PPG-00327

Resident Integrated Care Plan

Area	Personal Care Home and Transitional Care			
Section	Documentation			
Subsection	N/A			
Document Type	Policy			
Scope	All Personal Care Homes			
Approved By		**Original Effective Date**	**Revised Effective Date**	**Reviewed Date**
Glenda Short, Regional Lead Community & Continuing Care		2015-Mar-23	2023-Apr-05	2023-Apr-05

DEFINITIONS

Bedside Communication tool: used to communicate the Resident Care Plan to direct care providers at the bedside and is confidentially stored in the resident's room. Refers to the Activities of Daily Living (ADL) Guide (PMH483).

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

Lab Sheet: (PMH485) a tool to organize diagnostic tests for residents. It is a permanent part of the health record

Resident Integrated Care Plan: (PMH484) a comprehensive written plan of care developed by the interdisciplinary team with the resident and resident/alternate decision maker. The plan is based on the interdisciplinary assessment and guides the care provided to the resident.

Interdisciplinary team: Includes at minimum two health care disciplines. One discipline must be a Nurse (RN, LPN, or RPN) and the other a different discipline (e.g. Health Care Aide, Recreation, Therapy, etc.).

Nurse Leader: For the purposes of this policy, the Nurse Leader may be any one of the following: Care Team Manager, Client Care Coordinator or Clinical Resource Nurse.

POLICY

Within 24 hours of physical admission, the resident's basic care requirements are documented on the Resident Integrated Care Plan (ICP) (PMH484).

Within 8 weeks of admission, the resident's needs are assessed by an interdisciplinary team and a care plan is developed and documented on the ICP (PMH484) (LTC Care Conference, PPG-00916). All bolded tick boxes are to be completed within 8 weeks.

The ICP (PMH484) is regularly reviewed based on changes to clinical status and/or at least once every three months (90 days) by the interdisciplinary team.

The ICP (PMH484) is reviewed at least annually by all disciplines who provide direct care and services to the resident, including the resident and his/her alternate if possible (LTC Care Conference, PPG-00916).

The resident and/or their alternate have the opportunity to participate in the initial care plan, in the development of the ICP (PMH484) and in the annual care conference (LTC Care Conference, PPG-00916).

The ICP (PMH484) is communicated to direct care staff through the Activities of Daily Living (ADL) Guide (PMH483) and is updated when the ICP (PMH484) is updated so information is consistent.

The current ICP (PMH484) contains detailed and accurate information on all aspects of each residents' care needs as outlined by Personal Care Home Standards, Standard 7 – Integrated Care Plan.

Where necessary, individualized situations will include additional care planning and interventions. This may be necessary for residents who have communication, behavioral or other problems, resulting in engagement challenges for the resident with their care.

PROCEDURE

1. The ICP (PMH484) may be completed by any member of the health care team, responsible for care planning, and is reflective of the interdisciplinary team effort. The Nurse is primarily responsible for ensuring the care plan is clear, legible, current and complete.

2. Staff addressograph/label the ICP (PMH484) in the space provided on each page on all sides of the document.

3. Staff attach a current picture of the resident in the designated section of the care plan (page 1).

4. Staff document all information on the ICP (PMH484) in black/blue ink, completing each section, the ADL Guide (PMH483) is updated concurrently with the ICP:

    i. Within 24 hours of admission, the Nurse documents the resident's basic care requirements, including medication (see Medication Administration Record), treatments (Resident Treatment/Procedure Record, PMH1151), diet orders, assistance required with activities of daily living, allergies (Allergy and Alerts Record, PMH870) and safety and security risks. These areas have been shaded grey on the ICP (PMH484).
    ii. Within 8 weeks of admission, the interdisciplinary team assesses the resident's care needs and documents in the appropriate section of the care plan. This is done in conjunction with the resident's initial care conference, completed within 8 weeks of admission.
    iii. The ICP includes cues and tick boxes to assist staff:
    - Shaded sections are to be completed within 24 hours of admission
    - Bolded sections are to be completed within 8 weeks of admission
    - Tick boxes to provide direction on the level of assistance required (independent, cue, assist) must be completed.
    - If a tick box is not checked, it is considered 'not applicable' for the resident.

