Nursing care plans in acute mental health nursing

Care plans play an important part in mental health nurses’ work, not only as a legal record of care given, but as a therapeutic tool. This article sets out the principles of good record keeping and how nurses can make them more accurate and effective.

**Aims and intended learning outcomes**

This article promotes the care plan as a means of providing more effective care on acute inpatient units. It emphasizes the use of such plans within the context of a therapeutic relationship, using the care plan as a therapeutic tool. It highlights professional standards for record keeping and sets out the legislative framework for care planning in mental health nursing.

This article aims to promote understanding of the principles of good record keeping, and to develop more effective and accurate records. After reading this article, you should be able to:

- Identify ways and means of using the care plan as a therapeutic tool.
- Identify professional standards for record keeping.
- Understand the importance of the care plan as a legal document.
- Improve your own skills in writing care plans.

**Background**

There is little evidence in the psychiatric nursing literature that demonstrates the impact of care plans on client care and clinical outcome. Clinical effectiveness is not yet established (Thomas 1996). The Sainsbury Centre (1998) surveyed care plans of 113 acute inpatient units. Half of the problems identified in the care plans related to psychiatric illness, signs and symptoms, 20 per cent to risk of danger to self or to others, 10 per cent to physical health problems and 10 per cent to other issues.

Interventions related to two main areas of care: psychiatric treatments and medication and milieu-related interventions, including, for example, ‘spending time with the patient’. Generally, care plans lacked any evidence base for interventions. Few care plans linked the intervention to a particular outcome and evaluations were seldom completed. Thomas (1999) reports on an audit of care plans and finds little connectivity between assessments, care plans and progress notes, a lack of prioritisation of needs, and little evidence of evaluation, outcome measurement and discharge planning.

Neilson et al (1996) address the use of the care plan in relation to risk assessment and management and report that often nurses’ reactions to service users do not follow the written nursing care plan, and that the care outlined in the care plan was not a good reflection of the actual nursing care provided to service users.
Reynolds et al (1992) suggest that mental health practitioners generally receive little training in how to write and read a record, given the amount of time they tend to spend doing both. The literature suggests that nurses need assistance in developing care planning and record-keeping skills, but few research studies indicate methods to assist the nurse in improving these skills (Reynolds 1982). Some have developed audit tools to try and measure the quality of care planning (Teggart 1993) or by reviewing care planning procedures (Perkins and Fisher 1996).

Shea (1986) reports from research focusing on nurses’ attitudes and beliefs about care plans and suggests that only 40-60 per cent of clients have written care plans that are used. Neilson et al (1996) surveyed a random sample of care plans from acute psychiatric inpatient units addressing initial assessment; formulation of a care plan; co-ordination and implementation of care; evaluation and discharge planning. Overall, the quality of nursing care plans was poor.

De la Cuesta (1983) found nurses gave many reasons for their inability to care plan appropriately, including difficulties in articulating written problem statements and with analysis of data. Many nurses saw little relationship between the written plan and the actual care of the service user. They reported insufficient time to record the care plans. At worst, care plans were seen as unnecessary administration and bureaucracy of little clinical value. However, Yacsin and Watkins (1993) found that education helped to foster more positive views towards care planning.

Siegal and Fischer (1981) conducted the most comprehensive study of psychiatric records to date. This involved a national survey of over 4,000 multidisciplinary mental health professionals’ attitudes toward psychiatric records. The following are the main results of the survey:

- 60.5 per cent believed that there was some relationship between good records and good care, with an additional 26 per cent holding that there was a good relationship.
- The most pervasive problems were illegible handwriting, too much information, no problems identified at all, missing information and disorganisation of records.
- The clinical parts of the records were most frequently written and read.
- Most records had a structured format, progress notes, however, were generally unstructured.
- The records were used in different ways; psychiatrists, psychologists and social workers consulted records to make decisions, other staff consulted records to get instructions.
- Records for long-term service users were sparse compared with other groups of service users – perhaps an indicator of less active treatment.
- Psychiatrists made the greatest number of entries, psychologists the least. Nurses and psychiatrists emerged as the most frequent record users.
- About one third of treatment plans were missing from the sampled records.

An absolute minimum standard of user involvement is the signing of the care plan by the service user. This may imply his or her agreement with its content, or merely that he or she has had access to the care plan. However, if the client has not signed the care plan, the reason should be recorded.

