Care Plans: Preparing

What Is Involved in Preparing Care Plans?

- **Care plans (CPs)** help organize appropriate nursing interventions so that desired patient outcomes are achieved
  - **What:** The CP is designed to provide structure to the nursing process or method of nursing practice. Phases of the nursing process include assessment, development of nursing diagnoses, development of appropriate outcomes/goals, implementation of nursing interventions, and evaluation of those interventions. The CP is used to organize the phases of the nursing process and to improve the delivery of nursing care
  - **How:** Most written CPs are formatted as tables or outlines. After the nursing assessment has been completed and the nurse has identified applicable nursing diagnoses, he or she lists interventions and outcomes, including short-term and long-term goals. The CP is then updated or modified whenever expected goals are met, whenever the patient’s needs change, or as dictated by facility/unit-specific protocol (e.g., every 24 hours)
    - Many healthcare organizations have prewritten, standardized CPs designed for use with specific patient populations and to which individualized goals and interventions can be added according to the patient’s needs. The length of the CP may vary; in some clinical areas, abbreviated CPs (e.g., those limited to nursing diagnosis, intervention, and desired outcome) are used
    - In some facilities, traditional nursing CPs have been replaced by the clinical pathway, which is a standardized, task-oriented, multidisciplinary plan of care that details essential steps in the care of patients with a specific clinical problem and describes the patient’s long-term expected clinical course; it is used by all members of the healthcare team
  - **Where:** Most health care facilities and all hospitals in the United States utilize some form of the written CP, whether it is a prewritten, standardized document, or a completely individualized plan of care for each patient
  - **Who:** In the U.S., only registered nurse (RN) clinicians are licensed to perform the nursing assessment and develop the nursing CP (or the nursing component of the multidisciplinary CP). Licensed practical/vocational nurses (LPNs/LVNs), however, may be delegated to implement nursing interventions that are included in the CP. The Joint Commission (TJC) requires that hospital CPs be developed with input from other clinical specialists (e.g., social worker, dietitian, mental health clinician, wound care specialist). In addition, input from the patient and/or family is highly desirable in the development of the CP

What Is the Desired Outcome of Preparing Care Plans?

- The purpose of the CP is to ensure that nursing interventions address the patient’s unique needs and promote achievement of desired patient outcomes

Why Is Preparation of Care Plans Important?

- CPs encourage nurses to think critically about how best to address the patient’s healthcare needs. Because they are based on the nursing process, CPs allow nurses to proceed with nursing interventions systematically and progressively
CPs direct the nurse’s attention to the patient’s most obvious and most immediate needs (e.g., impaired skin integrity in a postsurgical patient) as well as to their less obvious concerns (e.g., impaired communication in a patient who is mechanically ventilated)

Although every CP should be adapted to the individual patient as needed, prewritten, standardized CPs are particularly helpful in making charting less time-consuming and tedious when working in an environment in which the needs and goals of most patients are similar. For example, on a nursing unit dedicated to the care of bariatric surgery patients, certain nursing diagnoses will apply to all patients (e.g., impaired skin integrity due to surgery, knowledge deficit related to the postoperative plan of care). Likewise, these patients will all require similar nursing interventions (e.g., skin care and patient education) and have similar short-term and long-term goals (e.g., preservation of skin integrity and verbalization of understanding of the postoperative plan of care). Individualized goals and interventions can always be added to prewritten CPs according to the patient’s ongoing needs

CPs are an important way of communicating with other nurse clinicians. At the change of the nursing shift, the oncoming nurse can review the patient’s CP, identify the patient’s needs, goals, and progress, and identify current nursing interventions

Information documented in the CP is often used for managed care reimbursement and/or is required by law (e.g., documentation of patient safety). CPs are an essential part of the patient’s medical record because they serve as proof of the care the patient received

**Facts and Figures**

Although there is a lack of evidence that CPs improve patient outcomes, it has been shown that care planning improves the quality of the patient assessment, assists in identification of appropriate nursing diagnoses, and positively affects patient satisfaction with their care (Jansson et al., 2010)

