Planning Person-Centred Care

LEARNING OBJECTIVES

After completing the chapter, the learner should be able to accomplish the following:

1. Describe the purpose and benefits of planning person-centred care
2. Identify three elements of comprehensive planning
3. Prioritise the person’s health problems
4. Describe how a person’s goals and nursing and midwifery care interventions are linked to the identified health problems
5. Develop a person-centred plan of care with goals that relate to nursing or midwifery interventions
6. Differentiate nurse and midwife-initiated interventions and medical initiated interventions
7. Use criteria to evaluate planning skills
8. Describe five common problems related to person-centred planning, their possible causes and remedies.

KEY TERMS

care intervention   discharge planning   ongoing planning
clinical pathways   goal   plan of person-centred care
computerised plans of care   initial planning   standardised plans of care
consultation   nursing/midwifery intervention
PLANNING PERSON-CENTRED CARE is the third phase in the process of delivering and evaluating care. This process of planning care is explored throughout this chapter in the context of person-centered care (see Fig. 17-1). The process involves the nurse or midwife working in partnership with the person and family to establish priorities, identify goals of care, select evidence-based care interventions and communicate the plan of care. The purpose of planning person-centred care is to address current and potential health problems. The plan of care is based on the information collected during the health assessment phase. The subjective and objective data are analysed and synthesised and this leads to the identification of health problems. Accurate identification of health problems allows for the effective planning and implementation of care. The identified strengths of the person are an integral part of the plan of care.

In the last two chapters, you have been exploring the health circumstances for Claire, the 18 year old with Type 1 diabetes. Through reflection and critical thinking you have participated in Chapter 15 in assessing Claire, and in Chapter 16 your exercise was to identify her particular health problems. Now, throughout this chapter you will be asked to consider the next phase in the planning of person-centred care for Claire who has now been admitted to your unit with a diagnosis of ketoacidosis requiring stabilisation. Critical thinking questions will be posed and reflective cues included to encourage you to focus on the planning of care to address Claire’s health problems. Through this activity you will continue to strengthen your clinical reasoning and reflection skills as the basis for thoughtful practice.

When planning person-centred care it is important to jointly establish goals of care with the person and family. A goal is an aim or an end. The terms “goal” or “expected outcome”, are often used interchangeably in many healthcare settings. The term goal is used in this textbook to describe the desired results (expected outcomes) that the person, family and healthcare team expect to achieve from the care interventions, implemented to address the identified health problem. If the goals specified in the plan of care are not valued by the person or do not contribute to the prevention, resolution or reduction in the person’s health problems or achievement of the person’s health expectations, the plan may be meaningless. The goals of care must therefore be realistic, achievable and measurable:

- The goal must be realistic so that the person, family and healthcare team members are confident that the goal is directly related to the identified health problem.
- The goal must be achievable and within the physical and mental abilities of the person to attain. If the goals are not achievable the person may lose interest or motivation. Healthcare team members and family often assist the person in identifying achievable goals.
- The goal must be measurable so that the person, family and healthcare team members can assess that the goals have been met (goal or outcome achievement). A time frame is usually required so that the care interventions implemented to meet the goals can be measured.

![Figure 17-1: Planning person-centred care. The nurse or midwife and the person work together to establish priorities, identify goals of care for the person and select the evidence-based interventions. It is important for the plan of care to be consistent with nursing and midwifery standards, congruent with other planned therapies, and realistic in terms of the person’s and the nurse’s or midwife’s abilities or resources. This recorded plan of care is an important nursing and midwifery responsibility](image-url)
Setting realistic, achievable and measurable goals allows you to plan effective individual care and provides the ability to change and modify the goals when required. Determining if the goals of care have been met is a critical skill for successful care interventions. An example of goal setting is provided in Box 17-1.

Planning care is a formal process and deliberate phase in the process of person-centred care. A formal plan of care allows you to:
- Individualise care that meets the person’s needs and maximises goal achievement
- Incorporate the person’s ability to participate in his or her care
- Maintain the person’s identity by allowing expression of values, beliefs and culture
- Set joint priorities and establish meaningful goals
- Evaluate the care given and determine if the goals of care have been met
- Facilitate communication among nursing and midwifery personnel and colleagues
- Promote continuity of high-quality, cost-effective care
- Coordinate care
- Evaluate the person’s responses to care interventions
- Create a record that can be used for evaluation, research, reimbursement and legal purposes
- Promote your professional development as a nurse or midwife.

Informal planning is often observed by students in practice settings. This is the link between identifying a person’s strengths or limitations and providing an appropriate response. When a nurse on a busy surgical unit learns that a postoperative patient is complaining of incision pain and quickly reshuffles priorities to allow time to assess the course and qualities of the pain and determine care interventions to reduce discomfort, planning has occurred. When a midwife realises the evening before discharge that she has not seen a particular father hold his new baby daughter and makes a mental note to observe the father–daughter interactions that evening and facilitate their bonding, planning has occurred. When a nurse in a residential aged care setting encounters a resident whose condition is deteriorating and places the person on the list for visiting pastoral care, planning has occurred. Informal planning on a more conscious level that may result from reflection is illustrated by a palliative care nurse who drives home pondering how best to support a person with terminal cancer who is gradually relinquishing his or her hold on life. This nurse may elect to initiate a more formal process of planning the next day after consulting with colleagues who have cared for people with similar health needs. In each of these examples, the process of informal planning allows an individual nurse or midwife to think about how best to help a particular person—ideally, with good results. What is lacking is a coordinated plan known by everyone caring for the person.

**BOX 17-1 An Example of Goal Setting**

Gerry Grant, a 78-year-old man with a long-term hemiplegia who mobilises with a stick, has been admitted to hospital for surgery to a fractured hip. Setting realistic, achievable and measurable goals for Gerry’s care will ensure that they are able to be attained within an accepted timeframe and that Gerry, his family and the healthcare team are able to work together with a common focus. It is a powerful motivator for all concerned if they believe that the goal can be achieved.

**Setting the goal—realistic/achievable:**

**Realistic goal:** Mr Grant is able to walk as he did before the fracture, with the aid of a stick.

**Unrealistic goal:** Mr Grant is able to walk unaided after the hip surgery.

**Rationale:** A person with long-term hemiplegia and a fractured hip may not be able to mobilise with the stick as more support may be required; walking with the aid of a frame may therefore be a more realistic and achievable goal.

**Measuring the goal—time frame:**

At four week post hip operation, Mr Grant is able to walk with the aid of the frame.

**Evaluation:** Has the goal been met?

**Goal met:** Mr Grant is able to walk with the aid of the frame.
requires to meet basic human needs (e.g. assistance with hygiene or nutrition) and describe appropriate care responsibilities for fulfilling the plan of care. Nurses and midwives design plans of care that incorporate both their independent and collaborative responsibilities. Because nursing and midwifery is concerned with the individual’s responses to health and illness, the plan of care is supportive of broad aims—to promote wellness, prevent disease and illness, promote recovery and facilitate coping with altered functioning.

