One method of developing care plans is to identify and establish measurable goals. Measurable goals can be chosen by the responsible practitioner with the nurse and other health care team members. Measurable goals are observable, achievable targets related to patient care and expected clinical outcomes.

Goals 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. Examples of measurable, realistic goals include the following:

- The patient will resume and maintain an adequate cardiac output as indicated by a heart rate, rhythm, and blood pressure that are within normal limits.
- The patient will demonstrate proper self-administration of insulin injections prior to hospital discharge.
- The patient will be able to walk from his bed to the visitor lounge with a standard walker, bearing weight as tolerated on the affected leg.

Note: A single, integrated plan of care that identifies measurable goals expected by each health care practitioner is preferable. It is good practice for the plan of care to reflect individualized, objective, and measurable goals to facilitate reassessment and revision of the plan of care.

Some departments may conduct multidisciplinary patient care conferences for patients receiving complex care from multiple services. Examples of such patients include the following:

- Patients receiving rehabilitative services
- Patients with multiple diagnoses in intensive care units
- Patients with complex discharge planning needs

Any results or conclusions from collaborative patient care team meetings or similar patient discussions are written in the patient's medical record.

Measurable Elements of COP.01.01

1. The care for each patient is planned by the responsible practitioner, nurse, and other members of the health care team within 24 hours of admission as an inpatient.
2. The plan of care is individualized based on the patient's initial assessment data and identified needs and is documented in the patient's medical record.
3. The plan of care is updated or revised based on any changes in the patient's condition and is documented in the patient's medical record. (*See also* AOP.01.05, ME 1; ASC.04.03, ME 4)
4. The results or conclusions of any patient care team meetings or other collaborative discussions are documented in the patient's medical record.

Standard COP.01.02

The provision of high-risk services is guided by professional practice guidelines, laws, and regulations.

Intent of COP.01.02

Providing high-risk services involves unique risks to patients and staff; the hospital establishes and implements guidelines and procedures to identify and decrease risks associated with these services. Some services are considered high risk because of the complex medical equipment, the nature of the treatment, the potential for harm to the patient, or toxic effects of certain high-risk medications.

High-risk care is supported by the use of such tools as the following:

- Clinical practice guidelines
- Hospital policy and procedures
- Clinical pathways

These tools are important for staff to understand and implement in a uniform manner. Hospital leaders are responsible for the following:

- Identifying services considered high risk in the hospital
- Using a collaborative process to develop written tools for guiding the uniform care
- Training staff in implementing these tools

Written tools for care must be tailored to the high-risk service to be effective in reducing risk. When providing high-risk services, the hospital establishes and implements guidelines and procedures that address the following:

- How care planning will occur, including special considerations related to the high-risk service
- The documentation required for effective communication among the care team
- Special consent considerations, if appropriate
- Patient-monitoring requirements, including the proper use of alarms
- Special qualifications or skills of staff involved in the care process
- The availability and use of specialized medical equipment

Hospital leaders identify additional risk for hospital-acquired conditions as the result of any procedures or plan of care. Examples of hospital-acquired conditions include the following:

- Deep vein thrombosis, pressure ulcers, and ventilator-associated infections in patients on life support
- Neurological and circulatory injury in restrained patients
- Bloodborne pathogen exposure in hemodialysis patients
- Central line infections
- Falls

When these risks are present, they must be prevented by educating staff and developing appropriate policies, guidelines, and procedures. The hospital uses measurement information to evaluate the services provided and integrates that information into the hospital's overall quality improvement program.

Measurable Elements of COP.01.02

1. Ⓓ Hospital leaders identify, in writing, the high-risk services, including at least the following when provided by the hospital:
   - Emergency services
   - Life support, including ventilators and extracorporeal membrane oxygenation
   - Infectious disease services
   - Dialysis
   - Restraints
   - Chemotherapy
   - Critical care services
2. Ⓓ Hospital leaders establish and implement written policies, procedures, and/or principles of care for high-risk services provided by the hospital.
3. Staff are trained to use the written tools for high-risk services.
4. Hospital leaders identify additional risks that may affect high-risk services and implement measures to reduce and/or prevent these risks.
5. Ⓓ Hospital-acquired conditions are tracked and included in the hospital's quality improvement program.

Clinical Alarm System Management

Standard COP.02.00

The hospital implements policies and procedures for safety of clinical alarm systems.