Nursing Plan of Care
Practice Guideline
Introduction

The College of Registered Nurses of Nova Scotia’s legislated mandate is to serve and protect the public interest through the regulation of individual registered nurses (RN) and nurse practitioners (NP). The nursing profession is privileged to be a self-regulating profession and the CRNNS’ governing presence allows the nursing profession to regulate itself. This means that registered nurses are able to lead, direct and make decisions about their own profession. Together, we work to ensure safe and quality nursing care in the interest of Nova Scotians.

This practice guideline is designed to assist RNs in understanding their accountability related to the development, implementation and evaluation of the nursing component of the plan of care and to offer guidance to meet this standard of practice. For the purposes of this guideline, the plan of care refers to the nursing component of the clients’ plan of care.

Legislative Requirement

The requirements related to the plan of care are defined in the Registered Nurses Act (2006), the CRNNS Standard of Practice for Registered Nurses (2017) and the CRNNS Entry Level Competencies for Registered Nurses (2013).

The RN Act states that developing, implementing, monitoring and adjusting the plan of care is part of the RN scope of practice. The standards reinforce this, as they state that each RN:

- uses critical inquiry to assess, plan, intervene, monitor and evaluate client care and related services (Indicator 2.1).
- establishes, maintains and evaluates the nursing component of a plan of care (Indicator 2.3).
- monitors the effectiveness of a plan of care and revises the plan appropriately in collaboration with the healthcare team (Indicator 2.5).

The Entry Level Competencies for RNs applies to new graduated RNs as well as all active-practicing RNs in Nova Scotia and care planning is addressed in the knowledge-based practice component of the competencies. The section on health care planning states that “within the context of critical inquiry and relational practice, plans nursing care appropriate for clients which integrates knowledge from nursing, health sciences and other related disciplines, as well as knowledge from practice experiences, clients’ knowledge and preferences, and factors within the health care setting” (p. 9). There are 10 listed competencies under this section.

What is the Plan of Care?

RNs are accountable to ensure that each client has a nursing plan of care in place that appropriately identifies priority problems, targets outcomes and specifies nursing interventions. The RN also has an accountability to participate in the development of the multidisciplinary plan of care. The purpose of the plan of care is to provide consistent care and to assist in the achievement of client-centered goals, developed collaboratively with the client, through nursing interventions. The care plan is a map for nursing care and demonstrates your accountability in client care. The plan of care may be a stand-alone document or it may be one component of an interprofessional plan of care. The plan of care is part of the permanent health record.

Types of Plans of Care

The plan of care is part of a legal medical record and may take on a variety of formats in any given organization (Potter & Perry, 2010). They may be hand-written, electronic or pre-printed pathways. In Nova Scotia, nurses are using plans of care on Meditech, other electronic means, care pathways, care maps and standardized care plans.

The employer is accountable to determine the format of the plan of care that fits the organizational context of practice. The employer is also accountable for policies and processes to support the development and utilization of a plan, whether it is nursing specific or interprofessional. Guidance of the specifics related to the how the plan of care is developed in an organization should be sought from the manager and/or nurse educator.
Purpose of Plan of Care

The purpose of a plan is to maximize health outcomes by documenting the client’s needs and to promote a consistent approach to care. The plan’s three functions are to establish the client’s:

1. **BASELINE PRESENTATION**
   The plan of care is an overall picture of a client’s priority needs, required actions and intended outcomes for optimal health. The plan is based on a comprehensive assessment completed by the registered nurse on admission. An established baseline is the reference point to which the registered nurse and other health care providers compare a client’s day-to-day progress.

2. **LEVEL OF PREDICTABILITY OR COMPLEXITY**
   The client’s level of complexity is made evident through the nursing plan of care (College of Registered Nurses of Nova Scotia & CLPNNS, 2012; CLPNNS 2013a). The RN uses the comprehensive assessment nursing diagnoses and nursing interventions, to determine the level of predictability (stable/unstable) and complexity for the client.

   The registered nurse must take all aspects of the comprehensive assessment into consideration when developing the client’s nursing diagnosis and therapeutic interventions. This in turn translates into the level complexity. For example, a client who is admitted post-operatively for a fractured hip, has diabetes cardiovascular disease and is of a low socio economical status may be considered complex. Another client who is admitted post-operatively for a fractured hip and has no co-morbidities and has strong support system may be considered stable.

