Care Plan Documentation

Care Plan Definitions

1. **Problem:**
   - Main focus of care for the shift
   - Not all problems are necessarily the focus of care for each shift.
   - Just because a patient has a co-morbidity, does not mean it is necessarily a problem during the patient shift or stay

2. **Interventions:**
   - Actions taken during the shift to maximize the prospects of achieving the goals for the patient

3. **Goal Progress:**
   - Met
     - The patient achieved the stated goal during the care providers time with the patient (shift)
     - The problem can still be the focus of care for subsequent care providers even if the goal was met
   - Ongoing
     - The patient did not achieve the stated goal during the care providers time with the patient (shift)
     - Best Practice is to review Care Plan documentation BEFORE caring for the patient by using the Iatrics Care Plan Visual Flowsheet and the EMR.

4. **Patient Desired Outcomes**
   - The defined patient outcome to be achieved during the hospital stay, by discharge, or by the end of a phase of care.
     - Examples:
       - "I want to pass gas today"
       - Patient is sedated, unable to indicate desired outcome.

5. **Response to Care**
   - Summary statement providing an overall picture of the patient.
   - Can include progress towards patient's own goal
     - Examples:
       - Responsive to lighter touch, with increased heart rate with family in the room
       - Able to ambulate without oxygen for further distances than yesterday. Family involved in care.