Documenting Teaching and the Plan of Care

Purpose:
The purpose of this self-learning module is to provide the opportunity for nursing staff to review the nursing process and become familiar with the new care plan and teaching plan. This module will provide the RN with instruction for charting on the revised flow sheet and Supplemental Acute Care Teaching plan.

Goal: 100% of RN nursing staff will complete a mock care plan and teaching plan and sign the in-service record.

Objectives:
1) Analyze assessment data to identify priority patient issues.
2) Apply Principles of the nursing process to develop a comprehensive care plan and teaching plan.
3) Develop an individualized care plan and teaching plan utilizing the SBAR report of a mock patient.
4) Demonstrate knowledge of where to locate patient education materials.
5) Evaluate your mock plan by comparing it to the sample provided.

Resources
The following resources have been put into place to help you plan and document your patient’s plan of care.

ANA: Nursing Scope and Standards of Practice

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Managers and Supervisors

Clinical Nurse IVs

Instructions
1) Read the contents of this packet.
2) Utilize the SBAR report of a mock patient (provided in this packet), to complete a care plan and teaching plan.
3) Compare your mock plan with the sample provided.
4) Print patient educational material “Infection Prevention Practices”
5) Complete your mock care plan and teaching plan, contained in this packet, within 2 weeks.
6) Sign the In-service record

Note: Signing the in-service record indicates the following:
1. You have read all the material and completed the plan on a mock patient.
2. You understand your responsibilities in planning and evaluating patient care.
3. You understand your responsibilities in documenting your patient’s care plan and teaching plan.
When nurses were surveyed, a large majority, were not able to speak to their patient’s plan of care and felt nursing diagnoses did not drive the care of their patient. Many of you have stated that it is cumbersome to individualize POPs in the computer, keep them up to date, and print out multiple teaching plans. We have developed a care plan and teaching plan that will be incorporated on the back of the flow sheet. There are now just 2 places to chart your teaching and plan of care, the flow sheet and the supplemental acute care teaching plan. (Both are provided in this packet.) We performed a trial of the care plan and teaching plan in the ICUs, SSDU, and on 4T. Nurses were able to give very valuable input. Changes were made to the plan based on a collaborative effort with nurses who did the trial, and with the med/surg and critical care practice councils.

You will no longer be charting POPs in the computer or printing out multiple teaching plans. All the care planning and most of the teaching will be documented on the back of the flow sheet.

Key Changes in Policy

1. Care Planning (PCR- Planning of Patient Care)

   Change from Nursing Diagnoses to Identified issues
   According to the ANA Nursing Scope and standards of Practice, the nurse analyzes assessment data to determine the diagnoses or issues. We will base our plan of care on identified issues. Identified outcomes will be formulated by establishing goals. **We will no longer require one Functional, one Psychosocial and one Physiological plan of care.** Instead, the nurse must assess the issues as discussed in this packet. All care planning will be done on the flow sheet.

2. Falls (PCR- Falls Reduction Program)
   Assessment will be done every shift instead of daily. Nurses will choose which universal precautions are appropriate for their patient. (Ex: Red socks as appropriate) Nurses will choose the method of communicating which patients are identified as a fall risks. (Are falling stars, red socks, or the huddle more effective in your unit?)

   **Immobile patients are not considered at risk for falls.**
The following issues must be addressed according to UCI Policy or circumstances described below

1. **Psychosocial**
   *Required for all patients*: Identify readiness to learn. If barriers are present, develop a plan to help overcome barriers. If at the end of the shift, the patient was able to learn with sufficient comprehension, check “goal met”. If the patient is sedated, and no family is available, please document this in the evaluative statement and check goal “not met”. Any other psychosocial issues should be addressed here. (example: Anxiety, spiritual distress, ineffective coping, suicide risk)

2. **Infection Prevention**
   All patients in isolation, all patients with invasive lines/tubes, all patients with surgical incisions, and patients with known infection must have a plan of care and documented teaching. *Every patient must be given educational material “Infection Preventions Practices”*. See Supplemental Acute Care Teaching plan for the required teaching topics.

