Care Planning in Continuing Care - Fundamentals

Policy, Practice, Access & Case Management

April 5, 2024

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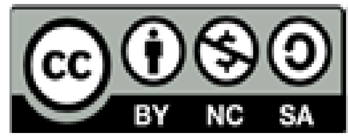

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What to Expect

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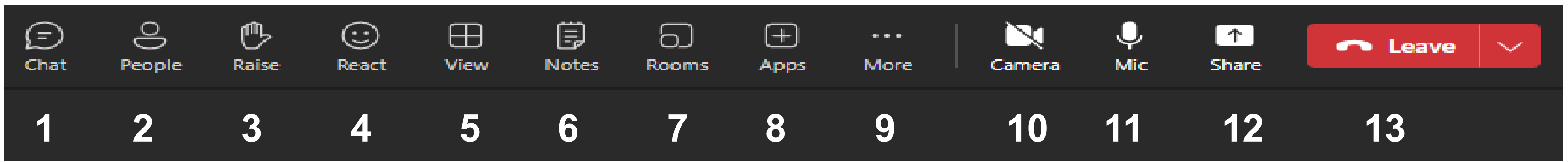
- 3 hours with breaks integrated throughout
- Pre-requisites
- Learner workbook parallels presentation
- Common terminology "Client" (aligns with CCHSS)

Microsoft Teams Navigation

1. **Chat**: Open the chat tool.
2. **People**: See who's been invited to the meeting and who's in attendance.
3. **Raise: Click to raise hand/lower hand**
4. **React:** Click to react: like, love, applause, laugh, surprise.
5. **View:** Changes layout of view
6. **Notes:** meeting notes
7. **Rooms**: Create and assign breakout room.
8. **Apps**: Add and use an app.
9. **More**: Click down to find more call and feature controls.
10. **Camera**: Start/stop your video.
11. **Mic**: Toggles the microphone on and off.
12. **Share**: Let's you choose a window on your computer to share.
13. **Leave**: Allows you to leave the meeting.



Zoom Navigation

1. **Mute/Unmute:** Toggles your microphone off and on.
2. **Start/Stop video**: Toggles your video on and off.
3. **Participants:** Lets you see who is in the meeting.
4. **Chat:** Opens the Chat tool.
5. **Share Screen:** Lets you choose a window on your computer to share. A facilitator will invite you to share in a breakout room.
6. **Record:** (not used in this education)
7. **Reactions:** Let's you can "clap" or give a "thumbs up"
8. **Leave Meeting:** Allows you to leave the meeting.

Land Acknowledgment

Provincial Seniors Health and Continuing Care would like to recognize that our work takes place on historical and contemporary Indigenous lands, including the territories of **Treaties 6, 7 & 8** and the homeland of the Métis.

This education is designed for the Interdisciplinary Care Team including:

- Case Managers
- Clients
- Informal supports
- Health care aides
- Allied Health
- Program Leaders, Managers, interRAI Leads
- Contract Service Providers

Disclaimer
References to continuing care (including home care, designated supportive living, long term care and hospice) may not reflect the updated language or terms found in the new Alberta *Continuing Care Act* which is anticipated to take effect April 1, 2024. Please refer to the definitions/glossary section of the document or website for updated terms.

Definitions

Continuing Care Home

Continuing care home means a facility or part of a facility where facility-based care is provided to residents, some of whom must be eligible residents.

Facility-Based Care

Facility-based care means the group of goods and services that is provided on an ongoing basis to residents of a continuing care home and that is made up of the following: prescribed accommodation goods and services, prescribed health goods and services, and prescribed other goods and services.

Home and Community Care

Home and community care means the prescribed health goods and services and prescribed other goods and services that are provided by a home and community care provider to an eligible individual in the individual's home or community but does not include facility-based care or supportive living services.

Supportive Living Accommodation

Supportive living accommodation means buildings or units in buildings that are intended for permanent or long-term residential living; where supportive living services are provided to assist residents to live as independently as possible. Does not include a continuing care home or a private dwelling where an individual provides care or services only to the individual's family members or friends.

