**PURPOSE:**

- To facilitate appropriate coordination, provide individualized care, continuity of care and promote positive patient outcomes.

**POLICY:**

- ___________________________(enter the name of agency here) will develop an individualized plan of care based upon an assessment that reflects the patient's identified problems and needs, consistent with physician or licensed independent practitioner’s orders or prescriptions in accordance with applicable laws and regulations. The individualized plan of care is developed by Agency licensed staff for each patient.

- When a patient is receiving services from more than one discipline, each discipline, i.e., nursing, therapies, social service, including contracted services, develops/contributes to the patient’s plan of care.

- Care planning is a collaborative process that takes into consideration the patient’s wishes with regard to medical intervention, treatment choices, family involvement, and if appropriate, end of life decisions.

- Care planning is a dynamic process that begins with the admission assessment and continues until the patient’s discharge from the Agency.

- Discharge planning is an ongoing process that begins with the patient’s admission for care and/or services.

**PROCEDURE:**

- The Registered Nurse and/or Licensed Therapist develops a plan of care within 24 hours of the start of care.

- The plan of care includes at least the following information:
  - List of dates of onset of problems/needs based upon assessment data and physician orders
<table>
<thead>
<tr>
<th>Home Health Policies and Procedures</th>
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<tr>
<td><strong>Section 3: Provision of Care, Treatment and Services</strong></td>
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<tr>
<td><strong>Policy Title:</strong> Coordination of Care</td>
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<td><strong>Effective Date:</strong></td>
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- Measurable, objective goal statements
- Interventions to address the identified patient needs
- Interventions, including teaching and training guidelines, are appropriate to the scope of practice of the individual developing and/or updating the plan of care and consistent with relevant clinical practice guidelines
- Measurable patient outcomes

- The Case Manager/Clinical Supervisor receives a verbal summary of the plan of care on the day of the initial/assessment visit.

- The original signed plan of care is submitted to the Agency office within 72 hours of the initial visit. A copy of the plan of care remains in the patient’s home.

- Copies of the plan of care are distributed to all members of the healthcare team who are providing care and/or services to the patient.

- The Case Manager/Clinical Supervisor is responsible for overseeing the care planning process to ensure that the plan is appropriate and realistic, based on the patient’s needs and clinical status and to promote positive outcomes, and to avoid duplication of services.

- In the event of potential or actual duplication of services, the Case Manager/Clinical Supervisor contacts the disciplines involved and conducts a care conference to correct the situation. The care conference may be conducted via telephone. The results of the care conference are documented and become a permanent part of the patient’s medical record.

- The plan of care is reviewed, updated and/or modified at least every two (2) weeks and more often if necessary. Each member of the healthcare team reviews the plan of care at least every two (2) weeks and more often if necessary, based on patient needs and clinical status to evaluate the appropriateness of the plan and the patient’s progress toward goals.

- Any reviews of and/or changes to the plan of care are dated and signed by the appropriate discipline whenever it is reviewed, whether or not there are changes to the plan of care. Any changes are communicated to other members of the healthcare team either verbally or in writing.
The physician is contacted as necessary and appropriate with reports of changes in the patient’s clinical status and/or needs, and for necessary orders and/or prescriptions.

Problem resolution dates are recorded as achieved.

Verbal care conferences conducted on an impromptu, as-needed basis should be documented in the visit notes of each of the disciplines involved.

Multidisciplinary care conferences are held on selected patients at least monthly and more frequently if needed, to promote coordination and continuity of care. The results are documented and a copy is retained in the patient’s medical record.

All disciplines involved in the patient’s care, including contracted services, are expected to attend the monthly conferences.

Results of the care planning process are tracked and trended as part of the organization wide performance improvement program.

CROSS POLICY REFERENCES
1. Admission Policy
2. Care Planning

FORMS
1. Care Plan
2. Case Conference Form