

# Care Planning

**Using the Care Plan Template on the National  
interRAI Software System**

18 May 2015, V9



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# Chapter 1

## Developing a Care Plan

### Chapter Contents

- Planning Nursing Care
- Professional and Legal Responsibilities
- Recommended Best Practice
- The Assessment Summary – linking the assessment to the Care Plan
- Assessment Summary Overview

### Chapter Learning Outcome

The learner will know how to develop a Care Plan based on assessment findings that meets professional and legal requirements and follows recommended best practice.

### Introduction

Once the interRAI Comprehensive Clinical Assessment is complete the next stage in the process is to respond to the assessment findings (i.e. Clinical Assessment Protocols ('CAPs') and 'Outcome Scores') by developing an appropriate plan of care for the resident.

The Software you are using to complete interRAI assessments also has a built-in Care Plan template. The use of the Momentum Care Planning Template is at the discretion of your Facility.

**You do not have to use this part of the software for your Care Plan development if a separate Care Plan format or process exists within your Facility.**

**The use of the Care Planning Template is at the discretion of your Facility.**

You must take into account the triggered CAPs and Outcomes Scores in any Care Plan you produce. In addition, if you believe issues exist but have not triggered CAPs, then you should also include those in the Care Plan, i.e. incorporate 'standard' care.

You have probably been creating Care Plans throughout your entire career and possess important skills and experience. These continue to be necessary in the Care Planning process following a comprehensive clinical assessment.

Before looking at how the Care Plan is recorded using the software, here is a quick recap of the skills and process used to develop nursing Care Plans for people living in aged residential care facilities.

## Planning Nursing Care

It is generally agreed that a nursing Care Plan is based on a nursing assessment and a nursing diagnosis, carried out by a nurse. It has four essential stages:

1. Identify the nursing diagnoses (problems or 'Focus' that nursing care can address).
2. State the expected benefit to the person (goals or expected outcomes).
3. State the specific actions the nurse will take to achieve the goals (interventions).
4. Evaluate the person's response to nursing actions and adjust the actions as required (evaluations).

## Professional and Legal Responsibilities

As a Registered Nurse you have professional and legal responsibilities around Care Planning. These are described in a number of documents. Care Plans should always adhere to these requirements:

### Nursing Council of New Zealand Registered Nurses scope of practice

This states that Registered Nurses: "... provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care..."<sup>1</sup>

### Age Related Residential Care Services Agreement<sup>2</sup>

This is the contract that your Facility has with the local District Health Board to provide residential care for older people. The contract states that each subsidised resident must have a Care Plan that is followed by all staff to guide care delivery.

Key points relating to Care Plans are:

- Based on an initial assessment that includes physical, psycho-social, spiritual and cultural aspects.
- Developed, documented and evaluated by an Registered Nurse within three weeks of admission.
- Considers the experiences and choices of the resident.
- Provides the resident and family/whānau with the opportunity to have input.
- Addresses the current abilities, level of independence, identified needs/deficits and takes into account personal preferences and individual habits, routines and idiosyncrasies.
- Addresses personal care needs, health care needs, rehabilitation/habitation needs, maintenance of function, and care of the dying.

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<sup>1</sup> Competencies for Registered Nurses, Nursing Council of New Zealand, December 2007

<sup>2</sup> Age-Related Residential Care Services Agreement: Provision of Aged Related Residential Care (2012) sections D16.2 to D16.4

<http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/age-related-residential-care-services-agreement>

- States actual or potential problems/deficits and sets goals for rectifying these and details required interventions.
- Must be evaluated every six months or following a change in resident health status.

## Health and Disability Services Standards 2008<sup>3</sup>

All hospitals, rest homes and those providers of residential disability care that have five or more residents need to meet the Health and Disability Services Standards 2008. The Standards cover all aspects of care. In terms of Care Plans, the Standards require that:

- Plans are individualised, accurate and up to date.
- Describe the desired support and/or intervention to achieve the desired outcomes identified by the on-going assessment process.
- Demonstrate service integration.
- For mental health consumers, they show early warning signs and relapse prevention.
- Are communicated in a manner that is understandable to the consumer and service provider responsible for the implementation and with consent their family/whānau of choice.

## Recommended Best Practice

The conditions listed above are the minimum professional and legal requirements. There are other important elements that you should consider when producing a Care Plan:

- **Make it achievable.** An effective Care Plan is realistically aimed at either improving or maintaining the resident's level of health and independence with the available interventions and resources.
- **Make it understandable.** The most effective Care Plan is not the one with the longest words and technical jargon but the one written in such a way that all staff, especially caregivers, can understand.
- **Make it comprehensive.** Does it fully use the information from the assessment? CAPs and Outcome Measures really do highlight the areas where intervention will make a difference.
- **Make it collaboratively.** Do the resident and their family/whānau fully understand and agree? Follow your Facility processes for signatures on the Care Plan.

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<sup>3</sup> Health & Disability Services Standards NZ 8134.1.3.5:2008

<http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-healthcare-services/health-and-disability-services-standards>

## Assessment Summary

The Assessment Summary section is the pivotal point of the assessment and Care Planning process and where you begin to utilise the strength of interRAI. This section forms the link

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### KEY POINT

*The Assessment Summary is crucial to the whole assessment and Care Planning process.*

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between your assessment and your plan of care and it is here that you will see the 'CAPs' identified for the first time.

In this section you record which 'CAP' areas are being included in the Care Plan, *including those areas that have not triggered 'CAPs'* but you want to include in standard Care Planning.

The Assessment Summary displays the triggered 'CAPs' and the level of those triggers. You include a 'CAP' in the Care Plan to:

- Resolve the problem,
- Reduce the risk of decline,
- Utilise potential for improvement.

You need to make a clinical decision as to which 'CAPs' will be included in the Care Plan. If you decide not to include a triggered 'CAP' in the Care Plan, your clinical decision making process or reasoning **must** be recorded in the 'Assessment Summary' text box.

When creating the Care Plan, you need to consider the reason the 'CAP' was triggered and consider the influence of any outcome measure. The *CAPs Manual* (orange) provides guidance on managing areas identified in the 'CAPs'. This evidence based manual provides decision support for nurses and has been shown to be effective for improvement of care for the older person.

The interventions you include in your Care Plan will take account of your Facility's policies and best practice procedures.



## Process for selecting 'CAPs' for Care Plan

1. Identify the reason the 'CAP' is triggered, the level of the trigger, and the opportunity or risk that is identified. 'CAPs' are identified at three different levels (level 1, 2 and 3) or by descriptors (high, medium, low or prevent decline, facilitate improvement), and can be a combination of the two. The 'CAPs' identify those who have a higher than expected likelihood of declining, and those who have an increased potential for improvement<sup>4</sup>. Your *CAPs Manual* (orange book) provides guidance on how these 'CAPs' might be addressed.
2. Consider the 'Outcome Scales' and how these might influence the priority of issues and your ability to address the risks and opportunities.
3. When considering what 'CAPs' to include and how these will be addressed, examine the resources available to you, your resident's preferences, strengths and needs.
4. Identify 'CAPs' to be included in your Care Plan by ticking the box 'Addressed in Care Plan'.
5. Record 'Standard Care' by identifying those 'CAPs' **not** triggered but which still need to be included in the Care Plan – tick the box 'Addressed in Care Plan'. Make a note that this will be included in the Care Plan and state the clinical reason for including it along with where in the Care Plan the need is addressed.
6. Complete notes in the text box provided for each triggered 'CAP' that you are **not** including in the Care Plan. These notes should record the clinical reasoning behind your decision. This record will then be available to you to remind you, at a later date, of your reasoning behind the Care Planning decision you have made at this point in time.

## Assessment Summary Overview

- When a 'CAP' has triggered and an intervention will be provided in the Care Plan – tick 'Addressed in Care Plan'.
- When a 'CAP' has triggered but an intervention will be **not be** provided in the Care Plan – record clinical reasoning in the large note box for not including 'CAP' in the Care Plan.
- When a 'CAP' has not triggered but support or standard care will be provided and included in the Care Plan – tick 'Addressed in Care Plan' and name/briefly describe the identified need and name of Care Plan area in the large note box (as shown in Figure 2).

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<sup>4</sup> Morris J., Berg K., Bjorkgren M., Finne-Soveri H., Fries B., Frijters D., Gilgen R., Gray L., Hawes C., Henrard J., Hirdes J., Ljunggren G., Nonemaker S., Steel K. & Szczerbinnska K. (2010). *interRAI Clinical Assessment Protocols (CAPs) For Use with Community and Long-Term Care Assessment Instruments* version 9.1. Washington: interRAI.

## Process for selecting 'CAPs' for standard care

Fill out a Form

Rai, Terry Ray NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 80

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis Fill out a Form

Return

Return to Summary Save as Draft Check Errors Print Prev Next Section Help

A B C D E F G H I J K L M N O P Q R AS S

Completed By Title Completed Date

**ASSESSMENT SUMMARY**

CAP	Triggered	Addressed in care plan	Assessment Summary
1 Physical Activities Promotion	Triggered (L1)	<input type="checkbox"/>	
3 Activities of Daily Living	Prevent Decline (L1)	<input type="checkbox"/>	
6 Physical Restraints		<input type="checkbox"/>	
7 Cognitive Loss	Monitor (L1)	<input type="checkbox"/>	
8 Delirium		<input type="checkbox"/>	

You are likely to include additional 'Foci' in your Care Plan for issues that did not trigger a 'CAP'. This may be because the resident needs ongoing support to manage an existing need. This is called standard care. Find the 'CAP' area associated with the 'Focus'. Indicate you are including this in the Care Plan by **ticking the box and briefly describing where in the Care Plan this need is addressed and why (state clinical reason).**

Fill out a Form

Rai, Terry Ray NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 80

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis Fill out a Form

Return

Return to Summary Save as Draft Check Errors Print Prev Next Section Help

A B C D E F G H I J K L M N O P Q R AS S

Completed By Title Completed Date

**ASSESSMENT SUMMARY**

CAP	Triggered	Addressed in care plan	Assessment Summary
1 Physical Activities Promotion	Triggered (L1)	<input type="checkbox"/>	
3 Activities of Daily Living	Prevent Decline (L1)	<input type="checkbox"/>	
6 Physical Restraints		<input type="checkbox"/>	
7 Cognitive Loss	Monitor (L1)	<input checked="" type="checkbox"/>	
8 Delirium		<input type="checkbox"/>	

1. 'Tick' the checkbox to include 'CAP' in Care Plan.

