Advance Care Planning Sample Care Plan

Person-Centered Care Planning

Person-centered care planning is a process that focuses on the person as the center of control and supports the person in making his or her own choices. This means not only understanding the person's impairments, but also their strengths, capacities, preferences, needs, and desired outcomes/goals. The person or their legally authorized representative (LAR) is an equal partner in the planning of their care. It means ensuring that each person or their LAR is involved in developing a care plan that addresses the person's likes, dislikes, and needs. It is important to note that in addition to the person/LAR, facility staff (including the CNA) must be involved in the care planning process. Facilities should strive for person-centered care that emphasizes individualization, relationships and a psychosocial environment that welcomes each person and makes him or her comfortable.

Federal Regulations – Comprehensive Care Plans

F655

§483.21 Comprehensive Person-Centered Care Planning

§483.21(a)(1)-(3) Baseline Care Plans

F656

§483.21(b)(1), §483.21(c)(3) Comprehensive Care Plan

How to create a Person-Centered Care Plan

A person-centered care plan is one that focuses on what is important to the person, his/her capacities, and the person's available supports. The main focus of the person-centered care plan should be the quality of the person's life as they define it.

There are several steps in the care planning process, including:

- **Preparation:** Understanding the person and their situation, gathering information, encouraging others who know the person to contribute their perceptions and ideas.
- **Pre-planning:** Working with the person/LAR to review information, set priorities, determine an agenda, and invite people to join in the planning process.
- **Action Planning:** Identifying the person's needs and desires, then developing action steps to accomplish their goals. This is often done in a team meeting but can also be done through a series of conversations with different people.
- **Quality Assurance:** Making sure the documentation meets standards and requirements.
- **Implementation and Monitoring:** Following through on action steps, checking progress, and revising the plan as necessary.

Care Plan Interventions

Individualized interventions are an important component of any person-centered care plan. Music & Memory is one such intervention that has been proven successful in people with dementia. Using digital music players, people are able to listen to personalized music play lists that tap deep memories and can bring the person with dementia back to a joyful life. These people are able to converse, socialize with others and stay present when provided with familiar music. Case examples and sample care plans that include interventions such as Music & Memory start on page three.

Case Example

Mr. James is 84 years old with a diagnosis of end-stage Alzheimer's disease admitted to the facility on 01/29/2022. His Admission records includes a Directive to Physicians and Family or Surrogates (Living Will/ Advance Directive) which does not specify Mr. James' preference for artificial nutrition and hydration. He was admitted as a Full Code. He is incapable of making health care decisions as documented by his physician.

Mr. James recently experienced increased decline in health including irreversible swallowing impairment, unavoidable weight loss, and was referred to hospice care for comfort care.

2/10/22 Care Planning progress note indicates: Care plan team, including Dr. Jones (attending physician), met with Ms. Smith, Mr. James's MPOA. Mr. James' current medical conditions, treatments and prognoses were discussed. DNR versus full code was also discussed as well as information regarding enteral nutrition, (e.g., indications, process, potential risks, and benefits).

Ms. Smith determined at that time, that a DNR order would be appropriate and signed the OOH DNR form. Ms. Smith stated Mr. James never discussed his personal feelings regarding enteral nutrition and hydration. She advised that she considered the information and was provided education material and website information to help support her decision. Ms. Smith was encouraged to contact staff or Dr. Jones for question or concerns.

R. Witherspoon MSW will maintain communication with Ms. Smith and inform the team of her decision when provided.

Date	Problem	Goals	Approach/Interventions	Discipline
2/10/2022	My advance directive indicates that I have an OOH DNR signed by my MPOA and physician effective 2/10/2022.	In the event of a medical emergency, I do not wish to receive life sustaining interventions. I prefer to pass away with comfort measures only. My DNR will be reviewed annually and with a change of condition	MD, All IDT, and all direct care staff will be notified of Mr. James DNR status. Staff will maintain all advance directives in a prominent location in the medical record. Staff will notify the physician and the MPOA of any changes in Mr. James' condition. Should cardiac arrest occur and/or breathing independently cease, staff will allow a natural death. OOH DNR signed by MPOA and physician 2/10/22 and placed on chart.	All
			Social services will ensure MPOA is aware that DNR can be revised to change code status at any time. Physician orders will be coordinated according to my end-of-life wishes Social services will provide ongoing support, provided opportunities for question and concerns, and will follow-up with Ms. Smith routinely.	Social Services
			Staff will ensure the attending physician; emergency medical technician and hospital personnel have my information relating to my documented advance directives and end-of-life wishes	Nursing