

Developing nursing care plans

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Abstract

This article aims to enhance nurses' understanding of nursing care plans, reflecting on the past, present and future use of care planning. This involves consideration of the central theories of nursing and discussion of nursing models and the nursing process. An explanation is provided of how theories of nursing may be applied to care planning, in combination with clinical assessment tools, to ensure that care plans are context specific and patient centred.

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Keywords

care bundles, care pathways, care plan, care planning, critical thinking, models of care, nursing process, nursing theory, patient-centred care

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Aims and intended learning outcomes

This article aims to enable you to develop a comprehensive understanding of nursing care plans so that you may begin to critique, adjust, develop and adapt them to suit the requirements of different contexts of care. After reading this article and completing the time out activities you should be able to:

- ▶ Outline the concepts and processes of planning care that enable you to use nursing care plans effectively.
- ▶ Discuss how nursing models and the nursing process relate to nursing care plans.
- ▶ Describe how nursing care plans can benefit patients and nurses.
- ▶ Identify potential problems with nursing care plans in practice.
- ▶ Outline the advantages and disadvantages of using nursing care plans in practice.

Introduction

Nursing care plans are based on nursing theory, which is taught throughout nurse education, but is seldom revisited thereafter. Nursing care plans are complex, involving many aspects of nursing theory and practice. Therefore, nurses may find it difficult to understand how these aspects relate to care planning in practice.

The terms 'care planning' and 'care plan' are often used interchangeably. This contributes to misunderstanding of the theory of care plans, encouraging some nursing staff to dismiss them as irrelevant to practice. 'Care planning allows a nurse to identify a patient's problems and select interventions that will help solve or minimize these problems' (Matthews 2010), and 'Care plans are the written records of this care planning process' (Barrett *et al* 2012). Essentially, care planning is the action, while a care plan is a record of that action.

Evolution of planning nursing care

In 1978, the planning of nursing care was becoming a common topic for discussion in the nursing profession (Clarke 1978). In contrast, a nurse job analysis in 1953 did not recognise or include care planning as a nursing task (Goddard 1953). Reflecting on past ways of working, Lelean (1973) observed that nursing care was often dictated by ward routine. It was a functional, activity-based method of nursing where patients became names on a list according to the procedures they required.

There are anecdotal stories of care being provided by word of mouth, via bath books, TPR (temperature, pulse, respiration) books, dressing books and work lists. This reflected a task-based system of nursing, where the emphasis was on the activity rather than the patient. However, by implication, there was planning of care using these lists, since care was provided and patients' needs were met. The aim now is to provide individualised care, with emphasis on the patient's unique needs.

This evaluation of care planning in nursing history does not make the assumption that nursing in the 1960s and 1970s was poor and nursing in the present day is better, nor does it reflect the level of care given or the outcomes experienced. Nurses have always planned, carried out and documented that care, albeit in varying levels of detail. It is the method of planning care that has changed over time (Walsh 1998). For example, consider a dressing change. In the 1970s, the care was planned in the dressing book, the task ticked off once completed and plans made to repeat the care if required, with a further entry in the dressing book. One can speculate that care plans may be required now more than ever, given the increased complexity of care, access to information and changing healthcare environments.

The nursing process

The development of the nursing process (Yura and Walsh 1967) may be considered the most influential change in approaches to thinking about nursing care. The nursing process is a clear and straightforward cyclical model, consisting of four concepts of nursing: assessment, planning, implementation and evaluation. The central consideration of the nursing process is that it looks first at the patient and then thinks about the care that is required, rather than deciding what care the patient needs and then looking at the patient and how this might be implemented. The emphasis is on patient assessment, encouraging

nurses to identify with the patient's potential and actual health problems (Aggleton and Chalmers 2000). Assessment may be considered the first stage in the planning of nursing care, since it starts the process of gathering information to make decisions about suitable interventions.

