MonashHealth EMR

Quick Reference Guide (QRG)

Documenting in Care Plans

A Care Plan is initiated to support the coordination of care and provide a centralised place in which to manage patient centred goals and showcase interventions in place.
It facilitates optimal outcomes for patients during their admission, by enabling an interdisciplinary team to share assessments, goals and interventions.

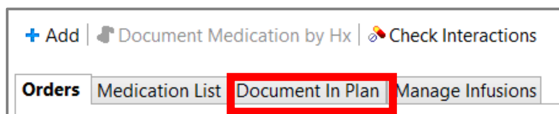
This guide will enable the user to:

- *Document in a Care Plan*
- *Discontinue a Care Plan*
- *Review the Care Plan Summary*

Document in a Care Plan

Once the Care Plan is ordered and signed for, it is present in the Orders tab to be documented against by clinicians.

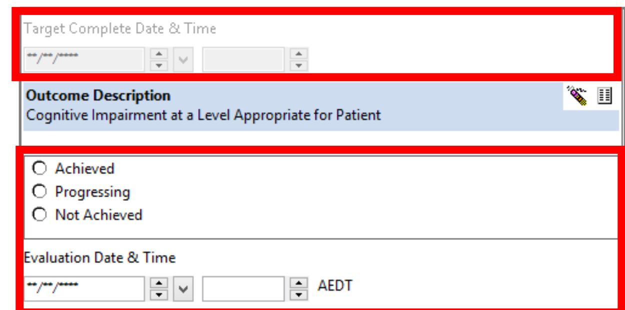
1. Click the Document in Plan tab



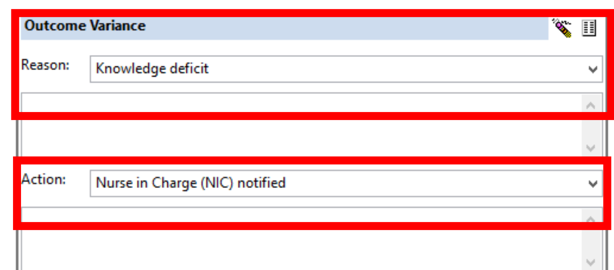
All active **Outcomes/Goals** are displayed

2. Click on the status icon to document against the outcome
3. Populate the **Target Complete Date** and **Time of the Outcome description** if required
4. Select the appropriate **Outcome Description** – Outcomes/Goals are Achieved, Progressing or Not Achieved

NOTE: Most Outcomes/Goals are to be achieved **'By Discharge'** and only need to be documented on completion or on discharge – **not every shift.**



5. Selecting **Progressing** and **Not Achieved** will open a window for the clinician to provide a reason and action for the outcome variance
6. Select a **Reason** and **Action** from a dropdown menu or enter a comment in the free text section below



7. Interventions are marked as either **Done** or **Not Done**
8. Selecting **Not Done** will open a window for the clinician to provide a reason and an action for the outcome variance

Target Complete Date & Time
Intervention Description
Falls Prevention Measures in Place
Done
Not Done

9. You can then select a **Reason** and **Action** from a dropdown menu or enter a comment in the free text section below

Outcome Variance
Reason: Patient refused/uncooperative
Action: Barrier to care discussed

10. Click Sign Documentation to save entry

Discontinuing Outcomes/Interventions within a Care Plan

Care Plans may be discontinued if a patient has achieved all of their outcomes/goals, OR if the patient is to be transferred to an area where the Care Plan will not continue to be documented against.

NOTE: The preferred workflow is to discontinue the individual outcomes/interventions.

To Discontinue individual Outcomes or Interventions:

1. In the **Orders** tab, open the required care plan
2. **Right** click on the relevant goal or intervention and select **Discontinue.**

Adapt Environment to Optimise Safety and Co
Falls Prevention Measures in Place
CPO Allocated
Promote Day
Provide Supp
Add At Risk o
Modify
Discontinue
Void
Outcome Info...

