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Optimising Patient Care through Patient Engagement Integrated Nursing and Conditions Service Guidance

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Summary of document
Guidance to support shared decision-making by engaging patients and guiding staff to agree and follow clear steps to optimise care.

Outcome of PPPG mandatory algorithm (more than 1 box may be ticked):			
Mandatory for CHCP to have in place ☐	Mandatory for ALL CHCP staff to read ☐	Mandatory for specific staff/services/roles ☐	Not mandatory ☒
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1. INTRODUCTION & STATUTORY REQUIREMENTS

It is widely acknowledged in healthcare literature that challenges are faced when patients find it difficult to engage with treatment plans as prescribed, especially, but not exclusively in relation to wound care. This can lead to frustration for both the patient and community nurse / Caseload Manager, and situations whereby best practice treatment advice is compromised. For wound care in particular the impact of perceived nonadherence can be extensive and result in non-healing of wounds and have many other clinical implications.

This guidance provides the structure to promote patient involvement in the shared decision-making process regarding their care and to optimise their care through improving patient engagement to prescribed treatment plans. The goal is to improve patient outcomes and to provide a clear structure for staff to work within to support patients. Improving patient outcomes should also have a direct impact on staff job satisfaction, this is in addition to reducing the demand for unplanned visit requests from patients and reduce complaints, and concerns, comments, and incident reporting.

When all the optimal opportunities for shared decision making are implemented, and all barriers to perceived nonadherence explored, it will be evident that staff are following the guidance and can be supported in their decision making regarding the patient's future plan of care. This may include the implementation of agreed care plans when boundaries / level of care is agreed and may include patient discharge from the relevant caseload.
It is important to remember that labelling an individual is unhelpful and often leads to barriers in accessing, understanding and accepting care (e.g. assuming that an individual is 'non-concordant'). This should mean that other strategies and communication methods are used, rather than the issue lying with the individual. There is strong evidence to illustrate that so-called 'non-concordance' is too often blamed on the individual, when in reality it is more likely to reflect the relationship between the individual and practitioner and may be due to a lack of knowledge or experience on the practitioner's part.

Terms frequently used:

Mental Capacity – see Ref 629 Mental Capacity and Deprivation of Liberty Safeguards Standard Operating Procedure.

Compliance – failure to comply – can be seen as disobedience, suggests patient yields to the prescription of health care workers in a submissive way

or – compliance refers to the degree to which a patient correctly follows medical advice

Concordance – more positive – patient is a decision maker working with the health professional to achieve best therapeutic outcomes

or – concordance refers to a process by which a patient and a health care professional make decisions together about treatment.

Adherence - adherence is the extent to which the patient's behaviour matches the agreed recommendations from the prescriber.

EPF Position Paper March 2015 Adherence and Concordance

To optimise care the following must be understood:

Informed Decision Making – is the gathering of facts and information that may be relevant to the decision. It is then making sense of or interpreting that information through critical analysis.

Shared decision making - is when health care professionals and patients work together. It puts patients at the centre of decisions about their own treatment and care. This means that:

- different choices available to the patient are discussed.
- care or treatment options are explored in full, along with the risks and benefits.
- patients reach a decision with their health and social care professional.

NICE Guidance About shared decision making | NICE

Patient engagement (World Health Organisation (WHO) 2016)

Patient engagement is increasingly recognised as an integral part of health care and a critical component of safe people – centred services. People using health services are increasingly asking for more responsive, open, and transparent health care systems. They expect HCPs to engage them in the decision-making process, although individual patients may vary substantially in their preferences for such involvement. Patients have their safety and wellbeing as primary drivers and thus, they can raise this as a priority in the health care they receive.

Engaged patients are better able to make informed decisions about their care options, offer their perspectives and identify what is important to them. In addition, resources may be better used if they are aligned with the patients' priorities, and this is critical for the sustainability of health systems worldwide.

Informed patients are more likely to feel confident to report both positive and negative experiences and have increased concordance with mutually agreed care management plans. This not only improves health outcomes, but also advances learning and improvement, while reducing adverse events.

