

R — Communication and relationships

16 statements · Recommended tool: CP-TALK Communication Check · Validated scales: Communication barrier checklist

R1 Difficulty speaking or being understood

Group: Communication and relationships | Type: Actual problem

Definition: Speech is unclear, limited, or absent, so needs are hard to communicate.

Possible causes: Stroke; throat injury; brain disease; sedation; ventilator

Signs and symptoms: Slurred speech; cannot find words; silence; gestures; frustration

Scenario. After a stroke, a man tries to talk but only makes sounds.

S: (Tries to speak.) "Wa... wa..."

O: Slurred speech; cannot find words; frustrated; right-sided weakness.

Tools: CP-TALK, CP-NEURO · Communication barrier checklist, GCS, pupils, NIHSS **CarePath**

diagnosis: **Difficulty speaking or being understood related to stroke, as evidenced by slurred speech and cannot find words.** **Interventions and rationale** | Intervention | Rationale | ---|---| | Speak slowly. | A slow pace gives a person with damaged speech pathways more time to process each word and respond, and lowers pressure and frustration. | | Use yes or no questions. | Yes or no questions need only a simple answer, so he can say what he needs without having to find or form words. | | Use picture boards. | Pictures let him point to needs when words fail, giving him a reliable way to be understood and some control. | | Allow extra time. | Stroke affects the speed of finding and forming words, so extra time prevents rushing him and reduces anxiety that makes speech harder. | | Refer to speech therapy. | A speech therapist can assess the type of speech problem and teach exercises and methods that help recovery of communication. | | Keep the call bell reachable. | If he can always reach the call bell, he can summon help when he cannot speak, which protects his safety and independence. | **Expected outcomes** - Within 3 days: communicates basic needs using speech, gestures, or a board. - Less frustration. - Uses the call bell. **Linking the data to the diagnosis** After a stroke the man tries to speak but only makes sounds such as "Wa... wa...", with slurred speech, difficulty finding words, frustration, and right-sided weakness. These data show speech is already impaired and his needs are hard to communicate, so this is an actual problem, not a risk, and it fits better than a hearing or language barrier diagnosis because he cannot produce words. The plan aims for him, within 3 days, to communicate basic needs by speech, gestures or a board, feel less frustrated, and use the call bell.

CarePath diagnosis: Difficulty speaking or being understood related to stroke, as evidenced by slurred speech and cannot find words.

Intervention	Rationale
Speak slowly.	A slow pace gives a person with damaged speech pathways more time to process each word and respond, and lowers pressure and frustration.
Use yes or no questions.	Yes or no questions need only a simple answer, so he can say what he needs without having to find or form words.
Use picture boards.	Pictures let him point to needs when words fail, giving him a reliable way to be understood and some control.
Allow extra time.	Stroke affects the speed of finding and forming words, so extra time prevents rushing him and reduces anxiety that makes speech harder.
Refer to speech therapy.	A speech therapist can assess the type of speech problem and teach exercises and methods that help recovery of communication.
Keep the call bell reachable.	If he can always reach the call bell, he can summon help when he cannot speak, which protects his safety and independence.

Expected outcomes: Within 3 days: communicates basic needs using speech, gestures, or a board. · Less frustration. · Uses the call bell.

Linking the data: After a stroke the man tries to speak but only makes sounds such as "Wa... wa...", with slurred speech, difficulty finding words, frustration, and right-sided weakness. These data show speech is already impaired and his needs are hard to communicate, so this is an actual problem, not a risk, and it fits better than a hearing or language barrier diagnosis because he cannot produce words. The plan aims for him, within 3 days, to communicate basic needs by speech, gestures or a board, feel less frustrated, and use the call bell.

R2 Difficulty hearing or seeing

Group: Communication and relationships | Type: Actual problem

Definition: Hearing or vision loss limits communication, safety, or understanding.

Possible causes: Aging; eye or ear disease; wax; infection; medicines

Signs and symptoms: Misses speech; leans forward; squints; bumps into things; loud television

Scenario. An older woman misunderstands staff and misses cues.

S: "What? Can you say that again?"

O: Leans forward; asks people to repeat; squints; poor hearing and vision; hearing aid battery flat.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Difficulty hearing or seeing related to aging, as evidenced by misses speech and leans forward. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Check hearing and vision aids. | A flat hearing aid battery or dirty glasses can cause avoidable communication problems, so checking and fixing aids is the quickest way to improve what she hears and sees. | | Reduce noise. | Background noise makes it harder to pick out speech, especially with hearing loss, so a quieter room helps her follow what is said. | | Face the patient. | Facing her lets her see lips and expressions, which support understanding when hearing is poor, and she can see that she is being spoken to. | | Speak clearly. | Clear, slightly slower speech without shouting is easier to understand than loud or rushed speech, which distorts sound and can feel disrespectful. | | Use writing and large print. | Written words and large print give another route for information when hearing and vision are both reduced, so instructions are not missed. | | Check safety. | Poor sight and hearing raise the risk of trips, falls and missed warnings, so checking the surroundings keeps her safe while she cannot rely on her senses. | ****Expected outcomes**** - Understands instructions with aids. - Moves safely. - Staff use clear speech. - Patient says she feels understood. ****Linking the data to the diagnosis**** The older woman says, "What? Can you say that again?", leans forward, asks people to repeat, squints, has poor hearing and vision, and her hearing aid battery is flat. These data show a sensory problem already limiting communication, so it is an actual diagnosis and fits better than a language barrier or a speech problem, because the difficulty is receiving information. The plan aims for her to understand instructions with her aids, move safely, be spoken to clearly by staff, and say she feels understood.

CarePath diagnosis: Difficulty hearing or seeing related to aging, as evidenced by misses speech and leans forward.

Intervention	Rationale
Check hearing and vision aids.	A flat hearing aid battery or dirty glasses can cause avoidable communication problems, so checking and fixing aids is the quickest way to improve what she hears and sees.
Reduce noise.	Background noise makes it harder to pick out speech, especially with hearing loss, so a quieter room helps her follow what is said.
Face the patient.	Facing her lets her see lips and expressions, which support understanding when hearing is poor, and she can see that she is being spoken to.
Speak clearly.	Clear, slightly slower speech without shouting is easier to understand than loud or rushed speech, which distorts sound and can feel disrespectful.
Use writing and large print.	Written words and large print give another route for information when hearing and vision are both reduced, so instructions are not missed.
Check safety.	Poor sight and hearing raise the risk of trips, falls and missed warnings, so checking the surroundings keeps her safe while she cannot rely on her senses.

