

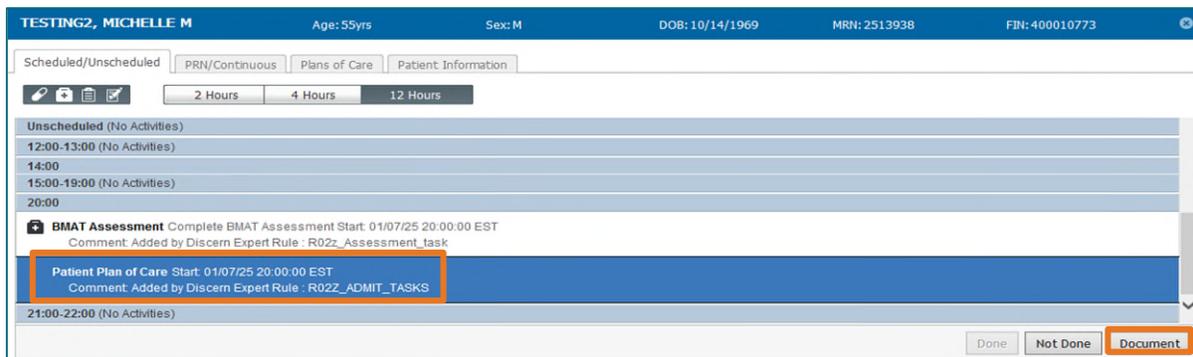
**Patient Plan of Care should be updated every shift and as needed for changes in a patient's condition.**

**Patient Plan of Care**

The **Patient Plan of Care** is instrumental in evaluating the progress of the patient from admission through discharge and aids in helping the patient and staff identify and manage problems in specific areas. The **Patient Plan of Care** has been updated to include women's health content.

➤ **Patient Plan of Care**

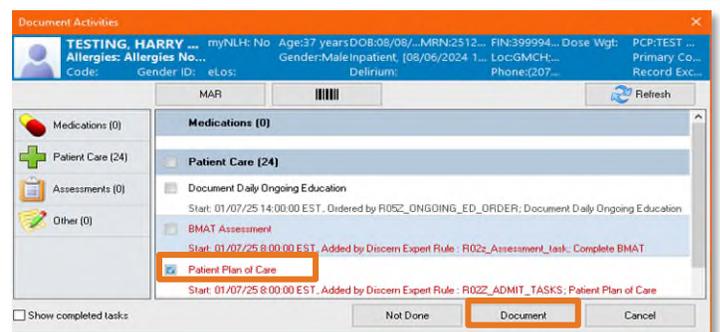
- **Patient Plan of Care** appears as a task in **CareCompass** and the **OB Tracker** once a shift.
- **CareCompass**
  - Click the circle with a number in the **Activities** column.
  - Select the **Patient Plan of Care** task and click **Document** to open the PowerForm for documentation.



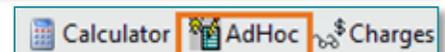
- **OB Tracker**
  - Select the **green +** in the **Activities** column.
  - Click the box to the left of **Patient Plan of Care** and select **Document** to open the PowerForm for documentation.