In general, planning nursing care is the process of setting goals that provide benchmarks for evaluating care. These goals may be adapted after the nursing intervention has been implemented. Modifications to this process may be used, depending on factors such as the culture of nursing, the context or the patient. A nursing diagnosis stage may be inserted between the assessment and planning stages. Carpenito-Moyet (2009) stated: 'a nursing diagnosis is a clinical judgment about individual, family or community responses to actual or potential health problems/life processes.' Therefore, a nursing diagnosis acknowledges the actual or potential health problem and labels it. 'A nursing diagnosis is commonly referred to as a diagnostic statement or identification of problem or need' (Matthews 2010). This stage is not often used explicitly in the UK. However, it may be argued that it is used implicitly throughout the nursing process since patient needs are identified and addressed. For example, consider a patient handover, where nursing diagnoses are often made after a formal assessment, and several nursing diagnoses, for example, anxiety, risk of impaired skin integrity and disturbed sleep pattern, may be used routinely.

If one applies the nursing process to a familiar life activity, such as buying a house, it is possible to understand its usefulness. A family plans to move house; the assessment consists of a list of needs, for example a garden, a primary school nearby and three bedrooms. The process is planned; visiting estate agents or using online tools. The intervention is when the family moves in. Evaluation of the situation is continuous, as the family assesses the house, lives in it, adapts it, reassesses and possibly moves out once their needs change.

Complete time out activity 1

Other nursing models

The next aspect of nursing theory to consider, while keeping the nursing process in mind, is nursing models. These models offer a range of beliefs and values to guide nurses through the stages of problem-solving and provide direction regarding that which is relevant and important (Barrett *et al* 2012). Walsh (1998) described the nursing process as a tool to provide structure to



1 Make a note of all the nursing models you can think of. Consider them individually and try to remember the basic principles of each. Is there any particular model which you believe applies best to your place of work? Discuss this with a colleague to find out if you agree.

care delivery and models of nursing as tools to instruct us on how care should be given.

Several definitions of nursing models refer to their use in the nursing process. They often provide detail to be used in conjunction with the nursing process to facilitate care. Many nursing models fit into one or more of the four stages of the nursing process. However, several nursing models were published before the nursing process was formalised. This lends validity to the nursing process, since it indicates that the process was in use informally before it was formally documented.

Models of nursing can be abstract and difficult to measure, yet are practised daily, usually without a formal label. Different models prioritise different aspects of care and reflect the care priorities of the nurse. Nurses in different environments provide care in a structured and detailed way, but their priorities and action points differ. For example, the priority in a critical care unit is to manage the needs that patients are unable to manage themselves, while the emphasis in an outpatient clinic may be on assisting patients with self-care and self-medication.

Certain models of nursing prompt nurses to ensure they are assessing the whole patient and nursing holistically. The Roper-Logan-Tierney model of nursing based on activities of daily living is frequently used in assessment and admission documentation (Roper *et al* 2000). King (1981) developed a model that emphasised the importance of therapeutic relationships, the ability of all humans to interact meaningfully with one another in pursuit of a common goal. This led to a shift from the four-stage nursing process towards developing a goal-oriented nursing record. King (1981) identified the importance of communication and information sharing when setting goals, since without communication, goals are unlikely to be met. Therefore, King's (1981) model emphasises the importance of excellent communication skills to establish a beneficial interaction to achieve the goals of care, rather than a checklist of aspects to cover in the patient assessment.

The Neuman systems model focused on the person as consisting of a core of resource, with several lines of resistance or defence (Neuman and Fawcett 2010). The model suggests that these lines of resistance fluctuate according to physiological, sociocultural, psychological, spiritual and developmental variables. A person experiencing an extreme level of any of these variables may find it difficult to resist their effects and may experience symptoms of ill health. For

example, a patient with a supportive family, no comorbidities and an effective relationship with their GP may recover more quickly from a myocardial infarction than a patient who is recently divorced and has type 2 diabetes and a history of missed GP appointments. In this model, nursing is required when the line of resistance has been diminished and can no longer protect a person. The emphasis is on preventive health to ensure that the patient is well-equipped to resist any stressors that may arise as a result of their diagnosis.