b. The resident's current medical diagnoses are to be documented in the space provided on the first page. The nurse is responsible to ensure the diagnosis list is kept current throughout the resident's admission.
   i. New diagnoses (acute or chronic) are to be written on the physician's order sheet and signed by the ordering practitioner. The order sheet is to be faxed to pharmacy so that it can be added to the MAR.
   ii. New diagnoses are to be added to the Resident Integrated Care Plan (PMH484).
   iii. Discontinued diagnoses are to be crossed out with a single line in red ink, highlighted in yellow, initialed and dated. Document the rationale in the Interdisciplinary Progress Notes (PMH877).
   iv. Diagnoses listed on the Resident Integrated Care Plan (PMH484), MAR and quarterly medication review forms are to be cross-referenced when the resident is transferred to/from another facility and at minimum, quarterly (PPG-01260, Care Transitions and Handovers).

c. To complete the Needs/Issues column on the ICP (PMH484), the writer dates and initials the Needs/Issues section, and checks the relevant care planning options in each section. The onset date may be used to identify areas in the Needs/Issues column that have been initiated on a date different from the section date. This date should be initialed.

d. Where applicable, the writer will utilize the ‘onset date’, ‘goals/outcomes’ and ‘interventions’ columns to develop individualized care planning. This section should be used when the general Needs/Issues section requires further explanation to guide care. These columns should also be utilized when the resident may be unable to contribute to ADL choice. This may be for residents who have communication, behavioral or other problems, resulting in engagement challenges for the resident with their care.

e. When appropriate, the writer completes the ‘onset date’, ‘goals/outcomes’ and ‘interventions’ columns (the interventions should be linear to the needs/issues and/or goals/outcomes column). The writer initials following the intervention added.
   Note: resident individualized care interventions and needs noted in the Interdisciplinary Progress Notes (PMH877) should be documented in the current care plan.

f. The goals identified at the resident’s care conference (8 week, annual, or other) and interventions to achieve those goals are to be documented in the relevant care planning section, where appropriate. (LTC Care Conference, PPG-00916).

5. The ICP (PMH484) is reviewed and updated at least once every 3 months (90 days) by the interdisciplinary team. The purpose of the quarterly review is to review the resident’s current needs based on their condition to ensure the care plan is current and accurate.
   a. The Nurse Leader or designate schedules the interdisciplinary quarterly review and informs all relevant disciplines of the date for the review. Three common approaches used to complete the quarterly care plan review are:
      1. Every Nurse is assigned resident(s) that they are responsible for completing all required steps (reviewing/completing documents) for the quarterly review.
      2. Each Nurse is assigned residents that they are responsible for completing the necessary documents review/completing/updating. The Nurse Leader or Nurse of the day completes the quarterly review on a scheduled day.
      3. The Nurse Leader is responsible for completing all required steps for the quarterly review.

      Note: If Recreation staff are unable to attend the interdisciplinary quarterly review, the Recreation staff are to complete their quarterly review assessments prior to the interdisciplinary quarterly care plan review (no more than 2 weeks prior). The interdisciplinary review team is to review the recreation quarterly review (in the Progress Notes, PMH877) and indicate same on the quarterly review form (PMH187).

b. Complete and discuss with an interdisciplinary team (indicate completion with a check mark next to the document name on the Interdisciplinary Quarterly Care Plan and Restraint Review form (PMH187):
   - Care Plan (PMH484) – review and update
   - Braden Scale for Predicting Pressure Ulcer Risk (PMH586) – complete
   - Violence Alert, if applicable (PMH502) – discuss potential deactivation or continued need
   - Falls Prevention and Management (PPG-00557) – discuss resident specific risk factors and interventions; review and update care plan.
   - Recreation Quarterly Review (PPG-00326) – complete at minimum 2 weeks prior to quarterly review; or participate in the quarterly review.
   - Restraints – review and ensure current for each restraint in use (document discussion: benefits, burdens, efforts to reduce restraints).
   - Bedside Communication Tool (ADL guide, PMH483) (PPG-01159) – review and update
   - Feeding and Swallowing Plan/TTMD-R for residents with feeding and swallowing difficulties. (PPG-00781)
   - Picture of Resident – reassess to determine that the photo reflects the resident's current physical appearance.

