Clinical Care Plan Detail-

PointClickCare Home Admin Clinical

Logout | Help | April 27, 2015

Residents
Dashboard
Quick Entry
Weights and Vitals
MDS Management Portal
UDA
Orders
Communications
Reports
PCC Sharepoint
Logout
Help
Resource Center / Support

Resident Search
by: Last Name
Go
Search all Facilities

Care Plan Detail

Resident
Triggered Care Plan Items: 0

Sort By:
Show Resolved/Cancelled:
Show Symbol Legend

All | Activities/Recreation | Food and Nutrition | Medical | Nursing | Social Services

New Focus | New Custom Focus | Printable View | Back | Care Plan PN | New Alert | Jump to MDS

prev | 1 2 3 4 | next

Focus	Goals	Interventions
	New Custom Goal	New Custom Intervention
edit pn Potential for pain related to Dx of MS and migraine HA + !!	edit pn Resident will be free from s/s of pain such as facial grimacing, moaning and/or crying !!	edit pn Administer pain medication as per MD orders and note the effectiveness. Notify MD if pain is not reduced. [Nrsg] !! edit pn Assist resident to repostion for comfort as needed. [Nrsg] !! edit pn Document/report complaints and nonverbal signs of pain. [Nrsg] !! edit pn Encourage resident to communicate presence of pain. [Nrsg] !! edit pn Give PRN medication for breakthrough pain as per MD orders and note the effectiveness. Notify MD if pain is not reduced. [Nrsg] !! edit pn Monitor pain on scale or 0-10. [Nrsg] !! edit pn Observe for potential side effects of medication such as: constipation, decline in function, sedation, or appetite suppression. [Nrsg] !! edit pn Position with pillows as needed for comfort. [Nrsg] !!
	New Goal New Custom Goal	New Intervention New Custom Intervention
edit pn While in the facility, Joycelyn indicates that it is important that she/he has the opportunity to engage in activities that are meaningful. + !!	edit pn Joycelyn will indicate that staff has taken the necessary actions to accommodate her/his routines and preferences by indicating s/he is satisfied with the activities in which s/he is engaged. + !!	edit pn Patient/resident has stated it is important to be around animals. Staff will bring dogs around to visit with her. [REC,NA,Nrsg] + !! K
	New Goal New Custom Goal	New Intervention New Custom Intervention
edit pn Resident is at risk for and/or exhibits symptoms of delirium due to: declining BIMS score + !!	edit pn Resident will be free of signs/symptoms of delirium with no unexplained or rapid changes in mental status, mood, and behavior or communication ability throughout review x90 days. + !! edit pn Resident will be absent of unexplained or rapid emotional/personality changes throughout review x90 days. + !! edit pn Resident will consistently retain current level of motor activity throughout review x90 days. + !!	edit pn Always approach the resident calmly and unhurriedly [All] + !! edit pn Attempt to refocus behavior to something positive when the resident is delusional [All] + !! edit pn Encourage activities of the resident's choice and preference [Act,Act] + !! edit pn Encourage resident to express feelings or fears and provide support [All] + !! edit pn Listen attentively. [All] + !!
	New Goal New Custom Goal	New Intervention New Custom Intervention
edit pn Joycelyn is at nutritional risk: r/t altered nutrient metabolism as evidenced by dx: DM2 and AIC >8.0. Has chronic wound on her coccyx. + !!	edit pn Joycelyn will consume 100% of at least 3 meals q day x 90days. + !! edit pn Joycelyn will increase calorie/protein intake to meet 100% of estimated needs in the next 90 days. + !!	edit pn Dislikes all pepper, bell peppers, chili. Dislikes will be noted in electronic dietary kardex. [F&N] !! edit pn Dislikes will print on dietary meal tickets. [F&N] !! edit pn Milk all meals. [F&N] + !! edit pn Weigh per center protocol alert dietitian and physician to any significant loss or gain [LcNrs,NA] !! edit pn Monitor for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicated [LcNrs,NA] !! edit pn Monitor intake at all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake [F&N,Nrsg] !! edit pn Provide diet as ordered [F&N,Nrsg] !! K

prev | 1 2 3 4 | next

New Focus | New Custom Focus | Printable View | Back | Care Plan PN | New Alert | Jump to MDS

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IV. THE TRANSITION FROM THE ASSESSMENT TO THE CARE PLAN

A. Problem: a situation that presents difficulty which requires corrective change. May be primary in nature (interfering with physical function) or secondary (unpleasant).

