

| <b>Organisation name</b><br>Site or unit |                                  | <b>STANDARD OPERATING PROCEDURE</b><br><b>Individualised Care Planning</b> |                    |
|------------------------------------------|----------------------------------|----------------------------------------------------------------------------|--------------------|
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| <b>Review date</b>                       |                                  | <b>Replaces</b>                                                            | 1.0                |
| <b>Owner</b>                             | Clinical lead for this procedure | <b>Approved by</b>                                                         |                    |
| <b>Classification</b>                    | Internal                         | <b>Applies to</b>                                                          | All clinical areas |
| <b>Signature</b>                         |                                  |                                                                            |                    |

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## Abbreviations

| Abbreviation | Meaning                |
|--------------|------------------------|
| MDT          | Multidisciplinary team |

| Abbreviation | Meaning                      |
|--------------|------------------------------|
| SOP          | Standard operating procedure |

## Key points

- Every patient has an individual care plan, built from the admission assessment, within the first day of care.
- Each problem in the assessment has a goal that can be measured, an intervention, a named person responsible, and a review date.
- The patient, and family where appropriate, take part in setting the goals, and their views are recorded.
- The plan is reviewed at each review date and at every change in condition, and the review is recorded.
- Stop and get help straight away if a patient has no individual care plan after the first day of care.

## 1. Purpose

To make treatment fit the patient, and to state clearly what the treatment is trying to achieve, so that progress can be judged. A generic plan does not fit the patient and guides nobody. This SOP sets out how a plan is written from the assessment, how goals are made measurable, how the patient is involved, and how the plan is kept up to date. It supports criterion 1.3.

## 2. Scope

| Element     | Coverage                                                                                                     |
|-------------|--------------------------------------------------------------------------------------------------------------|
| Who         | Responsible clinicians who write the plan, nurses and therapists who deliver it, and the patient and family. |
| Where       | All wards, clinics and departments of the facility.                                                          |
| When        | Within the first day of care; at each review date; and at any change in the patient's condition.             |
| Not covered | Time-limited emergency treatment, which is covered by the emergency procedure, and the discharge summary.    |

## 3. Definitions

| Term                  | Meaning                                                                                                                                                    |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Individual care plan  | The written plan for one patient: the problems, the goals, the interventions, the responsible person, and the review date for each.                        |
| Measurable goal       | A goal that states a target and a time, so that it can be checked. For example: "walk 20 metres with a frame by discharge" rather than "improve mobility". |
| Responsible clinician | The doctor or nurse who writes and updates the plan.                                                                                                       |
| Review date           | The date by which the plan must be looked at again, set for each problem.                                                                                  |

## 4. Background

A plan written from a generic template, or never updated, does not describe what is happening to the patient. An individual plan that uses the assessment, sets measurable goals, involves the patient, and is reviewed is the basis for judging whether treatment is working. The same plan is also what the team hands over when the patient moves between wards or leaves.

## 5. Responsibilities

| Role                        | Responsibility                                                                                        |
|-----------------------------|-------------------------------------------------------------------------------------------------------|
| Clinical director           | Approves this SOP and the plan template, and receives the quarterly audit.                            |
| Responsible clinician       | Writes the plan, sets the goals, and updates the plan at each review.                                 |
| Ward nurse                  | Delivers the planned care, records progress against each goal, and reports any problem with the plan. |
| Allied health professionals | Write the interventions for their discipline into the plan and review them.                           |
| Patient and family          | Take part in setting the goals, and tell the team if a goal no longer fits.                           |

## 6. Materials and equipment

| Item           | Requirement                                                                                                                 |
|----------------|-----------------------------------------------------------------------------------------------------------------------------|
| Care plan form | The facility's current approved form, with a row for each problem, goal, intervention, responsible person, and review date. |

## 7. Safety and exceptions

- **Urgent treatment first.** Do not delay urgent treatment to complete the plan. The plan follows as soon as the patient is stable, and within the first day of care.
- **Patient cannot take part.** Set the plan with the family or the nominated decision-maker, record the reason the patient could not take part, and review it when the patient can.
- **Disagreement.** Where the patient or family disagrees with a goal, record their view, explain the clinical reasons, and agree the plan or record that it has not been agreed.

