RESIDENT AND CARE PARTNER ORIENTATION TEMPLATE (SHORT-STAY RESIDENTS)

Welcome Packet:

Care Plan Orientation for Resident and Care Partner(s)

Nursing home care is a partnership. To be a true care partner, you and/or your chosen friend, family, or representative help develop the plan that guides the care you receive while you are here. The aim of person-centered care planning is to learn what goals, preferences and routines are important to you. For instance, is your goal to return home? Is your routine to wake at 7:00 a.m. and have a cup of coffee? Our team will assess your needs. Together, we will develop a plan to meet those needs in the context of your goals, preferences, and routines. Care plans are living documents that change as your needs change.

You can expect to have an initial care plan meeting and one every three months from then on. If you have a significant change in your condition or needs, we will hold an additional meeting. We are also happy to meet upon your request. The meetings can be held in person, by video chat or by phone.

Residents have rights and one of those rights is self-determination. The resident's ideas, goals, psychosocial needs, and preferences may not align with what their support person's goals are or the resources available. The care plan should reflect the resident's choices and preferences. When issues around cognitive impairment arise, we will work with decision-making representatives to prioritize resident rights, dignity, and control.

The goal of care planning for your short term stay is to get the care resources and support you need to integrate back into your life at home or prior level of living.

Prior to the meeting, you can expect…

- To be contacted by your care plan facilitator to set up a time and date for this meeting. The care plan facilitator will lead and assure an effective person-centered care planning process.
- Conversations about discharge planning—what are your plans for your time here and where you are going after your stay?
- To be asked about goals, preferences, and priorities. For example, what do you want out of your time here? What do you need to do to be able to go home?
    - We will help put goals in context of your life and what you were able to do before you came to the nursing home.
- Assessments by several disciplines, such as
    - In-depth medication review and updates

    - Social history evaluation to understand your story and what is most important to you.
    - Nursing assessments such as the condition of your skin, fall risk and mobility, evaluation of any wounds, needs for bathroom support and personal hygiene.
    - All disciplines learning about your preferences around your typical routines, habits, interests,and cultural and spiritual needs that you wish to continue while you are here.
    - Ultimately, what we need to know about you to help you succeed here

During this preparatory period, you should communicate any grievances or concerns you have with the care plan facilitator.

At the meeting, you can expect....

- [Who will be there-insert names and/or disciplines].
- [Where located- insert location of meeting and/or weblink for a virtual meeting].
- [How long- insert time, including expected duration of the meeting].
- To receive contact information for the care plan facilitator.
- For you and/or your chosen person to attend [insert at what interval? initial, quarterly, annual, sig change].
- The meeting will start with you or your chosen person sharing what is most important to you to get out of the meeting.
- To share problems, issues, concerns, and successes since the previous meeting.
- To follow up on any previous issues addressed.
- Although all your concerns may not be addressed in the meeting, the meeting should provide a plan and a contact to continue working through concerns.
- To review current medications and recent or upcoming appointments.
- To share specific preferences or requests (ex. you want to wear your own underwear or brand of briefs)—and have those preferences integrated into care.
- For the meeting to take place in the resident and/or family's primary language and the nursing home to provide an interpreter or translator if needed.
- For staff to confirm who you want the nursing home to call for care issues and questions. In general, staff will call one person; that person should contact other concerned family members/friends.

Following the meeting, you can expect…

- The care plan facilitator will contact you to report on the action items list.
- The staff to document the care plan decisions into the care plan.
- The team to communicate care plan changes to all staff involved in your care.
- Formal complaints/grievances to be documented on the nursing home form and the nursing home policy to be followed.

Above all else, we want to encourage you and your chosen person(s) to have open communication with our team. For all care planning needs the care plan facilitator will be your primary contact and [*insert*] will be your secondary contact. These individuals are not solely responsible for your care, but they will make sure the team is aware of your needs and will follow up with you when you express a need or concern.

We are excited to have you in our home and look forward to being your care partner.

RESIDENT AND CARE PARTNER ORIENTATION TEMPLATE (LONG-STAY RESIDENTS)

Nursing home care is a partnership. To be a true care partner, you and/or your chosen friend, family, or representative help develop the plan that guides the care you receive while you are here. The aim of person-centered care planning is to learn what goals, preferences and routines are important to you. For instance, is your goal to return home? Is your routine to wake at 7:00 a.m. and have a cup of coffee? Our team will assess your needs. Together, we will develop a plan to meet those needs in the context of your goals, preferences, and routines. Care plans are living documents that change as your needs change.

You can expect to have an initial care plan meeting and one every three months from then on. If you have a significant change in your condition or needs, we will hold an additional meeting. We are also happy to meet upon your request. The meetings can be held in person, by video chat or by phone.

Residents have rights and one of those rights is self-determination. The resident's ideas, goals, psychosocial needs, and preferences may not align with what their support person's goals are or the resources available. The care plan should reflect the resident's choices and preferences. When issues around cognitive impairment arise, we will work with decision-making representatives to prioritize resident rights, dignity, and control.

The goal of care planning for a long-term stay is to ensure that you are living your highest possible quality of life here.

Prior to the meeting, you can expect…

- The care plan facilitator will lead and assure an effective person-centered care planning process..

- To be asked about goals, preferences, and priorities. Some examples are: What do you like to do with your time? Who do you want to remain connected to outside the nursing home and how can we help?
    - We will help put goals in context of your life and what you were able to do before you came to the nursing home.
- Assessments by several disciplines, such as
    - In-depth medication review and updates
    - Social history evaluation to understand your story and what is most important to you.
    - Nursing assessments such as the condition of your skin, fall risk and mobility, evaluation of any wounds, needs for bathroom support and personal hygiene.
    - All disciplines learning about your preferences around your typical routines, habits, interests,and cultural and spiritual needs that you wish to continue while you are here.
    - Ultimately, what we need to know about you to help you succeed here
    - During this preparatory period, you should communicate any grievances or concerns you have with the care plan facilitator.

At the meeting, you can expect….

- [Who will be there-insert names and/or disciplines].
- [Where located- insert location of meeting and/or weblink for a virtual meeting].
- [How long- insert time, including expected duration of the meeting].
- To receive contact information for the care plan facilitator.
- For you and/or your chosen person to attend [insert at what interval? initial, quarterly, annual, sig change].
- The meeting will start with you or your chosen person sharing what is most important to you to get out of the meeting.
- To share problems, issues, concerns, and successes since the previous meeting.
- To follow up on any previous issues addressed.
- Although all your concerns may not be addressed in the meeting, the meeting should provide a plan and a contact to continue working through concerns.
- To review current medications and recent or upcoming appointments.
- To share specific preferences or requests (ex. you want to wear your own underwear or brand of briefs)—and have those preferences integrated into care.

- For the meeting to take place in the resident and/or family's primary language and the nursing home to provide an interpreter or translator if needed.
- For staff to confirm who you want the nursing home to call for care issues and questions. In general, staff will call one person; that person should contact other concerned family members/friends.

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