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§482.61(c)(1) Standard Treatment Plan. Each patient must have an individualized, comprehensive treatment plan based on an inventory of the patient's strengths and disabilities.

Interpretive Guidelines §482.61(c)(1)

The patient and treatment team collaboratively develop the patient's treatment plan. The treatment plan is the outline of what the hospital has committed itself to do for the patient, based on an assessment of the patient's needs. The facility selects its format for treatment plans and treatment plan updates.

Survey Procedure §482.61(c)(1)

Determination of compliance regarding treatment plans is accomplished by the surveyor using the following methods, and to the extent possible, the following order:
1. Observation of the patient and staff at planned therapies/meetings, in various settings both on and off the patient units, in formal and informal staff-patient interactions and in a variety of daily settings;
2. Interviews with patients, families, treatment staff and others involved directly or indirectly with active treatment;
3. Reviews of scheduled treatment programs (individual, group, family meetings, therapeutic activities, therapeutic procedures);
4. Attendance at multidisciplinary treatment planning meetings, if time permits; and
5. Medical record review.

Has the information gained from assessing/evaluating the patient been utilized to create an individualized treatment plan?

A disability is any psychiatric, biopsychosocial problem requiring treatment/intervention. The term disability and problem are used interchangeably. The treatment plan is derived from the information contained in the psychiatric evaluation and in the assessments/diagnostic data collected by the total treatment team. Based on the assessment summaries formulated by team members of various disciplines, the treatment team identifies which patient disabilities will be treated during hospitalization. Patient strengths that can be utilized in treatment must be identified. (See also §482.61(b)(7).) Treatment planning depends on several variables; whether the admission is limited to crisis intervention, short-term treatment or long-term treatment. The briefer the hospital stay, the fewer disciplines may be involved in the patient's treatment.

There must be evidence of periodic review of the patient's response and progress toward meeting planned goals. If the patient has made progress toward meeting goals, or if there is a lack of progress, the review must justify: (1) continuing with the current goals and approaches; or (2) revising the treatment plan to increase the possibility of a successful treatment outcome.

Consideration must be given to the type of psychiatric program(s) under review to determine the timeframe for treatment plan review. The interval within which treatment plan reviews are conducted is determined by the hospital, however, the hospital's review system must be sufficiently responsive to ensure the treatment plan is reviewed: whenever a goal(s) has been accomplished; when a patient is regressing; when a patient is failing to progress; or when a patient requires a new treatment goal. The facility is

expected to pursue aggressively the attendance of all relevant participants at the team meetings. Question any routine and regular absences of individuals who would be expected to attend.
Is the treatment plan individualized, i.e., patient-specific, or is there a predictable sameness from plan to plan?

When packaged plans or programs are used, do staff include needed individual adaptations in the plan?

Are the patient's observed behaviors consistent with the problems and strengths identified in the plan or update?

Have the views which the patient communicated to the surveyor regarding problems which require treatment during hospitalization and plans for discharge, been incorporated in the plan or update?