## 8. Procedure

### Before you start

- Read the admission assessment and any existing plan.
- List the problems identified in the assessment. Each problem needs a goal.

### Step 1. Write a goal for each problem

1. State the goal for the problem in terms the patient can understand.
2. Make the goal measurable: name what will be different, by how much, and by when. Example: "Pain score 3 or less at rest by day 3", "Eats at least half of each meal by day 5", "No fall in the next 4 weeks".
3. If a goal cannot be measured, record the best measure available (for example, the patient's own description with a scale) and say how it will be checked.

### Step 2. Choose the interventions and the owner

1. For each goal, write the intervention, the frequency or dose, and the person responsible.
2. Include the interventions that link to the other SOPs: falls (PSF-SOP-001-EN), pressure care (CLN-SOP-004-EN), nutrition (CLN-SOP-003-EN), VTE (CLN-SOP-005-EN).
3. Where an intervention needs an allied health professional, record the referral.

### Step 3. Agree the plan with the patient

1. Explain the plan in plain language. Ask the patient what matters most to them and whether each goal makes sense.
2. Where the family is involved, with the patient's agreement, include them. Record the views of each person.
3. Record the outcome: agreed, agreed in part, or not agreed, with the reason.

### Step 4. Review and update

1. Review each goal on its review date. Record progress as met, partly met, not met, or no longer relevant.
2. Update the plan at every change in condition, and when a goal is met, not met, or no longer relevant.
3. Where a goal is not met after two reviews, reassess the cause and change the intervention, and record the change.

## 9. Worked example

| Situation                                                                                                         | What to do                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>A 69-year-old woman after a bowel operation. Her assessment shows pain, poor mobility, and reduced intake.</b> | Three problems, three goals. Pain: "pain 3 or less at rest and able to walk to the bathroom by day 2". Mobility: "walks 10 metres with a frame by day 3, with physiotherapy" (intervention and owner recorded). Intake: "eats at least half of each meal by day 4" (nutrition referral linked to CLN-SOP-003-EN). Her daughter is involved at her request, and her views are recorded. The plan is reviewed on day 2, when the pain goal is partly met, and the analgesia is changed. |
| <b>The plan on the record has not been updated for five days, and the patient has had a fall.</b>                 | Treat as a change in condition: review the plan at once, update the goals and interventions, inform the responsible clinician, and record the fall under PSF-SOP-001-EN.                                                                                                                                                                                                                                                                                                              |

