Sample Care Plan – Advance Care Planning

Person-Centered Care Planning

Person-centered care planning is a process that focuses on the resident as the center of control, and supports the resident in making his or her own choices. This means not only understanding the resident's impairments, but also their strengths, capacities, preferences, needs, and desired outcomes/goals. The resident or their legally authorized representative (LAR) is an equal partner in the planning of their care. It means ensuring that each resident or his/her LAR is involved in developing a care plan that addresses the resident's likes, dislikes, and needs. It is important to note that in addition to the resident/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 resident 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 Plans

How to create a Person-Centered Care Plan:

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

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

- Preparation: Understanding the resident 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 resident's needs and desires, then developing action steps to accomplish his/her 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.

Individualized interventions are an important component of any person-centered care plan. Music & Memory is one such intervention that has been proven successful. Using digital music players, residents are able to listen to personalized music play lists that tap deep memories and can bring the resident with dementia back to life. These residents 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.

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Case Example - Mr. James

Mr. James is 84 years old with a diagnosis of Alzheimer's disease admitted on 1/29/10. He has no immediate family. Admission records include a Directive to Physicians and Family or Surrogates (Living Will) which does not specify Mr. James' preference for artificial nutrition and hydration, and a Medical Power of Attorney. He is admitted as a Full Code. He is incapable of making health care decisions as documented by his physician. He has recently experienced swallowing difficulty and weight loss. Initial nutritional assessment reveals his daily estimated energy requirements exceed his current estimated intake from meals and supplements.

Date	Problem	Goal	Approaches / Interventions	Discipline
12/10/17	Status of Advance Directive ~~☐ Full Code~~ ☐ Living Will or Directive to Physician-Family-Surrogate **X Medical Power of Attorney** **X Out of Hospital DNR** ☐ No decision at this time ☐ Organ Donor ☐ NO BLOOD PRODUCTS	Mr. James' Advance Directives will be honored. Mr. James' Advance Directive will be reviewed annually and with a change of condition.	• ~~The care plan team will meet with the MPOA to discuss a "DNR" and the use of artificial nutrition and hydration to maintain weight, as well as other end-of-life decisions.~~ • ~~Staff will start CPR should cardiac arrest occur and/or breathing independently cease, call EMS and transport to hospital as ordered.~~ • Staff will inform MPOA of the right to request assistance in making new advance directives and/or the right to change previously formulated advance directives at any time. • 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. 12/12/17 Update • ***Should cardiac arrest occur and/or breathing independently cease, staff will allow a natural death. OOH DNR signed by MPOA and physician 12/12/17 and placed on chart.***	MD and All Nursing Social Services All Staff Nursing Nursing

12/12/17 Care Planning progress note: Care plan team including Dr. Jones (attending physician), met with Ms. Smith, the MPOA for Mr. James. Mr. James' current medical conditions, treatments and prognoses were discussed. DNR versus full code was discussed as well as information regarding tube feeding (indications, process, potential risks and benefits). Ms. Smith determined that at this time, a DNR order would be appropriate and signed the OOH DNR form. Ms. Smith stated Mr. James never discussed his personal feelings regarding a feeding tube, so she will take the information provided and review it further before making a decision. Ms. Smith was encouraged to contact staff or Dr. Jones if she had any questions. R. Witherspoon MSW.