26.00.20 Delivery of Services.

(b) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures and State laws.

(1) All rehabilitation services orders must be documented in the patient’s medical record in accordance with the requirements at §482.24.

(2) The provision of care and personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of §409.17 of this chapter.

CFR 482.56(b)

(Revised November 12, 2010)

Each patient must have an individualized plan of treatment, based on the patient specific rehabilitation needs of the patient with input from family / caregivers. The treatment plan includes therapeutic treatment goals that are established in writing prior to the initiation of treatment.

At a minimum, the treatment plan must:

1. Be established by the practitioner ordering the service in collaboration with individuals qualified to provide the service(s);
2. Be based on the patient’s individualized assessment;
3. Include the type, amount, frequency and duration of services;
4. Include measurable short-term goals; incorporate patient, family and caregiver goals (AS APPROPRIATE); and
5. Be reviewed and revised, as necessary, to reflect changes in the patient’s response to therapeutic intervention. Updated treatment goals should reflect the changes in the patient’s status.

Changes to the treatment plan must be documented in writing and supported by clinical record information such as evaluation, test results, interdisciplinary staff conferences or Practitioner orders.

CHART REVIEW

Review patient records.

Verify:

1. Rehabilitation services are provided only in accordance with practitioner orders and that those orders are incorporated into the medical record.
2. Each patient has a plan of treatment established in writing prior to the beginning of treatment. The treatment plan is approved by the ordering practitioner prior to initiation of any therapy.
3. The treatment plan is established by the practitioner ordering the service in collaboration with individual(s) qualified to provide the service(s).
4. The plan should include:
   • treatment goals and type,
   • amount,
   • frequency, and
   • duration of services.
5. Changes in the treatment plan are documented in writing, supported by clinical record information such as evaluation, test results, or orders, and that changes have been approved by the practitioner.

Initially the plan may be general in nature, but is developed in more detail.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Orders</td>
<td>Verbal orders for the provision of treatment may be accepted and must be authenticated in accordance with the requirement in 482.56(b) and with Federal and State laws.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Verbal orders regarding treatment are acceptable if documented and signed by the person accepting the order. The time, date and contents of the verbal order and the name of the ordering practitioner must be entered in the record at the time of the order and be countersigned by the practitioner consistent with State laws and facility policy. (See standard 15.00.03 for requirements)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Orders</td>
<td>Outpatient therapy orders must be written by licensed physicians or other practitioners approved under state law and authorized by the medical staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient therapy may be ordered by practitioners who are not credentialed / recognized by the medical staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delegation of Function</td>
<td>subsequent to evaluation of the patient by qualified personnel.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Many facilities are struggling with maintaining compliance with this standard. Below are a couple of suggestions as acceptable options.

1. Delegation of the order being written by the physical therapist. If in the Medical Staff Bylaws and in accordance with State law, it states that this function may be delegated to a physical therapist, that is acceptable, but the attending physician is still responsible for any care the patient’s receiving. The attending physician must be made aware that he/she is responsible for whatever goes on with the patient.

2. The hospital medical staff could approve physical therapy protocols, in collaboration with the Physical Therapy department, and then have them available for use in whatever form that is decided on. (e.g. pre printed orders)

3. The attending physician may write an order that says “evaluate patient, develop a plan of care and implement plan.”

Note: Orders that state “Evaluate and Treat” are not acceptable.
26.01.09 Treatment Plan.
(Physical Therapy)

(b) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures and State laws.

1. All rehabilitation services orders must be documented in the patient's medical record in accordance with the requirements at §482.24.
2. The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of §409.17 of this chapter.

CFR 482.56(b)

(Revised November 12, 2010)

Each patient must have an individualized plan of treatment, based on the patient specific rehabilitation needs of the patient with input from family / caregivers. The treatment plan includes therapeutic treatment goals that are established in writing prior to the initiation of treatment.

At a minimum, the treatment plan must:
1. Be established by the practitioner ordering the service in collaboration with individuals qualified to provide the service(s);
2. Be based on the patient’s individualized assessment;
3. Include the type, amount, frequency and duration of services;
4. Include measurable short-term goals; incorporate patient, family and caregiver goals (AS APPROPRIATE); and
5. Be reviewed and revised, as necessary, to reflect changes in the patient’s response to therapeutic intervention. Updated treatment goals should reflect the changes in the patient’s status. Changes to the treatment plan must be documented in writing and supported by clinical record information such as evaluation, test results, interdisciplinary staff conferences or Practitioner orders.

The activities described in the written plan must be within the scope of practice, State licensure, or certification of the individual performing the activity.

