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QUICKCARE
COMPREHENSIVE LONG-TERM CARE SOFTWARE

From Care Plan to Progress Notes

A Guide for Success

The Nursing Care Plan is designed to be a specific approach for an individual resident. Care Plans provide the guidelines for care and must be designed for interventions specific to the needs of the resident.

Most facilities do an outstanding job of developing Care Plans with Problems, Goals and Interventions. And then, once the Care Plan is developed by the Interdisciplinary Team (IDT), it is filed in the chart, or another “easily accessible” file. However, the gap between initiating the Care Plan, implementing the Interventions and then evaluating the Care Plan’s effectiveness by the IDT is a very big gap, indeed. It is very important (**for substantiating the RUG score**) to document the process of implementing and evaluating the Interventions in either the Nursing Progress Notes or IDT Progress Notes.

The challenge for the nursing staff is:

- Reading the Care Plan and then
- Documenting that the interventions have been implemented and are being evaluated continuously.

There must be a path between the Care Plan and the resident’s chart that will reflect the compliance with Interventions on the Care Plan.

To prevent the IDT from reading the entire Care Plan, here are a few simple steps that can provide the path to ensure compliance:

1. Every problem on the Care Plan is numbered chronologically.
2. At the IDT meeting where the Care Plan is being developed, the team **starts** an abbreviated Care Plan sheet. This abbreviated Care Plan sheet indicates the specific Problems and the Interventions that need to be supported by more specific documentation by the IDT.
3. The abbreviated Care Plan sheet shows the Problem number from the Care Plan and the Interventions that require direct care implementation and more specific documentation.
4. The abbreviated Care Plan sheet is placed as the first sheet in the Nurses’ Notes section of the chart.
5. When any member of the IDT documents care, the Progress Note begins with the number of the problem from the abbreviated Care Plan and then the actual documentation for that Problem number.

An additional benefit is that the MDS coordinator will be able to obtain new information from the resident’s chart by simply searching for information by the Problem number from the abbreviated Care Plan.