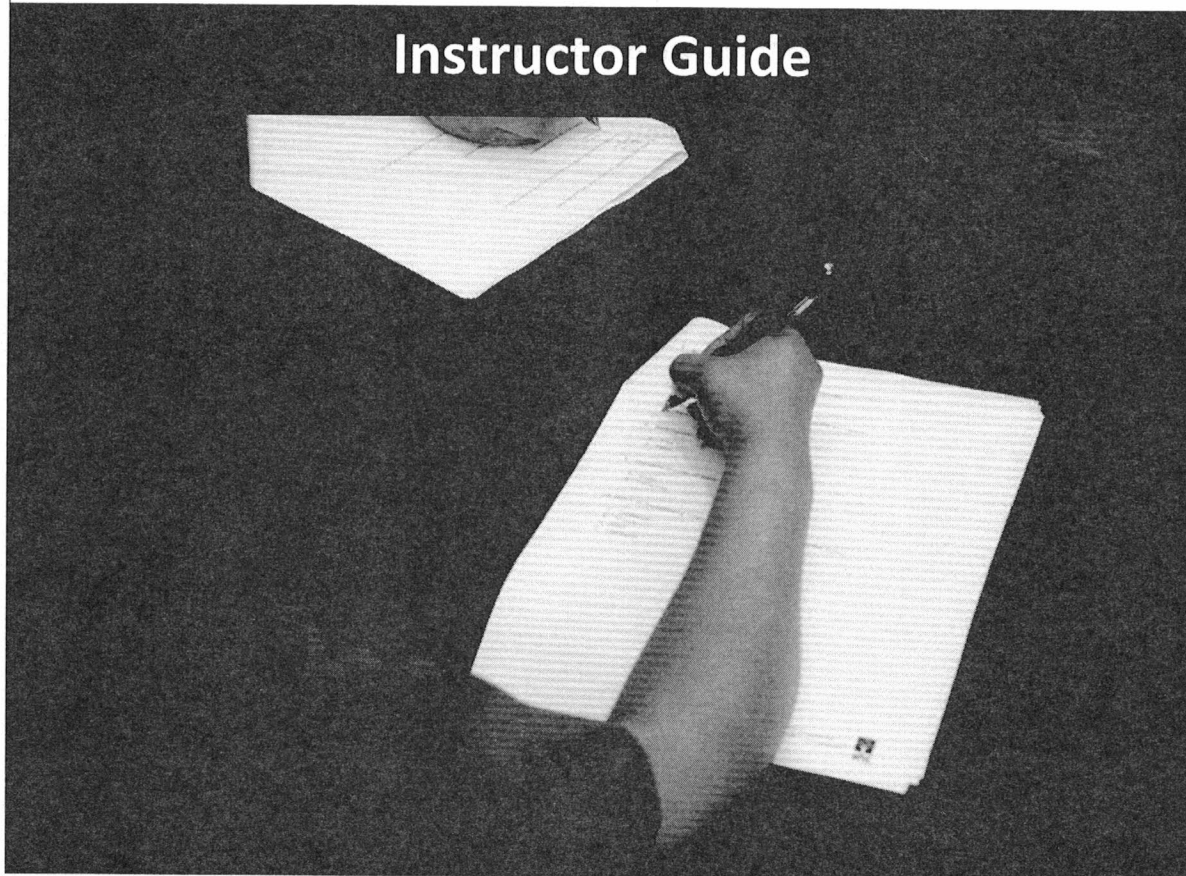


Service Plans

Instructor Guide



UPDATED JUNE 23, 2011



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INSTRUCTOR GUIDE:

SERVICE PLANS

Overview	This module will address the purpose of individualized resident service plans. Issues addressed in service plans, individualizing resident care, creating and updating service plans, and the role the caregiver plays in the service planning process will all be discussed. This module will also address regulatory requirements.
Video(s)	"Service Plans" (30 minutes)
Special Supplies	It is recommended that you bring sample service plans for staff to review during the training. Be sure to review the service planning schedule/frequency (e.g., quarterly, annually, etc.) used by your community.
Learning Objectives	<ol style="list-style-type: none">1. The purpose of a service plan;2. What the service plan should include;3. The role of the caregiver;4. Regulatory requirements.

