# FOLTSBROOK ADULT DAY HEALTH CARE
## INTERDISCIPLINARY PERSON-CENTERED CARE PLAN POLICY

**Policy**

It is the policy of FoltsBrook Adult Day Health Services (ADHS) that each registrant will have a written Person-Centered Care Plan developed, jointly with the registrant and/or authorized representative, and will be updated semi-annually, as needed and/or requested by the registrant. It will be written in plain language. The Program RN or designated staff member will ensure the completion of the Interdisciplinary Person-Centered Care Plan, with the participation of consultants in the medical, social, paramedical and related fields as appropriate.

The care plan will include:

1. Medical and Nursing goals, along with strengths and limitations anticipated for each registrant, and, as appropriate, the nutritional, social, rehabilitative and activity goals and limitations.
2. Registrant's potential to remain in the community.
3. Transfer or discharge plan when applicable.

Development and modification of the care plan is coordinated with the registrant, informal supports, consultants, healthcare providers, inside and outside the ADHC program who are involved in or with the registrant's care.

The Program RN or designated staff member and/or the Interdisciplinary Team members in the medical, social, paramedical and related fields, as appropriate, shall:

1. Record changes in the Registrant's status which require alterations in the registrant's plan of care.
2. Modify/Update the registrant's plan of care as necessary.
3. Review the registrant's plan of care at least twice (2) a year.

**Procedure**:

1. The initial plan of care will be completed within the first five (5) visits to the program or within thirty (30) days after admission to the Adult Day Health Care program. The Program RN or designated staff member will ensure the completion of the Interdisciplinary Person-Centered Care Plan, with the participation of consultants in the medical, social, paramedical and related fields as appropriate.
2. The ADHC Program RN or designated staff member shall schedule a care plan meeting when applicable.
    - During the care plan meeting, each discipline will share and discuss the developed care plan and address any concerns.
    - Each discipline will date and sign the attendance section/care plan review record which will become part of the care plan and kept in the registrant's medical chart.
3. A Person-Centered Care Plan will be developed:
    - Identifying Registrants goals and desired outcomes.
    - Staff interventions to facilitate goal outcomes.
4. Modifications may be made to the Person-Centered Care Plan, as necessary.
5. The Program RN or designated staff member will prepare suggested orders for the registrant based on the care plan and send these to the Primary Care Provider (PCP) for approval, signature and additional suggestions as indicated. The signed orders will be returned, implemented, and placed in the registrant's chart.
6. If a Registrant's request/goal cannot be met:

- Discussion with the appropriate disciplines will take place to evaluate and develop appropriate plan of action.
- The plan of action will be then discussed with registrant and/or authorized representative with an agreed upon time frame. If accepted, the plan of action will be implemented. If not, alternate approaches will need to be explored.
- All details will be charted in the Medical Record.

7. The Program RN or designated staff member will track concerns, patterns, or trends related to meeting Person-Centered goals, as well as concerns, recurrences, patterns of goals not able to be met.

**Procedure for Plan of Care Review:**

After completion of the initial interdisciplinary person-centered care plan, each registrant's care plan will be reviewed at least every six (6) months. At the same time, each registrant will be evaluated for continued stay and the continued stay form will be completed. (see policy: Continued Stay Form) Then as appropriate, each discipline shall:

1. Reassess the registrant, review the existing Person-Centered Care Plan, make the appropriate updates and note complications, progress, achievement of goals and ongoing status.
2. A new Person-Centered Care Plan will be written for each new problem, or an existing problem will be updated and/or revised.
3. If problems have been resolved and goals achieved this will be noted in an outcome column of the current Person-Centered Care Plan.
4. Plans will be modified or added to as necessary.
5. Each discipline will sign the care plan review record.
6. The Program Director or designated staff member will complete a new continued stay form.
7. The Program Director or designated staff member will complete the Physician's order renewal and send to attending for review, approval and signature. When Physician's order form is returned to the ADHC Program Director or designated staff member will review form for changes and initiate any new orders and care plan revisions.

**Attachments:**

- Interdisciplinary care plan review record.
- Continued stay form.
- Blank care plan.

Alyssa Fibres RN
Program Director's Signature

7/20/21
Date

Mark T. Foulis
Administrator's Signature

7/20/21
Date