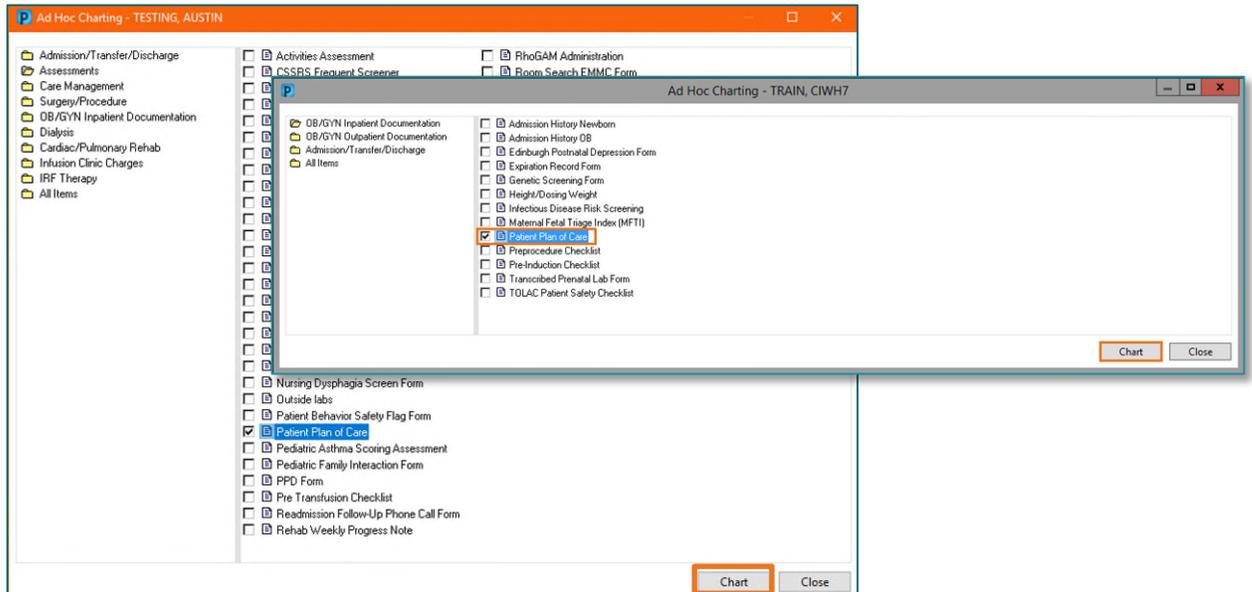
**NOTE:** Overdue tasks will display in red in both CareCompass and the OB Tracker.



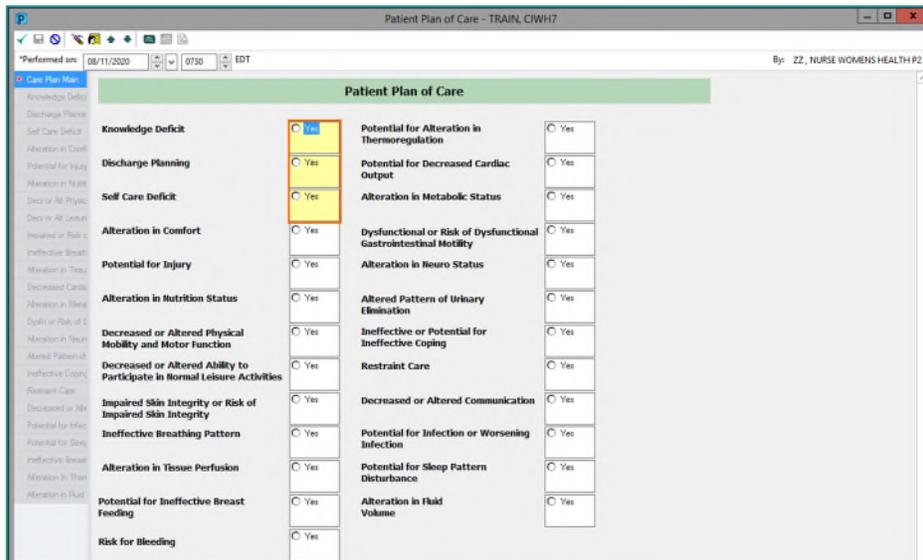
- The **Patient Plan of Care** can also be accessed from the toolbar by selecting **AdHoc**.



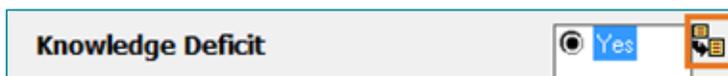
- Select Patient Plan of Care and Chart.



- Complete the required items (identified in yellow) and any other plan of care appropriate for the patient, such as Alterations in Comfort, Potential for Injury, etc.



