Procedure for the use of Family and Child Health Standardised Care Plans in the Public Health Nursing Service

Is this document a:

Policy [ ] Procedure [x] Protocol [ ] Guideline [ ]

HSE Community Operations – Primary Care – Public Health Nursing Service

National Healthy Childhood Programme

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PART A: 2.7 Outline of PPPG Steps

Title of PPPG: Procedure for the use of Family and Child Health Standardised Care Plans in the Public Health Nursing Service

*The term **patient** is used throughout the procedure it encompasses the terms client, individual, person, service user, mother, woman, parent, guardian, child or baby depending on the setting.*

An individual RPHN/RM should establish and maintain accurate, clear and current patient records within a legal, ethical and professional framework.

A 1.0 Assessment

A1.1 The quality of a RPHN/RMs record keeping should be such that continuity of care for a patient /family is always supported.

At a minimum, a patient healthcare record should include the following;

A1.1.1 An accurate assessment of the patient's physical, psychological and social wellbeing and, whenever appropriate, the views and observations of family members in relation to that assessment.

A1.1.2 Evidence in relation to the planning, provision and evaluation of nursing care.

A1.2 Following an assessment by the RPHN/RM in which the healthcare needs are identified, the RPHN/RM should document the assessment. It must be clear from the healthcare record that the patient has been assessed and their individualised care planned, provided and evaluated.

A1.3 Consent must be obtained prior to interventions to ensure all proposed treatments are discussed and fully understood. The patient's right to self-determination is a fundamental principle in relation to client centred care planning.

A2.0 Use of the standardised care plans

A2.1 Following the identification of healthcare needs a care plan should be initiated.

A2.1.1 list of the available standardised care plans is available in Appendix VI. The RPHN/RM should ensure the latest version of the appropriate standardised care plan is downloaded from the website. The care plans are available at www.Hse.ie/nhcp. The care plans are in PDF format on the website.

A2.2 The standardised care plan should be used with RPHN/RM judgement and must be adapted to address the individual needs of each patient. It is not acceptable to insert the care plan into the

maternal or child healthcare record without first individualising it to the needs of the patient. It is the responsibility of the PHN/RM to utilise their clinical judgement when writing a care plan in the Child Health Record/Maternal Postnatal Record (CHR/MHR). Many of the care plans prompt the RPHN/RM to insert specific observations in the nursing diagnosis column "as evidenced by:".

A2.2.1 The RPHN/RM should devise a care plan if there is no standardised care plan available to suit the identified healthcare need.

A2.3 Completing details on the Care Plan:

- Complete patient's name and date of birth
- Insert date/time (24 hour clock) the care plan is commenced
- Insert problem number
- Nursing Problem/Nursing Diagnosis – insert any additional information that will highlight the patient's own understanding of their problem/concern/need
- Identify expected goal(s) and include any specific goal as identified by the patient or the RPHN/RM if relevant
- Action Plan/Intervention – Interventions on the standardised care plans are evidence based. The RPHN/RM should add, edit, amend the care plan to suit the individual needs of the patient. Record any additional relevant interventions based on assessment in **'other'.** The responsibility rests with the RPHN/RM to script a care plan individual to the patients care needs.
- Evaluation Time Frame – insert the frequency/time frame to evaluate the care plan e.g. 48 hours, one week; one month
- Outcome - Record the date and the evaluation of the outcomes
- Record signature/print name/NMBI PIN
- Ensure care plan has been discussed and agreed and tick the box.
- See sample care plan Appendix VII

A2.3.1 The mother/parent wishes must be explicit in the care plan. This includes discussion regarding the child's treatment and their preferences, if known.

A2.4 Evaluation/Progress Notes must be initiated for each core care plan

A2.5 Evaluation/Progress sheets must be updated contemporaneously

A2.6 Evaluation/Progress records must provide evidence that the core care plan is being implemented; this involves the gathering of very specific and targeted information linked to a specific problem and goal/outcome.

A2.7 All healthcare staff should be encouraged to read each other's entries in the record as this facilitates good communication between healthcare staff.

A2.8 The final evaluation will involve the RPHN/RM using clinical judgement to evaluate if the goal has been achieved by the patient. In doing this, the RPHN/RM is evaluating the effectiveness of the nursing intervention and judging the patients outcomes (achievements or non-achievements of goals).

A3.0 Documentation

A3.1 Legal Considerations

Records are legal documents**.**

All records may be used to aid the legal process.

Nursing/Midwifery records may be, and frequently are, used as evidence in legal cases.

A3.2 All narrative notes are individualised, accurate, up to date, factual and unambiguous.

A3.2.1 Narrative notes should be devoid of any jargon, witticisms or derogatory remarks.

A3.2.2 It must be clear from the records that the patient has been assessed and their individualised care planned, provided and evaluated.

A3.3 All written records are legible.

A3.3.1 It is the RPHN/RM responsibility to ensure that the writing in a record is clear and legible.

A3.3.2 Handwriting that is difficult to read must be in print form.

A3.3.3 Black Ink must be used for all entries.

A3.3.4 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.

A3.4 All entries are signed.

