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ORIGINAL RESEARCH

Opinions of key stakeholders regarding the inpatient Individual Care Plan

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Objectives: In Ireland, regularly reviewed Individual Care Plans (ICPs) for inpatients at all acute psychiatric inpatient units are a requirement of the Mental Health Act 2001. In this study, we comprehensively evaluated and compared opinions of key stakeholders in relation to the ICP as a care delivery tool.

Methods: We employed a descriptive survey design. Questionnaires were distributed to 123 stakeholders (patients and mental health professionals (MHPs)) to evaluate and compare opinions regarding the impact of the ICP in relation to healthcare delivery and health outcomes, and regarding the structure and frequency of use of the ICP.

Results: Ninety-eight stakeholders (80%) completed study questionnaires. Stakeholders (patients (58%) and MHPs (85%)) reported that the ICP assisted in healthcare delivery. However, different attitudes between groups were noted in relation to whether the ICP contributed towards healthcare outcomes, with 64% of patients, but only 41% of MHPs reporting that the ICP positively contributed to mental healthcare outcomes. Some free-text comments described patient dissatisfaction with the role of the ICP for healthcare delivery, and MHP dissatisfaction that the ICP was time-consuming and did not significantly enhance standard patient care.

Conclusion: Whilst the implementation of the ICP is generally viewed positively by both patients and MHPs, considerable dissatisfaction by MHPs was also noted with certain aspects of how the ICP was delivered in practice. Practical adjustments to the implementation of ICP in order to build more positive stakeholder experiences appear warranted and worthy of further research.

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Key words: Individual Care Plan, patient care planning, patient care management, mental health services, survey and questionnaires.

Introduction

The Mental Health Act 2001 (MHA 2001), enacted on November 1, 2006, was introduced as the legislative framework within which a person with a mental disorder could be admitted and treated involuntarily in the Republic of Ireland (ROI) and replaced the existing legislation, the Mental Treatment Act 1945. The Mental Health Commission (MHC) is the independent body that oversees the appropriate functioning of the MHA 2001 and promotes good practices in the delivery of mental health services. One such practice is based on Regulation 15 of the MHA 2001, which states that each patient admitted to an approved centre (including both on a voluntary and involuntary basis) must have an individual care plan (ICP). The MHA 2001 defines an ICP as 'a documented set of goals developed, regularly reviewed and updated by the resident's multidisciplinary team (MDT), so far as is practicable in consultation with each resident' (MHA, 2001). The Judgement Support Framework has been developed by MHC as a guidance document to assist approved centres to comply with the MHA 2001. This framework defines regular reviews of the ICP as weekly in an acute setting and at least every 6 months for residents in a continuing care facility (MHC Judgement Support Framwork, 2020).

The ICP is designed to specify the treatment and care required in accordance with best practice, identify necessary resources available to the patient and specify appropriate goals for the patient, with the ICP recorded in 'one composite set of documentation', in the patients' clinical notes and a copy of which is provided for the patient (MHA, 2001). In this regard, it is important to distinguish between individual 'care planning discussions' which occur regularly between clinicians and patients in standard ward interactions and which most patients with long-term conditions describe having and deriving benefit from (Burt et al, 2012), and documented individual 'care plans' which are the subject of the current study.

In recent years, MHC annual reports suggest that many approved centres have experienced difficulty

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maintaining standards set by the MHC in relation to the ICP (Regulation 15 of the MHA 2001). For example, in 2014, only 41% of approved centres were fully compliant with this Regulation and nine approved centres subsequently had a condition added to their registration, necessitating monthly clinical audits of ICP compliance rates (MHC Annual Report, 2014). Despite this, no improvement in rates of compliance were noted (36% in 2016, MHC Annual Report, 2016). In 2017, the MHC developed report templates for ICPs for all approved centres which succeeded in increasing the compliance rates with Regulation 15 to 58% in the subsequent year (MHC Annual Report, 2017; MHC Annual Report, 2018).

Currently, in the ROI, the standard ICP generally consists of sections for both patients and members of the multidisciplinary clinical team. The ICP is offered to patients to complete and is reviewed and completed by the treating clinical team usually at weekly MDT meetings in collaboration with the patient. The ICP is thus intended to enable patients communicate with their clinical team in relation to a variety of needs including views regarding their hospitalisation and management, discharge planning and other specific requests.

