HACKETTSTOWN REGIONAL MEDICAL CENTER
Administrative Policy and Procedure

SECTION: PATIENT CARE SERVICES

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(Formerly AD-65)

TITLE: INTERDISCIPLINARY PLAN OF CARE and TEACHING RECORD

PURPOSE

To establish guidelines for completing documentation using the interdisciplinary plan of care and teaching record.

POLICY

It is the policy of HRMC to promote an interdisciplinary plan of care as an integral part of providing patient care. All healthcare providers are part of the team that is responsible for identification of problems, ensuring the implementation of the plan and desired outcomes. This includes the providers of appropriate education for the patients at HRMC.

SUPPORTIVE DATA

- The Interdisciplinary Plan of Care (IPC) is based upon assessments of patient needs as well as triggers identified from the admission data base.
- The assessment is an interdisciplinary process. Each discipline contributes to the patient assessment based on their individual scope of practice and/or standards of care.
- The generic plan of care is a suggested guideline. When completing the IPC, the healthcare providers must consider individual patient needs, clinical assessments and judgments in order to develop the most appropriate plan for each patient.
- By selecting choices provided, the disciplines are individualizing the plan of care. Should the choices provided on the document not meet the patient needs, information should be added to the appropriate column. All columns for diagnosis/problem, interventions and outcomes will have appropriate space for additional information to be added under "other".
- The RN is responsible for initiating the IPC within 24 hours of admission. Within this time frame the patient's needs are prioritized and the most urgernt need(s) are identified on the plan of care. The IPC will be revised as needed.
- Patients and/or family will be instructed on the plan of care. Every seven (7) days the plan of care is re-evaluated and a new form is started
- The IPC is discussed as part of handoff communication for RN to RN shift report and RN to RN transfer to another unit.
- The IPC should be updated as patient problems are identified, at the time of transfer to another unit (i.e. outcomes resolved, transfer to a lower level of care; additional problems identified upon transfer to a higher level of care)

TARGET POPULATION

All inpatients: 3N, 3S, PCU, ICU and 4S (general surgery patients)

PERSON RESPONSIBLE

Each discipline is responsible for updating and reviewing the plan of care as appropriate according to their interaction with the patient. The following disciplines will be identified in the IPC by:

RN - Registered Nurse	IC - Infection Control Practitioner	Pt. ED - Patient Educator
RD - Registered Dietician	PT - Physical Therapist	CWOCN - Wound/Ostomy RN
SW - Social Worker	OT- Occupational Therapist	RT - Respiratory Therapist
CM - Case Management	ST - Speech Therapist	PH - Pharmacist
CH- Chaplain	CAC- Counselor from Counseling and Addiction Center	

CHART PLACEMENT

During the patient's stay it will be kept in the "Plan of Care" binder on the unit. Once the patient is discharged it is kept in the Nurses' Notes following the admission database. Maternal Child Unit will keep the document in the chart, with the admission database. ICU will keep the document in patient specific binder.

CONTENT

Procedure

1. Stamp form with a patient addressograph on the lower left corner of the first page, left corner of the form.
2. Write the patient's admitting diagnosis and the date of initiation of the IPC.
3. If patient is unable to be instructed on the plan of care, the reason must be documented in the focus notes.
4. Each diagnosis selected by a discipline will require a "date, time and initial" in the column next to the appropriate diagnosis selected.
5. Select the diagnosis appropriate to the discipline. Each discipline is to address the plan of care if applicable/consulted throughout patient's course of stay.
6. Check appropriate boxes and the rationale for selecting the diagnosis under each.
7. Select all appropriate interventions and initial any intervention that will be done during the patient's hospitalization. These interventions are activities that are utilized to help the patient achieve his/her outcome.
8. Select the most appropriate outcome(s) for the patient to achieve. Initial the outcome or goal to achieve.
9. When the outcome is achieved, date and initial when resolved in the "resolve" column. Each section of the resolved column corresponds to goals listed.
10. Each day the primary RN, at the change of shift, will review all problems identified in the plan of care. After reviewing initial and time under the appropriate date.
11. Nursing may share the patient problem list with other disciplines such as Nutrition. Both nutritional care and nursing contribute to this and each have specific interventions to help the patient achieve his/her outcome.
12. All other disciplines will review the plan of care as appropriate, and sign off as stated above. Other disciplines will sign off their primary scope of care, but may be involved with other problems such as pain. It is appropriate to sign off there as well if they have assisted in any interventions.
13. Although each discipline addresses patient's needs within their scope during the course of stay, it does not preclude any discipline from identifying, intervening, assisting in care or reinforcing education. (i.e. the RN teaching the patient about crutch walking.)

14. All healthcare providers must have a full signature and title to accompany their initials found on the IPC. This will be found on the last page of each plan of care.
15. To ensure appropriate disciplines have been involved in the care, after reviewing and initialing the problem, check off the discipline represented in the last column, "involved disciplines."
16. Handoff communication amongst the disciplines: Patient care by all the involved disciplines is provided at the bedside. Verbal handoff communication will occur between the nursing staff and other disciplines after the non-nursing disciplines have seen and interacted with the patient.
17. Blanks are provided in each plan of care to further individualize the plan by any discipline in the healthcare team.

PATIENT EDUCATION/TEACHING RECORD

- Patient is instructed on their plan of care upon initiation of the plan. During daily review the plan of care is reinforced via verbal communication with patient.
- Education addressed by any discipline will be captured in the teaching record section of the care plan, located on the last page.
- Specific education points completed by the Patient Educator or other discipline will be entered in the interdisciplinary progress notes if unable to be captured on the teaching record.
- This section captures ongoing education during hospital stay. Initial one time education will be addressed on the admission database.
- Barriers to learning and communication are identified at time of admission, and should be referred to prior to presenting patient education.
- Complete date and time of education, write in topic that was covered, who the learner was, their readiness to learn, teaching method and evaluation of the teaching by using the key provided on the form.
- Initial all entries and have corresponding name/title for initials.
- Add comments after entry if applicable.

INTERDISCIPLINARY ROUNDS

- During the twice a week Patient Care Interdisciplinary Rounds, the plan of care will be reviewed with the healthcare team.
- This process will be documented with the stamper on the last page of the care plan by the Utilization Review Department.

UNRESOLVED PROBLEMS

It is conceivable that all problems will not be resolved during the patient's hospitalization. The section marked "unresolved problems" will be used at the time of discharge to address this. All problems/goals not met (as noted in resolved column with initials and date) will be automatically be included in this category. At the time of discharge, check off what interventions will be done for the patient post hospitalization that would assist them in resolving the problem after they are discharged.

REFERENCES

The nursing documentation in the Plan of Care is reflective of the nursing language. It uses established Nursing Standardized Language classifications from NANDA, NIC and NOC. The interventions and outcomes are defined in those references and will be referred to when language is unfamiliar to new staff.