

Teaming-Up to Create and Implement Care Plans

Center for Community & Family Services, Inc.

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Xander



4 year old male, when he came to us

Born 2 ½ months premature, 5 lbs. 4 oz, NICU for 30 days and was intubated. Received in-home care for 1 year

Parents concerned with speech, picky eater, lactose intolerance, very active, trips and falls frequently, and not completely potty trained. Physical exam recommended ophthalmology referral,. History of reactive airway disease need for medication at school.

Mother has history of traumatic brain injury, multiple sensory and back issues and history of cancer.

Parents had frequent re-locations. History of mental health and substance abuse.

Goals & Objectives

Verbalize difficulty of integrating services



Strengths of effective care planning



Provide examples and strategies for implementing care plans with multiple needs

Transitions: Identifying Participants

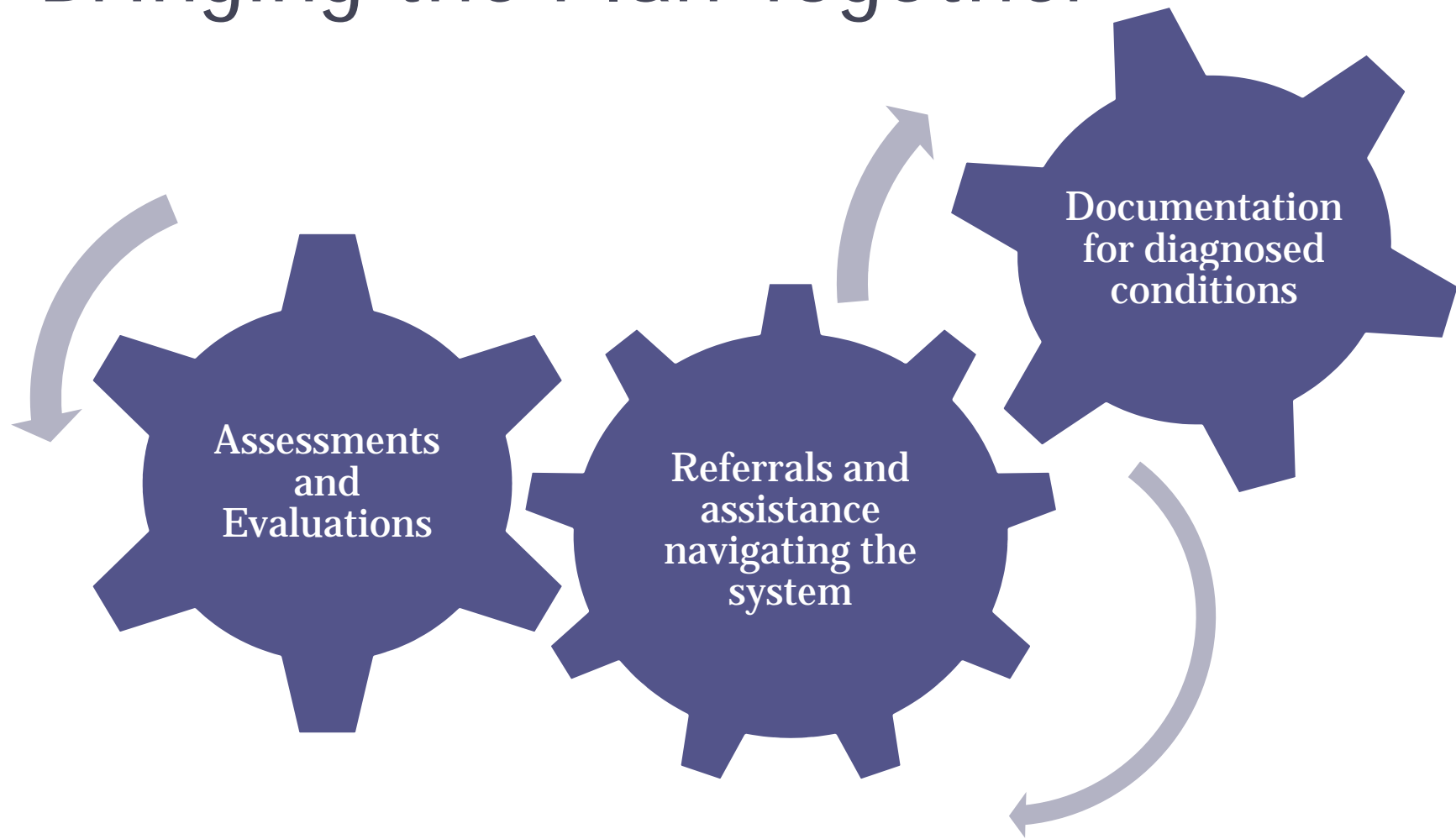
Step One

- Red Flag @ Enrollment
- Concerns identified by staff
- Signed-off by all pertinent specialist
- Identify those who need transition meeting

Step Two

- Transition Meetings held with multi-disciplinary staff present
- Gather further documentation
- Two-way communication with parents
- Identifying next steps

Bringing the Plan Together



Xander

Referred for speech/language at LEA.

