Evaluating a new care planning system in nursing homes

FOLLOWING an audit of nursing homes inspection reports in Somerset which showed that many homes were having difficulty keeping adequate nursing records and care plans, a research project was carried out with the aim of devising a better system. This led to the development of the Somerset Health Authority Records and Plans (SHARP) system, which was tailored to suit the needs of long-term care.

The particular aims of the project were:
- To develop a purpose-designed, evidence-based nursing documentation system for use in nursing homes;
- To devise a way of ensuring that the quality of care given to those in nursing homes could be readily evaluated from the care records;
- To develop a system that was user-friendly to nursing and care staff and at the same time gave all necessary information. As such, proprietors would be able to feel confident that the care given was reflected in the records.

Record-keeping
Many nursing homes do not keep adequate records. As a nursing home inspector, I have gathered anecdotal evidence of the attitudes of staff to record-keeping and of the reasons given for its being inadequate. Much of this evidence is borne out by the literature. One of the most often-cited reasons for keeping inadequate records is lack of time (Murray, 1997). However, Moody and Snyder (1995) found that ‘even when nurses were not busy, documentation was still incomplete’. McEroy et al (1995) cite a study that found that managers failed to recognise the time needed to maintain adequate records. According to the UKCC (1998): ‘record-keeping is an integral part of nursing ... not an optional extra to be fitted in if circumstances allow’.

Many nurses do not seem to realise the importance of maintaining adequate records and view it as a distraction from work. Despite evidence to the contrary (McEroy et al, 1995), many nurses working in nursing homes do not consider that there could be a correlation between good care and good documentation. The UKCC (1998) has also stated that the quality of record-keeping is a reflection of the standard of professional practice.

Background to the project
The need for better records in care homes has been highlighted by a number of major policy documents. At the time of devising the SHARP package, two significant documents were under development: the Care Standards Act (DoH, 2000), which was then at bill stage, and the document National Minimum Standards: Care homes for older people (DoH, 2001). The Care Standards Act makes provision for the setting of national minimum standards for all client groups and for these standards to be taken into account by regulators. The National Minimum Standards document sets the standards for a range of areas of care, including the keeping of ‘a service-user plan of care’. Although the final requirements were not known when the the SHARP project was being developing, the standards specified in 1999 for good practice were, so these were incorporated in the SHARP system.

A questionnaire was distributed to nurses in 13 homes in Somerset in October 1999 and 58 responses were received. Included was a question about whether time was allocated during each shift for record-keeping and, if so, how much. Responses varied from home to home and even within homes, suggesting there was no clear directive from the management or person in charge.

Devising the SHARP system
First, a nursing model was selected to use as a basis for the new system. Various models were considered, including Roy (Akinsanya et al, 1994), Orem (Cavanagh, 1991) and Roper-Logan-Tierney (Newton, 1991). The latter model was chosen, because it seemed to fit best the needs of predominantly older people. The system was devised using the framework of the nursing process (Aggleton and Chalmers, 1999), which requires that there is a systematic process for care delivery:
- Assessment;
- Goal-setting or a rationale for care;
- Prescription (and delivery) of care;
- Review and evaluation.

Perhaps the most significant key to delivering high standard care is the assessment of the patient/resident. Standard 7 of the National Minimum Standards document (DoH, 2001) emphasises the importance of a comprehensive assessment and states that this should form the basis of the service-user plan. The SHARP system incorporates other standards set out in this document; for example, risk assessments for pressure damage, moving and handling, nutrition and social care.

Formatted pages for many aspects of care are included in the documentation covering personal care, catheter, bowel, diabetes and wound care. Each of the formatted pages for specific problems includes prompts for assessing, identifying the rationale, prescribing and evaluating care. Evidence for these prompts was taken from the literature as appropriate.

Monthly audit and review is incorporated in the system, so that entries in this section can demonstrate that the care plan has been reviewed each month with the
service-user and/or representative, as required by the National Minimum Standards document (DoH, 2001). This helps to imply consent to treatment and care. The system was devised with consultation, advice and support from colleagues in Somerset Health Authority and from appropriate experts – a health and safety officer, for example. Seven nursing homes in Somerset were approached to start the piloting process. An introductory session to explain the project was held in each home, with as many staff attending as possible. A second introductory session to guide the nurses through the process was held to begin each shift to read and update the records, they were maintained to a higher standard.

Positive trends

- All homes produced more informative records than they had before
- The vast majority said they preferred it to their old system
- In homes where time was set aside at the beginning of each shift to read and update the records, they were maintained to a higher standard.

Negative trends

- Incomplete in terms of dates, signatures, review dates
- Nursing process steps not followed appropriately
- Not all essential pages were being used
- Poor use of ‘monthly audit’
- Care assistants not fully engaged in their role

Completed questionnaires were received from 50 care assistants, from whom feedback was mainly positive. Of those who responded, 62% replied that they felt more involved; none said that they felt less involved. The same percentage felt that they had an increased understanding of the problems and care required for their patients. The majority (92%) responded that they found the documents easy or very easy to use. Although practices vary from home to home, care assistants are not usually greatly involved in reading and writing care records, which are seen as the realm of the nurse. The positive feedback about increased involvement was therefore particularly welcome.

Completed questionnaires were received from inspectors for four homes, the responses revealing that three homes had completed their sample of records accurately and fully. Both inspectors found the system easy to use and commented that they would recommend it to other homes. The main themes of the evaluation are shown in Box 1.