Sheehan (1991) investigates the use of the care plan and reports a lack of negotiating with service users about the care they are given. Fanning et al (1972) assessed the attitudes of service users and staff in a mental health centre to service users’ participation in planning their own care. There was agreement between service users and staff that care and treatment should be planned collaboratively from the time of admission. The main problem with joint planning lay in its implementation.

Simpson and et al (1977) conducted a study on the effects of giving service users in a small psychiatric unit their complete medical and nursing notes to read on a daily basis. Medical and nursing staff and service users found this to be an effective way of actively involving users in treatment and provided opportunities for user education. Other advantages included a lower rate of inaccuracies in the records and greater care in documentation by staff.

Dirksen Yoder (1990) involved a small sample of service users in the evaluation of nursing actions and interventions documented in care plans, asking them to rate them according to helpfulness and frequency of intervention. Overall, service users valued actions that promoted independence, helped them learn new skills and increased knowledge relating to their medication. Being knowledgeable, competent, and friendly were identified as important characteristics of the nurse associated with the implementation of nursing actions.

The development and evaluation of a shared care record held by service users with severe mental illness in long-term care was the focus of a study by Essex et al (1990). Service users found the shared care records very acceptable and were enthusiastic about their use. They valued being consulted about what was recorded and found the record of their treatment and progress useful. They felt more informed and better able to make decisions. Shared-care records were acceptable to service users with severe mental...
User and carer involvement

Involvement of key workers, advocates

Providing summaries of assessments to users and carers in the form of a written care plan.

Involving key workers, advocates or other people during the care planning assessment interviews.

Mental health inquiries

In addition to research findings, reports and recommendations of mental health inquiries provide another source of evidence as a basis for practice. The Zito Trust offers a review of 58 mental health inquiries between 1969-1996. At least 21 of these inquiries identify assessment, care plans, documentation and record keeping as areas requiring attention. Specific recommendations relate to improved communication, interagency referral and working, and a systematic approach to user information (Sheppard 1996).

Recommendations associated with care plans, record keeping and documentation, include:

- The need for a single record for each service user
- Problems of communication of information between different professionals increase when each professional group keeps its own separate clinical record. Also, a single record system would allow information to cross organisational boundaries, for instance, between community care and in-service patient unit, primary and secondary care, primary care team and mental health or specialist service. Access to and sharing of information would be improved.
- Organisation of records – Many inquiries comment on the poor organisation of records and the problems this causes with finding relevant information when it is needed. Some recommendations suggest chronological systems reflecting the service user's experience of health and social care to date, with a separate section for specific tests and investigations.
- Content of records – Often the most relevant or most important information about care was simply not recorded. Essential information includes any incidence of violence or aggressive behaviour; prescribed medication and the actual experience of side-effects; legal status, whether the service user is detained under the Mental Health Act and the period covered; the relevant level of supervision and observation; pass status, whether or not they should be accompanied, if so, by whom; and, importantly, any changes in care need to be clear in the record.
- Responsibility for records – Reports from inquiries often comment on the lack of clarity over who is responsible for what in relation to the records. Each professional may make assumptions about what other professionals would record. This may lead to repetition and/or omission of information.
- Involvement of service user and family in care planning – The general lack of involvement was remarkable, particularly when the carers or families knew of information that could have made a difference. In one instance a professional even discounted the carer's opinion.
- Assessment and history taking – Some inquiries are critical of professionals’ lack of skill in conducting and recording assessment interviews. Some clients had experienced being assessed by several different professionals, each ignorant of what his or her colleagues had already done.
- Risk assessment – One of the common problems identified by enquiries was the poor state of knowledge of risk assessment and risk factors in relation to the client and his or her care. At times, there was variation across different professional groups as to what constituted a risk assessment. Nurses, doctors, police and social workers do not always share a common understanding of what constitutes a risk. Care plans should specify the type and nature of risks – to self, others or of neglect.
- Audit of documentation – Most enquiries recommend regular audit of records to ensure that they reach a minimal desired standard.
- Need for on-going training – The lack of education and training in care planning is highlighted. Regular training helps to maintain standards of documentation and can meet the needs or deficits in care planning skills identified in the audit of records.

UKCC guidelines

The UKCC identifies record keeping as a fundamental part of nursing and midwifery practice. The Guidelines for Records and Record Keeping (UKCC 1998) promote good record keeping as a mark of the skilled and safe practitioner. Accurate records protect the welfare of service users by promoting:

- High standards of clinical care.

