INTEGRATED CARE PLAN

☐Re-copied Date: _____ Initials: ____
☐Audited Date: _____ Initials: ____

ADDDRESSOGRAPH/LABEL

☐Initial Care Plan* Date: _____ Initials: _____	◆ **Needs to be completed within 24 hours of admission** Date:_____/_____/_____ Initials_____/_____/_____
Name Preferred: _____ Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single Public Trustee #: _____ ❒ N/A Support (available family, community & social network): ❒ N/A _____ _____ _____ _____ _____	Admission Date: _____ ◆ Advance Care Planning Level: _____ ◆ Health Care Directive: ☐ Yes ☐ No ◆ Proxy ☐ Yes ☐ No If more than one proxy, are they to act jointly or consecutively? ☐ Jointly or ☐ Consecutively *Refer to Resident Contact Information Form on resident's health record for contact details
Veterans Affairs Canada #: _____ Treaty #: _____ Band #: _____ Insurance Contract # _____ Group #: _____ Home Community/Town: _____ Highest Level of Education: _____ Past Occupation: _____ Physician: _____ Specialists/Other: _____ _____ _____ Funeral Home Name & Number: _____ _____ *Refer to Pre-admission/Admission History Form for detailed funeral arrangements	◆ Allergies & Reactions: ❒ *None Known* ❒ *Yes (specify type and reaction in red ink)* *Drugs :* _____ *Food:* _____ *Other:* _____ Preferred Language: _____☐ Spoken ☐ Understood _____☐ Spoken ☐ Understood Other Language ☐ N/A Trust Account: ☐ Yes ☐ No Tuck/Canteen Approval: ☐ Yes ☐ No Cable: ☐ Yes ☐ No Paper: ☐ Yes ☐ No Phone: ☐ Yes ☐ No
PACEMAKER/DEFIBRILLATOR: ☐ Yes ☐ No	
DIAGNOSIS/SURGICAL HISTORY (Indicate date where known)	

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WHAT MATTERS TO ME? (include resident/family goals while in care)	DATE	INITIALS & DESIGNATION

CULTURAL & SPIRITUAL BACKGROUND

Ethnic Background: _____

Religious Denomination: _____

Church Affiliation: _____

CULTURAL & SPIRITUAL CONSIDERATION	DATE	INITIALS & DESIGNATION

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◆ **COGNITIVE STATUS**						
☐ **MMSE**: (if clinically required): Date:					**Date**	**Interventions / Integrated Action / Change/Frequency** (end with initials and designation)
Orientated to: ☐ Person ☐ Place ☐ Time						
Mental Status: ☐ Alert ☐ Lethargic ☐ Confused ☐ Long Term Memory Intact ☐ Short Term Memory Intact						
Communication: Unimpaired communication: ☐						
Alternative Method of Communication:						
Speech: _____						
	Assistance					
	Independent	Partial	Maximum			
Visual Ability: _____						
☐ Glasses ☐ Not worn ☐ N/A ☐ Contacts	☐	☐	☐			
Hearing Ability: _____						
Hearing aid ☐ L ☐ R ☐ Not worn ☐ N/A	☐	☐	☐			
Emotional/Psychosocial Status, Personality & Behaviour Characteristics						
Behaviour management care plan: ☐ Yes ☐ No						
☐ Yes ***Date Initiated:*** _____ ☐ No						
☐ Content ☐ Agreeable to care ☐ Attention seeking						
☐ Wandering ☐ Risk of elopement ☐ Suspicious						
☐ Agitated ☐ Refuses/resists care ☐ Anxious						
☐ Suicidal ☐ Sad/depressed/withdrawn						
☐ Hoarding ☐ Delusions ☐ Hallucinations						
☐ Paranoia ☐ Aggression: ☐ Verbal ☐ Physical						
☐ Potential of injury: ☐ Self ☐ Other residents ☐ Staff						
☐ Family dynamics/relationships						
☐ Sexually expressive behaviour: ☐ Verbal ☐ Physical						
☐ Smoker: ☐ Supervised ☐ Independent ☐ Smoking Assessment completed						
☐ Substance abuse (type)						
☐ Other: _____						

