SECTION .0700 - PATIENT/FAMILY CARE PLAN

10A NCAC 13K .0701 CARE PLAN

(a) The agency shall develop and implement policies and procedures that ensure a written care plan is developed and maintained for each patient and family. The plan shall be established by the interdisciplinary team in accordance with the orders of the attending physician and be based on the assessment of the patient's and family's medical, psychosocial, and spiritual needs. The patient and family care coordinator shall have the primary responsibility for assuring the implementation of the patient's care plan. The care plan shall include the following:

(1) the patient's diagnosis and prognosis;

(2) the identification of problems or needs and the establishment of goals that are appropriate for the patient;

(3) the types and frequency of services required to meet the goals; and

(4) the identification of personnel and disciplines responsible for each service.

(b) The care plan shall be reviewed by the interdisciplinary team members and updated monthly. The interdisciplinary team and other personnel shall meet at a minimum every 15 days for the purpose of care plan review and staff support. Minutes shall be kept of these meetings that include the date, names of those in attendance, and the names of the patients discussed. Additionally, entries shall be recorded in the medical records of those patients whose care plans are reviewed.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, 1989;
Readopted Eff. January 1, 2021.