

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

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| SECTION I: | PATIENT FOCUSED FUNCTIONS |
| CHAPTER 2: | Assessment |
| PROCEDURE 2.6: | Integrated Treatment Planning Process |
| Governing Body Approval: | April 11, 2018, January 9, 2019, April 8, 2019 |
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PURPOSE: To describe the process for developing and maintaining a plan of recovery with each individual in the hospital's care. This plan is driven by needs jointly identified at the time of admission and provides a detailed set of goals the individual must attain to manage their illness, improve their quality of life, and be discharged or transitioned to the next level of care.

SCOPE: All clinical staff involved in treatment planning.

POLICY:

The concept of recovery is the guiding principle and operational framework for the Department of Mental Health and Addiction Services (DMHAS) and Whiting Forensic Hospital (WFH) as a part of the system of care. In collaboration with community providers or other mandated parties, the treatment planning and delivery process at WFH identifies and builds upon each recovering individual's strengths, interests and goals in an environment that promotes hope and recovery. WFH is committed to working with individuals in recovery to enhance their functional abilities through the development of skills necessary to return to a community setting.

The Integrated Treatment Planning process, which includes the identification of discharge criteria, is initiated at the time of admission. It is updated as required per the standards described in the body of the procedure. Integrated treatment planning is a collaborative process between the individuals in care and their treating care providers, which may also involve local community agencies (including legal entities), advocates, and significant others. Recovery is a process rather than an event. Thus, the hospital addresses the needs of individuals over time, across different levels of disability, and with different treatment partners as appropriate. Recovery principles are applied to the full range of engagement, intervention, treatment, rehabilitative and supportive services that an individual needs from the point of admission to the

time of discharge to the next provider of care and services. Recovery principles also are applied to health promotion and prevention services for all of the individuals WFH serves.

Definitions:

Recovery - is a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition.

Treatment Team - A treatment team is minimally comprised of a psychiatrist, primary nurse, clinical social worker, rehabilitation therapies representative, psychologist, MHA/FTS, and the individual in care. As indicated by clinical need a unit director or other staff may also participate. All individuals receiving care are entitled to have advocate(s) present when desired. Community providers or Agencies are invited as part of transitional planning efforts.

Discharge Planning –A process used to decide what the individual receiving care needs for a smooth transition toward discharge or the next level of care. When possible, the wishes and concerns of the individual, family or significant others and their conservators are identified and incorporated into the discharge planning. All treatment plans should identify factors that foster successful discharge (including the individual's strengths, preferences and personal goals), and challenges (including symptoms of mental illness; medical and cognitive issues, substance abuse, lack of housing and/or entitlements and past difficulties in community placements). Successful achievement of identified discharge related goals will help to ensure a successful transition to a community or alternate level of care setting. The individual's admission criteria which is often provided by the community provider provides key information about the issues which need to be addressed in discharge criteria. Once a community placement has been identified, the hospital's plan becomes focused on the skills and supports the individual will need to be successful in the chosen placement.

Barriers to Discharge: refers to non-symptom issues, but rather system issues that may impede the discharge planning process; i.e., homelessness, lack of entitlements, criminal justice involvement, history of significant risky behaviors towards others, etc. (Not to be confused with "Barriers to achieving the goal" see Sec. VI, subsection B.)

PROCEDURE:

I. Initial Assessment of Patients

All individuals admitted for care at WFH are assessed by a registered nurse and a physician. The registered nurse completes an Admission Nursing Assessment ([WFH-171](#)). In addition the admitting physician completes an Admission Psychiatric Evaluation ([WFH-314](#)).

1. These forms are completed based on the information provided by the individual, significant other, if present, and by careful review of all accompanying documentation at the time of admission. These documents contain valuable information regarding the reason for admission and can assist in the identification of both treatment priorities and discharge goals. The Admission Psychiatric Evaluation must contain the clinical rationale for admission, physician confirmation of the need for hospital level of care, and an initial plan of care. Most of the Nursing Assessment and the Admission Psychiatric Evaluation is completed within eight hours of admission (as delineated on assessment forms), and both forms must be entirely completed within twenty-four hours of admission. In addition the History and Physical is completed within twenty-four hours of admission. The MOCA and AIMS is completed by the attending physician within 5 days of admission.