SETTING GOALS AND PLANNING CARE

Successful implementation of each phase of the process of person-centred care requires high-level skills in critical thinking and clinical reasoning. To plan health care correctly, you must:

- Be familiar with standards and healthcare facility policies for setting priorities, identifying and recording goals for the person, selecting evidence-based interventions and recording the plan of care.
- Remember that the objective of person-centred care is to keep the person’s interests and preferences central in every aspect of planning and goal identification and to have them involved with each step of the process.
- Keep the ‘big picture’ in focus: What are the discharge goals for this person and how should they direct each intervention?
- Trust clinical experience and judgment but be willing to ask for help when the situation demands more than your qualifications and experience can provide, and value collaborative practice.
- Before establishing priorities, identifying goals and selecting care interventions, make sure that research supports your plan.
- Respect your clinical intuition.
- Recognise personal biases and keep an open mind.

Questions to facilitate critical thinking and clinical reasoning during planning and goal identification include:

- Setting priorities: Which problems require my immediate attention or that of the team? Which problems are my responsibility, and which should I refer to someone else? Which problems has the person identified and are the most important to him or her?
- Identifying health goals: What must I observe in the person to demonstrate the resolution of the identified problems? What is the time frame for accomplishing these goals? Do the goals need to be modified in light of the person’s response (or lack of response) to the planned interventions?
- Selecting evidence-based interventions: What do nursing science and my clinical experience suggest is the likelihood that this particular care intervention will help the person realise his or her goals? How can I tailor my interventions to increase the likelihood that the person will benefit? What is the worst thing that might happen with this intervention, how likely is it to happen, and what can I do to minimise the possibility of this harm?
- Communicating the plan of person-centred care: What priorities has the person identified today? Does the plan of care adequately address the person’s priorities today? Does the plan of care adequately address the specific needs of this particular person? Can anyone reading the plan of care know how to intervene effectively with this person?

COMPREHENSIVE PLANNING

In acute care settings, three basic stages of planning are critical to comprehensive nursing or midwifery care: initial, ongoing and discharge. In other settings such as long-term care, palliative care or a community clinic, initial and ongoing planning may be used in the primary stages. If you develop a comprehensive plan of care on the first day but fail to update the plan, the plan will not be effective or efficient. If the plan is not kept current, it cannot truly reflect the person’s needs. Failure to update the plan of care as needed is a common problem in all healthcare settings.

Initial Planning

Initial planning is developed by the nurse or midwife who performs the admission, health history and the physical assessment. This comprehensive plan addresses each problem and identifies appropriate goals for the person and the related care. Standardised care plans are prepared plans of care that list the identified health problems, goals and related care interventions common to a specific population or health problem. They can provide an excellent basis for the initial plan. Resources for standardised plans include computerised plans, textbooks with prepared care plans, and healthcare facility-developed plans/maps or clinical pathways. By using such standardised plans, you are free to direct time and expertise to individualising the plan to ensure that the person is the focus of care.

Ongoing Planning

Ongoing planning is carried out by any nurse or midwife who interacts with the person. Its chief purpose is to keep the plan up to date to facilitate the resolution of health problems, manage risk factors, and promote function. New data is collected and analysed and used to make the plan more specific and accurate and therefore more effective. The work of ongoing planning includes stating the person’s identified health problems more clearly, identifying new health problems, making previously developed goals more realistic,
developing new goals as needed and identifying care interventions that will best accomplish the personal goals.

At this stage of planning, standardised plans based on medical conditions or procedures might be useful in identifying new health problems and related care interventions, but the emphasis is clearly on individualising the plan to meet unique personal needs. For example, a common nursing order ‘push fluids’ would be rewritten as ‘offer 60 mL cranberry or orange juice between meals, and keep fresh water at bedside’. A preliminary order such as ‘explore with Mrs Jacob what existing support systems she has in place’ might be replaced with ‘keep daughter Barbara informed of mother’s progress and coach her in effective support strategies: contact details for Barbara Clems, Ph: (h) 448 3211, (w) 654 8999.’

Discharge Planning

Discharge planning is best carried out by the nurse or midwife who has worked most closely with the patient and family, possibly in conjunction with other members of the healthcare team, including social workers who have a broad knowledge of existing community resources. In acute care settings, comprehensive discharge planning begins when the patient is admitted for treatment. The initial assessment must include identifying risk factors that may complicate a smooth discharge so that these are factored into the plan to enable early resolution of impediments prior to discharge. Careful planning ensures that you use teaching and counselling skills effectively to help the patient and family develop sufficient knowledge of the health problem and the therapeutic regime to carry out necessary self-care behaviours at home competently. You need to be competent in the area of discharge planning as the person’s adherence to treatments has the potential to reduce hospital readmissions rates. Discharge planning and continuity of care is discussed further in Chapter 5.

ESTABLISHING PRIORITIES

It is important to rank the identified health problems based on the person’s needs, wishes and safety so that care interventions can be prioritised. As part of the prioritising process, you need to work with the person to classify the identified health problems as high, medium or low. High-priority health problems pose the greatest threat to the person’s wellbeing. Non-life-threatening health problems are ranked as medium priorities, and health problems that are not specifically related to the current health problem are of low priority. In all levels, psychosocial needs must be considered as well as physiological needs.

It generally makes sense to deal with medical (or suspected medical) problems or needs first. If these can be resolved, many human response problems are gone. If a nurse sees the classic clinical manifestations of appendicitis and tries to identify and manage a health problem of pain without consulting a doctor or nurse practitioner, the person’s appendix might rupture before a plan of care to relieve pain can be developed.

Three helpful guides to facilitate critical thinking when prioritising problems include Maslow’s hierarchy of human needs, personal preference and an anticipation of future problems.

Maslow’s Hierarchy of Human Needs

Because basic needs must be met before a person can focus on higher ones, people’s needs may be prioritised according to the following hierarchy:

1. Physiological needs
2. Safety needs
3. Love and belonging needs
4. Self-esteem needs
5. Self-actualisation needs.

For example, an older person who is incontinent of urine and sitting in a wet incontinence pad (physiological need) will be unable to participate fully in a music therapy diversional activity (self-esteem need) until the more basic need is met.

Personal Preference

It is best to first meet the needs the person thinks are most important; if this order does not interfere with other vital therapies. Take, for example, a woman who is admitted to an orthopaedic unit with a fractured pelvis and multiple lacerations after a car accident. The morning after the accident, she complains of pain and needs assistance with bathing and attention to her lacerations, but she refuses to do anything until she calls home to find out who is caring for her 15-month-old twins. The nurse should help her to call home before commencing other care, as long as it does not interfere with life-saving emergency care.

Anticipation of Future Problems

Nurses and midwives must tap into their knowledge base to consider the potential effects of different care actions. Assigning low priority to a health problem that a person wants to ignore but that could result in harmful future consequences for the person might result in you being culpable of negligence. For example, an obese person with multiple sclerosis and greatly decreased limb strength who spends most of the day in bed may see no value in diet modification and position changes. A nurse who is alert to the potentially serious problem of pressure ulcers would assign high priority to this identified health problem and incorporate weight management and position changes into the plan of care for this obese person.
Clinical Reasoning and Establishing Priorities

The work of setting priorities demands careful critical thinking. Alfaro (2002, p. 125) suggests the following questions:

1. What health problems need immediate attention and which ones can wait?
2. Which health problems are your responsibilities, and which do you need to refer to someone else?
3. Which health problems can be dealt with by using standard plans (e.g., critical or clinical pathways, standards of care)?
4. Which health problems are not covered by protocols or standard plans but must be addressed to ensure a safe hospital stay and timely discharge (or simply safe care of high quality)?

