### PURPOSE

To provide clinical direction to the clinicians providing direct patient care.

### POLICY

A written plan of care will be initiated within five (5) days of start of care and updated at least every 60 days or as patient’s condition warrants. The patient plan of care will be developed or revised within five (5) working days of initiation of each service or of the reassessment of the patient. All clinicians as well as the patient’s attending physician involved in the patient’s care, will contribute to the plan of care. The patient and family/caregiver will participate in decisions regarding the plan of care whenever possible. The care planning process will be documented on the plan of care, individualized discipline specific care plans (if applicable), clinical notes, medication profiles, care conference/summary forms, and discharge/clinical summaries.

The plan of care will be reviewed more frequently than every 60 days when a patient elects a transfer to another home health organization, a significant change occurs in the patient’s condition, or a patient is discharged and readmitted during the same 60-day period.

#### Definitions

1. *Plan Of Care*: The clinical plan of care includes:
   1. Pertinent primary and secondary diagnoses
   2. Food or drug allergies
   3. Homebound status
   4. Goals/outcomes to be achieved
   5. Patient’s mental status
   6. Functional limitations
   7. Activities permitted
   8. Safety measures
   9. Nutritional requirements
   10. Medications and treatments
   11. Specific procedures to be performed by therapies, including amount, frequency, and duration
2. Supplies and equipment required
3. Discharge or referral plans
4. Discharge teaching
5. Frequency and duration of visits
6. Prognosis
7. Rehabilitation potential
8. Other appropriate items such as precautions and contraindications
9. *Clinician*: Any Nurse, PT, OT, ST, MSW, or paraprofessional involved in the care of a patient, either directly or indirectly, including administrative, management, and supervisory personnel.

### PROCEDURE

1. At the time of the initial assessment, the clinician, along with other involved disciplines, will develop the patient plan of care based upon the patient’s identified needs and will review it with the patient and family/caregiver.
2. All clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, including but not limited to:
3. Individualized patient needs and resultant problems related to care, functional status, and family/caregiver support system
4. Changes in patient’s condition
5. Clinical drug monitoring, as appropriate
6. Pain and symptom management, as appropriate
7. Psychosocial and spiritual needs of patient and family/caregiver, as appropriate
8. Patient treatment choices
9. Based on the assessment and conclusions, the plan of care will include, but will not  
   be limited to:
   1. Identified patient problems and needs
   2. Reasonable, measurable, and individualized goals
   3. Type, frequency, and duration of actions to be taken to meet the patient goals
   4. Specific services to be provided
   5. Equipment and supplies
   6. Prognosis
10. Based upon the plan of care and assessments, a visit frequency schedule will be developed. A written copy of the visit frequency schedule will be given to the patient and/or caregiver.
11. The care planning decisions will be reflected in the specific services that will be provided and the associated actions planned and implemented to meet individualized patient problems and goals.
12. The plan of care will be based upon the physician's (or other authorized licensed independent practitioner’s) orders and will encompass the equipment, supplies, and services required to meet the patient’s needs.
13. Patient receiving physical therapy or speech therapy only will have a plan of care initiated by the primary physical therapist or speech therapist within 48 hours of completion of the initial assessment.
14. The plan of care will be revised as frequently as deemed necessary by the clinicians based on the ongoing assessments of the patient. Revision dates will be noted on the plan of care.
15. The frequency of the review of the plan of care will be based on changes in the patient’s health status, needs, and the environmental factors affecting care. The clinicians will be responsible to revise the plan of care or update the plan at least every 60 days.
16. Changes in the plan of care will be noted with the following documentation:
    1. Assessment
    2. Plan of care with clinical outcome goals
    3. Care plan with specific services/actions to be taken
    4. Clinical notes
    5. Physician orders
17. Clinicians will inform the patient’s physician of any changes that suggest a need to alter the plan of care. Changes must be written, dated, and signed by the professional making the changes.
18. The Case Manager or designee will sign the plan of care and document other clinical personnel who reviewed it.
19. Problems and/or needs related to patient’s condition, desires, abilities, family/caregiver support systems, and relevant medication monitoring will be included in the plan of care.
20. Services to be provided will be based on the prioritized needs of the patient. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes to determine if goals have been achieved.
21. Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes.
22. The Clinical Supervisor or designee will review the plan of care for all patients.