With implementation of the system the records were fuller, although in many instances they were not full enough, as was revealed when, on asking a nurse about a patient’s record, more information had been given verbally than had been written in the report. On asking why this information was not written down, the reason given was not always lack of time, but frequently that the nurse did not realise the significance or importance of documenting something, or could not pick out what was relevant and what was not. Sometimes the responses indicated the lack of importance given to the records.

Discussion

One of the limitations of this project is the possible lack of robustness of the research methods. For instance, part of the evaluation was based on descriptive assessments I made on each visit to a home. Furthermore, my role as the inspector may have influenced the feedback on the questionnaires. However, in mitigation, all the questionnaires were anonymous, and frank verbal feedback was received from nurses and care assistants in addition to comments they had made on their questionnaires. In addition, my colleagues were able to act in a peer review capacity on an informal basis, since the project was discussed in the team on a regular basis.

The evaluation shows that the project has achieved some positive outcomes and that most staff found the system user-friendly. However, the records in many cases were not as good as had been hoped. A number of reasons for this were put forward by the staff, the main one being lack of time, which is not unexpected. However, one crucial finding was that where specific time was allocated to reading and updating the care plans they were maintained to a much higher standard.

Other possible reasons for the records not being complete enough could be that I did not spend sufficient time on induction and training. However, any input had not been planned or systematic. Another reason may be that although many nurses in the homes had

BOX 1. THEMES REVEALED FROM EVALUATION OF THE SHARP SYSTEM

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<td>- Having got used to the system, I find it very concise and useful. - Everything is together in one place. - It is user-friendly and presentable. - ‘Overall, the system gives staff a clearer picture of residents’ needs’. - ‘It involves patient participation’.</td>
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REFERENCES


A wide range of experience and knowledge, not all of them had a working knowledge of the concept of the nursing process. As stated earlier, there is evidence to support a correlation between good care and good records (McElroy et al., 1995). Clearly, nurses must have sufficient skills and knowledge to give good care, but if they do not record this adequately does this really mean their care-giving is poor? There may be a link, because the care documentation records information, which means the recorder must have knowledge to be able to record it. If the nurse does not have the knowledge, information cannot be recorded.

The distinction between knowledge and information is clearly set out by Seely Brown and Duguid (2000). Clearly, without the appropriate knowledge, the appropriate action cannot take place. Box 2 sets out a range of scenarios which illustrate the consequences of poor record-keeping.

Record-keeping in the USA

My exploration of care-planning and documentation in care homes was given a comparative perspective by an educational visit to Florida in May 2001. I was able to see at first-hand how this aspect of care is managed in skilled nursing facilities (SNFs) in the USA. (An SNF is the equivalent of a nursing care home.)

There were some startling differences in the US approach to record-keeping and care planning. For example, nurses there were cautious about what exactly they committed to paper and what records they actually kept, because they feared that some records could be used by lawyers as a weapon against them, an approach that is a distinct contrast to Castledine’s (1998) advice to record incidents ‘however unusual or mundane’.

The primary method of care planning and documentation in the States is via the computerised resident assessment instrument for nursing homes. (McElroy et al., 1995). This is often referred to as the minimum data set (MDS) system. Any person wanting to access state or federal funds (Medicare and Medicaid) must be assessed according to the RAI. The computer suggests or triggers areas that need a specific plan of care – called a ‘resident assessment protocol’. These were undertaken by specific MDS nurses employed in each home who did not work on the floor but managed the system.

MDS is primarily an information-gathering system for the state and federal administration and, indeed, this was part of the remit for its design (Morris et al., 1990). It was not being used as a working tool by the staff on the floor to inform their practice. Staff devised their own worksheets to help them manage care on a day-to-day basis, and this was often task oriented. From this brief experience, I saw a system that almost had a life of its own, detached from patient assessment and care.

One area of documentation that was well developed and which had real benefit for patients, staff and relatives was the use of advanced directives. All patients admitted to an SNF were consulted on their five wishes concerning the care they were to receive (Box 3), using a document devised by the Commission on Aging with Dignity (1999). The completed document provided clear, unambiguous guidance for nursing and medical staff on how to care for service-users according to their wishes, or whom to consult should they not be able to express their wishes.

My experience in Florida was valuable in helping me form my own philosophy on care planning and documentation and one which is appropriate for the needs of Somerset’s care homes.

Conclusion

Although my visit to Florida came after much of the exploratory work for this project was completed, it clarified the essentials needed for adequate record-keeping in care homes in Somerset and perhaps the UK. The Florida experience and the SHARP pilot study show that the maintenance of comprehensive and meaningful records is not an easy task. The SHARP study has shown the need for a co-ordinated approach between education and training on the maintenance of records, and education and training in terms of the care given. The two elements cannot be separated.

References


Box 2. Possible Reasons for Poor Records, and the Consequences

- Inadequate knowledge, therefore it is not possible to record knowledge as information
- Adequate knowledge, but nurse is not able to discern what must be recorded as information
- Adequate knowledge, but poor recording system, so that adequate information cannot be recorded
- Adequate knowledge and adequate recording system, but nurse does not use the system properly
- Inadequate knowledge and inadequate recording system

Consequence: Poor care and poor records.

Box 3. Areas on Which Patients Were Consulted About Their Treatment While in a Care Home in the USA

- The person I want to make care decisions for me when I can’t
- The kind of medical treatment I want or don’t want
- How comfortable I want to be
- How I want people to treat me
- What I want my loved ones to know