A3.4.1 RPHNs/RMs must sign entries using their name as entered on the Register of Nurses and Midwives maintained by the Nursing and Midwifery Board of Ireland (NMBI).

A3.4.2 The name should also be printed beside the signature.

A3.4.3 The NMBI PIN number should be entered.

A3.4.4 If different health professionals write in the same part of the record, then the status of the professional should also be indicated e.g. PHN or RM.

A3.5 All entries are dated.

A3.5.1 The format to be used is: day/month/year followed by time, using the 24 hour clock dd/mm/yyyy hh:mm.

A3.6 Entries in the records are in chronological order.

A3.6.1 Entries in the health care record should normally appear in chronological order, with time stated. Any variance from this should to be explained.

A3.7 Documentation in the record is carried out as soon as possible after providing nursing care.

A3.7.1 It should always be clear from the notes what time an event occurred and what time the record was written.

A3.7.2 This may prove to be difficult in an emergency situation. Late entries are acceptable provided that they are clearly documented as such.

A3.7.3 The RPHN/RM should not “squeeze” a late entry into existing notes, nor write in the margins.

A3.7.4 RPHN/RMs should not record entries ahead of time, or otherwise, predate entries.

A3.7.5 RPHN/RMs 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.

A3.8 Abbreviations should only be used if drawn from a list approved by the HSE.

A3.9 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.

A3.9.1 No attempt should be made to alter or erase the entry made in error.

A3.9.2 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.

A3.10 A RPHN/RM making a referral or consulting with another member of the healthcare team should clearly identify, by name, the person in the record.

A3.11 Any information, instruction or advice given, by the RPHN/RM, to a patient should be documented.
A3.11.1 Patient education is a legitimate nursing intervention and should be recorded as such.

A3.12 All written data in respect of a patient's care plan should be kept in the assigned area for care plans in the healthcare record.

A3.12.1 One of the basic principles of the provision of care is that there should be one comprehensive healthcare record for each service user which is available to clinicians for treatment of the service user when required. Only in exceptional circumstances should there be a duplicate record (HSE 2011).

A3.12.2 The keeping of supplementary records should be the exception rather than the norm.

A3.13 The patient name and date of birth or unique identifier (IHI) should appear on every page of the record, including on care plans.

A3.13.1 The identity of the person for whom the record is being maintained should always be obvious to the reader.

A3.14 The standard of record keeping of those under supervision in the clinical area e.g. student public health nurses undertaking supervised clinical practice prior to registration, should be monitored by their preceptor or her/his delegate.

A3.14.1 PHN Students are required to learn the practice of writing/documenting the delivery and management of nursing care in the community. This skill requires instruction/supervision, as the student cannot be held totally accountable for the record while under supervision.

A3.14.2 If an entry by someone under supervision needs to be amended, then the procedure for any entry made in error should be followed.

PART B: PPPG Development Cycle

1.0 INITIATION

Introduction

The Institute of Community Health Nursing (ICHN) founded in 1985, was a professional and educational body which represented community nursing throughout the Republic of Ireland. It was established by a group of Directors of Public Health Nursing to support innovation and quality in areas of clinical practice, education and practice development through empowerment, leadership and advocacy. During its lifespan until its closure in April 2020 it provided opportunities for research and one of its major research projects was the development of standardised care plans in child, maternal and family health.

Background

In 2012, an evaluation of the Child and Family Health Needs Assessment project in HSE Dublin Mid Leinster revealed the need for standardised care plans specific to children and families (O'Dwyer 2012). This project reported variances in the method of care planning in different areas. The introduction of standardised care planning amongst community clinicians was identified to achieve the best possible outcomes for service users and this goal has been pursued by the ICHN.

In 2016, the ICHN Child and Family Health Interest Group (CFHIG) undertook a project in the area of developing standardised child care plans. From this work, a proposal emanated in 2018 to implement and evaluate 36 standardised care plans in the area of child, maternal and family health in three Public Health Nursing departments, Dublin West, Kildare/West Wicklow and Laois/Offaly.

Aim

The aim of the project was to evaluate the implementation of a suite of standardised child, maternal and family health care plans in the community setting. The standardised care plans were developed for PHN practice to safely support a safe, effective and quality child health core screening and surveillance service.

Objectives

To evaluate the implementation of standardised child maternal and family health care plans in a minimum of three to four public health nursing service areas.

To evaluate the implementation of standardised child maternal and family health care plans from the perspective of public health nurse practitioners, managers and clients.

To identify potential implications of introducing standardised child maternal and family health

care plans in public health nursing practice taking account of risk and governance consequences.

Summary findings:

The findings were returned to the CFHIG to review the 17 Standardised Care Plans (≥ 5 evaluation forms returned, deemed fit for purpose) in terms of modification commentary.

- Each Standardised Care Plan adopted to be viewed as a live document with regular review and updates undertaken to incorporate new evidence and research into the detail to reflect best practice.
- Consultation to be undertaken with interested stakeholders to elicit their perspective and input into the findings.
- Consideration to be given to the suggested development of additional Standardised Care Plans.

In utilising Standardised Care Plans, it is imperative that practitioners use their clinical skills in assessing and delivering care, to ensure that no oversight occurs in meeting the 'Nursing Problems'.

