*Personalized Nursing Care Plan

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Nursing Care Plan?

A nursing care plan is the written manifestation of the nursing process, which the American Nurses Association defines as "*the essential core of practice for the registered nurse to deliver holistic, patient-focused care.*"

The nursing process includes five key steps:

Personalized: designed or produced to meet someone's individual requirements. (Dictionary)

* NHS England (2015) has published guidance on delivering personalised care.
* There is evidence that personalised care planning can *lead to better patient outcomes* with, for example, *reduced hospital readmission rates* when inpatients are provided with *individualised discharge plans* rather than routine discharge care.

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COCHRANE NURSING CARE NETWORK

The effects of personalized care planning for adults living with chronic conditions

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CONCLUSIONS

Personalized care planning leads to improvements in certain indicators of physical and psychological health status and people's capability to self-manage their condition when compared with usual care. The effects are not large, but they appear greater when the intervention is more comprehensive, more intensive and better integrated into routine care. The authors concluded that personalized care planning is a promising approach that offers the potential to provide effective help to patients, leading to better health outcomes.

* Care plans can either be considered a ***bane*** or an ***invaluable tool*** to help focus efforts.

* Whatever end of the spectrum you fall on, love them or despise them, individualized care plans are a required component of many regulatory agencies.

* Knowing care plans are required doesn’t help move the needle towards the “love” side of the equation.

Even if the hospital requires care plans, unless it’s a strict requirement, there’s a good chance that nurses aren’t preparing one for every single patient

* because they’re too busy.
* overwhelmed with redundant paperwork.
* Most of the information in a nursing care plan is already required in multiple sections of each patient’s electronic health record (EHR), and nurses might not see the point in drafting an official plan of care.

* Unless care plans are required, nurses probably won’t make them.
* Unless care plans are useful, writing them will be perceived as more “busywork” — the bane of every nurse’s existence.

* The exercise of creating a care plan shouldn’t be a “check the box” chore.
* In addition to being a requirement, a care plan should be tailored to the Patient’s specific needs and diagnosis, as well as being utilized as a guide, teaching tool, or road map for continuity of care activities.
* Sounds great, right? Sure, but so far, this is just a reiteration of the fundamentals. Let’s get to “why” it is important to personalize a care plan.
* When you personalize a standardized care plan, you want to keep in mind that there is a balancing act between the evidence-based practices of the standard care plan and the Patient’s personal experience, individual needs, and perspective.

Care plans are a clear set of action that enable patient and healthcare practitioner to achieve a goal in relation to a specific problem or need.

* Problem/need/current ability
* Goal/aim/objective
* Action/plan/intervention

Problem: Mrs. Rekha has pain in her right knee due to recent surgery
Her pain score is 8/10 at rest

Goal: Mrs. Rekha would like to reduce her pain score from 8/10 to 4/10 in 4 days

Action:

1. Give prescribed analgesic 4 times a day
2. Mrs. Rekha will inform nursing staff if she requires additional analgesic for breakthrough pain
3. Record pain score 4 hourly
4. Mrs. Rekha has agreed to follow exercise regime planned by physiotherapist
5. Wound will be assessed for healing or any complications
6. Rekha will keep her feet raised on pillows
7. Rekha will inform healthcare personnel for any concerns or suggestions

All plan discussed and agreed by Mrs. Rekha

Sign of Nurse with date

S.M.A.R.T
Personalized
Collaborative
Concise
Legible

*Care plans should be

- Involve patient in decision making process
- How can the patient contribute to towards his/her care
- What decisions can he/she make
- Ensuring (where appropriate) that the patient takes ownership of his/her care plan

Personalized

Who else is contributing towards achieving the goal?

* Family
* Allied Health professionals
* Specialist
* Carers

*Collaborative

* Care plans should be to the point and have no ambiguity
* Team members should be able to coordinate the care exactly as planned
* Plan should be legible. All concerned should be able to read it.
* DONOT USE ABBREVIATIONS

Concise and legible

- Specific – *to the point - spell it out*
- Measurable – *pain score/ SPO2/spirometry/walking without assistance*
- Achievable – is goal realistic
- Relevant – *problem should in context and relevant to the patient. Goal should be relevant to the problem and action should be relevant to the goal*
- Timeframe – *realistic timeframe that provide guideline to review*

S.M.A.R.T

Focus of care

Continuity of care

Monitor progress

Communication

Timely referrals

Legal

* Why do we need to write care plans?

Care planning as part of the assessment process

A - ssess

S - et Goals

P - lan Care

I - nitiate the plan

R- eview and reflect

E - valuate

Assess

* Clinical assessment
* Listen to patient and identify what patient can do (ability prior to falling ill)
* Establish patient/family expectation of care
* Identify physical, social, psychological, spiritual needs

Set Goals

* What's important to patient
* What patient wants to achieve
* Working together for achievable goal

Plan Care

* What needs to happen to achieve the goal?

Problem: Mrs. Lal has lost 8 kg in last 6 months. She feels it may be due to nausea

Goal: Mrs. Lal would like to rregain some lost weight and enjoy her food. Aim is to gain 2 kg in 4 weeks.

Action:

1. Refer to doctor for assessment and investigation
2. Refer to dietician and review weekly
3. Mrs. Lal will maintain a food diary (To be reviewed weekly)
4. Mrs. Lal's daughter will bring home cooked food (in accordance with dietician advice)
5. Nursing staff will

- Encourage oral intake
- Administer anti-emetics as prescribed
- Maintain I/O chart,
- Intervene with IV fluids as prescribed
- Measure and record weight daily
- Monitor for s/s of refeeding syndrome

All plan discussed and agreed by Mrs. Lal

Sign of Nurse with date

Problem: Mobility

Goal: To be independently mobile

Action:

1. Refer to physiotherapist
2. Monitor vitals
3. Provide assistance with p/care

Problem: Shailesh is unable to walk without assistance due to loss of confidence following a recent fall.

Goal: Shailesh would like to regain his confidence and walk 5-6 meters with the aid of his stick.

Action:

1. Refer to doctor for review to rule out any underlying factors
2. Refer to physiotherapist and occupational therapist for assessment and advice
3. Monitor vital signs and pain score 4 times a day and reduce to twice daily of they are within normal range.
4. Shailesh will call healthcare staff when he needs assistance
5. Shailesh agrees to practice exercises as suggested by physiotherapist

All plan discussed and agreed by Shailesh *Sign of Nurse with date*

I - nitiate the plan – is the doing part.. putting plan into motion

R- eview and reflect

Was the goal….

* Achieved? Partially achieved? Not achieved?
* Reflect with the patient, physician and colleagues.
* What worked? What didn’t and why?

Set new goal or update current care plan

E – valuate

Document

* Variant actions / Problems / Progress / Omissions and Decisions / Referrals / Conversations and communications

* Show care and empathy
* Active listening
* Building rapport
* Identify Communication barriers
* Non-judgmental
* Assertive
* Facilitate

*Be Self aware

*Conclusion

* **Write a personalized care plan**
  * A personalized care plan that is meaningful to the Patient will result in better outcomes. A goal that means something to the Patient will keep that person engaged throughout the process because they can easily connect what is important to them to the health care intervention in their care plan

* **Involve patient in decision making process and refer them with name**

* **State goal with names** eg. Mrs. Lal would like to/needs support to ***rather than to be able to***….*This shift ownership from nurse to patient*

* **One problem and goal - Don't mix them up**

* “At the end of the day
I can truly say I made a difference
in someone’s life today….
And that is why I am
NURSE”

Thanks…..any questions?