Each of these models of nursing has different priorities. By including selective aspects of each of the models, it is possible for the nurse to develop patient centred, context-specific care plans that enable high quality care planning and comprehensive documentation. For example, a care plan encompassing aspects of the Roper-Logan-Tierney, King and Neuman models might adopt a holistic approach to the patient to ensure physical symptoms are assessed and self-care goals are set, and to initiate a therapeutic relationship to facilitate interventions and further assessment as required.

Despite their long history, models of nursing are still debated. Bakker and Mau (2012) stated that it is essential to incorporate the opinions of the main partners in care to develop a model of nursing that best reflects professional nursing practice. This approach encourages the development of models of nursing, where patients and the multidisciplinary team are consulted. Care pathways are one application of this theory.

Care pathways

Care pathways were first used in the 1990s in the United States and have been employed in the NHS in a range of clinical settings since 1992. They were introduced as a means of assisting healthcare professionals to deliver high quality, evidence-based and cost effective care (Kozier *et al* 2008). Walsh (1998) explained that in developing a care pathway, all professionals involved in patient care are brought together and come to a consensus about the standards of care and expected outcomes for selected patient groups within an agreed time frame.

Care pathways stimulate debate and discussion. Some patients meeting certain criteria will require the same general treatment. These treatments may be pharmaceutical, for example pain relief or they may be clinical, such as the placement of an intravenous cannula. The care pathway provides a stimulus to deliver and record such interventions. The idea of all patients

receiving the same treatments contradicts the concept of holistic patient-centred care that nurses are encouraged to deliver. However, if patients meet relevant criteria, standard interventions can be performed, freeing up time for individual care in other areas.

Clinical assessment tools

Clinical assessment tools are often used as a part of the nursing process and care pathways. They may be considered as a modern addition to nursing models that enable the nursing process. Clinical tools, for example the Glasgow Coma Scale (www.glasgowcomascale.org), aim to ensure that care is consistent, considered and appropriate to each patient. Using clinical assessment tools also provides a baseline from which to measure variation, improvement or deterioration in the patient's health status as care progresses.

Assessment skills may vary widely between staff and clinical tools provide guidance and objectivity to counter instinctual assessment. A patient with a normal blood pressure, heart rate and respiratory rate may still feel unwell, and the nurse should be able to reassure the patient and perform an assessment based on different priorities. The nurse may perhaps question the feelings of the patient; are they scared, confused or anxious?

Care bundles

The use of care pathways is a departure from a patient-specific nursing care plan. This may be redressed in part by including definite clinical instructions for specific problems. Care bundles were created by the Institute for Healthcare Improvement (2016a) to meet this requirement. A care bundle is a group of evidence-based best practices related to a disease or set of symptoms that result in improved outcomes when they are implemented together than when they are implemented individually (Norman 2010). For example, the Institute for Healthcare Improvement (2012) developed an evidence-based list of interventions that were linked to reductions in ventilator-associated pneumonia in patients in intensive care units. These interventions included positioning of the patient's head, regular assessment for extubation, oral care and daily sedation breaks.

Care bundles promote efficiency and patient safety, establish high quality care, and are cost effective and reason based, thus contributing to improved patient outcomes (Norman 2010). They are usually used in conjunction with

the nursing process. Nurses plan their care, gathering equipment and thinking it through; intervene, performing the care; and continually evaluate, ensuring the patient remains stable. In this way, the care bundle is applied to the intervention aspect of the nursing process, linking specialist clinical knowledge with fundamental nursing theory.

National Service Frameworks are extensions of the care bundle. They have been developed at government level to address high priority, high mortality diseases. They directly affect the care provided since they set clear requirements for care based on the best available evidence (Kozier *et al* 2008). Moreover, they provide guidance and support for organisations to enable them to achieve these requirements.