In this project, three areas emerged that required further exploration namely, the standardised care plans deemed fit for purpose (with modifications), those considered not fit for purpose and the additional development of new standardised care plans. The findings from the project suggested that further exploration and modification was required with the standardised care plans deemed 'fit for purpose'. In response to the findings above further work was completed by the ICHN CFHIG in 2019 and all care plans were reviewed in line with best practice. Cognisance was given to the available materials developed by the National Healthy Childhood Programme.

In 2021 consultation began with the Programme Manager for the National Healthy Childhood Programme, Programme Lead The Nurture Programme Infant Health & Wellbeing, National Practice Development Co-ordinator Public Health Nursing Service ONMSD, National Lead for PHN Services ONMSD and the former President of the ICHN to develop a pathway to allow the standardised plans to be used by Public Health Nurses under the governance of the National Healthy Childhood Programme.

To support this, a national procedure has been developed to support the implementation of the standardised care plans to be used in Public Health Nursing Practice.

It is envisaged that the use of the standardised care plans will enhance the quality of care and provision of evidence-based practice.

1.1 Purpose

The purpose of this procedure is to provide guidance to all registered RPHNs/RMs in the Public Health Nursing Service on the use of standardised family and child health care plans.

1.2 Scope

1.2.1 Target users; This procedure applies to all RPHNs and RMs working in the HSE Public Health Nursing Service nationally who provide family and child health care.

1.2.2 Population to whom it applies; this procedure applies to all mothers/guardians and children who receive care from the Public Health Nursing Service.

1.3 Objective(s)

1.3.1 To provide guidance and clarity to RPHNs/RMs on the use of family and child health standardised care plans.

1.3.2 To ensure good practice regarding the recording of clinical practice including assessment, care planning and evaluation in the maternal postnatal record and child health record in a standardised way.

1.3.3 To guide RPHNs/RMs on individualising the family and child care plans in addressing the individual needs of the client.

1.4 Outcome

A clear procedure is available for RPHNs and RMs to follow on the use of the family and child standardised care plans in their practice in order to promote continuity of care and uphold standards of best practice in nursing documentation.

1.5 PPPG Development Group

See Appendix II for Membership of the PPPG Development Group.

See Appendix III for PPPG Conflict of Interest Declaration Form.

1.6 PPPG Governance Group

1.6.1 See Appendix IV for Membership of the Approval Governance Group.

1.7 Supporting Evidence

1.7.1 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.

Department of Children and Youth Affairs (2019) Children First: National Guidance for the Protection of Welfare of Children.

European Commission (2016) General Data Protection Regulations accessed on

27/09/2021 https://ec.europa.eu/info/law/law-topic/data-protection/eu-data-protection-rules_en
Health Information and Quality Authority (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) National Standards for Safer Better Maternity Services.
Health Information and Quality Authority (2016) Supporting Peoples Autonomy: a Guidance Document.
Health Service Executive (2010) Code Of Practice for Healthcare Records Management Abbreviations
Health Service Executive (2019) National Consent Policy, Quality and Patient Safety Directorate (V1.3)
National Institute for Health and Clinical Excellence (2021) Postnatal Care. NICE guideline NG194.
Nursing and Midwifery Board of Ireland (2015) Scope of Nursing and Midwifery Practice Framework.
Nursing and Midwifery Board of Ireland (2015) Recording Clinical Practice Professional Guidance
Nursing and Midwifery Board of Ireland (2021) Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.
World Health Organisation (WHO) (2013) Recommendations on Postnatal care of the Mother and Newborn

1.7.2 List PPPGs that are being replaced by this PPPG.

This national procedure replaces any previously developed local procedures regarding the use of maternal and child standardised care plans in the Public Health Nursing service.

1.7.3 List related PPPGs.

Health Services Executive (2011) Standards and Recommended Practices for Healthcare Records Management.
Health Services Executive (2013) Record Retention Periods: Health Service Policy.
Health Service Executive (2016) National Framework for developing policies, procedures, protocols and guidelines (PPPGs).
Health Service Executive (2017) Policy on Lone Working.
Health Service Executive (2019) National Consent Policy.
Health Service Executive (2019) Data Protection Guidelines.
Health Service Executive (2019) Child Protection and Welfare Policy.

1.8 Glossary of Terms

1.8.1 Abbreviations

ADPHN	Assistant Director of Public Health Nursing
CFHIG	Child and Family Heath Interest Group
CHO	Community Healthcare Organisation
CHR	Child Health Record
CMD	Community Medical Doctor
CPNS	Child Protection Notification System
DOHC	Department of Health and Children
DPHN	Director of Public Health Nursing
GDPR	General Data Protection Regulation
GP	General Practitioner
HIQA	Health Information and Quality Authority
HCP	Health Care Professional
HSE	Health Services Executive
ICHN	Institute of Community Health Nursing
MPR	Maternal Postnatal Record
NMBI	Nursing and Midwifery Board of Ireland
NHCP	National Healthy Childhood Programme
NMBI	Nursing and Midwifery Board of Ireland
ONMSD	Office of the Nursing and Midwifery Services Director
PC	Primary Care
PCT	Primary Care Team
PPPG	Policy Procedure Protocol Guideline
PDC	Practice Development Coordinator
RPHN	Registered Public Health Nurse
RM	Registered Midwife

1.8.2 Glossary

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 patient care outcomes and standards of the nursing and midwifery professions (adapted from Krautscheid 2014 cited in Scope of Nursing and Midwifery Practice Framework Nursing and Midwifery Board of Ireland (NMBI), 2015).