3. This will display a line across the outcome/intervention

Interventions
Educate and Provide Emotional Support to Patient/Carer
Encourage Carers to Visit During Times When the Patient May
Provide Optimal Hydration and Nutrition
Monitor for Signs of Infection
Adapt Environment to Optimise Safety and Comfort
Falls Prevention Measures in Place
CPO Allocated
Promote Day / Night routine
Provide Support and Reassurance
Add At Risk of Delirium to Problem List

4. Click **Sign** to save documentation
5. **Refresh** the screen and status of the outcome/intervention will display as Discontinued and a date and time is displayed indicating when the outcome was discontinued.

Falls Prevention Measures ...	Activated	27/10/2020 9:52 AEDT
CPO Allocated	Discontinued	27/10/2020 9:53 AEDT - 27/10/2020 9:55 AEDT
Promote Day / Night routi...	Activated	27/10/2020 9:52 AEDT
Provide Support and Reass...	Activated	27/10/2020 9:52 AEDT

Discontinue a Care Plan

1. In the **Orders** tab, **right** click on the relevant Care Plan and select **Discontinue**
   OR Click on the Care Plan you wish to discontinue and click the blue **Cancel** icon

2. Click the **check boxes** next to any outcomes or interventions that are to remain

Discontinue - Cognitive Impairment (Delirium and Demen

Keep	Component	Status	Order Details
Outcomes			
☑	Cognitive Impairment at a Level Appropriate for Patient - Achieved	Activated	By Discharge
☑	Not at Risk of Harm to Self, Others, or Property - Achieved	Activated	By Discharge
☑	Carer Understands Cognitive Impairment Changes and Impact on Function - Achieved	Activated	By Discharge
☑	Carer Understands Care Strategies to Address Cognitive Impairment - Achieved	Activated	By Discharge
☐	4AT Score - Greater Than 0	Activated	27/10/2020 9:52 AEDT
☑	Falls Risk Screening Score - Greater Than or Equal 0	Activated	27/10/2020 9:52 AEDT
Interventions			
☐	Educate and Provide Emotional Support to Patient/Carer - Done	Activated	27/10/2020 9:52 AEDT
☐	Encourage Carers to Visit During Times When the Patient May	Activated	27/10/2020 9:52 AEDT

3. If there are none that you wish to keep, click **OK**

4. Click **Orders for Signature** at the bottom of the screen
5. Click **Sign** and **Refresh** the page
6. The status of the Care Plan will display as '**Discontinued**' and the selected outcomes/interventions will also display as discontinued.

Reviewing the Care Plan Summary

In ISBAR Handover

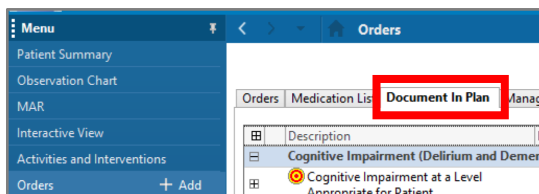
1. In the Patient Summary, **ISBAR Handover** tab
2. Under the Care Plans heading, all Initiated Care Plans will display. **Clicking** on the expand/collapse [+] [-] will display the last 2 documentations.

Hover over documentation to display full detail

3. If there has been no documentation in the last 24 hours, the last documentation will display with an asterisk.
4. The **Orders** and **Care Plan Summary** hyperlinks at the top of this section will open the relevant Menu item for quick documentation.

In Orders – Document in Plan

1. In **Orders**, click on the **Document in Plan** tab

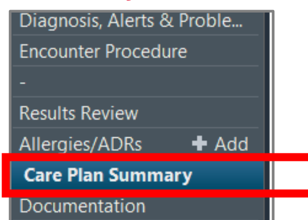


2. All Care Plans are visible, and the last documentation is displayed.

3. Clicking on the expand ⊞ to view patient progress and documentation.

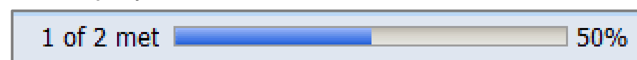
In the Care Plan Summary

1. In the Menu, select the **Care Plan Summary.**



The Outcomes/Goals of all Care Plans initiated on the patient are displayed

2. A ***green tick*** ✔ indicates that the goal has been met
3. A ***red cross*** ✖ indicates that the goals are progressing or have not been met
4. A percentage of goal progression is also displayed



This page is effective in reviewing the progress of the Care Plans.