c. A brief summary of the care plan review, including outcomes and any new goals, is documented in the 'discussion/action' section of the Interdisciplinary Quarterly Care Plan and Restraints Review form (PMH187). Additional documentation from the quarterly review can be documented in the progress note, if necessary, and is indicated by an asterisk (*) on the Interdisciplinary Quarterly Care Plan and Restraints Review form (PMH187). Document any new care needs and goals to the ICP (PMH484).

d. The participating members of the interdisciplinary team sign (including their designation) the Interdisciplinary Quarterly Care Plan and Restraints Review form (PMH187). The Nurse Leader or designate signs the bottom section of the form (signature). Need at minimum, two different health care disciplines, one which must be a Nurse.

6. A care conference is held at least annually (LTC Care Conference, PPG-00916). The ICP (PMH484) is reviewed and updated by the interdisciplinary team. The Care Conference goals are documented in the goal section of the ICP (PMH484).

7. Information on the ICP (PMH484) which is no longer applicable or relevant, should be crossed out using a single line in red ink through the item, highlight in yellow and provide date and initials. Rationale for discontinuation is required in the Interdisciplinary Progress Notes (PMH877).

8. When a section of the ICP (PMH484) is full:
   a. When it is identified by a team member, the need to recopy the care plan is communicated to the Nurse. The Nurse is then responsible for recopying the information onto a new page.
   b. The writer dates and initials on the space provided on the top of the page (left side) of the ICP. It is not necessary to recopy an entire care plan if only one page requires recopying. The entire double-sided page of the ICP (in need of recopying) will need to be recopied. If the first two pages are to be recopied, the writer indicates by the checkbox on page 1, that it is being recopied.
   c. If there are no changes in a section, the original date of implementation remains the same, and the writer documents this original date in the onset date or Needs/Issues column. The writer does not copy other staff members' initials, nor do they initial if they are recopying with no changes. Recopy all current data in this section as it appears without initials.
   d. If a change is made in the Needs/Issues or Intervention section while recopying, the writer documents the new implementation date and initials in the appropriate section of the care plan.

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e. If a change is made while recopying the care plan for the goals and/or interventions columns, a new date and initials is applied to the onset date column.
f. The old form is retained on the resident's health record (Clinical Documentation Standards, Appendix F, PPG-00206).

9. Lab diagnostic tests are documented on the Lab Sheet (PMH485). This sheet is a permanent part of the health record.
   a. Staff addressograph both sides of the Lab Sheet, and provide the same year for both sides of the Lab Sheet.
   b. The Nurse taking the lab order transcribes the order onto the Lab Sheet (PMH485).
   c. The date the lab is due is documented across the top row of the Lab Sheet. This is applicable for both standing lab diagnostic orders (PMHMSO.029) and new lab orders written in the physician orders.
   d. The Nurse taking the order should create a lab requisition at the time the order is transcribed, unless another site process is in place. Requisitions for labs ordered more than 3 weeks in advance are to be completed closer to the due date, following a site level process.
   f. When the results are received, the Nurse updates the Lab Sheet (PMH485). The Nurse initials the Lab Sheet in the appropriate section to indicate lab completion. Site level process should be utilized for lab results requiring follow up, based on best practice. For example, urgent results will be followed up on at the time of lab receipt.
   g. The Lab sheet is double sided; both sides are to be used for one year. A new Lab Sheet is to be initiated at the beginning of each calendar year. Labs still pending into the New Year will be transcribed onto the New Year's Lab Sheet, with the date the lab is due and identify labs required in applicable column.

