Plan of Care - Content PC.P45

Regulatory Citation(s):	42 CFR 418.56; 418.56(c)(106)
L-Tag(s):	538, 545 - 551

POLICY: The plan of care reflects patient and family goals and interventions that are based on the problems identified in the initial, comprehensive and updated assessments.

PROCEDURE:

1. The patient's plan of care includes all services necessary for the palliation and management of the terminal illness and its related conditions.

2. The plan of care includes, but is not limited to:
    a. interventions to manage pain and symptoms;
    b. a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs;
    c. measurable outcomes anticipated from implementing and coordinating the plan of care;
    d. drugs and treatments necessary to meet the needs of the patient;
    e. medical supplies, equipment, and appliances necessary to meet the needs of the patient; and
    f. documentation from the IDG of the patient or representative's level of understanding, involvement and agreement with the plan of care.

3. When the patient/representative evidence impediments to participating in care planning and understanding the plan of care, those impediments are documented in the patient's clinical record and the levels of understanding or lack of understanding are recorded. The IDG makes accommodations to support the patient/representative's ability to understanding and participation in the care planning process. All communication is made at the educational level of the patient/representative

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