Expected outcomes: Understands instructions with aids. · Moves safely. · Staff use clear speech. · Patient says she feels understood.

Linking the data: The older woman says, "What? Can you say that again?", leans forward, asks people to repeat, squints, has poor hearing and vision, and her hearing aid battery is flat. These data show a sensory problem already limiting communication, so it is an actual diagnosis and fits better than a language barrier or a speech problem, because the difficulty is receiving information. The plan aims for her to understand instructions with her aids, move safely, be spoken to clearly by staff, and say she feels understood.

R3 Feeling alone or cut off from others

Group: Communication and relationships | Type: Actual problem

Definition: The person has little contact or connection with other people and feels isolated.

Possible causes: Illness; mobility loss; moving house; bereavement; shyness

Signs and symptoms: Says he feels lonely; few visitors; withdrawn; low mood

Scenario. An older widower sees no one for days.

S: "I haven't spoken to anyone for days."

O: Lives alone; few visitors; low mood; television on all day.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Feeling alone or cut off from others related to illness, as evidenced by says he feels lonely and few visitors. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Encourage contact. | Regular contact with others reduces isolation and loneliness, which are linked to low mood and poorer health. | | Arrange visits. | Planned visits from family or friends give predictable company, which is hard for someone living alone to create for himself. | | Link to community groups. | Community groups offer shared interests and new relationships beyond family, so social contact can continue after discharge. | | Use phone or video calls. | Phone or video calls let him connect with people who cannot visit, which helps when distance or illness limits visits. | | Check mood. | Long loneliness can lead to depression, so checking his mood finds problems early so that further help can be arranged. | ****Expected outcomes**** - Within 2 weeks: has regular contact at least 3 times a week and joins one group. - Says he feels less lonely. ****Linking the data to the diagnosis**** The older widower says, "I haven't spoken to anyone for days," lives alone, has few visitors, low mood, and keeps the television on all day. These data show a lack of social contact that has already occurred, so this is an actual diagnosis and not a risk. It fits better than a grief or low mood diagnosis because the central problem is a lack of connection with other people. The plan aims for him, within 2 weeks, to have contact at least 3 times a week, join one group, and say he feels less lonely.

CarePath diagnosis: Feeling alone or cut off from others related to illness, as evidenced by says he feels lonely and few visitors.

Intervention	Rationale
Encourage contact.	Regular contact with others reduces isolation and loneliness, which are linked to low mood and poorer health.
Arrange visits.	Planned visits from family or friends give predictable company, which is hard for someone living alone to create for himself.
Link to community groups.	Community groups offer shared interests and new relationships beyond family, so social contact can continue after discharge.
Use phone or video calls.	Phone or video calls let him connect with people who cannot visit, which helps when distance or illness limits visits.
Check mood.	Long loneliness can lead to depression, so checking his mood finds problems early so that further help can be arranged.

Expected outcomes: Within 2 weeks: has regular contact at least 3 times a week and joins one group.
· Says he feels less lonely.

Linking the data: The older widower says, "I haven't spoken to anyone for days," lives alone, has few visitors, low mood, and keeps the television on all day. These data show a lack of social contact that has already occurred, so this is an actual diagnosis and not a risk. It fits better than a grief or low mood diagnosis because the central problem is a lack of connection with other people. The plan aims for him, within 2 weeks, to have contact at least 3 times a week, join one group, and say he feels less lonely.

R4 Struggling with family or work roles

Group: Communication and relationships | Type: Actual problem

Definition: Illness prevents the person from carrying out usual roles.

Possible causes: Illness; injury; job loss; caregiving demands; disability

Signs and symptoms: Cannot do usual duties; guilt; conflict; frustration

Scenario. A father cannot work after a spinal injury and feels useless.

S: "I can't provide for my family anymore."

O: Father after spinal injury; angry and withdrawn; avoids his children.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Struggling with family or work roles related to illness, as evidenced by cannot do usual duties and guilt. ****Interventions and rationale****
| Intervention | Rationale | |---|---| | Explore feelings. | Talking through anger, guilt and loss in a safe setting helps him process feelings that could otherwise lead to withdrawal or depression. | | Help redefine roles. | Roles can change without losing worth, so redefining them helps him find new ways to contribute to his family. | | Involve family. | Including the family helps them understand his feelings, share responsibilities, and support him, which eases strain on relationships. | | Refer to a social worker. | A social worker can help with practical problems such as income, benefits and services, which ease the worry behind his sense of failure. | | Set goals. | Small, achievable goals give him a sense of progress and control, and rebuild his belief that he still has value. | ****Expected outcomes**** - Within 1 week: discusses new roles with family, sets one goal, reports an increased sense of worth. ****Linking the data to the diagnosis**** The father cannot work after a spinal injury, says, "I can't provide for my family anymore," feels useless, is angry and withdrawn, and avoids his children. These data show he cannot carry out his usual family and work roles, so this actual diagnosis fits better than a general anxiety or low mood diagnosis. The problem has already happened, so it is not a risk statement. The plan aims for him, within 1 week, to discuss new roles with his family, set one goal, and report an increased sense of worth.

CarePath diagnosis: Struggling with family or work roles related to illness, as evidenced by cannot do usual duties and guilt.

Intervention	Rationale
Explore feelings.	Talking through anger, guilt and loss in a safe setting helps him process feelings that could otherwise lead to withdrawal or depression.
Help redefine roles.	Roles can change without losing worth, so redefining them helps him find new ways to contribute to his family.
Involve family.	Including the family helps them understand his feelings, share responsibilities, and support him, which eases strain on relationships.
Refer to a social worker.	A social worker can help with practical problems such as income, benefits and services, which ease the worry behind his sense of failure.
Set goals.	Small, achievable goals give him a sense of progress and control, and rebuild his belief that he still has value.

