BASELINE/ADMISSION/WORKING PERSON CENTERED CARE PLAN

Date _____ Initials _____

At risk for falls secondary to initial safety assessment or medical diagnosis.

Goal: I will not experience an avoidable fall with major injury x 21 days.

□ Call light within reach.
□ Adequate lighting.
□ Keep environment as free from clutter as possible
□ Assist with ADL's and transfers as indicated.
□ If ambulatory, appropriate footwear.
□ PT/OT Screen/ evaluation as ordered.
□ Seizure Disorder.
□ Other_____

_____

Date _____ Initials _____

Actual /at risk for pain.

Goal: I will have any identified pain relieved within 45 minutes of identification of pain x 21 days.

□ Medication as ordered.
□ Non-pharmacologic interventions where indicated.
□ Reposition/ROM; AROM as indicated.
□ Monitor q shift and document actual findings/indications of pain.
□ Monitor effectiveness of pain interventions per protocol.
□ Notify MD for unrelieved pain.
□ Other _____

_____

□ Other _____

_____

Date _____ Initials _____

At risk for pressure injuries secondary to initial admission risk assessment/past or current skin issues.

Goal: Minimize avoidable risks daily for 21 days.

□ Reposition/offload at least q ____ hours /PRN while awake and _____ hours and PRN while asleep.
□ Manage incontinence if present.
□ Foley catheter if ordered.
□ Pressure reducing mattress/cushion.
□ Tx per MD orders.
□ Adequate nutrition/hydration.
□ Monitor skin q shift and report any changes to MD.
□ Preventative skin care per protocol.
□ Offload heels while in bed.
□ Other _____

□ Equipment _____

Date _____ Initials _____

Safety risk due to:
□ **Wandering** □ **Combativeness**
□ **Other Behavior(s)_____**
□ **Not indicated**

Goal: I will remain free from avoidable injury related to behavior x 21 days.

□ Monitor for behaviors q shift and document any noted episodes
□ Notify MD if behavior increases
□ Adequate monitoring based on resident condition
□ Meds as ordered.
□ IDT/SS/MD Psych evaluation as ordered/indicated.
□ Other _____

□ Other _____

Date _____ Initials _____

Use of psychoactive medications for: (specify):

_____

_____

_____

□ **Not applicable**

Goal: No avoidable adverse reactions from medications x 21 days.

□ Monitor behavior(s) q shift.
□ Monitor for side effects q shift
□ Report any side effects or changes in behavior(s) to MD
□ Therapeutic level labs as ordered.
□ Other _____

□ Other _____

Date _____ Initials _____

Anticoagulation Therapy
□ **Not applicable**

Goal: Side effects will be minimized through monitoring labs as ordered and assessment of side effects x 21 days.

□ Monitor for bleeding/bruising q shift and notify MD as indicated. Document only untold findings.
□ Labs as ordered
□ Meds as ordered.
□ Other _____

□ Other _____

Resident_____ Room # _____ Physician _____

Date _____ Initials _____

Hemodialysis/Peritoneal Dialysis.
□ **Not applicable**

Goal: I will have any significant avoidable complications from HD or PD x 21 days.
□ Monitor shunt for thrill and bruit q shift.
□ Monitor for respiratory changes q shift. Document abnormal findings and notify MD.
□ Monitor for bleeding from shunt or catheter site q shift and notify MD for any noted bleeding.
□ Labs as ordered.
□ Dialysis as ordered.
□ Monitor dialysate if PD for turbidity.
□ Diet/fluids as ordered.
□ Other_____

_____

Date _____ Initials _____

Altered gas exchange requiring use of: □trach □oxygen.
□Not indicated

Goal: My airway will remain patent x 21 days.
□ O_2 as ordered.
□ Observe respiratory status q shift and PRN. Document abnormal findings and notify MD.
□ Respiratory treatment per orders.
□ Medications as ordered.
□ Elevate HOB as tolerated/ordered.
□ Labs/ABG's as ordered.
□ Other _____