The Nursing Assessment and the Admission Psychiatric Evaluation forms both contain a section that identifies the individual's psychiatric, behavioral, and medical treatment needs. This information will be used in the formation of the patient's Initial Treatment Plan detailed below.

II. Initial Plan of Care

The Initial Plan of Care is developed in conjunction with the individual admitted for care by the psychiatrist/physician and registered nurse within the first 24 hours of admission and is recorded in both the Nursing Assessment and the Admission Psychiatric Evaluation in the Initial Plan Sections at the back of these forms. The Initial Plan of Care is an interim plan of care designed to identify psychiatric, behavioral, and medical issues and initiate appropriate treatment and follow-up; including the noting of any further needed information and/or examinations/consultations that would aid in diagnosis and/or treatment, prior to the completion of the Initial (Master) Treatment Plan. The plan needs specifically to outline what the treatment team will do to stabilize the individual and tasks which must be completed to inform the Initial (Master) Treatment Plan. The individual should participate, as much as possible, in this Initial Plan of Care and informed consent should be attempted with accompanying documentation noted on the Admission Psychiatric Evaluation.

III. Interdisciplinary Assessment

The process of developing a patient-centered individualized treatment plan starts with the engagement of the individual in recovery in a series of assessments. Each member of the interdisciplinary treatment team completes their initial assessment prior to formulation of the Integrated (Master) Treatment Plan on day seven of the admission.

| Discipline | Assessment | Completion Time Frame |
|----------------|--------------------------------------|-----------------------|
| Psychiatry | Admission Psychiatric Evaluation | 24 Hours |
| Physician | History & Physical | 24 Hours |
| Nursing | Admission Nursing Assessment | 24 Hours |
| MHA/FTS | CASIG and SOGI* | 6 Days |
| Social Work | Psychosocial HX & Assessment | 6 Days |
| Rehabilitation | Rehabilitation Functional Assessment | 6 Days |
| Psychology | Psychology Assessment | 6 Days |

Specific information related to the completion of assessments is available in the applicable department's policy and procedure manual.

*The Client's Assessment of Strengths, Interests, and Goals (CASIG) is completed by an MHA/FTS with the individual in recovery to help them develop a clear list of goals and treatment priorities which are listed on the Staff Observation and Goal Identification (SOGI) form. The SOGI is used by the treatment team and individual to ensure that all treatment priorities are addressed in the Integrated Treatment Plan.

The Social Work Admission psychosocial history & assessment is completed by the clinical social worker in the timeframes noted in the table above. The conclusions and recommendations regarding treatment, and the role of the social worker in treatment and discharge planning will be outlined within the assessment.

IV. Initial (Master) Treatment Plan

The Initial (Master) Treatment Plan is a living document used to guide the individual's course of treatment in the hospital, and to facilitate discharge planning. The plan's structure and language must be consistent with recovery principles. It is prepared by the treatment team which consists of the individual in recovery, and a treating psychiatrist, psychologist, rehabilitation therapist, social worker, nurse, and a MHA/FTS, at a minimum. The Initial (Master) Treatment Plan is completed by the 7th day of admission. The process and document begin with a review of the Present Status of the individual in care.

The plan should integrate and coordinate all selected services, supports, and treatments provided to the individual while they reside at the hospital in a manner specifically designed to meet the individual's treatment and rehabilitation goals.

The plan should be holistic and consider health promotion, and disability prevention. The plan should include specific discharge criteria including the most appropriate discharge level of care, a problem list, long term and short term goals, objectives and interventions that are directly linked to the discharge criteria are included. The plan is constructed in RMS, and a copy of the completed plan is reviewed with and provided to the individual in recovery.