3. **Pain (Pain Policy. Adult Pediatric)**
   A plan of care must be initiated for any patient with complaints of persistent or unrelieved pain.

4. **Restraints ( PCR- Restraint and Seclusion)**
   If your patient is in restraints, you must assess whether or not less restrictive means will be successful in preventing the reason for restraints. A plan of care must be initiated for any patient in restraints. Patients requiring behavioral restraints require further documentation and time limited orders as noted in policy.

5. **Falls ( PCR- Falls Reduction Program)**
   *Assessment required for all patients*: All patients will be assessed for risk of falls every shift, or more frequently if condition changes. Patients at risk must have a plan of care and teaching on the risk of falls.

6. **Risk for Impaired skin integrity**
   *Assessment required for all patients*: The Braden scale must be completed for all patients every 24 hours. All patients must be assessed for presence of ulcers, skin tears, burns, etc. Either check impaired skin integrity or check skin intact based on your assessment. Impaired Skin Integrity N/A (skin intact).
   All patients with a Braden scale ≤ 18 must have a care plan for “Risk for impaired skin integrity”. All patients with impaired skin integrity must have an “Impaired skin integrity” care plan as well as a “Risk for Impaired skin integrity “care plan.

7. **Physiological/Functional Issues:**
   * Required, based on individualized needs of the patient. The nurse utilizes assessment data to determine key issues, and develops a plan of care necessary to promote health and a safe environment.
   Example- Patient with a bowel obstruction should have a Nutrition/Elimination plan of care.
1. **Assessment.** Collect comprehensive data pertinent to the patient’s health or situation. Chart your assessment.

2. **Analyze your assessment data to identify your patient’s key issues.** Check the square of the identified issue, or check N/A. 
   
   N/A = interventions not indicated. (The patient is already at goal, at baseline, or the issue is not assessed to be a priority.)

3. **Derive expected outcomes by choosing a goal(s)** that is already listed, or write in a goal. Involve the patient, family, and other healthcare providers in formulating goals when possible and appropriate. Develop expected outcomes that provide direction for continuity of care.

4. **Develop an individualized plan** that includes strategies to attain expected outcomes. Develop the plan in conjunction with the patient, family and others, as appropriate. You may choose interventions listed, and/or write in interventions to individualize the plan.

5. **Implement the identified plan** in a safe and timely manner. Coordinate implementation of the plan with the multidisciplinary health care team. Use health promotion and health teaching methods appropriate to the situation and the patient’s developmental level, learning needs, readiness, ability to learn, language preference, and culture. You may also document your teaching on the Supplemental Teaching Plan. Daily teaching should be documented on the care plan. One time or mandatory topics/handouts should be documented on the supplemental teaching plan.

6. **Evaluate** the effectiveness of the planned interventions in relation to patient responses and the attainment of the expected outcomes/goals. Note weather goal was met or not met.

   **Unless noted in your evaluation or nursing notes, you are stating that all planned interventions were completed, and the patient/family received teaching with sufficient comprehension during your shift.**

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**Steps 1 through 4 should be done at the beginning of the shift. Step 5 should be implemented throughout the shift. Step 6 should be done near the end of the shift.**
Putting it all together

Example:
1) Assessment of the patient: Assessed at Risk for Falls,
2) Identify as key issue
3) Goal: prevent fall
4) Develop Plan
5) Throughout the day, educate the patient and family on the risk of falls, perform safety rounds q 2 hrs, encourage the family to stay with the patient, offer toileting with rounds, keep bed low and locked, side rails up and keep the room clear of trip hazards.
6) Evaluate the effectiveness of the plan and attainment of the expected goal.