_____

□ Other _____

_____

Date _____ Initials _____

Potential/Actual infection R/T (specify): _____
□Not indicated

Goal: My infection will be resolved in 21 days.
□ Medications as ordered.
□ Labs/radiology as ordered.
□ Increase fluids to _____ CC/day.
□ Monitor for s/s of infection worsening and notify MD.
□ VS as ordered/indicated.
□ Treatments as ordered.
□ Precautions as indicated.
□ Isolation: Type _____

□ Other _____

_____

□ Other _____

_____

Date _____ Initials _____

Intravenous therapy secondary to (specify) _____
□ **Not applicable**

Goal: My intravenous site will be free from avoidable infection x 21 days.
□ Administer IV meds as ordered.
□ Observe for s/s of redness at insertion site.
□ Update MD as needed.
□ Provide IV site care per protocol.

□ Other _____

_____

□ Other _____

_____

Date _____ Initials _____

Cardiac instability
□ **Not applicable**

Goal: I will minimize risks of cardiac complications over the next 21 days.
□ Medications as ordered.
□ Observe for s/s of cardiac distress. Document abnormal findings and notify MD.
□ RD/DTR consult as indicated.
□ Diet/fluids as ordered.
□ Monitor PO intake.
□ Labs as ordered.
□ HOB elevated as indicated.
□ Other _____

_____

□ Other _____

_____

Date _____ Initials _____

Diabetes
□ **Not applicable**

Goal: I will have no significant episodes of hyper or hypoglycemia with complications x 21 days.
□ Glycemic medication as ordered.
□ Monitor blood sugars as ordered.
□ Notify MD if ordered interventions not effective in treating either hyper or hypoglycemia.
□ Diet as ordered.
□ RD/DTR to evaluate as indicated.
□ Other _____

□ Other _____

Resident_____ Room # _____ Physician _____

Date _____ Initials _____

Nutrition risk secondary to:
□ **enteral feeding**
□ **history of poor PO intake**
□ **Not indicated**

Goal: I will have no s/s of avoidable malnutrition x 21 days.
□ Enteral feedings as ordered.
□ TPN as ordered.
□ RD/DTR consult as indicated.
□ Diet as ordered.
□ Provide culturally/religiously sensitive meals.
□ Obtain and honor food preferences.
□ Monitor PO intake.
□ Labs as ordered.
□ Supplements/snacks as ordered.
□ Abd binder
□ Other_____

_____

Date _____ Initials _____

GI disorder.
□ **Not applicable**

Goal: My s/s will stabilize with 15 to 21 days.
□ Medication as ordered.
□ Diet/fluids/IV as ordered.
Document abnormal findings and notify MD
□ Observe for s/s of dehydration.
Document abnormal findings and notify MD.
□ RD/DTR consult as indicated.
□ Labs as ordered.
□ Other _____

_____

□ Other _____

_____

Date _____ Initials _____

Routine for meals.

Goal: I will verbalize satisfaction with my meal routine.
□ Breakfast preference.
Time:_____
Place: _____
Food: _____
_____
□ Lunch preference.
Time: _____
Place: _____
Food: _____
_____
□ Dinner preference.
Time: _____
Place: _____
Food: _____
_____
□ Snack preference: _____
_____

Date _____ Initials _____

Foley, suprapubic catheter, colostomy and/or urostomy will be patent x 21 days.
Reason/Dx: _____
□ **Not applicable**

Goal: My catheter or ostomy will be patent with no s/s of infection x 21 days.
□ Provide foley cath, colostomy or urostomy care q shift or as ordered.
□ Observe for s/s of infection or changes in skin around site. Document abnormal findings and notify MD.
□ Keep tubing clean and off the floor.
□ Secure tubing to leg.
□ Other _____

_____

□ Other _____

_____

Date _____ Initials _____

Alteration in bowel/bladder secondary to (specify):
_____
□ **Not applicable**

Goal: My skin will not be impacted by incontinence x 21 days.
□ Provide peri care as indicated.
□ Bedside commode.
□ Bedpan.
□ Urinal.
□ Check and change incontinence pads q 2 hours and PRN.
□ Other _____