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◆ **BATHING AND DRESSING**					
	Assistance			**Date**	**Interventions / Integrated Action / Change/Frequency** (end with initials and designation)
	Independent	Partial	Maximum		
Bath Day: _____					
Hair care: Daily routine Other care: ☐ Shampoo during bath ☐ Shampoo by hairdresser/barber	☐	☐	☐		
Hands and face	☐	☐	☐		
Finger nails	☐	☐	☐		
☐ Shave ☐ Make-up	☐	☐	☐		
☐ Bed bath ☐ Shower ☐ Tub	☐	☐	☐		
Peri-care ☐ Peri-wash ☐ Other	☐	☐	☐		
Skin care ☐ Lotion ☐ Other	☐	☐	☐		
Foot care ☐ Nursing ☐Foot care nurse ☐ Other _____ ☐ Consent	☐	☐	☐		
Shoes and socks	☐	☐	☐		
Dressing: Regular ☐ tops ☐ bottoms Open Back ☐ tops ☐ bottoms	☐	☐	☐		
☐ Compression stockings ☐N/A Size: _____ Elastigrip ☐ Yes ☐ No _____ mmHg Brand _____ Purchase Date: _____ ABI Score & Date: _____	☐	☐	☐		
Oral Care	☐	☐	☐		
Own teeth: ☐Upper ☐ Lower **No teeth**: ☐Upper ☐Lower **Dentures:** ☐Upper ☐ Lower **Partial**: ☐Upper ☐Lower **Mouth care positioning:** ☐ Standing ☐ Sitting ☐ Lying **Times of day:** ☐ after meals ☐ morning ☐ bedtime **Brush:** ☐ Yes ☐ N/A **Paste:** ☐ Yes ☐ No Type: _____ **Floss:** ☐ Yes ☐ N/A **Rinse**: ☐ Yes ☐ No Type: _____					

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REST/SLEEP PATTERN								
☐Up for meals only ☐AM rest ☐PM rest ☐Bed rest								
Wake up time:_____Bed time: _____								
Sleeping habits: _____								
◆ **ELIMINATION**								
Continent of bladder: ☐ Yes ☐ No Continent of bowel: ☐ Yes ☐ No	**N**	**D**	**E**	Assistance: Independent	Partial	Maximum	**Date**	**Interventions / Integrated Action / Change/Frequency** (end with initials and designation)
☐ Toilet	☐	☐	☐	☐	☐	☐		
☐ Commode	☐	☐	☐	☐	☐	☐		
☐ Urinal	☐	☐	☐	☐	☐	☐		
☐ Bed pan	☐	☐	☐	☐	☐	☐		
☐ Pad	☐	☐	☐	☐	☐	☐		
☐ Brief ☐ Pull-up Size: ___ Size: ____	☐	☐	☐	☐	☐	☐		
☐ Other	☐	☐	☐	☐	☐	☐		
☐ Ostomy Type: _____				☐	☐	☐		
☐ Suprapubic Size: _____				☐	☐	☐		
☐ Foley Size: _____				☐	☐	☐		
NUTRITION								
◆ Diet: ☐ Regular ☐ Therapeutic _____								
◆ Diet allergies: ☐ None								
◆ Difficulties: ☐ Eating ☐ Swallowing ☐ Other ☐ None ☐ TTMD-R: Date Completed: _____								
◆ Eating: ☐ Independent ☐ Prompt ☐ Assist ☐ One item at a time ☐ Aids: _____								
◆ Texture: ☐ Regular ☐ Soft ☐ Minced ☐ Total minced ☐ Pureed ☐ Blended ☐ Soft with minced meat ☐ No fluids with solids								
◆ Liquids: ☐ Thin - Level 0 ☐ Mildly Thick - Level 2 ☐ Moderately Thick - Level 3 ☐ Extremely Thick - Level 4								
Portion Size : ☐ Small ☐ Regular ☐ Large								
Supplements (type, frequency, volume): _____ ☐ ◆ Tube feed ☐ N/A								
◆ Special needs/preferences: _____								