Course Learning Objectives

By the end of this course, you will be able to:

1. **Define** the core concepts of care planning
2. **Identify** accountabilities for care planning
3. **Demonstrate** person-centred care, personhood, and a strength-based approach in care planning
4. **Describe** the care planning process
5. **Associate** care planning and quality improvement
6. **Summarize** care planning resources

Topics

- What is Care Planning?
- Priorities in Care Planning
- Care Plan Process
- Quality Improvement
- Next Steps

Care Planning Proficiency

Novice	Advanced Beginner	Competent	Proficient	Expert
Building knowledge	Gaining in-depth experience	Recognizes patterns accurately	Responds to changing needs	Prioritizes relevant information

Why We Care Plan

Freepik, 2023

Accountabilities

System Level

Organizational Level

Client Level

Priorities in Care Planning

- Strength-Based Care
- Personhood & Person-Centred Care
- Case Management
- Collaborative Practice

Priorities in Care Planning

Write in your workbook a few words that describe the emotions you would feel if you were receiving care from a health care provider.

Share with the group what holistic care means to you.

Strength-Based Care

- Existing competencies
- Resources
- Capacity to learn
- Involvement

Who am I?

- Values
- Spirituality
- Habits
- Abilities
- Hopes
- Fears

Priorities in Care Planning

Person-Centred Care

Social Worker

Volunteer

Occupational Therapist

Nutrition Services

Registered Nurse

Physician

Licensed Practical Nurse

Health Care Aide

Recreation Therapist

Informal Supports

Speech Language Pathologist

Physio-therapist

"**Case Management** is a collaborative, person-centred strategy for the provision of quality health and supportive services through the effective and efficient use of available resources to support the patient's achievement of goals."

Continuing Care Case Management Framework & Guidelines, 2011

Collaborative Practice

- Partnership between client, families & healthcare providers
- Establishes clear priorities, roles & responsibilities
- Enables high quality care
- Leads to best possible individual outcomes

Collaborative Practice

Write in your workbook a list of people involved in collaborative practice

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Stretch Break

5 minutes

Home and Community Care Education
(slides 1-52 & 74-end)

Continuing Care Home Education
(slides 1- 23, 53 – end)

Scenario

Care Planning Process

Home and Community Care Scenario

Home and Community Care Scenario

Contributing to Quality Care

…I knew we needed to complete their goals of care and do what we could to keep them living in the same situation.

-Crystal's Story-Working Together

Care Plan Process – Home and Community Care

Contributing to Quality Care

Unmute and share who else might be part of this collaboration

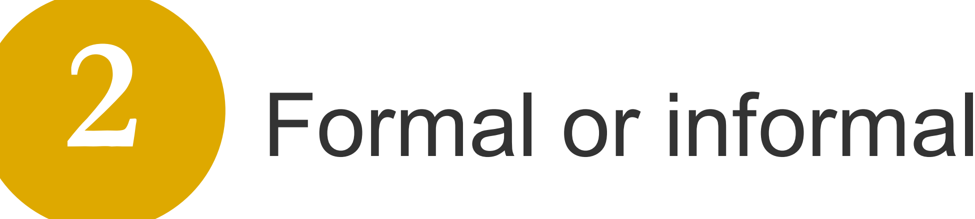
Examples:

- Health Care Aides
- Cancer Care Nurse Practitioner, Physician
- Spiritual Care Practitioner
- Palliative Care Nurse Consultant

Care Plan Process

Care Plan Process: Assessment

1. All domains: emotional, intellectual, mental, physical, social, spiritual



Share with the group one to two resources used to ensure comprehensive assessment at your site.

In your workbook, describe how different disciplines contribute to assessments.

