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Accessible Summary

What is known on the subject?

- A written plan is designed to improve communication and co-ordinate care between mental health inpatient wards and community settings.
- Reports of care plan quality issues and staff and service user dissatisfaction with health care bureaucracy have focused on working age mental health or general hospital settings.
- Little is known about mental health staff perspectives on the value of written care plans in supporting dementia care.

What this paper adds to existing knowledge?

- Competing demands on staff time and resources to meet administrative standards for care plans caused a tension with their own professional priorities for supporting care.
- Mental health staff face difficulties using electronic records alongside other systems of information sharing.
- Further exploration is needed of the gap between frontline staff values and those of the local organisation and managers when supporting good dementia care.

What are the implications for practice?

- Frontline staff should be involved in designing new information systems including care plans.
- Care plan documentation needs to be refocused to ensure it is effective in enabling staff to communicate amongst themselves and with others to support people with dementia.
- Practice-based mentors could be deployed to strengthen good practice in effective information sharing.

Abstract

Background: Reports of increased healthcare bureaucracy and concerns over care plan quality have emerged from research and surveys into staff and service user experiences. Little is known of mental health staff perspectives on the value of written care plans in supporting dementia care.

Aim: To investigate the experiences and views of staff in relation to care planning in dementia services in one National Health Service (NHS) provider Trust in England.

Method: Grounded Theory methodology was used. A purposive sample of 11 multidisciplinary staff were interviewed across three sites in one NHS Trust. Interviews were transcribed, coded and analysed using the constant comparative method.

Findings: Five themes were identified and are explored in detail below: 1) Repetition; 2) the impact of electronic records on practice; 3) ambivalence about the value of paperwork; 4) time conflicts; and 5) alternative sources of information to plan care.

Discussion: Participants perceived that written care plans did not help staff with good practice in planning care or to support dementia care generally. Staff were frustrated by repetitive documentation, inflexible electronic records and conflicting demands on their time.

Implications for practice: Frontline staff should be involved in designing new information systems including care plans.

Keywords: Care plans, Dementia care, Practice development, Quality of care, Staff perception

Relevance Statement

Written care plans serve both an administrative and clinical function in mental health nursing. In dementia care they can be a useful therapeutic tool to communicate a person's needs and an individualised way to meet those needs when the person is at their most vulnerable. However the evidence in other areas of mental health nursing suggest quality issues with care plans and staff and service user dissatisfaction with a perceived increase in health service bureaucracy. Evidence in dementia care settings on how care plans are used by staff to support service users and carers is lacking.

Introduction

Written care plans are considered fundamental in supporting good quality care, particularly as a 'means of communication among team members who cannot meet as a group.' (Schultz & Videbeck, 2009, p23-24). Created in the context of different influences, daily progress notes and care plans are legal documents and there are national laws, professional guidelines, and local policies that govern the standards of record keeping in care environments (Department of Health 2008, Department of Health 2010, NMC 2015, ICO 2016). Mental health care planning documentation is produced in this environment of macro influences, alongside micro determinants such as local standardised paperwork,

ward/team culture, individual staff understanding and training, and the level of service user involvement.

In England the main framework for mental health care planning is the Care Programme Approach (CPA).

Introduced in 1990, as a structured approach to planning care for those people with mental illness, the CPA was proposed to address the co-ordination of care from hospital discharge into the community and promote communication between different agencies (Department of Health 1990). More recent CPA guidance (Department of Health 2008) emphasised the collaboration of service users and carers in developing a personalised plan of care.

The UK's National Dementia Strategy (Department of Health 2009) and 'Quality Outcomes for people with dementia' (Department of Health 2010) also stressed the need for individualised care planning to self-manage dementia, whilst knowing how to contact services when needed. However it is recognised that it can be time-consuming and challenging to engage dementia service users in care planning. Adams (2008) argues a “double vulnerability” of disability to service user involvement (p280) as people with dementia often have mobility or sensory impairments additional to their problems with understanding and expression.

