Person Centered Care Planning
EHSCP Care Homes

Which ambition of the Nursing and Midwifery Strategy does your project align to? *Deliver excellent person-centred compassionate care.*

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Aim Statement

Our project's aim was to replace current care documentation within the City of Edinburgh care homes with standardised documentation which would be more person centred and easier for staff to complete and use. The support plans would include health plans containing clinical information on residents' health conditions which was not previously in plans. Evaluation documentation was also introduced to evaluate and audit the documentation as this was not being evidenced and was a recommendation from the care inspectorate.

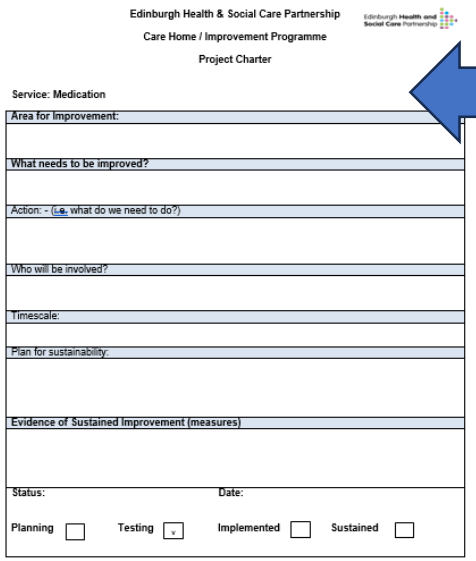
According to the Health & Social Care Standards- ***Care providers must ensure that staff have access to and use clear, accurate and up-to-date individualised care plans to provide care which meets residents' needs in a way which is acceptable to them.***

Project Scope

QI leads met with the senior care home manager and care home managers to discuss the challenges with the current documentation and what improvements could be made.

The QI leads completed a scoping exercise across Scotland to find out what care plan documentation was in use in various services and settings. We then agreed on documentation that could deliver what we wanted. The size of the project was significant to introduce this across 9 care homes, implementing new documentation for approximately 500 residents and training over 400 members of staff in less than 12 months.

Project Planning using a Quality Management system


Edinburgh Health & Social Care Partnership

Care Home / Improvement Programme

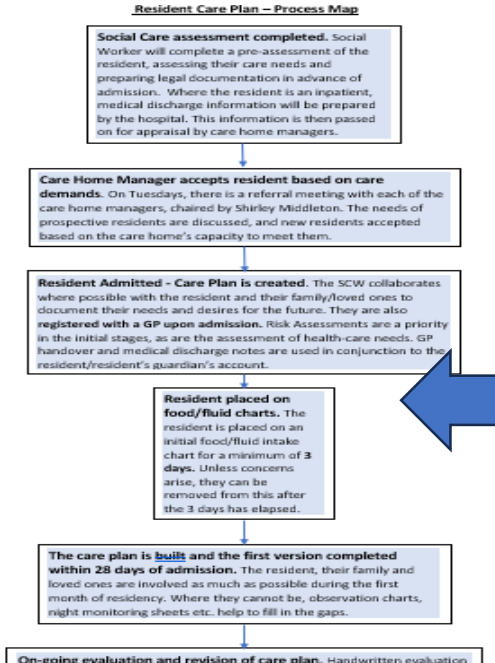
Project Charter

Service: Medication

Area for Improvement:
What needs to be improved?
Action: - (i.e. what do we need to do?)
Who will be involved?
Timescale:
Plan for sustainability:
Evidence of Sustained Improvement (measures)

Status: Date:

Planning ☐ Testing ☑ Implemented ☐ Sustained ☐


Resident Care Plan – Process Map

Social Care assessment completed. Social Worker will complete a pre-assessment of the resident, assessing their care needs and preparing legal documentation in advance of admission. Where the resident is an inpatient, medical discharge information will be prepared by the hospital. This information is then passed on for appraisal by care home managers.

Care Home Manager accepts resident based on care demands. On Tuesdays, there is a referral meeting with each of the care home managers, chaired by Shirley Middleton. The needs of prospective residents are discussed, and new residents accepted based on the care home's capacity to meet them.

Resident Admitted - Care Plan is created. The SCW collaborates where possible with the resident and their family/loved ones to document their needs and desires for the future. They are also **registered with a GP upon admission.** Risk Assessments are a priority in the initial stages, as are the assessment of health-care needs. GP handover and medical discharge notes are used in conjunction to the resident/resident's guardian's account.

