Care Planning

Using the Care Plan Template on the National interRAI Software System

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Chapter 1
Developing a Care Plan

Chapter Contents
- Planning Nursing Care
- Professional and Legal Responsibilities
- Recommended Best Practice
- The Assessment Summary – linking the assessment to the Care Plan
- Assessment Summary Overview

Chapter Learning Outcome
The learner will know how to develop a Care Plan based on assessment findings that meets professional and legal requirements and follows recommended best practice.

Introduction
Once the interRAI Comprehensive Clinical Assessment is complete the next stage in the process is to respond to the assessment findings (i.e. Clinical Assessment Protocols (‘CAPs’) and ‘Outcome Scores’) by developing an appropriate plan of care for the resident.

The Software you are using to complete interRAI assessments also has a built-in Care Plan template. The use of the Momentum Care Planning Template is at the discretion of your Facility.

You do not have to use this part of the software for your Care Plan development if a separate Care Plan format or process exists within your Facility.

The use of the Care Planning Template is at the discretion of your Facility.

You must take into account the triggered CAPs and Outcomes Scores in any Care Plan you produce. In addition, if you believe issues exist but have not triggered CAPs, then you should also include those in the Care Plan, i.e. incorporate ‘standard’ care.

You have probably been creating Care Plans throughout your entire career and possess important skills and experience. These continue to be necessary in the Care Planning process following a comprehensive clinical assessment.

Before looking at how the Care Plan is recorded using the software, here is a quick recap of the skills and process used to develop nursing Care Plans for people living in aged residential care facilities.
Planning Nursing Care

It is generally agreed that a nursing Care Plan is based on a nursing assessment and a nursing diagnosis, carried out by a nurse. It has four essential stages:

1. Identify the nursing diagnoses (problems or ‘Focus’ that nursing care can address).
2. State the expected benefit to the person (goals or expected outcomes).
3. State the specific actions the nurse will take to achieve the goals (interventions).
4. Evaluate the person’s response to nursing actions and adjust the actions as required (evaluations).

Professional and Legal Responsibilities

As a Registered Nurse you have professional and legal responsibilities around Care Planning. These are described in a number of documents. Care Plans should always adhere to these requirements:

Nursing Council of New Zealand Registered Nurses scope of practice

This states that Registered Nurses: “… provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care…”

Age Related Residential Care Services Agreement

This is the contract that your Facility has with the local District Health Board to provide residential care for older people. The contract states that each subsidised resident must have a Care Plan that is followed by all staff to guide care delivery.

Key points relating to Care Plans are:

- Based on an initial assessment that includes physical, psycho-social, spiritual and cultural aspects.
- Developed, documented and evaluated by an Registered Nurse within three weeks of admission.
- Considers the experiences and choices of the resident.
- Provides the resident and family/whānau with the opportunity to have input.
- Addresses the current abilities, level of independence, identified needs/deficits and takes into account personal preferences and individual habits, routines and idiosyncrasies.
- Addresses personal care needs, health care needs, rehabilitation/habitation needs, maintenance of function, and care of the dying.

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1 Competencies for Registered Nurses, Nursing Council of New Zealand, December 2007
2 Age-Related Residential Care Services Agreement: Provision of Aged Related Residential Care (2012) sections D16.2 to D16.4
• States actual or potential problems/deficits and sets goals for rectifying these and details required interventions.
• Must be evaluated every six months or following a change in resident health status.

Health and Disability Services Standards 2008
All hospitals, rest homes and those providers of residential disability care that have five or more residents need to meet the Health and Disability Services Standards 2008. The Standards cover all aspects of care. In terms of Care Plans, the Standards require that:

• Plans are individualised, accurate and up to date.
• Describe the desired support and/or intervention to achieve the desired outcomes identified by the on-going assessment process.
• Demonstrate service integration.
• For mental health consumers, they show early warning signs and relapse prevention.
• Are communicated in a manner that is understandable to the consumer and service provider responsible for the implementation and with consent their family/whānau of choice.