Care Plan Process: Decision Making

Analysis

Identifying actual assessed needs of the client

Goal Setting

Focus on creating client-centered goals

Care Plan Process: Decision Making

Analysis

- Identifying assessed needs of the client
- Understanding the client's preference about meeting needs (if applicable)
- Understanding the root cause of each need

Identify Root Cause: 5 Why's

#	Why?	Answer
1	Why are Mr. & Mrs. Jones at risk of having Psychosocial well-being concerns?	Mr. & Mrs. Jones are at risk of increased stress and reduced coping.
2	Why are Mr. & Mrs. Jones at increased risk of stress and reduced coping?	Mr. Jones is responsible for the full-time caregiving of Mrs. Jones.
3	Why is Mr. Jones responsible for the full-time caregiving of Mrs. Jones?	Mr. and Mrs. Jones do not have any other support.
4	Why do Mr. & Mrs. Jones not have any other support?	They are not aware of formal supports available & their informal support (family) live far away.
5	Why are Mr. & Mrs. Jones not aware of formal support options?	Home care has just assessed their needs & has not provided the information yet.

Care Plan Process: Decision Making

Goal Setting

- Focus on creating client centred goals
- Negotiation
- Work with client to ensure options are understood
- Respect personhood

Setting Goals

S	M	A	R	T
Specific	**Measurable**	**Achievable**	**Realistic**	**Timely**
Defined outcome	Determine progress	Attainable	Appropriate for the individual and situation	Defined timeline
The individuals goal is …	*We will track progress by …*	*We will achieve this goal by doing the following…*	*This goal helps the individual because …*	*We will complete this goal by …*

Write a SMART goal that addresses Mr. and Mrs. Jones need for respite.

Mr. Jones will receive necessary supports to manage Mrs. Jones care within 1 week as evidenced by Mr. Jones expressing improved levels of stress and coping abilities.

Care Plan Process: Planning

Right care, right place, right provider

Encourage client independence and participation

Honour the client's privacy and comfort

Ensure the right person is performing the task

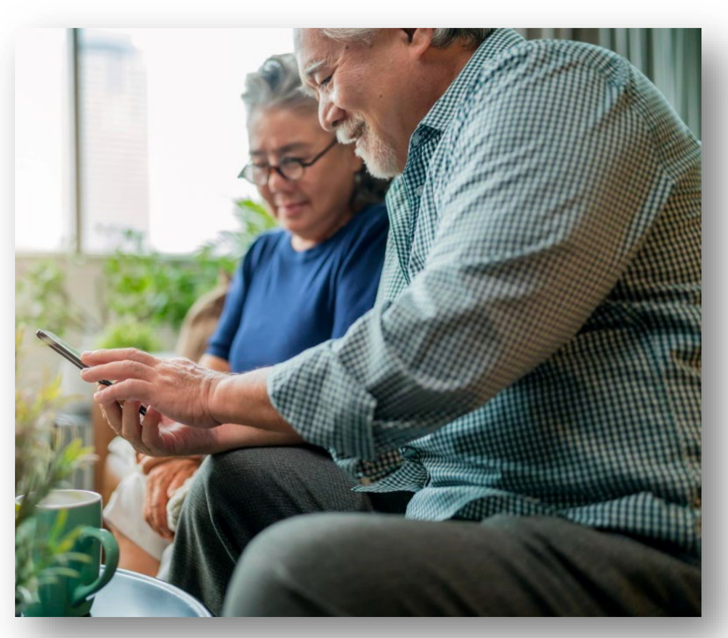
Interventions (Examples)

Intervention	Frequency	Provider
Respite & bath	4 hours weekly	HCA
Teach, coordinate, assess, monitor	Weekly x 3, then reassess	Case Manager

Care Plan Process: Communication

Communication is key to implementation.

- Tools to communicate key changes
- Document all steps
- Client should have a copy of the care plan



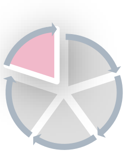
Care Plan Process: Communication

In your workbook
write down the different ways you communicate within your team.

Share with the group what is most important to communicate during shift report.