Assessments

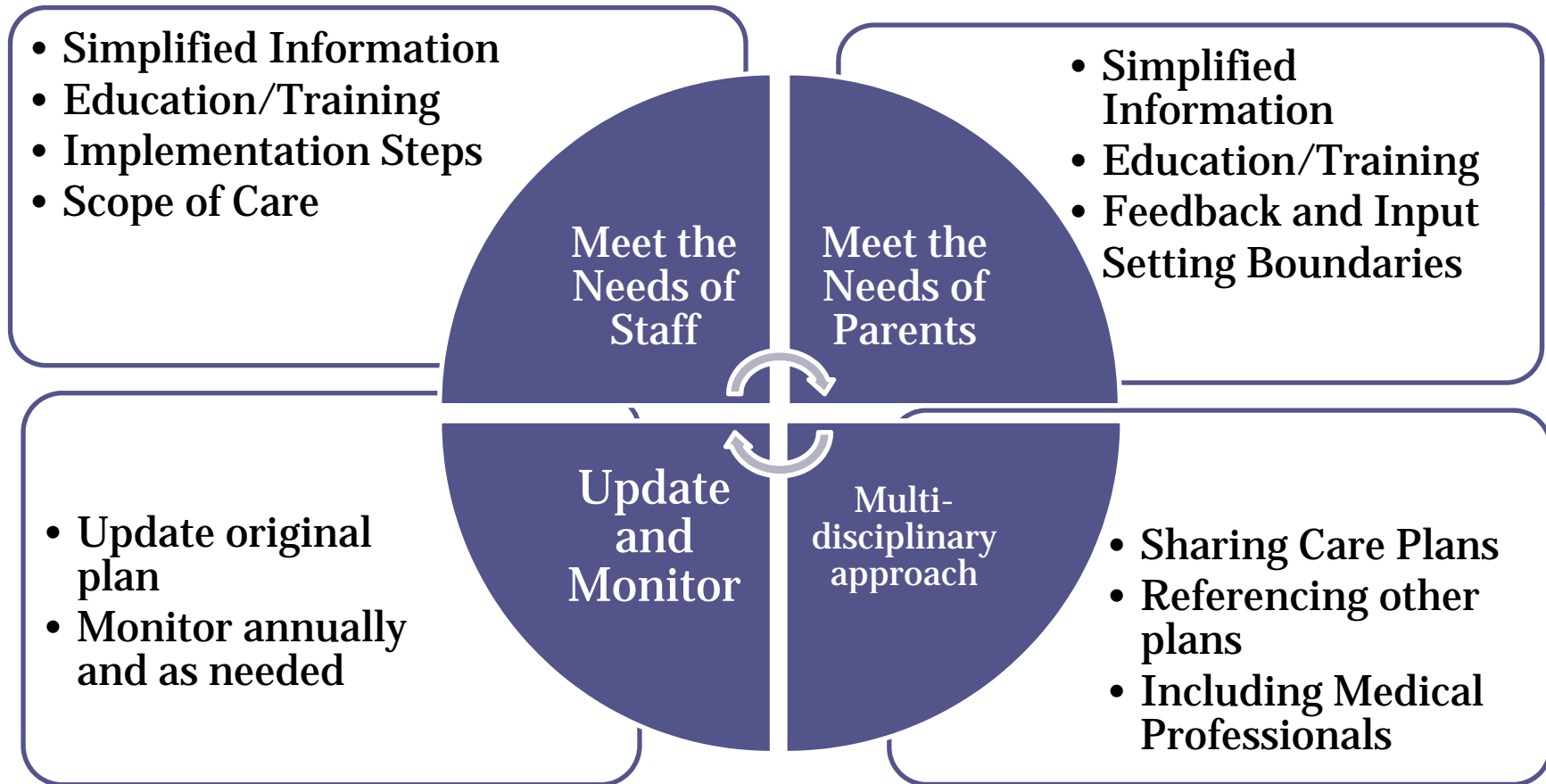
Added to food substitution list for dairy,
request medical documentation from MD.
Nutrition observation in classroom

Documentation

Follow-up on ophthalmology referral and
medication authorization.