Recommended Best Practice
The conditions listed above are the minimum professional and legal requirements. There are other important elements that you should consider when producing a Care Plan:

• Make it achievable. An effective Care Plan is realistically aimed at either improving or maintaining the resident’s level of health and independence with the available interventions and resources.
• Make it understandable. The most effective Care Plan is not the one with the longest words and technical jargon but the one written in such a way that all staff, especially caregivers, can understand.
• Make it comprehensive. Does it fully use the information from the assessment? CAPs and Outcome Measures really do highlight the areas where intervention will make a difference.
• Make it collaboratively. Do the resident and their family/whānau fully understand and agree? Follow your Facility processes for signatures on the Care Plan.

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3 Health & Disability Services Standards NZ 8134.1.3.5:2008
Assessment Summary

The Assessment Summary section is the pivotal point of the assessment and Care Planning process and where you begin to utilise the strength of interRAI. This section forms the link between your assessment and your plan of care and it is here that you will see the ‘CAPs’ identified for the first time.

KEY POINT

*The Assessment Summary is crucial to the whole assessment and Care Planning process.*

In this section you record which ‘CAP’ areas are being included in the Care Plan, including those areas that have not triggered ‘CAPs’ but you want to include in standard Care Planning.

The Assessment Summary displays the triggered ‘CAPs’ and the level of those triggers. You include a ‘CAP’ in the Care Plan to:

- Resolve the problem,
- Reduce the risk of decline,
- Utilise potential for improvement.

You need to make a clinical decision as to which ‘CAPs’ will be included in the Care Plan. If you decide not to include a triggered ‘CAP’ in the Care Plan, your clinical decision making process or reasoning must be recorded in the ‘Assessment Summary’ text box.

When creating the Care Plan, you need to consider the reason the ‘CAP’ was triggered and consider the influence of any outcome measure. The CAPs Manual (orange) provides guidance on managing areas identified in the ‘CAPs’. This evidence based manual provides decision support for nurses and has been shown to be effective for improvement of care for the older person.

The interventions you include in your Care Plan will take account of your Facility’s policies and best practice procedures.
Process for selecting ‘CAPs’ for Care Plan

1. Identify the reason the ‘CAP’ is triggered, the level of the trigger, and the opportunity or risk that is identified. ‘CAPs’ are identified at three different levels (level 1, 2 and 3) or by descriptors (high, medium, low or prevent decline, facilitate improvement), and can be a combination of the two. The ‘CAPs’ identify those who have a higher than expected likelihood of declining, and those who have an increased potential for improvement⁴. Your CAPs Manual (orange book) provides guidance on how these ‘CAPs’ might be addressed.

2. Consider the ‘Outcome Scales’ and how these might influence the priority of issues and your ability to address the risks and opportunities.

3. When considering what ‘CAPs’ to include and how these will be addressed, examine the resources available to you, your resident’s preferences, strengths and needs.

4. Identify ‘CAPs’ to be included in your Care Plan by ticking the box ‘Addressed in Care Plan’.

5. Record ‘Standard Care’ by identifying those ‘CAPs’ not triggered but which still need to be included in the Care Plan - tick the box ‘Addressed in Care Plan’. Make a note that this will be included in the Care Plan and state the clinical reason for including it along with where in the Care Plan the need is addressed.

6. Complete notes in the text box provided for each triggered ‘CAP’ that you are not including in the Care Plan. These notes should record the clinical reasoning behind your decision. This record will then be available to you to remind you, at a later date, of your reasoning behind the Care Planning decision you have made at this point in time.

