Plan of Care
INTEGRITY AUDIT TOOL

What is the Plan of Care?

The Plan of Care lays out the needs and goals of the patient and family based on information identified in the initial and ongoing assessment.

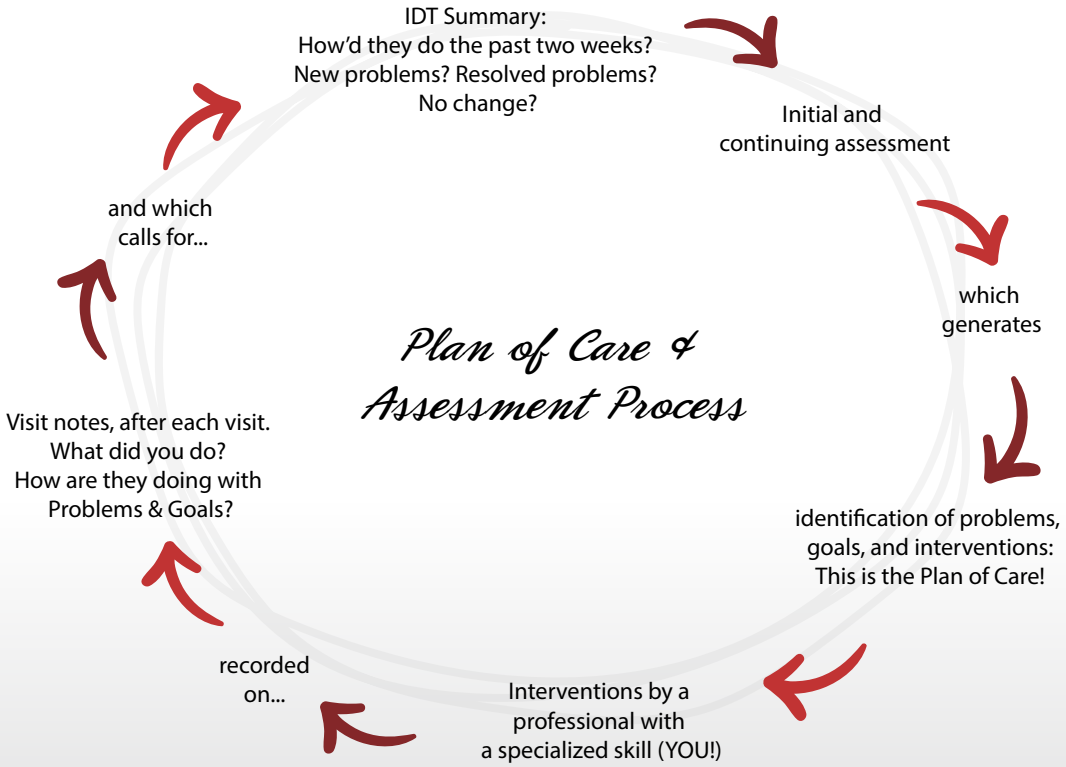
Based on those goals, the hospice team determines what professional interventions will help meet those goals.

They record those interventions, along with the patient and family's response, in their progress notes and assessment updates. Ideally, they also capture metrics (like a pain rating) to quantify the progress (or lack of).

So...

- If something is in the assessment, it should be included on the Plan of Care.
- If a team member is addressing something in a visit note, it should be an issue on the Plan of Care.
- If a problem is identified on the Plan of Care, it should also have been described in an assessment.
- If the Plan says 2-3 visits a week, there should be 2-3 visits that week.

It's all connected!



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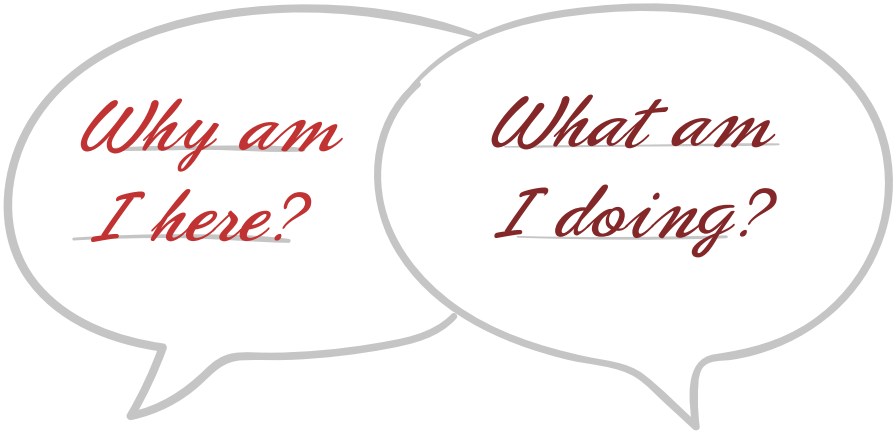
Self-Check
PROCESS FOR CLINICIANS

Front Door Self-Check

Before knocking on the door for your visit, ask yourself:



Your answer should be to address and assess a Problem from the Plan of Care and help the patient meet a Goal.

