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Faith Community Nursing

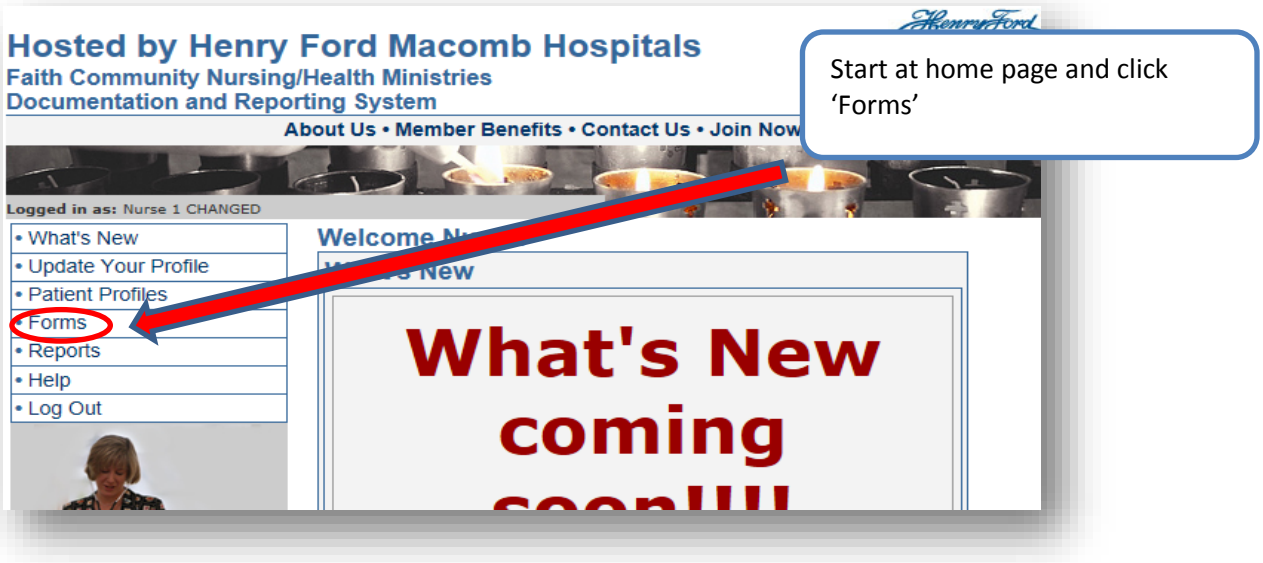
Advance Care Planning Documentation Guide

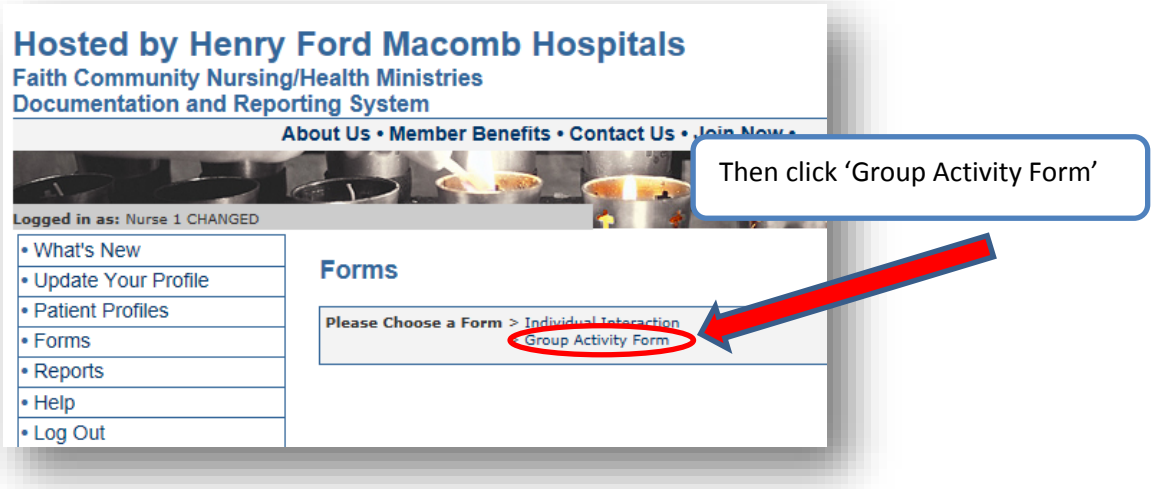
Documentation is a critical standard of professional nursing practice and Faith Community Nursing is no different. The THR Faith Community Nursing Program relies on adequate and accurate data from our covenant FCNs to determine outcomes and effectiveness of our resources.

Since the Advance Care Planning education within this toolkit can be shared in a variety of ways, this guide is provided to help you document your ACP activities appropriately.

Log in to the Henry Ford Online Documentation System at: www.fcndocumentation.com using your email address and password. Contact your THR FCN Program Coordinator if you have any difficulties logging in or need access to this system.