QUIZ: SERVICE PLANS

Name: _____

Date: _____

1. Service plans can take many formats and sizes.
 - a. True
 - b. False

2. The purpose of a service plan is to coordinate the care of the resident.
 - a. True
 - b. False

3. Service plans should address:
 - a. Cognitive needs
 - b. Activity preferences
 - c. Activities of daily living
 - d. All of the above

4. One generic service plan is sufficient for every resident.
 - a. True
 - b. False

5. The service plan is written after the resident has been at the facility for at least one year.
 - a. True
 - b. False

6. Typical parts of a service plan include:

- a. Needs, goals, and interventions
- b. Favorite foods, color, and music of resident
- c. Whether or not the resident likes to play sports
- d. None of the above

7. Good sources of resident information include:

- a. The resident's physician
- b. Family of the resident
- c. The resident himself
- d. All of the above

8. The resident should always be asked about their daily preferences as part of the service planning process.

- a. True
- b. False

9. The caregiver's input on the service plan is critical.

- a. True
- b. False

10. The service plan does not have to be signed.

- a. True
- b. False

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Certificate of Completion

THIS IS TO RECOGNIZE

FOR DEDICATION TO QUALITY RESIDENT CARE
THROUGH EDUCATION AND PROFESSIONAL DEVELOPMENT.