Expected outcomes: Within 1 week: discusses new roles with family, sets one goal, reports an increased sense of worth.

Linking the data: The father cannot work after a spinal injury, says, "I can't provide for my family anymore," feels useless, is angry and withdrawn, and avoids his children. These data show he cannot carry out his usual family and work roles, so this actual diagnosis fits better than a general anxiety or low mood diagnosis. The problem has already happened, so it is not a risk statement. The plan aims for him, within 1 week, to discuss new roles with his family, set one goal, and report an increased sense of worth.

R5 Family caregiver overwhelmed

Group: Communication and relationships | Type: Actual problem

Definition: Tiredness, stress, or strain in the person who gives unpaid care.

Possible causes: Long care; poor sleep; no breaks; financial stress; no help

Signs and symptoms: Exhaustion; anger; poor health; neglecting self; feeling trapped

Scenario. A wife caring for her husband with dementia 24 hours a day is worn out.

S: "I'm so tired. I can't do this alone."

O: Wife caring for her husband with dementia 24 hours a day; sleeps 4 hours; weight down; tearful.

Tools: CP-TALK, CP-FLUID · Communication barrier checklist, MUST, fluid chart, glucose ****CarePath diagnosis:**** Family caregiver overwhelmed related to long care, as evidenced by exhaustion and anger. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Acknowledge her effort. | Recognizing her effort validates the hard work she does and reduces guilt, which can make her more open to accepting help. | | Teach skills. | Learning safer, easier ways to give care, such as lifting and handling dementia behaviors, lowers her workload and the risk of injury. | | Encourage breaks. | Regular breaks give her time to rest and recover, and chronic exhaustion without rest harms her health and her ability to keep caring. | | Arrange respite and support groups. | Respite care lets someone else look after her husband for a while, and support groups give her understanding from people in the same situation. | | Refer to a social worker. | A social worker can arrange practical help, services and funding, which reduces the load she is carrying alone. | ****Expected outcomes**** - Within 2 weeks: takes at least 2 breaks a week, names one support source, reports lower strain. ****Linking the data to the diagnosis**** The wife cares for her husband with dementia 24 hours a day and says, "I'm so tired. I can't do this alone." She sleeps 4 hours, has lost weight, and is tearful. These data show the strain is already affecting her health, so this is an actual diagnosis and not a risk of caregiver strain. It fits better than a diagnosis for the husband, because the problem lies with the carer. The plan aims for her, within 2 weeks, to take at least 2 breaks a week, name one support source, and report lower strain.

CarePath diagnosis: Family caregiver overwhelmed related to long care, as evidenced by exhaustion and anger.

Intervention	Rationale
Acknowledge her effort.	Recognizing her effort validates the hard work she does and reduces guilt, which can make her more open to accepting help.
Teach skills.	Learning safer, easier ways to give care, such as lifting and handling dementia behaviors, lowers her workload and the risk of injury.
Encourage breaks.	Regular breaks give her time to rest and recover, and chronic exhaustion without rest harms her health and her ability to keep caring.
Arrange respite and support groups.	Respite care lets someone else look after her husband for a while, and support groups give her understanding from people in the same situation.
Refer to a social worker.	A social worker can arrange practical help, services and funding, which reduces the load she is carrying alone.

Expected outcomes: Within 2 weeks: takes at least 2 breaks a week, names one support source, reports lower strain.

Linking the data: The wife cares for her husband with dementia 24 hours a day and says, "I'm so tired. I can't do this alone." She sleeps 4 hours, has lost weight, and is tearful. These data show the strain is already affecting her health, so this is an actual diagnosis and not a risk of caregiver strain. It fits better than a diagnosis for the husband, because the problem lies with the carer. The plan aims for her, within 2 weeks, to take at least 2 breaks a week, name one support source, and report lower strain.

R6 Conflict or breakdown in family support

Group: Communication and relationships | Type: Actual problem

Definition: The family cannot work together or support the patient.

Possible causes: Serious illness; disagreements; poor communication; stress

Signs and symptoms: Arguments; blame; missed visits; no shared decisions

Scenario. Siblings argue over the care of their sick mother.

S: "My sister never helps and we keep arguing."

O: Siblings argue at the bedside; blame; no shared plan; patient upset.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Conflict or breakdown in family support related to serious illness, as evidenced by arguments and blame. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Hold a family meeting. | A planned meeting brings everyone together in one place so they hear the same information and can talk instead of arguing at the bedside. | | Give facts. | Clear facts about the mother's condition and needs reduce guesswork and blame, so the discussion stays on her care. | | Mediate. | A neutral person can keep the discussion fair, stop blaming, and help each person be heard, which makes agreement more likely. | | Set shared goals. | Shared goals focus the family on what is best for their mother and give each person a clear part to play. | | Refer to a social worker or counselor. | A social worker or counselor has skills for resolving family conflict and can give support after the meeting. | ****Expected outcomes**** - Within 3 days: family meeting held and shared care plan agreed. - Fewer arguments. ****Linking the data to the diagnosis**** The sick mother's adult children argue at her bedside, blame each other, have no shared plan, and the patient is upset. One says, "My sister never helps and we keep arguing." These data show the family is not working together now, so this actual diagnosis fits better than a diagnosis of caregiver strain, because the main problem is conflict. The problem has already occurred. The plan aims for a family meeting to be held within 3 days, a shared care plan agreed, and fewer arguments.

CarePath diagnosis: Conflict or breakdown in family support related to serious illness, as evidenced by arguments and blame.

Intervention	Rationale
Hold a family meeting.	A planned meeting brings everyone together in one place so they hear the same information and can talk instead of arguing at the bedside.
Give facts.	Clear facts about the mother's condition and needs reduce guesswork and blame, so the discussion stays on her care.
Mediate.	A neutral person can keep the discussion fair, stop blaming, and help each person be heard, which makes agreement more likely.
Set shared goals.	Shared goals focus the family on what is best for their mother and give each person a clear part to play.
Refer to a social worker or counselor.	A social worker or counselor has skills for resolving family conflict and can give support after the meeting.

Expected outcomes: Within 3 days: family meeting held and shared care plan agreed. · Fewer arguments.

