

 <p>Connecticut Valley Hospital Nursing Policy and Procedure</p>	<p>SECTION B: THE NURSING PROCESS</p> <p>CHAPTER 7: NURSING PLAN OF CARE PROCESSES</p> <p>Policy and Procedure: 7.1 Nursing Plan of Care</p>
<p>Authorization: Nursing Executive Committee</p>	<p>Date Effective: May 1, 2018 Scope: Registered Nurses</p>

Standard of Practice:

The Registered Nurse will develop an individualized nursing plan of care in collaboration with the patient, significant others and the interdisciplinary team. The nursing plan of care will be extracted from the patient's integrated Master Treatment Plan (MTP).

Standard of Care:

The patient will have his/her nursing care needs identified and assessed by a Registered Nurse on an ongoing basis in a nursing plan of care, which is included as an integrated part of the MTP.

Policy:

The Registered Nurse will assess the patient throughout his/her hospitalization and will incorporate nursing concerns into the Patient's MTP. Data collected during the Admission Nursing Assessment, the Annual Reassessment, and at any point throughout the patient's hospital stay, shall be reviewed during Treatment Plan Reviews and whenever a significant change in the patient's condition prompts a Focus Treatment Plan Review.

Procedure:

1. The Registered Nurse collects subjective and objective data during the Admission Nursing Assessment and collaboratively formulates with the psychiatrist/physician an Initial Plan of Care. The Initial Plan of Care will guide the patient's treatment until the Master Treatment Plan is developed. The Nursing Plan of Care is documented on the last page of the Nursing Assessment.
2. The Initial Plan of Care is developed in conjunction with the patient by the Psychiatrist/Physician and Registered Nurse within the first 24 hours of admission. The Initial Plan of Care addresses immediate treatment needs, specifying who will provide nursing interventions at what interval. ***The Treatment Kardex is used as an extension of the Nursing Plan of Care.***

3. Additionally, upon admission, a Primary Registered Nurse will be assigned to each patient and will coordinate the patient's nursing care throughout hospitalization. When the patient's assigned Primary Registered Nurse is not on duty, a covering RN will be assigned to the patient. The patient's Primary RN/designee is responsible for monitoring the implementation of Nursing interventions and assessing effectiveness.
4. Prior to the development of the Integrated Master Treatment Plan, the patient's assigned Primary Nurse/designee will create, review and/or revise plan as appropriate, the patient's nursing focused goals, strengths, assets and barriers. Once finalized in the RMS, the Primary Nurse/designee will produce the Nursing Plan of Care. The Primary Nurse/designee will print the Nursing Plan of Care and place it in the Change of Shift report book.
5. During the treatment team meeting, the Primary RN/designee collaborates with the treatment team to identify individualized nursing interventions that address the patient's goals and provides an update on the progress being made toward goal achievement. Changes in interventions, goals, strengths, assets and barriers will be made as needed by assigned Nursing staff.
6. The Primary RN/designee also participates in a Focus Treatment Plan Review which is takes place whenever there is a significant change in the patient's condition, i.e., significant change in physical health (conditions to consider; 2 or more falls in a 30-day period, significant deterioration in medical status, use of indwelling catheters, medical devices, chemotherapy treatment, hemodialysis, hospice care, admission from MD/AC), unexplained injuries, psychiatric/behavioral health (conditions to consider; return from AWOL status, assaultive behavior, suicide attempt, suicidal gestures or expressions of self harm; special observations; restraint or seclusion episode; experience of/or exposure to trauma; possession of non-permissible items that are considered dangerous for that patient or the milieu; suspected substance abuse; inappropriate sexual behaviors; any illegal activities conducted by the patient; significant increase in symptoms; persistent refusal of treatment interventions; level placed on hold; other events specified by the clinician). The Primary Nurse/designee carries the responsibility to print a new Nursing Plan of Care reflective of the change of condition. A copy of the completed Nursing Plan of Care is to be placed in the Change of Shift Report book.