POLICY:	**Integrated Care Plan for Personal Care Homes & Transitional Care**
Program Area:	**Personal Care Home**
Section:	**General**
Reference Number:	**CLI.6410.PL.002**
Approved by:	**Regional Lead – Community & Continuing Care**
Date:	Issued: **2025/Jan/07** Revised yyyy/mmm/dd

PURPOSE:

To provide direction to staff working in personal care homes (PCHs) and transitional care (TC) about establishing and maintaining a collaborative, comprehensive integrated care plan.

BOARD POLICY REFERENCE:

Executive Limitation (EL-02) Treatment of Clients

POLICY:

Manitoba Health, Seniors and Long-term Care require all PCHs to meet the standards as outlined in the Personal Care Home Standards and Licensing Regulation under the Health Services Insurance Act.

TC is not included under the above regulation however these sites may elect to use the Integrated Care Plan (CLI 6410.PL.002.FORM.03) in replacement of the nursing Kardex for those individuals who are awaiting placement for a PCH. The Delivery of Care Record (CLI 6410.PL.002.FORM.05) is used in both PCH and TC settings for all residents awaiting placements.

The Integrated Care Plan (ICP) is used by interdisciplinary team members to provide a consistent and person-centered plan of care for all residents in PCHs and TC.

The ICP is developed in collaboration with each resident and/or alternate-decision maker. If the resident and/or their alternate decision-maker are not able to participate in the development of the ICP, the interdisciplinary team are to proceed and discuss with them following the development of the plan of care.

The initial care plan is completed within twenty-four (24) hours of admission and the entire ICP is completed within eight (8) weeks of admission. Documentation on the ICP is completed according to the Completion of the Integrated Care Plan Reference Guide (CLI 6410.PL.02.SD 01).

Staff involved in providing care are to follow the individualized plan of care for each resident.

Quarterly reviews of the resident's health status and ICP take place for each resident and are documented on the Interdisciplinary Quarterly Care Plan and Restraints Review Form (CLI 6410. PL.02.FORM.09). Updates are made on the ICP on quarterly basis and when changes arise for the resident.

The 6-to 8-week post-admission and annual care conferences occur for each resident and are documented on the Integrated Care Plan Review Form (CLI 6410.PL.02.FORM.10).

The ICP is part of each resident's permanent health record and entries are dated and initialed in blue or black ink and allergies with reactions recorded in red ink.

Random audits of the IPCs are to be completed, at minimum, on an annual basis at each PCH and TC. Audits may occur more frequently if a need is identified.

DEFINITIONS:

Alternate Decision-maker: a person who has decision-making capacity and is willing to make decisions on behalf of a resident who does not have the capacity to make a decision. An alternate may be legally authorized (e.g. health care proxy or committee) or may be a person designated (e.g. family member) in the absence of a legally authorized individual.

Integrated Care Plan (ICP): a document that outlines what matters to the resident and/or alternate decision-maker in relation to the resident's plan of care and includes the goals of care and interventions that are to be taken to achieve these goals. The ICP outlines the type of assistance the resident requires with activities of daily living along with a number of identified measures in order to meet Manitoba Health, Seniors and Active Living Standards for Personal Care Homes.

Person-Centered Care: demonstrates respect for a person's unique history, preferences and abilities and focuses on the person rather than a task at hand and encourages a person to participate in decisions about their own care.

Resident: any person who resides at a personal care home or may include those patients who are awaiting placement for a PCH in TC.

IMPORTANT POINTS TO CONSIDER:

Manitoba Health, Seniors and Active Living Standards for Personal Care Homes (2015) indicate that the ICP is to include the following information:

- Type of assistance required with bathing, dressing, mouth and denture care, skin care, hair and nail care, foot care, eating, exercise, mobility, transferring, positioning, and bladder and bowel function, including any incontinence care product(s) required;
- Mental and emotional status including personality and behavioral characteristics;
- Available family and community supports;
- Hearing and visual abilities and required aids;
- Rest periods and bedtime habits, including sleeping patterns;

- Safety and security risks and any measures required to address them;
- Language and speech, including any loss of speech capability and any alternate communication method used;
- Rehabilitation needs;
- Therapeutic Recreation requirements;
- Preference for participating in recreational activities;
- Religious and spiritual preferences. Southern Health-Santé Sud also extends this to cultural preferences;
- Medication and treatments by an ordering provider;
- Food preferences and diet orders;
- Food allergies;
- Any special housekeeping considerations for the resident's personal belongings;
- Whether the resident has made a health care directive. Southern Health-Santé Sud also includes whether an advanced care plan has been developed;
- Any other need identified by a member of the interdisciplinary team.

