Oifig an Stiúrthóra Seirbhísí Altranais & Cnáimhseachais | Office of the Nursing and Midwifery Services Director

National Procedure for the use of Standardised Clinical Care Plans in the Public Health Nursing Service

Policy ☐ Procedure ☒ Protocol ☐ Guideline ☐ Clinical Guideline ☐

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Procedure for the use of Standardised Clinical Care Plans in the Public Health Nursing Service.
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Use of Standardised Clinical Care Plans in the Public Health Nursing Service.
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Short summary:
The purpose of this procedure is to provide guidance to all registered nurses/midwives working within the Public Health Nursing Service on the use of Standardised clinical care plans.
Description:
• To provide guidance to all nurses/midwives on the use of standardised clinical care plans. • To guide nurses/midwives on individualising the standardised clinical care plans in order to address the individual needs of the client. • To promote best practice regarding the recording of clinical practice including assessment, problem identification, goal planning, intervention and evaluation in the client healthcare record in a standardised way.

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1.0 Planning

1.1. Overview

Deriving from the national Public Health Nursing (PHN) service Quality Improvement (QI) Governance Group, a practice gap was identified which led to a request to develop standardised clinical care plans to guide clinical practice documentation nationally. Thus, a procedure development group was formed consisting of 33 members representing Practice Development Coordinators (PDCs), Assistant Directors of Public Health Nursing (ADPHNs), registered Public Health Nurses (RPHNs) and Community Registered General Nurses (CRGNs) across all Community Health Organisations (CHOs) nationally (Appendix 1). Consensus was reached as to which clinical care plans to prioritise based on the most common clinical problems encountered day to day within the PHN service. The formation of 4 sub-groups enabled the development of a suite of standardised clinical care plans as part of this project which will continue to evolve.

This national procedure has been developed to support the implementation of the standardised clinical care plans. Registered Nurses (RNs) (to include registered RPHNs, CRGNs) and Registered Midwives (RMs) should establish and maintain accurate, clear and contemporaneous client care records within a legal, ethical and professional framework (Nursing and Midwifery Board of Ireland (NMBI), 2015a). Furthermore, NMBI (2015b) indicate that the quality of records maintained by nurses and midwives is a reflection of the quality of the care provided by them to clients. Care plans have a legal function that represents the care service that the client receives (Østensen *et al.,* 2020). Therefore, it is envisaged that the use of the standardised care plans will support person centred, evidenced based care with a view to enhancing the quality and safety of client care.

1.2. Purpose

The purpose of this procedure is to provide guidance to all nurses/midwives working within in the PHN Service on the use of standardised clinical care plans.

1.3. Scope

1.3.1. Target users

Target users; this procedure applies to all registered nurses/midwives working within the PHN Service nationally who provide clinical nursing care.

1.3.2. Target population

This procedure applies to all clients who are in receipt of clinical nursing care from the PHN Service.

1.4. Objective(s)

1.4.1 To provide guidance to all nurses/midwives on the use of standardised clinical care plans.

1.4.2 To guide nurses/midwives on individualising the standardised clinical care plans in order to address the individual needs of the client.

1.4.3 To promote best practice regarding the recording of clinical practice including assessment, problem identification, goal planning, intervention and evaluation in the client record in a standardised way.

1.5. Outcome(s)

A procedure is available for all nurses/midwives on the use of the standardised clinical care plans.

The aim of standardised clinical care plans is to:

- Promote evidence-based practice
- Reduce variation in practice and service delivery
- Lead to higher quality of care and greater client satisfaction
- Strengthen client's confidence and skills to manage their health
- Avoid unnecessary duplication
- Act as educational tools
- Act as a basis for audit, evaluation and continuous improvement
- Impact positively on the data outcomes from Quality Care Metrics (QCMs) (HSE, 2018).

1.6. Disclosure of interests

None.

All signed declaration of interest forms are retained by the National Practice Development Coordinator (PDC) for Public Health Nursing on behalf of Office of the Nursing and Midwifery Service Directorate (ONMSD).

1.7. Rationale / alignment with HSE national priorities

The nurse/midwife is professionally responsible to ensure complete and appropriate documentation (NMBI, 2015b; NMBI, 2021). This document supports the service by promoting best practice regarding the recording of clinical practice including assessment, problem identification, goal planning, intervention and evaluation in the client record in a standardised way.

1.8. Supporting evidence

1.8.1 List relevant legislation/PPPGs.

Department of Health and Children (1966) Circular 27/66 District Nursing Service.

Department of Health and Children (2000) Circular 41/2000.

European Commission (2016) General Data Protection Regulations accessed via https://ec.europa.eu/info/law/law-topic/data-protection/eu-dataprotection-rules_en.

Health Information and Quality Authority (HIQA) (2012) A Guide to the National Standards for Safer Better Healthcare.

Health Information and Quality Authority (2015) Guidance for Providers of Health and Social Care Services: Communicating in Plain English.

Health Information and Quality Authority (2016) Supporting Peoples Autonomy: a Guidance Document.

Health Service Executive (2010c) Code of Practice for Healthcare Records Management Abbreviations.

Health Services Executive (2011) Standards and Recommended Practices for Healthcare Records Management.

Health Service Executive (2016) National Framework for developing policies, procedures, protocols and guidelines (PPPGs). HSE, Dublin.

Health Service Executive (2019) Data Protection Guidelines.

Health Service Executive (2022) National Consent Policy, Quality and Client Safety Directorate (Version 1.2). HSE, Dublin.

Health Services Executive (2023) HSE National Records Retention Policy: Health Service Executive, Dublin.

Nursing and Midwifery Board of Ireland (2015a) Scope of Nursing and Midwifery Practice Framework.

Nursing and Midwifery Board of Ireland (2015b) Recording Clinical Practice Professional Guidance.

Nursing and Midwifery Board of Ireland (2021) Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.

1.8.2 List PPPGs that are being replaced by this procedure

This national procedure is the first national procedure to support the use of standardised clinical care plans for use within the PHN service.

2.0 Methodology

2.1. List of key questions this National 3PG will answer

Key questions (clinical/non-clinical)

- What is the guidance required by nurses/midwives to use the standardised clinical care plans?
- What is the evidence base to support the use of the standardised clinical care plans?
- Do standardised clinical care plans improve documentation?
- Do standardised clinical care plans improve quality and safety of client care?
- Barrier and facilitators for the use of standardised clinical care plans?
- How best to individualise standardised clinical care plans?

2.2. Describe and document the evidence search

A review of the relevant literature regarding the use of standardised care plans was undertaken by the chair of this national procedure development group. The search yielded limited information. Subsequently, a request was submitted for the assistance of the national HSE library service. A WebEx meeting held between the group chair and library service helped to define the literature review questions and it was agreed to perform a search over a 10 year span to include English language only and to expand the search beyond community nursing services to include other services such as the acute setting and other health and social care services. The search was expanded to include literature greater than 10 year span due to limited relevant findings (Appendix 4).

The term standardised care plans replaced core care plans in the 1990s. Literature

reviewed was identified through searches of CINAHL, Medline, the Cochrane database, Google search of the following websites; NMBI, Health Information Quality Authority (HIQA), NICE. Key words included care plan, standard care plan, standardised care plan, evidence based standardised care plan, clinical care plans, individualised care plans, documentation, multidisciplinary, healthcare, Irish policy and nursing and quality and safe care (see appendix 4 for search history summary).

2.3. Describe the method of screening and evidence appraisal

Evidence in relation to utilising standardised care plans was considered. In evaluating the evidence the following areas were considered:

• What are the results/conclusions?

• Are the results relevant to the procedure?

The evidence consisted of a hybrid of qualitative and quantitative research looking at the use, effectiveness, barriers, enablers in the use of standardised care plans.

In developing this procedure, assistance from the national library service was sought to search the literature with a request for level 4 ‘summary of evidence’ (Appendix 4). A comprehensive search with an evidence summary informed the detail of this procedure. Recommendations supporting the use of standardised care plans and the individualising of standardised care plans were formulated through a review of the literature by the chair of the procedure development group.

Following several drafts, the final content of the standardised clinical care plans was informed by staff feedback from a pilot of the standardised clinical care plans over the month of May 2023 across 15 Director of PHN (DPHN) sites nationally ensuring broad representation of key stakeholders. Feedback from frontline staff indicated a strong desire to further expand the number of standardised clinical care plans beyond the initial 12 clinical care plans developed. All care plans are informed by the latest evidence based practice which was established by each sub group.

The procedure development group agreed on the final iteration for submission to the national PHN service QI governance group for their approval.

The nurse/midwife is professionally responsible to ensure complete and appropriate documentation (NMBI, 2015b; NMBI, 2021). While care plans are an essential record of actions undertaken by nurses/midwives for clients, many nurses struggle to articulate the complex relationship between theory and practice in their documentation (Ballantyne, 2016). This reflection of evidence based practice is essential considering that our records relating to care planned and

undertaken can be utilised for research, audit, and evaluation and in legal proceedings. Many documented cases of professional misconduct against nurses and midwives relate to poor documentation therefore it must be objective enough to stand up to scrutiny (Marinič, 2015). Without complete documentation there is no evidence to prove that care was provided to the client leading to the old adage 'what is not recorded has not been done' (Marinič, 2015; Taiye, 2015). Thus, this procedure aims to enhance the nurse/midwife's knowledge of, and skills in, the care planning process, appropriate use of standardised clinical care plans thus influencing the maintenance of quality nursing documentation.

