



Care Plan 101: An Introduction to Care Planning for Activity and Recreation Professionals

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Creating and implementing individualized care plans for residents in long-term care facilities is a very important responsibility of activity and recreation professionals. The activity assessment determines the content of the care plan. Not all residents will have an "activity-care plan", but most care plans should have "activity-related interventions" found in the comprehensive care plan. Care plans may be written regardless if a resident triggers on the MDS 2.0. It is important to set realistic, measurable goals, interdisciplinary interventions, and create care plans that are individualized and person-centered.

What is a Care Plan?

The RAI user manual defines care planning as, "A systematic assessment and identification of a resident's problems and strengths, the setting of goals, the establishment of interventions for accomplishing these goals."

Why write Care Plans?

- Document strengths, problems, and needs
- Set guidelines for care delivery
- Establish resident goals
- Identify needs for services by other departments
- Promote an interdisciplinary approach to care and assign responsibilities
- Provide measurable outcomes that can be used to monitor progress
- Meet federal and state requirements
- Meet professional standards of practice
- ***Enhance the resident's quality of life and promote optimal level of functioning!***

What is a Care Plan Meeting?

A forum to discuss and review a resident's status including any problems, concerns, needs, and/or strengths

Who usually attends a Care Plan Meeting?

- MDS Coordinator
- Nurse(s)
- CNA's
- Dietician
- Rehabilitation Therapist(s)
- Recreation Staff
- Social Worker
- Resident
- Family Member/Guardian

When are Care Plans written?

- A minimum of seven days after the MDS completion date

- Some care plans warrant immediate attention
- As necessary
- Must review at least quarterly

The Role of the Recreation/Activities Department

- Identify the resident's leisure/recreation needs
- Identify barriers to leisure pursuit and help minimize these barriers
- Identify the resident's leisure/recreation potential
- Provide the necessary steps to assist the resident to achieve their leisure/recreation goal/s
- Provide interdisciplinary support by entering a variety of recreation interventions on various (non-activity) care plans
- Monitor and evaluate residents response to care plan interventions

Components of a Care Plan

- Statement of the problem, need, or strength
- A realistic/measurable goal that is resident focused
- Approaches/interventions the team will use to assist the resident in achieving their goal
- Important dates and time frames
- Discipline(s) responsible for intervention
- Evaluation

Target areas for Recreation/Activities

- Cognitive Loss
- Communication
- ADLS
- Psychosocial
- Mood
- Nutrition
- Falls
- Palliative Care
- Activities
- Recreation Therapy
- Pain Behavior
- Restraints

Activity/Recreation Care Plan Samples

These are just a few samples. Remember, the most important aspect of care planning, is *INDIVIDUALIZATION!*

Statements (the resident's name is usually used instead of the word "resident")

- Resident has limited socialization r/t to depression
- Resident prefers to stay in room and does not pursue independent activities
- Resident is bed-bound r/t to stage 4 pressure ulcer and is at risk for social isolation
- Resident demonstrates little response to external stimuli r/t to cognitive and functional decline
- Resident enjoys resident service projects such as changing the R.O. boards
- Resident becomes fearful and agitated upon hearing loud noises in group activities r/t to dementia
- Resident has leadership abilities
- Resident prefers a change in daily routine and wishes to engage in independent craft projects

Goals

- Resident will respond to auditory stimulation AEB smiling, tapping hands, or vocalizing during small group sensory programs in 3 months
- Resident will actively participate in 2 movement activities weekly in 3 months
- Resident will remain in a group activity for 15 minutes at a time 2x weekly in 3 months
- Resident will accept in room 1:1 visits by recreation staff 2x weekly in 3 months
- Resident will socialize with peers 2x weekly during small group activities in 3 months
- Resident will respond to sensory stimulation by opening eyes during 1:1 sessions in 3 months
- Resident will actively participate in Horticultural Therapy sessions in the green house, 1x monthly in 3 months
- Resident will continue to assist other residents in writing letters on a weekly basis in 3 months
- Resident will exhibit no signs of agitation during small group activities 3x weekly in three months
- Resident will engage in self-directed arts and crafts projects 1x weekly in 3 months

Interventions/Approaches

- Provide a variety of music i.e. Big Band and Irish
- Utilize maracas and egg shakers to elicit movement
- Provide PROM to the U/E during exercise program
- Involve resident in activities of interest i.e. singalongs, adapted blowing and trivia
- Offer 1:1 visits in the late afternoon to discuss recent Oprah episode
- Seat resident next to other Korean speaking resident during groups
- Provide tactile stimulation i.e. hand massages and textured object i.e. soft baseball
- Provide olfactory stimulation i.e. vanilla extract and cinnamon for reminiscing
- Utilize adapted shovel and watering can during HT sessions
- Provide easy grip writing utensils and a variety of greeting cards/stationary
- Involve resident in small sensory groups i.e. SNOEZELEN and Five Alive
- Seat resident near a window
- Provide a variety of independent arts and craft projects
- Provide adapted scissors and paint brush

Exercise

Imagine that you are a resident in a long-term care facility and you are bed-bound for a health-related condition and are at risk for social isolation and inactivity. Write a goal and at least seven interventions/approaches that are relevant to you.