The initial care plan that is completed ***within 24 hours of admission*** is to include, at *minimum*, the following areas:

- Date and initial that all minimum areas have been completed within 24 hours;
- Advanced Care Plan/Health Care Directive/Proxy Name;
- Allergies with Reactions;
- Cognitive Status;
- Emotional/Psychosocial Status, Personality & Behaviour Characteristics;
- Bathing & Dressing;
- Elimination;
- Nutrition: Sections ***initially*** to be completed include: diet, diet allergies, difficulties eating (excluding TTMD-R), any assistance required with eating, texture, liquids, tube feeding (if applicable), special needs/preferences;
- Medications which are documented on the Medication Administration Record (MAR);
- Mobility/Transferring. Sections initially to be completed include: mobility, positioning;
- Safety & Security Aids;
- Oxygen Needs;
- Treatments which are documented under Additional Information on the ICP.

The Completion of the Integrated Care Plan Reference Guide (CLI.6410.PL.SD.01) is a working document that describes 'how to' complete the ICP in accordance with standardized definitions for each section.

The Reference Guide for Goals of Care (CLI 6410.PL.02.SD.02) describes what a goal is, briefly outlines tips for establishing goals and provides examples of focused goals for residents in various areas such as: activity/exercise, cognitive/perceptual, intake and eliminiation, comfort/safety, commuication, family/caregiver relationships and lifestyle. Goals of care are not limited to these areas however it offers suggestions for clinicians to consider when developing a resident's plan of care.

PROCEDURE:

Prior to or Upon admission:

Designated staff person completes the Pre-admission/Admission History Form (CLI.6410.PL.002.FORM.01) and the Resident Contact Information Form (CLI. 6410.PL.002.FORM.02) and files it on the resident's health record.

Within 24 hours of admission:

1. Admitting nurse(s) is/are to:
    a. Review and follow the Completion of the ICP Reference Guide prior to developing the ICP.
    b. Complete the initial ICP utilizing the ICP Form (CLI.6410.PL.002.FORM.03) and seek input from the resident and/or alternate decision-maker in doing so. The minimum areas to be completed on the ICP are noted above and are identified with a diamond (◆).
    c. Obtains medications and treatment orders by the ordering provider and documents them on the order sheet or through the medication reconciliation process.
    d. Transcribes the medications to the Medication Administration Record (MAR)
    e. Obtain height and weight and documents them and the admission date on the Clinical Record Form (CLI 6410.PL.002.FORM 04).
    f. Completes month, year and areas to be monitored on the Delivery of Care Record (CLI.6410.PL.002.05) such as, but not limited to, frequency of monitoring restraints, if needed, and whether there are any special care needs.
    g. Communicates the initial care plan to direct care staff who are responsible for the provision of care (includes those involved with the assessment, planning, and/or providing care to the resident).

Every Shift Change:

1. Health Care Aides/Resident Assistants are to document on the Delivery of Care Record regarding the care that was provided on each shift (nights, days, evenings) using the legends on the form for each section.
2. Health Care Aides/Resident Assistants are to report any concerns or changes in any residents' needs to the assigned nurse for the resident.
3. The Delivery of Care Record is filed on each resident's permanent health record at the end of each month and a new Delivery of Care Record is to be initiated on the first day of the following month.

Within 8 weeks of admission:

1. Interdisciplinary team members (IDT), noted below, are to complete an assessment, in collaboration with the resident and alternate decision-maker, within eight (8) weeks of admission utilizing the following regional forms:
    a. Nurse(s) complete the Current System Assessment (CLI.6410.PL.002.FORM.06)
    b. Dietician completes Nutrition Assessment (CLI.6410.PL.002.FORM.07)
    c. Recreation/Activities complete the Therapeutic Recreation/Activity Assessment (CLI.6410.PL.002.FORM.08)
2. Nurses or interdisciplinary team complete the Resident & Family Goals of Care section referring to the Reference Guide for Goals of Care.
3. Nursing or designate offer the resident, where able, and their alternate decision-maker an opportunity to participate and discuss the resident's plan of care during the 6-8-week care conference. Alternate decision-makers are given the option to participate in-person or remotely (e.g. phone) if this is the most feasible option. Documentation of efforts taken to notify the alternate decision-maker are made on the Conference Notification & Attendance section of the Integrated Care Plan Review form. If multiple attempts are made and additional space is needed, a chart note(s) is written on the IPN.
4. IDT members, along with the resident and alternate decision-maker, if able, participate in the scheduled 6-8-week care conference. Nursing and Recreation/Activities, at minimum, participate, in-person, in each resident's care conference. Other IDT members and the alternate decision-maker may participate in-person or by other means (e.g. phone).
5. Each staff member that attends the 6-8-week post-admission care conference is required to sign the form. If a staff person attends remotely, the person leading the conference documents their remote attendance.
6. If a resident and/or alternate decision-maker are not able to attend the 6-8-week post-admission care conference this is documented on the Integrated Care Plan Review form by the person leading the conference.

