Lothian NHS Board

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Date 11/06/2025
Your Ref
Our Ref 10089

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Dear

FREEDOM OF INFORMATION - MENTAL HEALTH CARE PLANS

I write in response to your request for information in relation to mental health care plans. Please note that there are no Trusts within the NHS in Scotland.

Question:

1. Please send me a copy of any documents outlining guidelines or codes of conduct regarding **mental health care plans** which have been used or disseminated within the Trust.

2. Please send me a copy of any documents outlining guidelines or codes of conduct regarding **care coordinators** which have been used or disseminated within the Trust.

Answer:

Please see enclosed.

Question:

3. Please send me copies of all Serious Incident Review documents which relate to the treatment of mental health patients within your trust.

Answer:

Please see enlosed Adverse Event Management Policy.

Due to the very small numbers of reports (evidenced in response 9946) and the specific and identifiable nature of them, it is not possible to release any of the reports even in a redacted format.

To protect the identity of the individuals involved any figure of 5 or less has not been shown in these responses. Since we do not have their consent to release this data from their records, the information is exempt under section 38(1)(b) of the Freedom of Information (Scotland) Act i.e. to provide it would breach the Data Protection Act (2018).

Reports still being review cannot be released under Section 30 of the Freedom of Information (Scotland) Act 2002 - Prejudice to effective conduct of public affairs.

Information is exempt information if its disclosure under this Act-

(b) would, or would be likely to, inhibit substantially-
(i) the free and frank provision of advice; or
(ii) the free and frank exchange of views for the purposes of deliberation; or
(c) would otherwise prejudice substantially, or be likely to prejudice substantially, the effective conduct of public affairs.

In NHS Lothian, all events where a person is harmed or there was potential for harm are recorded on DATIX. NHS Lothian classify Serious Adverse Events (SAEs) as those resulting in a severity of Major Harm* or Death. All SAEs are reviewed for learning and an improvement plan put in place and implemented if relevant. An improvement plan is not always required as the findings of the review do not always identify any care of service delivery problems. Conversely, an improvement plan may include actions to address issues which are not directly related to the event but have been identified during the review as opportunities for service improvement.

* Major Harm defined as – Intervention required to sustain life / long term incapacity or disability requiring medical treatment and/or counselling (e.g., All fractures with exception of fingers and toes)

I hope the information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive
Enc.

Adverse Event Management Policy

Title:			
Adverse Event Management Policy			
Date effective from:	01/09/2023	**Review date:**	01/09/2026
Approved by:	Policy Approval Group		
Approval Date:	05/09/2023		
Author/s:	Quality and Safety Assurance Lead		
Policy Owner:	Associate Director for Quality Improvement and Safety		
Executive Lead:	NHS Lothian Medical Director		
Target Audience:	All NHSL staff, Health & Safety staff, Managers		
Supersedes:	Adverse Event Management Policy Version 2		
Keywords (min. 5):	Adverse event, risk, near-miss, SAE, harm		

Adverse Event Management Policy

Version Control

Date	Author	Version/Page	Reason for change
April 2014	Quality and Safety Assurance Lead	1.0	
May 2018	Quality and Safety Assurance Lead	1.1	Under review
June 2018	Quality and Safety Assurance Lead	2.0	Review approved
May 2023	Quality and Safety Assurance Lead	2.1	Under review
Sept 2023	Quality and Safety Assurance Lead	3.0	Review approved

Executive Summary

NHS Lothian aims to support staff to provide high quality care that is safe, effective and person-centred for every person every time. However, provision of healthcare is complex, and adverse events can and do occur which do or could have a major effect on the people involved. It is important that as an organisation, we learn from these events, share that learning and make improvements to minimise the risk of recurrence and improve the safety and quality of our services.

The approach to learning from adverse events builds upon NHS Lothian values, which are reflected in the principles and requirements of this policy and associated procedure. These are:

- Care and Compassion
- Dignity and Respect
- Quality
- Teamwork
- Openness, Honesty and Responsibility

NHS Lothian policy requires that adverse events and near-misses are reported and reviewed in a timely and effective way, in partnership with patients, carers, families and staff. Furthermore, that learning from review is identified, shared and used to inform improvements to services.

This policy is in support of and should be read in conjunction with the NHS Lothian Health and Safety Policy.

Adverse Event Management Policy

Contents

1.0 Purpose

It is acknowledged that things can and do go wrong in the provision of healthcare. The purpose of this policy is to ensure that a consistent approach is taken by all services and in all settings to the management and review of these events when they do or could have occurred.

Adverse event management is one part of NHS Lothian's integrated approach to risk management and continuous improvement through learning and changing practice. Making improvements informed by learning from adverse events, complaints and claims, and robust implementation of processes to assess risk and put in place actions to mitigate that risk are the cornerstones of improving the safety and quality of healthcare. Governance and accountability for implementation of systems and processes for adverse event management are therefore aligned through operational management and governance arrangements.

2.0 Policy statement

NHS Lothian policy requires that adverse events and near-misses are reported and reviewed in a timely and effective way, in partnership with patients, carers, families and staff. Furthermore, that learning from review is identified, shared and used to inform improvements to services. The focus for adverse event review is on adopting a systems approach with a clear emphasis on learning and promoting best practice.

The Healthcare Governance Committee has delegated responsibility on behalf of the Board for governance oversight in relation to implementation of this policy.

3.0 Scope

The key focus of this policy is on adverse events which do affect, or could have affected people, and could have caused, or did result in harm. Events which did or could have led to harm to the organisation, such as damage to property, system failure, service disruption, financial loss or adverse publicity, are also included.

The policy covers all of NHS Lothian's services and activities including all staff and students.

The principles of this policy also apply to Primary Care independent contractors GP practices, dental practices, community pharmacies and optometrists. Work will be undertaken in partnership with national programmes led by Healthcare Improvement Scotland to explore how implementation can be supported in Primary care and also with our Health and Social Care Partnership colleagues in respect of health and social care integration.

4.0 Definitions

4.1 Adverse event

An adverse event is defined as “an event that could have caused, or did result in harm to people, including death, disability, injury, disease or suffering and/or immediate or delayed emotional reactions or psychological harm”. Adverse events experienced as harassment on the grounds of age, disability, ethnicity or race, religion or belief, or sexuality are included. Harm is defined as “an outcome with a negative effect”.

Harm to a person includes unexpected worsening of a medical condition and the inherent risk of an investigation or treatment. It is often not possible to determine whether or not the harm could have been avoided until a review is carried out.

Harm to parts, or all of, NHS Lothian as an organisation are also included, for example: system failure, service disruption, financial loss or adverse publicity.

A *near-miss* is an adverse event where a harmful outcome was avoided either by chance or by intervention.

4.2. Severity of harm

The actual level of harm (known as severity) is used in NHS Lothian to group adverse events. This will determine communication and escalation and guide the level of review required. High level definitions of severity are set out below and further detail provided in the adverse event grading table.

Death/ Major harm – unexpected death or major injury with either intervention required to sustain life or long-term incapacity or disability requiring medical treatment and/or counselling.

Moderate –significant injury (short-term effects), requiring medical treatment or counselling, agency reportable (e.g. police)

Minor – minor injury or illness, first aid treatment possibly required

No known adverse effect at this time – no harm resulting on this occasion, but had the potential to cause harm

Damage to or loss of property is similarly graded as major/moderate/minor/no known adverse effect at this time.

4.3 Significant Adverse Events (SAEs)

Adverse events resulting in major harm to people or death, or serious harm to the organisation, are known as Significant Adverse Events (SAEs) in NHS Lothian.

As noted in paragraph 3.1 above, harm to a person includes unexpected worsening of a medical condition and the inherent risk of an investigation or treatment **and** it is often not possible to determine whether or not the harm could have been avoided until a review is carried out.

5.0 Implementation roles and responsibilities

5.1. Implementation

An operational procedure complements the policy and informs implementation by providing further detail of the standard methodology for the management of adverse events and specific processes for certain types of adverse event which must be followed. (See associated materials section 6.0)

The key requirements for implementation can be summarised as follows:

- Adverse events and near-misses are reported and managed in a timely and effective manner in partnership with patients, carers, families and staff
- All people, including staff who are involved in an adverse event are offered support at a time and in a way which meets their needs
- Feedback is given to staff and will inform decision-making
- Learning from adverse events is identified and used to inform service improvements that enhance the safety and quality of healthcare provided
- Learning is shared both within and out with NHS Lothian to provide opportunities for improvement
- NHS Lothian complies with its legal duties in respect of adverse events, including compliance with the statutory organisational Duty of Candour requirements where applicable
- Actions are reviewed by senior management in a manner that allows the NHS Lothian Healthcare Governance Committee and the NHS Lothian Health & Safety Committee to provide the Lothian NHS Board with an assurance statement.

There are a number of key principles which underpin implementation, which reflect NHS Lothian values as described in section 1. These are set out below:

- An emphasis on learning and promoting best practice – the system is focused on learning at all levels - local team, service, Lothian and, where appropriate, nationally, and makes extensive use of improvement methodology to test and implement the necessary changes. Near-misses are reviewed regularly to promote learning and system improvements
- A systems approach – adverse events act as a ‘window’ on the healthcare system, allowing a systems analysis. This is important to allow a reflection on the weaknesses of the system, or in the case of near-misses, the strengths, and prevent future adverse events
- Openness about failures – adverse events are identified, reported and managed in a timely manner, and patients and their families are told what went wrong and why. Reviews of events happen quickly following their occurrence. Adverse event reporting is expected to increase as we move to a more open culture
- A just culture – individuals are treated fairly. Organisational culture is based upon the values of trust, openness, equality and diversity, which encourage and support staff to recognise, report and learn from adverse events

- A positive safety culture – avoidance, prevention and mitigation of risks is part of NHS Lothian's approach and attitude to all its activities, and is recognised at all levels of the organisation. Decisions relating to the management of adverse events are risk-based, informed and transparent to allow an appropriate level of scrutiny
- Personal, professional and organisational accountability – everyone is responsible for taking action to prevent adverse events, including speaking up when they see practice that endangers safety, in line with the Whistle Blowing Policy. Roles and responsibilities will be explicit and clearly accepted with individuals understanding when they may be held accountable for their actions. The principal accountability of all NHS care providers is to patients, their families and carer
- Teamwork – everyone who works for NHS Lothian is an essential and equal member of the team and needs to be valued, treated well and empowered to work to the best of their ability. Teamwork is recognised as the best defence of system failures and is explicitly encouraged and fostered within a culture of trust, mutual respect and open communication.

It is recognised both throughout NHS Scotland and locally that there are challenges in reliable implementation of best practice, as described in this policy and associated procedure, in managing and learning from adverse events and applying that learning. NHS Lothian will therefore continue to work with staff to improve systems and processes and build capacity and capability through ongoing development.

5.2. Roles and Responsibilities

All staff have a responsibility for reporting adverse events and implementing this policy and associated procedure as appropriate to their role.

The Medical Director has lead executive responsibility for the management of adverse events. The Medical Director provides assurance to the Board through bi-annual reporting to the Healthcare Governance Committee on processes and outcomes for adverse event management and exception reporting on specific events or processes as required.

Managers, in line with operational management structures, have responsibility for the management and review of adverse events and consequences to ensure appropriate management and service improvement. Managers will be supported professionally by medical or nursing colleagues at local or board level as appropriate.