The use of standardized, prewritten CPs has increased due to dissatisfaction with the duration of time required for clinical documentation and the risk for double documentation

- A comparison of 16 studies on end-of-life (EoL) care in the United Kingdom found that standardized, prewritten CPs were preferred by healthcare personnel, served to reduce ambiguity in relation to EoL treatment processes, and prompted important discussions on patient and familial choices sooner in the dying trajectory (Luckett, 2017)
- However, there is a lack of consensus among hospitals regarding what constitutes a standardized CP. Investigators in Sweden determined that, of documents labeled as standardized CPs submitted by 25 Swedish hospitals, only 4% addressed essential components of the nursing process, and that the quality of the documents in use varied significantly (Olsson et al., 2009)

Investigators in a randomized controlled study of 94 community-based patients with schizophrenia reported that, in comparison to standard care provided at a mental health center, in-home care using personalized nursing CPs enabled patients to be more independent with activities of daily living (ADLs) and reduced family burden (Roldan-Merino et al., 2013)

**What You Need to Know Before Preparing a Care Plan**

Understanding of the purpose of the CP, its role in providing structure to the nursing process, and the information it provides as part of the patient’s medical record is important (see *Why Is Preparation of Care Plans Important?*, above)

- Depending on facility standards and protocols, the CP will incorporate some or all of the phases of the nursing process, which are as follows:
  - *Assessment*, which involves a detailed evaluation of the patient’s health history and current physical and mental health status, and emotional, cultural, and spiritual needs
  - *Nursing Diagnosis*, which involves making clinical judgments concerning the patient’s response to an actual or potential problem. A nursing diagnosis is formulated as a statement about the patient’s health problem, contributing factor(s), and characteristics. A nursing diagnosis is different from a medical diagnosis. Examples include
    - ineffective coping related to physical illness, as evidenced by disinterest in self-care and lack of appetite
    - ineffective airway clearance related to increased production of pulmonary secretions, as evidenced by decreased oxygen saturation and respiratory distress
    - pain related to impaired circulation of the lower extremities, as evidenced by complaints of leg spasms and impaired mobility
    - knowledge deficit related to nutritional and fluid needs, as evidenced by dehydration and weight loss
  - *Outcome Identification*, which involves setting client-centered, measurable goals that are agreed upon by the patient and nurse clinician. These may be either short-term or long-term, but must have a specified deadline or expiration date. Examples of outcome-identified goals include the following:
- Patient ambulates 30 feet using a walker by postoperative day 6
- Patient verbalizes absence of pain by hospital discharge
- Patient attains normal body weight by inpatient day 12
- Patient has no signs of urinary tract infection before discharge

Nursing Intervention, which involves putting into place the actions the nurse must take to facilitate attainment of expected outcomes/goals. Examples include
- measure urinary output every 8 hours
- encourage fluid intake
- instruct patient in passive range of motion exercises
- assess for pain every 4 hours

Evaluation, which is the phase during which the clinician evaluates whether or not the expected outcomes/goals have been met. Evaluation occurs upon expiration of the expected outcome/goal or before patient discharge, if that comes first. The clinician documents goals that have not been met in the patient’s medical record, along with additional measures that have been taken to facilitate patient recovery (e.g., “Requested referral to home healthcare for ongoing wound care.”)