2. Briefly describe where in your Care Plan the 'CAP' / resident's need is being addressed and why.

You need to make a clinical decision as to which CAPs will be included in the care plan. If you decide not to include a triggered CAP in the care plan, your clinical decision making process or reasoning must be recorded in the Assessment Summary text box.

# Chapter 2

## Copying a Previous Care Plan

### Chapter Contents

- Reviewing Previous Care Plans in the software system
- Copying a Previous Care Plan

### Chapter Learning Outcomes

The learner will understand how to review previous Care Plans, if they exist. They will understand how to copy and update a previous Care Plan.

### Introduction

**This chapter of the Care Plan book, “Copying a Previous Care Plan”, deals with the situation where a Care Plan for your Resident has already been created in the Momentum Software.**

**The next chapter, “Creating a new Care Plan”, covers creating a new Care Plan for your Resident. You will only do this if you are creating the first Care Plan for this Resident in the Momentum Software.**



# Reviewing Previous Care Plans

To review a previous Care Plan, from the 'Resident Overview' screen click on the 'Care Plan' tab to view the Care Plan list.

**View Care Plan List**

Care PI

Resident Search Resident Overview ADT Forms **Care Plan** interRAI Progress Notes Physician Orders QIs CAPs Outcomes

Save

Next Care Plan Review:

Add Copy Show History

Care Plan Type	Status	Start Date
Home Care	Active	02-07-2014

1. 'Click' on the folder on the left of the screen.

In the example below a Care Plan that was created in the Home Care setting is displayed.

**Edit Care Plan**

Care Plan, Example

NHI: 2227001  
Date of Birth: 10-10-194  
Gender / Age: Female / 7

Resident Search Resident Overview ADT Forms **Care Plan** interRAI Progress Notes Physician Orders QIs CAPs Outcomes

Return Save

Status: Active  
Authorized: Downes, Andrew  
Start Date: 02-07-2014  
End Date:   
Comments & Contingency Plan Intervention List

Presenting Situation  
02-07-2014  
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua. Ut enim ad minim veniam, quis nostrud exercitation ullamco laboris nisi ut aliquip ex ea commodo consequat. Duis aute irure dolor in reprehenderit in voluptate velit esse cillum dolore eu fugiat nulla pariatur. Excepteur sint occaecat cupidatat non proident, sunt in culpa qui officia deserunt mollit anim id est laborum

2. 'Click' on 'Presenting Situation' button to view recorded notes.

3. 'Click' on 'Return' button to go back to the previous screen.

Select Expected Outcome

Rank	Start Date	Expected Outcome	Evaluation Date	Evaluation Status
1	02-07-2014	Client will mobilize safely	31-07-2014 12:00 AM	partially achieved

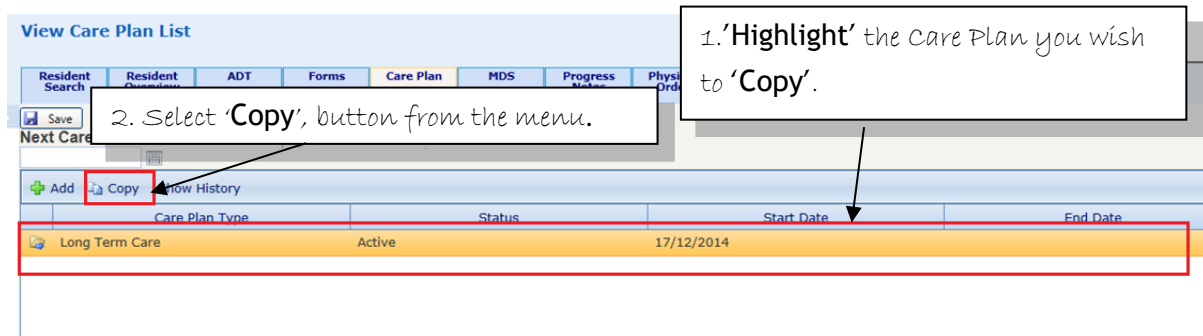
Select Disciplines

	Start Date	End Date	Provider and Schedule	Monthly Hours	Schedule Detail
1	02-07-2014	24-07-2014	Physician - Starting July 2, 2014, Ev...	000 hrs, 00 mins	

# Copying a Previous Care Plan

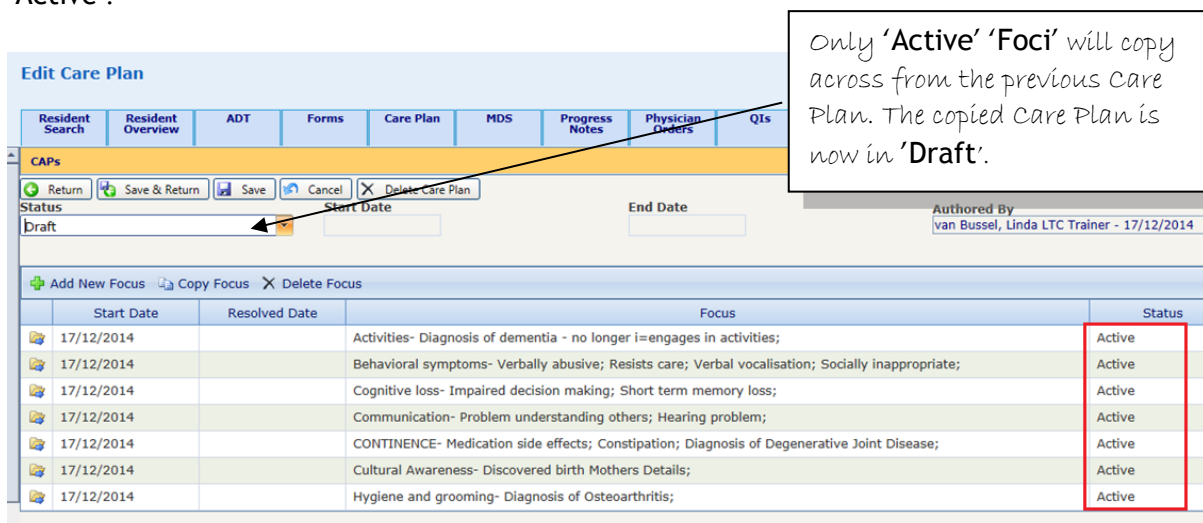
If there is a *previous Care Plan*, click 'Copy' to copy that previous Care Plan across.

To 'Copy' an existing Care Plan from the 'Care Plan List', highlight the present Care Plan and select 'Copy' button from the menu. There will only ever be one there.



Once the Care Plan has been copied you can then work on the Care Plan.

The copied Care Plan will appear in the list as a draft, however the 'Foci' 'Status' will be 'Active'.



Each of the 'Foci' must be saved as a 'Draft' before further editing.

Now click on a specific Care Plan 'Focus'. We need to make 'Focus' 'Draft' and click 'Save'.

**Edit Focus**

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs

CAPs

Return Save & Return Save Prev Next

Focus:

Activities

Status: Active

Start Date: 17/12/2014 End Date:

Modified Date: 17/12/2015

Associated

Select Related Factors

Related Factor

Diagnosis of dementia - no longer i=engages in activities

Start Date Expected Outcome Evaluation Date Evaluation Status

17/12/2014 Joan will experience a sense of enjoyment and wellbeing in life over the next 180 days

Select Interventions

Start Date	End Date	Intervention	Discipline	Schedule
17/12/2014	12/06/2015	ACTIVITIES MANAGEMENT	Diversional Therapist, All care st...	Every Day

'Click' on a specific Care Plan focus. Then under 'Status' from the drop down menu select 'Draft'.

The 'Focus' now needs to be edited.

https://southern.interrai.health.nz/Production/CarePlan/EditFocus.aspx

Momentum Healthware

Anyone, Bob NHI: TJM9999 Date of Birth: 27/08/1923 Gender / Age: Male / 91

Home | Help | Logout

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Edit Focus

Common Tasks

Resident Overview

Enter a New Progress Note

Search for a Resident

My Recent Residents

To Do Dashboard

Information Recap Dashboard

Add a New Resident

Bed Occupancy

Bed Swap

Transfer Residents

Change Working Facility

Incomplete MDS Assessments

ADT

Assessments/Forms

Care Plan

Demographics

Names

Identifiers

Personal Details

Phone Numbers

Addresses

Photos

Contacts

CAPs

Return Save & Return Save Prev Next

Focus:

Activities

Status: Draft

Start Date: 17/12/2014 End Date:

Last Modified By: Allen, Richard (Mr.) LTC System Clinician Last Modified Date: 13/02/2015

Select Related Factors

Related Factor

Diagnosis of dementia - no longer i=engages in activities

Select Expected Outcomes

Start Date	Expected Outcome
17/12/2014	Joan will experience a sense of enjoyment and wellbeing in life over the next

Select Interventions

Start Date	End Date	Intervention	Discipline	Schedule
17/12/2014	12/06/2015	ACTIVITIES MANAGEMENT	Diversional Therapist, All care st...	Every Day

1. 'Click' on 'Select Related Factors'.