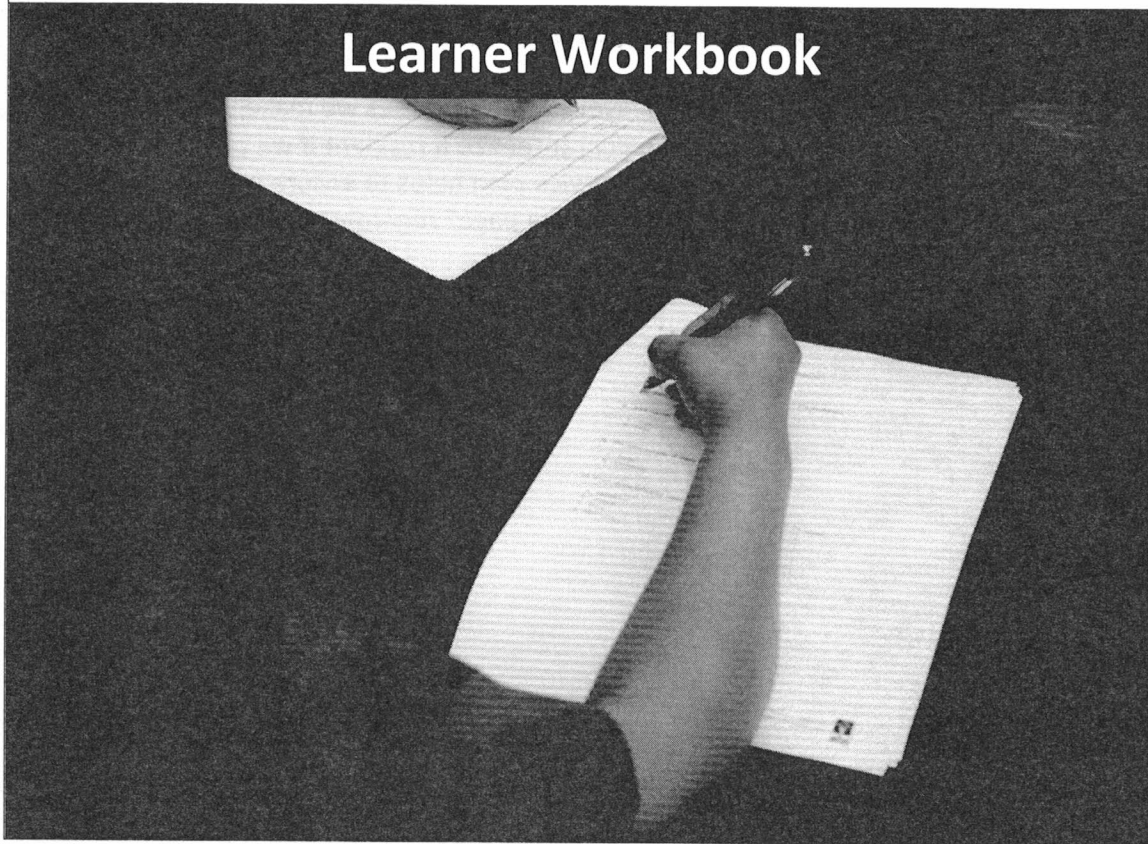
SERVICE PLANS

Instructor Signature

Date

Service Plans

Learner Workbook



UPDATED JUNE 23, 2011



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SERVICE PLANS

Service plans should be specific to each resident and their preferences. Not all service plans are alike as each resident is unique and has different capabilities and care needs. A service plan is a written plan of care developed to achieve the best form of assistance for the individual resident by the Direct Care Staff. Good service plans do not just happen; they require preparation, input, and communication.

The purposes of a service plan are to:

1. Plan and coordinate resident care and services;
2. Fulfill regulatory compliance; and
3. Have a written tool to improve communication between facility staff, residents, responsible parties, and other stakeholders.
4. Provide documentation for risk management purpose

A service plan can also help to ensure we deliver on the promises we make to our residents and his/her families. It is important not to make guarantees to a resident if we cannot live up to those promises. The process of developing a service plan helps to ensure everyone involved (you, the resident, the family, etc.) are “on the same page” regarding the plan for care and service.



THE CORE COMPONENTS

Although some residents may have similar needs and are capable of the same things, it is important to create a service plan that is not generic but specific to each resident based on the resident's needs and preferences. The process of effective service plans is to assess, plan, receive feedback, reassess, and continue this cycle over again.



A service plan should include the following components:

1. The level of service the resident will receive, along with the needs and preferences of the resident, and the plan to meet those needs.
2. The amount, type, the frequency of health-related services needed by the resident.
3. Each individual responsible for the provision of the service plan.

A plan to meet the needs and preference of the resident, including the level of service required:

How much care is the resident already receiving? How much is he/she capable of doing on their own and how much assistance will he/she require from the Community staff? Again, not all residents are exactly alike. In some Communities, for example, they have three different levels of laundry service available for the resident.

Examples include:

- The care staff completely takes care of resident's laundry
- The care staff assists residents in doing his/her laundry
- Residents do his/her own personal laundry

The amount, type, and frequency of health-related services needed by the resident:

There are several necessary questions you will want to address when putting together the service plan. Below are examples of some questions you may ask in order to obtain the information needed to meet the personal needs and desires of each resident for his/her service plan.

SERVICES NEEDED (CHECK ITEMS AND EXPLAIN)

YES NO

Help in transferring in and out of bed and dressing.

Help with bathing, hair care, personal hygiene.

Does client desire and is client capable of doing own personal laundry and other household tasks (specify)

Help with moving about the Community.

Help with eating (need for adaptive devices or assistance from another person)

SERVICES NEEDED (CHECK ITEMS AND EXPLAIN)

YES NO

Special diet/observation of food intake:

Toileting, including assistance equipment, or assistance of another person:

Continence, bowel or bladder control. Are assistive devices such as a catheter required?

Help with medication:

The core components addressed in the service plan include:

- Activities of daily living
- Assistive devices the resident requires
- Psychosocial needs
- Activity preferences
- Cognitive needs
- Medications

Activities of Daily Living

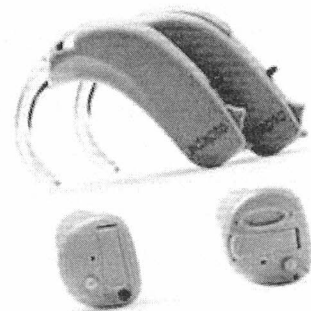
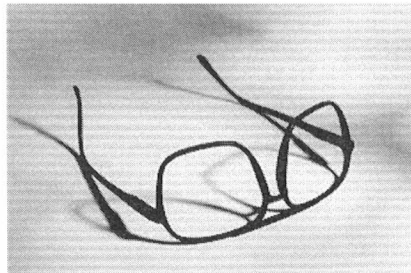
This includes what specific activities and the amount of care the resident requires for day to day activities. For example: bathing, grooming, toileting, etc. Another factor this addresses is timing. When does the resident prefer to bathe? Is the resident a morning person or an evening person? Some Communities allow their residents to set his/her own schedules. The resident wakes up when he/she chooses, and eats when he/she desires to eat.

