

Care Planning: The Process

MU Patient Education Series

A care plan is an agreement between you and your health professional (and/or social services) to help you manage your health day-to-day. The plan of care is the plan that is developed with the goal of improving you. The care plan looks at the total person and serves as a guide for care. Your involvement in your care plan is vital to your health, and it is your right.

What you need to know:

- The care plan is initiated when you are admitted
- The care plan is an ongoing process
- Family is welcome to participate
- You should be advised and involved in your plan of care
- Care plans are reviewed periodically
- Care plans can change over time or as needed

What is included in the care plan?

- Your health plan (goals you want to work towards)
- Treatment plan
- Labs, tests, exams (effect on care)
- Mental status (social and emotional evaluation and support)
- Future plans (discharge)
- Medication
- Nutrition (a diet plan)
- Therapy (an exercise plan)
- Activity & support services
- Language
- Religion
- Medical history

Who is involved in the care plan?

- Nurse
- Doctor/Surgeon/Consultant
- Nursing Assistant
- Physical Therapy
- Occupational Therapy
- Pharmacist
- Social Worker/Case Manager
- Dietician

All the information in the care plan is private, seen only by you and the people who give you care or support. If you want someone else to be allowed to see the care plan, you can say so.

Remember the care plan varies for different people and is based on level of care required. Care plans can be very complex or very simple. The overall objective is to ensure that the patient's needs, goals and preferences are met and that the overall health of the individual is a priority.