CARE PLANNING

- Care planning is 'real time'. When you start your shift check the care planning required for your patient that would have been updated as necessary from the previous shift. If you change the care plan during your shift – make those changes in your shift column.
- Ensure the patient/whanau have been consulted on the changes in their care at this time and the rationale for those changes. Add patient specific goals/ education and any particular speciality needs in the first Patient and Area specific section.
- The care plan should reflect at all times what the current plan is.
- If you feel there is no change to the care plan document from the previous shifts strategies document N/C in your column. You must rewrite the current plan when starting a new document i.e. you cannot carry N/C over to a new document.
- All care planning should be discussed with the patient or their whanau – it is a record of what the patient's goals and needs are. Evaluation of the care plan can occur in the clinical record as well as documenting any variances in care and actions taken. Update the care plan where variance has occurred.
- For good guiding principles of documentation follow this link http://www.nzno.org.nz/services/publications and download the Documentation 2010 document under Practice.
- Do not use abbreviations in the clinical notes and Care plan that are not approved. E.g. A+O, PAC.
- Ensure your strategies/shift column has individualised strategies according to the patient's particular needs. Refer to the flipchart for approved strategies and the particular self learning packages for guidance.