be very detailed.

Care plans are a crucial part of supporting and helping the process of recovery. The process of care planning should enable people to take more control of their lives whilst they are receiving care and treatment and ensure that their needs and aspirations have been taken into account.

Involvement of the individual in their treatment and care is an important principle underpinning the Mental Health (Care and Treatment) (Scotland) Act 2003 (The MH Act) and care plans show that this is happening.

There are many ways of involving the person, even in situations where there are significant communication difficulties or when compulsion is required to ensure treatment is delivered.

In this guidance we use the term "individual" "person" or "people" where possible rather than "patient", as not everyone with a care plan will be a hospital inpatient.

¹ Mental Welfare Commission for Scotland. Human Rights in Mental Health Services 2017 www.mwscot.org.uk/media/369925/human_rights_in_mental_health_services.pdf

What is this guidance about and who is it for?

This guidance is about good practice in the development of person centred care plans for people using mental health, dementia and learning disability services. This guidance may be helpful for all clinical staff who develop and use care plans in a health and social care setting and for people who use services and their carers.

Although this guidance is written primarily for nurses working in these services in Scotland - within in patient and community settings, the NHS, local authority or independent sector - inclusive care plans involve all members of a multidisciplinary team. Clinical staff from different disciplines e.g. psychiatrist, occupational therapist, etc. each provide specific services. A care plan will include the contribution of other health and social care staff and co-ordinates the team and the individual working together towards a common goal.

Care plans should be specific to the individual. They should be accessible and useful to the professionals who need to access them. We have not provided a pro-forma document for a standard care plan in this guidance. The scope of this guidance is wide and it would not be possible to produce one template document that would meet the needs of everyone.

Many services have developed their own template documents that reflect the individual model of care used in the service, meet local standards of record keeping, and keep the person at the heart of their care plan.

In this guidance we focus on the principles that underpin care planning, providing a range of options and best practice suggestions. We hope it will be helpful for services as they develop their own care plan formats, in collaboration with the people who will use them; both staff and the people the plans will be centred around.

Why we wrote this guidance

The Commission carries out around 100 local visits and two national themed visits every year. Our findings and the recommendations we make draw on established good practice (such as national health and social care standards, dementia standards for Scotland etc.). Our reports include the observations we make on the day of the visit, the professional expertise and judgement of our visitors, and what people we met with tell us.²

On our visits we find that the quality and level of participation varies considerably and we regularly make recommendations about the quality of care plans at hospital, care home and prison visits across the NHS and independent sector. The number of those recommendations continues to rise, and we were told by staff that good practice guidance available for staff across Scotland would be helpful.

Excellence in Care:

The Excellence in Care (EiC) programme³ is a national approach designed to assure and improve nursing and midwifery care across ward and community settings, in NHS health boards/health and social care partnerships.

² Mental Welfare Commission for Scotland. Recommendation and outcomes from our local visits 2017 www.mwscot.org.uk/media/385772/recommendations_and_outcomes_from_our_local_visits_2017.pdf

³ Scottish Government, www.gov.scot/publications/excellence-care-scotlands-national-approach-assuring-nursing-midwifery-care-event-report/pages/3/ Ref E in C

EiC will provide data to improve care through a series of measures developed by nursing and midwifery staff alongside Health Improvement Scotland and NHS National Services Scotland (NSS). To support EiC, A 'dashboard' system has been developed by NSS. This system - called 'Care Assurance and Improvement Resource' (CAIR) - will inform the quality of care and drive quality improvement in nursing and midwifery.

Mental health, specialist dementia and learning disability nurses have developed their own specific measures that will apply across inpatient and community services. These include person centred care planning, and this guidance can be used to support the development of this at a local level.

How we produced this guidance

We held a consultation event in November 2018 with 60 attendees including representation from a wide range of mental health and learning disability nursing staff, people with lived experience of mental illness, relatives/carers and educators. At this event we explored the key elements of care planning to try and reach a consensus view of what a good care plan looks like.

Our engagement and participation officer (lived experience) also consulted with 148 people at a series of meetings across the country⁴. Most were people with lived experience of mental ill health, but almost as many were friends and family (carers) some people with dementia and acquired brain injury, and a small number of workers (mainly advocacy workers)

Those meetings sought to find out from people with lived experience and their friends and family how they would like to be involved in care planning, what a care plan might look like and contain, and any other issues to do with care plans. The notes of the meetings have now been compiled into a [report on the MWC website](#). We have also included some excerpts from that report in this guidance (see coloured boxes).

