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

The purpose of a Careplan, is to accurately record the events of their nursing care and interventions and capture the story of the patient experience. 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. NMBI[2] (2015), maintains that "The quality of records maintained by nurses and midwives is a reflection of the quality of care provided by them to patients. Nurses and midwives are accountable and responsible for the standard of practice which they deliver and to which they contribute".

In CHI at Crumlin, we use a modified version of the Roper, Logan, Tierney Model of Nursing Care, which uses the 'Activities of Living' to manage the nursing care needs during the patient care journey. The Careplans are used in the context of family centred and person centred care which promotes partnership and negotiation with both Infant/Child and family[3]. Each child admitted receives Careplan 1 - Activities of Living and then a choice of other careplans determined by the reason for admission. In conjunction with careplans, an evaluation of care is included which allows the staff member to assess and reevaluate care as required during their shift, with all care being captured in the context of the Safer Better Healthcare Standards (2012).

As part of the Healthcare Record, Nursing documentation must comply with the National Hospitals Office Code of Practice for Healthcare Records Management 2011. [4]To assist nursing staff in CHI at Crumlin NPC Documentation Guidelines for Nursing Staff (2017)[5] are available for use.

CAREPLANS	EVALUATION SHEET
• Use Careplan 1 with all other care plans, this careplan deals with all normal daily care. Make additions to Careplan 1 for daily needs, such as when bath or hygiene needs. Specific hygiene needs that need to be highlighted can be addressed in the evaluation of care. • A Careplan will not be available for all specific problems. Use a selection of the Careplans to reflect the care required. • 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. • refer to Documentation guidelines for Nursing Staff (2015) • Use black pen only for documentation	• 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, blood tests 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.

1 Nursing and Midwifery Council (2005) *Guidelines for Records and Record Keeping*. NMC, London
2 Nursing and Midwifery Board of Ireland (2015) *Recording Clinical Practice,* NMBI, Dublin, Ireland.
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 (2020), Nursing Practice Committee, CHI at Crumlin, *Documentation Guidelines for Nursing Staff*, Crumlin, Dublin, Ireland.

GUIDELINES FOR AUDIT OF NURSING DOCUMENTATION

The purpose of auditing the nursing documentation in the Healthcare record is to determine the quality of the nursing interventions and 'read the story of the child's journey'[1]. The principles of nursing documentation are guided by NMBI (2015) *Recording Clinical Practice-Professional Guidance* and *Documentation Guidelines for Nursing staff* (2020). Nursing documentation is audited by each clinical area – a quality care metrics super user and peer reviewed by the Quality department on a regular basis. Quality Care Metrics are reported to the Senior Nursing Management team and are streamed nationally results of which are available to senior nursing management nationally

Nurses are required to:

1. Individualise each patient's care episodes
2. Streamline patient care and improve patient focus within the nursing documentation
3. Document what is required in accordance with documentation guidelines (OLCHC 2015), (HSE, 2012).
4. Review and alter nursing documentation on a regular basis in keeping with the evidence base and best practice.
5. Reduce unnecessary writing
6. Reduce time wasted on repetitious documentation
7. Ensure the documentation is of a standard that appropriately reflects the care received by the patient, and reads as such.
8. Date, time and sign each entry with NMBI pin.

How to carry Quality Care Metrics

1. Find a quiet place to audit
2. Randomly choose charts of discharged children five are required at least
3. If there are none available it is ok to audit the inpatient, however you need to let me know on the audit form that the child is an inpatient or alternatively place a line through the discharge section with N/A.
4. You must have a username and password to log on to QCM
5. Answer the questions with a tick √ **or an X**
6. Audit the nursing section only. Ensure the context of the care and other associated careplan documents are reviewed. All fields should be complete if not or N/A has not been inserted the answer is no to the question.
7. Read the narrative on the communication sheet. This narrative should be relevant and be an update of care delivered. Nursing care plans should be updated and individualized.
8. If there any observations that cannot wait please alert the senior staff member on duty at the time.

[1] HIQA (2012) Safer Better Healthcare Standards, HIQA, Cork, Ireland