



# EHR Go Guide: Care Plans

## Introduction

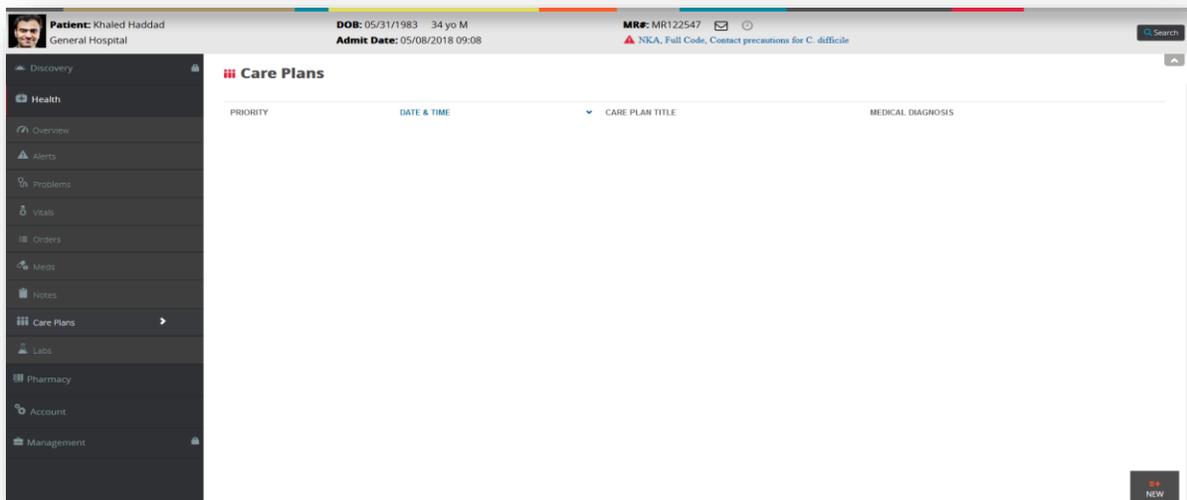
Understanding how to create a care plan is a vital skill. This guide will provide an overview of how to enter and edit new care plans in EHR Go.

## Additional resources

Students should have a good working knowledge of how to enter information into the EHR.

## Entering a Care Plan

When you launch a patient chart in EHR Go, you will be brought to the Overview tab. Click on the **Care Plans** section to get started. This screen will be initially blank until a care plan is added. To get started click on **New** in the bottom right corner.



You will then be taken to the **Care Plan Edit** screen. This screen displays an initially blank care plan with the following fields:



- **Care Plan Title:** Enter an appropriate title for the care plan.
- **Date:** This will automatically populate.
- **Author:** This will default to the name of the student user.
- **Priority:** This field will vary depending on your SOP and is linked to the diagnosis. If a diagnosis requires multiple care plans you would fill in this field accordingly (i.e. primary, secondary, tertiary).
- **Medical Diagnosis:** This field should contain the diagnosis that the care plan is designed to help treat.
- **Goal:** This field should contain the overall goal of the care plan.

Once all the information has been entered, click on save.

A screenshot of the EHR Go 'Care Plan Edit' interface. The top header shows patient information: 'Patient: Khaled Haddad', 'DOB: 05/31/1983 34 yo M', 'MR#: MR122547', and 'Admit Date: 05/08/2018 09:08'. A search bar is in the top right. A left sidebar contains navigation options: Discovery, Health, Overview, Alerts, Problems, Vitals, Orders, Meds, Notes, Care Plans (selected), Labs, Pharmacy, Account, and Management. The main content area is titled 'Care Plan Edit' and contains several input fields: 'Care Plan Title \*' (with a placeholder 'Please enter care plan title'), 'Date' (populated with '05/08/2018 14:02'), 'Author' (populated with 'Kim Anderson, RN'), 'Priority' (with a placeholder 'Please enter priority'), 'Medical Diagnosis' (with a placeholder 'Please enter medical diagnosis'), and 'Goal' (with a placeholder 'Please enter goal'). At the bottom right, there are 'SAVE' and 'CANCEL' buttons.

Once you have saved the care plan, you will be shown the **Care Plan Details** screen. This screen will display your already created care plan, as well as two new sections **Outcomes** and **Interventions/Activities**. On this screen you may also edit the care plan title page or delete it. Outcomes and Interventions cannot be edited once they have been saved

A screenshot of the EHR Go interface showing a patient's care plan details. The patient is Khaled Haddad, 34 years old, admitted on 05/08/2018. The care plan title is 'No longer sick', created by Kim Anderson, RN, with a goal of 'To no longer have a cold'. The screen includes a sidebar with navigation options like Discovery, Health, Overview, Alerts, Problems, Vitals, Orders, Meds, Notes, Care Plans, Labs, Pharmacy, Account, and Management. At the bottom right, there are buttons for EDIT, DELETE, and CLOSE.

