Guideline for Discussion and Documentation of IDT

SITUATION

1. Purpose of home visits i.e. wound care, teaching
2. Current diagnosis/co-morbidities
3. Caregivers-patient/family involvement, paid help
4. Home environment
5. Medication regime

Example: 68 y o female Mary Jones, being seen for CHF management, SN and PT active. Seen 3 x a week for nursing. Patient continues to gain weight, initiated CHF pathway, primary caregiver is daughter who does not live with patient, and patient has missed 2 evenings of medication from medi-planner (daughter being taught to fill medi-planner).

BACKGROUND

1. Previous level of function.
2. If hospitalized-reason for hospitalization.
3. Issues that have lead up to this episode of service i.e. falls history, previous wound treatment, medication regime.

Example: Hospitalized for CHF, weight gain and not taking meds per MD order. History of Afib and depression.

ASSESSMENT

1. Barriers to goals-key contributing factors.
2. Patient's goals.
3. Need for service and equipment.
4. Home safety evaluation.

Example: Patient wants to remain in own home. Patient is not remembering to take meds and is not following diet. It is unclear if patient understands diet, appears to need diet teaching. Assess for cognitive eval, OT eval, needs Lifeline and Telehealth. Appears to need help with personal care.

RECOMMENDATIONS

1. Refer for services/equipment/community services and resources.
2. Pathway/teaching for Patient and caregiver.

Example: Continue Pathway and medication teaching with daughter and patient. Refer for OT eval, Lifeline, Telehealth, HHA, MSW for community resources. If continues to have difficulty understanding and adhering to diet refer to dietician.

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