Part I- Entering Sessions as a Group Interaction





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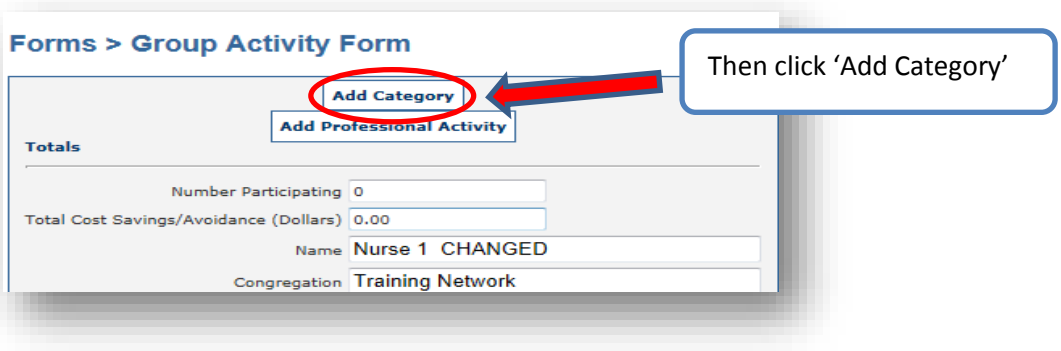

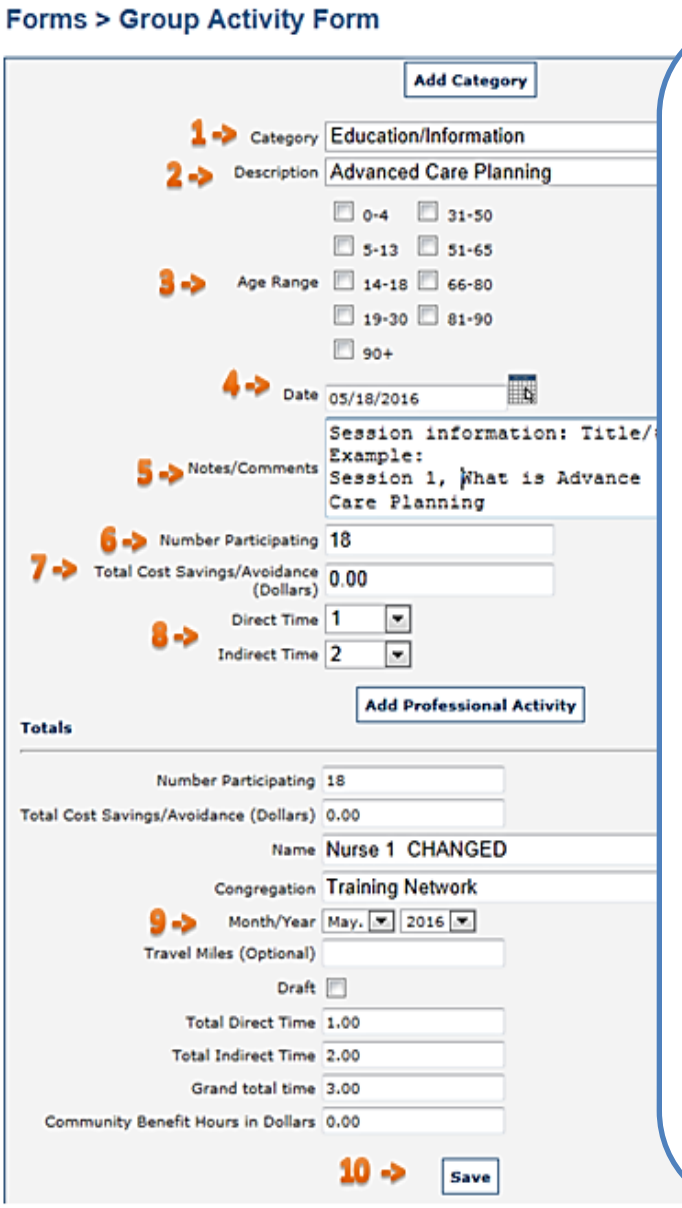

1. Click on the Category box and select 'Education/Information'

2. Click on Description box and select 'Advanced Care Planning'

3. Check the age ranges of the participants (if known-optional)

4. Enter the date of the session

5. Enter session title and number (if offering multiple sessions). Enter any other information as desired.

6. Enter # of participants

7. Cost avoidance will be 0.00 for this level of interaction (this is assessed with participant follow up)

8. Enter how long the session lasted Direct Time) and amount of time spent preparing and following up (Indirect Time)

Under Totals section at bottom:

9. Make sure the Month/Year matches the date of the event above

10. Click 'Save'

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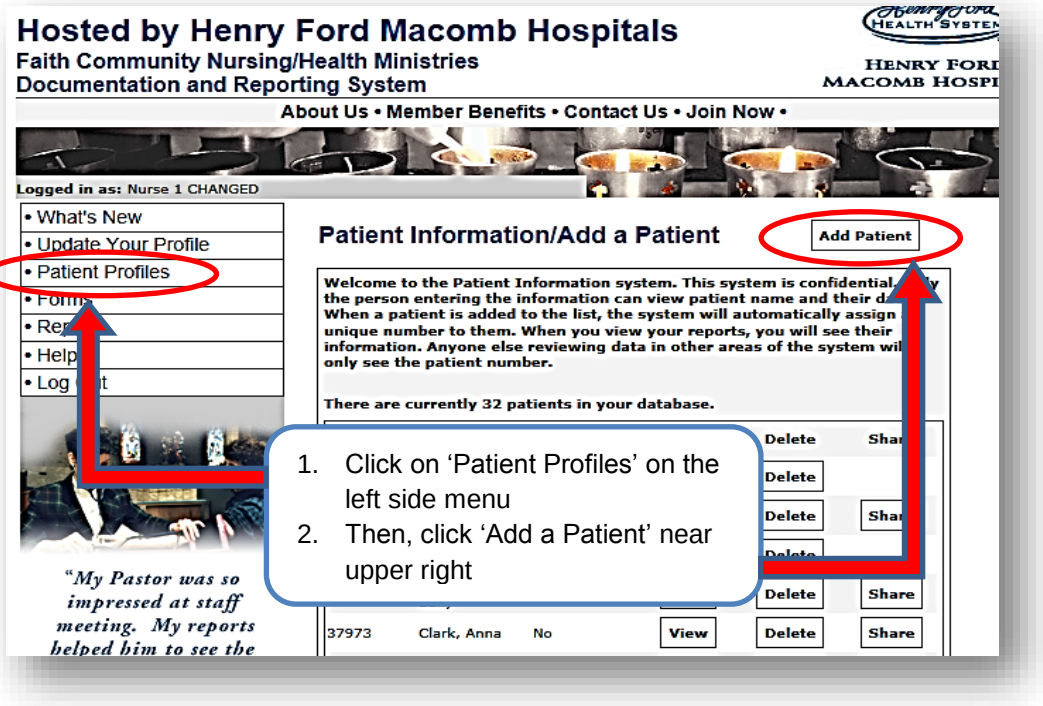
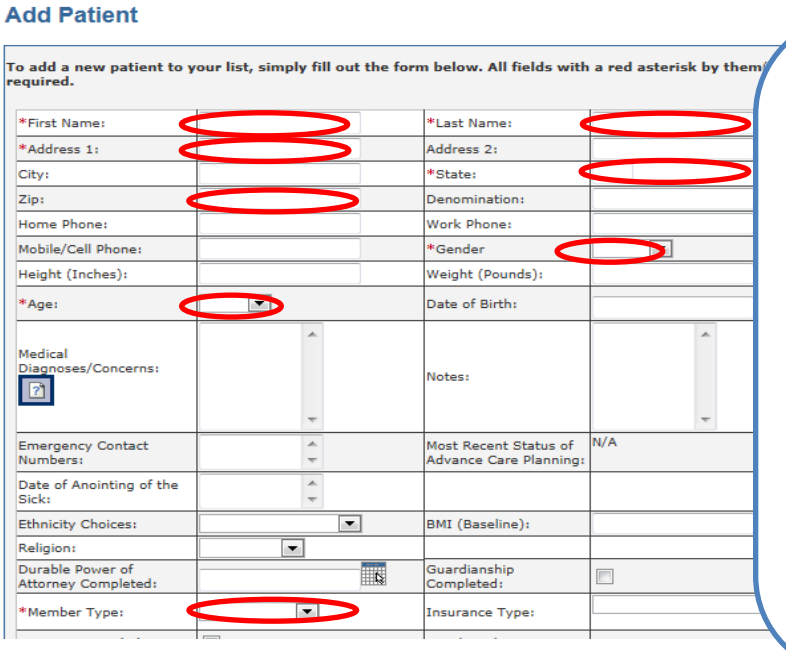
Part 2 - Individual Interaction/Follow up

(Note: the individual patient MUST be entered into your patient database *before* individual ACP documentation can be entered)

Section A – Adding a New Patient (if patient is already entered, skip to section B)





This form contains many options for patient information. You can choose how much of this patient information you want to collect and enter. Information can also be added over time. Required information is marked with red asterisk *

- First/last name
- Address/state (can use church address)
- Zip code (please use actual, not church)
- Gender
- Age range
- Member type

Then, click 'Save' at the bottom.

