Care planning exercise

Aged residential care collaborative

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Reducing Harm from Falls programme

June 2014

Definition

Fall prevention care planning is:

- a process by which the residents' risk assessment information is translated into an action plan to address the identified patient needs
- These resident specific actions are additional to the care we provide to keep all residents safe.

Care planning accounts for multiple factors that pertain to a resident's problems and therefore all clinical data needs to be synthesised to create the plan of care.

Questions I am often asked

Falls prevention care planning

- What care planning tool would you advise?
- Falls prevention is complex; how can we avoid using checklist care plans while ensuring strategies are not missed?
- Nurses complain about the amount of paperwork required when admitting patients; how do we condense while ensuring patient assessment and planning is complete?
- How do you individualise a care plan when many actions are considered essential in keeping patients safe?
- Is there a list of cares for all regardless of the risk and, if so, how can we ensure compliance with their implementation?

General findings from 20 DHBs' falls care plans

- No DHB care plans the same
- Majority relied on tick box lists
- No clear distinction between business as usual care and individualised patient falls strategies
- Little evidence that patient and family involved but those that did mainly suggest giving the patient an information pamphlet
- Patient goals seldom mentioned
- Evaluation of strategies rarely mentioned
- Some gave instruction as to when a reassessment would be required
- No care plan guidelines (suggested strategies to be explored)
- Policies and procedures did not provide clear direction of the standard of care planning

Your turn to do some work

Thank you to those who brought in their risk assessments and care plans.

This next reflective session is about

all sharing and all learning

Reflective exercise

1. Check that you have de-identified any reference to the resident on the paperwork you have brought in
2. Cut off your logos if you prefer
3. Now find someone in the room that you do not know and do not work with and sit next to them
4. Swap your paperwork
5. You will be working in pairs; each of you will have to reflect from two lens – one as a carer new to the facility and one as the manager/clinical manager

Reflective exercise

- Where is the care plan housed and is it easy for the new carer to access?
- *Would I, as a new carer, go and access it?*
- Is falls risk discussed at each handover and how do you know? (*use a template for handover for example)*
- *If I thought the risk had changed for the resident, would I be able to speak out?*
- Will the new carer be allocated the same clients each *shift (continuity of care that builds knowledge and makes changes easy to recognise*)
- *If I get changed often, will I know enough about the client to keep them safe?*
- Are there reminders/processes in the client room regarding the falls risk and strategies needed to keep the client safe (signaling system)
- *Do I have to go to the notes each time to remind me if I forget or things change?*

Reflective exercise

- How does InterRAI assessment inform the falls care plan in your place?
- Is the link to InterRAI obvious on your care plan and how ?
- *How are the findings of InterRAI shared with me?*
- Do the identified risks in your risk assessment have corresponding strategies in the care plan?
- How is implementation of the care plan strategies measured each day?
- *How is my input documented?*
- Is there evidence on the care plan that the strategies have been updated in real time as the resident's risk changes.
- *If I notice a change, what should I do?*

