I. **PURPOSE**

The Nursing plan of care is a part of the individualized Interdisciplinary Treatment Plan for each patient at Richmond State Hospital. The RN uses data gathered through nursing assessments, evaluations and interactions with the patient. Other nursing staff members also provide data gathered through observations of and interactions with the patient that is used to continually review, evaluate and update the treatment plan. to provide care and continuing review/evaluation the patient's progress. A specific Nursing Care Plan may be developed to meet short term patient needs based on the nursing process.

II. **SCOPE**

Nursing

III. **POLICY**

1. Nursing Care Plans are developed by Registered Nurses for patients (see policy #120.09) who have medical or psychiatric conditions that require specific nursing interventions to manage those conditions.

2. Assessments goals, interventions and outcomes related to nursing care are included in the interdisciplinary treatment plan and are the responsibility of the Registered Nurse. These treatment plan elements are electronically submitted by the RN assigned to the patient prior to treatment team meeting entered into the computer-generated treatment plan document. Registered Nurses will document in the patient record a summary of the patient's response to nursing care and the unit milieu (see policy #120.04). Data included in the summary will be utilized to update the overall patient's treatment plan during the treatment plan review process. Examples include:
   a. Summary of behavior and mental status during review period with focus on high risk behaviors- prns, S&R, UL, Aggression, new or continuing symptoms, any patterns particular to a shift.
   b. Describe nursing interventions for above findings, as well as the patient's response to those interventions, paying particular attention to the interventions contained in the nursing care plans for the patient.
   c. Physical data – appetite, weight, sleep, hygiene, status of any chronic conditions for which nursing interventions are used.
   d. Specific areas where improvement is evident and where there is lack of progress or no change. Mention fluctuations of status in program levels and cause, if known.
   e. New Patients or transfers: Date of transfer to program, response to or orientation and the unit.

2. Designated nurses are expected to be present at treatment team meetings to provide nursing input and to amend nursing goals, interventions and assessments as needed.

3. All unit Nursing staff assigned to give care/interventions should sign the Interdisciplinary Treatment Plan.

4. Psychiatric attendants assigned as case attendants to the patient will meet with the patient on a regular basis and document the patient's progress toward goals outlined in the treatment plan.

5. Psychiatric attendants assigned to the patient should be present at the treatment team meeting.

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Source: All Nursing Policy Manuals

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Related Policies and Procedures

120.04 Progress Note Documentation; 120.09 Nursing Care Plans