**MOMENTUM HEALTHCARE** Select Related Factors

Home | Help | Logout

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Select Related Factors

Common Tasks

- Resident Overview
- Enter a New Progress Note
- Search for a Resident
- My Recent Residents
- To Do Dashboard
- Information Recap Dashboard
- Add a New Resident
- Bed Occupancy
- Bed Swap
- Transfer Residents
- Change Working Facility
- Incomplete MDS Assessments
- ADT
- Assessments/Forms
- Care Plan
- Demographics
- Names
- Identifiers
- Personal Details
- Phone Numbers
- Addresses
- Photos
- Contacts

Return Save & Return

Focus: Activities

Show only selected

Show entire Library

Add Related Factor Not Found in Library

Related Factor	Non-Library
<input checked="" type="checkbox"/> Diagnosis of dementia - no longer i=engages in activities	<input checked="" type="checkbox"/>
<input type="checkbox"/> Diagnosis of Cancer	<input type="checkbox"/>
<input type="checkbox"/> Activity involvement potential for increase	<input type="checkbox"/>
<input type="checkbox"/> Activity involvement requires staff initiation	<input type="checkbox"/>
<input type="checkbox"/> Activity involvement optimal	<input type="checkbox"/>
<input type="checkbox"/> Activity involvement limited to sensory stimulation and passive participation	<input type="checkbox"/>

2. 'Click' on a 'Related Factor'.

You can choose from a 'Library' of 'Related Factors' or create your own.

To edit expected outcomes 'Click' on 'Select Expected Outcome'.

**MOMENTUM HEALTHCARE** Edit Focus

Home | Help | Logout

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Edit Focus

Common Tasks

- Resident Overview
- Enter a New Progress Note
- Search for a Resident
- My Recent Residents
- To Do Dashboard
- Information Recap Dashboard
- Add a New Resident
- Bed Occupancy
- Bed Swap
- Transfer Residents
- Change Working Facility
- Incomplete MDS Assessments
- ADT
- Assessments/Forms
- Care Plan
- Demographics
- Names
- Identifiers
- Personal Details
- Phone Numbers
- Addresses
- Photos
- Contacts

Return Save & Return Save Prev Next

Focus: Activities

Status: Draft Start Date: 17/12/2014 End Date:

Last Modified By: Allen, Richard (Mr.) LTC System Clinician Last Modified Date: 13/02/2015

Select Expected Outcomes

Start Date	Expected Outcome	Evaluation Date	Evaluation Status
17/12/2014	Joan will experience a sense of enjoyment and wellbeing in life over the next 180 days		

Select Interventions

Start Date	End Date	Intervention	Discipline	Schedule
17/12/2014	12/06/2015	ACTIVITIES MANAGEMENT	Diversional Therapist, All care st...	Every Day

1. Hover the mouse over the line if you wish to read the full text of 'Expected Outcome'. 'Click' on the text if you wish to edit.

3. 'Click' on 'Save & Return'.

2. 'Click' on the text to personalise Outcome description, i.e. putting in the Resident's name

3. Click on the specific 'Expected Outcome' to set an end date for a 'Selected Outcome'.

4. 'Click' the 'Calendar' icon next to the 'End Date' and choose a date for the six monthly review.

5. 'Click' on 'Save & Return'.



(Optional) Select a 'Classification' from the drop down menu. See the example of 'Medium term objective goal.'

**Expected Outcome Evaluations**

Anyone, Bob NHI: TJM9999 Date of Birth: 27/08/1923 Gender / Age: Male / 91

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Expected Outcome Evaluations

Common Tasks: Resident Overview, Enter a New Progress Note, Search for a Resident, My Recent Residents, To Do Dashboard, Information Recap Dashboard, Add a New Resident, Bed Occupancy, Bed Swap, Transfer Residents, Change Working Facility, Incomplete MDS Assessments, ADT, Assessments/Forms, Care Plan, Demographics, Names, Identifiers, Personal Details, Phone Numbers, Addresses, Photos, Contacts

Focus: Activities

Expected Outcome: Joan will experience a sense of enjoyment and wellbeing in life over the next 180 days

Start Date: 17/12/2014 End Date: 13/08/2015

Classification: -- Please select an item --  
 -- Please select an item --  
 Long term objective/goal  
 Medium term objective/goal  
 Short term objective/goal

6. From the 'Classification' drop down menu select the 'objective'.

7. Then click 'Save & Return'.

## Adding an Intervention

We recommend that you add your own 'Intervention(s)'.

**Edit Focus**

Anyone, Bob NHI: TJM9999 Date of Birth: 27/08/1923 Gender / Age: Male / 91

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Edit Focus

Common Tasks: Resident Overview, Enter a New Progress Note, Search for a Resident, My Recent Residents, To Do Dashboard, Information Recap Dashboard, Add a New Resident, Bed Occupancy, Bed Swap, Transfer Residents, Change Working Facility, Incomplete MDS Assessments, ADT, Assessments/Forms, Care Plan, Demographics, Names, Identifiers, Personal Details, Phone Numbers, Addresses, Photos, Contacts

Focus: Activities

Status: Draft Start Date: 17/12/2014 End Date: 13/02/2015

Last Modified By: Allen, Richard (Mr.) LTC System Clinician Last Modified Date: 13/02/2015

Select Expected Outcomes

Start Date	Expected Outcome	Evaluation Date	Evaluation Status
17/12/2014	Joan will experience a sense of enjoyment and wellbeing in life over the next 180 days		

1. 'Click' on the 'Select Interventions' button.

'Add' a new intervention or 'Edit' an existing 'Intervention'.

Select Interventions

nt sw | ADT | Forms | Care Plan | MDS | Progress Notes | Physician Orders | QIs | CAPs | Outcomes

Return Save & Return

Focus: ADL function

Show only selected Filter by Category: All

Show entire Library Filter by Discipline: All

+ Add Intervention Not Found in Library

Intervention	Category
<input type="checkbox"/> Analgesics before activities causing pain	
<input type="checkbox"/> Consult Occupational Therapy	
<input type="checkbox"/> Consult Physical Therapy	Consults
<input type="checkbox"/> Define ADL needs	ADL
<input type="checkbox"/> Encourage and praise all efforts at independence	
<input type="checkbox"/> Monitor nutritional intake	
<input type="checkbox"/> Monitor for decline in ADL performance	
<input type="checkbox"/> Reinforce teaching	
<input type="checkbox"/> Review safety precautions	Safety

2. To 'Add' a new intervention 'Click' on the 'Add' button.

3. You can also write your own intervention here.

Select Interventions

nt sw | ADT | Forms | Care Plan | MDS | Progress Notes | Physician Orders | QIs | CAPs | Outcomes

Return Save & Return

Focus: ADL function

Show only selected Filter by Category: All

Show entire Library Filter by Discipline: All

+ Add Intervention Not Found in Library

Intervention	Category
<input checked="" type="checkbox"/> DRESSING	
<input checked="" type="checkbox"/> PERSONAL HYGIENE	
<input type="checkbox"/> Analgesics before activities causing pain	Treatments
<input type="checkbox"/> Consult Occupational Therapy	Consults
<input type="checkbox"/> Consult Physical Therapy	Consults
<input type="checkbox"/> Define ADL needs	ADL
<input type="checkbox"/> Encourage and praise all efforts at independence	Psychosocial
<input type="checkbox"/> Monitor nutritional intake	Nutrition
<input type="checkbox"/> Monitor for decline in ADL performance	Treatments
<input type="checkbox"/> Reinforce teaching	Teaching
<input type="checkbox"/> Review safety precautions	Safety

4. 'Save & Return'.

Update the schedule details for the 'Intervention'.

**Edit Focus**

Rai, Terry Ray NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 80

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis **Edit Focus**

**CAPs**

Return Save & Return Save Prev Next

Focus: Activities  
Status: Draft Start Date: End Date:  
Last Modified By: Allen, Richard RN Last Modified Date: 22-08-2014

Select Related Factors  
Related Factor  
Activity involvement requires staff initiation

Select Expected Outcomes  
Start Date Expected Outcome  
22-08-2014 Terry will have purposeful interactions and sensory stimulation initiated by staff to support current level of function

Select Interventions  
Start Date End Date Intervention Discipline Schedule  
Create your own intervention  
Encourage and praise all efforts at independence  
Encourage participation in activities of choice

1. 'Click' on the 'Calendar' icon of the 'Intervention'.

https://southern.intelrai.health.nz/Production/Common/ScheduleDetailsAndTasks.aspx Momentum Healthcare New Tab

**Schedule Details**

Anyone, Bob NHI: TJM9999  
Date of Birth: 27/08/1923  
Gender / Age: Male / 91

Home | Help | Logout Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes **Schedule Details**

Common Tasks  
Resident Overview  
Enter a New Progress Note  
Search for a Resident  
My Recent Residents  
To Do Dashboard  
Information Recap  
Dashboard  
Add a New Resident  
Bed Occupancy  
Bed Swap  
Transfer Residents  
Change Working Facility  
Incomplete MDS Assessments

ADT  
Assessments/Forms  
Care Plan  
Demographics  
Names  
Identifiers  
Personal Details  
Phone Numbers  
Addresses  
Photos  
Contacts

Focus: Activities  
Intervention: ACTIVITIES MANAGEMENT  
Schedule Details

Schedule Note  
Start Date/Time 17/12/2014 11:04 AM  
End Date/Time December 2014  
Reoccurrence Schedule S M T W T F S  
49 30 1 2 3 4 5 6  
50 7 8 9 10 11 12 13  
51 14 15 16 17 18 19 20  
52 21 22 23 24 25 26 27  
1 28 29 30 31 1 2 3  
2 4 5 6 7 8 9 10

Disciplines Responsible  
Show only selected  
Add Discipline Not Found in Library

Discipline Non-Library  
Activity Coordinator  
All care staff  
Clinical Nurse Manager  
Diversional Therapist  
Enrolled Nurse/Nurse Assistant  
Occupational Therapy

'Click' on the 'Calendar' icon. The 'Time' will come up as the time you are entering. Do put the 'End Date' below or enter 180 days under 'Duration' as one will auto populate.

