

Alberta Health Services

# PCS 5.67 Care Planning

3/11/2015

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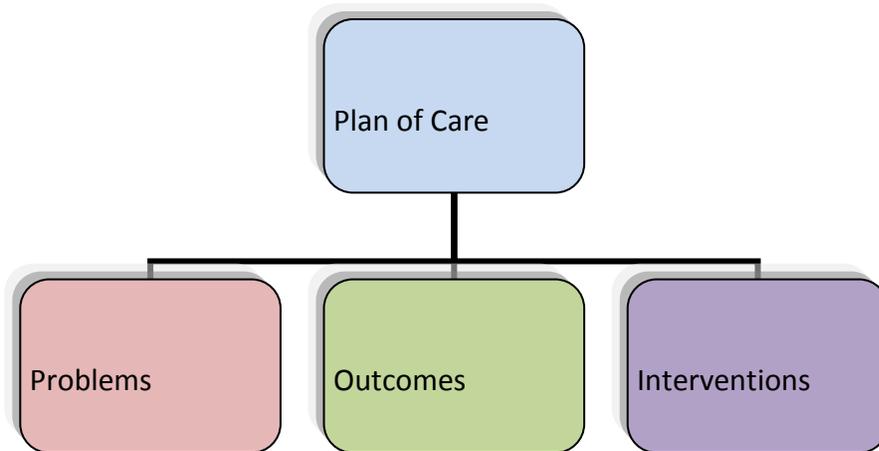
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The Process Plan Routine allows the interdisciplinary team to establish a plan of care for the client and to update that plan throughout the course of the client's care.

The Care Plan consists of **Problems**, **Long Term Outcomes**, and any **Interventions** used to achieve that Outcome.



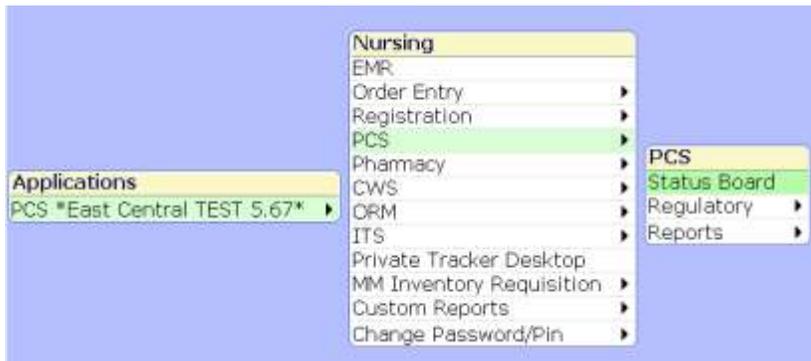
## CZ- Care Planning in Central Zone

The Process Plan of Care Routine allows you to establish a plan of care that is specific for your client and update that Plan of Care throughout their stay.

The Process Plan of Care Screen displays:

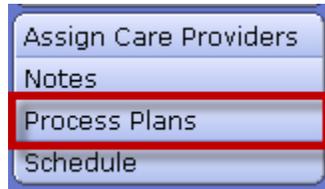
- Standards of Care (SOC)
- Problems
- Long Term Outcomes
- Interventions that are linked to an Outcome, or
- Additional Interventions (not linked to an Outcome)

1. From the menu select you site, PCS, and Status Board. Your status board will appear.

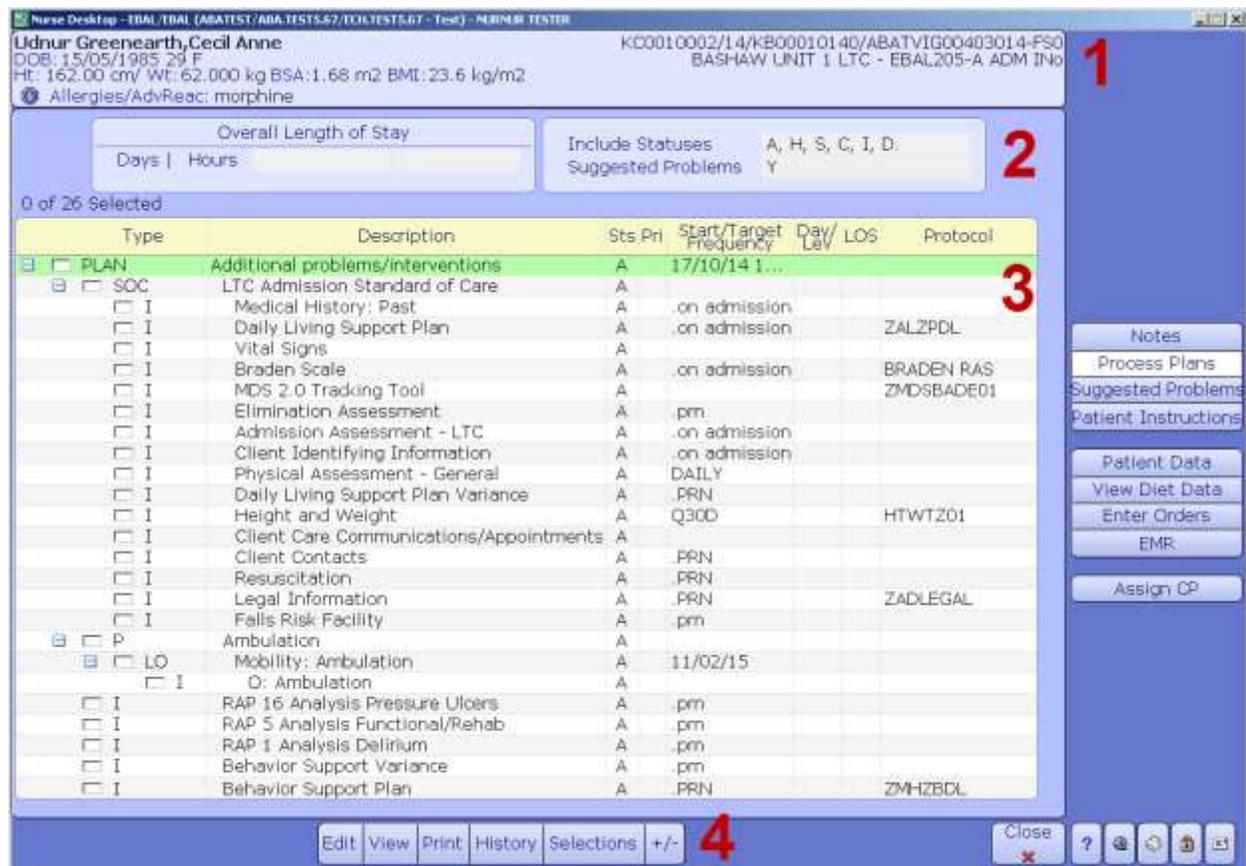


Name	Diagnosis	Results	BP	Temp	Diets	Diet Texture
Room-Bed	Falls Risk Score	Glucose		SPO2	Diet #2	Fluid Consi...
Physician	Intervention	Isolation C...	Pulse	L/Min	Diet #3	PRN Med:
<b>UDADM STANG,CRAIG</b>						
EBAL204-A						
Kunzelman,Dena						
<b>UDADM WATERS,LIN...</b>						
EBAL203-A						
Hodinski,Karly						
<b>UDBAR LANG,BEATRI...</b>						
EBAL201-A						
Schutz,Gord						
<b>UDNUR GREENEARTH...</b>			125	36.8		
EBAL205-A			62	95		
Aasman,Edward John	2300		70			
<b>UDOE DUCK,DAISY</b>	COPD	LAB			GLUTEN FREE	MINCED
EBAL207-A						NO MODIFIC...
Mucciarone,Tony						

2. Click on the *Process Plans* button on the Right hand side panel Process Plans



3. Once you open the *Process Plan* of care the client information will display.



**1** Patient demographic and location information:

Udnuur Greenearth, Cecil Anne  
DOB: 15/05/1985 29 F  
Ht: 162.00 cm/ Wt: 62.000 kg BSA: 1.68 m2 BMI: 23.6 kg/m2  
Allergies/AdvReac: morphine  
BASHAW UNIT 1 LTC - EBAL205-A ADM INO

**2** Overall Length of Stay and Include Statuses:

Overall Length of Stay: Days | Hours  
Include Statuses: A, H, S, C, I, D  
Suggested Problems: Y

**3** List of Care Plans:

Type	Description	Sts Pri	Start/Target Frequency	Day/Lev	LOS	Protocol
PLAN	Additional problems/interventions	A	17/10/14 1...			
SOC	LTC Admission Standard of Care	A				
I	Medical History: Past	A	.on admission			
I	Daily Living Support Plan	A	.on admission			ZALZPDL
I	Vital Signs	A				
I	Braden Scale	A	.on admission			BRADEN RAS
I	MDS 2.0 Tracking Tool	A				ZMDSBADE01
I	Elimination Assessment	A	.pm			
I	Admission Assessment - LTC	A	.on admission			
I	Client Identifying Information	A	.on admission			
I	Physical Assessment - General	A	DAILY			
I	Daily Living Support Plan Variance	A	.PRN			
I	Height and Weight	A	Q300			HTWTZ01
I	Client Care Communications/Appointments	A				
I	Client Contacts	A	.PRN			
I	Resuscitation	A	.PRN			
I	Legal Information	A	.PRN			ZADLEGAL
I	Falls Risk Facility	A	.pm			
P	Ambulation	A				
LO	Mobility: Ambulation	A	11/02/15			
I	O: Ambulation	A				
I	RAP 16 Analysis Pressure Ulcers	A	.pm			
I	RAP 5 Analysis Functional/Rehab	A	.pm			
I	RAP 1 Analysis Delirium	A	.pm			
I	Behavior Support Variance	A	.pm			
I	Behavior Support Plan	A	.PRN			ZMHZBDL

**4** Edit View Print History Selections +/-

**Section 1:** Patient demographic and location information which is populated from the ADM module.

**Section 2:** Data in these fields have auto populated.

**Overall Length of Stay:**

**Include Statuses:** This area identifies Statuses for the Plan of Care.

A-Active, H- Hold, S- Stat, C- Complete, I- Inactive, D- Discharged, X- Cancelled

**Suggested Problems:** when a suggested problem has been selected on the RAP Analysis Assessment, a **Y** will appear in this field until you make a decision to add it to the Plan of Care or not.

**Section 3:** Identifies all Problems with attached Long Term Outcomes, Interventions, Target Dates, Frequencies and Protocols that have been selected for this client.

Type:

- **Plan:** Plan of Care
- **P:** Problem
- **LO:** Long Term Outcome
- **I:** Intervention

**Description:** displays the name or description of the entry

**Stat:** current Status of the entry e.g. A for Active or C for Complete

**Pri:** Used for Critical Pathways (currently not used by ECH)

**Start/Target/Frequency:**

- Start date and time applies to the Plan of Care.
- Target dates are for Outcomes.
- Frequency for Interventions. Not all Interventions will have a frequency predefined. You may add one, but it is not always necessary.

**Day/Level:** Used for Critical Pathways (currently not used by ECH).

**LOS:** Used for Critical Pathways (currently not used by ECH).

**Protocol:** A mnemonic will display if a Protocol is available for that Intervention, Click on the Function button **V** and select View Protocol.