10. When a resident is discharged/deceased or when the ADL Guide (PMH483) is full/no longer able to be updated clearly, it is placed in confidential shredding.

11. When pages of the ICP (PMH484) and/or Lab Sheet (PMH485) are full, staff file them in the appropriate section of the health record (Clinical Documentation Standards, PPG-00206).

12. Annually and more frequently, if indicated or required, the Nurse Leader:
   a. Completes a Care Plan Audit (PMH604) on 10% of residents, or a minimum of 5 residents
   b. Summarizes the results of the audit on the Care Plan Audit (PMH604). This includes areas identified as needing improvement, action plan for improvement, communication of results and follow-up required.
   c. If the results of any component of the Care Plan Audit (PMH604) are less than 100%, further follow-up is required to ensure improvement. The action plan on the Care Plan Audit (PMH604) outlines the improvement plan. The Nurse Leader completes the recommendations and actions identified on the Care Plan Audit (PMH604). After an appropriate time frame, but no more than 6 months, the Nurse Leader completes another audit on 10% of residents (or a minimum of 5 residents), for those components only.
   d. Forwards the Care Plan Audit (PMH604) to the Care Team Manager, who forwards the data to the Standards & Projects Facilitators.
   e. The Nurse Leader will report the Care Plan Audit (PMH604) to nursing team members.
   f. The Standards & Projects Facilitators develop an annual report on care plan documentation. This information is reviewed at appropriate meetings.

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RELATED MATERIAL

PMH187, Interdisciplinary Quarterly Care Plan and Restraint Review Form
PMH483, Activities of Daily Living
PMH484, Resident Integrated Care Plan
PMH485, Lab Sheet
PMH502, Violence Screening Tool
PMH586, Braden Scale for Predicting Pressure Ulcer Risk
PMH604, Care Plan Audit
PMH870, Allergy and Alerts Record
PMH877, Interdisciplinary Progress Notes
PMH1151, Resident Treatment/Procedure Record
PPG-00016, Client Identification
PPG-00112, Wound Prevention & Management Pressure Ulcer Prevention & Treatment
PPG-00206 Clinical Documentation Standards (Thinning guidelines, Appendix F)
PPG-00324, Least Restraints in Long Term Care
PPG-00326, Recreation/Activities Documentation
PPG-00557, Falls Prevention and Management
PPG-00781 Feeding and Swallowing Management (PCH and Transitional Care)
PPG-00789, Resident Treatment/Procedure Record
PPG-00916, LTC Care Conference
PPG-01159, Bedside Communication Tool
PPG-01260, Care Transitions and Handovers
PPG-01339, Allergy and Alerts
Resident Integrated Care Plan and Quarterly Review Handout
Sample of Resident Integrated Care Plan (PMH484) - completed
Sample Lab Sheet (PMH485) - completed

REFERENCES

PCH Standards 7 – Integrated Care Plan – Personal Care Home Standards Regulations

DOCUMENT HISTORY

Version	Changes
2015-Mar-23	New.
2015-Nov-25	Revised. Compare to previous version for details.
2018-May-23	Revised. Policy updated to reflect the new PMH care plan and policies.
2018-Jun-20	Revised. Policy updated to include clarity with Lab Sheet use and wording clarity plus include promotion of Feeding and Swallowing Management policy.
2019-Aug-21	Revised. Changed wording for procedure #12 – any component of the audit that scores less than 100% requires follow-up. Combined the audit and summary form (PMH604 and PMH605). Revised the Care Plan Audit summary section to reflect the procedure change.
2019-Dec-18	Revised. Changed definition of 'interdisciplinary team', revised/added to list of documents to review for the quarterly review (5,3, b), changed wording for 8a.
2020-Jun-17	Revised. Added 4b – direction on documenting diagnosis.
2023-Apr-05	Revised. Updated to align with revised Bedside Communication Tool PPG-01159. Updated Alternate Decision Maker definition.

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