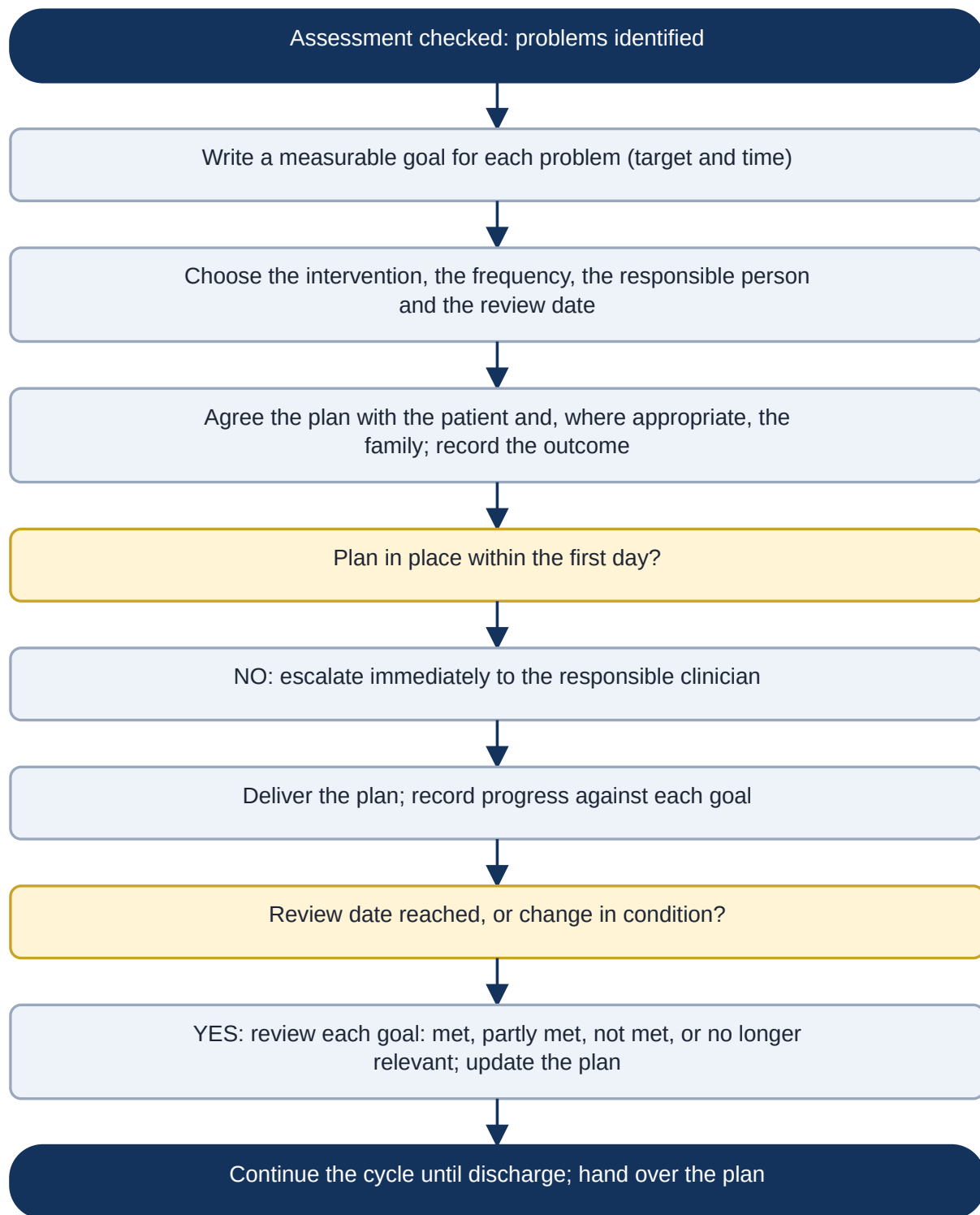


Figure 1. Care planning cycle

## 10. Decision points

| If                                      | Then                                                                             |
|-----------------------------------------|----------------------------------------------------------------------------------|
| No plan after the first day             | Escalate immediately to the responsible clinician.                               |
| A goal is not met on review             | Review the intervention; change it and record the change.                        |
| Patient or family disagrees with a goal | Record the view, explain the reasons, and agree or record that it is not agreed. |
| Change in condition                     | Review and update the plan at once.                                              |

## 11. Escalation

| Event                                       | Inform                                         | Timescale       |
|---------------------------------------------|------------------------------------------------|-----------------|
| No individual care plan after the first day | Responsible clinician and ward or unit manager | Immediately     |
| Plan not reviewed on the due date           | Ward or unit manager                           | Same shift      |
| Repeated gaps on one unit                   | Clinical director and quality team             | Within one week |

## 12. Monitoring and compliance

| Indicator                                 | Target           | Method                       | Frequency | Owner         |
|-------------------------------------------|------------------|------------------------------|-----------|---------------|
| Patients with a plan within the first day | 100% of patients | Audit of 20 records per unit | Monthly   | Ward manager  |
| Goals written as measurable               | 100% of goals    | Audit of 20 plans per unit   | Monthly   | Clinical lead |
| Plans reviewed on the due date            | 100% of plans    | Audit of 20 records per unit | Monthly   | Ward manager  |

## 13. Records

| Record                           | Kept in        | Retention                                    |
|----------------------------------|----------------|----------------------------------------------|
| Individual care plan and reviews | Patient record | As set by the institutional retention policy |

## 14. Training and competence

- **Induction:** writing measurable goals, linking interventions to the assessment, and using the plan form. Competence is assessed by rewriting three vague goals as measurable goals.
- **Annual update:** audit of care plans against this SOP.

## 15. Related documents

| ID             | Title                                          | Relationship        |
|----------------|------------------------------------------------|---------------------|
| CLN-SOP-001-EN | Structured clinical assessment on admission    | Source of the plan  |
| PSF-SOP-001-EN | Falls Risk Assessment and Prevention           | Falls interventions |
| CLN-SOP-004-EN | Pressure injury risk assessment and prevention | Skin interventions  |

## 16. References

1. ASF Accreditation Standards, Standard 1 (Assessment, Care Planning and Safety), criterion 1.3. No external clinical guideline was cited; the goal-setting method is local practice and must be confirmed by the clinical director.