Whenever language difficulties which may impede the individual in recovery's ability to participate in treatment planning or treatment are identified, the hospital will provide appropriate translator services. WFH will make all reasonable efforts to provide the individual, or their designated representative(s), with preferred language interpretation of any recovery treatment plan. In addition we will make reasonable efforts to provide a written translation of treatment plan.

The plan consists of a series of goals, objectives, and interventions designed to address the needs identified by the person in recovery and treatment team.

A. Goals & Objectives:

Goals: The long term and short term goals and objectives developed in the course of treatment planning need to be linked and relevant to the individual's strengths and level of functioning. All identified needs must have either a related set of goals and objectives or a documented rationale for the need not being addressed in the plan.

The Individual's Life Goal is the Long Term Goal that the patient wishes to accomplish in treatment and must include a quote from the patient.

At least one goal must relate directly to Discharge Criteria. This goal will delineate a specific set of skills and behaviors that an individual will need to demonstrate mastery of in order to be discharged to the next level of care. {There is a direct correlation between the discharge criteria and the discharge location placement criteria.}

Objectives: All objectives need to be written in behavioral and measurable terms (i.e. what the individual specifically will do and for how long a period of time). Progress towards or the achievement of goals and objectives should be documented in the appropriate discipline- specific treatment note and reflected in future treatment plans.

- B. *Problem List*: A listing of all behavioral and/or medical conditions identified by the discipline assessments and ultimately determined by the attending psychiatrist. Each condition included on the Problem List should have a corresponding objective and treatment intervention or be deferred with a clinical rationale (determined to not require treatment at this time).
- C. *Interventions (RMS: Services)*: represent the proposed menu of available treatment options. They are aligned with a respective objective and treatment goal and linked to a responsible discipline. Staff interventions must be patient-centered, individualized and specific in the content and should be chosen to assist the patient in meeting his/her documented goal(s) for the problem that is being addressed. They specify the name of specific staff responsible for implementing the intervention, the type of intervention, and the frequency and duration of the intervention. The selection of specific interventions should consider personal preferences as well as; trauma history; risk/safety issues; medical issues, age specific issues, gender specific issues and functional level. The rationale along with the potential risks/side effects and benefits of medication need to be included in the treatment discussion. The results of the treatment options discussion needs to be reflected in the treatment plan.
- D. Nursing Plan of Care:

1. An important component of the Integrated Treatment Plan is the Nursing Plan of Care. The Nursing Plan of Care lists key information and services for nursing staff (RNs, LPNs, MHAs, and FTSS) related to the psychiatric and medical care of the individual in recovery. This may include specific prompts related to treatment approaches and individual risk triggers. The plan will also list the frequency and focus of interactions.
2. The Nursing Plan of Care is an extractable component of the Integrated Treatment Plan in the RMS, which provides nursing staff a clear and concise resource that outlines the psychiatric and medical treatment interventions required by the individual in recovery.

V. Treatment Plan Review

The Treatment Plan is reviewed on a regular basis to ensure that it effectively addresses the wishes, concerns and needs of the individual receiving care. The review begins with a Present Status assessment, which serves the purpose of a case formulation, and the Present Status is completed at the time of the Initial (Master) Treatment Plan. It introduces the plan review by identifying interval changes and progress toward discharge criteria that have occurred. Any new risk, medical, legal, or diagnostic issues identified, medication updates (rationale for use, potential risks/side effect benefits), or other reasons for reconsideration of the treatment plan. The team reviews the treatment plan, achievement of goals and objectives, and progress towards discharge criteria with the individual.

Unmet discharge criteria constitute the clinical justification for continued hospitalization, which must be documented in the discharge section of the treatment plan. The previously identified most appropriate discharge level of care is reviewed and revised as necessary. The Treatment Plan Review meeting is a collaborative process between the treatment team, the local community agencies, advocates and significant others along with the individual in recovery. Once again, the process begins with a review of the present status of the individual in care.

