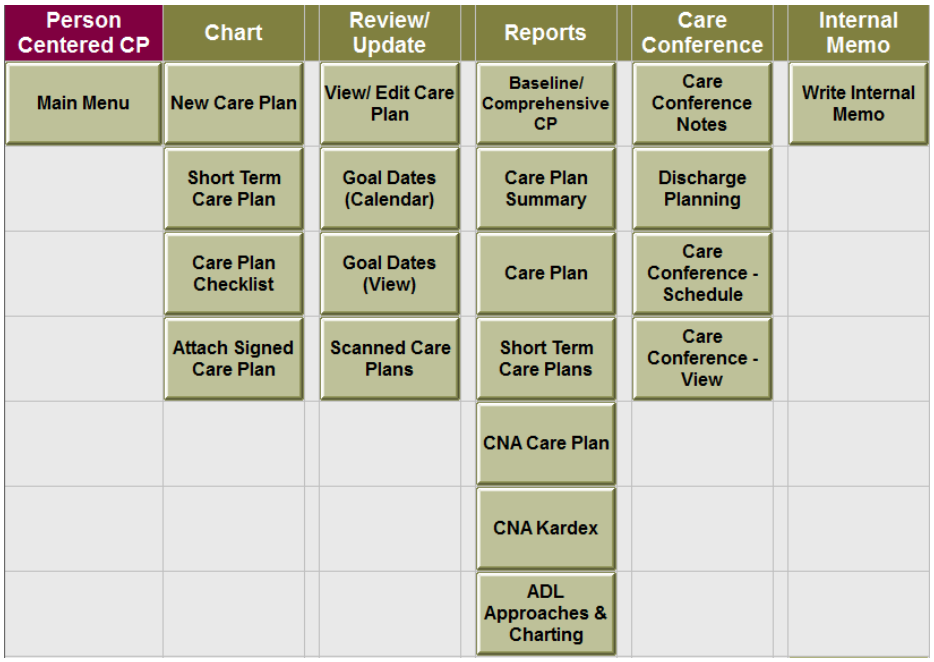
Person Centered Care Plans

Care Plans may be written three different ways:

- From scratch
- From short term care plan triggers
- From a CAA screen

*A quality care plan is one which is so individualized that it is readily identified as belonging to a resident even without the resident's name displaying.



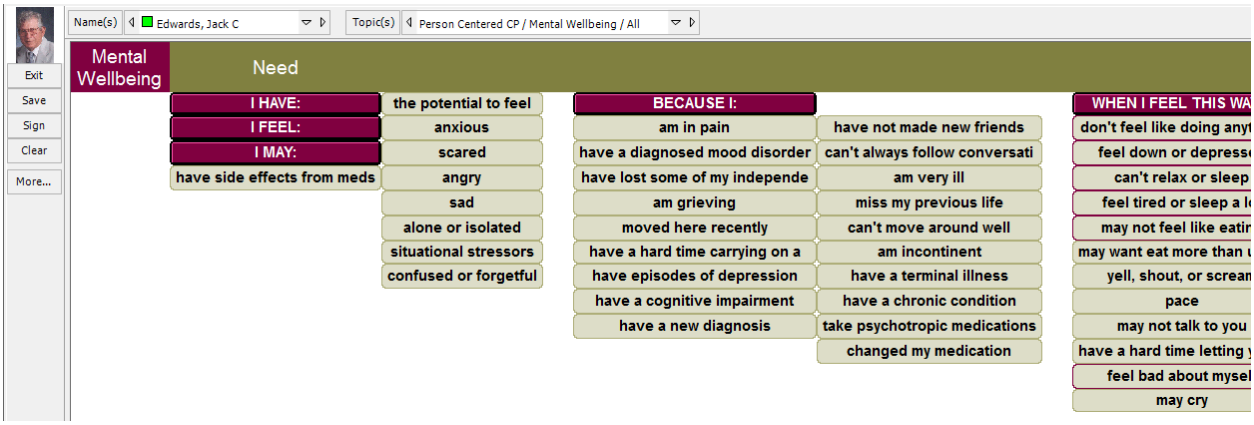
Write a Care Plan from Scratch

Care Plans may be written from scratch using the words available on the screen and typing resident-specific information. The system comes complete with choices that were developed based upon *Changing the Culture of Care Planning: A Person-Directed Approach* published by Action Pact at www.culturechangenow.org.