The goal as quality care providers should be to maintain the sense of independence and choice. If we assist the resident in things he/she is capable of doing, the resident will eventually lose the ability to do that particular activity.

You want to be encouraging to the resident to be independent, but also to be safe. You do not want to frustrate nor endanger the resident.

Assistive Devices

The service plan should include information about any assistive devices the resident may use. For instance: walkers, wheelchairs, hearing aids, glasses, etc.



Psychosocial Needs

Psychosocial is a term that describes our sense of self in a context of our interactions with others. Psychosocial needs can address the emotions of the resident.

Some questions you may ask:

- Is this resident isolating himself/herself?

- Does he/she appear to be confused or forgetful?
- Does this resident have a history of depression?

Many factors contribute to how we feel about ourselves and how our feelings impact the way we relate to others. A person's psychosocial health needs are entangled with each of the seven dimensions of life:

- | | |
|----------------|-----------------|
| • Physical | • Environmental |
| • Emotional | • Social |
| • Intellectual | • Spiritual |
| • Occupational | |

Each dimension of life described by our psychosocial health needs is connected to one another. Each element affects the others both positively and negatively. Elderly persons are often confronted with difficult life experiences all at one time compared to those persons who are younger. These experiences influence the way he/she feels about himself/herself.

One way to best develop and use a successful service plan is to understand the resident's needs by viewing the world through his or her eyes. Why does the resident feel the way he/she feels? What does the resident need each day in order to enjoy himself/herself in their Community and sense a valuable purpose in his or her life?

Activity Preferences

Some examples to ask the resident include:

What types of activities does the resident enjoy doing? When does he/she like to do certain activities throughout the day?



Some Communities are designed like a neighborhood. Each living quarters is a “home” and throughout the Community are different significant parts of the “neighborhood.” Some may design their dining rooms into a restaurant. They may have some residents who enjoy cooking and are capable of assisting in the kitchen. Others may enjoy helping with restaurant duties.

The service plan can be a valuable asset to the Community by assisting the cooks with useful suggestions as well as being familiar with the food needs of each resident. Food allergies can be very serious, especially for our elderly residents. It is a good recommendation to include any food allergies on the service plan when discussing care needs of the resident in the area of food needs.

In some assisted living Communities, the residents give suggestions about what types of food should be served during meals. Service plans allow these ideas to become reality.

Cognitive needs

It is also important to focus on the cognitive needs of the resident when putting together and implementing the service plan.

Some questions to ask regarding their cognitive needs:

Is the resident alert to person, place, and time? Does the resident suffer with confusion? Is the resident prone to wander? Does the resident suffer with memory impairment?

The service plan should include what the resident needs to be reassured about on a day to day basis and areas in which they need someone to assist the resident with problems he/she may face. For example: a resident may suffer with dementia and may need to be reminded of where he/she is. Cognitive decline can affect the needs of the resident in daily activities as well. The resident who wanders may need extra supervision throughout the day.



Medications

It is crucial that the amount, type, and timing of medications be accurate. It is important to know each of these factors when putting together the service plan so the resident will receive any necessary medications when required. Be sure to confirm any medication needs with the resident's physician. Talk to your supervisor if you have any questions regarding medications and how to utilize the service plan in this area.

Each individual responsible for the provisions of the service plan

The service plan should include information that describes who is going to do what and when. Communication is the key! Service plans help organize each day and map out the responsibilities each person plays in the daily activities. It is important that the service plan be clear and specific in order to avoid confusion and frustration. As we have mentioned before, as service plans are unique to each resident, there will be specific responsibilities of the resident and specific responsibilities of the Direct Care Staff who are assisting the resident's needs.



CHECK FOR UNDERSTANDING: SERVICE PLANS

When putting together a service plan there are several things you will need to address. Typical service plans include the following:

- A. The level of service the resident is requiring, and each person responsible for providing the care
- B. The amount, type, and frequency of health-related services needed by the resident
- C. Both A and B

Explain your answer:

The Stakeholders Involved

Many people are involved in developing and implementing a service plan. Stakeholders are persons or groups of people with direct interest, investment, or involvement in the resident's care needs. Stakeholders can vary in the amount of involvement in the service planning process, but they all play a key role in assisting the resident to achieve his/her goal.

Who is involved in the process?

- The resident
- Family
- Primary caregiver (spouse, son or daughter, etc)
- Physician's report
- Social workers, case managers
- Physical Therapist/Occupational Therapist/Respiratory Therapist
- Spiritual advisors

The initial interview process can be difficult for residents and their families, and the resident may feel like he/she is giving up so much. It is important to stay positive and assure them that you are here to listen and meet their needs and assist them in maintaining their capabilities and encourage their self-determination and personal preferences.

KEEP IT POSITIVE!

During this initial process it is also critical to focus on the positive. You want this experience to be comfortable and as smooth as possible for both the resident and their families.

Always keep in mind the key is to LISTEN. The first and best source is the resident. What is the resident saying about his/her specific care needs? Listen to what the resident is capable of doing on his/her own and what he/she desires in the realm of care. What does the resident desire in their social base activities and personal care needs?

Secondly, the family and primary caregiver, such as a spouse, son or daughter of the resident, are a valuable resource and can often offer many details that are critical to the outstanding

care given in our Community. They may have detailed information that the resident themselves may not be aware of. Most of the time it is the primary caregiver who has been taking care of the resident's care needs and would be able to deliver this beneficial information.

Another source to consider when developing the service plan is the private duty or home health care services which the resident may have previously received. Many factors are involved in gaining information necessary for the accurate service plan; therefore, it is essential to take advantage of every opportunity to receive the information needed to best meet these care needs.

The physician's report is another very important source. You must read it carefully and go over the details. You will find clues to the care needs of the resident within the report, but you must be careful not to skim past those resourceful details. It is also recommended that you ask the resident's physician if you have any medical questions or concerns in order to properly provide care for the resident.



Social workers or case managers can also be very helpful sources of information of the care needs of the resident. You may also consider the Physical Therapist, Occupational Therapist, and Respiratory Therapist. They, along with social workers and case managers, can be great resources of continuing care to the resident. Find out some of the treatments they may have for the resident and how you can continue to provide that effective care as well.

Be sure not to over look the spiritual and psychosocial needs of the resident. You should include their spiritual advisors in the initial process. Members of the clergy can also be insightful with the psychosocial needs of the resident and be very helpful to this area on the service plan.

They can help address three main areas that we each deal with in life:

1. The need to find a meaning and purpose to life;
2. The need to feel a sense of belonging and love; and

3. The need to find reconciliation with the human Community and God or a higher power as defined by the resident.

Service Planning Process

Service planning is a process that includes appraisal/assessment of resident's needs, establishing goals, performing interventions, and receiving feedback/evaluating results. This cycle is continually used to reassess and meet the resident's needs throughout his/her stay in your Community.

A typical format for a service plan will include four main objective parts.

1. Needs of individual resident;
2. Goals of what we hope to achieve while caring for the resident;
3. Interventions, the specific involvement that we will use to achieve those goals; and
4. Evaluations, how is the resident progressing, and what changes need to be made.

These objectives should be realistic, obtainable, and measurable.

Let's look at a case study of a resident's need for an assistive device:

Sue is capable of walking with a walker, but has a tendency to fall every once in a while due to a recent accident. It is important to put this information on the service plan and include the instructions on how to monitor and assist her when traveling from different areas in the Community.

On the next page is an example of how this may look on a service plan.

Example of Service Plan

SERVICE PLAN

Resident: Sue Date Created: Jan. 2010

Needs	Goals	Interventions	Evaluations
<ul style="list-style-type: none"> Impaired mobility, related to recent hospitalization 	<ul style="list-style-type: none"> Resident will ambulate independently using front-wheeled walker 	<ul style="list-style-type: none"> Remind resident to use her walker Walk w/resident to and from dining room Walk w/resident to and from activities or other long distances 	<ul style="list-style-type: none"> Observe the progress of the resident Evaluate any changes that need to be addressed Update the service plan accordingly

The previous example demonstrates how to fill out a typical service plan. Write out the need of the individual resident. Write out the goals they would like to achieve and what are the goals that would best assist them in living a life of independence and free will. And finally, write out the interventions used to achieve those goals. Each of these needs, goals, and interventions will be different, unique, and focused on that resident. You will also want to continually evaluate the resident, his/her needs, goals and interventions and maintain an updated service plan according to the evaluations.

Developing a service plan is like putting together a puzzle. You must gather all the pieces you need to see the big picture. Before you actually write anything down on paper or type anything out on the computer, it is central to observe the resident yourself. Assessments provide the necessary details and data from which to construct a focused service plan.

When you develop a service plan ask yourself, "How can I see and meet as many needs as possible to help this resident?". If the resident is not able to come to your Community for the appraisal, make a home visit. Often there are times when one has gone to the hospital to visit

the resident who is briefly under hospital care. Take advantage of these great opportunities to visualize the level of care the resident is in need of and desires.

If the resident is in a skilled nursing facility or rehabilitation facility, you may also want to consider it a wonderful opportunity to see him/her in an environment where you can ask questions and get advice from other care staff. You will have onsite resources that can give you useful insight to continually give your resident all the assistance he/she requires in order to succeed.

Because the process of setting up the service plan can be embarrassing and uncomfortable at times for the resident and his/her family, you should strongly consider ways to maintain the dignity of both the resident and the family members during this experience. One way to consider the approach is to discuss in private the personal care needs.



You never want to discuss in public the private issues. This can be very embarrassing for both the resident and for family members. You want to avoid embarrassment while going over personal information. It is critical to provide privacy.

There are some cases when it is better to discuss information alone with the family and not in front of the resident. As in many situations you encounter, it is important to use your good judgment when discussing these issues.

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The Role of the Direct Care Staff

What is the role of the direct care staff?

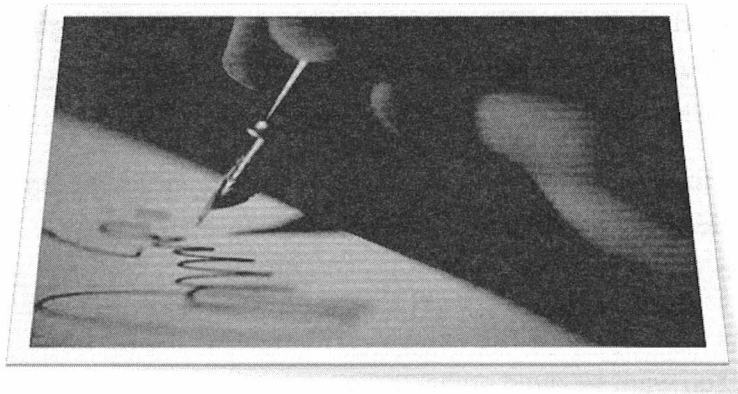
Typically the service plan is created by the nurse or administrator; however, the direct care staff plays a critical role in the service planning process as well.

Direct care staff have daily interaction with each resident as his/her caregiver. Direct care staff can provide valuable input into the service planning process and bring insight on daily observations that only care staff can provide. For example, care staff may have conversations with the resident about his/her changing needs that are necessary to be addressed in the service plan. Different issues may be observed by direct care staff that no one else has had the opportunity to experience.

Direct care staff naturally spend more time with residents than anyone else, and become familiar with their needs, preferences, and habits.

Communication is vital. Discuss the communication process in your Community to ensure direct care staff's involvement in developing and updating resident's service plans.

It is also necessary that each service plan is signed and dated by the appropriate person(s). It is recommended that each service plan be signed by the resident, the administrator, and the nurse if applicable. Be sure to check with your state regulations as each state is different. Be familiar with the policies of who must sign and date the service plan.



Where do we keep the service plan?

It is important to store the service plan in a place where it will be used effectively. For instance, some Communities choose to keep it in a separate binder from the resident charts. This way they can easily access several service plans all at one time.

The key is to make the service plans accessible.