The Associate Director for Quality Improvement & Safety is responsible for development and maintenance of systems and processes to support the management of adverse events, including DATIX (the electronic integrated risk management system used to manage adverse events in NHS Lothian), provision of training, toolkits, guidance and expert support to the service and information for Board-level groups.

The Head of Health and Safety Services is responsible for providing expertise and support in relation to the review of occupational health and safety adverse events.

6.0 Associated materials

An operational procedure complements the policy and informs implementation by providing further detail of the standard methodology for the management of adverse events and specific processes for certain types of adverse event which should be followed. The associated materials are documents below. The key processes included in the procedure must be followed including completion of standard documentation.

Reporting an Adverse Event

All events must be reported on Datix (NHS Lothian Risk management information system) link to reporting page

Document	Description	Approved By
paper record	Paper copy of adverse event reporting form (for use when Datix is unavailable)	Quality & safety assurance lead
Reporting Requirements Under RIDDOR	Details of the RIDDOR definitions and reporting requirements to Health & Safety Executive	Head of Health & Safety
Specific Types of Adverse Events (AEs)	A list of the most relevant external bodies that have additional actions and/or reporting requirements for specific types of adverse events	Quality & safety assurance lead
Responsibilities – Adverse Event Management.	Specific responsibilities for effective management of adverse events	Quality & safety assurance lead

Managing AEs with major harm or death

Document	Description	Approved By
Managing an Event with Major Harm or Death – Management Team Actions	Process map of the management teams responsibilities for managing events resulting in major harm or death	Medical Director
Level of Review for Major Harm and Death Events – decision making flowchart	Flowchart to guide decision making on the level of review	Medical Director
Communication & Escalation of Significant Adverse Events (SAEs)	Details the appropriate communication and escalation for Significant Adverse Events	Medical Director

Commissioning Checklist for Level 1 SAE Reviews	Commissioning Checklist to assist in Commissioning Level 1 SAE Reviews	Medical Director
NHSL AE Review Template	Adverse Event Review template for recording Level 1 and Local Adverse Event reviews with major harm or death	Medical Director
Briefing Note Template	Briefing note for recording information to enable effective decision making on whether a Level 1 or Local AE review should be commissioned	Medical Director
Structured Mortality Review Tool (SMRT) Template	Structured Mortality Review Tool for reviewing deaths	Medical Director
Falls with Significant Harm / Grade 4 Pressure Ulcers	Process for reviewing and approving Patient Falls and Pressure Ulcers	Medical Director
Mental Health & Substance Misuse Protocol	Process for the review of unexpected deaths for Mental Health Services and Substance Use Services	Associate Medical Director for Mental Health
Maternity & Neonatal Services Protocol	Process for the review of Major Harm and Death events in Maternity and Neonatal Services	National guidance/AMD Women's services
Agreed Alternate Processes	Standard operational procedure for reviewing/approving major harm or death agreed alternative SAE processes. Including bespoke templates list.	Medical Director

Reviewing SAEs

Managing an Adverse Event with Major Harm or Death – Review Team Actions	Process map detailing the actions for the review team to follow when carrying out significant adverse event review	Medical Director
NHS Lothian Adverse Event Review Protocol	Sets out the standard process for reviewing adverse events in NHS Lothian	Medical Director

Communication and Support for People involved in Adverse Events

Document	Description	Approved By
Process & Checklist for Communicating with Patient & Families	Details the process for communicating with patient and families following a Significant Adverse Event Review and provides a checklist	Medical Director

Staff Support - Managers Action Flowchart	Details actions to be taken by managers to support staff following a significant adverse event	Quality & safety assurance lead
Information on Significant Adverse Event Review Process for Staff	Information leaflet for staff involved in significant adverse events and the review process	Quality & safety assurance lead
Staff Support Checklist	Checklist of actions to be taken by managers in supporting staff following a significant adverse event	Quality & safety assurance lead
Staff Support following a Significant Adverse Event	Leaflet to provide information about support services available for staff who had been involved in a significant adverse event	Quality & safety assurance lead

7.0 Evidence base

This policy reflects the principles and requirements set out in Healthcare Improvement Scotland 'Learning from adverse events through reporting and review – a national framework for Scotland December 2019 (4th edition), which has been developed drawing on international evidence and best practice relating to the management of adverse events.

8.0 Stakeholder consultation

There has been wide consultation with service colleagues who are regularly involved in investigating and reviewing adverse events. Additional specialists such as Health and Safety colleagues were consulted on content, to ensure read across with other policy material. Policy displayed on consultation zone for 4 week period for all NHS Lothian staff to comment on.

9.0 Monitoring and review

This policy will be formally reviewed every three years. The Medical Director as the lead Executive will continuously review implementation of the policy and procedure and prompt earlier review if required.

Mental Health
Person-centred Care Plans
Standing Operating Procedure

V1 effective from:	February 2025	**Review Date:**	February 2026
Author:	Janice Wilkinson – Lead Nurse QI & Standards Amended from Model Ward PCCP SOP v3 written by Lorna Turner		
Executive Leads:			
Target audience:	All NHSL Staff in inpatient areas		

Contents

1. Purpose

To develop an electronic outcome-based care plan to improve the compliance with person-centred care planning by introducing a system that will provide reliable care planning processes. The system will provide a consistent method of communication of a patient's care across the whole care team to improve patient outcomes. The Person-centred Care Plans have been mapped to NMC record keeping and Scotland's principles to ensure compliance.

2. Introduction

The Model Ward Project was set up in recognition of an organisational need to review care planning. Following a visit by the senior leadership team to Manchester to view PatienTRAK and the subsequent organisational decision in February 2020 to scope the functionality of TrakCare (TRAK) as an alternative to purchasing a new system. Funding was secured from Acute Services to support the scoping and testing of the alternatives. A multi-professional project team was established, and a ward identified to model TRAK solutions. The Model Ward Project Team met fortnightly since July 2020 and have been developing and testing solutions using Quality Improvement Methodology.

3. Key objectives

- Risk Assessment review dates displayed as icons on TRAK floor plan with a colour coded process in place to identify when risk assessments are due.
- Access to one Person-centred Care Plan, divided into 14 elements of care with an alignment to Lothian Accreditation Care Assurance Standards (LACAS)
- Daily summary of care created from the progress note and transported directly into the clinical record.

4. Scope (identified areas)

All areas that currently use TRAK within NHS Lothian Acute sites, and Community Hospitals that form the H&SCP and Mental Health have been identified and will be moving over to the new Person-centred Care Plans (PCCP).

Areas not including in this phase of the scope are ones that currently not using TRAK to document care e.g., risk assessments and care plans on paper.

Areas who are using TRAK but have some aspects of care planning on paper are in scope unless specific agreement with Project Lead.

From the 23.04.2025 all patients in Mental Health inpatient areas will have their care plans transferred over to the new Mental Health Person-centred Care Plans. Risk assessments will be updated, in order, for the icon to be activated on the ward floor plan.

5. Definitions

- PCCP – Person-Centred Care Plan
- H&SCP – Health & Social Care Partnership
- NMC – Nursing & Midwifery council
- LACAS – Lothian Accreditation Care Assurance Standards
- eRoster – Electronic Staff Off Duty Roster
- EPR – Electronic Patient Record
- PVC – Peripheral Vascular Catheter
- IPC – Infection Prevention Control
- Mental Health PCAT – Mental Health Person-centred Assurance Tool

6. Responsibilities

A Model Ward Implementation Group has been set up with membership of the group identified within the scope. Each site / area has a lead, and each ward has identified a champion who will help facilitate the implementation of the key components of Person-centred Care Plans and associated risk assessments within their own area.

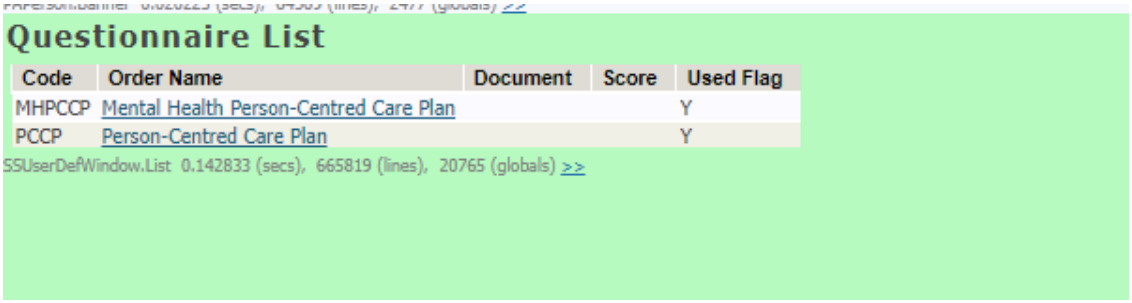
Each Registered Nurse will be responsible for completing the Person-centred Care Plan resource pack and informing their line manager when they have done so. The line manager has the responsibility of adding this information onto eRoster, (add skill – Introduction into PCCP).

Completion of the Person-centred Care Plans should be carried out daily and it is the responsibility of the nurse providing care to ensure this is completed before going off duty.

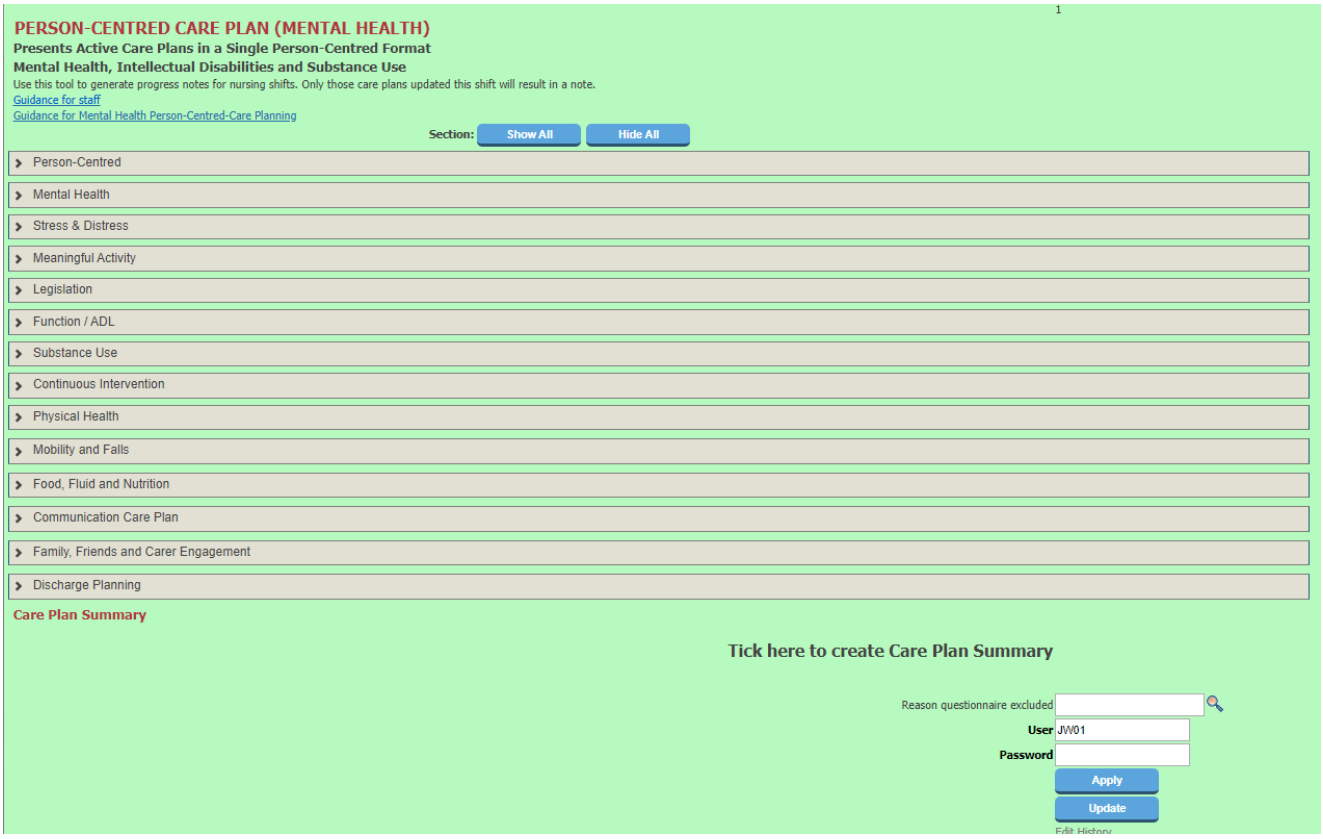
7. Specific Procedure (to access the Mental Health Person-centred Care Plan)

