Individualised care planning

Standard operating procedure (SOP) | CLN-SOP-002

Document type	Standard operating procedure (SOP)
Title	Individualised care planning
Document ID	{{facility.code}}-CLN-SOP-002
Version and status	1.0 | Issued for use. Pending ASF Expert Committee ratification
Prepared by	{{roles.quality_lead.name}}, Quality lead
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Effective date	{{document.effective_date}}
Next review	{{document.review_date}} (12 months, or sooner after any incident or change)
Replaces	None (new document)
Standards and criteria supported	Standard 1 (Assessment, Care Planning and Safety), criterion 1.3
Evidence basis	E-006, E-009
Status of this document	Recommended best-practice model. A hospital may adopt, adapt or replace it with an equivalent that meets the same criteria.

At a glance: what to do

1. Each care plan is built from the patient's own assessment, not a template.
2. The plan states the goals or desired results of treatment.
3. The patient, and family where appropriate, take part in setting it.
4. The plan is updated as the patient changes.

Stop and get help straight away if: a patient has no individual care plan after the first day of care.

1. Purpose

To make the treatment fit the patient and to state what it is trying to achieve (1.3).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of {{facility.legal_name}}
When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions and abbreviations

Term	Meaning in this SOP
Clinical lead	The doctor or nurse in charge of the area at the time

4. Background and rationale

To make the treatment fit the patient and to state what it is trying to achieve (1.3).

5. Responsibilities

Role	Duties in this SOP	Competence needed
Responsible clinician	Writes and updates the plan	Doctor or nurse
Patient and family	Take part in setting the goals	Patient

6. Equipment, materials and resources

Item	Specification or standard	Check before use
Records and forms named in this document	Current version	Checked before use

7. Safety and infection prevention

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Follow the steps in order. Where a step says "If", take the action for the case that applies. Do not skip a step. If a step cannot be done, use section 11 and section 12.

Step	Action	How to do it	Key point
1	Plan from the assessment.	• Write the plan from the admission assessment (CLN-FRM-002), using the patient's own problems.	Built from this patient.
2	Set goals with the patient.	• Agree the goals or desired results with the patient, and family where appropriate. • Record their view.	The patient is part of the plan.
3	Update.	• Review the plan at each change in condition and at the set review date.	The plan changes with the patient.

Decision points

- No decision points in this procedure.

10. Special situations

Situation	What to do
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

11. Problems and escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

12. Monitoring and compliance

What is checked	Target	How often	Who	If the target is missed
Patients with individual plan by day 1	100%	Monthly	Clinical director	Escalate to chief executive
Plans with goals and patient involvement recorded	At least 90%	Monthly	Clinical director	Escalate to chief executive

13. Records

Record	Where it is kept	Kept for
Record named in this document	Patient record or the area file	{{facility.records_retention_years}} years

14. Training and competence

- Staff are trained in this document at induction and refreshed each year, with a recorded competency check.

15. Related documents

ID	Title	Relationship
CLN-FRM-003	Individual care plan	Plan form

16. Evidence

ID	Source and status
E-009	ASF Expert Committee consensus.
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

EC = ASF Expert Committee consensus. Items marked EC are reviewed by the Committee each year.

17. Change history

Version	Date	What changed	Approver and signature
1.0	{{document.effective_date}}	First version	Pending Expert Committee approval