Whereas care planning discussions occur for most patients with long-term conditions, the production of a documented care plan is less common and the benefits of its universal implementation remain unclear (Burt et al. 2012). A systematic review that examined patient involvement in collaboratively planning their healthcare across a range of medical specialties demonstrated both staff and patients found (albeit not universally) such collaborative work rewarding, that staff subsequently expressed more favourable attitudes towards patients and that patients attained increased information regarding the health service providing their care. However, this collaborative approach was not conclusively associated with a greater quality of care, improved patient health outcomes or increased patient satisfaction with care received (Crawford et al. 2002). In relation to patients admitted to psychiatric inpatient units, there is currently limited data examining the impact of an ICP. A recent qualitative study examining care planning in a psychiatric inpatient unit in Australia noted that patients valued being involved in the development of their ICP which for some was viewed as important for their recovery. However, patients also reported that their ICP was not well integrated into their wider management plan and described feeling largely excluded from decisions pertaining to their care, despite the use of an ICP (Reid *et al.* 2018). This study supported a number of previous findings demonstrating that patients treated for mental health disorders have a strong preference to be actively and collaboratively involved in decisions pertaining to their management (De las Cuevas et al., 2011; Perestelo-Perez et al. 2011).

Throughout this paper, we use the term 'healthcare delivery' to refer to the communication and implementation of healthcare interventions and 'healthcare outcomes' to refer to the whether those interventions have had an impact on symptoms and functioning. The interplay between these is complex and beyond the scope of this paper (Cowing et al., 2009, Glickman et al., 2007).

The ICP was designed to specify appropriate treatments and improve care delivery for patients; however, to date, to our knowledge no published studies have evaluated patients and mental health professionals' (MHPs) views pertaining to the benefit of the ICP as a means of supporting care delivery. Consequently, in this study, we wanted to comprehensively evaluate and compare the opinions of key stakeholders in relation to the ICP as a care delivery tool. Stakeholders consisted of patients and MHPs including consultant psychiatrists, non-consultant hospital doctors, psychiatric nurses, psychologists, social workers, occupational therapists and addiction counsellors.

Methods

Setting

This study was carried out in the 50 bedded Adult Acute Mental Health Unit at the University Hospital Galway. The unit has designated rooms to hold MDT meetings for 12 consultant-led general adult psychiatry and speciality teams who generally meet once per week for multidisciplinary care planning. Every inpatient stay follows the code of practice on admission, transfer and discharge to and from an approved centre set by MHC (MHC, 2009). The key worker, usually the primary nurse, is identified for each patient to ensure that relevant documentation related to the ICP is made available to patients and that they are offered their documented care plan to sign and a copy to retain for review. The proforma for the care plan includes sections for needs, goals and interventions and is reviewed and updated by teams on a weekly basis. The ICP is applied to all inpatients, regardless of how acute or long term their condition is. All staff members receive training annually on the ICP in addition to learning attained via peer support. Regular audits of the care planning process are carried out in this approved centre.

Descriptive survey

Descriptive questionnaires were developed based on the ICP currently utilised across mental health services in the ROI (Mental Health Commission Guidance Document on Individual Care Planning Mental Health Services 2012). Two questionnaires, one for

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patients (Appendix 1) and one for MHPs (Appendix 2), were designed and circulated to other disciplines and a service user advocate for comment prior to its final version. The MHP questionnaire was phrased in such a way, so that the same questions could be answered by the different MHP stakeholders despite their different roles and experience. To allow comparison of measures between the MHP and patient groups, similar questions in the patient questionnaire were constructed with a simpler nomenclature for better comprehensibility by patients (Appendix 2). 'Free-text' options were included in both questionnaires to enable respondents to elaborate on their experiences of the ICP.

Participants

All of the participants in this study were recruited from the same acute psychiatric inpatient unit in an Irish sector-based mental health service. Exclusion criteria for patients were inability to comprehend written English, inability to provide informed consent due to a lack of capacity secondary to severe mental illness, a diagnosis of dementia and moderate to severe intellectual disability (IQ < 50). After an explanation of the purpose of the study and that it would have no bearing on clinical care, verbal consent to participate in this study was taken from each inpatient who did not meet exclusion criteria, between October 1, 2017 and January 31, 2018 ($n = 51$). Questionnaires were hand-delivered and patients provided with adequate time to ask questions from the researcher and instructed where to return the anonymous questionnaire at their own convenience. Questionnaires were distributed to all MHPs ($n = 72$) at their weekly MDT meetings and to inpatient nursing stations on two occasions. Minimal socio-demographic details and no unnecessary clinical information were collected.

Statistical analysis

Statistical analysis was performed using the Statistical Package for Social Sciences 23.0 for Windows (SPSS Inc., IBM, New York, USA). Categorical data were analysed using the chi-square test (or Fisher's exact test where appropriate) to examine differences in demographic characteristics and responses between the groups and subgroups. Free-text data were examined according to the stakeholder group and open-coded based on the framework of the questionnaire and on any other themes that emerged. These data were then grouped into themes by consensus of the researchers (AN, BH and CMcD).