In these engagements, it proved impractical to find out exactly how many people had a care plan but it was very clear that most people had not seen their care plan, very few people had been asked to be involved in the creation of their care plan and many people had very little idea of what a care plan was.

⁴ [Care plans: how people with lived experience and their friends and family want to be involved, August 2019](#)

What information should a care plan contain?

Care plans should contain actions; what is being done to support the person. This should be detailed and show what is being done and how that contributes to a positive outcome.

Care plans form part of the medical record, and must meet local policies and standards for record keeping. Good record-keeping is an integral part of nursing practice and is essential to the provision of safe and effective care

Some care plans, for example at an early stage of admission to hospital, may be limited in the information that is available particularly following an admission at a time of crisis. An admission care plan should be in place to cover the initial identified needs and allow time to undertake a more detailed assessment.

An initial admission care plan may cover the first 72 hours of an admission and after this time it should be discontinued and a more detailed care plans put in place.

As well as key personal details, the care plan should be based on assessment, the aim of any planned intervention, who is responsible for each intervention (where and when) and evaluation of the care. There should be evidence of participation; how the person was involved in planning, consideration of capacity and consent and safeguarding issues (particularly risk, vulnerability, crisis arrangements).

These represent minimum requirements and the framework in which the care plan can be constructed. A good care plan is one that can be read by any member of the healthcare team and acted upon quickly. If it is too elaborate or too generic it can be less effective in meeting its goals.

The Nursing and Midwifery Council has not produced a guidance document on keeping records, but state that nurses, midwives and nursing associates should keep clear and accurate records which are relevant to their practice. The issue of record keeping is addressed in more detail within part 10 of the NMC Code of conduct. However, many other sections of the code, including those relating to working in partnership with people, assessing needs, communicating and working cooperatively will also have relevance to care planning.^{5 6}

⁵ Nursing and Midwifery Council. The Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates www.nmc.org.uk/standards/code/

⁶ rcni.com/hosted-content/rcn/first-steps/legal-issues-record-keeping

Good practice guidance on the preparation of care plans using the principle of participation and the nursing process

The principle of participation

Everyone has the right to participate in decisions which affect them.

A human rights based approach is about increasing the ability and accountability of health and social care staff to respect, protect and fulfil human rights and about empowering people to know and claim their rights. Respect for human rights can and should inform decision making, develop better participation for those in receipt of care, foster strong working relationships and ensure that care is personalised⁷.

The principle of participation means that people should be allowed and encouraged to be involved in decisions about their care, including involvement in their own care planning.

Active participation in care planning has become more prevalent in recent years but requires a concerted effort from all staff, particularly if the person's engagement is poor or they remain unwell. Time for careful assessment to gain their views, draw up advance statements, and discuss their situation with family and friends are all crucial. Importantly, these actions are reflected in the principles of the Mental Health Act which highlight that these views should be taken into account. While it may not always be possible to uphold people's views, they should be heard and incorporated into recovery and care plans.

The Patient Rights (Scotland) Act 2011 and the Charter of Patient Rights and Responsibilities highlight communication and participation with patients as a key theme for the NHS in Scotland. Realistic Medicine puts the person receiving health and care at the centre of decision-making and encourages a personalised approach to their care.⁸

Nurses can ensure that people are able to inform their care and treatment by involving them in care planning. Their perspectives should be incorporated as much as possible. Having a personal statement incorporated into an advance statement⁹ can be helpful particularly if the patient is very unwell and not able to express their wishes.

Section 76 care plans

People subject to a compulsory treatment order under the MH Act will also have what is known as a section 76 care plan. There is a formal requirement under the Act for this to be produced in a specific format and updated by the responsible medical officer. This guidance does not relate to the s76 care plan but nursing staff should know where this is kept and the information it contains. More information on s76 care plans can be found in our best practice guidance on the preparation of care plans for people subject to compulsory care and treatment.¹⁰

Recovery-focused

People wanted mention of things that would happen in the future that they could look forward to and which would help them believe there is a possibility of recovery.

⁷ Mental Welfare Commission for Scotland. Human Rights in Mental Health Services 2017 www.mwcscot.org.uk/media/369925/human_rights_in_mental_health_services.pdf

⁸ www.gov.scot/publications/chief-medical-officer-scotland-annual-report-2015-16-realising-realistic-9781786526731/

⁹ www.mwcscot.org.uk/media/307049/advance_statement_guidance.pdf

¹⁰ www.mwcscot.org.uk/media/240815/best_practice_guidance_on_preparation_of_care_plans

The emphasis on treating the person as an individual and not merely as a collection of symptoms is an inherent part of the recovery focus that drives mental health care today. Care plans are a crucial part of supporting and helping the process of recovery and assuring the process is structured and recorded.