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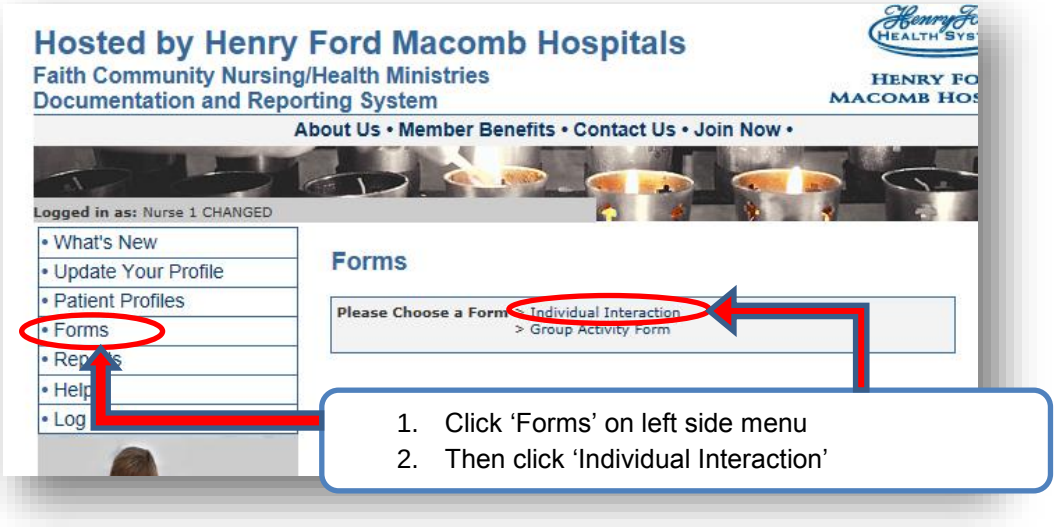
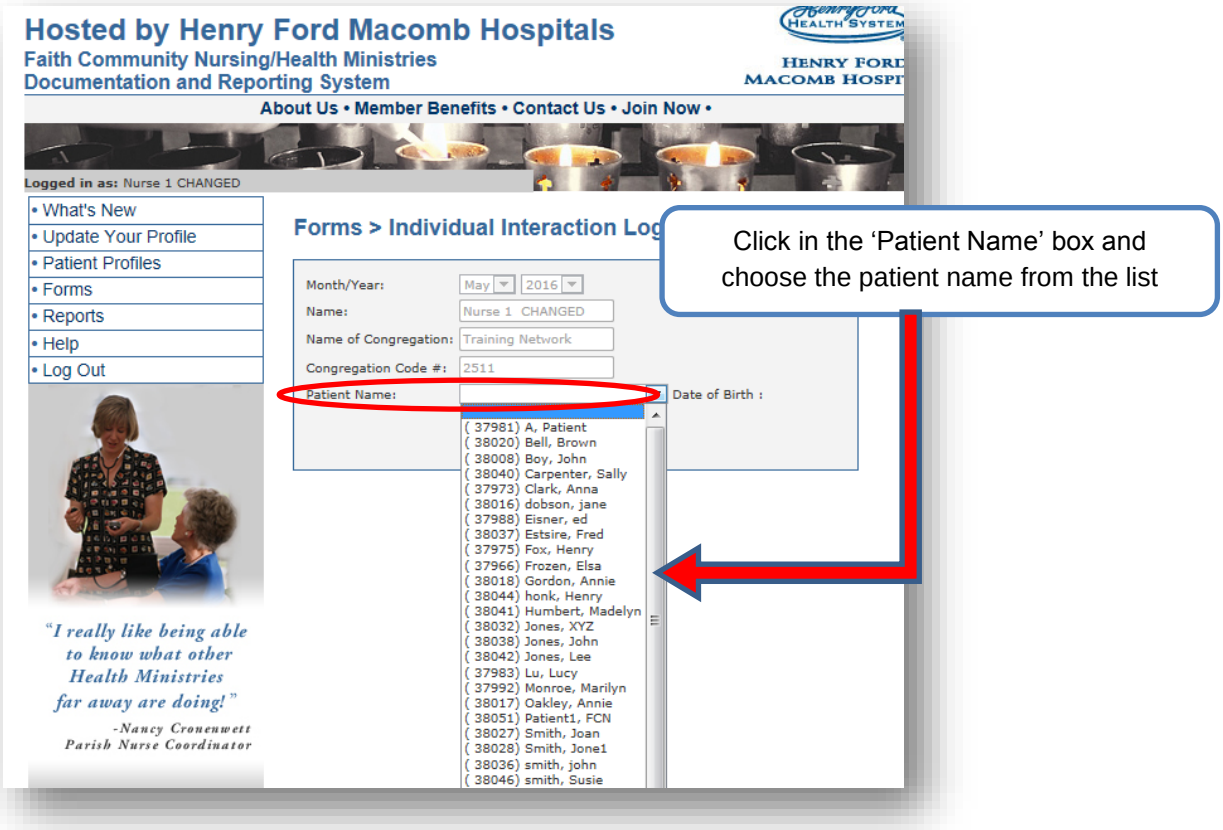
Section B – Documenting Individual Interaction/Follow up