Internationally, care plans and documentation are key features of most care delivery systems in mental health and other complex conditions (Goodwin et al. 2013, Thiel 2013) yet there has been little structured research undertaken (Van Houdt et al. 2013). A small number of studies have explored staff attitudes in relation to care planning in different settings. These include evaluations of new developments such as electronic care planning (Lee, 2006, Dahm & Wadensten, 2008), a specific type of care plan model or way of recording care planning (Murphy et al. 2000, Berger, 2006, Jansson et al. 2011). Others have looked at transitional points of care and how care planning operates across care systems (Jones & Bowles 2005, Cranwell et al. 2016). In the UK this has included staff, service user and carer views in relation to CPA care planning in England and Care and Treatment Plans in Wales (Simpson 2005, Simpson et al. 2016). A small number of international studies have highlighted quality issues, stressing the difficulties nurses have in linking care documentation to the care they deliver (Sainsbury's Centre for Mental Health 1998, Tunmore & Thomas 2000, Voutilainen et al. 2004, Tornvall & Wilhelmsson, 2008), a theme that emerges in a systematic review of research methods used in evaluating care documentation (Saranto & Kinnunen, 2009).

However, none of these studies have looked exclusively at staff use of care plans with dementia service users.

In the UK there have been reports critical of the quality and relevance of both inpatient and community care plans in mental health settings (CQC 2009, CQC 2015), alongside reports condemning increasing bureaucracy, the quantity of paperwork and the resultant pressures on staff (Cunningham et al. 2012, DoH 2012, RCN 2013, Simpson et al. 2016). Similarly, research studies suggest ongoing dissatisfaction among staff and patients that healthcare professionals spend too much time completing paperwork at a perceived cost to time spent with service users (Sullivan 1993, Moyle et al. 2003, Simpson 2005, Simpson et al. 2016). However, with the exception of Moyle et al. (2003) in Australia, current literature is limited to working age adult mental health settings.

Yet, care and support is planned and takes place on dementia wards and in the community and people receive services between these settings. With policy emphasising the importance of individualised care planning in dementia care, it is important to explore the experiences of staff writing and using care plans in those settings.

The aim of this study was to investigate the experiences and views of staff in relation to care planning in dementia

services in one National Health Service (NHS) provider Trust in England. The objectives were to explore:

- a) The value to care staff of information in written care plans that accompany a service user moving in or out of different dementia care settings;
- b) How staff in these different dementia inpatient and community settings perceive that care plans inform their delivery of care on a day-to-day basis; and
- c) How staff access and use other sources of information to inform and communicate care.

Methods

Design

A grounded theory qualitative interview study (Corbin & Strauss, 2008) was used to explore the experiences of staff in relation to care planning in dementia services.

Originally developed by Glaser and Strauss (1967) grounded theory focuses on the processes of interaction between the social roles and behaviour of individuals (Holloway & Wheeler, 2002; McCann & Clark, 2003). As there is little available peer-reviewed literature on care planning in dementia services, grounded theory was identified as an appropriate methodology to conduct an initial exploration of the topic.

Setting

The study was conducted in three different dementia settings in a diverse inner city area of London, England: one 21-bed inpatient mixed gender dementia assessment unit (DAU); one 18-bed inpatient mixed gender dementia continuing care unit (DCC); and a community mental health team (CMHT) working with service users mostly of 65 years and above, commonly with a diagnosis of dementia or needing an assessment for suspected dementia.

Participants

Participants were purposively selected; the main inclusion criteria was to include staff who read, wrote or evaluated care plans and related documentation. In the two ward settings this included qualified and unqualified staff, including nurses, nursing assistants, occupational therapists and psychologists. In the CMHT this was predominantly qualified staff, including nurses, social workers, occupational therapists and psychologists. Initial exclusion criteria were administrative and domestic staff, as their roles would not require them to read and write care plans. Also, medical staff, as although they participate in developing care plans through multi-

disciplinary discussions, they do not routinely write or evaluate these care plans.

