CROUSE COMMUNITY CENTER
ADULT DAY HEALTH CARE

DEVELOPING THE PLAN OF CARE

Registrant Led Plan of Care Process

Reference: CMS Final Rule, 42 CFR 441.301 (c) (1), (c) (1) (ii), (c) (1) (vii), (c) (2), (c) (2) (iv), (c) (4) (iv), (c) (4) (v)

Policy:

Registrants have the right to make their own decisions. The person-centered plan of care process shall be led by the registrant to ensure a person-centered, meaningful and effective plan of care. The registrant shall be central to the process, recognized as an expert on his/her goals and concerns. It shall support and empower the registrant. The process shall not be constrained by any pre-conceived limits on the registrant's ability to make choices.

Procedure:

1. Registrants shall be viewed as experts in their own lives, they are the expert in their own "illness experience".
2. The registrant will lead the process whenever possible and to the extent of his or her abilities. If the registrant has a legal representative, this person shall lead the process with the input of the registrant.
3. When cognitive or intellectual limitations interfere with decision making the staff and registrant representative/caregiver will incorporate non-verbal communication of the registrant and history provided into the plan of care whenever possible.
4. Each staff person writing a plan of care shall collaborate with the registrant, suggesting goals, needs and interventions to be included in the plan of care.
5. Needs, strengths, preferences and goals shall include the registrant's own words whenever possible.
6. The center will provide necessary information and support to ensure that the registrant is enabled to make informed choices and decisions about his or her care. Information and support may include:

a. Findings of the assessment;

b. Discussion of the disease process, symptoms of the disease;

c. Treatment options and possible side-effects of the treatment;

d. Outside services and supports that may assist the registrant to reach his or her goal(s); and

e. Assessed and reported strengths.

7. Those persons the registrant has identified to be included in the plan of care process shall be contacted, and their input incorporated into the plan of care (although the registrant will always have final acceptance).

8. Each discipline will assist the registrant to refine these goals and concerns to ensure that they are measurable, attainable (within six-months), specific, relevant and timely.

9. If the registrant is unable to, or has not identified a concern or goal that the individual discipline assesses to be a concern or goal, the individual discipline shall suggest concerns or goals they have identified to the registrant to be included in the plan of care, and engage the registrant in a discussion about including the concern/goal in the registrant's plan of care. The registrant may choose to include it in the plan of care or not.

10. If the registrant chooses not to have the plan of care included, the discipline shall document the discussion in the registrant's chart and it will not be included.

11. Each discipline shall collaborate with the registrant on his or her personal preferences/needs/goals for the delivery of services and supports to assist the registrant to reach his or her goals.