

# 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:

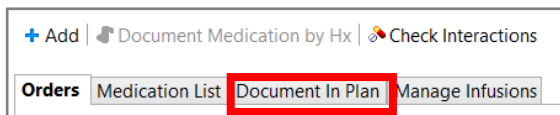
- Document in a Care Plan
- Discontinue a Care Plan
- Review the Care Plan Summary

### 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.



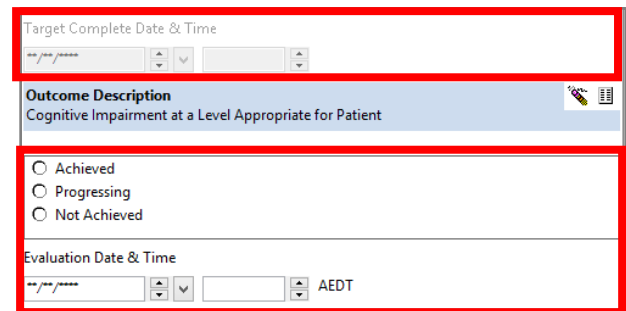
1. Click the Document in Plan tab



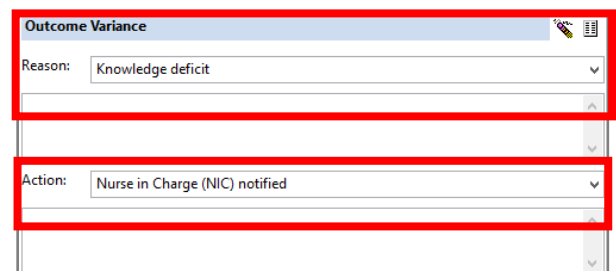
All active **Outcomes/Goals** are displayed

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  
 --/--/---- AEDT

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 Comfort

Falls Prevention Measures in Place

CPO Allocated

Promote Day / Night routine

Provide Support and Reassurance

Add At Risk of Delirium to Problem List

Modify

Discontinue

Void

Outcome Info...

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

Interventions	
<input type="checkbox"/>	Educate and Provide Emotional Support to Patient/Carer
<input type="checkbox"/>	Encourage Carers to Visit During Times When the Patient May
<input type="checkbox"/>	Provide Optimal Hydration and Nutrition
<input type="checkbox"/>	Monitor for Signs of Infection
<input type="checkbox"/>	Adapt Environment to Optimise Safety and Comfort
<input type="checkbox"/>	Falls Prevention Measures in Place
<input checked="" type="checkbox"/>	CPO Allocated
<input type="checkbox"/>	Promote Day / Night routine
<input type="checkbox"/>	Provide Support and Reassurance
<input type="checkbox"/>	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.

<input type="checkbox"/>	Falls Prevention Measures ...	Activated	27/10/2020 9:52 AEDT
<input checked="" type="checkbox"/>	CPO Allocated	Discontinued	27/10/2020 9:53 AEDT - 27/10/2020 9:55 AEDT
<input type="checkbox"/>	Promote Day / Night routi...	Activated	27/10/2020 9:52 AEDT
<input type="checkbox"/>	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

Keep	Component	Status	Order Details
<b>Outcomes</b>			
<input checked="" type="checkbox"/>	Cognitive Impairment at a Level Appropriate for Patient - Achieved	Activated	By Discharge
<input checked="" type="checkbox"/>	Not at Risk of Harm to Self, Others, or Property - Achieved	Activated	By Discharge
<input checked="" type="checkbox"/>	Carer Understands Cognitive Impairment Changes and Impact on Function - Achieved	Activated	By Discharge
<input checked="" type="checkbox"/>	Carer Understands Care Strategies to Address Cognitive Impairment - Achieved	Activated	By Discharge
<input type="checkbox"/>	4AT Score - Greater Than 0	Activated	27/10/2020 9:52 AEDT
<input checked="" type="checkbox"/>	Falls Risk Screening Score - Greater Than or Equal 0	Activated	27/10/2020 9:52 AEDT
<b>Interventions</b>			
<input type="checkbox"/>	Educate and Provide Emotional Support to Patient/Carer - Done	Activated	27/10/2020 9:52 AEDT
<input type="checkbox"/>	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**