Ethics

The NHS Trust's Research Ethics Committee (REC) approved this study as a service evaluation, prior to its submission to City University's School of Health Sciences Research Ethics Committee (REC) for scrutiny and approval in October 2013 (Ref: MSc/13-14/21). The REC required that the research sites selected excluded any in which the researcher had supervisory or managerial relationships with staff to minimise bias or staff resistance. The lead researcher also attended staff meetings to assure staff that the purpose of the study was to identify what informs care rather than scrutinise care delivered. Participants were assured of confidentiality and anonymity and informed that participation was voluntary and they could withdraw from the study at any time. At the request of the REC, detailed demographics on participants were *not* collected given the risk of identification in a small localised sample.

Procedure

An initial e-mail was sent to the managers of the three teams to request the lead researcher meet staff at a team meeting, prior to any recruitment. This enabled potential

participants to consider the aims of the study without pressure, and to ask questions. Staff were left the participant information sheet to consider in their own time. The researcher subsequently arranged to meet with individual staff interested in participating to further explain the study, respond to any queries and obtain consent if they agreed to participate. Initially seven out of 38 staff responded and agreed to participate. A further four staff were recruited after the researcher attended additional team meetings to encourage allied professionals and unqualified staff to participate.

Data Collection

Data were collected using semi-structured interviews from November 2013 to February 2014. Interviews were conducted and digitally recorded by the lead author in all three settings concurrently, and transcribed verbatim. A topic guide with questions and possible prompts was used (see Table 1) and interviews lasted an average of 40 minutes (range 22-61 minutes).

Insert Table 1: Example interview questions and prompts

Public Patient Involvement and piloting

The initial study proposal and a list of possible interview questions were discussed with a 14-member mental health service user and carer research advisory group (SUGAR) (Simpson et al. 2014). These potential questions were drawn from the review of the literature and consultation with a group of clinical researchers. The SUGAR group's comments led to the removal of questions which didn't adequately match the aims and objectives of the study and the inclusion of questions on staff views of service user and carer involvement in care planning. This draft schedule was piloted with two members of the dementia community team (a social worker and nurse) where the researcher worked. Their feedback helped clarify whether questions elicited the data sought to meet the study's aims and objectives. Further changes to question wording were made to make them more open and exploratory.

Analysis

Each transcript was read by the lead author several times to engage with the data. Coding began with a sentence-by-sentence, word-by-word analysis to identify words or phrases that appeared meaningful. This initial stage of

‘open coding’ (Corbin & Strauss, 2008) began once the first interview was transcribed and continued alongside further data collection in keeping with grounded theory. This provided an opportunity to tailor further interview questions accordingly.

Coding was conducted by the first author and discussed with the second author who reviewed transcripts and coding during regular supervision sessions. Initial coded data were further analysed in a constant comparison with subsequent data collected and then checked by the second author. Gradually, axial coding led to the collating of codes within over-arching themes and categories. This process led to further exploration of the literature and theoretical sampling as the researcher followed indications in the themes and made efforts to recruit more allied professionals and unqualified staff. Because of the scale of the study and time limitations it was not possible to conduct selective coding to identify a single over-arching category, relating all sub-categories or themes.

Findings

A total of 11 staff participated: eight registered mental health nurses, one allied professional, and two nursing

assistants. Four of the eleven interviews were conducted in the CMHT, four on the dementia assessment unit and three in the continuing care ward.

Five themes were identified and are explored in detail below: 1) Repetition; 2) the impact of electronic records on practice; 3) ambivalence about the value of paperwork; 4) time conflicts; 5) alternative sources of information to plan care. All five themes are illustrated with anonymous quotations, appended with the type of team and unique participant identifier (e.g DAU01).

1. Repetition

Whilst over half of those interviewed spoke about the increasing amount of care plan documentation in recent years, an overwhelming experience expressed by all staff was of seemingly pointless and time consuming repetition in the paperwork required of them to document care.