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Keeping (UKCC 1993) states that inadequate and ineffective record keeping may lead to:
- Impaired continuity of care;
- Discontinuity of communication between staff;
- The risk of medication or other treatment being duplicated or omitted;
- Failure to focus attention on early signs of deviation from the norm;
- Failure to place on-record significant observations and conclusions.

The Sainsbury Centre (1998) survey reports that many care plans included goal statements, such as, ‘To develop a therapeutic relationship with the patient’ with no description of how this should be achieved. Very broad statements are generally unhelpful. A more specific and focused client-centred approach is necessary. Box 3 identifies other general and meaningless phrases in common use.

All too often, care plan statements, problems and goals are similar for any number of service users on a particular inpatient unit, despite those individuals having quite different experiences and needs. Care plans should be specific to the individual, i.e. individualised. The types of statements in Box 3 may identify what mental health nurses do as a routine part of their work with all service users. Such statements do not individualise a care plan nor provide a plan of service user-centred care. However, they may indicate the broad approach to care that is adopted by nurses on the unit. They could be used to reflect the overarching context of care and, for example, be incorporated into a unit or ward philosophy.

Additional problems include the interchangeable use of problem/need statements, goal statements and interventions; the use of terms or statements that are vague and unclear; that focus on the nurse’s responsibility rather than the service user’s needs or problems; and statements that are too prescriptive, unrealistic, verbose and lengthy. The use of abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements; be readable on any photocopies.

Records should also:
- Be written wherever possible, with the involvement of the service user or their carer;
- Be written in terms that the service user can understand;
- Be constructive;
- Identify problems that have arisen and the action taken to rectify them;
- Provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

Box 3. Care plan clichés

- ‘Assess mental state’
- ‘Maintain a safe environment’
- ‘Establish one to one’
- ‘Establish one to ward environment’
- ‘Develop a therapeutic relationship’
- ‘Give medication as prescribed’
- ‘Monitor signs and symptoms’
- ‘Allow patient to ventilate his/her feelings’

Common problems with care plan statements

The UKCC’s Standards for Records and Record Keeping (UKCC 1993) states that inadequate and ineffective record keeping may lead to:
- Impaired continuity of care;
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REFERENCES


Assessment

Assessment involves identification of both problems and needs. Nursing care plans often use the terms interchangeably with ‘Problem/Need’ headings. Problems and needs may be related directly – problems caused by unmet need. However, it may not be so straightforward in practice. Problems may arise despite the needs of the individual, for example, when the nature and severity of mental illness involves the risk of violence to others. Problems for the individual client may arise because of the healthcare system. For many people, the experience of hospital admission is itself, distressing. The needs of the individual client may be compromised by a range of factors, including the level of social support, access to services, appropriate treatment and care.

Clients will be admitted to acute inpatient units with a wide range of problems and needs. It is neither possible nor appropriate to address all of these at once. It will be necessary to prioritise problems and needs for the period of admission. The reason for admission and associated factors or circumstances may provide a focus for the process of setting priorities in care. Problems and needs may be prioritised in relation to:

- the client perspective;
- resources – including available services and interventions;
- the risk of harm to self, to others, and of self-neglect.

Urgent problems and needs may be those associated with risk of harm to self and others, and self neglect that need to be addressed immediately. An urgent problem may have been resolved by hospital admission. Problems and needs may be important but not urgent. Perception of importance and urgency will vary according to individual attributes and characteristics, circumstances, timing, information and resources.

Prioritising problems and needs:

The goal of care is the end point or broad outcome that one strives to attain. Goals identify the desired outcome associated with health gain for the client, i.e. a client-centred outcome. The identification of goals is part of a purposeful therapeutic process established within the context of the nurse – client relationship. Goals convey what it is that is to be achieved. The achievements of specific goals may represent improvements in other areas of functioning. Objectives are often used in care planning. These may be steps towards a goal or components of goals. Objectives may focus on a reduction in the incidence of a problem or need. They should be practically achievable, given the time and resources available. Ideally, goals and objectives represent a change desired by the client. In order to identify desired outcomes, it may be helpful to consider: ‘What do I (the nurse) expect to see or do and what do I (the service user) expect to see or do – as a consequence of the intervention?’

The outcomes of care specify the end result or desired improvement – need to be observable, measurable or quantifiable in some way. For example, a change in the rate or frequency of a particular

Identifying problems and needs

Assessment involves the initiation of a therapeutic relationship between nurse and client.
behaviour. Outcomes need to be identified and recorded prior to interventions being carried out. Jenkins (1990) suggests this process involves:
1) Assessment and identification of individual problems and needs.
2) Precise definition of goals, objectives, outcomes or targets.
3) A review of available resources, strategies and interventions.