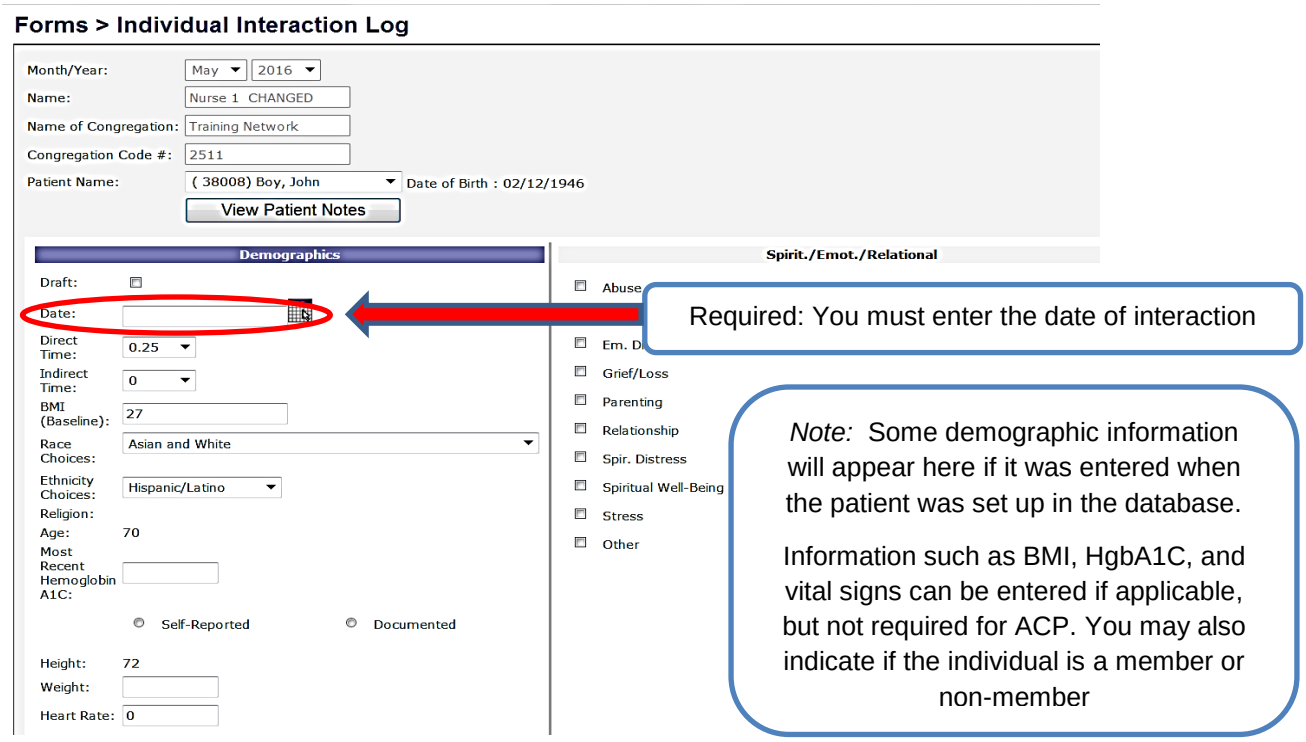


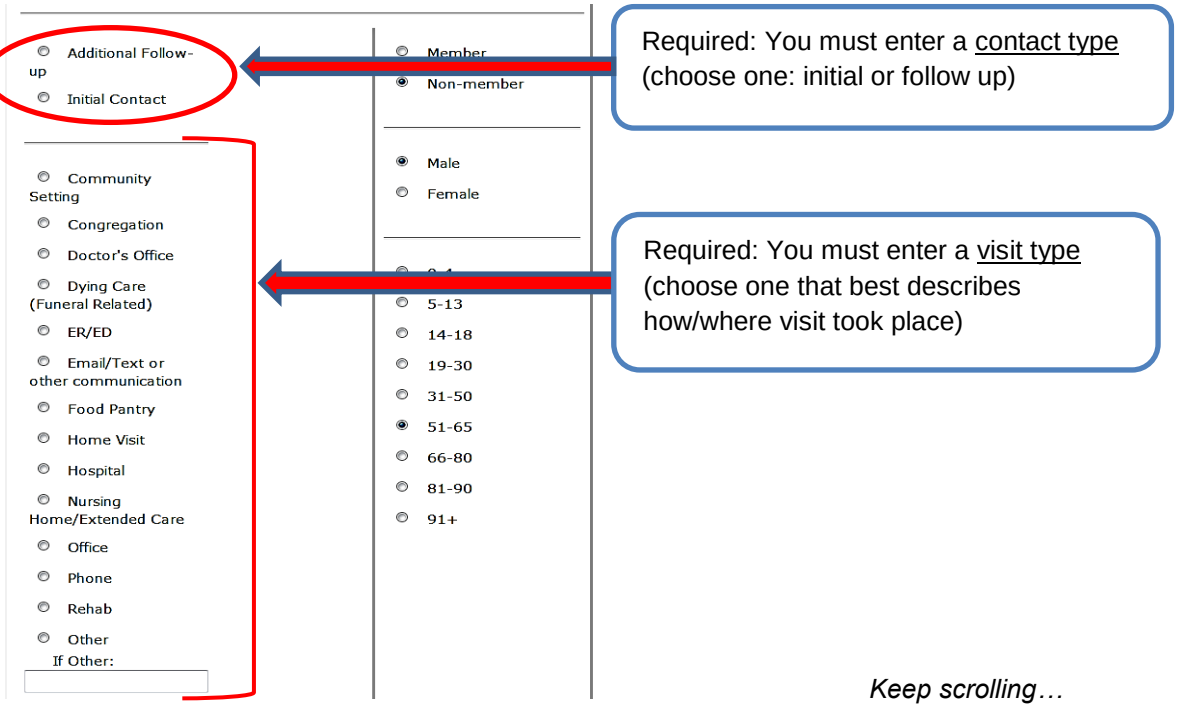


The patient interaction log contains many options for patient information.

Remember you can choose and enter the options you find applicable/beneficial. This guide will focus on what is specifically required for documenting Advance Care Planning Program on an individual basis.