Referrals/Follow-up

Starting The Care Plans



Implementation

Timeframes

- Specific Dates
- Progressive Steps
- Ongoing treatment and appointments

Supplies

- Medications on-site with documentation
- Special Equipment provided
- Classroom Environment considerations

Compliance

- Is child/family able to implement plan
- What difficulties are staff having
- Do parents have questions or concerns

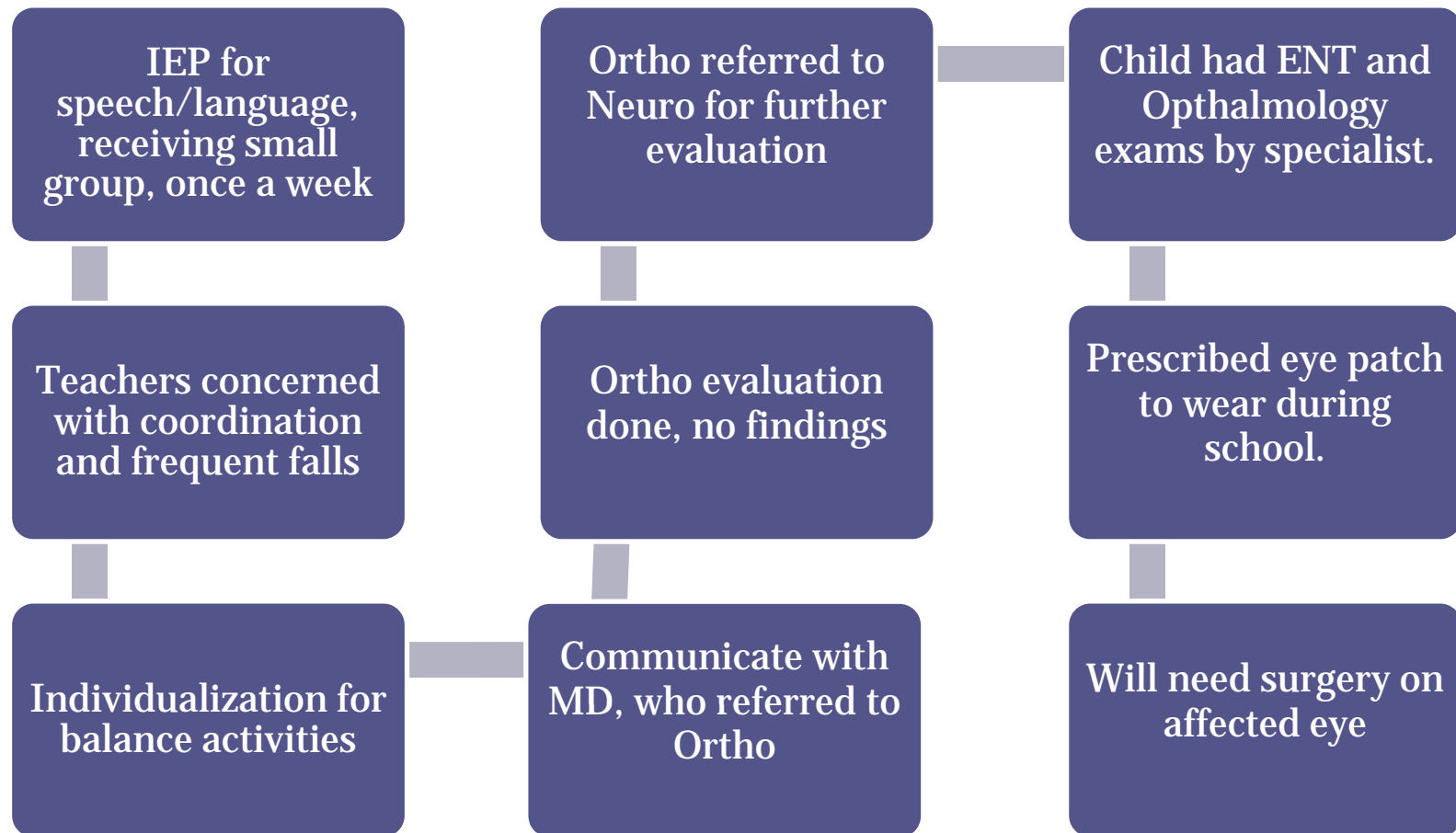
Care Plan

- Size of Care Plan varies
- Some items may need to be added or deleted.
- Can develop specific care plans for frequent or common conditions,
- Asthma
- Cast Care
- Allergy
- Used as training documentation for staff accountability
- Attach original doctors/discharge notes