- Care plans that have had documentation will be indicated with a paper icon.



➤ **Documentation Components**

- In each section, a similar format is used.
  - Documentation with a radio button is one selection.
  - Documentation with boxes is multi-select.

- **Status**
  - Select the appropriate response for the patient.

**Status**

- Initiate
- On-going
- Resolved
- Re-open

- **Goal Progress**
  - Evaluates the status of the patient's progress toward the identified goal.

**Goal Progress**

- Goal met
- Goal partially met
- Goal not met
- Requires additional intervention
- Patient refused

- **Related To**
  - Related to identifies areas that may limit meeting the goal for the patient.

**Related To**

- Decreased understanding of diagnosis, medications, tests, procedures and treatment plan
- Language barrier
- Physical/Mental impairment
- Ineffective coping or denial
- Other:

- **Evidenced By**
  - Identifies key factors that display the need for continued efforts in this area.

**Evidenced By**

- Verbalized knowledge deficit
- Verbalizes misinformation
- Does not correctly perform desired health behavior
- Other:

- **Expected Outcomes/Goals**
  - Determine the expected outcomes or goals for the patient.

**Expected Outcomes/Goals**

- Pt and/or family will verbalize an understanding of daily plan of care which may include but is not limited to treatments, tests, procedures and medications
- Pt. will be discharged with verbal and written instructions pertinent for diagnosis, medications, activity, diet, treatments, follow-up appointments, signs and symptoms to observe for and when to call the doctor
- Pt will describe disease process, causes, and factors contributing to symptoms
- Pt and/or caregiver will demonstrate understanding of all medications (purpose, dose, frequency, route) by discharge
- Pt will verbalize understanding of the teaching topics
- Pt will describe procedure/test
- Other:

- **Target Date**
  - Enter an anticipated date for meeting the goals or a target of discharge.

**Target Date**  Discharge or transfer

- **Interventions**

- Interventions are multi-select. When the **Provide education** is selected, the options on the right will be available to chart what topics education will be provided on.

**Interventions**

<input type="checkbox"/> Complete Learning Needs Assessment and update PRN	<input type="checkbox"/> Medications including potential food/drug interactions
<input type="checkbox"/> Provide education including written material as appropriate on	<input type="checkbox"/> Diagnosis, treatment plan and normal recovery progression
<input type="checkbox"/> Encourage questions	<input type="checkbox"/> Tests and procedures
<input type="checkbox"/> Encourage verbalization of fears	<input type="checkbox"/> Dietary restrictions/needs
<input type="checkbox"/> Teach postoperative care	<input type="checkbox"/> Other:
<input type="checkbox"/> Ensure patient has a responsible person that is aware of plan of care	
<input type="checkbox"/> Other:	

- **Comment**

- A free text field where personal information for the goal can be entered.
- Use the **return** icon to return to the main form once documentation in the care plan is complete.
- Click the **green checkmark** to sign the form.

Comment



➤ **Frequency**

- The **Patient Plan of Care** should be completed at admission and reviewed/updated every 12 hours.
- When reviewing the **Patient Plan of Care**, previously charted responses will display.
  - Update as appropriate.
  - The **Status** and **Goal Progress** need updated each time.

**Knowledge Deficit**

<b>Status</b>	<input type="radio"/> Initiate <input type="radio"/> On-going <input type="radio"/> Resolved <input type="radio"/> Re-open	<b>Goal Progress</b>	<input type="radio"/> Goal met <input type="radio"/> Goal partially met <input type="radio"/> Goal not met <input type="radio"/> Requires additional intervention <input type="radio"/> Patient refused
<b>Related To</b>	<input checked="" type="checkbox"/> Decreased understanding of diagnosis, medications, tests, procedures and treatment plan <input type="checkbox"/> Language barrier <input type="checkbox"/> Physical/Mental impairment <input type="checkbox"/> Ineffective coping or denial <input type="checkbox"/> Other:		