Name of Policy:	**Individualized Multidisciplinary Treatment Plan (ITP)**
Policy Number:	3364-122-22
Department:	Nursing Service –Inpatient Psychiatric Hospital
Approving Officer:	Director of Nursing/Chief Nursing Officer
Responsible Agent:	Director of Nursing
Scope:	The University of Toledo Medical Center

THE UNIVERSITY OF TOLEDO 1872

Effective Date: 4/1/2023
Initial Effective Date: 3/1993

_____	New policy proposal	_____	Minor/technical revision of existing policy
X	Major revision of existing policy	_____	Reaffirmation of existing policy

(A) Policy Statement

Each patient admitted into The Behavioral Health Inpatient Units at the University of Toledo Medical Center will have a Multi-disciplinary Individualized Treatment Plan (ITP). The Interdisciplinary Treatment Plan first page is a tool for organizing a complete list of patient problems, strengths, and weaknesses identified by the various disciplines. The problems are listed by each discipline based on his or her assessment. Problems are defined as those issues that will have an impact on the treatment of the patient

(B) Purpose of Policy

1. To provide individualized treatment for each inpatient.
2. To coordinate care of patients across disciplines.
3. To serve as the data base for progress and further treatment needs.
4. To assure the treatment plan provides appropriate care from all members of the hospital disciplines.
5. To ensure plans for care, treatment, and service are individualized to meet the patient's unique needs and circumstances.

(C) Procedure

1. The treatment planning process is continuous and dynamic, beginning at the time of admission and continuing through discharge. Patients and/or families/patient representatives are invited to be involved in the treatment planning process as clinically appropriate.

2. Concurrent with their participation in the daily treatment program, each patient works towards individual treatment goals during hospitalization. These goals reflect thoughtful evaluation of the patient and identification of problems, strengths, weaknesses, and interventions designed to assist the patient in achieving the goals.

3. On admission, the Nurse consults with the Admitting Physician and any other staff involved in the intake process. Based on the psychiatric evaluation and the Nursing Assessment, the Nurse initiates the Interdisciplinary Treatment Plan by listing identified problems, strengths, and weaknesses. The problem list is developed from intake information, the medical/psychiatric History and Physical, the Nursing Assessment, an initial interview with the patient and/or family, and any other assessments already completed.

4. The initial treatment team meeting is held no later than 72 hours after admission at which time the Interdisciplinary Treatment Plan is reviewed and revised. Each team member is responsible for having completed their assessment and to present a summary in the team meeting. The treatment team meetings are directed by the attending psychiatrist. The social worker or therapist serves as Treatment Plan Coordinator for each patient. This individual is responsible for ensuring that the appropriate documentation is entered on the treatment plan. The social worker or therapist is also responsible for explaining the plan to the patient, soliciting their input, and obtaining their signature. A treatment review meeting are held weekly and more frequently, if clinically indicated.

5. Problems entered on the Interdisciplinary Treatment Plan form the basis of the patient's individual treatment plan. Each discipline performing an assessment adds their findings to the problems list. The therapist/social worker is responsible for coordinating this process.

6. The initial treatment-team planning meeting is held within three days of admission. The purpose of this is to integrate all elements of the Assessment process and ensure their incorporation into the Interdisciplinary Treatment Plan.

7. Key elements essential to all stages of treatment planning may include the following:

    a. Problems are written in behavioral terms not diagnosis. Co-occurring medical conditions requiring management should be identified.
    b. Short-term goals are written in observable and measurable terms.
    c. Treatment plans are based on systematic evaluations of patient's assets (strengths) and limitations/stressors (weaknesses).
    d. Treatment Plans may include the patient/family/patient representatives' other goals for treatment and expected outcomes.
    e. Treatment plans specify the frequency of each treatment intervention/procedure and name the disciplines and persons responsible for interventions.
    f. Treatment plans specify criteria for discharge.

8. TREATMENT PLAN REVIEW PROCEDURE

1. Each patient is reassessed to determine current clinical problems, needs and responses to treatment. Reviews occur when major clinical changes occur and at least every 7 days minimally or more often if clinically indicated.

2. Record progress or lack of progress for each short-term goal. Determine the extent to which the interventions were implemented and the extent to which the goals were accomplished. Discuss any modifications that should be made to the interventions or goals and give a narrative statement describing progress or response to the treatment interventions in the lines provided. Review of major family, social or life events that may complicate treatment occurs and all changes in treatment are documented. When all goals are accomplished, a problem is considered resolved and/or new problems are assigned.

3. Discuss whether the family/patient representative participated in treatment, and results.

4. Patient's Participation in Treatment Plan Review: The social worker or therapist will discuss treatment goals and progress with the patient and incorporate patient input into the treatment planning process and document same. The patient family/significant other are encouraged to attend treatment plan reviews.

5. Additional comment : Note areas that may affect treatment or limit extent of recovery or outcomes.

6. Estimated Length of Stay: List the new and revised ELOS.

Approved by:		**Review/Revision Date:**
/s/ Tamara Cerrone, BSN, RN Nursing Director	Date	3/94 5/1995 4/1996 5/97 5/1998 4/1999 8/2001 1/02 4/04 3/2007 5/17/2010 4/8/2014 6/2016 6/2018 6/2021 4/2023
/s/ Tanvir Singh, MD Service Chief	Date	
/s/ Kurt Kless MSN, RN Chief Nursing Officer	Date	
Review/Revision Completed By: *Administrator Ambulatory Services & Behavioral Health* *Kobacker UBC*		**Next Review Date:** 4/2026
Policies Superseded by This Policy: 1-M-22		