**Section 4:** The toolbar associated with Process Plans

**Enter:** Allows you to Enter a Standard of Care, Problems, Outcomes and Interventions under the Additional Care Plan, or to Copy (Care Plan) from Previous Visit

**Edit:** Allows you to Edit Status of items on the Plan of Care, Edit Frequency of Interventions, Edit Suggested Problems, and Patient Data (such as Diagnosis, reason for admission, etc.)

**View:** Allows you to **View** the Plan of Care/SOC, Suggested Problems, Frequency, Protocols, and Text

**Print:** Allows you to Print Profiles such as a Resident Profile report, Worklist and the Plan of Care

## **CZ-Developing the Plan of Care**

A Plan of Care must be developed for each client. On admission to LTC the new client brings information with them from previous programs and services. Throughout the admission

process information is gathered through a series of assessments on the SOC and from the Admission MDS 2.0.

When the admission assessment process is complete it is the responsibility of the Case Manager, with input from the Interdisciplinary Team, to analyze the assessment information, identify client-specific problems and, using the RAPS Analysis Assessments, apply professional judgment to determine a Plan of Care. This happens using the following steps:

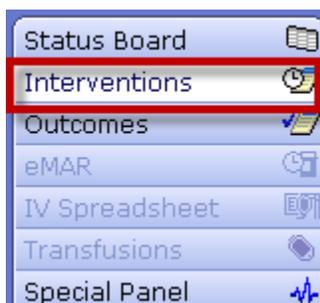
- Complete the MDS (Enter/Edit)
- Generate the RAPS (Enter/Edit RAPS Questionnaire)
- Review each individual RAP and identify which will be priorities to address in the Care Plan. Each RAP must be addressed.
- Document whether to further evaluate this RAP or not (RAP Summary of Findings)
- Summary of Findings

You may free-text in your decision and the rationale or you may take advantage of "Canned Text" that has already been composed for you. Click FS (Get-Key), then F9 (Look-up Key) on your keyboard and select from the options available there (If the canned text is not entirely appropriate you may edit it).

The RAPs identified as having a higher priority/urgency will require further analysis. A *RAP Analysis Assessment* has been developed for each RAP to assist in finding the root cause which then can be added to the Plan of Care as a Problem.

### Accessing the RAP Analysis Assessments

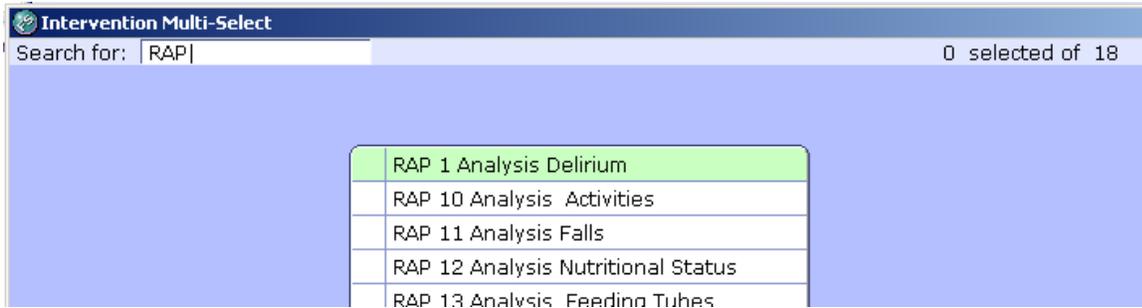
1. From your PCS status board, select your patient.
2. Click Interventions



3. Click Add Intervention



4. Type "RAP" in Search for field. The list of Interventions will appear.



5. Select the RAP Analysis Intervention # you want,
6. Click Add and Close at the bottom of the screen. This will take you back to the
7. Intervention Worklist where you will now see your selected RAP Intervention listed in magenta.

MDS 2.0 Tracking Tool		A	SC		37 days			
Client Care Communications/Appointments		A	SC					
RAP 13 Analysis Feeding Tubes		A	NEW	prn				

8. Click on the Intervention to open the RAP Analysis Assessment.

### Completing the RAP Analysis Assessment

The RAP Analysis Assessments are unique in that they are built with the ability to bring forward significant and relevant information from the MDS for your review; then ask several summary questions that lead you through a process of examining all the factors that may be contributing to this issue being a problem for the client.

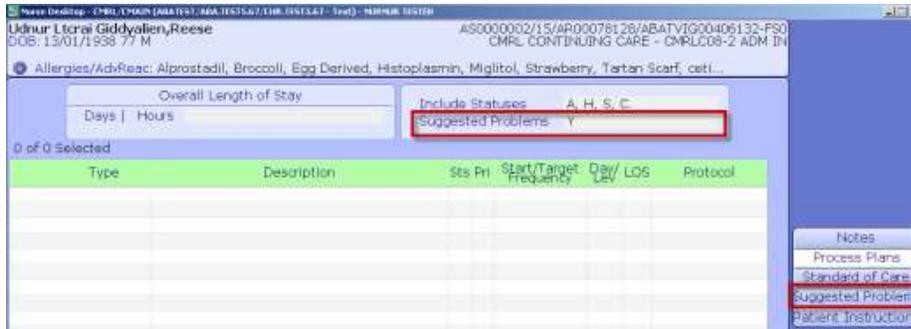
1. *Click Recall Values* and the MDS assessment values will auto populate into the *RAP Analysis fields*.
2. Review the data and answer the summary questions. By the time you get to the Problem Analysis section at the end, one or more Suggested Problems should have emerged.
3. In consultation with the interdisciplinary team and with the client, family and/or alternate decision maker, Problems that are to be addressed in the Plan of Care Process are identified. You may select more than one problem if it is appropriate for your client.
4. Click on one or more of the problem options in the Analysis section of the assessment. This will automatically link that problem to the *Process Plan of Care Screen*. When you open that screen a "Y" will appear in the *Suggested Problem* field in the mid-right section of the screen.

Include Statuses	A, H, S, C, I, D.
Suggested Problems	Y

5. From here the **Suggested Problem** can be added to the **Plan of Care**.

### CZ-Adding a Problem to the Plan of Care:

You will know that there are problems to add when you come to the Process Plan of Care screen and you notice that there is a “Y” under **Suggested Problems**.

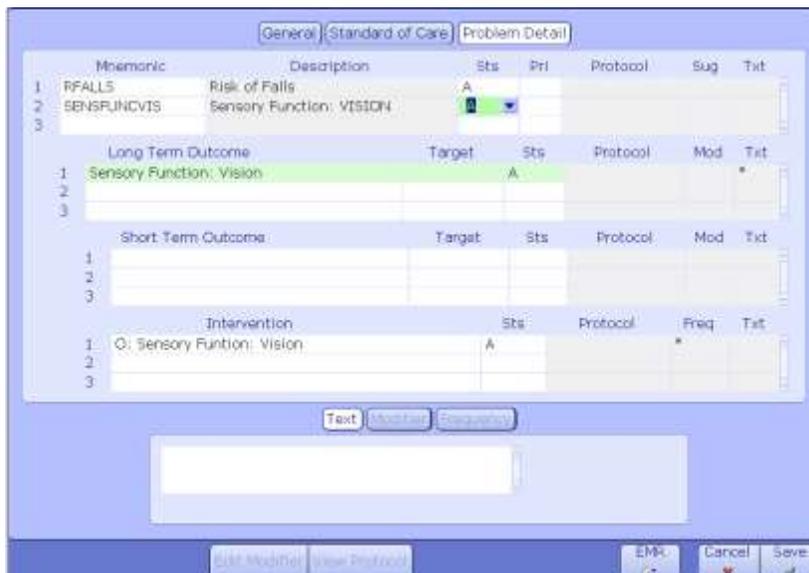


You must now use your clinical judgment, in consultation with the client and interdisciplinary team, as to whether to add this problem to the Careplan.

1. Select the problem once you entered into the Suggested Problem menu.

1 of 1 Selected				
<input checked="" type="checkbox"/>	Problem	Care Provider	Date	Time
<input checked="" type="checkbox"/>	Visual Function	Cheri E Komar	05/02/15	1146

2. Click Add from the bottom toolbar. This will take you to Patient’s Additional Problems/Interventions.



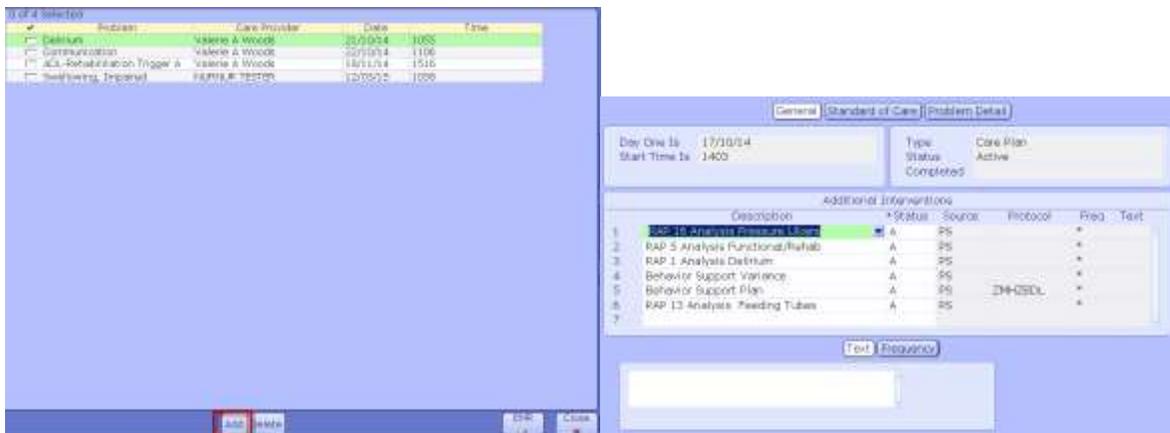
3. Once in this Additional Care Plan, select the description and save the newly added problem. This will add the Problem onto the Process Plan.

Overall Length of Stay		Include Statuses				
Days   Hours		A, C, I, D:				
0 of 7 Selected						
Type	Description	Sts Pri	Start/Target Frequency	Day/Lev	LOS	Protocol
<input type="checkbox"/> PLAN	Additional problems/interventions	A	26/02/15 0...			
<input type="checkbox"/> P	Communication	A				
<input type="checkbox"/> LO	Communication	A				
<input type="checkbox"/> P	Visual Function	A				
<input type="checkbox"/> LO	Sensory Function: Vision	A				
<input type="checkbox"/> I	MDS 2.0 Tracking Tool	A	Q8HX21			MDSTRACK01
<input type="checkbox"/> I	MDS 2.0 Tracking Tool	A	Q8HX21			MDSTRACK01

- After saving this Plan of Care, you will be returned back to the Suggested Problem page. Continue this process of adding problems until all are added.
- Once all the problems are added to the Additional Care Plan from the Suggested Problems, return back to the Process Plan by clicking the Close button on the bottom toolbar.

### CZ-Enter/Edit Additional Problems/Interventions

- From the Suggested Problem screen click the Add button to launch the Add Additional Problems screen.



