

State-approved Curriculum Nurse Aide I Training Program

MODULE M The Interdisciplinary Care Plan

Student Manual 2024 Version 2.0



NC DEPARTMENT OF **HEALTH AND HUMAN SERVICES**

Division of Health Service Regulation



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North Carolina Department of Health and Human Services
Division of Health Service Regulation
North Carolina Education and Credentialing Section

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Module M - The Interdisciplinary Care Plan Definition List

Activities of daily living (ADLs) – terms used in healthcare to refer to the basic needs required to care for oneself on a day-to-day basis.

Assessment – a systematic way to collect and analyze data about a resident; the first step in delivering nursing care. Including not only physiological data, but also psychological, sociocultural, spiritual, economic, and life-style factors as well.

Delegation - the assignment of resident care activities and/or tasks to nursing personnel who are present to assist, without the registered nurse losing responsibility for the assignment; the registered nurse always retains full responsibility for the resident.

Delegatee - One who is delegated a nursing responsibility by either an Advanced Practice Registered Nurse (APRN) or a registered nurse; one must accept responsibility and display competency in performing a task. A delegatee may be an Unlicensed Assistive Personnel (UAP).

Evaluation – both the resident's status and the effectiveness of the nursing care and goal met to modify the care plan as needed.

Evidence-Based Practice – the use of research findings to guide decisions.

Implementation – nursing care conducted according to the care plan to assure continuity of care for the resident.

Interdisciplinary Care Plan - detailed plan of care created by representatives from several medical disciplines or specialties with each discipline focused on a specific resident's condition, treatment goals, and methods for improving outcomes.

Maslow's Hierarchy of Needs – a theory developed by Abraham Maslow, a researcher of human behavior, which explains the necessity of meeting an individual's physical needs before meeting psychosocial needs.

Nursing Diagnosis – the registered nurse's clinical judgment about the resident's response to actual or potential health conditions or needs.

Nursing measures – measurable and achievable short- and long-range goals set by the registered nurse based on the assessment and diagnosis of the resident.

Physiological - relating to the way in which a living organism or bodily part functions; physical.

Planning – based on the assessment and diagnosis, goals set that are measurable and achievable short- and long-range goals; data, diagnosis, and goals written in the

resident's care plan for nurses as well as other health professionals caring for the resident have access to it.

Self-Actualization - the realization or fulfillment of one's talents and potentialities, especially considered as a drive or need present in everyone.

Self-esteem - confidence in one's own worth or abilities; self-respect.

Standards of Care – a set of guidelines, methods, processes, and actions of delivering care.

Therapeutic - having a beneficial effect on the body or mind.

Unlicensed Assistive Personnel (UAP) – any unlicensed personnel who may participate in resident care activities through the delegation process. The UAP is trained to function in a supportive role, regardless of title, to whom a nursing responsibility may be delegated. This includes but is not limited to a nursing aide (NAs), patient care technicians, medication aids (MAs), and home health aides (formerly referred to as “unlicensed” assistive personnel/UAP).

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Content	Notes
<p>(S-1) Title Slide (S-2) Objectives</p> <ol style="list-style-type: none"> 1. Define and discuss Maslow's Hierarchy of Needs in the development of the Interdisciplinary Care Plan 2. Define the Interdisciplinary Care Plan and discuss its importance 3. Discuss the Role of the Nurse Aide in the interdisciplinary care plan 4. Describe Documentation of Care by the Nurse Aide 5. Describe Delegation of tasks 	
<p>(S-3) Maslow's Hierarchy of Needs (1)</p> <ul style="list-style-type: none"> • Self-Actualization • Self-Esteem • Love and Belonging • Safety and Security • Physiological Needs <p>Maslow's Hierarchy of Needs – a theory, developed by Abraham Maslow, researcher of human behavior, which explains the necessity of meeting an individual's physical needs before meeting psychosocial needs. Maslow's Hierarchy of Needs is used to assist nurses prioritize and develop a plan of care on resident-centered outcomes.</p> <ul style="list-style-type: none"> • Physical Needs: nutrition (water and food), elimination (toileting), breathing/circulation (vital signs), sleep, sex, shelter, and exercise • Safety and Security: injury prevention (call lights, hand hygiene, fall precautions, assistive devices, close observation); build trust (communication, reassurance, empathy); ensure clean, safe environment (free from harm, recognition, and alleviation of fears) and resident and family education • Love and Belonging: supportive relationships free from social isolation, therapeutic communication skills, meaningful relationships • Self-Esteem: acceptance into a community or facility, personal achievement, sense of control or empowerment, accepting one's physical appearance and mental capabilities • Self-Actualization: empowering environment, spiritual growth, ability to recognize other's point of view, reaching one's maximum potential 	
<p>(S-4) Maslow's Hierarchy of Needs (2)</p> <ul style="list-style-type: none"> • The NA is a vital link in assisting the resident to achieve individual levels of need 	

