Nurses Association OF NEW BRUNSWICK

Care Planning: An Essential Element of RN Practice

Registered Nurses (RNs) have always assessed clients, planned and carried out nursing interventions and then captured this process through documentation. The words *care planning, plan of care* and *care plan* are often used interchangeably and since the 1970s, care planning or the formal process of identifying client health problems with proposed solutions, has been a part of the nursing role (Ballantyne, 2016). A plan of care[1] is a written or electronic document that captures the treatment plan for a client and is based on assessed needs and identified health goals. It may be included as part of the client's permanent health record, depending on employer policy.

The *Standards of Practice for Registered Nurses,* indicator 2.1 states that the RN uses critical inquiry to assess, plan, intervene and evaluate client care and related services (NANB, 2019). One cannot consider care planning without this four-step nursing process because the plan of care is based on the information gathered during the assessment and evaluation (Ballantyne, 2016).

Client-centered Care with Objective and Subjective Data

Care planning is based on data gathered from the healthcare team and the client and should include an assessment of actual or potential health problems and risks. The client should be involved in the planning process so that the interventions are not 'done-to', but rather, 'done-with' the individual. Information gathering should include objective data such as vital signs and diagnostic reports, as well as subjective data such as client's self-reported symptoms and health history (Kusler & Sims, 2012). Furthermore, any changes to the plan should be discussed with the client in a timely manner.

Please review the NANB standard titled 'Client-Centered Practice' in the *Standards of Practice for Registered Nurses* (NANB, 2019) for further expectations and direction for nursing practice.

Goals That Provide Benchmarks for Evaluating Care

The creation of a nursing care plan can be viewed by RNs and employers, as time-consuming and not useful. However, quality assessing and planning results in many positive outcomes such as:

- a communication tool that articulates identified health needs and goals;
- clarity of who is the best care provider to meet those goals;
- clarifying how much time is required to provide consistent and high-quality nursing care; and
- the health care team being able to evaluate the success of the interventions that are within the care plan.

[1] Plan of Care: A plan to guide nursing care that supports interprofessional practice and collaboration. Priority nursing interventions supporting each client's unique care and focused on the achievement of client centered goals provide a map that guides care (CRRNNS, 2019).

Just as an RN is expected to assess and intervene with nursing care throughout the nurse-client relationship, the RN is also expected to evaluate the client's response to interventions and modify the care plan as needed. Standard indicator 2.3 states that the RN monitors the effectiveness of the plan and revises it in collaboration with the client and the health care team (NANB, 2019). Evaluation includes looking at what needs to be continued, modified or changed completely, in order to achieve the best health outcomes. The care plan is a living document and not a one-time creation.

Critical Thinking and Holistic Care

Every human is unique and therefore clients need to be viewed holistically as an individual and not as a symptom or a grouping of health needs. For example, two persons with the same diagnosis may have significantly different outcomes, depending on their emotional supports and existing stressors in their lives. Care planning should allow for customization of care to meet individual needs, while ensuring consistency in the quality of care being provided (Kay, 2019). Employers should have policy in place along with documentation tools, to support the practice of assessing clients and developing plans of care (Ballantyne, 2016).

The care plan can be used as a valuable resource to guide nursing practice. It may serve as a time-management resource when creating a shift assignment or as a reminder of needs-to-be-addressed (such as time-sensitive interventions or the reporting of clinical test results). Additionally, a care plan may serve as a summary of pertinent information during rounds or during handover of care (see "handover of care doc title" for more information).

Interdisciplinary Team Communication

Although plans of care are created and used primarily by the nursing care team, they should also be a resource document for all health disciplines involved in a client's care (Kay, 2019). Collaborative care can be strengthened for better client outcomes when the entire team knows the health goals and the plan to achieve those goals. Negative outcomes that may have occurred from previous interventions or any known risk-factors, when captured in the care plan, can help alleviate risk of future negative outcomes. If kept current, a care plan can serve as a valid communication tool amongst the healthcare team and be a great resource for discharge planning.

Nursing care plan capture an overarching look at what was assessed as health needs or health problems; what goals and plans were identified to address those health needs; how and by whom the interventions are to take place and the re-evaluation of the client's needs after the interventions. Care plans also recognize the value of client-centered care by inclusion of the client and/or significant others in what is planned, implemented and evaluated. Clients will be empowered when they are able to have some control and contribution to their care, recovery, and future wellbeing.

References

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