When planning person-centred care for each day, it is helpful to consider the following:

- Have changes in the person’s health status influenced the priority of identified health problems? For example, when a routine home visit to an older adult reveals evidence of possible elder abuse, a new set of priorities for care is needed. This may even result in a new identified health problem.
- Have changes in the way the person is responding to health and illness or the plan of care affected those identified health problems that can be realistically addressed? For example, you have identified an inability to cope as a high-priority health problem for a person after the person learned about his medical diagnosis, and you plan to initiate counselling. If the person adamantly requests to be left alone for a day to think things through, you will have to modify priorities of care for that day. What decisions should you make?
- Are there relationships among the identified health problems that require that one be worked on before another can be resolved?
- Can or should several problems be dealt with together?

After answering these questions, you rank the identified health problems in the order in which they should be addressed. Setting priorities enables you to make sure that time and energy is being directed first to the person’s most important problems.

BOX 17-2 Guidelines for Writing Goals

Written goals can be evaluated by determining if they conform to the following criteria:

- Each goal is derived from only one identified health problem.
- Both long-term and short-term goals are identified.
- Cognitive, psychomotor and affective goals appropriately signal the type of change needed by the person.
- The person and family who participate in identifying goals will value them.
- Each outcome is brief, specific and clearly describes one observable, measurable behaviour/manifestation, is phrased positively and specifies a realistic time line.
- The goals are supportive of the total person-centred treatment plan.

IDENTIFYING AND WRITING GOALS

Learning to identify and write appropriate goals for person-centred care takes practice. The text that follows and the guidelines in Box 17-2 will help you to identify goals that will maximise your effectiveness when working those in your care.

Deriving Goals from Identified Health problems

Goals are derived from the identified health problem. For each identified health problem in the plan of care, at least one goal should be written that, if achieved, demonstrates a direct resolution of the health problem (Table 17-1). A specified time frame should also be included in the goal, and these are determined by evidence-based nursing, midwifery and medical guidelines. Wherever possible, the time frames should be negotiated with the person.

<table>
<thead>
<tr>
<th>Problem Statement</th>
<th>Identified Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain due to fractured right arm</td>
<td>Within 4 hours, the person will report pain is absent or diminished</td>
</tr>
<tr>
<td>Nutritional imbalance leading to significant weight gain</td>
<td>By 12/6/20XX the person will reach target weight of 52 kg</td>
</tr>
<tr>
<td>Inability to mobilise independently</td>
<td>Before discharge, the person will ambulate the length of the hallway independently</td>
</tr>
</tbody>
</table>
Other goals that contribute to the resolution of the health problem may be written. For example, for the identified health problem ‘Significant weight gain due to excessive snacking and inactivity’, in addition to the outcome ‘within 12 weeks (12/6/20XX), Ms Lee will lose 10 kilograms and reach target weight (52 kg)’, the following goals are appropriate: ‘within 3 days of teaching: she will identify 10 low-joule snack foods she is willing to try; she will have 3-day diet recall consistent with nutritionally balanced 6,276 kilojoule diet; and she will report incorporating three half-hour periods of walking each week’. If a person can identify low-joule snack foods and adopt a more active lifestyle, there is a greater likelihood the target weight will be reached, but it is entirely possible for a person to achieve these secondary goals without resolving the chief problem. Remember, at least one goal per identified health problem must directly resolve the problem.

Establishing Long-Term Versus Short-Term Goals

Goals may be either long term or short term. Long-term goals require a longer period (usually more than a week) to be achieved than do short-term goals. They also may be used as discharge goals, in which case they are more broadly written and communicate to the entire nursing or midwifery team the desired end results of the care for a particular person. For example, two women, both 77 years of age, are on a nursing unit after undergoing similar operations for fractured left hips. One woman, Mrs Goldstein, has spent the past two years in bed in a nursing home; the other woman Mrs Silverstein fractured her hip at the YMCA, where she swims daily. Their care should not be the same because it is directed toward different long-term goals, even though their short-term goals might be similar (Box 17-3).

Involving the Person and Family in Goal Development

One of the most important considerations in writing goals is to encourage the person and family to be involved in their development. This is central to person-centred care. The more involved they are, the greater the probability that the goals will be achieved. When developing them together, you and the person will look at the identified health problem and ask, ‘What changes or goals will result in the prevention or resolution of this problem?’ The answer becomes the goal for the person.

Identifying Goals Supportive of the Total Treatment Plan

When identifying goals, it is always important to remember that you care for people, not problems. This means that every written goal should support the overall treatment plan
and ‘make sense’ in terms of the overall goals for the individual. For example, identifying nutritional goals may be appropriate for a person who is losing weight, but if this person is in a palliative care unit and dying, this may not be an appropriate aim, if it is incompatible with the overall goal of a peaceful death with dignity.

Recall Claire and the circumstances of her health journey that were revealed in Chapters 15 and 16. The next step in planning Claire’s care is to identify the goals and care interventions that will guide you and the healthcare team in implementing Claire’s plan of care. Reflect on her assessment and identified health problems, and then create a list of her potential short-term goals. Then:

1. Identify Claire’s short-term and long-term goals.
2. Write a goal statement for one of the short-term goals and one of the long-term goals you have identified.

Now consider the following questions:

1. Why is it important to identify both short-term and long-term goals?
2. How will you know that Claire shares the identified goals?
3. Can you identify the factors that may limit Claire achieving the identified goals?

Writing Measurable Goals

To be measurable, goals should have the following:

- Subject: The person or some part of the person
- Verb: Indicates the action the person will perform
- Performance criteria: Describe in observable, measurable terms the expected behaviour or other manifestation
- Target time: Specifies when the person is expected to be able to achieve the goal.

Verbs helpful in writing measurable goals include:

- Define
- Prepare
- Identify
- Design
- List
- Verbalise
- Describe
- Choose
- Explain
- Select
- Apply
- Demonstrate

The target time or time criterion may be a realistic, actual date or a statement indicating time, such as before discharge, after viewing X-ray, or whenever observed.

The following are examples of properly constructed measurable goals:

- During the next 24-hour period, fluid intake will total at least 2,000 mL.
- At the next visit, 23/12/20XX, Ms Lee will correctly demonstrate pelvic floor exercises.

It might be helpful to include special conditions when writing a goal if this information is important for other members of the healthcare team (e.g. ‘Before discharge, Ms Lee will ambulate independently the length of hallway and back, using a Philadelphia collar to support cervical vertebrae’).