Problem		Care Provider	Date	Time
<input type="checkbox"/> Debris	Waters & Woods	22/10/14	1000	
<input type="checkbox"/> Communication	Waters & Woods	22/10/14	1100	
<input type="checkbox"/> ALA-Rehabilitation Trigger A	Waters & Woods	18/11/14	1516	
<input type="checkbox"/> Self-feeding, Inpatient	WATERS, WOODS	12/05/15	1000	

Additional Interventions					
Description	Status	Source	Protocol	Freq	Text
1. Self-feeding, Inpatient	A	PS		*	
2. RAP 3 Analysis Functional/Rehab	A	PS		*	
3. RAP 1 Analysis Delirium	A	PS		*	
4. Behavior Support Variance	A	SS		*	
5. Behavior Support Plan	A	PS	IM-CSDL	*	
6. RAP 13 Analysis Feeding Tubes	A	PS		*	
7.					

- There are 3 tabs at the top of the screen:



#### General: Additional Interventions

This section displays all **Additional Interventions** that have been added individually using the Add Intervention Process. These Interventions **do not** appear on the Plan of Care attached to

Problems or Outcomes. If you need to edit any of the Additional Interventions it may be done here as well as from the Intervention Worklist screen.

**Mnemonic:** Computer code allowing unique identification of that problem .

**Description:** Description of the Problem

**Text:** When an Asterisk (\*) is displayed in this field it indicates Text associated to the problem. You may view, edit or add text associated to a problem. Text should usually be edited in this screen to make it specific for your client. When you click on a problem, the associated text appears in the box below. Remember to click Save to save any text.

**Status:** The status of a problem depends on the Status of associated Outcomes and Interventions. At this prompt, the system updates the status of a problem, or you can enter or edit the problem status.

**Sug:** If an Asterisk is in this field it indicates that this Problem was added through a RAP Analysis.

**Pri:** Used for Clinical Pathways (currently not used by ECH)

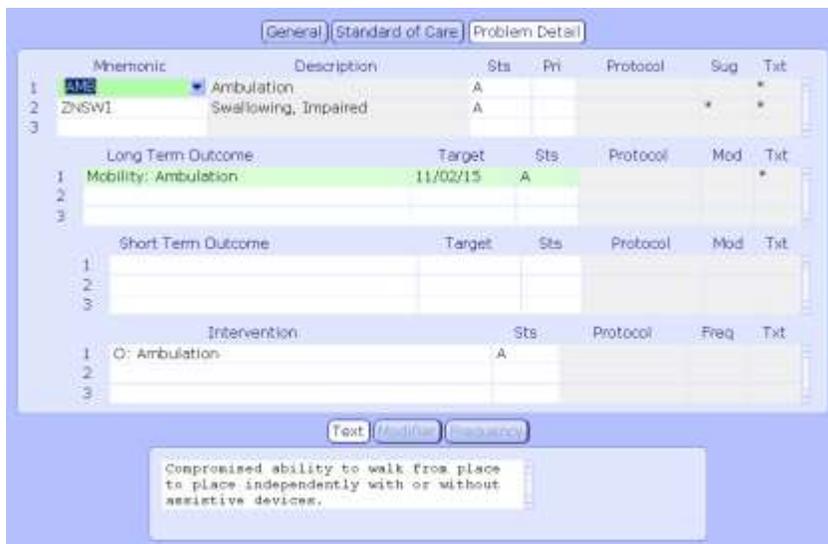
**Protocol:** If a Protocol has been assigned to a problem, the mnemonic of the Protocol will display here.

**Standard of Care:** Not currently in use in Central Zone.

**Problem Detail:** Contains the detailed information about the patient problems and associated Outcomes.

### CZ-Defining Long-term Outcomes and Interventions associated to a Problem

1. From the Suggested Problems window, select the Problem Detail Screen.



Mnemonic	Description	Sts	Pri	Protocol	Sug	Txt
1 AMB	Ambulation	A				*
2 ZNSW1	Swallowing, Impaired	A			*	*
3						

Long Term Outcome		Target	Sts	Protocol	Mod	Txt
1	Mobility: Ambulation	11/02/15	A			*
2						
3						

Short Term Outcome		Target	Sts	Protocol	Mod	Txt
1						
2						
3						

Intervention		Sts	Protocol	Freq	Txt
1	O: Ambulation	A			
2					
3					

Text Modify Remove

Compromised ability to walk from place to place independently with or without assistive devices.

### Long-term Outcomes

- Displays all suggested Long-term outcomes that have been built linked to the selected problem. There may be more than one long-term outcome for a problem.
- Long-term Outcomes may be edited at any time to make them appropriate or specific for your client, using the F9 Look-up or clicking the dropdown.
- If you have more than one outcome you must address each Long-term outcome individually. Each Long-term Outcome will have specific Interventions attached.

**Note:** If at any time you **add, edit** information, remember **SAVE** you work.

**Description:** A description of the Outcome using approved clinical terminology.

**Mod:** (Currently not used by ECH)

**Text:** When an Asterisk is displayed in this field, this indicates text associated to this outcome. This is editable from this screen. When an Outcome is highlight the associated text appears at the bottom of the screen.

**Target Dt: a Target Date must be filled in.** This is the date the expected Outcome is to be achieved. Target dates are best aligned with MDS assessments e.g. T +90.

**Status:** Status of the Outcome e.g. Complete (C), Active (A) or Inactive (I). To edit, click in the Status field to highlight the Status. Click the dropdown to search. Choose the status you would like. Status should be reviewed at every quarterly assessment.

If you want to Inactivate an Outcome that is active you will receive this warning asking whether you want to inactivate all associated Interventions to that Outcome.

Answering *yes* will *inactivate* the *Outcome* as well as the *associated Interventions*.

If you have an inactivated Outcome, and it has inactive Interventions linked to the Outcome **you will not** be able to change the Status until you reactivate the Interventions.

This message will display a warning you that you have inactive Interventions if you try to change the Status of that outcome.

If you *change all Outcomes* associated to a Problem to Inactive, it *will change* the Problem to Inactive *as well*.

**Reactivate an Outcome** you must start with:

Activating the Interventions associated to the Outcome that you would like to reactivate by editing the status. This will automatically activate the Outcome as will as the Problem.

**Protocol:** Will display the mnemonic associated to the outcome. Click on the \* in the toolbar to view the Protocol.

### Short-term Outcomes

- At this time there are no predefined short-term outcomes for problems. Short term outcomes may be used by certain clinical groups. They can be accessed by placing your

cursor in a short term outcome field and clicking the drop down to access the short term outcome field.

- It is not required that Clinicians use short term outcomes at this time.

### Interventions:

Displays pre-defined Interventions to assist in attaining the Long term Outcome. These Interventions may be deleted/edited as appropriate for this problem for this client. Interventions may also be added at this time.

**Outcome Interventions** are identified by an **O:** in front of the description and it is attached to every Problem and its associated Long-term Outcome. Their purpose is to measure progress toward achieving that Long-term Outcome.

General Standard of Care Problem Detail

Mnemonic	Description	Sts	Pri	Protocol	Sug	Txt
2	ZNSWI Swallowing, Impaired	A			*	*
3						
4						

Long Term Outcome	Target	Sts	Protocol	Mod	Txt
1	Aspiration Prevention	A			*
2	Swallowing Status	A			*
3					

Short Term Outcome	Target	Sts	Protocol	Mod	Txt
1					
2					
3					

Intervention	Sts	Protocol	Freq	Txt
1 >> O: Swallowing Status	A		*	
2				
3				

Text Modifier Frequency

Date	*Time	Frequency
1 12/03/15	1152	.prn
2		
3		

Whenever a New problem and associated Long-term Outcome have been added, the Outcome Intervention must be done to establish a baseline. It is then repeated at each quarterly reassessment to measure progress over time toward the LT Outcome. This will help identify whether or not you are attaining the Long-term Outcome and guide decisions about revisions to the Plan of Care. Each Long-term Outcome requires an Outcome Intervention.

**Description:** description of Intervention

**Text:** When an Asterisk is displayed in this field, this indicates Text associated to this

Intervention. This is editable from this screen.

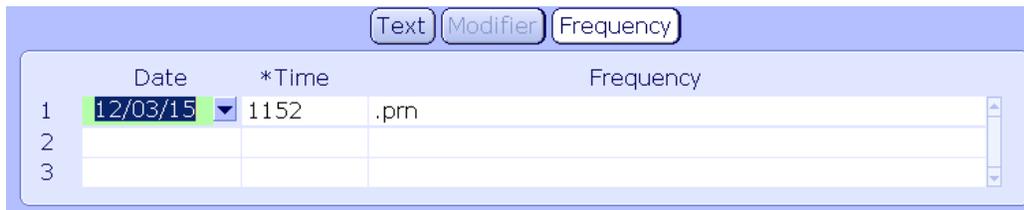
**Freq:** When an Asterisk is displayed, a documentation frequency has been pre-defined. The frequency may be edited. Click the frequency button for more information on the frequency.

**Status:** Status of the Intervention e.g. Complete, Active et.. This is editable from this screen. Click the dropdown and choose the status you would like .

**Protocol:** Will display the mnemonic linked to the Intervention.

### To Enter/Edit Intervention Frequency

1. Highlight the Intervention you want to enter/edit the frequency for.
2. Click the Frequency button



The screenshot shows a software interface with three buttons at the top: 'Text', 'Modifier', and 'Frequency'. Below the buttons is a table with three columns: 'Date', '\*Time', and 'Frequency'. The table has three rows, numbered 1, 2, and 3. Row 1 contains the date '12/03/15', the time '1152', and the frequency '.pm'. Rows 2 and 3 are empty.

	Date	*Time	Frequency
1	12/03/15	1152	.pm
2			
3			

3. Adjust the Date and Time.
4. Click to the next line to add additional frequencies.
5. Click Save.

Note: You can set up sequential frequencies. For example: You can define the start date and time for frequencies of Q4HX4 followed by a frequency or Q2D to start at a later date.

Once you have completed addressing all of your problems and selecting outcomes and Interventions for that problem, **YOU MUST file Your Plan of Care**. All interventions that have been selected will now appear on your Intervention Worklist for that client.

Documentation for each of those interventions can be done according to the frequencies assigned.

## CZ-Edit Plan of Care

At any time you may edit the Plan of Care for your client.

This function can be used to edit information that is already in the Plan of Care or Add a Problem that may or may not be associated to a RAP but has been **defined** as a Problem. (e.g. Palliative or Pain). Each *new* Problem will need an Outcome and Intervention(s) defined. This can happen at any time during the client's stay.

1. In the Plan of Care screen, click Edit and select Edit Plan of Care.



The screenshot shows the 'Plan of Care' screen with a table of problems. The table has columns for Type, Description, Sts, Pri, Start/Target, Day/LOS, and Protocol. A red box highlights the 'Edit' button at the bottom of the table. To the right of the table is a vertical list of buttons: Patient Data, Edit Frequency, Edit Plan of Care, Edit Priority, Edit Status, Edit Text, Prioritize Problems, and Suggested Problems.

2. The Enter/Edit Patient's Additional Problems/Interventions screen will display. To edit an existing Problem **highlight** the Problem and follow the same process as you did when you originally entered the Problem.