The evidence

Topic 3 Health Quality & Safety Commission website www.hqsc.govt.nz

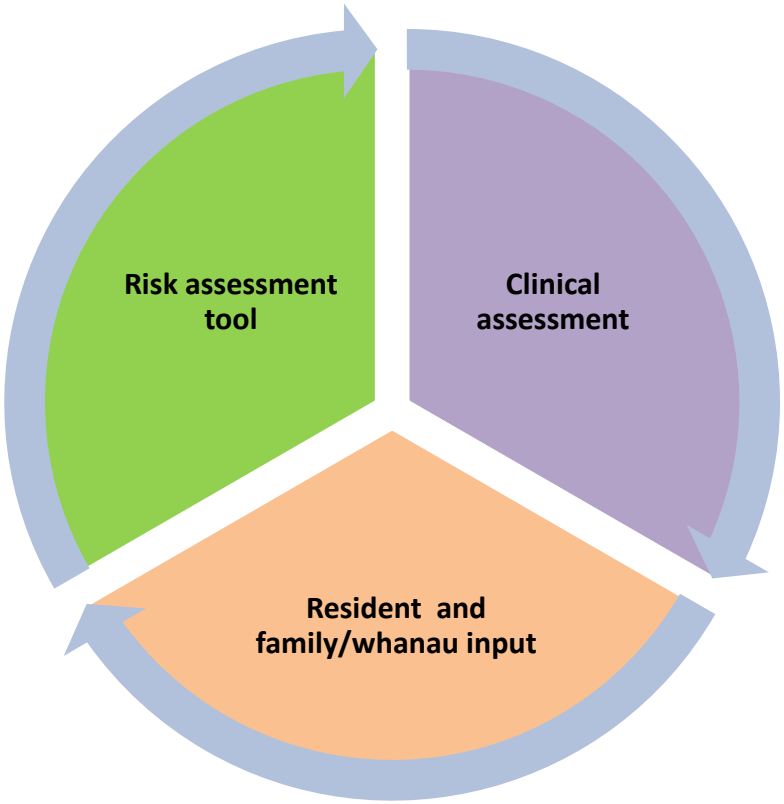
Contains a summary of all recent evidence

Recommendations

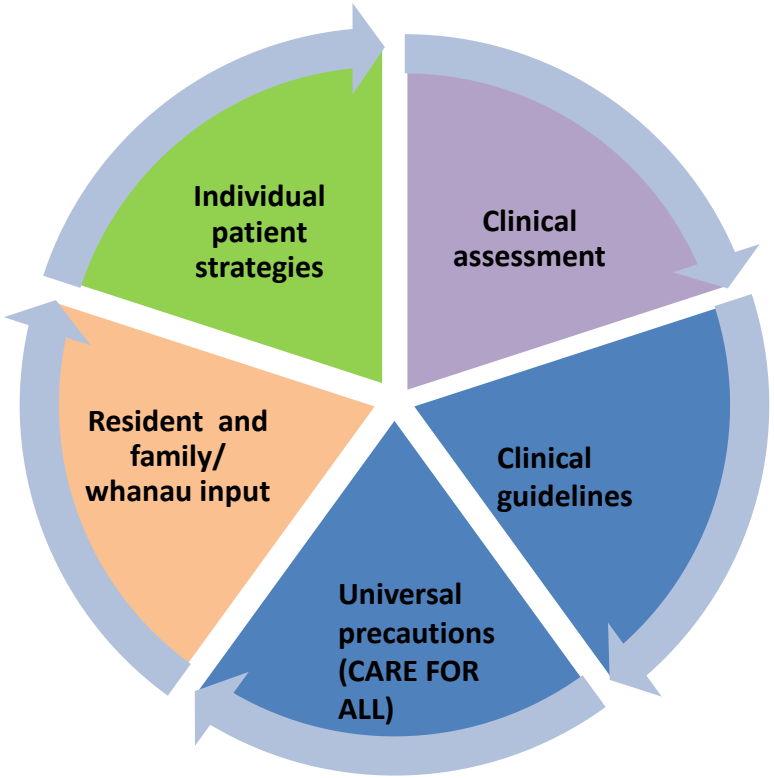
Care plans

- Implemented universal precautions are automatically part of careplan and be business as usual
- Direct correlation between the risk factors identified and individual care strategies planned
- Guidelines are useful in helping clinicians to identify strategies but should not be used as tick list/box exercise
- Residents and families are partners in care so document their involvement
- Resident information pamphlets are a tool to enhance partnership not the only answer
- Structure of individual falls care plan should be integrated into general care plan, have patient goals and a method of evaluating effectiveness of strategies
- Patient condition dictates when reassessment of both risk status and careplan reoccurs

A falls prevention model



Falls risk assessment



Falls care planning

Reducing harm from falls