NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES

POLICY AND PROCEDURE

SUBJECT: INPATIENT TREATMENT PLAN

NUMBER: NN-IM-MR-13

ORIGINAL DATE: 03/27/89

REVIEW/REVISE DATE: 07/27/91, 08/12/92, 08/09/95, 08/03/00, 09/04/03, 10/05/06, 4/15/10, 5/17/12

APPROVAL: Cody L. Phinney, MPH, Agency Director

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I. PURPOSE

To establish minimum standards for the Northern Nevada Adult Mental Health Services (NNAMHS) inpatient treatment planning process.

II. POLICY

It is the policy of NNAMHS that each consumer admitted to the inpatient units have a written, person-centered, comprehensive treatment plan based on his or her expressed needs.

III. REFERENCES:

1. NRS 433.494 – Individual plan for service for consumer
2. NRS 433.554-4C1 – Failure to establish or carry out an appropriate plan of treatment for the consumer
3. NRS 433.A750 – Unlawful acts
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4. NRS 433.484 – Rights concerning care, treatment and training; consumer must be advised; consent to plan of care; treatment or training or transfer; exceptions
5. Conditions of participation – Part 482
6. Northern Nevada Adult Mental Health Services Policy NN-RI-04 Restraint/Seclusion
7. Division MHDS Policy and Procedure #2.005 Restraint/Seclusion of Patients
8. Joint Commission Accreditation Manual for Hospitals: Planning Care, Treatment, and Services
9. CMS: 482.61(c) Standard: Treatment Plan
10. MHDS Policy 4.031 Treatment Plan and Treatment Team
11. AVATAR Training Policy NN-HR-24 Staff Training on Electronic Medical Record (EMR) AVATAR

IV. DEFINITIONS

1. Person-centered: Person-centered implies individualized and total involvement of the consumer for whom the treatment-planning process is taking place in every step of the treatment planning process.
2. Long-term goals: These are directed toward the consumer's level of functioning in the areas of living, working, health and socializing as desired at the point of return to the community.
3. Short-term objectives: These describe the consumer's observable behaviors or circumstances that are measurable and define the progress (i.e. stabilization) toward the desired goal.
4. Treatment methods: The therapeutic interventions and activities utilized by the clinician to help the consumer to reach their intended goal.
5. Target date: The date by which the consumer can reasonably be expected to meet their objective.
6. Date met the date the objective actually has been met.

7. EMR: Electronic Medical Record
8. Review Date: The date on which the treatment team conducts the review of the treatment plan.
9. Responsible Staff: The name and title (discipline) of the staff member(s) responsible for the intervention.
10. Multidisciplinary Treatment Team: The team may be composed of the following individuals:
    a. Psychiatrist
    b. Psychologist
    c. Registered Nurse
    d. Licensed Clinical Social Worker
    e. Certified Recreational Therapist
    f. Mental Health Technician
    g. Service Coordinator
11. Treatment Plan: an outline of what the organization has committed itself to do for the consumer based on an assessment of the consumer's strengths and needs.

V. PROCEDURE

1. There will be one treatment plan that is used for each area of treatment either In-patient Psychiatric Observation Unit (POU). Each will have their own treatment plan. All the disciplines working in a treatment area will enter into the same treatment plan. A discipline can add a new problem or define/edit an existing problem specifically for that discipline's goal. If a plan is finalized, the discipline adding to the plan will default the existing information forward and add/edit their part of the plan. This will create a new treatment plan that needs to be finalized, printed, signed by staff and consumer on Treatment Plan Signature Sheet (MR #275), and placed in the consumer's chart.

