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|  CLINICAL DATA BASE GUIDELINES | NO. 68 |
| CARE PLANNING PROCESSWhen revising goals on the Care Plan that are not met, there always has to be some sort of change. Generally, we change the problem as needed or the goal to be more specific, or add new approaches/methods to the goal to help the resident reach it. The changes must be made prior, during or immediately following the Care Plan Meeting so the Care Plan is ready to be typed as soon after the meeting as possible by Medical Records. Only authorized staff members (i.e. licensed nurses, Medical Records Coordinator or transdisciplinary staff) may make changes on the care plan. When a change is made, the existing method should be crossed out with one line and the new method penciled in at the bottom.Check the frequencies on the RAPS and MDS/Quarterly Comment page to ensure they match the frequency on the Care Plan problems during the meeting also.The resident/family input sheets for Care Plan meeting must be reviewed at the meeting. Social Services is responsible for writing a follow-up on each input sheet to address any problems/concerns and how they were resolved. A copy of these completed input sheets with SS follow-up is to be given to the Administrator following the meeting.Also, following each Care Plan Meeting, we need to do a Care Plan Follow-up as documentation on the Care Plan Follow-up form located in the Social Services section of each resident’s chart. The note needs to state whether the resident and/or family attended the meeting, what happened during the meeting, and if neither resident nor family attended that a copy of Care Plan was sent to the family (if resident gave permission). Then sign off with Social Worker’s name and initials. All 3 bits of information need to be included. The Care Plan Follow-up form must be placed in the Social Services section of the chart behind our monthly progress notes when each follow-up is completed. |
| Approved: | Effective Date: | Revision Date: | Change No.: | Page: 1 of 1 |