1. From the Care Planning Access screen, click **New Care Plan**, select the resident's name, and click **OK**.
2. Choose the Care Plan topic(s) and click **OK**. If choosing more than one, hold CTRL on the keyboard or click the **Multi** button at the bottom of the screen.
3. Document a care plan by working left to right and clicking question words first followed by canned response words or free text.

a. Be sure to review any information in the view screen below the Write screen. If there is a care plan already in that you would like to add onto, then you will need to use editing features outlined in the section below for *Edit Care Plans*.

4. When finished documenting on this screen, click the arrow pointing to the right next to the Topic button if more than one topic had been selected. This will save the entry and take the user to the next care plan topic
5. If only one topic had been selected, click **Save**.
6. When finished, click **Exit** to go back to the Care Planning Access menu.



Document a Short-Term Care Plan

Several standardized short-term care plans are available for use. This type of documenting may be used when a basic care plan is needed for the chart, but this is considered a short-term care plan and is not resident specific or detailed. These short-term care plans have a goal time of two weeks and would need to be *discontinued* and have the information incorporated into the regular, appropriate person-centered care plan topic(s) before that time frame.

1. From the Care Planning Access screen, click **Short Term Care Plan,** select the resident's name, and click **OK**.
2. From the Trigger Selection screen, select the appropriate care plan trigger(s) that you would like to have ECS create. You can select more than one care plan by holding CTRL on the keyboard. Click **Load**.
3. A progress bar will appear, and once it disappears, the care plan(s) are documented.
4. Repeat steps 1-3 as many times as desired to generate the appropriate short-term care plan(s).
5. Click **View/Edit Care Plan** to review the results.
6. Click **Exit** to return to the Care Planning Access menu.

Write a Care Plan from the CAA Screen

See MDS handout for instructions on opening and documenting CAAs.

1. After the CAA is completed, click the drop-down menu next to the Topic button. Care plan folders that pertain to the CAA should be listed there.
2. Click the desired Care Plan topic.
3. Document a care plan by working left to right and clicking question words first followed by canned response words or free text.
4. Click **Save** when care plan is complete.
5. If more care plans are needed, click the drop-down menu next to the Topic button and choose another care plan.
6. Click **Exit** when CAAs are complete.

View Care Plan

1. From the Care Planning Access menu, click **View/Edit Care Plan**, select a resident's name, and click **OK**.
2. The resident's current care plans will appear in the view screen.
3. Click **Exit** to return to the Care Planning Access menu.

Edit Care Plans

Example 1: Changing a part of an existing entry

(e.g., update the Goal and Goal Time, or add to/remove approaches)

1. Follow steps for viewing Care Plans.
2. Click the entry to turn it red. This is called 'tagging' the entry.
3. Click **Edit**. A menu will appear.
4. Select **Discontinue and Copy**. A box will pop up: *Are you sure you want to DC selected entry?* Click **Yes**.
5. A Write screen will load with a copy of the entry. Make the appropriate changes to the copied entry.
6. Click **Next** to save your entry and return to the view screen.
7. The entry will appear grey to show the edit is complete.
8. Click **Go** to refresh the screen and see the changes.
9. Click **Exit** when finished to return to the Care Planning Access menu.