Resident placed on food/fluid charts. The resident is placed on an initial food/fluid intake chart for a minimum of **3 days.** Unless concerns arise, they can be removed from this after the 3 days has elapsed.

The care plan is built and the first version completed within 28 days of admission. The resident, their family and loved ones are involved as much as possible during the first month of residency. Where they cannot be, observation charts, night monitoring sheets etc. help to fill in the gaps.

On-going evaluation and revision of care plan. Handwritten evaluation

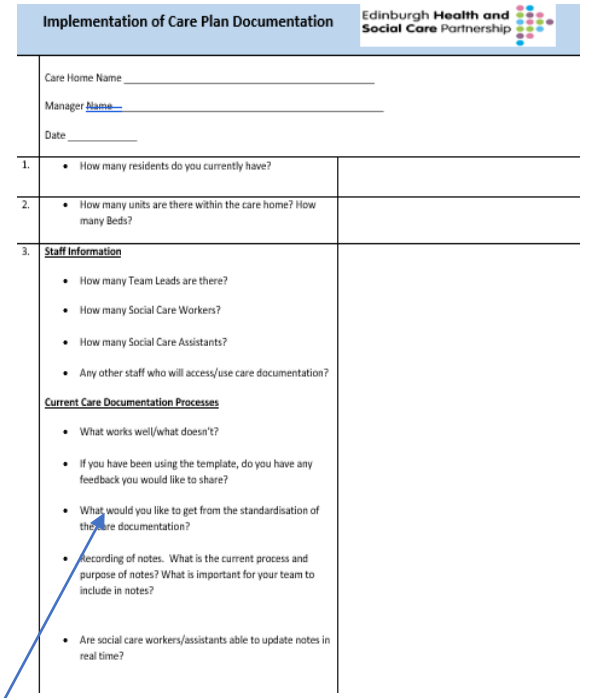
Project Charters were created that included actions, timescales, and sustainability plans.

- **We liaised with external care home stakeholders including the residential review team, Care inspectorate, Quality leads, OT, SALT, CHET, and Diet & Nutrition .**
- **We completed scoping Questionnaires and one to one interviews with Care Home Managers**
- **We presented the project at various forums, The care home strategic oversight group and Care home manager meetings. Documentation was then provided to other services for feedback. From this MHSCP requested to implement the same documentation within their care home.**

To compliment the new documentation and align with standardising care home documents, we developed a New logo for the care homes/front covers/inserts

Process mapping and questionnaires allowed us to understand systems/processes for administering care/medication, identifying any gaps/good/bad practice.

The initial support plans were tested across the homes. Feedback was then reviewed, and any improvements identified were carried out.


Implementation of Care Plan Documentation

Edinburgh Health and Social Care Partnership

Care Home Name _____

Manager Name _____

Date _____

1. How many residents do you currently have?
2. How many units are there within the care home? How many Beds?
3. **Staff Information**
   - How many Team Leads are there?
   - How many Social Care Workers?
   - How many Social Care Assistants?
   - Any other staff who will access/use care documentation?

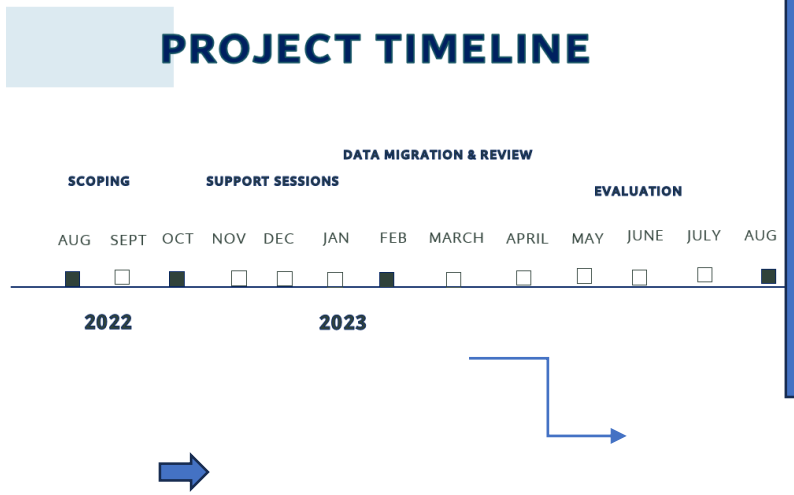
Current Care Documentation Processes

- What works well/what doesn't?
- If you have been using the template, do you have any feedback you would like to share?
- What would you like to get from the standardisation of the care documentation?
- Recording of notes. What is the current process and purpose of notes? What is important for your team to include in notes?
- Are social care workers/assistants able to update notes in real time?