## CZ-To Add a Problem to the Plan of Care through the Edit Plan of Care Process

1. From the Status Board click Process Plan, then Suggested Problems, then Add and select the Problems page.
2. Put cursor in the first available blank field in the Problem section.



The screenshot shows the 'Problem Detail' screen. It has tabs for 'General', 'Standard of Care', and 'Problem Detail'. The main table has columns for Mnemonic, Description, Sts, Pri, Protocol, Sug, and Txt. The first three rows are highlighted. Below the table are sections for 'Long Term Outcome', 'Short Term Outcome', and 'Intervention', each with a table for Target, Sts, Protocol, Mod, and Txt.

3. To search click the drop down arrow or press F9
  - a. To narrow your search you can type the first few letters of the problem prior to pressing the drop down or F9
  - b. **String search method**- type a "?", then a short descriptor of the problem you are looking for. To display the available options select the *F9 Lookup*. (e.g. "?pall)
4. Click on the appropriate problem from the list.
5. The problem will display and any information on that line will auto populate. The associated Outcomes and Interventions will populate as well.

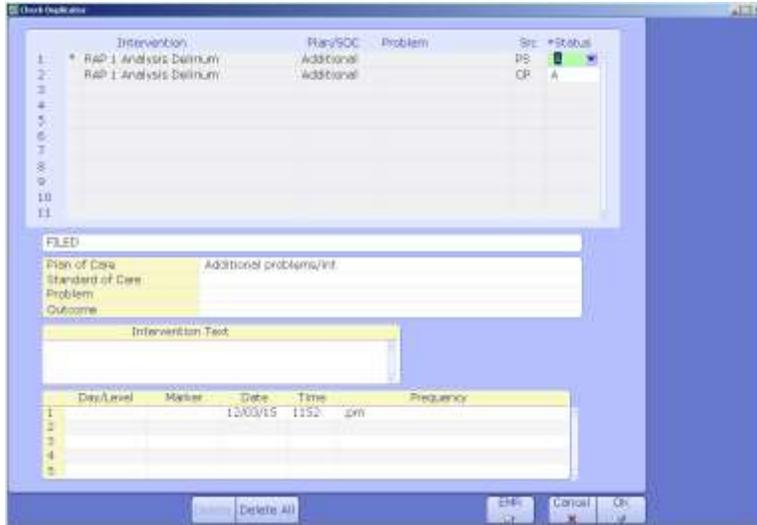
	Mnemonic	Description
2	ZNSWI	Swallowing, Impaired
3		
4		
Long Term Outcome		
1	Aspiration Prevention	
2	Swallowing Status	
3		
Short Term Outcome		
1		
2		
3		
Intervention		
1	» O: Swallowing Status	
2		
3		

You can now specify areas such as Target Dates for Outcomes and Add Additional Intervention if more are required than what is there. You also have the ability to remove an Intervention if it will not be required for the client at this time.

**Note:** You will not be able to remove an Intervention if at any point in time this Intervention has ever been documented on. If an Intervention has been documented on you will only be allowed to inactivate it.

### CZ-Duplication of an Intervention

Once you file the changes the system will check for duplication. If it identifies that you are attempting to add an Intervention that is already on the clients Intervention Worklist this screen will display.



This screen will display all Interventions that are duplicated as well as where they were added from.

- Under Plan/SOC they will display as Additional.
- Under Problem it will display the Problem that it was added to as an Additional Intervention. Under SRC it will identify the Source. e.g. CP(Plan of Care), SC (Standard of Care), PS (Intervention Worklist).
- Status will display the current status of the Intervention.

There is a section at the bottom of the screen that will display the Intervention details. To view the details highlight the Intervention and the associated details will display.

- New: Added to Plan of Care but not yet filed.
- Filed: Filed and not able to be deleted.
- Deleted: Indicates this will be deleted once filed.

Information within the Interventions detail section cannot be edited from here.

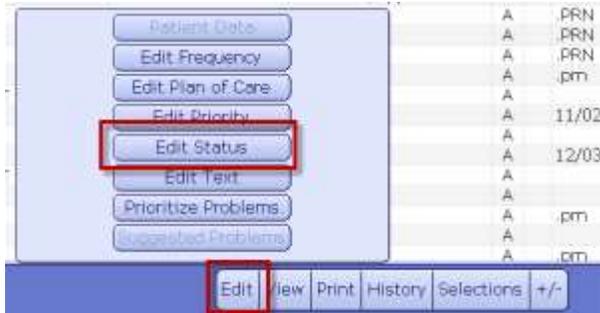
To delete a *NEW* duplicate Intervention:

1. Click the Intervention(s) and select \* .
2. This will insert a checkmark in front of the Interventions and will be deleted upon filing.

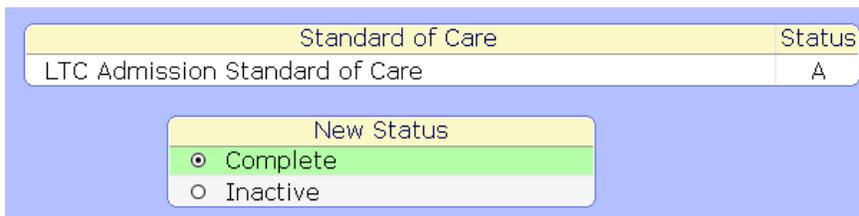
### CZ-Editing a Status

If an Intervention has been documented on and is no longer required, the Status of that intervention may be changed. Statuses displayed here will be the same as displayed in the Intervention section.

1. *Highlight the Intervention* that you wish to change the status on.
2. Click Edit and select Edit Status



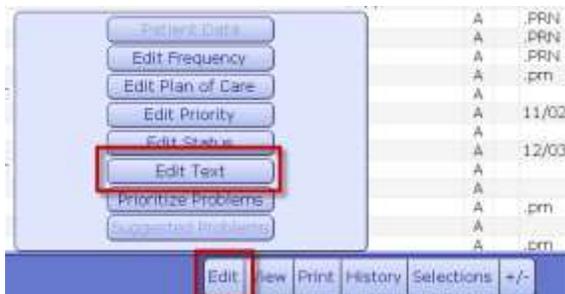
3. A popup with a choice a Status will display.



4. Select the Status.
5. Click Save

### CZ-Edit Text

1. Highlight any description within the Process Plan of Care that you would like to Add, Edit or Delete text from.
2. Click Edit and then Edit Text.



3. Enter data, edit the data, or delete the data.
4. Save.

**Note:** If you were just viewing you may select ESC. This will take you back to the Plan of Care Screen.

**CZ-Expand or Contract**

1. Highlight the Description
2. Click the + sign: This will expand all Additional information ; Interventions Long term Outcomes etc within the Plan .

Type	Description	Sts	Pri
<input type="checkbox"/> PLAN	Additional problems/interventions	A	
<input type="checkbox"/> SOC	LTC Admission Standard of Care	A	
<input type="checkbox"/> P	Ambulation	A	
<input type="checkbox"/> P	Swallowing, Impaired	A	
<input type="checkbox"/> T	RAP 16 Analysis Pressure Ulcers	A	

0 of 34 Selected

Type	Description	Sts	Pri	Start/Target Frequency	Day/Lev	LOS	Protocol
<input type="checkbox"/> PLAN	Additional problems/interventions	A		17/10/14 1...			
<input type="checkbox"/> SOC	LTC Admission Standard of Care	A					
<input type="checkbox"/> I	Medical History: Past	A		.on admission			
<input type="checkbox"/> I	Daily Living Support Plan	A		.on admission			ZALZPDL
<input type="checkbox"/> I	Vital Signs	A					
<input type="checkbox"/> I	Braden Scale	A		.on admission			BRADEN RAS
<input type="checkbox"/> I	MDS 2.0 Tracking Tool	A					ZMDSBADE01
<input type="checkbox"/> I	Elimination Assessment	A		.pm			
<input type="checkbox"/> I	Admission Assessment - LTC	A		.on admission			
<input type="checkbox"/> I	Client Identifying Information	A		.on admission			
<input type="checkbox"/> I	Physical Assessment - General	A		DAILY			

**CZ-Printing the Plan of Care**


1. When you click on the Print Button a selection box with all available information you are able to print will display.
2. Click the option you would like to print. This will display a popup screen that will ask for certain criteria regarding the information that you would like to print.
3. Click OK. This will take you to the Print Destination Screen.
4. You may click View or Print.

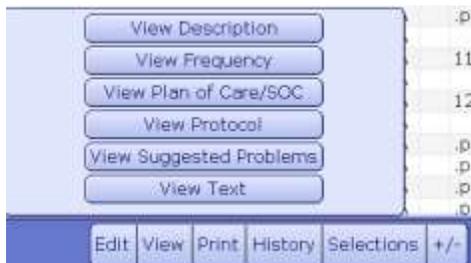
### CZ-Selections

1. Click the Selections Button
2. This allows you to view all Statuses that you have selected. You may choose to display only Active Status Interventions as the default on your Plan of Care.
3. Click OK.



### CZ-View

This button will allow you to view detail in your Plan of Care but not to enter/edit. E.g. frequency, Plan of Care, Protocol etc.



### CZ-Enter/Edit the Plan of Care

1. You may select Additional Care Plan or Copy from Previous Visit.
  - a. When selecting the Additional Care Plan, it will automatically take you to the Enter/Edit Patient Additional Problems Intervention screen.
2. When selecting Copy from Previous Visit:
  - a. Takes you to the lookup screen to select a visit.
  - b. Highlight the last visit that you want to copy.
  - c. Click OK. All information from that visit will auto populate into this visit.

**Note:** Only the Yes answers will auto populate

## CZ-History

Selecting this button will take you to the Process Intervention History Screen. You may only view the history of Outcomes or Interventions. You can view All Activity or Documented Activity.

Number	Description	Status	Source
1750035	Daily Living Support Plan	A	SC

Activity Type	Occurred Date Time By	Recorded Date Time By	Old Value	New Value, assessment, or comment
Create	13/01 1358 RM	13/01 1358 RM		
Ed Directs	13/01 1358 RM	13/01 1358 RM		
Document	13/01 1600 RM	14/01 1053 RM		

	Date	Time	By
Occurred	13/01/15	1358	RM Rebecca Maclesza
Recorded	13/01/15	1358	RM Rebecca Maclesza

Recorded at Client: EVRCPH005

## NZ-Care Planning in North Zone

Click on **Process Plans** on the Right side of your Status Board screen to access the Plan of Care.

Assign Care Providers
Notes
<b>Process Plans</b>
Schedule

**Note:** The Process Plan is essentially the “List” of all of the care. In Continuing Care, the “Care plan” consists of 3 parts: Process Plan, Daily Living Support Plan and Behavior Support Plan.

