SUBJECT: PLAN FOR THE PROVISION OF PATIENT CARE AND SERVICES	REFERENCE #1002
	PAGE: 1 OF: 1
DEPARTMENT: HOSPITALWIDE	EFFECTIVE:
APPROVED BY:	REVISED:

HOSPITAL MISSION AND VALUES:

- __________________ Hospital is a not-for-profit/for-profit facility, owned and operated by __________________ (name of corporation, etc.) which provides selected healthcare services.

- Our Mission is to: (List the mission statement here)

PHILOSOPHY OF PATIENT CARE SERVICES:

- As a premier provider of community based, family oriented healthcare, __________________ Hospital believes it can best maintain this level of service through a customer focus, where we continually strive to understand and exceed the expectations of our customers. This focus is enabled through effective communication systems, staff education, team building, process improvement, work redesign and an empowered work force.

- In collaboration with the community, __________________ Hospital will provide customer-focused care and service through:

  - A mission statement which serves as a foundation for planning.

  - Long-range strategic planning with hospital leadership.

  - Establishment of core values which guide employee behavior. __________________ Hospital will support personnel relations that foster growth, encourage innovation and support teamwork. The organization recognizes the relationship between positive personnel relations and its ability to achieve organizational objectives and will pursue the means to strengthen and enhance this association.

  - Provision of services that are appropriate to the scope and level required by the patient population to be served.

  - Ongoing evaluation of services provided through performance improvement activities.

  - Integration of services through a variety of mechanisms, i.e., continuous quality improvement (CQI) teams, informational meetings, staff meetings, leadership council and employee education.

  - Priority focus on patient relations, their interests, needs and expectations.

    - ♦ Recognition of the need to be a responsible member of the community through contribution toward the quality of life through activities, services and involvement with

SUBJECT: FUNCTIONAL ASSESSMENT AND REASSESSMENT OF THE PATIENT	REFERENCE #2029
DEPARTMENT: HOSPITALWIDE	PAGE: 1 OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- It is the policy of this facility to perform functional reassessments on all patients who have been identified during initial patient assessment to have functional dysfunction. All reassessments of the patient's functional ability will be performed by a licensed/registered rehabilitation services professional. Treatment plans will be revised as necessary according to the patient's functional status.

- A functional status screening is completed within 24 hours of inpatient admission when warranted by the patient's needs and/or clinical condition.

PROCEDURE:

- Based on an initial assessment and evaluation of the patient's physical, cognitive, emotional and social status, a rehabilitation treatment plan will be developed and documented in the patient's medical record. At periodic intervals, pursuant to the patient's functional status and according to the patient's treatment plan and expected functional goals, the patient will receive reassessment of functional capabilities.

- Functional reassessments will be planned and written in the patient's treatment plan; however, functional reassessments may be performed at any time in the patient's treatment progression.

- Functional reassessments will be performed by a licensed/registered rehabilitation services professional, with assessment outcomes documented in the patient's medical record.

- The patient's plan of care will be revised according to the patient's functional reassessment.

SUBJECT: CARE PLANNING	REFERENCE #4002
DEPARTMENT: MEDICAL SURGICAL UNIT	PAGE: 1 OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

Care, treatment and services are planned to ensure that they are appropriate to the patient's needs. Therefore, it is the policy of __________________ Hospital to provide an individualized, interdisciplinary plan of care for all patients that is appropriate to the patient's needs, strengths, limitations and goals. Care planning will be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals for the patient that are reasonable and measurable. The plan of care will be documented through the use of computerized care planning.