End of Shift Evaluation

If the goal was met and you completed all your planned interventions, you do not need to chart anything but Goal Met. You may choose to include an evaluative statement. If the goal was not met, and/or any one of the planned interventions was not completed, then you must write an evaluative statement and/or write a note in the “Nurses Notes” section on the flow sheet. If your plan was not effective and you wish to propose a revision to the plan, check the appropriate box and communicate the proposed revision to the next shift. An overall progress note stating how the patient is doing should be written in the “Nurses Notes”.

End of shift Progress Note: The most effective way of communicating how the patient did during your shift.
Documenting Patient/Family Teaching

There are 2 places to document your patient teaching

1. Care plan
   Most of your teaching may be documented on the back of the flow sheet as part of the plan of care. Please state your method of teaching in your plan and any additional resources utilized to assist the patient in learning.

   - Circle which is appropriate - patient/family or both
   - Explain plan of care to wife and daughter. Continue to try to orient patient to situation with frequent reminders and explanations.

2. Supplemental Acute Care Teaching Plan
   Required teaching topics (ex. infection prevention, diabetes, stroke, ostomy care, anticoagulation, medications, CHF, discharge care) are found on the “Supplemental Acute Care Teaching Plan.” Patient educational material and on demand TV topics that are available for the patient are listed on the plan.

   By dating and signing the supplemental acute care teaching plan you are stating: The patient or family received the education with sufficient comprehension. Do not sign the form if the patient or family is unable to sufficiently comprehend the information. At discharge or transfer, utilize the “Notes” section at the back of the Supplemental Acute Care teaching plan to address any reasons why required topics were not able to be taught with sufficient comprehension.

   Please familiarize yourself with the topics included on the flow sheet and on the supplemental teaching plan.

   You may still utilize the teaching plans in the computer, if they help guide your teaching, but it is not required.
Supplemental Acute Care Teaching Plan

- Infection Prevention teaching should start on admission with General Infection Prevention education to all patients. (Hand Hygiene, speaking up, Respiratory Hygiene/Flu Visiting when well)
- Education for indwelling lines/tubes is to be given before the procedure, or as soon as possible, if not able to educate prior to the procedure. This includes infection prevention education regarding central line placement (CLABSI prevention), surgical site infection prevention, prevention of VAP, and Foley related UTI.
- MDRO/ C. difficile education is to be given upon diagnosis and again at discharge regarding homecare instructions.
- Education should be provided upon implementation of isolation precautions.

Locating Approved Patient Education materials:

- Infection Prevention Practices
- Utilize Approved Patient Education handouts found on SharePoint, “Patient Health Education”
- Any Patient who has a central line, Foley, or ventilator should be given a FAQ sheet found on SharePoint
- Give to all patients going to surgery

The teaching plan shows which FAQ sheets, on demand TV topics or patient education material is available.

Locate "Infection Prevention Practices" approved patient education, Print a copy and turn in to your supervisor with your completed care plan.

Notice the topics available on the SharePoint Patient Health Education site in English and in Spanish.
**Chart Education**

**Material given to the patient**

Circle which one’s apply to the patient

**Required Stroke Education.**

**Discharge Education:**
- Reconciled list of medications explained to patient

**On Demand TV topics available in English and Spanish**

**Required anticoagulation education**

**Chart care notes given to the patient**

**Chart Education Material given to the patient**

**Required Heart failure Education**

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### Neurological:

**Stroke**
- Stroke management and typical progression in the hospital setting
- Verbalizes Warning signs of stroke
  - Sudden numbness or weakness of face, arm or leg, especially on one side of the body
  - Sudden confusion, trouble speaking or understanding
  - Sudden trouble seeing in one or both eyes
  - Sudden trouble walking, dizziness, loss of balance or coordination
  - Sudden, severe headache with no known cause
- Verbalizes understanding of Personal Risk Factors
  - HTN, Cigarette smoking, Heart disease, Diabetes, TIA, High cholesterol
- Verbalizes understanding that stroke is an emergency and need to call 9-1-1 if stroke is suspected
- Verbalizes understanding that t/ u care is needed after discharge