Care Plan: a nursing care plan outlines the nursing care to be provided to the client/patient. 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.

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).

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

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 2015).
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 2019 V1.3).
Nursing Assessment: during the assessment stage the nurse gathers information about the patient/ client 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 defined as a clinical judgment about individual, family, or community responses to actual or potential health problem. 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).
Desired outcome: the goal which the intervention is expected to achieve, each problem should have an anticipated outcome to correctly evaluate the patient's progress. Goals may be immediate, short or long term. (NANDA 2000cited in Carpenito-Moyet, L. 2008)
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, L. 2008).
Nursing process: is a dynamic, systematic goal orientated framework for problem-solving that helps the nurse to care for the patient 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.
Patient: a person who uses health and social care services. In some instances, the terms 'client', 'individual', 'person', 'people', 'resident', 'service user', 'mother', woman or 'baby' are used in place of the term patient, depending on the health or social care setting.
The 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 patient that is based on trust,

understanding, compassion, support and serves to empower the patient 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 2015).

2.0 DEVELOPMENT OF PPPG

The standardised care plans were developed and piloted by the Child and Family Interest Group of the Institute of Community Health Nursing. The care plans have been reviewed in line with the Child Assessment Manual for PHNs (NHCP 2020) and the Guideline on Maternal Postnatal Care in the PHN service (pending approval 2021). Please see section 8.0 for acknowledgements.

2.1 List the questions (clinical/non-clinical)

What is the guidance required by RPHN/RMs to use the standardised family and child health care plans?

What is the evidence base to support the use of the standardised family and child health care plans?

2.2 Describe the literature search strategy

A review of the relevant literature regarding the use of standardised care plans was undertaken by a HSE librarian. The term standardised care plans replaced core care plans in the 1990s. Studies reviewed were identified through searches of Medline, CINAHL, the Cochrane database, Nursing and Midwifery Board of Ireland (NMBI). Key words included care planning, standardised care plans, documentation, multidisciplinary, healthcare, Irish policy and quality patient care.

2.3 Describe the method of appraising evidence

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 PPPG?

The evidence consisted mainly of quantitative research looking at the effectiveness of standardised care plans. One systematic literature review of accuracy in nursing care plans and using standardised nursing language was included.

2.4 Describe the process the PPPG Development Group used to formulate recommendations

Recommendations were formulated through a review of the literature and discussion within the procedure development group. Assistance from a librarian was sought to search the literature and the ICHN report on the testing phase of the care plans was also made available.

2.5 Provide a summary of the evidence from the literature

The Irish healthcare system is described as being based on a complex and costly mix of private, statutory and voluntary provisions (Staines *et al* 2018). Policy benchmarks in the development of the Irish health services include The White Paper (1947 & 1949) and The Health Acts (1953,

1970, 2004). Underpinning aspirations included developing new structures for service delivery in Ireland, including the reorientation of focus on the delivery of care to a more community-based service. Other legislation which impacted community nursing included the Notification of Birth Acts (1907 and 1915), both of which relate to visiting new-borns. Child Care Act (1991) and Children First Act (2015), which mandated a co-ordinated response to child welfare and child protection.

To support the move of service delivery to primary care, strategy in the form of Sláintecare (2017) was introduced to provide an overarching infrastructure to shape service delivery. Sláintecare sets out a high level policy roadmap to deliver whole system reform and universal healthcare, phased over a ten year period. Sláintecare details reform proposals which, if delivered, will establish; a universal, single-tier health service where patients are treated solely on the basis of health need; the reorientation of the health system 'towards integrated primary and community care, consistent with the highest quality of patient safety in as short a time-frame as possible' (Burke *et al*. 2018).

One approach of supporting the achievement of policy aspiration is the development of tools to support standardised best care practices for service users. Timely, appropriate intervention can transform the experience of all involved in the delivery of healthcare. Following assessment, a clear documented plan of care for service users has been associated with benefits including clarity of treatment plans, ease of prioritisation of goals and involvement of clients in the overall management plan (Ademola *et al*. 2011). This contributes to supporting good nursing practices throughout the community setting. Tierney (2018) emphasises the importance of stakeholders working collectively to implement community participation within interdisciplinary teams. One method of achieving integration would be the collaborative use of common care planning across all disciplines.