Staff discussed the repetitive content of care plan templates, as well as duplication of processes regarding documentation imposed by the team, the Trust and nationally by the NHS. However, at times it suggested a misunderstanding of the reasons for updated care plans to be transferred between teams, as articulated by this ward nurse:

“I find that if they (CMHT) refer to us, we should not do the repetition of sending another CPA (document)... back to them, because they have already sent the patient to us.” (DAU01)

With regard to the structure of the paperwork required, another member of staff said she felt ward-designed templates had encouraged repetition:

“I think... it is down to the ward...there are some paperwork, which I think we can combine together...I think that is just double job!” (DAU04)

Some questioned whether the repetitive structure of care plans would cause others to miss important information being communicated, resulting in a negative impact on care delivery. CMHT staff particularly articulated this about the CPA document; one stated that GPs complained to her that the CPA document was too long and it put them off reading it. Another CMHT nurse said this was also an issue with sharing a copy of the care plan with carers, and they used the last doctor’s clinic letter for a summary of pertinent information. Ward staff spoke of utilising either the Decision Support Tool (DST) (DoH, 2012) assessment document or the previous ward’s discharge summary in preference to the CPA care plan, for the clearest, most relevant information to inform care.

Paradoxically, despite this experience of repetition, some staff explained that they added additional 'boxes' to the formatted CPA paperwork, as they could not express in the existing structure the needs of someone with dementia:

“I have often inserted a box in the care plan and written some extra stuff in, just so it is recorded somewhere” (CMHT02)

2. The impact of electronic records on practice

All staff interviewed expressed mixed feelings about the impact of electronic records on the day-to-day structure of their work and flow of communication including written care plans between different clinical areas.

One advantage of the system introduced 18 months earlier, was that it provided staff with another resource to aid their 'detective work' to support someone with dementia who might not be able to reliably express themselves. However rather than sharing current care plans stored electronically, staff claimed that it was particularly helpful in accessing background and

historical information on individuals, for example,
previous history and risks.

“the personal history profile can be useful, just
towards understanding why the person is as they
are...the thing is the current care plan does not
really give you anywhere to put that” (CMHT02)

Staff across all three areas acknowledged that despite
saving some time by making it easier to share information
across teams based in different locations, overall the
electronic record was time-consuming to access and the
particular type of database used had limited functionality.
This was a source of frustration for staff, who wanted to
use the technology available to save time on paperwork
and be freed to spend time on patient care. Instead using
an electronic record sometimes limited their work, by
physically taking them away from contact with service
users and carers to access a computer.

“it’s time consuming, because this time we are
sitting down typing that part of the CPA, we can be
spending with our patients, that quality time on a
one-to-one” (DAU01)

Ward nursing staff, in particular, commented on the 'pressure' and guilt they felt in leaving the 'floor' to complete care plans on the computer, noting that previously they could still be on the ward when using paper records. One nursing assistant, with over 20 years' experience, explained:

“writing is important, writing is communication....but we should not leave the patient for writing....when we were writing on paper ...we sometimes write sort of sitting with the patient...but now we are writing on computers ...it takes away from patient care” (DAU03).

3. Ambivalence about the value of paperwork

The analysis identified real ambivalence amongst staff about the purpose and usefulness of care plans and other documentation, which was often at odds with their own awareness of the rationale and professional requirements for recordkeeping.

Most staff interviewed spoke of knowing that there was an importance in writing documentation. However, there seemed an underlying contradiction between staff acknowledging this importance, and the value they put on paperwork as 'real work'. Frequently, staff made clear

statements, usually earlier in the interviews, that paperwork was a priority for ensuring good care:

“it’s important, for the type of work we do....especially the content....you write it in a way that everyone can read and understand it, then it will be good” (DCC02)

Yet this often belied comments made later in which staff questioned who actually read the paperwork produced and called reading care plans at the start of a shift 'time-wasting. Some staff talked in disempowered ways regarding the ownership of the documentation they spent hours writing and declared a belief that policy standards for documentation were more to do with performance management than delivering care.