### CHART REVIEW

Review medical records.
.Verify:
1. **Physical Therapy services are provided only in accordance with practitioner orders and that those orders are incorporated into the medical record.**

2. Each patient has a treatment plan established in writing prior to the beginning of treatment. **The treatment plan is approved by the ordering practitioner prior to initiation of any therapy.**

3. **The treatment plan is established by the practitioner ordering the service in collaboration with an individual qualified to provide the service.**

4. **The treatment plan includes:**
   - Treatment goals
   - Type, amount, frequency, and duration of services.
   - Goals reflect patient and family input (as appropriate)

5. Changes in the treatment plan are documented in writing and supported by clinical information. **Changes are approved by the ordering practitioner.**

2009 Healthcare Facilities Accreditation Program (HFAP)
Accreditation Requirements for Healthcare Facilities
**Verbal Orders**
1. Verbal orders for the provision of treatment may be accepted and must be authenticated in accordance with the requirement in 482.56(b) and with Federal and State laws.
2. Verbal orders regarding treatment are acceptable if documented and signed by the person accepting the order. The time, date and contents of the verbal order and the name of the ordering practitioner must be entered in the record at the time of the order and be countersigned by the practitioner consistent with State laws and facility policy. (See standard 15.00.03 for requirements)

**Outpatient Orders**
1. Outpatient therapy orders must be written by licensed physicians or other practitioners approved under state law and authorized by the medical staff.
2. Outpatient therapy may be ordered by practitioners who are not credentialed / recognized by the medical staff.

**Delegation of Function**
Many facilities are struggling with maintaining compliance with this standard. Below are a couple of suggestions as acceptable options.
1. Delegation of the order being written by the physical therapist. If in the Medical Staff Bylaws and in accordance with State law, it states that this function may be delegated to

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Orders</td>
<td>1. Verbal orders for the provision of treatment may be accepted and must be authenticated in accordance with the requirement in 482.56(b) and with Federal and State laws. 2. Verbal orders regarding treatment are acceptable if documented and signed by the person accepting the order. The time, date and contents of the verbal order and the name of the ordering practitioner must be entered in the record at the time of the order and be countersigned by the practitioner consistent with State laws and facility policy. (See standard 15.00.03 for requirements)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Orders</td>
<td>1. Outpatient therapy orders must be written by licensed physicians or other practitioners approved under state law and authorized by the medical staff. 2. Outpatient therapy may be ordered by practitioners who are not credentialed / recognized by the medical staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delegation of Function</td>
<td>Many facilities are struggling with maintaining compliance with this standard. Below are a couple of suggestions as acceptable options. 1. Delegation of the order being written by the physical therapist. If in the Medical Staff Bylaws and in accordance with State law, it states that this function may be delegated to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD / ELEMENT</td>
<td>EXPLANATION</td>
<td>SCORING PROCEDURE</td>
<td>SCORE</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
<td>-------------------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>a physical therapist, that is acceptable, but the attending physician is still responsible for any care the patient's receiving. The attending physician must be made aware that he/she is responsible for whatever goes on with the patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The hospital medical staff could approve physical therapy protocols, in collaboration with the Physical Therapy department, and then have them available for use in whatever form that is decided on. (e.g. pre printed orders)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The attending physician may write an order that says “evaluate patient, develop a plan of care and implement plan.” Note: Orders that state “Evaluate and Treat” are not acceptable.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
26.02.09 Treatment Plan.

(Occupational Therapy)

(b) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures and State laws.

(1) All rehabilitation services orders must be documented in the patient’s medical record in accordance with the requirements at §482.24.

(2) The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of §409.17 of this chapter. CFR 482.56(b)

Each patient must have an individualized plan of treatment, based on the patient specific rehabilitation needs of the patient with input from family / caregivers. The treatment plan includes therapeutic treatment goals that are established in writing prior to the initiation of treatment.

At a minimum, the treatment plan must:
1. Be established by the practitioner ordering the service in collaboration with individuals qualified to provide the service(s);
2. Be based on the patient’s individualized assessment;
3. Include the type, amount, frequency and duration of services;
4. Include measurable short-term goals; incorporate patient, family and caregiver goals (AS APPROPRIATE); and
5. Be reviewed and revised, as necessary, to reflect changes in the patient’s response to therapeutic intervention. Updated treatment goals should reflect the changes in the patient’s status. Changes to the treatment plan must be documented in writing and supported by clinical record information such as evaluation, test results, interdisciplinary staff conferences or Practitioner orders.

The activities described in the written plan must be within the scope of practice, State licensure, or certification of the individual performing the activity.