_____

□ Other _____

_____

Date _____ Initials _____

Cognitive impairment secondary to _____.
□ **Not applicable**

Goal: My confusion will have minimal impact on care x 21 days.
□ Communicate using short simple questions and statements.
□ Allow sufficient time to respond.
□ Use calm soothing voice.
□ Other _____

_____

□ Other _____

_____

Resident_____ Room # _____ Physician _____

Date _____ Initials _____

Therapy Services
□ **Not indicated**

Current Therapy Order(s):

_____

_____

_____

Due to/Related to:

_____

_____

_____

Resident Stated/Goal:

_____

_____

_____

Date _____ Initials _____

ADL Preferences

Goal: I will choose the type, time and needed assistance for accomplishing ADL's.

Prefers: □ Shower □ Bed Bath

In the: □ morning □ afternoon □ evening

Prefers to wear _____
_____

Type of hair care desired:
_____

Type and place of hair removal:
_____

Oral Care routine: _____
_____

Other grooming, makeup etc. details
_____

Date _____ Initials _____

Daily Routine for Sleep

Goal: I will be able to establish my sleep routine as I have been accustomed to.
□ Prefers to exit bed on their ___ side.
□ Prefers to get up at _____.
□ Prefers to go to bed at _____.
□ Takes naps at _____.
□ Prefers to wear _____ to sleep in.
□ While in bed, likes to: □ read
□ watch TV □Listen to _____
□ Other important sleep details.
□ Pillows _____
□ Room Temperature _____
□ Covers _____
□ Preferred position _____
□ Other important sleep information
_____

_____

Date _____ Initials _____

Palliative/End of life care
□ **Not applicable**

Goal: I will remain comfortable throughout the dying process over the next 21 days.
□ PT Evaluation/Screen
□ OT Evaluation/Screen
□ RNA program
□ Assist with ADL's as indicated based on tolerance and need.
□ Allow sufficient time to complete tasks
□ Pain medication as ordered.
□ Allow liberal visiting hours.
□ Honor all resident/advocate choices
□ Other _____
_____
_____

Date _____ Initials _____

Discharge Plan

Resident Stated Goal: (Indicate)
_____
_____
_____

□ Discharge potential? □yes □no

□ Other
_____
_____
_____

□ PASARR Recommendation (if applicable):
_____
_____
_____
_____

Date _____ Initials _____

Actual/Potential Concern:
_____
_____

Goal(s):
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Interventions:
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Resident_____ Room # _____ Physician _____

BASELINE/ADMISSION/WORKING PERSON CENTERED CARE PLAN

Date _______________ Initials ______

Actual/Potential Concern:

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Goal(s):

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Interventions:

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Date _______________ Initials ______

Actual/Potential Concern:

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Goal(s):

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Interventions:

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Date _______________ Initials ______

Actual/Potential Concern:

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Goal(s):

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Interventions:

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Date _______________ Initials ______

Actual/Potential Concern:

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Goal(s):

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Interventions:

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Date _______________ Initials ______

Actual/Potential Concern:

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Goal(s):

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Interventions:

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Date _______________ Initials ______

Actual/Potential Concern:

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Goal(s):

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Interventions:

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Resident_________________________________ Room # __________ Physician ________________________________

BASELINE/ADMISSION/WORKING PERSON CENTERED CARE PLAN

Date of Care Conference: _____

New & Pertinent Diagnoses Reviewed: _____

_____

Advanced Directives: _____ CPR Status: _____

Diet: _____ Weight: _____

Topic Discussed	Discussed With		Comments
	Resident	ResRep	
Diagnosis			
Cognitive			
Visual			
Communication			
ADL/Rehab			
Continence			
Mood/Behavior			
Activities			
Falls/Safety			
Nutrition			
Skin			
Pain			
Medication Issues			
Risk/Consequences			
Discharge Potential			
Special Requests			
Psychotropic Meds			

Summarize Discussion of Initial Care Conference

Attendees of Initial Care Conference			
Facility Staff	Title	Resident/Family	
		□ Understand □ Agree □ Disagree with plan	
		Signature	Relationship

Resident_____ Room # _____ Physician _____