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Thanks for visiting! *Portions of this statement are modified from a TermsFeed document. Used with permission. Creating and implementing individualized care plans for residents in long-term care facilities is a very important responsibility of activity and recreation professionals. The recreation/activity assessment determines the content of the care plan. Not all residents will have an "activity-care plan", but most care plans should have "activity-related interventions" found in the comprehensive care plan. Care plans may be written regardless if a resident triggers on the MDS 3.0. It is important to set realistic, measurable goals, interdisciplinary interventions, and create care plans that are individualized. The RAI user manual defines care planning as, "A systematic assessment and identification of a resident's problems and strengths, the setting of goals, the establishment of interventions for accomplishing these goals." Document strengths, problems, and needs Set guidelines for care delivery Establish resident goals Identify needs for services by other departments Promote an interdisciplinary approach to care and assign responsibilities Provide measurable outcomes that can be used to monitor progress Meet federal and state requirements Meet professional standards of practice Enhance the resident's quality of life and promote optimal level of functioning! A forum to discuss and review a resident's status including any problems, concerns, needs, and/or strengths MDS Coordinator Nurse(s) CNA's Dietician Rehabilitation Therapist(s) Recreation Staff Social Worker Resident Family Member/Guardian A minimum of seven days after the MDS completion date Some care plans warrant immediate attention As necessary Must review at least quarterly Identify the resident's leisure/recreation needs l Identify barriers to leisure pursuit and help minimize these barriers l Identify the resident's leisure/recreation potential l Provide the necessary steps to assist the resident to achieve their leisure/recreation goal/s l Provide interdisciplinary support by entering a variety of recreation interventions on various (non-activity) care plans Monitor and evaluate residents response to care plan interventions Cognitive Loss Communication ADLS Psychosocial Mood Nutrition Falls Palliative Care Activities Recreation Therapy Pain Behavior Restraints These are just a few samples. Remember, the most important aspect of care planning, is INDIVIDUALIZATION Resident has limited socialization r/t to depression Resident refers to stay in room and does not pursue independent activities Resident is bed-bound r/t to stage 4 pressure ulcer and is at risk for social isolation Resident demonstrates little response to external stimuli r/t to cognitive and functional decline Resident enjoys resident service projects such as changing the R.O. boards Resident becomes fearful and agitated upon hearing loud noises in group activities r/t to dementia Resident has leadership abilities Resident prefers a change in daily routine and wishes to engage in independent craft projects Note: With the implementation of the MDS 3.0 statements will likely represent more of "preference-type" language. Resident will respond to auditory stimulation AEB smiling, tapping hands, or vocalizing during small group sensory programs in 3 months Resident will actively participate in 2 movement activities weekly in 3 months Resident will remain in a group activity for 15 minutes at a time 2x weekly in 3 months Resident will accept in room 1:1 visits by recreation staff 2x weekly in 3 months Resident will socialize with peers 2x weekly during small group activities in 3 months Resident will respond to sensory stimulation by opening eyes during 1:1 sessions in 3 months Resident will actively participate in Horticultural Therapy sessions in the green house, 1x monthly in 3 months Resident will continue to assist other residents in writing letter on a weekly basis in 3 months Resident will exhibit no signs of agitation during small group activities 3x weekly in three months Resident will engage in self-directed arts and crafts projects 1x weekly in 3 months Provide a variety of music i.e. Big Band and Irish Utilize maracas and egg shakers to elicit movement Provide PROM to the U/E during exercise program Involve resident in activities of interest i.e. singalongs, adapted blowing and trivia Offer 1:1 visits in the late afternoon to discuss recent Oprah episode Seat resident next to other Korean speaking resident during groups Provide tactile stimulation i.e. hand massages and textured object i.e. soft baseball Provide olfactory stimulation i.e. vanilla extract and cinnamon for reminiscing Utilize adapted shovel and watering can during HT sessions Provide easy grip writing utensils and a variety of greeting cards/stationary Involve resident in small sensory groups i.e. SNOEZELEN and Five Alive Seat resident near a window Provide a variety of independent arts and craft projects Provide adapted scissors and paint brush Imagine that you are a resident in a long-term care facility and you are bed-bound for a health-related condition at risk for social isolation and inactivity. Write a goal and at least seven interventions/approaches that are relevant to you. If you're interested in an easier way of completing attendance records and other forms of documentation, please click here. Creating a well-structured care plan is essential for delivering person-centred care that meets the unique needs of each individual. Whether you're a care provider or support worker, understanding how to write an effective care plan is crucial for ensuring holistic, coordinated care.What is a Care Plan?A care plan is a detailed document that outlines an individual's care needs, goals, and preferences, ensuring that everyone involved in their care is on the same page. It promotes collaboration among healthcare providers, carers, and the individual themselves.Step 1: Initial AssessmentStart by gathering essential details during the initial assessment. This forms the foundation of the care plan. Essential details include:Personal Details – Basic information about the individual.Health and Well-being Goals – Include aspirations and desired outcomes.Self-Care and Support – Address the level of self-care the person can manage and any additional support needed.Medical Information – Include test results, diagnoses, medication details, and clinical notes. Collaborate with GPs or request discharge notes for accurate details.Care Preferences – Document the individual's preferences to ensure person-centred care.Step 2: Use a TemplateTake all the information from your initial assessment and start writing that up into a simple care plan template. You can find a number of free care plan templates online, or you may choose to create your own custom care plan templates that are tailored to the type of care your business provides.Tip: The format of your care plan depends on the type of care you provide. For example, domiciliary care may require different versions for morning and evening care.Step 3: Consult with OthersTo gain a comprehensive