Care Plan - Residential Care

Sections 80 and 81 of the *Residential Care Regulation* require a licensee to ensure that every person in care has one of the following two types of care plan:

- a short-term care plan developed upon admission to guide caregivers in all matters of providing care and protecting and promoting the health and safety of all persons in care.
- a comprehensive care plan suitable for a long term residency developed within 30 days of admission (if a person will only be in care for 30 days or less, this longer-term care plan is not required).

What is a care plan?

A care plan is a document that records the care to be provided to an individual that includes the consideration of that person's unique abilities, physical, social and emotional needs, and cultural and spiritual preferences. Care plans provide guidance to caregivers so they can effectively care for and meet the unique needs of persons in care. The structure of care plans may differ by facility and individual as a care plan is the result of an individual planning process.

Section 81 of the *Regulation* prescribes some elements that must be part of all care plans such as; information regarding medication, behavioural intervention, use of restraints if applicable, oral health, nutrition, recreation and leisure, consideration of falling (if long term care), consideration of wandering, special instructions from parent (if child or youth), and orders related to the admission to the facility. There are many other factors involved in ensuring the health, safety and dignity of persons in care and these should be reflected in a care plan.

Why is a care plan needed?

Individuality: People who live in residential care facilities are vulnerable because of age, health condition, or circumstance and require 24 hour care and/or supervision by professional staff. The care plan is a mechanism for planning how to best meet the individual's unique needs by creating a document that presents a comprehensive picture of that individual and his/her situation.

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Various care providers: Persons in care often have complex health care needs that may be met by multiple caregivers. A care plan is a communication tool between the person in care, their support system, and health care providers. A care plan may describe general health status as well as the person in care's chronic conditions (e.g., epilepsy, diabetes) that require special care.

Changing needs: A care plan also ensures that if there are changes in an individual's health that require a shift in how care is provided, new directions are communicated to everyone. For example, if a resident is prescribed a new medication, this information will be recorded in the care plan; similarly, the new medication may require a change in diet. In this instance, staff referring to the care plan will immediately know that there is a new medication and a revised nutrition plan.

Safety: Care planning increases safety and reduces the risk of harm of persons in care. Care plans include information about allergies, sensitivities, and people who are prohibited from seeing a person in care for safety reasons. Care plans may also include risk assessments so that specific, integrated prevention plans can be created to reduce harm. For example, fall prevention planning should be linked to recreation and activity plans, medication, and occupational therapy.

How is a care plan developed?

Care plans are as unique and as individual as each person. Information for a care plan will come from a variety of sources including the person in care (and/or family or persons making health care decisions on behalf of the resident) and those caring for that individual. The resident's family is often the best source of historical and contextual information about their family member. Care facility and other agency (e.g., day program) staff that provide services to the individual are also an important source of information. Together, these people are able to provide the information necessary to construct a complete picture of a person in care's needs and preferences, not only in terms of health but also in other areas such as recreational habits or religious practices that support a person in care's overall health, safety and dignity.

While a care plan's contents will vary depending on the individual and the type of care he/she is receiving, the first step in developing the plan is to gather information (e.g., what are the abilities of the person in care? what supports and services does the person in care have or need? how will staff be assigned to support the person in care? what special equipment and supplies are needed?) A care plan may also include a list of medical, safety, and emergency considerations and should outline how a person in care will be accommodated at the facility. It should identify who will be making health care decisions for the person in care if he/she is unable to do so, and may also establish short and long term goals.

Some facilities or organizations may have a template for a care plan and a set of procedures for developing one while others may have a less formal process.

How do I know if the care plan is working or if it needs to be changed?

Reviewing a care plan is the best way to assess if it is working or needs to be amended. The *Residential Care Regulation* requires that a care plan be reviewed at least once a year or after a significant change in the health or circumstance of the person in care. However, this is the minimum standard set by regulation; a care plan may need to be reviewed more often. Reviewing a care plan means collecting information and asking questions (e.g how has the person in care changed since admission? what is working? what is not working? how can it be changed? is the person in care happy?)

For more information, please contact the community care licensing program in your area.

Contact Information

Northeast		**Northern Interior**		**Northwest**	
Fort St. John	250-263-6000	Prince George	250-565-2150	Terrace	250-631-4222
Dawson Creek	250-719-6500				

This information is not to be regarded as a substitute for the Community Care and Assisted Living Act and regulations or legal advice. If you require legal advice about the issues discussed here please contact independent legal counsel.

Reference:
Ministry of Health Services - March 2008

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