Care Plan Redesign-Lesson 1
Nursing

Care Plans: The Key to Patient Care Coordination
Learning Format

• This lesson is presented in a Power Point format without audio.

• A Knowledge Check (quiz) will be presented after you have completed all four lessons.
Objectives

• Understand the professional and regulatory responsibilities of the health care team in planning individualized care
• Discuss the objectives for care plan redesign
• Articulate key features of SJH care plan policy
• Articulate standard care plan definitions
Drivers for Change

• Current state of care plan process:
  – Cumbersome
  – Not user friendly
  – Redundant
  – Time consuming
  – Allows for variance in documentation
  – Does not flow well with the nurses’ daily work

• Nurses tend to regard care plans as ‘just a requirement’

• Regulatory survey findings in many ministries have indicated weaknesses in our care plan process which warranted us to identify changes needed to improve care planning documentation across the health system.
Goals of Redesign

• Make it easier for clinicians to document care plan.
• Care plan documentation that is part of the clinician’s workflow.
• To meet all professional and regulatory requirements of documentation.
• To make the care plan easier to view which will enhance communication between care givers.
• Create a standardized policy for all ministries.
Important Definitions

- **Plan of Care**: over arching long term plan that includes all levels of care and all team members (including patient)

- **Care plan**: disease-specific set of related problems or health concerns with interventions completed by a specific discipline

- **Problem**: a stand-alone plan for a single patient issue (nausea and vomiting, for example)

- **Goal**: the defined patient outcome to be achieved during hospital stay, by discharge, or by the end of a phase of care

- **Interventions**: actions taken to maximize the prospects of achieving the goals

- **Outcome evaluation**: status, at one or more points during care; response to care
Why Are Care Plans Needed?

• Underuse of care plans may lead to:
  – Near-misses, errors, and compromised care (Keenan et al., 2008).

• The plan of care offers clinicians the ability to communicate the needs of the patient and assess outcomes of care (Estrada & Dunn, 2012).
Nurses have an Essential Role

- The Future of Nursing report states that care coordination is one of the long-standing contributions of nurses.
- Care coordination is considered an essential competency of nurses in every level of care.
- Care coordination is critical to patient safety.
- Many experts feel that care coordination has become the foundation of health care reform.

(Bahle et al, 2015)
Nursing Process

• The nursing profession has a problem-solving process that “combines the most desirable elements of the art of nursing with the most relevant elements of systems theory, using the scientific method.” (Shore, 1988)

• The original concept of the nursing process was introduced in the 1950s as a three-step process of assessment, planning, and evaluation based on the scientific method of observing, measuring, gathering data, and analyzing the findings.
Nursing Process

• Over time, this process became part of the conceptual framework of all nursing curricula and is *included in the legal definition of nursing in the nurse practice acts of most states.*

• The nursing process has expanded to five steps:
  1. **Assessment** (systematic collection of data relating to clients and their problems and needs)
  2. **Diagnosis** (analysis and interpretation of data)
  3. **Planning** (prioritizing needs, identifying goals, and choosing solutions)
  4. **Implementation** (putting the plan into action), and
  5. **Evaluation** (assessing the effectiveness of the plan and changing the plan as indicated by current needs)
Although some nurses view the nursing process as separate, progressive steps, the elements are actually interrelated. Taken together, they form a continuous circle of thought and action throughout the client’s contact with the healthcare system. The process combines all the skills of critical thinking and good nursing care because it creates a method of active problem-solving that is both dynamic and cyclic.
Care Planning—the Professional Obligation of Registered Nurses

• Care planning is specifically relegated to nurses in the Nurse Practice Acts in California and Texas
• Accrediting organizations place high emphasis on the care plan (TJC, 2015)
• ANA states that the act of developing, coordinating, and implementing the plan of care is an essential element of RN professionalism, autonomy, and scope of practices

(Keller, 2015)
Interdisciplinary Care Planning

• All healthcare disciplines are interrelated, and therefore the actions for each discipline have implications for the others.
• This interrelationship allows for exchange of information and ideas and for development of plans of care that include all data pertinent to the individual client and family.
• The nurse is often the person responsible for coordinating these various activities into a comprehensive functional plan, essential in providing holistic care for the patient.
Standard Process allows for Standard Policy

• Defines purpose and definition of “plan of care” (POC).

• Outlines the elements in the POC.

• Reflects the process flow of care plan initiation and documentation.

• To be adopted by each ministry by the end of April 2016.
The new care plan has many new changes. Three areas that will be explained in more detail on the following slides:

– Patient desired outcome
– Goal (met or ongoing)
– Patient’s response to care
Patient Desired Outcome (s)*

• Presented as a “free-text” box
• Documented as the patient’s statement of his / her desired outcomes
• Could be a short term shift goal or a long term discharge goal.
• Examples
  – Pass gas
  – Walk to the bathroom without help
  – Have better pain control
  – Sleep better
  – Just go home
Goal

• Previously referred to as “progress towards goal”
  – Met
    • The patient achieved the stated goal during the care provider's time with the patient (shift)
    • The problem can still be the focus of care during for subsequent care providers even if the goal was met
  – Ongoing
    • The patient did not achieve the stated goal during the care provider's time with the patient (shift)
    • Best practice is to review Care Plan documentation BEFORE caring for the patient by using the Iatrics Care Plan Visual Flowsheet
• A “free-text” box at the bottom of the care plan assessment.
• To be stated as a summary description of the patient’s response to care. Examples:
  – Able to ambulate without oxygen for further distances than yesterday. Family involved in care.
  – Patient understands plan of care and tolerated walking short distances with little to no shortness of breath. In good spirits.
  – Hemodynamically stable, but required frequent adjustments to vasopressors.
  – Responsive to lighter touch, with increased heart rate with family in room.
  – Patient stating that food takes good and shows increased interest in food.
Summary of SJH Care Plan Redesign

• Increases ease of documentation.
• Healthcare providers can track care rendered.
• Pulls together patient care needs and issues.
• Provides proof care was given, plan and outcomes were addressed/met.
• Formatted to standardize multiple disciplines’ access for patient care and outcomes.
• Regulatory requirements will be met.
Conclusion

“As health care professionals, we have the skill and knowledge, however we must never forget that the patient has to be at the center of each care team and help us to design a plan of care that will yield meaningful outcomes”.

~Wendy Bunting MS, CCC-SLP
Director of Therapy Services
Riverside Rehabilitation Institute
References


References


• Steps To Creating A Priority List. (nd). Retrieved from http://www2.sunysuffolk.edu/mccabes/NR33%20priority%20List%