Select 'Reoccurrence Schedule' and 'Disciplines Responsible'.

1. 'Click' on the 'Reoccurrence Schedule' and select using the radio button.  
Note: Make sure you choose the appropriate 'Reoccurrence Schedule' i.e Daily

2. Choose 'Disciplines' check 'tick boxes'.

Click on 'Show only selected' and this will reduce 'Disciplines' on your screen to only those you have chosen.

You will have existing 'Interventions' that you will want to add or edit.

Instructions for staff can be detailed in 'Comments' field. You can change 'Interventions' in the 'Comments' section. This is where you tell your staff how to care for your residents.

It is important to save the work after every change: click on 'Save & Return'.

Make the 'Focus' 'Active' from the drop down menu under 'Status'.

1. Select 'Active' from the drop down menu 'Status'.

2. 'Click' on 'Save & Return'

Repeat these steps for each 'Focus' you add, and click 'Save & Return'.

The 'Active' 'Focus' move to the bottom of the list.'

Repeat the steps above for each 'Focus', to make each 'Focus' 'Active'.

Once all 'Foci' are checked and are 'Active' you can then activate the whole Care Plan.

Make the Care Plan 'Active' (do not do this until all 'Foci' are edited....if you do then repeat copy-edit process).

You can't edit an 'Active' Care Plan, or print a 'Draft'.

**Make the Care Plan 'Active.'**

Start Date	Resolved Date	Focus	Status
13/02/2015		Activities- Diagnosis of dementia - no longer i=engages in activities;	Active
13/02/2015		Behavioral symptoms- Verbally abusive; Verbal vocalisation; Resists care; Socially inappropriate;	Active
13/02/2015		Cognitive loss- Impaired decision making; Short term memory loss;	Active
13/02/2015		Communication- Hearing problem; Problem understanding others;	Active
13/02/2015		CONTINENCE- Diagnosis of Degenerative Joint Disease; Medication side effects; Constipation;	Active
13/02/2015		Cultural Awareness- Discovered birth Mothers Details;	Active
13/02/2015		Hygiene and grooming- Diagnosis of Osteoarthritis;	Active

Set the Care Plan Review Date.

**1. 'Click' on 'Care Plan'.**

**2. 'Click' on the 'yellow folder' for the 'Care Plan' you want to review.**

Care Plan Type	Status	Start Date	End Date
Long Term Care	Active	13/02/2015	

Add 'Date' and 'Save'. The date must be put in manually.

https://southern.interrai.health.nz/Production/CarePlan/CarePlanListMultiType.aspx

Momentum Healthcare

Anyone, Bob NHI: TJM9999 Date of Birth: 27/08/1923 Gender / Age: Male / 91

Home | Help | Logout

Resident Search Resident Overview ADT

Common Tasks

Resident Overview

Enter a New Progress Note

Search for a Resident

My Recent Residents

To Do Dashboard

Information Recap Dashboard

Add a New Resident

Bed Occupancy

Bed Swap

Transfer Residents

Change Working Facility

Incomplete MDS Assessments

Care Plan

View Care Plan List

Add a New Care Plan

Care Plan Summary View

Evaluate Outcomes

Reports

User preferences

Save

Next Care Plan Review: 02/08/2015

2. 'Click' on 'Save'

1. 'Add the date', using the 'Calendar'.

Care Plan Type	Status	Start Date	End Date
Long Term Care	Active	13/02/2015	

The date displays on the 'Resident Overview' screen.

https://southern.interrai.health.nz/Production/ClientMgmt/CCROverview.aspx

Momentum Healthcare

Anyone, Bob NHI: TJM9999 Date of Birth: 27/08/1923 Gender / Age: Male / 91

Home | Help | Logout

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes

Common Tasks

Resident Overview

Enter a New Progress Note

Search for a Resident

My Recent Residents

To Do Dashboard

Information Recap Dashboard

Add a New Resident

Bed Occupancy

Bed Swap

Transfer Residents

Change Working Facility

Incomplete MDS Assessments

Demographics

Names

Identifiers

Personal Details

Phone Numbers

Addresses

Photos

Contacts

Providers

Additional Information

Confidentiality

Full Name: Anyone, Bob (Mr.)

Date of Birth: 27/08/1923

Age: 91

Gender: Male

Record Status: Active

Likes to be called: Bob

Primary Language: Afrikaans

Marital Status: Widowed

Primary ID: TJM9999

Allergies: Nil

Diet:

Primary Diagnoses: A test, COPD, Gout, Hypertension, Osteoporosis

Advance Directives: Nil

Providers: Viljoen, Shelley National InterRAI LTC Trainer - Registered Nurse

Primary Contact: Another Contact - Family, Relationship: Cousin, Work Phone: Home Phone: 03 399 1111, Mobile Phone: Comments:

Resident Safety Concerns: Falls risk

Infection Precautions: Universal Precautions

End of Life Instructions:

Next Assessment: 02/07/2014 - ILTCF 9.1

Next Care Plan Review: 02/08/2015



# Chapter 3

## Creating a **New** Care Plan

### Chapter Contents

- Creating a **new** Care Plan
- Stage 1– Adding a Focus and reviewing ‘CAPs’
- Stage 2 – Add Related Factors
- Stage 3 – Choose Expected Outcomes
- Stage 4 – Add Interventions
- Stage 5 – Schedule the Interventions
- Stage 6 – Making the Care Plan active

### Chapter Learning Outcomes

The learner will understand how to create a **new** Care Plan, if there are no previous Care Plans, and record it in the software.

### Introduction

**Remember if there is a previous Care Plan for the resident, you will not create a new Care Plan, you will copy a previous Care Plan following the process described in the previous chapter Copying a Previous Care Plan.**

Once the Comprehensive Clinical Assessment is complete the next stage in the process is to respond to the assessment findings (i.e. ‘CAPs’ and ‘Outcome Scores’) by developing an appropriate plan of care for the resident.

This chapter teaches you how to create a Care Plan in the software in six stages.

You must take account of the triggered ‘CAPs’ and ‘Outcomes Scores’ in any Care Plan you produce. In addition, if you believe issues exist but have not triggered ‘CAPs’, then you should also include those in the Care Plan, i.e. incorporate ‘standard’ care.

In addition to the CAP focused care detailed above you must also use your clinical judgment and incorporate standard care into your Care Plan.

# Creating a **New** Care Plan (first ever Care Plan using Momentum software)

Go to the 'Resident Overview' screen.

**Resident Overview**

Resident Search	Resident Overview	ADT	Forms	Care Plan	MDS	Progress Notes	Physician Orders	QIs	CAPs	Outcomes
<b>Full Name</b> Rai, Terry Ray (Mr.)		<b>Date of Birth</b> 24-08-1933		<b>Age</b> 80	<b>Gender</b> Male					
<b>Likes to be called</b> Terry		<b>Primary Language</b> English		<b>Marital Status</b>						
<b>Alerts and warnings</b> - Food- Medication Penicillin-rash Peanuts-rash and nausea										
<b>Diet</b> Diabetic, low fat diet										
<b>Primary Diagnoses</b> Gallstones Macular Degeneration (self reported)										

Additional Information

Remember if there is a previous Care Plan for the resident, click '**Copy**', following the process described in the Section Copying a Previous Care Plan on page 13.

**View Care Plan List**

Resident Search	Resident Overview	ADT	Forms	Care Plan	MDS	Progress Notes
<b>Next Care Plan Review:</b> 11-02-2015						
<b>+ Add</b> Copy Show History						
Care Plan Type					Status	

To create a **new** Care Plan click on '**Add**' – you will only do this if it is the first ever Care Plan for this Resident created using Momentum software.

The Care Plan is recorded in five stages:

1. **Focus** - Select the area of concern that needs to be addressed.
2. **Related Factors** - Add any issues that positively or negatively affect the area of concern.
3. **Expected Outcomes** - Add the resident's goal for this area.
4. **Interventions** - Add the type of actions that will be taken to achieve the goal.
5. **Scheduling** - Identify the '*when, how, who, and what*' of the '**Interventions**'.

## Stage 1: Adding a Focus and Reviewing 'CAPs'

You can review the 'CAPs' triggered by your assessment from the Care Plan screen.

**Edit Care Plan** Rai, Terry Ray NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 81

**CAPs** Most Recent Prev

Assessment: **DRAFT: LTCF Assessment version 9.1: First assessment** Reference Date: 24-07-2014 12:00 AM

A. Problem Area	Trigger Information
1. Physical Activities Promotion	Triggered (L1)
3. Activities of Daily Living	Prevent Decline (L1)
6. Physical Restraints	
7. Cognitive Loss	Monitor (L1)
8. Delirium	
9. Communication	
10. Mood	
11. Behaviour	
13. Activities	
15. Social Relationship	
16. Falls	
17. Pain	
18. Pressure Ulcer	Triggered (L1)
19. Cardiorespiratory Conditions	
20. Undernutrition	High Level (L2)
21. Dehydration	Physician Visit (L1)
22. Feeding Tube	
23. Prevention	
24. Appropriate Medications	
25. Tobacco and Alcohol Use	
26. Urinary Incontinence	Facilitate Improvement (L3)

A 'Focus' is an area of care to be included in the Care Plan. You can choose a focus from the 'Focus Library' or create your own.

Review your 'CAPs' and reviewed your 'Assessment Summary' for any other 'Foci' that need to be added before you make your Care Plan 'Active'. Do not activate your Care Plan unless you have added and activated all your 'Foci'. Remember you cannot edit an 'Active' Care Plan.