Assessment Summary Overview

- When a ‘CAP’ has triggered and an intervention will be provided in the Care Plan – tick ‘Addressed in Care Plan’.
- When a ‘CAP’ has triggered but an intervention will be not be provided in the Care Plan – record clinical reasoning in the large note box for not including ‘CAP’ in the Care Plan.
- When a ‘CAP’ has not triggered but support or standard care will be provided and included in the Care Plan – tick ‘Addressed in Care Plan’ and name/briefly describe the identified need and name of Care Plan area in the large note box (as shown in Figure 2).

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Process for selecting ‘CAPs’ for standard care

You are likely to include additional ‘Foci’ in your Care Plan for issues that did not trigger a ‘CAP’. This may be because the resident needs ongoing support to manage an existing need. This is called standard care. Find the ‘CAP’ area associated with the ‘Focus’. Indicate you are including this in the Care Plan by ticking the box and briefly describing where in the Care Plan this need is addressed and why (state clinical reason).

1. ‘Tick’ the checkbox to include ‘CAP’ in Care Plan.

2. Briefly describe where in your Care Plan the ‘CAP’/resident’s need is being addressed and why.
Chapter 2
Copying a Previous Care Plan

Chapter Contents

- Reviewing Previous Care Plans in the software system
- Copying a Previous Care Plan

Chapter Learning Outcomes

The learner will understand how to review previous Care Plans, if they exist. They will understand how to copy and update a previous Care Plan.

Introduction

This chapter of the Care Plan book, “Copying a Previous Care Plan”, deals with the situation where a Care Plan for your Resident has already been created in the Momentum Software.

The next chapter, “Creating a new Care Plan”, covers creating a new Care Plan for your Resident. You will only do this if you are creating the first Care Plan for this Resident in the Momentum Software.
Reviewing Previous Care Plans

To review a previous Care Plan, from the ‘Resident Overview’ screen click on the ‘Care Plan’ tab to view the Care Plan list.

1. ‘Click’ on the folder on the left of the screen.

In the example below a Care Plan that was created in the Home Care setting is displayed.

2. ‘Click’ on ‘Presenting Situation’ button to view recorded notes.

3. ‘Click’ on ‘Return’ button to go back to the previous screen.
Copying a Previous Care Plan

If there is a previous Care Plan, click ‘Copy’ to copy that previous Care Plan across.

To ‘Copy’ an existing Care Plan from the ‘Care Plan List’, highlight the present Care Plan and select ‘Copy’ button from the menu. There will only ever be one there.

Once the Care Plan has been copied you can then work on the Care Plan.

The copied Care Plan will appear in the list as a draft, however the ‘Foci’ ‘Status’ will be ‘Active’.

Each of the ‘Foci’ must be saved as a ‘Draft’ before further editing.

Now click on a specific Care Plan ‘Focus’. We need to make ‘Focus’ ‘Draft’ and click ‘Save’.
The ‘Focus’ now needs to be edited.

1. ‘Click’ on ‘Select Related Factors’.

‘Click’ on a specific Care Plan focus. Then under ‘Status’ from the drop down menu select ‘Draft’.
You can choose from a ‘Library’ of ‘Related Factors’ or create your own.

To edit expected outcomes ‘Click’ on ‘Select Expected Outcome’.

1. Hover the mouse over the line if you wish to read the full text of ‘Expected Outcome’. ‘Click’ on the text if you wish to edit.

2. ‘Click’ on a ‘Related Factor’.

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3. Click on the specific ‘Expected Outcome’ to set an end date for a ‘Selected Outcome’.

4. ‘Click’ the ‘Calendar’ icon next to the ‘End Date’ and choose a date for the six monthly review.

5. ‘Click’ on ‘Save & Return’.

2. ‘Click’ on the text to personalise Outcome description, i.e. putting in the Resident’s name

3. ‘Click’ on ‘Save & Return’.
(Optional) Select a ‘Classification’ from the drop down menu. See the example of ‘Medium term objective goal.’

6. From the ‘Classification’ drop down menu select the ‘objective’.

7. Then click ‘Save & Return’.

Adding an Intervention
We recommend that you add your own ‘Intervention(s)’.