The following images represent the log as it will appear on your screen as you scroll down the webpage.





Keep scrolling…

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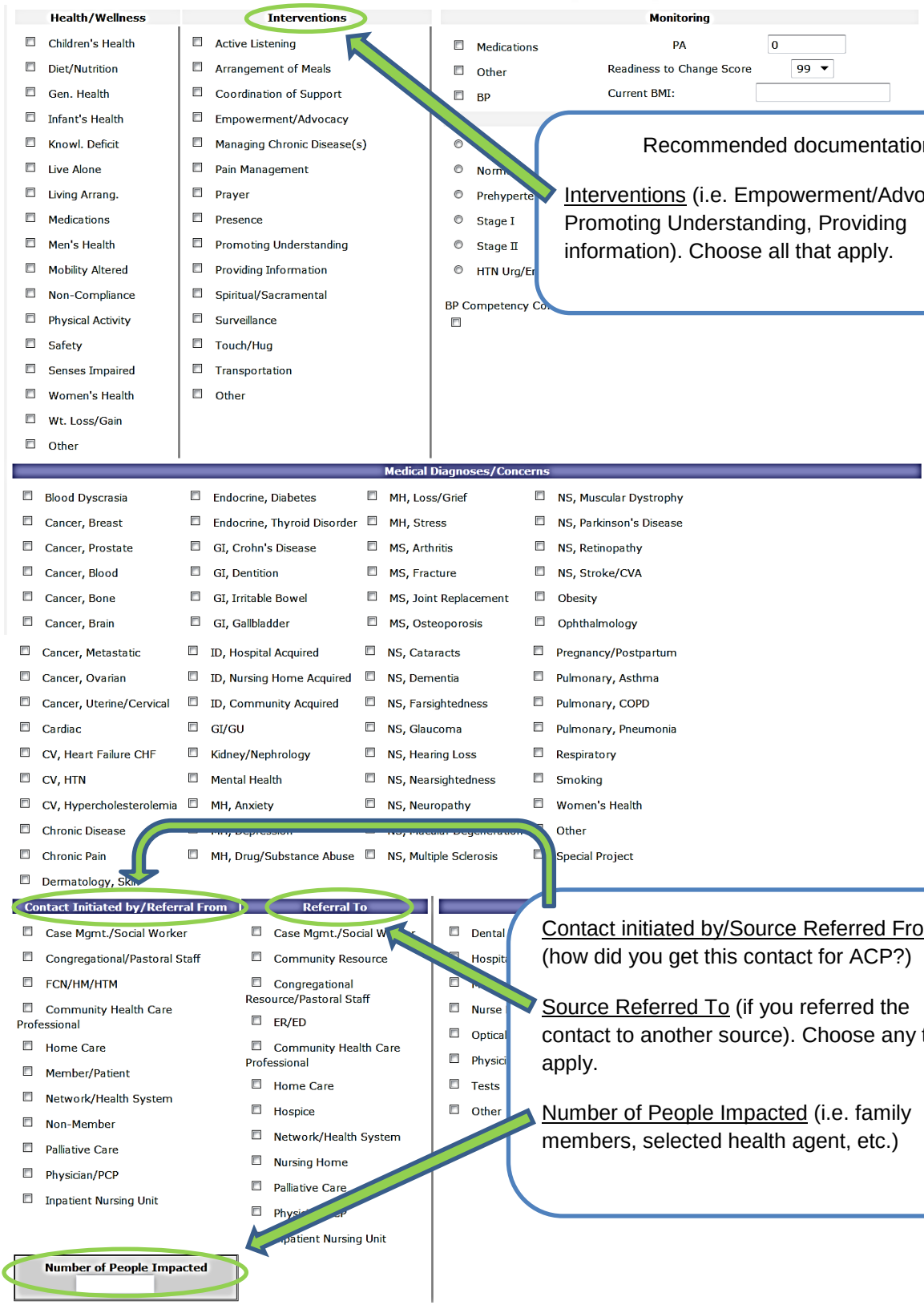

Recommended documentation:

Interventions (i.e. Empowerment/Advocacy, Promoting Understanding, Providing information). Choose all that apply.

Contact initiated by/Source Referred From (how did you get this contact for ACP?)

Source Referred To (if you referred the contact to another source). Choose any that apply.

Number of People Impacted (i.e. family members, selected health agent, etc.)

