Education points provided to Senior Nursing staff March/April 2015 on documentation requirements

Check if the patient has a questionnaire completed and if so use this to inform the risk screening and assessment document. **Example**: there are sometimes points raised in this document that never make it into the care plan i.e. smoker wants to quit – not followed up, or patient had a fall – not identified in the risk screen.

Staff must complete both sides of the Risk Screening and Assessment document to inform care planning needs.

CARE PLANNING - PATIENT INVOLVEMENT

Involve the patient or family in the care plan by completing it AT THE BEDSIDE were possible.

The Care plan must have a date at the top left when the patient was last consulted. This would be used at the initial care plan and with subsequent care plans if the plan has changed significantly. If there are no changes/consultation use the previous date on subsequent care plans.

Evidencing patient involvement in the care plan

- Involve the patient or family in the care plan by completing it AT THE BEDSIDE were possible. Have discussions, make agreements, identify their key goals, and help them understand your goals for them.
- Complete the consult date at the top of the care plan – use the date that the patient was first consulted on (initial care plan), change the date when the patient is next consulted with care plan changes. If there is no change to care continue to use the last date consulted.
- Use the patient goal section where they have one.

CARE PLANNING - USING THE FIRST COLUMN OF THE CARE PLAN

The first column on the care plan is for ticking the management that is required for the patient from the risk screening and assessment document. See flipchart for examples.

EXAMPLE Pressure Injury risk section – Add in your Braden, then use clinical judgement – if judgement identifies a comorbidity to consider - tick Clinical Judgment box.

Use circles in the first column to denote the PI risk category At Risk, Mod to High Risk, Very High Risk. Where your clinical judgement has raised the risk. I.e. Braden identified as a 12 but has PVD so is automatically a Very High Risk – circle the Very High Risk in that column.

Pam is directing that you manage all the lower risk strategies too. eg if they are a Mod risk, then you tick the previous At risk management strategies too. If a Very High Risk – you tick and use the Mod-High and At risk strategies too. Elaborate on how you will implement the management strategy in the shift column – see how we have done this in the sample flipchart.

EXAMPLE Falls Risk – tick the category of risk the patient fits into A,B,C,D,E, F in the Management Column. Use the new flipchart for determining the category of risk for the patient – these

descriptors will help you define which category to use. The updated management strategy flipchart page will give you best practice points to add as management to the shift columns. EXAMPLE: Patient has a risk category B – Unable to get up and go (due to current pain) and C - Risk taker – she may or has gotten up without calling for assistance and F - Altered Elimination – she needs to get up to the toilet more often as is on IV fluids. Add as a strategy in the shift column that Mrs ……. has agreed to call for assistance to the toilet **before she urgently** needs help. This is part of the conversation you can have with the patient as you complete the care plan or identify a fall risk.

CARE PLANNING - Some tips to save time and improve outcomes

- **All staff must use the flipchart for assessment and care planning.** Recent RCA's have noted that ineffective care planning is impacting on patient safety. Use the strategies in the flipcharts to communicate to your fellow colleagues what the patient requires.
- Care planning is to focus solely on the assessment items that are requiring management i.e. don't write in sections that aren't identified as an issue in the risk screening and assessment document or to the patient. EXMAPLE if the patient has no cultural, lifestyle or support issues you don't need to complete this section of the care plan. Focus on the sections required.
- Every patient needs a malnutrition rescreen at day 5. Always tick this box and add in the date of the rescreen in the shift column, so if the patient is still here on that day it is done.
- Add dates/times for other management items to remind staff Eg IV line changes, Flush TKVO
- Use plans not tasks in the shift columns. EXAMPLE – Toileting plan means having a plan with the patient on when toileting help is required. E.g. Patient will call for toilet OR HA to toilet Mrs ….. 2-3hrly during day/11.30pm at night (according to history of toileting or change in elimination from hospital treatment)
- Think of what your colleagues need to care for the patient the following shift
- Update the care plan during the shift – less likely to forget to do it
- When we introduce Bedside Handover use the care plan in handover
- Still add clinical judgement/rationales in the clinical notes.

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