The Scottish Recovery Network describes recovery as follows:¹¹

“Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual’s recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.”

The concept of recovery may be less directly relevant for people with dementia or a learning disability but the same principles around supporting the person to live a life they view as meaningful and satisfying apply. Acceptance of the principles of a recovery focus for an individual, even where recovery is unlikely, will ensure that the care plan is reviewed on a regular basis and able to respond to changes in individual needs and circumstances.

Person-centred

At our consultation event we asked what people understood by the term person centred care. The majority agreed that it was about making the person the focus, looking at them as a unique individual and making sure services are flexible to meet their needs in the way that is best for them.

People with mental illness, learning disability and related conditions are frequently defined by their condition and their lives are viewed through this lens. This often leads to a narrow focus of care planning which ignores essential aspects of an individual’s life.

Getting to Know Me was developed by the Alzheimer Scotland Dementia Nurse Consultant group and is a useful document recording a person’s needs, likes and dislikes, personal preferences and background.¹²

Treatment is not just about the nursing care and medical treatment which is proposed. An individual’s physical health, social and recreational, spiritual and financial needs may all have a bearing on their recovery. This is not to say that the care plan should cover all aspects of an individual’s life, but there should be evidence that a broad approach has been taken in the creation of the care plan. The focus should be on the person and not just on their condition.

People need time given to them. An important element of engagement occurs when people are able to take the time to get to know a person as a person, to spend time doing things they like with them and seeing them as individuals. This is often much easier when someone has had some continuity in their care and know their helpers well. It can be hard to open up and trust a person and this can be necessary if someone is to start an intimate conversation about their care.

¹¹ www.scottishrecovery.net

¹² www.alzscot.org/information_and_resources/information_sheet/3472_getting_to_know_me

Using the nursing process

The nursing process is a clear and straightforward model consisting of four concepts of nursing: assessment, planning, implementation and evaluation. The nursing process looks first at the person and then thinks about the care that is required. The emphasis is on individual assessment, encouraging nurses to identify the patient's potential.

Assessment

The first stage in the planning of nursing care, it starts the process of gathering information to make decisions about suitable interventions.

The nurse's communication skills are key; listening to and checking what they have been told and seeking information from others such as friends, carers and other professionals. Everyone has a right to agree how much they want family and friends to be involved in their care and support (unless there is a legitimate reason to restrict this, in which case any restriction should be the least possible). This will affect how much information, if any, staff can give to carers but it is still important to listen to what carers can contribute to understanding the person and their situation.¹³

The principles of the Mental Health Act 2003 make it very clear that the wishes of the individual and their carers should be taken into consideration during treatment, so nurses should include questions about family, friends and key personal contacts in any initial assessment. In addition, a full discussion should take place with the person around the nature and level of contact and their consent should be gained regarding the amount of information to be shared with family members. The role that family and friends play in a person's life, and how much support they can offer can set a benchmark for the nature and frequency of contact.

Assessment needs to consider the whole person and include psychological factors, spiritual factors, biological and social factors in order to be holistic (Lloyd 2010).

Risk assessment is an extremely important part of any assessment process and should form part of a holistic assessment. The assessment and management of risk can seem overwhelming and is often seen as the top priority to the detriment of other important aspects of care.

People had a great need for staff to be able to see them as a person, to see behind the mask they sometimes put up and get to the 'real' them. They can struggle to communicate and be frightened of doing so and need people to reach out to them. Involving them in their care and in providing treatment, taking the time to listen to the person. If people do not feel they are listened to then it is hard for them.

¹³ Carers and Confidentiality 2018 https://www.mwscot.org.uk/sites/default/files/2019-06/best_practice_guidance_on_preparation_of_care_plans.pdf

Planning

Once needs have been identified there must be a clear plan about how they can be met.

Each identified need should have a clear, measurable goal for the expected outcome. The goal needs to be realistic and there may need to be a range of short and long term goals so that there are realistic targets to work towards.

The expectation should be that the care plan is shared with the individual unless there are compelling reasons not to do this and if it is not shared then the reasons for this need to be clearly documented .Sometimes the person may be asked to sign a copy of their care plan to indicate that this has been shared and discussed with them. This is not always possible though and there needs to be clear record made in the care file as to why the care plan was not shared and also if there was disagreement about the content .

Signing the document is less important than the actual involvement of the person though it should evidence how staff sought to maximise involvement of the person in their plan.

Sometimes people will choose not to participate with the care plan but staff should still ensure that they are kept informed about their care and given the opportunity to participate at a future time and to the extent that they are comfortable with.