In Ireland a number of regulatory bodies i.e. Mental Health Commission (MHC), NMBI, HIQA, and Health & Safety Authority (H&SA) have set out requirements to have robust documentation governance in place across the health service. In addition, several regulatory reports, inspections and recommendations from serious incidents have identified significant gaps in relation to nursing documentation. The HIQA published a set of requirements to achieve standards in relation to the production and utilisation of information across the Irish health services (HIQA, 2012). The HIQA National Standards for Safer Better Healthcare (2012) highlights the need for accurate, relevant, legible and complete information. The standards outline the need for appropriate information and communication technology to assist with both the collection and reporting of quality information related to client care. Many high profile cases reminds us that there are adverse consequences for inadequate or inappropriate documentation which can include deficits in care. NMBI (2021) outlines the individual responsibility of all registered nurses and midwives in being answerable for the decisions made in the course of one's professional practice. The use of standardised clinical care plans offers evidence-based sets of pre-formulated nursing diagnoses, related goals, resources, characteristics and interventions that nurses can select from when completing a care plan (Monsen *et al.* 2011). By using a standardised care plan structure combined with standardised nursing language, documentation quality is expected to improve by easing the documentation of nursing care, and facilitating communication and workflow (Østensen *et al*. 2020). The existence of a care planning process has been associated with predictors of positive outcomes for client care. McIlfatrick *et al*. (2018) evaluated service user outcomes in a sequential mixed methods study. Qualitative analysis identified an overarching theme that a lack of care planning was associated with unmet needs. This indicated an unprepared care planning process in the implementation of care by clinical teams in addressing client needs.

Nursing care can be objective based on scientific knowledge, experience, intuition and critical thinking (Waldow & Borges, 2011). According to Juvé-Udina (2012) a standardised care plan is “a structured summary of real problems and/or potential complications, together with the prescription of nursing interventions to achieve health results of a certain client population (or groups)”. Essentially standardised care plans have the potential to enhance the quality of nursing documentation in terms of content and completeness, thereby better supporting workflow, easing the documentation process, facilitating continuity of care, and permitting systematic data gathering to build evidence from practice (Østensen *et al.* 2021). In the optimal case, a standardised care plan will be based on up-to-date, evidence-based knowledge with an overall aim of nurses following a common plan in caring for a specific group of clients (Dahm & Wadensten, 2008). The overall goal is to ensure that all clients receive the same high-quality care. However, individualised care planning should take account of the uniqueness and values of clients, considers their personal characteristics, clinical conditions, personal life situation as well as preferences in the participation of care and as a result produces positive impact on the outcome of the care itself (Martins and Perroca, 2017). Furthermore, individualising standardised care plans means that the nurse/midwife formulates client-specific diagnoses, goals and interventions and plans the necessary care based on the assessment performed on the client and their family, and evaluates the results obtained (Castellà-Creus *et al*. 2019a & 2019b). The HIQA standards (HIQA, 2012) have shaped care delivered in a variety of settings to ensure care is planned safely & effectively in consultation with the client or their representative where required. Nurses and midwives must ensure these standards are visible in the care delivered and in the documentation arising from that care.

The 5 step nursing process has been an integral part of client care for decades and more recently, nursing diagnoses have become another step in this process (Alfaro-LeFevre, 2014). By acknowledging actual/potential health problems following nursing assessment, nursing goals/ interventions are developed to resolve them, acknowledging the impact of nursing on client and organizational outcomes (D’Agostino *et al*. 2017; MoraisI *et al.* 2018). Utilising clinical judgement skills, nurses examine client responses to their present health situation, and identify appropriate interventions to achieve goals of care (Sanson *et al.* 2017). Limited understanding and a recognised theory-practice gap, challenge not only the effective use of nursing systems, but also the responsibilities of registered nurses and midwives to keep records clear, intelligible and accurate (Glasper *et al.* 2015; Hussein and Osuji, 2017). Parahoo (2014) found that nurses and midwives who receive additional education, can understand and utilise nursing knowledge more clearly in their practice, therefore nurses and midwives must be supported to

learn how to utilise all these tools to increase the quality and safety of care.

Following assessment, a clear documented plan of care for clients has been associated with benefits including clarity of treatment plans, ease of prioritisation of goals and greater involvement of clients in the overall management plan (Ademola and Sheerin, 2012). It has been proposed that the nature and quality of documented care planning is not standardised and requires development in Ireland (O'Brien & Cowman, 2011). Detailed, accurate records are essential requirements to support care planning and the achievement of consistently high standards of care. Furthermore, NMBI (2021) indicates that nurses and midwives are prepared to make explicit their rationale for decisions made in his/her professional practice and reminds us that we should justify such decisions in the context of legislation, professional standards and guidelines, evidence-based practice and professional and ethical conduct (NMBI, 2021). Therefore, accurately identifying client's needs and preferences are part of nurses'/midwives' responsibilities. When nurses/midwives are able to accurately identify client cues, they can assist clients to meet their goals and return to their highest level of functioning (Australian Commission on Safety and Quality in Health Care, 2017). The literature reminds us that every client has the right to make their own decisions based on their own beliefs & values (Morrell *et al.* 2019 and HIQA, 2016).

All stages of the nursing process require capacity of judgement or clinical reasoning. This judgement is a mental ability that enables a nurse/midwife to take the most appropriate decisions that help prevent and/or resolve problems in each one of the client's situations. To develop it, nurses/midwives need to be able to think critically, basing their thoughts on a series of skills and behaviours (Castellà-Creus *et al.* 2019a & 2019b). When nurses/midwives do not use critical thinking skills, diagnostic errors can occur in client care (Morris, 2021).

In line with the NMBI professional code (NMBI 2021), nurses/midwives should be aware of their level of accountability when utilising a standardised care plan. Understandably, nurses/midwives cannot apply standardised care plans to all clients and, therefore, knowledge and critical thinking skills are required to ensure that care is client centred. The standardised care plan may address the majority of needs relating to specific problems, however nurses/midwives need to assess whether an individualised care plan needs to be generated or whether the standardised care plan can be adapted to meet the individual need. The

nurse/midwife should devise an individual care plan when there is no standardised care plan for the identified healthcare needs.

Administering client-centred care implies being able to individualise the care according to a client's needs and those of their family (Köberich *et al.* 2016). The individualisation process is the fundamental element for working with standardised care plans. This process consists of adapting the standardised care plan to a client's needs, according to the assessment and the subsequent re-evaluations required by their condition. The result is the application of an individualised care plan (Juvé-Udina 2012). Failure to carry out this individualisation can lead to the risk of only diagnosing expected, common problems (Castella-Creus *et al.* 2019a & 2019b). The client's wishes must inform the content of the care plan in making it truly individualised. However, a client's need for autonomy may conflict with care guidelines or suggestions that nurses or other healthcare workers believe is best (Haddad & Geiger, 2020). Within the Irish context, the HIQA (2016), the HSE (2022) and the Decision Support Service (2023) sign posts professionals to how best to achieve autonomy of decision making, valuing client choice and promoting client centred care.

In summary, standardised care plans need to be written in line with the latest guidance and research related to that problem and updated if new evidence is found (Barrett *et al.* 2012). It is important that standardised care plans are updated when there is new evidence. In studies on the use of standardised care plans the majority of the nurses were of the opinion that standardised care plans increased their ability to provide the same high-quality basic care for all clients (Dahm & Wadensten, 2008). Furthermore another study showed that nurses considered standardised care plans manageable and, unlike free text, their structured content made it possible to record the care planning in a more complete and relevant manner (Svensson *et al.* 2012). The standardised care plans accompanying this procedure are evidence based, meaning that interventions associated are based on empirical evidence and thereby provide a means to disseminate evidence into practice. Castella-Creus *et al.* (2019a) & (2019b) reported that better use of standardised care plans would improve nurses' access to appropriate and accurate information in decision-making, thus improving the documentation process and quality of care.

2.4. Resource implications

This procedure is available online on the PHN page of the HSE website www.hse.ie/phn. The care plans in both the editable (for completion on a computer) and printable (for handwritten completion) forms are available on https://dochub.healthservice.ie**.** The DPHNs nationally will be informed of the availability of these resources for the PHN service. An information session will be offered to all DPHNs/ADPHNs/Nurses/midwives as part of the formal roll out of the standardised care plans and this associated procedure. The national group of PDCs will offer assistance as required or the equivalent representative/champion as identified by the relevant DPHN.

2.5. Attach any copyright or permissions sought

No copyright or permissions are required in relation to this document.

3.0 Procedure

For the purpose of this procedure, the term 'client' will be used throughout; it encompasses the terms patient, individual, person, service user, male & female & indicates the person in receipt of the nursing intervention & the recipient of care.

Throughout this procedure and the standardised clinical care plans, the term 'nursing problem/nursing diagnosis' is used to indicate a clinical nursing judgment and this term will also refer to identified concerns, issues, deficits related to the client's health status.

3.1 Background – see page 4 section 1.1 for overview.

3.2 Standardised clinical care plans are pre-developed plans developed by healthcare organisations to ensure that clients with a particular condition receive consistent care. These care plans are used to ensure that minimally acceptable criteria are met and to promote the efficient use of the nurse's time by removing the need to repeatedly develop care plans reflecting common actions for clients (Nurselabs, 2023). Standardised care plans promote more complete documentation whilst supporting nurses' workflow (Charalambous & Goldberg, 2016).

