Interdisciplinary Plan of Care
• TJC views the patient care plan as the “structuring framework for coordinating communication that will result in safe and effective care” (Keenan et al, 2008).

• The care plan is a “road map” to guide all who are involved with the patient’s care.
  - Provides a central focus and quick communication tool for all disciplines involved in the care process.
Hospital Standards:

- The provision of care, treatment, and services to patients is composed of four **core processes** or elements:
  - Assessing patient needs
  - Planning care, treatment, and services
  - Providing the care, treatment, and services the patient needs
  - Coordinating care, treatment, and services
Standard PC.01.03.01

The organization plans the patient’s care.

1. The hospital plans the patient’s care, treatment, and services based on needs identified by the patient’s assessment, reassessment and results of diagnostic testing.  (See also RC.02.01.01, EP 2)

5. The written plan of care is based on the patient’s goals and the time frames, settings, and services required to meet those goals.

22. Based on the goals established in the patient’s plan of care, staff evaluate the patient’s progress.

23. The hospital revises plans and goals for care, treatment, and services based on the patient’s needs.  (See also RC.02.01.01, EP 2)
Who Uses Care Planning Process?

- The Registered Nurse is responsible for:
  - Initiating the plan of care based on a comprehensive assessment, desired outcomes, and evidence based practice
  - Safely implementing the plan of care/action either directly or by delegation
  - Evaluating the responses
  - Communicating accurately in writing and orally (Tennessee State Board)
• Other Disciplines:
  - Physicians
  - Dieticians
  - Rehabilitation Caregivers
  - Respiratory Caregivers
  - All other disciplines that provide direct or indirect care
    • Radiology
    • Lab
    • Pharmacy
    • Case Management
    • Child Life
Care Planning Forms Across MSHA

- Multiple forms exist across MSHA, regardless of the form, the same elements must be documented:
  - Date and time the problem was initiated or added to the care plan
  - A defined outcome that is measurable and reasonable and a defined timeframe for achieving
  - Individualized outcomes and interventions
• Elements for documentation
  - The interventions should be evidence based.
    • Use Zynx and Mosby’s Resources as a guide
  - Documentation in the patient record must indicate progress to goals.
  - The care plan must be updated every 12 hours by the RN.
  - When goals are met, document “met” on the care plan with the date.
  - If a goal was revised, it must be documented on the care plan including date and time.
• Elements for documentation
  - At discharge, **ALL** goals must be closed out by documenting either met or unmet.
    • Unmet goals must be addressed for follow up after discharge. This must be documented in the patient record.
Next Steps for Successful Care Planning:

• Learn about the documentation process you will use at your facility
• Follow up with your preceptor/supervisor for support
• Investigate Zynx and Mosby’s
References