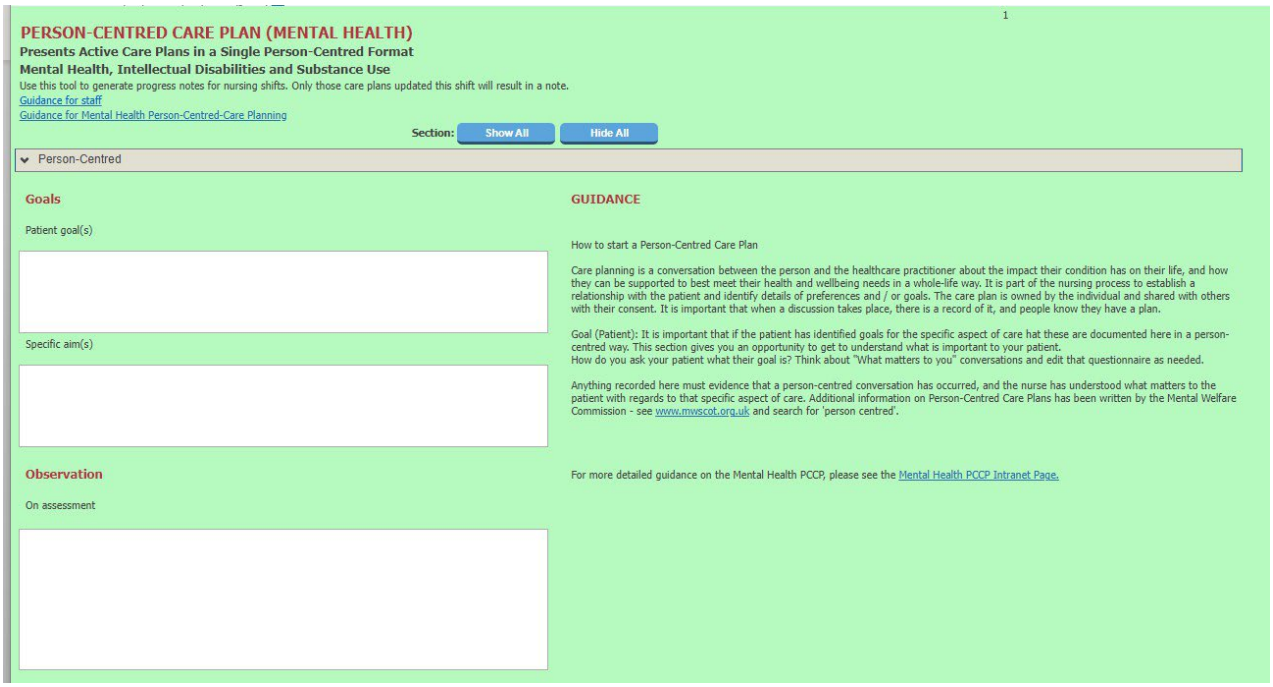
STEP 1: EPR >> Overview/Progress >> Care Planning >> Person-centred Care Plan

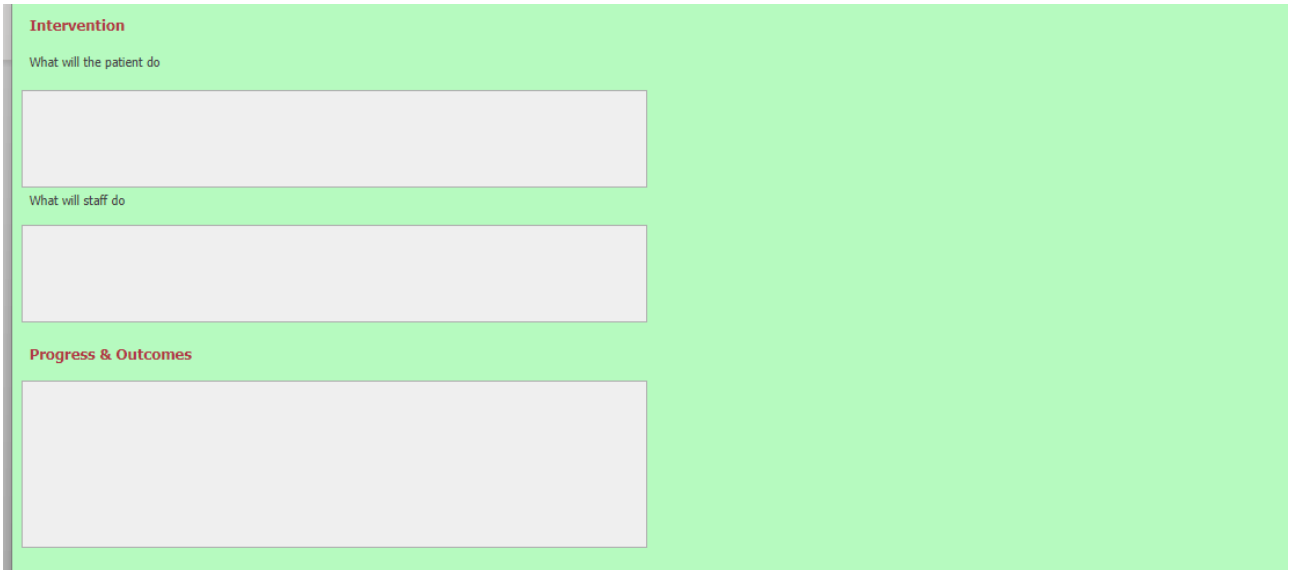
STEP 2: Select Mental Health Person-Centred Care Plan



Once within the Care Plan: All 14 Accordions can be expanded to access each section of the Care Plan – click on the Accordion you wish to open. If the Accordion contains information, it will be displayed in bold.







8. How to start a Person-centred Care Plan

Care planning is a conversation between the person/family/carers and the healthcare practitioner about the impact their condition has on their life, and how they can be supported to best meet their health and wellbeing needs in a whole-life way. It is part of the nursing process to establish a relationship with the patient and the people who are significant to them and identify details of preferences and/or goals. The care plan is owned by the individual and shared with others with their consent. It is important that when a discussion takes place, there is a record of it, and people know they have a plan.

Goal (Patient)

It is important that if the patient has identified goals for the specific aspect of care that these are documented here in a person-centred way. This section gives you an opportunity to get to understand what is important to your patient. Where the patient is unable to express identified goals of care due to their mental health presentation this should be documented within the patient goals box and re-explored as their presentation allows. It is important to list to the patient's family, friends, and carers to aid in the understanding of the patient and their situation. If the patient has an advance statement, this should be reviewed to determine whether they have indicated any goals or specific aims.

How do you ask your patient what their goal is?

Think about **"What matters to you"** conversations and the individuals communication preferences.

1. What's important to you at this moment?
2. What are some of the things you would like to achieve as a result, of this support or from being in hospital?
3. When you have a good day, what are the things that make it good?
4. Have you considered the spiritual care needs of your patient? ***(Spiritual care can help a person reconnect with what really matter to them.)***
5. Does your patients have beliefs or values which are important / affect their currently***. (A person's beliefs and values may support or challenge them at times of illness and may influence how they think about aspects of their care e.g. attitude to taking medication, dietary requirements, bereavement or end of life care).***

Anything recorded in here must evidence that a person-centred conversation has occurred, and the nurse has understood what matters to the patient with regards to that specific aspect of care.

Specific Aim [s] – you can identify one or several aims of care these should be specific personalised aims.

Observation on assessment – Document what you observed using your clinical knowledge of how your patient presents on admission / transfer to your area. By using your clinical judgement, you deem a patient not needing a Person-centred Care Plan for one of the elements of care you must document your rationale in this section.

'Lorna's skin on examination today is healthy and intact, Waterlow score is 9 and Lorna has confirmed that she has no issues or concerns at this time regarding her skin but will inform staff if any concerns arise'.

Patient & Staff Interventions – there are free text boxes to write patient and staff interventions relating to that care plan which have been agreed in conjunction with the patient and staff.

Daily Progress & Outcomes – Here you can document the person-centred care you have delivered to your patient during your shift, conversations you may have had or areas of concern you have noted about changes in their care.

Once you have completed your patient's progress & outcomes sections and about to finish your shift tick the **Create Care Plan Summary:** ***See Step 3.***

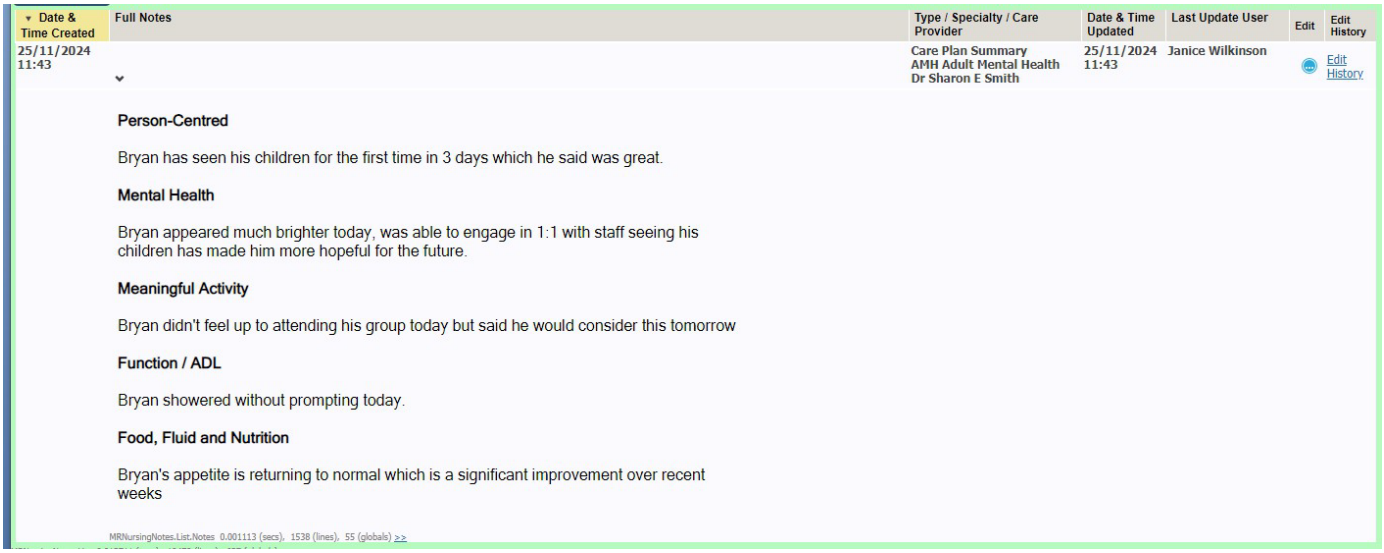
Step 3

To create an overall "**Care Plan Summary"**

Note: *only do this when you have finished writing the required daily progress and outcomes sections for your patient and REMEMBER to do this before going off duty.*

This will generate a Care Plan Summary based on all the 'Progress & Outcomes' for each PCCP.