Levels of patient involvement:

1. **Fully involved**: the patient feels confident and is capable of monitoring and managing their care which may include support by regular visits to / by a clinician, and is able to make decisions about their care

2. **Shared involvement**: where the patient and the clinician have equal responsibility for the monitoring and management of the care required

3. **Not involved**: where the patient is passive or unable to take on responsibility of the care required and relies on others to make decisions about their care. This may be caregivers in collaboration with the clinician or the clinician alone.

For some individuals care has to be a compromise, and realistic goals must be set. Negotiation should always be a continuous process and finding common ground is needed, rather than retaining all control and employing a paternalistic approach. It is important to remember with some therapies e.g. compression that ‘some care is better than no care’. As well as setting realistic goals, a degree of flexibility is important — not every element of treatment can be controlled, and we may need to expect some deviation from ideal plans.

2. SCOPE

This guidance applies to all health care staff employed within CHCP CIC who provide or perform patient care within the Integrated Nursing and Conditions Services.

3. PURPOSE

The purpose of this guidance is to support shared decision making and the optimisation of care through patient engagement and a negotiated agreement to guide staff through the steps to be taken to facilitate this.

Optimising care through patient engagement and promoting shared decision-making aims to improve patient outcomes and experience, and increase capacity / reduce demand on community nurses safely, whilst ensuring maintenance of a high standard of service

Potential Benefits:

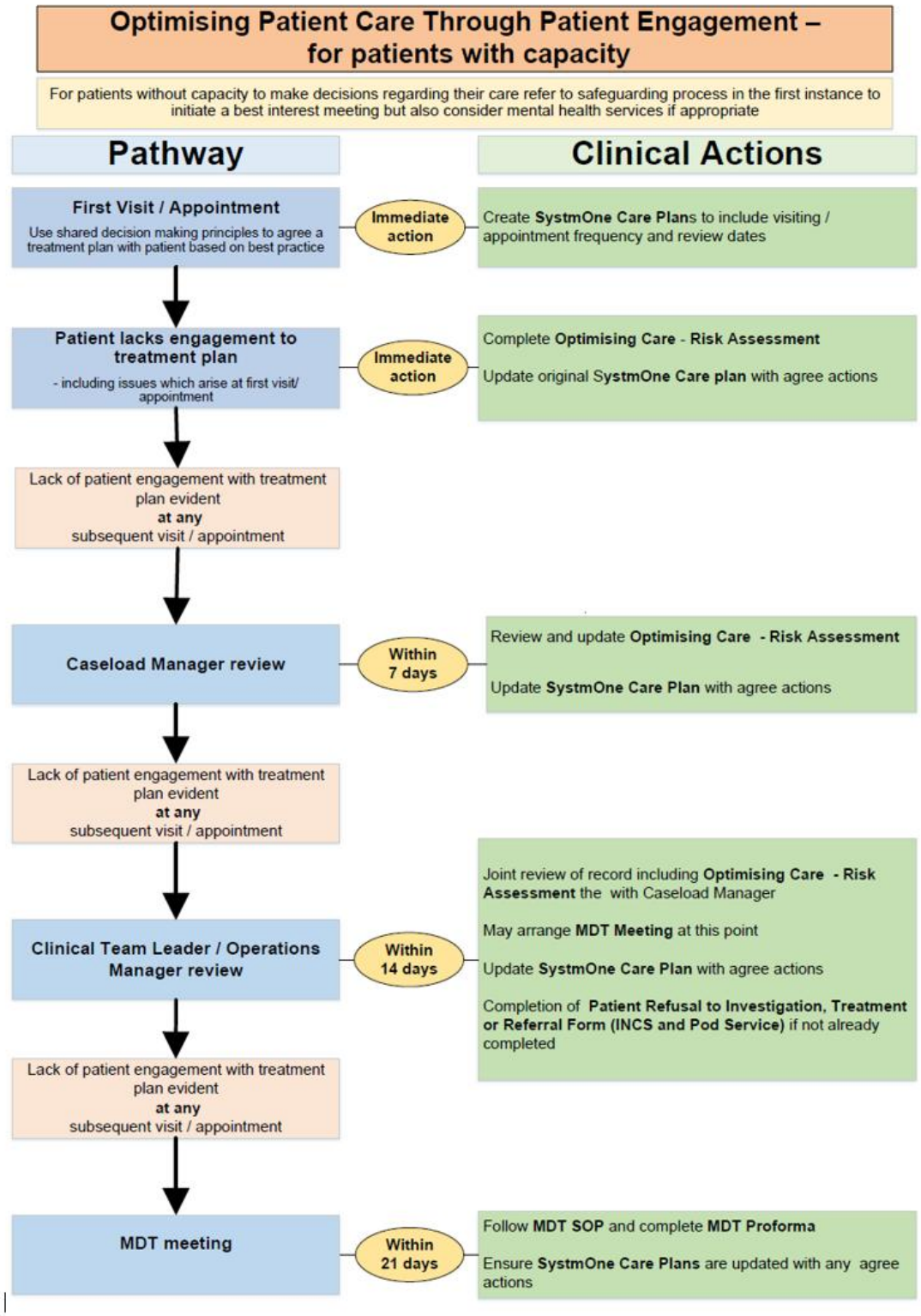
- Patient benefits
    - Improved patient outcomes e.g. improved wound healing rate
    - Improved patient satisfaction and experience
    - Increased patient understanding in their evidenced based care plan.
    - Improved engagement in shared decision-making
    - Mutually agreed holistic personalised plan of care
- Clinical benefits
    - Improved healing rates e.g. wound care
    - Promoting shared and self-care with patients / relatives / carers
    - Agreed optimal evidence care is assessed, planned, implemented and evaluated within the patients personalised plan of care
    - Supports onward referrals
- Organisational benefits
    - Reduced unplanned visit demand
    - Reduce number of complaints, concern, comments incident reports
    - Ensuring the right patient, is seen in the right place, by the right person, at the right time
- Staff benefits
    - Increased job satisfaction
    - Enhanced engagement with patients / family / carers
    - Improved skills and knowledge to support patients in their decision making and adherence to treatment plans
    - Guidance to follow and implement for complex non adherent patients
    - Support from Senior Management Team when dealing with complex non adherent patients
    - Provides underpinning evidence that care has been considered / delivered and recorded during investigations and complaints process
- Financial benefits
    - Potential to reduce Wound Care Formulary spends as number of non-adherent patients with high-cost treatment regimes would reduce