Linking the data: The sick mother's adult children argue at her bedside, blame each other, have no shared plan, and the patient is upset. One says, "My sister never helps and we keep arguing." These data show the family is not working together now, so this actual diagnosis fits better than a diagnosis of caregiver strain, because the main problem is conflict. The problem has already occurred. The plan aims for a family meeting to be held within 3 days, a shared care plan agreed, and fewer arguments.

R7 Difficulty trusting or cooperating with care

Group: Communication and relationships | Type: Actual problem

Definition: The person resists or distrusts treatment, staff, or advice.

Possible causes: Past bad experience; fear; culture; poor communication; stigma

Signs and symptoms: Refuses treatment; argues; misses visits; hides information

Scenario. A patient distrusts staff and refuses medicines.

S: "I don't trust you people."

O: Refuses medicines; argues; hides information; past bad experience.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Difficulty trusting or cooperating with care related to past bad experience, as evidenced by refuses treatment and argues. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Build trust. | Trust is the base for any cooperation, and he is more likely to accept care from staff who show they are honest and reliable. | | Listen. | Listening shows respect and lets him express fears and past hurts, which are often the real reason for refusal. | | Explain reasons. | When he understands why a medicine or treatment is needed, he can make an informed choice instead of refusing from fear or suspicion. | | Involve the patient in decisions. | Sharing decisions gives him a sense of control, which reduces resistance and makes him more likely to stick with the plan. | | Respect beliefs. | Respecting his beliefs shows that his values matter, which reduces conflict and the feeling that care is being forced on him. | | Be consistent. | Staff who act the same way every time show they can be relied on, which builds trust over time. | ****Expected outcomes**** - Accepts some care within days. - States concerns. - Builds rapport. - Agrees to a shared plan. ****Linking the data to the diagnosis**** The patient says, "I don't trust you people," refuses medicines, argues, hides information, and has had a past bad experience. These data show distrust that is already blocking care, so this is an actual diagnosis, not a risk. It fits better than a knowledge deficit, because he understands but does not trust, and better than a language barrier because communication is possible. The plan aims for him to accept some care within days, state his concerns, build rapport, and agree to a shared plan.

CarePath diagnosis: Difficulty trusting or cooperating with care related to past bad experience, as evidenced by refuses treatment and argues.

Intervention	Rationale
Build trust.	Trust is the base for any cooperation, and he is more likely to accept care from staff who show they are honest and reliable.
Listen.	Listening shows respect and lets him express fears and past hurts, which are often the real reason for refusal.
Explain reasons.	When he understands why a medicine or treatment is needed, he can make an informed choice instead of refusing from fear or suspicion.
Involve the patient in decisions.	Sharing decisions gives him a sense of control, which reduces resistance and makes him more likely to stick with the plan.
Respect beliefs.	Respecting his beliefs shows that his values matter, which reduces conflict and the feeling that care is being forced on him.
Be consistent.	Staff who act the same way every time show they can be relied on, which builds trust over time.

Expected outcomes: Accepts some care within days. · States concerns. · Builds rapport. · Agrees to a shared plan.

Linking the data: The patient says, "I don't trust you people," refuses medicines, argues, hides information, and has had a past bad experience. These data show distrust that is already blocking care, so this is an actual diagnosis, not a risk. It fits better than a knowledge deficit, because he understands but does not trust, and better than a language barrier because communication is possible. The plan aims for him to accept some care within days, state his concerns, build rapport, and agree to a shared plan.

R8 Not enough help at home

Group: Communication and relationships | Type: Actual problem

Definition: Home support is too little for the person's needs.

Possible causes: Discharge; living alone; limited family; disability; costs

Signs and symptoms: Cannot manage meals or hygiene; no helper; safety risks

Scenario. An older man goes home alone after surgery with no help.

S: "I'm going home alone and I don't have anyone."

O: Lives alone; after surgery; limited mobility; no helper arranged.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Not enough help at home related to discharge, as evidenced by cannot manage meals or hygiene and no helper. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Assess needs. | A full assessment shows what he can and cannot do alone, such as meals, hygiene and moving about, so help matches real needs. | | Arrange home care. | Home care services can supply meals, personal care and checks, so he is safe and can recover after surgery without relying on others. | | Involve family and a social worker. | Family and a social worker can find extra help, funding and community resources that he may not know about or know how to ask for. | | Teach tasks. | Teaching tasks he can safely do himself, adapted to his limited mobility, helps him manage daily needs and avoid injury or setbacks. | | Plan follow-up. | Follow-up lets problems at home be spotted early, so help can be adjusted before he becomes unsafe or is readmitted. | ****Expected outcomes**** - Home support arranged before discharge. - Patient states how to get help. - Safe discharge. ****Linking the data to the diagnosis**** The older man says, "I'm going home alone and I don't have anyone." He lives alone, is recovering from surgery, has limited mobility, and no helper is arranged. These data show that support at home does not match his needs, so this actual diagnosis fits better than a risk of injury, because the lack of help is already present. The plan aims for home support to be arranged before discharge, for him to state how to get help, and for a safe discharge.

CarePath diagnosis: Not enough help at home related to discharge, as evidenced by cannot manage meals or hygiene and no helper.

Intervention	Rationale
Assess needs.	A full assessment shows what he can and cannot do alone, such as meals, hygiene and moving about, so help matches real needs.
Arrange home care.	Home care services can supply meals, personal care and checks, so he is safe and can recover after surgery without relying on others.
Involve family and a social worker.	Family and a social worker can find extra help, funding and community resources that he may not know about or know how to ask for.
Teach tasks.	Teaching tasks he can safely do himself, adapted to his limited mobility, helps him manage daily needs and avoid injury or setbacks.
Plan follow-up.	Follow-up lets problems at home be spotted early, so help can be adjusted before he becomes unsafe or is readmitted.

Expected outcomes: Home support arranged before discharge. · Patient states how to get help. · Safe discharge.

Linking the data: The older man says, "I'm going home alone and I don't have anyone." He lives alone, is recovering from surgery, has limited mobility, and no helper is arranged. These data show that support at home does not match his needs, so this actual diagnosis fits better than a risk of injury, because the lack of help is already present. The plan aims for home support to be arranged before discharge, for him to state how to get help, and for a safe discharge.

