Careplan TEMPLATE

Emergency Details

First Response Details

First response in case of a medical emergency - Enter information how to handle the first response (i.e. Call 911, call hospital, call family/friends, call doctor

Emergency Contact Information

POA - List POA(s) for this resident with their phone numbers, email addresses, mailing addresses and any other pertinent information.

Family Contacts - List family and/or POA contacts in the order that they should be contacted. All phone numbers, email addresses, mailing addresses and any other pertinent information.

Medical Personnel - List all medical contacts who should be called in case of emergency and the situation in which they should be called. List all phone numbers, email addresses and mailing addresses as well as any other pertinent information.

Hospital of Choice - List hospital(s) of choice for resident/family and for what issues. For example, families may prefer one hospital for a fall and another for a particular health issue. List address and telephone number.

Hospice of Choice - List resident's/family's Hospice of choice including address and phone number.

Funeral Home of Choice - Please list the resident's/family's funeral home of choice including address and phone number.

DNR Information

DNR/Living Will Details - DNR and/or Living Will established? If so attach PDF here and note where to find hardcopy of theses orders.

Other Emergency Details

Comments/Issues - List any other details requested by the resident, family or home office regarding what to do in case of an emergency.

Personal Bio

Personal History/Background

Family History - List here details of family history, siblings, spouse(s), children, communities in which they lived, etc.

Work History - List here details about where the client worked, type of work they did, what they enjoyed about it, etc.

Veteran Status - Was the client a veteran, where did they serve and when? Any special stories they have shared, etc.

Retirement Life - List here details of things they have enjoyed in their retirement. This could be things like travelling, fishing, golfing, cooking, etc.

Former Living Arrangements - List here details about where they were living before coming to our service, were they still in a private residence, were then in a facility, etc.

Personal Health

Current Health Status

Current Health Issues - List details here or attach PDF if extensive amount of information.

Current Physical Issues - Enter details here or attach PDF if information is extensive.

Past Surgery/Procedures List * - List all past surgeries or procedures here by earliest to most recent date. If list is too long a PDF can be attached.

Physical Characteristics - List height, weight, any other pertinent physical attributes.

Habits Effecting Health - List if client is a smoker, drinker, etc.

Oxygen User - Does client require oxygen and if so details around it.

Family Medical History * - Scan the form completed by the family and attach as a PDF here

Other Health Details - List any other specific items related to Personal Health of client

Healthcare Providers (Drs, Therapists, Social Workers, etc.)

Physicians List - Enter all current physicians including primary care and all specialists. Include Dr. name, office name, office phone number and address.

Dentist - Enter current dentist and any oral care specialists.

Physical Therapist - Enter PT's name, company name, company phone number and address as well as usual time for appointments if scheduled regularly. If home exercise prescribed attach a PDF with the instructions.

Occupational Therapist - Enter OT's name, company name, company phone number and address as well as usual time for appointments if scheduled regularly. If home exercise prescribed attach a PDF with the instructions.

Speech Therapist - Enter Speech Therapist's name, company name, company phone number and address as well as usual time for appointments if scheduled regularly. If home exercise prescribed attach a PDF with the instructions.

Recreational Therapist - Enter Recreational Therapist's name, company name, company phone number and address as well as usual time for appointments if scheduled regularly. If home exercise prescribed attach a PDF with the instructions.

Nursing Services - Enter RN name, company name, company phone number and address as well as usual time for appointments if scheduled regularly.

Other Professional Caregivers - Enter Caregiver name and phone number as well as usual time for care engagements if scheduled regularly.

Case Worker - Enter Case Worker name, company name, company phone number and address as well as usual time for appointments if scheduled regularly.

Social Worker - Enter Social Worker's name, company name, company phone number and address as well as usual time for appointments if scheduled regularly.

Current Healthcare Recommended Activities

Doctor Recommended Activities - List any doctor recommended activities. Things like: exercises, vitals logging, wrapping of a limb, heat or ice use, wound care, etc.

Therapist Recommended Activities - List any activities that a therapist has recommended, either Physical, Occupational, Recreational or Speech Therapist. These can be things such as how to have a client get out of bed or transfer to a wheelchair, or exercises recommended by a therapist, or even how to talk to the client to get them to do there activities.

Dentist Recommended Activities - Enter any dentist recommended activities, such as using a special toothpaste or rinse, flossing with a certain tool, brushing after every meal, etc.

Family Recommended Health Activities - List any details on things the family have asked us to do for the well-being of their loved one. For example, take and record blood pressure at x time every day, wrap ankle when complaining of pain, don't allow client to sleep with their hearing aids on, etc.