Complete time out activity 2

Critical thinking


There are many useful tools and models that assist in the planning of nursing care and consequently the production of useful, patient centred, contextual care plans. To date, the development of standardised care plans for individual nursing diagnoses or conditions has been the next step in the process of care planning. Not every model or clinical tool will be used in each care plan. Equally, every patient is different. Critical thinking skills should always be applied to practice to ensure that nurses do not make assumptions or work unquestioningly.

Price and Harrington (2016) described critical thinking as a process in which information is gathered, sifted, synthesised and evaluated, to understand a subject or issue. They applied this in practice, explaining that critical thinking enables the nurse to function as 'a knowledgeable doer, someone who selects, combines, judges and uses information to proceed in a professional manner'. Nurses cannot apply standard care plans to all patients and, therefore, critical thinking ensures that care is patient centred and adapted as necessary.

Complete time out activities 3 and 4

Role of nursing care plans

When applying critical thinking to nursing care plans, it should not be assumed that care plans are always beneficial because they have been around for years. Kaufman (2012) described nursing care plans as the common language of nurses, indicating a clear familiarity with them and potential reliance on them. However, this should not prevent nurses questioning the use



2 Refer to the Institute for Healthcare Improvement (2016b) document on using care bundles to improve health care. In particular, source statistics on how care bundles have improved patient outcomes for aspects of acute care. Discuss with a colleague how you could improve patient outcomes in your clinical area.



3 Nursing and Midwifery Council (NMC) revalidation, which comes into effect on April 1 2016, encourages nurses to consult their code of conduct and reflect on how it links to their professional practice. Read *The Code: Professional Standards for Practice and Behaviour for Nurses and Midwives* (NMC 2015). Which parts of *The Code* may be directly related to the use of nursing care plans? Reflect on how your practice adheres to these parts of *The Code*. Compare your answers to the points mentioned later in this article.

4 Nurses are required to keep a portfolio of evidence for revalidation. Planning activities and identifying development aims is an essential part of preparing for revalidation. Using a nursing care plan or nursing process format, write a plan for the upcoming year. Assess your development needs, plan goals, and include courses you might like to participate in, and the people you might need to speak to, to realise your plans. Use the document throughout the year to monitor your progress and re-evaluate the skills and knowledge you need to acquire.

of nursing care plans and their role in clinical practice. When asking: ‘What is the role of the nursing care plan in practice?’ there are three main answers:

1. To facilitate standardised, evidence-based, holistic care.
2. To record care.
3. To measure care.

A nursing care plan can facilitate holistic care for patients, when used by nurses throughout their career. A nursing care plan can be used as a learning tool (Kaufman 2012), whereby a novice nurse may rely on such a plan to guide their practice. Experienced staff may rely more on their experience. However, providing nursing care is challenging and there are several potential barriers to care.

Shorter lengths of patient stay, higher patient acuity and technological advances are factors that may restrict the amount of time available to care for patients (Norman 2010). Other issues that may affect patient care include staffing levels and an increasing number of complex patients with multiple comorbidities. A useful and relevant nursing care plan may help a member of the nursing team to acknowledge these barriers and work around them. Moreover, such barriers mean that the standard of care cannot always be relied on; omissions may be made and human error is more likely. A documented care plan can offer guidance and clarity and may also provide justification for using nursing time to ensure a thorough patient assessment.

Nursing care plans can also be used to record the care that has been given. This allows nursing staff to acknowledge the care provided, share it to ensure continuity and reassess its effects and patient needs as required. This documentation enables nurses to demonstrate that they are working within the professional standards of practice outlined by the NMC (2015). *The Code: Professional Standards for Practice and Behaviour for Nurses and Midwives* (NMC 2015) states: ‘nurses must keep colleagues informed when sharing the care of individuals with other healthcare professionals and staff’. It requires registered staff to keep ‘clear and accurate records relevant to their practice’ and states that this documentation should be contemporary, kept secure and attributed to the professional in question. A comprehensive nursing care plan that has documented care meets these requirements, and may protect the nurse in the case of a complaint or disciplinary action.