“part of me always wonders if it is a bit of a tick box... about all these kind of management things... they don’t want anything to come back to them” (CMHT03)

A specific issue amongst the CMHT staff emerged: all four interviewed spoke of wanting documents and processes that worked as the CPA should, but none seemed to identify the current policy as enabling them to do that.

Instead community staff discussed their wish to have a care plan for the multidisciplinary team (MDT) that summarised succinctly the pertinent information regarding the dementia service user, enabled communication across different parts of the service and that could be referred to in a crisis. All of these aspirations are tenets of the Trust's CPA policy, in accordance with national guidelines, but this is not how these staff were experiencing it in practice. In fact, they described the CPA documentation as a barrier to achieving good practice. One nurse said:

“make it relevant to dementia care rather than just being this performance, that performance, because... then it would feel like our paperwork, because then if we were going to present it to anybody... they would be able to pick it up and say ‘oh! yes, I can see where you are going with this’.”
(CMHT04)

When all staff were asked directly about the positive aspects of paperwork they described it as a way to reflect and see patterns that might help in their work with patients. However, in comparison to negative comments made these answers did not come readily, and some staff seemed surprised or confused by the question and

thought a while before answering. The majority of data included under this theme was either obviously negative, betrayed an underlying resentment of paperwork, or questioned its usefulness. One nurse questioned:

“you're thinking who's actually gonna read this?”
(CMHTo4)

A few staff remarked that they thought they were the main person to read their own care plans, and then only when they came to review them. However, there was evidence from ward staff that they read community CPA care plans, and found them useful. However, this was when they had time, sometimes later on in a person's admission.

“there was a patient...I don't think I read his CPA care plan, but sometimes when you do night duty...you have some time to read the care plans....it's very helpful, if not it's just like going into an unknown”
(DCCo1)

4. Time conflicts

Time conflicts for staff were identified as an important theme, illustrating the struggle staff had with the value of

their time in and out of work. The subject of time came up frequently throughout interviews, but it was more complex than staff just saying they did not have enough time. Staff spoke of 'juggling' competing demands in the time they had, 'creating time' and the 'struggles' with time. Five of the eleven staff said that they completed paperwork outside of their contracted work hours. Some said this was their choice, others implied that there was no other way to fit everything in. Some gave examples of trying to better organise the time they gave to clinical and administrative work, planning it with supervisors or management, but ultimately felt it was expected by the same supervisors that the clinical work take precedence.

“I’ll say to my manager “I want to allocate two days... I just wanna do care plans only” ...that's when two or three clients something happen, so you have to run out and before you know it, the end of the month come in... and it's flagging up, you need to write this and that, so you feel a bit pressured to finish the care plan.” (CMHT01)

All staff talked in detail and with genuine compassion about the labour-intensive nature of working with people with dementia, and the network of carers and

professionals involved. Staff described dementia service users' reliance on them sometimes for even their most basic needs, as they were affected by disorientation, memory loss and personality changes.

“Because they are relying on us, so most of the time we are with them...or if the family come...it can be really, really difficult to get to the paperwork” (DCCo2)

Staff spoke of the risks that dementia service users faced, including falls, physical health problems, and vulnerability in the community. They talked about balancing these risks with promoting independence and putting effort into understanding and improving the quality of life of people in their last years. They explained that this work cannot be rushed, is emotionally taxing and many, particularly ward staff, expressed anxieties and guilt at using time on paperwork during their 'clinical' hours. Yet across all areas staff quantified the hours, or even days, that go into completing certain lengthy CPA and Decision Support Tool (DST) documents:

“ the CPA document, which is very huge, and there is another one, which is a big document it's a

DST...which takes about six, seven hours to complete” (DAUo2)

This constant quantifying of administrative tasks by staff demonstrates the regular conflict that goes on for them in how they spend their time. This was borne out by the antagonistic or passive phrases used to describe time in relation to completing paperwork alongside clinical work, and their time off duty. These included talking of time “pressure” (CMHTo1); having “more paperwork imposed upon us” (CMHTo2) and the effect this had on planning time; “we don’t get the time” (DCCo3) and managers trying to “accommodate our time to write...but I could not make time” (DAUo3).

