The TNP in daily practice
Introduction

OBJECTIVES OF THIS WORKSHOP

- To consolidate previously acquired skills.
- To demystify common difficulties that are frequently expressed about the TNP.
Introduction

QUIZ - MYTH OR REALITY?

1. The reason for the hospitalization or consultation should be the first problem/need entered in the TNP.
2. Each directive should include an action verb, ideally it should begin by one.
3. Each assessment finding has to be linked to at least one nursing directive.
4. Certain activity sectors, such as schools or FMG, such as community care, do not require to have a TNP determined
5. The time for each problem/need is the time when the problem is observed, not the time when it was entered in the TNP.
Introduction
QUALITY OF PRACTICE

Quality care (QC)

Quality of documentation (QD)
Introduction
QUALITY OF PRACTICE

Quality of documentation

Objective of the workshop

B

You today

A

Quality care
The TNP – reserved activities
Nurses Act
Recorded in the client’s file, the therapeutic plan is determined and adjusted by the nurse on the basis of her clinical assessment. It provides an evolving clinical profile of the client’s priority problems and needs, and states the nursing directives issued for the client’s clinical follow-up, particularly as regards clinical monitoring, care and treatment. The therapeutic nursing plan covers the continuum of care and services and may encompass more than one episode of care.
When to record elements in the TNP?
A FUNDAMENTAL QUESTION

Applying the documentation standard when determining a TNP

- Hospitalized client
- Client residing in a CHSLD
- Outpatient client
- Client receiving home care

Does the client require a clinical follow-up determined by the nurse’s assessment?

Yes
No

TNP
No TNP
Understanding the professional standard behind the TNP

DOCUMENTATION STANDARD

> The standard:
  > “Using a separate documentation tool within the client’s file, the nurse records the therapeutic nursing plan she determines, along with any subsequent adjustments she makes based on the client’s clinical course and the effectiveness of the care and treatment.” source: OIIQ, 2009

> What is a file?
  > File: a collection of documents containing information on the same subject […] source: OQLF
  > It’s the perspective of the components of a file that allows us to have a global vision.
Understanding the professional standard behind the TNP

LEGAL CONSIDERATIONS

> Documentary evidence

> A document considered as permanent (e.g. written in pen or software), for which its authenticity has been validated, constitutes an evidence. E.g. TNP, a physician’s prescription.

> Testimonial evidence

> A testimonial or document whose authenticity cannot be guaranteed (e.g. a pencilled-in report or an unsigned document) does not have the same value as documentary evidence. E.g. Cardex.
The TNP and progress notes, together, should make it possible to:

- provide **nursing follow-up** (60/40 concept)
- Accounting for clinical follow-up
The form, step by step
"ASSESSMENT FINDINGS" SECTION

Reporting assessment findings: establishing actions in regards to the client’s priority problems and needs
The form, step by step

“ASSESSMENT FINDINGS” SECTION

- The chronological reference of the assessment finding
- The date and time must be registered understandably.

<table>
<thead>
<tr>
<th>Date</th>
<th>Heure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date and time of finding
The form, step by step
“ASSESSMENT FINDINGS” SECTION

> Determining the client’s problems and needs on the bases if a clinical assessment

> Problems/needs are entered chronologically, not in order of priority.

> Numbering is used with the sole objective of linking problems/needs with nursing directives.

Number of problem or need
The form, step by step

“ASSESSMENT FINDINGS” SECTION

- Description of the problem or need
  - Only problems or needs that have an impact on the client’s clinical follow-up are entered in the TNP.
  - To facilitate clinical follow-up, the problem or need must be entered in a brief, clear and precise manner
The form, step by step

“ASSESSMENT FINDINGS” SECTION

<table>
<thead>
<tr>
<th>Date</th>
<th>Heure</th>
<th>Initiales</th>
</tr>
</thead>
</table>

- **Date and time when the problem or need was resolved or satisfied**
- **Initials of nurse who found that the problem was resolved or the need satisfied**
## CONSTATS DE L’ÉVALUATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Heure</th>
<th>N°</th>
<th>Problème ou besoin prioritaire</th>
<th>Initiales</th>
<th>RÉSOLU / SATISFAIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>888888</td>
<td>8888</td>
<td>8</td>
<td>XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX</td>
<td></td>
<td>Xxx</td>
</tr>
<tr>
<td>16/04/04</td>
<td>9h00</td>
<td>2</td>
<td>Major depressive episode</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 :00</td>
<td></td>
<td>3</td>
<td>Type 2 diabetes</td>
<td>L.R.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>High risk of suicide (III)</td>
<td>C.L</td>
<td></td>
</tr>
</tbody>
</table>

## SUIVI CLINIQUE

<table>
<thead>
<tr>
<th>Date</th>
<th>Heure</th>
<th>N°</th>
<th>Directive infirmière</th>
<th>Initiales</th>
<th>CESSÉE / RÉALISÉE</th>
</tr>
</thead>
</table>

Signature de l’infirmière:  

<table>
<thead>
<tr>
<th>Louise Rozon</th>
<th>L.R.</th>
<th>Med. 3B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carole Lambert</td>
<td>C.L.</td>
<td>Med. 3B</td>
</tr>
</tbody>
</table>
When there is more than one assessment finding for the same problem or need, «---» are used to point out to this new entry, whether it’s a detail reflecting new information or an evolution of the problem or need that has an impact on the clinical follow-up.

