

**CENTRAL STATE HOSPITAL  
PLAN**

SUBJECT: PLAN FOR CARE

ANNUAL REVIEW MONTH: May

RESPONSIBLE FOR REVIEW: Chief Nurse Executive

LAST REVISION DATE: July 2009

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**I. OUR MISSION**

To assist individuals who have behavioral healthcare needs as they move toward recovery.

**II. VISION FOR THE HOSPITAL**

Recovery is possible for everyone.

**III. VALUES**

***Integrity:*** Our first priority is to recognize the dignity, respect and rights of everyone.

***Service:*** We assist individuals with their recovery by providing access to prevention, education, habilitation and treatment.

***Excellence:*** We use education and performance improvement to help everyone reach their highest potential.

***Cooperation:*** We collaborate with individuals, families and other providers to enhance recovery.

***Compassion:*** We care.

**IV. POPULATION**

Care is provided to Georgia residents admitted to Central State Hospital (CSH) according to Georgia law, and/or agreements with other State Departments and health care providers.

People are evaluated, admitted and treated for acute and long-term care problems which may be psychiatric, developmental disability, psycho-geriatric or forensic in nature.

The People who are served in this facility are primarily:

- Mentally ill adults from the twenty-three (23) county central Georgia area.

- Adults with developmental disabilities of all levels who are primarily from the central and southeast Georgia regions.
- Adults with developmental disabilities or mental illness who have severe medical and/or aging related disorders that require 24 hour skilled nursing care.
- Forensic psychiatric adults from the criminal justice system throughout Georgia and people from other Department of Behavioral Health and Developmental Disabilities (DBHDD) regional hospitals who are considered dangerous and in need of maximum security.

The age ranges for the population that is served in this facility are defined, for the purpose of planning age specific activities, as:

Adult = age 18 - 64.  
Geriatric = 65+.

**V. CARE**

Care at Central State Hospital is defined as the prevention and treatment of behavioral and physical problems/needs as identified and monitored through the interdisciplinary treatment team process and includes the education of clients and their family members to improve care outcomes.

Treatment is provided through the interdisciplinary process which utilizes the knowledge, skills and talents of professionals and paraprofessionals from many disciplines.

Care begins with assessment whereby each client's needs are assessed by qualified staff. This determination is based on an assessment of the client's relevant physical, psychological, and social needs. It includes the collection and analysis of data about the person to determine what additional information is needed, their priority care needs and the care to be provided.

The provision of care continues with the ongoing process of evaluation and revision unique to the client's response to treatment interventions. Care is provided in collaboration with the client and significant others and includes the planning, implementation and monitoring of services that promote emotional, mental, and physical health, prevent

illness, alleviate suffering, restore health and aid the client in achieving his/her optimum potential. All interventions are designed to assist the client in his or her own recovery, as defined by that client.

The processes involved in the provision of care include but are not limited to, medical care, nursing care, supportive care, treatment of a disease or condition, physical and psychosocial rehabilitation/recovery, habilitation for those who have developmental disabilities, and health promotion. The activities of the care function focus on the following:

- Formulation, maintenance and support of a plan for actions/interventions to meet the individual needs of the person.
- Implementation of the planned actions/interventions.
- Monitoring the client's response to the planned actions/interventions and/or the outcomes of care provided.
- Modification of the Client's treatment plan based on reassessment, the need for further care and the achievement of identified goals.
- Planning for the supports needed after discharge from this hospital.

#### **VI. CARE PROVIDERS**

Care is provided by a variety of health care professionals and support staff who are responsible and accountable and have authority to develop and implement professional standards that foster the mission and vision of the hospital and which incorporate the stated values.

Each professional discipline is responsible for defining appropriate qualifications and competency requirements for the specific discipline. Provider responsibilities and duties are defined in the individual professional plans for the services and in individual job descriptions noted in each professional service plan. Evaluation of individual competence to provide care is based on criteria developed by the professional services and is completed and reviewed by qualified members of that service.

#### **VII. ASSESSMENT**

Each client's treatment needs are assessed by qualified professional staff beginning at the initial contact for service and covering, at a minimum, the physical, psychological and social needs of the client. Data is collected by a variety of professionals and is then analyzed by the treatment team to identify the information needed to make recommendations and decisions to meet the identified needs of the client.

Information is gathered when the client enters the intake setting or service to:

- Identify the reason that brings the client to the hospital;
- Determine if the hospital can provide the care needed; and
- Identify further assessments needed.

The need for further assessment is based on the treatment that the client is seeking, the condition of that client, and the agreement to treatment by the client or guardian.

Reassessments for each client are conducted at regularly specified times to determine the client's response to treatment and are also conducted when a significant change in the client's condition, to include a significant change in the diagnosis, occurs.

Because of the differences in regulations and care settings affecting service areas of the hospital, certain assessment/reassessment timeframes are defined in specific program guidelines. However, the following requirements apply for all new admissions to Central State Hospital:

Admission assessment - Point of admission  
Psychiatric Evaluation - Within 24 hours of Admission to PTFS  
History and Physical - Within 24 hours of Admission  
Initial Nursing Assessment - Within 24 hours of Admission

#### **VIII. ENTRY INTO THE SETTING**

Initial criteria for admission to Central State Hospital are determined by the Mental Health Codes of Georgia. Additional criteria are in accordance with admission guidelines from Medicaid and Medicare regulations and the mission of the hospital.

