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.

   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.

____
(*Facility Name or Day Program*)

RESTRICTED HEALTH CONDITION CARE PLAN

Date: ___________

Health Care Plan for: ____
(*Consumer Name*)

Restricted Health Condition: ____
(*As listed in Title 22*)

The following individuals participate in the plan:

________________________________, Client

________________________________, Authorized Representative

________________________________, Licensee

________________________________, FNRC

________________________________, Medical Professional (FNP, PA-C, MD) (First & Last Name, Title)

____ ____________________
Address Phone

________________________________, 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: ____ Telephone: __________________

____ Telephone: __________________

Professional Care & Staff Training for Restricted Health Condition

☐ Home Health Agency
☐ Licensed Professional Performing Duties (if applicable):
☐ 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:

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________
Attach additional names if applicable Attach Attendance sheet

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: ____ 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.**

________________________________*(Consumer)* has the following medical diagnosis pertaining to this Restricted Health Condition: ____
____.

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

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

I, ____________________, 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.

____

(Physician's Signature) *Date*

Placement Agency Review of Restricted Health Condition Care Plan

____
Licensee signature Date

Plan reviewed by:____
Nurse, Far Northern Regional Center Date

Plan approved by: ____
Associate Director, Case Management 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.

____

Name of Placement Agency

____

Date