Documentation and record keeping of clinical care including interactions between the patient and the multi-disciplinary team is essential for effective service planning. It supports patient care being delivered in a supportive, professional manner tailored to the patients' needs. 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. The Nursing and Midwifery Board of Ireland has highlighted the importance of appropriate documentation in the Code of Conduct (NMBI 2015). The Health Information and Quality Authority (2012) have determined a set of requirements to achieve standards in relation to the use of information across the Irish health services. The National Standards for Safer Better Healthcare highlights the need for accurate, relevant, legible and complete information. It outlines the need for appropriate information and communication technology to assist with both the collection and reporting of quality information related to patient care. There are adverse consequences for inadequate or inappropriate documentation which can include deficits in care and interruption to achieving effective multidisciplinary, co-ordinated services. Phelan & McCarty (2016) examined the context of community nursing (Public Health Nurses and Community Registered General Nurses) in Ireland. Despite many reports pointing to the need for service reform since 1975, community nursing in Ireland has remained static in terms of demographic change, policy change and structural change within the health services delivery systems. This study applies the concept of missed care and uses a health economics approach to generate data on the work of community nurses. It is now opportune to explore the option of

having a set of standardised care plans that community nurses can access and utilise as a resource in both the planning and implementation of individualised care planning.

The existence of a care planning process has been associated with predictors of positive outcomes for patient 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 patient needs. Even though care planning is considered complex and dynamic, the advantages of using such a process include comprehensiveness, easier to find information, can add additional information, better for complex cases and easier to adapt subject for changes in practice were all reported as being achievable in the use of care planning. The availability and use of care planning support continuous assessment, progress reporting, referrals and coordination amongst the multidisciplinary team. To be effective, there is an onus on professionals to accurately record care in a timely manner and ensure that records are available for the purpose of sharing data.

The nursing process is structured into five phases: assessing, diagnosing, planning, implementing, and evaluating the care provided (Alfaro-LeFevre 2014). The diagnosing, planning and evaluation phases are recorded using nursing care plans (Ballantyne 2016). The process of care planning is a mechanism for documenting, recording, communicating and sharing care requirements and the care provided. Standardized care plans (SCP) have the potential to enhance the quality of nursing records 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 patient (Dahm & Wadensten 2008). The overall goal is to ensure that all patients receive the same high-quality care.

All stages of the nursing process require capacity of judgement or clinical reasoning. This judgement is a mental ability that enables a person to take the most appropriate decisions that help prevent and/or resolve problems in each one of the patients' situations. To develop it, nurses need to be able to think critically, basing their thoughts on a series of skills and behaviours (Castellà-Creus *et al*. 2019). In line with the NMBI professional code (NMBI 2015), nurses should acknowledge their level of accountability when utilising a standardised care plan. Understandably, nurses cannot apply standardised care plans to all patients and, therefore, knowledge and critical thinking skills are required to ensure that care is patient centred. The standardised care plan may address the majority of needs relating to specific problems, however nurses 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 should devise an individual care plan when there is no standardised care plan for the identified healthcare needs.

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 patient population (or groups)".

Administering patient-centred care implies being able to individualize the care according to a patient's needs and those of their family (Köberich *et al*. 2016). The individualization process is the fundamental element for working with SCP. This process consists in adapting the SCP to a patient's needs, according to the assessment and the subsequent re-evaluations required by their condition. The result is the application of an individualized care plan (Juvé-Udina 2012). Failure to carry out this individualization can lead to the risk of only diagnosing expected, common problems (Castella-Creus *et al*. 2019).

SCPs 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 SCPs are updated when there is new evidence. In studies on the use of SCPs the majority of the nurses were of the opinion that SCPs increased their ability to provide the same high-quality basic care for all patients (Dahm & Wadensten 2008). Furthermore another study showed that nurses considered SCPs 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 SCPs accompanying this procedure are evidence based, meaning that interventions associated are based on empirical evidence thereby provide a means to disseminate research evidence into practice. Castella-Creus *et al*. (2019) reported that better use of standardised care plans would improve nurses' access to appropriate and accurate information in decision-making, thus improving the charting process and quality of care.

2.6 Detail resources necessary to implement the PPPG recommendations

The procedure and care plans will be available online through the National Healthy Childhood Programme. The DPHNs will be informed of the availability of these resources for the PHN service. An online information session will be offered to the DPHN group.

2.7 Outline of PPPG Steps/Recommendations

See part A

3.0 GOVERNANCE AND APPROVAL

3.1 Outline Formal Governance Arrangements

This national procedure was commissioned by the Programme Lead of the National Healthy Childhood Programme. Final approval of the guideline was issued from National Community Operations and follow up reviews will be initiated by Programme Lead of the National Healthy Childhood programme. Refer to Appendix IV for Membership of the Approval Governance Group. This national document will be submitted to the HSE National Central Repository Office for referencing.

3.2 List method for assessing the PPPG in meeting the Standards outlined in the HSE National Framework for developing PPPGs.

The PPPG Checklist (Section 3.4) was reviewed in conjunction with the final procedure to ensure compliance with the standards as outlined in the HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (2016). This completed checklist and the final draft of the procedure was submitted to the National Community Operations for approval.