5. Alternative sources of information to plan care

All staff interviewed identified and discussed other sources of information that they relied upon to plan and inform day-to-day care. These differed across the CMHT and wards, and also highlighted a difference between the nursing assistants and qualified staff. On wards, the verbal handover was unanimously discussed as the key source of information to provide day-to-day care, followed by daily progress notes, if staff referred to a

written record. However, the two nursing assistants put more emphasis on reading the care plans of those patients allocated to them for a shift. Qualified ward staff were less likely to read care plans on a shift, either because they wrote the care plan themselves, or because they were allocated patients they knew from admission.

“I’ve not read a care plan today, but I know because I have done (written) the care plans, so I know, and ...I read the computer notes” (DAU01)

Although ward staff spoke about the importance of information from family and carers, particularly at the start of an admission, they did not identify their input as vital day-to-day, once they got to know someone on the ward. However, in the community where staff were concerned more about the levels of unknown risk, the input of family and paid or unpaid carers, was crucial as an alternative source of information, overriding written care plans. Both groups of staff described their own observation of a service user, through their therapeutic relationship as being highly informative to their care.

“we get the information from the referrer, but then mostly from the family and getting to know the patient....don’t assume because they have

dementia they don't know what they are doing”
(DCCo2)

In the community this was qualified by the need to test observations with reports from carers or family. None of the staff stated that written care plans were central to their provision of care on a daily basis.

Discussion

In considering the overall aim of this study the staff experience is more complex than 'too much paperwork, not enough time'. The key findings reflect those found previously in other settings which indicate that nursing does not necessarily support the provision of safe, quality care and continuity. Nurses often utilize 'shadow' recordkeeping systems to aid in immediate patient care activities and decisions (Keenen et al. 2008). There is also a largely negative attitude towards formal care planning. Competing demands on dementia staff time and resources to meet national and organisational goals for care plans created tension with their own professional priorities in supporting care. Similar results are reported in a survey of 2,917 registered nurses working across 401 medical/surgical wards in England, where time and workload pressures resulted in care activities being left

undone. This included talking with patients and developing and updating care plans (Ball et al 2013).

Regarding the study's objectives, the first concerned the flow of information that may go with a dementia service user into different parts of the healthcare system. If it is accepted that a care plan is valuable in communicating key information, this becomes crucial as someone transitions in and out of different settings, such as between hospital and community services (Jones & Bowles, 2005, Cranwell et al, 2016). This is especially so for people with dementia who may not be able to reliably communicate care information for themselves (Kitwood 1997, Walsh, 2006, Brooker, 2007).

Staff struggled to explicitly identify this importance and attached only limited value to written care plans in supporting care at transition points. The care plan templates and other documentation were described as lengthy and repetitive, and staff were concerned key messages would get lost. Yet they sometimes added sections to documentation, making it even longer. This reflects an earlier study of nurses in acute elderly care wards who were found to develop their own unique methods for obtaining and using information to guide patient care separate to formal care plan processes

(Hardey et al 2000). It is important to note in the present study that whilst the majority of repetition of care plan content and processes seemed to be enforced by the interpretation of national and Trust policies, some of it was self-imposed by individuals or teams. Yet, reflecting findings in a UK survey of registered nurses (Cunningham et al. 2012), dementia staff interviewed here expressed the waste of time this repetition represents to them. Given the stated complaint of the burden of repetition, against reports of staff adding more to the documentation, it is crucial to consider what drives this contradiction.