**Edit Care Plan**

**Resident Search** **Resident Overview** **ADT** **Forms** **Care Plan** **MDS** **Progress Notes**

**CAPs**

Return Save & Return Save Cancel Delete Care Plan

**Status** Draft Start Date

+ Add New Focus Copy Focus Delete Focus

**Start Date** **Resolved Date**

No records to display.

**New Focus**

Resident Search Resident Overview ADT Progress Notes Physician Orders

Return Save

4. Click on 'Save' when you are finished.

Add the following custom Focus to the resident's care plan

Create your own Focus here

OR

Select one or more desired Focus from the Focus Library

3. Create your own 'Focus' in the field here.

2. 'Tick' the 'Focus' you want to include in the Care Plan, from this list or create your own 'Focus' at Step 3.

<input type="checkbox"/>	
<input type="checkbox"/>	Activities
<input type="checkbox"/>	ADL function
<input type="checkbox"/>	Behavioral symptoms
<input type="checkbox"/>	Cardiac symptoms
<input type="checkbox"/>	Cognitive loss
<input type="checkbox"/>	Communication
<input type="checkbox"/>	Delirium
<input type="checkbox"/>	Dental care
<input type="checkbox"/>	End of life care

## Stage 2: Add Related Factors

You can identify multiple 'Related Factors'. These are problems, opportunities, medical diagnoses, or symptoms that have created or affect the 'Focus' and need to be considered when managing the 'Focus'. This can provide important information for staff to understand the factors that may impact on the resident's potential to improve or decline.

**Edit Focus**

Rai, Terry Ray

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis Edit Focus

CAPs

Return Save & Return Save Prev Next

Focus: Activities

Status: Draft Start Date: End Date:

Last Modified By: Allen, Richard RN Last Modified Date: 22-08-2014

1. 'Click' on 'Select Related Factors'.

Select Related Factors

No records to display.

Select Expected Outcomes

No records to display.

Select Interventions

No records to display.

You can choose from a library of 'Select Related Factors' or create your own.

*Note:* The 'CAPs' drop down is still available to assist you in developing your Care Plan.

**Select Related Factors**

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs

Return Save & Return

Focus: Cognitive loss

☐ Show only selected

☐ Show entire Library

+ Add Related Factor Not Found in Library

	Related Factor
<input type="checkbox"/>	Impaired decision making
<input type="checkbox"/>	Short term memory loss
<input type="checkbox"/>	Problem understanding others
<input type="checkbox"/>	Long term memory loss
<input checked="" type="checkbox"/>	

2. Tick the boxes for the 'Relevant Related Factors' or create your own.

3. To create your own Related Factor, 'Click' on 'Add Related Factor Not Found in Library'.

4. 'Click' on 'Save & Return'.

### Stage 3: Choose Expected Outcomes

An 'Expected Outcome' is the goal of care for the next 180 days. This needs to be individualised and specific, measureable and achievable, realistic and timeframed (SMART). You can choose 'Expected Outcomes' from the 'Library' or create your own.

**Edit Focus**

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Ana

CAPs

Return Save & Return Save Prev Next

Focus: Activities

Status: Draft Start Date: End Date:

Last Modified By: Allen, Richard RN Last Modified Date: 22-08-2014

✓ Select Related Factors

Activity involvement requires staff initiation

✓ Select Expected Outcomes

No records to display.

✓ Select Interventions

No records to display.

1. 'Click' on 'Select Expected Outcomes'.

If using an 'Expected Outcome' from the library, you can individualise this by replacing 'Resident' with your resident's name and modifying the wording of the 'Expected Outcome' as needed.

The screenshot shows the 'Select Expected Outcomes' window. At the top, there are tabs for 'Resident Search', 'Resident Overview', 'ADT', 'Forms', 'Care Plan', 'MDS', and 'Progress Notes'. Below these are buttons for 'Return' and 'Save & Return'. The main area is titled 'Focus: Activities' and includes a 'Filter by Category' dropdown set to 'All'. A table lists 'Expected Outcome' items with checkboxes in the first column. The first item is 'Terry will have purposeful interactions and sensory stimulation initiated by staff to support current' with the category 'Activities'. The second item is 'Resident will participate in activities of choice that support or enhance cognitive, physical and psychosocial fu' with the category 'Activities'.

3. Hover mouse over line if you wish to read the full text of 'Expected Outcome'. 'Click' on the text if you wish to edit.

2. 'Tick' the check box for the 'Expected Outcome' that best describes the resident's goals of care.

4. 'Click' on 'Save & Return'.

Only one 'Expected Outcome' should be selected for each 'Focus'.

## Creating Your Own Outcome

**Resident Search** **Resident Overview** **ADT** **Forms** **Care Plan** **MDS** **Progress Notes**

Return Save & Return

**Focus: Activities**

☐ Show only selected **Filter by Category:** All ☐ Show entire Library

1. 'Click' on 'Add Expected Outcome Not Found in Library'.

<input type="checkbox"/>	
<input type="checkbox"/>	Resident will have purposeful interactions and sensory stimulation initiated by staff to support
<input type="checkbox"/>	Resident will participate in activities of choice that support or enhance cognitive, physical and

**Resident Search** **Resident Overview** **ADT** **Forms** **Care Plan** **MDS** **Progress Notes** **Physio Order**

Return Save & Return

**Focus: Activities**

☐ Show only selected **Filter by Category:** All ☐ Show entire Library

2. 'Click' in the box and type in an 'Expected Outcome'.

<input type="checkbox"/>	Expected Outcome
<input type="checkbox"/>	Resident will have purposeful interactions and sensory stimulation initiated by staff to support current level
<input type="checkbox"/>	Resident will participate in activities of choice that support or enhance cognitive, physical and psychosocial
<input checked="" type="checkbox"/>	Create outcome here

3. 'Click' on 'Save & Return'.

*Note:* No category is required for Outcomes.

## Setting an 'End Date' and classification for an 'Expected Outcome'

You may wish to add an 'End Date' and a classification e.g. short term goal, medium, or long term goal to your 'Expected Outcome'.

**Edit Focus**

Rai, Terry Ray      Date of Birth:      Gender / Age:

Resident Search   Resident Overview   ADT   Forms   Care Plan   MDS   Progress Notes   Physician Orders   QIs   CAPs   Outcomes   Ana

**CAPs**

Return   Save & Return   Save

**Focus:**

ADL function

Status: Discontinued   Start Date: 10-08-2014   End Date: 24-08-2014

Last Modified By: Allen, Richard RN   Last Modified Date: 24-08-2014

1. 'Click' on the 'Expected Outcome'.

Start Date	Expected Outcome	Evaluation Date	
10-08-2014	Resident will participate in performing ADL's at the fullest capacity possible for next 90 days.	24-08-2014 10:09 PM	1. Achie

Select Expected Outcomes

Select Interventions

	Start Date	End Date	Intervention	Discipline
<input checked="" type="checkbox"/>			DRESSING ASSISTANCE	
<input checked="" type="checkbox"/>			TOILETING	

Step 1. Go back onto the folder, click on folder. Select 'End Date' for six monthly review using the date picker on calendar.

2. 'Click' on the 'Calendar' icon next to 'End Date' and choose a relevant date.

Start Date	End Date
10-08-2014	10-09-2014

Resident will participate in performing ADL's at the fullest capacity possible for

Classification: -- Please

Evaluation Status

1. Achieved

September 2014

	S	M	T	W	T	F	S
36	31	1	2	3	4	5	6
37	7	8	9	10	11	12	13
38	14	15	16	17	18	19	20
39	21	22	23	24	25	26	27
40	28	29	30	1	2	3	4
41	5	6	7	8	9	10	11



3. (Optional) Select a 'Classification' for the 'Expected Outcome', from the drop down menu.

Start Date: 10-08-2014      End Date: 10-09-2014

Classification:

-- Please select an item --

-- Please select an item --

1. Long term goal

2. Medium term goal

3. Short term goal

4. 'Click' on 'Save & Return' button to return to the Care Plan main screen.

Evaluation Status

Note: The start date does not change.

## Stage 4: Add Interventions

'Interventions' describe the types of care required.

An 'Intervention' is a name of an area of care where staff would look to find the specific care instructions. You will add the specific care instructions later. You can use an 'Intervention' from the library or create your own.

Edit Focus

Resident Search   Resident Overview   ADT   Forms   Care Plan   MDS   Progress Notes   Physician Orders   QIs   CAPs   Outcomes   A

CAPs

Return   Save & Return   Save   Prev   Next

Focus: Activities

Status: Draft   Start Date:   End Date:

Last Modified By: Allen, Richard RN   Last Modified Date: 22-08-2014

✓ Select Related Factors

Activity involvement requires staff initiation

✓ Select Expected Outcomes

Start Date	Expected Outcome
22-08-2014	Terry will have purposeful interactions and sensory stimulation initiated by staff to support current level of functioning for next 9...

✓ Select Interventions

Start Date	End Date	Intervention
No records to display.		

1. 'Click' on 'Select Interventions'.

We recommend that you create your own 'Interventions'.

## Choosing an 'Intervention' from the 'Library'

There is a 'Library' of 'Interventions' available for you to use in the Care Plan. If there are no 'Interventions' available to view, you are able to view all the interventions in the database by selecting 'Show entire Library'.

The screenshot shows the 'Select Interventions' window with the 'Focus: Activities' section. The 'Show entire Library' checkbox is checked, and a callout box points to it with the text: '1. 'Click' on the check box for 'Show entire Library'.'