Lastly, and perhaps most controversially, a nursing care plan allows care to be measured. The requirement to measure care and ensure that it meets essential standards and benchmarks may be seen by some nursing staff as time-wasting. Historically, nursing has been seen as a vocational act, noble and self-sacrificing. The requirement to assess the care given may sometimes be seen as an affront to the experience, expertise, disposition and personality of a nurse. However, measurement of care is essential to ensure that patients are receiving the same level of care, despite being cared for by different nurses with different levels of education and experience, and with different priorities and models of working.

One important criticism of nursing care plans is the difficulty in maintaining their relevance as patient needs change. LaDuke (2008) remarked: ‘Today’s nurse continually receives and analyzes new data, rapidly transforming them into action amid crushing workloads. Any care planning document that requires constant manual revision to reflect this changing information is a problem, not a solution.’ LaDuke (2008) concluded that nursing care plans belong in nurse education and should not be used in clinical practice unless they can be guaranteed to provide real-time information with test results and specific instructions for implementation.

Care Planning in the Treatment of Long Term Conditions: Final Report of the CAPITOL Project (Department of Health (DH) 2012a) provided interesting insights. The report acknowledged that: ‘Care plans are designed to provide a record of agreements between patient and professional about goals and preferences, and to help to organise services around the needs of individual patients and ensure that needs are regularly reviewed’ (DH 2012a). The report was designed with the aim of assessing the implementation and outcomes of nursing care plans within the NHS. The DH (2012a) report found that there were so few care plans in place that part of the CAPITOL project was shifted to focus on identifying the perceived and actual barriers that prevented care plans being put in place, rather than evaluating their usefulness.

The DH (2012a) report identified ambivalence concerning the effectiveness and relevance of care plans and a lack of clarity on how the care plan should be structured, especially in relation to comorbidities and the contributions of multidisciplinary staff at separate locations. Where limited time



5 Design a nursing care plan using the 6Cs of nursing as a basic framework for a group of patients you are familiar with. Try to ensure that all their needs are accounted for.

6 Critique a nursing care plan that you use in practice. Attempt to identify its strengths and limitations. Does it provide patient-centred care? Is there anything missing? Is the format easy to use? How would you change it?

7 Now that you have completed the article, you might like to write a reflective account as part of your revalidation. Guidelines to help you are on page 62.

was available, the report established that care plans were given lower priority when compared with other markers of care. For example, there was increased understanding of the Quality and Outcomes Framework (QOF) programme (Health and Social Care Information Centre 2016) – a voluntary programme that awards achievement points to GPs when managing long-term conditions such as asthma or diabetes. When combined with incentives, the QOF was used more readily. The DH (2012a) report demonstrated that the effects of effective care plans and care planning were unclear and that further work was required to improve levels of care planning which may result in patient benefits. **Complete time out activity 5**

Discussion

Keogh (2015) stated that the essence of professionalism is being able to describe the services you provide and define how well you do it. A clear, accurate and contemporary nursing care plan should enable nurses to achieve this, maintaining professional integrity while providing excellent evidence-based care.

There are many unanswered questions regarding care plans. Further investigation is required to determine if wards that are failing to deliver basic care use care plans routinely. Radcliffe (1999) observed that care plans for children under five years have been held in their home with their parents for many years. This ‘red book’ has documented nursing care, providing healthcare goals, guidelines and care notes. Therefore, would optimum care planning be achieved when patients are able to write their own care plan with the help of the nurse, read it at the end of their care and evaluate it for themselves?

It is difficult to reach a conclusion on the benefits of nursing care plans. The evidence is contradictory and differences in the information and structure between healthcare organisations make direct comparisons difficult. Perhaps we are attempting to standardise aspects of nursing care that cannot be standardised. Considering the 6Cs of nursing: care, compassion, competence, communication, courage and commitment (DH 2012b) as a set of goals for nursing, is it possible to equate a clear, accurate nursing care plan with a compassionate and caring nurse? Comprehensive nursing care plans may not compensate for the absence of beneficial personality traits that patients would like to see in nursing staff.