People said that there are times when people would not be able to participate in drawing up care plans. This could be especially so, soon after admission to hospital. People said that in these circumstances it may only be later on that they are able to participate in any meaningful way in their care and care planning.

People wanted a record of what they are like when they are ill, what the triggers for their illness are and the sorts of things they worry about and need dealt with when they are ill and need elements of their home life taken care of, such as pets.

Implementation

The implementation phase is the follow through on the decided plan of action.

The individualised plan should be specific about who will be involved and when and focus on achievable outcomes. Implementation can take place over the course of hours, days, weeks or even years.

Our visits indicate that there are varying degrees of understanding among individuals about what their care plans say. For some it is because of the language, for others it is because they have limited literacy skills and therefore cannot read what is written.

Mental illness, learning disability and related conditions can and do impact on people's ability to retain and/or understand information. It is therefore crucial that there is an accessible record of what has been agreed. We have seen very good examples of care plans for people with learning disability which involve the use of pictures and drawings.

What the care plan might look like

People said:

- *They would like a photo of themselves and maybe their family, so that people could recognise them. They also said it would be good to have some script around this describing their likes and dislikes and themselves as people.*
- *For people, who struggle with reading, that pictures and drawings may be better ways of describing their care.*
- *They should be asked how they would like their care plan to be presented and that it should reflect those views.*
- *Mind maps, speech bubbles, diagrams and flow charts might all be good ways of presenting their care in a way they would understand.*
- *We should learn from the 'all about me' sections of care plans that are often used for people with learning disabilities or dementia. These should be at the front of the care plan and have a description of their likes and dislikes.*
- *Care plans should be written in a way that was easy to understand and contain a minimum of jargon. They should be simple and maybe written in sections and stages.*
- *Different people have different needs for the way that their care plan is written; a professional may have a need for much more complex information about medication than a person with lived experience and therefore there may need to be different versions of care plans.*

Evaluation

The care plan should make clear when it will be reviewed and who will be involved in that, looking to see if there been an observable change.

This can often be difficult to define and measure. It can though be helpful to measure as this demonstrates that progress is being made in particular areas even when it's not immediately apparent. For some the long term outcome may be to reduce levels of stress/distress in particular situations rather than to leave hospital or return to work.

People wanted a record of what they wanted to achieve during their stay or in their life and what their goals are, from their point of view. They also wanted a record of and measures to say whether they were achieving their goals and recovering.

Audit of care plans

Audit of care plans

Audit is distinct from the evaluation stage of care planning but is part of an ongoing process of quality improvement. Poor quality care plans will lead to poor care and poor care outcomes.

We often recommend when we visit that care plans would benefit from being audited to ensure the quality of care plans and the documentation that supports them. Developing an audit tool based on what is most important look at area that need improvement, ensures a consistent approach to care planning.

Audits can look at just one particular aspect of the care planning process that has been identified as needing improvement or can look at many aspects including the standard of record keeping. Building on previous audits is a good way to drive ongoing improvements in the process of care planning.

The audit should though be clear about what it is that's being measured, identifying any action required and carrying out that action. Useful action may include peer review of care plans to foster organisational learning and improvement as well as assurance.

Some people said that sometimes they were involved in the creation of care plans and happy and relieved at what was in them but that they did not end up achieving what the care plan said it would do. If the care plan does not provide what it says it should then people will lose faith in it.

Ideas for care plan audit

- Individual knows about their care
- Involved in preparation of care plan
- Carer/ relative/ significant other involved in care plan (if agreed by patient or lacks capacity)
- Documentation meets standards for NMC/ NHS record keeping
- Easy access to care plan/ copy of care plan
- Frequency of reviews agreed
- Includes professionals involved in care
- Includes responsibilities of individual, professionals and others
- Takes into account current challenges/ strengths/ skills and support needs
- Shows aspiration, clear goals, hopes and future plans
- Short/ longer term goals identified
- Use of WRAP
- Assessment tools used and acted on
- Spiritual/ cultural needs identified and addressed
- Recreational activities and therapies
- Understandable language
- Use of aids such as pictures to represent aspects of care plan
- Includes education/ information provided, for example:
 - Mental Health issues/ diagnosis • Mental Health Act • Advanced statement • Named Person • Rights of appeal • Specified persons • Crisis Management • Medications prescribed/ being considered • Investigations • Consent to Treatment • Advocacy/ solicitor access • Finances • AWI

- **Risk**
 - Includes risk assessment and risk management
 - Explanation of risk to individual/carer/ significant other

- **Observation/ restrictions**
 - Explanation of observation status
 - Rationale for decisions
 - Review periods
 - Patient rights¹⁴

- **Reviews**
 - Progress towards goals
 - Achievements acknowledged
 - Respond to changes
 - Patient version of care plan provided

¹⁴ Reference *Rights in mind*
<https://www.mwscot.org.uk/law-and-rights/rights-mind>

Appendices

From *A New Era for Mental Health Nursing in Scotland, 2020 and beyond* prepared by Boards and Mental Health Nursing Leads Group 2016.

