Part V. Plan for Supports Revised

Provider: Team Nursing Services, Inc. Service: RN Skilled Nursing

Describe support instructions and preferences that occur consistently across activities and settings.

[These instructions apply whenever support is provided and do not require duplication in the activities section of the Plan for Supports. Include a description of the need for high intensity services or overnight safety supports as applicable. These support instructions impact the duration of activities and describe how the person learns best. For example, ***Mary uses a communication board to share her preferences throughout the day. Make sure she brings it along when leaving home and place it on her lap when asking questions.****]*

Mary is a beautiful person who loves spending time with her family and friends at the programs she attends. Being healthy and feeling well are important so she is able to participate in activities she likes such as the day program, church, and going to visit her brother and mother. Being clean, looking good, and being able go for manicures and pedicures are important to her.

Mary will grimace and hum when she is not feeling well and these symptoms must be acted upon immediately as she has a history of bowel obstruction, pneumonia, seizures and skin breakdown. Staff from all programs and her family need to have the nursing on-call number. Nursing will be available to provide an immediate assessment or will instruct staff to call 911 and send to the emergency room if indicated.

Mary requires others to recognize and intervene on her behalf when she is sick or at risk of becoming sick. Alerting medical staff when Mary is not acting herself, or if you observe behavior that unusual for her contact nursing immediately.
Mary needs a high fiber low fat diet and at least eight (8oz) glasses of fluids a day to help keep her bowels working properly and to remain healthy. When she is unable to take in orally 80% of her meals and fluids, she needs to receive a G-tube feeding and water bolus to bring her total calorie and fluids amount up to this prescribed amount. Mary does not like to get out of bed to eat breakfast, so her morning meal will be administered through her G-tube.

Mary feels most comfortable with staff who know her likes and dislikes, what her daily routine consist of, and how to communicate with her.

Mary requires proper seating on the toilet in her room or at the day support program bathroom to facilitate proper bowel function. Follow Lift, Transfer and Seating Protocol implemented at all locations. Mary also has a history of fractures due to osteoporosis, safe lifting and

transferring are important for safety.

It is important that Mary be able to live in an environment where it is peaceful and free from loud noises or others who get angry and raise their voice. She enjoys listening to a variety of music and bird watching. She likes to listen to music that matches her mood and energy level. If Mary refuses music, this is a sign that she is not feeling well.

Outcomes and Activities

LIFE AREA **Employment**	Mary has activities that match her interests in order to identify skills or interests that could be transferred to a job skill/task.		
Key steps and services to get there	***Expand community presence by discovering preferred locations (CE, GH), explore volunteer opportunities (CE), develop personal care plan for community settings (SN, CE, GH), explore AT/DME for overcoming barriers to accessing the community(SN,CE,SC), explore new activities to learn new interest (GH).***		
Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for the person to be successful and how they participate with each support activity.	**How often?**
Mary has a personal care plan that identifies the care Mary will need in order to participate in community activities. Skill-building: ☐ *Yes* ☒ *No*	Staff in each setting are trained and have demonstrated competency on Mary's specific needs. Mary no longer requires personal care in order to participate.	1. Nurse will meet with each service provider and review the personal care needs Mary has. Nurse will identify how much training will be necessary for each provider location. 2. Nurse will consult with each provider to ensure personal care plan is incorporated into each Part V development. Supplies needed to care for Mary in the community are obtained. (Travel bag with wipes, change of clothes, incontinence briefs, supplies for G-Tube feedings in community) 3. Nurse will provide observation and oversight as staff carry out Mary's plans to ensure safety and that protocols are followed. Nurse will monitor plan to ensure changes and updates are made and providers are made aware of. 4. Nurse will consult with SC and PT/OT on equipment that would benefit Mary in the community setting. Equipment such as "brown" spoon, Bullet Hand held blender will need	4 hour the first week to develop personal care plan and meet with Mary's providers, 32 hours for protocol development and 32 hours for staff training and education 8

		to be obtained for community activities. 5. Provide Medication Administration/Treatments and monitoring medication side effects.	units weekly for units for ongoing, monitoring.
LIFE AREA **Meaningful day**	Mary is understood.		
Key steps and services to get there……	***Link with SLP (SC), obtain AT recommended by SLP (SC), work with SLP to implement device into Mary's daily routine (GH, CE, SN), provide opportunities for choices and decision making throughout the day (GH, CE, SN).***		
Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for their person to be successful and how they participate with each support activity.	**How often?**
Mary's is able to make choices and communicate with medical staff. Skill-building: ☐ *Yes* ☒ *No*	Mary communicates all her needs and choices effectively.	RN will meet with Mary at each program site to discuss her personal care plan and ensure each provider acknowledges how to provide Mary with choice. 1. RN will prepare flash cards represent Mary's favorite foods to consume by mouth. A set of cards will be made available at each program site. Favorite foods are identified from information gathered from Mary, DSP's, family members, and friends. 2. Mary will be shown the cards and point to the one she wishes to purchase for lunch giving her choice. 3. Mary will be offered the choice of eating breakfast or to have a G-tube feeding. Mary likes to have breakfast in the quiet of her room, this helps to set the tone for her day. 4. If Mary is starting to get upset, she will be given the choice such as music to help her calm, watching the bird feeders outside or going to a quiet area to listen to music. Mary has a list of activities that indicates her preferences. How does Mary communicate "upset"? crying, no interest in activity, refusal to listen to music, unable to console, sad face. She will stare at you until she has your attention. 5. When Mary is not feeling well she will exhibit the following:	32 units for assessment and development of protocol. 32 units for education of Mary and staff. 8 units for monitoring per week.

		grimacing, humming, change in routine, change in level of engagement in activities, refusal to listen to music, crying. Nursing staff should be notified so that an assessment can be completed due to Mary's history.	