Other Care Professional Recommended Activities - List details of any recommended activities that do not fall under the other categories

Medications

Medication Lists

Medication Allergies - List any known allergies to any medications or any known interactions from medications.

Prescription Medication List * - List all prescription medications that client takes with dosage and time of day taken. If there are too many to list you can attach a pdf file here of the current prescriptions.

Over-the-Counter Medication List - List all over the counter medications taken with dosage and time of day taken. These can be as needed medications, vitamins, supplements or any regularly taken OTC products.

Short Term Medication List - Please list any short term medications, for example a antibiotic for an infection or UTI, pain medication taken due to a recent issue, etc.

Med Times

Med Times - AM - List details for time and circumstances, i.e, on empty stomach or with food, not to be taken with juice or milk, etc.

Med Times - Midday - List details for time and circumstances, i.e, on empty stomach or with food, not to be taken with juice or milk, etc.

Med Times - Evening - List details for time and circumstances, i.e, on empty stomach or with food, not to be taken with juice or milk, etc.

Med Times - Night - List details for time and circumstances, i.e, on empty stomach or with food, not to be taken with juice or milk, etc.

Med Times - Other - List details for time and circumstances, i.e, on empty stomach or with food, not to be taken with juice or milk, etc.

Medication Administration (Water/Food/etc.)

One at a Time or All at Once? - How does client prefer to take their medication?

With Drink - Is a particular drink used to get medication down, are there any meds that must be taken with a particular drink like water or milk or that must not be taken with a particular drink? Does the client have to moisten their mouth first with their drink?

With Food - Are some meds required to be taken with food or before food on empty stomach?

Cut, Crushed and/or Eaten - Are there some meds that get cut up, crushed or opened and stirred into something edible like yogurt or applesauce?

Other Methods of Taking Medications - List any other methods by which client takes their medications, injection, nebulizer, patch applied, etc.

Other Medication Information

Medication Refusal? - List who to contact and how to handle if resident refuses to take medication.

Special Instructions - List any odd details, like perhaps AM Meds are split into some before food and some after, trouble swallowing without taking a drink first, tries to hide medication so as to not have to take it, etc.

Other - List any oddities about certain medications, for example, one medication may be taken at different doses at different times of day or days of week.

Comments or Issues - Please list here any issues that you have had with medications today.

Ambulation/Safety and Equipment Used

Walking/Mobility Equipment

Cane - Does client use cane for stability?

Walker - Does client use walker and what type, brakes/no brakes?

Wheelchair - Does client use a wheelchair (motorized or manual?), do they require assistance transferring to/from the wheelchair?

Scooter - Does client use a scooter, what type, do they require transfer assistance to/from it?

Other - List any other items used for ambulation or transfer.

Lifts, Transfer Equipment, etc.

Gait Belt - Does client require gait belt for safety in walking and transfers? List any special instructions.

Transfer Board - Does client use a transfer board for safe transfers? List any special instructions.

Sit-to-Stand - Does client require a Sit-to-Stand to be moved from one location to another? List any special instructions.

Hoyer Lift - Does client use a Hoyer Lift for transfer to/from bed? List any special instructions.

Other Equipment - List any other equipment used and any special instructions for that equipment. For example a floor to ceiling poles or ceiling mounted trapeze for transfer assistance, etc.

Comments or Issues

Comments or Issues - List any details here of any issues you came across with ambulation and/or safety during your shift.

Personal Hygeine

Bathing Assistance/Schedule

Bathing Schedule - List Days of Week and/or Times of Day when bathing is scheduled and update this information for the End of Shift Review. List types: bath, shower, bed bath, etc.

Bathing Assistance - List assistance required, for example resident needs help transferring to shower chair, client does their own bathing, resident requires two people for bathing, stand by for help required, etc.

Bed Bath Required - Does client get a bed bath due to mobility issues? List any special instructions.

Products Used - List any special products used for showering/bathing like special soaps, shampoos, lotions, creams, no-water soap or shampoo, etc.

Product Allergies or Special Concerns - List an allergy problems concerns to certain products or any special instructions around certain products.

Tender Areas or Special Care Areas - List any areas that need to be treated with tenderness or areas that require special attention.

Other Bathing Concerns/Issues - List any other details regarding bathing/showering procedures for this client.

Grooming Assistance/Schedule

Assistance with Shaving - Does client need assistance with shaving, is a specific shaving cream, after shave or cologne used? There there any instructions for these procedures?

