**Section 250.970 Nursing Care Plans**

a) There shall be evidence that the nursing service provides safe, efficient, and therapeutically effective nursing care through the planning of the care of each inpatient, and patient in observation, and the effective implementation of nursing care plans.

b) In any case where it is determined that a nursing care plan is not necessary, that decision shall be documented in the patient's record.

c) The nursing care plan for each patient shall be coordinated with their medical management plan and the patient's representative.

d) Each nursing care plan shall, at minimum, indicate:

1) The patient’s problems as identified by the nursing staff and what nursing care is needed;

2) How it can best be accomplished;

3) What methods and approaches are believed likely to be most successful; and

4) What modifications are necessary to ensure the best results.

e) Each nursing care plan shall be initiated upon the admission of the patient to the hospital and shall include a discharge plan.

f) The nursing care plans shall be available to all nursing personnel and shall be reviewed and revised as necessary.

g) Nursing care plans may be considered as a part of and filed with the patient's record.

(Source: Amended at 47 Ill. Reg. 14455, effective September 26, 2023)