Results

A response rate of 82.3% ($n = 42$) and 77.7% ($n = 56$) was noted for patients and MHPs, respectively. Most patients at the time of completion of the questionnaire had been an inpatient for more than 1 week ($n = 38$, 90.5%) and 22 patients (53.7%) had been attending the mental health services for at least 5 years. MHPs consisted of 21 doctors (37.5%), 23 psychiatric nurses (41.1%) and 12 allied health professionals (21.5%), with 30 MHPs (53.6%) having at least 10 years' experience working in the mental health services.

Thirty-four patients (81.0%) reported receiving a copy of their ICP, with 24 (58.5%) patients who expressed a view that the ICP improved the delivery of their care (Table 1). Most patients ($n = 27$, 64.3%) expressed the opinion that the ICP was an important contributor to their mental health outcome and without an ICP, they would expect a disimprovement in their care ($n = 31$, 75.6%). However, 21 patients (51.3%) also considered that the ICP was similar to discussions conducted in a standard ward-round interview with their treating team, with only 7 (17.1%) patients disagreeing that it served the same function as a standard ward-round interview. The majority of patients supported its current weekly frequency ($n = 34$, 82.9%) and 29 patients (72.5%) expressed the view that they would not make any changes to the ICP.

The majority of MHPs ($n = 47$, 85.5%) expressed the view that the ICP is a useful instrument for improving delivery of care to patients. Less than half of MHPs ($n = 23$, 41.8%) considered that the ICP was a significant factor in improving health outcomes, whilst the remainder either thought it was not possible to measure the ICPs impact on health outcomes ($n = 18$, 32.7%), not significant in its impact ($n = 11$, 20.0%) or viewed it negatively ($n = 3$, 5.5%). More than half of MHPs either agreed that ICP 'added nothing' beyond the management plan outlined in the progress notes ($n = 18$, 32.1%) or were neutral about this ($n = 12$, 21.4, Table 2). Most MHPs ($n = 42$, 75.0%) thought that the ICP was effective for identifying goals and 33 MHPs (59.0%) thought that the ICP helps patients to achieve their treatment goals.

When patients were compared to MHPs (Table 3, Fig. 1), a lower proportion of the patients that MHPs expressed the view that ICP helped delivery of care ($\chi^2 = 9.718$, $p = 0.008$). In relation to views towards whether the ICP was beneficial in relation to healthcare outcomes, there was not a statistically significant difference between the groups ($\chi^2 = 6.162$, $p = 0.104$), although more professionals than patients considered it impossible to measure (32.7% vs 14.3%). A more detailed analysis demonstrated that more patients compared to MHPs believed that the ICP had a positive impact on health outcomes ($\chi^2 = 4.813$, $p = 0.04$). There was a significant difference of opinion between patients and MHPs when it came to the function of an ICP compared with a ward round (Table 3), with

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Table 1. *Patients demographic data and views on ICP*

Variable	*n* (%)
Duration attending mental health services*	
<1 year	10 (24.4)
1–5 years	9 (22.0)
5–10 years	8 (19.5)
10–15 years	5 (12.2)
>15 years	9 (22.0)
Duration of hospitalisation	
<1 week	4 (9.5)
1–8 weeks	23 (54.9)
>8 weeks	15 (35.7)
Q3. Received a copy of ICP or ICP discussed with you?	
Yes	34 (81.0)
No	7 (16.7)
Unsure	1 (2.4)
Q4. ICP helps in the delivery of your care?*	
Yes	24 (58.5)
No	7 (17.1)
Don't know	10 (24.4)
Q5. ICP and health outcome?	
Important contributor to mental health outcome	27 (64.3)
Impossible to measure its impact	6 (14.3)
No significant impact	8 (19.0)
Negative impact upon health outcome	1 (2.4)
Q6. ICP serves the same function as management plan in ward-round interview?	
Strongly Agree	4 (9.8)
Agree	17 (41.5)
Neutral	13 (31.7)
Disagree	4 (9.8)
Strongly disagree	3 (7.3)
Q7. Impact if weekly ICP was not completed?	
Improvement in delivery of care	7 (17.1)
No change to delivery of care	3 (7.3)
Some reduction in delivery of care	17 (41.5)
Significant reduction in delivery of care	14 (34.1)
Q8. Change the ICP?	
Yes	11 (27.5)
No	29 (72.5)
Q9. Suggested ICP frequency?	
Weekly	34 (82.9)
Fortnightly	4 (9.8)
Monthly	1 (2.4)
Other time periods	2 (4.9)

*Not all participants answered this question.

almost half of MHPs but only 17% of patients disagreeing that they served the same function.

