

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER CARDINAL HILL REHAB UNIT AT SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 310 SOUTH LIMESTONE ST LEXINGTON, KY 40508	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>An abbreviated survey investigating ARO#KY00017306 was conducted 11/03/11 through 11/04/11. ARO#KY00017306 was unsubstantiated with related deficiencies cited. The highest Scope and Severity (S/S) was a "D".</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure services provided met professional standards of quality related to Physician's Orders being followed for one (1) of three (3) sampled residents, (Resident #1). Resident #1 had a surgical wound to his chest and the facility failed to ensure the ordered treatment was provided on each shift.</p> <p>The findings include:</p> <p>Review of Resident #1's clinical record revealed an admission date of 07/07/11, and diagnoses which included Coronary Artery Bypass Graft (CABG), Post-operative Cerebrovascular Accident (CVA), and Bacteremia. Further review revealed the resident was discharged on 07/20/11.</p> <p>Review of a Physician's Order, dated 07/07/11, revealed an order to apply Santyl ointment (a debriding agent) to the resident's left chest wall and cover with a dry dressing. Further review</p>	F 281	<p>F281 483.20(k)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The affected resident #1 had been discharged on 7/20/11. At time of discharge resident #1 had no adverse reactions as a result of the cited deficiency. All inpatient Treatment Administration Records were reviewed by the Director of Nursing and charge nurse on November 7, 2011 and no other patients were found to be affected by the cited deficiency.</p> <p>All residents receiving treatments could potentially be affected by the cited deficiency. On November 7, 2011 the director of nursing, and the administrator, reviewed and revised the Policy and Procedure, "Treatment Administration Record". (Exhibit 1) The policy and procedure reflects that if a treatment is not completed for any reason that this shall be documented by way of being circled and initialed on the TAR.</p>	11/28/11