Nurse Desktop - LMHA/AC (ABATEST,ABA,TEST5.67/PNR,TEST5.67 - Test) - NURINUR TESTER

**Udel Pyre, Pierce** DJ0014612/14/DJ00058249/ABATVIG00421901-FS1  
 DOB: 05/07/1998 16 M HT: 110.00 cm/ Wt: 40.000 kg BSA: 1.14 m2 BMI: 33.1 kg/m2  
 NURSING UNIT 4W MAIN - LMHA4WM040-2 ADM IN

Allergies/AdvReac: Mussels

Overall Length of Stay: Days | Hours

Include Statuses: A, H, S, C, I, D.  
Suggested Problems

0 of 83 Selected

Type	Description	Sts	Pri	Start/Target Frequency	Day/Lev	LOS	Protocol
PLAN	Female Reproductive Surgery	A		06/10/14 1...			
P	Reproductive Function	A					
LO	Knowledge Outcome: Reproductive Funct...	A					
I	Teach: Post Op Teaching	A		PRN			
I	Teach: Incentive Spirometry	A		PRN			
I	Teach: Body Image	A		PRN			
LO	Behavior Outcome: Reproductive Function	A		25/10/14			
I	Respiratory Assessment	A		DAILY			
LO	Status Outcome: Reproductive Function	A					
I	Urinary Catheter Insertion/Removal	A		PRN			
I	Vaginal Bleeding Assessment	A		PRN			
PLAN	Additional problems/interventions	A		06/10/14 1...			
SOC	Medical Admission SOC	A					
I	Inpatient Admission	A		.on admissi...		ZPAG	
I	Inpatient Discharge Preparation	A		.on admissi...			
I	Early Screening for Discharge Planning	A		PRN			
I	Safe Client Handling Functional	X		.on admissi...			
I	Height and Weight	A		.on admissi...		HTWT201	
I	Medical History: Past	A		.on admissi...			
I	Braden Scale	A		.on admissi...		BRADEN RAS	
I	CAM: Confusion Assessment Method	A		PRN			
I	Vital Signs	A		.on admissi...			
I	Shift Care Record	A		07,15,23			
I	Physical Assessment - Acute	A		07,15,23			
I	Morse Fall Scale	A		.on admissi...		ZMORSEFALL	
I	Comfort Rounds	A		08,10,12,14...			
I	Pertinent Information	A					

Process Plans  
Standard of Care  
Patient Instructions  
View Diet Data  
Enter Orders  
EMR  
Assign CP

Enter Edit View Print History Selections +/-

Close

This is the **Process Plans of Care** screen. The Care Plan for that client is listed here and is comprised of all Problems, Outcomes and Interventions for that client. Any members of the interdisciplinary team with access to the care plan will be contributing to and managing it. It is the Care Plan, which holds and drives all information and action to the other screens.

Interventions and/or Standards of Care may be added to the care plan via the Status board, using the "Add Intervention" routine. We will now discuss the second way to add a Standard of Care to the care plan AND how Problems and Outcomes with associated Interventions are added to the care plan.

Types:

P: Problem

LO: Long-term Outcomes

I: Interventions

### NZ-Process Plans of Care Toolbar



**Enter:** Allows you to Enter a Standard of Care, Problems, Outcomes and Interventions under the Additional Care Plan, or to Copy (Care Plan) from Previous Visit

**Edit:** Allows you to Edit Status of items on the Plan of Care, Edit Frequency of Interventions, Edit Suggested Problems, and Patient Data (such as Diagnosis, reason for admission, etc.)

**View:** Allows you to **View** the Plan of Care/SOC, Suggested Problems, Frequency, Protocols, and Text

**Print:** Allows you to Print Profiles such as a Resident Profile report, Worklist and the Plan of Care

### NZ-Add Standard of Care

**Note:** This is done on the day of admission for all maintenance and respite residents in CC.

1. Click into **Interventions** on the right hand side tool bar.

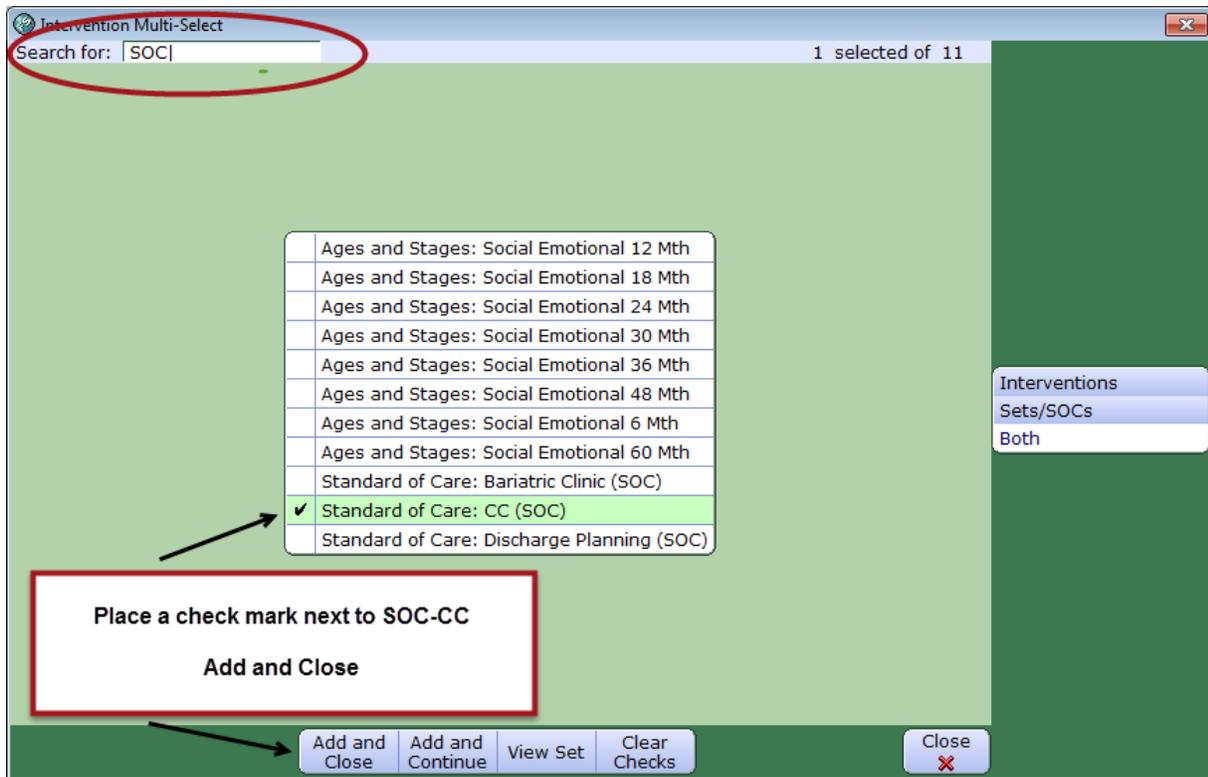


2. Click **Add Intervention** button at the bottom of screen.



- Type **SOC** in the “Search” to review the SOC.

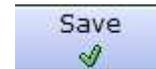
**Mnemonic:** The dictionary abbreviation of the Standard of Care



- Select the **SOC-CC** (Standard of Care – Continuing Care) by clicking with the mouse in the box to the left of the selection. A check mark will then be displayed.
- Click **Add and Close** to add the SOC to the Intervention page. A set of interventions will be added to the Intervention list. (Intervention words are magenta color which indicates new and not yet saved)

Intervention ▼	Text/ Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Data
Admission Assessment - LTC		A	NEW	Q1DX1				▶
Annual Medical		A	NEW	Q365D				
Behavior Support Plan		A	NEW	Q90D				
Behavior Support Variance		A	NEW	PRN				▶
Client Contacts		A	NEW	Q1DX1				
Client Identifying Information		A	NEW	Q1DX1				
Daily Living Support Plan		A	NEW	Q90D			▶	▶
Daily Living Support Plan Variance		A	NEW	PRN			▶	
Elimination		A	NEW	Q1D			▶	▶
Goals of Care Designation (GCD)		A	NEW	Q1DX1			▶	
Goals of Care Designation Form Completed		A	NEW	Q1DX1				
Height and Weight		A	NEW	Q30D			▶	▶

6. Click **Save** on the bottom right corner of the page.



Once saved, the added interventions will return in black – indicating they are saved.

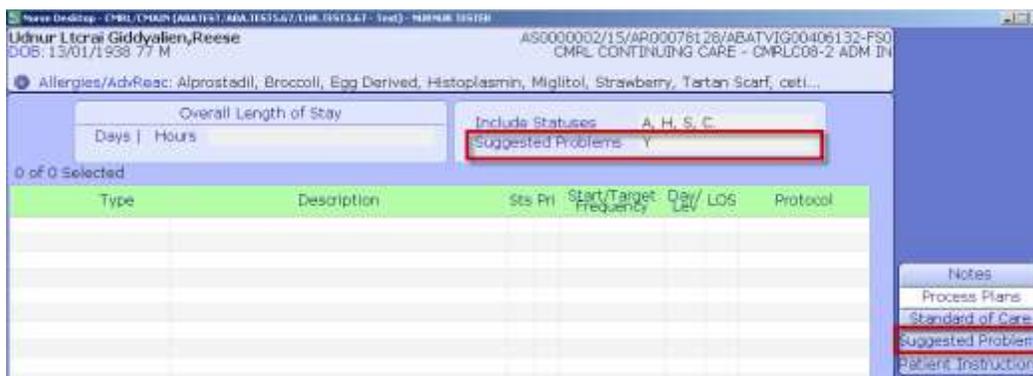
Intervention ▼	Text/Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Data
Admission Assessment - LTC		A	PS	Q1DX1		1000		▶
Annual Medical		A	PS	Q365D		1000		
Behavior Support Plan		A	PS	Q90D		1000		
Behavior Support Variance		A	PS	PRN				▶
Client Contacts		A	PS	Q1DX1		1000		
Client Identifying Information		A	PS	Q1DX1		1000		
Daily Living Support Plan		A	PS	Q90D		1000	▶	▶
Daily Living Support Plan Variance		A	PS	PRN			▶	
Elimination		A	PS	Q1D		1000	▶	▶
Goals of Care Designation (GCD)		A	PS	Q1DX1		1000	▶	
Goals of Care Designation Form Completed		A	PS	Q1DX1		1000		
Height and Weight		A	PS	Q30D		1000	▶	▶

The assessments can now be documented as required.

### NZ-Add RAP Problems to Process Plan

Once a client's MDS and RAPS have been completed, Problems in the system will automatically be generated. These need to be added to the Care plan.

You will know that there are problems to add when you come to the Process Plan of Care screen and you notice that there is a "Y" under **Suggested Problems**.



You must now use your clinical judgment, in consultation with the client and interdisciplinary team, as to whether to add this problem to the Care plan.

- Select the problem once you entered into the Suggested Problem menu. You may select all of the RAP problems at once by checking each box.

3 of 3 Selected

<input checked="" type="checkbox"/>	Problem	Care Provider	Date	Time
<input checked="" type="checkbox"/>	Mood State	Carolyn J Killeen	26/01/15	1449
<input checked="" type="checkbox"/>	ADL-Rehabilitation Trigger A	Carolyn J Killeen	30/03/15	1326
<input checked="" type="checkbox"/>	Urinary Incont. & Indwelling ...	Carolyn J Killeen	30/03/15	1326

- Click **Add** from the bottom toolbar.



- This will take you to Patient's Additional Problems/Interventions. Select **Problem Detail** at the top of the page. The problems selected will be displayed in the top portion of the screen.