R9 Language barrier

Group: Communication and relationships | Type: Actual problem

Definition: The person and staff do not share a common language.

Possible causes: Foreign patient; migration; no interpreter; dialect

Signs and symptoms: Misunderstanding; nodding without understanding; mistakes; anxiety

Scenario. A patient who speaks only Arabic cannot understand English instructions.

S: (Speaks only Arabic.) "I don't understand."

O: Nods without understanding; mistakes with medicines; anxious; no interpreter used yet.

Tools: CP-TALK, CP-MIND · Communication barrier checklist, PHQ-9, GAD-7, C-SSRS **CarePath diagnosis:** Language barrier related to foreign patient, as evidenced by misunderstanding and nodding without understanding. **Interventions and rationale** | Intervention | Rationale | |---|---| | Use a qualified interpreter. | A trained interpreter gives accurate, confidential translation of medical terms, which untrained helpers may get wrong, so errors with medicines are less likely. | | Use simple words and pictures. | Simple words and pictures support understanding across languages and reduce the chance of misreading instructions. | | Give translated leaflets. | Written instructions in his own language let him review them later and share them with family, so he can follow the plan at home. | | Confirm understanding. | Nodding does not mean understanding, so asking him to repeat the instruction back through the interpreter shows whether it was really understood. | | Involve family only when appropriate. | Family may know the patient well but can change or leave out information and may breach privacy, so they should only help when suitable. | **Expected outcomes** - Understands instructions with an interpreter. - Teach-back accurate. - Fewer errors. - Translated written notes given. **Linking the data to the diagnosis** The patient speaks only Arabic and says, "I don't understand." He nods without understanding, has made mistakes with medicines, is anxious, and no interpreter has been used yet. These data show that staff and patient do not share a language and that errors are already happening, so this is an actual diagnosis and not a risk. It fits better than a health literacy problem, because the barrier is language. The plan aims for him to understand instructions with an interpreter, answer teach-back correctly, make fewer errors, and receive translated written notes.

CarePath diagnosis: Language barrier related to foreign patient, as evidenced by misunderstanding and nodding without understanding.

Intervention	Rationale
Use a qualified interpreter.	A trained interpreter gives accurate, confidential translation of medical terms, which untrained helpers may get wrong, so errors with medicines are less likely.
Use simple words and pictures.	Simple words and pictures support understanding across languages and reduce the chance of misreading instructions.
Give translated leaflets.	Written instructions in his own language let him review them later and share them with family, so he can follow the plan at home.
Confirm understanding.	Nodding does not mean understanding, so asking him to repeat the instruction back through the interpreter shows whether it was really understood.
Involve family only when appropriate.	Family may know the patient well but can change or leave out information and may breach privacy, so they should only help when suitable.

Expected outcomes: Understands instructions with an interpreter. · Teach-back accurate. · Fewer errors. · Translated written notes given.

Linking the data: The patient speaks only Arabic and says, "I don't understand." He nods without understanding, has made mistakes with medicines, is anxious, and no interpreter has been used yet. These data show that staff and patient do not share a language and that errors are already happening, so this is an actual diagnosis and not a risk. It fits better than a health literacy problem, because the barrier is language. The plan aims for him to understand instructions with an interpreter, answer teach-back correctly, make fewer errors, and receive translated written notes.

R10 Trouble understanding health information

Group: Communication and relationships | Type: Actual problem

Definition: Low reading ability or health literacy makes instructions hard to follow.

Possible causes: Low literacy; complex language; stress; poor vision; older age

Signs and symptoms: Cannot explain the plan; misses doses; avoids forms

Scenario. A patient signs forms but cannot explain the medicine plan.

S: "I'm fine, I understand." (cannot repeat the plan)

O: Signs forms but cannot explain medicines; low literacy; embarrassed.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Trouble understanding health information related to low literacy, as evidenced by cannot explain the plan and misses doses.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Use plain words. | Everyday words are easier to understand than medical terms, so plain language makes sure he really understands the plan. | | Short steps. | Small steps are easier to take in and remember than a long list, and avoid overwhelming him. | | Teach-back. | Asking him to explain the plan in his own words checks real understanding without making him feel tested, since signing a form does not show that he understands. | | Pictures. | Pictures show information in a way that does not depend on reading skill, and are easier to remember. | | Simple written notes. | Simple notes give him something to look at at home, which helps him remember what to take and when. | | Repeat. | Repeating key points over time helps move information into memory, especially when he is stressed or embarrassed. | ****Expected outcomes**** - Within 2 sessions: explains the plan in his own words by teach-back and takes medicines correctly. ****Linking the data to the diagnosis**** The patient says, "I'm fine, I understand," but cannot repeat the plan. He signs forms yet cannot explain his medicines, has low literacy, is embarrassed, and misses doses. These data show a gap between appearing to understand and truly understanding, so this actual diagnosis fits better than a general lack of knowledge, because the cause is low literacy and not lack of teaching. The plan aims for him, within 2 sessions, to explain the plan in his own words using teach-back and to take his medicines correctly.

CarePath diagnosis: Trouble understanding health information related to low literacy, as evidenced by cannot explain the plan and misses doses.

Intervention	Rationale
Use plain words.	Everyday words are easier to understand than medical terms, so plain language makes sure he really understands the plan.
Short steps.	Small steps are easier to take in and remember than a long list, and avoid overwhelming him.
Teach-back.	Asking him to explain the plan in his own words checks real understanding without making him feel tested, since signing a form does not show that he understands.
Pictures.	Pictures show information in a way that does not depend on reading skill, and are easier to remember.
Simple written notes.	Simple notes give him something to look at at home, which helps him remember what to take and when.
Repeat.	Repeating key points over time helps move information into memory, especially when he is stressed or embarrassed.

Expected outcomes: Within 2 sessions: explains the plan in his own words by teach-back and takes medicines correctly.

Linking the data: The patient says, "I'm fine, I understand," but cannot repeat the plan. He signs forms yet cannot explain his medicines, has low literacy, is embarrassed, and misses doses. These data show a gap between appearing to understand and truly understanding, so this actual diagnosis fits better than a general lack of knowledge, because the cause is low literacy and not lack of teaching. The plan aims for him, within 2 sessions, to explain the plan in his own words using teach-back and to take his medicines correctly.