RECEIVED
NOV 30 2011
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 11/30/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER CARDINAL HILL REHAB UNIT AT SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 310 SOUTH LIMESTONE ST LEXINGTON, KY 40508		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 1 revealed the treatment was to be performed every shift and as necessary.</p> <p>Review of the Admisslon Minimum Data Set (MDS) Assessment, dated 07/07/11 revealed the facility assessed Resident #1 to have a surgical wound that required surgical wound care.</p> <p>Review of the Treatment Administration Record (TAR) for July 2011, revealed an order for Santyl ointment to the resident's surgical wound and cover with a dry dressing each shift. Continued review of the TAR revealed no documented evidence the treatment was provided on the 7:00 PM to 7:00 AM shifts on 07/07/11, 07/08/11, 07/09/11, and 07/13/11. In addition, on 07/10/11, 07/15/11, 07/16/11, and 07/17/11 the treatment was circled for the 7:00 PM to 7:00 AM shift, however there was no evidence of documentation related to why the treatment was circled.</p> <p>Interview, on 11/04/11 at 4:28 PM, with Licensed Practical Nurse (LPN) #1 revealed if treatments were circled on the TAR it indicated the treatment had not been performed. Interview, on 11/04/11 at 3:21 PM, with Registered Nurse (RN) #2 revealed confirmation of LPN #1's information in regards to the circled treatments and if there was no documentation it meant the treatment had not been performed.</p> <p>Interview, on 11/04/11 at 4:45 PM, with the Director of Nursing (DON) revealed there should have been documentation of the treatments having been performed on 07/07/11, 07/08/11, 07/09/11, and 07/13/11. Additionally, she stated if treatments were circled it meant the treatment wasn't done. Further interview revealed there</p>	F 281	<p>The nurse will then document in the nurse's notes the reason why the treatment was not completed and put on the MD communication sheet to notify the physician.</p> <p>To enhance compliance and understanding of the Policy and Procedure "Treatment Administration Record" under the direction of the director of nursing, an in-service was given to all RN/LPN on the unit on November 16, 2011. (Exhibit 2). The in-service emphasized the proper documentation for non-completed treatments as well as notification to the ordering physician.</p> <p>Effective, November 28, 2011, a quality-assurance program was implemented under the supervision of the director of nursing to monitor the carrying out of treatment services ordered by the physician and proper documentation reflected on the TAR, nursing notes and notification of the physician if a treatment was not completed. The director of nursing or a designated representative will perform daily TAR using the TAR documentation tool (Exhibit 3). The TARS checks x 30 days, then weekly x 60 days, then monthly x 60 days. Any TAR reflecting</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011	
NAME OF PROVIDER OR SUPPLIER CARDINAL HILL REHAB UNIT AT SAMARITAN HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 310 SOUTH LIMESTONE ST LEXINGTON, KY 40508		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE non-completed treatments and/or incorrect documentation of treatments will immediately be corrected and reported to the director of nursing. The results will be reported on a quarterly basis x 2 quarters to the quality assurance committee meeting for further review or corrective action.	(X5) COMPLETION DATE
F 281	Continued From page 2 should have been documentation of why the treatments were circled and not performed. She further indicated the treatment should have been performed as ordered on the 7:00 PM to 7:00 AM for the eight days.	F 281	non-completed treatments and/or incorrect documentation of treatments will immediately be corrected and reported to the director of nursing. The results will be reported on a quarterly basis x 2 quarters to the quality assurance committee meeting for further review or corrective action.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to follow the written Plan of Care for one (1) of three (3) sampled residents, (Resident #1). Resident #1 was care planned to receive treatments as ordered however the facility failed to follow the Care Plan as treatments were not completed each shift as ordered. The findings include: Review of Resident #1's clinical record revealed the facility admitted Resident #1 on 7/07/11, with diagnoses which included a surgical chest wound related to a Coronary Artery Bypass Graft (CABG). Review of a Physician's Order, dated 07/07/11, revealed a treatment order for the surgical wound to Resident #1's chest. The treatment was to be performed every shift.	F 282	F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONAL/PER CARE PLAN The affected resident #1 had been discharged on 7/20/11. At time of discharge resident #1 had no adverse reactions as a result of the cited deficiency. All care plans were reviewed by the Director of Nursing on November 7, 2011. No other residents were found to be affected by the cited deficiency on November 4, 2011. All residents could be potentially affected by the cited deficiency, the director of nursing, and the administrator reviewed the Policy and Procedure C08: Care Planning and no revisions were necessary. (Exhibit 4). The director of nursing and the administrator reviewed and revised the Policy and Procedure "Physician Order Review Responsibility of Nurse Verification". (Exhibit 5). The policy outlines the procedure for verification of MD orders and that if any order has not been carried out that an incident report form be completed and the MD notified.	11/28/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2011
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER CARDINAL HILL REHAB UNIT AT SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 310 SOUTH LIMESTONE ST LEXINGTON, KY 40508		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 3</p> <p>Review of the Initial/Immediate Care Plan for Resident #1, dated 07/07/11, revealed a plan for "Wound/Skin Tear". Further review of this care plan revealed treatments were to be provided as ordered.</p> <p>Review of the Treatment Administration Record (TAR) revealed no documented evidence the ordered treatment, for the surgical wound to Resident #1's chest, had been provided for eight days on the 7:00 PM to 7:00 AM shifts.</p> <p>Interview, on 11/04/11 at 4:45 PM, with the Director of Nursing (DON) revealed the treatment should have been provided as ordered and as indicated on the Initial/Immediate Care Plan.</p>	F 282	<p>To enhance compliance and understanding of both policies, "Care Planning and Physician Order Review", an in-service was given to all nursing by the director of nursing on November 16, 2011. (Exhibit 6). Effective November 28, 2011 a quality-assurance measure was implemented under the supervision of the director of nursing, to monitor the verification of order review and care planning of orders. The director of nursing or designated representative review care plans and verification of orders of each resident using the following documentation tool. (Exhibit 7). These checks will be preformed daily x 30 days, weekly x 60 days and then monthly x 30 days. Any incomplete care plans or physician orders will be immediately corrected and reported to the director of nursing. The results will be reported on a quarterly basis to the quality assurance committee x 2 quarters for further review or corrective action.</p>		

Cardinal Hill Hospital Rehabilitation Unit

NURSING POLICY AND PROCEDURE

TREATMENT ADMINISTRATION RECORD (TAR)

POLICY STATEMENT:

It shall be the policy of the CHRU to document treatments on a separate Treatment Assessment Record (TAR).