Menzies (1970) emphasises the use of “checks and counter-checks” (p16) and ritual of tasks, to counteract the anxiety faced when making decisions in health care systems. The repetition of processes described here regarding documenting care could serve a purpose in assuaging the anxiety felt by the individuals and/or the organisation, and therefore become a 'good reason' for repetition (Garfinkel, 1967). Sub-conscious functions of repetitive documentation would need to be addressed if recommendations for improving practice are to succeed.

In exploring the second and third objectives regarding the value of care plans to daily care and alternative sources of

information, it became apparent that staff use an electronic record alongside a number of systems for recording and sharing care. These include verbal handovers, discussions with carers and other written records. This may partially account for the experience of repetition. Staff found the new shared electronic record helpful in communicating information across different teams in the Trust. However, they were frustrated by the limitations of the database used and resentful of technology removing them from time with patients and carers. These findings concur with other UK studies that sought staff views (Ballard, 2006, Simpson et al. 2016) and a Swedish study specifically seeking views on electronic care planning in a general hospital (Jansson et al, 2011). This suggests organisation-imposed information systems are failing to support staff in the way intended and frontline staff must be involved in quality improvements to these systems (Cunningham et al., 2012, RCN, 2013, Brown et al. 2015).

Taken together these themes indicate that written care plans in dementia settings in this Trust are expected to serve too many purposes, which cannot easily be distilled into one or two all-encompassing documents. This creates an inherent tension which individual staff and teams then experience in trying to complete these documents.

Currently, written care plans are required to guide individualised dementia care; support service user and carer collaboration; provide MDT communication of care; serve audit requirements; and act as a legal document worthy of public scrutiny. Whilst not all mutually exclusive, it is difficult to meet all these standards in one document, leading to a dilution of quality and decrease in value to different stakeholders. Nurses and other staff need to strongly advocate for the documentary tools that best meet the needs of their patients, families and profession roles.

Strengths and Limitations

Although this study is small and undertaken in one NHS Trust, it was given some breadth by being conducted over three different areas of care, across two London boroughs. Furthermore, the findings echo those identified in other mental health settings and suggest these will be transferrable to staff working in other dementia services. Limitations of time also prevented the inclusion of service users or carers' voices, or an analysis of the care plans themselves. It would be important for any future research to include these.

What the study adds to international evidence

Co-ordinated care is a focus of modern health policy in many countries (Van Houdt, et al., 2013) and collaborative care planning is central to UK mental health policy and practice (DoH, 2008 DoH, 2010; Bee et al 2015, Simpson et al. 2016) This paper adds a useful contribution to current evidence by detailing the value of care plans uniquely to the staff involved in co-ordinating care in dementia settings.

To our knowledge this is the first study of staff experiences of written care planning in dementia services, and illuminates some of the tensions faced by staff trying to use care plans to support care. Staff detailed conflicts with time spent attempting to write care plans alongside delivering good quality but labour-intensive practical care. They also reported contradictory values attached to these two areas of their work. Therefore, these findings add new knowledge to existing studies regarding the perceived burden of healthcare bureaucracy on staff (Murphy et al., 2000, Moyle et al. 2003).

Staff also recounted the repetition of information systems they face and the impact of electronic records on care. In recent years an emphasis on the introduction of electronic records in healthcare systems (Saranto and Kinnunen, 2009) has led to research evaluating their effect in general and primary care settings (Dahm & Wadensten,

2008, Jansson et al. 2011). The tendency for technological advances to take staff further away from direct contact with dementia service users and their families was identified in this study and requires further investigation.

Implications for Practice

This study suggests there is less of a gap between national policy and staff values than there is between staff and the local organisation and managers. To effect real changes to practice, congruence between the goals of frontline staff and management will need to be reached. Existing studies make specific connections between the education of staff and care planning, emphasising the importance of practice-based mentors when implementing positive changes to the quality of documentation (Voutilainen, 2004; Ballard, 2006; Jansson et al, 2011). Our findings suggest the need for a radical rethink in relation to achieving the right balance between documenting and actually delivering effective compassionate practice.

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