R11 Relationship or intimacy difficulty

Group: Communication and relationships | Type: Actual problem

Definition: Illness or treatment strains close relationships.

Possible causes: Illness; surgery; medicines; body change; fear; stress

Signs and symptoms: Avoids closeness; worry; conflict; silence

Scenario. A man after a heart attack fears having sex.

S: "I'm afraid it will happen again."

O: Man after heart attack; avoids his partner; worried; asks few questions.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Relationship or intimacy difficulty related to illness, as evidenced by avoids closeness and worry. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Create a private safe space. | Privacy lets him talk about a sensitive topic without embarrassment, so his real fears can be spoken aloud. | | Give information. | Accurate facts about safe activity after a heart attack correct myths and reduce fear that intimacy will cause another one. | | Include the partner. | Including his partner lets both share their worries and understand the facts, which can reduce distance between them. | | Refer for counseling. | A counselor trained in intimacy and relationship problems can give deeper help if fear and avoidance continue. | | Respect values. | Respecting his values and culture keeps the conversation comfortable and makes him more willing to take part. | ****Expected outcomes**** - Discusses concerns openly. - Receives accurate information. - Resumes intimacy as advised by the doctor. ****Linking the data to the diagnosis**** The man after a heart attack says, "I'm afraid it will happen again." He avoids his partner, is worried, and asks few questions. These data show closeness is already affected by fear linked to his illness, so this actual diagnosis fits better than a general anxiety diagnosis because the worry centers on the relationship. The problem has already begun, so it is not a risk. The plan aims for him to discuss his concerns openly, receive accurate information, and resume intimacy as advised by the doctor.

CarePath diagnosis: Relationship or intimacy difficulty related to illness, as evidenced by avoids closeness and worry.

Intervention	Rationale
Create a private safe space.	Privacy lets him talk about a sensitive topic without embarrassment, so his real fears can be spoken aloud.
Give information.	Accurate facts about safe activity after a heart attack correct myths and reduce fear that intimacy will cause another one.
Include the partner.	Including his partner lets both share their worries and understand the facts, which can reduce distance between them.
Refer for counseling.	A counselor trained in intimacy and relationship problems can give deeper help if fear and avoidance continue.
Respect values.	Respecting his values and culture keeps the conversation comfortable and makes him more willing to take part.

Expected outcomes: Discusses concerns openly. · Receives accurate information. · Resumes intimacy as advised by the doctor.

Linking the data: The man after a heart attack says, "I'm afraid it will happen again." He avoids his partner, is worried, and asks few questions. These data show closeness is already affected by fear linked to his illness, so this actual diagnosis fits better than a general anxiety diagnosis because the worry centers on the relationship. The problem has already begun, so it is not a risk. The plan aims for him to discuss his concerns openly, receive accurate information, and resume intimacy as advised by the doctor.

R12 Abuse or neglect in the family

Group: Communication and relationships | Type: Actual problem

Definition: Signs that a family member is being harmed or not properly cared for.

Possible causes: Stress; caregiver burden; power imbalance; substance use

Signs and symptoms: Unexplained injuries; fear; poor hygiene; neglect; conflicting stories

Scenario. A frail patient arrives dirty and underfed with bruises.

S: "It's nothing. I'm fine."

O: Frail patient arrives dirty and underfed; bruises; conflicting stories; caregiver controlling.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Abuse or neglect in the family related to stress, as evidenced by unexplained injuries and fear. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Observe and document. | Careful, factual records of injuries, appearance and statements provide objective evidence that supports protective action and any later investigation. | | Speak privately. | Speaking alone lets her talk without fear of the caregiver, who may be controlling, so the truth is more likely to come out. | | Ensure safety. | Her safety comes first, so she should not be left alone with someone who may be harming her until the situation is assessed. | | Report per policy. | Reporting through the right channels brings in people trained and legally empowered to investigate and protect her, so she is not left at risk. | | Offer support. | Support such as counseling and social services helps her recover, and may also help a stressed caregiver get help. | | Follow the law. | Laws and policies on reporting abuse protect vulnerable adults and nurses, so acting within them keeps the response correct and safe. | ****Expected outcomes**** - Patient safe. - Concerns reported per policy. - Support arranged. - Neglect addressed. ****Linking the data to the diagnosis**** The frail patient arrives dirty and underfed, with bruises, conflicting stories, and a controlling caregiver. She says, "It's nothing. I'm fine." These data show harm or neglect that has already occurred, so this is an actual diagnosis and not a risk, and the minimizing answer should not reassure the nurse. It fits better than a diagnosis for poor nutrition alone, because the pattern points to the family setting. The plan aims for the patient to be safe, concerns reported per policy, support arranged, and the neglect addressed.

CarePath diagnosis: Abuse or neglect in the family related to stress, as evidenced by unexplained injuries and fear.

Intervention	Rationale
Observe and document.	Careful, factual records of injuries, appearance and statements provide objective evidence that supports protective action and any later investigation.
Speak privately.	Speaking alone lets her talk without fear of the caregiver, who may be controlling, so the truth is more likely to come out.
Ensure safety.	Her safety comes first, so she should not be left alone with someone who may be harming her until the situation is assessed.
Report per policy.	Reporting through the right channels brings in people trained and legally empowered to investigate and protect her, so she is not left at risk.
Offer support.	Support such as counseling and social services helps her recover, and may also help a stressed caregiver get help.
Follow the law.	Laws and policies on reporting abuse protect vulnerable adults and nurses, so acting within them keeps the response correct and safe.

Expected outcomes: Patient safe. · Concerns reported per policy. · Support arranged. · Neglect addressed.

Linking the data: The frail patient arrives dirty and underfed, with bruises, conflicting stories, and a controlling caregiver. She says, "It's nothing. I'm fine." These data show harm or neglect that has already occurred, so this is an actual diagnosis and not a risk, and the minimizing answer should not reassure the nurse. It fits better than a diagnosis for poor nutrition alone, because the pattern points to the family setting. The plan aims for the patient to be safe, concerns reported per policy, support arranged, and the neglect addressed.