Example 2: Adding a new approach

(e.g., there are no approaches for a discipline [e.g., dietary] and now need to add some)

1. Follow steps for viewing Care Plans.
2. Click the entry to turn it red. This is called 'tagging' the entry.
3. Click **Edit**. A menu will appear.
4. Select **Append.**

5. A Write screen will load. Scroll over to the desired approach(es) you wish to add and document.
6. Click **Next** to save your entry and return to the view screen.
7. Click **Go** to refresh the screen. The appended items will be attached to the existing care plan with a '**+**' sign.
8. Click **Exit** when finished to return to the Care Planning Access menu.

Example 3: Resolving a Care Plan

(e.g., when a goal is met, and the care plan is no longer needed)

1. Follow steps for viewing Care Plans.
2. Click the entry to turn it red. This is called 'tagging' the entry.
3. Click **Edit**. A menu will appear.
4. Select **Discontinue and Append**. A box will pop up and ask: Are you sure you want to DC selected entry? Click **Yes**.
5. A Write screen will load. Scroll to the right to locate the Evaluation portion of the care plan.
6. Click the appropriate word (goal was met / goal was not met) to complete the care plan evaluation.
7. Click **Next** to save your entry and return to the view screen.
8. Click **Go** to refresh the screen. These entries will no longer show.
9. Click **Exit** when finished to return to the Care Planning Access menu.

Example 4: Evaluating and Revising a Care Plan

(e.g., when a goal is not met, and the care plan needs to be modified)

1. Follow steps for viewing Care Plans.
2. Click the entry to turn it red. This is called 'tagging' the entry.
3. Click **Edit**. A menu will appear.
4. Select **Append**.
5. A Write screen will load. Click on the **^Evaluation** button to jump over to the Evaluation portion of the care plan.
6. Click the appropriate word (goal was met / goal was not met) and specify further if needed, to complete the care plan evaluation.
7. Click **Next** to save your entry and return to the view screen.
8. Click **Go** to refresh the screen. Again, click on the care plan with the evaluation that was just appended, to turn it red.
9. Click **Edit** and then select **Discontinue and Copy.** The care plan will copy itself back into the Write screen. Remove the evaluation portion and modify any other items that need to be changed.
10. Click **Next** to save your entry and return to the view screen.
11. Click **Go** to refresh the screen. The evaluated care plan will no longer show and the newly revised one will.
12. Click **Exit** when finished to return to the Care Planning Access menu.

Example 5: Discontinuing a Short-Term Care Plan

(e.g., the two-week goal time has reached or is approaching)

1. Follow steps for viewing Care Plans.
2. Click the entry to turn it red. This is called 'tagging' the entry.
3. Click **Edit**. A menu will appear.
4. Select **Discontinue**. These care plan types may only be discontinued and items from them that may not be resolved must be incorporated into the main care plan.
5. Click **Go** to refresh the screen. The short-term care plan will no longer appear.
6. Click **Exit** when finished to return to the Care Planning Access menu.

View Discontinued Care Plan Approaches

1. From the Care Planning Access menu, click **View/Edit Care Plan,** select resident name(s), and click **OK.**
2. Click the Control button at the top of the View screen. Select the **DC'd Entries** checkbox, then click **OK**. Click **Go**.
3. If a printed copy is desired, click the **Print** button, select the print options, and click **OK**. Then select the printer and click **OK**.
4. Click **Exit** to return to the Care Planning Access screen.

Care Plan Goal Dates (Calendar)

This will generate a calendar report of only those care plans with specific goal dates. If you utilize the general date options for two weeks/three months, then refer to the Goal Date option below.

1. From the Care Planning Access menu, click **Goal Dates (Calendar),** select resident name(s), and click **OK**.
2. The calendar will load for the current month. If another date range is desired, click **Control**, edit the Start Date and End Date, and click **OK**.
3. If a printed copy is desired, click the **Print** button, select the print options, and click **OK**. Then select the printer and click **OK**.
4. Click **Close** to return to the Care Planning Access menu.