General Standard of Care **Problem Detail**

	Mnemonic	Description	Sts	Pri	Protocol	Sug	Txt
1	RAP.COG.LOSS	Cognitive Loss/Dementia	A			*	
2	RAP.VISUAL	Visual Function	A			*	
3	RAP.BEHAVIOR	Behavioral Symptoms	A			*	

	Long Term Outcome	Target	Sts	Protocol	Mod	Txt
1	Cognition	06/04/15	A			*
2						
3						

	Short Term Outcome	Target	Sts	Protocol	Mod	Txt
1						
2						
3						

	Intervention	Sts	Protocol	Freq	Txt
1					
2					
3					

- Once in this Additional Care Plan, click the **Save** button on the bottom right corner to save the newly added problem. After saving this Plan of Care, you will be returned back to the Suggested Problem page. Continue this process of adding problems until all are added.
- Once all the problems are added to the Additional Care Plan from the Suggested Problems, return back to the Process Plan by clicking the **Close** button on the bottom toolbar.

Overall Length of Stay		Include Statuses				
Days   Hours		A, C, I, D.				
0 of 41 Selected						
Type	Description	Sts Pri	Start/Target Frequency	Day/Lev	LOS	Protocol
<input type="checkbox"/> PLAN	Additional problems/interventions	A	12/01/15 1...			
<input type="checkbox"/> P	Cognitive Loss/Dementia	A				
<input type="checkbox"/> LO	Cognition	A	06/04/15			
<input type="checkbox"/> P	Visual Function	A				
<input type="checkbox"/> LO	Sensory Function: Vision	A	06/04/15			
<input type="checkbox"/> P	Behavioral Symptoms	A				
<input type="checkbox"/> LO	Aggression Self-Control	A	01/05/15			
<input type="checkbox"/> P	Dehydration/Fluid Maintenance	A				
<input type="checkbox"/> LO	Fluid Balance	A	01/05/15			
<input type="checkbox"/> P	Communication	A				
<input type="checkbox"/> LO	Communication	A				
<input type="checkbox"/> P	Pressure Ulcers	A				
<input type="checkbox"/> LO	Tissue Integ: SKIN AND MUCOUS MEMBR...	A				
<input type="checkbox"/> P	ADL-Rehabilitation Trigger A	A				
<input type="checkbox"/> LO	Self Care: Activities of Daily Living	A				
<input type="checkbox"/> P	Mood State	A				
<input type="checkbox"/> LO	Mood Equilibrium	A				
<input type="checkbox"/> P	Urinary Incont. & Indwelling Cath	A				
<input type="checkbox"/> LO	Urinary Continence	A				
<input type="checkbox"/> I	Morse Fall Scale	A	.ADMISSION			ZMORSEFALL
<input type="checkbox"/> I	Client Contacts	A	Q1DX1			

The RAP Problems (P) have been added to the Process Plan. The Long term Outcome (LO) is automatically attached to each problem.

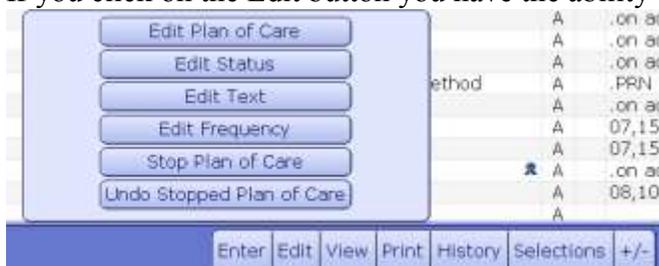
### NZ- Process Plan Toolbar Options



#### Edit

Most of the Edit Functions are best done from the Status Board/Intervention Work list and were covered previously under Documentation.

If you click on the Edit button you have the ability to:

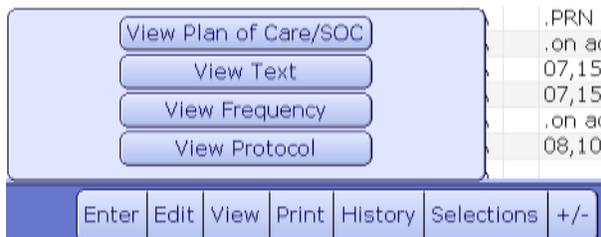


- Edit Plan of Care

- Edit Status
- Edit Frequency
- Edit Text
- Stop Plan of Care
- Undo Stop Plan of Care

### View

The View button allows you to **View**:



- The Plan of Care. (Takes you to the Additional Problems/Interventions Screen).
- Suggested Problems
- Frequency of an Intervention that you have highlighted
- Protocols associated with an Outcome or Intervention that you have highlighted
- Text associated with a Problem, Outcome or Intervention that you have highlighted.

### Print

The Print button allows you to:

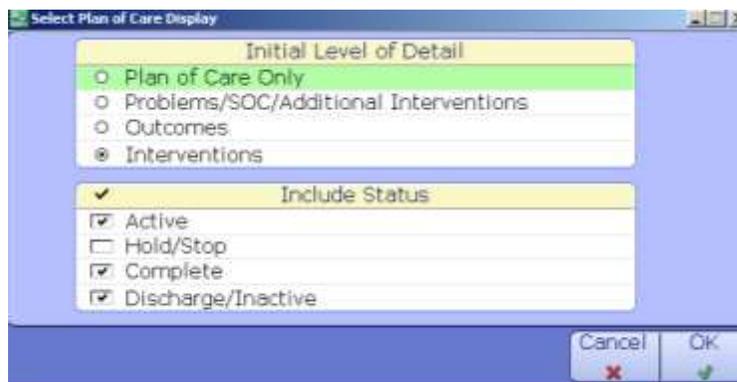


Allows you to **Print** the following:

- Plan of Care
- Discharge Summary
- Audit
- EMR Report
- Care Summary
- Profile
  - Will have a Pop-Up box asking you which Format. Do an F9 (Look-Up) to view your choices. A Resident Profile is an example format.
- Variance Tracking
- Worklist (May also be printed directly from the Status Board)
- Plan of Care
  - A Pop-Up box will appear asking you which components of the care plan you wish to print.
- Print Problems

### Selections

Allows you to change your Plan of Care Display



### NZ-Documenting Outcomes

Where documenting on interventions records the daily care activity of our client(s), documenting on outcomes records the purpose and rationale for those actions. Without documentation of outcomes we have no documented evidence to support our care choices. Outcomes should always be client-centered. Any outcome added to the care plan must be an outcome that the client supports. Outcomes are added to the care plan via an attached Problem. Before you are able to document on Outcomes, you must attach a Problem with its associated Outcome to the care plan. This is covered in the Care Planning section.

The PCS system has been built so that the interdisciplinary team documents from a common problem list, with a common long-term outcome and general and/or discipline specific short-term outcomes (goals) associated to it.

1. Click on **Outcomes** on the tool bar on the right side of your screen.

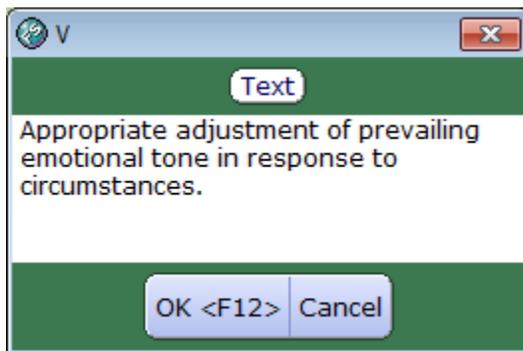
Problem ▼	✓	Text	Outcome	Target Date	Status	History	Prtcl	Assoc Data
ADL-Rehabilitation Trigger A		☞	Self Care: Activities of Daily Living		A			
Behavioral Symptoms		☞	Aggression Self-Control	01/05	A	76 days		
Cognitive Loss/Dementia		☞	Cognition	06/04	A	76 days		
Communication		☞	Communication		A			
Dehydration/Fluid Maintenance		☞	Fluid Balance	01/05	A	76 days		
Mood State		☞	Mood Equilibrium		A			
Pressure Ulcers		☞	Tissue Integ: SKIN AND MUCOUS MEMBRANES		A			
Urinary Incont. & Indwelling Cath		☞	Urinary Continence		A			
Visual Function		☞	Sensory Function: Vision	06/04	A	76 days		

2. Following along the columns on the Problem/Outcome screen from left to right:

**Problem:** Describes the name of the problem

**Checkmark:** Click here to highlight the outcome you wish to document on or edit

**Text:** Describes and allows you to write/edit the actual outcome in a goal format using SMART (Specific, Measurable, Achievable, Realistic and Time) format.



**Outcome:** Lists the outcomes associated with the problem. Outcomes may be either Long-Term or Short-Term. Short-Term outcomes are either general or discipline specific.

**Target Date** – Displays and allows you to enter/edit a Target date for achieving the outcome.



**NOTE:** A Target Date *must* be entered in order to document on the outcome. You will be provided with a Calendar to select your target date. Choose the date and click “OK” (make sure you have chosen the correct year).

Your Target Date should reflect when you will be back to assess this Outcome. Continuing Care uses the Next Scheduled RAI Due Date Report to generate a Target Date. Follow unit specific guidelines.

**Status:** Status of the Outcome. Defaults as Active, but may be edited to Complete, or Inactive.

**History:** Describes the last time documentation occurred on that outcome and the details of who documented and what was done. From here you may EDIT as described previously under *Documenting: Interventions*, or “Undo” if an error was made.

**Protocol:** Describes any protocol associated to that outcome. A Black Triangle will appear if there is a Protocol to view.

**Associated Data:** Any EMR associated data linked to that outcome which may assist you in documentation will be listed here. A Black Triangle will appear if there is any associated data to view.

### Steps to Document on Outcomes:

- i. Select the Outcome to document on.
- ii. Click into the cell in the Target Date column - a calendar automatically is displayed.
- iii. Enter a target date. Click OK .
- iv. At the bottom of the screen, click Document. A text box automatically displays. Read the text and click OK.
- v. The Date and Time Screen is displayed, click OK to document at present time.
- vi. Answer one option in the query that is presented. Use the Comment section to provide a more detailed SMART goal if applicable.

Progress and Text Queries	
Urinary Continence Overall Rating	<input type="radio"/> Never Demonstrated <input type="radio"/> Rarely Demonstrated <input checked="" type="radio"/> Sometimes Demonstrated <input type="radio"/> Often Demonstrated <input type="radio"/> Consistently Demonstrated <input type="radio"/> Not Applicable
Urinary Continence Overall Rating Comment	

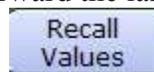
- vii. Click Save when completed.
- viii. Choose the next Outcome and repeat process until all Outcomes are completed. Do not document on other discipline’s outcomes that may be present on the list (eg: social work outcome).

**NOTE:** You will only see the Outcomes that you have access to document on in PCS. To view all Outcomes, go to the EMR under Care Activity/Outcomes.

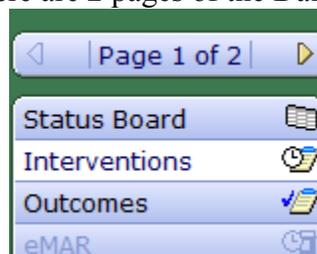
## Documenting on the Daily Living Support Plan and the Behavior Support Plan assessments.