The 'Care Plan Summary' will display at the end of the Care Plan questionnaire and in Overview progress >> Clinical Notes (see screenshot below):



Date & Time Created	Full Notes	Type / Specialty / Care Provider	Date & Time Updated	Last Update User	Edit	Edit History
25/11/2024 11:43		Care Plan Summary AMH Adult Mental Health Dr Sharon E Smith	25/11/2024 11:43	Janice Wilkinson		Edit History

Person-Centred

Bryan has seen his children for the first time in 3 days which he said was great.

Mental Health

Bryan appeared much brighter today, was able to engage in 1:1 with staff seeing his children has made him more hopeful for the future.

Meaningful Activity

Bryan didn't feel up to attending his group today but said he would consider this tomorrow

Function / ADL

Bryan showered without prompting today.

Food, Fluid and Nutrition

Bryan's appetite is returning to normal which is a significant improvement over recent weeks

MRNursingNotes.List.Notes 0.001113 (secs), 1538 (lines), 55 (globals) >>

Once the 'Care Plan Summary' has been created, the 'Progress & Outcomes' free text areas will be blank for the following day.

9. Display of the Risk Assessment Status Icons

A number, of Risk Assessment Status Icons will be available on the floor plan, risk evaluation screen and the new Person-centred Care Plan. The Icons will indicate if a risk assessment needs to be completed for the first time or reviewed.

The table below shows the different Icons and what they indicate.

Icon	Description	Action Required
	Risk assessment is required to be completed for the first time	√
	Risk assessment is due on the day	√
	Risk assessment review timescale is overdue	√
	Risk assessment is up to date	×

Ward Floor Plan

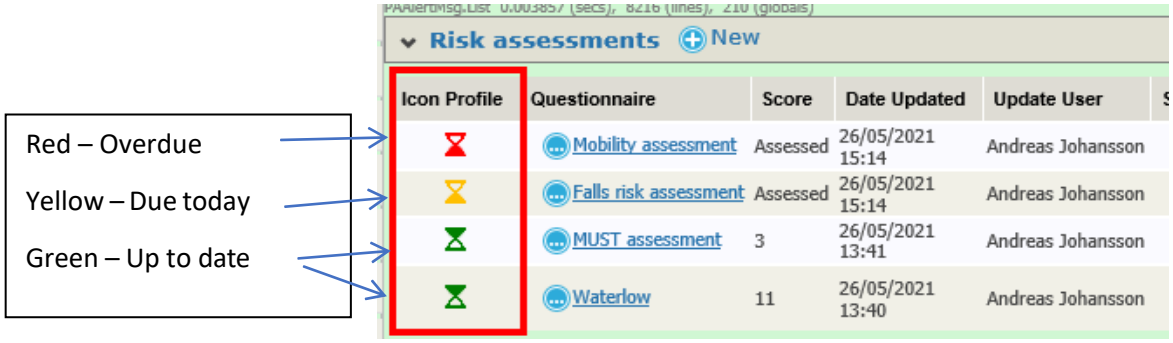
- The icons displayed here are interactive, i.e., clicking the icon will open the 'Risk Evaluation' screen
- Only are displayed on the ward floor plan and not the

*Note: Hovering over the icon with the mouse cursor on the ward floor plan will display additional information about actions required.

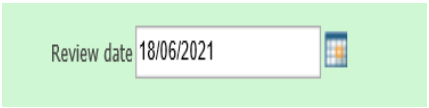
Risk Evaluation >> Risk Assessment Bundle

- Either or is displayed on the left side of the risk assessment link
- If the assessment has been completed, no icon is displayed
- If the assessment has been considered but not a risk as this time and the box has been ticked to indicate this it will not generate an icon

Either ⌛ or ⌛ is displayed in the Icon Profile (see screenshots below) depending on the completion status of the risk assessment on the below screens.



The risk assessment has a review date. The box is situated at the bottom of the risk assessment. (see below)



The review dates for the risk assessments are set as the table below. However, you can use your clinical judgement and change the review date for your patient.

Adult

Risk Assessments	Complete within	Review timetable (rule for Prompt)
Mental Health Risk Assessment	6 hours of admission	Weekly
4AT	24 hours of admission	**Risk Score** 0 – weekly unless condition changes 1 - 3 Review Every 3 days 4 or above – Should be reviewed daily as a minimum but might require more frequent review based on clinical judgement

Risk Assessments	Complete within	Review timetable (rule for Prompt)
		Please note it is important to repeat the 4AT if your patient is transferred to another ward
Additional Risks	24 hours of admission	No review prompt
Bladder & Bowel Function Assessment	24 hours of admission	Daily
Falls Risk Assessment	24 hours of admission	**Falls Risk** High Falls Risk - Review Daily Low Falls Risk – Every three days
Mobility Assessment	24 hours of admission	Every Three Days
MRSA / CPE IPC Assessment	24 hours of admission	No review prompt – only repeated if moving to a high-risk area and based on clinical judgement or IPCT advice
MUST Assessment	24 hours of admission	**Risk Score** 3 or above – Daily Below 3 – Every three days
Nutritional Profile	24 hours of admission	No review prompt
Peripheral Vascular Catheter (PVC)	On insertion	If PVC inserted = prompt daily (Maintenance bundle)
Rational for use of bedrails	24 hours of admission	**Bed Rail** Yes – Every three days No - Weekly
Urinary Catheter procedure record	On insertion	If catheter inserted = prompt daily (maintenance bundle)
Waterlow	6 hours of admission	**Risk Score** 15 or more daily / 14 or less every three days *The Waterlow score needs to be completed within 6 hours of admission to hospital (Acute Sites & Community Hospitals) and not between each patient move within the same hospital, as previously undertaken*
Oral Hygiene Assessment tool	24 hours of admission	Review prompt is generated depending on the maintenance Bundle score. Score 0-4 = repeat every three days Score 5-9 = repeat every three days Score 10 or more = repeat daily
Pain Risk Assessment	6 hours of admission	Daily and / or following PRN / frequent analgesia

Children and Young People

Risk Assessments	Who / Age Range	Review timetable (rule for Prompt)
Mental Health Risk Assessment (within 6 hours of admission)	All patients	Weekly
PYMS (within 24 hours of admission)	Over 1 / under 16	Score = 1: Every 3 days Any other score: weekly
MUST (within 24 hours of admission)	16 and over	**Risk Score** 3 or above – Daily Below 3 – Every three days
Glamorgan (within 6 hours of admission)	16 and under	Daily
PVC daily (if PVC inserted = prompt x 2 daily (maintenance bundle))	All patients with PVC inserted	If inserted 2 times daily check
MRSA / CPE IPC Assessment (within 24 hours of admission)	All patients	No review prompt – only repeated if moving to a high-risk area and based on clinical judgement or IPCT advice
Additional risks (within 24 hours of admission)	All patients	No further review after completed on admission
Bladder and bowel (ad hoc – no alert)	Adhoc	No initial alert. If recorded, then once daily
Falls (ad hoc – no alert)	Adhoc	No initial alert. If recorded High falls risk: daily Low falls risk: every 3 days
Mobility (ad hoc – no alert)	Adhoc	No initial alert. If recorded every 3 days

Questionnaires (Adult & Children and Young People)

Risk Assessments	Complete Within	Review timetable (rule for Prompt)
Mental Health Pass Plan	6 hours of admission	Weekly
What Matters to You	24 hours of admission	Monthly
Distress Preferences	72 hours of admission	Monthly
Physical Health	3 months	6 monthly

10. Monitoring Effectiveness & Evaluation

10.1 Electronic Patients Records (EPR) reports – (daily / weekly) Snapshot data is generated directly from Trak and emailed to Senior Charge Nurses / Deputy Charge Nurse to inform:

- Percentage of completed risk assessments
- Percentage of overdue risk assessments
- Average days risk assessments overdue
- The number of times the care plan summary report has been generated in a 24-hour period.

10.2 Mental Health PCAT will provide assurance that care planning is happening in partnership with the patient, that what matters to them is being listened to and acted upon, and that documented care plans are of high quality, resulting in care provided being truly person-centred.

10.3 Senior Charge Nurses or Deputy Charge Nurses should complete Mental Health PCAT on 5 patients per month, and it is advised that one per week is completed to ensure the time is taken to complete it thoroughly. The tool features 16 sections looking at the quality of the care plans within TRAK, NEWS charts.

10.4 Part of the evaluation process is to collect feedback from Patients' and relatives/carers, this is included in Mental Health PCAT. We need to recognise how important it is that patients, relatives', or carers feel involved in planning their goals of care on a; daily basis, believe staff recognise what is important to the patient when delivering / providing care and that patients/ relatives or carers feel involved in decisions around their care.

10.5 Results of Mental Health PCAT data should be reviewed by the SCN and should form part of the monthly one to one conversation between the Clinical Nurse Manager and the Senior Charge Nurse, where the data should be used to celebrate success and used to identify where quality improvement work should be prioritised with the team. It is essential that this is not seen as punitive, but that teams and staff feel supported and enabled to make improvements.

11. Guidance for Admission Areas

Your patient has been identified as requiring admission into your clinical area

Start the admission process by including these key questions

- What & Who Matters to your patient
- From their response document their goals

Priority Care Plans in the first hour of admission

- Person-centred Care Plan
- Mental Health Care Plan

The admitting nurse should use knowledge of the initial diagnosis of the patient's reason for admission and by applying clinical judgement and a clear rational why decisions have been made commence the appropriate care plans and associated risk assessments for their patient at that time

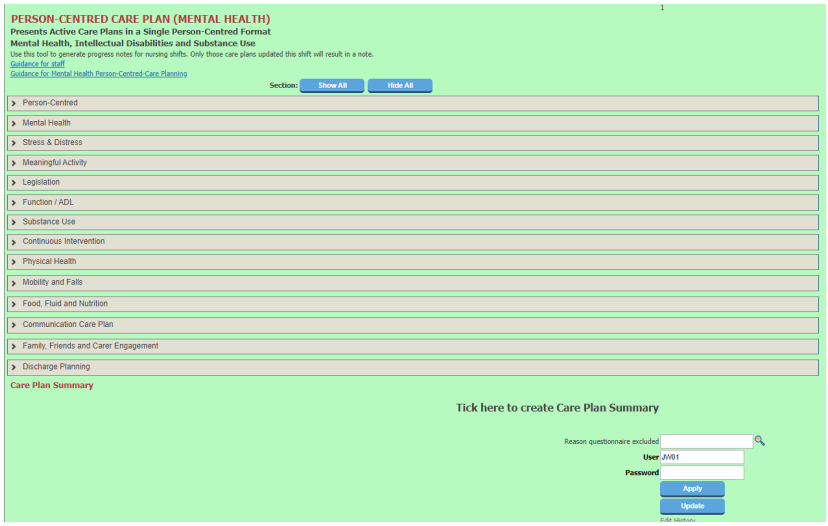
- Mental Health Risk Assessment – (within 24hrs)
- MUST / PYMS Risk Assessment (Within 24hrs)
- Waterlow / Glamorgan Risk Assessment (6hrs)
- Bedrail Assessment (Adults) – (within 24hrs)
- Falls Risk Assessment (Adults) - (within 24hrs)
- Nutritional Profile (Adults) – (within 24hrs)
- Bladder & Bowel Function (Adults) - (24hrs)
- 4AT (Adults) - (within 24hrs)
- Oral hygiene (Adults) - (within 24hrs)
- Mobility Assessment (Adults) – (within 24hrs)

Remembering Admission Areas - This is the starting point for Person-centred Care Planning. Each care plan should be adapted and tailored to each patient as they continue their journey of care through the system

Admission area scenario's

A 35yr old man is admitted due to a relapse in his mental health.

