1



SPECIAL NEEDS RESOURCE PROJECT e-newsletter Things to Think About!



By Brandan Atkin

If you would like a free online version of a Care Plan, please visit the following link:

http://www.healthatoz.com/healthato z/Atoz/phr/register/phrregister.jsp?C alledFrom=PHR

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Care Plans By Linda Jorgensen

It seems that every time we receive services from someone we are confronted with a document called a "Care Plan". We have one for occupational therapy, physical therapy, home health care, our DSPD case manager has a "Plan Of Care" and every time we walk into our nearest medical center one of the first documents the nursing staff whips out, secondary only to our admission papers, is a care plan. Even the school nurse has one for medical care given at school.

What, exactly, is a Care Plan and why do we need one?

A Care Plan is a document that is used to record medical care and treatment of any individual needing care on a daily basis. Plans contain doctor's orders for medications, therapies, exercise, equipment management, appointments, etc. A plan of care helps caregivers manage all the day-to-day activities of the person in their care. Presented in a certain order, this information is used to ensure the process of care remains routine from day to day regardless of who may be giving that care. Everyone knows exactly what he or she is to be doing as long as the written care plan is followed. With a written care plan in place providers do not have to rely on their own memory. They can double check the care plan as often as necessary to ensure they are meeting their client's needs on a daily basis and watch for any developing trends that may need addressing by a physician or care manager.

While most hospitals and agencies have their own specific care plan forms the information recorded remains pretty much the same.

A care plan generally includes the following information:

- Diagnosis
- Medications
- Physician's orders (when necessary).
- Individual's activity levels and limitations.
- A list of equipment needed.
- Dietary restrictions.
- A list of allergies.
- Behaviors and intervention methods.
- Detailed care instructions.
- Specific services which each person or agency provides.
- Emergency Instructions.
- Notes and comments regarding the cares given and observations made during a care visit.

Medical professionals in various specialties use care plans most frequently but care plans may also be a valuable tool when used in the home environment. Respite providers, family members, family friends etc. may all find a care plan helpful when assisting you in caring for your child at home during your absence.

Building a Care Plan

You will need a 3-ring binder or loose-leaf notebook with inside pockets to hold all necessary documents. Put your doctor's instructions on the inside front cover, making sure to keep the originals. Medication information sheets can be put in a page protector or the back cover pocket, as needed.

You may develop your own care plan form or you may print several copies of the Care Plan form found in the SNRP **Forms section**. Use a 3-hole punch to punch holes in the forms and place the forms in your binder. This becomes your official Care Plan.

After using your care plan for a week you'll be able to adjust as needed. Care Plans may be changed as often as your child's needs change. Always do what works for you, your child, and the individuals helping you care for your child. Use notes, pictures, or anything else to describe needed tasks and avoid possible confusion. Also, use an ink pen (NO PENCIL) to keep a permanent record.

Lastly, be sure to place your Care Plan where everyone needing to use it can easily access it. Documenting your child's care will improve the care given and could prevent care related health problems in the future.



"Nurse, get on the internet, go to SURGERY.COM, scroll down and click on the 'Are you totally lost?' icon."