3.3 Individualisation of standardised clinical care plans involves tailoring a standardised care plan to meet the specific needs and goals of the individual client. A collaborative approach between the nurse/midwife and client allows

more personalised and holistic care better suited to the client's unique needs, strengths and goals (Coulter & Oldham, 2016). Additionally, studies have shown that individualisation can lead to improvements in physical and psychological health and strengthen client's confidence and skills to manage their health (Coulter *et al*. 2015). When clients feel that their care is tailored to their specific needs, they are more likely to feel heard and valued (Kwame and Petrucka, 2021). The HIQA (2016) identify the necessity for all healthcare professionals to facilitate increased autonomy regarding client care decisions. This is particularly important in today's healthcare environment, where client satisfaction is a measure of quality (Prakash, 2020).

3.4 Consent must be obtained prior to completing any assessment or providing any intervention to ensure client participation and self-determination as a fundamental principle of person centred care planning (HIQA, 2016). All proposed interventions must be discussed with the client. The HSE's national consent policy (HSE, 2022, v1.2) indicates the following key steps in facilitating informed consent and assisted decision making by checking if the client:

- Understands information relevant to the decision
- Retains that information long enough to make a voluntary choice
- Uses or weighs up that information as part of the process of making the decision
- Communicates their decision in whatever way they communicate (not only verbally)

3.5 Care planning

Care planning is an ongoing process which starts from the first contact with the client and involves 5 key cyclical steps (American Nurses Association, 2017) as follows:

- **A**ssessment
- **D**iagnosis: Nursing diagnoses/identification of client problem(s)
- **P**lanning goals/expected outcomes
- **I**nterventions (nursing intervention and client intervention/self-management)
- **E**valuation

3.5.1 Assessment

The process starts with a comprehensive assessment of the client's physical, psychological, social and spiritual health needs (Younas, 2017), as well as

identifying their abilities and deficits. In particular, client assessment may also relate to the following areas; sexual, psychosocial, cultural, cognitive, functional, age-related, economic and environmental. Information in this area can be subjective and objective.
For a comprehensive assessment to be achieved, reliable & valid assessment and risk identification tools must be used (as per local client healthcare record) to establish the client's health status e.g. physical, psychological and social (Wiener *et al*. 2016) which informs the screening and detection of problems. Where appropriate, the views and observations of the client and family members in relation to that assessment should be sought (NMBI, 2015b).

3.5.2 Diagnosis/Problem Identification: Following assessment by the nurse/midwife**,** the client's identified healthcare problem(s)/diagnosis should be documented in the care plan. This nursing diagnosis is a clinical judgement concerning human responses (individual, family, group or community) to health conditions or life processes (Herdman & Kamitsuru, 2017). The information gained from the assessment is used to identify actual and potential problems, as well as strengths (Yildirim and Ozkahraman, 2011). Based on these assessment findings, the person's needs are categorised & prioritised to formulate a nursing diagnosis/problem identification.

3.5.3 Planning Expected Client Goals: This stage is where goals are set and interventions are planned to reduce, resolve or prevent the client's problems, while supporting the client's strengths in an organised, goal-directed way (Kozier *et al*. 2008). These specific goals will be set in partnership with the client/decision-making assistant/co-decision-maker/court appointed decision-making representative that will be achieved through a combination of both nursing intervention(s) and client self-management. These may be long and/or short-term goals of care. Hogston (2011) advises using the six REEPIG criteria to ensure that planned care is of the highest standards: Realistic, Explicit, Evidence-based, Prioritised, Involved and Goal-centred as follows:

Realistic	Resources available to achieve
Explicit	Explicitly stated, clear in exactly what needs to be done
Evidence-based	Research based that supports what is being proposed
Prioritised	The most urgent problems being dealt with first
Involved	Involves both the client and other members of the MDT
Goal-centred	Care planned will meet and achieve the goal set
	(Hogston, 2011)

3.5.4 Intervention: Nursing intervention focuses on specific actions the nurse will take to address the nursing diagnosis and help the client achieve the expected outcome(s) (Klumer, 2008) in addition to the self-management actions that the client will take to achieve the goals of care. They should be based on evidence-based best practice.

3.5.5 Evaluation: includes monitoring and evaluating a client's progress through frequent re-assessment and making necessary adjustments to the care plan as the client's health status and goals change (Ernstmeyer and Christman, 2021). Within the care plan template this evaluation is indicated at the section titled '**care plan review due date'.** In the case that further interventions are required, they are completed in the section titled '**subsequent review and care plan actions'** and signed and dated by the nurse/midwife who has undertaken the subsequent review and addition of actions. This section is hand written as the care plan is in the client's healthcare record at this point.

3.6 Use of the Standardised Clinical Care Plans

3.6.1 A list of the available standardised clinical care plans is available in Appendix 5. The nurse/midwife should ensure the latest version of the appropriate standardised clinical care plan is downloaded from the national PHN service website indicated by version number, individual care plan number & year of publication which is visible at bottom right of each care plan. The care plans are available in editable word format on the website www.hse.ie/phn. The care plans will also be available in a printable version to allow completion by hand.

3.6.2 It is the responsibility of nurses/midwives to utilise their clinical judgement when completing a care plan in the client healthcare record.

The standardised clinical care plan must be adapted to address the individual needs of each client. It is not acceptable to insert the care plan into the client's healthcare record without first individualising it to the client. The standardised care plans prompt the nurse/midwife to insert specific observations in the '**nursing problem/nursing diagnosis'** column and in the '**expected goals'** section where it states 'other client specific goals'. The standardised care plans can be individualised also within the **'action plan/intervention'** section named 'other actions'.

3.6.3 In the event that a standardised clinical care plan is not available to suit the identified nursing problem/nursing diagnosis of the client, the nurse/midwife should devise a care plan as per local practice and incorporate up to date evidence based practice to guide the nursing interventions.

3.6.4 Completing the standardised clinical care plan (See sample care plan in appendix 7 with instructions for each section):

- **Addressograph:** If you have an addressograph attach it and add one to each page of the care plan.
- If an addressograph is not available, complete client's name and date of birth on each page of the care plan as follows.
- **Client name and date of birth:** Insert clients name and date of birth as client identifiers. In the interactive version, once the client's name and DOB is typed in, it populates this detail on each page automatically.
- **IHI:** Complete the Individual Healthcare Identifier (IHI) if available.
- **Insert problem number:** Each nursing problem/nursing diagnosis for which a care plan is developed will have a separate problem number. Problem numbers should be assigned chronologically. A care plan index may be commenced to log care plans & their respective care plan problem numbers (Appendix 6). Within the index page, the column titled 'additional comments' may be used to log care plans developed for the client other than the national standardised clinical care plans. When a nursing problem is resolved/closed, this completes that problem number; the problem number should not be reused. If the problem re-

occurs, a new number is assigned – see scenario example below at **table 1**.

Table 1:

Scenario Example:
Client X, a 72 year old client not previously known to the PHN service presents with a referral letter from her doctor seeking treatment for a leg ulcer.
Client X has a leg ulcer = nursing diagnosis.
A care plan is commenced and is assigned **problem number 1.**

Client X reveals she also has urinary incontinence.
Client X has urinary incontinence = nursing diagnosis.
A care plan is commenced and is assigned **problem number 2**.

Client X's leg ulcer is dressed 3 times a week for 5 weeks and is healed by week 5, Care plan number 1 goals have been achieved and the problem is resolved/closed.

Client X presents in 12 weeks with a new leg ulcer on the same leg.
Client X has a leg ulcer = nursing diagnosis.
A care plan is commenced and is assigned **problem number 3.**

- **Date/time care plan commenced:** Insert date/time (24 hour clock) that the care plan is commenced.
- **Date care plan closed:** Insert date the care plan is closed.
- Record the provision of information in regard to the **nature, purpose, benefits and risks of interventions**.
- **Consent** is obtained by ticking the relevant box (**see figure 1 below**):
    - Client
    - Parent/legal guardian (for a child up to the age of 16)
    - Other (where decision making assistance is required, choose one of the following options as relevant)
        - Client & decision-making assistant
        - Decision making representative
        - Designated healthcare professional
        - Person appointed under enduring power of attorney

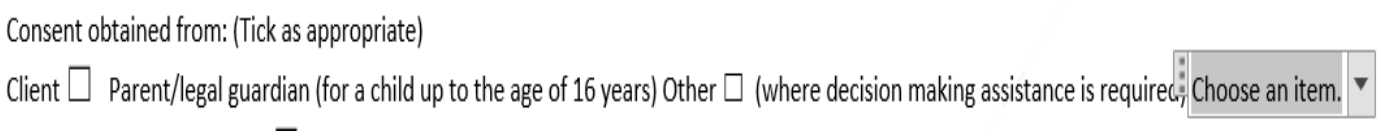

Figure 1

- In the event that care or an aspect of **care is refused**, the details should be recorded.

3.6.4.1 Nursing Problem/Nursing Diagnosis: Within each of the standardised care plans, nursing problems/nursing diagnosis are pre-populated. In order to individualise the care plan, the nurse/midwife will insert any additional information that will highlight the client's expression and understanding of their nursing problem/nursing diagnosis and any other information relevant to the client.

3.6.4.2 Expected Goals: Within each of the standardised care plans, goals are pre-populated. In order to individualise the care plan, the nurse/midwife will identify expected goal(s) as relevant and include any specific goal as identified by the client or the nurse/midwife.