- Improved potential to manage unplanned workloads as more patients would be engaged in treatment plans or have an agreed action plan in place which would not include ‘on demand’ visits / appointments

4. DOCUMENT DETAILS

The guidance is to be used for all patients assessed as having capacity who make a decision against healthcare advice, it should also be used when a Carer with Lasting Power of Attorney for Health and Welfare decides on behalf of the patient against healthcare advice.

The guidance should be immediately implemented when there is evidence that a patient decides to decline all, or elements, of a best practice treatment plan.



4.1 Guidance to Timeframes

The pathway and timeframes for clinical actions to be undertaken are provided within the guidance to ensure that all opportunities to optimise patient care through patient engagement are taken and there is a structure for staff to follow.

No timeframes are stipulated for progression through the pathway as it is recognised that this will vary greatly from patient to patient and at any point care may be optimised, a care plan agreed and no further action, other than regular monitoring, may be required.

For some patients the time between each stage of the pathway may be quite lengthy as the patient and staff work together to identify the barriers and enablers to optimising care and there may be opportunities where the pathway is cyclical as actions are agreed and implemented to improve care

Likewise, it is recognised that patients may have individual circumstances and / or risks which may require an escalation to any stage of the guidance pathway, and this may include an immediate and urgent Multidisciplinary Team (MDT) meeting.