In terms of suggested frequency of the ICP, no difference between patients and MHPs views was observed ($\chi^2 = 4.680$, $p = 0.108$). When the preferred frequency of ICP was compared in MHPs subgroups, doctors had a lower preference for weekly ICPs compared to psychiatric nurses and allied health professionals (47.6% v. 82.6% and 75.0%; $\chi^2 = 6.197$, df = 2, Fisher's exact $p = 0.041$). Further analysis showed that a lower percentage of doctors ($n = 4$, 19%) compared to nurses ($n = 14$, 60.9%) and allied health professionals ($n = 5$, 45.5%) expressed the view that the ICP was having a positive impact on health outcomes ($\chi^2 = 8.014$, df = 2, Fisher's exact $p = 0.019$).

There were 42 responses in the free-text option from patients (Box 1) and 56 responses from MHPs (Box 2) with the greatest number of these from psychiatric nurses. Five themes emerged from these free-text responses (Box 1 and Box 2). Themes associated with the greatest free-text responses included involvement of patients in decision-making (patients = , MHP = 9), effects on healthcare delivery (patients = 10, MHPs = 13), contribution to mental health outcome (patients = 7, MHPs = 4), difference or similarity with ward-round reviews (patients = 3, MHP = 8) and potential changes to the structure or frequency of the current ICP (patients = 10, MHPs = 22). Patients were most positive about their involvement in their ICP (3 out of 4 comments) and most negative about the value of the ICP for healthcare delivery (4 negative and 3 neutral comments out of 10 comments). MHP were most positive regarding patient involvement in their ICP (8 out of 9 comments) and were most negative about how the ICP was different to a regular ward-round review (5 negative and 3 neutral comments).

Discussion

To our knowledge, this is the first study to date in the mental health services in Ireland to evaluate the perceived value of the ICP across different stakeholder groups. Overall, this study utilising both quantitative and qualitative data supports the use of ICPs with both patients and MHPs stating that the ICP increases patient involvement in their healthcare, identifies patients health needs and improves the delivery of their care. Support for the added value of the ICP was not universal, and over 50% of patients reported that the ICP had a similar function to a standard ward-round review. Additionally, MHPs were less convinced that the ICP had a positive impact on health outcomes than patients. The ICP was valued by most patients as helpful for the delivery of their care and a contributor to health outcomes utilising quantitative data, with the majority of patients stating they did not wish to change its current structure. Patients reported that the ICP was useful in goal-setting and aided in communication with their treating mental health team. Some free-text comments from patients were supportive of these views, but others were less supportive. A number of comments described completing the same ICP on a weekly basis as repetitive and other patients noted that the ICP did not

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Table 2. *Mental health professionals demographic data and views on ICP*

Variable	*n* (%)
Professional group	
Doctors	
Consultant psychiatrists	8 (14.3)
Non-consultant hospital doctors	13 (23.2)
Psychiatric nurses	23 (41.1)
Allied health professionals	
Psychologists	5 (8.9)
Occupational therapists	3 (5.4)
Social workers	3 (5.4)
Addiction counsellors	1 (1.8)
Years of experience working in mental health services	
<1 year	8 (14.3)
1–5 years	10 (17.9)
5–10 years	8 (14.3)
10–15 years	10 (17.9)
>15 years	20 (35.7)
Q3. ICP is a beneficial tool that improves the delivery of care*	
Yes	47 (85.5)
No	5 (9.1)
Don't know	3 (5.5)
Q4. ICP Involves patient and contributes to health outcomes?	
Necessary to involve patients directly in their care and is a significant contributor to improved health outcomes	23 (41.8)
Necessary to involve patients directly in their care, but it is impossible to measure contribution to health outcomes	18 (32.7)
Necessary to involve patients directly in their care, but not a significant contributor to health outcomes	11 (20.0)
A barrier to patient care given the time burden it places on the MDT	3 (5.5)
Q5. ICP adds nothing beyond the management plan as outlined in the progress notes?	
Strongly agree	7 (12.5)
Agree	11 (19.6)
Neutral	12 (21.4)
Disagree	23 (41.1)
Strongly disagree	3 (5.4)
Q6. ICP is effective in identifying a comprehensive set of goals for a patient?	
Strongly agree	9 (16.1)
Agree	33 (58.9)
Neutral	10 (17.9)
Disagree	4 (7.1)
Strongly disagree	0 (0.0)
Q7. ICP is effective in helping patients achieve their goals during the course of treatment?**	
Strongly agree	3 (5.4)
Agree	30 (53.6)
Neutral	17 (30.4)
Disagree	5 (8.9)
Strongly disagree	1 (1.8)
Q8. Changes to ICP*	
Make it longer, as it is not comprehensive enough to improve patient care or outcomes	4 (7.7)
Make it shorter as it takes too much time to complete	27 (51.9)
Nothing, as it is beneficial for patient care and/or outcomes	19 (36.5)
Other changes	2 (3.8)
Q9. Suggested ICP frequency	
Weekly	38 (67.9)
Fortnightly	15 (26.8)
Monthly	3 (5.4)

*Three participants did not respond to these questions.
** Rounded percentage.