## 17. Change history

| Version | Date | Summary of change       | Approved by          |
|---------|------|-------------------------|----------------------|
| 1.0     |      | First approved version. | ASF Expert Committee |

| Version | Date | Summary of change                                                                                                                                      | Approved by |
|---------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| 1.2     |      | Substantive revision: measurable-goal method with examples, linked interventions, patient and family agreement steps, review rules and worked example. |             |

## Annex A. Care plan audit record

Use this record for each audit session. Record one line per patient or task observed. Enter Y, N or NA as shown in the column heading.

| Date | Unit | Patient reference | Plan in place after day 1 (Y / N) | Measurable goals (Y / N) | Patient or family involved (Y / N / NA) | Reviewed on due date (Y / N) | Comment |
|------|------|-------------------|-----------------------------------|--------------------------|-----------------------------------------|------------------------------|---------|
|      |      |                   |                                   |                          |                                         |                              |         |
|      |      |                   |                                   |                          |                                         |                              |         |
|      |      |                   |                                   |                          |                                         |                              |         |
|      |      |                   |                                   |                          |                                         |                              |         |
|      |      |                   |                                   |                          |                                         |                              |         |
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|      |      |                   |                                   |                          |                                         |                              |         |
|      |      |                   |                                   |                          |                                         |                              |         |
|      |      |                   |                                   |                          |                                         |                              |         |
|      |      |                   |                                   |                          |                                         |                              |         |

## Annex B. Monitoring chart

The unit records its monthly result on this chart and reviews it at the monthly meeting. Plot each month as a point or a bar, and note the actions taken beside it.

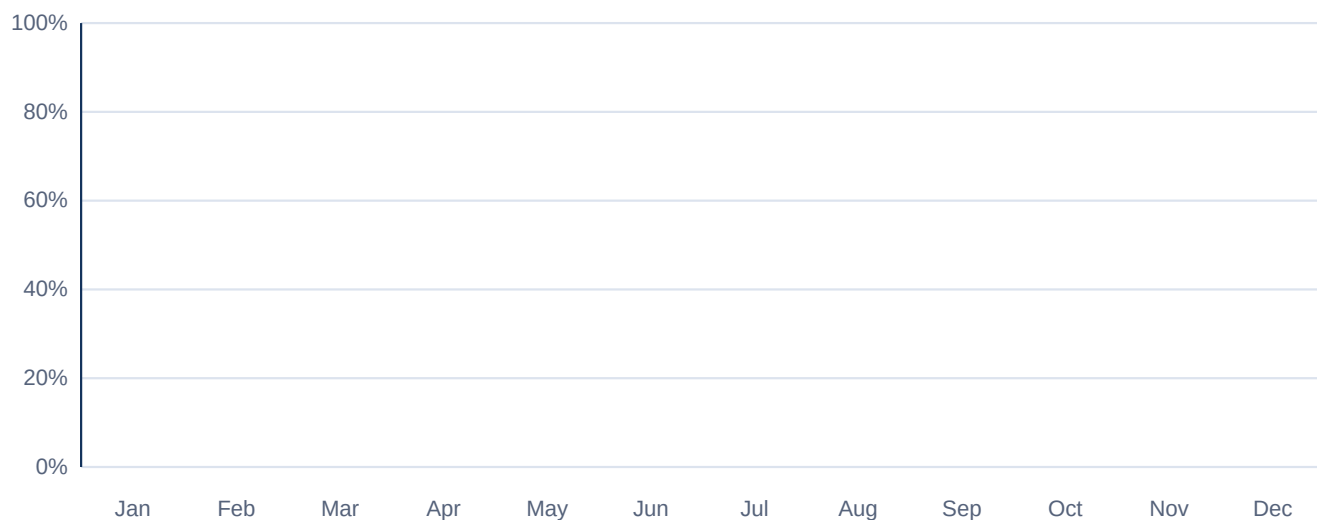


Figure B.1 Care plans in place and reviewed by month. Target as set by the facility (see the monitoring table).