**Provided Patient Education Material**
- Stroke Care Notes
- Self care measures after a stroke Care Note

**Viewed on demand TV topic:**
- Stroke

### Cardiovascular/Tissue Perfusion

**Viewed On Demand TV Topic:**
- “Heart Failure”
- “Hypertension”
- “Cardiovascular Nutrition”

**Provided Patient Education Material:**
- Heart Failure Guide to Hospital Care
- Cardiology Discharge Instructions (Clinical Pathway Site)
- CABG Care Notes (Inpatient Care)
- Valve Replacement Care Notes
Utilize the following SBAR report on patient Peter Piper to chart your mock care plan and teaching plan on the samples provided in this packet. Assume your assessment of this patient is the same as the SBAR report. Following the nursing process, derive the priority issues for this patient and develop an individualized plan of care. Document the teaching that should be done on this patient on the care plan and on the supplemental Acute Care Teaching Plan. There are 6 steps in planning and evaluating your plan of care.

For now, follow steps 1-5. (Refer to page 3)
### SBAR Patient Report Guidelines: Acute Care

#### Situation
- Patient’s name, gender: Peter Piper, male
- Age 75
- Daily weight: 85 kg
- Admitting Diagnosis: CVA, hx of DVTs
- Admit Date: 6/30/10
- Primary Medical Team/Attending: Medicine
- Primary Resident: Joe Jones Primary RN: Sally
- Legal status: Full Code

#### Safety
- Fall Risk: Yes  No Fall Protocol in place:  
  - Isolation:  Yes  No  Type:  
  - Restraints: Yes  No  Type: Bilateral wrist
  - Attempting to pull kofeed tube:
    - 1:1 Sitter  Yes  No  Type:  

#### Perioperative/Periprocedural Care
- Last OR/Procedure date/type: n/a
- Scheduled OR/Procedure: n/a
- Preop list complete: n/a

#### Background
- History (pertinent to this hospitalization):
  - Diabetes, Renal Insufficiency, Ischemic Stroke
  - Allergies
  - NKDA
- Date of Last Hospitalization: 10/08 TIA
  - Culture, Language, Family: English speaking, wife and daughter stay at bedside most of the time
  - Developmental issues: None
  - Spiritual needs: Chaplain coming by to see patient
  - Barriers to Learning: Confused and agitated
  - Location of patient belongings: has eye glasses and dentures at bedside

#### Assessment: (Current Status)

##### Current Vital Signs:
- BP: 140/80  HR: SR 84
- RR: 20  Pulse Oximetry: 95%
- Temp: 36.5
- Fever Treatment: n/a
- Type of temperature regulation: n/a

##### Promotion of Comfort
- Nonpharmacological pain management: none
- Baseline pain scale score: denies c/o pain
- Pain Management: none
- Sleep/rest pattern: not sleeping well, restless and agitated

##### Psychological Comfort
- Coping assistance: wife and dtr at bedside
- Anxiety reduction techniques: enc. family to stay at bedside, music, massage

##### Medication Management
- IV access/IV fluids: D5 1/2NS at 50cc/hr
- Last PRN Medication(s): ativan 0.5 mg at 0600
- Recent changes in medication regimen: None

##### Respiratory
- Airway type: spontaneous
- Suctioning needs: n/a
- Lungs Clear
  - Oxygen amt./ventilator settings: R/A
  - Acid-base status: n/a
  - Respiratory monitoring: none

##### GI/Nutrition
- Diet orders: Just started Jevity at 20cc/hr. advance as tolerated /Goals Met  Y N  failed swallow eval. NPO
- Last BM: incontinent of stool x 2. Soft, brown
- Constipation/Diarrhea management: none
- Ostomy type/care: none
- Other tube/lines/drains: Kofeed L nare at 70 cm