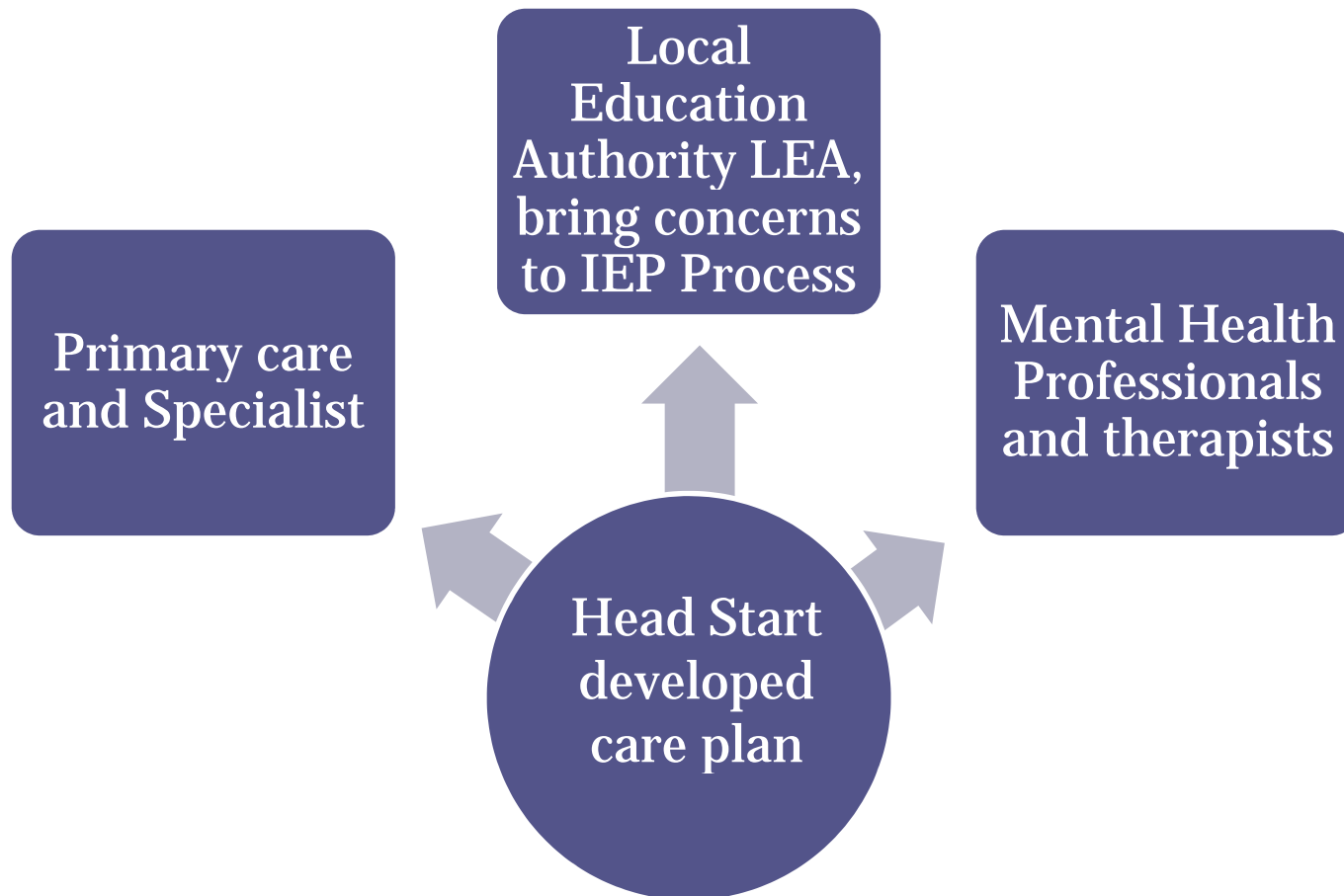
Care Plan
Effective: _____ Updated: _____

Child Name:	DOB:	Center:	
Parent Name:	Cell #	Home #	
	Weight	Height	
Diagnosis & Description:			
Background:			
Goals:			
Other Plans:	<input type="checkbox"/> IEP <input type="checkbox"/> Behavior Intervention Plan <input type="checkbox"/> Health Plan <input type="checkbox"/> Medication Plan	Comments:	
Plan of Care:	Signs and Symptoms		
	Classroom Instructions		
	Monitor		
	Emergency Procedures		
Training			
Equipment			
Parent Signature		Date:	
Nutrition Specialist Signature:		Date:	
Health Specialist Signature:		Date:	
Teacher Signature:		Date:	
Staff Signature:		Date:	
Staff Signature:		Date:	
Staff Signature:		Date:	

Case Management - Strategy for Updating and Monitoring



Disseminating Information



Resources

- **American Diabetes Association School, Care Plan**
<http://www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/>
- **Asthma and Allergy Foundation of America, School Action Card** <http://www.aafa.org/pdfs/AsthmaActionCardstudent.pdf>
- **California Child Care Health Program, Illness Sheets**
<http://www.ucsfchildcarehealth.org/html/pandr/illnesssheetsmain.htm>
- **Food Allergy and Anaphylaxis Network, Action Plan**
<http://www.foodallergy.org/files/FAAP.pdf>
- **American Academy of Pediatrics, Red Book**