Homes were asked to test the plans prior to implementation & provide feedback for Improvement

Project Implementation

A phased implementation was completed across the 9 homes across 10 months (Oct 2022-Aug 2023.



Appropriate training and support for team members was organised to ensure all staff were equipped and confident to work with the new documentation.

Staff lists were collated for each home and 3 training sessions were provided daily, Morning, Afternoon & Evening to accommodate all staff

Training/Guidance/Troubleshooting documents/ were created as support tools. This included providing training resource folders, Vimeos, Step by step guides.

A training schedule was created for all the homes. Once training was completed, the transition from old to new documentation began.

Where required additional training, and support was provided. This included organising each homes hard drive to ensure all old documentation was removed and new plans were saved electronically correctly. 1-1 sessions were provided with identified 'champions' to ensure they were confident in their role.

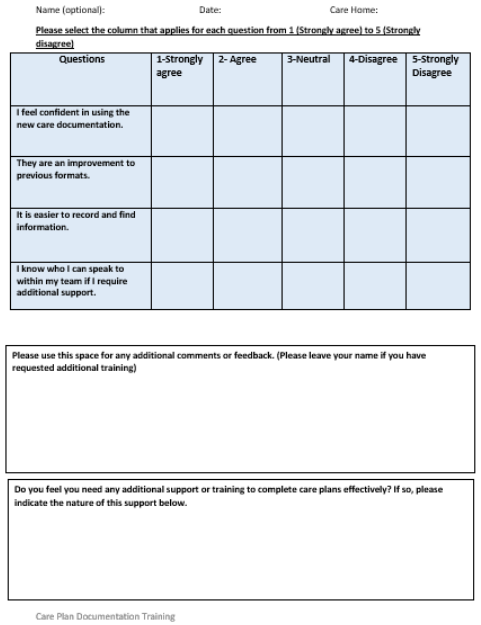
We liaised with each homes to agree a timescale for the transition of documents. Regular check ins, audits would take place to ensure the smooth transition and ensure progress was being made within set timelines.

During the implementation stage 416 staff were trained & Over 80% of the 339 support plans plans had been transitioned

Evaluation stage

We conducted a thorough post-implementation review to assess the projects performance, impact and the achievement of objectives.

- Progress was reviewed within set timescales. We completed comprehensive content reviews/audits using our newly developed audit tool /evaluation forms. This allowed us to monitor progress and provide quality assurance.
- We observed residents and how reflective and accurate their plans were of their current care needs.
- Evaluations were completed with staff via questionnaires to determine the impact of training and the documentation. Using questionnaires/email/attending Care Home Manager meetings we collated feedback to use for any further improvements. Data was displayed in Pareto charts.
- Root cause analysis allowed us to identify and mitigate issues and adapt our strategy, as necessary.



Name (optional): Date: Care Home:

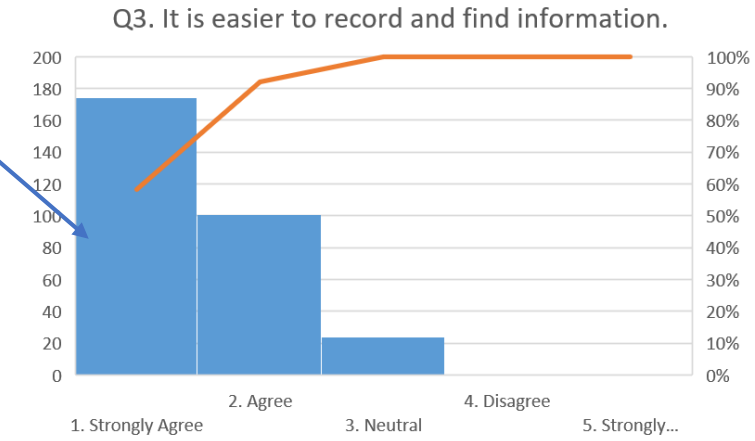
Please select the column that applies for each question from 1 (Strongly agree) to 5 (Strongly disagree)