Every Month:

- Nurse obtains each resident's weight on a monthly basis and documents on the Clinical Record Form.

Every 3 months:

1. Nursing and Recreation/Activities review and update each resident's ICP at minimum every three (3) months, as noted below, and document on the Interdisciplinary Quarterly Care Plan and Restraints Review Form.
2. Vital signs (blood pressure, pulse, respirations, temperature, oxygen saturation) taken, by nurse, and documented on the Clinical Record Form at minimum on a quarterly basis.
3. At minimum, two health care team members of different disciplines (e.g. nurse and HCA) review and discuss whether there have been any changes in the resident's status and whether any changes are needed with respect to the resident's plan of care. Recreation/Activities are

to date/initial on the Interdisciplinary Quarterly Care Plan and Restraints Review Form that their quarterly review is completed.
4. Following the review, a minimum of two additional health care team members are to sign the Interdisciplinary Quarterly Care Plan and Restraints Review Form on the same day.

When Changes Arise with Resident:

1. Interdisciplinary team members update the ICP, for their respective disciplines, when a resident has changing care needs and/or a health condition(s).
2. Interdisciplinary team members communicate changes to direct care staff who are responsible for the provision of care and document these changes in the Integrated Progress Notes (IPN) (CLI.4510.PR.002.FORM.01).

Annually:

Annual Care Conference:

1. IDT members review the most recent quarterly review and current ICP and document on the Integrated Care Plan Review Form. IDT document in sections relevant for their discipline (Dietician completes Nutrition Section, Recreation/Activities completes Therapeutic Recreation Section, Nursing or designate completes remaining sections).
2. Nursing or designate offer the resident, where able, and their alternate decision-maker an opportunity to participate and discuss the resident's plan of care during the annual care conference. Alternate decision-makers are given the option to participate in-person or remotely (e.g. phone) if this is the most feasible option. Documentation of efforts taken to notify the alternate decision-maker are made on the Conference Notification & Attendance section of the Care Plan Review form. If multiple attempts are made and additional space is needed, a chart note(s) is written on the IPN.
3. IDT members, along with the resident and alternate decision-maker, if able, participate in the scheduled annual care conference. Nursing and Recreation/Activities, at minimum, participate, in-person, in each resident's annual care conference. Other IDT members and the alternate decision-maker may participate in-person or by other means (e.g. phone).
4. Each staff member that attends the annual care conference is required to sign the form. If a staff person attends remotely, the person leading the conference documents their remote attendance.
5. If a resident and/or alternate decision-maker are not able to attend the annual care conference this is documented on the Integrated Care Plan Review form by the person leading the conference.

Quality Improvement/ Evaluation:

1. On an annual basis, at minimum, a designated staff person at each site completes an audit utilizing the Integrated Care Plan & Suicide Risk Assessment Audit Form (CLI 6410.PL. 002.FORM 11). Detailed audit instructions are outlined on the audit form.
2. Site leadership or designate at each site reviews and analyzes the audit results and makes recommendations, as required, based on the audit results.

3. Site leadership at each site implements recommendations and follows up on the recommended changes and determines if re-auditing is necessary based upon the audit results. Site leadership may determine that there is a need to re-audit the ICPs more frequently if a need is identified, such as, but not limited to, not fully meeting the Manitoba Health, Seniors and Long-Term Care Standards for Personal Care Homes.
4. Site leadership submits audit results to the Directors, Health Services – Personal Care Homes/designate on an annual basis or more frequently.

SUPPORTING DOCUMENTS:

CLI.6410.PL.002.FORM.01	Pre-admission/Admission History Form
CLI.6410.PL.002.FORM.02	Resident Contact Information Form
CLI.6410.PL.002.FORM.03	Integrated Care Plan
CLI.6410.PL.002.FORM.04	Clinical Record Form
CLI.6410.PL.002.FORM.05	Delivery of Care Record
CLI.6410.PL.002.FORM.06	Current System Assessment
CLI.6410.PL 002.FORM.07	Nutrition Assessment
CLI.6410.PL 002.FORM.08	Therapeutic Recreation/Activity Assessment
CLI.6410.PL 002.FORM.09	Interdisciplinary Quarterly Care Plan and Restraints Review Form
CLI.6410.PL 002.FORM.10	Integrated Care Plan Review Form
CLI.6410.PL 002.FORM.11	Integrated Care Plan & Suicide Risk Assessment Audit Form
CLI.6410. PL.002.SD.01	Completion of the Integrated Care Plan Reference Guide
CLI. 6410.PL.002.SD.02	Goals of Care Resource Guide

REFERENCES:

CLI.4510.PR.002.FORM.01 Integrated Progress Notes (IPN)

Manitoba Health, Seniors and Active Living (2015). *Personal Care Homes Standards Visit Package: Standards for Personal Care Homes. Standard 7: Integrated Care Plan*