|  |  |
| --- | --- |
| Subject: Comprehensive Care Plan | Effective Date:  Revised Date:  Revised Date:  Revised Date: |
|  |  |

POLICY:

The unit must develop and implement a comprehensive person-centered care plan for each patient, consistent with the patient’s rights that includes measurable objectives and timeframes to meet a patient's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

The comprehensive care plan must describe the following:

## The services that are to be furnished to attain or maintain the patient's highest practicable physical, mental, and psychosocial well-being and,

## Any services that would otherwise be required but are not provided due to the patient’s exercise of rights including the right to refuse treatment. (example would be that the patient is in for medical treatment and could benefit from therapy but refuses - the care plan should note such and what is being done for his functional needs in lieu of therapy).

The services provided or arranged by the program, as outlined by the comprehensive care plan, must:

## Meet professional standards of quality.

## Be provided by qualified persons in accordance with each resident's written plan of care.

## Be culturally competent and trauma informed.

The Interdisciplinary Treatment Team, in conjunction with the patient, family, significant, and/or concerned other(s) when possible shall develop a comprehensive care plan that includes measurable objectives and timetables to meet the patient's medical, nursing, rehabilitation, and psychosocial needs.

PROCEDURE:

# An initial care plan will be initiated by the RN staff on the shift of admission and added to as needed when new potential or actual problems are identified.

# Each discipline will review the completed pre-admission data as part of their comprehensive assessment and will determine their action plan based on:

## anticipated discharge destination

## previous functional abilities

## current medical and function condition

## current support system available

## anticipated discharge functional status

## anticipate length of stay.

# The PT, OT, SLP, RT, Dietician, will develop discipline specific plan and add treatment plan to the initial nursing care plan as appropriate once they have completed their comprehensive assessments.

## For instance, the frequency of each therapy discipline treating the patient will be added to the interdisciplinary care plan as well as what if anything should the nursing staff participate in, special equipment(s) to be used etc. but the full treatment plan will be documented on each discipline specific assessment.

## Dietary and RT (if pertinent) will add any special instructions to nursing on the care plan.

# Patient discharge goals will be determined during the initial interdisciplinary team meeting and the care plan will be reviewed at this time and weekly thereafter to ensure that all identified issues are documented, and care planned.

# Nursing staff will document to the care plan problems, skills, and discharge goals daily as appropriate.

# Upon discharge, nursing will document the status of each problems identified during the stay as to whether they were resolved and if not, what is the plan post-discharge.

# See the Interdisciplinary Team Process P&P for more details.