

PROCEDURE FOR: Documentation: Patient Care Plan

- POLICY:**
1. The Patient Care Plan serves as a communication and documentation tool for clinical staff as they work with the patient, family and interdisciplinary team to:
 - a. Plan the patient's care based on clinical, psychosocial, teaching/learning, spiritual and cultural needs and other identified individual needs.
 - b. Set outcomes based on goals.
 - c. Identify interventions to be implemented for attaining goals.
 2. The care plan will be initiated by the nurse upon completion of the admission assessment and databases.
 3. Problems will be reviewed and prioritized at least once daily by the nurse. If the condition or status of the patient changes significantly, reprioritization of the problem(s) may be warranted.
 4. Active problems are prioritized using the following priority codes:
 - 1 High priority / immediate intervention warranted
 - 2 Moderate priority / intervention needed or continued
 - 3 No intervention needed at this time, except to continue to monitor / assess
 - R Resolved / goals met
 5. Data supporting the patient's individualized specific focus/problem, interventions (including assessments and monitoring), and patient response will be reflected through the use of unit-specific flowsheets, and Focus/DAR (data-action-response) notes in the patient record. Documentation should be directed based on the priority code assigned to active problems. Suggested guidelines for documentation are:

Priority Code 1: DAR progress note each shift.

Priority Code 2: Documentation may be reflected on the flowsheet, however a DAR progress note is necessary when active interventions or outcomes cannot be captured in flowsheet form, or when data, action or response need to be detailed (i.e., episodes of patient teaching), or summarized.

Priority Code 3: Although continued monitoring may be reflected in flowsheet assessment, the frequency of a progress note may be delineated per protocols, i.e., discharge planning note q 72 hours, detailed wound measurement q 7 days as well as upon admission, transfer or discharge.

Priority Code R: Note required if supporting evidence for resolution cannot be reflected in flowsheet documentation.

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<u>ACTION</u>	<u>POINTS OF EMPHASIS</u>
1. Include patient identification on each page of the care plan in the designated area and identify admit date and diagnosis at the top of page 1.	
2. Identify the month and consecutive dates on the top right column spaces on each page.	
3. As patient-specific focus problems are identified, active the problem by documenting the date in the left hand "date" column.	3. Consider what are "active" problems for the patient: those for which interventions (other than standard assessments) are either taking place or planned. Note: routine monitoring and assessments may occur as a standard of care w/o activation of a "problem".
4. Upon identifying/activating a problem, the nurse then places a priority code number and his/her initials in the appropriate date/shift box on the right.	
5. Identify goals and interventions. These may be selected from items that are pre-printed by checking the box to the left of the goal(s) or intervention(s) that are specific to the patient. Additional or alternate goals or interventions may be written under "other".	5. Some goals and interventions are pre-checked (✓) to denote a standard of care that applies to all patients, even if the actual problem is not activated. Additional individualized goals and interventions should be selected to reflect the patient's needs. Updates to goals or interventions should be dated.
6. Problems are to be reviewed/priority coded at least once daily by the nurse assigned to care for the patient. Reprioritize and re-code problems as patient condition warrants. Place the appropriate code in the column on the right side of each Focus/Problem section.	6. Reprioritization and recoding may occur on either shift and should occur with any significant change in patient status.
7. Identify resolution of a problem by placing an "R" and the date in the left-hand date column for the date it is resolved.	7. Data supporting resolution of the problem is to be reflected in the patient's chart, either in the flowsheet or DAR note.
8. Each individual who documents on the care plan must identify his/her initials and sign on page 6 of the form.	8. Page 6 may be used to identify additional problems if needed.
9. Document Focus/DAR notes for <u>high priority problems</u> each shift, to relate data, actions and response to interventions.	9. Staff is encouraged to document brief Focus/DAR notes <u>throughout the course of the shift</u> , reflecting data, actions and responses as they occur.

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10. Document any additional data in Focus/DAR format per the guidelines on page 1 (#5) and general nursing documentation guidelines.
10. Examples of additional required documentation include: admit or transfer notes, discharge plan, restraint initiation or re-evaluation, details of teaching.
11. The same care plan is to be continued as the patient transfers from unit to unit. Unresolved problems (especially priority one and two problems) should be communicated in hand-off report.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 5/07

REVISION DATES: 3/08, 7/09