##### GU
- Urinary/bowel Tubes: foley Date inserted: 6/30
  - Bladder/Bowel Training: Yes  No
  - Hemodialysis/CRRT: n/a Urine Output: 40cc/hr

##### Electrolyte/Acid-Base Management
- Blood Glucose monitoring/management: insulin sliding scale
  - Last BS: 180
- Electrolyte management: KCL 40 meq IVBP at 0700
**Vasoactive drips:** n/a  
**Neurological**  
- Baseline mental status: confused and agitated. Oriented to person only. MAE, follows commands. L sided weakness  
- Type of Neurological monitoring: q 4 hrs  
- Seizure management/precautions: n/a  
**Cardiovascular/Tissue Perfusion**  
- Telemetry: Yes No Rhythm:  
- Blood products: n/a  
- VTE prophylaxis (type): heparin sq  
- Hemodynamic monitoring: n/a  
**Skin/Wound**  
- Wound type & management: pressure ulcer to coccyx Stage: II  
- Pressure Ulcer High Risk: Yes No  
- Pressure Ulcers: Actual Yes No  
**Immobility**  
- Specialty bed: low air low  
- Cast/Splint or type of immobilization device: n/a  
- Care R/T immobilization devices: n/a  
- Weight bearing:  
- Devices: (FWW/W-C/Commode)  
**Activity & Exercise**  
- Activity orders/nursing care: OOB to chair x 2 person assist  
- OT PT ST  
**Facilitation of Self-Care**  
- Total care  
**Recommendation (Plan for continuing care):**  
Highest priority nursing problems/goals:  
1) Risk for falls- prevent fall, enc. family to stay at bedside  
2) Restraints- successfully administer treatment  
3) Neurological/ goal- speech clear and appropriate- facilitate day/night sleep schedule, reorient frequently, enc. use of eye glasses  
4) Nutrition/ Elimination- Advance TF to goal/tolerate TF, maintain BS 110-150,  
5) Skin- prevent further breakdown  
- Teaching Plans Implemented: Risk for falls, purpose of restraints, frequent reorientation, NPO, use of TF,  
- Orders not yet implemented: stat Coumadin 5mg  
- Expected date of Discharge: 7/10  
- Labs, tests, procedures for follow-up:  
- Date/Time & content of Last Communication with family: here all shift  
- Referrals needed: Speech therapy for improved swallowing  
- Additional Questions/Comments:  

**Assessment continued**
Once you have completed steps 1-5, go back and do an end of shift evaluation.

**End of Shift Evaluation (Use the following information to complete step 6)**

**Peter Piper**  
Fall Risk  
Bilateral Wrist Restraints

**Vital signs BP 136/72**  
**SR 76**  
**RR 16 96% on RA**  
**Temp 98.6**

**No complaints of Pain**

**Psychological Comfort:** has been able to rest comfortably today.  
Wife and daughter at bedside  
IV fluids **TKO**

**Neuro:** Oriented to person and place but still forgetful.  
Continues to need frequent orientation. He continues to require restraints as he attempts to pull keofeed tube. MAE, L sided weakness

**Cardiac:** 136/72, SR 76  
**Respiratory** RA, lungs clear  
**GI** - TF at goal. Remains NPO. Incontinent of stool x 1.  
**GU**- Foley dc’d  
**BS** – insulin sliding scale- last BS 145  
**Skin**- stage II to coccyx

**Activity** OOB to chair x 2 today with 2 person assist. Able to bear weight

**Facilitation of Self Care:** Able to brush own teeth and hair today.

Once you have completed your mock care plan and teaching plan, compare it to the sample provided and evaluate your plan.

1. Were you able to identify the patient’s key issues? If not, which ones did you miss and why?

2. Did you choose realistic, attainable goals?

3. Did you individualize your plan?

4. Did you document teaching in the appropriate places? (On the care plan and on the supplemental teaching plan?)

5. Did you evaluate the plan effectively

6. Were you able to locate and print “infection prevention practices”?