A-0396
(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.23(b)(4) - The hospital must ensure that the nursing staff develops and keeps current a nursing care plan for each patient that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The nursing care plan may be part of an interdisciplinary care plan.

Interpretive Guidelines §482.23(b)(4)

Nursing care planning starts upon admission. It includes planning the patient's nursing care to meet the patient's needs and interventions toward meeting patient treatment goals while in the hospital as well as planning for discharge to meet post-hospital needs. A nursing care plan is based on assessing the patient's nursing care needs (not solely those needs related to the admitting diagnosis). The assessment considers the patient's treatment goals and, as appropriate, physiological and psychosocial factors and patient discharge planning. The plan develops appropriate nursing interventions in response to the identified nursing care needs. The nursing care plan is kept current by ongoing assessments of the patient's needs and of the patient's response to interventions, assessment of patient treatment goals, and updating or revising the patient's nursing care plan in response to assessments. The nursing care plan is part of the patient's medical record and must comply with the medical records requirements at §482.24.

Hospitals have the flexibility of developing the nursing care plan as part of a larger, coordinated interdisciplinary plan of care. This method may serve to promote communication among disciplines and reinforce an integrated, multi-faceted approach to a patient's care, resulting in better patient outcomes. The interdisciplinary plan of care does not minimize or eliminate the need for a nursing care plan. It does, however, serve to promote the collaboration between members of the patient's health care team.

The required documentation for the nursing component of an interdisciplinary care plan remains the same. For other components, the hospital should follow the current documentation policies that it uses to document services provided by other disciplines, such as services provided by physical therapists, occupational therapists, speech-language

pathologists, and others. Documentation should follow the standards of practice for those disciplines in addition to any specific requirements that the hospital might want to establish. The documentation must also comply with the requirements of the medical records requirement at §482.24. (77 FR 29049, May 16, 2012)

Survey Procedures §482.23(b)(4)

Select a sample of nursing or interdisciplinary care plans. Approximately 6-12 plans should be reviewed. For each plan reviewed, with respect to the nursing care component:

- Was the plan initiated as soon as possible after admission for each patient?
- Does the plan describe and reflect patient goals as part of the patient's nursing care assessment and, as appropriate, physiological and psychosocial factors and patient discharge planning?
- Is the plan consistent with the plan for medical care of the practitioner responsible for the care of the patient?
- Is there evidence of reassessment of the patient's nursing care needs and response to nursing interventions and, as applicable, revisions to the plan?
- Was the plan implemented in a timely manner?