Following the completion of the RAI 2.0 assessment and the RAPS, as well as once the RAP problems are added onto the Process plan and the Outcomes are documented, the two support plans are to be updated. The Daily Living Support Plan and the Behavior Support Plans are updated quarterly after the RAI and RAPS completion and/or prn as the resident's needs change. Information gathered from other disciplines assessments (ie: physiotherapy, occupation therapy, nutrition, etc) and any other relevant reports can be included in the care plan development.

1. Highlight the Daily Living Support Plan. Click into Document.
2. Complete (or update) the Daily Living Support Plan. If this assessment has previously been documented on, you may use the Recall Values button at the bottom of the screen to pull forward the last entered documentation.



3. Once the documentation has been pulled forward, edit and update the assessment. Note that there are 2 pages of the Daily Living Support Plan assessment.



Above the Status Board on the right hand side tool menu the number of pages of a lengthy assessment is displayed.

4. Once the Daily Living Support Plan is updated and completed click Save to file the assessment.
5. Update the Behavior Support Plan.  
Reminder: Use the **Insert Occurrence** located on the tool bar on the bottom of the screen to document separate behaviors.



6. Save to file the assessment upon completion.

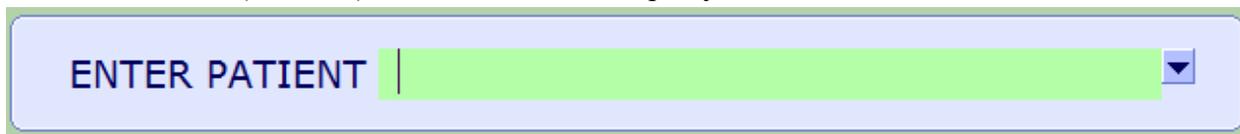
**Print** the updated Daily Living Support Plan and the Behavior Support plan. Remove the previous care plans and replace with the updated care plans into the designated care plan binders.

To print the Daily Living Support Plan and the Behavior Support Plan:

1. Highlight Reports under PCS.
2. Highlight the report to print and click to enter.



3. Enter residents name by using the drop down menu key or enter last name of resident, first name (or initial) and use the F9 look up key. Choose the resident and click on name.



The image shows a search bar with a light blue background and a white border. On the left, the text 'ENTER PATIENT' is written in blue. To the right of the text is a white input field with a green highlight. At the end of the input field is a blue downward-pointing arrow icon.

4. Click OK.
5. Select Print on the right hand side tool bar to print care plan.

## AC-Care Planning in Acute Care

### AC-What is the Plan of Care Assessment

1. The Plan of Care assessment is a collaborative care plan that identifies the issues, patient's goals, the progress toward those goals and barriers.
2. The Plan of Care assessment is used by multiple disciplines which provide a broader picture of who is involved in the patient's care and the approach as a team.

### AC-Where to Find the Plan of Care Assessment

1. The Plan of Care assessment is part of the Medical Admission SOC and the Surgical Admission SOC.
2. The SOC is usually added by the Unit Clerk at the time of admission or can be added by the Nurse through Process Plans.
3. Once the SOC has been added and the Plan of Care assessment will appear on your patient's worklist and is ready to be used.
4. The Plan of Care assessment can be added as an individual assessment, but this will not be necessary as it will always be added at the time of admission.

### AC-When to Document on the Plan of Care Assessment

1. When a patient is admitted an initial assessment, as per discipline, will be completed. Through the initial assessments and discussions with the patient, the areas of concern that will need to be captured in the Plan of Care assessment will be identified.
2. During the patient's stay, update the Plan of Care based on discussion with the team during Rapid Rounds, if the patient has identified new goals for themselves or there is a change in the patient's condition.

**Note:** The Plan of Care assessment is to be updated daily by the Day Shift.

## AC-Documenting on the Plan of Care Assessment

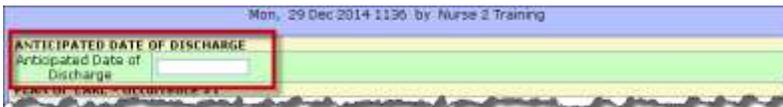
When setting up the Plan of care for the first time, document by using the Document button. Ongoing documentation for each discipline will be through Document Spreadsheet.



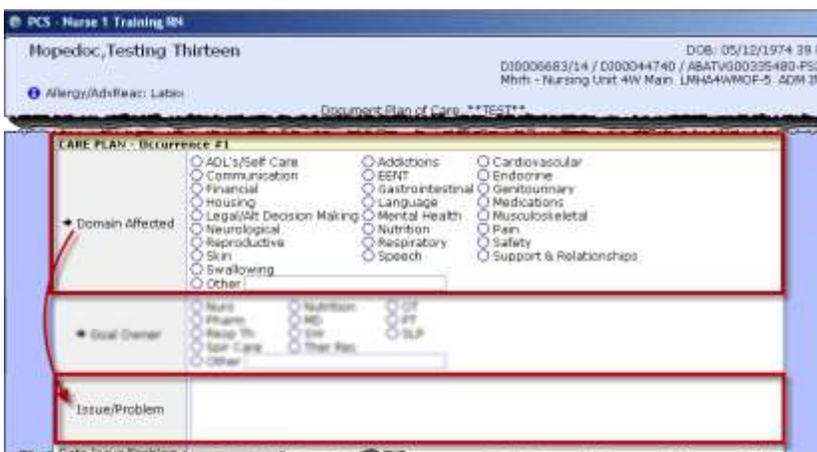
1. **Select** *Plan of Care* from the Interventions window (will turn green)
2. **Click** Document at bottom of window

**Note: Do Not Recall Values.** Recalling Values pulls through all discipline's information not just the discipline entering at that point. If information was documented from five different disciplines, all the documentation from all five will be recalled.

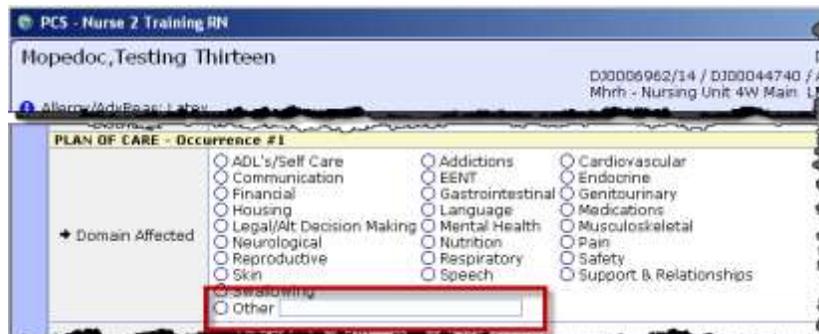
3. **Enter Anticipated Date of Discharge** – determined through consultation with care team during Rapid Rounds



**NOTE:** If other disciplines have already documented on an active Plan of Care, the Domain and Goal Owners will display as already answered. If there are no entries for a discipline, a user will need to insert an occurrence to insert patient goals specific to your discipline.



4. Document the issue or problem. When writing the **Issue/Problem** remember to:
  - Make sure the **Issue/Problem** fits with the **Domain Affected** (e.g. Domain Affected - Musculoskeletal and Issue/Problem - Low Saturation would not fit, Hip Fracture would fit)
  - Use point form, does not need to be a paragraph
  - Use clinical reasoning



PCS - Nurse 2 Training RN  
Hopedoc, Testing Thirteen  
D30006962/14 / D300044740 / A  
Mhrh - Nursing Unit 4W Main 15

PLAN OF CARE - Occurrence #1

Domain Affected

- ADL's/Self Care
- Communication
- Financial
- Housing
- Legal/Alt Decision Making
- Neurological
- Reproductive
- Skin
- Addictions
- EENT
- Gastrointestinal
- Language
- Mental Health
- Nutrition
- Respiratory
- Speech
- Cardiovascular
- Endocrine
- Genitourinary
- Medications
- Musculoskeletal
- Pain
- Safety
- Support & Relationships
- Other

**NOTE:** When selecting Domain and Goal Owner you cannot have duplicates above as it will not display correctly in the EMR. E.g. If Musculoskeletal was selected as a domain another domain could be Mobility.

**Cannot do:** Musculoskeletal PT for one problem and Musculoskeletal PT for the second problem. They match.

**Can do:** Musculoskeletal PT and Mobility PT. They do not match.

**Can do:** Musculoskeletal Nursing and Musculoskeletal PT. They do not match.

5. Document the Goal Owner. The **Goal Owner** must own the **Goal Statement(s)**
    - Use point form
    - Use clinical reasoning
    - Example of a Goal Statement could be:
      - i. Domain Affected – Skin
      - ii. Goal Owner - Nurs
1. Patient's post-op incision will remain clean, healing and free of infection during acute care stay.
  2. Patient's ulcer on coccyx will show signs of new granulation tissue within 7 days



The screenshot shows a software window titled "Repelec\_Twisting Throat". It contains several sections: "Patient Information" with fields for name, address, and phone; "Goal Owner" with radio buttons for various roles; "Goal Progress" with radio buttons for "Met", "Not Met", "Progress Toward Goal", and "No Progress Toward Goal"; and "Intervention Set(s) Added" with a list of medical categories and checkboxes.

Use **SMART** Goals:

**Specific** – What is the specific goal?

**Measurable** – What are the standards or parameters?

**Achievable** – Is the task feasible?

**Realistic** – Are sufficient resources available?

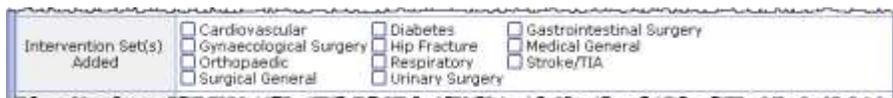
**Time-Bound** – What are the start and end dates?

6. Enter Goal Progress. Goal Progress is used to evaluate progress and should **NOT** be documented on when first identifying the goal.



A horizontal bar containing four radio button options: "Met", "Not Met", "Progress Toward Goal", and "No Progress Toward Goal".

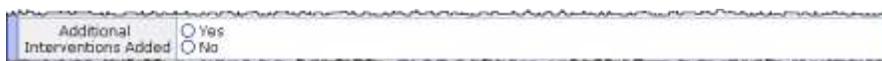
7. Select any additional Intervention Sets that were added through the Process Plans.



A box titled "Intervention Set(s) Added" containing a grid of checkboxes for various medical categories: Cardiovascular, Diabetes, Gastrointestinal Surgery, Gynaecological Surgery, Hip Fracture, Medical General, Orthopaedic, Respiratory, Stroke/TIA, and Surgical General, Urinary Surgery.

**NOTE:** Adding through Process Plans allows for removal of unnecessary assessments. See Adding Additional Interventions.

8. Select Additional Interventions Added Yes or No if additional individual interventions/assessments were added.



A horizontal bar containing two radio button options: "Yes" and "No".

9. Enter in any Barriers to Achieving Goal



10. Click  when documentation is complete.

Note: Do Not Recall Values. Recalling Values pulls through all discipline's information not just the discipline entering at that point. If information was documented from five different disciplines, all the documentation from all five will be recalled.

