SUGGESTED INSTRUCTIONS FOR RESTRICTED HEALTH CONDITION CARE PLANS

There are specific items that must be included in the instruction for each restricted health condition; refer to licensing regulations, Title 22, Division 6 before arranging a licensed professional to provide the instructions.

1) Restricted Health Condition Care Plan (page 2) is completed by the licensee. **Attach the written plan of care for the client.**

   If licensee is informed by Community Care Licensing (CCL) that a condition does not require a restricted health care plan it is recommended that the licensee have this confirmed in writing from CCL.

2) Licensee staff must be instructed in incidental medical assistance, services, and procedures by a licensed medical professional (doctor, nurse, etc.). **Written instructions and training material from this training should be attached** to the Professional Care & Staff Training for Restricted Health Condition (page 3) and kept on file in the facility.

3) The **Physician's Statement (page 4) is completed by the physician and must include his/her signature.**

4) Once completed, send plan to the consumer's service coordinator at FNRC (keep a copy on site as a draft until you have received the final approved plan back from FNRC). The Placement Agency Review of Restricted Health Conditions Care Plan (page 5) will be approved by a FNRC representative and returned to the licensee. The licensee is required to keep the approved plan at the facility site.

5) Licensee must ensure that all staff providing incidental medical assistance/services/procedures have been trained by a licensed professional and that the training is documented in the facility personnel files. The Annual Review & Training for Restricted Health Condition Care Plan (page 6) will be completed on an annual basis.

It is the licensee's responsibility to complete the plan and to ensure the plan is updated per Title 22 regulations, and staff are appropriately trained as needed. If the licensee has questions or concerns they are to contact Community Care Licensing at (530) 895-5033.

_____The Name of Your Facility/Program _____

(*Facility Name or Day Program*)

RESTRICTED HEALTH CONDITION CARE PLAN

Date: _(Date plan is developed)_____

Health Care Plan for: _____**The Client/Resident's Full Name**_____
(Consumer Name)

Restricted Health Condition: ____**The Medical Diagnosis/Restricted Condition**___
(As listed in Title 22)

The following individuals participate in the plan:

____**The Client/Resident's Full Name**_____, Client

____**The Conservator/POA**_____, Authorized Representative

___**The Facility/Program Administrator**___, Licensee

___**The Client's Service Coordinator**_____, FNRC

__**The Provider who wrote the orders**____, Medical Professional (FNP, PA-C, MD) (First & Last Name, Title)

_____ _____
Address Phone

_____**The nurse providing the training**___, Other (*Facility Staff, Licensed Medical Professionals, Family Members, etc)*

_____, Other (*Facility Staff, Licensed Medical Professionals, Family Members, etc)*

_____, Other (*Facility Staff, Licensed Medical Professionals, Family Members, etc)*

Medical Professional Contacts: **(if an emergency call 911)**
(related to restricted health condition)

Name/Title: _____**Home Health Nurse/MD**____ Telephone: _____

_____ Telephone: _____

Professional Care & Staff Training for Restricted Health Condition

☐ Home Health Agency
☐ Licensed Professional Performing Duties (if applicable): **Facility/Program's LVN/RN, or Client's medical provider**
☐ Not applicable

_____
(Name)

_____
(Address)

_____
(Telephone)

_____
(Contact Person)

_____
(Duties Performed)

Title 22
The following facility staff has been trained to perform routine care related to the consumer's restricted health condition, as delegated by the licensed professional; to recognize objective symptoms, observable by a lay person; and how to respond to the consumer's health problems, including who to contact.

Names of facility staff who have been trained to perform incidental medical assistance:

Signatures of trainees or **"See Attached Sign in Sheet"**

_____ _____

_____ _____
Attach additional names if applicable **Attach Attendance sheet**

Date of Training: ___**Date of Training** _____

***Attach Training materials and written instructions from the licensed professional outlining the procedures to be performed by the trained staff.**

Licensed professional performing training:

Name/Title: ___**Print Name of Trainer**_____ Telephone: _____

Address: _____

Additional training: _____
(if related to change in condition or care needs)

Physician's Statement

This section must be completed and signed by attending physician

NOTE TO PHYSICIAN: **The condition must be chronic and stable or temporary in nature and must not require 24-hour nursing care.**

Client's Full Name *(Consumer)* has the following medical diagnosis pertaining to this Restricted Health Condition: **Medical Diagnosis/Restricted Condition**.

Specific services needed to care for this medical condition **(*attach physician orders*):**

What treatment or device is being ordered? ie. CPAP, Nebulizer, Wound Care, Blood Sugars/Insulin, etc. "Monitor for symptoms, and effectiveness of treatment", "Report Adverse Reactions", "Assist with use of device"

Written instructions/procedures are attached to this plan to implement physician orders.

I, **Printed Provider Name**, certify that this condition is either chronic and stable at this time or temporary in nature, that the consumer is able to assist, to the best of his/her ability, in the care of this condition and that 24-hour nursing care is not required. Licensee has been instructed in caring for this Restricted Health Condition. This plan meets medical scope of practice requirements.

MD, NP, PA's Signature
(Physician's Signature) *Date*

**** Attach a copy of the Physician's Orders related to the Restricted Condition.**

****Attach a copy of the most recent MAR (if applicable) showing the Physician's Orders have been transcribed correctly.**

****Attach a copy of any logs used to document monitoring or interventions for the Restricted Condition ie. BM log for enemas and suppositories, Skin log for ostomies or wounds, etc.**

Placement Agency Review of Restricted Health Condition Care Plan

Facility/Program Administrator's Signature

Licensee signature Date

Plan reviewed by: _____

Nurse, Far Northern Regional Center Date

Plan approved by: _____

Medical Director, Far Northern Regional Center Date

Annual Review & Training for Restricted Health Condition Care Plan

NOTE TO LICENSEE: It is important to have the care plan of a consumer with a chronic condition reviewed, by a licensed professional, on a regular basis. Please keep this sheet attached to your care plan. After a licensed professional reviews the plan and deems it still appropriate, please have him/her sign and date below. ***It is advised to have this completed at the time of the consumer's annual physical examination.***

I have reviewed and approved _____'s (consumer) Restricted Health Condition Plan. This agency will monitor implementation of the plan.

I have reviewed staff performance and provided the necessary training/retraining related to the consumer's RHCP, and new staff training as needed.

_____
Signature of Licensed Professional providing performance review and training/retraining.

_____
Date

_____
Name of Placement Agency

_____
Signature of Placement Agency Nurse

_____
Signature of Placement Agency Medical Director

_____
Date

*****Initially, leave this page blank. To be used next year at annual review*****