understanding, consult with the client, their family, previous carers, GPs, and support workers. This helps you to paint a fuller picture of who you are caring for and how they liked to be cared for. In this post, you'll discover the best examples of person centred care plans templates.Not sure where to start with care planning? Looking for a guide or example care plan to help you get started?There's a wealth of information available to support you through every aspect of care planning, (for example here at Birdie we've created our own guide to care planning and a blog that outlines the basics of care planning software, plus tips on having the right conversations). But when it comes to a real care plan example that you can follow, the available options are a little limited. That's because there is no one-size-fits-all, standardised template for care planning. Where can I find a care plan example template?Care plans must be created individually to suit the needs of the people you're caring for. A care plan for an individual with dementia would be vastly different to a care plan for a young adult who needs support due a disability.That's why, when it comes to finding an example care plan template for your home care agency, you might find it difficult to find one you can download or replicate. We've included a printable example of a care plan template, based on the questions we use on the Birdie system, at the bottom of this article. It covers the personal information and preferences section of a care plan, and is a great starting point for setting goals and assigning tasks. If you need help with goal setting, you can read this SMART template guide from Birdie too. To help you, the next few steps in this article will walk you through the basics of a person centred care plan and show you how you can use the principles to create your own care plans. You can download and print a care plan example template at the end.Elements to include in a care plan template...Here are a few elements to includes in your person-centred care plan template:Personal informationMedical historyMental healthSocial supportEnvironmental risksNutrition requirementsInterests and activitiesCommunicationOf course, there are many, many more you could focus on and each element may have multiple sub-elements inside, but not all areas will be required for every person.Each area of the care plan template should include...The area you're focusing on (for example, communication or personal care)The person's desired outcomes in this areaHow you will support them with their outcomes/how they would like supportYou'll also like: Domiciliary care - Complete guideDo I need to create every care plan from scratch?You don't always need to create a care plan from scratch. The elements inside each care plan should be different for each client, but you could start with a basic care plan framework for each client and personalise accordingly. That's exactly how we create care plans at Birdie. Our care planning software allows you to choose the areas that need more information and you can fill out the relevant sections, without having to create a new document every time. Article continues below this videoRead the following page to discover how Birdie can help you with your care management needs! Or book a free demo to talk to one of our experts who can show you the Birdie platform! No faff and no strings attached. How we create person centred care plans that are in-line with CQC requirements at BirdieWithin each category you can add objectives and tasks, and personalise these alongside your clients. For example:If the person in your care has recently been discharged from hospital after a fall, they may have a goal to be able to resume an activity (for example; walking in the garden) once again.By making a note of this goal with them, you can devise a plan to support them, using all of the elements above. Walking in the garden may require:A risk assessment of the gardenThe medical history of the person (how long until their injuries heal, for example)Social support from outside (how can occupational therapists and families help progress this goal?)A waterlow assessment to inform decisions on how often this person should be encouraged to move/change positions if they are currently immobileAs this goal (and every goal) is very specific, it's difficult to provide a one-size-fits-all framework for a care plan that can be adapted to suit everyone's requirements, however... Read also: How to setup a care agencyIf you're not using care planning software like Birdie, you could instead download our free care management paper template pack. In this pack you'll find printable templates for care planning, MAR chart, body maps and a client profile template, along with examples of how to complete these templates. Download your free pack today! One really important area in every care plan is the personal details section, where you can list a person's preferences, needs and any external social and economic factors that may influence their care needs. Click below for a free template from Birdie for you to download and print.Read also: Everything you need to know about advanced care planningThe benefits of using care Plan templates in homecareUsing a care plan template in home care offers numerous benefits that enhance the quality of care provided. A well-designed care plan template ensures consistency in care, as it standardizes the documentation process and helps caregivers follow a structured approach. This consistency is crucial for maintaining high standards of care across different caregivers and shifts.Additionally, a care plan template improves communication among caregivers by providing a clear and concise care plan example that everyone can follow. This reduces misunderstandings and ensures that all caregivers are on the same page regarding a person's needs and preferences.Care plan templates also facilitate compliance with regulatory requirements, such as those set by the CQC. By using a standardized care plan example, caregivers can easily ensure that all necessary elements are included, reducing the risk of missing important information.Overall, incorporating a care plan template into your home care routine streamlines the care planning process, making it more efficient and effective, and ultimately improving the quality of care provided to each individual.A quick note on digital vs paper care planningIt can be argued that digital records are better than paper records in care management because they enhance efficiency, accessibility, and accuracy, enabling quicker updates and easier sharing of information among care providers. They also reduce the risk of data loss and ensure better compliance with data protection regulations. Find out more about person centred care planning here or get a free SMART care plan template, here.We hope this overview of some care plan examples helps you with your person centred care planning. If you're interested in digitising your care planning process with care planning software, get in touch with our team - they'll be happy to walk you through the available options and help you decide on the right digital plan for you.