Intervention	Category
<input type="checkbox"/> Adapt environment to meet resident need	
<input type="checkbox"/> Analgesics before activities causing pain	Treatments
<input type="checkbox"/> Anticipate and encourage communication of needs	Psychosocial
<input type="checkbox"/> Be supportive of resident's own fear and suffering	Psychosocial
<input type="checkbox"/> Consistent environment / routine	Psychosocial
<input type="checkbox"/> Consult Occupational Therapy	Consults
<input type="checkbox"/> Consult Physical Therapy	Consults
<input type="checkbox"/> Consult Psychiatry	Consults
<input type="checkbox"/> Consult Social Work	Consults
<input type="checkbox"/> Consult Spiritual Care	Consults
<input type="checkbox"/> Define ADL needs	ADL
<input type="checkbox"/> Educate and support family members	Teaching
<input type="checkbox"/> Educate family	Teaching
<input type="checkbox"/> Educate staff regarding specific communication aids to use	Treatments

You can 'Filter' the list by 'Category' to only display those most relevant to the 'Focus' you are working in.

The screenshot shows the 'Select Interventions' window with the 'Filter by Category' dropdown menu open. A callout box points to the dropdown with the text: '1. 'Filter by Category' from the drop down list.'

Intervention	Category
<input type="checkbox"/> Adapt environment to meet resident need	
<input type="checkbox"/> Analgesics before activities causing pain	
<input type="checkbox"/> Anticipate and encourage communication	
<input type="checkbox"/> Be supportive of resident's own fear and s	

Return Save & Return

**Focus: Cognitive loss**

Show only selected Filter by Category: All

Show entire Library Filter by Discipline: All

+ Add Intervention Not Found in Library

2. 'Click' on check box beside the 'Intervention' you wish to use.

Intervention	Category
<input type="checkbox"/> Provide privacy and space for quiet time	Psychosocial
<input type="checkbox"/> Record relevant information daily	Monitoring
<input type="checkbox"/> Restraint	Safety
<input type="checkbox"/> Review safety precautions	Safety
<input type="checkbox"/> Shaving	Personal care
<input type="checkbox"/> Showering	Personal care
<input type="checkbox"/> Thickened fluids - Grade	Nutrition
<input type="checkbox"/> Toilet on toilet chair	Continence
<input type="checkbox"/> Toileting on commode	Continence
<input type="checkbox"/> Two person transfer	Mobility
<input type="checkbox"/> Two to four hourly toileting	Personal care
<input type="checkbox"/> Use of hearing aids	Personal care
<input type="checkbox"/> Use of lifting belt	Mobility
<input type="checkbox"/> Use of slippery sam	Mobility
<input type="checkbox"/> Use of spectacles	Personal care
<input type="checkbox"/> Vital signs	Treatments
<input type="checkbox"/> Wash	Personal care

COGNITIVE MANAGEMENT

CAPs

Return Save & Return Save Prev Next

**Focus:** Cognitive loss

Status: Draft Start Date: End Date:

Last Modified By: Allen, Richard (Mr.) LTC System Clinician Last Modified Date: 13/02/2015

✓ Select Related Factors

Related Factor
my custom related factor

✓ Select Expected Outcomes

Start Date	Expected Outcome	Evaluation Date	Evaluation Status
13/02/2015	a custom outcome		

✓ Select Interventions

Start Date	End Date	Intervention	Discipline	Schedule
		COGNITIVE MANAGEMENT		

The planned 'Intervention(s)' are now recorded.

## Adding your own Intervention

Adding your own 'Interventions' allows you to personalise your Care Plan and develop your own style for using the Care Plan. We recommended that you use short label-like names for your 'Interventions'. This makes your Care Plan easy to read.

If you have interventions that you want to add or edit follow these steps.

**Select Interventions**

Resident Search | Resident Overview | ADT | Forms | Care Plan | MDS | Progress Notes | Physician Orders | QIs | CAPs

Return | Save & Return

Focus: Activities

Show only selected | Filter by Category: All | Filter by Discipline: All

Show entire Library

+ Add Intervention Not Found in Library

1. 'Click' on 'Add Intervention Not Found in Library'.

Intervention	Category
Encourage and praise all efforts at independence	Psychosocial
Encourage participation in activities of choice	Psychosocial

2. 'Click' in the box on the empty line.

3. Type in your own 'Intervention' in CAPITALS.

4. 'Click' on 'Save & Return'.

If you type in your 'Intervention' in CAPITALS, it will stand out when printed.

**CAPs**

Return | Save & Return | Save | Prev | Next

Focus: Activities

Status: Draft | Start Date: | End Date: |

Last Modified By: Allen, Richard RN | Last Modified Date: 22-08-2014

✓ Select Related Factors

Related Factor: Activity involvement requires staff initiation

✓ Select Expected Outcomes

Start Date	Expected Outcome	Evaluation Date
22-08-2014	Terry will have purposeful interactions and sensory stimulation initiated by staff to support current level of functioning for next 9...	

✓ Select Interventions

Start Date	End Date	Intervention	Discipline
		Create your own intervention	
		Encourage and praise all efforts at independence	
		Encourage participation in activities of choice	

5. Your 'Intervention' is now recorded.

The date on your Care Plan doesn't change, but the date on the intervention saves does.

## Stage 5: Schedule the Interventions

'Scheduling' the 'Intervention' involves identifying:

- **when** the care will take place,
- **how** often,
- **who** is responsible,
- **what** is to be done.

**Edit Focus**

Rai, Terry Ray NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 80

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis Edit Focus

**CAPs**

Return Save & Return Save Prev Next

Focus: Activities

Status: Draft Start Date: End Date:

Last Modified By: Allen, Richard RN Last Modified Date: 22-08-2014

Select Related Factors

Related Factor

Activity involvement requires staff initiation

Select Expected Outcomes

Start Date	Expected Outcome
22-08-2014	Terry will have purposeful interactions and sensory stimulation initiated by staff to support current level of function

Select Interventions

Start Date	End Date	Intervention	Discipline	Schedule
		Create your own intervention		
		Encourage and praise all efforts at independence		
		Encourage participation in activities of choice		

Ensure your Care Plan is evaluated *before* the 'End Dates' or else you will not be able to copy it.

## Scheduling Screen

**Schedule Details**

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes

Return Save & Return Save

Focus: Cognitive loss

Intervention: COGNITIVE MANAGEMENT

**Schedule Details**

Schedule Note

Start Date/Time: 13/02/2015 01:19 PM Duration: 181 Day(s)

End Date/Time: 13/08/2015 12:00 AM Frequency: -- Please select an item --

**Reoccurrence Schedule**

☐ Daily  
☐ Weekly  
☐ Monthly  
☐ Yearly  
☒ One Time

**Disciplines Responsible**

Show only selected

Add Discipline Not Found in Library

	Non-Library
<input type="checkbox"/> Activity Coordinator	<input type="checkbox"/>
<input type="checkbox"/> Administration	<input type="checkbox"/>
<input type="checkbox"/> All care staff	<input type="checkbox"/>
<input type="checkbox"/> All staff	<input type="checkbox"/>
<input type="checkbox"/> Carer	<input type="checkbox"/>
<input type="checkbox"/> Clinical Nurse Manager	<input type="checkbox"/>

*Note:* Make sure you choose a 'Reoccurrence Schedule'.

**Schedule Details** Muppet, Bert   
 Date of Birth: 04/04/1926   
 Gender / Age: Male / 88

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis **Intervention Schedule**

Return Save & Return Save

**Focus:** Cognitive loss  
**Intervention:** COGNITIVE MANAGEMENT

**Schedule Details**

Schedule Note

Start Date/Time: 13/02/2015 01:19 PM Duration: 181 Day(s)  
End Date/Time: 13/08/2015 12:00 AM Frequency: -- Please select an item --

Reoccurrence Schedule

☒ Daily  
☐ Weekly  
☐ Monthly  
☐ Yearly  
☐ One Time

☒ Every 1 Day(s)  
☐ Every Weekday

**Disciplines Responsible**

☐ Show only selected

Add Discipline Not Found in Library

Discipline	Non-Library
<input checked="" type="checkbox"/> Enrolled Nurse/Nurse Assistant	<input type="checkbox"/>
<input checked="" type="checkbox"/> All care staff	<input type="checkbox"/>
<input type="checkbox"/> Activity Coordinator	<input type="checkbox"/>
<input type="checkbox"/> Administration	<input type="checkbox"/>
<input type="checkbox"/> All staff	<input type="checkbox"/>
<input type="checkbox"/> Carer	<input type="checkbox"/>

4. Select the 'Disciplines Responsible' for the 'Intervention'.

**Schedule Details** Muppet, Bert   
 Date of Birth: 04/04/1926   
 Gender / Age: Male / 88

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis **Intervention Schedule**

Return Save & Return Save

**Focus:** Cognitive loss  
**Intervention:** COGNITIVE MANAGEMENT

**Schedule Details**

Schedule Note

Start Date/Time: 13/02/2015 01:19 PM Duration: 181 Day(s)  
End Date/Time: 13/08/2015 12:00 AM Frequency: -- Please select an item --

Reoccurrence Schedule

☒ Daily  
☐ Weekly  
☐ Monthly  
☐ Yearly  
☐ One Time

☒ Every 1 Day(s)  
☐ Every Weekday

**Disciplines Responsible**

☒ Show only selected

Add Discipline Not Found in Library

Discipline	Non-Library
<input checked="" type="checkbox"/> Enrolled Nurse/Nurse Assistant	<input type="checkbox"/>
<input checked="" type="checkbox"/> All care staff	<input type="checkbox"/>
<input type="checkbox"/> Activity Coordinator	<input type="checkbox"/>
<input type="checkbox"/> Administration	<input type="checkbox"/>
<input type="checkbox"/> All staff	<input type="checkbox"/>
<input type="checkbox"/> Carer	<input type="checkbox"/>

5. Select the 'End Date' for the 'Focus'.

6. 'Tick' on 'Show only selected' and this will reduce 'Disciplines' on your screen to only those you have chosen.

## Comments Section - Instructions for Caregivers

You can individualise the Care Plan to meet the care needs of your resident. You enter the care instruction detail for the caregivers/nurses in the 'Comments' box for each 'Intervention' in each 'Focus'.