Assistance with Hair Grooming - Procedures and products/tools used, any fears or anxiety issues around this

Assistance with Make-up - What items does client need help with and what are those procedures. Does client have particular perfumes or colognes?

Nail Care - Does client need help with trimming nails or removing polish and painting nails? If bad we can recommend a podiatrist for trim work.

Products Used - List any special products used when grooming this client. For example, special deodorant, perfume, cologne, powders, creams, etc.

Product Allergies/Issues - List any issues with any particular products or any issues with special products.

Other Grooming Instructions - List any other grooming details client requires.

Oral Hygiene

Dentures/Partial Plate - Does Client Wear Dentures or have a partial plate, if so, what are the procedures around these as far as soaking, removing, brushing, etc.

Assistance with Teeth Brushing - Procedures around brushing of teeth and oral hygiene

Products Used - List any special toothpaste, denture cream, floss, etc. that client uses

Issues (Allergies, Oral Problems, etc.) - Does client have any product allergies, any oral problems that require special attention, etc.

Other Comments or Issues - List any other products or procedures that need to be used and/or followed.

Eye Care

Contacts - Does Client wear contacts, if so what procedures are followed, can they do this themselves or do they require assistance.

Glasses - Does client wear glasses, if so, where are they stored, any specifics on their care?

Eye Injuries, Diseases or Conditions - Does client have cataracts, glaucoma, or any injury or other condition that require special treatment?

Products Used - List any products used for eye care. Special eye drops, solutions for contact care or for glasses cleaning.

Equipment Used - Any special equipment used in caring for the eyes or an eye condition. For example, wears a patch during the day, wears a protective covering over eye at night, etc.

Other Eye Related Comments or Issues - List any other information regarding eye care or issues.

Ear Care

Hearing Aids Worn - List details about hearing aids, when they should be in, what to do with them when taken out, etc.

Ear Injuries, Diseases or Conditions - List any issues pertaining to the health of the residents ear health

Products Used - List any products that are used and how they are used

Equipment Used - List any equipment used in the resident's ear health

Other Ear Related Comments or Issues - List any other details related to the ear health/care of this resident.

Clothing/Dressing Assistance/Schedule

Dressing Assistance - List instructions regarding how client dresses for the day. Can they do this on their own, do they pick out their own clothing, do they require stand-by assistance, do they require full assist to get dressed with no ability to help, etc.

Products Used - Does client wear an adult diaper or pad for incontinence issues, TED hose for circulation, special shoes or any other products during their dressing process.

Equipment Used - Does client wear a brace for any medical issue, a wrap or a boot for support of an injured area, etc.? If so, do they need help with these and are there special instructions for putting these on?

Tender Areas/Special Concerns - List any details regarding tender areas or special concerns when dressing. For example, fall risk must sit to put clothing on, sore ankle, can't lift arms over head, etc.

Other Comments or Issues - Any other details or special instructions for getting client dressed?

Wound/Injury Care

Cleansing - Instructions for cleaning wound or injured area.

Products Used - List special products used for wound or injury care.

Wound Care - List details about products used for dressing/bandaging a wound and any special instructions that should be followed

Injury Care - List any procedures regarding how an injury is treated or cared for. For example, back brace worn when sitting or ankle should be wrapped tightly and elevated, etc.

Equipment Used - List any special equipment used for wound or injury care. For example, special tub used for soaking a wound, or special brace worn on injured area, etc.

Other Comments or Issues - List any other comments or issues regarding wound and injury care procedures or problems.

Comments or Issues

Comments or Issues - List any comments or issues with personal hygiene on your shift.

Sleep Information/Details

Regular Sleep Times

Waking Time - What time does client normally wake for the day?

Mandatory Waking Time - Does client need to be up by a certain time for medication, appointments or for some other reason?

Nap Times - List all nap time information. Does client nap all day, at specific times, do they require to be up at a certain time, etc.

Bed Time - What time does client normally go to bed, are there any issues if they go earlier or later?

Mandatory Bed Time - Does client have to be in bed by a certain time for a specific reason? If so, list reasons here.

Other Sleep Time Information - List any special instructions related to sleep times. For example, must wake every hour to take vitals, should not sleep more than x amount of time during naps, etc.

Sleep Time Routines/Procedures

Bedroom Setup - Does client use a special pillow, do they sleep on their side, back, stomach, do they prefer the door open or closed in the room they are in, do they use heated or special blankets, etc.?