Keep scrolling…

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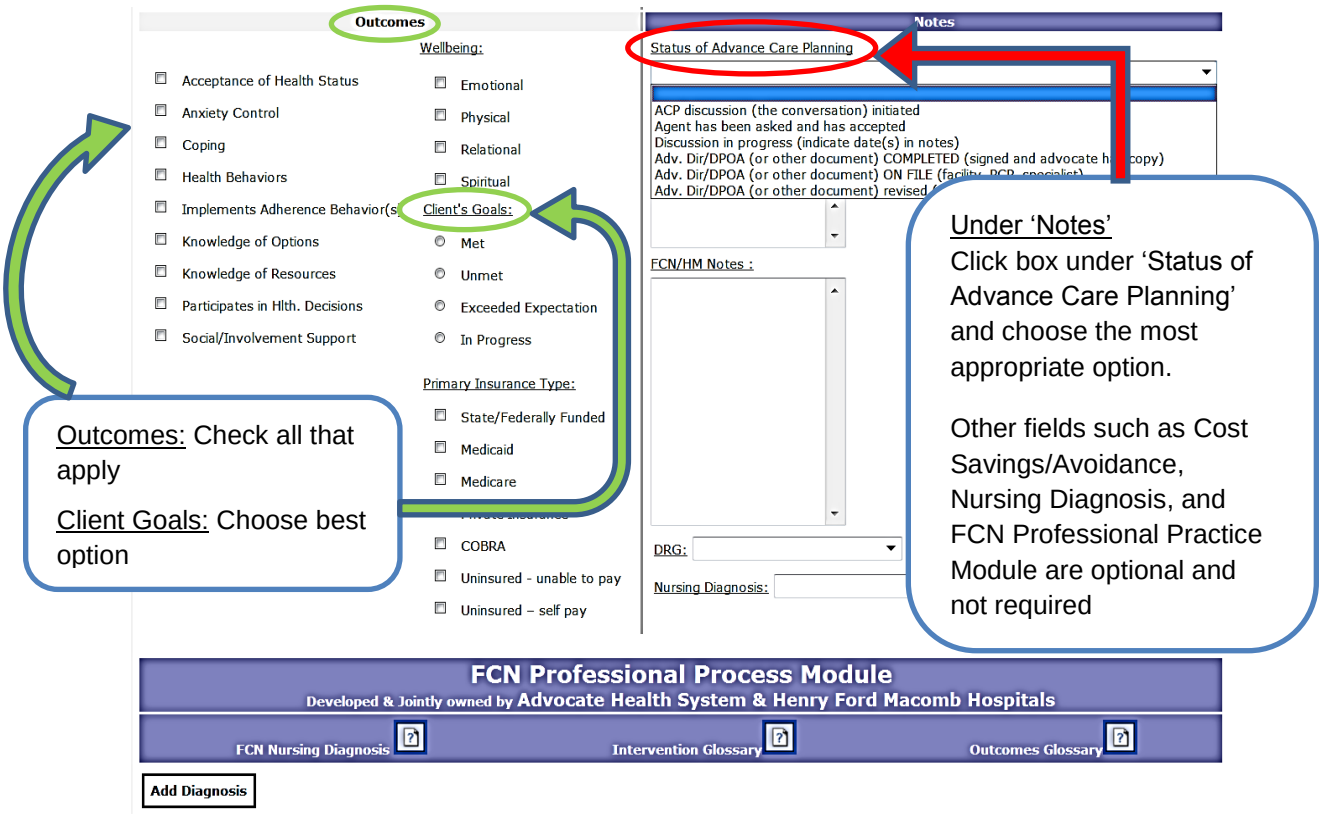
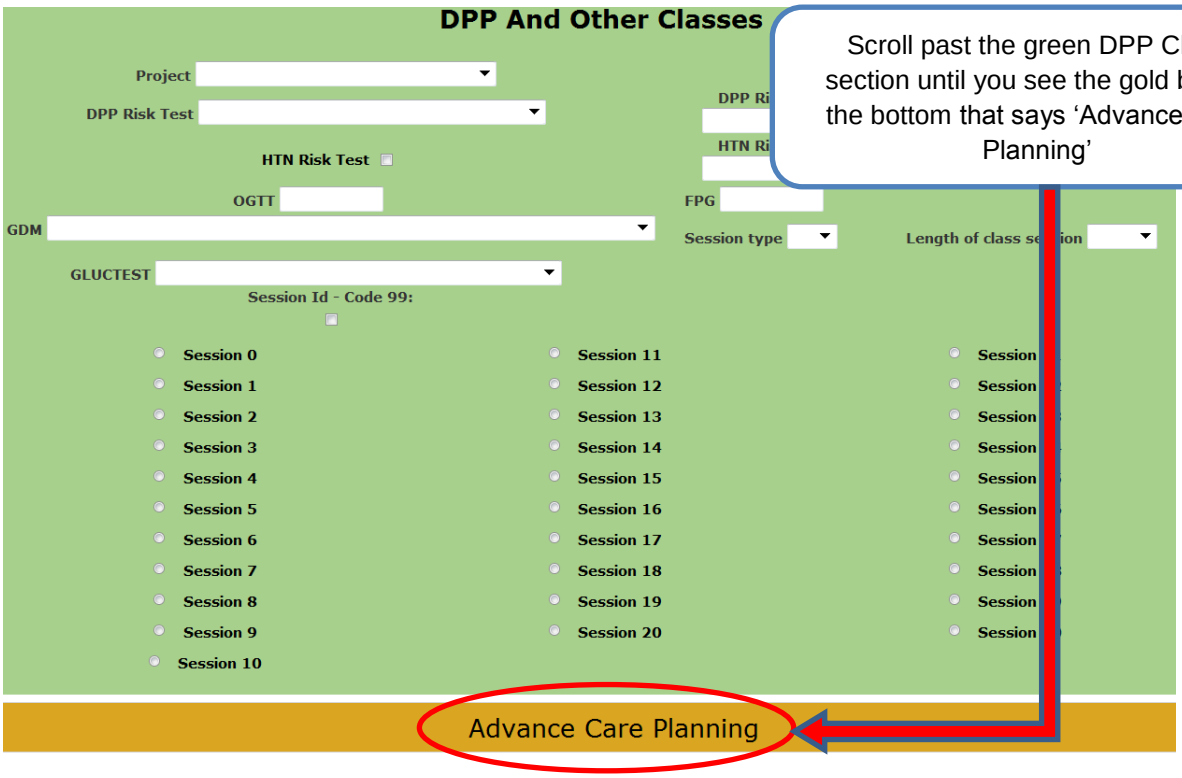