   It is important to recognize that a client’s level of predictability or complexity is dynamic and will change as clients, their issues, and their responses to interventions change. The plan of care is a fluid document and changes to the plan will be made as the client’s condition changes.

   The level of complexity is a key determinant that the registered nurse must consider when determining the most appropriate care provider. An appropriate assignment of client care cannot be made without the completion of the nursing component of the plan of care, which establishes predictability and complexity.

3. **GUIDES THE PRACTICE OF THE REGISTERED NURSE AND OTHERS BY OUTLINING ONGOING CARE REQUIREMENTS**
   The nursing plan of care is designed to identify and address the client’s health needs as determined by the nursing diagnosis and interventions. Registered nurses and other nursing staff use the plan to assess and measure a client’s progression. The plan helps all nursing staff determine if the client is meeting, exceeding or not meeting the established goals. When the client exceeds or fails to meet the goals, the registered nurse, along with the client, must determine if the goals or interventions need to adjusted or if other members of the intraprofessional team need to be consulted.

Components of the Plan of Care

The plan of care is designed to be a client-centred, action-orientated document which outlines the following components:

**COMPREHENSIVE NURSING ASSESSMENT**

A comprehensive assessment identifies the needs, preferences, and abilities of the client and includes a physical and psychosocial assessment. Assessment is used to determine the client’s presenting signs and symptoms, the client’s psychosocial status using the determinants of health. The data and information gathered and analyzed to determine a nursing diagnosis.

Some organizations use an admission data base as the tool used by nursing to complete the comprehensive assessment. Although this tool may seem long, the collection of this information on admission will inform the development of a plan of care which results in an efficient use of resources. For example, consideration of the clients’ home environment and financial status is required to develop an appropriate discharge plan.
If your organization does not have an admission database tool, you may want to discuss developing a tool with your manager. There are many examples of various types of admission databases which focus on specific populations. A search of the internet will provide you with examples of these tools.

Health is determined by complex interactions among social and economic factors, physical environment and individual behaviors, which do not exist in isolation from each other (Canadian Council of Social Determinants of Health, 2013). These determinants of health are essential in the comprehensive nursing assessment (see image 1.0)

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**Image 1.0**

**NURSING DIAGNOSIS**

Nursing diagnosis is based upon the human response to a condition or disease and helps the RN determine the focus of nursing care to be provided to a client. Nursing diagnosis can also be referred to as focus areas or priority areas. The diagnosis reflects an issue or state of health to direct the plan of care that falls within the nurse’s scope of practice. Nursing diagnosis may include the client, family, or community. Nursing diagnoses are based on data obtained during the comprehensive nursing assessment.

Most nurses would be familiar with the North American Nursing Diagnosis Association (NANDA). It is not required by CRNNS that this format be used in the plan of care; it is required however that the nursing component of the clients plan of care has a nursing diagnosis. The employer will determine the format of the plan of care, which will include the nursing diagnosis. An example of a nursing diagnosis for a client admitted for a total joint replacement could be; Acute pain related to total knee replacement surgery

**GOAL OF THE PLAN OF CARE**

Goals and expected outcomes are specific client behaviors or physiological responses that the registered nurse and the client set to achieve (Potter & Perry, 2010). They provide a clear focus for the types of interventions necessary for client care and provide a focus for evaluation of the interventions. (Potter & Perry, 2010). Clients need to be able participate in setting goals; unless goals are set mutually and there is a clear plan for action, clients may not follow the plan of care. Goals and outcomes need to be relevant to the client needs and be specific, observable, measurable, and time limited (Potter & Perry, 2010). Some examples of a client-centered goal for a client admitted for a total joint replacement could be;

- Client’s self report of pain will be 3 or less on a scale of 0 to 10.
- Client will be able to mobilize with minimal discomfort (pain scale of 3 or less).

