

Care Conference Care Plan Summary

The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. Baseline care plans are required to address, at a minimum, the following:

- Initial goals based on admission orders
- Physician orders
- Dietary orders
- Therapy services
- Social services
- PASARR recommendation, if applicable

Care Conference Summary as shown below will provide this detail.

01/19/2023

We are so grateful to have this opportunity to care for your loved one. In this short period of time we have learned that Sunny enjoys life's simple pleasures and has demonstrated the following strengths:
Sunny has always been independent and would like to return home to be caregiver for spouse

We would like to take this opportunity to share with you a summary of goals or ways that we plan to assist Sunny in maintaining their highest level of independence, promote comfort, and assist with their healing process. The Summary of goals are as follows:
Rehab Potential: STG to ambulate 50 feet, LTG to return home with FWW independently
Discharge Planning: 6 weeks PT,OT
Long Range Goal: Improve in all ADLS to supervision assist only
Short Range Goal: Maintain active with all ADLS, strive for independence
Self Medication Administration: Resident is not a candidate for self administration of medications

Sunny has the following Physician, Nursing, and Therapy Orders in place:
CPR
-; DIET: No concentrated sweets; No added salt; Regular Consistency; Thin Liquids
Acetaminophen 325 mg tablet [generic]
Milk of Magnesia 400 mg/5 mL oral suspension [Magnesium hydroxide]
Dulcolax (bisacodyl) 10 mg rectal suppository [Bisacodyl]
Fleet Enema 19 gram-7 gram/118 mL [Sodium phosphates]

We currently have the following Advanced Directives in place for Sunny:
Resuscitate:
Resuscitate Level: CPR
Healthcare Proxy: Yes
Living Will: Yes
Hospitalize:

Once again we would like to thank you for entrusting the care of your loved one with us. If you have any questions, comments, or concerns please feel free to contact us.

Thank you,
Jennifer Narewski RN

Triggering Initial CarePlan on Admission and Linking an Approach to POC

The Care Plan approaches in the Care Plan Master can be linked to the Resident ADL/Daily Care List (Resident Care Guide and/or other ADLs). When the resident care plan is updated and the approach with the POC Link is updated based on the resident's care needs, the approach is automatically updated in the ADLs and can be viewed for additional guidance when providing daily charting.

1. Choose the **Care Plan Category**.
2. Select the Approach(es) and click on the POC Link in the Daily Charting for Approach.
3. Click **+Add New** to add the approach to the POC item(s).

The screenshot displays the 'Care Plan Master - Outline View' interface. On the left, a navigation pane shows categories: '3 Visual Function/Visual Problem', '4 Communication - Hearing/Recept', and '5 ADLs/Functional Status/Rehab'. The main area shows a 'Problem' (1) and a 'Goal' (1). Below these are several 'Approach' items (1-9) with detailed descriptions and device requirements. A 'POC Links' dialog box is open, showing a table with columns 'Category', 'Group #', 'Item #', and 'Description'. The table contains two entries: (1, 1, 4) 'Resident Care Guide Transfer/Ambulation/Mobility' and (2, 1, 1) 'BED MOBILITY Self performance'. The dialog has '+Add New', 'Ok', 'Cancel', and 'Help' buttons.

Category	Group #	Item #	Description
1	1	4	Resident Care Guide Transfer/Ambulation/Mobility
2	1	1	BED MOBILITY Self performance