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TITLE:	PLAN OF CARE	POLICY NUMBER:	
POLICY DATE:	MONTH, YEAR	SUPERSEDES DATES:	ALL PRIOR
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POLICY STATEMENTS

PURPOSE

To describe the process for development of the patient's plan of care.

POLICY

Patient care is planned based on the initial assessment findings that identify problems, deficits, and needs. Progress is then evaluated based on the deficits noted, response to treatment given, and progress toward the goals established at the time of the initial evaluation. The plan of care is periodically modified based on progress toward the goals of treatment.

Development Of The Plan Of Care

The data collected in the initial assessment will be utilized to establish the plan of care for the patient.

Interdisciplinary Treatment Approach

The department of physical medicine contributes to the interdisciplinary treatment approach in the following ways:

- Participates in organization-wide interdisciplinary treatment planning meetings
- Participates in discharge planning meetings and activities
- Participates in unit meetings related to care planning
- Communicates essential information about patient care to the appropriate individuals using approved facility mechanisms of communication (documentation, verbal communication, meetings, etc.)

APPLIES TO:
All Settings

CFR REFERENCES:

42CFR485.711

SURVEY TAG REFERENCES:

CMS-1893: I-47, I-50
CMS-437B: M-85
CMS-437A: M-61, M-62
CMS-1537: A-0467

JCAHO STANDARDS:
PC.4.10
PC.5.50
PC.6.10

CARF STANDARDS:
2.44
2.46
3.C.11
3.C.31

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Department Specific Plan Of Care

Each service will develop a plan of care that includes:

- A list of the noted problems, deficits, or dysfunctions
- A prioritization of those needs
- Interventions to address the problems, deficits, or dysfunctions
- Frequency and duration of treatment
- Time-linked goals that specify specific levels of progress expected
- Criteria that would allow patients to move to a less restrictive environment, if appropriate
- The patient's personal goals for treatment
- Specific goals related to ADL, learning, and working
- Prognosis for goal achievement
- Barriers to achievement of the treatment goals
- Facilitators to achievement of the treatment goals
- Precautions to be followed during treatment
- Potential discharge

Patient And Family Involvement In The Plan Of Care

The identified deficits and strategies for improvement will be discussed with the patient or guardian and the family as appropriate. The patient and family are encouraged to participate not only in the planning for care but also in the care program outlined (to the extent that this is appropriate and beneficial).

In the case of minors, the parent, siblings, and peer group may be involved in the care planning and treatment process.

The patient and family will be informed of:

- Risks and possible benefits of treatment
- Cooperative efforts required from the patient and/or family to achieve the desired goals
- Alternative treatment available when they choose not to follow the plan established
- The consequences of not participating in therapy

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Patient Needs Not Addressed

When a patient's need is identified that is not addressed in the plan of care, the evaluating therapist will document the reason this need is not being addressed. Potential reasons for not addressing an identified deficit are:

- Deficit is low priority and is not likely to be addressed in the time frames of this admission
- Deficit is long-standing and has not responded to prior treatment
- Assessment indicates that the deficit is not likely to be improved with treatment
- Deficit is not likely to be improved with resources available at this facility and patient/family has been informed of where services may be provided
- Barriers to goal achievement make progress unlikely
- Patient's medical condition precludes addressing the deficit at this time

Implementation

Each service is responsible for the implementation of the department specific plan of care, for measuring progress toward goals, and for communicating progress and patient needs to the team.

Modifications

Modifications in the department specific treatment plans will be made based on reassessment of the patient at specific intervals and related to the following elements:

- Progress toward goals
- Failure to make progress
- Unusual response to treatment
- Failure to participate
- Other significant data

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Modifications will be coordinated with other members of the treatment team to assure that a coordinated effort toward patient treatment is achieved.

Discontinuation Of The Treatment Plan

The plan of care will be discontinued and the patient discharged when one or more of the following occur:

Inpatient Services

- The patient has been discharged from the facility and no orders have been received to continue treatment as an outpatient
- The patient achieves the goals of therapy
- The patient refuses to continue therapy
- The patient is transferred to a higher level of care and there are no orders to continue therapy
- The patient is not making progress and there is no further benefit to continue treatment
- The patient is regressing and collaborative team efforts recommend discharge from service
- The physician discontinues treatment

Outpatient Services

- The patient has finished the ordered course of therapy and there are not any continuation orders received from the physician
- The patient has achieved all goals of the therapy plan
- The patient voluntarily discharges him/herself
- Attendance is insufficient to achieve reasonable progress toward goals
- Patient becomes disruptive to the care of other patients in the treatment program
- Patient has a significant decrease in ability and requires further medical assessment

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- The patient is non-compliant with treatment to the extent that treatment is not beneficial and does not improve compliance with counseling from organization staff
- The patient is not making progress and there is no further benefit to continue treatment
- The patient is regressing and, in collaboration with other members of the healthcare team, a decision is made to discontinue therapy
- The patient fails to keep three consecutive appointments without canceling/rescheduling
- The patient is seeking alternative care that, in combination with the physical medicine program being given, would place him/her at risk for injury, complications, or over treatment
- The patient is participating in alternative treatment for which the risks are not known
- The patient requires services or skills not available in the department and the patient is referred to a provider who is able to provide these services

Discharge Planning

Planning for patient discharge begins when the patient enters the treatment program. As part of the initial assessment and plan of care progress, goals for discharge will be established and patient needs related to that discharge would be identified and addressed. The patient will be informed of the plan for discharge, and participate in determining the needs to be addressed for a successful discharge.

RESPONSIBILITY

[Insert Name or Title of Person Responsible] is responsible for assuring compliance with this policy.

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APPROVALS AND REVIEWS

INITIAL REVIEW DATE:	REVIEWED AND APPROVED BY: [INCLUDE NAME AND DEPARTMENT]	COMMENTS:
ANNUAL REVIEW DATE:	**REVIEWED AND APPROVED BY:**	**COMMENTS:**

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