**Patient:** Khaled Haddad  
General Hospital

**DOB:** 05/31/1983 34 yo M  
**Admit Date:** 05/08/2018 09:08

**MR#: MR122547**  
▲ NKA, Full Code, Contact precautions for C. difficile

### Care Plan Details

**Care Plan Title**  
No longer sick

**Date**  
05/08/2018 14:02

**Author**  
Kim Anderson, RN

**Priority**  
Primary

**Medical Diagnosis**  
Common Cold

**Goal**  
To no longer have a cold

**Outcomes** (+)

**Interventions/Activities** (+)

EDIT DELETE CLOSE

We will now cover the **Outcomes** and **Interventions/Activities** sections. While they cover two different topics, inputting information into them is the same. Click on the corresponding plus sign (+) to bring up the **New Intervention/Activity** or the **New Outcome** screen.

A screenshot of a mobile application form titled 'New Intervention/Activity'. The form has a white background with a grey border. At the top, there is a blue header bar with the text 'New Intervention/Activity'. Below the header, there are two fields: 'Date' with a value of '05/08/2018 15:16' and a calendar icon, and 'Author' with a dropdown menu showing 'Kim Anderson, RN'. Below these fields is a large text area labeled 'Detail' with a plus sign in the top right corner. Below the 'Detail' field is another text area labeled 'Comment' with a plus sign in the top right corner. At the bottom right of the form, there are two buttons: a red 'SAVE' button and a yellow 'CANCEL' button.

The **date** and **author** field populate automatically but can be modified if necessary. In the **detail** field, enter the intervention or activity. This is usually 1-2 short sentences. An example could be ‘reposition patient every 2 hours’. Select save when you are done. It is recommended you use a number or letter system to connect Interventions to Outcomes.

The **Comment** box is for any additional information that is needed to be entered. This is where a text book reference can be entered, or an explanation as to why this intervention was chose for this care plan.

- Make certain that everything is entered correctly before clicking save. Once you click save you can cannott the content of the intervention.
- If it has already been saved and the intervention does not need to be in the care plan, click on the plus (+) sign next to **New Evaluation**. In the detail box enter something such as cancelled, intervention remove, or entered in error.
- Once finished entering the details, click save.

A screenshot of a "New Intervention/Activity" form. It has a teal header. The form contains fields for "Date" (05/08/2018 15:16) and "Author" (Kim Anderson, RN). Below these is a "Detail" section with a text area containing "1. Ensure proper fluid intake". There is also a "Comment" section with an empty text area. At the bottom right are "SAVE" and "CANCEL" buttons.

As shown in the example below, you can click on the plus sign to add an evaluation to either the Outcomes or Interventions/Activities you have just entered.

A screenshot of the "Care Plan Details" screen. The title is "Care Plan Details". It shows a care plan for "No longer sick" by Kim Anderson, RN, with a primary priority and a goal of "To no longer have a cold". The screen is divided into two main sections: "Outcomes" and "Interventions/Activities".  
Under "Outcomes", there are two items:  
1. "2. Patient is complaining of 'always being hungry'" with an "ADD EVALUATION" button.  
2. "1. Will no longer be dehydrated." with an "ADD EVALUATION" button. Below this, an evaluation is shown: "05/08/2018 17:00 Patient is no longer dehydrated."  
Under "Interventions/Activities", there are two items:  
1. "2. Ensure that the patient is eating three times a day" with an "ADD EVALUATION" button.  
2. "1. Ensure proper fluid intake" with an "ADD EVALUATION" button. Below this, an evaluation is shown: "05/08/2018 15:27 Started new saline drip." At the bottom right are "EDIT", "DELETE", and "CLOSE" buttons.

A screenshot of a "New Evaluation" form. It has a title bar "New Evaluation" and two input fields: "Date" with the value "05/08/2018 15:33" and a calendar icon, and "Author" with a dropdown menu showing "Kim Anderson, RN". Below these is a "Detail" section with a large empty text area. At the bottom right are "SAVE" and "CANCEL" buttons.

When you are done with your care plan, click on close and you will be brought back to the **Care Plans** screen.

A screenshot of the "Care Plans" screen. It has a title bar "Care Plans" and a table with the following data:

PRIORITY	DATE & TIME	CARE PLAN TITLE	MEDICAL DIAGNOSIS
Primary	05/08/2018 14:02	No longer sick	Common Cold

A "NEW" button is visible in the bottom right corner.



You can come back and finish the Care Plan by highlighting and clicking on the Care Plan listed under the Care Plans tab.

**Outcomes** behave just like **Interventions/Activities** and contain the same editable fields. In the **details** box, enter the expected outcome, or the outcome itself, for performing the intervention with any patient. Again, it is recommended to apply a tracking convention to properly associate outcomes to interventions/activities.

When you are ready to add an evaluation for the outcome, click on the plus (+) sign to the right of the word **Evaluation**.

- In the **Details** box write the evaluation for the intervention and outcome, this is where results of the intervention are entered. Did you meet the outcome that you had written and/or did this lead to meeting the short-term goal?
- You may choose to write in the detail if it did or did not meet the short-term goal. When finished entering the evaluation, click the **Save** button.

## Modifying an Existing Care Plan

Some EHR Go patients already have care plans started in their charts. The student users will not be able to delete an already available care plan but can add information to it. See previous section on how to add Outcomes, Interventions/Activities, Evaluations, and Comments. The student users will also be able to add new care plans as described previously.

**Important!** When you are finished, click on **Close Session** to save your work.