3.6.4.3 Action Plan/Intervention: Pre-populated interventions on the standardised clinical care plans are evidence based. The nurse/midwife should record any additional relevant interventions based on re-assessment as indicated by **'other actions'.**

Under the section titled **'initial assessment & care planning'** the nurse/midwife should tick the box to indicate all of the appropriate actions/interventions were implemented or choose appropriate actions/interventions to suit the individual needs of the client. The responsibility rests with the nurse/midwife to complete the care plan individual to the client's care needs. Not all interventions may be relevant to the client's identified needs/goals; where an intervention is not relevant, the boxes relevant to those actions/interventions are left unticked **as per figure 2 below.**

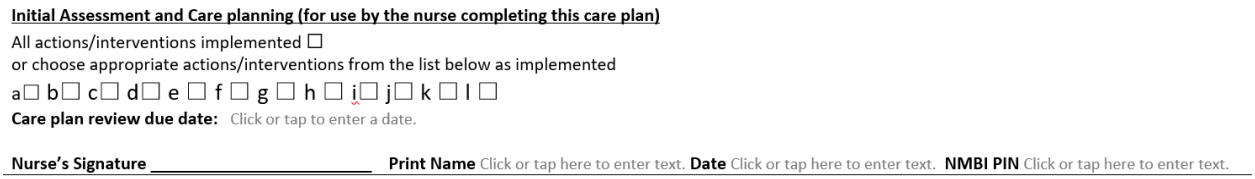

Figure 2

3.6.4.4 Care Plan Review Due Date – the nurse/midwife should insert the date when the evaluation is due – **see figure 3.**

- The care plan review will be based on clinical judgement and according to procedures, policies, protocols and guidelines.
- Sign signature section and print name and NMBI PIN in the appropriate section.
- See sample completed clinical care plan in Appendix 7.

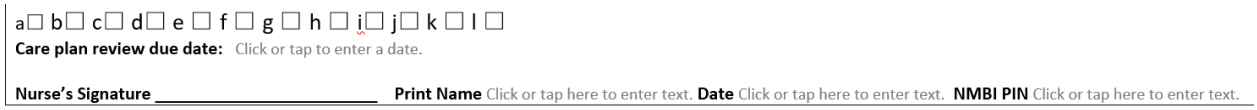

Figure 3

3.6.4.5 In the case that further interventions are required, they are completed in "**subsequent review and care plans"** section and signed and dated by the nurse who has undertaken the subsequent review and documents the addition of actions. This section is hand written as the care plan is in the client's healthcare record at this point - **see figure 4.** A template sheet titled 'subsequent reviews' is available in appendix 11 to allow for further reviews if required**.**

Subsequent review and care plan actions

Information provided regarding the nature, purpose, benefits and risks of interventions ☐
Consent obtained from: (Tick as appropriate)
Client ☐ Parent/legal guardian (for a child up to the age of 16 years) Other ☐ (where decision making assistance is required) Choose an item.
Care /aspect of care refused ☐ Click or tap here to enter text.
Choose appropriate actions/interventions from the list below as implemented
a☐ b☐ c☐ d☐ e ☐ f ☐ g ☐ h ☐ i☐ j☐ k ☐ l ☐ m ☐ n ☐ o ☐ p ☐
or add other actions here:

Care plan review due date:_____
Nurse's Signature _____**Print Name** _____ **Date** _____ **NMBI PIN** _____

Figure 4

3.6.4.6 Evaluation/Progress Notes must be initiated for each standardised clinical care plan.

3.6.4.6.1 Evaluation/Progress Notes must be updated contemporaneously.

3.6.4.6.2 Evaluation/Progress Notes must provide evidence that the standardised care plan is being implemented; this involves the gathering of very specific and targeted information linked to a specific problem and goal/outcome.

3.6.5 All healthcare staff should be encouraged to read each other's entries in the client healthcare record as this facilitates good communication between healthcare staff and aids continuity of care.

3.6.6 In the case where the care plan problem/diagnosis has not been resolved and the care plan is of 1 year's duration, the care plan should be reviewed at least annually following client re-assessment. This review should also include verification that the up to date care plan version number is in use.

3.7 Closure of Care Plan

3.7.1 When the client's goals have been met, the care plan should be closed and the date is recorded.

3.7.2 Care plans that are closed should be filed in the client's healthcare record according to local procedures/guidelines.

3.7.3 The closure of the care plan should be recorded in the care plan index where in use.

3.8 Documentation

3.8.1 Legal Considerations for nursing documentation:

- Records are legal documents
- All records may be used to aid the legal process
- Nursing/Midwifery documentation within client healthcare records may be, and frequently are, used as evidence in legal cases

3.8.2 All narrative within the progress notes must be individualised, accurate, up to date, factual and unambiguous.

3.8.2.1 Narrative progress notes should be devoid of any jargon, witticisms or derogatory remarks.

3.8.2.2 It must be clear from the records that the client has been assessed and their individualised care is planned, provided and evaluated.

3.8.3 All written records are legible.

3.8.3.1 It is the nurse/midwife's responsibility to ensure that the writing in a record is clear and legible.

3.8.3.2 Handwriting that is difficult to read must be in print form.

3.8.3.3 Black ink must be used for all entries.

3.8.3.4 Care should be taken to ensure that the record is permanent and facilitates photocopying if required. Pencil should never be used, as it can be altered or erased.

3.8.4 All entries in the progress notes are signed.

3.8.4.1 Nurses/midwives must sign entries using their name as entered on the Register of Nurses and Midwives maintained by the NMBI.

3.8.4.2 The nurse/midwife's name must also be printed beside the signature.

3.8.4.3 The nurse/midwife's NMBI PIN number must be entered.

3.8.4.4 Where signature banks exist in client healthcare records, the nurse/midwife must enter their signature and NMBI PIN in the signature bank.

3.8.4.5 If different health professionals write in the same part of the record, the registration status of the professional should also be indicated e.g. RPHN or CRGN.

3.8.5 All entries must be dated.

3.8.5.1 The format to be used is: day/month/year followed by time, using the 24 hour clock dd/mm/yyyy hh:mm; example 10/07/2023 1315hrs.

3.8.6 Entries in the client's record should appear in chronological order, with time stated. Any variance from this should to be explained.

3.8.7 Documentation in the record is carried out as soon as possible after providing nursing care.

3.8.7.1 It should always be clear from the record what time an event occurred and what time the record was written.

3.8.7.2 This may prove to be difficult in an emergency situation. Late entries are acceptable provided that they are clearly documented as retrospective entries.

3.8.7.3 The nurse/midwife should not "squeeze" a late entry into existing notes, nor write in the margins.

3.8.7.4 Nurses/midwives should not record entries ahead of time, or otherwise, predate entries.

3.8.7.5 Nurses/Midwives should not re-write entries in the record or discard the originals, even if it is for a simple reason e.g. a torn page or a spilled drink.

3.8.8 Abbreviations should only be used if drawn from a list approved by the HSE (HSE, 2010c).

3.8.9 Entries made in error should be bracketed and have a single line drawn through them so that the original entry is still legible. Errors should be signed and dated.

3.8.9.1 No attempt should be made to alter or erase the entry made in error.

3.8.9.2 If an enquiry or litigation is initiated, then the record must not be altered in any way either by the addition of further entries or by altering an entry made in error.

3.8.10 A nurse/midwife making a referral or consulting with another member of the healthcare team should clearly identify, by name, the person in the record.

3.8.11 Any information, instruction or advice given by the nurse/midwife to a client should be documented. The version number of any educational material given to the client or carer should be documented.

3.8.11.1 Client education is a legitimate nursing intervention and should be recorded as such.

3.8.12 All written data in respect of a client's care plan should be kept in the assigned section for care plans in the client healthcare record**.**

3.8.12.1 One of the basic principles of the provision of care is that there should be one comprehensive nursing record for each client which is available to the nurse/midwife for treatment of the client when required. Only in exceptional circumstances should there be a duplicate record (HSE, 2011).

3.8.12.2 The keeping of supplementary records should be the exception rather than the norm.

3.8.13 The client's name and date of birth or unique identifier (IHI), addressogram (where applicable) should appear on every page of the record, including on care plans.

3.8.13.1 The identity of the person for whom the record is being maintained should always be obvious to the reader.

3.8.14 The standard of record keeping of those under supervision in the clinical area e.g. student PHNs undertaking supervised clinical practice prior to registration, should be **monitored by their preceptor or her/his delegate.**

3.8.14.1 Student PHNs are required to learn the practice of writing/documenting the delivery and management of nursing care in the community. This skill requires instruction and supervision, as the student is not solely responsible/ he/she cannot be held totally accountable for the record while under supervision**. Entries to the client record should be countered signed/co-signed by preceptor/delegate preceptor.**

3.8.14.2 If an entry by someone under supervision (i.e. student PHN) needs to be amended, then the procedure for any entry made in error should be followed as per section **3.8.9** above.

3.8.15 Nurses/midwives should adhere to HSE, HIQA and NMBI guidelines regarding documentation, record keeping and file management. The client healthcare record must be filed securely in line with General Data Protection Regulations (GDPR).