PROCEDURE:

- Within eight (8) hours of admission all patients shall have a computerized plan of care generated by the registered nurse or the licensed practical/vocational nurse under the direct supervision of the registered nurse.
    - Any direct admission or postoperative admission that is expected to be a "23-hour hold" patient will have assessments and revisions of plan of care within one (1) hour of arrival on the Medical Surgical Unit. This plan of care will be documented through revision on the PACU plan of care or the Medical Surgical 24-hour flow sheet. It is noted in these instances, the documents are not computerized.
- The plan of care shall be individualized, based on the diagnosis, patient assessment and personal goals of the patient and his/her family.
- The planning for care, treatment and services will include the following:
    - Care planning is based on data collected from patient assessments with integration of those assessment findings in the care planning process.
    - Developing a plan for care, treatment and services that includes patient care goals that are reasonable and measurable.
    - The needs of the patient, goals, time frames, required services and the service settings are critical considerations in determining the plan for care.
    - Regularly reviewing and revising the plan for care, treatment and services.
    - Determining how the planned care, treatment and services will be provided.

SUBJECT: DISCHARGE PLANNING	REFERENCE #13002
DEPARTMENT: NURSING	PAGE: 1 OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- Discharge planning is a process and service where patient needs are identified and evaluated and assistance given in preparing him/her to move from one level of care to another. Nursing personnel will collaborate with all members of the healthcare team to plan events within a given setting which enables the patient to regain as normal and productive a role as possible, providing for efficient, compassionate and economical methods for the delivery of health services.

- Discharge planning shall be initiated on admission and continue through discharge, with education and patient planning for the home care environment.

PROCEDURE:

- During the admission assessment, patient planning will be initiated to identify problems and make appropriate entries on the problem list or plan of care. Interaction with appropriate members of the healthcare team will occur throughout the patient's hospitalization to enable a comprehensive plan for patient care to be developed.

- Counsel and involve the patient and/or family in:
  - Acceptance of illness, disability and needed treatment
  - Coping with illness complicated by social and emotional problems
  - Self-care and nursing measures in the home situation
  - Reason for transfer to another facility
  - Reason for discharge from the facility
  - Any anticipated need for continued care, treatment and services after discharge

- Obtain necessary order for discharge. Discuss all patient needs with the Discharge Planner, as appropriate.

- Verify transportation arrangements.

- Complete discharge instructions sheet or transfer sheet (if patient is going to another facility).

DOCUMENTATION:

All discharge planning, including patient, family or significant other teaching, will be documented in the medical record on the patient plan of care and Nurses' Notes as appropriate.

SUBJECT: WAIVED AND POINT-OF-CARE TESTING	REFERENCE #14003
DEPARTMENT: CLINICAL LABORATORY	PAGE: 1 OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

To ensure that all waived and point-of-care testing done at this hospital is carried out according to policy and for the maximum benefit of the patients and care providers. The testing must be performed under legal, regulatory and professional accreditation guidelines as appropriate.

POLICY:

All waived and point-of-care tests done at this hospital, which are used to provide information for screening, diagnosis, prevention or treatment of any disease or impairment shall meet all regulatory requirements as required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Clinical Laboratory Improvement Amendment of 1988 (CLIA ’88), and/or the College of American Pathologists (CAP). The responsibility to oversee and monitor regulatory compliance of the program is the responsibility of the Clinical Laboratory Director.

DEFINITIONS:

- Waived Test: As defined by the Department of Health and Human Services (DHHS), a simple laboratory examination or procedure which is cleared by the FDA for home use; employs methods that are so simple and accurate as to render the likelihood of erroneous results negligible; or poses no reasonable risk of harm to the patient if the test is performed incorrectly. (Note: Tests that are performed at this hospital that fall into the waive category must meet the standards established by regulatory agencies for such tests.)

- Provider Performed Microscopy Procedures (PPMP): Procedures that must be performed during the patient’s visit by the provider or by a member of the group practice and can only be performed using Bright-field or phase contrast microscope. PPMP is a subcategory of moderately complex procedures.

- Point-of-Care Test (POCT): Laboratory testing performed at the patient site, usually by non-laboratory employees (i.e., nurses, respiratory therapists). The Clinical Laboratory assumes primary responsibility for accreditation and/or regulatory compliance. Most point-of-care testing done at this hospital are actually waived tests and a few are of moderate complexity.