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Table 3. *Views of different stakeholders on delivery of care*

	Patients	MHPs	Statistics
	n (%)	*n* (%)	X^2, *df*, *p*
ICP helps in delivery of care?*			
Yes	24 (58.5)	47 (85.5)	9.718, 2, **0.008**
No	7 (17.1)	5 (9.1)	
Don't know	19 (24.4)	3 (5.5)	
ICP helps with healthcare outcomes?*			
Positive impact on health outcomes	27 (64.3)	23 (41.8)	6.162, 3, 0.104
Impossible to measure its impact on health outcomes	6 (14.3)	18 (32.7)	
No significant impact on health outcomes	8 (19.0)	11 (20.0)	
Negative impact on health outcomes	1 (2.4)	3 (5.5)	
ICP serves a same function as standard ward-round reviews?*			
Agree	21 (51.3)	18 (32.1)	9.108, 2, **0.010**
Neutral	13 (31.7)	12 (21.4)	
Disagree	7 (17.0)	26 (46.5)	
ICP optimal frequency?*			
Weekly	34 (82.9)	38 (67.9)	4.3757, 2, 0.112
Fortnightly	4 (9.8)	15 (26.8)	
Monthly or other time periods	3 (7.1)	3 (5.4)	

*Not all participants answered these questions.
Fisher's exact test utilised.
Bold values indicate statistically significant findings ($p < 0.05$).

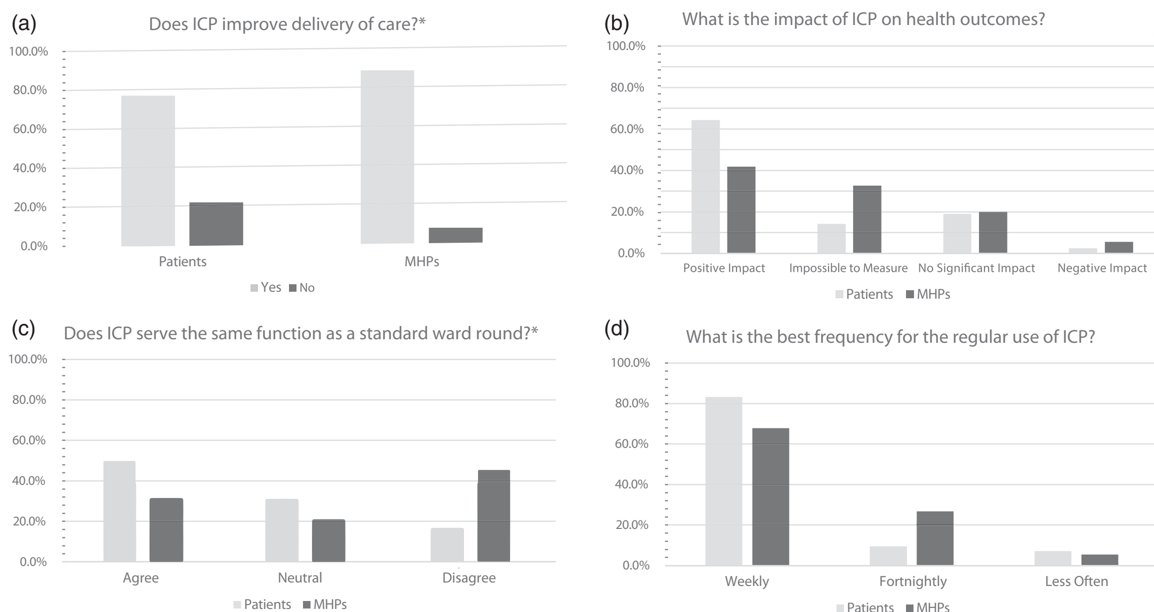

Fig. 1. Comparing the results from patients and MHPs in relation to the impact of ICP on (*a*) healthcare delivery, (*b*) healthcare outcomes, (*c*) its function compared to ward rounds and (*d*) frequency of use of the ICP. An asterisk indicates statisitically significant findings ($p < 0.05$)

address the range of concerns they wished to express. Potential reasons for this may relate to the complexity of some patients overall needs, or a differential perspective of patients of their treatment needs compared to their mental health team. Notably, only 17% of patients disagreed that the ICP had a different function to a management plan constructed during a standard ward-round interview. Thus, whilst this study, consistent with previous findings (De Las Cuevas, et al., 2011; Perestelo-Perez et al. 2011), demonstrates that patients generally valued their involvement in their own healthcare, the documented ICP as implemented in this

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Box 1. Themes Emanating from Free-Text Data: Patient Comments