3.3 Attach any copyright/permission sought

Not applicable

3.4 Insert approved PPPG Checklist

Standards for developing Non-Clinical PPPGs	Checklist
Stage 1 Initiation	
The decision making approach relating to type of PPPG guidance required (Policy, Procedure, Protocol, Guideline), coverage of the PPPG (national, regional, local) and applicable settings are described.	√
Synergies/co-operations are maximised across departments/organisations Hospital/Hospital Groups/Community Healthcare Organisations (CHO)/National Ambulance Service (NAS)) to avoid duplication and to optimise value for money and use of staff time and expertise.	√
The scope of the PPPG is clearly described, specifying what is included and what lies outside the scope of the PPPG.	√
The target users and the population/patient group to whom the PPPG is meant to apply are specifically described.	√
The views and preferences of the target population have been sought and taken into consideration (as required).	N/A
The overall objective(s) of the PPPGs are specifically described.	√
Stakeholder identification and involvement: The PPPG Development Group includes individuals from all relevant stakeholders, staff and professional groups.	√
Conflict of interest statements from all members of the PPPG Development Group are documented, with a description of mitigating actions if relevant.	√
The PPPG is informed by the identified needs and priorities of staff, service users and others (as appropriate).	√
Stage 2 Development	**Checklist**
Systematic methods used to search for and appraise evidence are documented (for PPPGs which are adapted/adopted from international guidance, their methodology	√

is appraised and documented as required).	
There is an explicit link between the PPPG and the supporting evidence.	√
PPPG guidance/recommendations are specific and unambiguous.	√
The potential resource implications of developing and implementing the PPPG are Identified e.g. education/training/information, staff time and research.	√
Education and training is provided for staff on the development and implementation of evidence-based PPPG (as required).	√
Stage 3 Governance and Approval	**Checklist**
Formal governance arrangements for PPPGs at local, regional and national level are established and documented.	√
The PPPG has been reviewed by independent experts prior to publication (as required).	√
Copyright and permissions are sought and documented (as required).	N/A
Stage 4 Communication and Dissemination	**Checklist**
A communication plan is developed to ensure effective communication and collaboration with all stakeholders throughout all stages.	√
Plan and procedure for dissemination of the PPPG is described.	√
The PPPG is easily accessible by all users e.g. PPPG repository.	√
Stage 5 Implementation	**Checklist**
Written implementation plan is provided with timelines, identification of responsible persons/units and integration into service planning process.	√
Barriers and facilitators for implementation are identified, and aligned with implementation levers.	√
Education and training is provided for staff in the development and implementation of PPPGs.	√
Stage 6 Monitoring, Audit, Evaluation	**Checklist**
Process for monitoring and continuous improvement is documented.	√
Audit criteria and audit process/plan are specified.	√
Process for evaluation of implementation and effectiveness is specified.	√

Stage 7 Revision/Update	Checklist
Documented process for revisions/updating and review, including timeframe is provided.	√
Documented process for version control is provided.	√

I confirm that the above Standards have been met in developing the following:

Title of PPPG: Procedure for the use of Family and Child Health Standardisded Care Plans in the Public Health Nursing Service

Name of Person(s) signing off on the PPPG Checklist:

Name: Sinead Lawlor **Title: National Practice Development Coordinator for PHN services**	**Signature:** Sinead Lawlor **Date:** 18/10/2021

This signed PPPG Checklist must accompany the final PPPG document in order for the PPPG to be approved.

4.0 COMMUNICATION AND DISSEMINATION

4.1 Describe communication and dissemination plans

The approved document will be circulated to all DPHNs nationally for dissemination to their respective nursing departments. A copy of the procedure is available on the HSE website to download at; https://www.hse.ie/nhcp

5.0 IMPLEMENTATION

5.1 Describe implementation plan listing actions, barriers and facilitators and timelines

This procedure in the use of standardised care plans was identified as necessary to support safe effective practice and ensure continuity of care for children and families.
Arrangements will be made with ICT to make the procedure available online. An update will be offered to DPHNs/ADPHNs regarding the implementation of the procedure.
The introduction of the national standardised child health record and the national standardised maternal postnatal record will also contribute to supporting the implementation of this procedure in Community Healthcare Organisations (CHOs).
The ADPHN will assess the application of this procedure through team meetings, professional supervision sessions and through caseload audit reviews.

5.2 Describe education/training plans required to implement the procedure

A briefing session will be offered to the DPHNs and ADPHNs. Communication with the Higher Education Institutes responsible for student PHN education will occur to ensure awareness of this procedure. Training in adherence to correct completion of nursing documentation is provided at induction for all new nursing staff. Individual support is provided by the ADPHN or Clinical Skills Facilitator (where in post) as required.

5.3 Identify lead person(s) responsible for the implementation of the PPPG.

The DPHN is responsible for implementing, managing and auditing this procedure within her/his area of responsibility.
The National Healthy Childhood Programme, National Lead for PHN services and National Practice Development Coordinator for PHN services will support the implementation.

5.4 Outline specific roles and responsibilities.

The National Healthy Childhood Programme, National Lead for PHN services and National Practice Development Coordinator for PHN services will support the implementation.

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.

The Role of the Assistant Director of Public Health Nursing: The ADPHN is responsible for the implementation of the procedure by ensuring that current documents are available to all RPHN/RMs in health centres. The ADPHN is responsible for ensuring that all RPHNs/RMs have knowledge of the procedures to be followed within the document. The ADPHN will ensure that all RPHN/RMs are aware of any revisions to the procedure and ensure older versions of the procedure are removed from circulation. A database record of all RPHNs who have signed the signature sheet (Appendix I) will be maintained by the ADPHN and the DPHN will be notified of any noncompliance with sign-off of the procedure. MAPS portal where in use will support this function.

