State of Iowa Department of Corrections

Policy and Procedures

Policy Number: FPH-30
Applicability: Institutions
Policy Code: Public Access
Iowa Code Reference: 229, 812, 904
Chapter 10: Forensic Psychiatric Hospital
Sub Chapter: Hospital Record
Related DOC Policies: NA
Administrative Code Reference: 481-51
Subject: Interdisciplinary Plan of Care
PREA Standards: NA
Responsibility: Warden Mike Heinricy, Dr. Theresa Clemmons
Effective Date: August 2024
Authority:

1. PURPOSE

A. To establish an interdisciplinary team care planning process to ensure that patient care and treatment is planned appropriately for the patient's needs and severity of condition, impairment, disability or disease.

B. To assure a planning process that maximizes and maintains each patient's optimal mental, physical, psychosocial, spiritual and functional status.

C. To establish a system in which the care and treatment planning process is timely, systematic, and comprehensive and incorporates input from all disciplines.

D. To provide a mechanism for patient input to the care plan.

2. Policy

A. IMCC Forensic Psychiatric Hospital (FPH) utilizes an interdisciplinary team to provide an individualized comprehensive patient assessment and care planning process in order to maximize and maintain every patient's potential and quality of life.

B. Based on a comprehensive interdisciplinary assessment, the care team will address individualized patient needs to include mental, behavioral, physical, psychosocial, functional, activities, emotional, spiritual, and communication needs. Care planning addresses needs resulting from the patient's condition and considers the patient's expectations and characteristics.

C. The interdisciplinary care plan is developed as soon as possible after admission, but no later than one week after completion of the initial assessments. The goal is to complete the plan of care within 24 hours of admission.

D. Individual care and initial treatment goals are identified. These goals are reasonable and measurable. Each patient's care plan identifies goals that:

    1. Reflect the patient's input and unique needs.

    2. Are realistic and measurable.

    3. Include a time frame for achievement, when appropriate.

E. Interventions are identified and planned to meet each patient's goals. The responsible discipline for each intervention provided will be identified. The care plan should identify how frequent specific services will be provided.

F. If indicated the patient education process is interdisciplinary and may be:

    1. As part of the care plan the patient is educated appropriate to his or her assessed needs, abilities, readiness, preferences, and length of stay.

    2. The care planning process incorporates information from the patient's assessment about his or her education needs.

3. PROCEDURE

A. Initial Patient Care Planning

1. Each discipline will conduct their interview with the patient present. If the patient is unstable, this will be documented.

2. The goal is to complete the comprehensive plan of care for the patient as a team.

3. The intent is to include the patient in the planning process and clarify the goals with them and their role in achieving the goals. The patient is asked to sign the plan of care when able.

4. The plan of care is to be an electronic record which can be printed and filed in the patient's hospital file. The record is kept on the public drive and is accessible to the necessary disciplines. Access to change is limited to the Supervisor and designated recorders.

B. Monthly Plan of Care Review

1. Patients will have a Plan of Care review each month.

    a. Patient is present, when able.

    b. The Social Worker or designee will lead the meeting and is responsible to notify Team members of the patients to be reviewed.

    c. The plan of care is revised when appropriate to reflect the patient's current needs, based on evaluation of:

        1) Progress towards goals.

        2) Response to care and treatment.

        3) Significant changes in the patient's status.

2. The plan of care may be superseded by doctor's order as it is recognized that changes occur. If the patient status changes, then the effective plan of care becomes the doctor's order until the changes are incorporated into the care plan. The care plan should include details such as incentives.

3. FPH team members have the ability to apply certain restrictions based upon an assessment of a patient's status as appropriate. Restrictions will be communicated to the rest of the FPH team. Restrictions will be added as needed and reviewed by the treatment team when possible.

C. Meeting Membership, Roles and Responsibilities for Patient Plan of Care Review.

1. Team Membership - Care is planned by an interdisciplinary team representing all appropriate professional staff.

a. Core Team Members

1) Nursing

2) Psychiatry

3) Medical

4) Social Work

5) Correctional Counselor

6) Therapeutic Recreation

7) Health Services Administrator/Designee

8) Security

b. Consultative Members

As appropriate to the patient's needs, the team may include representatives from the following departments and services:

1) Chaplain

2) Nutrition Services

3) Administration

4) Dental

5) Pharmacy

6) Psychologist

c. Patient as a team member:

The patient is invited to participate in the development and review of the care plan.

2. Roles and Responsibilities of team members:

a. All disciplines are responsible for adhering to Federal and State regulations pertaining to their specialty.

3. The Social Worker or designee will:

   Facilitate plan of care process

   a. To keep an updated weekly listing of patients to be reviewed and notify team members of this schedule.

   b. To make sure a mechanism is in place for obtaining information from other shifts.

   c. To develop a mechanism for sharing the care plan information with appropriate nursing and correctional officer personnel not attending the meeting.

   d. Update the status of suggested interventions from notes from the previous meeting.

D. The Care Plan

1. The Social Worker/Designee shall save each revised plan of care by date under the patient folder so it can display the changes made over time. If no change is made, it can be noted on the bottom of the care plan with the date reviewed with no change. A printed copy is obtained and filed in the patient's hospital record.

2. The original care plan **FPH-30 F-1**, is signed by the patient and a hard copy is kept in the hospital record or scanned into the electronic medical record.

3. Any changes made to the care plan is dated and scanned into the electronic medical record.