### AC-Adding an Intervention Set

1. From Process Plans, click Enter
2. Select Additional Care Plan



3. In the Enter/Edit Patient's Additional problems/interventions click on the empty field at the bottom of the window under Additional Interventions.
4. Type / and click the drop down to search for an Intervention Set



	Description	Status	Source	Protocol	Freq	Text
1	MDS 2.0 Tracking Tool	A	PS	MDSTRACK01	*	
2	MDS 2.0 Tracking Tool	A	PS	MDSTRACK01	*	
3	Behavior Support Plan	A	PS		*	
4	Daily Living Support Plan Variance	A	PS	SOCC	*	
5	Daily Living Support Plan	A	PS	SOCC	*	
6	/					
7						

Mnemonic	Description
ENQDIAB	Diabetes Assessment
ENQDMPREG	Diabetes: Pregnancy Assessment
ENQPUMP01	Diabetes: Insulin Pump
PHZTBDOT	PH TB Direct Observation Therapy (DOT)
BH2TRMFD	BH TB Latent Infection

**NOTE:** If looking for an individual Assessment, type “?” followed by a key word (e.g. ?skin)  
If looking for Intervention Sets, type “/” followed by F9 or click the drop down arrow.

- The Intervention Set lookup window will open or if using the key word search (eg: ?skin) the individual Assessment will open.

Mnemonic	Description
ENQDIAB	Diabetes Assessment
ENQDMPREG	Diabetes: Pregnancy Assessment
ENQPUMP01	Diabetes: Insulin Pump
PHZTBDOT	PH TB Direct Observation Therapy (DOT)
PHZTBMED	PH TB Latent Infection
SOCBAR	Standard of Care: Bariatric Clinic
SOCCC	Standard of Care: CC
SOCDP	Standard of Care: Discharge Planning

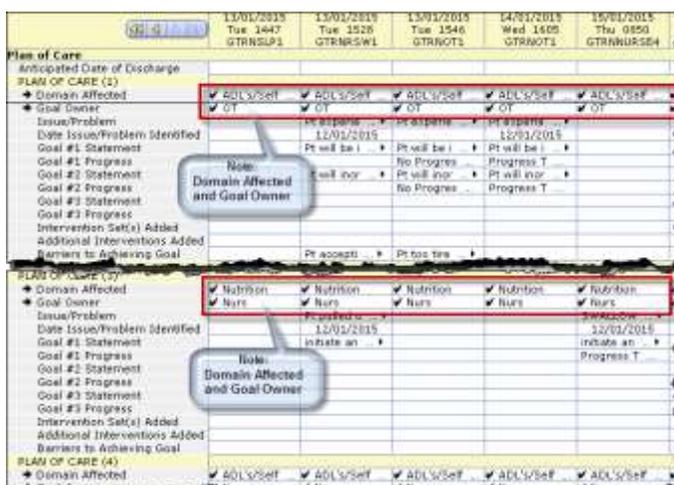
- Select the Intervention Set you wish to add from the list. The associated Interventions will be added.

- Delete any interventions within the added set that are not required by highlighting and press delete.

- Click Save.

### AC-Ongoing Documentation through Documentation Spreadsheet

- Highlight the **Plan of Care** intervention.
- Click **Document Spreadsheet** at bottom of window.
- Look for the documentation that matches the appropriate discipline.



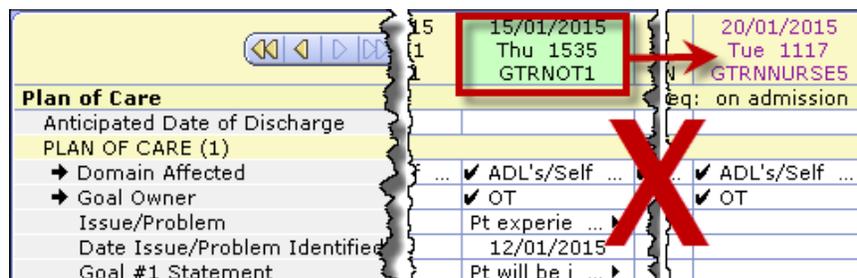
The screenshot displays a 'Plan of Care' window with a spreadsheet view. The columns represent dates: 11/01/2015 (Tue 1447), 11/02/2015 (Tue 1525), 11/03/2015 (Tue 1546), 11/04/2015 (Wed 1405), and 11/05/2015 (Thu 0850). The rows are organized into sections: 'PLAN OF CARE (2)', 'PLAN OF CARE (3)', and 'PLAN OF CARE (4)'. Each section lists 'Domain Affected', 'Goal Owner', 'Issue/Problem', and 'Date Issue/Problem Identified'. Two callouts point to specific entries: one for 'ADL's/Self' and another for 'Nutrition', both with the note 'Note: Domain Affected and Goal Owner'. The spreadsheet cells contain progress indicators like 'No Progress', 'Progress T', and 'Pt will be I'.

**NOTE: Documenting on Goals**

Do not document on goals that are owned by other disciplines.

- A column can be copied over to the purple column but a user needs to be careful to make sure the correct discipline is being copied.

**NOTE:** In this screen shot a Nurse has dragged over Occupational Therapists documentation, **DO NOT COPY** other disciplines documentation.



	15/01/2015 Thu 1535 GTRNOT1	20/01/2015 Tue 1117 GTRNNURSE5
Anticipated Date of Discharge		eq: on admission
PLAN OF CARE (1)		
→ Domain Affected	✓ ADL's/Self ...	✓ ADL's/Self ...
→ Goal Owner	✓ OT	✓ OT
Issue/Problem	Pt experie ...	
Date Issue/Problem Identified	12/01/2015	
Goal #1 Statement	Pt will be i ...	

**Copy**

- To copy, select the correct documentation and left click and hold the mouse button over the header (date and time) of the column that contains the discipline's goals.

20/01/2015  
Tue 1117  
GTRNNURSE5

- Hold and drag over to the purple header column.
- Release the mouse button.
- Individual boxes can be dragged over from other columns.
- Left click and hold the mouse button over the desired individual box.
- Drag over into the empty box in the purple column.
- Release the mouse button.
- Edit any documentation that needs to be updated by clicking the individual boxes in the column and update the information accordingly.

9. If individual boxes were not entered previously, click into the empty field and enter the new information.

14/01/2015 Wed 1605 GTRNNURSE4	15/01/2015 Thu 0848 GTRNNURTRN	20/01/2015 Tue 1117 GTRNNURSE5
Freq: on admission		
12/01/2015 pt will be i	12/01/2015	12/01/2015
Progress T ...	→	Progress T ...
pt will incl ...		
Progress T ...		

**Note:** Updating Documentation: It is everyone's responsibility to verify documentation reflects the assessment of the Plan of Care before saving.

Depending on changes with the patient, a user may want to update the:

- Goal statements
- Goal progress - Goal Progress is used to evaluate progress and should not be documented on when first identifying the goal.
- Barriers to achieving goal

**Note:** Avoid Fragmentation: Do not fragment the Plan of Care by excluding portions when documenting. (eg. If not updating Goal #1 but adding Goal #2, drag Goal #1's statement into the documentation, leave the progress blank if appropriate and then add Goal #2's statement.

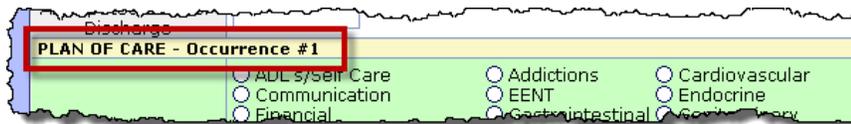
### AC-Adding Additional Problems

The patient may have more than one problem identified requiring you to insert a second Occurrence for the Plan of Care.

If other disciplines have already documented on an active Plan of Care, the Domain and Goal Owners will display as already answered. If there are no entries for a discipline, a user will need to insert an occurrence to insert patient goals specific to your discipline.

### Inserting an Occurrence

When a Domain/Goal has been previously entered and a new occurrence is required, make sure an area is highlighted below the Plan of Care – Occurrence #1 line.



1. Click **Insert Occurrence** at bottom of window.
  - a. The Insert Occurrence Button will be greyed out if the Anticipated Date of Discharge question is highlighted. Make sure a question is highlighted under the PLAN OF CARE occurrence to activate the Insert Occurrence button.
  - b. *Plan Of Care – Occurrence #2* will be added.



2. Continue to document on Occurrence #2.

### AC-Viewing Documentation in the EMR

#### Care Trends View in EMR

1. From the *Interventions* Window click **EMR**.
2. Click **Care Trends**. Care Trends window will open.



- Click on Education.



Medical/Surgical	Long Term	Behavioral	Rehabilitation
HEENT	Neurologic	Pain	Cardiovascular
Nutrition	GI/GU	Reproductive	Musculoskeletal
Psychosocial	Education	Activity/Safety	

	7/3/14 07:26
Visual Assistive Device	Glasses
	Refuses to wear

- Click on the yellow labelled Treatment Plan Education Topics.

	15/12/14 14:41	15/12/14 14:47	15/12/14 14:55
	Genitourinary Nurs	Genitourinary Nurs	Pain Nurs
Treatment Plan Education Topics	Gastrointestinal Nurs Pain Nurs Pain Nurs	Gastrointestinal Nurs Pain Nurs	Pain Nurs

- Click on the Domain tab to see information.



	15/12/14 14:37
Issue/Problem	
Date Issue/Problem Identified	15 Dec 2014
Goal #1 Statement	
Goal #1 Progress	Met
Goal #2 Statement	
Goal #2 Progress	Progress Toward Goal
Barriers to Achieving Goal	
Intervention Set(s) Added	
Recorded By	Nurse 3 Training

**NOTE:** View the individual entries for the Plan of Care assessment in the EMR through Care Activity. Choose Date, Name or Recorded By for your preferred viewing option.

## AC-Questions and Answers

### Can I edit or undo the plan of care?

If you need to edit or undo your documentation for the Plan of Care assessment, you will follow the same steps as you would for any other assessment on the worklist. This does not change.

**Can I add more than one intervention set?**

Yes. In Process Plans, add the first intervention set and then add the second intervention set. Check the assessments that have been added for duplications and remove any unnecessary assessments.

**Can I still add single assessments when I am adding a set?**

Yes. You can add a set and add additional assessments. Remember to use the “/” or “?” for your searches.

**What is the issue/problem is resolved?**

When an issue/problem is resolved, you can update the goal progress to “Met” and save your documentation. Go back into the Plan of Care assessment and discontinue that occurrence and save. The occurrence will now display as grey in Document Spreadsheet.

**NOTE:** Only discontinue if ALL goals are met not just 1 of 3.

**Will Editing a goal statement impact previous documentation?**

No. Any previously entered documentation will remain the same unless that care provider edits their specific entries. Updating the goal statement only impacts your own documentation and becomes the new goal statement for that issue/problem.

## AC-Care Planning Checklist

Check off what has been covered and understood. If any information has been missed please follow-up with your Manager.

- What is the Plan of Care Assessment
- Where to find the Plan of Care Assessment
- When to document on the Plan of Care Assessment
- Documenting on the Plan of Care Assessment
- How to add an Intervention Set
- How to update the Plan of Care
- How to View Documentation in the EMR

Once signed please give this sheet to the Manager.

I have read and understand the information provided in this training guide including not to use Recall Values with this assessment.

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Name

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Date