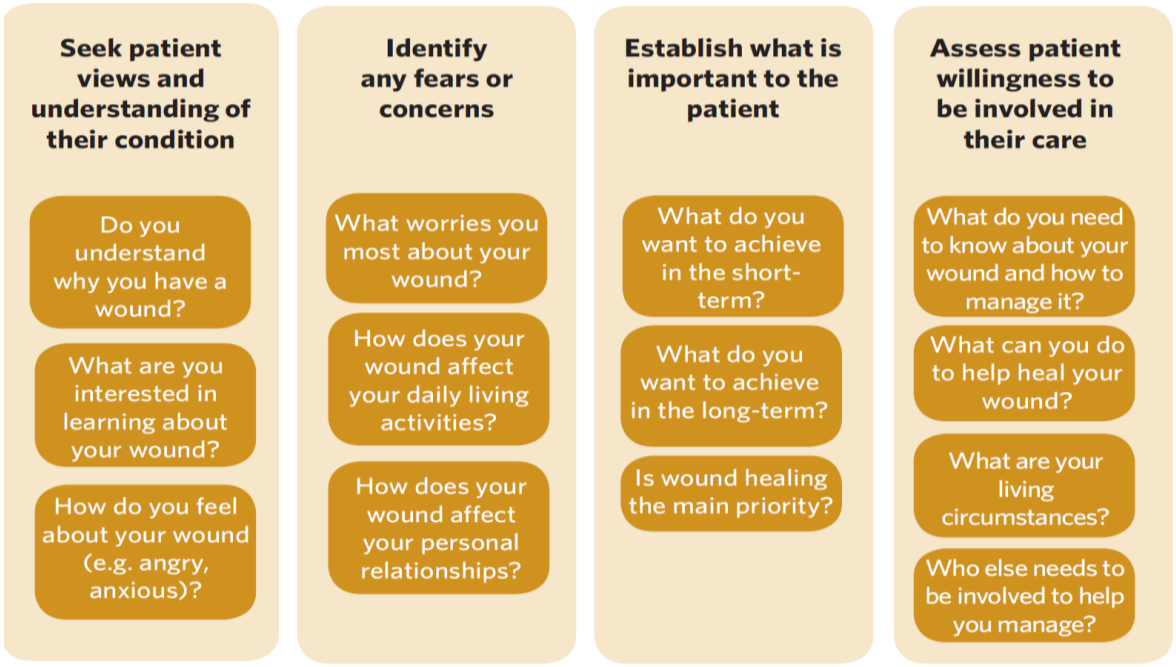
However, once it is evident that a patient lacks engagement to a treatment plan the timeframes to undertake and complete the clinical actions should be adhered to as closely as possible to ensure that all barriers and enablers to care are addressed in order to optimise care and promote patient engagement.

4.2 Additional information to support the clinical actions

4.2.1 First Visit / Appointment

It is vital at the first visit / appointment that the assessing clinician asks the right questions to develop an understanding of the patient's problems and to listen to the patient and what is important to them. This communication allows the clinician to understand the issues clearly from a patient perspective. Clear and concise communication and engaging the patient in this way can lead to improved adherence and better patient outcomes.

Fig 1: Question Builder: A discussion tool for identifying levels of patient involvement



Whilst the above Question Builder focuses on wound care the structure and questions are transferable across many patient presentations and interventions required.

4.2.2 Patient lacks engagement with treatment plan

Including decisions made by patients at the time of a first visit or appointment.

The **Optimising Care - Risk Assessment**, see Related item 1 should be completed immediately when there is evidence that a patient decides to decline all, or elements, of a best practice treatment plan.

- **Optimising Care - Risk Assessment** can be found within the SystmOne record on the **Community Nursing Assessment-reassessment 2022 > Assessment Tab**
  See Related item 2 Optimising Care – Risk Assessment User Guide
- The **Optimising Care - Risk Assessment** should be completed to identify and capture all the barriers to patient engagement and document all the actions taken to enable the patient to become more engaged with a best practice care plan.
- The above may include involvement of GP, Tissue Viability Service, Professional Lead or another specialist when appropriate.
- Involving the family / carer may also be appropriate at this stage.
- Vulnerable Adults Risk Management (VARM) should also be considered if appropriate.