1. ‘Click’ on the ‘Select Interventions’ button.

‘Add’ a new intervention or ‘Edit’ an existing ‘Intervention’.
2. To ‘Add’ a new intervention ‘Click’ on the ‘Add’ button.

3. You can also write your own intervention here.

4. ‘Save & Return’.
Update the schedule details for the ‘Intervention’.

1. ‘Click’ on the ‘Calendar’ icon of the ‘Intervention’.

‘Click’ on the ‘Calendar’ icon. The ‘Time’ will come up as the time you are entering. Do put the ‘End Date’ below or enter 180 days under ‘Duration’ as one will auto populate.
Select ‘Reoccurrence Schedule’ and ‘Disciplines Responsible’.

1. ‘Click’ on the ‘Reoccurrence Schedule’ and select using the radio button.  
   Note: Make sure you choose the appropriate ‘Reoccurrence Schedule’ i.e Daily

2. Choose ‘Disciplines’ check ‘tick boxes’.

Click on ‘Show only selected’ and this will reduce ‘Disciplines’ on your screen to only those you have chosen.

You will have existing ‘Interventions’ that you will want to add or edit.
Instructions for staff can be detailed in ‘Comments’ field. You can change ‘Interventions’ in the ‘Comments’ section. This is where you tell your staff how to care for your residents.

It is important to save the work after every change: click on ‘Save & Return’.

Make the ‘Focus’ ‘Active’ from the drop down menu under ‘Status’.
Repeat these steps for each ‘Focus’ you add, and click ‘Save & Return’.

1. Select ‘Active’ from the drop down menu ‘Status’.

2. ‘Click’ on ‘Save & Return’

The ‘Active’ ‘Focus’ move to the bottom of the list.

Repeat the steps above for each ‘Focus’, to make each ‘Focus’ ‘Active’.

Once all ‘Focus’ are checked and are ‘Active’ you can then activate the whole Care Plan.
Make the Care Plan ‘Active’ (do not do this until all ‘Foci’ are edited….if you do then repeat copy-edit process).

You can’t edit an ‘Active’ Care Plan, or print a ‘Draft’.

Set the Care Plan Review Date.

Add ‘Date’ and ‘Save’. The date must be put in manually.
1. ‘Add the date’, using the ‘Calendar’.

2. ‘Click’ on ‘Save’

The date displays on the ‘Resident Overview’ screen.
Chapter 3
Creating a New Care Plan

Chapter Contents

- Creating a new Care Plan
- Stage 1 – Adding a Focus and reviewing ‘CAPs’
- Stage 2 – Add Related Factors
- Stage 3 – Choose Expected Outcomes
- Stage 4 – Add Interventions
- Stage 5 – Schedule the Interventions
- Stage 6 – Making the Care Plan active

Chapter Learning Outcomes
The learner will understand how to create a new Care Plan, if there are no previous Care Plans, and record it in the software.

Introduction
Remember if there is a previous Care Plan for the resident, you will not create a new Care Plan, you will copy a previous Care Plan following the process described in the previous chapter Copying a Previous Care Plan.

Once the Comprehensive Clinical Assessment is complete the next stage in the process is to respond to the assessment findings (i.e. ‘CAPs’ and ‘Outcome Scores’) by developing an appropriate plan of care for the resident.

This chapter teaches you how to create a Care Plan in the software in six stages.

You must take account of the triggered ‘CAPs’ and ‘Outcomes Scores’ in any Care Plan you produce. In addition, if you believe issues exist but have not triggered ‘CAPs’, then you should also include those in the Care Plan, i.e. incorporate ‘standard’ care.

In addition to the CAP focused care detailed above you must also use your clinical judgment and incorporate standard care into your Care Plan.
Creating a **New** Care Plan (first ever Care Plan using Momentum software)

Go to the ‘Resident Overview’ screen.

