Completion of Integrated Care Plan Reference Guide

SECTION A: OVERVIEW

The Integrated Care Plan (ICP) is a working tool for all disciplines to provide a consistent, individualized, resident-focused plan of care to address care goals for residents in personal care homes and for those awaiting placement in transitional care sites. The ICP is to be developed in collaboration with the resident and/or alternate decision-maker.

General principles for completing the ICP, on each page, are as follows:

- All entries are to be completed in blue or black ink.
- Include the addressograph/client identification.
- Check (√) "Initial Care Plan" and document the date for the first ICP. The initial ICP needs to be kept together. As such, the entire ICP is to be re-copied the first time any page is full and it is to be filed in the resident's chart. After that, individual ICP pages may re-copied as needed.
- When re-copying or auditing the ICP, date and initial the top of each page
- Date is to recorded as (dd/mm/yyyy).
- Date column remains blank until changes are made to the ICP. This date reflects changes to the assessment and care needs with details documented in the integrated progress note (IPN). Write the date starting at the top of the column with each subsequent date below.
- Check (√) the level of assistance needed to provide the care, as applicable. Any time a partial assistance is checked an intervention needs to be documented.
- Every section must be completed. If sections have no action required, document N/A.

The first page of the ICP contains demographic, financial, medical history, and contact information for the resident and is to be updated when changes occur.

The second page includes a "***What Matters to Me?"***section where documentation is aimed at improving communication, fostering shared decisions and ensuring that care is aligned with "what matters" to residents and their alternate decision-maker. This section is also to be used to record goals of care which are to include the intended purpose of the health care intervention(s) and support(s) as recognized by the resident and alternate decision-maker. An example of a goal may be:

> *Resident wants to use the toilet as independently and for as long as possible. Examples of interventions may be: implement regular toileting routine, do daily strengthening exercises with resident, consult for exercises which the resident can do and would benefit the resident.*

A ***Cultural & Spiritual Background and Consideration section*** is also included on the second page. Information such as the resident's ethnic background, religious denomination, church affiliation and any special cultural and spiritual considerations are to be included in this area.

On pages three to eight, there is detailed information about the resident care needs including areas such as: ***Cognitive Status, Emotional/Psychosocial Status, Personality & Behavioural Characteristics, Bathing and Dressing Requirements, Rest/Sleep Patterns, Elimination, Nutrition, Mobility/Transferring, Safety and Security Aids, Oxygen Needs, various Risk Rating Scores (Elopement Risk Rating, Risk for Falls Assessment, Braden Scale), and Housekeeping /Laundry Considerations***. For the activities of daily living (ADL) sections, there is an "Assistance" column to indicate the assistance, if any, required by the resident. The definitions (independent, partial, maximum), which are noted below, are to be used when assessing each resident and forming the resident's care plan.

There is a **Therapeutic Recreation Assessment Requirements & Preferences** section, on page 8 which refers to information from the Activity Pro program. The dates of when the intial recreation/activity assessment and care plan were completed in Activity Pro as well as, any updates are to be documented in this section.

Specialist Appointments and Additonal Information are to be documented on, pages 8 & 9, respectively. Any treatment information is to be documented under additional information.

Interventions/Integrated Action/Change Column:
This area is for narrative comments to support an individualized plan of care to achieve the goals of care for the resident. Documentation is to include the following:

- State any resident specific actions and/or considerations that correspond with the care needs/goals identified.
- Write the date (dd/mm/yyyy) directly preceding the action.
- Write the action starting at the top of each column section; be specific with what action is to be done. (e.g.: Cognitive Status: Take to room and play favorite music when anxious. Bathing & Dressing: To wear an undershirt at all times.).
- Initial and write the designation of the writer at the end of the action.

SECTION B: REQUIREMENTS WITHIN 24 HOURS OF ADMISSION

Initial Care Plan
Within 24 hours of admission, basic care requirements and initial goals of care for the resident are to be documented by the appropriate staff on the ICP (CLI.6410.PL.002.FORM.03) including, but not limited to the following:

- advanced care planning level
- health care directive
- proxy name

- allergies and reactions
- cognitive status
- bathing and dressing requirements
- elimination and nutrition needs
- mobility and positioning needs
- safety and security aids
- oxygen needs
- any treatment(s) (under the Additional Information Section)
- Medications are to be documented on the Medication Administration Record (MAR)

The initial care requirements are denoted with a diamond (◆) on the ICP.