Lighting Details - Does client use a night light, do they leave light on in bedroom, bathroom, elsewhere in the house, etc.?

Sound/Noise Details - Does client sleep with Television, Radio, White Noise in the background, etc.? Are they sensitive to noises in the home, if so list details about these issues.

Bed Alarm - Does client use a bed alarm for caregiver to be notified if they try to get up? If so, list details about how to properly set this up and what to do if it goes off.

Monitoring Equipment - Does client have a sound monitor in their sleep space so caregiver can hear if they wake? If so, list details on setup and what to do when client is moving.

Nightstand Setup - Does client leave items on their nightstand for nighttime use. Items like medication, water, chapstick, etc. Does client have an alarm clock they want to be set or a cell phone they want plugged in? List all information and details with this setup routine.

Sleep Issues - Does client snore, walk in their sleep, talk in their sleep, have other sleep movements, etc. that caregiver should be aware of? List all details here.

Fall Risk - Is client a fall risk if they try to get out of bed unassisted? If so, list details here that are in place to avoid this occurring.

Other Sleeptime Equipment - Does client use any other items while sleeping like a cpap machine, eye mask, sleep cap, etc.?

Other Sleep Details - List any other information not already specified.

Comments or Issues

Sleep Problems - Did resident have any issues sleeping last night? If so, enter time they woke up and how long they were awake for.

Other Sleep Comments or Issues - List any comments or issues experienced with sleep details during your shift.

Toileting

Bathroom Assistance Requirements

Bathroom Visit Assistance Needed - Can client use the restroom on their own or do they require assistance? If assistance needed, list details here. For example, must accompany client to/from restroom, requires transfers to/from toilet, etc.

Equipment Used - Does client have special toileting equipment, for example, bed pan, hand rails, raised seat, transfer board, security pole, etc.?

Bathroom Schedule - List details here if the resident requires a schedule for going to the restroom, for example every 2 hours, before or after meals, etc.

Other Bathroom Details - List any other details regarding toileting, things like this resident requires pants to be pulled all the way to the floor, or this resident has frequent UTIs so be mindful, etc.

Products Used - Does client use any special creams, powders, wipes, etc. when using the restroom, if so list them here.

Adult Diapers

Adult Diapers/Pads - Does client wear adult diapers, if so, all day or only at night and do they wear any other pads or use any other products for incontinence issues?

Changing Products Used - List sizes and types of diapers or pads, any creams, powders or other products used when changing a diaper, etc. List also the location of these items.

Sanitary Products/Procedures - List location of gloves, wipes, other cleanup items as well as how to dispose of soiled items.

Changing Instructions - List any special instructions here, for example, tender on one side, warm wipes before using, use cream only when necessary, etc.

Brief Change Schedule - Does resident require a change at certain time intervals, like every two hours, or do they require a change before or after a certain event like before or after meals, before or after naps, etc.

Adult Diaper Change Outcome - Details regarding the outcome of a change.

Other Comments or Issues - List any other problems/issues with adult diaper changes. Resident gets frequent UTIs so be mindful, resident requires creams put on after diarrhea, etc.

Special Instructions

Special or Unique Instructions - Does client require any special care in using the restroom or changing an adult diaper? Examples, uses a wet washcloth on neck when trying to go, needs the water turned on to try to trigger, can't feel left side so ensure they are sitting properly, etc.

Comments or Issues

Toileting Comments - If there issues or problems with bowels or urination those should be noted for the family

Dietary Information

Dietary Restrictions

Food Allergies - List any known food allergies for this resident.

Medical Restrictions - Does client need a low sodium, low fat or some other type of diet, are soft foods or finger foods required, etc.?

Likes/Dislikes - List here things the resident likes to eat and drink and what they don't if they have any particular likes and dislikes.

Other Details - List any other details here regarding the residents dietary needs that were not covered in the other categories.

Special Instructions/Equipment

Special Equipment - Does client use special utensils, a bib, are drinks served with a straw, etc.

Special Instructions - Does client require finger foods, items cut up, assistance with eating, drinks on a certain side, etc.?

AM Meal Details

Breakfast Likes/Dislikes - List information about Resident's likes and dislikes at the morning meal, things like items they like to eat, if they drink coffee or tea, etc.

Special Equipment/Setup - List here any special equipment or setup revolving around the morning meal. Things like, coffee needs to be cooled before drinking, bib must be worn, needs to eat with a spoon, etc.

AM Meal Results - This is where caregivers will give details of how much or what was eaten if families want to know this. The "Rating" will be used for how much of their food was eaten 0 being they didn't eat at all and 9 being they ate all food served to them.