Discharge related goals and objectives are flagged in the Treatment Plan, and the review of treatment progress data needs to be reflected in the review document.

The plan review is outcome driven and is based on the monitoring of the individual's progress in achieving their identified treatment goals and objectives. Group and individual treatment clinicians who provide treatment "off unit" have the responsibility to communicate with the treatment team.

In addition, the discussion related to identified problems, and if applicable, identifying barriers to discharge and methods implemented to overcome them must be documented in the reviewed plan.

Current treatment data, and a team discussion that includes the individual in recovery, should guide the revision of the treatment plan to reflect the individual's current status and short term treatment goal(s). If no progress has been made on the objective, the objective either needs to be revised or have a clinical justification for continuance. If an objective has been achieved this is noted, and when applicable, a new objective and appropriately linked treatment interventions will be developed to continue progress towards discharge.

The Treatment Plan Review is constructed in the Recovery Management System (RMS), and results in a paper version of the (Master) Treatment Plan. A copy of the revised plan must be reviewed, signed and received by the attending and the individual receiving care. All members of the team should review and sign the treatment plan. A copy of the original or revised plan of care is given to the individual receiving care.

The reviewed treatment data and team discussion (including the individual in recovery) should guide the revision of the treatment plan to reflect the individual's current status and treatment needs. If no progress has been made on an objective for 2 consecutive months, the objective either needs to be revised or have a clinical justification for continuance. If an objective has been achieved this is noted, and when applicable, a new objective and appropriately linked will be developed to continue progress towards discharge.

The Treatment Plan Review is constructed in RMS, and results in an updated version of the (Master) Treatment Plan. A copy of the revised plan is reviewed with and provided to the individual receiving care.

The review schedule is:

1. By Days 21, 35, 49, and 63 of the admission;
2. Every 30 days thereafter; and
3. Within 7 days of transfer to another unit, then per rules above based on length of stay.

Every 90 days the review should be considered a Quarterly Review and the fourth Quarterly Review will be an Annual Review. These reviews must contain meaningful summary assessments of the individual's progress during the interval, the barriers to progress and discharge, and the plan to overcome these barriers. This plan should be reflected in the goals, objectives, and interventions.

In preparation for the Treatment Plan Review, the assigned nursing staff should meet with the individual in recovery and discuss the treatment progress to date including progress towards meeting discharge/transition criteria. Either a copy of the current (Master) Treatment Plan or the SOGI completed as part of the CASIG should be used as part of this review process.

Whenever a Treatment Plan Review results in alterations to the Nursing Plan of Care an updated version should be extracted to assist staff in providing the required care. This information also needs to be included in cross shift reports to ensure proper communication of changes.

If the review process indicates that the individual receiving care has met all discharge related criteria they should be identified as “Discharge Ready.” The designation of “Discharge Ready” is made directly on the Treatment Plan Review.

The designation should include the type of placement sought, placement site availability, appropriateness of alternatives, what services will be provided while they await placement, and who will be responsible for ensuring every effort is made to place the individual.

VI. Focused Treatment Plan Review

The (Master) Treatment Plan is also reviewed whenever the individual in recovery experiences a significant change in their psychiatric/behavioral condition and/or physical health. An FTPR will also be done in response to a patient’s failure to participate in active treatment, or alternative treatment activities as demonstrated by persistent unexcused absences from group or individual therapy within a one week timespan.

For psychiatric/behavioral or a physical health related change of condition the review is solely focused on the treatment plan alterations necessitated by the change of condition of the individual, i.e. their new needs and/or safety risks.

FTPRs related to failure to participate in active treatment should address the nature of the patient’s refusal/nonparticipation and identify alternative interventions for prescribed groups. Individual engagement by clinicians and other team members may be warranted. If the patient is refusing to participate in alternative interventions/individual engagement, the team should identify specific engagement interventions for use by nursing staff to improve patient readiness and/or ability to participate in group or individual therapy.

