GNYHCFA SAMPLE POLICY AND PROCEDURE

Topic: Comprehensive Care Plan

Policy: Each resident will have an individualized interdisciplinary plan of care in place. The baseline care plan will be completed within 48 hours of admission. The Interdisciplinary Team will continue to develop the care plan in conjunction with the RAI (MDS 3.0) and CAAS completing and conducting CCP meeting by Day 21 post admission. The Comprehensive Care Plan will be reviewed and revised on a quarterly basis, with a significant change in condition, on re-admission from inpatient hospital stay, and as requested by the Resident/Representative. The Comprehensive Care Plan will be resident centered having the individual resident as the locus of control. The Comprehensive Care Plan will be ongoing, focusing on each individual resident as a unitary being. Residents and their representatives will play an active role in the development of goals and implementation of the residentsô Comprehensive Care Plan.

Procedure:

1. The admitting Registered Nurse will complete baseline care plan on admission within 48 hours to address the following areas:
    - Resident/Resident Representativeôs initial Goals
    - Skin Prevention
    - Fall Prevention
    - Pain Management
    - Advanced Directives
    - Psychosocial Mood State/Adjustment to Placement/PASSR Needs as indicated
    - Specific Care Plan on the main reason for admission to facility i.e: Dementia, ORIF, CHF etcetera.
2. The Interdisciplinary team will develop and implement the Comprehensive Care Plan within 21 days of admission. This comprehensive care plan will address resident goals, actual and potential problems, needs, strengths and individual preferences of the resident.
3. Each discipline will be responsible for the initiation and ongoing follow up for care plans as related to their area of expertise.
4. The Interdisciplinary Team will review the plan of care plan at CCP meeting with the resident and his/her representative.
5. The resident and/or representative will be offered a Care Plan Summary during the Admission, Annual, and/or Significant Change Care Plan review meetings and upon request.
6. The Care Plan Summary will include:
    - Resident /Resident Representative Goals
        - All medications , treatments
        - All diagnosis, Medical Orders
        - Restorative Therapies

SAMPLE

- Resident Specific Information
- Recent Blood Tests and Diagnostic Tests
- Ambulation and Transfer Status
- Advanced Directives
- The Resident care Profile that is used by the nursing Assistants
- Areas of concern that are being addressed by the IDT
- Any other Medical Records as requested by the resident and/or representative.

7. The IDT will review the Care Plan Summary with the resident/representative and provide any needed education/clarification.
8. The IDT will provide the resident/representative a Current Care Plan Summary at any time as per their request.

SAMPLE

GREATER NEW YORK HEALTH CARE FACILITIES ASSOCIATION

COMPREHENSIVE CARE PLAN PACKET FOR RESIDENTS

TITLE	**RESPONSIBLE TEAM MEMBER**	**MAY NOT BE INDICATED/LEAVE IN PACKET**	**Comments**
1. Fall	Nursing		**Started on admission**
2. Pain	Nursing		**Started on admission**
3. Skin Prevention	Nursing		**Started on admission**
4. Advanced Directives	Nursing/Social Services		**Started on admission**
5. Adjustment to new environment	Nursing/Social Services	This care plan closes at initial team meeting	**Started on admission**
6. Main Medical Reason for Admission	Nursing		**Started on admission**
6. Behavioral Symptoms	Nursing	Individual CCP to be done for each specific behavior	
7. Psychotropic Drug Use	Nursing	Only if resident is on psychotropic medications	
8. Mental Illness/PASRR	Nursing/Social Services		**Started on Admission**
9. Cognition	Social Services		
10. Res Mood state/ Psychosocial Wellbeing	Social Services		
11. Ability to Communicate	Nursing		
12. Visual Function	Nursing		
13. Customary Routine	Nursing		
14A Activity-Independent Resident	Recreation		
14B. Activity-Assistance Resident	Recreation		
15. Activities of Daily Living	Nursing		
16. Elimination Needs/Toileting Needs/Urinary Incontinence	Nursing		
17. Normal Bowel Patterns/Constipation	Nursing		
18. Breathing Patterns	Nursing		
19. Nutritional Status	Dietary		
20. Dehydration/Fluid	Dietary		

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21. Oral Hygiene	Dietary/Nursing		
22. Swallowing Ability/risk for Aspiration	Dietary		
23. Meal Services	Dietary/Nursing		
26. Foot Care	Nursing		
27. Medication Administration	Nursing		
28. Prevention TST testing/quarterly screening for TB	Nursing		
29. Immunizations	Nursing		
30. Family/Significant other participation in Care Planning/Satisfaction with POC	Social Service/Team		
31. Discharge Planning	Social Service/Team		
All other Care Plans needed can be downloaded from the Care Plan Library to address the following:			
Medical Diagnosis			
Psychiatric Diagnosis			
Skin Conditions			
Behaviors			
Preferences			
Other			

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Resident Care Plan Summary for:

_____

The Resident/Representative's Goals for Care:

_____
_____
_____
_____
_____

Problem Areas Identified by the Resident/Representative:

_____
_____
_____
_____
_____

Interdisciplinary Team Goals for Resident:

_____
_____
_____
_____
_____
_____

The following areas were reviewed with Resident/Representative and a copy of the Resident Care Profile, and Current Medical Orders and Nursing Interventions was provided:

- Diagnosis
- Medications
- Recent Lab and Diagnostic Tests
- Consults
- Activities of Daily Living
- Current Weight: _____ Weight Changes: _____
- Restorative Services
- Food Preferences
- Activities

Comments/Concerns Expressed by Resident /Representative:

_____
_____
_____

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_____
_____

_____
Interdisciplinary Team Member DATE

_____
Resident/Representative DATE

A copy of the care plan summary will be placed or scanned in the Medical Record for future reference

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