Remember if there is a previous Care Plan for the resident, click ‘Copy’, following the process described in the Section Copying a Previous Care Plan on page 13.

To create a **new** Care Plan click on ‘Add’ – you will only do this if it is the first ever Care Plan for this Resident created using Momentum software.

The Care Plan is recorded in five stages:

1. **Focus** - Select the area of concern that needs to be addressed.

2. **Related Factors** - Add any issues that positively or negatively affect the area of concern.

3. **Expected Outcomes** - Add the resident’s goal for this area.

4. **Interventions** - Add the type of actions that will be taken to achieve the goal.

5. **Scheduling** - Identify the ‘when, how, who, and what’ of the ‘Interventions’.
Stage 1: Adding a Focus and Reviewing ‘CAPs’
You can review the ‘CAPs’ triggered by your assessment from the Care Plan screen.

1. ‘Click’ on the orange ‘CAPs’ bar to view triggered ‘CAPs’.

2. To view why a ‘CAP’ has triggered ‘click’ on the yellow folder.

A ‘Focus’ is an area of care to be included in the Care Plan. You can choose a focus from the ‘Focus Library’ or create your own.

Review your ‘CAPs’ and reviewed your ‘Assessment Summary’ for any other ‘Foci’ that need to be added before you make your Care Plan ‘Active’. Do not activate your Care Plan unless you have added and activated all your ‘Foci’. Remember you cannot edit an ‘Active’ Care Plan.

1. ‘Click’ on ‘Add New Focus’.
Stage 2: Add Related Factors
You can identify multiple ‘Related Factors’. These are problems, opportunities, medical diagnoses, or symptoms that have created or affect the ‘Focus’ and need to be considered when managing the ‘Focus’. This can provide important information for staff to understand the factors that may impact on the resident’s potential to improve or decline.

You can choose from a library of ‘Select Related Factors’ or create your own.

Note: The ‘CAPs’ drop down is still available to assist you in developing your Care Plan.
Stage 3: Choose Expected Outcomes
An ‘Expected Outcome’ is the goal of care for the next 180 days. This needs to be individualised and specific, measureable and achievable, realistic and timeframed (SMART). You can choose ‘Expected Outcomes’ from the ‘Library’ or create your own.
If using an ‘Expected Outcome’ from the library, you can individualise this by replacing ‘Resident’ with your resident’s name and modifying the wording of the ‘Expected Outcome’ as needed.

2. ‘Tick’ the check box for the ‘Expected Outcome’ that best describes the resident’s goals of care.

3. Hover mouse over line if you wish to read the full text of ‘Expected Outcome’. ‘Click’ on the text if you wish to edit.

4. ‘Click’ on ‘Save & Return’.

Only one ‘Expected Outcome’ should be selected for each ‘Focus’.
Creating Your Own Outcome

1. ‘Click’ on ‘Add Expected Outcome Not Found in Library’.

2. ‘Click’ in the box and type in an ‘Expected Outcome’.

3. ‘Click’ on ‘Save & Return’.

Note: No category is required for Outcomes.
Setting an ‘End Date’ and classification for an ‘Expected Outcome’

You may wish to add an ‘End Date’ and a classification e.g. short term goal, medium, or, long term goal to your ‘Expected Outcome’.

Step 1. Go back onto the folder, click on folder. Select ‘End Date’ for six monthly review using the date picker on calendar.

1. ‘Click’ on the ‘Expected Outcome’.

2. ‘Click’ on the ‘Calendar’ icon next to ‘End Date’ and choose a relevant date.
Note: The start date does not change.

**Stage 4: Add Interventions**

‘Interventions’ describe the types of care required.

An ‘Intervention’ is a name of an area of care where staff would look to find the specific care instructions. You will add the specific care instructions later. You can use an ‘Intervention’ from the library or create your own.

