481—41.11(135H) Individual plan of care. "Individual plan of care" means a written plan developed for each child. The plan of care shall be designed to improve the condition of each child to the extent that inpatient care is no longer necessary.

41.11(1) The plan of care must be based on a diagnostic evaluation that includes examination of the:

a. Medical,

b. Psychological,

c. Social,

d. Behavioral, and

e. Developmental aspects of the child's situation.

The plan of care shall reflect the need for inpatient psychiatric care.

41.11(2) The plan of care shall be developed by the team of professionals specified in rule 481—41.13(135H) in consultation with the recipient, the parents, legal guardian or other person into whose care the child will be released after discharge. The plan of care shall include:

a. Diagnoses, symptoms, complaints and complications indicating the need for admission;

b. Treatment objectives;

c. An integrated program of therapies, activities and experiences designed to meet the objectives;

d. A description of the functional level of the individual;

e. Any orders for:

(1) Medications,

(2) Treatments,

(3) Restorative and rehabilitative services,

(4) Activities,

(5) Therapies,

(6) Social services,

(7) Diet, and

(8) Special procedures recommended for the health and safety of the patient; and

f. At an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

41.11(3) The plan of care shall be reviewed every 30 days by the team referred to in rule 481—41.13(135H) to:

a. Determine that services being provided are or were required on an inpatient basis; and

b. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

This rule is intended to implement Iowa Code section 135H.3.