CHART REVIEW

Review medical records.

Verify:

6. Occupational Therapy services are provided only in accordance with practitioner orders and that those orders are incorporated into the medical record.

7. Each patient has a treatment plan established in writing prior to the beginning of treatment. The treatment plan is approved by the ordering practitioner prior to initiation of any therapy.

8. The treatment plan is established by the practitioner ordering the service in collaboration with an individual qualified to provide the service.

9. The treatment plan includes:
   • Treatment goals,
   • Type, amount, frequency, and duration of services
   • Goals reflect patient and family input

10. Changes in the treatment plan are documented in writing and supported by clinical information. Changes are approved by the ordering practitioner.
Verbal Orders
1. Verbal orders for the provision of treatment may be accepted and must be authenticated in accordance with the requirement in 482.56(b) and with Federal and State laws.
2. Verbal orders regarding treatment are acceptable if documented and signed by the person accepting the order. The time, date and contents of the verbal order and the name of the ordering practitioner must be entered in the record at the time of the order and be countersigned by the practitioner consistent with State laws and facility policy. (See standard 15.00.03 for requirements)

Outpatient Orders
1. Outpatient therapy orders must be written by licensed physicians or other practitioners approved under state law and authorized by the medical staff.
2. Outpatient therapy may be ordered by practitioners who are not credentialed / recognized by the medical staff.

Delegation of Function
Many facilities are struggling with maintaining compliance with this standard. Below are a couple of suggestions as acceptable options.
1. Delegation of the order being written by the physical therapist. If in the Medical Staff Bylaws and in
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
</tr>
</thead>
</table>
| accordance with State law, it states that this function may be delegated to a physical therapist, that is acceptable, but the attending physician is still responsible for any care the patient’s receiving. The attending physician must be made aware that he/she is responsible for whatever goes on with the patient.  
2. The hospital medical staff could approve physical therapy protocols, in collaboration with the Physical Therapy department, and then have them available for use in whatever form that is decided on. (e.g. pre printed orders)  
3. The attending physician may write an order that says “evaluate patient, develop a plan of care and implement plan.”  
Note: Orders that state “Evaluate and Treat” are not acceptable. |
26.03.09 Treatment Plan.
(Speech Therapy)

(b) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures and State laws.

(1) All rehabilitation services orders must be documented in the patient’s medical record in accordance with the requirements at §482.24.

(2) The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of §409.17 of this chapter.

CFR 482.56(b)

Each patient must have an individualized plan of treatment, based on the patient specific rehabilitation needs of the patient with input from family / caregivers. The treatment plan includes therapeutic treatment goals that are established in writing prior to the initiation of treatment.

At a minimum, the treatment plan must:
1. Be established by the practitioner ordering the service in collaboration with individuals qualified to provide the service(s);
2. Be based on the patient’s individualized assessment;
3. Include the type, amount, frequency and duration of services;
4. Include measurable short-term goals; incorporate patient, family and caregiver goals (AS APPROPRIATE); and
5. Be reviewed and revised, as necessary, to reflect changes in the patient’s response to therapeutic intervention. Updated treatment goals should reflect the changes in the patient’s status.

Changes to the treatment plan must be documented in writing and supported by clinical record information such as evaluation, test results, interdisciplinary staff conferences or MD/DO Practitioner orders.

The activities described in the written plan must be within the scope of practice, State licensure, or certification of the individual performing the activity.

CHART REVIEW
Review medical records.
Verify:
11. Speech Therapy services are provided only in accordance with practitioner orders and that those orders are incorporated into the medical record.
12. Each patient has a treatment plan established in writing prior to the beginning of treatment. The treatment plan is approved by the ordering practitioner prior to initiation of any therapy.
13. The treatment plan is established by the practitioner ordering the service in collaboration with an individual qualified to provide the service.
14. The treatment plan includes:
   • Treatment goals
   • Type, amount, frequency, and duration of services
   • Goals reflect patient and family input.
15. Changes in the treatment plan are documented in writing and supported by clinical information. Changes are approved by the ordering practitioner.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
</table>

**Verbal Orders**
1. Verbal orders for the provision of treatment may be accepted and must be authenticated in accordance with the requirement in 482.56(b) and with Federal and State laws.
2. Verbal orders regarding treatment are acceptable if documented and signed by the person accepting the order. The time, date and contents of the verbal order and the name of the ordering practitioner must be entered in the record at the time of the order and be countersigned by the practitioner consistent with State laws and facility policy. (See standard 15.00.03 for requirements)

**Outpatient Orders**
1. Outpatient therapy orders must be written by licensed physicians or other practitioners approved under state law and authorized by the medical staff.
2. Outpatient therapy may be ordered by practitioners who are not credentialed / recognized by the medical staff.

