The best laid care plans

Up-to-date, client-focused care plans are invaluable tools for the addiction nurse and indeed all nurses and midwives, write a HSE addiction services team from Dublin

THROUGH developing and providing effective and sustainable services the Addiction Services in the HSE-South Western Area endeavour to promote healthy options for individuals, families and communities working in a partnership approach with clients and fellow service providers.1

There are currently 28 clinics, 2,418 clients and 15 nurses in the South Western Area of the HSE Addiction Services Dublin Mid-Leinster.

It is accepted in nursing practice that nursing care is communicated and recorded as part of the client’s care and treatment.2 An individual nurse/midwife must establish and maintain accurate clear and current client records within a legal, ethical and professional framework.3

Addiction treatment clients often suffer from secondary health and psychosocial problems at the time of their entry into treatment,4 thus necessitating the use of appropriate documentation.

Care planning is the process of setting goals and interventions based on needs identified by an assessment and planning how to meet these goals with the client.5 The Care Plan Committee for the HSE Community Addiction Services Dublin Mid-Leinster reconvened in February 2007.

Improvements

The aim of the Care Plans Committee was to review the existing care plans that have been in place since 2003. The first step to care planning is accurate and comprehensive assessment.6 The existing care plans did not have an assessment form; therefore a form incorporating socio-demographics, physiological, physical and psychological profiles was created. It was felt by nurses working within the service that a more comprehensive and less time consuming system of planning care was required.

The aim of the committee was to provide clients and nurses in the Community Addiction Services with up-to-date efficient and user friendly care plans based on a client focused nursing model.

Intervention

Several models of nursing were reviewed including Roper Logan and Tierney’s model of nursing, the Tidal Model and Roy’s Adaptation model of nursing.

Nurses act to promote their client’s level of adaptation during health and illness by way of the nursing process,7 so it was agreed that Roy’s Adaptation Model of Nursing was the model that would meet the service needs of the nursing department. This model8 defines nursing as a healthcare profession that focuses on human life processes and patterns and emphasises promotion of health for individuals, families, groups and society as a whole.

Changes

The care plan committee took a number of steps prior to launching the care plans:

• A comprehensive new assessment form was created
• The hepatitis A and B vaccination care plan was changed to a generic vaccination care plan in order to incorporate all other vaccinations that are administered in the service
• The DVT care plan was changed to an Innohep care plan as this is the anticoagulant treatment of choice used in the Community Addiction Services
• A new care plan on viral screening was created
• The pregnancy care plan was reviewed by the clinical midwife specialist
• The Hep C/vaccination/viral screening care plans were reviewed by the hepatitis CNS
• The low mood care plan was reviewed by

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the (CNS) Young Persons Programme who is from a psychiatric nursing background
  • The Innohep care plan was sent to Leo Pharma for review
  • The wound care plan was reviewed by a representative from Coloplast Ltd
  • The HIV care plan was reviewed by the HIV CNS at St James’s Hospital
  • Care plans such as wound care, nutrition, low mood and methadone detox were designed to incorporate client involvement
  • The care plans were ‘piloted’ in the Cork Street and Jobstown clinics and were adjusted accordingly
  • The committee presented the care plans at the December 2007 nurses meeting and gave a comprehensive overview of the changes that were made.
  The ‘go live’ date for the care plans was February 8, 2008. A review was begun in May with a pilot feedback questionnaire and a documentation audit was carried out in August 2008.

Feedback questionnaire and audit results

A feedback questionnaire was distributed to nurses asking them what they liked, disliked and what changes they would make. Thirteen nurses were sent questionnaires and six questionnaires were returned (46.15%) (See Table 1).

An Bord Altranais’ gives specific guidelines regarding recording clinical practice. The documentation audit was carried out bearing these guidelines in mind. Topics such as signing, dating and error recording were audited. The results were then compared with the results of the 2007 documentation audit (See Table 2).

The results of the audit along with an education session on documentation were presented at the monthly nurses meeting and a nursing policy regarding documentation of client care was implemented.

Quality client focused care

National and international evidence consistently shows that good quality drug treatment is highly effective in reducing illegal drug use and improving the health of drug misusers.3 The overall feedback from the questionnaire was positive, with nurses citing that the care plans were clear, concise and more client focused. The assessment form was seen as an ‘excellent’ addition to the nursing care plans.

The documentation audit showed a general improvement in how nurses record client care, and also showed some areas of weakness. It is hoped that the introduction of a nursing documentation policy and the provision of an education session will address these weaknesses.

The Care Plan Committee will continue to review and audit the care plans on an annual basis. The quality of records maintained by nurses and midwives is a reflection of the quality of care provided by them to patients.1

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References
6. Fox HF. What is a Care Plan? 2008 www.careplans.com
8. Roy SC, Andrews HA. The Roy Adaptation Model. 2nd Ed. Appleton & Lange; Stamford, CT, 1999

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Table 1

<table>
<thead>
<tr>
<th>Likes</th>
<th>Dislikes</th>
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<tbody>
<tr>
<td>Very clear</td>
<td>A lot of repetition</td>
</tr>
<tr>
<td>Short</td>
<td>Assessment form very long</td>
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Table 2

<table>
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<th>Question</th>
<th>2007</th>
<th>2008</th>
<th>Comment</th>
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<tbody>
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<td>50%</td>
<td>5.6% Improvement</td>
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<tr>
<td>Is each entry dated?</td>
<td>63.3%</td>
<td>87.73%</td>
<td>24.43% Improvement</td>
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<td>Is each entry timed?</td>
<td>29%</td>
<td>2.84%</td>
<td>26.16% Disimprovement</td>
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<tr>
<td>Is each entry signed?</td>
<td>73.6%</td>
<td>81.14%</td>
<td>7.54% Improvement</td>
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<td>56.6%</td>
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<td>12.26%</td>
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<td>5.655%</td>
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<td>No Change</td>
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<tr>
<td>Are records up to date?</td>
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<td>Is the status of the person recorded?</td>
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<td>31.1%</td>
<td>98.2% Improvement</td>
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