EXHIBIT 9

PURPOSE:

To outline the SPHS treatment planning process.

POLICY:

It is the policy of Sheppard Pratt Health System to provide psychiatric care via a multidisciplinary treatment team under the supervision of a licensed physician. Under this system, services are provided to patients by a wide variety of disciplines in addition to psychiatrists, e.g., psychologists, social workers, nurses, rehabilitation therapists, diagnostic and prescriptive teachers, and certified alcoholism counselors, as necessary, according to the needs of the individual patient.

DEFINITION:

The Master Treatment Plan is a plan of active treatment, based on the current diagnostic impression and an overall evaluation of the patient's specific needs and problems, which aims at the arrest, reversal, and/or amelioration of the patient's illness and symptoms. It shall include an inventory of the patient's strengths as well as weaknesses, and set forth measurable goals or behaviorally stated objectives aimed at maximal restoration of the patient's adaptive capacity and his/her return to the community as soon as possible. An anticipated discharge date shall be included.

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GUIDELINES/PROCEDURE:

I. Individual treatment planning shall be developed which addresses all required areas of functioning. Individual treatment planning is accomplished through the formulation of the Master Treatment Plan and Treatment Plan Review(s).

II. Treatment plans shall be developed by the treatment team based on patient assessments at the direction of the attending physician/primary therapist. The physician's Psychiatric Admission Note serves as the patient's treatment plan for the first five days of admission. This is developed within 24 hours of the patient's admission and includes the patient's chief complaint, history of present illness, current medication, diagnosis, and strengths and weaknesses. Initial treatment goals and criteria for termination of treatment are identified.

III. The Master Treatment Plan shall be completed by the fifth day of treatment. The Treatment Plan shall be reassessed by members of the treatment team as problems or goals change, after seclusion or restraint events, and at least every 14 days for the first 8 weeks and monthly after the first 8 weeks of a particular hospital stay.

IV. The patient's medical record shall contain all required documentation regarding the Master Treatment Plan and Treatment Plan Review(s) and be signed by the physician responsible for implementation of the plan. Each discipline that participated in the development of the above is

to be identified, and where appropriate, the patient's medical record shall reflect their findings and recommendations.

V. The patient (or guardian) shall sign the treatment plan acknowledgement form to indicate participation in the treatment plan process. If the patient (or guardian) declines to sign the form, the staff member will indicate this on the form. Family members and relevant others shall assist in the formation of discharge and aftercare planning as seems appropriate in each individual case.

VI. All reasonable efforts shall be made to secure and provide the patient with all services identified in the Master Treatment Plan and Treatment Plan Review(s). Justification for needs identified but not addressed shall be documented and appropriate referrals made.

References:

CM-420.4 Health Information Management

Attachments:

Revision Dates:

Reviewed Dates:

11/87, 8/90, 8/92, 6/93, 10/96, 4/97, 4/97, 5/00, 10/01, 2/02, 7/05, 1/09, 5/11

Signatures:

Ernestine Cosby: 5/23/11
Robert Roca: 5/23/11

PURPOSE:

To gather data to identify nursing care needs and, via use of objective assessment techniques and patient participation, to establish an initial database which reflects nursing's role in the Master Treatment Plan (MTP) process.

POLICY:

All newly admitted patients shall have an Admission Nursing Assessment completed within 8 hours of admission.

PROCEDURE:

I. The patient shall be interviewed to obtain data to complete the document within 8 hours of admission. This document is the responsibility of the RN. However, an LPN may complete all parts of the document except the Fall Risk Assessment, Suicide Risk Assessment, and Mental Status Assessment.

II. In the event that the patient is unable or unwilling to participate in the Admission Nursing Assessment, the patient's medical record, ER records, or family members/legal guardian may provide information. Efforts will be made to complete as much of the document as possible.

III. In the electronic medical record, the Admission Nursing Assessment document can be opened via the document's icon.

IV. The Admission Nursing Assessment includes:

A. Translation needs
B. Code status
C. Allergies
D. Physical characteristics
E. Surgical history/surgical site image
F. LMP where applicable
G. TB screening
H. Mammogram history, if applicable
I. Immunization history
J. Pain Screen
K. Objective Pain Scale, if applicable
L. Subjective Pain Scale, if applicable
M. Review of symptoms
N. Ulcer and non-ulcer skin assessments
O. Fall Risk Assessment
P. ADLs

Q. Nutritional Screen
R. Medication history (prescribed and over the counter medications), if applicable
S. Social information
T. Legal history
U. Clinical information
V. Patient self assessment coping inventory
W. Seclusion/Restraint notification
X. Mental Status Assessment
Y. Health teaching/Learning needs
Z. Suicide Risk Assessment
AA. Nursing problem list & Plan of Care

References:

Nursing Procedure Manual

Attachments:

Revision Dates:

Reviewed Dates:

3/11, 9/14

Signatures:

Ernestine Cosby: 10/10/14
Robert Roca: 9/29/14

PURPOSE:

To define criteria for conducting a History and Physical Exam per accreditation and regulatory requirements.