**Delegation of Function**
Many facilities are struggling with maintaining compliance with this standard. Below are a couple of suggestions as acceptable options.
1. Delegation of the order being written by the physical therapist. If in the Medical Staff Bylaws and in
<table>
<thead>
<tr>
<th>STANDARDS / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
</table>

accordance with State law, it states that this function may be delegated to a physical therapist, that is acceptable, but the attending physician is still responsible for any care the patient’s receiving. The attending physician must be made aware that he/she is responsible for whatever goes on with the patient.

2. The hospital medical staff could approve physical therapy protocols, in collaboration with the Physical Therapy department, and then have them available for use in whatever form that is decided on. (e.g. preprinted orders)

3. The attending physician may write an order that says “evaluate patient, develop a plan of care and implement plan.”

Note: Orders that state “Evaluate and Treat” are not acceptable.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.04.09 Treatment Plan. (Audiology)</td>
<td>Each patient must have an individualized plan of treatment, based on the patient specific rehabilitation needs of the patient with input from family / caregivers. The treatment plan includes therapeutic treatment goals that are established in writing prior to the initiation of treatment. At a minimum, the treatment plan must: 1. Be established by the practitioner ordering the service in collaboration with individuals qualified to provide the service(s); 2. Be based on the patient’s individualized assessment; 3. Include the type, amount, frequency and duration of services; 4. Include measurable short-term goals; incorporate patient, family and caregiver goals (AS APPROPRIATE); and 5. Be reviewed and revised, as necessary, to reflect changes in the patient’s response to therapeutic intervention. Updated treatment goals should reflect the changes in the patient’s status. Changes to the treatment plan must be documented in writing and supported by clinical record information such as evaluation, test results, interdisciplinary staff conferences or Practitioner orders. The activities described in the written plan must be within the scope of practice, State licensure, or certification of the individual performing the activity.</td>
<td>CHART REVIEW</td>
<td>1 2 3 4 NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review medical records. Verify: 16. Audiology services are provided only in accordance with practitioner orders and that those orders are incorporated into the medical record. 17. Each patient has a treatment plan established in writing prior to the beginning of treatment. The treatment plan is approved by the ordering practitioner prior to initiation of any therapy. 18. The treatment plan is established by the practitioner ordering the service in collaboration with an individual qualified to provide the service. 19. The treatment plan includes: • Treatment goals, • Type, amount, frequency, and duration of services. • Goals reflect patient/family input. 20. Changes in the treatment plan are documented in writing and supported by clinical information. Changes are approved by the ordering practitioner.</td>
<td></td>
</tr>
<tr>
<td>STANDARD / ELEMENT</td>
<td>EXPLANATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Verbal Orders      | 1. Verbal orders for the provision of treatment may be accepted and must be authenticated in accordance with the requirement in 482.56(b) and with Federal and State laws.  
2. Verbal orders regarding treatment are acceptable if documented and signed by the person accepting the order. The time, date and contents of the verbal order and the name of the ordering practitioner must be entered in the record at the time of the order and be countersigned by the practitioner consistent with State laws and facility policy. (See standard 15.00.03 for requirements) |
| Outpatient Orders  | 1. Outpatient therapy orders must be written by licensed physicians or other practitioners approved under state law and authorized by the medical staff.  
2. Outpatient therapy may be ordered by practitioners who are not credentialed / recognized by the medical staff. |
| Delegation of Function | Many facilities are struggling with maintaining compliance with this standard. Below are a couple of suggestions as acceptable options.  
1. Delegation of the order being written by the physical therapist. If in the Medical Staff Bylaws and in accordance with State law, it states |
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>that this function may be delegated to a physical therapist, that is acceptable, but the attending physician is still responsible for any care the patient’s receiving. The attending physician must be made aware that he/she is responsible for whatever goes on with the patient.</td>
</tr>
<tr>
<td></td>
<td>2. The hospital medical staff could approve physical therapy protocols, in collaboration with the Physical Therapy department, and then have them available for use in whatever form that is decided on. (e.g. pre printed orders)</td>
</tr>
<tr>
<td></td>
<td>3. The attending physician may write an order that says “evaluate patient, develop a plan of care and implement plan.”</td>
</tr>
<tr>
<td></td>
<td>Note: Orders that state “Evaluate and Treat” are not acceptable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2009 Healthcare Facilities Accreditation Program (HFAP) Accreditation Requirements for Healthcare Facilities