- The patient's SystmOne care plan(s) should be updated with any actions identified within the **Optimising Care - Risk Assessment**, including the goals and timeframes discussed and agreed.
- Where appropriate the referrer should be informed of the patient's lack of engagement with a best practice care plan
- Immediate escalation to the Caseload Manager should be undertaken if there are any residual concerns or if the assessing nurse is unable to complete all above actions.
- Immediate escalation to other points in the pathway may also be necessary dependant on the individual circumstances and / or risks identified.
- Following assessment, it may be appropriate to discharge the patient from the service

It is essential that there is continued monitoring and review by the INCS of the care plan and actions agreed, within the set timeframes. If there is any lack of patient engagement with the agreed treatment plan evident at any subsequent visit / appointment the next stage of the pathway should commence.

4.2.3 Caseload Manager review

Immediate escalation to Clinical Team leader / Operations Manager may also be appropriate dependent on circumstance.

It is essential that there is continued monitoring and recorded clinical evaluation by the INCS of the care plan and actions agreed, within the set timeframes. If there is any lack of patient engagement with the agreed treatment plan evident at any subsequent visit / appointment the next stage of the pathway should commence.

4.2.4 Clinical Team Leader / Operations Manager review

A joint review of the patient record should take place and include the Caseload Manager and any other member of the team who is relevant to the review.

- At this review the following should be considered:
  - Discharge from service
  - Agreement to a treatment / care plan based on elements of care, treatment and management the patient is willing to accept
  - Escalation to a Multi-Disciplinary (MDT) meeting
- If, at the review, it is deemed all barriers and enablers to improving patient adherence to treatment have been exhausted the Caseload Manager should ensure that the **Patient**

Refusal to Investigation, Treatment or Referral Form (INCS and Podiatry Service) is signed and the patient is given a copy

4.2.4.1 Review of the agreed treatment / care plan

When a Treatment / Care Plan is agreed and commenced as part of the process above the decisions made by the patient should be challenged at appropriate clinical opportunities and documented in the SystmOne record with formal review dates as follows:

1. Within 4 weeks of implementing the form
2. At least quarterly thereafter
3. If there is a change of circumstance or an incident
4. Immediately when there is a change in the patients Mental Capacity

The formal review should address the following:

- Has the patient / carer changed their decision?
- Have you reviewed all the questions and actions listed on the initial assessment? (Complete a new one if circumstances or multiple actions have changed)
- Are there any new actions?
- Is the care / treatment still recommended for the patient?
- Patient choice actions agreed? – add to action plan if appropriate

If there is any lack of patient engagement with the agreed treatment plan evident at any subsequent visit / appointment the next stage of the pathway should commence.

4.2.5 Multi-disciplinary Team (MDT) meeting

See: CHCP Ref 1216 Multi-Disciplinary Team Meeting Integrated Nursing and Conditions Service Standard Operating Procedure**.**

4.3 Discharge

It is important to establish the exact issue when patients lack engagement to a best practice care plan, and it may be that other Policies, Procedures, Protocols and Guidance documents are relevant to support their care and management as below:

Ref 673: CHCP Management of Patients Who are Late / Do Not Attend (DNA) appointments and Failed home visits – Integrated Nursing and Conditions Team Hull and East Riding Guidance

Ref 247: CHCP Policy on the Prevention and Management of Violence and Aggression at Work

4.4 Patient information

All patients should be provided with the relevant information, in plain language, and access to the resources they need.

It is important that patients are provided with information about their own care, but this needs to be at an appropriate level tailored to the individual.

The information should be delivered in the best way and at the appropriate rate, however, it is important not to 'overload' as this may cause patients to switch off and not take in or remember important information.

Patients should be given the chance to ask questions, and information for them to take away can be very useful and may include a printed copy of their care plan.

Different formats of information sharing should be considered e.g. written or audio information or directing patients to relevant web sites etc.

Contact numbers - It is essential that patients and / or carers are always provided with details of who to contact, and how to contact them, following any appointment / or home visit.

4.4.1 Carers support

The patient's carers should also be offered referral to the Carers' Information and Support Service (CISS) where they are able to access advice and information about services and financial support which may help to make their lives easier when they are supporting a loved one, family member or friend who is ill, frail or disabled.