B. Needs: very much like a secondary problem – there is a definite lack of something that is wanted or deemed necessary. And can, for the most part, be met through the activity program.

C. Look at which problems or needs are appropriate for activity intervention. Some problems have no solutions. Some needs can't be met and some problems/needs can't be addressed by the activity department.

D. Problems/Needs will be stated accurately and as descriptions of behavior. Use both objective and subjective statements. Don't use labels or list the diagnoses. State them from the viewpoint of the resident. Prioritize the problems/needs.

E. Goal: a desired result, outcome, or purpose toward which the resident is working.

F. The goal is determined with the resident. It is time limited (3 months), MEASUREABLE, reasonable for the resident to accomplish, and stated in positive terms. The staff must be able to monitor the goal.

G. Plan/Approaches: an idea of how to assist the resident in accomplishing the goal.

H. The plan is to be comprehensive and include all aspects of the resident's daily routine that the activity staff can interact with. Always include an approach that specifically addresses the goal. If the plan is effective then the resident will be able to meet his goal. The staff must be able to follow through with the entries in the plan/approaches

I. Care plans will be truly interdisciplinary under the OBRA regulations so all disciplines may be responsible for a number of problems.

J. You will attend Resident (Patient) Care Plan Meetings.

K. Care Plans change as the resident progresses or regresses. They can be changed at any time.

WRITING EFFECTIVE CARE PLANS

- Three areas to consider in writing a specific Care Plan

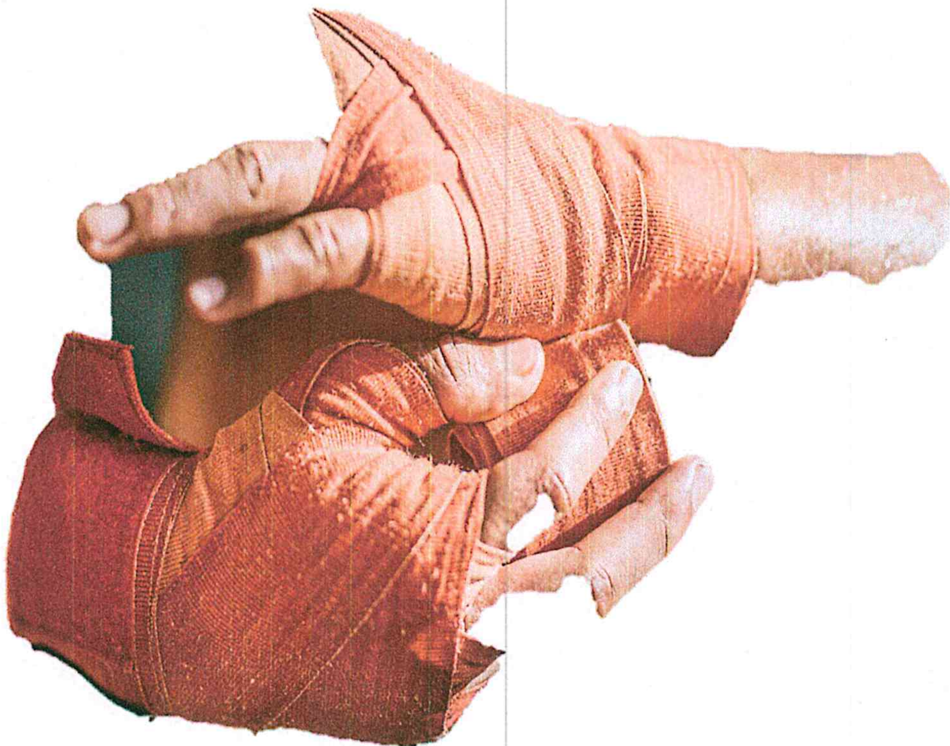
1. Problem/Need/Strength
2. Goal – Goals always begin with; Resident Will__________________
3. Approaches – What the staff will do to help the resident achieve the goal.,