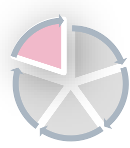
Care Plan Process: Evaluation

- Review
  - ✓ client goals
  - ✓ documentation
  - ✓ frequency of intervention(s)
- Validate assessed needs
- Update care plan



Closing the Loop

	Question	Answer
1	Why are Mr. & Mrs. Jones at risk of having Psychosocial well-being concerns?	The risk of psychosocial well-being concerns have reduced with Home Care Intervention.
2	Why are Mr. & Mrs. Jones at increased risk of stress and reduced coping?	Home Care intervention has helped Mr. Jones to feel improved levels of stress and coping.
3	Why do Mr. & Mrs. Jones not have any other support?	They do now! Home care is providing respite weekly, am and hs care daily, and bath weekly. The CM is assessing their needs regularly.
4	Why do Mr. & Mrs. Jones not have any other support?	They do now! Home care is providing respite weekly, am and hs care daily, and bath weekly. The CM is assessing their needs regularly.
5	Why are Mr. and Mrs. Jones not aware of formal support options?	The CM has done a great job of informing them of what service options are available to them.



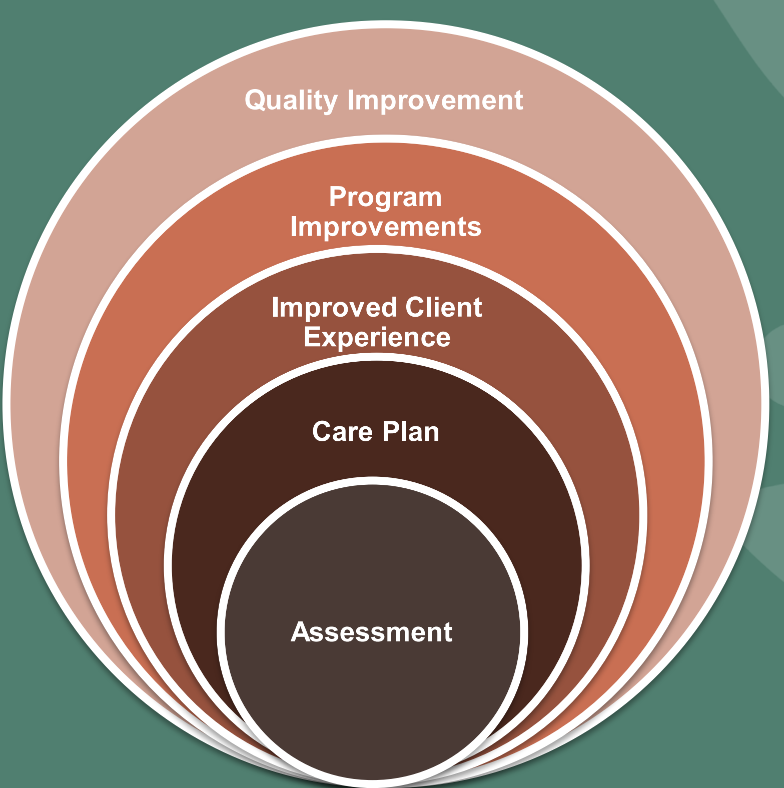
Break

5 minutes

Quality Improvement

Just Culture	Patient First Strategy	Quality Indicators
• Safe, encouraged, and enabled • Continuous quality and safety improvement	• Excellence in patient experience	• Formal or informal • Novel or anticipated • Client to system level impact

What does Care Planning have to do with Quality Improvement?



Clients & Quality Improvement

- Quality Councils
- Patient Relations
- Resident and Family Councils

Reporting & Learning System

Home > Tools > Reporting & Learning System for Patient Safety (RLS) > **Submit a Report**

Reporting & Learning System for Patient Safety (RLS)

Home | About | Training | **Submit a Report** | Reviewer Login | RLS News | Contact

- Fall
- Medication or Other Substance
- Laboratory or Blood Products
- Venous Thromboembolism (VTE)
- Pressure Injury/Skin Wound
- Other Patient Safety Event
- Medical Device Incident or Problem (MDIP)
- Pharmacy Good Catch (Pharmacy Staff Use Only)

Clients & Quality Improvement

A | A | A | High Contrast Off

HQCA
Health Quality Council of Alberta

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I am looking for...

Improving healthcare together

We are a provincial agency that brings together patients, families, and our partners from across healthcare and academia to inspire improvement in patient safety, person-centred care, and health service quality.