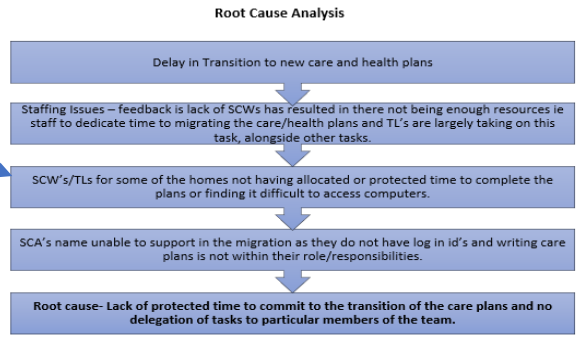
Questions	1-Strongly agree	2- Agree	3-Neutral	4-Disagree	5-Strongly Disagree
I feel confident in using the new care documentation.					
They are an improvement to previous formats.					
It is easier to record and find information.					
I know who I can speak to within my team if I require additional support.					

Please use this space for any additional comments or feedback. (Please leave your name if you have requested additional training)

Do you feel you need any additional support or training to complete care plans effectively? If so, please indicate the nature of this support below.

Care Plan Documentation Training





Evaluation stage

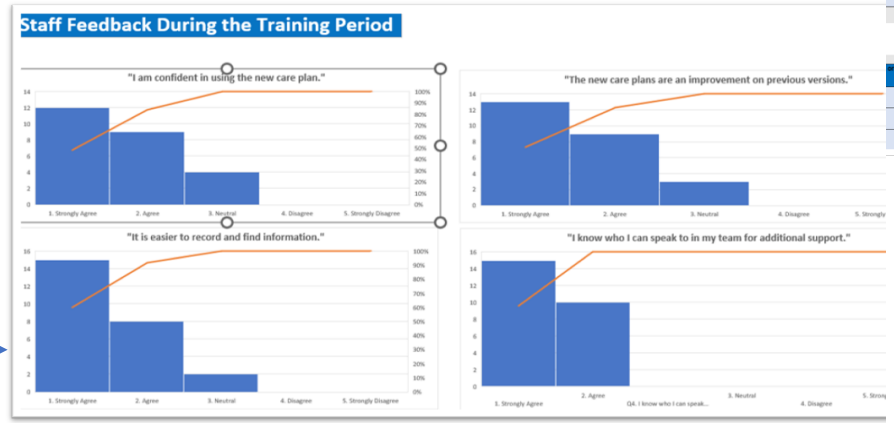
- **340 Staff said the new documentation was an improvement to previous plans and for those who did not respond this was due to them not being involved in the writing of care/health plans.**

- **Each home was provided with a comprehensive evaluation document which provided a full breakdown of all support provided i.e. the no of staff trained/staff feedback/Identified Champions. We also included Recommendations and areas for improvement.**

Feedback from Training

"Enjoyed, comprehensive explanation. Thank you. It will be good having a standardised system across all the care homes."

"The new care plans are easier to understand. The training was very good and able to discuss any questions".



- 13 members of staff requested IT Training to be more efficient in their role.
- 3 requested training on mental health.
- 2 requested more in-depth training on End of life.
- Some staff mentioned they do not have access the learning hub.

Care Inspectorate Feedback Post Implementation

NHS Lothian

Within 12 months the care documentation was implemented into 9 CEC care homes. The homes have since been inspected by the Care Inspectorate and reports commented on how person centred the care and health plans were:

Clovenstone
The plans were person centred and included preferences of people experiencing care. Personal plans contained comprehensive information and guidance was available for staff to follow to ensure people's needs were met.

Marionville
The new plans we observed demonstrated person centeredness, people's preference and wishes.

Royston
Healthcare plans were a beneficial addition to each person's care plan and gave staff a better understanding of people's health conditions and how this might affect their needs and abilities.

Ferrylee
Personal Plans contained people's health, wellbeing and preferences which allowed staff to care for and support them as they wished. As a result, people received support that was right for them.

Jewel House
The plans we sampled were person centred, contained information relating to dependency, risk assessments with evidence of regular reviews.

Fords Road
Personal Plans clearly detailed how people's health & wellbeing needs would be met. People's preferences were noted in plans and staff adhered to them.

Thank you for listening

Any questions?