



Treatment Care Plans – Therapist and Nursing

Treatment Care Plan Overview

Treatment care plans are guides to help the clinician develop client goals and monitor a client's progress. A treatment care plan represents the progression of a client's therapy. Treatment plans can be edited to accommodate changes in a client's therapy. Treatment care plans are developed to address client problems and difficulties documented in client assessments.

The overall goal of a treatment care plan is to demonstrate the necessity for further treatment.

Problems describe the difficulties the client is having. For example, "client has oppositional defiant disorder."

Goals are the desired result of the course of action. For example, "I want to sleep through the night."

Objectives are the course of action that will be taken to achieve the client's default treatment goals. For example "encourage appropriate expression of the client's thoughts and feelings."

Interventions are actions taken to remedy the client's problems. For example, "consult with primary care physician."

Steps To Complete the Treatment Care Plans

1. On the **Select Client** screen, search for and select the client by highlighting (green bar).
2. Select the **Treatment Care Plan** in the Forms and Data Widget
3. If the client has multiple episodes, choose the episode from the **Select Episode** pre-display.
4. Complete the Red/Required Fields; **Plan Date**, **Plan Type** and **Treatment Plan Status**. Note the Treatment Plan Status **Must** be in **Draft** to **Launch the Plan**.

The screenshot shows a web-based form for creating a Treatment Care Plan. The form includes several input fields and a dropdown menu. A red box highlights the 'Plan Date' field, which is currently empty. Another red box highlights the 'Treatment Plan Status' section, where the 'Draft' radio button is selected. A red arrow points to the 'Plan Type' dropdown menu, which is currently set to 'Draft'. A final red arrow points to the 'Launch Plan' button at the bottom right of the form. The form also includes fields for 'Last Updated', 'Last Updated By', and 'Plan End Date'.

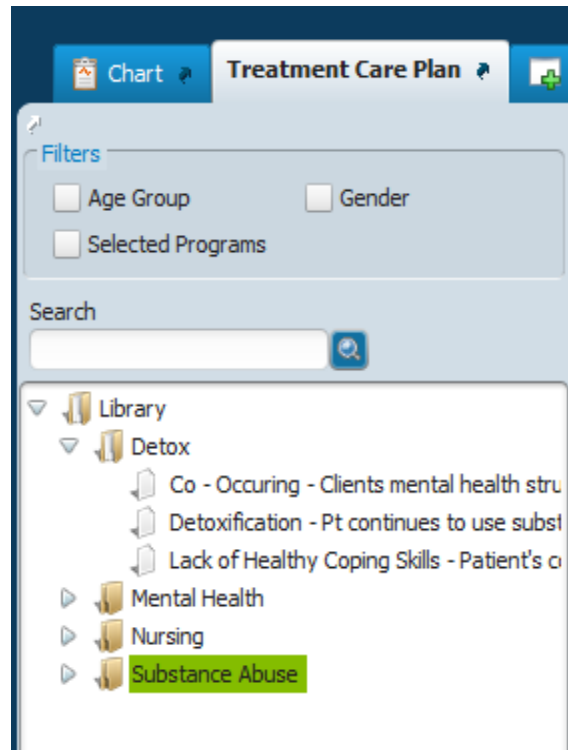


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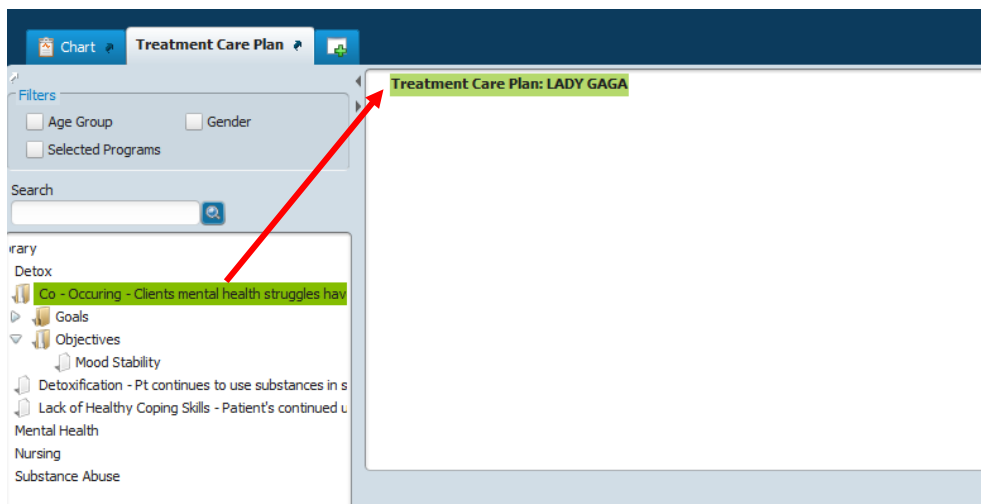