SECTION C: COMPLETING EACH SECTION OF THE ICP

Cognitive Status

Note the resident's orientation, mental status, and the Mini Mental State Examination (MMSE) score and date, if clinically required, by checking the boxes and documenting the date corresponding to the assessment. Make notes in the interventions column about any assessment findings which are not represented by a box.

Under **Communication** note the resident's assessed abilities under each heading of speech, vision, hearing or alternative method of communication. Document which aids the resident uses, as well as the level of assistance the resident requires.

Independent:	Requires no assistance/supervision.
Partial assistance:	Requires partial assistance and/or supervision. Resident cannot independently physically perform vision/hearing aid tasks and needs partial physical assistance to perform vision/hearing aid tasks. Any time a partial assistance is checked an intervention needs to be documented.
Maximum assistance:	Completely dependent for all aspects of communication aid management.

Emotional Status, Psychosocial Status, Personality & Behaviour Characteristics

Check the boxes corresponding to the assessment. Make notes in the interventions column about any assessment findings which are not represented by a box and intervention which are used to help the resident with behavioural symptoms.

Bathing and Dressing

Check the level of care assistance a resident requires with each type of care need based on the levels outlined:

Independent:	Requires no assistance/supervision.
Partial assistance:	Requires partial assistance and/or supervision. Resident cannot independently physically perform hygiene/bathing/dressing tasks and needs partial physical assistance to perform hygiene/bathing/dressing tasks. Any time a partial assistance is checked an intervention needs to be documented.
Maximum assistance:	Completely dependent for all aspects of dressing. More than one person may be needed for assistance.

Residents are to be consulted daily, regardless of level of care assistance needed, about choices in hygiene, bathing and dressing.

Under **ora**l **care** check off the boxes corresponding to the resident's routine in the left-hand column. Provide any additional detail in the interventions column.

Rest/Sleep Pattern

Check the boxes corresponding to the resident's usual routine and make any additional comments about the resident's routines in the interventions column.

Elimination

Check the level of care assistance a resident requires based on the levels outlined:

Independent:	Independent in toileting, including management of occasional incontinence or ostomy care.
Partial assistance:	Requires physical assistance with toileting / bedpan / urinal. Assistance managing incontinence products is required. Any time a partial assistance is checked an intervention needs to be documented.
Maximum assistance:	Requires full assistance with all aspects of toileting. Requires changing of incontinence products.

Check whether the resident needs the level of assistance on day, evening or night shift, or a combination or all of them. Under brief and pull-up, write down the brand and size of brief and pull-up the resident uses.

Nutrition

A physician's order is not required for diet orders. The resident's initial diet is to be discussed with the resident and his alternate decision-maker and clinical judgment is to be applied in deciding on the initial diet for a resident. Ongoing nutrition needs and diet orders are informed by the interdisciplinary assessment, which are to include the clinical dietitian's assessment, the Test of Texture Modified Diets Revised (TTMD-R), and possibly assessment and recommendations made by a Speech Language Pathologist.

Mobility/Transferring

Check the box corresponding to the resident's required assistive devices (i.e. no aid required, cane, walker, wheelchair) for mobility and transfers.

Check the box for the level of assistance required for use with the assistive device according to the Safe Client Handling and Injury Prevention Program (SCHIPP) assessment conducted.

Under **positioning** check the box of the level of assistance required by the resident for positioning.

Under **prescribed rehabilitation needs** check the box of the type of program assessed as most beneficial to the resident to which the resident has agreed and which is being implemented and adhered to. Where the resident has not agreed to or does not want to participate in a walking program, exercises or range of motion, check N/A and document the decision in the IPN. Where the resident is participating in a program, check the level of assistance required.

Under **mobility aid/equipment/assistive devices** document the type, serial number and whether the equipment is owned or rented by the resident.