**NURSING INTERVENTIONS**

Nursing interventions are actions carried out by a nurse to implement the nursing plan of care. The development and implementation of interventions are individually based on the nursing assessment and are developed in consultation with the interprofessional team, including the client.
There are three types of nursing interventions: a) nurse initiated, b) physician initiated, and c) collaborative (Potter & Perry, 2010).

a. nurse initiated interventions are independent nursing interventions; they do not require orders or direction from another health care professional. An example of an independent nursing intervention is directing a client to splint an incision during coughing post-operatively.

b. physician initiated or dependent nursing interventions are those that require orders or directions from physicians or other health professionals. The interventions are directed toward treating or managing a medical diagnosis. The RN intervenes by carrying out the written or verbal orders. An example of a dependent nursing intervention is the administration of medication or changing a dressing.

c. collaborative interventions or interdependent nursing interventions are interventions that require the combined knowledge, skill, or expertise of a number of health care professionals. Interdisciplinary health care team conferences are helpful in determining interdependent nursing interventions. An example of a collaborative intervention is a nursing consultation with the unit social worker to help prepare the client for discharge.

EVALUATION

Evaluation is an ongoing process, of reviewing subjective and objective data from the client, family and other health care team members (Potter & Perry, 2010). The RN also reviews information regarding the client's current condition treatment, resources available for recovery and the expected outcomes. During the evaluation, the RN makes clinical decisions and continually redirects nursing care. For example, when the RN evaluates the client pain severity, the RN applies knowledge of the disease process, physiological response to interventions and the correct procedure for pain severity measurement to interpret whether a change has occurred and whether the change is desirable.

Evaluation leads to either the discontinuation of the plan of care or a revision to the existing plan of care (Potter & Perry, 2010). If the client meets all the established goals and are in agreement with the discontinuation of the plan of care then that specific portions of the plan of care may be discontinued. When goals are not met, the plan of care will need to be mutually revised with the client making changes to goals and interventions as appropriate to develop a more realistic plan for the client.

How do the RN and the LPN work together to develop the plan of care

In many clinical settings, RNs work collaboratively with their licensed practical nurse (LPN) colleagues to meet the needs of their client population. Both nurses have a role in the plan of care and it is important for registered nurses to know how their accountabilities related to care planning differ from the accountabilities of their LPN colleagues.

When a client is admitted, the RN completes a comprehensive assessment and based on this assessment develops the nursing plan of care. The plan must identify the priority needs/nursing diagnosis, nursing actions and the intended outcomes for the client's optimal health. The RN also determines the most appropriate care provider based on the plan of care, context of practice, client needs, practice environment and individual capacity of the care provider (CRNNS, 2012). The RN collaborates with the LPN to ensure that clients are meeting their expected outcomes. When clients become unpredictable or are not meeting expected outcomes, the RN collaborates with the LPN to revise the plan of care as necessary. The RN also collaborates with the LPN to evaluate the plan of care to ensure that clients have met their expected outcomes prior.

The LPN collaborates in the development of the nursing plan of care. LPNs can collaborate by:

- Completing an initial assessment and sharing that information with the RN so the RN can develop the plan of care, or
- Completing the initial assessment and a draft plan of care which must be approved by the RN prior to being initiated.
The LPN can then implement the plan of care to achieve identified client outcomes. As long as the client is meeting the established outcomes, the LPN may independently change the plan of care. If a client is not meeting established outcomes or becomes more complex or outcomes become more unpredictable, the LPN consults with the RN so changes can be made to the plan of care (CRNNS, 2012). For more information of the LPNs role in the plan for care please see the document: The Professional Practice Series the Nursing Care Plan (CLPNNS, 2013).

**Care pathways, Care Maps and Standardized Care Plans**

As discussed earlier, organizations determine what type of care plan tool best meets the needs of their clients. Care pathways, care maps, and standardized care plans are used throughout the province of Nova Scotia. These care planning tools should be evidence-based and therefore are appropriate methods of planning care. It is important to remember that these tools must be individualized if it is determined that the client has a priority need that is not addressed in the tool.

If organizations use these types of tools, typically there is a policy/process developed for individualizing the plan of care. In these situations, it is important to follow your organizational policy. In general, individualizing the plan of care follow the same steps that were discussed above in relation to developing diagnosis, goals, interventions and evaluation.

The development and implementation of the nursing component of the client’s plan of care is a core function of RN practice. This essential element of RN practice contributes to continuity of client care and in improving the health and wellness of all Nova Scotians.

**References**


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