PROCEDURE:

1. Upon admission, a TAR will be generated for new patients. The TAR will reflect Weekly Weights and Weekly Skin Assessments as standing treatments for all patients.
2. When orders for other treatments are received, the nurse responsible for signing off the order shall add these orders to the TAR with the new order date.
3. Routine lab orders shall be considered as treatment orders for this purpose and shall be placed on the TAR with the date that labs are to be performed.
4. Treatments are to be initialed on the TAR after completion.
5. All PRN treatments will be checked daily and if the treatment has been completed the TAR will be initialed, if the treatment does not require an action, then a check mark will be placed on the TAR indicating that the nurse has checked the treatment.
6. If a treatment is not completed for any reason; i.e. patient refusal, equipment not present, medication not available) then this shall be documented by way of being circled and initialed on the TAR. The nurse will document in the nurse's notes the reason why the treatment was not completed and put on the MD communication sheet to notify the physician.
7. Additional information pertinent to the performance of the treatment i.e. wound descriptions, description of skin problems or skin free of problems, are to be documented in the nurse's notes.
8. TAR's are to be placed in the TAR book for each hall. These are to be left until the end of the month or until the patient is discharged whichever comes first, and are to be considered a portion of the permanent record of the patient.

Approved by: _____

Date: _____

Reviewed by: _____

Date: _____

**CARDINAL HILL REHABILITATION HOSPITAL
INSERVICE EDUCATION ATTENDANCE REPORT**

Exhibit
2

CODE: _____

DATE OF INSERVICE: 11/16/11
 HOURS OF INSERVICE: 2x 1hr
 INSERVICE TITLE: Treatment Administration Record Pop
 CONDUCTED BY: _____ EMP# _____
 _____ EMP# _____

TARGET AUDIENCE: RN/LPN

- OBJECTIVES:
- 1) What to do if you have scheduled tx & refuses
 - 2) Documentation
 - 3) What you should include on ^{order} call plan TAE when
 - 4) placing orders

ATTENDANCE

EMPLOYEE # EXAMPLE: 12111	NAME (MUST PRINT) JOHN DOE	DEPT. EDUC
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

SUBMITTED BY: [Signature]

DATE: 11/16/11

November 16, 2011

Attached please find a copy of the Policy and Procedure for Treatment Administration Record (TAR).

Please notice that the charting shall be consistent for all nursing staff and should be reflected on the TAR. If the patient is ordered a **scheduled treatment** and refuses then the staff will circle the appropriate box on the TAR, place their initials in the circle and then place on the communication sheet for notification to KC. For whatever reason a treatment is not done it should be documented in the nurse's notes outlining the reason and that the MD was notified. If the treatment is completed then the initials of the treatment nurse should be reflected on the TAR do not add anything else on the TAR. If the order is a **PRN order** then a check mark should be placed on the TAR if the treating nurse checks the order and nothing needs to be completed and if the order is completed then only the initials of the treating nurse should be placed on the TAR.

When placing orders on the TAR, they should include the date of when the order is received, how often, when to begin, to what area (i.e. for dressing changes) and for how long. If any order has to be changed, then a discontinuation of the previous order needs to take place by highlighting the old order and rewriting the new order. Also a new order must be written by the MD for the new order. **DO NOT CROSS OUT AND WRITE OVER THE EXISTING ORDER.**

See example of TARS attached.

If you have any questions, please see Teresa or Geneva

Thanks.

Teresa

Cardinal Hill Hospital Rehabilitation Unit

NURSING POLICY AND PROCEDURE

TREATMENT ADMINISTRATION RECORD (TAR)

POLICY STATEMENT:

It shall be the policy of the CHRU to document treatments on a separate Treatment Assessment Record (TAR).

PROCEDURE:

1. Upon admission, a TAR will be generated for new patients. The TAR will reflect Weekly Weights and Weekly Skin Assessments as standing treatments for all patients.
2. When orders for other treatments are received, the nurse responsible for signing off the order shall add these orders to the TAR with the new order date.
3. Routine lab orders shall be considered as treatment orders for this purpose and shall be placed on the TAR with the date that labs are to be performed.
4. Treatments are to be initialed on the TAR after completion.
5. All PRN treatments will be checked daily and if the treatment has been completed the TAR will be initialed, if the treatment does not require an action, then a check mark will be placed on the TAR indicating that the nurse has checked the treatment.
6. If a treatment is not completed for any reason; i.e. patient refusal, equipment not present, medication not available) then this shall be documented by way of being circled and initialed on the TAR. The nurse will document in the nurse's notes the reason why the treatment was not completed and put on the MD communication sheet to notify the physician.
7. Additional information pertinent to the performance of the treatment i.e. wound descriptions, description of skin problems or skin free of problems, are to be documented in the nurse's notes.
8. TAR's are to be placed in the TAR book for each hall. These are to be left until the end of the month or until the patient is discharged whichever comes first, and are to be considered a portion of the permanent record of the patient.