PCCP to prioritise & commence with associated Risk Assessments



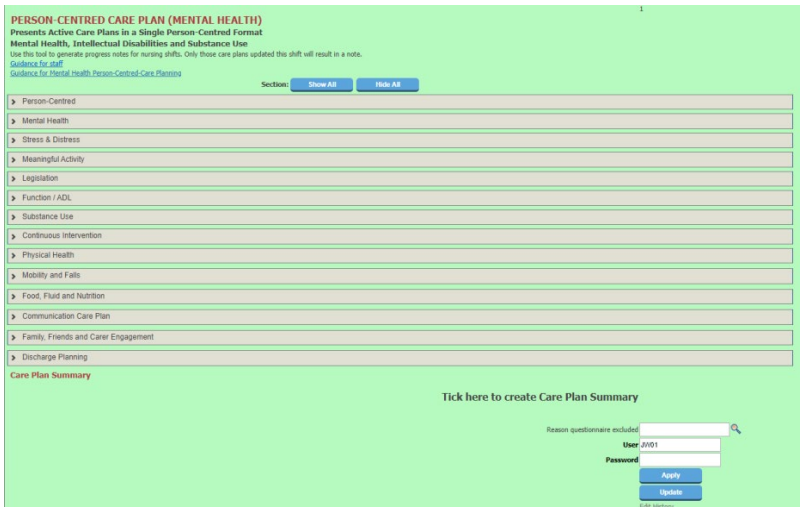
Person- Centred Care

Mental Health

Stress & Distress

A 73yr old women has been admitted due to a deterioration in her mental health requiring her to be detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. She has a history of suffering from poor mobility and falling.

PCCP to prioritise & commence with associated Risk Assessments



Person – Centred Care

Mental Health

Stress & Distress

Legislation

Mobility & Falls

12. Useful documents

Workbook PCCP Sept 2022 version 2.1 Word version CAMHS.rtf

Workbook PCCP Sept 2022 version 2.1 Word version LD.rtf

Workbook PCCP Sept 2022 version 2.1 Word version MH.rtf

[MH PCAT SOP & guidance to be added when developed / built on MEG]


Workbook PCCP Sept 2022 version 2.1.pdf


Distress Preferences Guide - TRAK MH Pap


Care Planning And Risk Assessments Ico


LACA ps to assurance v2 June 2

Guiding Principles

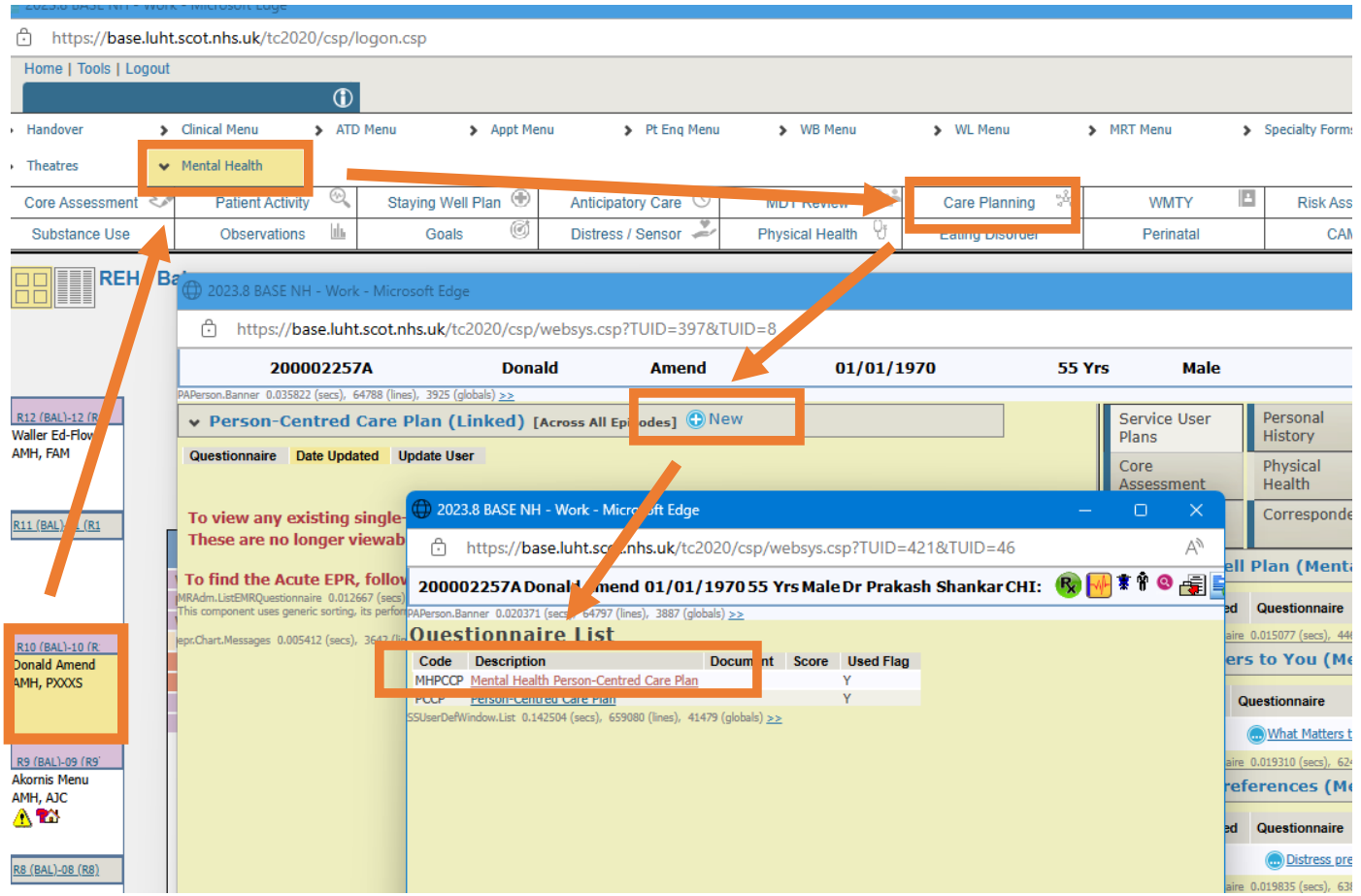
Spiritual Care

Multi-Faith Resources for Healthcare Staff

Oral Hygiene Assessment SOP v2 Final.pdf

SOP Version Control			
Date	**Author**	**Version**	**Reason for change**
	L Turner / J Wilkinson	1.0	

Very Quick Guide – adding a Mental Health Person Centred Care Plan



1. Select the patient on the floor plan
2. Click ‘Mental Health’ in the very top level menu
3. Choose ‘Care Planning’ from the submenu
4. If no MH PCCP already, click ‘+New’ and choose ‘MHPCCP’ [do NOT choose PCCP]
5. If a MHCCP is already inexistence, click that to open it

Introduction to Person-centred Care Planning Workbook

Authors: Janice Wilkinson Version 2.1 Revised from original PCCP workbook May 2021	
Date Authorised	
Authorised by:	
Review Date:	
Key Words:	Person-centred care planning, values, CAMHS

Background

Following a Model Ward Pilot in NHS Lothian, person-centred care planning on Trakcare (TRAK) was introduced in July 2021. Initially 130 areas signed up initially and the roll out continues with more areas coming on board with person-centred care planning on TRAK.

About this Resource

This workbook has been designed for you to use with the guidance and support of members of your team who are Person-centred Care Planning Champions to guide you in writing person- centred care plans. We recommend this workbook should be utilised in conjunction with key supporting documents in particular:
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- Reflect on the current legislation and drivers relating to person-centred care planning.
- Explore your own personal values and beliefs in providing person-centred care and writing care plans.
- Practise writing person-centred care plans with the support of your Person-centred Care Planning Champion.
- Identify your future learning needs and support with your Person-centred Care Planning Champion.

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2. Exploring values.
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Once you have completed sections 1-5, it is anticipated you will discuss your learning with the Person-centred Care Planning Champion in your area to plan your next steps (section 6+7).

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Before you begin, take some time to reflect on what person-centred care means to you and your understanding of person-centred care planning Document your thoughts below. **You may want to revisit this section once you have completed this resource and add to your notes.**

Think about what experience you have to date what care plan documentation have used already? Identify good areas of your practice? Identify what you find challenging?

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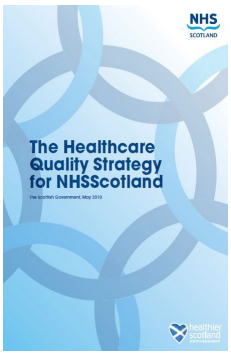
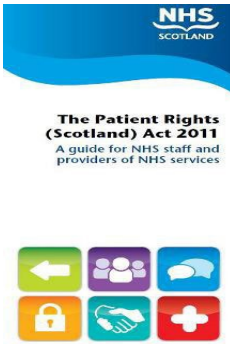
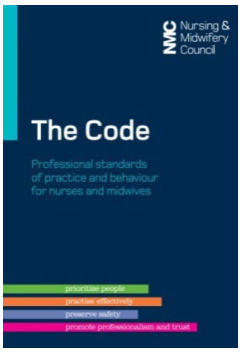


Healthcare Quality Strategy



Patients right act (2011)



Person-centred care

The Code in Action Animation

Healthcare Improvement Scotland ihub https://ihub.scot/improvement-programmes/scottish- patient-safety-programme-spsp/essentials-of-safe-care/person-centred-care/

Reflecting on these resources, what specifically relates to person-centred care planning?

When making notes consider aspects including patient involvement, shared decision making, choice and agreement and consent

Section 2: Exploring Values

Person-centred care planning is one element of person-centred care. To be able to care plan in a way that always puts the patient at the centre of the care planning process then it is important you spend some time exploring the key values that ensure person centred ways of working.

Access and read the following

Our Values – NHS Lothian | Our Organisation

How to achieve a person -centred writing style in care plans (Butterworth 2012)

The above link will work from an NHS Lothian networked computer. The article can also be accessed via the Knowledge Network: you will need to be logged in to access it.

Activity 3 Reflect on how you would you describe your own personal values. How do your own values compare with NHS Lothian Values? Record your reflections below

Click here to access an audio recording of practitioners discussing applying these values when delivering care

Section 3: Exploring Language in Person-centred Care Plans

When we write and talk about patients our language does not always reflect person-centred principles. It is common for care to be described as a series of problems. In the work by Butterworth, she summarises key values required to achieve a person-centred approach. This audible power point gives examples of how we might demonstrate these values in our documentation.

Activity 4

In the examples below consider what statement best matches how you currently document care. Please also consider what statement is more person-centred. Reflect on any changes you can make to your documentation to make it more person-centred.