Patient involvement in healthcare

Positive comments

1) 'Sometimes it is easier to put things in writing rather than talking'. #19
2) 'It lets the team know what needs I have'. #21

Negative comments

1) 'I feel like what I've written on it isn't acknowledged. The majority of things I want discussed are ignored and not on my care plan or addressed'. #20

Helps in care delivery

Positive comments

1) 'It's individual to me and this helps me'. #26
2) 'It gives feedback to the patient on his illness and any concerns he has. I think it is a great idea'. #30

Negative comments

1) 'The delivery of care to me and all patients is not helped by a piece of paper'. #9
2) 'It doesn't cover relevant problems. It tends to be repetitive, from week to week'. #15

Contributes to mental health outcome

Positive comments

1) 'It gives a good indication on my level of wellness' #28
2) 'I feel the individual care plan affords an accurate gauge in which to assess and plan patient's wishes'. #42

Negative comments

1) 'I received the care plan, I haven't yet found out when it will begin and also when or what the long-term plan will be'. #10

Similarity to ward-round interviews

Positive comments

1) 'What you think are the problems and what the problems are may not match which you become aware of with the ICP'. #25

Negative comments

1) 'Seems more of a formality. Might help if team discussed patient answers with patient as opposed to just at team meeting with staff'. #24

ICP structure – suggestions for change

1) 'Sometimes there is not enough room to write everything you need to'. #19
2) 'Once and thereafter if there is any further change in treatment'. #32
3) 'Make questions more specific, remove generic topics'. #8

service was not universally viewed by patients as having a differentially beneficial impact above verbal care planning in a standard ward interaction. This view is consistent with a large UK study conducted in over 1 million patients with long-term medical needs, of whom only 39% considered that care planning was of

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Box 2. Themes Emanating from Free-Text Data: MHP Comments

Patient involvement in healthcare

Positive comments

1) 'It allows client to be involved and take responsibility for care' (#56, AHP)
2) 'Improves patient involvement in their care and enabled them to identify their needs'. (#4, Con)
3) 'Enhances communication with MDT and service user. Empowers service users'. (#31, Nurse)

Negative comments

1) 'Some service users find it pointless'. (25#, Nurse)

Helps in care delivery

Positive comments

1) 'It is individual and tailored to the service users specific needs and goals'. (#29, Nurse)
2) 'Needs are identified from patients perspective'. (#52, AHP)
3) 'Allows team and client to prioritise goals'. (#55, AHP)

Negative comments

1) 'Improves patient involvement but delivery of care not necessarily improved by ICP'. (#6, Con)
2) 'Multidisciplinary element can be lacking'. (#15, NCHD)

Contributes to mental health outcomes

Positive comments

1) 'Provides individual care. Goals can be set and achieved'. (#34, Nurse)
2) 'Needs are identified and a plan is formed to meet these needs'. (#49, AHP)

Negative comments

1) 'Bureaucratic measure that absorbs staff time unnecessarily and adds little to care'. (#3, Con)

Similarity to ward-round interviews

Positive comments

1) 'I consider ICPs as the most collaborative method of naming and working on goals with clients and captures all needs and issues on one shared document'. (#49, AHP)

Negative comments

1) 'Replicates what is done already'. (#1, Con)
2) 'The plan is documented in medical notes, so care plan is duplication'. (#10, NCHD)

ICP structure and frequency of use – suggestions for change

1) 'It adds little to care and far too frequent. Should be left to team to decide frequency'. (#3, Con)
2) 'Ask patients what are their expectations for their care'. (#6, Con)
3) 'Should be computerized'. (#7, NCHD)
4) 'Have shorter version available for some patients'. (#8, NCHD)
5) 'Needs and goals are too similar, only include one of these'. (#12, NCHD)
6) 'Include more tick-boxes to reduce time for completion'. (#28, Nurse)
7) 'It works reasonably well as a guide for teams but service user involvement and collaboration in completing and reviewing it could be much improved'. (#47, AHP)

AHP, allied health professional; Con, consultant; NCHD, non-consultant hospital doctor.

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definite benefit in managing their health (Burt et al., 2012). Notably, previous MHC annual reports have often found that approved centres are not fully compliant with ICP standards, and it is possible that a yet more comprehensive ICP may be associated with greater satisfaction rates in patients. A randomised controlled trial study on efficacy of written asthma action plan supports this where it found that a specific action plan defined as complete and individualised was more beneficial for patients when compared to incomplete action plan (Gibson & Powell 2004).