Midday Meal Details

Lunch Likes/Dislikes - List information about Resident's likes and dislikes at the midday meal, things like items they like to eat or don't like, what drinks they enjoy, etc.

Special Equipment/Setup - List here any special equipment or setup revolving around the midday meal. Things like foods need to be cut up, drinks need to be on the right hand side, etc.

Midday Meal Results - This is where caregivers will give details of how much or what was eaten if families want to know this. The "Rating" will be used for how much of their food was eaten 0 being they didn't eat at all and 9 being they ate all food served to them.

PM Meal Details

Dinner Likes/Dislikes - List information about Resident's likes and dislikes at the evening meal, what they like and don't like to eat or drink.

Special Equipment/Setup - List here any special equipment or setup revolving around the evening meal. Things like bib must be worn, needs meat cut up to small pieces, drink must be on left side, etc.

Evening Meal Results - This is where caregivers will give details of how much or what was eaten if families want to know this. The "Rating" will be used for how much of their food was eaten 0 being they didn't eat at all and 9 being they ate all food served to them.

Snack Event Details

Snack Likes/Dislikes - List items around snacking for this resident. Things like they enjoy an evening snack while watching TV, or they like an afternoon cookie with a hot drink, etc.

Special Equipment/Setup - List details about resident's snack time. Things like, likes to have a cookie while in their recliner or use a cup with a lid when drinking in the living area, etc.

Snack Results - This is where caregivers will give details of how much or what was eaten if families want to know this. The "Rating" will be used for how much of their food was eaten 0 being they didn't eat at all and 9 being they ate all food served to them.

Comments or Issues

Dietary Comments/ Issues - List any other dietary issues not specifically mentioned in the other categories.

Cognition

Cognition Level (1-10)

General Cognition Level - Enter a number from 0-9, with 9 being very aware and alert and 0 being no longer aware of their surroundings, loved ones, daily routines.

Cognition Level Today - List any details regarding this resident's cognitive status and how it effects their behavior and ADLs.

Engagement Likes/Dislikes

Social

Church - Does client belong to a Church and if so what is their schedule for this. Who takes them to this?

Clubs or Groups - Does client belong to any clubs or groups, for example, card playing club, senior group, etc. List any details here.

Visiting Friends - Does client enjoy going to friends' homes? List any details here.

Plays or Movies - Does client enjoy going to plays or movies? Who takes them to these activities? List details here.

Interactive and/or Cognitive

Card Playing - Does client enjoy playing cards and if so what kinds of games do they know how to play? List any details here.

Reading - Does client enjoy reading or being read to? List details here.

Jigsaw Puzzles - Does client enjoy jigsaw puzzles, and do they need help? List any details here.

Board Games - Does client enjoy board games and if so where are they and do they need help? List any details here.

Puzzle Books - Does client enjoy working puzzles (crosswords, sudoku, etc.)? List any details here.

Personal Computer/Tablet - Does client enjoy working on the computer, do they need assistance with this? List all details here.

Hobbies - Does client have any hobbies, for example, knitting, stamp collecting, scrapbooking, etc.) that they enjoy and do they need assistance? List details here.

Cognitive Activities Today - What activities did this resident participate in.

TV Interests

Favorite Shows - Does client have particular shows they enjoy? List details here.

Favorite Channels - Does client have certain channels they enjoy? List details here.

Sports - Does client enjoy watching any sports? List details here.

DVD/VCR/DVD - Does client have any recorded items they enjoy watching regularly? List details here.

Music Interests

Music Interests - Does client enjoy certain types or certain artists in particular? Does music help to stabilize their mood? Is there any music they do NOT enjoy. List details here.

Play Instrument - Does client play an instrument? List any details here.

Other Likes

Other - List other activities/engagements that client enjoys.

Other Dislikes

Client Dislikes - Activities or engagement that client does NOT want to participate in.

Comments or Issues

Comments or Issues - Comments or issues related to client engagements and interaction. Things like certain activities help to stabilize their mood, certain activities cause them to get agitated, they don't play with with certain residents or caregivers, etc.

Other Information

FACE Sheet Details

Previous Address - List previous address here, required for state regulation of group homes.

Sponsor (Referring Agency/Person) - List agency or person who brought this client to Our Family Home. This is required for state regulations of group homes.

Comments or Issues

Comments or Issues - List any issues you had today with any non-specific are items. This could be anything from family caregiver arrived late today to the hidden key was not in its usual spot today.

[end]