*Note:* Enter your care instructions in a list by pressing enter on the keyboard after each instruction. This puts each instruction on a new line. You can also number these.

## Stage 6: Making the Care Plan 'Active'

In order to activate the Care Plan you need to ensure each 'Focus' is active.

You also need to refer to adding a new 'Focus' if the 'CAPs' and outcomes have changed.

Select the 'Focus' you wish to activate, review the information and, when you are ready to activate, select 'Active' from the list options for status and click 'Save and Return'.

Repeat the steps above for each 'Focus' to make them 'Active'. At this stage you can also add new 'Foci' as per page 27 of this Workbook.

Once all 'Foci' in your Care Plan are 'Active' you can activate the whole Care Plan.

The screenshot shows the 'CAPS' (Care Plan) interface. At the top, there are tabs for Resident Search, Resident Overview, ADT, Forms, Care Plan, MDS, Progress Notes, Physician Orders, QIs, and CAPS. The 'CAPS' tab is selected. Below the tabs, there is a 'Status' dropdown menu with options: Draft, Active, and Discontinued. The 'Active' option is highlighted. To the right of the 'Status' dropdown, there are fields for 'Start Date' and 'End Date'. Below these fields, there is a 'Save & Return' button, which is circled in red. To the right of the 'Save & Return' button, there are buttons for 'Save', 'Cancel', and 'Delete Care Plan'. Below the 'Save & Return' button, there is a 'Delete Focus' button. Below the 'Delete Focus' button, there is a table with columns: Start Date, Resolved Date, and Focus. The table contains several rows of data, including 'Behavioral symptoms', 'Bowel Management', 'Cardiac symptoms', and 'Cognitive loss- my custom related factor;'. Two callout boxes are present: one pointing to the 'Save & Return' button with the text '3. Click on 'Save & Return'.', and another pointing to the 'Active' option in the 'Status' dropdown with the text '2. Select 'Active' from the options for 'Status'.'

Your Care Plan is now 'Active' with the same date as your 'Foci'.

The screenshot shows the 'View Care Plan List' interface. At the top, there are tabs for Resident Search, Resident Overview, ADT, Forms, Care Plan, MDS, Progress Notes, Physician Orders, QIs, CAPS, and Outcomes. The 'Care Plan' tab is selected. Below the tabs, there is a 'Next Care Plan Review' section. It contains a 'Save' button, a 'Next Care Plan Review' label, and a date field. The date field is highlighted with a red box and contains the date '13/02/2015'. Below the date field, there is a table with columns: Care Plan Type, Status, and Start Date. The table contains one row of data: 'Long Term Care', 'Active', and '13/02/2015'. Below the table, there is a 'Select' button.

Enter a six monthly review date, using the date icon.



# Chapter 4

## Evaluating a Care Plan

### Chapter Contents

- Evaluate a Care Plan
- Delete a Care Plan 'Focus'
- Discontinue a Care Plan 'Focus' while the Care Plan is 'Active'

### Chapter Learning Outcomes

The learner will know how to modify previous Care Plans, to discontinue a Care Plan 'Focus' and to delete a Care Plan 'Focus'.

### Introduction

After you have completed a Care Plan and implemented the care and support required to provide quality outcomes for your resident; you will need to evaluate if the care and issues identified in your Care Plan remain relevant and appropriate. Regular evaluations are scheduled at least six-monthly or if the resident has a change in their health status.

The software allows you to complete and update regular evaluations for your active Care Plan.

Ensure you are evaluating your previous Care Plan not the current one you are working on.

### Evaluate a Care Plan

If the Care Plan is not working for your resident, from time to time the Registered Nurse will need to evaluate the Care Plan. This may be due to a change in the person's health status (improved or deteriorated), or following the six-monthly scheduled review of the resident's care needs.

During the evaluation you will check whether:

- 'Expected Outcomes' have been achieved,
- whether the 'Interventions' are all still relevant,
- whether the 'Focus' list is still correct.

## Evaluating a Care Plan for a Resident

**View Care Plan List**

Rai, Terry Ray NHI: MAM0508 Date of Birth: 24-08-1933 Gender / Age: Male / 81

Resident Search Resident Overview ADT Forms **Care Plan** MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis

Save  
Next Care Plan Review:  
11-02-2015

Add Copy Show History

Care Plan Type	Status	Start Date	End Date
Long Term Care	Active	10-08-2014	

1. 'Click' on 'Care Plan' tab.

2. 'Click' on the yellow folder for the 'Care Plan' you want to review.

On the 'Edit Care Plan' screen:

**Edit Care Plan**

Rai, Terry Ray NHI: MAM0508 Date of Birth: 24-08-1933 Gender / Age: Male / 81

Resident Search Resident Overview ADT Forms **Care Plan** MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis **Edit Care Plan**

CAPs

Return Save & Return Save Cancel Error Out  
Status: Active Start Date: 10-08-2014 End Date: Authored By: Milne, Margaret (Miss) Nurse - 10-08-2014

Add New Focus Copy Focus Delete Focus

Start Date	Resolved Date	Focus	Status
10-08-2014		ADL function- Ambulation assistance required; Toileting assistance required; Personal hygiene assistance required;	Active
10-08-2014		Cognitive loss- Diagnosis of Dementia;	Active
10-08-2014		Cultural and Spirituality- Terry states he is Lonely; Devout Catholic beliefs; Hass been withdrawn from family and church;	Active
10-08-2014		Falls moderate to high risk- Acute confusion; History of falls; Wandering;	Active

3. 'Click' the yellow folder for the 'Focus' you want to review.

**Edit Focus**

Rai, Terry Ray NHI: MAM0508 Date of Birth: 24-08-1933 Gender / Age: Male / 81

Resident Search Resident Overview ADT Forms **Care Plan** MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis **Edit Focus**

CAPs

Return Save & Return Save Prev Next

Focus:  
ADL function  
Status: Active Start Date: 10-08-2014 End Date: Last Modified By: Milne, Margaret (Miss) Nurse Last Modified Date: 10-08-2014

Associated Progress Notes

Select Related Factors

Related Factor
Ambulation assistance required
Personal hygiene assistance required
Toileting assistance required

Select Expected Outcomes

Start Date	Expected Outcome	Evaluation Date	Evaluation Status
10-08-2014	Resident will participate in performing ADL's at the fullest capacity possible for next 90 days.		

Select Interventions

Start Date	End Date	Intervention	Schedule
		DRESSING ASSISTANCE	
		TOILETING	

4. 'Click' on yellow folder for 'Expected Outcome'.

Expected Outcome Evaluations

Rai, Terry Ray

NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 81

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis Expected Outcome Evaluations

Return Save & Return Save

Focus: ADL function

Start Date: 24-08-2014 End Date:

Expected Outcome: Resident will participate in performing ADL's at the fullest capacity possible for next 90 days.

Add Error Out

24-08-2014 10:09 PM

5. 'Click' on 'Add'. This will enter the current date and time of your evaluation.

Expected Outcome Evaluations

Rai, Terry Ray

NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 81

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis Expected Outcome Evaluations

Return Save & Return Save

Focus: ADL function

Start Date: 10-08-2014 End Date:

Expected Outcome: Resident will participate in performing ADL's at the fullest capacity possible for next 90 days.

Add Error Out

24-08-2014

1. Achieved  
2. Partially achieved  
3. Not achieved

6. 'Click' in the box under 'Evaluation Status' and select one from the drop down list.

Expected Outcome Evaluations

Rai, Terry Ray

NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 81

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis Expected Outcome Evaluations

Return Save & Return Save

Focus: ADL function

Expected Outcome:

24-08-2014 10:09 PM

Save Cancel Delete

Comment Title

Comment Text  
add an evaluation/comment here

Added By

24-08-2014 10:23 PM

7. 'Click' on the 'Comments' box and add an 'Evaluation comment' then click 'Save'.

8. 'Click' on 'Save & Return'.

**Edit Focus**

Rai, Terry Ray NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 81

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis Edit Focus

**CAPs**

Return Save & Return Save Prev Next

Focus: Associated Progress Notes

ADL Function  
Status: Active  
Last Modified By: Milne, Margaret (Miss) Nurse

Select Expected Outcomes

Start Date	Expected Outcome	Evaluation Date	Evaluation Status
10-08-2014	Resident will participate in performing ADL's at the fullest capacity possible for next 90 days.	24-08-2014 10:09 PM	1. Achieved

Select Interventions

Start Date	End Date	Intervention	Discipline	Schedule
		DRESSING ASSISTANCE		
		TOILETING		

9. 'Expected Outcome' now shows with an 'Evaluation Date' and an 'Evaluation Status'.

## Deleting a Care Plan 'Focus'

A 'Focus' can only be deleted whilst the Care Plan is in 'Draft' form.

**Edit Care Plan**

Rai, Terry Ray NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 81

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis Edit Care Plan

**CAPs**

Return Save & Return Save Cancel Delete Care Plan

Status: Draft

Add New Focus Copy Focus Delete Focus

Start Date Resolved Date

Activities - Activity involvement requires staff

End Date Authored By

1. To delete, 'Click' on the 'Focus' line to highlight then click on the 'Delete Focus' button.

2. Click on 'Save & Return.'

*Note:* To remove a 'Focus' you can either change the status to discontinued or delete it, while the Care Plan is in 'Draft'.

