HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Provision of Care		
Document:	Multidisciplinary Policy and Procedure		
Title:	Patient's Plan of Care		
Applies To:	All Healthcare Provider		
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1. PURPOSE:

1.1 Individualized set of actions that the assigned health care team will implement to resolve or support the diagnosis identified by each patient's assessment, provide proper treatment and achieve optimal clinical outcomes.

1.2 Proper communication and documentation of each patient's plan of care by the assigned multidisciplinary healthcare teams in the patient's medical record to facilitate the integration and coordination of care.

2. DEFINITIONS:

2.1 **Plan of Care (Care Plan)** – a treatment plan especially designed for each patient, based on individual strengths and needs. The caregivers develop the plan with input from the family and communication with each other. The plan establishes goals and details appropriate treatment and services to meet the special needs of the patient. The planning is an interdisciplinary process.

2.2 **Measurable Goals** – are observable, achievable targets related to each patient care and expected clinical outcomes. They should be realistic, specific to the patient and time based to provide a means for measuring progress and outcomes related to the plan of care.

3. POLICY:

3.1 The MRP (most responsible physician) develops a comprehensive, individualized plan of care for each patient, in collaboration with the required multidisciplinary healthcare professionals and the family, within the first 24 hours of admission. It is based on the initial assessment data and identified needs and aims to meet all patients' needs.

3.2 The plan of care is completed and documented in the patient's medical record within 24 hours of admission and whenever there is a change in patient condition or earlier based on the patient's condition and needs (nursing plan of care is completed whenever possible before the end of the shift).

3.3 The patient and family are involved in developing the plan of care and are educated on how to follow the plan of care prescribed by their providers.

3.4 The plan of care contains the measurable goals/ desired outcomes towards discharge.

3.5 The plan of care should include a provisional date of discharge set within 24 hours of admission.

3.6 The planning process is collaborative and uses the data from the initial assessment and from periodic reassessments performed by physicians, nurses and other healthcare practitioners to identify and to prioritize the treatments, procedure, nursing and other healthcare professionals care to meet the patient's needs and improve outcome.

3.7 MRP reviews the plan of care on a daily basis. He/ she modify it as appropriate upon any significant change in the patient's condition or when new treatments are added or discontinued. He/ she coordinates, when required, for additional plans of other healthcare providers and approves and follows up the implementation of the plan of care as set by other consulted physicians.

4. PROCEDURE:

4.1 On admission, the assigned consultant in collaboration with the specialist, resident and nursing staff will perform initial assessment of the patient including complete history, physical examination, nutritional, socioeconomic and rehabilitation status and other needs.

4.2 These data, in addition to results of laboratory and imaging diagnostic tests are used to establish a comprehensive information base for developing the individualized multidisciplinary plan of care for each patient within a maximum of 24 hours upon admission or earlier according to patient's needs.

4.3 The multidisciplinary plan of care is developed in coordination with other required relevant healthcare professionals e.g. dietician, pharmacist, social worker, physiotherapist and consultants from other services.

4.4 Consultations to other required services are communicated.

4.5 The physician care plan will be the nucleus for other disciplines care plans as nurses, respiratory therapists, physiotherapists, dieticians, social workers and others.

4.6 The assigned physician will communicate the plan with the assigned nursing staff and other involved healthcare professionals.

4.7 Physician care plan includes:

- 4.7.1 Diagnosis
- 4.7.2 Expected length of stay
- 4.7.3 Main lines of treatment, services and interventions needed to provide to the patient e.g.
  - 4.7.3.1 Surgery
  - 4.7.3.2 Diagnostic procedures: laboratory and/ or radiological tests, lumbar puncture
  - 4.7.3.3 Therapeutic procedures: blood transfusion, physiotherapy, dietary regimens etc.
  - 4.7.3.4 Protective or preventive procedures e.g. restraint, need of isolation
  - 4.7.3.5 Identify and establish measurable goals that can be selected by the responsible physician in collaboration with the nurse and other healthcare practitioners.
    - 4.7.3.5.1 Measurable goals should be realistic, observable, achievable targets related to patient care and expected clinical outcomes
    - 4.7.3.5.2 They should be specific to the patient and time bounded to provide a means for measuring progress of the plan of care and outcomes e.g. readiness for discharge
    - 4.7.3.5.3 Examples of measurable, realistic goals include the following:
      - 4.7.3.5.3.1 The patient will demonstrate proper self-administration of insulin injections prior to hospital discharge.
      - 4.7.3.5.3.2 The patient will be able to walk from his bed to certain distance after specified post-operative time
      - 4.7.3.5.3.3 Wean off ventilator over certain time.
      - 4.7.3.5.3.4 Family demonstrates ability to manage infant care.