### CONSTATS DE L’ÉVALUATION

<table>
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<tr>
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<th>Heure</th>
<th>No</th>
<th>Problème ou besoin prioritaire</th>
<th>Initiales</th>
<th>RÉSOLU / SATISFAIT</th>
<th>Professionnels/Services concernés</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/04/04</td>
<td>9h00</td>
<td>2</td>
<td>Major depressive episode</td>
<td>--</td>
<td>--</td>
<td>JB</td>
</tr>
<tr>
<td>18 :00</td>
<td>4</td>
<td>3</td>
<td>Type 2 diabetes</td>
<td>L.R.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19:30</td>
<td>4</td>
<td>2</td>
<td>High risk of suicide (III)</td>
<td>C.L</td>
<td>--</td>
<td>P.A.</td>
</tr>
<tr>
<td>16/04/07</td>
<td>11H00</td>
<td>4</td>
<td>Low risk of suicide</td>
<td>P.A.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Major depressive episode and grieving the death of daughter Julie: 18:00
The form, step by step

“ASSESSMENT FINDINGS” SECTION

> To promote interdisciplinarity, the section indicating the professionals/ departments involved gives an overall portrait to the person consulting the file of who is involved.

> Such an entry is made in cases where it is not obvious who is involved.

<table>
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<th>Date</th>
<th>Heure</th>
<th>No</th>
<th>Problème ou besoin prioritaire</th>
<th>Professionnels/ Services concernés</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/04/04</td>
<td>9h00</td>
<td>2</td>
<td>Dépression situationnelle</td>
<td>JB</td>
</tr>
<tr>
<td>18/04/04</td>
<td>16h30</td>
<td>4</td>
<td>Risque suicidaire élevé</td>
<td>P.A.</td>
</tr>
<tr>
<td>19/04/04</td>
<td>19h30</td>
<td>4</td>
<td>Risque suicidaire faible</td>
<td>Psicologista</td>
</tr>
<tr>
<td>16/04/07</td>
<td>11H00</td>
<td>4</td>
<td>Risque suicidaire faible</td>
<td>P.A.</td>
</tr>
</tbody>
</table>


The form, step by step
"CLINICAL FOLLOW-UP" SECTION

> Let’s be clear and concise!
The form, step by step
"CLINICAL FOLLOW-UP" SECTION

> Chronological reference pointing to the directive

Date (and time) of the initial determination or subsequent adjustment to the nursing directive
The form, step by step
“CLINICAL FOLLOW-UP” SECTION

> Directives without a problem/need = impossible

> Problem/need without directives = several possibilities:
  > If the follow-up has not yet been determined
  > If the problem/need has an impact on the clinical follow-up but does not itself require a clinical follow-up
  > If current clinical follow-up is adequate
Directives should be formulated as precisely as necessary to ensure that they are understood and applied.

Write the directive as you wish it to be applied.
The form, step by step
“CLINICAL FOLLOW-UP” SECTION
Repeated or ongoing interventions need to be discontinued while, in the case of one-time interventions, when they were carried out.

(--) are not used to show progress for directives in the “Clinical follow-up” section. To change a directive, you must discontinue it and then issue a new directive.

If the discontinuation/completion date is the same as the date of the directive, you are probably in the wrong form! Write a progress note in the file instead!
Every change in the TNP is the result of an assessment made by a nurse. Therefore, it is essential to document the justification for making this adjustment to the clinical follow-up.

The progress note should support the TNP and should be:

- relevant
- accurate
- complete
- organized
Tips

1. THE REPORT

> Helps us to define what is really relevant.

> Also helps us to formulate what is relevant in a simplified way.
2. EVIDENCE: MEDICAL EXAMPLE-ATIVAN 3MG PO Q.4H

What is the need?
- Follow-up (Rx)

Why is follow-up needed?
- Assessment finding (Dx)

Why make this assessment finding?
- Progress note
Tips
2. EVIDENCE

What is the need?
• Follow-up (Rx)

Why is follow-up needed?
• Assessment finding (Dx)

Why make this assessment finding?
• Progress note
Conclusion

› Remember: keep the TNP simple!
› It was created to help nurses with clinical follow-up, not to make it more complicated!
Quiz

MYTHS AND REALITIES

1. The reason for the hospitalization or consultation should be the first problem/need entered in the TNP.
   > Myth

2. Each directive should include an action verb, ideally it should begin by one.
   > Myth

3. Each assessment finding should be linked to at least one nursing directive.
   > Myth
Quiz

MYTHS AND REALITIES

4. Certain activity sectors, such as community care, do not require to have a TNP determined

> Myth

5. The time for each problem/need is the time when the problem/need was observed, not the time when it was entered in the TNP.

> Reality
Useful information

> Counselling Department
  > Phone: 514-935-2501, press 1
  > Email: pti@oiiq.org
> For further information, please visit the [pti.oiiq.org website](http://pti.oiiq.org).