Approved by: _____

Date: _____

Reviewed by: _____

Date: _____

CARDINAL HILL REHABILITATION UNIT ADMINISTRATIVE POLICY AND PROCEDURE

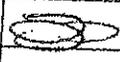
Policy #: C08 Care Planning

Policy: Care, treatment and services are planned to ensure that they are appropriate to the patient's needs. Therefore, it is the policy of CHRU to provide an individualized, interdisciplinary plan of care for all patients that is appropriate to the patient's needs, strengths, limitations and goals. Care planning will be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals for the patient that are reasonable and measurable. The plan of care will be documented and filed in the medical record of the patient.

PROCEDURE:

- Within seven (7) days of completion of the comprehensive assessments, all patients shall have a computerized plan of care generated by the registered nurse or the licensed practical/vocational nurse under the direct supervision of the registered nurse.
 - The interdisciplinary care plan will be completed no later than 72 hours after comprehensive assessments are completed.
- The plan of care shall be individualized, based on the diagnosis, patient assessment and personal goals of the patient and his/her family.
- The planning for care, treatment and services will include the following:
 - Care planning is based on data collected from patient assessments with integration of those assessment findings in the care planning process.
 - Developing a plan for care, treatment and services that includes patient care goals that are reasonable and measurable.
 - The frequency of care, services and treatment
 - Team members responsible for care, services and treatment
 - Financial implications of said care, services and treatment
 - Discharge planning; return to the community or discharge to an appropriate level of care
 - The needs of the patient, goals, time frames, required services and the service settings.
 - Regularly reviewing and revising the plan of care, treatment and services.

- Determining how the planned care, treatment and services will be provided.
- Documenting the plan for care, treatment and services.
- Monitoring the effectiveness of care planning and the provision of care, treatment and services.
- The plan of care will be evaluated frequently, based on the patient's clinical condition, care goals and the plan for treatment, care and services, and revised as needed to meet the needs of the patient's changing condition.
- Patients and/or families are involved in care planning.
- The plan of care will consider strategies to limit the use of restraints and/or seclusion as appropriate to the condition of the patient.
- The plan of care shall address the learning needs of the patient and/or family.
- After the initiation of the plan of care by nursing, those disciplines consulting in the care shall contribute to the plan as appropriate to the patient's assessed needs.
- All staff using the computerized plan of care are responsible for interdisciplinary collaboration to establish goals and appropriate interventions, as well as ongoing evaluations and revisions.
- Care plan review will be conducted every two (2) weeks.
- Care plans will also be reviewed when indicated by changes in the patient's condition.

Initial Date	November 2005
Effective Date	November 2005
Reviewed	 11/14/11
Revised	
Replaces	
Signature	

Cardinal Hill Hospital Rehabilitation Unit

PHYSICIAN ORDER REVIEW RESPONSIBILITY OF NURSE VERIFICATION

POLICY STATEMENT:

- Every licensed nurse will be responsible to ensure that the physician's orders of each of their residents have been carried out as intended. All licensed nurses are responsible for verifying orders entered by the Unit Secretary. (Every attempt shall be made to review orders within one (1) hour for accuracy.)
- Verification of orders entered into the computer, written on the Kardex, MAR and TAR shall be completed throughout the shift.
- Every licensed nurse shall be accountable for accurate transcription of physician's orders for their assigned residents.
- A dated signature and classification must accompany review of all orders written and transcribed by the previous shift as evidence of procedure completion.
- Incomplete orders which are not verified will result in follow-up by the Nurse Manager or Nursing Supervisor.

PURPOSE:

- To verify the follow-through and transcription of physicians' orders from the previous shift.
- To ensure resident safety and comply with the standards of care.
- To verify the necessity to initiate, continue or change appropriate treatments and preparations as ordered.
- To maintain appropriate continuity in resident care.

PROCEDURE:

- As part of the shift routine, the assigned nurse will inquire about new orders written throughout the shift.
- The nurse will specifically check the physician's order prescribed on the previous shift.
- After the assigned nurse verifies an order has been written, the orders will be reviewed and carried out as per the physician order.