[Health Quality Council of Alberta | Improving Healthcare in Alberta (hqca.ca)](hqca.ca)

Quality Management Reports (QMR)

Freepik.com, 2023

- Measure progress toward quality goals
- Informs decisions related to:
  - Quality
  - Client safety
  - Performance
  - Workflow
  - Patient flow

Quality Improvement in Action

- Improved client experiences
- Desired outcomes
- Measurable

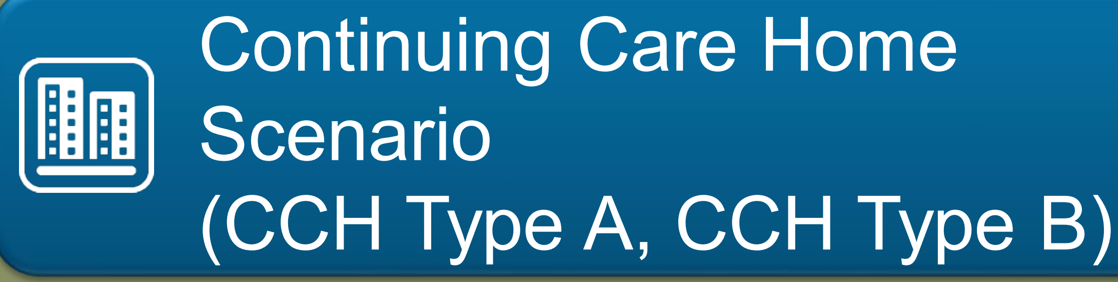
OLD WAYS
WONT
OPEN NEW
DOORS

Quality Improvement in Action

Share with the group how this example had impact

Scenario

Care Planning Process



Continuing Care Home Scenario – Contributing to Quality Care

“I could see both the side of management and the side of the Health Care Aides, but to me, consistent staffing just made sense for the residents. From our perspective the roll-out was seamless.”

-The Good Daughter

Contributing to Quality Care

"We had a new care plan for their mother, and I had assured them that we would implement it.
But, I also knew things would have been missed because of the rotation."

-The Big Leap

Care Plan Process – Continuing Care Home

Contributing to Quality Care

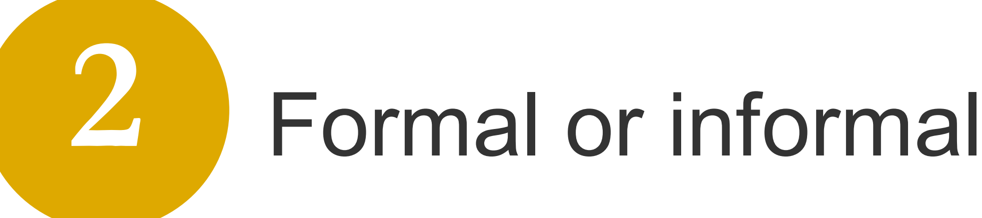
Unmute and share who else might be part of this collaboration

Examples:

- Nutrition Services
- Occupational Therapy
- Recreation Therapy
- Spiritual Care
- Server
- Front Desk Receptionist

The Care Plan Process

Care Plan Process: Assessment



1 All domains: emotional, intellectual, mental, physical, social, spiritual

2 Formal or informal

Share with the group one to two resources used to ensure comprehensive assessment at your site.

In your workbook, describe how different disciplines contribute to assessments.

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Analysis

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Goal Setting

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Care Plan Process: Decision Making

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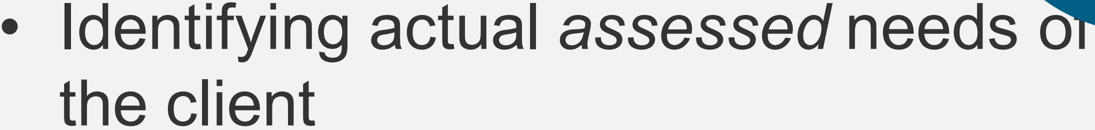


- Identifying actual *assessed* needs of the client
- Understanding the client's preference about meeting needs (if applicable)
- Understanding the root cause of each need

Identify Root Cause: 5 Why's

	Why	Answer
1	Why is Carol calling her family in the middle of the night?	Carol cannot fall asleep.
2	Why can't Carol fall asleep?	Carol does not have a regular bedtime routine.
3	Why doesn't Carol have a bedtime routine?	The staff do not know Carol very well.
4	Why do the staff not know Carol very well?	Staff assignments are rotated monthly. It takes time to know how to care for a new group of clients.
5	Why does the assignment change every month?	This was best practice 5 years ago: gives staff a chance to work with all clients; reduces staff fatigue; provides equitable workload.

