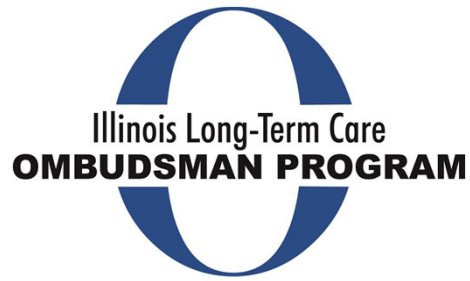


Illinois Long-Term Care OMBUDSMAN PROGRAM

USING YOUR CARE PLAN FOR PERSON-CENTERED/DIRECTED CARE

ALL LONG-TERM CARE ENTITIES REQUIRE FOR THEIR TO BE A PLAN IN PLACE FOR EACH PERSON WHO RESIDES IN THEIR BUILDINGS

Skilled, Intermediate & IL Veterans Homes = Care Plan	Assisted Living & Supportive Living = Service Plan	Sheltered Care = not specifically called anything
Specialized Mental Health Rehab Facilities (SMHRF) = Treatment Plan	Intermediate Care for Facilities the Developmentally Disabled = Individual Program Plan	Medically Complex for the Developmentally Disabled = Individual Habilitation Plan



**ALL LONG-TERM CARE FACILITIES
HAVE GUIDANCE ON WHAT THESE
PLANS SHOULD LOOK LIKE**

**Handout included in chat and this will be
posted on the Ombudsman's website**



CARE PLANS



ABOUT THE MEETING

You get to decide who you want to have involved in the meeting including the Ombudsman

If you need more time than the allotted time, make an appointment to continue the conversation

Frequency that these are reviewed depends on the type of facility but...

these can be reviewed and updated at any time!

HOW TO USE CARE PLANS/SERVICE PLANS EFFECTIVELY

- Involved the resident in the care conversation; have them help set their own goals and approaches
- Include the Nurses Aide to help articulate care needs and how the resident is doing
- Use the care plan when the facility may “disagree” with the residents desires
- This should be the directions about how to care for each person as the individual that they are.
- Stay away from computer generated problems goals and approaches: “Canned Care Plans”

WHAT IT SHOULDN'T LOOK LIKE

- People talking about the person and the person has no input into the care conversation
- A lot of technical language that may be intimidating to the person
- A bunch of department heads sitting in a room who don't really know who the person is

Problem/Need	Goal	Approach/Interventions
Mr. Jones is an insulin dependent diabetic and has been informed that he should not have sweets at night time, but he still desires to have ice cream after dinner. He understands and articulated the risk involved but he has made a person-centered decision to still have ice cream when he wants it.	Mr. Jones will have ice cream whenever he requests it.	<ul style="list-style-type: none"> • When Mr. Jones asks for ice cream, provide him with his personal desire independent of his diabetes. • Provide Mr. Jones with educational materials regarding the effect of a spiked sugar level that could be caused by the ice cream. • Nutritionist to periodically meet with Mr. Jones to discuss his diabetes and to share other ideas regarding the ice cream that he want including low-sugar ice creams while still respecting Mr. Jones decisional capacity on what type of ice cream he wants

WHAT A PLAN MAY LOOK LIKE

ANOTHER IDEA: I-CARE PLAN

Problem/Need	Goal	Approach/Interventions
I would like tea instead of coffee at each meal	I will receive tea at the onset of each meal as I desire.	<ul style="list-style-type: none"> • Inform all care and dining staff of Mr. Jones desire for tea at each meal. • Place a sign in the kitchen by the coffee/tea pot to remind dining staff of his personal desire • If staff forget, Mr. Jones will remind the staff; if they persistently forget, Mr. Jones will inform the DON and the Dietary Manager so that they can remedy the situation ASAP.

USING THE CARE
PLAN TO GET YOUR
PERSON-CENTERED
NEEDS MET –

***WHAT IT LOOKS LIKE
IN REAL LIFE!***