Outcomes: Check all that apply

Client Goals: Choose best option

Under 'Notes'
Click box under 'Status of Advance Care Planning' and choose the most appropriate option.

Other fields such as Cost Savings/Avoidance, Nursing Diagnosis, and FCN Professional Practice Module are optional and not required



Scroll past the green DPP Class section until you see the gold box at the bottom that says 'Advance Care Planning'

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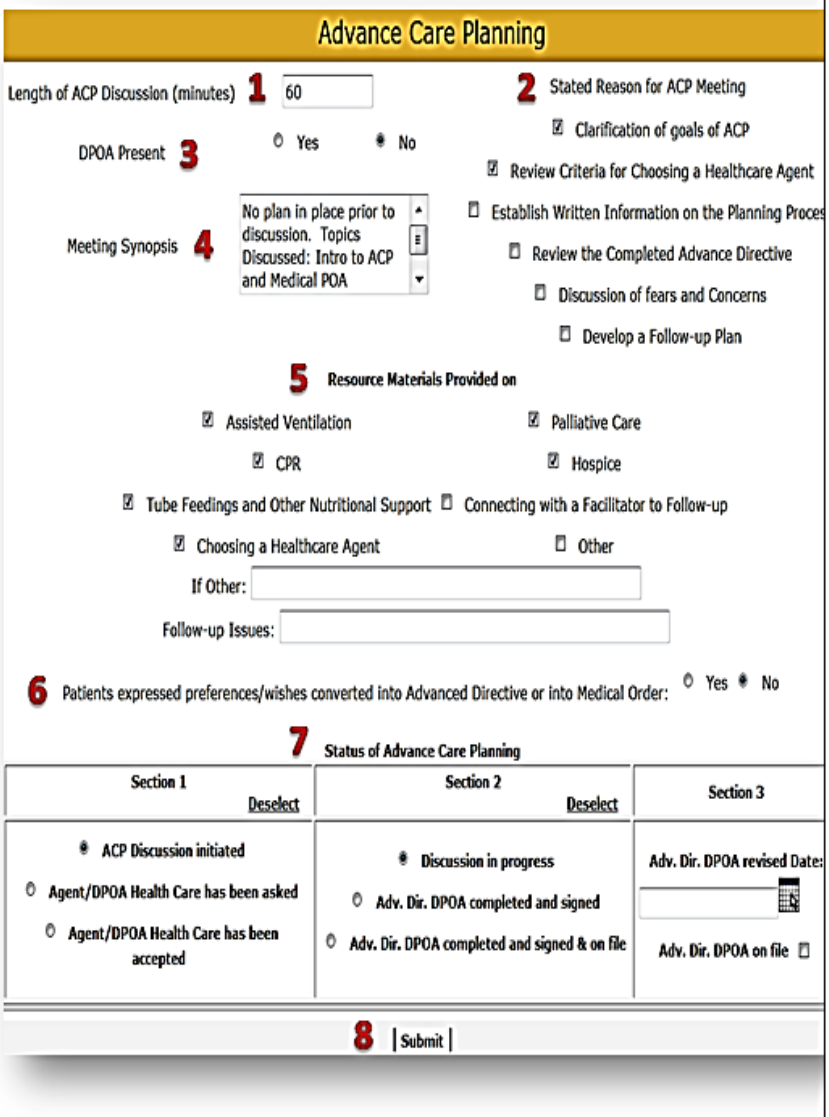
IMPORTANT!!

Please complete this area of documentation to enable critical tracking of the successful use of this Advance Care Planning Resource within Faith Community Nursing.



1. Type in the length (in minutes) of ACP discussion

2. Click all reasons that apply for ACP discussion

3. Is the DPOA present at discussion?

4. In the 'Meeting Synopsis' box, type the following information:

- Y or N if there was an ACP plan before discussion
- Which Advance Care Planning presentation topics covered? (i.e. *Intro to ACP, Medical POA, Living Will, Out of Hosp DNR*). List all that were discussed.

5. Click all that apply for Resource Materials provided during this Advanced Care Planning Discussion and Follow-up Issues (if any identified)

6. Did the Pt. sign an Advanced Directive with the discussion?

7. Click the best statement in Section 1 and Section 2 to describe the status of this Advanced Care Planning Discussion (choose one option only per Section)

Section 3 only applies if current Advance Directive documents are revised (enter revision date) or if Advance Directive is kept on file at congregation (check the box)

8. Click Submit