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<ul style="list-style-type: none"> • The order of importance begins at the lowest level on the hierarchy • Lower-level needs must be met before higher-level needs are met 	
<p>(S-5) The Interdisciplinary Care Plan</p> <p>The health care team has the responsibility to provide a plan of care:</p> <ul style="list-style-type: none"> • Based on the individual needs of the resident • Used for coordination and continuity of care • Used to support directives given from the doctor and other members of the healthcare team <ul style="list-style-type: none"> – The interdisciplinary care plan is sometimes simply called the Care Plan. All healthcare members involved in the care of the are represented in the care plan – The care plan outlines the individual priorities and goals established for the care of each resident – The care plan establishes the standards of care – Evidence-based research shows the interdisciplinary care plans are beneficial not only for each resident, but also for healthcare team members included in planning care 	
<p>(S-6) The Importance of the Interdisciplinary Care Plan</p> <ul style="list-style-type: none"> • The care plan is organized, individualized, and has purpose • The care plan begins on admission • The care plan guides the healthcare team members on the delivery of care • The care plan is instrumental for resident safety • The care plan determines consistent care for the resident <ul style="list-style-type: none"> – The interdisciplinary care plan identifies a nursing diagnosis (a health problem) with interventions that should be measurable by the healthcare team – The care plan is based on evidence-based practice 	
<p>(S-7) The Interdisciplinary Care Plan</p> <p>Care of the resident is a constantly changing process requiring reassessments per regulatory agencies</p> <ul style="list-style-type: none"> • Regulations regarding how to properly document resident care come from: <ul style="list-style-type: none"> – State Boards of Nursing – The American Nurses Association – The Joint Commission – Centers for Medicare and Medicaid Services (CMS) *Formerly Health Care Financing Administration (HCFA) 	

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<ul style="list-style-type: none"> Workplace policies and procedures https://www.cci-nursing.com/wp-content/uploads/2021/01/Reporting-and-Documentation-1.pdf <ul style="list-style-type: none"> In many healthcare facilities, interdisciplinary teams are an essential part of care planning. The highly structured multidisciplinary process occurs either at the resident's bedside or in a location that can accommodate representatives from the entire care team. This type of care planning increases communication effectiveness among healthcare staff by building a sense of collaboration and teamwork and crystalizing the overall picture of care each resident needs. Interdisciplinary care plans: Teamwork makes the dream work Wolters Kluwer 	
<p>(S-8) Implementation and Evaluation of the Care Plan</p> <ul style="list-style-type: none"> Requires teamwork Effective communication Accurate observations Detailed reporting <ul style="list-style-type: none"> Nursing care is implemented according to the care plan thereby providing continuity of care for the resident. How the care is implemented must be documented in the resident's record Both the resident's status and the effectiveness of the nursing care must be continuously evaluated, and the care plan modified as needed 	
<p>(S-9) The Role of the Nurse Aide</p> <ul style="list-style-type: none"> Assist the team in collecting information through interactions with the resident Encourage the resident to participate in meeting established goals Provide care determined to positively impact the well-being of the resident Report observations to help the healthcare team determine if priorities and goals are met The nurse aide assists the nurse in collecting information through interactions with the resident by obtaining accurate heights and weights, vital signs, and recording accurate intake and output <ul style="list-style-type: none"> The nurse aide supports the resident by encouraging them to participate in meeting established goals The nurse aide provides care determined by the care plan to positively impact the well-being of the resident by turning, repositioning, assisting with toileting and 	

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<p>other activities of daily living (ADLs) as defined by the care plan and as requested by the resident</p> <ul style="list-style-type: none"> – The nurse aide observations are essential to report by helping the healthcare team determine if priorities and goals are met • Accurate documentation is key to assist the nurse with evaluating interventions • Nurse relies on observations by nurse aides to assist with evaluation • Reporting of the reaction to interventions is the most important part during intervention stage is to accurately report reactions to interventions <p>If an intervention does not work, the nurse modifies the resident's interdisciplinary care plan.</p>	
<p>5-10) Documentation of Care by the Nurse Aide</p> <p>Documentation is not difficult, but it must be done properly.</p> <ul style="list-style-type: none"> • Refer to Module L Communication with the Health Care Team • Additional reminders: <ul style="list-style-type: none"> – Nurse aides need to take note of all relevant information on their residents from a resident's vital signs to their food intake. The rule of thumb is, if it is related to a resident's care, then it has to be documented – What is important to remember about resident care documentation? – Each resident has a medical chart that acts as a permanent legal record of their care – The nurse aide serves as the “eyes and ears” of the rest of the health care team. Observations help the team make the necessary changes in the resident's care plan – The information a nurse aide reports by telling the registered nurse or by writing it down affects the care residents receive – The supervisor will check the quality of documentation when completing annual performance reviews. Therefore, reporting how and what a nurse aide documents on residents demonstrate professionalism – All resident care report and documents must be kept confidential – The charting done by nurse aides is vital to resident care. Nurse aides spend a lot of time with residents 	