MHPs were also generally supportive of the ICP as improving the delivery of care and for identifying a comprehensive set of goals for patients, with free-text comments supporting the role of the ICP in increasing the patient involvement in their healthcare, and although only a minority of MHPs thought that implementation of the ICP directly affected healthcare outcomes, the majority agreed that it assisted healthcare delivery. This highlights that the general attitude amongst healthcare staff is that the ICP is useful tool for engaging and communicating with patients about their care, rather than having much direct impact on the actual care implemented. The MHP subgroup who reported the least potential benefits of the ICP in its current form were doctors. There are a number of possible reasons why doctors might be more sceptical regarding the value of the ICP compared to other MHPs. Firstly, the ICP adds a time burden for doctors, since the responsibility of ensuring ICP completion at MDT meetings is generally the responsibility of the doctor who is required to sign the ICP. Secondly and mainly consultant psychiatrists as particularly evident from free-text comments, appear to believe that the ICP duplicates care planning already performed in individual patient interactions and adds an additional bureaucratic task for the MDT to complete. Previous research amongst doctors across a range of medical specialities noted that doctors believed that their obligations pertaining to clinical documentation were excessive, with 73% of respondents stating that these documentation obligations negatively impacted on patient care (Christino et al., 2013).

The majority of patients perceived no difference between a standard ward round and the ICP. This may simply reflect that standard interactions in both ward rounds and care planning meetings involve not just patient assessment, but discussing and explaining multidisciplinary interventions in a collaborative manner. Thus, patients may already feel involved in their care during wards rounds, and the additional benefit of the care planning meeting is around receiving similar information in a documented form. MHPs were more divided on this point with the majority disagreeing. Thus, patients may reflect less multidisciplinary presence in ward rounds (normally attended just be medical and nursing disciplines) compared to larger multidisciplinary care planning meetings.

Although implementation of the ICP may not directly impact healthcare outcomes, it is recognised by both patients and MHPs as a valuable tool for healthcare delivery/engagement of the individual in their care plan. The main issue that needs to be addressed is then how it is optimally implemented to be less burdensome on staff, for example, to allow flexibility around the optimal frequency to suit all stakeholders.

Despite, overall stated satisfaction with the current structure of the ICP (particularly amongst patients), a wide range of suggestions were provided by all stakeholders. MHPs believed that the current ICP was too long, at least for some patients, with several MHPs noting a lack of clarity for some aspects of the ICP. Divergent opinions regarding potential changes to the structure of the ICP were noted by patients; however, a free-text box of sufficient space allowing general comments not otherwise addressed in the ICP was the most commonly noted comment.

Strengths of this study include the high response rate from both patients and MHPs and utilisation of the same questionnaire across several MHP stakeholder groups with the questionnaire for patients created to allow the differential views of all stakeholders exposed. There are a number of limitations with this study, however, including the lack of a validated questionnaire and the relatively low numbers of some stakeholder groups. The fact that only one approved unit was utilised may reduce the generalisability of this study; however, similar ICPs as regulated by the MHC are used nationally. Individuals who chose to make a free-text response(s) were self-selected with interpretation of free-text comments open to potential bias as researchers were not in a position to explore meaning with participants. However, 60% of patients and 71% of MHPs included free-text comments, suggesting that the comments did not emanate from a small cohort of stakeholders, and themes derived from comments were reached by consensus after considerable discussion between the researchers. Minimal information on clinical characteristics which might have influenced variation in responses was collected from the patients, for example, it is possible that involuntary patients had generally negative attitudes towards their overall care including the benefit of ICPs.

Conclusion

This study provides valuable insights into the views of all stakeholders regarding the ICP. Overall, the implementation of the ICP is supported by both patients and

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MHPs, and in many cases is noted as supporting the delivery of care. Considerable dissatisfaction with some aspects of ICP implementation was also identified, especially for MHPs and for doctors within the MHP group. This included the lack of a differential impact of the documented ICP compared to standard care planning at ward-round reviews, the repetitive nature of completing the ICP on a weekly basis and a perceived redundant workload secondary to this. Future adjustments to the ICP might be considered based on the findings from this study, including more flexible frequency of completion for inpatients depending on their length of hospitalisation and changing needs, and the inclusion for patients of a free-text box of sufficient space allowing general comments not otherwise addressed in the ICP. Future multi-site studies inclusive of larger numbers of participants across a range of stakeholder groups would be welcome to evaluate the impact of such future changes to the ICP.

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Conflict of interest

The authors declare no conflict of interest in the subject matter discussed in this manuscript.

Ethical standards

Ethical approval was attained prior to the commencement of this study from the Galway University Hospitals Clinical Research Ethics Committee. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation with the Helsinki Declaration of 1975, as revised in 2008.

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Appendix 1. Questionnaire on ICP for MHPs.

Individual Care Plan (ICP)* Questionnaire

This questionnaire is designed to gauge how useful you feel ICP is in the management of care for service users.

Please complete all the questions below. The purpose of this questionnaire is to understand clinicians' opinions on how the Individual Care Plan (ICP) contributes to service users' health outcomes.