Core Role of Mental Health Nurses

- Providing care and interventions based on meeting people's physical, emotional, social, psychological and spiritual needs.
- Engaging people in care and treatment.
- Working with people to assess, plan, implement and evaluate programmes of care and support, based on individual rights, focussed on recovery as an expectation.
- Assessing risk and supporting the therapeutic management of risk.
- Creating and sustaining therapeutic environments in inpatient settings.
- Delivering psychosocial interventions and psychological therapies.
- Supporting people receiving pharmacological interventions, including medication management and prescribing.
- Providing case coordination and care management services, coordinating inputs from other professionals, services and agencies.
- Assisting people to connect with mainstream activities by working with a range of agencies out with health and social care.
- Practicing therapeutic management of a range of challenging situations, including aggression, violence and self-harm.
- Adopting an illness – prevention, health promotion focussed stance.
- Tackling health inequalities.
- Advocating for people and supporting people's access to independent advocacy services.

Dementia Skilled – Improving Practice Learning Resource

- [This document can be found here.](#)
- Modules 2 and 5 relate to 'Promoting person and family centred care and community connections' and 'Supporting and Protecting People's rights', although the whole resource has a focus on rights based and person-centred care and supported decision making.

Equal Health Skilled Resource (Learning Disability)

- [This document can be found here.](#)
- Modules 2 and 5 relate to 'Promoting person and family centred care and community connections' and 'Supporting and Protecting People's rights', although the whole resource has a focus on rights based and person-centred care and supported decision making.

NHS Tayside Mental Health Standards

- [This document can be found here.](#)

Exemplars of care plan templates:

- [NHS Lanarkshire forensic mental health "My Plan"](#)
- [NHS Lothian rehab recovery plan](#)
- [NHS Grampian ELP](#)
- [NHS Grampian Hospital Passport](#)
- [NHS Borders Stress and Distress care plan](#)



Summary of best practice points for care planning

- Get to know the person first and assess how much and how able they are to be involved.
- Assess the person's communication style and needs.
- Look at different communication methods e.g. technology, talking mats, social stories and pictures.
- Check out the person's understanding of any discussion: do not assume that the person understands just because they do not ask questions.
- Consider capacity and keep this under review.
- Ask about an advance statement where appropriate: if no advance statement in place then encourage them to consider making one in the future and suggest sources of support for this.
- Involve the named person, the independent advocate and the carer: he or she may have useful and relevant additional information and may also be involved in the delivery of care.
- If the person has a welfare proxy appointed under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), involve and consult them as appropriate.¹
- Document the person's views, including his or her needs (met and unmet) and aspirations and goals.
- Use routine enquiry in relation to trauma.
- Use tools such as Wellness Recovery Action Planning (WRAP)¹ (Scottish Recovery Network) to encourage clearer expressions from individuals.

¹ A welfare proxy is either a welfare power of attorney previously appointed by the individual, or a welfare guardian appointed by the Sheriff Court.

The care plan should:

- Incorporate examples of the individual's views, opinions, wants and goals in terms of their care.
- Be driven by the individual's view of what improvement will look like.
- Be produced collaboratively but show clear separation regarding actions for professionals and the individual.
- Be produced in collaboration and with the contribution of other professionals.
- Contain carer views and their role and expectations in care delivery.
- Be accessible in a format that is meaningful to the person, e.g. use pictures where these would help understanding, increase size of font for those with poor vision; have two versions of the care plan, one for the formal record and another that is tailored for the individual's own use.
- Display a method of having the person sign/agree their care plan and indicators of ownership.
- Be accessible to other care providers and health care professionals, including GPs, CPNs, and SW etc.

Reviews should:

- Encourage and support the person to attend, assistance from advocacy services and peer support workers can be beneficial.
- Be broken down into key themes to see if there's progress.
- Recognise (and celebrate) progress.
- Be flexible, change when the care plan is not working.
- Ensure that when interventions need to change, this is documented and the care plan updated to reflect the changes required.
- Acknowledge the fear of progression for some.
- Involve carers and others in the evaluation.
- Consider the use of measures/rating scales for evaluation.