POLICY:

It is the policy of Sheppard Pratt Health System to conduct History and Physical Exams to determine whether there is anything in the patient's overall condition that would affect the planned course of the patient's psychiatric treatment.

PROCEDURE:

I. Inpatient Admission

A. The History and Physical Exam (H&P) must be performed and available in the medical record within 24 hours of all inpatient admissions including recent readmissions to the Hospital.

B. The H&P shall be conducted and documented by a physician, Physician Assistant, or Nurse Practitioner designated as providing medical management for the patient. For after-hour admissions on the Towson campus, the Physician Assistant, the Nurse Practitioner, or on-call Resident shall be responsible for conducting and documenting the History and Physical within 24 hours of admission. No countersignature by a physician is required on the H&P completed by a Physician Assistant or Nurse Practitioner.

C. The H&P may be documented on the Medical History and Physical Exam form or the Admission Holding Note in the medical record.

D. Patients who are readmitted to the Center for Eating Disorders must have had a History and Physical completed within 30 days prior to their inpatient admission. An update documenting any changes from the original History and Physical shall be completed in a progress note within 24 hours of their readmission.

II. The H&P shall include the following:

A. Medical and surgical history, including allergies
B. Review of systems
C. Gynecological history, if applicable
D. Immunization history for children and adolescents
E. Physical examination, including Neurological exam
F. Pain assessment
G. TB screen

H. Diagnosis, if applicable
I. Orders, if applicable

III. The attending physician shall review his/her patient's H&P. If the patient refuses a H&P upon admission, the attending physician shall document his/her assessment of the patient's medical history and review of systems in his/her Physician Admission Note, either initially or as an update. A physical shall be conducted once the patient agrees.

IV. If there is concern about the quality of the H&P, the attending physician shall review the H&P with his/her Service Chief and/or Medical Director who then shall report any concerns to the VP of Medical Affairs. The Medical Executive Committee shall monitor the quality of the H&Ps via the reported concerns to the VP of Medical Affairs.

V. ECT

A. All persons scheduled for ECT, either as inpatients or outpatients, must have a Pre-ECT medical consultation (H&P) from the SPHS internist or Nurse Practitioner completed within 2 weeks of initiation of ECT treatment. The pre-ECT medical consultation includes the reason for the consult, a list of current medications, history of the present illness, a review of systems, past medical and surgical history, a physical exam, and clinical impression/recommendations. Prior to anesthesia induction, the anesthesiologist will review the pre-ECT medical consultation, updating information as required by current findings and conditions reported by the patient. The update will be documented on the ECT Pre-Anesthesia Assessment form. The anesthesiologist shall meet the following requirements:

1. Document an examination for any changes in the patient's conditions since the Pre-ECT medical consultation was performed,

2. If no changes are noted, indicate that the Pre-ECT medical consultation was reviewed, the patient was examined, and that no change has occurred.

B. If the anesthesiologist finds that the Pre-ECT medical consultation was incomplete, inaccurate, or otherwise unacceptable, he/she shall require a new medical consultation

C. In all cases, the Pre-ECT medical consultation must be completed prior to initial anesthesia induction.

D. For patients receiving ongoing ECT, the Interim History and Physical Exam for ECT must be completed if the Pre-ECT medical consultation was conducted more than 30 days prior to the patient's last ECT treatment. The Interim History and Physical Exam for ECT includes a review of systems and physical exam focused on respiratory and cardiac areas and the patient's documentation about new medical problems or medications, if any, since his/her last ECT treatment. In these cases, the Interim History and Physical Exam for ECT must be completed prior to anesthesia induction. The Pre-ECT medical consultation shall also be completed annually.

References:

CM-150.1 Electroconvulsive Therapy (ECT)
CM-120.6 Non-Medication Orders
CM-210.4 Inpatient Admissions

Attachments:

Revision Dates:

3/12, 9/12

Reviewed Dates:

1/09, 5/11, 1/12, 3/12, 9/12

Signatures:

Ernestine Cosby: 9/18/12
Robert Roca: 9/18/12