Patient Plans of Care for Inpatient Facilities

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This section contains information to help providers complete written patient plans of care in accordance with Federal regulations.

Patient Plans of Care

Institutional providers such as acute hospitals, psychiatric hospitals, and Nursing Facilities Level B must include a written Plan of Care in each patient's medical record.

Individual written plans are required by *Code of Federal Regulations* (CFR), Title 42, to be approved and signed by a physician. They should include:

- Diagnosis, symptoms, complaints and complications;
- Description of individual's functional level;
- Objectives;
- Orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures;
- Plans for continuing care; and
- Plans for discharge.

State reviewers will monitor federal requirements during onsite and/or annual medical reviews.

CFR, Title 42

Providers can refer to the following CFR, Title 42, sections pertaining to Plans of Care:

‹‹**CFR, Title 42 Plans of Care Table**››

Facility Type	CFR Section
Acute Hospitals	Section 456.80
Psychiatric Hospitals	Section 456.180
Skilled Nursing Facilities	Section 456.280

or, note the following summary of CFR, Title 42:

Acute Hospital Written Plan of Care

I. The Acute Hospital Written Plan of Care

(a) Before admission of a patient to a hospital or before authorization for payment, a physician and other personnel involved in the care of the individual must establish a written Plan of Care for each applicant or recipient.

(b) The Plan of Care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Any orders for –

(i) Medications,

(ii) Treatments,

(iii) Restorative and rehabilitative services,

(iv) Activities,

(v) Social services, and

(vi) Diet;

(4) Plans for continuing care, as appropriate;

(5) Plans for discharge, as appropriate.

(c) Orders and activities must be developed in accordance with the physician's instructions.

(d) Orders and activities must be reviewed and revised as appropriate by all personnel involved in the care of an individual.

(e) A physician and other personnel involved in the recipient's case must review and sign each Plan of Care at least every 60 days.

Psychiatric Hospital Written Plan of Care

II. The Psychiatric Hospital Written Plan of Care

(a) Before admission of a patient to a psychiatric hospital or before authorization for payment, the attending physician or staff physician must establish a written Plan of Care for each applicant or recipient.

(b) The Plan of Care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives

(4) Any orders for –

(i) Medications,

(ii) Treatments,

(iii) Restorative and rehabilitative services,

(iv) Activities,

(v) Therapies

(vi) Social services

(vii) Diet, and

(viii) Special procedures recommended for the health and safety of the patient;

(5) Plans for continuing care, including review and modification to the Plan of Care; and

(6) Plans for discharge.

(c) The attending or staff physician and other personnel involved in the recipient's care must review and sign each Plan of Care at least every 90 days.

Nursing Facility Level B Written Plan of Care

III. The Skilled Nursing Facility Written Plan of Care (includes distinct parts of acute hospitals and NF-Bs)

(a) Before admission of a patient to an NF-B or before authorization for payment, the attending physician must establish a written Plan of Care for each applicant or recipient in an NF-B.

(b) The Plan of Care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives

(4) Any orders for –

(i) Medications,

(ii) Treatments,

(iii) Restorative and rehabilitative services,

(iv) Activities,

(v) Therapies

(vi) Social services

(vii) Diet, and

(viii) Special procedures recommended for the health and safety of the patient;

(5) Plans for continuing care, including review and modification to the Plan of Care; and

(6) Plans for discharge.

(c) The attending or staff physician and other personnel involved in the recipient's care must review and sign each Plan of Care at least every 60 days.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.