

Policy: It is the policy of the Division that each individual served have a written, individualized treatment plan based on an assessment of the individual's strengths and needs entered into the record of treatment in keeping with this policy and in keeping with state and federal law (NRS 433.494 through NRS 433.750).

Purpose: This policy sets the minimal standards for the treatment planning process within the Division. The treatment plan includes how the treating clinician and/or treatment team will assist the individual in meeting their individualized treatment goals. The plan provides both a synopsis of, and an index to, the individual's treatment history. The plan will include:

- I. The goals of treatment specific to each individual;
- II. The title and the name of the specific staff person, or agency (when service is provided by another agency), who will assist the consumer to achieve maximum self-sufficiency, including duration and frequency of contacts;
- III. Where the individual is in the process and progress of treatment with current target date. Since the plan is a summary statement, details of specific treatment steps followed in reaching each objective, specifics of progress, and proposed revisions are all recorded in the progress notes. The plan serves as a guide to locating these details.

Definitions:

- Initial and current diagnosis - This is a diagnosis on Axis I, II, III, IV, and V of the current DSM classification system. It indicates that the individual's problems are primarily the result of a mental disorder and that treatment in a Division inpatient or outpatient setting is appropriate.
- Individual Consumer Strengths and Resources - The individual's strengths must be utilized in the development of the goals and treatment plan. These strengths must be descriptive and not interpretive. Strengths are personal attributes, i.e., knowledge, interests, skills aptitudes, personal experiences, education, resources, talents and employment status, which may be useful in developing a meaningful treatment plan.
- Problems/Needs - These are the symptoms, behaviors, social, legal or family circumstances which led to the need for treatment and which, when resolved or the patient has reached optimal self care, will enable goal attainment. Problem statements should describe specific, observable behaviors or circumstances in order to facilitate the clear statement of measurable treatment objectives.
- Treatment methods (interventions) are the planned clinical/therapeutic interventions and activities, which will be used in resolution of each problem/need. More than one treatment method might be used to solve a particular problem/need. For example, the use of neuroleptic medication and behavioral modification techniques might be combined to reduce the observable effects of delusional symptoms. Interventions might also require

the use of more than one agency/entity. In this instance, the name of the agency/entity must be entered into the section titled responsible staff. For example, a Group Home provider might be utilized to provide Activities of Daily Living Skill Training.

- Treatment Planning Objectives are statements of desirable, and where possible, measurable behavioral symptom, social, legal or family change that demonstrate elimination or significant reduction of the individual's identified problem/need. These objectives must relate back to the active problems/needs defined on the problem list. Treatment planning objectives are the short and long-term goals of treatment. Short-term goals are usually related to the desired resolution of acute or otherwise significant conditions that prevent discharge from the program. Long-term goals are the end point of treatment with the patient reaching optimal self-sufficiency (all identified problems/needs resolved).
- Target date - For each objective outcome, a date is given for when the objective is expected to be met.
- Date met - This is the date the objective is met.

Procedures:

- I. On client's admission, identified problems are entered on the problem list form by the attending clinician.
- II. Attending clinician must then enter the problem on the treatment plan and develop appropriate treatment methods, objectives, target dates, and identification of responsible staff within the time frame specified by agency policy. Additional problems may be placed on the problem list form at anytime during the individual's course of treatment by the attending clinician or by a treatment team member working with that client. The treatment team member initiating a problem shall discuss revision of the problem list in the treatment team meeting with the physician present.
- III. A plan shall be considered initiated when:
 - A. The treatment objectives and diagnosis have been entered; and
 - B. At least one treatment method, related to the objective, with date and responsible staff, has been written for each problem/need identified.
- IV. All active problems/needs entered on the problem list must be addressed either by intervention, referral or deferred on the treatment plan.
- V. Entries are made on the treatment plan as follows:
 - A. Diagnosis (current DSM axis as determined by the facility psychiatrist or attending clinician);
 - B. Date, number, and problem statement of each problem identified on the problem list;

- C. Enter at least one treatment method for each problem;
 - D. Enter the measurable objectives; and
 - E. Enter the name and title of the staff, or other agency/entity responsible for each method.
- VI. All treatment activities delineated in an individual's treatment plan will be recorded in the facility progress notes by:
- A. Using the approved format (i.e. SOAP, DAP, Narrative, etc.) approved format (i.e. SOAP, DAP, narrative, etc.)
 - B. Each staff member providing a service will make entries;
 - C. Each entry will be dated, timed, and signed by the person making the entry; and
 - D. Each entry will refer to one or more problem(s) being addressed by the problem number.
- VII. When new problems are entered after the treatment plan has been developed, a "signature" form will be used to continue with the treatment planning.
- VIII. Treatment Plan and Review:
- A. Each time a treatment plan is developed, it must be reviewed with the consumer as to the nature and consequences of the treatment, the reasonable risks and benefits of the treatment and alternative procedures and treatments available, if any. The treatment plan must also be signed by:
 - 1. The consumer if he/she is over 18 years old and legally competent; or
 - 2. The individual's parent or legal guardian if under age 18; or
 - 3. The legal guardian of a consumer adjudicated mentally incompetent; and
 - 4. The attending psychiatrist; and
 - 5. Any other disciplines included.

If the individual refuses to sign, that must be noted and dated on the form and reasonable action must be taken on an ongoing basis to get the consumer to sign. This process needs to be documented in the progress notes.
 - B. Treatment plans must be formally reviewed with the individual at a minimum of every ninety (90) days, pursuant to NRS 433.494 and facility policy.
 - C. Each treatment plan review is recorded on the progress notes, or specific agency form, as follows:
 - 1. Date and time of review; and
 - 2. Current diagnosis on all axis, or if diagnosis has not changed note "no change"; and
 - 3. Enter problem number and statement for each unresolved problem from problem list; and

4. Identify the status of each problem at the time of the treatment plan review.

D. If the problem/need is deemed resolved:

1. Enter date in "date met" column on the problem list and treatment plan; and
2. Make entry in progress notes indicating rationale for problem resolution indicating the reason the problem will not be addressed beyond this date.

E. Revised Problem/Need: If there is a need for reformulating a problem, the responsible staff will:

1. Enter the new problem number in the "revised problem" column; and
2. Enter the problem number and the revision on the next available line of the plan review form. The new problem must be entered on the problem list; and
3. Make entry in the progress notes indicating the reason for the change; and
4. Appropriate methods and criteria must be developed for each new problem.

F. Each time a treatment plan review is completed, it must be signed by;

1. The individual consumer;
2. The facility psychiatrist or primary clinician; and
3. Any other disciplines involved.

If the individual refuses to sign, that must be noted and dated on the form, and action taken as per agency policy.

IX. Each Division agency shall develop specific written procedures to implement the provision of this policy or shall incorporate this policy into the agency policy manual.



Administrator

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