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MOBILITY/TRANSFERRING					
	Assistance			Date	Interventions / Integrated Action / Change/Frequency (end with initials and designation)
	Independent	Partial	Maximum		
◆ **Mobility**					
☐ Walking ☐ Cane ☐ Walker	☐	☐	☐		
☐ Wheelchair Leg Rest: ☐ L ☐ R	☐	☐	☐		
☐ Transfers self or:	☐	☐	☐		
☐ Ceiling Lift ☐ Floor lift	☐	☐	☐		
☐ Transfer disc ☐ Sit to stand lift	☐	☐	☐		
☐ Sliding board ☐ Transfer belt	☐	☐	☐		
☐ Transfer pole ☐ Grab bar or pole	☐	☐	☐		
☐ Lift sling ☐ Remove sling in bed/sitting ☐ S ☐ M ☐ L ☐ XL					
◆ **Positioning**					
☐ Tube slider ☐ Positioning sheet set	☐	☐	☐		
☐ Slider sheet ☐ Positioning sling					
☐ Turning sling ☐ Limb sling					
☐ Other: _____	☐	☐	☐		
Prescribed Rehabilitation Needs ☐ N/A					
☐ Walking ☐ N/A	☐	☐	☐		
☐ Range of motion ☐ N/A	☐	☐	☐		
☐ Exercises	☐	☐	☐		
☐ Other ☐ N/A	☐	☐	☐		

MOBILITY AID/EQUIPMENT/ASSISTIVE DEVICES:		
Type	**Serial Number**	**Owner/Rent**

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◆ **SAFETY & SECURITY AIDS** ☐ **N/A**		
	Date	**Interventions / Integrated Action / Change** (end with initials and designation)
☐ See restraint care plan		
☐ Wander management system		
☐ 1/4 side rail ☐One ☐Two		
☐ Wheelchair brakes – independent		
☐ Motion sensor ☐Bed/chair sensor		
☐ Fall mats ☐Low bed		
☐ Hip protectors Size: _____		
☐ Seatbelt - able to unfasten		
☐ Mattress type: _____		
☐ Other _____		
◆ **OXYGEN NEEDS** ☐ **N/A**		
☐ Portable ☐ Concentrator ☐ Nasal prongs ☐ Mask		
☐ Continuous Flow rate: _____ Litres/min		
☐ Intermittent Flow rate: _____Litres/min		
☐ Sleep apnea machine (CPAP/BiPAP) Settings _____		

ELOPEMENT RISK RATING (QUARTERLY AND WHEN RISK SCORE CHANGES)

LEVEL	**SCORE**	**Score**	**Date**	**Score**	**Date**	**Score**	**Date**	**Score**	**Date**
Low Risk	0 - 8	1.		4.		7.		10.	
At Risk	9 - 10	2.		5.		8.		11.	
High Risk	11 or above	3.		6.		9.		12.	

RISK FOR FALLS ASSESSMENT SCORE (COMPLETE ONLY WHEN RISK SCORE CHANGES)

LEVEL	**SCORE**	**Score**	**Date**	**Score**	**Date**	**Score**	**Date**	**Score**	**Date**
At Risk for falls	< 7	1.		4.		7.		10.	
High Risk for falls	≥ 7	2.		5.		8.		11.	
High Risk for Falls **and** Unsafe ambulation	>12	3.		6.		9.		12.	

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK SCORE (COMPLETE ONLY WHEN RISK SCORE CHANGES)

LEVEL	**SCORE**	**Score**	**Date**	**Score**	**Date**	**Score**	**Date**	**Score**	**Date**
At Risk	15 - 18	1.		5.		9.		13.	
Moderate Risk	13 - 14	2.		6.		10.		14.	
High Risk	10 – 12	3.		7.		11.		15.	
Very High Risk	≤ 9	4.		8.		12.		16.	

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HOUSEKEEPING/LAUNDRY CONSIDERATIONS		
Laundry done by: ☐ Facility ☐ Family:		
Contact for clothing needs: _____		
Special laundering needs: _____		
Special housekeeping needs: ☐ N/A or: _____		

THERAPEUTIC RECREATION ASSESSMENT REQUIREMENTS & PREFERENCES See attached Activity Pro Care Plan	DATE	INITIALS & DESIGNATION
Initial Assessment and Care Plan		
Initial Therapeutic Recreation Assessment		
Initial Therapeutic Recreation Care Plan Developed		
Care Plan Updates (document when updates are made in Activity Pro)		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		
Care Plan Updated		

SPECIALIST APPOINTMENTS	DATE	INITIALS & DESIGNATION

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ADDITIONAL INFORMATION (◆ Treatments to be documented within 24 hours of admission)	DATE	INITIALS & DESIGNATION

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