We recommend that you create your own ‘Interventions’.
Choosing an ‘Intervention’ from the ‘Library’
There is a ‘Library’ of ‘Interventions’ available for you to use in the Care Plan. If there are no ‘Interventions’ available to view, you are able to view all the interventions in the database by selecting ‘Show entire Library’.

1. ‘Click’ on the check box for ‘Show entire Library’.

You can ‘Filter’ the list by ‘Category’ to only display those most relevant to the ‘Focus’ you are working in.

1. ‘Filter by Category’ from the drop down list.
2. ‘Click’ on check box beside the ‘Intervention’ you wish to use.

3. ‘Click’ on ‘Save & Return’ button.

The planned ‘Intervention(s)’ are now recorded.
Adding your own Intervention

Adding your own ‘Interventions’ allows you to personalise your Care Plan and develop your own style for using the Care Plan. We recommended that you use short label-like names for your ‘Interventions’. This makes your Care Plan easy to read.

If you have interventions that you want to add or edit follow these steps.

1. ‘Click’ on ‘Add Intervention Not Found in Library’.
2. ‘Click’ in the box on the empty line.
3. Type in your own ‘Intervention’ in CAPITALS.
4. ‘Click’ on ‘Save & Return’.
5. Your ‘Intervention’ is now recorded.

If you type in your ‘Intervention’ in CAPITALS, it will stand out when printed.

The date on your Care Plan doesn't change, but the date on the intervention saves does.
Stage 5: Schedule the Interventions

‘Scheduling’ the ‘Intervention’ involves identifying:

- **when** the care will take place,
- **how** often,
- **who** is responsible,
- **what** is to be done.

Ensure your Care Plan is evaluated before the ‘End Dates’ or else you will not be able to copy it.

Scheduling Screen

1. ‘Click’ on the ‘Calendar’ icon of the ‘Intervention’.
2. ‘Click’ on the ‘Calendar icon’. Your start date will populate automatically. (The ‘Time’ will come up as the time you are entering).
   Do put the ‘End Date’ here or enter 180 days under ‘Duration’ as one will auto populate.
3. Choose the ‘Reocurrence Schedule’ or Frequency e.g. ‘Daily’.

**Note:** Make sure you choose a ‘Reocurrence Schedule’.
4. Select the ‘Disciplines Responsible’ for the ‘Intervention’.

5. Select the ‘End Date’ for the ‘Focus’.

6. ‘Tick’ on ‘Show only selected’ and this will reduce ‘Disciplines’ on your screen to only those you have chosen.
Comments Section - Instructions for Caregivers

You can individualise the Care Plan to meet the care needs of your resident. You enter the care instruction detail for the caregivers/nurses in the ‘Comments’ box for each ‘Intervention’ in each ‘Focus’.

1. Type instructions for staff in ‘Comments’ box here.

2. ‘Click’ on ‘Save & Return’.

Note: Enter your care instructions in a list by pressing enter on the keyboard after each instruction. This puts each instruction on a new line. You can also number these.

Stage 6: Making the Care Plan ‘Active’

In order to activate the Care Plan you need to ensure each ‘Focus’ is active.

You also need to refer to adding a new ‘Focus’ if the ‘CAPs’ and outcomes have changed.

Select the ‘Focus’ you wish to activate, review the information and, when you are ready to activate, select ‘Active’ from the list options for status and click ‘Save and Return’.

1. ‘Click’ on ‘Active’ for each ‘Focus’ in your Care Plan.
Repeat the steps above for each ‘Focus’ to make them ‘Active’. At this stage you can also add new ‘Foci’ as per page 27 of this Workbook.

Once all ‘Foci’ in your Care Plan are ‘Active’ you can activate the whole Care Plan.

Your Care Plan is now ‘Active’ with the same date as your ‘Foci’.