Common Errors

Common errors when writing goals include the following:

- Expressing the goal as a care intervention. Incorrect: ‘Offer Mr Myer 60 mL fluid every 2 hours while awake.’ Correct: ‘Mr Myer will drink 60 mL fluid every 2 hours while awake, beginning 12/12/20XX.’
- Using verbs that are not observable and measurable. Incorrect: ‘Mrs Gaston will know how to bathe her newborn.’ Correct: ‘After attending the infant care class, Mrs Gaston will correctly demonstrate the procedure for bathing her newborn.’ Verbs to be avoided when writing goals include ‘know’, ‘understand’, ‘learn’ and ‘become aware’. These verbs are too general and cannot be measured.
- Including more than one behavioural manifestation in short-term goals. Incorrect: ‘Mr James will list dangers of smoking and stop smoking.’ Correct: ‘By next meeting, 3/11/20XX, Mr James will (1) identify three dangers of smoking and (2) describe a plan showing he is willing to try to stop smoking. By 6/11/20XX, he will report that he no longer smokes.’
- Writing goals that are so vague that the person, family or other nurses or midwives are unsure of. Incorrect: ‘Mr James will cope better.’ Correct: ‘After teaching, Mr James will (1) describe two new coping strategies he is willing to try and (2) demonstrate decreased incidence of previously observed ineffective coping behaviours (chain smoking, withdrawal behaviour, heavy alcohol consumption).’

DEVELOPING EVALUATIVE STRATEGIES

Well-written goals define the evaluative strategies to be used by the nurse or midwife. Goals are meaningless unless the person’s progress towards their achievement is evaluated. In the documentation you should record today’s date, the goal and the date it is achieved. Evaluative statements (Box 17-4) include a statement about achievement of the desired goal and list actual behaviour as evidence supporting the statement. If the plan is not achieved, recommendations for revising the plan of care are included in the evaluative statement. Chapter 19 deals specifically with the evaluative component of the process of person-centred care.
You now have a list of goals and a goal statement for one short-term and one long-term goal for Claire. Write an evaluative statement for the short-term and long-term goal, using Box 17-3 as a guide. Now consider the following questions:
1. How will you know that the goals identified for Claire are realistic and achievable?
2. If a goal is not met, what steps would you need to take to ensure that Claire’s plan of care does include goals that she can achieve?

PERSON-CENTRED CARE INTERVENTIONS

A care intervention is any treatment, based on clinical judgment and knowledge, which a nurse or midwife performs to enhance a person’s health outcomes (McCloskey & Bulechek, 2004). There are nurse- or midwife-initiated, medical-initiated and collaborative interventions.

A nurse- or midwife-initiated intervention is an autonomous action based on scientific rationale that is executed to benefit the person in a predictable way related to the identified health problem and projected goals. Interventions are actions performed to:
1. Monitor health status
2. Reduce risks
3. Resolve, prevent or manage a health problem
4. Facilitate independence or assist with activities of daily living

Nurse- or midwife-initiated care interventions that fall within their scope of practice do not require orders from a doctor (or other team members). These interventions are developed from the problems that were identified as a result of the assessment process. Care interventions are selected that specifically address factors that cause or contribute to the person’s health problems (Figure 17-2). For example, many factors may contribute to obesity, such as deficient nutritional knowledge, convenience of high-joule fast foods, lifetime snacking habits, limited food budget, little exercise and low self-esteem. The nurse working with a person who wants to lose weight could attempt to deal with all these factors, but this approach would be inefficient. Through the assessment process the health problems that are identified will highlight specific factors that contribute to a particular person’s weight problem, care interventions can be selected to deal directly with these factors.

Similarly, care interventions with the identified problem of nutritional imbalance leading to significant weight gain due to a lifetime snacking habits and heavy reliance on high-joule fast foods, might include education about the fat content and joules in fast foods. It may also include an exploration of ways the person could change his or her eating habits to eat more nutritionally balanced meals with fewer joules. Thus, the approach is not the same for every person with a weight problem. The art of caring involves the careful identification of the specific interventions needed by particular people to meet their individual needs.
Identifying and Selecting Appropriate Nurse/Midwife-Initiated Interventions

After writing the goals together with the person, the nurse or midwife identifies various care interventions to help the person achieve the identified goals.

The effectiveness of the interventions is directly proportional to their knowledge of varied care strategies. Consider these different care options identified by three midwives when they are asked to describe antenatal care for a woman two days after caesarean delivery who is complaining of pain in the incisional area.

Midwife A
- Check what type of pain medication is ordered, and give it if the time interval is sufficient.

Midwife B
- Assess the quality of the pain, and use this time to communicate support by means of expression and squeeze of hand.
- Administer analgesic if indicated.
- Assess effectiveness of the analgesic ordered.

Midwife C
- Assess quality of the pain, and explore the possibility of contributing factors such as the effects of increased gas in the abdominal area or concern about the newborn, herself, or other family members.
- Use empathic listening (possibly touch) to communicate support and to encourage the mother to share her concerns.
- Change her position in bed.
- Offer a backrub.
- If appropriate, suggest activity that will distract attention from the pain (e.g. watching a film about newborn care or listening to music).
- Give the prescribed medication for pain, and observe its effect.
- When administering the medication, use the power of positive suggestion to enhance its effectiveness: ‘This will start taking the pain away in about 10 minutes and will help you relax.’

It is possible that the woman simply needs prescribed analgesic to achieve the identified goal: ‘The woman will report minimal to no pain at assessment every 2 hours.’ In that case, all three midwives would be effective in meeting the woman’s need for care. However, it is highly possible that the prescribed medication is not working or the pain is compounded by the mother’s fears about caring for her new baby or by her worries that the baby will ruin her relationship with her husband. Therefore, midwife C, whose knowledge level is more comprehensive and who demonstrates good clinical judgment, is most likely to be effective in resolving the problem.

The more varied the options available to you, the more effective the care response. In different situations, a skilled procedure, the appropriate use of silence, respectful listening, humour, teaching, counselling and touch can all be effective care strategies. If you are merely task-oriented and satisfied to meet every problem with a mechanical procedure you are limiting your effectiveness.

When selecting the care interventions use the guidelines in Box 17-5. Use of these guidelines increases the chances that the person will achieve the desired goals. Ongoing evaluation enables you to determine the effectiveness of the selected interventions.

Competent nurses and midwives use research findings, experience and knowledge of the person to aid in the selection of effective care interventions. Consultation with other colleagues and continuing education enable nurses and midwives to develop effective approaches to problems.

Writing Interventions in the Person-Centred Plan of Care

Care interventions describe in writing and thus communicate to colleagues and other healthcare team members, the specific care to be implemented. Well-written care interventions accomplish the following:
- Assist the person to meet specific goals that are related directly to one identified health problem
- Clearly and concisely describe the actions to be performed (answer the questions who, what, where, when and how)
- Are dated when written and when the plan of care is to be reviewed
- Are signed by the nurse or midwife planning the intervention
- Use only those abbreviations accepted in the facility (these are usually found in their policy manual; a list of commonly accepted abbreviations is provided in Appendix C)
- Refer to the facility’s procedure manual or other literature for the steps of routine, lengthy procedures.

Following are examples of well-stated care interventions:
- Offer Ms Lee 60 mL water or juice (prefers orange or cranberry juice) every two hours while awake for a total minimum oral intake of 500 mL.