R13 Parenting difficulty

Group: Communication and relationships | Type: Actual problem

Definition: A parent struggles to meet a child's physical, emotional, or safety needs.

Possible causes: Young parent; poor knowledge; stress; poverty; lack of support

Signs and symptoms: Neglect; harsh discipline; missed visits; unsafe home

Scenario. A teenage mother is unsure how to feed her infant.

S: "I don't know how to feed my baby."

O: Teen mother; unsure about feeds; infant crying; limited support.

Tools: CP-TALK · Communication barrier checklist **CarePath diagnosis:** Parenting difficulty related to young age and limited support, as evidenced by uncertainty about feeding and an infant who is crying.

Interventions and rationale

Intervention	Rationale
Teach skills.	Showing how to feed and care for her baby gives her the knowledge and confidence she lacks, which supports the baby's growth and safety.
Praise efforts.	Praise for what she does well builds confidence and encourages her to keep learning and trying.
Arrange support.	Support from family, friends or services eases the load on a young parent with limited help and lowers stress.
Make home visits.	Home visits let the nurse see real conditions, give teaching in context, and spot problems that would be missed in hospital.
Link to community resources.	Community resources such as parenting classes and clinics provide continued help after the nurse is no longer involved.
Watch for safety.	Watching for safety makes sure the infant is fed, kept safe, and not harmed while the mother is still learning.

Expected outcomes - Within 1 week: feeds baby correctly, states hunger cues, links to community support. - Baby thriving.

Linking the data to the diagnosis The teen mother says, "I don't know how to feed my baby." She is unsure about feeds, the infant is crying, and she has limited support. These data show a young parent who cannot yet meet her baby's needs, so this actual diagnosis fits better than a risk statement or a weak bond diagnosis, because the main problem is skill and knowledge. The plan aims for her, within 1 week, to feed the baby correctly, state hunger cues, link to community support, and see the baby thriving.

CarePath diagnosis: Parenting difficulty related to young age and limited support, as evidenced by uncertainty about feeding and an infant who is crying.

Intervention	Rationale
Teach skills.	Showing how to feed and care for her baby gives her the knowledge and confidence she lacks, which supports the baby's growth and safety.
Praise efforts.	Praise for what she does well builds confidence and encourages her to keep learning and trying.
Arrange support.	Support from family, friends or services eases the load on a young parent with limited help and lowers stress.
Make home visits.	Home visits let the nurse see real conditions, give teaching in context, and spot problems that would be missed in hospital.
Link to community resources.	Community resources such as parenting classes and clinics provide continued help after the nurse is no longer involved.
Watch for safety.	Watching for safety makes sure the infant is fed, kept safe, and not harmed while the mother is still learning.

Expected outcomes: Within 1 week: feeds baby correctly, states hunger cues, links to community support. · Baby thriving.

Linking the data: The teen mother says, "I don't know how to feed my baby." She is unsure about feeds, the infant is crying, and she has limited support. These data show a young parent who cannot yet meet her baby's needs, so this actual diagnosis fits better than a risk statement or a weak bond diagnosis, because the main problem is skill and knowledge. The plan aims for her, within 1 week, to feed the baby correctly, state hunger cues, link to community support, and see the baby thriving.

R14 Weak bond between parent and baby

Group: Communication and relationships | Type: Risk problem

Definition: Early bonding may be delayed by separation, illness, or stress.

Risk factors: Premature baby; maternal illness; separation; stress; depression

Warning signs: Avoids the baby; little eye contact; does not respond to baby's cues

Scenario. A mother separated from her premature baby shows little interest in visits.

S: "I'm scared to touch him."

O: Premature baby in the NICU; mother avoids touching; little eye contact; tearful.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Weak bond between parent and baby related to premature baby and maternal illness (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Encourage touch and skin-to-skin care. | Touch and skin-to-skin contact help parent and baby bond, steady the baby's heart rate and temperature, and make the mother feel more confident. | | Involve her in care. | Taking part in feeding and care shows her she matters to her baby and helps her feel like a mother, not a visitor. | | Explain baby's cues. | Understanding what her baby's signals mean helps her respond to him, which builds closeness and reduces her fear. | | Praise bonding. | Praise for each small step builds her confidence and encourages her to keep trying to touch, hold and respond to her baby. | | Offer support. | Emotional support helps her cope with fear, illness and separation, which can otherwise get in the way of bonding. | ****Expected outcomes**** - Within days: holds baby skin to skin, responds to his cues, says she feels closer to him. ****Linking the data to the diagnosis**** The mother of a premature baby in the NICU says, "I'm scared to touch him," avoids touching, makes little eye contact, and is tearful. The risk factors are prematurity, separation and maternal illness. The bond is not yet broken; these early signs show she may be at risk but no lasting problem has been shown, so a risk diagnosis is right, not an actual one. The plan aims to prevent it: within days she holds her baby skin to skin, responds to his cues, and says she feels closer to him.

CarePath diagnosis: Weak bond between parent and baby related to premature baby and maternal illness (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Encourage touch and skin-to-skin care.	Touch and skin-to-skin contact help parent and baby bond, steady the baby's heart rate and temperature, and make the mother feel more confident.
Involve her in care.	Taking part in feeding and care shows her she matters to her baby and helps her feel like a mother, not a visitor.
Explain baby's cues.	Understanding what her baby's signals mean helps her respond to him, which builds closeness and reduces her fear.
Praise bonding.	Praise for each small step builds her confidence and encourages her to keep trying to touch, hold and respond to her baby.
Offer support.	Emotional support helps her cope with fear, illness and separation, which can otherwise get in the way of bonding.

Expected outcomes: Within days: holds baby skin to skin, responds to his cues, says she feels closer to him.

Linking the data: The mother of a premature baby in the NICU says, "I'm scared to touch him," avoids touching, makes little eye contact, and is tearful. The risk factors are prematurity, separation and maternal illness. The bond is not yet broken; these early signs show she may be at risk but no lasting problem has been shown, so a risk diagnosis is right, not an actual one. The plan aims to prevent it: within days she holds her baby skin to skin, responds to his cues, and says she feels closer to him.

R15 Loss of privacy or dignity

Group: Communication and relationships | Type: Risk problem

Definition: Care may expose the person or treat them with less respect than they deserve.