The process of setting goals, objectives and outcomes can be both therapeutic and evaluative. This is particularly so, if they:
- are desirable to the client;
- are negotiated between the client and the nurse;
- indicate a commitment to change;
- clarify complex problems;
- relate to long-term improvement.

Interventions are the actions that will be implemented in order to reach the goal. Once the goals are agreed, the interventions – the possible and likely means of achieving the goals – can be identified. The identification of appropriate interventions involves clarity about the results you hope to obtain. Interventions should be consistent with the goal. They should be:
- client-centred;
- achievable;
- evidence-based;
- oriented to health need or gain.

The identification of planned, regular interventions in the care plan promotes consistency and continuity in the approach to care. The rationale and purpose for the intervention, i.e. why it is required, should be identified, along with who will implement it, and when. A review date should be set.

Evaluation This focuses on all components of the plan, i.e. the interventions, the outcome of interventions in relation to the goals, and achievement of goals. You may evaluate whether or not interventions are being implemented and whether goals are being achieved. The effectiveness of interventions is determined by evidence that the desired results have been achieved -- the demonstration that the client has accepted, used or otherwise benefited from the intervention. Clearly, merely recording interventions does not mean they are being implemented and whether goals are being achieved.

Evaluation of interventions involves consideration of continuing the effort, and of the feasibility of trying different interventions. It may involve a re-assessment of the original problem. The initial assessment should be based on a baseline of comparative information -- a measurement against which evaluative judgements about planning and implementation of the plan may be made. Now do Time Out 7.

Conclusion

This article promotes the use of the care plan as a therapeutic tool that can be used more effectively on acute units. The relationship between different elements of the care plan should be clear, with continuity and consistency across problems and needs, care goals and objectives, interventions, outcomes and evaluation.

Box 4. Tools for composing care plan statements

Writing problem statements

It may be helpful to write a care plan statement that links the problem to any causative, or triggering, factors, along with the main effects or result. Gordon (1997) identifies a structure or template for this type of statement, referring to it as a PES problem statement format. 'The problem (P) is caused by (E) which results in (S)'. This statement identifies the health problem (P), key etiologic or related factors (E) and any defining characteristics, signs or symptoms (S).

For example: 'John's anger is caused by his difficulty in talking about how he feels, which leads to him taking his aggression out on those he is close to, for example, his wife Mary.' Alternatively -- use the service user's own words to describe the problem:

For example: John says: 'I just can't help myself, nobody listens to me and I don't know what to do. I never meant to hurt her.'

Writing objective statements

Objective statements have three main components:
- The desired or observable activity or behaviour.
- The conditions -- the circumstances under which the behaviour or activity takes place, for example, the amount, frequency, or duration.
- Criterion -- the level, quality or standard on the objective behaviour.

Behavioural objectives focus on the desired or objective behaviour as an outcome. 'Who (subject) -- will do what (behaviour) under what circumstances (conditions) -- to what degree of success (criterion)'. For example, John will approach his key worker when he feels frustrated and begins to get angry and use anger management techniques he has identified to control his feelings, safely.

Explanatory objectives focus on processes of verbal or intellectual activity, rather than the observable behaviour as an outcome. 'Who (subject) -- will do what (verbal or intellectual activity) under what circumstances (conditions)'. For example, John will meet with his key worker to discuss his angry feelings and appropriate ways of dealing with them.

A less prescriptive use of these statements may be used, for example, replacing 'Who will do what with ‘... has agreed to ...' or ‘... wants to ...'.

Writing SMART statements

Statements in care plans share the qualities of SMART statements. These are Specific, Measurable, Achievable, Realistic, and Time bound.

TIME OUT 7

With a colleague, as part of your clinical supervision, focus on a care plan you are using. Identify whether any of the issues identified in the section, 'Common problems with care plans' apply to your care plan. Use the tools in Box 4 to review and rewrite the care plan. When you feel confident, take the care plan to the client and include him or her in the process.

Service users and their carers should be involved in care planning, with the assessment phase used as a means of initially engaging them in this process.

The importance of the care plan as a legal document is emphasised and standards for record keeping reinforced as a routine component of professional practice. Practical suggestions and guidance for writing more effective and accurate records have been provided as a means of improving clinical practice.