These are fictional statements for training purposes

Example 1
Statement 1: Suffers from arthritis and is uncooperative with medication
Statement 2: Peter has arthritis, he has a good understanding of his condition, it is important to Peter that he maintains his independence and that the amount of medication he takes is kept to a minimum. He has expressed that he does not want to take his medication as he is worried about the side effects.

Example 2
Statement 1: Cannot express herself clearly and becomes verbally aggressive and agitated
Statement 2: Mary is able to communicate but sometimes cannot find the right words. Mary is concerned about not being understood. It is important to her that she has the opportunity to express herself. Mary can become frustrated, and she shows this by shouting out and banging her fists on the table.

Example 3
Statement 1: Complaining of pain
Statement 2: Joan has told us she is in pain; she is worried how this will affect her ability to wash and dress herself. It matters to Joan that she stays as independent as possible so she can return home.

Example 4
Statement 1: Suffers from anxiety, asks lots of questions.
Statement 2: Mr Smith has said he can become anxious. It is important to him to be kept well informed and that he can update his family. His aim is to stay informed by asking questions when necessary. He aims to manage his anxiety using relaxation techniques and he feels comfortable to ask for help if he requires it.

Section 4: Starting a Person-centred Conversation

Each person's care needs, expectations and choices will be unique to them. Key to person centred, outcomes based care planning are the conversations where we must identify what these outcomes will be for a person. Our role is to support the person to express what is important to them. The person should be given the opportunity to share with us what is working well and what they would want to change about their care, their expectations of care, their aims and goals and what support they require.

As healthcare professionals we will advise and guide the person and together we will agree what will be in their care plan**.** Creating the care plan this way will focus on what is important to the person and will ensure this is reflected in the care and support they receive.

What matters to you? is a Scotland-wide campaign to encourage and support meaningful conversations between people who provide health and social care and the people, families and carers who receive such care. More information can be found on the What Matters to You Website.

This handy guide includes tips on how to start a conversation in order to discuss what matters to you.

Ongoing communication between the healthcare team, the person and their families and carers are essential to ensure the persons care plan continues to remain relevant for the person. It enables care to be adapted over time to reflect a person's changing needs.

Think about "What matters to you" conversation. Other ways you may phrase this will be in context for the person. It could be a question like:

- What's important to you at this moment?
- What are some of the things you would like to achieve whilst you are in hospital?
- When you have a good day, what are the things that make it good?

From having these types of conversations, you will be able to clarify with the person what is important to them.

Activity 5

Consider the 2 scenarios – What is important to the person, what matters to them?
How would you document this in a person-centred way?

Practice in the boxes below
Remember to also demonstrate person-centred values in your entry

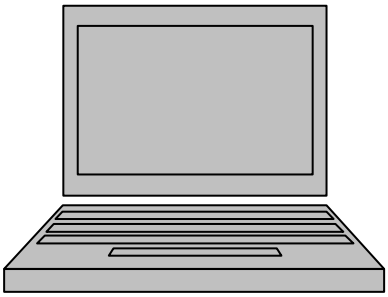
These are fictional scenarios for training purposes

1. ***Bella is 14 years old and has been admitted to hospital as she has had a deterioration in her anorexia nervosa. Bella enjoys being at school and studying English, out of school she enjoys dancing. Bella has been restricting her eating, not following her prescribed meal plan and has been overexercising which has contributed to her relapse symptoms. Bella is fearful about the prospect of receiving any interventions.***

2. ***Lewis is 16 years old and has been admitted to hospital for assessment of his bipolar disorder. He is presenting as manic, impulsive, unable to stay focused on any activities, has pressured speech, reduced sleep, and appetite. He enjoys playing on his Xbox and swimming with his friends. His 16th birthday party is in a few weeks, and he wants to be able to go to that.***

Summary so far;
It is anticipated that you will have;

- Explored why a person can expect a person-centred care plan
- Recognised the importance of reflecting on and clarifying personal and organisational values
- how to begin a "what matters to you" conversation
- Considered how you currently document care



Section 5: Writing a Person-centred Care Plan

In this section you will be asked to complete a person-centred care plan, documenting care in a person-centred way. It is anticipated you will apply everything that you have explored so far. This is your opportunity to practice. A scenario has been provided for this activity however if you feel you require further practice, please discuss this with the Person-centred Care Planning Champion in your area who can provide further scenarios for you.

Remember the Person-centred Care Planning Champion in your area can support you with this: they can discuss writing the care plan with you and provide feedback once it is written.

Before you start listen to this audible power point
Listening to this power-point will gives you useful advice on completing care plans in a person-centred way and includes fictional TRAK entries for the various sections contained in TRAK

Once you have completed the care plan, please discuss this with the Person-centred Care Planning Champion in your area, it is anticipated that you will;

- Receive feedback on the care plan you have written
- Discuss how you have found the process of writing in a person-centred way
- Explore how you can apply this learning in the context of your practice
- Discuss and identify what your first steps towards writing person centred care plans will be.
- Be shown how to access the person-centred care plan and the other outcomes-based care plans on TRAK

Activity 6

Using the template **below to** write a person-centred care plan for Harry
The care plan is based on a TRAK based person-centred care plan with the relevant sections included:

Harry Smith, age 14, likes to be known as Harry.

Harry has a diagnosis of anorexia nervosa and is being assessed to find out if he has a neuro development (ND) disorder. He has been an inpatient for 8 weeks. He has been recovering well in hospital.

Discharge Plan
Harry's parents are worried that Harry won't follow his prescribed meal plan and that he will return to overexercising on discharge home. It is important to Harry's parents that they are kept well informed about his care.

Harry is frustrated at being in hospital, he wants to go home and see his pets and play on his Xbox. It is important to Harry that he is kept up to date and informed about his care and any changes to his meal plan or the level of activity he is able to do. Harry is worried about the ND assessment he is having.

This is a fictional scenario for training purposes

Important!

Before you commence writing the care plan please refer to:

Mental Health Person-centred Care Plans Standard Operating Procedure (SOP)

Within the person-centred care plan there are 14 sections (accordions). Think which ones would be relevant to complete for Harry. Please refer to Page 17-18 in the SOP for guidance. With each accordion you would continue to document in a person-centred way.

When a section (accordion) is not relevant you must record the rationale within that section(s) in "observation on assessment" box.

Person Centred Care Plan

Patient Goal	Write Harry's goal here (this lets us know that a person-centred conversation has taken place)
Specific Aim [s]	• Involve patient and family with care goals • Recognise who matters to the patient and when they matter • Involved in decisions about care • Involve with discharge planning
Observation on assessment	In this section document what you as the nurse may have observed, about Harry. What additional sections (accordions) may be required?

What will the patient do?	Are there any specific interventions for Harry?
What will the staff do?	• What matters to you? conversation recorded within 24 hours of admission • Family encouraged to visit • Getting to know me completed • Care preferences recorded
Daily Progress	Think about what care you may have delivered to Harry and document here

Section 6: Next Steps Person-centred Care Planning in Practice

Use this space to plan how you will apply what you have learned when using the new person-centred care plans on TRAK. You may want to consider;

- **What changes can you make initially that you can continue to build on?**
- **Do you need more practice?**
- **Do you want to access more resources?**
- **How does this contribute to an overall culture of person-centred care?**
- **As well as considering how you document care are there any other changes to your practice you would consider making?**

Document your next steps here

Section 7: Quality Improvement and Person-centred Care Planning

NHS Lothian is committed to improving person-centred care and care planning. To ensure continuous Quality Improvement the Model Ward Steering Group have developed a Person-Centred Care Assurance Tool known as PCAT 4. The PCAT 4 allows a Senior Charge Nurse or Quality Improvement Facilitator to benchmark the quality of a completed care plan against the standards for Best Practice, to identify opportunities for improvement and areas of good practice. To view this tool, click below

Person-centred Assurance Tool 4 (PCAT 4)

Activity 7

Suggested additional activity: You may want to accompany the Senior Charge Nurse when they are completing a Person-centred Assurance Tool. What are you noticing? What is going well?

Congratulations on completing this resource. Remember to discuss that you have completed this resource with you SCN/Team Lead who can register this on e -roster as a SKILL.

Completion of this tool can be used as evidence for NMC Revalidation.

Additional Resources

NHS Scotland – Design principles to create person-centred records (March 2024). You can read or download this document from HIS website

Butterworth article full reference: Butterworth C (2012): **How to achieve a person centred writing style in care plans** Nursing Older People,Oct. Vol 24. No 8. Page 21-26

Mental Health (scot.nhs.uk) – accessible from an NHS Lothian networked computer

Mental Health Person-centred Care Plans Standard Operating Procedure)

Person Centred Audit TOOL (PCAT4):

Appendix 1 – Sample Care Plan

Person Centred Care Plan		
Goal	Patient Goal	
	Specific Aim [s]	
	Observation on Assessment	
Intervention		
	What will the patient do?	
	What will the staff do?	• What matters to you? conversation recorded within 24 hours of admission • Family encouraged to visit • Getting to know me completed • Care preferences recorded
	Daily Progress	

Person-centred

Care Planning

Introduction to Person-centred Care Planning Workbook

Authors: Janice Wilkinson Version 2.1 Revised from original PCCP workbook May 2021	
Date Authorised	
Authorised by:	
Review Date:	
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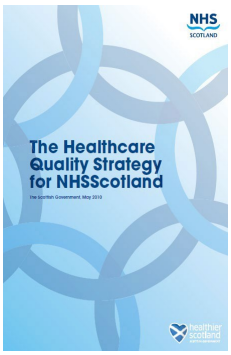

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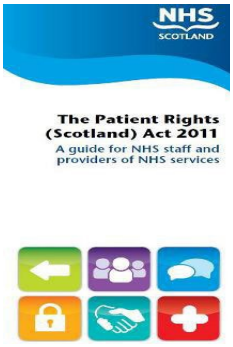

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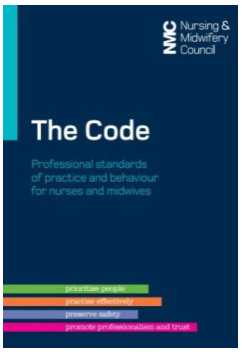

Person-centred care

The Code in Action Animation

Healthcare Improvement Scotland ihub https://ihub.scot/improvement-programmes/scottish- patient-safety-programme-spsp/essentials-of-safe-care/person-centred-care/

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Section 3: Exploring Language in Person-centred Care Plans

When we write and talk about patients our language does not always reflect person-centred principles. It is common for care to be described as a series of problems. In the work by Butterworth, she summarises key values required to achieve a person-centred approach. This audible power point gives examples of how we might demonstrate these values in our documentation.

Activity 4

In the examples below consider what statement best matches how you currently document care. Please also consider what statement is more person-centred. Reflect on any changes you can make to your documentation to make it more person-centred.

These are fictional statements for training purposes

Example 1
Statement 1: Suffers from arthritis and is uncooperative with medication
Statement 2: Peter has arthritis, he has a good understanding of his condition, it is important to Peter that he maintains his independence and that the amount of medication he takes is kept to a minimum. He has expressed that he does not want to take his medication as he is worried about the side effects.

Example 2
Statement 1: Cannot express herself clearly and becomes verbally aggressive and agitated
Statement 2: Mary is able to communicate but sometimes cannot find the right words. Mary is concerned about not being understood. It is important to her that she has the opportunity to express herself. Mary can become frustrated, and she shows this by shouting out and banging her fists on the table.

