# Integrated Care Plan Review Form

**Review Date: _____** **Admission Date: _____**

☐ Post Admission Conference (6 – 8 weeks) ☐ Annual Conference

**Any entries completed prior to conference require an initial and designation**

## CONFERENCE NOTIFICATION & ATTENDANCE

Family notified of conference? ☐ Yes ☐ No Date: _____ Person contacted: _____

Resident present at conference: ☐ Yes ☐ No ☐ Declined ☐ Unable

☐ Family members (Name & Relation):

_____

_____

☐ Reviewed conference results with family/resident not present at conference ☐ N/A

Name(s): _____

## RESIDENT/FAMILY INPUT

☐ Review & Update 'What Matters to Me?':

_____

_____

## DIAGNOSIS(ES) ☐ Reviewed from ICP

Comments:

_____

_____

## COGNITIVE STATUS ☐ Reviewed from ICP & Quarterly Review

Comments:

_____

_____

MMSE Score: _____ Date: _____ ☐ N/A

## EMOTIONAL/PSYCHOLOGICAL STATUS, PERSONALITY & BEHAVIOUR CHARACTERISTICS

☐ **Reviewed from ICP & Quarterly Review** ☐ **Reviewed Non-Forced Care Practice with Resident and/Family**

Comments:

_____

_____

_____

Violence Prevention Screening Outcome: GDS/Sig Caps Outcome: _____

_____

Smoking Assessment: _____ Date: _____

☐ N/A

Safety Plan: _____

Comments:

_____

_____

_____

# Integrated Care Plan Review Form

**BATHING AND DRESSING** ☐ **Reviewed from ICP & Quarterly Review**
☐ **Reviewed Clothing & Toiletry needs**

Comments:

_____
_____
_____

Oral Health Assessment and Care Plan Guide completed (required quarterly): ☐ Yes

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**REST/SLEEP PATTERN** ☐ **Reviewed from ICP & Quarterly Review**

Time Up: _____ Time to Bed: _____
Rest Time: Morning: _____ Afternoon: _____ Evening: _____
Night: Sleep Pattern: _____

---

**NUTRITION** ☐ **Reviewed from ICP & Quarterly Review**

Nutrition Assessment by Dietitian Date: _____ Texture: _____
Current weight: _____ Last quarterly weight: _____ % weight change: _____
Portions ☐ Small ☐Regular ☐Large
Supplements: _____ SLP Involvement ☐
Comments:

_____
_____
_____

Most Recent TTMD-R Date: _____ Changes: _____

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**ELOPEMENT SCALE** ☐ **Reviewed from ICP & Quarterly Review**

Comments:

_____
_____

---

**FALLS RISK ASSESSMENT** ☐ **Reviewed from ICP & Quarterly Review**

Falls Risk Assessment: ☐ At risk for falls ☐High risk for falls ☐High risk for falls & Unsafe ambulation
Falls Prevention/Intervention Checklist: ☐No change ☐Reviewed Changes
Number of falls in the past year: _____ Number of injuries related to falls: _____
Comments:

_____
_____

**BRADEN SCALE** ☐ **Reviewed from ICP & Quarterly Review**

Braden Scale: ☐ At risk ☐Moderate Risk ☐High risk ☐Very high risk
Comments:

_____
_____

# Integrated Care Plan Review Form

**MOBILITY/TRANSFERRING** ☐ **Reviewed from ICP & Quarterly Review**

Most Recent SCHIPP Assessment Date: _____ SCHIPP Logo Updated: ☐ Yes ☐ No

Mobility Aide: ☐Owned ☐ Rented

Most Recent OT/PT Involvement:

_____

_____

Comments:

_____

_____

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**SAFETY & SECURITY AIDS** ☐ **Reviewed from ICP & Quarterly Review**

Comments:

_____

_____

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**RESTRAINTS** ☐ **Reviewed from ICP & Quarterly Review**

Type of restraint(s): _____

Restraints Review:

☐ Describe efforts made to resolve the issue for which each restraint was initiated and plan for further investigation:_____

_____

_____

☐ Record residents response to restraint(s):

_____

_____

☐ Plan for return to independence (if feasible) or purpose for continued use of restraint(s):

_____

_____

☐ Recommendation (Document any changes or discussion with family in the Integrated Progress Notes (IPN) and update the Restraint Care Plan.

☐ Continue with restraint Discontinue restraint ☐ Modify/Change Restraint
Complete restraint assessment, if modifying/changing restraint

Consent reviewed: ☐ Yes ☐ No Date: _____

Comments:

_____

_____

_____

# Integrated Care Plan Review Form

**HOUSEKEEPING/LAUNDRY** ☐ **Reviewed from ICP & Quarterly Review**
Comments:
_____
_____

**TREATMENTS/PROCEDURES** ☐ **Reviewed from ICP & Quarterly Review**

| | | | |
|---|---|---|---|
| Active Wounds | ☐ N/A | Allergies & Reactions Review | ☐ N/A |
| Treatment Review | ☐ N/A | Medication Changes | ☐ Reviewed from MAR |
| Pain assessment | ☐ N/A | Vital Signs: ☐ Reviewed | |

Comments:_____
_____
_____

**CULTURAL/SPRITUAL NEEDS** ☐ **Reviewed from ICP & Quarterly Review**
Comments:_____
_____

**THERAPEUTIC RECREATION** ☐ **Reviewed from ICP & Quarterly Review** ☐**Report Attached**
Comments:_____
_____
Resident
Services:_____
_____

**ADVANCED CARE PLANNING/HEALTH DIRECTIVE/ POWER OF ATTORNEY REVIEW**

| | |
|---|---|
| Reviewed with Resident/Family: | ☐ Yes ☐ No |
| Advanced Care Plan chosen: | ☐ Comfort ☐ Medical ☐ Resuscitation |
| Is this a change (if so ensure ACP form updated) | ☐ Yes ☐ No |
| Reviewed Alternate Decision-maker/Power of Attorney | ☐ Yes ☐ No ☐ Not Applicable |

Comments:_____
_____

# Integrated Care Plan Review Form

| COMMENTS/CONCERNS | PERSON RESPONSIBLE FOR FOLLOW UP | DATE OF COMPLETION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| ANNUAL REVIEW CHECKLIST | |
|---|---|
| ☐ Allergies with reactions reviewed and updated | ☐ Contact information reviewed & updated |
| ☐ Picture updated (if Applicable) | ☐ Oxygen order documented (if applicable) ☐ N/A |
| ☐ Review chart order, thin and rearrange as necessary | ☐ Integrated Care Plan reviewed and Updated<br>Initial: _____ |

**INTERDISCIPLINARY TEAM-all present disciplines to sign**

Date: _____ Signature: _____ Designation: _____

Date: _____ Signature: _____ Designation: _____

Date: _____ Signature: _____ Designation: _____

Date: _____ Signature: _____ Designation: _____

Date: _____ Signature: _____ Designation: _____

Date: _____ Signature: _____ Designation: _____

Date: _____ Signature: _____ Designation: _____