In other words, the resident will do something that you can clearly see, track, hear, measure in order to meet the goal (keep the goal simple, concise, and only one goal to one problem)

GOALS/APPROACHES

- R – Resident Oriented
- A – Achievable
- M – Measurable
- B – Behavioral
- O – Outcome

- S – Staff
- A – Assist
- M - Method



FEDERAL REGULATIONS

Section 483.20 of the federal regulations set the guidelines for comprehensive care plans.

1. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical nursing and mental and psychosocial needs that are identified in the comprehensive assessment…
2. A comprehensive care plan must be –

- Developed within 7 days after the completion of the comprehensive assessment
- Prepared by an interdisciplinary team
- Periodically reviewed and revised by a team of qualified persons after each assessment.

CARE PLAN GOAL SETTING

A comprehensive care plan is an essential tool for delivery of quality care and achievement of positive outcome of care. The clinical record system hinges on this document. If all resident needs are identified and addressed with realistic and specific, individualized goals stated, the follow through with interventions leads to the desired outcome.

Unmet needs or unidentified problems and/or strengths can lead to a decline in the resident's condition.

Utilizing the information gathered in the assessments, (Activity, MDS, CAA's) an activity plan is written and is part of the Resident Care Plan

THE CARE PLAN CONTAINS

The Care Plan Contains

- Identification of the resident’s problem/strength/need
- Goal
- Times in which to attain the goal (every 3 months, date)
- Interventions/approaches
- Assignment of staff’s responsibility for implementation of the plan.
- All residents will have a need for an activity care plan or intervention by the AD. By the very fact that they are now a resident living in your nursing facility, and they can no longer satisfy their need for a diversional or recreational activity.

RESIDENT CARE PLANS

- A care plan problem/strength/need should be resident oriented, specific, and individualized.
- A care plan goal is what action should be accomplished by the resident. (What the resident will do, what action, in what activity, and how often/times)
- A care plan intervention/approach is how the staff will go about to ensure the resident achieves the goal.
- **All Care Plans should be**
- Specific-Measurable-Realistic-Observable-Individualized, most important...........**Resident Orientated.**

STEER CLEAR OF THE FOLLOWING PHRASES

Maintain present participation, Provide mental stimulation, Promote outlets for creative abilities, Encourage more active participation, Increase confidence and self esteem, Enhance adjustment to environment.

These phrases for goal statements because they imply staff, not resident action and goals are too vague and general.

There is a great demand for a list of goal statements from which to choose. It is not only difficult to design such a list, but also is not desirable. Since a previously stated criteria for goals is, they must be individualized. It is too tempting to simply pick one from a list if it were available.

- **Maintain** – it does not allow for growth, and that's what goals are all about.

A LIST OF VERBS THAT CAN BE USED TO REFER TO RESIDENT'S ACTIONS.

Display, repeat, exhibit, remain, verbalize, name, identify, respond, distinguish, demonstrate, choose, prepare, plan, select, apply, describe, recognize, locate, use, express, decide, recall, discuss.

When writing a goal remember, ask yourself

"What do I want the resident to do?" What action, how often, in what activity, can I track it?

INTERDISCIPLINARY TEAM

- **The care developed with the input from the interdisciplinary team.**

The AD is an integral part. Activity planning is a universal need for residents. Residents experience an activity deficit when hospitalized because they can no longer pursue their usual recreational activities and diversions as they did when they lived in their community.

Before you write a RCP, check with the other disciplines on your team.

If the problem/need/strength is already identified, you can either tag onto their RCP with a goal and/or approaches. Generally, the rule is, if you have identified a specific problem from the MDS, to the CAA sheet and have triggered a need to care plan, then you must identify the problem/need/strength on that specific resident.

