PC.16 A comprehensive plan of care is developed collaboratively and documented for each patient.

PC.16.1 The plan of care is developed through a collaborative approach between the healthcare team(s), patient, and family.

PC.16.2 The plan of care is based on the assessment findings and aimed to meet all patients' needs.

PC.16.3 The patient and family are involved in developing the plan of care.

PC.16.4 The plan of care contains the measurable goals/desired outcomes towards discharge.

PC.16.5 The plan of care is completed within 24 hours of admission or earlier based on the patient's condition and needs. (Nursing plan of care is completed whenever possible before the end of the shift).

PC.16.6 The plan of care is reviewed by the most responsible physician on a daily basis.

PC.16.7 The plan of care is modified as appropriate upon any significant change in the patient's condition or when new treatments are added or discontinued.

PC.16.8 The plan of care includes a provisional date of discharge set within 24 hours of admission.

PC.16.9 The plan of care is documented in the patient's medical record.

Standard Intent:

The plan of care outlines care and treatment to be provided to an individual patient. The plan of care identifies a set of actions that the health care team will implement to resolve or support the diagnosis identified by assessment. The overall goal of a plan of care is to achieve optimal clinical outcomes. The planning process is collaborative and uses the data from the initial assessment and from periodic reassessments performed by physicians, nurses, and other health care practitioners to identify and to prioritize the treatments, procedures, nursing care, and other care to meet the patient's needs. The patient and family are involved in the planning process with the health care team.
The plan of care is developed within 24 hours of admission as an inpatient. Based on the reassessment of the patient performed by the patient's health care practitioners, the plan of care is updated as appropriate to reflect the evolving condition of the patient. The plan of care is documented in the patient's record. The plan of care for a patient must be related to his/her identified needs. Those needs may change as the result of clinical improvement or new information from a routine reassessment. The plan of care is revised based on these changes and is documented in the record as notes to the initial plan, or they may result in a new plan of care. One method of developing care plans is to identify and establish measurable goals. Measurable goals can be selected by the responsible physician in collaboration with the nurse and other health care practitioners. Measurable goals are observable, achievable targets related to patient care and expected clinical outcomes. They must be realistic, specific to the patient, and time-

based to provide a means for measuring progress and outcomes related to the plan of care.

PC.17 Patients are reassessed to ensure effectiveness of care plans.

PC.17.1 All patients are reassessed at appropriate intervals to determine:

PC.17.1.1 Response to treatment.

PC.17.1.2 Compliance with treatment.

PC.17.1.3 Complications and side effects.

PC.17.1.4 Plan for continued treatment or completion of treatment.

PC.17.2 Medical reassessment must be performed at least once daily, including weekends and holidays, and in response to any significant change in the patient's condition.

PC.17.3 Nursing reassessment must be performed on every shift with a frequency dictated by the patient's condition, response to treatment, and physician's order.

PC.17.4 Reassessments are documented in the patient's medical record.

PC.17.5 The hospital defines situations where re-assessments are performed more infrequently (e.g., long stay patients mainly requiring a nursing care).

Standard Intent:

Reassessment by all the patient's health care practitioners is key to understanding whether care decisions are appropriate and effective. Patients are reassessed throughout the care process at intervals based on their needs and plan of care or as defined in hospital policies and procedures. The results of these reassessments are noted in the patient's record for the information and use of all those caring for the patient. Reassessment by a physician is integral to ongoing patient care. A physician assesses an acute care patient at least daily, including weekends, and when there has been a significant change in the patient's condition. Reassessments are conducted and results are entered in the patient's record

- At regular intervals during care.
- Nursing staff reassessment at every shift or as needed based on the patient's condition.
- Daily by a physician for acute care patients or as needed based on the patient's condition.
- In response to a significant change in the patient's condition. if the patient's diagnosis has changed and the care needs require revised planning; and to determine if medications and other treatments have been successful and the patient can be transferred or discharged.

PC.18 Clinical practice guidelines, pathways, and protocols are developed or adopted to guide priority clinical care services.