BOX 17-5 Guidelines for Selecting Person-Centred Care Interventions

Care interventions should be:
- Appropriate in terms of the identified health problem and related goals expected for the person
- Consistent with research findings and standards of care
- Realistic in terms of the abilities, time and resources available to the nurse or midwife and the person
- Compatible with the person’s values, beliefs and psychosocial background
- Valued, whenever possible, by the person and family
- Compatible with other planned therapies
Teach Ms Lee the necessity of carefully monitoring fluid intake and output; remind her to mark off fluid intake on each shift on record at bedside (if this is appropriate).
Walk with Ms Lee to bathroom for toileting every two hours (on even hours) while she is awake.

The set of care interventions written to assist a person to meet a goal must be comprehensive. Comprehensive care interventions specify the observations (assessments) that need to be made and how often; the care interventions that need to be achieved and when they must be done; and the teaching, counselling and advocacy needs of the person and family.

Many interventions are inadequate because they fail to indicate the ongoing assessment priority needs for a specific problem or goal. Clearly stated assessment priorities helps all nurses and midwives to be more aware of this important personal data.

Similarly, it is often assumed that all people have the same teaching needs. Nothing could be farther from the truth. In fact, many people have an excellent knowledge base (which might be greater than that of the nurse or midwife for a particular disease). Their need for care might be a need for counselling, instead of teaching, as they learn to live with a chronic illness, for example. However, it is important to obtain proof of the person’s knowledge or competency before proceeding with the plan of care. For example, a person with diabetes would need to state the signs and symptoms of hypoglycaemia or give a demonstration of being able to perform a blood glucose test. Comprehensive nursing and midwifery care interventions relate to individual needs.

Now that you have identified Claire’s goals of care, you need to determine the care interventions that you will implement for each of the identified goals. Review the identified goals and write down the care interventions that you will implement for each of the goals, and then consider the following questions:
1. What resources are available to assist you in identifying the care interventions?
2. Medical and nursing interventions intersect or compete at times. What issues can you identify that may arise in this instance?

Medical Interventions
A medical-initiated intervention is an intervention initiated by doctors in response to a medical diagnosis but carried out by a nurse or midwife in response to a doctor’s order. For example, a doctor examining a patient brought into the emergency department after a motor vehicle accident might ask the nurse to administer a medication to relieve pain and schedule the patient for X-rays and other diagnostic tests. The nurse who performs these interventions is implementing doctor-initiated interventions. Both the doctor and the nurse are legally responsible for these interventions. Nurses and midwives are expected to understand why these interventions are being initiated and to be knowledgeable about how to execute the interventions safely and effectively. Nurses or midwives who question the appropriateness of doctor-initiated interventions are legally responsible to seek clarification of the order with responsible parties. Under no circumstances should you implement a questionable intervention, even at the urging of a doctor or other professional. A questionable intervention is one where the person’s integrity and wellbeing is being comprised either by unethical or unlawful practice. Chapter 12 addresses legal issues.

Collaborative Interventions
Nurses and midwives also carry out treatments initiated by other healthcare professionals, such as pharmacists or physiotherapists. For example, when caring for a person who was injured in a motor vehicle accident and is now in a rehabilitation program, they might eventually be implementing interventions written by a physiotherapist, occupational therapist or other member of the healthcare team.

Structured Care Methodologies
Efforts to standardise nursing and midwifery care have taken different forms. Approaches popular during different decades include procedures (1960s), standards of care (1970s and 1980s) and clinical practice guidelines (1990s). Each of these approaches aims to help you identify and select interventions that produce optimal care, reduce legal risks and lower healthcare costs. A description of each approach follows:
- Procedure: A set of how-to action steps for performing a clinical activity or task
- Standard of care: A description of an acceptable level of care or professional practice
- Clinical practice guideline: A statement or series of statements outlining appropriate practice for a clinical condition or procedure.

The Australian Council on Healthcare Standards (ACHS) and the Cochrane Library produce guidelines for quality care. The Joanna Briggs Institute publishes the latest, most comprehensive scientific evidence and expert analysis. These institutions provide standards for delivering and evaluating care for patients with the same medical diagnosis or problems that have been identified through the health assessment process. Within these standardised frameworks, nurses and midwives are encouraged to personalise the care strategies and interventions so that individual needs are addressed and a person-centred approach is undertaken.

Box 17-6 compares structured care methodologies that are used in Australia and New Zealand. Additional examples may be found in Chapter 19.

Consulting
When designing the plan of person-centred care more information may be needed about the nature of the problems underlying the need for care or about specific interventions.
**Consultation**, a process in which two or more individuals with varying degrees of experience and expertise discuss a problem and its solution, often proves helpful. Nurses and midwives might consult with colleagues and other members of the healthcare team, including doctors, dieticians, social workers, physiotherapists and occupational therapists. Consultations are a valuable means for you to expand your knowledge and repertoire of effective strategies.

### COMMUNICATING AND RECORDING THE PLAN OF CARE

The **plan of person-centred care** is the written guide that directs the efforts of the nursing or midwifery team as they work with people to meet their health goals. It specifies the identified health problems, goals and associated care interventions. Well-written plans of care offer many benefits to the person, nurse and midwife, the ward or unit, administration and the profession. Primarily, plans of care ensure that the nursing or midwifery team works efficiently to deliver holistic, goal-oriented, individualised care. A well-written plan of care accomplishes the following:

- Represents an effective philosophy of nursing and midwifery and advances the four aims of: promoting health, preventing disease and illness, promoting recovery, facilitating coping with altered functioning.
- Is prepared by the nurse or midwife who is treating the person and is recorded on the day the person presents for treatment and care according to facility policy; modifications to the initial plan are signed and dated.
- Is responsive to the individual characteristics and needs of the person.
- Clearly identifies the assistance the person needs and collaborative responsibilities for fulfilling the medical and interdisciplinary plan of care (clearly specifies identified health problems, goals, care interventions and evaluative strategies).
- Directs the person-centred assessment priorities, caregiving behaviours, and teaching, counselling and advocacy behaviours.
- Is based on scientific principles and incorporates findings of current research.
- Meets the developmental, psychosocial, and spiritual needs of the person, as well as his or her physiological needs.
- Is updated to reflect changes in the person’s status and related needs for care.
- Addresses the discharge needs of the person and family.
- Provides for as much individual and family participation as possible.
- Is compatible with the medical plan of care and that of the interdisciplinary team.
- Creates a record that can be used for evaluation, research, reimbursement and legal purposes.

Many suggestions for plans of care appear in the nursing and midwifery literature. Each school of nursing and midwifery and each healthcare facility has their own format, which may reflect a particular theory or approach. Common to all formats is a minimum of three columns for documenting identified health problems, goals (some may use the term outcomes in place of goals) and care interventions. Formats may differ in the way assessment data and the evaluations are addressed.