Care Plan Process: Decision Making

Goal Setting

- Focus on creating client centred goals
- Negotiation
- Work with client to ensure options are understood
- Respect personhood

Setting Goals

S	M	A	R	T
Specific	**Measurable**	**Achievable**	**Realistic**	**Timely**
Defined outcome	Determine progress	Attainable	Appropriate for the resident and situation	Defined timeline
The resident's goal is …	*We will track progress by …*	*We will achieve this goal by doing the following…*	*This goal helps the resident because …*	*We will complete this goal by …*

Write a SMART goal that addresses Carol's need for improved sleep.

Share the goal you have written.

Carol's altered sleep pattern related to environmental factors and psychological factors will improve within 3 months as evidenced by fewer calls to the family between 2200 and 0500.

Care Plan Process: Planning

- Right care, right place, right provider

- Encourage client independence and participation

- Honour the client’s privacy and comfort

- Ensure the right person is performing the task

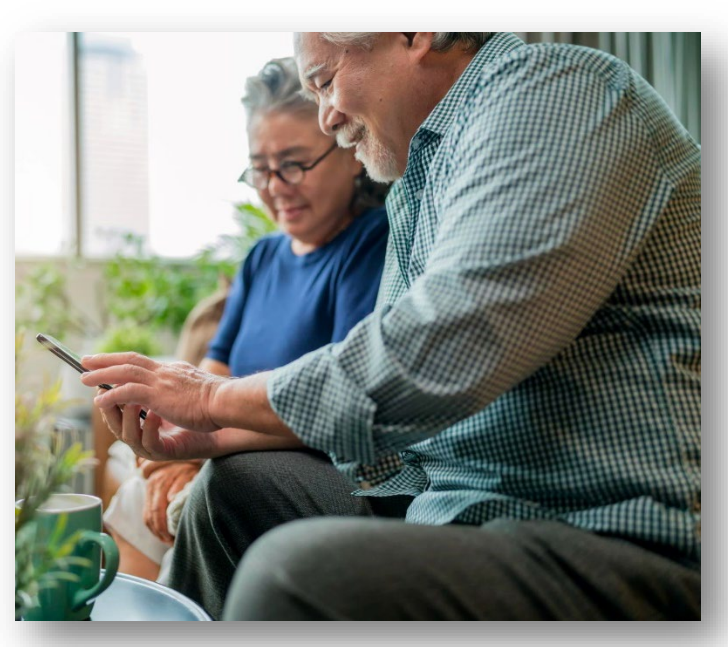
Interventions

Intervention	Frequency	Provider
Ensure client settled into bed by 2200	Daily	HCA
Offer snack at 2100	Daily	HCA
Provide 15 minutes of 1-to-1 support	As needed: when family reports 2 or more phone calls from client between 2200 and 0500 on same day	HCA, volunteer

Care Plan Process: Communication

Communication is key to implementation.

- Tools to communicate key changes
- Document all steps
- Client should have a copy of the care plan



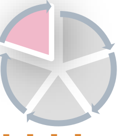
Care Plan Process: Communication

In your workbook
write down the different ways you communicate within your team.

Share with the group what is most important to communicate during shift report.

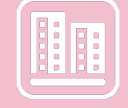
Care Plan Process: Evaluation

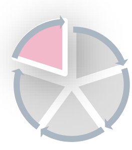
- Review client goals
- Review documentation
- Frequency of intervention
- Validate unmet needs
- Update care plan



Closing the Loop

	Question	Outcome
1	Why is Carol calling her family in the middle of the night?	Carol has called her daughter in the middle of the night only X times in past 3 months.
2	Why can't Carol fall asleep?	Carol's bedtime routine promotes sleep now.
3	Why doesn't Carol Have a regular bedtime routine?	Carol now has a regular bedtime routine.
4	Why do staff not know Carol very well?	No longer an issue-the HCA's working with Carol know her well.
5	Why does the assignment change every month?	The site has changed their practice - specific HCAs are assigned to provide Carol's care.