Enter a six monthly review date, using the date icon.
Chapter 4
Evaluating a Care Plan

Chapter Contents
- Evaluate a Care Plan
- Delete a Care Plan ‘Focus’
- Discontinue a Care Plan ‘Focus’ while the Care Plan is ‘Active’

Chapter Learning Outcomes
The learner will know how to modify previous Care Plans, to discontinue a Care Plan ‘Focus’ and to delete a Care Plan ‘Focus’.

Introduction
After you have completed a Care Plan and implemented the care and support required to provide quality outcomes for your resident; you will need to evaluate if the care and issues identified in your Care Plan remain relevant and appropriate. Regular evaluations are scheduled at least six-monthly or if the resident has a change in their health status.

The software allows you to complete and update regular evaluations for your active Care Plan.

Ensure you are evaluating your previous Care Plan not the current one you are working on.

Evaluate a Care Plan
If the Care Plan is not working for your resident, from time to time the Registered Nurse will need to evaluate the Care Plan. This may be due to a change in the person’s health status (improved or deteriorated), or following the six-monthly scheduled review of the resident’s care needs.

During the evaluation you will check whether:

- ‘Expected Outcomes’ have been achieved,
- whether the ‘Interventions’ are all still relevant,
- whether the ‘Focus’ list is still correct.
Evaluating a Care Plan for a Resident

1. ‘Click’ on ‘Care Plan’ tab.

2. ‘Click’ on the yellow folder for the ‘Care Plan’ you want to review.

3. ‘Click’ the yellow folder for the ‘Focus’ you want to review.

4. ‘Click’ on yellow folder for ‘Expected Outcome’.

On the ‘Edit Care Plan’ screen:
5. ‘Click’ on ‘Add’. This will enter the current date and time of your evaluation.

6. ‘Click’ in the box under ‘Evaluation Status’ and select one from the drop down list.

7. ‘Click’ on the ‘Comments’ box and add an ‘Evaluation comment’ then click ‘Save’.

8. ‘Click’ on ‘Save & Return’.
Deleting a Care Plan ‘Focus’
A ‘Focus’ can only be deleted whilst the Care Plan is in ‘Draft’ form.

1. To delete, ‘Click’ on the ‘Focus’ line to highlight then click on the ‘Delete Focus’ button.
2. Click on ‘Save & Return.’

Note: To remove a ‘Focus’ you can either change the status to discontinued or delete it, while the Care Plan is in ‘Draft’.

Discontinuing a Care Plan ‘Focus’ while the Care Plan is ‘Active’

1. Select your ‘Active Care Plan’.
2. Highlight the ‘Focus’ you wish to discontinue.

3. Select ‘Discontinue’ from the drop down list.

4. ‘Click’ on ‘Save & Return’.
Chapter 5
Printing a Care Plan

Chapter Contents
- Printing a Care Plan

Chapter Learning Outcomes
The learner will know how to print off the current Care Plan or an historic Care Plan from the software.

Introduction
Once your Care Plan is complete and made active, you will want to print it to add to your resident file. This chapter teaches you how to print a Care Plan from the software. You must have a printer connected to the computer you are printing from.

Printing a Care Plan
Only ‘Active’ Care Plans can be printed.

1. ‘Click’ on the ‘Care Plan’ tab to view the current Care Plan.
2. Under the Care Plan menu options on the left of your screen, ‘Click’ on ‘Selected Care Plan Report’.

You can also print the most current active Care Plan from the reports menu on the left of your screen.

3. ‘Click’ ‘Current Care Plan Report’ from left side menu.
Care Plan report example:

You can also print a historic Care Plan.

1. From the ‘Care Plan’ tab, ‘Click’ on the ‘Show History’ button to view old discontinued Care Plans.
Please note:

The content of this document is subject to change. Regular upgrades to the National interRAI Software System will result in changes and enhancements to the Software.

To ensure you have the latest version please check the interRAI website.

http://www.interRAI.co.nz If you have any questions regarding the content of this document, please contact the project on 0800 10 80 44 or email interRAI@dhbss.health.nz.