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5. If appropriate, from the Library field open all the components of Detox, Mental Health, Nursing and Substance



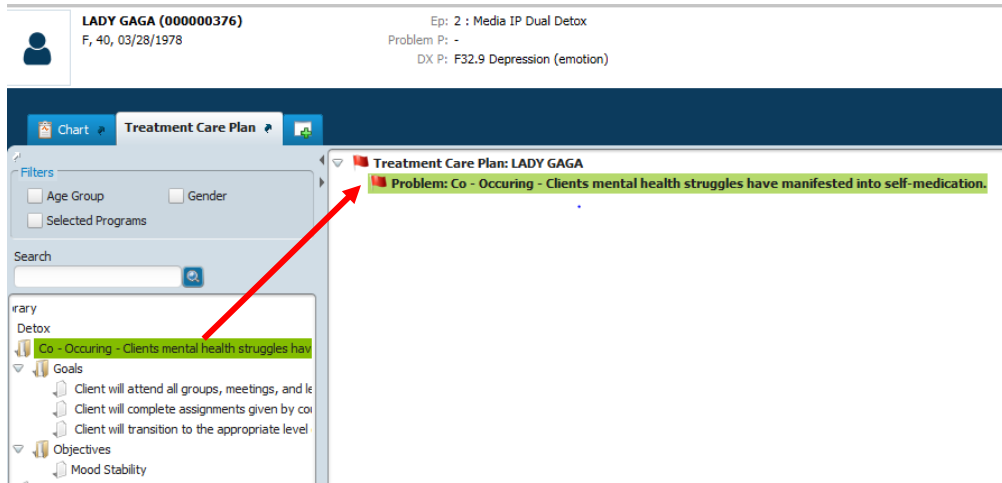
6. To add a problem from the custom defined library, you must drag and drop the problem from the library to the top line of the Treatment Care Plan



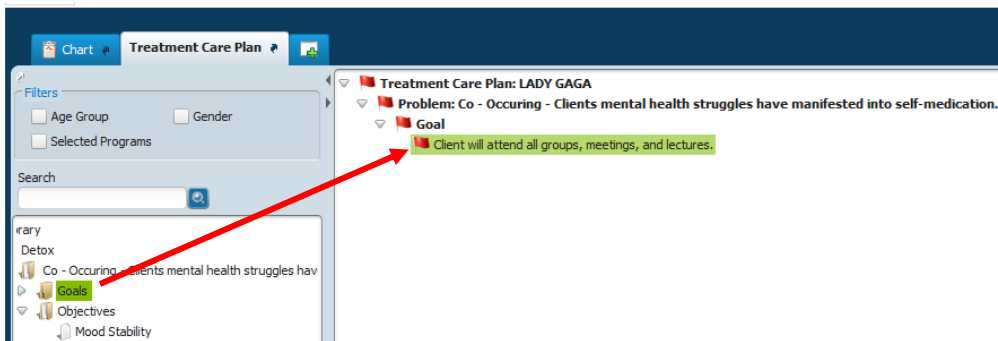


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7. Next open the goals and drag the goal to the Problem



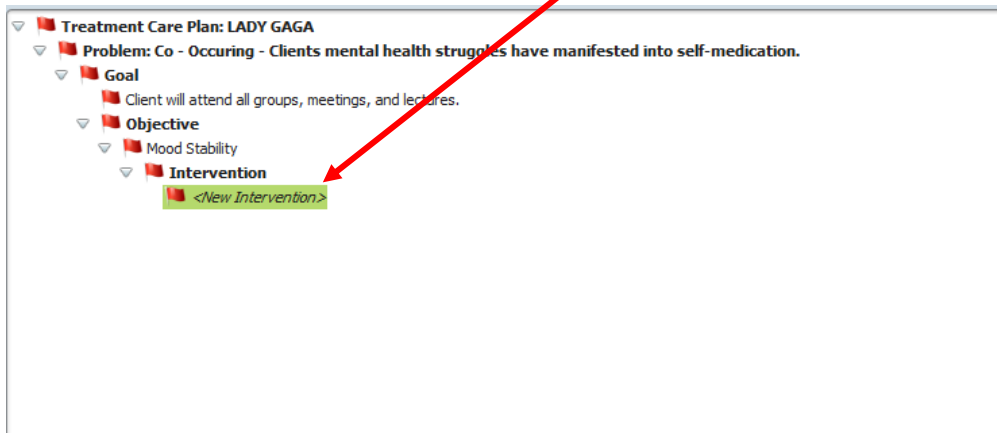
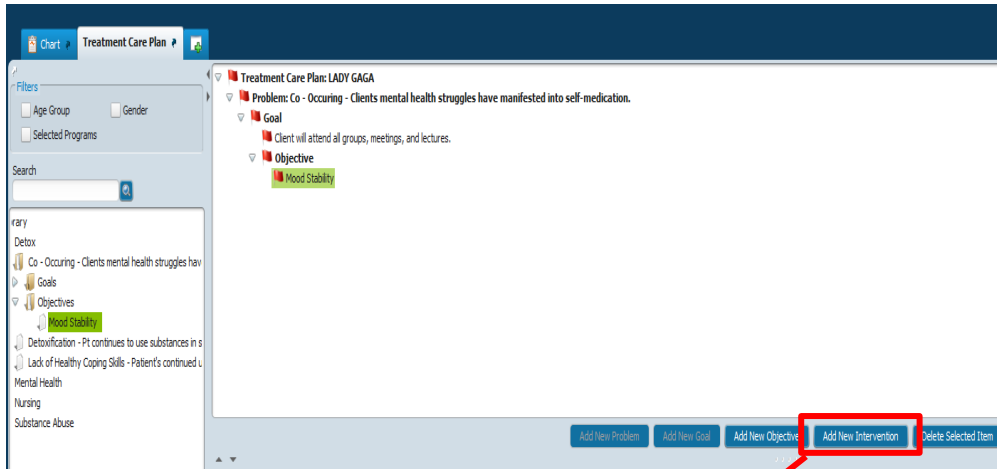
8. Next open the goals and drag the goal to the Problem





