Title: **TREATMENT PLANNING PROCESS**
Responsibility: Trained Inpatient Behavioral Health staff

Purpose of Guidelines: To ensure plans for care, treatment, and service are individualized to meet the patient's unique needs and circumstances.

A. Each patient admitted to Inpatient Behavioral Health has an individualized written treatment plan that is based on interdisciplinary clinical assessments. 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.

B. 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.

C. Treatment planning is the structured process by which identified patient problems are resolved via specific goal-oriented treatment interventions. Continued care needs are identified as part of the treatment planning process, discontinued, or revised.

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

1. Problems are written in behavioral terms not diagnosis. Co-occurring medical conditions requiring management should be identified.

2. Short-term goals are written in observable and measurable terms.

3. Treatment plans are based on systematic evaluations of patient's assets (strengths) and limitations/stressors (weaknesses).

4. Treatment Plans may include the patient/family/patient representatives, other goals for treatment and expected outcomes.

5. Treatment plans specify the frequency of each treatment intervention/procedure and name the disciplines and persons responsible for interventions.

6. Treatment plans specify criteria for discharge.

Procedure:

INTERDISCIPLINARY TREATMENT PLAN OVERVIEW

1. 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. Problems should include the reason for the admission, medical conditions, legal concerns, etc. The first problem is always the reason that justifies admission. Problems are stated in behavioral terms, not DSM diagnosis. Problems are determined to be active, referred or monitored. As patient problems are identified in the assessment process, they are entered appropriately on the Problem List by the treatment team member them. This process begins at admission, as the physician, nurse and the clinical staff identifies problems throughout the first 24 hours. Additional problems identified through the assessment process are entered onto the Problem List and patients are reevaluated as necessary. The active problems listed on the Problem List form the basis for the Interdisciplinary Treatment Plan and the Individual Treatment Plans.

2. Strengths and weaknesses are derived from the interdisciplinary assessments. The strengths and weaknesses are used to assist in determining appropriate short- and long-term goals as well as interventions

3. The Interdisciplinary Treatment Plan is initiated by the nurse on admission; the Interdisciplinary Treatment Plan is developed in consultation with other staff involved in the intake process and address the most immediate and obvious needs of the patient. Medical, psychiatric, and educational needs are addressed. Discharge and continuing care issues are addressed in the Interdisciplinary Treatment Plan

A. PROBLEM IDENTIFICATION AND INTERDISCIPLINARY TEAM MEETING

1. 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.

2. 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.

3. 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.

Additional assessments are completed as needed. These are ordered by the Attending Psychiatrist and may include:

Type of Assessment	*To Be Completed By*
Occupational Therapy Assessment	Occupational Therapist
Nutritional Assessment	Nutritionist or designee
Psychological Testing/Assessment	Psychologist
Vision Testing	Consultant
Hearing Assessment	Consultant
Dental Examination	Consultant
Speech/Language	Consultant

1. Interdisciplinary Team Meetings

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 is held weekly and more frequently, if clinically indicated.

PROCEDURE FOR COMPLETING INTERDISCIPLINARY TREATMENT PLAN

1. One person enters problems that have been identified based on his/her assessment.

2. A diagnosis does not constitute a problem. Problems should be listed as either behaviors or symptoms that contribute to dysfunction or require hospitalization.

3. The Identified Problem List are taken from the psychiatric evaluation

4. The Patient/Family Involvement in Treatment Plan is completed by the assigned staff member and is based on the patient's consent for others to be involved in the treatment. The patient and family goals for treatment are written in their own words.

5. The Discharge/Continuing Care section is completed by the social worker or therapist.

6. It should be noted whether the patient/family/patient representative were reviewed at the treatment team meeting and if so the signatures of each person attending.

7. Individual Treatment Plans are written based on the active problems identified. The Individual Treatment Plans include the problem, the problem name, evidenced by, and related to, long-term goals, short-term goals and interventions by each discipline. Each section is to be completed by the assigned staff member.

8. Define long-term and short-term goals for problem resolution on the Individual Treatment Plans. Long-term goals are broad and encompassing statements of desirable behavioral change that a patient should achieve to reflect a maximum or optimal care outcome. Long-term goals are expected to be achieved by the time the patient is discharged. A logical and specific relationship should exist between each long-term goal and each identified active problem/need.

9. Document the date that the long- or short-term goals have been resolved. In addition, date and document all changes or additions to the goals or problems.

10. Define short-term goals that will be indicators of movement towards the long-term goal on the Individual Treatment Plans. Short-term goals must be specific and measurable, representing steps toward reaching the long-term goal. The short-term goal should include expected outcomes. Short-term goals are directly related to the long-term goals and the identified active problems/need. Short- term goals should address the behavior/symptoms identified in the problem as evidenced by or related to section.

11. Define specific interventions which comprise the treatment that will be utilized to help patient achieve short- and long-term goals on the Individual Treatment Plans. Include the frequency of each activity, (example: process group 1 hour five times a week to identify contributors to depression) which discipline will be responsible for implementation, focus of intervention, and when possible, the name of person.

12. List specific, measurable criteria for discharge, i.e., what the patient will do to demonstrate they are ready for discharge.

13. Each time the plan is revised, enter date. If plan has been revised, indicate this and note any revisions in appropriate area (goals, objectives, treatment, etc.).

14. When a goal has been accomplished, chart that the goal was completed.

15. Individual Treatment Plans should include active co-occurring conditions.

LONG AND SHORT-TERM GOALS

A. Long-term goals are the general ends toward which efforts are directed (e.g., reality orientation, control of violent behavior, positive peer interaction, etc.). The treatment plan shall contain specific long-term goals that the patient should achieve by discharge to attain, maintain, and/or re-establish emotional and/or physical health as well as maximum growth and adaptive capabilities.

B. Short-term goals are observable, measurable behaviors that the patient will engage in within a specified time frame. These desired behaviors reflect the goals of the patient and staff (e.g., initiates a non-problematic interaction with another patient at each free time period for one week). Short-term goals should be written so that they are:

- Specific – They should be concise and clearly defined.
- Observable – They should be stated in terms that can be perceived (seen, heard, touched, etc.)
- Measurable – They should be stated in terms of frequency, quantity, etc.
- Realistic - They should be obtainable considering the patient, staff, and resources available to carry out the program.

Has A Time Frame - A target date should be specified for reaching a stated short-term goal.

INTERVENTIONS

1. Interventions are the actions each discipline will take to assist the patient in meeting the short-term goals. Each discipline lists interventions related to the problem and the short-term goals.

2. Interventions are discipline specific.

3. Interventions are specific and should be concise and clearly defined.

4. Interventions list the frequency, the action/focus, and the person responsible for completion.

TREATMENT PLAN REVIEW PROCEDURE

A. 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 seven days minimally or more often if clinically indicated.

B. 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.

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

D. 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.

E. Note areas that may affect treatment or limit extent of recovery or outcomes.

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

G. Staff: All treatment team staff should attend.

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