2. Treatment plans will remain in draft form until the Treatment Team has completed their portion of the plan. After the Treatment Team has completed their portions of plan, it will be finalized by social services and again reviewed with the consumer, with initials and date at that time on the Treatment Plan Signature Sheet (MR#275).
3. The treatment plan is an evolving document that can quickly guide any staff member dealing with the consumer to assist with that consumer's particular needs/goals. The treatment plan must be based on an assessment of the consumer's strengths and needs.
4. POU Treatment Plan

   An initial treatment plan is initiated by the admitting clinician in conjunction with the consumer upon admission, whenever possible, printed, signed on Treatment Plan Signature Sheet, by the consumer and the admission staff or any Nursing staff as part of the Treatment Team, and placed in the consumer's chart within 24-hours.

   a) If the consumer is unable to sign or refuses to sign, that will be documented on the Treatment Plan Signature Sheet (MR#275) under consumer signature with date and time. The nursing staff will also sign as completed the treatment plan and attempted to review with consumer.
   b) The Initial treatment plan will remain in draft form until the Social Services and the doctor have reviewed the plan and aggress on content. After that the plan will be finalized (Master Treatment Plan) and offer review with the consumer and if not signed, will attempt to gain signature.

5. Inpatient Treatment Plan

   a. The inpatient service includes several departments and a variety of treatment options. A consumer admitted to the inpatient units is being assessed and treated by all disciplines that are part of the multidisciplinary treatment team.

b. Responsibility for coordinating the treatment plan between services is carried out by nursing.

c. An Initial Treatment Plan will be initiated together with the consumer at each inpatient admission. The consumer's treatment plan is signed by the consumer or his/ her guardian and all treatment team members present at that time. If the consumer refuses or is unable to sign, that will be documented and each attempt to review treatment plan with consumer will be documented.

d. The clinician developing the treatment plan upon admission to inpatient will select the Initial Treatment Plan to create a new initial treatment plan for in-patient.

6. The Social Service department and Recreational Therapists will add their objectives, interventions, and goals for the consumer within 5 days of admit. At this time, Social Services will be reviewing and finalizing the Master Treatment Plan with the consumer. Another initial and date will be obtained at that time by the staff and consumer on the MR #275.

a. Each finalized Treatment Plan is reviewed every seven days in the multidisciplinary treatment team and whenever there is a change in condition but in no case less than every ninety days thereafter.

Updating Treatment Plan: The treatment plan should be updated as the Treatment Team feels it necessary and at the following junctures: whenever a goal(s) has been accomplished; when a consumer is regressing; when a consumer is failing to progress; or when a consumer requires a new treatment goal, objectives, intervention or a new problem has presented

1. Treatment Plan Update Includes:

(i) Resolve existing problem

(ii) Objective met or updated

(iii) Service is updated

(iv) New or updated intervention

(v) New or updated objective

(vi) New problem

(vii) Progress towards goal

(viii) Select the current IP Master Treatment plan. Select add and default in the information.

(ix) Brief Treatment Plan Description: "NN IP Update (clinician type, i.e., RN, AT, SW) **/**/**** (date)

(x) Plan Start Date: (Date plan initiated)

(xi) Plan Expiration Date

(xii) Expected Discharge Date: If known

2. Any addition has to be signed (initialed) and dated by the consumer and/or his/her guardian at the earliest multidisciplinary treatment team meeting with the consumer or at the earliest time the guardian is available.

7. Review of Treatment Plan:
   a. The treatment plan is to be reviewed weekly and updated as needed. This information can be noted in Weekly Update by nursing staff in progress note. Either, no change in plan, objectives and interventions remain the same or noted change in treatment plan.
   b. Documentation of the review and changes are evidenced in the treatment team notes in the consumer record. Progress notes are directed at the consumer's progress or lack of progress in achieving their goals.
8. Responsibility for treatment team coordination:
   a. Each treatment team meets a minimum of weekly with the consumer or their guardian. All disciplines are required to be present for completion of the treatment plan.
   b. The physician leads the treatment team and planning process, i.e. timeliness of treatment plans and treatment plan reviews. The social worker facilitates the treatment team meeting.

c. Each discipline is responsible for completing their treatment plan entry prior to second treatment team meeting with the consumer. The plan is reviewed at each meeting to assure we are all working towards the same goals.

d. Following a treatment team meeting, it is the responsibility of each discipline to enter any changes or revisions to the treatment plan that has been identified during that meeting either by the consumer or the treatment team.