Sec. 19a-495-6j. Assessment and patient centered plan of care

(a) At the time of admission, an initial assessment shall be completed by a licensed registered nurse to identify and meet the immediate needs of the patient. Within forty-eight hours of a patient's admission, a licensed registered nurse shall complete the assessment to evaluate the patient's immediate physical, psychosocial, emotional, and spiritual status.

(b) Not later than five days after a patient's admission to the hospice inpatient facility, the interdisciplinary team shall complete a comprehensive assessment for the patient that shall include but not be limited to the following:

(1) History of pain, symptoms, and treatment;

(2) Characteristics of pain and symptoms;

(3) Physical examination;

(4) Current medical conditions and drugs and biological products;

(5) Patient or family's goal for pain and symptom management;

(6) Condition causing admission;

(7) Relevant history as well as complications and risk factors that affect care planning;

(8) Functional status;

(9) Imminence of death;

(10) Severity of symptoms;

(11) Drug profile;

(12) Bereavement;

(13) The need for referrals or further evaluation by appropriate health professionals; and

(14) Data elements that allow for the measurement of patient outcomes and are related to aspects of care.

(c) The comprehensive assessment shall be updated as frequently as the condition of the patient requires, but not less than once every fourteen calendar days.

(d) Upon completion or update of the comprehensive assessment, a written patient centered plan of care shall be established or revised for the patient.

(e) Such patient centered plan of care shall be developed to include only those services that are acceptable to the patient and family.

(f) The patient and family shall be involved whenever possible in the implementation and continuous assessment of the patient centered plan of care.

(g) The interdisciplinary team shall ensure that the patient and family receive education and training provided by the licensee regarding the responsibilities of the patient and family for the care and services identified in the patient centered plan of care.

(h) The patient centered plan of care shall include, but not be limited to:

(1) Pertinent diagnosis and prognosis;

(2) Interventions to facilitate the management of pain and other symptoms;

(3) Measurable targeted outcomes anticipated from implementing and coordinating the patient centered plan of care;

(4) A detailed statement of the patient and family needs addressing the:

(A) Physical, psychological, social, and spiritual needs;

(B) The scope of services required;

(C) The frequency of services;

(D) The need for respite or general inpatient care;

(E) Nutritional needs;

(F) Drugs and biological products;

(G) Management of pain and control of other symptoms; and

(H) Management of grief.

(5) Drugs and treatments necessary to meet the needs of the patient;

(6) Medical supplies and appliances necessary to meet the needs of the patient;

(7) The interdisciplinary team's documentation of the patient's and family's understanding, involvement, and agreement with the patient centered plan of care; and

(8) Such other relevant modalities of care and services as may be appropriate to meet individual patient and family care needs.

(i) The patient centered plan of care shall be reviewed and updated by the interdisciplinary team as needed, but not less than once every fourteen calendar days. This review and update shall be documented in the medical record.

(j) A revised patient centered plan of care shall include information from the patient's updated comprehensive assessment and the patient's progress toward outcomes specified in the patient centered plan of care.

(Effective July 31, 2012)