**BOX 17-6 Structured Care Methodologies**

<table>
<thead>
<tr>
<th>Clinical Pathway</th>
<th>Guideline</th>
<th>Protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Represents a sequential, interdisciplinary and minimal practice standard for a specific population</td>
<td>Broad, research-based practice recommendations</td>
<td>Prescribes specific therapeutic interventions for a clinical problem unique to a subgroup of people within the cohort</td>
</tr>
<tr>
<td>Provides flexibility to alter care to meet individualised needs</td>
<td>May or may not have been tested in clinical practice</td>
<td>Multifaceted; may be used to drive practice for more than one discipline</td>
</tr>
<tr>
<td>Abbreviated format, broad perspective</td>
<td>Practice resources helpful in construction of structured care methodologies</td>
<td>Broader specificity than an algorithm; allows for minimal provider flexibility by way of treatment options</td>
</tr>
<tr>
<td>Phase or episode driven</td>
<td>No mechanism for ensuring practice implementation</td>
<td>May be ‘layered’ on top of a pathway</td>
</tr>
<tr>
<td>Ability to measure cause-and-effect relationship between pathways and goals for the person prohibited by lack of control; changes in goals directly attributable to the efforts of the collaborative practice team</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Healthcare Facility Plans of Care

Governments now require healthcare facilities to formulate, maintain and support a specific plan of care, treatment and rehabilitation. A great variety of formats are used to communicate the plan of care. In most healthcare facilities, the plans of care, regardless of their format, communicate directions for three different types of nursing and midwifery care: care related to basic human needs, care related to identified health problems, and care related to the medical and interdisciplinary plan of care.

Care Related to Basic Human Needs

The plan should concisely communicate to all those providing care, the data relating to the person’s usual health habits and patterns that are needed to direct daily care. For example, it is important to know whether a toddler is toilet-trained and what words the toddler uses to indicate the need to void or defecate. Directives about usual health habits and patterns might be modified by current treatment orders, such as an order to fast for a diagnostic procedure or to limit or increase activity. This information is useful only if it is kept current as the condition of the person changes. Any nurse or midwife should be able to find in the plan of care the instructions needed to provide competent care.

Care Related to Identified Health Problems

The plan contains goals and care interventions for every identified health problem as well as a place to note the person’s responses to care. This section is the heart of the plan of care because it represents the independent component of practice. If well developed, it demonstrates your clinical competence, awareness of the individual needs of the person, and creativity in mobilising the resources of the person and the caregiving team to meet the person’s health needs.

Care Related to the Medical and Interdisciplinary Plan of Care

The plan of care also records current medical orders for diagnostic studies and treatment and specified related nursing and midwifery care.

Computerised Plans of Care

Many healthcare settings have adopted computerised clinical information systems to deal with the complexities of clinical work. Within these systems nurses and midwives have access to computerised plans of evidence-based care that can then be personalised to create person-centred care plans. The benefits of using computerised plans of care include ready access to a large knowledge base; improved record keeping, with resultant improvement in audits and quality assurance; documentation by all members of the healthcare team with printouts for the patient’s record and for change-of-shift reports; and reduced time spent on paperwork.

In Australia the cost of adverse events (injury or harm to a person) is estimated to be $2 billion nationally per annum, of which 51% were considered preventable. The importance of the use of computerised clinical decision support tools and mobile technologies in healthcare settings cannot be overstated (Runciman, 2006). Evidence-based computerised care plans allow for prompts or cues that alert you of a need to consider a particular piece of information or include a particular intervention so that an error or omission in care is avoided. Further advances in error prevention are also being introduced with computerised clinical decision supports that can also be integrated into the computerised plans for person-centred care. This has the potential to prevent drug errors and actual injury to the person being cared for by the nurse or midwife. Mobile technologies such as personal digital assistants (PDAs), tablet computers and laptop computers are increasingly being used. PDAs are the most frequently used of these technologies and having access to information, especially pharmacological databases and person-centred care maps, at the bedside in real time with the patient has the potential to improve the quality and safety of the care provided (Farrell & Rose, 2008).

Case Management Plans of Care

Case management is a healthcare delivery system that has as its objective the provision of high-quality, cost-effective care for individuals, families and groups. The emphasis is on clearly stating the goals for the person and the specific time frames within which they can reasonably be achieved. Clinical pathways and care maps are tools used to communicate standardised, interdisciplinary plans of care. Figure 17-3 illustrates how a care map may be used as a template for planning and recording care. It sets out the standards of practice expected in the ward/unit (see section instructions for skin integrity) and it includes special instructions that have resulted from quality improvement projects (see section instructions for nutrition) that are relevant to the particular clinical setting.

The clear articulation of the expected standards for practice helps the nurse plan individualised care for each patient. Chapter 20 provides examples of how clinical pathways are used with select documentation tools in a standardised system.

A concept map is another tool used to assist in planning care. A concept map used as a plan of care is a diagram of the problems a person is experiencing and the interventions that are planned. They are also used to organise personal data, analyse relationships in the data, and enable you to take a holistic view of the person’s situation (Schuster, 2002). With a person-centred approach, the person will be at the centre of the map and your ideas about problems and treatments are the ‘concepts’ that will form its basis. Figure 17-4 provides an example of a concept map related to John Brown, a 58-year-old man, admitted to the medical ward with a medical diagnosis of a right-sided stroke. The assessment data has shown that he has difficulty mobilising, vision problems, cannot perform his activities of daily living independently and his thinking process has been affected. The concept map shows how these health problems can be documented.
### Chapter 17 Planning Person-Centred Care

#### PATIENT NAME: MRN: DOB:

<table>
<thead>
<tr>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>PM</td>
<td>ND</td>
</tr>
</tbody>
</table>

**Investigations**

**Mental Status**

- Alert
- Orientated
- Drowsy
- Confused
- Unconscious

**CAM Score required if not alert and orientated**

- Resistive to care, aggressive or agitated

Complete CAM Score, record in the box.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Frequency</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPR &amp; BP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpO₂</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIWA-AR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Daily weigh (record kgs daily) in the box.**

**Mobility Activity**

Identify level of assistance required for transfers

*Refer to Mobility Status chart*

- Record Falls Risk Score daily & prn
- Record postural BP if not attended O/A

**Nutrition, Hydration & IV Therapy**

**IV Therapy:** ensure cannula removed

- Reduce due:
  - Cannula Score
  - Special/normal diet Red or Blue Alert
  - Ensure diet flip chart correct
  - Fluid restriction
  - Circle NG/PEG/TPN rate

**Skin Integrity**

- Record Norton Score once daily in square
- Pressure area report in AM shift report
- Pressure area care required

**Hygiene / ADL’s**

- Independent
- Full sponge
- Assist sponge
- Full shower chair
- Assist shower
- Full bath with trolley bath
- Mouth & eye care required

**Elimination**

- Patient continent
- Patient Incontinent Urine
- Patient Incontinent Faeces
  - Chart bowels daily (each shift) on Stool Chart

**Communication**

- Speech Normal
- Slurred
- Dysphasic
- Aphasic
  - Assist with communication aids if speech difficulties present

**Education**

- Commence education for patients & carers

**Discharge Planning**

- Advise pt/family of discharge destination
- & approx date, Commence interagency forms/planning for home adjustments as needed/planning for transport home

**Special needs & technical activities**

- O₂ rate & device:

---

**Figure 17-3** An example of a care map

TPR (Temperature, Pulse, Respirations), BP (Blood Pressure), GMR (Glucometer reading), SpO₂ (Oxygen saturation), CIWA-AR (Alcohol Withdrawal Scale), GCS (Glasgow Coma Scale), U/A (urinalysis), NG (naso-gastric), PEG (percutaneous endoscopic gastrostomy), TPN (Total Parenteral Nutrition).

