Practice Pointer: Collaborative Care Planning

Category: Clinical Documentation**,** Collaborative Care Planning

Impacts: All care team members who use collaborative plans of care

Practice Standard:

- All patients will have documented care plans that includes documentation of clinical decision making to show the care provided.
- Care planning activities and documentation is done in collaboration with the patient/family and interprofessional team members as appropriate.
- Documentation of care planning must be:
    - Initiated at the point of intake or care engagement.
    - Developed according to the patient's assessed needs.
    - Revised as new information becomes available or there is a change in the client's health status.

What to know:

A care plan is:

- An individualized and focused plan, created in collaboration with patient/family that demonstrates and communicates a team based, systematic approach to achieving the stated goals of care.
- Documentation of the on-going, collaborative care process that includes:
    - Identification of focus or need (identified via assessment e.g. Morse assessment score identifies 'Risk for Fall' as area of focus)
    - Identification of goals of care (e.g. Patient will be free from falls during hospitalization)
    - Related care interventions e.g.
        - Clinical and functional needs
        - Services required
        - Safety planning
    - Implementation of the plan, documentation of interventions and achievement of goals
    - Evaluation of patients response and effectiveness of the plan

What to Do:

- Use patient assessment information and the Pre-Hospital Functional Screener (PHFS) to identify area's of focus for care planning for your patients
- Collaborate with interprofessional care team members (as clinically appropriate)
- Collaborate with the patient, and their family (as appropriate) in creating the goals of care

- Document the goals of care and related care interventions in the appropriate locations in the patient chart e.g.:
    - Interprofessional Patient Care Plan (IPCP)
    - Care Plan section of the Wound Assessment and Treatment Flow Sheet (WATFS) for patients with wounds
    - Behavioural Care Plan (VBACT) when applicable
    - Unit/care area specific care plans as directed by unit leaders
- Evaluate the patient's response to interventions, achievement of goals of care, and update the plan as needed