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9. Open the Objectives, drag the objective to the Goal.



10. Start at the bottom of the tree (with intervention) for the problem to complete the Missing details at the bottom of the screen. Notice New Intervention is highlighted green. Individualize the intervention to the client and document the status.





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Treatment Care Plan: LADY GAGA

- Problem: Co - Occuring - Clients mental health struggles have manifested into self-medication.
- Goal
 - Client will attend all groups, meetings, and lectures.
- Objective
 - Mood Stability
- Intervention
 - Add New Intervention**

Buttons: Add New Problem, Add New Goal, Add New Objective, Add New Intervention, Delete Selected Item

Intervention (include frequency and duration)

Date Opened: 04/09/2018

Status: [Dropdown]

Date Closed: [Date Picker]

Predefined: No Yes

11. If there are no interventions in the library. You must select **Add New Intervention**

Treatment Care Plan: LADY GAGA

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- Goal
 - Client will attend all groups, meetings, and lectures.
- Objective
 - Mood Stability
- Intervention
 - Add New Intervention**
 - [New] This is the individualized intervention for the client

Buttons: Add New Problem, Add New Goal, Add New Objective, Add New Intervention, Delete Selected Item

Objective: Mood Stability

Date Opened: 04/09/2018

Status: [Dropdown]

Date Closed: [Date Picker]

Predefined: No Yes





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12. Move up the tree to the Goal. Individualize the goal to the client in the text box for Goal and document status.

13. Move up the tree to the Problem. The problem will flow from the diagnosis form if the provider documents “Add to the Problem List” as “yes”. Enter a problem which is a snow med code (medical terminology). Document the onset date of the problem and the status of the problem. In the problem text box individualize the problem to the client and document the status of the individualized problem.