Safety & Security Needs

Check any required safety aids in the corresponding box, or write any other safety aids beside the "Other" box. Check N/A if no safety aids are needed.

Oxygen Needs

Note the type of oxygen needs the resident has by checking the correct boxes. If the resident has no oxygen needs, check off the not applicable (N/A) box.

Risk Rating Scores

Elopement Risk Rating

Space is provided for twelve (12) elopement risk rating scores. Start in the left column at the number one (1) and proceed to record subsequent falls risk scores in the order they are completed. The rating scale is described in more detail in the Elopement Risk Rating Scale (CLI.6410.PL.032.FORM.01).

Falls Risk Assessment Score

Space is provided for twelve (12) falls risk assessment scores. Start in the left column at the number one (1) and proceed to record subsequent falls risk scores in the order they are completed. The rating scale is described in more detail in the Falls Risk Screening Tool (CLI.6410.PL.014.FORM.01).

Braden Scale for Predicting Pressure Sore Risk Score

Space is provided for sixteen (16) Braden Scale scores. Start in the left column at the number one (1) and proceed to record subsequent falls risk scores in the order they are completed. The rating scale is described in more detail in the Braden Scale for Predicting Risk of Pressure Injuries (CLI.4110.SG.002.FORM.01).

Housekeeping/Laundry Considerations

Special housekeeping needs which may be considered include:

- Family dust personal items in the resident's room;
- Resident does not want to be in the room when cleaning is happening;
- Resident wants to be in the room when cleaning is happening

These are only examples. If there are no special housekeeping considerations, "N/A" should be checked.

Therapeutic Recreation Assessment Requirements & Preferences

Information in this section is attached from the Activity Pro program. This information may change over time and it is important that Recreation review this section regularly to best inform all members of the interdisciplinary team about the resident's preferences for participation in activities.

Specialist Appointments

This section is to be used to document any upcoming specialist appointments.

Additional Information

This section is to be used for any treatments or care needs which cannot effectively be captured in other areas of the ICP. Examples would include:

- Wound care instructions;
- Special post-operative instructions;
- Detailed rehabilitative instructions; and
- Detailed behavioural management plan instructions
- Outings with a family member
- Wedding band removed and placed in safe

SECTION D: CHANGES TO EXISTING ICP

When any changes are made to the care plan, the appropriate member of the health care team documents the change in the relevant section (i.e. Recreation Worker may change care needs in the Therapeutic Recreation Assessment Requirements & Preferences Section but not in the Bathing & Dressing section; Dietitian can make changes in the Nutrition Needs Section but not in the Respiratory Section.)

When the level of assistance or intervention changes, using a ruler, cross out the old level or intervention, date & initial, check (√) the revised level of assistance or intervention as applicable, and write a corresponding note in descending order starting at the top of each section, **not** directly across from the individual plan of care need.

All changes to the ICP must have a corresponding IPN reflecting assessments made, rationale for any changes, changes made, and any plans for monitoring/reassessment. If applicable, put a reminder on the nurse's day calendar, dietary consult binder, etc. on the date to be reassessed.

The rating scales for **Risks for Falls Assessment** and **Braden Scale for Predicting Pressure Sore risk**) section needs to be updated when the level changes. The Elopement Scale is to be completed quarterly and and when the risk score changes.

When changes arise, immediately notify **all affected** departments about the change using the most appropriate method(s). Each department/discipline is to implement the change according to their procedures.

SECTION E: RE-COPYING THE ICP

When the section or page in the ICP is full or illegible:

- Check (√) "Re-copied", date and write your initial on the top of the page.
- As noted above, the initial ICP needs to be kept together. As such, the entire ICP is be re-copied the first time any page is full and it is to be filed in the resident's chart. After that, individual ICP pages may re-copied, as needed.
- Transfer all care plan elements from the old page to the new page, including any sections checked (√),dates in the "Date" column, and any notes made in the "Interventions/Integrated Action/Change"column.
- Re-copy original date with corresponding note but **not** the initial(s) of the Health Care Team member who originally wrote the Intervention/Integrated Action/Change.
- Place the old copy in the health record.
- The new and original care plans must remain in the active health record. Only subsequent re-copied care plans may be archived.