GUIDELINES AND RULES FOR INTERDISCIPLINARY CARE PLANNING

Purposes/Goals

1. To Establish mutually agreed upon resident goals for treatment.
2. To determine effective individualized approaches/interventions and to assign the discipline responsible for carrying them out.
3. To evaluate progress or lack of progress to earlier goals and to revise the problem, goal or approaches as indicated

Members

Resident
Resident's family
Nursing (Licensed, CAN)
Social Services
Activities
Dietary Director
Rehabilitation (PT,OT,ST)
Restorative

Meeting

Care Planning meetings are conducted once or twice weekly for one hour to complete plans on newly admitted residents and to review progress of all residents on a quarterly basis. It is also appropriate to review residents who have experienced major condition changes resulting in the need for significant revisions of the plan.

Meeting Rules

1. Each participant must be prepared prior to the meeting i.e. assessment completed, problems and/or potential problems identified and suggested goals established.
2. The resident and family/significant others must be present if at all possible.
3. No gossip or "war stories" permitted
4. Start on time and end on time
5. Allow no interruptions
6. Establish a schedule and assign times for each resident (New resident ½ hour to 45 minutes, quarterly resident 20 minutes)
7. Include only those involved in each resident's care in that portion of the meeting allocated to that particular resident.
8. Create a positive, relaxed environment for the meeting
9. Remember each resident deserves you undivided attention for the length of time required to plan their care.

REMEMBER.....

- A Care Plan can be activity based by a group, in-room, 1:1, or self-directed (independent).
- Residents must have at least 3 contacts (group, family, 1:1, self-directed, family) per week.
- You can not be all things to all people all the time.

IF YOU HAVE NOT DOCUMENTED, WRITTEN THINGS DOWN, IT NEVER HAPPENED.

SAMPLE "RESIDENT CARE PLAN" GUIDELINE

FYI:

If a resident doesn't want to attend ACT programs that is acceptable as long as the resident is self-directed within room and has their own chosen daily routine. This must be clearly stated on assessment and program notes.

If this is not the case, then develop with the resident an individual self-directed and/or activity staff provides a 3x a week individual program per identified need, strength and interest.

SAMPLE:

Resident will do specific task or attend and/or participate in (identify specific program based on level of function)____ ___________________________ doing what action________________________________ how many times______________________ on an indep, with cueing or supervisory basis. End with for 3 months or by 3 months (put the date)___________________.

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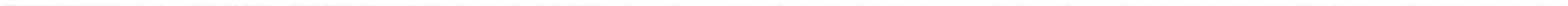
7-STEP ACTIVITY CARE PLAN GUIDE

[P]roblem Description, Concern, Need or Strength (For the RESIDENT)	Goal/Objective (What the RESIDENT will do)	Approach/Interventions (What the STAFF will do)
1. "Resident ______________." **DESCRIBE** what about the Resident do you feel will most affect their activity participation? ... What might interfere with their fullest possible social, physical or emotional functioning? Consider their: physical limitations, mental awareness, motivations, behaviors, communication, socialization. 2. **ASSESS** what does the Resident seem to need in general terms concerning activities? *(Use as pertinent Resident quotes.)* ### DOUBLE CHECKS ### • Review with the other disciplines their PCP entries and coordinate together on cross-over problems and needs OR • Review existing PCP entries and add any relevant activity interventions.	2. "Resident will ______________ ... a. Do what or respond how IN ______________ b. What type of activity ______________ c. How often ______________ d. By when 3. a. Do what or respond how: Use specific action verbs, describe observable behaviors. Include as possible to what duration (how long will they keep doing it? 15 minutes?) b. In what type of activity: Group, small groups, visit programs, self-directed activities, one-to-one. c. How often: At a minimum, total activity contacts/participation should be ___ times a week minimum (based on current trends). d. By when: Use a date (e.g., 6/8/2000) usually 3 months away (or enter date into review date). ### DOUBLE CHECKS ### Is the goal: • Reasonable to abilities? • Understandable to all staff? • Measurable on attendance logs? • Behavioral–can you watch it happen? • Achievable–can it be done?	4. Use descriptive verbs, as they apply to helping Resident attain goal. "Invite (encourage, assist, remind ...) Resident to activities of interest, target ..." (List all of the group activities this Resident may be interested in based on your assessment.) 5. "Provide activity visit programs for ..." (list all types or content of one-to-one visits based on assessment). 6. Include any and all adaptations or special approaches that apply to encouraging this Resident's active or responsive involvement. Consider physical limitations, Resident comfort and moods and personable schedule, attention span, promoting their fullest participation in group settings, etc. 7. "Refer also to PCP #'s __________." Cross-reference as need. ### DOUBLE CHECKS ### • You are accountable for your approaches. Don't set out to do what you can't deliver in 1 to 2 days. • All Resident's past and present interests need to be provided for unless discussed in assessment. • There must be "follow-across," a topic in approaches must coordinate with the topic in problem column.