4.5 Referral back into the service

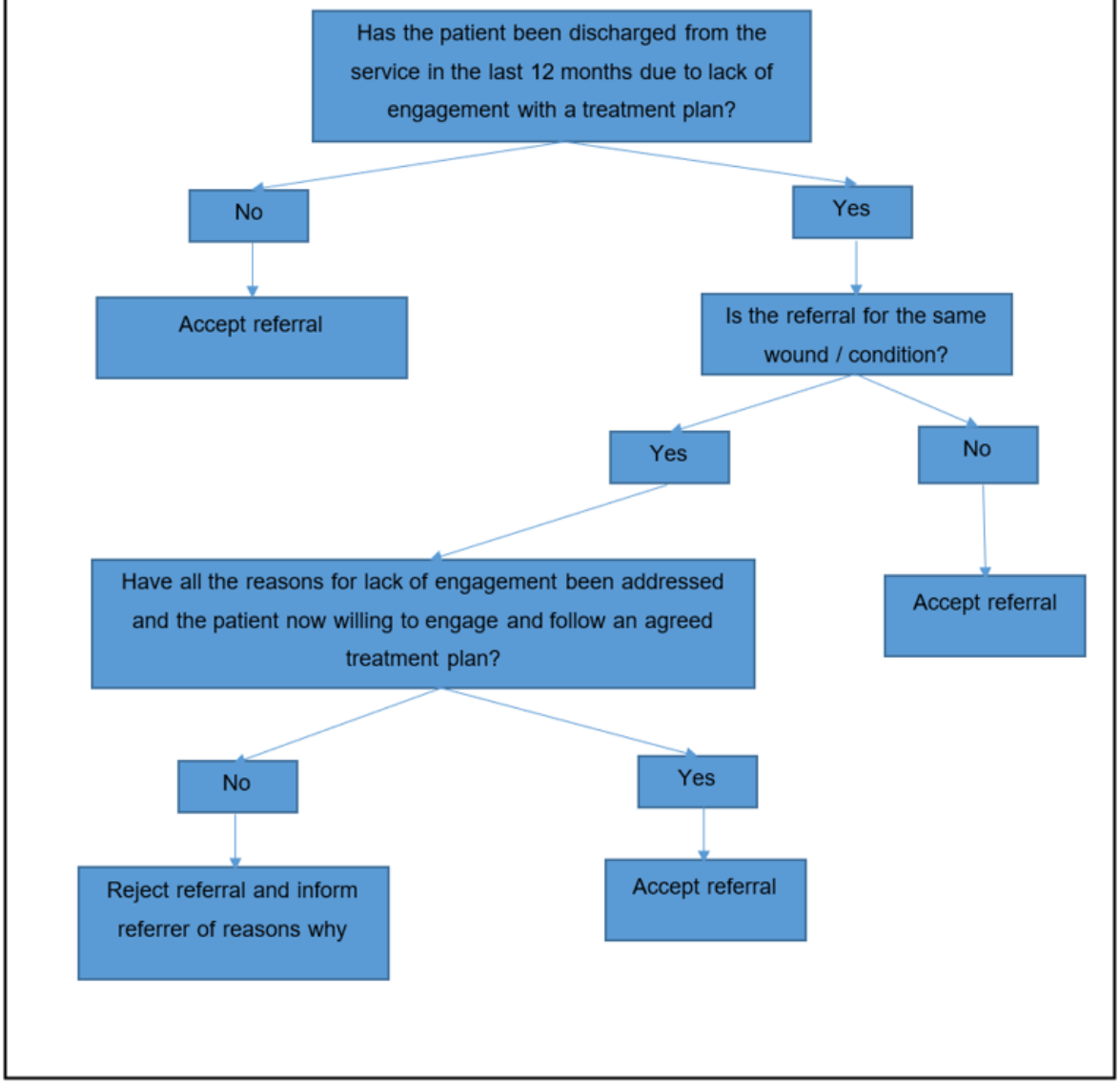
Discharge from the service due to lack of engagement with a treatment plan is valid for a period of 12 months and pertains to the treatment the patient was receiving at that time.

Discharge greater than 12 months old will be invalid, hence the patient should be accepted back into the service for assessment and care.

If the patient is re-referred with a different treatment / problem at any time an appointment must be given / home visit offered but the same processes will be applicable to the new problem.