Example 3
Statement 1: Complaining of pain
Statement 2: Joan has told us she is in pain; she is worried how this will affect her ability to wash and dress herself. It matters to Joan that she stays as independent as possible so she can return home.

Example 4
Statement 1: Suffers from anxiety, asks lots of questions.
Statement 2: Mr Smith has said he can become anxious. It is important to him to be kept well informed and that he can update his family. His aim is to stay informed by asking questions when necessary. He aims to manage his anxiety using relaxation techniques and he feels comfortable to ask for help if he requires it.

Section 4: Starting a Person-centred Conversation

Each person's care needs, expectations and choices will be unique to them. Key to person centred, outcomes based care planning are the conversations where we must identify what these outcomes will be for a person. Our role is to support the person to express what is important to them. The person should be given the opportunity to share with us what is working well and what they would want to change about their care, their expectations of care, their aims and goals and what support they require.

As healthcare professionals we will advise and guide the person and together we will agree what will be in their care plan**.** Creating the care plan this way will focus on what is important to the person and will ensure this is reflected in the care and support they receive.

What matters to you? is a Scotland-wide campaign to encourage and support meaningful conversations between people who provide health and social care and the people, families and carers who receive such care. More information can be found on the What Matters to You Website.

This handy guide includes tips on how to start a conversation in order to discuss what matters to you.

Ongoing communication between the healthcare team, the person and their families and carers are essential to ensure the persons care plan continues to remain relevant for the person. It enables care to be adapted over time to reflect a person's changing needs.

Think about "What matters to you" conversation. Other ways you may phrase this will be in context for the person. It could be a question like:

- What's important to you at this moment?
- What are some of the things you would like to achieve whilst you are in hospital?
- When you have a good day, what are the things that make it good?

From having these types of conversations, you will be able to clarify with the person what is important to them.

Activity 5

Consider the 2 scenarios – What is important to the person, what matters to them?
How would you document this in a person-centred way?

Practice in the boxes below
Remember to also demonstrate person-centred values in your entry

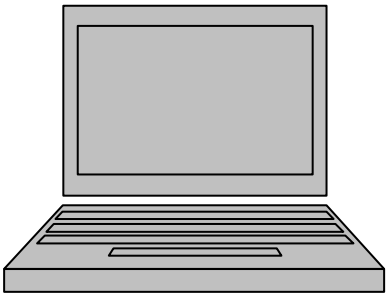
These are fictional scenarios for training purposes

1. ***Joe is a 27-year-old male, diagnosed with a learning disability who is admitted to hospital due to low mood and concerns regarding his ability to keep himself safe within the community. He has 20 hours of support each week and he enjoys spending time with his support team playing pool and accessing the local gym. He advises that his friend from the gym has a special birthday coming up and he is keen to attend. Joe is very independent, and it is important that he is involved in decisions regarding all aspects of his care.***

2. ***Stephanie is a 32-year-old woman diagnosed with a learning disability and generalised anxiety disorder. She is admitted to hospital due to increased symptoms of anxiety and behaviours which are difficult to manage within the community. Prior to admission Stephanie worked 15 hours per week as a volunteer within a charity shop. She is concerned that as she is now in hospital she will lose the friendships she has made at the charity shop and the hours she is able to work.***

Summary so far;
It is anticipated that you will have;

- Explored why a person can expect a person-centred care plan
- Recognised the importance of reflecting on and clarifying personal and organisational values
- how to begin a "what matters to you" conversation
- Considered how you currently document care



Section 5: Writing a Person-centred Care Plan

In this section you will be asked to complete a person-centred care plan, documenting care in a person-centred way. It is anticipated you will apply everything that you have explored so far. This is your opportunity to practice. A scenario has been provided for this activity however if you feel you require further practice, please discuss this with the Person-centred Care Planning Champion in your area who can provide further scenarios for you.

Remember the Person-centred Care Planning Champion in your area can support you with this: they can discuss writing the care plan with you and provide feedback once it is written.

Before you start listen to this audible power point
Listening to this power-point will gives you useful advice on completing care plans in a person-centred way and includes fictional TRAK entries for the various sections contained in TRAK

Once you have completed the care plan, please discuss this with the Person-centred Care Planning Champion in your area, it is anticipated that you will;

- Receive feedback on the care plan you have written
- Discuss how you have found the process of writing in a person-centred way
- Explore how you can apply this learning in the context of your practice
- Discuss and identify what your first steps towards writing person centred care plans will be.
- Be shown how to access the person-centred care plan and the other outcomes-based care plans on TRAK

Activity 6

Using the template **below to** write a person-centred care plan for Olivia.
The care plan is based on a TRAK based person-centred care plan with the relevant sections included:

Olivia Smith, 28 years old.

Olivia lives in shared accommodation with 24-hour support. She is admitted to hospital due to concerns regarding significant weight loss and behaviours which the support team are unable to manage within the community. She is diagnosed with a learning disability, autism, asthma, and diabetes.

Both Olivia and her support team advise that she likes to be known as Livia.

Diabetes

Livia has always had a restricted diet which has an impact on how her support team are able to manage her diabetes. Her diabetes is currently diet controlled and she likes to have sugar in her tea and coffee and enjoys chocolate biscuits. Livia is aware this is not advised however she does not feel she needs to follow the advice given. She feels that checking her blood glucose more than once per day is too often, however at her home the team are able to persuade Livia to carry out more frequent tests. Livia responds well to the use of visual prompts and social stories to help her understanding.

Asthma

Livia uses a salbutamol inhaler when required and would like that left beside her. She doesn't do peak flows and doesn't understand what they are or why she needs to do them. It is important that Livia is well informed as it is making her feel worried that if she does not do them, this will have an impact on her health and her ability to go for walks with her friends.

Nocturnal Enuresis

During the hospital admission staff members report that Livia is frequently incontinent overnight. Livia does not report this to staff and appears unaware that this may be a problem. When a staff member talks to Livia about this and possible solutions, Livia reports that she did know this was happening but was too embarrassed to tell staff. She advises that this happens a lot and would like some support to prevent this if possible.

Livia feels frustrated at being in hospital, she lives a busy life and wants to get back to her normal daily routines as quickly as possible. It is important that she is kept up to date and informed about her care. It may be the case that adaptations will be required to do so.

This is a fictional scenario for training purposes

Important!

Before you commence writing the care plan please refer to:

Mental Health Person-centred Care Planning Standard Operating Procedure (SOP)

Within the person-centred care plan there are 14 sections (accordions). Think which ones would be relevant to complete for Olivia. Please refer to Page 17-18 in the SOP for guidance. With each accordion you would continue to document in a person-centred way.

When a section (accordion) is not relevant you must record the rationale within that section(s) in "observation on assessment" box.

Person Centred Care Plan

Patient Goal	Write Olivia's goal here (this lets us know that a person-centred conversation has taken place)
Specific Aim [s]	• Involve patient and family with care goals • Recognise who matters to the patient and when they matter • Involved in decisions about care • Involve with discharge planning
Observation on assessment	In this section document what you as the nurse may have observed, about Olivia. What additional sections (accordions) may be required?

What will the patient do?

Are there any specific interventions for Olivia?

What will the staff do?

- What matters to you? conversation recorded within 24 hours of admission
- Family encouraged to visit
- Getting to know me completed
- Care preferences recorded

Daily Progress

Think about what care you may have delivered to Olivia and document here

Section 6: Next Steps Person-centred Care Planning in Practice

Use this space to plan how you will apply what you have learned when using the new person-centred care plans on TRAK. You may want to consider;

- **What changes can you make initially that you can continue to build on?**
- **Do you need more practice?**
- **Do you want to access more resources?**
- **How does this contribute to an overall culture of person-centred care?**
- **As well as considering how you document care are there any other changes to your practice you would consider making?**

Document your next steps here

Section 7: Quality Improvement and Person-centred Care Planning

NHS Lothian is committed to improving person-centred care and care planning. To ensure continuous Quality Improvement the Model Ward Steering Group have developed a Person-Centred Care Assurance Tool known as PCAT 4. The PCAT 4 allows a Senior Charge Nurse or Quality Improvement Facilitator to benchmark the quality of a completed care plan against the standards for Best Practice, to identify opportunities for improvement and areas of good practice. To view this tool, click below

Person-centred Assurance Tool 4 (PCAT 4)

Activity 7

Suggested additional activity: You may want to accompany the Senior Charge Nurse when they are completing a Person-centred Assurance Tool. What are you noticing? What is going well?

Congratulations on completing this resource. Remember to discuss that you have completed this resource with you SCN/Team Lead who can register this on e -roster as a SKILL.

Completion of this tool can be used as evidence for NMC Revalidation.

Additional Resources

NHS Scotland – Design principles to create person-centred records (March 2024). You can read or download this document from HIS website

Butterworth article full reference: Butterworth C (2012): **How to achieve a person centred writing style in care plans** Nursing Older People,Oct. Vol 24. No 8. Page 21-26

Mental Health (scot.nhs.uk) – accessible from an NHS Lothian networked computer

Mental Health Person-centred Care Plan Standard Operating Procedure

Person Centred Audit TOOL (PCAT4):

Appendix 1 – Sample Care Plan

Person Centred Care Plan		
Goal	Patient Goal	
	Specific Aim [s]	
	Observation on Assessment	
Intervention		
	What will the patient do?	
	What will the staff do?	• What matters to you? conversation recorded within 24 hours of admission • Family encouraged to visit • Getting to know me completed • Care preferences recorded
	Daily Progress	

Person-centred

Care Planning

Introduction to Person-centred Care Planning Workbook

Authors Janice Wilkinson Version 2.1 Revised from original PCCP workbook May 2021	
Date Authorised	
Authorised by:	
Review Date:	
Key Words:	Person-centred care planning, values, mental health

Background

Following a Model Ward Pilot in NHS Lothian, person-centred care planning on Trakcare (TRAK) was introduced in July 2021. Initially 130 areas signed up initially and the roll out continues with more areas coming on board with person-centred care planning on TRAK.

About this Resource

This workbook has been designed for you to use with the guidance and support of members of your team who are Person-centred Care Planning Champions to guide you in writing person- centred care plans. We recommend this workbook should be utilised in conjunction with key supporting documents in particular:
Mental Health Person-centred Care Plan Standard Operating Procedure

Overall Aim: To provide a learning framework for person-centred care planning so that you can apply these principles in clinical practice.

Learning Outcomes:

- Reflect on the current legislation and drivers relating to person-centred care planning.
- Explore your own personal values and beliefs in providing person-centred care and writing care plans.
- Practise writing person-centred care plans with the support of your Person-centred Care Planning Champion.
- Identify your future learning needs and support with your Person-centred Care Planning Champion.

There are **7** sections in this workbook which contains a variety of learning. It is anticipated that you will work through each of the 7 sections. Each section will have resources for you to access and learning activities for you to complete.

1. Introduction: Why person-centred care planning?
2. Exploring values.
3. Exploring the use of language in person-centred care.
4. Starting a person-centred conversation.
5. Writing a person-centred care plan.
6. Next steps/person-centred care planning on TRAK.
7. Quality improvement and person- centred care plans.

Once you have completed sections 1-5, it is anticipated you will discuss your learning with the Person-centred Care Planning Champion in your area to plan your next steps (section 6+7).

Please also inform your line manager once you have completed this resource. Your line manager can then add this as a **skill** – "Introduction to Person-centred Care Planning" onto e-roster to register you have completed this workbook.

