

Institutional Handbook of Operating Procedures Policy 09.13.08	
Section: Clinical Policies	Responsible Vice President: Executive Vice President – UTMB Health System
Subject: General Policies	Responsible Entity: Nursing Services

I. Title

Interdisciplinary Plan of Care

II. Policy

Inpatients will have a plan of care initiated within twenty-four (24) hours of admission. The plan of care includes:

1. Provider orders
2. Provider’s history and physical
3. Notes (progress, consult, etc.)
4. [Conditional documentation](#)
5. [Best Practice Advisories](#)
6. Plan of Care (IPOC) forms (or EHR) with individualized care plan documented
7. Other appropriate documents that relate the plan of care to the interdisciplinary team

The development, implementation, and maintenance of a patient's plan of care is an interdisciplinary process. All disciplines involved in the care of a patient collaborate to develop the patient's plan of care. Each healthcare team member provides input into the plan of care. The patient/family/significant other is included in the development, implementation, maintenance, planning, and evaluation of the care provided.

Patients receive care and treatment based on an assessment of their needs, the severity of their disease, condition, impairment, or disability. The data obtained from the assessment is used to determine and prioritize the patient’s plan for care.

The patient's progress will be evaluated as necessary and the plan of care will be revised as indicated.

An interdisciplinary plan of care will be documented for all patients. Elements of the plan of care are found throughout the patient’s record.

The patient goals and plan of action are updated by the individual who identified the problem, or by other healthcare team members according to their expertise and credentials. Multiple healthcare team members may have input to and document on, a plan of action for any health care concern.

UTMB respects the diverse cultural needs, preferences, and expectations of the patients and families it serves to the extent reasonably possible while appropriately managing available resources and without compromising the quality of health care delivered.

III. Required Documentation

- A. A patient problem is included in the plan of care when actual clinical, behavioral, educational and/ or social issue(s), or the risk of those issue(s) are preventing the patient from transitioning to the next level of care.

- B. Documentation for the plan of care will include a minimum of:
Patient problems
 - 1. Patient goals
 - 2. Plan of action
 - 3. Date plan initiated
 - 4. Date plan revised
 - 5. Date plan completed or discontinued
 - 6. Discharge planning

IV. Other Care Planning Considerations

If the admission assessment and screening identifies the need for a referral, a healthcare provider will initiate a consult. An in-depth assessment will be completed by the appropriate discipline within the scope of their credentials. The consult will become a part of the permanent medical record.

Patient/family/significant other healthcare learning needs and associated educational plan will be documented.

V.

<i>Originated: 09/25/1997</i>	
<i>Reviewed with Changes</i>	<i>Reviewed without Changes</i>
06/20/2014	12/19/2003
2/18/2016	03/05/2019

VI. Contact Information

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