3.9 Specific roles and responsibilities

3.9.1 Outline Formal Governance Arrangements

This national procedure and accompanying care plans were commissioned by the National PHN service QI governance group. Final approval of the procedure was issued from the QI governance group. Follow up reviews will be initiated by the National PHN service QI governance group. Refer to Appendix 2 for Membership of the Approval Governance Group. This national procedure will be submitted to the HSE's National Central Repository Office and the HSE's national document hub.

3.9.1.1 The Role of the Director of Public Health Nursing

The DPHN is responsible for implementing, managing and auditing this procedure within her/his area of responsibility. The DPHN will identify and support on-going related educational opportunities to further enhance knowledge and skills.

3.9.1.2 The Role of the Assistant Director of Public Health Nursing

The ADPHN is responsible for the implementation of the procedure by ensuring that all nurses/midwives have access to this procedure. The ADPHN is responsible for ensuring that all nurses/midwives have knowledge of the steps to be followed within the document. The ADPHN will ensure that all nurses/midwives are aware of any revisions to the procedure. Compliance with this procedure will be monitored by all ADPHNs by ensuring all staff have confirmed their 'reading' of the procedure via electronic confirmation via the MAPS portal.

3.9.1.3 The Role of the Nurse/Midwife

Each nurse/midwife is responsible for adhering to this procedure and using it to guide their practice in the delivery of the service they provide. Each nurse/midwife is responsible for ensuring that they read and understand the document and have confirmed this electronically through the MAPS portal. When areas of concern are identified, where legislation is known to have changed or where a health, welfare and safety risk is identified, it is the responsibility of each nurse/midwife to ensure that their ADPHN is informed in order to ensure appropriate review and amendments are made to the procedure or accompanying care plans. It is every nurse/midwife's responsibility to ensure they are working within their scope of practice at all times and that they identify their training needs to their manager to maintain standards of care. Nurses/midwives should adhere to HSE, HIQA and NMBI guidelines regarding documentation, record keeping and file management.

3.9.1.4 Role of Practice Development Coordinator in Public Health Nursing

The PDC (where in post) supports the implementation and operationalisation of this procedure. She/he has a key role in the transfer of knowledge to frontline staff through the dissemination of current evidence based practice.

4.0 Consultation

4.1. Stakeholder involvement

The content of the standardised clinical care plans was informed by staff feedback from a pilot of the standardised clinical care plans over the month of May 2023 across 15 Director of PHN (DPHN) sites nationally ensuring broad representation of key stakeholders. Feedback from frontline staff indicated a strong desire to further expand the number of standardised clinical care plans. All care plans are informed by the latest evidence based practice which was established by each sub group.

The penultimate draft was sent out nationally to capture wider stakeholder review and feedback. All feedback was collated and is held by the National Practice Development Coordinator for Public Health Nursing. This feedback was reviewed by the development group and recommendations accepted or rejected.

The procedure development group agreed on the final iteration to go forward for approval to the national PHN service QI governance group.

4.2. External review

A draft of the care plans and procedure was circulated to Nursing Professor UCD and State Claims Agency. All feedback was collated and is held by the National Practice Development Coordinator for Public Health Nursing. This feedback was reviewed by the development group and recommendations accepted or rejected.

5.0 National implementation plan

See appendix 8 for details of the implementation plan.

6.0 Governance and approval

This procedure was identified as a key requirement by the National PHN Service QI governance group to support safe effective practice and ensure continuity and consistency of care for clients.

6.1 Procedure Development Group

See Appendix 1 for Membership of the Procedure Development Group. See Appendix 3 for Procedure Conflict of Interest Declaration Form (Held by the national PDC on behalf of the ONMSD).

6.2 Procedure Governance Group

See Appendix 2 for Membership of the Approval Governance Group.

7.0 Communication and dissemination plan

The approved procedure will be circulated to all DPHNs nationally for dissemination to their respective nursing departments. A copy of the procedure is available on the National PHN website to download at; https://www.hse.ie/phn and at: https://dochub.healthservice.ie**.** This procedure will also be housed on the HSE National Central Repository for all National 3PGs.

8.0 Sustainability

8.1. Plan for national monitoring and audit

Monitoring of this procedure will be coordinated by the national lead for the PHN service as the chair of the QI governance group.

8.1.1 Monitoring

Monitoring of this procedure will occur by the ADPHN through professional supervision, team meetings, annual caseload reviews and documentation audit and through monitoring of any relevant complaints or compliments.

8.1.2 Audit

Audit of the operation of this procedure will be initiated by each DPHN in

consultation with the local CHO audit lead or designated person. Good governance arrangements and an identified lead person are required to ensure systematic monitoring (HIQA, 2012). Audit will be carried out retrospectively by the designated person appointed by the DPHN one year after this procedure's implementation. This procedure will be the standard for audit using the attached audit tool (Appendix 9).

Frequency of audit, sampling processes and timescales for completions will be determined at local level following the first initial audit. Quality care metrics may assist in this process. Action plans will be developed as a result of the audit findings if necessary.

8.1.2.1 The objectives of the audit will be:

- To provide evidence of compliance with the national procedure
- To ensure standardisation of application of the procedure
- To identify areas of improvement, make recommendations & prioritise actions

8.2 Evaluation

Evaluation of the procedure will be initiated by the DPHN/ADPHN and will occur through feedback at professional team meetings/quality care metrics (QCMs). Following audit, comments and feedback should be submitted to the National Lead for the PHN service or the National PDC.

8.3 National audit tool

This procedure will be the standard for audit using the attached audit tool (Appendix 9).

9.0 Review / update

9.1 Next review date

This is the first version of a national procedure for the use of standardised clinical care plans in the PHN Service. This procedure will be revised every three years on the date specified on the front page of this document. This review will be triggered by the national PHN service QI governance group. In the event an electronic healthcare record is introduced to the PHN service, this procedure will require review. An earlier review of this procedure if required will be initiated by the national PHN service QI governance group. Should updated versions of the standardised care plans be developed, DPHNs will be informed by the national PHN service lead.

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Appendix 10.1: Care Plan Specific References

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11.0 Glossary of terms

11.1 Abbreviations

ADPHN	Assistant Director of Public Health Nursing
CHO	Community Healthcare Organisation
CRGN	Community Registered General Nurse
DPHN	Director of Public Health Nursing
GDPR	General Data Protection Regulation
HIQA	Health Information and Quality Authority
H & SA	Health and Safety Authority
HSE	Health Services Executive
MHC	Mental Health Commission
NANDA	North American Nursing Diagnosis Association
NMBI	Nursing and Midwifery Board of Ireland
ONMSD	Office of the Nursing and Midwifery Services Director
PDC	Practice Development Coordinator
PHN	Public Health Nursing
PHNs	Public Health Nurses
PPPG	Policy Procedure Protocol Guideline **or aka 3PGs**
QCM	Quality Care Metrics
QI	Quality Improvement
RCN	Royal College of Nursing
RGN	Registered General Nurse
RNs	Registered Nurses
RPHN	Registered Public Health Nurse
RM	Registered Midwife

11.2 Definitions

Accountability: being able to give an account of one's nursing and midwifery judgements, actions, and omissions as they relate to life-long learning. It also incorporates maintaining competency, and upholding both quality client care outcomes and standards of the nursing and midwifery professions (adapted from Krautscheid 2014 cited in Scope of Nursing and Midwifery Practice Framework for Nursing and Midwifery (NMBI, 2015a).

Care Plan: a nursing care plan outlines the nursing care to be provided to the client. It is a set of actions the nurse will implement to resolve the nursing problems identified by assessment and it does this by using the nursing process.

Client: 'client' encompasses the terms patient, individual, person, service user, male & female & indicates the person in receipt of the nursing intervention & the recipient of care (Health Service Executive (HSE), 2022).

Client centred care: client care that focuses on the needs and rights of the client which respects his/her values and preferences and actively involves him/her in the provision of care (HIQA, 2012).

Clinical judgment: Clinical judgment is the conclusion or enlightened opinion at which a nurse arrives following a process of observation, reflection and analysis of observable or available information or data (Phaneuf, 2008).

Competency: the attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a registered nurse or registered midwife. Competence relates to the nurse's or midwife's role or practice within a division of the Register, is maintained through continuing professional development and is adaptive to the needs of a changing population profile (NMBI, 2015a).

Consent: the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication about the proposed intervention. (HSE, 2022 V1.2).

Desired outcome: the goal which the intervention is expected to achieve, each problem should have an anticipated outcome to correctly evaluate the client's progress. Goals may be immediate, short or long term. (NANDA, 2000 cited in Carpenito-Moyet, 2008).

Must: Commands the action a nurse or midwife is obliged to take from which no deviation whatsoever is allowed (NMBI, 2023).

Nursing Assessment: during the assessment stage the nurse gathers information about the client's health care needs (in a systematic and organised way) and their ability to manage their needs. The assessment phase is a vital part of the nursing process as all other stages rely on the valid and complete data collected and documented (Henry *et al*. 2014).

Nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or a vulnerability for that response, by an individual, family, group or community. Whereas a **medical diagnosis** identifies a disorder, a **nursing diagnosis** identifies problems that result from that disorder (Younas, 2017). It provides the basis for the selection of interventions to achieve outcomes for which the nurse is accountable (North American Nursing Diagnosis Association (NANDA) 2000 cited in Carpenito-Moyet, L. 2008).

Nursing Intervention: Nursing is the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death. It is concerned with empowerment, identification of

nursing needs, therapeutic interventions, personal care, information, education, advice and advocacy, physical, emotional and spiritual support (Royal College of Nursing (RCN), 2003).

