CARE PLAN INFORMATION FOR CAREGIVERS IN RESIDENTIAL FACILITIES

COMMUNITY CARE FACILITIES LICENSING PROGRAM

Information shared in this INFOsheet provides suggestions and considerations that will assist in meeting requirements of the *Community Care and Assisted Living Act* and the Residential Care Regulation in regards to creating individual care plans for the persons in care at the facility. As described in the Residential Care Regulation, licensed residential care facilities are required to have a written individual care plan for every person in care at the facility that must include:

a) A plan to address medication, including self-administered medication;
b) A plan to address behavioral intervention, if applicable;
c) A plan to address the use of restraints, if applicable;
d) An oral health care plan;
e) A nutrition plan;
f) A recreation and leisure plan;
g) A fall prevention plan, if applicable;
h) A plan to prevent persons in care from leaving and to locate those persons if they have left the facility without notifying an employee;
i) Written special instructions given by parents of a child/youth, if applicable; and
j) Any conditions or requirements under the Mental Health Act, the enactment or order associated with the admission of the person in care, if applicable.

Please refer to the following sections of the Residential Care Regulation for more detail regarding what is required by the legislation:

- Section 80 regarding short-term care plans on admission;
- Section 81 regarding requirements for care plans if more than a 30-day stay;
- Section 82 regarding implementation of care plans;
- Section 83 regarding requirements for nutrition plans and the services to be provided to persons in care by dietitians;
- Section 84 regarding information related to restraints that are to be recorded in a care plan; and
- Section 85 regarding policies for the purposes of guiding staff in all matters relating to the care and supervision of persons in care.

What is the goal in developing a care plan?

- ❑ To ensure an integrated multidisciplinary approach to providing care to each person in care;
- ❑ To maintain or return the person in care to the best possible state of health and well-being;
- ❑ To provide a communication tool for caregivers;
- ❑ To maximize the individual's quality of life.

What should a care plan include?

- ❑ Assessment of the person in care's needs.
  - Needs are defined as a lack of something, a requirement, or a desire.
  - Individualize and make specific for the person in care's needs.
  - Consider the preferences of the person in care and their ability to make informed choices.
  - Review background information, including the person in care's history, diagnosis and lifestyle.

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- ❑ Goals for the person in care.
  - Goals should be SMART – Specific, Measurable, Attainable, Realistic, Timely
  - Goals should be linked to outcomes
  - Set an anticipated date of completion.

- ❑ Approaches to satisfy the person in care's needs.
  - State what is to be done, when and by whom.
  - Provide clear, simple directions for the caregivers to follow.

- ❑ Objective evaluation of the care plan to identify what approaches were successful and those, which required improvement.
  - State a review date.
  - Review on a regular basis.
  - Document the person in care's refusal to follow the care plan and/or the reasons why the care plan was not followed.
  - Clearly document all changes or reviews.

Any other considerations for care plans?

- ❑ Include the person in care and/or advocate in decisions regarding their care.
- ❑ Consider the physical, social, emotional, and spiritual needs of each person in care.
- ❑ View the person in care as a whole person with unique characteristics and strengths.
- ❑ Persons in care have the right to make informed choices and refuse treatment. Alternative courses of action should be explored.
- ❑ Develop care plans using a team approach including the person in care, caregivers, family/advocates, physician, health care professionals, funding agency representatives, and other appropriate individuals.
- ❑ Protect the privacy of persons in care when handling care records.
- ❑ Ensure care plans are readily accessible to the caregivers.

What about putting the care plan on a computer?

- ❑ Care plans can be put on a computer provided they:
  - Are accessible to all caregivers and
  - Protect the privacy of persons in care.
- ❑ Keep a paper copy in the person in care's record (including historical information). This is useful in the event of a power failure or computer malfunction.

What about the format?

- ❑ Many licensed community care facilities already have their own format for care plans. Check with other facilities for their care plan format. Review your format to see if it can be improved.
- ❑ Licensing suggests that major headings/sections include:
  - Assessment (challenges, needs, desires)
  - Goals
  - Approaches
  - Evaluation (review date)
  - Staff member responsible