Trust-wide core care plans

This article discusses the concept and implication of core care plans. The authors also assess the effect of the introduction of core care plans introduction within the Scarborough and North East Yorkshire Healthcare NHS Trust.

Date of acceptance: June 12 1997.

Since its adoption from the US some 20 years ago, the nursing process and its essential component the individualised patient care plan, have been promoted as the theoretical and philosophical basis of British nursing and the method of organising and delivering care. It was introduced against a background of discontent with existing ways of nursing and its aim was to integrate nursing theory and practice and implement more satisfactory methods of care delivery (Daws 1988). However, there is evidence to suggest that the use of the nursing process and care planning has been difficult (Audit Commission 1991, Batehup and Evans 1992, McMahon 1988).

EVOLUTION OF CORE CARE PLANS
Several authors have advanced reasons why implementing the nursing process has been problematic including:

- The 'top down' approach and the speed which characterised its introduction into nursing in the UK (De la Cuesta 1983, Ford and Walsh 1994, McMahon 1988)
- Minimal preparation and education to enable nurses to accommodate the change (De la Cuesta 1983)
- Lack of perceived value of care plans by nurses
- The time involved in writing care plans reduces actual nursing time to 'care' and contributes to work pressure and stress (McElroy et al 1995, Rundell 1991).

Since the introduction of the nursing process, nurses have experimented with a variety of care planning methods, including hand written care plans, standardised care plans and, more recently, computerised systems. Glasper et al (1987) highlighted the conflict between the reality of ward workload and the philosophy of the nursing process. Wright (1990, 1987) described how during a process to develop a nursing model for the Tameside Nursing Development Unit in 1986, a number of common factors featured repeatedly, leading to the formulation of 'core care plans' for the most commonly encountered practice problems.

Wright (1990) and Glasper et al (1987) suggested that the benefits of standardised or 'core' care plans are:
- Reducing the complexity of care planning activity
- Saving time
- Improving the standard of documentation
- Increasing the accessibility of care plans for patients

As Wright (1990) pointed out: 'Realistic plans must be concise and precise otherwise they are of no value in the practice setting...and become purely academic exercises.'

Few studies have been conducted to investigate which system of care planning is the most effective. A study undertaken by Bakken Henry et al (1994) looked at the use of different types of care plans for people with AIDS, hospitalised because of pneumonia. No difference was found between the type of care plan used and patient outcome, but the use of standardised care plans did increase the total number of plans in use.

Bakken Henry et al (1994) concluded that the improvements occurred because the standardised care plans were less labour intensive to complete. Bowman and Thompson (1987) however, warned that using standardised care plans could undermine the importance of the assessment phase of the nursing process and stifle creativity and the development of nurses’ decision making skills. It is important, therefore, to consider the potential pitfalls as well as the potential benefits of implementing any system of care planning.

INTRODUCING CORE CARE PLANS
The nursing directorate at Scarborough and North East Yorkshire Healthcare NHS Trust considered the introduction of core care plans for several reasons:
- A Delphi study (Gibson 1996) undertaken by the directorate showed that nurses felt they required more skills in care planning
- The trusts’ nursing audit programme showed consistently that wards that used core care plans achieved a higher ‘monitor’ score (Goldstone and Fearon 1995)
- The surgical division was on the verge of introducing a system of graduated patient care. It was felt that improved care planning was imperative to ensure the success of this initiative.

In order to formulate the core care plan, a group of senior nurses from across the trust was established. The group was led by the assistant chief nurse and the remit agreed and circulated (Box 1). Within a period of three months, 76 core care plans had been written, circulated and agreed. An example of one core care plan can be seen in Box 2.

The group discovered that there were additional
benefits to the process of producing the plans. During the process inconsistencies in practice were identified. One example was the use of filters when transfusing blood. Within the trust some wards always used filters, some only after three units and some not at all. Following advice from the transfusion department it was decided that filters were not necessary when using transfusion-giving sets and the core care plans reflected this decision.

The introduction of core care plans was led and supported by the clinical practice development nurse (CPDN), a new nursing role set between nursing practice, management and continuing education. The role is pivotal for developing practice. Negative attitudes to care planning in the past have been related to a perceived lack of support from nurse managers (McElroy et al 1995) and insufficient education (De la Cuesta 1983). A combination of rational and empirical approaches to change management was employed in order to ensure that all staff were familiar with the project rationale.