4.8 Documentation:

- 4.8.1 The assigned consultant/ his/her designee will:
  - 4.8.1.1 Document the care plan on the physician order sheet
  - 4.8.1.2 Document the treatment plan implementation, observation of the patient condition, response and outcomes in the multidisciplinary progress notes of the patient's medical record.
  - 4.8.1.3 Sign on the section of ' treating physician review' on the multidisciplinary plan of care form to indicate that he/she has reviewed the plan and goals of other members of the managing healthcare team.
- 4.8.2 Each treatment team member (physicians, nurses, nutritionists, respiratory therapists and other assigned healthcare staff) will be accountable for detailing, documenting and implementing those parts of the care plan which are in his/her domain on the patient's multidisciplinary progress notes, nurses progress notes, designated forms and on the 'Multidisciplinary Plan of Care form'. All are included in the patient's medical record.

4.9 Based on the reassessment of the patient regularly performed by the assigned health care practitioners, the plan of care is updated as appropriate to reflect the evolving condition of the patient e.g. clinical

improvement or new abnormal laboratory or radiology results, or from a sudden change in the patient's condition. E.g. loss of consciousness. The plan of care is revised based on these changes and is documented in the progress notes of the patient's medical record as notes to the initial plan, or they may result in a new plan of care.

4.10 The multidisciplinary staffs use the assessment findings for planning and delivery of education as appropriate to the plan of care.

4.11 There is a nursing plan of care developed for each patient that is:

- 4.11.1 Consistent with the medical plan of care
- 4.11.2 Reviewed on every shift, upon any significant change in the patient's condition and when new treatments are added or current treatments are discontinued
- 4.11.3 Documented in the patient's medical record.

4.12 Patients who are admitted for surgery will have:

- 4.12.1 Preoperative medical assessment and plan of care documented including history and physical examination, preoperative diagnosis, diagnostic tests, informed consent, planned procedure etc.
- 4.12.2 Post – operative plan of care written by the responsible surgeon before discharge from recovery room. It includes:
  - 4.12.2.1 Post-operative monitoring parameters and its frequency
  - 4.12.2.2 Wound care
  - 4.12.2.3 Care of drains and catheters
  - 4.12.2.4 Special patient positioning requirements
  - 4.12.2.5 Nutritional instructions
  - 4.12.2.6 When to start mobilization
  - 4.12.2.7 Special referrals (physical therapy, respiratory therapy)
  - 4.12.2.8 A new order for all required medications
  - 4.12.2.9 Any other post-operative care needed including required follow up.

5. MATERIAL AND EQUIPMENT:

5.1 Multidisciplinary Plan of Care Form
5.2 Multidisciplinary Progress Notes

6. RESPONSIBILITIES:

6.1 Assigned Consultants/ Specialists/ Residents
6.2 Assigned Nursing Staff
6.3 Assigned Respiratory Therapist
6.4 Assigned Nutritionist
6.5 Assigned Physiotherapist
6.6 Assigned Social Workers
6.7 Other Assigned Healthcare Providers.

7. APPENDICES:

7.1 Multidisciplinary Plan of Care Form

8. REFERENCES:

8.1 MCH, Directorate Of Health Affairs Holy Capital.

9. APPROVALS:

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Approved by:	Mr. Fahad Hazam AlShammari	Hospital Director		January 19, 2025

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ___/___/14___ H ___/___/20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

MULTIDISCIPLINARY PLAN OF CARE FORM

DIAGNOSIS: .....

DATE & TIME	DEPT. CODE	DISCIPLINE INITIAL/JOB NUMBER	ASSESSMENT / PATIENT NEEDS	PLAN /GOAL	INTERVENTION / ACTION PLAN	TREATING PHYSICIAN REVIEW		
						DATE and TIME REVIEWED	DATE and TIME ACHIEVED	INITIAL / JOB NUMBER

KEYWORDS: D-dietary MD-medical staff N-nursing P-pharmacy PR-patient relations PT-physiotherapy OT occupational therapy RT-respiratory therapy SS-social services

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Name:_____ الاسم:

MRN: رقم الملف الطبي:

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