Nursing evaluation: the nurse's judgement on the effectiveness of nursing actions towards goal achievement within a specified time frame (NANDA, 2000 cited in Carpenito-Moyet, 2008).

Nursing process: is a dynamic, systematic goal orientated framework for problem-solving that helps the nurse to care for the client while promoting critical thinking (Henry *et al*., 2014). Yura & Walsh (1967) established a number of stages in the nursing process. There are currently 5 steps assessment, diagnosis, planning, implementation and evaluation.

Progress notes: notes used to document nursing/midwifery actions such as client care or response to care; contact with clients/families/carers; contacts with other professionals or agencies.

Scope of Nursing Practice is the range of roles, functions, responsibilities and activities which a registered nurse is educated, competent and has authority to perform (NMBI, 2015).The definition of scope of nursing practice should be understood in the context of the following definition provided by the Nursing and Midwifery Board of Ireland: Nursing is a professional, interpersonal caring process that encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings through the promotion of person centred care. Fundamental to nursing practice is the therapeutic relationship between the nurse and the client that is based on trust, understanding, compassion, support and serves to empower the client to make life choices. Nursing involves the use of clinical judgment to guide professional intervention for the promotion of health, prevention of illness and injury, provision of safe care to the person, families, communities, and populations (NMBI, 2015a).

Should: Indicates a strong recommendation to perform a particular action from which deviation in particular circumstances must be justified (NMBI, 2023).

12.0 Acknowledgements

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13.0 Appendices

Appendix 1 Membership of the Procedure Development Group
Appendix 2 Membership of the Approval Governance Group
Appendix 3 Conflict of Interest Declaration Form
Appendix 4 Search Strategy
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Appendix 6 Care Plan Index
Appendix 7 Sample Clinical Care Plan with built in Instructions
Appendix 8 National Implementation Plan
Appendix 9 Procedure Audit Tool
Appendix 10 Checklist
Appendix 11 Subsequent Reviews Additional Sheet

Appendix 1: Membership of Development Group

Membership of the Procedure Development Group	
Name	**Role/Position**
Chairperson(s) of the Procedure Development Group: Yvonne Delaney, Assistant Director of PHN - Practice Development Coordinator (PDC) Laois/Offaly and Longford/Westmeath, CHO8. Sinead Lawlor - National PDC for Public Health Nursing Services.	
Brenda Horgan	PDC CHO9
Anne Tully	PDC CHO 1
Olivia O'Connor	PDC CHO 2
Fiona Martin	PDC, CH0 8
Deirdre McEldowney	PDC, CHO 9
Tara Mulleary	PDC, CHO 1
Edel Maxwell	PDC, CHO
Edel Marken	ADPHN CHO 9
Tara Curran	CNS Tissue Viability Dublin North City
Edel Norris	CRGN, CHO 3 & INMO Representative
Deirdre Mulligan	PHN, CHO 7

Membership of the Procedure Development Group Continued:	
Tracy Dowling	PHN, CHO 5
Ann Mason Huntley	IADPHN, CHO 4
Stephanie O' Neill	CRGN, CHO 6
Laura Money	CRGN, CHO 1
Margaret Dwyer	ADPHN, CHO 6
Sharon Linnane	ADPHN, CHO 2
Elizabeth Delaney	TVN, CHO 2
Sarah Hendrick	CRGN, CH0 4
Julie Lee	CRGN, CHO 2
Niamh Smith	CRGN, CHO 8

Appendix 2: Membership of Approval Governance Group

Membership of National PHN Service QI Governance Group	
Name	**Role and position**
Grainne Ryan	National Lead PHN services
Mary Shanahan	DPHN (CHO 3)
Anne Marie McDermott	DPHN (CHO 2)
Helen Sweeney	DPHN (CHO 4)
Sinéad Lawlor	National PDC
Tara Mulleary	PDC (CHO 1)
Olivia O'Connor	PDC (CHO 2)
Anne Tully	PDC (CHO 1)
Pauline Keogh-	DPHN (CHO 7)
Nikki Dempsey-	ADPHN (CHO 2)
Janet Caulfield	ADPHN (CHO 8)
Lloyd Philpott	HEI/UCC/Lecturer
Sarah Hegarty	PHN INMO CHO 5
Yvonne Heaney	PHN (CHO 2)
Andrea Collins	Clinical Skills Facilitator (CHO 9)
Rachel Eustace	PHN INMO CHO 9
Kathleen Heery	RGN Continence Advisor (CHO 1)
Tara Curran	RGN CNS Tissue Viability (CHO 9)
Carmel Twomey	RGN (CHO 4) Digital CNM2
Deirdre O'Brien	RGN (CHO 7)
Eileen Tormey	Quality and Safety rep
Tracey McEntee	HCA (CHO 3)

Sign-off by Chair of Approval Governance Group

Procedure for the use of Standardised Clinical Care Plans in the Public Health Nursing Service was formally ratified and recorded in the minutes of the Approval Governance Group on 19/3/2024

Name: (print)	Grainne Ryan
Title:	National Lead of PHN Service
Signature: **(e-signatures accepted)**	
Registration number: **(if applicable)**	

Appendix 3: Conflict of Interest Declaration Form

CONFLICT OF INTEREST DECLARATION FORM

This form has been completed and is being held in the master file by the national PDC for the PHN Service on behalf of the ONMSD.

Appendix 4*:* Search Strategy

Leabharlann Sláinte na hÉireann
Health Library Ireland
EVIDENCE

Search Planning Form: Level 3 (COMPREHENSIVE SEARCH); Level 4 (COMPREHENSIVE SEARCH + EVIDENCE SUMMARY)

Level 3 COMPREHENSIVE SEARCH

Level 4 COMPREHENSIVE SEARCH + EVIDENCE SUMMARY

Keywords: Standardised/standardised care plans

Agreed Question: Best practice in developing and using Standardised Clinical Care Plans

Scope: Systematic Literature Review

Limits: last 10 years preferred

Question Category: Other

Key Concepts: Click or tap here to enter text.

Sources: MEDLINE, Web of Science, EMBASE, TRIP, CINAHL, Google Scholar, Google

Search Strategy: standard* N3 care plan OR SCP* OR EB-SCP* AND nurs* OR ANP OR CNM OR RGN OR RN OR CNS OR RPN

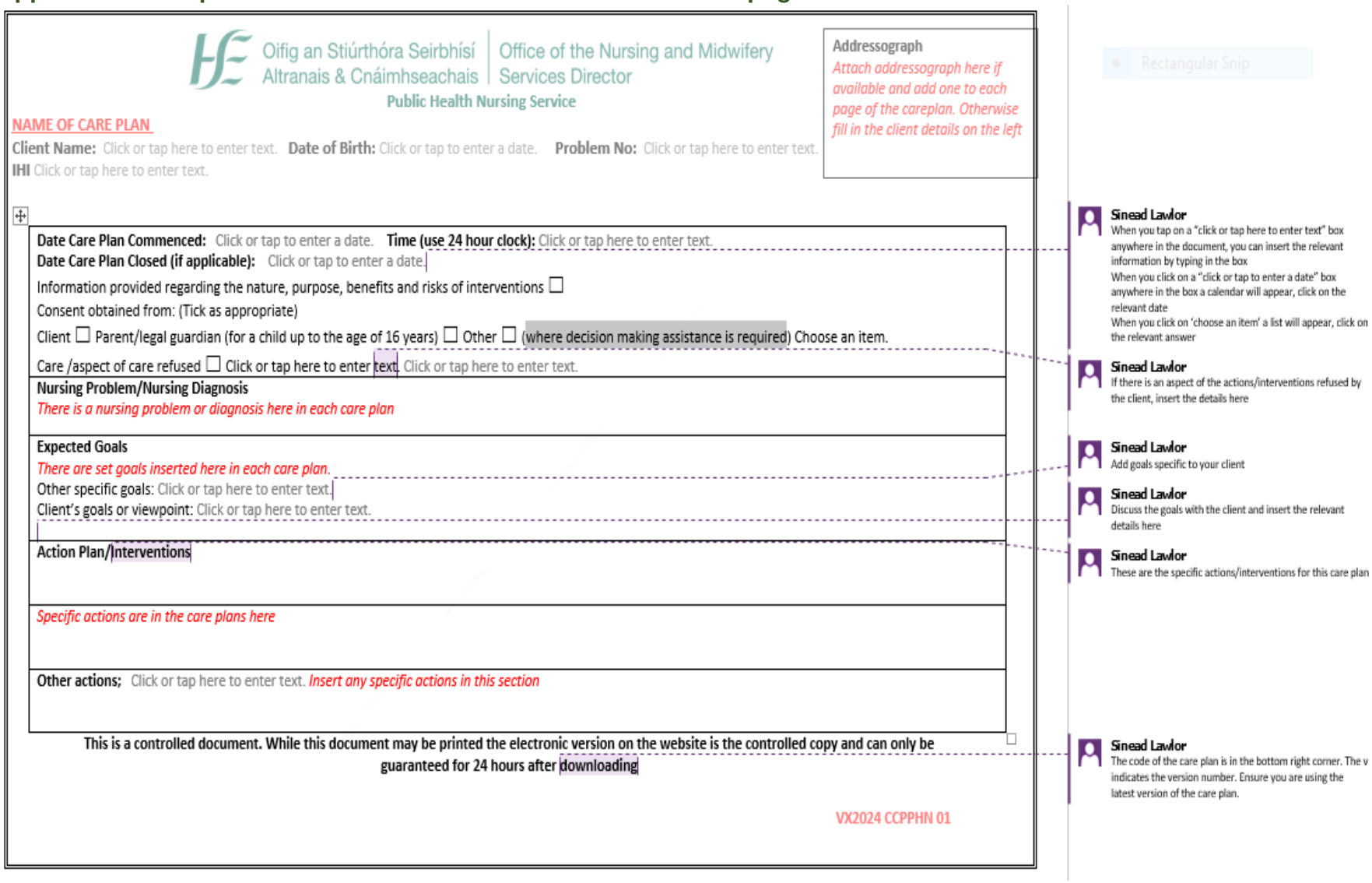
Appendix 5: List of Standardised Clinical Care Plans & Codes