The Role of the RPHN: Each RPHN/RM is responsible for adhering to this procedure and using it to guide their practice in the delivery of the service they provide. Each RPHN/RM is responsible for ensuring that they read and understand the document and sign the attached signature sheet (Appendix I) or have confirmed this through the MAPS policy portal where it is in use. 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 RPHN to ensure that their ADPHN is informed in order to ensure appropriate review and amendments are made to the procedure. It is every RPHNs 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. RPHNs should adhere to HIQA and NMBI guidelines regarding documentation, record keeping and file management.

Role of Practice Development Co-ordinator 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.

6.0 MONITORING, AUDIT AND EVALUATION

6.1 Describe the plan and identify lead person(s) responsible for the following processes:

6.1.1 Monitoring.

Monitoring of this procedure will occur by the ADPHN through professional supervision, team meetings and documentation audit.

6.1.2 Audit.

Audit of the operation of this procedure will be initiated by the DPHN in consultation with the local CHO audit lead. Good governance arrangements and an identified lead person are required to ensure systematic monitoring (HIQA, 2012b). Audits should evaluate record keeping and file management systems and practises (HIQA 2012). Audit will be carried out retrospectively by the designated person appointed by the DPHN. This procedure will be the standard for audit using the attached audit tool (Appendix V).

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 and prioritise actions

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 are developed as a result of the findings.

6.1.3 Evaluation.

Evaluation of the procedure will be initiated by the DPHN/ADPHN and will occur through feedback at professional team meetings, direct patient feedback to the National Healthy Childhood Programme.

7.0 REVISION/UPDATE

7.1 Describe procedure for the update of the PPPG (including date for revision).

This procedure will be revised every three years on the date specified on the front page of the document. This review will be triggered by the National Healthy Childhood Programme. In the event an electronic health record is introduced to the PHN service, this procedure will require review.

7.2 Identify method for amending PPPG if new evidence emerges.

An earlier review of this procedure if required will be initiated by the National Healthy Childhood Programme.

7.3 Complete version control update on PPPG Template cover sheet.

This is the first version of a national procedure in the use of standardised care plans in the Public Health Nursing Service. See version control document on cover sheet for updated sections.

8.0 ACKNOWLEDGEMENTS

Ms. Patricia O Dwyer, PHN Consultant and PHNs nationally who developed a draft of the Child and Family Health Core Care Plans during 2011-2014

Members of the Child and Family Health Interest Sub Group who co-ordinated the initial pilots and revised and updated the Standardised Child and Family Health Care Plans, 2014 - 2015.
Sheila Geoghegan
Brenda Horgan
Aisling Keogh
Maria Flaherty
Aideen Heneghan
Patricia McLoughlin
Mary o Malley
Patricia O Dwyer
Kathleen Griffin

PHNs in Dublin, Midlands and Kildare for undertook the initial pilots November 2015 – December 2015.

Members of the Child and Family Interest Group who provided additional feedback;
Teresa Cronin
Margaret Donovan
Eilish Whelan
Sinead Lawlor

PHNs Dublin, Midlands and Kildare area who piloted the Standardised Child and Family Health Care Plans October 2018 – March 2019.

Child Health Interest Group members who reviewed the feedback from the pilot and revised and updated the care plans: March – December 2019
Anne Lynott, President ICHN
Kathleen Griffin, Chair Child and Family Health Interest Group
Aideen Heneghan
Brenda Horgan
Helen Mulcahy
Denise Gillespie

Mary O Malley
Patricia McLoughlin
Sinead Lawlor

June 2021
Review of the core care plans in line with the national healthy childhood programme and the national maternal postnatal guideline.
Anne Lynott
Sinead Lawlor

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10.0 APPENDICES

Appendix I Signature Sheet
Appendix II Membership of the PPPG Development Group
Appendix III Conflict of Interest Declaration Form Template (held at NHCP)
Appendix IV Membership of Approval Governance Group
Appendix V Audit Tool
Appendix VI List of Standardised Care Plans
Appendix VII Sample Care Plan

Appendix I:

Signature Sheet

I have read, understand and agree to adhere to this Policy, Procedure, Protocol or Guideline:

Print Name	Signature	Area of Work	Date

Appendix II:

Membership of the PPPG Development Group

Please list all members of the development group (and title) involved in the development of the document.

Anne Pardy Programme Lead National Healthy Childhood Programme	Signature:  Date: 11/11/2021
Anne Lynott DPHN Dublin West	Signature:  Date: 18/10/2021
Virginia Pye National Lead for PHN Services	Signature:  Date: 18/10/2021
Chairperson PPPG Development: Sinead Lawlor National Practice Development Co-ordinator for Public Health Nursing	Signature:  Date: 18/10/2021

Appendix III: Conflict of Interest Declaration Form (Template)

CONFLICT OF INTEREST DECLARATION

This must be completed by each member of the PPPG Development Group as applicable

Title of PPPG being considered:

Procedure for the use of Family and Child Health Standardised Care Plans in the Public Health Nursing Service

Please circle the statement that relates to you

1. I declare that I DO NOT have any conflicts of interest.

2. I declare that I DO have a conflict of interest.

Details of conflict (Please refer to specific PPPG)

_____
_____
_____
_____

(Append additional pages to this statement if required)

Signature

Printed name

Registration number (if applicable)

Date

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this PPPG is required to furnish a statement, in writing, of:

(i) The interests of the person, and

(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

Appendix IV:

Membership of the Approval Governance Group

Please list all members of the relevant approval governance group (and title) who have final approval of the PPPG document.