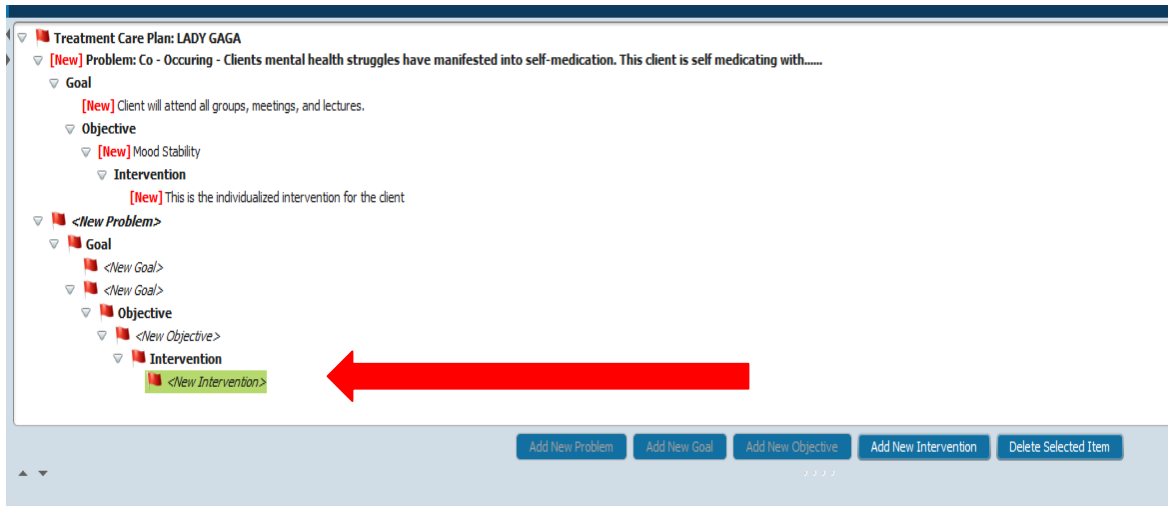


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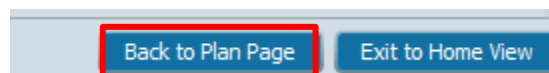
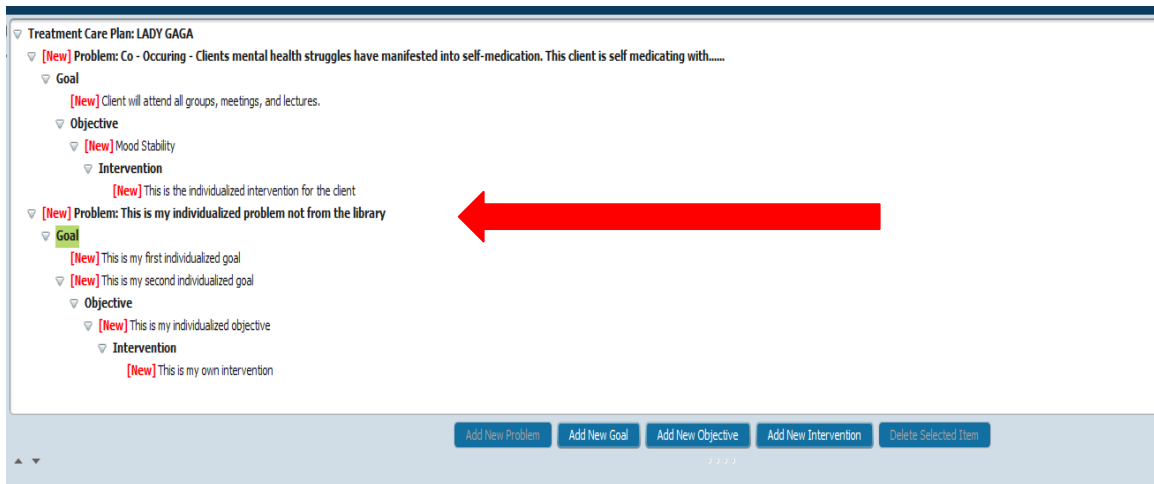
14. If all Red/Required fields are completed the red flags will be eliminated.

NOTE:

If the library does not contain the Problems, Goals, Objectives or interventions you are looking for you may create your own. Select **Add New Problem, Add New Goal, Add New Objective, Add New Intervention**. Start at the bottom of the tree with Intervention and complete the missing details for intervention then move up the tree to Objective, Goal and Problem continuing to complete the missing details. Notice the red flags indicating the details are missing.



Once all details are completed the red flags will be eliminated. Once the flags are eliminated, Select **Back to Plan Page**





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15. Document the patients **Strengths, Limitations** and **Discharge Planning** as relevant to treatment.

The screenshot shows a form with three distinct sections, each with a light blue header and a white text area below it. The sections are labeled 'Strengths', 'Limitations', and 'Discharge Planning'. The text areas are currently empty.

16. Document if the client was offered a copy of the treatment care plan, if you provided a copy and obtained a signature. Document the date you obtained the signature.

The screenshot shows a form with several fields and a signature window. At the top, there is a question 'Patient offered a copy of treatment plan?' with radio buttons for 'Yes' and 'No'. Below this is a dropdown menu. The next two questions are 'Patient provided a copy?' and 'Able to obtain client signature?', both with 'Yes' radio buttons. Below these is a 'Patient Signature' field with a 'No Picture' label. A signature window titled 'Please Sign' is open, showing 'OK', 'Clear', and 'Cancel' buttons. At the bottom, there is a 'Patient Signature Date' field with a date picker and buttons for 'Today' and 'Yesterday'. A 'Get Signature' button is located at the bottom of the signature area.





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- Once you have completed the Treatment Care Plan scroll to the top of the plan and change the Treatment Plan Status to **Final** and Submit.

The screenshot shows the 'Treatment Care Plan' interface. On the left sidebar, the 'Submit' button is highlighted with a red box. The main form area contains several fields: 'Plan Date' (04/16/2018), 'Last Updated' (04/16/2018), 'Last Updated By' (PRESCRIBER, TRAINER 1), 'Plan Type' (Initial), and 'Plan End Date' (04/16/2018). The 'Treatment Plan Status' section is highlighted with a red box and contains two radio buttons: 'Draft' (unselected) and 'Final' (selected). There is also a 'Pending Approval' radio button which is unselected.