


<b>Name of Policy:</b> <u>Individualized Treatment Plan</u> <b>Policy Number:</b> 3364-143-25 <b>Department:</b> Lenore W. and Marvin S. Kobacker Center <b>Approving Officer:</b> Vice President & Executive Director <b>Responsible Agent:</b> Clinical Practice Manager & Agency Executive Director <b>Scope:</b> Kobacker Center	 <b>THE UNIVERSITY OF TOLEDO</b> <small>1872</small>
	<b>Effective Date:</b> October 31, 2008 Initial Effective Date: October 31, 2008
<input checked="" type="checkbox"/> New policy proposal <input type="checkbox"/> Major revision of existing policy	<input type="checkbox"/> Minor/technical revision of existing policy <input type="checkbox"/> Reaffirmation of existing policy

**(A) Policy Statement**

An Individualized Treatment Plan or “ITP” will be developed for each client and will become part of the Medical Record (MR).

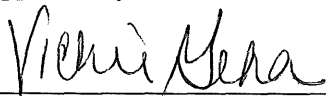
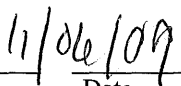
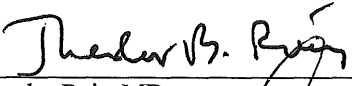
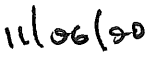
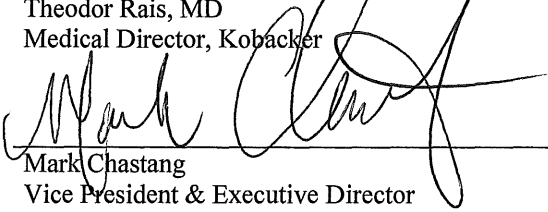
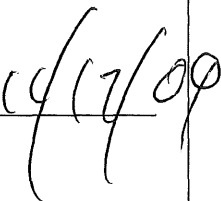
**(B) Purpose of Policy**

The Individualized Treatment Plan is used to monitor progress during the course of treatment.

**(C) Procedure**

1. The development of the individualized treatment plan is a collaborative process between the client and the interdisciplinary team based on a diagnostic assessment, a continuing assessment of needs, and the successful identification of interventions/services. The individualized treatment plan shall document, at minimum, the following:
  - a. A description of the specific mental health need(s) or identified problems of the patient; including strengths and limitations.
  - b. The goals identified for the patient focusing on what can be accomplished while in the hospital. Goals should be written in specific terms that are **Specific, Measureable, Achievable, Reasonable, Time delineated.**
  - c. All interventions should be discipline specific and contain specifically what each discipline will be doing with the patient.
  - d. Review dates should be recorded with follow up as necessary. If a goal is not met, then either a new goal needs to be made and/or additional interventions should be noted.
  - e. Evidence that the plan has been developed with the active participation of the patient and/or family members, parents, legal guardians/custodians or significant others shall also be documented; or
  - f. As relevant, the inability or refusal of the patient to participate in service planning and the reason(s) given; and
  - g. The date of the goal should be entered along with the dates of any changes made on the ITP. The signature of the staff member providing service must be dated and timed.

2. The individual treatment plan must be initiated as soon as possible but within at least 72 hours of admission.
3. The individual treatment plan shall be periodically reviewed and updated as appropriate to patient response to treatment.

<b>Approved by:</b>  _____ Vickie Geha, BSN, RN, MEd Administrator, Ambulatory Services & Behavioral Health	 _____ Date	<b>Review/Revision Date:</b>
 _____ Theodor Rais, MD Medical Director, Kobacker	 _____ Date	
 _____ Mark Chastang Vice President & Executive Director	 _____ Date	
<i>Review/Revision Completed By:</i> Kobacker Administration		<b>Next Review Date:</b> 10/1/2011
<b>Policies Superseded by This Policy:</b> new		

*It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.*