Activity Care Samples

NEEDS	GOALS	APPROACHES
1. Sensory Stimulation- Special Activity Material	Manipulate special activity material for 15 minutes twice a week. Review in 3 months.	Staff will provide special activity material in small groups. Block, puzzles, plastic objects. Document responses.
2. Supportive reminder and instruction during activity participation.	Resident will continue activity with instruction and reminders during activity participation as needed. Review in 3 months.	1.Staff will remind as to task, sequence and progress. 2. Reward and acknowledge resident's success and accomplishment 3.Document response.
3. Spiritual involvement	Resident will join religious activities of choice. Review in 3 months – on going	1.Staff will inform resident of religious services and programs. 2. Provide religious material
4. Social interaction limited to selected resident and/or volunteer – intellectual stimulation	Resident to establish social contacts with peer residents. 1:1 volunteer twice a week. Review in 3 months	1. Assist with identification of resident volunteer with introductions based on interest 2. Provide 1:1 3. Provide book cart once a week.
5. Transportation to and from activities due to medical condition	Resident will be provided transportation daily to and from activities. On-going 3-month review.	Activity nursing volunteer staff will provide daily transportation to and from activity of choice.
6. Leadership – self-government.	Assume leadership role in resident council activities. Review in 3 months.	1.Invite resident to the resident council. 2. Encourage participation. 3. Acknowledgement progress results.
7. Exploration of activity pursuits.	Resident will participate in a variety of activities to discover activity interests. 3 activities per week, 15 minute participation. 3 month review	1.Staff will inform of activities 2. Provide literature and information on activities. 3. Acknowledge and encourage
8. Resident interaction for friendship and social exchange	Resident will join 2 activity groups each week and establish 3 friends. Review in 3 moths.	1. Encourage activity participation in social exchange with peer group. 1)coffee socials 2) discuss progress with resident.

Activity Care Plan

Name: [redacted] Date

Problem/Behavior/Need/Strength	Goal	Start Date	Target Date	Intervention	Responsible Discipline
[redacted] engages in preferred activities routinely. Preferred activities include Bingo, TV, Movies, group games, coloring and going outdoors to smoke although her out of bed time is limited for wound care management.	[redacted] will engage in preferred activities daily by next review period.		3 month Review	• Will provide monthly calendar of activities. • Will invite and encourage attending preferred group activities when able to be out of bed. • Will offer praise and positive feedback when participating in group activities. • Will encourage and praise independence and autonomy. • Will encourage compliance with wound care interventions. • Will offer/provide supplies for independent activities while in bed i.e. coloring sheets and utensils.	Activities,

COPY

Care pl[hole-punched]veloped by Laura Nicholson A.D.