Your response should be that you are doing an Intervention that requires the services of your specific professional discipline.

If the answers to the above questions do not reflect that there is Problem, Goal or Intervention requiring attention and documented on the Plan of Care, ask yourself:

Were you there to address or assess a Problem not listed on the Plan of Care?
If so, change the Plan of Care.

Were you there only for a social visit?
If so, add a volunteer to the Plan of Care.

Is there another team member that would better serve the need?
If so, change the Plan of Care.

Has the Problem requiring your discipline resolved?
If so, change the Plan of Care.

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Self-Check
PROCESS FOR CLINICIANS

Charting Self-Check

As you take a few minutes to document your visit, ask yourself:

Am I about to write about a Problem documented on the Plan of Care?

If not, what are you writing about? *If it is a new Problem, add it to the Plan of Care.*

If not, is there someone else that should be here? *Am I documenting the addition of that Hospice Team member?*

Regarding the Problem, am I about to document an Intervention that requires the unique skills of my profession?

Did I notice anything new that requires the attention of my Hospice Team?

If so, communicate that, document the communication *and update the Plan of Care.*

This may have been a social visit. *Consider changing the visit frequency and/or Plan of Care.*

None of the above?

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Audit Tool DIRECTIONS

The tool can work forward from the Assessment, backward from the Visit Notes, or from the middle starting with the Plan of Care. The audit should reflect that anything that appears in one column appears in all columns. If not, the Care Planning process may have broken down.

Sample Positive Entries

Assessments (initial and/or ongoing)	Plan of Care (Problems and Goals) including Frequency	Visit Notes (Interventions)	Care Plan Integrity?
6/1 Stage 2 wound on left heel noted	6/1 Wound Care problem does appear on the Plan of Care, 2x a week	6/1 through present: Wound Care is documented 2x weekly in visit notes	Yes!
7/15: Updated social work assessment notes document that caregiver leaves patient tied to a chair while he is at work	7/15: Problem added under "Safety"	7/15-7/20: SW notes indicate suspected elder neglect addressed with report to Department of Elder Affairs & visit from same agency; placement in ALF follows	Yes!
6/5 to present Pain identified in all assessments	6/5: Visit frequency by Nurse to address pain is set and remains unchanged at 2x weekly	6/5 to present Notes address pain intervention, and visits occur 2x weekly	Yes!

Sample Negative Entries

Assessments (initial and/or ongoing)	Plan of Care (Problems and Goals) including Frequency	Visit Notes (Interventions)	Care Plan Integrity?
7/2: No chaplain requested, no spiritual or religious issues identified on initial comp assessment	7/2: Spiritual Care is nonetheless identified on the Plan of Care	7/2 to present Visit notes reflect 2 chaplain visits monthly	No! Follow up with patient and family regarding goals of care and adjust Plan of Care accordingly
6/2: Initial Assessment indicates there are no advance directives	8/1: No problem on the Plan of Care	6/2 to present: Visit notes do not reflect that any discussion regarding advance directives have taken place	No! Send appropriate team member to address with family and document outcome and update Plan of Care if there is a goals to execute Advance Directives
5/30: Respiratory Therapy ordered at the times of admission 1x weekly	6/30: No problem on the Plan of Care	5/30 to present: Visit notes reflect increased difficulty breathing	No! Dispatch RN to meet patient and family goals and update Plan

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Plan of Care
MEDICAL RECORD AUDIT (PATIENT)

Medical Record # and Start of Care	Date of Audit	Audit Results:

Assessments (initial and/or ongoing)	Plan of Care (Problems and Goals) including Frequency	Visit Notes (Interventions)	Care Plan Integrity?

Name of Auditor:

Notes/Action Plan:

Clinician Care
PLANNING AUDIT

Clinician Name	Date of Audit	Audit Results:

MR#	Assessments (initial and/or ongoing)	Plan of Care (Problems and Goals) including Frequency	Visit Notes (Interventions)	Care Plan Integrity?

Name of Auditor:

Notes/Action Plan: