What are care plans?

Care plans are a diagrammatic representation of care that transfers thinking into practice. They encourage holistic nursing and offer direction on nursing care.

Models tell us what to look out for when assessing a patient and evidence based care should then be provided.

Care plans are a legal document that shows accountability, identifies the care to be given, and a record that shows who planned and gave that care.

Care plans are an excellent way of showing student veterinary nurses exactly what to look for when nursing a patient.

How to create a care plan?

A care plan can be constructed to suit an individual practice or a set condition e.g. diabetic care plan. Care plans are used in addition to hospitalisation (observation forms) forms as these record ongoing observations, medications and fluid therapy.

The nursing process can be used as a guide to develop your own care plan, you will be required to include the following:

**Nursing assessment**
Information gathering from family, physical examination, team members and diagnostic tests. This can include both subjective and objective data plus details on the ‘normal’ or usual behaviour of the patient.

**Nursing diagnosis**
From looking at the information found in the assessment the nurse creates a list of actual and potential problems faced by the patients. The following parameters should be included for all patients: eating, drinking, urinating, defecating, breathing, body temperature, grooming, exercise, sleep/resting, pain, normal behaviour.

**Plan**
Organises the nursing interventions based on the diagnosis list. Create short and long term goals to achieve e.g. to eat 1/3rd of the BER and to stand unaided.

Importance of goal can be prioritised by firstly dealing with physiological needed e.g. food, water, warmth, rest and pain. Then with safety needs e.g. security, prey species kennelling and biosecurity. Then finally with psychological needs e.g. TLC, interaction and exercising.

**Implementation**
This is the actual ‘doing’ part. Observations are recorded then on hospitalisation forms, fluid therapy charts, medications carts and nutrition charts etc.

**Evaluation**
Offers the veterinary team a chance to reflect when required on how effective each nursing intervention has been and allows a new plan to begin.

Evaluation could be as frequent as every 5 minutes for critical needs like breathing or as long as every few days for exercise or rehabilitation needs.
Using established templates

Human centred care plans can be applied into practice or adapted for use. The two common templates are the Roper, Logan and Tierney (RLT) Humans needs model or the Orem care plan both available from the Documents library on the RCVS website.

A veterinary nursing model has been generated, the Ability model created by Andrea Jeffery and Hilary Orpet is available in the BVNA Members Area of the Website under ‘Downloads’.

You can also create a set of care plans already pre-formatted to an individual medical or surgical condition. For example of your practice does a lot of cruciate repairs and agreed rehabilitation care plan can already be set up detailing exercise and physiotherapy requirements. These can then be amended slightly to suit each individual patient. Similarly for a medical; a patient care plan to nurse a patient with pancreatitis can be established. A critical care plan may only detail vital signs that are important to that patient at that time e.g. airway, breathing, circulation, pain, and nutrition.

Suggested further reading


Main, C. (June 2011). Working with nursing care plans. VNJ. 26 (2), 207-211.


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