- The licensed nurse will compare the orders written with the resident's Kardex, Treatment Administration Record and Medication Administration Record.
- In black ink, the licensed nurse encompasses the orders received with a bracket, date, signature and classification.
- If orders have not been carried out, complete an incident report form and notify the Director of Nursing and notify the physician.

Approved by:



Date:

11/15/11

Reviewed by:



Date:

11/15/11

**CARDINAL HILL REHABILITATION HOSPITAL
INSERVICE EDUCATION ATTENDANCE REPORT**

Exhibit
6

CODE: _____

DATE OF INSERVICE: 11/14/11
 HOURS OF INSERVICE: 3.00 hr
 INSERVICE TITLE: Care Planning P2P
 CONDUCTED BY: _____ EMP# _____
 _____ EMP# _____

TARGET AUDIENCE: RN/LPN

- OBJECTIVES:
- 1) Policy & why we do care planning
 - 2) What should you include in care plan (Tx, other services)
 - 3) Each plan of care should be individualized
 - 4) Procedure of care planning

ATTENDANCE

EMPLOYEE # EXAMPLE: 12111	NAME (MUST PRINT) JOHN DOE	DEPT. EDUC
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

SUBMITTED BY: Theresa

DATE: 11/17/11

CARDINAL HILL REHABILITATION UNIT

ADMINISTRATIVE POLICY AND PROCEDURE

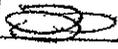
Policy #: C08 Care Planning

Policy: Care, treatment and services are planned to ensure that they are appropriate to the patient's needs. Therefore, it is the policy of CHRU to provide an individualized, interdisciplinary plan of care for all patients that is appropriate to the patient's needs, strengths, limitations and goals. Care planning will be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals for the patient that are reasonable and measurable. The plan of care will be documented and filed in the medical record of the patient.

PROCEDURE:

- Within seven (7) days of completion of the comprehensive assessments, all patients shall have a computerized plan of care generated by the registered nurse or the licensed practical/vocational nurse under the direct supervision of the registered nurse.
 - The interdisciplinary care plan will be completed no later than 72 hours after comprehensive assessments are completed.
- The plan of care shall be individualized, based on the diagnosis, patient assessment and personal goals of the patient and his/her family.
- The planning for care, treatment and services will include the following:
 - Care planning is based on data collected from patient assessments with integration of those assessment findings in the care planning process.
 - Developing a plan for care, treatment and services that includes patient care goals that are reasonable and measurable.
 - The frequency of care, services and treatment
 - Team members responsible for care, services and treatment
 - Financial implications of said care, services and treatment
 - Discharge planning; return to the community or discharge to an appropriate level of care
 - The needs of the patient, goals, time frames, required services and the service settings.
 - Regularly reviewing and revising the plan of care, treatment and services.

- Determining how the planned care, treatment and services will be provided.
- Documenting the plan for care, treatment and services.
- Monitoring the effectiveness of care planning and the provision of care, treatment and services.
- The plan of care will be evaluated frequently, based on the patient's clinical condition, care goals and the plan for treatment, care and services, and revised as needed to meet the needs of the patient's changing condition.
- Patients and/or families are involved in care planning.
- The plan of care will consider strategies to limit the use of restraints and/or seclusion as appropriate to the condition of the patient.
- The plan of care shall address the learning needs of the patient and/or family.
- After the initiation of the plan of care by nursing, those disciplines consulting in the care shall contribute to the plan as appropriate to the patient's assessed needs.
- All staff using the computerized plan of care are responsible for interdisciplinary collaboration to establish goals and appropriate interventions, as well as ongoing evaluations and revisions.
- Care plan review will be conducted every two (2) weeks.
- Care plans will also be reviewed when indicated by changes in the patient's condition.

Initial Date	November 2005
Effective Date	November 2005
Reviewed	 11/14/11
Revised	
Replaces	
Signature	

November 16, 2011

Attached please find the Policy and Procedure for **Care Planning**. Each nurse is responsible to read and follow the policy for their assigned patients.

The responsibility of the nurse has not changed: each clients care plan should be reviewed per shift and signed by the nurse responsible for that patient. If a new order is written on your shift it is the responsibility of the nurse to make sure the care plan reflects that order.

Teresa