FACILITY

CARE PLAN

PROBLEM NO.	DATE	PROBLEMS & STRENGTHS	GOALS	EVALUATION DATE	APPROACH	TIME CODE	DISCIPLINE	Y/N	GOAL ANALYSIS
4	MM/DD/YY	Modified (I) c̄ decisions Requires some supportive cues in new situations R/T dx of schizophrenia easily annoyed Very sociable with others at times	Resident will agree to actively participate in social related acts QD s̄ becomming annoyed with situations over next 90 days Resident will actively participate in interest related acts of choice QD. s̄ becomming annoyed c̄ situations over next 90 days		1) Provide Res c̄ calendar & invite to all interest related acts ie music, socials, parties, creative, exercise, recreational, parties 2) allow her to (I) select which acts she prefers to attend 3) Prompt verbal + physical partic-ipation as needed 4) If she becomes annoyed c̄ situations calmly re-direct discuss c̄ Res. interventions to help resolve issues 5) Follow thru c̄ suggestions 6) Acknowledge appropriate behavior + not acting on negative issues		ACT N SS D ACT N SS ACT ACT SS ACT SS N ACT N SS		

DATE OF PRINT	PATIENT	MEDICAL RECORD NO.	ADMISSION DATE	STATION	ROOM	BED	AGE	DATE OF BIRTH	SEX	LOC/CM	PAGE of
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ATTENDANCE/PARTICIPATION SHEETS

- Attendance is kept for each activity on each resident.
- The attendance sheets are to be kept for 10 years.
- Use a form which is most convenient for you
- Use to analyze/track/monitor effectiveness of the program and the RCP.
- Must be accurate.
- Must identify current interest related activities.
- Document the resident’s level of participation for each activity, or if the resident refused, or unavailable for current interest activity.
- Keep up daily and DO NOT back date at any time.

ACTIVITY PARTICIPATION RECORD

Activity Plan: ____

____

____

____

____

Circled Code Indicates Individual Programming					
	I = Independent	S = Supervision	M = Moderate Assist	D = Total Dependent	0 = Observer
	P = Passiv, env. stim	R = Refused	✓ = Resident Contact	U = Unavailable	

Start Date: ___/___/___ mo da yr	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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LAST NAME	FIRST NAME	INIT.	ADMIT DATE	ATTENDING MD	ROOM #	RESIDE

Month: ______	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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COMMENTS: ____

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LAST NAME	FIRST NAME	INIT.		ATTENDING MD	ROOM #	RESIDENT #

PROGRESS NOTE AGENDA CHECKLIST

- Has Resident achieved the goal?
- Review the RCP and give an updated status. Start with – 1st column (i.e., problem/need/strength) please include strengths when possible as this is an excellent baseline to enhance achievement and progress.
- Give the status of each approach – keep in mind the approaches should reflect assessment data.
- Physical assessment with limitations/strengths – what is the current status.
- Social Service information with ethical/cultural, family, friends – do they go out of the facility, does family visit.
- Cautions (i.e., behavioral, safety factors) – what is the status.

PROGRESS NOTES CONTINUED

- Other activity related problems/needs (i.e., rehab programs, community programs, self directed, 1:1, room programs.)
- Interest and needs related programs – you do not need to list all attended programs but indicate significant programs with participation and do they need cueing, set up, supervision, or are they at an independent level. Identify new programs of interest when needed.
- Any other significant changes/achievements.
- If resident is in need of a "New Goal" what role did other resident play and identify new goal with see, RCP#.
- Sign and date.
- Do Not keep carrying a goal over and over.
- If they have not reached the goal within 6 months, **revise**.

ACTIVITY PROGRESS NOTES EXAMPLES:

Quarterly Progress Note

Tom is alert and aware of people and things around him. He has occasional periods of confusion that seem to occur in the early morning. Current goal is: Tom will remain in activity programs of interest, bingo and skipbo, for 5 minutes 3 times per week by 6/6/99. In the past quarter, Tom has attended and actively participated in Bingo 2 X's weekly for 15 minutes, checkers 4 X's weekly for 5 minutes, and the monthly birthday party for 20+ minutes. He refuses to attend the weekly Skipbo group. (This activity is currently offered in the morning). He appears to enjoy the birthday party as he sits with other male residents and will stay for the entire party. Tom told the activity assistant that he enjoys "parties". Tom stated that he would like something to do in the evening hours.