1. Please select your role in the multidisciplinary team (MDT):

- [ ] Consultant Psychiatrist
- [ ] Non-consultant Hospital Doctor
- [ ] Nurse
- [ ] Psychologist
- [ ] Social Worker
- [ ] Occupational Therapist
- [ ] Other ______________

2. Please indicate how long you have been working in the mental health services field:

- [ ] < 1 Year
- [ ] 1-5 Years
- [ ] 5-10 Years
- [ ] 10-15 Years
- [ ] > 15 Years

3. Do you consider the ICP a beneficial tool that improves the delivery of care?

- [ ] Yes
- [ ] No
- [ ] Don't know
- [ ] Please describe the reasons for your response:

4. According to your opinion, ICP is

- [ ] necessary as a way to involve the service users directly in their care and a significant contributor to improved final health outcomes.
- [ ] necessary as a way to involve the service users directly in their care, but it is impossible to measure how it contributes to final health outcomes.
- [ ] necessary as a way to involve the service users directly in their care but not a significant contributor to improved final health outcomes.
- [ ] a barrier to patient care given the time burden it places on the MDT.

5. Please indicate how much you agree or disagree with the following statement:

The documented ICP adds nothing beyond the management plan as outlined in the progress notes.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral
- [ ] Disagree
- [ ] Strongly Disagree

6. Please indicate how much you agree or disagree with the following statement:

The ICP is effective in identifying a comprehensive set of goals for a service user.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral
- [ ] Disagree
- [ ] Strongly Disagree

7. Please indicate how much you agree or disagree with the following statement:

The ICP is effective in helping service users achieve their goals during the course of treatment

- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral
- [ ] Disagree
- [ ] Strongly Disagree

8. What, if anything, would you change about the ICP?

- [ ] Nothing; as is, the ICP is beneficial for patient care and/or outcomes.
- [ ] I would make it shorter because it takes too much time to complete.
- [ ] I would make it longer because it is not comprehensive enough to improve patient care or outcomes.
- [ ] I would include the following fields/questions/sections: ______________
- [ ] I would remove the following fields/questions/sections: ______________

9. Currently, ICPs are reviewed and updated weekly, would you change this frequency?

- [ ] No, weekly reviews are fine
- [ ] Yes, please specify (e.g. fortnightly, monthly): __________

* "Individual care plan" refers to the written weekly care plan that is reviewed and updated for inpatients in Ireland.

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Appendix 2. Questionnaire on ICP for patients.

Individual Care Plan (ICP)* Questionnaire

This questionnaire is designed to gauge how useful you feel ICP is in the management of care for service users.

Please complete all the questions below. The purpose of this questionnaire is to understand how the Individual Care Plan (ICP) contributes to your health outcomes.

1. I have been attending mental health services for the past:

- [ ] < 1 Years
- [ ] 1-5 Years
- [ ] 5-10 Years
- [ ] 10-15 Years
- [ ] > 15 Years

2. Please tick the length of your inpatient admission:

- [ ] Less than 1 week
- [ ] Between 1 week and 2 month
- [ ] More than 1 month

3. Have you received a copy of an individual care plan or has your care plan been discussed with you?

- [ ] Yes
- [ ] No
- [ ] Don't know

Proceed to the next question only if you answered Yes to Question 3

4. Do you consider the individual care plan helps in the delivery of your care?

- [ ] Yes
- [ ] No
- [ ] Don't know
- [ ] Please describe the reasons for your response:

____
____
____
____
____

5. In my opinion the ICP is

- [ ] An important contributor that improves my mental health outcome.
- [ ] Not a significant contributor to my mental health outcome.
- [ ] Has a negative impact upon my mental health outcome.
- [ ] It is impossible to measure how it contributes to my mental health outcome.

6. What is written in the copy of ICP that is given to me normally ends up being the same as the management plan discussed with me in the ward-round interviews anyway:

- [ ] Strongly Disagree
- [ ] Disagree
- [ ] Neutral
- [ ] Agree
- [ ] Strongly Agree

7. According to your opinion, if the weekly ICP were not completed there would be:

- [ ] An improvement in the delivery of my care
- [ ] No change in the delivery of my care
- [ ] Little change in my delivery of care
- [ ] Significant reduction in my delivery of care

8. Would you change anything about the ICP form?

- [ ] Yes
- [ ] No

If yes:

- [ ] I would include the following fields/questions/sections:

____
____

- [ ] I would remove the following fields/questions/sections:

____
____

9. Currently, ICPs are reviewed and updated weekly, would you change this frequency?

- [ ] No, weekly reviews are fine
- [ ] Yes, please specify (e.g. fortnightly, monthly): __________

* "Individual care plan" (ICP) refers to the written weekly care plan that is reviewed and updated at your multidisciplinary team meeting and discussed with you.

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