See Appendix C for a list of abbreviations commonly used in healthcare facilities.
Student Plans of Care

Concept mapping is often used in undergraduate curricula to develop the knowledge base for the student to start the process of care planning using critical thinking and clinical reasoning. The plans of care that students are required to develop are often more detailed than those found in practice settings. The aim is to assist students to assimilate each of the steps of the process of care. Although plans of care formats vary among different programs and healthcare facilities, most are designed so the student systematically proceeds through the inter-related steps of the process.

The accompanying Student Plan of Care 17-1 provides an example of how a plan of care is developed. This demonstration provides a plan of care developed for Mrs Jones, a 76-year-old woman who has been admitted to hospital with a diagnosis of transient ischaemic attack (TIA). Her condition is stable and the two identified health problems, written in the plan address in order of priority are, her lack of knowledge relating to preventing further TIA or stroke and her inability to cope with illness, the recent death of her husband, and the relocation with her daughter. Place yourself in the position of the student writing this plan of care as you consider each of the following sections.

Assessing

It was important that you, the student, completed a thorough database when conducting the person-centred assessment of Mrs Jones. Remember that as part of your assessment of Mrs Jones you would need to have:
1. Listened attentively to her.
2. Maintained her identity by allowing her to express her values, beliefs and culture.

You should have then recorded the clustered assessment data that led to the determination of each identified issue in the assessment findings column. Recording these data helped you to link specific defining characteristics with problem statements.

Identifying Health Problems

You identified Mrs Jones’ health problems and recorded them in the assessment findings column in a prioritised list beginning with the top-priority problem for each identified health problem, a clear and concise problem statement that was followed by a statement that identifies specific contributing factors.

Planning Achievable Health Outcomes

The plan of care column contains the expected changes in health status or in personal behaviours (i.e. goals for Mrs Jones). If achieved, these resolve the problem statement in the identified health problem.
Implementing Care Interventions

Specific care interventions are written for each rationale. These specify what care interventions are to be performed, how they are to be performed, when they are to be performed and who is to perform them. In many nursing and midwifery programs, students are asked to document the source of the care interventions they propose. Although students might be able to remember some strategies, developing the practice of consulting the nursing and midwifery literature is a sure means to increase their knowledge. Some programs also require students to provide a scientific rationale for the interventions they propose. A succinct rationale statement demonstrates that the student is deliberately choosing the nursing or midwifery intervention because of its high probability to effect the desired change.

Evaluating Care

Incorporating evaluative statements in the plan of care clearly communicates the message that care is never complete until achievement of outcomes is evaluated. Just as some say that teaching does not occur if learning does not take place, so it is that planned care is incomplete if the desired goals of the person are not achieved.

### STUDENT PLAN OF CARE 17-1

**for Mrs Jones**

**Case history**
Mrs Jones is a 76-year-old woman who has been admitted to your unit with a diagnosis of transient ischaemic attack. Her husband passed away six months ago and Mrs Jones has moved in with her daughter Lisa after selling the family home. Her daughter is with her as you take the assessment history.

**Assessment findings**

**Subjective data**
‘Will I get a stroke now? I don’t think I could handle that.’ ‘How can I help myself prevent it?’
Her daughter reports her mother had been a very independent, strong woman in the past and seemed to ‘crumple’ after husband’s death.

**Objective data**

Admitting diagnosis: Transient ischaemic attack (TIA)
BP: 184/120
Past history of headaches

**Identified health problems**

**Problem 1**
- Lack of knowledge relating to preventing further TIA or stroke

**Problem 2**
- Inability to cope with illness, recent death of husband, and relocation with daughter

**Planning achievable goals**

Before discharge, the Mrs Jones will:
- Describe the terms TIA and stroke, identifying the underlying disease process, causes and symptoms
- Correctly describe the treatment plan:
  1. Medications (drugs, intended effect, dose, time, route)
  2. Dietary modifications
  3. Exercise prescription
  4. Signs and symptoms to report
  5. Follow-up appointment date.

After consultation with the social worker Mrs Jones will:
- Verbalise her feelings related to the loss of her husband, loss of family home, loss of health
- Identify personal strengths and supports that will help her now.

Before discharge, Mrs Jones will:
- Verbalise that she feels ‘okay’ (sufficiently in charge of her life) about returning home.

**Problem 1 Care interventions**

1. Assess what the Mrs Jones knows about TIA and stroke (correct any misinformation). Assess learning needs, readiness to learn, and factors that will influence learning.
2. Plan teaching and learning sessions to involve family members or significant others
3. Include in the teaching plan a description of TIA and stroke and the underlying disease process, causes, symptoms and treatment plan.
4. After the treatment plan has been developed, make sure the person and family can restate it (teaching) and value the prescribed lifestyle modification (counselling).

**Rationale**

Each person’s learning needs are different; each person learns in own unique way; learning is dependent on readiness.

The more support people who have knowledge and are committed to the plan of care, the greater the probability the person will achieve goals.

New self-care behaviours are dependent on knowledge.

New self-care behaviours are dependent on motivation. Unless the person is committed to stroke prevention and values this outcome, she will not follow the treatment plan.
Consider what you have learnt in relation to the development of a plan of care for Claire.

Using the Student Plan of Care 17.1 as a guide, develop a plan of care for Claire which incorporates all the information that you have collected about her. You will need to refer back to Chapters 15 and 16 and use the information you have gathered in this chapter.

Use the following as a further guide:
- Health history—write a short synopsis of Claire’s health history and include in your plan of care.
- Assessment findings—refer back to Chapter 15 where assessment data relating to Claire’s case was presented. Summarise these finding and include them in your plan of care.
- Identified health problems—in Chapter 16 you identified several health problems relating to Claire’s care. List each in your plan of care in order of priority.
- Planning achievable goals—earlier in this chapter you were asked to write goals that are realistic and achievable. Include each of these goals in your plan of care.
- Care interventions—earlier in this chapter you were asked to write care interventions. Include each of these care interventions in your plan of care.

Evaluation of care—before filling in this section of the plan of care, read Chapter 19 Evaluating Care, and then come back and finalise your plan of care for Claire.

When you have completed Claire’s plan of care reflect on ways in which you might improve your planning skills.

ISSUES RELATED TO PROBLEM IDENTIFICATION AND CARE PLANNING

Issues commonly encountered while developing plans of care include failure to involve the person in the planning process, insufficient data collection, use of inaccurate or insufficient data to identify the problems, goals that are stated too broadly, goals that are derived from inaccurately identified problems, failure to write plans of care that do not resolve the problem and failure to update the plan of care.
Developing knowledge skills

In this chapter you have been learning about planning care as part of the process of person-centred care. Once you have had the opportunity to practice the process of person-centred care and by carrying out a plan of care you will be more confident to practise these identified skills and procedures.

What have you learnt?
- Basic knowledge of how to complete plan of person-centred care
- The ability to collect the appropriate data to complete a plan of person-centred care
- Knowledge of what constitutes accurate and appropriate data for a plan of person-centred care
- Ability to understand and interpret the meaning of the collated data
- How to recognise actual and potential barriers to being able to collect accurate and appropriate data for comprehensive plan of person-centred care.