Appendix 5: *List of Standardised Clinical Care Plans & Codes*	
Care Plan Code	**Name of Standardised Clinical Care Plan**
V1 2024 CCPPHN 01	Pressure Ulcer Prevention
V1 2024 CCPPHN 02	Personal Care
V1 2024 CCPPHN 03	Medication Administration
V1 2024 CCPPHN 04	Catheter Management
V1 2024 CCPPHN 05	Safeguarding
V1 2024 CCPPHN 06	Falls Risk Management
V1 2024 CCPPHN 07	Promoting Urinary Continence and Managing Incontinence
V1 2024 CCPPHN 08	Bowel Care Management
V1 2024 CCPPHN 09	Urinary Catheter Maintenance and/or Bladder Irrigation
V1 2024 CCPPHN 10	Surgical Wound
V1 2024 CCPPHN 11	Client at risk of Autonomic Dysreflexia
V1 2024 CCPPHN 12	Diabetes Management

Appendix 6: Clinical Care Plan Index

Clinical Care Plan Index				
Client's Name			**Client's DOB**	
Problem Number	Clinical Care Plan Name	Date Care Plan Commenced	Date Care Plan Closed	Additional Comments

Appendix 7: Sample Clinical Care Plan with Guidance for use – page 1 of 3



Oifig an Stiúrthóra Seirbhísí Altranais & Cnáimhseachais | Office of the Nursing and Midwifery Services Director

Public Health Nursing Service

Addressograph

Attach addressograph here if available and add one to each page of the careplan. Otherwise fill in the client details on the left

NAME OF CARE PLAN

Client Name: Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date. **Problem No:** Click or tap here to enter text.

IHI Click or tap here to enter text.

Date Care Plan Commenced: Click or tap to enter a date. **Time (use 24 hour clock):** Click or tap here to enter text.

Date Care Plan Closed (if applicable): Click or tap to enter a date.

Information provided regarding the nature, purpose, benefits and risks of interventions ☐

Consent obtained from: (Tick as appropriate)

Client ☐ Parent/legal guardian (for a child up to the age of 16 years) ☐ Other ☐ (where decision making assistance is required) Choose an item.

Care /aspect of care refused ☐ Click or tap here to enter text. Click or tap here to enter text.

Nursing Problem/Nursing Diagnosis

There is a nursing problem or diagnosis here in each care plan

Expected Goals

There are set goals inserted here in each care plan.

Other specific goals: Click or tap here to enter text.

Client's goals or viewpoint: Click or tap here to enter text.

Action Plan/Interventions

Specific actions are in the care plans here

Other actions; Click or tap here to enter text. *Insert any specific actions in this section*

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Sinead Lawlor
When you tap on a "click or tap here to enter text" box anywhere in the document, you can insert the relevant information by typing in the box
When you click on a "click or tap to enter a date" box anywhere in the box a calendar will appear, click on the relevant date
When you click on 'choose an item' a list will appear, click on the relevant answer

Sinead Lawlor
If there is an aspect of the actions/interventions refused by the client, insert the details here

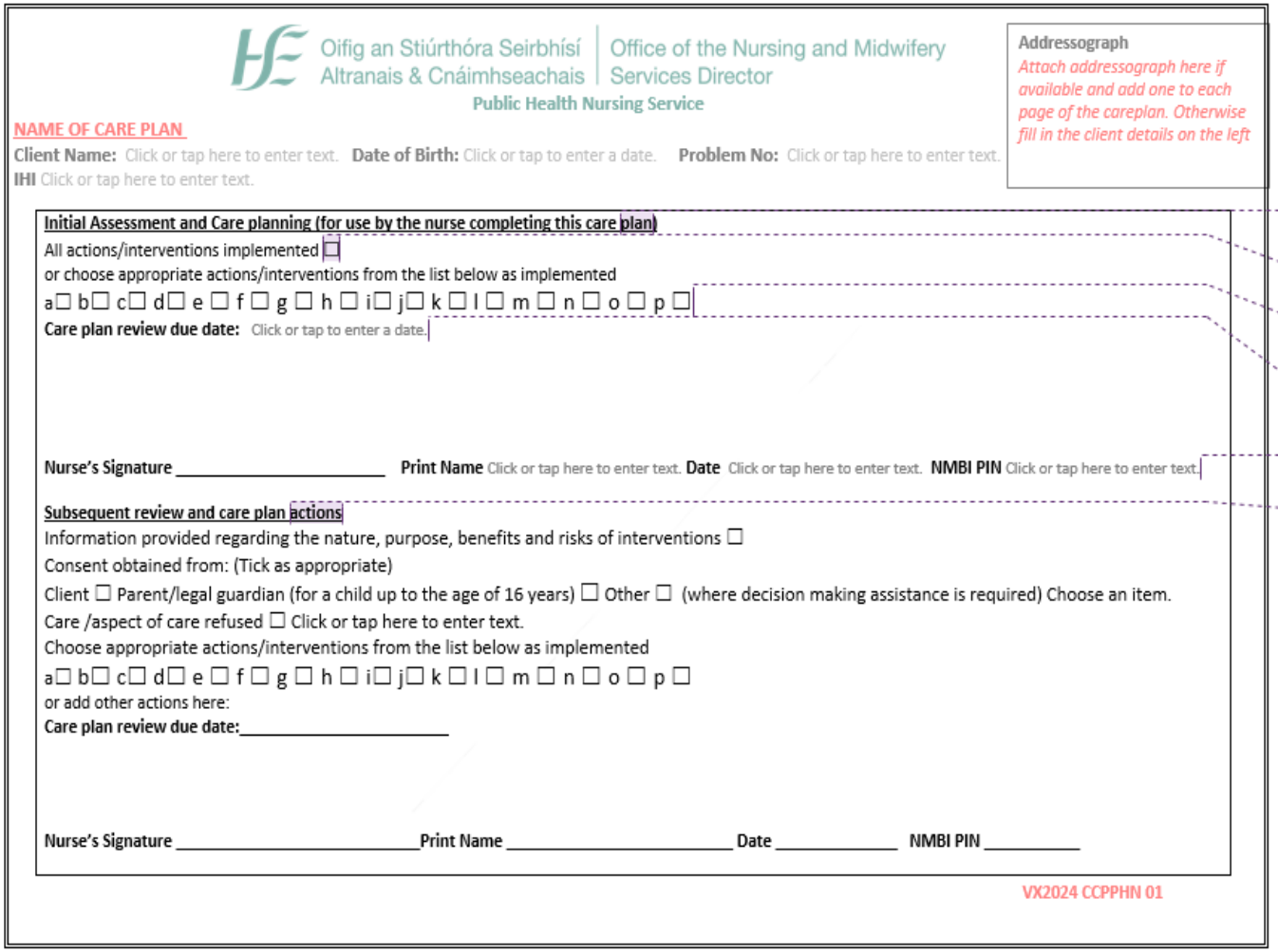
Sinead Lawlor
Add goals specific to your client

Sinead Lawlor
Discuss the goals with the client and insert the relevant details here

Sinead Lawlor
These are the specific actions/interventions for this care plan

Sinead Lawlor
The code of the care plan is in the bottom right corner. The v indicates the version number. Ensure you are using the latest version of the care plan.

Appendix 7: Sample Clinical Care Plan with Guidance for use – page 2 of 3



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Addressograph

Attach addressograph here if available and add one to each page of the careplan. Otherwise fill in the client details on the left

NAME OF CARE PLAN

Client Name: Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date. **Problem No:** Click or tap here to enter text.

IHI Click or tap here to enter text.

Initial Assessment and Care planning (for use by the nurse completing this care plan)

All actions/interventions implemented ☐

or choose appropriate actions/interventions from the list below as implemented

a☐ b☐ c☐ d☐ e ☐ f ☐ g ☐ h ☐ i☐ j☐ k ☐ l ☐ m ☐ n ☐ o ☐ p ☐

Care plan review due date: Click or tap to enter a date.

Nurse's Signature _____ **Print Name** Click or tap here to enter text. **Date** Click or tap here to enter text. **NMBI PIN** Click or tap here to enter text.

Subsequent review and care plan actions

Information provided regarding the nature, purpose, benefits and risks of interventions ☐

Consent obtained from: (Tick as appropriate)

Client ☐ Parent/legal guardian (for a child up to the age of 16 years) ☐ Other ☐ (where decision making assistance is required) Choose an item.

Care /aspect of care refused ☐ Click or tap here to enter text.