Complete time out activity 6

Conclusion

Nursing care plans may be used as a tool to promote holistic care. The care planning process is central to patient-centred care, enabling nursing staff to plan the interventions and, where possible, discuss them with the patient. However, health care is complex. Different groups of patients require different interventions and different care goals. A care plan for one patient may not suit another, even if they have the same needs. Therefore, care plans should be used with consideration.

Nurses should continually question the care they provide and evaluate their plan of care. Selective use of tools by nurses, for example care plans, care bundles, care pathways, and clinical assessment tools, can result in a patient-centred care plan that facilitates the delivery of care, ensures that nothing is forgotten, and records and measures the quality of care, to the benefit of the patient and the nurse **NS**

Complete time out activity 7

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Nursing care plans

TEST YOUR KNOWLEDGE BY COMPLETING SELF-ASSESSMENT QUESTIONNAIRE 832

1. Care planning enables nurses to:

- a) Identify a patient's problems
- b) Select interventions that will help solve a patient's problems
- c) Select interventions that will help minimise a patient's problems
- d) All of the above

2. Which is not a concept in the nursing process?

- a) Implementation
- b) Evaluation
- c) Discharge
- d) Assessment

3. Which is prioritised in King's nursing model?

- a) Therapeutic relationships
- b) Individual resources
- c) Activities of daily living
- d) Preventive health

4. Care pathways:

- a) Apply to all patients with a given condition
- b) Involve standard interventions
- c) Involve clinical interventions only
- d) Involve pharmaceutical interventions only

5. Care bundles:

- a) Apply to the evaluation phase of the nursing process
- b) Are a group of evidence-based best practices that result in improved outcomes when implemented individually
- c) Promote efficiency and patient safety
- d) Are based on specialist clinical knowledge

6. Clinical assessment tools:

- a) Are subjective
- b) Provide a baseline from which to measure variation, improvement or deterioration
- c) Depend on the level of skill of the nurse
- d) Depend on the nurse's intuition

7. Which of the following do UK National Service Frameworks address?

- a) High priority, high mortality disease
- b) High priority, low mortality disease
- c) Low priority, low mortality disease
- d) Low priority, high mortality disease

8. Critical thinking ensures that:

- a) Nurses make assumptions safely
- b) Care is patient-centred and adapted as necessary
- c) Individual judgement is unnecessary
- d) Alternatives are not considered

9. Which of the following is not a function of nursing care plans?

- a) To assist standardised evidence-based holistic care
- b) To co-ordinate multidisciplinary care
- c) To measure care
- d) To record care

10. What is the main purpose of measuring care?

- a) To ensure all patients receive the same level of care
- b) To identify staff training needs
- c) To justify staffing levels
- d) To ensure all staff are competent to practice

This self-assessment questionnaire was compiled by Beth Knight

The answers to this questionnaire will be published on March 9

The answers to SAQ 830 on discharging patients from acute care, which appeared in the February 10 issue, are:

- 1. d 2. a 3. c 4. b 5. d
- 6. c 7. b 8. b 9. a 10. c

How to use this assessment

This self-assessment questionnaire (SAQ) will help you to test your knowledge. Each week you will find ten multiple-choice questions that are broadly linked to the CPD article. Note: there is only one correct answer for each question.

- ▶ You could test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- ▶ You might like to read the article to update yourself before attempting the questions.

When you have completed your self-assessment, add it to your professional portfolio. You can record the amount of time it has taken. Space has been provided for comments.

You might like to consider writing a reflective account, see page 62.

Report back

This activity has taken me _____ hours to complete.

Other comments:

Now that I have read this article and completed this assessment, I think my knowledge is:

- Excellent
- Good
- Satisfactory
- Unsatisfactory
- Poor

As a result of this I intend to:
