Our care planning solution allows electronic care plans to be created and tailored to patient needs and supports staff in recording care. It helps with planning the care in a holistic and collaborative manner, using agreed local and national guidelines in conjunction with NICE, N&MC and NHSD, to ensure patient care is optimised.

The module helps users and patients to identify, manage and prepare a suitable plan to reach desired outcomes, be they personal or defined by admission. It ensures that a patient gets the same standard, quality and accuracy of care regardless of which members of staff are on duty. As a ‘living document’ it encourages multidisciplinary engagement with the patient and creates a timeline of activity which is easy to review, edit and navigate.

A patient’s care plan is developed using a template, focusing on the essentials of care, including nutrition, mobility, sleeping, tissue viability, falls prevention, psychological needs, recording of clinical interventions, communication and sexuality. The solution’s flexibility allows for additional needs, goals and activities to be developed collaboratively with the patient, ensuring the care given is tailored to the individual.

Care planning integrates seamlessly with other solutions and the user base. It reduces the need for information to be recorded on paper and makes it much easier to track the status of a plan as it develops.
Key components:

Locally configurable templates:
Create care plan templates based on patient pathways.

SNOMED support:
Include SNOMED care planning terms in the care plan content.

Audit capability:
Each care plan entry is time-stamped, providing a full audit trail of the entire care plan.

Guidelines and protocols support:
Ensure appropriate care is delivered, pathways are followed, and problem management is implemented using recommended guidelines and care protocols.

Narrative captured within the care plan:
Clinicians can record their actions and interventions directly on the patient care plan, providing a narrative within the context of the care plan.

Access to the wider EPR:
Authorised users will be able to navigate to the wider patient record, from activities and interventions, to complete an action such as an assessment or order an x-ray.

Structured patient care communication:
Needs, goals and intervention templates are stored in an organised format to support structured patient care communication, providing an auditable patient care record.

Links to other patient information:
Manage care using electronic patient information linking to specific parts of the record, such as clinical notes, letters, appointments and referrals, improving efficiency and user experience.

Supports Clinical Negligence Scheme for Trusts objectives:
Needs, goals and activities are clearly defined and communicated to those involved in the care of a patient, ensuring care is consistent, reducing clinical risk and supporting Clinical Negligence Scheme for Trusts (CNST) objectives.

Key features:

• Supports an organisation to standardise care delivery and follow best practice.
• Enables efficient working through integration of data and other modules.
• Supports seamless sharing and actioning of care plans across multiple platforms and devices.
• Allows and encourages wider multi-disciplinary teams to get involved in the care plan.

Key benefits:

• Improved patient safety
• Improved clinical outcomes and patient experience
• Improved patient flow and financial performance
• Improved information sharing and care co-ordination
• Improved continuity of care across health communities
• Improved management of resources
• Releases nurses’ time to care.

“The flexibility of CareFlow care planning is a major benefit. As nursing practice develops and expands nationally and locally, we know we can adapt our version to instantly reflect changes, making our care plans future proof.”

Claire Grant, Chief Nursing Information Officer, Barnsley Hospital NHS Foundation Trust