For example, as a direct care staff, you may have many residents you assist each day. By having the service plans in a separate binder that is specifically for resident service plans, you are able to look through several service plans at one time, instead of having to pull each resident chart. This enables you to fulfill your responsibility more effectively.



CHECK FOR UNDERSTANDING: SERVICE PLANS

Direct Care Staff play an important role in the development of the service plan not just in the application of the information provided.

- A. True
- B. False

Explain your answer:

The Clock

When the service plan is created

Now that you know what a service plan is and its beneficial purpose to the Community as a whole, you may ask yourself, "Where do I start? When is the service plan supposed to be created?" Because many states have different regulations, be sure to ask your supervisor to provide the requirements of your state's policy and procedures regarding the time in which the service plan must be created.

It is recommended that you create the service plan initially when the resident moves into the Community. There may be several adjustments that you will want to make once the resident moves in and you find areas that may not have been identified or addressed initially.

The objective is to create a positive, proactive, and measurable plan that enables the resident to feel important and let the resident know he/she has a purpose each day. The service plan should reflect the ways to best reach these aspirations. Ultimately the goal is to establish the groundwork for the resident to move beyond the need to a natural and logical "next step."

When you initially meet with the resident, you want to keep the conversation positive. Always maintain the resident's dignity, never make the resident feel uncomfortable. The resident may hold some things back at first until they have completely moved into the Community. It is a good practice to continually monitor the needs of each resident and allow the service plan to reflect each of his/her specific needs. This is why the evaluation process never completely ends.

You will also want to update the service plan each time there is a change in the resident's schedule and needs. It can be very dangerous to use an outdated service plan. Since all states are different, be sure to ask your supervisor to provide you the information on the requirements of modifying services plans and how often they must be updated.

Why it is important to keep the service plan up to date?

Say for example that Joe initially was capable of sleeping soundly at night. Recently though, Joe has been more prone to wander once it becomes later in the night. His service plan has not been modified since he initially moved into the Community five years ago. This can be very dangerous to not be aware of these changes. It is important that no matter how big or small the change is in the schedule or needs of the resident, that the changes be updated on their service plans.



CHECK FOR UNDERSTANDING: SERVICE PLANS

Typically a service plan is created at what time?

- A. After the resident has lived in the Community for three months
- B. Before the resident has been assessed by the administrator
- C. At the initial acceptance of the resident into the Community
- D. It is not important when the service plan is created

Explain your answer:

Service plans are set up to help assist each resident to live his/her life to the fullest. As an assisted living Community, you want your residents to feel like someone actually cares about his/her needs and desires. The resident wants to find a place where they can feel at home, and the service plan is a way to help make this happen. It is vital that each service plan be up to date and accurate to the needs and desires of each resident.



CHECK FOR UNDERSTANDING: SERVICE PLANS

A Service Plan should promote resident's independence, dignity, choice, self determination, and the highest capability in all aspects of life. It is important that they be updated at all times.

A. True

B. False

Explain your answer:

Service Plan Tips

Ultimately there are no guarantees that a person will achieve the goals and objectives contained in the service plan. However, the greatest probability that the individual will spend the service period committed to doing his/her best to reach those goals depends on each person committing to utilize the service plan every day.

On the next page are a few tips that you may want to apply to your Community Service Plans. Maintaining positive and consistent communication among all persons involved will keep communication as simple as possible.

Tips to Utilize Your Service Plan:

1. Think of ways to use the service plan to connect each resident with other residents in the Community who may have similar interests.
2. File old service plans in an organized place in case you need them for future reference.
3. Remember to respect the resident's privacy as much as possible and never release information without the person's consent or the consent of his/her legal representative.

If you ever feel like the service plan is inaccurate or that there is an intervention that is no longer appropriate, you should speak with your supervisor. It is best to revise the plan to continue with the highest quality of service you can provide to the resident.

The key is recognizing the vital role the service plan plays in the care and supervision of an individual. A service plan can be a valuable tool if used the way it is designed in order to achieve the goals to provide independence, self-esteem and choice for each resident. Like a puzzle there are many resources in which to create a successful service plan and direct care staff play a critical part as well. Be sure to use the service plan each day, and ask your supervisor if you have any questions regarding the policies in your Community.