Break

5 minutes

Quality Improvement

Just Culture

- Safe, encouraged, and enabled
- Continuous quality and safety improvement

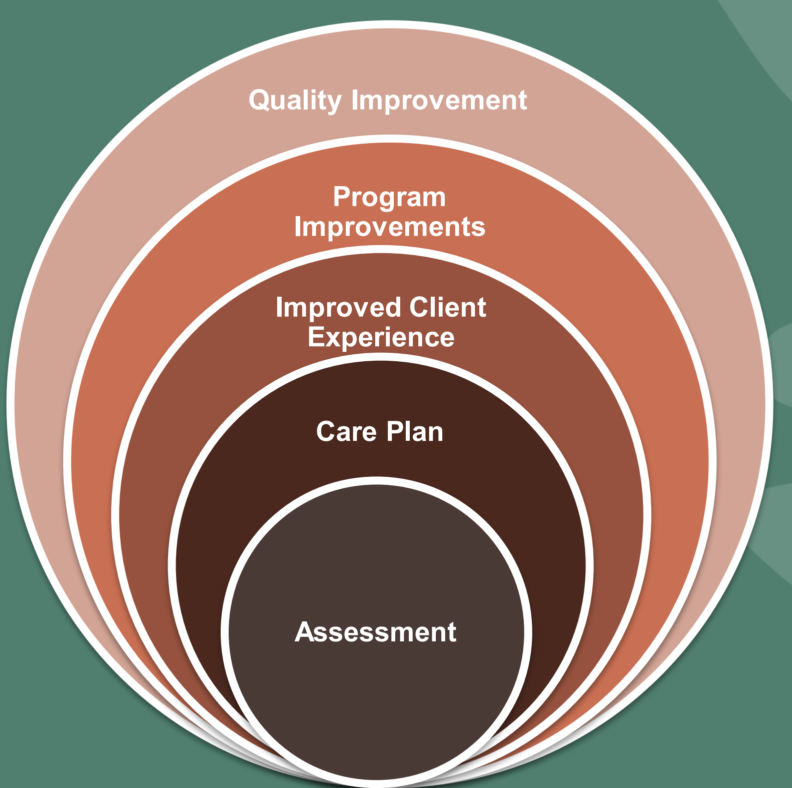
Patient First Strategy

- Excellence in patient experience

Quality Indicators

- Formal or informal
- Novel or anticipated
- Client to system level impact

What does Care Planning have to do with Quality Improvement?



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Quality Management Reports (QMR)

Freepik.com, 2023

- Measure progress toward quality goals
- Inform leadership decision making
- Increase transparency, inform knowledge transfer and identify areas for quality improvement

Quality Improvement in Action

- Improved client experiences
- Desired outcomes
- Measurable

Quality Improvement in Action

Share with the group how this example had impact? How did it lead to a larger QI?

Successful organizations understand the importance of implementation, not just strategy, and, moreover, recognize the crucial role of their people in this process.

-Jeffrey Pfeffer

Next Steps

Courses & Learning Tools

- Care Planning Education Resource
- Workbook links

Learning Opportunities

- Care Planning in Continuing Care-Putting it into Practice
- Case Management
- Connect Care
- interRAI Instruments

Ongoing Support

- Superusers
- Educators
- Managers

October 2020

Care Planning Education Resource

For more information
seniors.health@ahs.ca

Policy, Practice, Access
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Learning Objectives Review

Now you can:

- **Define** the core concepts of care planning
- **Identify** accountabilities for care planning
- **Demonstrate** person-centred care, personhood, and strength-based approach in care planning
- **Describe** the care planning process
- **Associate** care planning and quality improvement
- **Summarize** care planning resources

Questions?

continuingcare@ahs.ca

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