TJ Dunford Head of Operations: Primary Care	Signature: _____ Date: 29/11/2021

Appendix V:

Audit tool for the procedure on the use of the Family and Child Health Standardised Care Plans in the Public Health Nursing Service

An Audit should be carried out within 6 months of implementation of this guideline using this audit tool. Frequency of audit, sampling processes and timescales for completions will be determined at local level following the first initial audit.

Please answer all questions indicating Yes or No or Not Applicable and give a comment if necessary.

Appendix VI:

No	Question	Yes	No	N/A	Comment
1	Has the nurse read the procedure on the MAPs portal or signed the signature sheet confimr the procedure was read?				
2	In the care plan have the principles of good documentation been adhered to: black ink, legible, date and timed with 24 hour clock, signature and NMBI number?				
3	Is there evidence that the Care plan was discussed with the patient/parents/guardians?				
4	Is the patient name and date of birth recorded on the care plan?				
5	Has the problem been clearly identified?				
6	Has the care plan been individualised to this patient?				
7	Was a review date set?				
8	Is the evaluation of the care plan evident?				
9	Is the closure of the care plan evident?				
10	Is there evidence the progress notes were maintained during each episode of care?				

Action areas identified :

Quality improvement plan:

Date and time:
Audit completed by: **Title:**
Health Centre: **CHO:**

Care plan code	Name of care plan
CPPHN 01	Jaundice at first postnatal visit
CPPHN 02	Infant with cleft lip or palate having difficulty feeding
CPPHN 03	Nappy Rash
CPPHN 04	Infant or child has dry skin patches
CPPHN 05	Infant has symptoms of infant colic
CPPHN 06	Mum has difficulty latching baby to the breast due to confirmed tongue tie (Ankyloglossia)
CPPHN 07	Infant is posseting (spitting up after feeding)
CPPHN 08	Head lag at 3 - 4 months of age
CPPHN 09	Infant has a sticky eye
CPPHN 10	Positional palgiocephaly
CPPHN 11	Umbilicus is moist or sticky
CPPHN 12	Weight has dropped two or more centiles on the UK_WHO (Ireland) growth chart (0-4)
CPPHN 13	Infant not sitting unsupported at 9 -11 months
CPPHN 14	Infant has delayed fine motor skills at 9 - 11 months
CPPHN 15	Parent fearful that the infant-child will choke on lumpy food
CPPHN 16	Unsafe sleeping environment for infant
CPPHN 17	Constipation in infant
CPPHN 18	Parent expresses concerns about the child's altered bowel habit
CPPHN 19	Parent expresses concerns about the child's temper tantrums
CPPHN 20	Parent expresses concerns about the child's sleep difficulties (e.g. getting to sleep or staying asleep)
CPPHN 21	Delayed toilet training in the preschool child
CPPHN 22	Unsafe home environment for the infant or child

CPPHN 23	Breast Engorgement in breastfeeding mother
CPPHN 24	Mother has painful perineum following a normal or assisted delivery
CPPHN 25	Mother has a caesarean section wound
CPPHN 26	Mother has cracked nipples
CPPHN 27	Mother has pain when latching to the breast (excluding cracked nipple or mastitis)
CPPHN 28	Mother has signs and symptoms of mastitis
CPPHN 29	Maternal constipation in the first 6 weeks postnatal period
CPPHN 30	Mother has positive answers to mental health screening questions
CPPHN 31	Parent is experiencing difficulty with parenting skills in relation to infant-child care needs
CPPHN 32	Parent is experiencing difficulty in creating a nurturing environment for their infant or child
CPPHN 33	Parent is socially isolated
CPPHN 34	Mother has symptoms of PND following screening with EPDS

Appendix VII Sample Care Plan

Date and time	Problem No	Nursing Problem / Nursing Diagnosis	Expected Goal's	Action Plan/ Intervention	Evaluation Time frame	Outcome Date and time	Signature Print Name NMBI PIN
dd/mm/yy hh:mm 24 hour clock	Sequential numbers for each problem and correspond with the progress notes numbering	Insert any additional information that will highlight the patient's own understanding of their problem/concern/need	Identify expected goal(s) and include any specific goal as identified by the patient or the RPHN/RM if relevant	Interventions on the standardised care plans are evidence based. The RPHN/RM should add, edit, amend the care plan to suit the individual needs of the patient. Record any additional relevant interventions based on assessment in 'other'. The responsibility rests with the RPHN/RM to script a care plan individual to the patients care needs.	Insert the frequency/time frame to evaluate the care plan e.g. 48 hours, one week; one month	Record the evaluation of the interventions and insert the date and time (24 hour clock)	