TJC supports the use of standardized CPs, no longer requiring that a CP be written for each individual patient
- Use of standardized CPs can teach nurses to recognize the accepted requirements of care for patients and improve continuity of care
- A disadvantage to using standardized CPs is that individualized patient care needs can remain unrecognized: It is important to remember that use of standardized CPs should not replace the use of professional judgment and decision making

Preliminary steps that should be performed before preparing a CP include:
- Review components of the nursing process, and become familiar with common nursing diagnoses
- Review facility/unit-specific protocol for documenting the CP. Note the frequency with which the CP must be updated
  - Because computerized charting is more prevalent in the healthcare setting than previously, note if your facility utilizes a written or computerized CP documentation system, and familiarize yourself with the applicable form(s) or computer program(s)
- Gather necessary supplies, including:
  - Patient’s medical record
  - Standardized CP document
  - Black ink pen

How to Prepare a Care Plan

- Identify the patient according to facility protocol
- Introduce yourself to the patient and family member(s) and explain your clinical role
- Assess the patient/family and for knowledge deficits and anxiety regarding the patient’s overall health status and development of the plan of care
  - Determine if the patient and/or family requires special considerations regarding communication (e.g., due to illiteracy, language barriers, deafness); make arrangements to meet these needs if they are present so that the patient and/or family can actively participate in care planning
  - Follow facility protocols for using a professional certified medical interpreter when a communication barrier exists
- Explain the purpose of the patient assessment and development of the plan of care; answer any questions and provide emotional support as needed
- Perform a detailed nursing assessment
  - Gather information related to the patient’s health history, living situation, social habits, and current physical, emotional, cultural, and spiritual needs
- Gather the appropriate document(s) to develop the CP
  - Adhere to facility protocol for documenting the CP
  - Collaborate with other clinical specialists in developing the multidisciplinary CP
- Use information obtained from the nursing assessment to derive and document appropriate nursing diagnoses. Avoid using medical diagnoses
  - For assistance, use guidelines and diagnoses suggested by NANDA International, formerly the North American Nursing Diagnosis Association) at www.nanda.org
Document expected outcomes/goals
• Develop both short-term and long-term goals. Verify that each goal is measurable with a deadline or expiration date. The date of discharge may be used for long-term goals

Document nursing interventions to accompany each nursing diagnosis
• Confirm that each of the nursing interventions involves reasonable and appropriate actions the nurse must take to facilitate achievement of expected outcomes. Do not incorporate unrealistic interventions, such as those that do not correlate with the level of care (e.g., do not write “measure urinary output every 1 hour” if the level of care and unit protocol dictates measurement of urinary output every 8 hours)

Document achievement of expected outcomes/goals at the time the goal is met, upon expiration of the outcome, or at patient discharge
• If the expected outcome/goal was not met, evaluate why and document how the issue will continue to be addressed on the CP

Update the CP whenever the patient’s plan of care changes and according to facility protocol
• An alert system may be implemented as part of the CP in order to send professionals a reminder to contact colleagues for information and assistance depending on any change in the patient’s status

Other Tests, Treatments, or Procedures That May Be Necessary Before or After Preparing a Care Plan
• The nurse must review the plan of care according to facility protocol. This may mean reviewing and making changes to the CP during each nursing shift or every 24 hours, or less frequently such as once per week (e.g., as is the case in certain rehabilitation or home care facilities) or once per month (e.g., such as in long-term care environments). It is the nurse clinician’s responsibility to verify completion of the CP at patient discharge

What to Expect After Preparing a Care Plan
• The CP will address the patient’s unique needs and incorporate appropriate nursing diagnoses, nursing interventions, and measurable outcomes
• The CP will be developed with input from the patient and multidisciplinary clinician specialists
• The nurse clinician will utilize the CP on an ongoing basis to achieve desired patient outcomes

Red Flags
• Do not routinely limit nursing diagnoses, interventions, or goals to those already printed on the CP, when using standardized, prewritten CPs
• Carefully consider the findings of the individualized patient assessment to identify and address each patient’s unique needs
• It is not sufficient to follow the established CP without documenting the performance of nursing interventions and achievement of patient outcomes
• Inadequate documentation can place the nurse clinician and healthcare facility at risk for legal liability

What Do I Need to Tell the Patient/Patient’s Family?
• Educate the patient about his/her right to participate in the plan of care; whenever possible, obtain information from the patient and family members regarding their healthcare expectations and needs

References