Activity 1
Before you begin, take some time to reflect on what person-centred care means to you and your understanding of person-centred care planning Document your thoughts below. **You may want to revisit this section once you have completed this resource and add to your notes.**

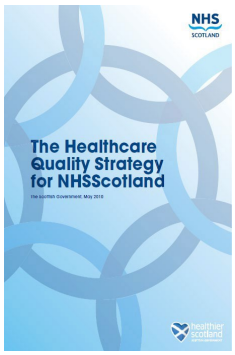
Think about what experience you have to date what care plan documentation have used already? Identify good areas of your practice? Identify what you find challenging?

Section 1: Introduction: Why Person-centred Care Planning?

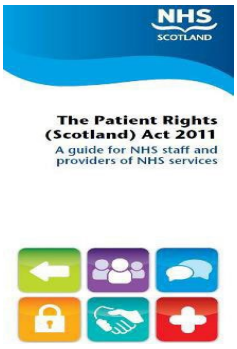
Begin by watching this video delivered by Gillian McAuley, Nursing Director, Acute Services, NHS Lothian who introduces this resource.

Activity 2

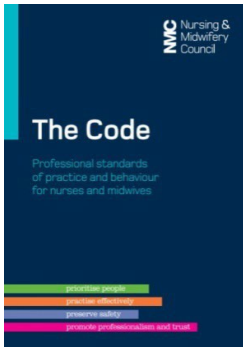
Access and explore the following resources and record your thoughts in the text boxes below.



Healthcare Quality Strategy



Patients right act (2011)



Person-centred care

The Code in Action Animation

Healthcare Improvement Scotland ihub https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/essentials-of-safe-care/person-centred-care/

Reflecting on these resources, what specifically relates to person-centred care planning?

When making notes consider aspects including patient involvement, shared decision making, choice and agreement and consent

Section 2: Exploring Values

Person-centred care planning is one element of person-centred care. To be able to care plan in a way that always puts the patient at the centre of the care planning process then it is important you spend some time exploring the key values that ensure person centred ways of working.

Access and read the following

Our Values – NHS Lothian | Our Organisation

How to achieve a person -centred writing style in care plans (Butterworth 2012)

The above link will work from an NHS Lothian networked computer. The article can also be accessed via the Knowledge Network: you will need to be logged in to access it.

Activity 3 Reflect on how you would you describe your own personal values. How do your own values compare with NHS Lothian Values? Record your reflections below

Click here to access an audio recording of practitioners discussing applying these values when delivering care

Section 3: Exploring Language in Person-centred Care Plans

When we write and talk about patients our language does not always reflect person-centred principles. It is common for care to be described as a series of problems. In the work by Butterworth, she summarises key values required to achieve a person-centred approach. This audible power point gives examples of how we might demonstrate these values in our documentation.

Activity 4

In the examples below consider what statement best matches how you currently document care. Please also consider what statement is more person-centred. Reflect on any changes you can make to your documentation to make it more person-centred.

These are fictional statements for training purposes

Example 1
Statement 1: Suffers from arthritis and is uncooperative with medication
Statement 2: Peter has arthritis, he has a good understanding of his condition, it is important to Peter that he maintains his independence and that the amount of medication he takes is kept to a minimum. He has expressed that he does not want to take his medication as he is worried about the side effects.

Example 2
Statement 1: Cannot express herself clearly and becomes verbally aggressive and agitated
Statement 2: Mary is able to communicate but sometimes cannot find the right words. Mary is concerned about not being understood. It is important to her that she has the opportunity to express herself. Mary can become frustrated, and she shows this by shouting out and banging her fists on the table.

Example 3
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Statement 2: Joan has told us she is in pain; she is worried how this will affect her ability to wash and dress herself. It matters to Joan that she stays as independent as possible so she can return home.

Example 4
Statement 1: Suffers from anxiety, asks lots of questions.
Statement 2: Mr Smith has said he can become anxious. It is important to him to be kept well informed and that he can update his family. His aim is to stay informed by asking questions when necessary. He aims to manage his anxiety using relaxation techniques and he feels comfortable to ask for help if he requires it.

Section 4: Starting a Person-centred Conversation

Each person's care needs, expectations and choices will be unique to them. Key to person centred, outcomes based care planning are the conversations where we must identify what these outcomes will be for a person. Our role is to support the person to express what is important to them. The person should be given the opportunity to share with us what is working well and what they would want to change about their care, their expectations of care, their aims and goals and what support they require.

As healthcare professionals we will advise and guide the person and together we will agree what will be in their care plan**.** Creating the care plan this way will focus on what is important to the person and will ensure this is reflected in the care and support they receive.

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Think about "What matters to you" conversation. Other ways you may phrase this will be in context for the person. It could be a question like:

- What's important to you at this moment?
- What are some of the things you would like to achieve whilst you are in hospital?
- When you have a good day, what are the things that make it good?

From having these types of conversations, you will be able to clarify with the person what is important to them.

Activity 5

Consider the 2 scenarios – What is important to the person, what matters to them?
How would you document this in a person-centred way?

Practice in the boxes below
Remember to also demonstrate person-centred values in your entry

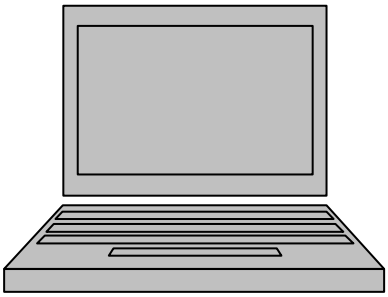
These are fictional scenarios for training purposes

1. ***Beth is 43 years old and has been admitted to hospital due to low mood and suicidal ideation, she is unable to keep herself safe at home. It is her daughter's 13th birthday party in a few weeks, and she wants to be able to go to that. Beth is very independent, and it is important to her that she is involved in all decisions about her care. She works in a high-powered job and is keen to get back to work.***

2. ***Paul has been diagnosed with bipolar disorder. He has been admitted to hospital due to displaying increasingly extreme risk-taking behaviours resulting in him being in contact with the police. Paul is suffering from poor sleep and weight loss due to mania. He does not like how he looks and wants to regain the weight he has lost. Paul enjoys spending time with friends, watching football, and walking his dog.***

Summary so far;
It is anticipated that you will have;

- Explored why a person can expect a person-centred care plan
- Recognised the importance of reflecting on and clarifying personal and organisational values
- how to begin a "what matters to you" conversation
- Considered how you currently document care



Section 5: Writing a Person-centred Care Plan

In this section you will be asked to complete a person-centred care plan, documenting care in a person-centred way. It is anticipated you will apply everything that you have explored so far. This is your opportunity to practice. A scenario has been provided for this activity however if you feel you require further practice, please discuss this with the Person-centred Care Planning Champion in your area who can provide further scenarios for you.

Remember the Person-centred Care Planning Champion in your area can support you with this: they can discuss writing the care plan with you and provide feedback once it is written.

Before you start listen to this audible power point
Listening to this power-point will gives you useful advice on completing care plans in a person-centred way and includes fictional TRAK entries for the various sections contained in TRAK

Once you have completed the care plan, please discuss this with the Person-centred Care Planning Champion in your area, it is anticipated that you will;

- Receive feedback on the care plan you have written
- Discuss how you have found the process of writing in a person-centred way
- Explore how you can apply this learning in the context of your practice
- Discuss and identify what your first steps towards writing person centred care plans will be.
- Be shown how to access the person-centred care plan and the other outcomes-based care plans on TRAK

Activity 6

Using the template **below to** write a person-centred care plan for David.
The care plan is based on a TRAK based person-centred care plan with the relevant sections included:

David Smith, age 55, likes to be known as David.

David is married with 2 grown up children. He lives with his wife Mary; Mary likes to take care of him which David enjoys. Mary is extremely important to David, and he trusts her completely. David was diagnosed with type 2 diabetes a year ago.

Mental Health

David is experiencing psychosis and is finding it difficult to trust anyone except his wife Mary. He has not been taking his medication or eating as he believes these are poisoned.

Diabetes

Diet controlled, David likes to take sugar in his tea and coffee and enjoys a chocolate biscuit too – he knows this is not what is advised however David believes that he does not need to follow this advice. He feels that any more than once a day is too often to check his blood glucose, however whilst at home Mary has been able persuade him to do more frequent tests if required.

Chronic Obstructive Pulmonary Disease (COPD)

David suffers from COPD which is managed with the use of inhalers. He has not been using his inhalers recently as he believes they are poisoned. He normally smokes 20 cigarettes a day however recently this has increased to 60 a day which has resulted in financial issues due to this added expenditure.

David is frustrated at not being able to smoke in and around the hospital and he wants to get back home as quickly as possible so that Mary can take care of him. It is important to Harry that he is kept up to date ad informed about his care.

This is a fictional scenario for training purposes

Important!

Before you commence writing the care plan please refer to:

Mental Health Person-centred Care Planning Standard Operating Procedure (SOP)

Within the person-centred care plan there are 14 sections (accordions). Think which ones would be relevant to complete for David. Please refer to Page 17-18 in the SOP for guidance. With each accordion you would continue to document in a person-centred way.

When a section (accordion) is not relevant you must record the rationale within that section(s) in "observation on assessment" box.

Person Centred Care Plan

Patient Goal	Write David's goal here (this lets us know that a person-centred conversation has taken place)
Specific Aim [s]	• Involve patient and family with care goals • Recognise who matters to the patient and when they matter • Involved in decisions about care • Involve with discharge planning
Observation on assessment	In this section document what you as the nurse may have observed, about David. What additional sections (accordions) may be required?

What will the patient do?	Are there any specific interventions for David?
What will the staff do?	• What matters to you? conversation recorded within 24 hours of admission • Family encouraged to visit • Getting to know me completed • Care preferences recorded
Daily Progress	Think about what care you may have delivered to David and document here

Section 6: Next Steps Person-centred Care Planning in Practice

Use this space to plan how you will apply what you have learned when using the new person-centred care plans on TRAK. You may want to consider;

- **What changes can you make initially that you can continue to build on?**
- **Do you need more practice?**
- **Do you want to access more resources?**
- **How does this contribute to an overall culture of person-centred care?**
- **As well as considering how you document care are there any other changes to your practice you would consider making?**

Document your next steps here

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NHS Lothian is committed to improving person-centred care and care planning. To ensure continuous Quality Improvement the Model Ward Steering Group have developed a Person-Centred Care Assurance Tool known as Mental Health PCAT. The Mental Health PCAT allows a Senior Charge Nurse or Quality Improvement Facilitator to benchmark the quality of a completed care plan against the standards for Best Practice, to identify opportunities for improvement and areas of good practice. To view this tool, click below

Person-centred Assurance Tool 4 (PCAT 4)

Activity 7

Suggested additional activity: You may want to accompany the Senior Charge Nurse when they are completing a Person-centred Assurance Tool. What are you noticing? What is going well?

Congratulations on completing this resource. Remember to discuss that you have completed this resource with you SCN/Team Lead who can register this on e -roster as a SKILL.

Completion of this tool can be used as evidence for NMC Revalidation.

Additional Resources

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Mental Health Person-centred Care Plan Standard Operating Procedure

Person Centred Audit TOOL (PCAT4):

Appendix 1 – Sample Care Plan

Person Centred Care Plan		
Goal	Patient Goal	
	Specific Aim [s]	
	Observation on Assessment	
Intervention		
	What will the patient do?	
	What will the staff do?	• What matters to you? conversation recorded within 24 hours of admission • Family encouraged to visit • Getting to know me completed • Care preferences recorded
	Daily Progress	

Person-centred

Care Planning