COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Care Plans		**NUR-007**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

SCOPE

This policy applies to Mangum Regional Medical Center, Registered and Licensed Practical Nurses who are involved in the care of inhouse patients.

PURPOSE

To assure proper management and care for the patient, the nursing staff will develop and update a care plan for each patient. This will provide coordinated treatment and care, and smooth transition of the patient between departments and shifts.

DEFINITIONS

NA

POLICY

This hospital provides a care plan for each patient admitted. The care plan will be individualized to the patient' s needs and initiated upon admission, updated or modified as patient care needs change, or when a change in care or condition occurs for resolution of problems and to stay current with other problems which might arise.

PROCEDURE

A. On admission, a patient care plan will be initiated and placed in the patient's medical record;
B. The care plan will be initiated by the admitting RN;
C. The care plan will be individualized for the needs of the patient by a RN;
D. The plan will be updated for resolution of problems and presenting problems as they arise.

E. The patient has the right to participate in the development and implementation of his or her plan of care including discharge planning as part of the patient's plan of care.
F. The hospital will take appropriate actions to engage the patient, or the patient's representative, actively in the development of the discharge evaluation, not only as a source of information required for the assessment of self-care capabilities, but also to incorporate the patient's goals and preferences as much as possible into the evaluation (a patient's goals and preferences may be, in the hospital's view, unrealistic. Identifying divergent hospital and patient assessments of what is realistic enables a discussion of these differences and may result in an assessment and subsequent development of a discharge plan that has a better chance of successful implementation).
G. Required components of the care plan:
    - It includes planning the patient's care while in the CAH as well as planning for transfer to a hospital, to a post-acute care facility or for discharge.
    - The 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, and updating or revising the patient's nursing care plan in response to assessments.
    - The nursing care plan is part of the patient's clinical.
    - The nursing care plan is part of a 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 and serves to promote the collaboration between members of the patient's health care team.

REFERENCES

Appendix W §485.635(d)(4)

ATTACHMENTS

NA

REVISIONS/UPDATES

Date	Brief Description of Revision/Change