Risk factors: Exposure; no privacy; rushed care; stigma; cultural insensitivity

Warning signs: Embarrassment; covers body; refuses care; complaints

Scenario. A patient is due a dressing change in a shared ward where the curtain rail is broken.

S: "I hope no one sees me."

O: Shared ward; broken curtain rail; procedure needs the abdomen exposed; patient pulls the gown closed; anxious.

Tools: CP-TALK, CP-MIND · Communication barrier checklist, PHQ-9, GAD-7, C-SSRS **CarePath diagnosis:** Loss of privacy or dignity related to no privacy and exposure (risk factors); no signs of the problem are present yet. **Interventions and rationale** | Intervention | Rationale | |---|---| | Use curtains and screens. | Curtains and screens block the view of other patients and visitors, which protects privacy during a procedure that exposes the abdomen. | | Knock before entering. | Knocking before entering shows respect for personal space and gives the patient a chance to prepare. | | Keep covered. | Keeping the body covered except for the area being treated reduces exposure and embarrassment, and respects her wish not to be seen. | | Explain care. | Explaining what will happen and why lowers anxiety and lets her feel in control of what is done to her body. | | Call by name. | Using her preferred name shows respect and treats her as a person, not a case or bed number. | | Respect culture. | Cultural beliefs about modesty and touch vary, so respecting them prevents distress and keeps her willing to accept care. | **Expected outcomes** - Privacy kept in all care. - Patient says she feels respected. - Accepts care. **Linking the data to the diagnosis** The patient needs a dressing change in a shared ward where the curtain rail is broken, and the procedure needs her abdomen exposed. She says, "I hope no one sees me," pulls her gown closed, and is anxious. Her dignity has not yet been breached, but the risk factors of no privacy and exposure are present, so this is a risk diagnosis and not an actual one. The plan aims to prevent harm: privacy is kept in all care, she says she feels respected, and she accepts care.

CarePath diagnosis: Loss of privacy or dignity related to no privacy and exposure (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Use curtains and screens.	Curtains and screens block the view of other patients and visitors, which protects privacy during a procedure that exposes the abdomen.
Knock before entering.	Knocking before entering shows respect for personal space and gives the patient a chance to prepare.
Keep covered.	Keeping the body covered except for the area being treated reduces exposure and embarrassment, and respects her wish not to be seen.
Explain care.	Explaining what will happen and why lowers anxiety and lets her feel in control of what is done to her body.
Call by name.	Using her preferred name shows respect and treats her as a person, not a case or bed number.
Respect culture.	Cultural beliefs about modesty and touch vary, so respecting them prevents distress and keeps her willing to accept care.

Expected outcomes: Privacy kept in all care. · Patient says she feels respected. · Accepts care.

Linking the data: The patient needs a dressing change in a shared ward where the curtain rail is broken, and the procedure needs her abdomen exposed. She says, "I hope no one sees me," pulls her gown closed, and is anxious. Her dignity has not yet been breached, but the risk factors of no privacy and exposure are present, so this is a risk diagnosis and not an actual one. The plan aims to prevent harm: privacy is kept in all care, she says she feels respected, and she accepts care.

R16 Care conflicts with culture

Group: Communication and relationships | Type: Actual problem

Definition: Care routines clash with the person's cultural practices or values.

Possible causes: Beliefs; religion; gender preferences; diet; rituals

Signs and symptoms: Refuses care; delays decisions; conflict with staff; family objections

Scenario. A woman declines male staff for personal care because of her religious beliefs.

S: "I can't allow a man to help me wash."

O: Declines male staff; religious beliefs; delays care.

Tools: CP-TALK · Communication barrier checklist ****CarePath diagnosis:**** Care conflicts with culture related to beliefs, as evidenced by refuses care and delays decisions. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Ask respectfully. | Asking respectfully shows that her beliefs matter and finds out exactly what she needs, rather than guessing. | | Adapt where safe. | Where it is safe, meeting her preference, such as female staff, respects her values and lets care go ahead without distress. | | Involve family and chaplain. | Family and a chaplain can explain what her faith allows and support her in choosing, which may resolve the conflict. | | Offer a carer of the same gender for personal care where possible. | Matching carer gender respects religious beliefs and dignity and makes it more likely she will accept care. | | Explain options. | Clear explanation of the options lets her make an informed choice and avoids refusal because of misunderstanding. | ****Expected outcomes**** - Preference respected where safe. - Personal care completed by suitable staff. - Patient feels respected. ****Linking the data to the diagnosis**** The woman declines male staff for personal care and says, "I can't allow a man to help me wash." Her religious beliefs are the stated reason, and she is delaying care. These data show a clash between routine and her values that is already affecting care, so this is an actual diagnosis, not a risk. It fits better than a diagnosis of non-adherence, because her reason is cultural and not a lack of willingness. The plan aims for her preference to be respected where safe, personal care completed by suitable staff, and the patient feeling respected.

CarePath diagnosis: Care conflicts with culture related to beliefs, as evidenced by refuses care and delays decisions.

Intervention	Rationale
Ask respectfully.	Asking respectfully shows that her beliefs matter and finds out exactly what she needs, rather than guessing.
Adapt where safe.	Where it is safe, meeting her preference, such as female staff, respects her values and lets care go ahead without distress.
Involve family and chaplain.	Family and a chaplain can explain what her faith allows and support her in choosing, which may resolve the conflict.
Offer a carer of the same gender for personal care where possible.	Matching carer gender respects religious beliefs and dignity and makes it more likely she will accept care.
Explain options.	Clear explanation of the options lets her make an informed choice and avoids refusal because of misunderstanding.

Expected outcomes: Preference respected where safe. · Personal care completed by suitable staff. · Patient feels respected.

Linking the data: The woman declines male staff for personal care and says, "I can't allow a man to help me wash." Her religious beliefs are the stated reason, and she is delaying care. These data show a clash between routine and her values that is already affecting care, so this is an actual diagnosis, not a risk. It fits better than a diagnosis of non-adherence, because her reason is cultural and not a lack of willingness. The plan aims for her preference to be respected where safe, personal care completed by suitable staff, and the patient feeling respected.