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

Cognitive Impairment (Delirium and Dementia) Care Plan (Discontinued)			
Last updated on: 27/10/2020 10:04 AEDT by: ZZZTEST Nurse, RN1			
<b>Outcomes</b>			
Cognitive Impairment at a Level Appropriate for Patient	Activated	By Discharge	
Not at Risk of Harm to Self, Others, or Property	Activated	By Discharge	
Carer Understands Cognitive Impairment Changes and Impact on Function	Activated	By Discharge	
4AT Score	Discontinued	27/10/2020 9:52 AEDT - 27/10/2020 10:04 AEDT	
Falls Risk Screening Score	Activated	27/10/2020 9:52 AEDT	
<b>Interventions</b>			
Educate and Provide Emotional Support to Patient/Carer	Discontinued	27/10/2020 9:52 AEDT - 27/10/2020 10:04 AEDT	✓ 27/10/2020 10:03 ...
Encourage Carers to Visit	Discontinued	27/10/2020 9:52 AEDT - 27/10/2020 10:04 AEDT	✓ 27/10/2020 10:03 ...
Monitor for Signs of Infection	Discontinued	27/10/2020 9:52 AEDT - 27/10/2020 10:04 AEDT	✓ 27/10/2020 10:03 ...
Adapt Environment to Optimize Patient's Safety	Discontinued	27/10/2020 9:52 AEDT - 27/10/2020 10:04 AEDT	✓ 27/10/2020 10:03 ...
Falls Prevention Measures	Discontinued	27/10/2020 9:52 AEDT - 27/10/2020 10:04 AEDT	✓ 27/10/2020 10:03 ...
CPO Allocated	Discontinued	27/10/2020 9:53 AEDT - 27/10/2020 9:55 AEDT	
Promote Day / Night routine	Discontinued	27/10/2020 9:52 AEDT - 27/10/2020 10:04 AEDT	✓ 27/10/2020 10:03 ...
Provide Support and Reassurance	Discontinued	27/10/2020 9:52 AEDT - 27/10/2020 10:04 AEDT	✓ 27/10/2020 10:03 ...
Add At Risk of Delirium to Care Plan	Completed	27/10/20 09:52:00 AEDT, Stop date 27/10/20 09:52:00 AEDT	

## Reviewing the Care Plan Summary

### In ISBAR Handover

- In the Patient Summary, **ISBAR Handover** tab

The screenshot shows the 'Patient Summary' interface with the 'ISBAR Handover' tab selected. A sidebar menu on the left contains various options, and the 'Care Plans' option is highlighted with a red box. The main content area shows a list of care plan items, including 'Goals of Care', 'Care Team', 'Chief Complaint', 'Problem List', 'Allergies / Adverse Drug Reactions (1)', 'Scales and Assessments', 'Care Plans', 'Vital Signs', 'Lines/Tubes/Drains', and 'Fluid Balance Chart'.

The screenshot shows the 'Scales and Assessments' section of the ISBAR Handover. The 'Care Plans' link is highlighted with a red box. Below it, there is a list of care plans with expand/collapse icons (+) and (-).

- Under the Care Plans heading, all Initiated Care Plans will display. **Clicking** on the expand/collapse **[+]** **[-]** will display the last 2 documentations.

The screenshot shows the 'Care Plans' section with a 'Care Plan Summary' table. The first three rows are highlighted with red boxes:

Description	Last Evaluated	Target
[+] Cognitive Impairment (Delirium and Dementia) Care Plan, Cognitive Impairment (Delirium and Dementia) Care Plan (Initiated) 11/05/2021 18:...		
[+] Falls Prevention and Management Adult Care Plan, Falls Prevention and Management Adult Care Plan (Initiated) 06/05/2021 08:52 AEST		
[+] Altered Mobility Care Plan, Altered Mobility Care Plan (Initiated) 16/04/2021 09:36 AEST		

Description	Last Evaluated	Target
[+] Cognitive Impairment (Delirium and Dementia) Care Plan, Cognitive Impairment (Delirium and Dementia) Care Plan (Initiated) 11/05/2021 18:...		
Cognitive Impairment at a Level Appropriate for Patient	24/05/2021 08:20 AEST	By Discharge
Not at Risk of Harm to Self, Others, or Property	24/05/2021 08:23 AEST	By Discharge
Carer Understands Cognitive Impairment Changes and Impact on Function	24/05/2021 04:00 AEST	By Discharge
Carer Understands Care Strategies to Address Cognitive Impairment	24/05/2021 07:58 AEST	By Discharge
4AT Score	24/05/2021 08:20 AEST	
Falls Risk Screening Score	24/05/2021 08:23 AEST	
Falls Risk Screening Score	24/05/2021 08:23 AEST	
Falls Risk Screening Score	24/05/2021 08:23 AEST	
Educate and Provide Emotional Support to Patient/Carer	24/05/2021 07:58 AEST	
Educate and Provide Emotional Support to Patient/Carer	24/05/2021 07:58 AEST	Note: Patient very concerned about her cognit...
Educate and Provide Emotional Support to Patient/Carer	24/05/2021 07:57 AEST	
Encourage Carers to Visit During Times When the Patient May be Distressed	24/05/2021 09:25 AEST	Note: daughter unable to come in at 10:30 this...
Encourage Carers to Visit During Times When the Patient May be Distressed	24/05/2021 07:57 AEST	Note: Daughters are rotating their visits. They is...
Encourage Carers to Visit During Times When the Patient May be Distressed	24/05/2021 07:58 AEST	
Employ De-escalation Communication Strategies	24/05/2021 07:58 AEST	

Hover over documentation to display full detail

24/05/2021 07:57 AEST	
24/05/2021 07:57 AEST	Note: Daughters are rotating their visits. They will...
24/05/2021 07:58 AEST	Note: Daughters are rotating their visits. They will make sure to attend at about 1000, 1600 & 2000 each day.
24/05/2021 07:58 AEST	

- If there has been no documentation in the last 24 hours, the last documentation will display with an asterisk.