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and may be the first person to notice changes in a resident's condition. By documenting observations, the nurse aide helps the residents receive the best care possible.	
<p>(S-11) Documentation of Care</p> <ul style="list-style-type: none"> • Acute Care is short term immediate medical care • Home Care is services provided to a homebound individual • Long Term Care is medical and personal care to people who are unable to live independently • Special tips for documentation in Acute Care: <ul style="list-style-type: none"> – Keep in mind that patients in acute care settings tend to be quite sick. If a nurse aide is instructed to document vital signs every four hours, it is important to take vitals and document the results on time. – Remember patients in acute care can become sicker in a matter of minutes. And, as they get better, they can be discharged on short notice. It is especially important to complete your documentation in a timely fashion. • Special tips for documentation in Home Health: <ul style="list-style-type: none"> – Home health client's documentation should show the client meets requirements for reimbursement – Take extra care to keep documentation confidential, especially in the client's home and in one's car where friends or neighbors might see it • Special tips for documentation in long term care (LTC) <ul style="list-style-type: none"> – Residents of long-term care (LTC) facilities may stay for weeks, months, or even years. Some of them may need skilled care (which requires more frequent documentation). Others receive a lower level of care (which requires less frequent documentation). <p>A resident's condition may change slowly over time. Even if the resident may seem the same day after day. Do not forget to watch out for and document physical and mental changes.</p>	
<p>(S-12) Delegation of Tasks</p> <ul style="list-style-type: none"> • The registered nurse assesses knowledge and skills of the delegate and matches tasks to skills • Delegation to the nurse aide improves efficiency and shows trust <ul style="list-style-type: none"> – The registered nurse uses delegation process to assign duties and tasks – The registered nurse maintains accountability and responsibility – The registered nurse delegates on resident-by-resident basis 	

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The UAP is trained to function in a supportive role, regardless of title, to whom a nursing responsibility may be delegated.	
(S-13) The 5 Rights of Delegation <ul style="list-style-type: none"> • Right Person • Right Task • Right Circumstance • Right Directions and Communication • Right Supervision and Evaluation 	
(S-14) Responsibilities of the Nurse Aide in Delegation <ul style="list-style-type: none"> • Accept tasks based on own competence level • Maintain competence for delegated responsibility • Maintain accountability for delegated tasks <ul style="list-style-type: none"> — A nurse aide should never be afraid to ask for help — A nurse aide should always ask questions to understand the task delegated by the registered nurse — A nurse aide should always talk with the nursing supervisor regarding performing a task beyond the nurse aide's skill level <p>The task(s) registered nurses delegate should always be within the capability of the nurse aide, unlicensed assistive personnel (UAP), who will be in charge of the task for the right person, for the task and at the time of delegation. The registered nurse should be clear what the task is through the right directions and communication for the nurse aide. Nurse aides under the supervision of registered nurses will learn what their responsibilities are and what to do when they must fulfill a delegated function</p>	
(S-15) The Interdisciplinary Team <ul style="list-style-type: none"> • The resident's health and wellbeing are dependent upon the entire team. <ul style="list-style-type: none"> — Maslow's Hierarchy of Needs is designed to organize basic life priorities. The model guides caregivers on how to address physical, mental, psychological, and emotional needs — The Interdisciplinary Care Plan requires each healthcare member to collaborate in the assessment and reassessment of a resident then strive to integrate interdisciplinary documentation of needs, goals, strategies, and interventions — One of the most critical responsibilities of all health care professionals is producing proper documentation. Documentation, also called charting, is a clear and accurate method of keeping track of everything that 	

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<p>happens to each resident. It is a part of the nurse aide’s responsibilities to communicate with other team members about the resident so the team can plan for and provide the best care.</p> <ul style="list-style-type: none">— When nursing care needs to be delegated it is imperative the delegation process governed by the state is clearly understood so that it is safely, ethically, and effectively carried out.	

Handout #M12 National Guidelines for Nursing Delegation
<https://www.ncbon.com/sites/default/files/2024-01/dt-delegation-to-uap.pdf>

**Handout #M13 Decision Tree for Delegation to Unlicensed
Assistive Personnel (UAP)**
[ana-ncsbn-joint-statement-on-delegation.pdf \(nursingworld.org\)](#)