## Discontinuing a Care Plan 'Focus' while the Care Plan is 'Active'

**View Care Plan List**

Rai, Terry Ray NHI: MAM0508  
Date of Birth: 24-08-1933  
Gender / Age: Male / 81

Resident Search Resident Overview ADT Forms Care Plan MDS Progress Notes Physician Orders QIs CAPs Outcomes Analysis

Save

Next Care Plan Review:  
11-02-2015

Add Copy Show History

Care Plan Type	Status	Start Date	End Date
Long Term Care	Active	10-08-2014	

1. Select your 'Active Care Plan'.

Search Overview Notes Orders Plan

CAPs

Return Save & Return Save Cancel Error Out

Status: Active Start Date: 10-08-2014 End Date: Authorized By: Milne, Margaret (Miss) Nurse - 10-08-2014

Add New Focus Copy Focus Delete Focus

Start Date	Resolved Date	Focus	Status
10-08-2014	24-08-2014	Cognitive loss- Diagnosis of Dementia;	Discontinued
10-08-2014		ADL function- Ambulation assistance required; Toileting assistance required; Personal hygiene assistance required;	Active
10-08-2014		Cultural and Spirituality- Terry states he is Lonely; Devout Catholic beliefs; Hass been withdrawn from family and church;	Active
10-08-2014		Falls moderate to high risk- Acute confusion; History of falls; Wandering;	Active

2. Highlight the 'Focus' you wish to discontinue.

Edit Focus

Rai, Terry Ray NHI: MAM0508 Date of Birth: 24-08-1933 Gender / Age: Male / 81

Resident Search Resident Overview ADT Forms Care

CAPs

Return Save & Return Save Preview Next

Focus: ADL function

Status: Active Start Date: 10-08-2014 End Date: Modified Date: 14

Discontinued

Associated Progress Notes

Select Related Factors

Select Expected Outcomes

Start Date	Expected Outcome	Evaluation Date	Evaluation Status
10-08-2014	Resident will participate in performing ADL's at the fullest capacity possible for next 90 days.	24-08-2014 10:09 PM	1. Achieved

Select Interventions

Start Date	End Date	Intervention	Discipline	Schedule
		DRESSING ASSISTANCE		
		TOILETING		

4. 'Click' on 'Save & Return'.

3. Select 'Discontinue' from the drop down list.



# Chapter 5

## Printing a Care Plan

### Chapter Contents

- Printing a Care Plan

### Chapter Learning Outcomes

The learner will know how to print off the current Care Plan or an historic Care Plan from the software.

### Introduction

Once your Care Plan is complete and made active, you will want to print it to add to your resident file. This chapter teaches you how to print a Care Plan from the software. You must have a printer connected to the computer you are printing from.

### Printing a Care Plan

Only 'Active' Care Plans can be printed.

The screenshot shows the 'View Care Plan List' interface. At the top right, patient information is displayed: 'Care Plan, Example', 'NHI: ZZ', 'Date of Birth: 10', and 'Gender / Age: Fe'. Below this is a horizontal menu with tabs: 'Resident Search', 'Resident Overview', 'ADT', 'Forms', 'Care Plan' (highlighted in yellow), 'MDS', 'Progress Notes', 'Physician Orders', 'QIs', 'CAPs', and 'Outcomes'. Below the menu, there is a 'Next Care Plan Review' section with a date '27-08-2014' and a calendar icon. Below that are buttons for 'Add', 'Copy', and 'Show History'. At the bottom is a table with columns: 'Care Plan Type', 'Status', 'Start Date', and 'End Date'. The table contains one row: 'Long Term Care', 'Active', '02-07-2014', and an empty 'End Date' cell. An arrow points from the 'Care Plan' tab to a callout box containing the text: '1. 'Click' on the 'Care Plan' tab to view the current Care Plan.'

Care Plan Type	Status	Start Date	End Date
Long Term Care	Active	02-07-2014	

**MOMENTUM HEALTHWARE** Edit Care Plan

Home | Help | Logout

Resident Search | Resident Overview | ADT | Forms | Care Plan | MDS | Progress Note

Common Tasks

ADT

Assessments/Forms

Care Plan

View Care Plan List

Add a New Care Plan

Care Plan Summary View

Evaluate Outcomes

Selected Care Plan Report

Demographics

History And Physical

MDS

Progress Notes

Physician Orders

Reports

User preferences

CAPs

Return Save & Return Save Cancel Error Out

Status Active Start Date 02-07-2014

Add New Focus Copy Focus Delete Focus

	Start Date	Resolved Date	
	02-07-2014	02-07-2014	Cardiac symptoms- Risk for hypoxia;
	02-07-2014		Behavioral symptoms- Physically abusive;

2. Under the Care Plan menu options on the left of your screen, 'Click' on 'Selected Care Plan Report'.

You can also print the most current active Care Plan from the reports menu on the left of your screen.

**MOMENTUM HEALTHWARE** View Care Plan List

Home | Help | Logout

Resident Search | Resident Overview

Common Tasks

Care Plan

Reports

Face Sheet

Transfer Referral Report

Current Client Summary Report

InterRAI Suite Trend

Current Care Plan Report

User preferences

Save

Next Care Plan Review: 27-08-2014

Add Copy Show History

	Care Plan
	Long Term Care

3. 'Click' 'Current Care Plan Report' from left side menu.



## Care Plan report example:

### Care Plan Report

Resident: Care Plan, Example  
Unit/Room: North Wing\108 - A  
Care Plan Start Date: 02/07/2014  
Care Plan End Date:

Care Plan Print Date: 16-09-2014 04:37 PM  
Status: Active

Focus	Start Date: 02/07/2014	End Date: 02/07/2014
Cardiac symptoms		
<b>Related Factors:</b> <ul style="list-style-type: none"> <li>Risk for hypoxia</li> </ul>		
<b>Outcomes</b> Resident will have cardiac symptoms managed by nursing and medical interventions to promote the highest practicable level of functioning for the next 90 days.	Start Date: 02/07/2014	Evaluation Date (Status):
<b>Interventions</b> an intervention - Every Weekday, AM (Dietician)	Start Date: 02/07/2014	End Date: 29/07/2014
Last Modified / Approved By: Downesassessor, test Care Manager		

Focus	Start Date: 02/07/2014	End Date:
Behavioral symptoms		
<b>Related Factors:</b> <ul style="list-style-type: none"> <li>Physically abusive</li> </ul>		
<b>Outcomes</b> Resident will be free of behavioral symptoms that interfere with the safety and welfare of the resident or others for the next 90 days.	Start Date: 02/07/2014	Evaluation Date (Status): 15/07/2014 (3. Not achieved)
<b>Interventions</b> Consult Psychiatry - Every Week on Monday and Tuesday, AM (HCA) some notes here too	Start Date: 02/07/2014	End Date: 24/07/2014
Last Modified / Approved By: Downesassessor, test Care Manager		

Resident: Care Plan, Example  
NHI: ZZZ7001

Page 1 of 1

You can also print a historic Care Plan.

### View Care Plan List

Resident Search	Resident Overview	ADT	Forms	Care Plan	MDS	Progress Notes	Physician Orders	QI						
<div>  Save </div> <div> <b>Next Care Plan Review:</b>  27-08-2014 </div> <div>  Add  Copy Show History </div> <table border="1"> <thead> <tr> <th>Care Plan Type</th> <th>Status</th> <th></th> </tr> </thead> <tbody> <tr> <td>Long Term Care</td> <td>Active</td> <td>02-07-20</td> </tr> </tbody> </table>									Care Plan Type	Status		Long Term Care	Active	02-07-20
Care Plan Type	Status													
Long Term Care	Active	02-07-20												

1. From the 'Care Plan' tab, 'Click' on the 'Show History' button to view old discontinued Care Plans.

**View Care Plan List**

Resident Search Resident Overview ADT Forms **Care Plan** MDS Progress Notes Physician Orders QIs CAPs Outcomes

Save

Next Care Plan Review:  
27-08-2014

Add Copy Show Current

Care Plan Type	Status	Start Date
Long Term Care	Active	02-07-2014
Home Care	Discontinued	02-07-2014

2. All 'Discontinued' Care Plans will be displayed.

3. 'Click' on the folder for the Care Plan you want to print.

**MOMENTUM HEALTHWARE** Edit Care Plan

Home | Help | Logout

Resident Search Resident Overview ADT Forms **Care Plan** MDS Progress Notes Physician Orders QIs CAPs Outcomes Edit Care Plan

Common Tasks  
ADT  
Assessments/Forms  
Care Plan

View Care Plan List  
Add a New Care Plan  
Care Plan Summary View  
Evaluate Outcomes  
Selected Care Plan Report

Demographics  
History And Physical  
MDS  
Progress Notes  
Physician Orders  
Reports  
User preferences

Return Save

Status: Discontinued  
Authorized By: Downes, Andrew  
Start Date: 02-07-2014  
End Date: 02-07-2014

Comments & Contingency Plan Intervention List

Presenting Situation

02-07-2014  
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua. Ut enim ad minim veniam, quis nostrud exercitation ullamco laboris nisi ut aliquip ex ea commodo consequat. Duis aute irure dolor in reprehenderit in voluptate velit esse cillum dolore eu fugiat nulla pariatur. Excepteur sint occaecat cupidatat non proident, sunt in culpa qui officia deserunt mollit anim id est laborum.

Select Expected Outcome

Rank	Start Date	Expected Outcome	Evaluation Date	Eval
1	02-07-2014	Client will mobilize safely	31-07-2014 12:00 AM	partially achieved

Select Disciplines

Start Date	End Date	Provider and Schedule	Monthly Hours
		Physician - Starting July 2, 2014, Ev...	000 hrs, 00 mins

4. The Care Plan will be displayed.

5. 'Click' on 'Selected Care Plan Report' from the Care Plan menu on the left of your screen.

## Please note:

The content of this document is subject to change. Regular upgrades to the National interRAI Software System will result in changes and enhancements to the Software.

To ensure you have the latest version please check the interRAI website.

<http://www.interRAI.co.nz> If you have any questions regarding the content of this document, please contact the project on **0800 10 80 44** or email [interRAI@dhbss.health.nz](mailto:interRAI@dhbss.health.nz).