Since Tom is meeting his current goal, the current care plan has been revised to the following: Tom will choose one activity of interest per day and will participate in each activity as evidenced by staying in the activity for the entire time. Approaches: 1) The activity staff will provide the resident with a monthly activity calendar 2) The activity staff will assist the resident in selecting the daily activity 3) The activity staff and nursing will remind the resident of the activities chosen prior to there start time 4) The nursing staff will escort, if necessary, Tom to the activities of choice 5) The activity staff and volunteers will verbally encourage Tom to remain in the activity for the entire time 6) Verbally praise Tom for attending the activities of choice 7) The activity staff will identify Tom's interests for evening activities 8) The activity staff will provide Tom with supplies for evening activity interests 9) The evening nursing staff will remind Tom about evening activities and make sure that Tom has his supplies, cards, video tapes, sanding blocks and paper. **SIGNATURE, TITLE,** ______________________________

Quarterly Progress Note

Gloria is alert and oriented to people only. She stays in her bed due to physician's orders and her diagnosis of MS. Gloria's weak physically but enjoys visitors. Gloria's family visits once a week on Sunday afternoon. She has received one-to-one visits 3 x's per week in the past quarter. During the one-to-one visits, she enjoys conversing about the soap opera "General Hospital" and "ER" and expresses interest in quilting. The activity staff contacted a volunteer at the local quilting club and she brings quilts and other projects in for Gloria to look at, 1 x per week. Gloria expresses joy and happiness during these visits.

Goal: Gloria will respond to one-to-one visits by engaging in conversation, 3 x's per week by: Gloria is currently meeting this goal and has expressed a desire to continue with the one-to-one visits by the activity staff and volunteers. This goal will remain the same for the next quarter. Approaches include: 1) The activity staff will provide current one-to-one activities based on the resident's interests, quilting, soap operas 2) The activity staff will offer additional types of activities based on her interests and needs, lotion rubs, nail care, mystery novels 3) The nursing staff will encourage Gloria to talk about interests when doing ADL's 4) The house keeping staff will engage in conversation when they are in cleaning Gloria's room 5) Volunteers from the quilting club will continue to visit weekly, Tuesday evenings 6) The activity staff will provide Gloria with a quilting catalog to read and some mystery books on tape-daily.
SIGNATURE, TITLE——————————————————

Change in Condition Note

A new MDS 3.0 was completed today due to a significant change in condition. Bonnie has been experiencing a change in terms of her daily routine and cognitive awareness. She appears to be more confused and becomes disoriented when left on her own. Lately, she has been found lost in the kitchen while coming down to the activity room. Previously, Bonnie had been attending the morning exercise group on a daily basis per her last quarterly review. During the activity she would follow the directions and laughed as she enjoyed herself. Now she will participate in 50% of the exercises and then gets up to wander around the facility. Bonnie's goal will be revised to include participation in a smaller exercise group called nature walks. This will allow Bonnie to continue with her movement and wander around the facility and grounds in a structured and supervised activity. Goal: Bonnie will participate in the daily nature walk group as evidenced by staying with the group during the activity time. Approaches: 1) The activity staff will provide Bonnie with a monthly activity calendar and will highlight the times of the nature walk 2) The activity staff will set Bonnie's alarm clock for 10 minutes prior to the start of the nature walk 3) The nursing staff will remind Bonnie to attend the nature walk 4) The nursing staff will direct and if necessary escort Bonnie to the facility lobby for the nature walk 5) The activity staff will engage in conversation with Bonnie during the nature walk 6) The activity staff will verbally redirect Bonnie if she wanders during the nature walk 7) The activity staff will praise Bonnie for attending the nature walk activity 8) The activity and nursing will provide sensory stimulation items/supplies on the wing day room for Bonnie. SIGNATURE, TITLE——————————————————

MDS 3.0 Care Plan Cookbook for Preferences and Activities

An MDS 3.0 and OBRA-Based Guide to Building Care Plans for Quality of Life

2012 Edition

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