Community Nursing BULLETIN No. 25

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FOR DISTRIBUTION TO ALL DVA COMMUNITY NURSING STAFF

DVA is committed to supporting Providers to provide veteran centric care. The use of comprehensive Nursing Care Plans is one way to promote care that is veteran centric, facilitates the delivery of evidence based care, ensures nothing is forgotten and supports an environment of quality and safety.

This bulletin is being issued to provide an update to Department of Veterans' Affairs (DVA) Community Nursing (CN) providers in relation to the Nursing Care Process.

Nursing Care Plans

The Nursing Care Process is a 4 step process of assessment, planning, implementation, and review that is fundamental to a Registered Nurse's (RN) everyday practice. Nursing Care Plans document the nursing care from the outcome of the assessment to the review and must be developed and completed by an RN, as outlined in the Nursing and Midwifery Board of Australia' *Registered Nurses Standards,* Standard 5: Develops a plan for nursing practice.

Nursing Care Plans may be documented in varying formats. They should be person centred, goal oriented, and developed in collaboration with the client and their authorised representative if appropriate.

Nursing Care Plans should be easy to read and have a logical process and flow. It is expected that nursing needs will change and resolve at differing times and consequently Nursing Care Plans should be dated and signed as they are developed and reviewed by the RN. It is a requirement that all Nursing Care Plans (for DVA's CN program) are signed by both the RN and the client or their authorised representative, as documented in the DVA Notes for community nursing providers (*the Notes*) September 2020, Section 10.2 Care Documentation.

Nursing Care Plan components:

- Clinical and personal care needs identified from the comprehensive nursing assessment
- Client's agreed goals and actions (short and long term objectives)
- Identified clinical and home related risks
- Clinical care intervention/s consistent with best practice and evidence
- Personal care interventions consistent with best practice and evidence
- Desired outcome/s Delegation of care within Scope of Practice as per *the Notes,* Section 5.3.4 Delegation of Care
- Review dates

- Agreed days and timeframes that services will be delivered

Nursing Care Process:

Assessment

The RN conducts a comprehensive nursing assessment and develops the Nursing Care Plan based on the assessment outcomes prior to the commencement of services. Further nursing assessments are done as part of regular reviews or when the care needs change.

Planning

The RN determines how care is to be delivered for each nursing intervention identified in the nursing assessment. Nursing Care Plans should be developed in collaboration with the client or their authorised representative if appropriate. The Nursing Care Plan should include the following:

- The short and long term goals and objectives to successfully resolve and manage each identified nursing need;
- The interventions required for each nursing need;
- Nursing equipment required to successfully complete interventions;
- Level of personnel needed to successfully complete each planned interventions;
- Referrals to allied health and other health professionals as clinically indicated;
- Frequency and length of time needed for visits;
- Agreed visit days and timeframes;
- Planned review dates as per *the Notes*, Section 5.3.4 Delegation of Care review requirements and any additional requirements as identified from the nursing assessment; and
- Nursing Care Plans should be signed by the RN and the client / their authorised representative.

Implementation of care

Once care has been planned and agreed by the client or their authorised representative, a written Nursing Care Plan is created by the RN and care can commence. A copy of the Nursing Care Plan should be provided to the client. The Nursing Care Plan needs to be:

- Easily accessible to the staff delivering the care at the time care is delivered; and
- Legible with clear instructions to staff of each intervention required, when it is required, and who completes the intervention.

Nursing actions may be delegated within the appropriate scope of practice, with supervision and review by the RN consistent with legislative requirements. The RN maintains legal and professional accountability for the delivered care and also for the delegation. Delegation of care may be to an Enrolled Nurse (EN) or Nursing Support Staff (NSS).

Review of care delivered

The delivered care and Nursing Care Plan of client's needs to be reviewed as stated in *the Notes*, Section 8.5 Review of Care and whenever care needs change. A review of the care needs of the client must be conducted, as a minimum, at the following times throughout their episode of care.

<u>DVA Planned review dates:</u>

- Every seven days for a client receiving personal care and requiring assistance with self-administration of a Schedule 8 drug. The review must be conducted by an RN or EN with approved medication administration qualification.
- Every seven days for a client with an Exceptional Case approval in place. The review must be

conducted by an RN.

- Every 28 days for a client receiving clinical care. The review must be conducted by an RN;
- Every 28 days for a client receiving personal care only. The review must be conducted by an RN or EN.
- The three month review must be conducted by an RN for all clients receiving care.
- Any change in condition – RN or EN (with RN oversight).

Review outcomes should be documented in the progress notes with a title notation identifying the note as either an RN/EN review where applicable.

Summary

The RN is responsible and legally accountable for the development, maintenance, and review of all Nursing Care Plans. Nursing Care Plans are a legal record of how a nursing organisation delivers care to a client and consequently should be logically planned, professionally implemented, and regularly reviewed.

Delegated staff require access to the Nursing Care Plan to ensure the delivery of adequate and safe clinical practice that has continuity and integrity. The Nursing Care Plan is essential to professional nursing care and is an important piece of clinical documentation reflecting the client's nursing journey throughout their episode of care.

The Notes, Section 10.2 Care Documentation articulate the nursing process by outlining key elements expected in Nursing Care Plans.

References:

DVA Notes for Community Nursing Providers, September 2020
https://www.dva.gov.au/providers/health-programs-and-services-our-clients/community-nursing-services-and-providers-0

Nursing and Midwifery Board Australia https://www.nursingmidwiferyboard.gov.au

Nursing and Midwifery Board Australia *Registered Nurses Standards,* Standard 5: Develops a plan for nursing practice https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx

Australian Commission on Safety and Quality in Healthcare. NSQHS Standards. Second Edition
https://www.safetyandquality.gov.au/standards/nsqhs-standards