The need for admission to the hospital is determined by a qualified physician based on assessment data and data from other sources of information such as family, significant others, other treatment facility documents, community care referral, legal documents, etc. Refer to DBHDD Policy 6805-201 (Criteria for Admission to DBHDD Hospitals for Persons with Mental Illness).

Admission assessment and determination is usually performed in the Admissions Office, open 24 hours per day, seven days per week. Exceptions include certain pre-arranged admissions to the Forensics and Developmental Disabilities Services. A Qualified Mental Retardation Professional must evaluate any

client who is to be admitted to one of the ICF/MR facilities prior to the determination to admit.

**IX. PLAN OF CARE**

Each person receives care based on his/her individual needs as determined by the assessment process. The goal of the care planning process is to provide individualized, planned and appropriate care in a setting that supports the treatment, recovery and/or habilitation/rehabilitation goals and specific needs and severity level of his/her disease, condition, impairment or disability.

At admission, the admitting physician develops the initial 72-hour Plan of Care. Following appropriate assessments by qualified staff, the findings from the assessments and other diagnostic findings are analyzed to formulate, maintain and support a Plan of Care for care, treatment and habilitation/rehabilitation/recovery. The plan is formulated and coordinated by an interdisciplinary treatment team, the client and, if possible, the family or significant others. The plan contains statements of strengths, weaknesses, diagnoses, needs, and interventions. It also identifies target dates and staff responsible for implementation.

Implementation of the Plan of Care is the responsibility of the treatment staff identified during the planning process and is carried out in accordance with appropriate hospital standards, policies and procedures. Treatment staff is also responsible for monitoring the client's response to the care provided and the effectiveness of the plan. The plan is continuously evaluated and modified as necessary based on reassessment data.

All interventions identified on the plan respect and advocate for and protect each person's rights and ability to make choices, to develop and maintain a sense of achievement and to participate in his/her care to the maximum extent possible.

**X. INTERDISCIPLINARY TREATMENT TEAM**

An Interdisciplinary Treatment Team (IDT) is responsible for collaboration and coordination of each person's assessment and care. The IDT core members are the Team Leader, the Medical Staff member, the Nurse, and the Social Worker. Other professionals are included as needs are identified. The composition of the treatment team and the intensity of the collaboration vary as appropriate to the care needs of each client.

The team meets on a regular schedule to discuss and review the assessment results, Plan of Care and progress of each client. The client is included in the treatment team meeting

unless that client chooses not to participate. Family or significant others, as requested by the client being served, are also invited to participate in these meetings. Time frames for regular reviews depend on the setting and on the condition of the client. Monitoring of the Plan of Care is continuous and changes are made as the condition and needs of the client warrant.

The treatment team is responsible for ensuring continuity through continuous assessment, reassessment, diagnosis, planning and treatment. The plan for care is individualized but it is the responsibility of the treatment teams to ensure that the same level of care is available for all people served.

#### **XI. EDUCATION**

Educational programs are provided in accordance with the Central State Hospital Education Plan. The goal of education is to improve health outcomes by promoting recovery, speeding return to function, promoting healthy behavior and appropriately involving the client in his/her care decisions.

Education is an interdisciplinary process and is planned for each client based on an assessment of his/her education and training needs. The assessment considers cultural and religious practices, desire and motivation to learn, physical and/or cognitive limitations and language barriers. Instruction is presented in a manner which is understandable to the client and his/her family.

Educational programs include but are not limited to:

- understanding of disease process in an effort to encourage prevention and health promotion;
- safe and effective use of medications, when applicable;
- safe and effective use of medical equipment, when applicable;
- instruction on potential drug-food interactions and counseling on nutrition intervention and/or modified diets, as appropriate;
- habilitation/rehabilitation techniques to facilitate adaptation to and/or functional independence in the environment, if needed;
- management of pain, if needed;
- access to available community resources, if needed; and
- when or where to obtain further treatment, if needed.

#### **XII DISCHARGE PLANNING**

Discharge planning begins at the time of admission. The discharge process provides for continuing care based upon

the client's assessed needs at the time of discharge. To facilitate continuity after discharge, the client and his/her family are assisted in understanding and following the care plan.

Discharge planning identifies the needs the client may have after discharge and arrangements for such services are made to meet those needs. Discharge planning involves the client, his/her family, physician, nurse, social worker and other members of the treatment team appropriate to the needs of the client.

### **XIII. ORGANIZATION**

Care is ensured by leaders of the professional services in the following hospital activities:

- Budget planning and management.
- Strategic and facility planning.
- Physical design for new or renovation of existing care areas.
- Recommendation and selection for purchase of equipment.
- Organization/reorganization of services.
- Evaluation of products.
- Recruitment and selection of qualified staff.
- Recommendations for staffing necessary to accomplish quality person centered care.
- Staffing guidelines and variances.

### **IVX. ANNUAL EVALUATION OF THE PLAN**

On an annual basis, the facility leadership team will evaluate and determine the progress made in each area of this plan.

### **APPROVED:**

This plan has been approved by the CEO and CMO on October, 2009.