To enhance your learning and facilitate further understanding of this chapter, refer to thePoint online resource.

Developing critical thinking skills

1. An alert 82-year-old widow who has a history of unsafe behaviours has recently been discharged from the hospital to her home. Caregivers attempted to secure her consent to be transferred to a nursing home, but she flatly refused. Responsible for her home care, you list risk for harmful injury as a priority identified health problem. Join several students and independently list the nursing measures that are most likely to achieve the outcome of preventing injury. Compare your lists of interventions and discuss how practicing nurses can be sure they select the best care interventions for each expected outcome for the person.

Review questions

1. During care intervention and rationale and planning achievable goals step of the process of care, you work in partnership with the person and family to do which of the following?
   (1) Formulate and validate prioritised identified issues
   (2) Identify expected goals
   (3) Select evidence-based nursing/midwifery interventions
   (4) Communicate the plan of care
   a. 1 and 3
   b. 2 and 4
   c. 2, 3 and 4
   d. All of the above

2. Mr Price tells you he fears becoming ‘hooked on drugs’ and consequently waits until his pain becomes unbearable before requesting his PRN analgesic. You plan to be more attentive to Mr Price and assess his needs for pain management more closely. Which of the following consequences of informal planning ought to be the major concern you?
   a. The lack of a coordinated plan known by everyone will result in uneven pain management
   b. Faulty prioritisation of the person’s needs
   c. Inability to evaluate the person’s responses to nursing care
   d. Lack of a record for reimbursement purposes

3. When helping Mr Price turn in bed, the nurse notices that his heels are reddened and plans to place him on precautions for skin breakdown. This is an example of:
   a. Initial planning
   b. Standardised planning
   c. Ongoing planning
   d. Discharge planning

4. Use Maslow’s hierarchy of human needs to prioritise the following problems from highest priority (1) to lowest priority (4):
   (1) Disturbed body image
   (2) Ineffective airway clearance
   (3) Spiritual distress
   (4) Impaired social interaction
   a. 2, 4, 1, 3
   b. 3, 1, 4, 2
   c. 1, 4, 3, 2
   d. 3, 2, 4, 1

5. From which of the following are goals derived?
   a. The problem statement of the identified health problem
   b. The cause of the problem
   c. The defining characteristics of the problem
   d. The evaluative statement

6. Which of the following is an example of an affective goal?
   a. Within one day after teaching, the person will list three benefits of continuing to apply moist compresses to leg ulcer after discharge.
   b. By 12/06/20XX, the person will correctly demonstrate application of wet-to-dry dressing on leg ulcer.
   c. By 19/06/20XX, the person’s ulcer will begin to show signs of healing (e.g. size will shrink from 7 cm to 5 cm).
   d. By 12/06/20XX, the person will verbalise valuing health sufficiently to practice new health behaviours to prevent recurrence of leg ulcer.

7. Which of the following is an optional element in a measurable goal?
   a. Subject
   b. Verb
   c. Performance criteria
   d. Conditions
   e. Target time
8. Which of the following goals are correctly written?
   (1) Offer Mr Myer 60 mL fluid every 2 hours while awake.
   (2) During the next 24-hour period, the person’s fluid intake will total at least 2,000 mL.
   (3) By discharge Mrs Gaston will know how to bathe her newborn.
   (4) At the next visit, 23/12/20XX, the person will correctly demonstrate relaxation exercises.
   a. (1) and (3)
   b. (2) and (4)
   c. (1), (2), (3)
   d. All of the above

9. Which of the following guidelines for goal writing are correct?
   (1) At least one of the goals shows a direct resolution of the problem statement in the identified health problem.
   (2) The person (and the family) values the goals.
   (3) The goals are supportive of the total treatment plan.
   (4) Each goal is brief and specific (clearly describes one observable, measurable behaviour/manifestation), is phrased positively and specifies a time line.
   a. (2) and (4)
   b. (1) and (3)
   c. (1), (2), (3)
   d. All of the above

10. Which of the following are examples of well-stated care interventions?
   (1) Offer the person 60 mL water or juice (prefers orange or cranberry juice) every 2 hours while awake for a total minimum PO intake of 500 mL.
   (2) Teach the person the necessity of carefully monitoring fluid intake and output; remind the person to mark off fluid intake each shift on record at bedside.
   (3) Walk with the person to bathroom for toileting every 2 hours (on even hours) while the person is awake.
   (4) Manage the person’s pain.
   a. (1) and (3)
   b. (2) and (4)
   c. (1), (2), (3)
   d. All of the above

**Answers with rationale**

1. The correct answer is c. Formulating and validating identified health problems occurs during the identifying health problem phase of the process of care.
2. The correct answer is a. If you fail to incorporate this learning into the formal plan of care, other professional caregivers will not be aware of the need to monitor the person’s pain needs more closely. (b), (c), and (d) may all be correct responses, but they should not be your major concern.
3. The correct answer is c. Ongoing planning is problem-oriented and has as its purpose keeping the plan up to date as new actual or potential problems are identified.
4. The correct answer is a. Maslow’s hierarchy is (1) physiological needs; (2) safety needs; (3) love and belonging needs; (4) self-esteem needs; and (5) self-actualisation needs. (2) Is an example of a physiological need, (4) is an example of a love and belonging need, (1) is an example of a self-esteem need, and (3) is an example of a self-actualisation need.
5. The correct answer is a. Goals are derived from the problem statement of the identified health problem. For each identified health problem in the plan of care, at least one goal should be written that, if achieved, demonstrates a direct resolution of the problem statement.
6. The correct answer is d. Affective goals describe changes in the person’s values, beliefs, and attitudes. Cognitive goals (a) describe increases in the person’s knowledge or intellectual behaviours; psychomotor goals (b) describe the person’s achievement of new skills. (c) is an outcome describing a physical change in the person.
7. The correct answer is d. Conditions specify the particular circumstances in or by which the outcome is to be achieved. Not every outcome specifies conditions.
8. The correct answer is b. Common errors when writing the person’s goals include the following:
   (1) Expressing the person’s goal as a nursing intervention. Incorrect: ‘Offer Mr Myer 60 mL fluid every 2 hours while awake.’ Correct: ‘Mr Myer will drink 60 mL fluid every 2 hours while awake, beginning 24/02/20XX.’
   (2) Using verbs that are not observable and measurable. Incorrect: ‘Mrs Gaston will know how to bathe her newborn.’ Correct: ‘After attending the infant care class, Mrs Gaston will correctly demonstrate the procedure for bathing her newborn.’
   Verbs to be avoided when writing goals include ‘know’, ‘understand’, ‘learn’ and ‘become aware’.
9. The correct answer is d.
10. The correct answer is c. (4) lacks sufficient detail to effectively guide nursing intervention. The set of nursing interventions written to assist the person to meet an outcome must be comprehensive. Comprehensive nursing interventions specify what observations (assessments) need to be made and how often; what nursing interventions need to be done and when they must be done; and what teaching, counselling, and advocacy needs that the persons and families have.

**Bibliography**


---

**Web resources**


Cochrane Library: www.cochrane.org