CA

72471 Special Treatment Program Service Unit-Patient Health Records and Plans for Care

(a)

The facility shall maintain an individual health record for each patient which shall include but not be limited to the following: (1) A list of the patient's care needs, based upon an initial and continuing individual assessment with input as appropriate from the health professionals involved in the care of the patient. Initial assessments by a licensed nurse shall commence at the time of admission of the patient and shall be completed within seven days after admission. (2) The plan for meeting behavioral objectives. The plan shall include but not be limited to the following: (A) Resources to be used. (B) Frequency of plan review and updating. (C) Persons responsible for carrying out plans. (3) Development and implementation of an individual, written care plan based on identified patient care needs. The plan shall indicate the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. The objectives shall be measurable, with time frames, and shall be reviewed and updated at least every 90 days.

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admission of the patient and shall be completed within seven days after admission.

(2)

The plan for meeting behavioral objectives. The plan shall include but not be limited to the following: (A) Resources to be used. (B) Frequency of plan review and updating. (C) Persons responsible for carrying out plans.

(A)

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(B)

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(C)

Persons responsible for carrying out plans.

(3)

Development and implementation of an individual, written care plan based on identified patient care needs. The plan shall indicate the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. The objectives shall be measurable, with time frames, and shall be reviewed and updated at least every 90 days.

(b)

There shall be a review and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

(c)

The patient care plan shall be approved, signed and dated by the licensed healthcare practitioner acting within the scope of his or her professional licensure attending the patient.

(d)

There shall be at least monthly progress notes in the record for each patient which shall include notes written by all members of the staff providing program services to the patient. The notes shall be specific to the needs of the patients and the program objectives and plans.

(e)

At the time of reassessment there shall be a summary of the progress of the patient in the program, the appropriateness of program objectives and the success of the plan.