ACCEPTANCE OF REFERRALS FOLLOWING DISCHARGE FOR PREVOUS LACK OF ENGAGEMENT

- flow chart for Shift Coordinators / Caseload Managers



5. COMPLIANCE, MONITORING & REVIEW

The application of this guidance will be discussed and reviewed within clinical supervision.

The Operations Manager for Nursing and Conditions and / or Clinical Team Leader will be responsible for ensuring that staff implement and follow the guidance within this document during managerial supervision.

This guidance will be reviewed every 3 years or sooner if prompted by changes in legislation or best practice requirements.

6. TRAINING & OTHER RESOURCE IMPLICATIONS

Prior to undertaking any care as described within this document all staff with an identified role and / or responsibility must access, read and sign up to this document via MyCompliance.

In addition, staff working within the INCS should identify their own knowledge and skill requirements in line with their role and / or responsibility and identify requirements within clinical supervision and development reviews.

7. REFERENCES, ASSOCIATED DOCUMENTS, NATIONAL GUIDANCE & RELATED ITEMS

References:

- CHCP Ref 629 Mental Capacity and Deprivation of Liberty Safeguards Standard Operating Procedure
- CHCP Ref 673 Management of Patients who are Late / Do Not Attend (DNA) Appointments and Failed Home Visits within Integrated Nursing and Conditions Service Guidance
- CHCP Ref 247 Policy on the Prevention and Management of Violence and Aggression at Work
- CHCP Ref 359 Discharge from Community Services
- CHCP Ref 1216 Multi-Disciplinary Team Meeting Integrated Nursing and Conditions Service Standard Operating Procedure
- EPF Position Paper March 2015 Adherence and Concordance
- NICE Guidance About shared decision making | NICE
- Patient engagement (World Health Organisation (WHO) 2016) content

- Vulnerable Adults Risk Management (VARM) Health and Wellbeing – Hull

Associated Documents/National Guidance:

- CHCP Ref 34 Consent to Treatment Policy
- International Best practice Statement – Optimising Patient Involvement in Wound Management Wounds International – Delivering latest news and innovative content for wound healing.
- Optimising Wound Care through Patient Engagement Wounds International – Delivering latest news and innovative content for wound healing.
- NHS Royal Wolverhampton NHS Trust:

  Patient Autonomy Risk Assessment Pathway (MI-431814-24.09.19-V-2)

  Patient Choice Action Plan (MI-43762142-24.09.19-V-3)

Related Items:

Related item 1 – Optimising Care Risk Assessment

Related item 2 - Optimising Care Risk Assessment User Guide

8. APPENDIX A – ABBREVIATIONS & DEFINITIONS

8.1. Abbreviations:

CHCP CIC	City Health Care Partnership Community Interest Company
CISS	Carers' Information and Support Service
EPF	European Patients' Forum
GP	General Practitioner
INCS	Integrated Nursing and Conditions Service
MDT	Multi-disciplinary Team
NICE	National Institute for Health and Care Excellence
SOP	Standard Operating Procedure
VARM	Vulnerable Adults Risk Management
WHO	World Health Organisation

8.2. Definitions:

SystmOne (S1)	Electronic Patient Record

9. APPENDIX B – ROLES & RESPONSIBILTIES

Professional Leads / Clinical Practice Teachers

- provide / facilitate updates to staff and individual training when necessary
- facilitate staff to implement the guidance
- support review of the guidance at agreed time intervals or when process changes

Operational Managers / Clinical Team Leaders

- share information contained within the guidance with teams
- ensure staff compliance to the guidance

All Clinical Staff

- must follow the guidance as documented below and in accordance with all other relevant CHCP Policies and SOPs

10. APPENDIX C – VERSION CONTROL AND AMENDMENT LOG (FULL HISTORY)

Version No.	Type of Change	Date	Description of change(s)	Author
V1.1	Amendment	08/2023	Risk Assessment Questionnaire name change	Angela Hind
V1.2	Amendment	01/2024	Standardisation of care plan names and clarification of capacity	Angela Hind
V2	Full Review	06/2026	Full document review	Angela Hind