Choose appropriate actions/interventions from the list below as implemented

a☐ b☐ c☐ d☐ e ☐ f ☐ g ☐ h ☐ i☐ j☐ k ☐ l ☐ m ☐ n ☐ o ☐ p ☐

or add other actions here:

Care plan review due date:_____

Nurse's Signature _____**Print Name** _____ **Date** _____ **NMBI PIN** _____

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Sinead Lawlor
The care plan should be printed off and inserted in the client's healthcare record

Sinead Lawlor
If all the interventions are relevant and actionable tick here

Sinead Lawlor
If only some of the interventions are relevant – tick the appropriate interventions here

Sinead Lawlor
Complete the date the evaluation is due

Sinead Lawlor
The nurse who carries out the initial documentation of the care plan should sign, date, NMBI PIN here.

Sinead Lawlor
In the case that further interventions are required, they are completed in this section and signed and dated by the nurse who has undertaken the subsequent review and addition of actions.
This section is hand written as the care plan is in the client's healthcare record at this point.

Appendix 7: Sample Clinical Care Plan with Guidance for use – page 3 of 3

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Addressograph

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NAME OF CARE PLAN

Client Name: Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date. **Problem No:** Click or tap here to enter text.

IHI Click or tap here to enter text.

Subsequent review and care plan actions

Information provided regarding the nature, purpose, benefits and risks of interventions ☐

Consent obtained from: (Tick as appropriate)

Client ☐ Parent/legal guardian (for a child up to the age of 16 years) ☐ Other ☐ (where decision making assistance is required) Choose an item.

Care /aspect of care refused ☐ Click or tap here to enter text.

Choose appropriate actions/interventions from the list below as implemented

a☐ b☐ c☐ d☐ e ☐ f ☐ g ☐ h ☐ i☐ j☐ k ☐ l ☐ m ☐ n ☐ o ☐ p ☐

or add other actions here:

Care plan review due date:_____

Nurse's Signature _____ **Print Name** _____ **Date** _____ **NMBI PIN** _____

VX2024 CCPPHN 01

Appendix 8: National Implementation plan

National 3PG Title: Procedure for the use of standardised clinical care plans in the public health nursing service.
Date National 3PG approved: 19/03/2024
Expected date of full implementation: The care plans will be launched nationally within 3 months of the approval date.
National 3PG implementation lead/role: Grainne Ryan, National Lead for Public Health Nursing Service

IMPLEMENTATION ACTION	Implementation barriers / enablers	List of tasks to implement the action	Lead responsibility for delivery of the action	Expected completion date	Expected outcomes
Information sessions developed nationally and delivered via webinar.	• **Enabler:** Support of PDCs or DPHN appointed champion • **Enabler:** Webinar will be recorded for all nurses/midwives to watch beyond the 'go live' webinar. • **Enabler:** Sample clinical care plan developed with instructions embedded to aid correct use of clinical care plans. • **Enabler:** PowerPoint slide set to support implementation. • Barrier: IT access is variable.	• Identify PDCs to assist with CHO wide implementation. • Link with DPHNs to identify champions to support implementation. • Set date for national live webinar. • Provide and record webinar. • Disseminate recorded webinar and slides. • Provide DPHN areas with access to care plans (2 care plan formats & procedure, • DPHNs to be advised for the procedure to be uploaded to the MAPS portal for mandatory reading/compliance.	Sinead Lawlor National PDC	6 months from approval date	The standardised clinical care plans and associated procedure will be available for use across the PHN services nationally 6 months from approval date.

National Implementation Plan Continued

Education / training required to implement the National 3PG:

- National procedure on the use of standardised clinical care plan available on www.hse.ie/phn and in the national central repository of the HSE.
- Sample care plan with embedded instructions.
- Live webinar.
- Recorded webinar.
- PDC support/champion's support for implementation.
- The national procedure will require dissemination to all DPHNs nationally and supporting information sessions will be provided as part of the formal roll out of the standardised care plans and their associated procedure. A standardised PowerPoint presentation will be developed to ensure uniformity in terms of the information conveyed to all nurses/midwives.
- Communication from the national PHN office with the Higher Education Institutes responsible for student PHN education will occur to ensure awareness of the national procedure.
- Local induction programmes for new nurses commencing employment will include briefing on all 3PGs approved for use within the PHN service.

Resources: A copy of the procedure and the standardised clinical care plans is available on the National PHN website to download at; https://www.hse.ie/phn and on the HSE's document hub at https://dochub.healthservice.ie

Recorded webinar disseminated to all DPHNs.

Information resources links built into each care plan as part of standardised care.

Appendix 9: Audit Tool for the Procedure on the use of the Standardised Clinical Care Plans in the PHN Service

Audit should be carried out within 12 months of implementation of this procedure using this audit tool. Frequency of subsequent audit, will be determined at local level following the first audit. **Please answer all questions indicating Yes (Y) or No (N) or Not Applicable (N/A) and give a comment if necessary in the 'evidence' column.**

No	Is standard/criteria being met for the following statements:	Y	N	N/A	Evidence
1	Has the nurse read the procedure on the MAPs portal?				
2	Have the principles of good documentation been adhered to throughout the care plan; e.g. use of black ink, legible, date and timed with 24 hour clock, signature and NMBI number?				
3	Is there evidence that information was provided regarding the nature, purpose, benefits & risks of interventions?				
4	Is there evidence that consent was gained?				
5	Is the client's name and date of birth recorded on the care plan?				
6	Has the problem(s) been clearly identified?				
7	Is the care plan number evident?				
8	Has a care plan index been commenced?				
9	Has the care plan been individualised to reflect specific Client need?				
10	Was an evaluation review date set?				
11	Is the evaluation of the care plan evident?				
12	In the case where the care plan problem/diagnosis has not been resolved and the care plan is of 1 year's duration, is there evidence that the care plan has been reviewed at least annually following client re-assessment. Please verify that the up to date care plan version number is in use.				
13	Is the closure of the care plan evident where applicable?				
14	Is there evidence that the progress notes were maintained during each episode of care?				

Date & time of Audit:
Audited by (name/title):
Health Centre/Primary care centre:
Compliance Rate %: /14

Quality Improvement plan required: Yes/No (please circle)
Action areas identified:

Appendix 10: Checklist

Checklist for Best Practice in Developing HSE National 3PGs		
Stage 1	**Deciding the need**	
1.	Aligned with HSE National Priorities	☒
2.	Clearly defined document type (P,P,P or G)	☒
3.	Approval obtained to develop	☒
Stage 2	**Planning**	
4.	Governance clearly established	☒
5.	Appropriate stakeholder involvement	☒
6.	Defined in-scope and out-of-scope	☒
7.	Development Group (terms of reference/conflict of interest forms)	☒
Stage 3	**Development**	
8.	Evidence methodology based	☒
9.	Creation of guidance / recommendations	☒
10.	Explicit link between the evidence to guidance / recommendations	☒
11.	Circulated for national consultation/independent expert review (as required)	☒
12.	Audit Tool developed	☒
Stage 4	**Implementation**	
13.	Implementation plan completed / Team established	☒
14.	Communication and dissemination plan developed	☒
15.	Supports: advice, tools, resources developed and where to access	☒
Stage 5	**Sustainability**	
16.	Monitoring and Audit Plan outlined	☒
17.	Audit outcomes: structure in place to link to quality improvement and risk management processes	☒
Document Control		
18.	Mandatory pages 1+2 of this template are fully completed.	☒

I confirm that all of the above key activities have been met: ☒

Chairperson name: Yvonne Delaney	**Title: Assistant Director of Public Health Nursing (PHN) Service – Practice Development Coordinator.**
Signature: (e-signatures accepted)	Yvonne Delaney
Registration number: 63194	
Co-chair name: Sinead Lawlor	**National Practice Development Coordinator**
Signature: (e-signatures accepted)	Sinead Lawlor
Registration number: 40339	
Date:	16/02/2024

Appendix 11: Subsequent Reviews – Additional Sheet page 1 of 2

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Addressograph

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INSERT NAME OF CARE PLAN_____

Client Name: Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date. **Problem No:** Click or tap here to enter text.

IHI Click or tap here to enter text.

Subsequent review and care plan actions

Information provided regarding the nature, purpose, benefits and risks of interventions ☐

Consent obtained from: (Tick as appropriate)

Client ☐ Parent/legal guardian (for a child up to the age of 16 years) ☐ Other ☐ (where decision making assistance is required) Choose an item.

Care /aspect of care refused ☐ Click or tap here to enter text.

Choose appropriate actions/interventions from the list below as implemented

a☐ b☐ c☐ d☐ e ☐ f ☐ g ☐ h ☐ i☐ j☐ k ☐ l ☐ m ☐ n ☐ o ☐ p ☐ q ☐ r☐ s☐ t☐ u☐ v☐ w☐ x☐ y☐ z☐ aa☐ bb☐ cc☐ dd ☐ ee ☐ or add other actions here:

Care plan review due date:_____

Nurse's Signature _____**Print Name** _____ **Date** _____ **NMBI PIN** _____

Appendix 11: Subsequent Reviews – Additional Sheet page 2 of 2

Oifig an Stiúrthóra Seirbhísí Altranais & Cnáimhseachais | Office of the Nursing and Midwifery Services Director

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Subsequent review and care plan actions

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cc☐ dd ☐ ee ☐ or add other actions here:

Care plan review due date:_____

Nurse's Signature _____ **Print Name** _____ **Date** _____ **NMBI PIN** _____