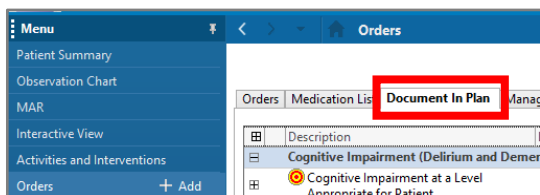
Description	Last Evaluated	Target
[+] Cognitive Impairment (Delirium and Dementia) Care Plan, Cognitive Impairment (Delirium and Dementia) Care Plan (Initiated) 11/05/2021 18:...		
[+] Falls Prevention and Management Adult Care Plan, Falls Prevention and Management Adult Ca (Initiated) 06/05/2021 08:52 AEST		
No Falls	24/05/2021 09:25 AEST	By Discharge
Patient/Carer Understands Falls Prevention Measures	24/05/2021 08:23 AEST	By Discharge
Falls Risk Screening Score	24/05/2021 08:23 AEST	
Falls Risk Screening Score	24/05/2021 08:23 AEST	
Falls Risk Screening Total Risk	24/05/2021 08:23 AEST	
Falls Risk Screening Total Risk	24/05/2021 08:23 AEST	Medium risk
Falls Risk Screening Total Risk	24/05/2021 08:23 AEST	Medium risk
Clinician Assessed Level FRAT	24/05/2021 08:23 AEST	Medium risk
Clinician Assessed Level FRAT	24/05/2021 08:23 AEST	Medium risk
Ensure clutter Free and Safe Environment	* Not Done	
Bed/Chair Suitable Height	* Done	
Bed/Chair Suitable Height	* Done	
Appropriate Footwear	* Done	
Appropriate Footwear	* Done	

- The **Orders** and **Care Plan Summary** hyperlinks at the top of this section will open the relevant Menu item for quick documentation.

The screenshot shows the 'Care Plans' section with two links at the top: 'Orders' and 'Care Plan Summary'. Both links are highlighted with red boxes.

### 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.

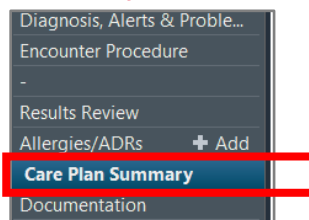
Description	Last Evaluated	Target	Status
<b>Cognitive Impairment (Delirium and Dementia) Care Plan (Initiated) 11/05/2021 10:08 AEST</b>			
Cognitive Impairment at a Level Appropriate for Patient		By Discharge	✓
Not at Risk of Harm to Self, Others, or Property		By Discharge	✓
Carer Understands Cognitive Impairment Changes and Impact on Function		By Discharge	✓
Carer Understands Care Strategies to Address Cognitive Impairment		By Discharge	✓
4AT Score	20/05/2021 16:07 AEST		✓
Falls Risk Screening Score	20/05/2021 16:07 AEST		✓
Educate and Provide Emotional Support to Patient/Carer	24/05/2021 7:56 AEST		✓
Use "Getting to Know You" Tools to Provide Optimum Care (ex. Sunflower, TOP 5)	24/05/2021 7:57 AEST		✓
Encourage Carers to Visit During Times When the Patient May be Distressed	24/05/2021 7:57 AEST		✓
Personal Items Such as Eyeglasses, Hearing Aids and Dentures are Worn	24/05/2021 7:58 AEST		✓
Employ De-escalation Communication Strategies	24/05/2021 7:58 AEST		✓
Provide Optimal Hydration and Nutrition	24/05/2021 7:58 AEST		✓
Adapt Environment to Optimise Safety and Comfort	24/05/2021 7:59 AEST		✓
Falls Prevention Measures in Place	24/05/2021 8:00 AEST		✓
Promote Day / Night routine	24/05/2021 8:00 AEST		✓
Provide Support and Reassurance	24/05/2021 8:00 AEST		✓

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

Description	Last Evaluated	Target	Status
<b>Cognitive Impairment (Delirium and Dementia) Care Plan (Initiated) 11/05/2021 10:08 AEST</b>			
Cognitive Impairment at a Level Appropriate for Patient		By Discharge	✓
Not at Risk of Harm to Self, Others, or Property		By Discharge	✓
Carer Understands Cognitive Impairment Changes and Impact on Function		By Discharge	✓
Carer Understands Care Strategies to Address Cognitive Impairment		By Discharge	✓
4AT Score	20/05/2021 16:07 AEST		✓
Falls Risk Screening Score	20/05/2021 16:07 AEST		✓
Educate and Provide Emotional Support to Patient/Carer	24/05/2021 7:56 AEST		✓
Use "Getting to Know You" Tools to Provide Optimum Care (ex. Sunflower, TOP 5)	24/05/2021 7:57 AEST		✓
Encourage Carers to Visit During Times When the Patient May be Distressed	24/05/2021 7:57 AEST		✓
Done	24/05/2021 7:57 AEST		✓
Done	19/05/2021 10:30 AEST		✓

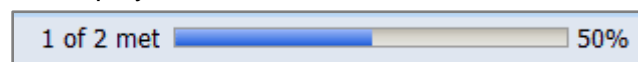
### In the Care Plan Summary

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.