CHI
Children's Health Ireland
at Crumlin

GUIDELINES FOR USE OF NURSING CARE PLANS AND EVALUATION / COMMUNICATION SHEETS

The purpose of a Careplan, is to capture the story of the patient experience, and accurately record the events of their nursing care and interventions. The NMC[1] (2005) believes that "record-keeping is a fundamental part of practice for nurses, midwives and specialist community public health nursing practitioners and should not be viewed as a distraction from caring for patients". Keeping this in mind the patient safety aspect of the care process can also be captured. Dimond[2] (2002), suggests that "Good practice in record-keeping can help to protect the welfare of patients by ensuring high standards and continuity of care in addition to improved communication between members of the healthcare team".

In Our lady's Children's hospital we use a modified version of the Roper, Tierney Logan Model of Nursing care which utilises the Activities of Living to manage the patient care journey. The Nottingham Model as described by Smith (1995) is an extension of the Roper, Tierney, Logan Model and involves the parent and child in their own care making the nursing care model child and family centred and as close to care in the home as possible. The Careplans are used in the context of family centred care which promotes partnership and negotiation with both Infant/Child and family[3].

As part of the Healthcare Record, Nursing documentation must comply with the National Hospitals Office Code of Practice for Healthcare Records Management 2007.[4] To assist nursing staff in OLCHC NPC Guidelines on Documentation of Nursing Care (2009)[5] are available for use.

GENERAL PRINCIPLES

CAREPLANS

- Use Careplan 1 with all other care plans, this careplan deals with all normal daily care.
- A Careplan will not be available for all specific problems.
- Use a selection of the Careplans to reflect the care required.
- Make additions to Careplan 1 to cover other daily needs, such as when bath or hygiene needs.
- Specific hygiene needs can be also addressed in the evaluation of care.
- If Intravenous Access is required care plan 9 can be used in conjunction with care plan 1, discontinue the section under hydration on Careplan 1 if not in use. Remember to date and sign this section.
- Review and update Careplans at each change of shift or as often as care requirements change.
- Each change in care or update should be dated timed and signed.
- Highlight changes to the care on the evaluation sheet also dated timed and signed.
- The focus of care will be on the care plans, they are an effective tool for handing over patient care.
- Please adhere to the Guidelines on Documentation of Nursing Care (2009).
- Please use black pen only for documentation but colours may be used to highlight entries.

EVALUATION SHEET

- One evaluation / communication sheet is required for all Careplans.
- Evaluation / Communication sheets will reflect all nursing care.
- Communication from all other disciplines will be included.
- All interventions such as bathing, X-rays, bloods can be captured in the intervention column.
- Duplication of nursing care is not expected but a short summary can be given of changes.
- It is essential that care updates and changes are reflected in the Careplans.

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[1] Nursing and Midwifery Council (2005) Guidelines for Records and Record Keeping. NMC, London
[2] Dimond B, (2002) Legal Aspects of Nursing. Third Edition. Longman, London
[3] Smith F. (1995) Children's Nursing in Practice: The Nottingham Model. Blackwell Science, Oxford.
[4] NHO (2007), National Hospitals Office Code of Practice for Healthcare Records Management, HIQA, Dublin
[5] NPC (2009), Nursing Practice Committee, OLCHC, Guidelines on Documentation of Nursing Care, Dublin, Ireland.

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