

## **Introduction of new universal care plans to improve patient care**

Patients being treated in Lincolnshire's hospitals are benefitting from a new care record introduced across United Lincolnshire Hospitals NHS Trust

The Take Note project, launched earlier this year, was aimed at improving patient record documentation

It created new care records which are now used for all inpatients, which are a single, uniform way of keeping patient notes in a folder that stays with the patient from admission to discharge, even if they move wards.

All staff caring for the patient write into the same record, which enables staff to care for patients without spending time duplicating paperwork and writing down unnecessary information,

Clinical Improvement Facilitator Carole Mackinder said: "Effective documentation is key to the provision of good care for our patients.

"This new documentation means that now, all of our staff in all disciplines are writing in one record rather than in lots of different places," she said.

"Also, we have developed eight mandatory care plans to be used for patients that are based on Essence of Care benchmarks. All the care plans start with a dignity statement and outcome, so that patients can be assured that they will receive care based on quality standards, but at the same time, the care plans will be personalised for each patient."

The new documentation is designed to capture the viewpoint of the patients and their carers, so they should feel more involved with their care.

The care plans cover

- 1 Communication
- 2 Physiological observations
- 3 Nutrition
- 4 Continence
- 5 Pain
- 6 Hygiene and skin integrity
- 7 Mobility and environment
- 8 Discharge planning