October 1 1996 was the launch date for using new care plans and was widely publicised throughout the trust. The CPDN attended divisional and professional meetings, met with the ward managers and as many nurses as possible to explain the implementation, discuss any concerns and identify educational needs and potential problems. This ensured that both staff and management were prepared for change, that potential problems could be identified and eliminated and that the CPDN could identify the level of support and education required by different clinical areas.

Each ward received a folder containing the first series of pre-printed core care plan laminates from which to photocopy. The folder also contained an explanation of how to use them together with a copy

Box 2. Example of a core care plan – pressure sore risk

<table>
<thead>
<tr>
<th>Name</th>
<th>Unit Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORE CARE PLAN</td>
<td>RISK OF DEVELOPING PRESSURE SORES</td>
</tr>
<tr>
<td>Problem</td>
<td>High pressure risk score and is at risk of developing tissue damage</td>
</tr>
<tr>
<td>Problem No</td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>Prevention of pressure sores</td>
</tr>
</tbody>
</table>

Interventions

- Identify pressure sore risks using the Waterlow Score on admission and repeat assessment
- Complete tissue viability documentation as hospital policy
- Nurse on appropriate pressure relieving mattress/equipment (specify)
  Reposition patient every hours. Inspect risk areas and record any changes
- Encourage and assist patient with independent movement as condition allows
- Maintain adequate hydration and nutrition and refer to dietician if condition indicates
- Maintain good personal hygiene
- Other

Signature

Date | Evaluation | Signature
--- | --- | ---


of the trust’s policies relating to care planning and nursing documentation. A further series of care plans has been developed and introduced subsequently. Since the introduction of the new care plans, the CPDN has visited the relevant clinical areas on a regular basis and attended ward meetings to discuss any problems, answer queries and provide support to staff. In addition, the CPDN has conducted ward- and classroom-based teaching sessions about the nursing process, care planning and nursing documentation.

**EVALUATION**

The introduction of this care planning system is aimed at ensuring the standard of nursing documentation is consistent with professional and legal requirements. The impact of the system on the standard and completeness of nursing records must, therefore, be subject to an ongoing evaluation process. Established methods, such as documentation audit and quality indicators, were implemented between February and April 1997 to provide baseline data for the audit cycle.

The system has not been in place long enough to assess whether significant improvements in practice have occurred. Although recent audits have been conducted with greater rigour and depth than in previous years which means results cannot be directly compared with those obtained before the implementation of core care plans, the indications are encouraging.

Monitor scores relating to goals of care and the methods used to achieve them, have improved significantly across the trust. Documentation audit identified that care planning correlated well with the assessment phase of the nursing process, as most care plans in use could be related to identified problems. But evidence also suggests that duplication of information between the care plan evaluation and other records still occurs. There is also some uncertainty about what should be documented in the evaluation section of the core care plan.

In general, the core care plans have been well received by nurses on the wards. Nurses on duty while the audit was taking place were asked to complete a four-item questionnaire which had a 50 per cent response rate. Of these, 87 per cent said core care plans were easy to use, 53 per cent that the plans saved time, 52 per cent that they enabled nurses who were unfamiliar with the ward, for example bank or agency staff, to provide patient care immediately, 61 per cent noted that the plans helped with the delivery of care to unfamiliar patients, for example people transferred from other areas of the trust. Relevant information about care is easier to locate when everyone is using the same system. However, staff comments indicated that the usefulness of core care plans depends upon proper completion.

The introduction of core care plans has profound and far-reaching implications for the evolution of nursing practice, not least that such a project aims to stimulate thought and discussion about nursing activity. The processes of such projects are, therefore, as important as the outcomes. For example, although the care plan working group did not refer to models or care plans that had been developed elsewhere, it was interesting to discover similarities between the plans and those developed in other areas (Wright 1990).

The CPDN will continue to liaise with ward managers and staff and utilise audit information to plan, implement and evaluate further practice development activities. This also requires the identification of nurses’ current attitudes towards care planning and its use in everyday clinical practice. The first phase of a research project, based on Shea’s (1986) conceptual framework of the motivating factors involved in care planning behaviour, is currently in progress to examine nurses’ attitudes to using care plans.

**CONCLUSION**

The UKCC (1993) guidelines state that nursing records should be ‘an essential and integral part of care and not a distraction from its provision’. The second phase of the project will be to identify how far these attitudes are reflected in care planning practice within the trust and the degree of integration of care planning with other aspects of nursing work.

Nurses working in the community and a neighbouring trust hospital have expressed interest in implementing core care plans and the group has taken on new members to assist in this process.