Care Plan Goal Dates (View)

This will generate a list of all residents that have a care plan goal that is already over or coming overdue. A two-week goal will begin displaying on this list at day six, and a three-month goal will begin displaying on this list at day 82.

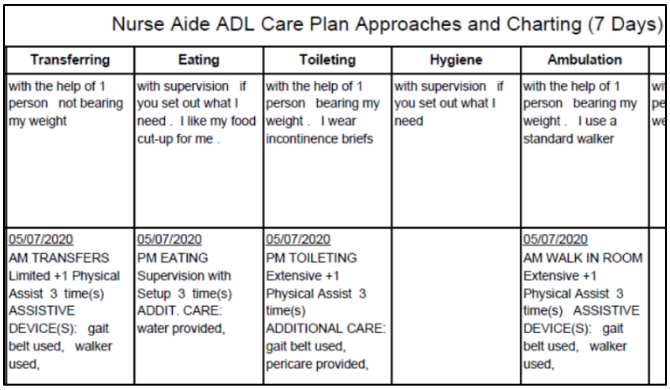
1. From the Care Planning Access menu, select the resident(s) name, and click **Goal Dates (View)**.
2. The view screen will load with only care plans that are overdue or about to come overdue.
3. If a printed copy is desired, click the **Print** button, select the print options, and click **OK**. Then select the printer and click **OK**.
4. Click **Close** to return to the Care Planning Access menu.

View/Print Reports

1. From the Care Planning Access menu, click onto the button of the report you would like to view, select resident(s), and click **OK** to load the report.
2. The report preview will appear. Click the printer icon in the top left corner of the preview to send the report to your printer, verify your printer selection and click **OK**.
3. Click **Exit** to return to the Care Planning Access menu.

Description of Report Types

- **Short Term Care Plans –** Any care plans will have a goal time of two weeks will display on this report.
- **Baseline or Comprehensive Care Plan –** This comprehensive care plan task includes the entire Person-Centered Care Plan, Physician Orders, Nursing Orders, Therapy Plan of Care, and the most recent PASRR documentation. This document may be electronically signed by selecting the Signature button once the report preview appears. Double click onto **Signature of Pt/Resp Part.** A box will appear to which the signature can be added. Click **OK** once done signing the document. If wanting to date the document as well, click **Signature of Date**, write, or type in the date and click **OK** to add to document.
- **Care Plan Summary (for the resident) –** Includes the resident's goals, basic care needs, diet orders, medication orders, and treatment orders.
- **Care Plan Report –** Displays the entire Person-Centered Care Plan.
- **CNA Care Plan/Kardex –** The CNA Care Plan/Kardex details to staff how to provide daily cares to each resident. Both reports will only display approaches specific to CNAs.
- **ADL Approaches & Charting –** In the top row of the report, the resident's ADL care plan approaches display. Below that, all charting for the past seven days appears. This assists users in determining if a resident's level of care may be changing and require adjustments to their care plan.



Nurse Aide ADL Care Plan Approaches and Charting (7 Days)

Transferring	Eating	Toileting	Hygiene	Ambulation	
with the help of 1 person not bearing my weight	with supervision if you set out what I need . I like my food cut-up for me .	with the help of 1 person bearing my weight . I wear incontinence briefs	with supervision if you set out what I need	with the help of 1 person bearing my weight . I use a standard walker	wi pe we
05/07/2020 AM TRANSFERS Limited +1 Physical Assist 3 time(s) ASSISTIVE DEVICE(S): gait belt used, walker used,	05/07/2020 PM EATING Supervision with Setup 3 time(s) ADDIT. CARE: water provided,	05/07/2020 PM TOILETING Extensive +1 Physical Assist 3 time(s) ADDITIONAL CARE: gait belt used, pericare provided,		05/07/2020 AM WALK IN ROOM Extensive +1 Physical Assist 3 time(s) ASSISTIVE DEVICE(S): gait belt used, walker used,	