Interdisciplinary Care Planning and Documentation

References
You will need to refer to Policy Statements/Procedural Guidelines and Standards of Care which are located on the AtlantiCare Health System intranet web site. You will also find area specific Clinical Practice Policy & Procedure manuals to guide you in the care of patients in your specialty area.

Refer to the appropriate policies/procedural guidelines - you can find them on the AHS web site.
- Patient Data Base – Initial Assessment
- Patient History and Admission Assessment
- Screening and Referral
- Interdisciplinary Plan of Care
- Ongoing Assessment
- Patient Family Education

Interdisciplinary Care Planning Process (APIE)
Assessment
An orderly process consisting of the identification, gathering, and organization of subjective and objective data pertaining to the patient, family, and significant other. Subjective data is information the patient tells you. Objective data is information that you can see, hear, feel, smell, laboratory test results, etc. Each member of the health care team performs assessments as defined by their scope of practice.

Initial Assessment
- An initial admission assessment is performed on all patients upon admission and documented.
- The data collection component of the initial assessment may be performed and documented by any member of the health care team who has been trained and authorized to do so.
- Referrals to other disciplines are generated based upon defined high risk screening criteria
- The patient database/history must be reviewed, and referrals generated, by the Registered Nurse if data collection is performed by any other member of the health care team.
- The physical assessment component of the initial admission assessment must be performed and documented by the Registered Nurse.
- Timeframes for completion of the patient database/history vary depending upon practice setting; refer to Policy and Procedure.

Reassessment
- Assessment is continuous and ongoing throughout the acute care episode.
- Reassessments must be performed and documented a minimum of every 12 hours for all patients regardless of practice setting and are documented as appropriate.
- Routine reassessment timeframes vary depending upon practice setting; refer to Policy & Procedure.
- Reassessments must also be performed and documented, and Patient problems and needs must be addressed:
1. upon a significant change in the patient’s condition
2. upon a change in the level of care
3. post-invasive procedure

Plan
An organized step in the process that consists of the identification of actual patient problems/needs and desired outcomes/goals that result in a documented plan of care. Patient problems/needs are identified based upon the data collected during assessment/reassessment. Outcomes/goals are targets that provide focus and direction in solving the identified problem or meeting the identified need.

- Patient problems/needs and outcomes/goals constitute the interdisciplinary plan of care.
- The Registered Nurse manages the patient's plan of care along with the other members of the healthcare team consistent with their scope of practice.
- All disciplines, participating in the care of the patient, must be represented on the Interdisciplinary Plan of Care.
- Patient goals must be patient oriented, realistic, and measurable.
- All patient problems/needs must be addressed and documented on a minimum of every 24 hours on the Interdisciplinary Plan of Care.
- A change in patient condition requires identification of a new problem/need and goal/outcome within the Interdisciplinary Plan of Care.

Patient/Family Education
Care providers are responsible for identifying, planning, and coordinating the teaching interventions necessary to meet the ongoing goals of the patient/family. Care providers are responsible for initiating interventions designed to address specific learning needs. Patients/Families are involved in the education process. The patient’s learning needs, abilities, preferences, and readiness to learn are assessed upon admission of care to both inpatients and outpatients. This assessment will be a continuous process performed by the interdisciplinary team caring for the patient/family during their ongoing health care.

- Review the General Patient Family Education Standard for details.
- During the initial assessment ask for learning preferences and document.
- Patient/Family education documentation must reflect specifically what is taught to the patient or family and must include learning preferences, readiness, barriers that would inhibit learning, method of teaching, and evaluation of the learning episode.
- If the patient has barriers to learning or is not ready, establish a plan, write a goal, and document. When you educate family document, document, document.
- At time of discharge make sure the patient has legible Discharge Instructions and also has medication information that contains both the brand and generic names.
- Use approved materials only and utilize Krames information whenever possible.
- Food/Drug Interaction.
- If you find that you have language barriers access our services for the Limited English Proficient Patient (Language Line). For medical care/interventions you must use a reliable interpreter. Avoid using family members to interpret medical information as they may not understand or may not relay exactly what you are trying to say. Services are
available for both limited English proficient patients as well as for those patients who are deaf or hearing impaired. Document, document, document.

Intervention
The specific orders and/or interventions that are implemented are consistent with the medical treatment plan or the interdisciplinary plan of care.

Evaluation
The step in the process that involves determining the patient's response to the interventions and/or the effectiveness of the interventions in achieving the desired outcome/goal. The evaluation may drive the need for reassessment and revision to the plan of care.

Transfer
Transfer means the movement, including discharge, of an individual either between ARMC campuses from ARMC to an outside facility at the direction of any persons employed by, or affiliated or associated directly or indirectly with ARMC, but does not include the movement of a patient who has been declared dead or who leaves the facility against medical advice.

- **Transfers from ARMC to Another Facility**: All transfers to another facility shall require the completion of the Patient Transfer Consent/Refusal Form and the Summary of Patient Condition Form

- **Interdivisional Transfers from one Campus ED to the Other Campus Clinical Nursing Unit**: Patient Transfer Consent/Refusal Form, Summary of Patient Condition Form and SBAR Report Sheet for Patients requiring immediate coronary intervention

- **Interdivisional Transfer from one Campus Inpatient Unit to the Other Campus Inpatient Unit**: Patient Transfer Consent/Refusal Form, Transfer Sending/Receiving Power Forms

- **Transfer from PIP to ARMC 1 Pines or Another Facility**: Patient Transfer Consent/Refusal Form, Involuntary Form (as indicated) and the Summary Patient Condition Form

- **Intradivisional Transfer from one Unit to Another Unit Within the Same Campus**: Transfer Sending/Receiving Power Forms

- **Sending a Patient for an Operative/Invasive Procedure**: Transfer Sending Power Form

- **Receiving a Patient from an Operative/Invasive Procedure**: Transfer Receiving Power Form

**Remember**: Upon transfer from one campus to the other, a new patient identification band must be made and immediately placed on the patient to ensure proper patient identification.
Discharge

- All patients are discharged with discharge instructions.
- Discharge teaching and instructions are documented on discharge instruction forms by the Registered Nurse.

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