Whenever there is a change in condition that would warrant an FTPR, the physician on duty and the charge RN will, collaboratively, fully assess the event or cause and discuss a revised plan of care; this will be documented in both the physician’s and RN’s progress note, including a very detailed immediate plan of care along with any follow-up issues that need to be addressed. The charge RN will initiate the FTP, and any required orders corresponding to the revised plan of care will be written by the physician on a Physician Order Sheet. The treatment changes will be communicated to all unit staff through the inter-shift report process. The treatment team will convene on the next business day, and complete the Focused Treatment Plan Review, make further adjustments to the interventions as indicated, and the physician will sign the plan. The FTPR must include a review of the situation warranting the FTPR and a description of the interventions that were modified as a result of the change in condition.

The individual in recovery is included in the process unless he/she is unable or unwilling to participate.

If the individual does not participate, the treatment plan revisions should be reviewed with the individual, by the treatment team, at the earliest possible opportunity. The Focused Treatment Plan Review is constructed by the clinical team in RMS, closed and printed, and results in an updated version of the Integrated Treatment Plan. A copy of the revised plan is reviewed with and provided to the individual in recovery.

The triggering events for an FTPR include but are not limited to:

The placement of a patient on Constant Observation (CO)

Restraint events

Seclusion events

Acute deterioration to physical health

Deterioration in physical health requiring transfer to an acute treatment facility

Failure to participate in treatment

Acute deterioration of psychiatric condition

Aggression toward self or others

Change in behavioral condition

Suicidal Ideation

Suicide attempt

Fall Risk

VII. Treatment Team Structure & Function

Each individual receiving care is assigned to a Treatment Team on the first business day following admission.

Integrated Treatment Plans are developed collaboratively by the individual and the clinical treatment team, which include representatives from the professional disciplines and paraprofessional staff. Each team will have certain staff members designated with particular *functional* roles in addition to their clinical roles:

Team Leader: This role is always assigned to the clinical team's psychiatrist (also referred to as the *Attending Psychiatrist*). The Team Leader has overall clinical responsibility for the team. The Team Leader's responsibilities include assuring that each individual receiving care has a comprehensive aftercare/discharge plan. This process and treatment planning as a whole can only occur as an interdisciplinary process, and the Team Leader needs to assure that all members of the team participate appropriately.

Team Coordinator: This role is assigned to the Unit Director. The Team Coordinator is responsible for convening the team and other people or agencies (i.e. advocates, community agencies) required to complete an integrated planning process. This responsibility applies to both regularly scheduled treatment plan meetings and any special additional meetings which may be necessitated by emergent needs.

Clinical Social Worker: The clinical social worker is the key link to outside contacts and agencies, and, therefore, plays a crucial role in the successful discharge or transition to another level of care of the individuals in the hospital. The clinical social worker gathers past treatment, social history, and assists in the identification of key issues that must be resolved to discharge the individual which will become the discharge goals and objectives.

Once this discharge plan has been formulated, the clinical social worker monitors the individual's recovery and ensures the timely coordination of all community assets and resources (i.e. financial entitlements, Local Mental Health Authority, natural supports). The clinical social worker documents his/her continuing efforts towards placement in the progress notes section of the medical record, during the entire course of treatment in the hospital.

Upon discharge or placement in another level of care, the clinical social worker documents in their final note, where the individual will be moving to, who the community providers will be by agency and provider along with any necessary supports which will be employed.

This plan is further documented in the Discharge/Aftercare Report form ([WFH-2](#) for), which the clinical social worker is responsible for comparing to the discharge progress note to ensure that all identified necessary supports and services are in place.

For those individuals who have met discharge criteria but remain in the hospital because the level of care does not currently exist, the clinical social worker continues to work collaboratively with the treatment team, the individual and community based assets and resources. In the case of "Discharge Ready" individuals, the minimal documentation standard is monthly progress notes that detail all efforts made towards discharge planning and progress towards that goal.