LIFE AREA **Healthy Living**	Mary is free from hospitalizations.		
Key steps and services to get there……	***Develop transfer, seating, and repositioning protocol (SN), follow transfer, seating and repositioning protocols (CE, GH), develop pain protocol (SN), follow pain protocol (CE, GH), develop seizure protocol (SN), follow seizure protocol (GH, CE), provide training and oversite (SN).***		
Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for their person to be successful and how they participate with each support activity.	**How often?**
Mary has healthy skin and is free from issues that could result in hospitalization. Skill-building: ☐ *Yes* ☒ *No*	Mary has smooth healthy skin with no breakdown, pressure injuries, or injuries associated with fall. Mary repositions herself providing relief needed in pressure areas. Mary can transfer with minimum assistance.	1. The RN will develop Protocols for transferring, seating and repositioning based on physician orders and PT recommendations. Protocols will be sent to the PCP for approval. Nurse monitors for unusual trends and notifies PCP if changes occur. 2. The RN ensures all the Protocols are determine if still pertinent, meet Mary's needs and preferences, and update accordingly. Provide observation of staff to ensure compliance with and competent in implementing all protocols and health documentation. Nurse will review staff documentation for issues that arise while in community and help resolve. 3. Nursing will be available via phone to discuss Mary's symptoms with staff and family when he has any status change and will complete an on-site assessment. 4. Nurse will research best practices and evidenced based educational materials for staff training on increasing bowel motility with correcting seating and positioning. Moving Mary frequently facilitates bowel and bladder function.	32 units for assessment and development of protocol. 32 units for education of Mary and staff. 8 units for monitoring and continued training per week.

Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for their person to be successful and how they participate with each support activity.	**How often?**
Mary is free from falls and follows the lifting, transferring, and seating protocols to ensure safety daily. Skill-building: ☐ *Yes* ☒ *No*	Mary transfers safety with minimum assistance. There are no reports of falling or injuries. The use of a lift is not required. Mary is able to sit in the correct position when toileting and eating.	1. Nursing will develop a lift, transfer and seating protocol and educate Mary and the staff on proper use of the lift, commode chair and the placement of the safety strap and other equipment in the home, community and day program. Nurse will develop protocols following PT/PCP recommendations. 2. Nursing will ensure that all caregivers understand the use of universal precautions and the proper equipment and interventions for assisting Mary after toileting. Train staff on cleaning equipment after each use. 3. Nursing will inspect all equipment (lift, slings, wheelchair, shower chair, bedside toilet chair) and order supplies weekly to assure equipment is clean and in good working order and supplies are available. 4. Mary uses a wheelchair for her mobility and requires assistance to change positions and exercise her arms and legs. Moving Mary frequently helps to facilitate good bowel and bladder function as well as minimizes the risk of pressure injury. Follow Positioning and Skin Integrity Protocol and model them for staff. 5. Nurse provides staff training on seating protocol. This protocol addresses proper seating for toileting and seating during mealtimes when Mary chooses to eat by mouth. Positioning during G-Tube administration is addressed during G-Tube training. Observation and competency will be demonstrated to ensure safety.	32 units for assessment and development of protocol. 32 units for education of Mary and staff. 8 units for monitoring per week.

Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for their person to be successful and how they participate with each support activity.	**How often?**
Mary has support during seizures and when a break through seizures occurs staff will provide care to keep her safe. Skill-building: ☐ *Yes* ☒ *No*	All protocols are being implemented correctly and all caregivers are trained in seizure first aid. Mary's seizures are stable and do not require monitoring. All staff are trained to provide care for seizures and there is no staff turnover. Mary communicates issues with the Neurologist.	The RN will: 1. Meet with Neurologist and obtain orders. 2. Develop protocols to reflect these orders on seizure management. 3. Provide education and training to staff and family regarding protocols and when to call 911. 4. Develop Seizure Tracking Record, and train staff and family on use. 5. Provide summary of seizure activity to Neurologist every quarter. Monitor for increase in seizure activity and determine if a neurology appointment is needed. Monitor seizure log each week to identify trends or changes in frequency. 6. Provide assessment in the event seizure causes a fall.	32 units for assessment and development of protocol. 32 units for education of Mary and staff. 8 units for monitoring per week.

Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for their person to be successful and how they participate with each support activity.	**How often?**
Mary's health status is monitored and she is free from infections. Skill-building: ☐ *Yes* ☒ *No*	Mary eats without risk for aspiration and pneumonia. Mary does not require stoma care. Mary does not require nursing assessment, instruction, monitoring and consultation regarding risk of infections.	1. RN will complete a comprehensive health assessment every week to identify any changes in health. Nurse will provide comprehensive assessment more often if Mary is not feeling well or caregivers have identified changes in alertness, temperature, change in respiratory status, or complications with stoma, indications of aspiration, swelling and redness, or other indications of infection. 2. RN will monitor documentation and charting (bowel movements, Input/output, nutrition, vital signs(BP, P, R, T, Spo2), redness, swelling, symptoms of pain and staff reports recognizing that she is exhibiting symptoms of not feeling	32 units for assessment and development of protocol. 32 units for education of Mary and staff. 8 units for

		well. 3. Nurse will consult with the PCP, or if arrangements for her to go Urgent Care/ER. Nurse will attend appointments to ensure orders are obtained and implemented.	monitoring per week.

Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for their person to be successful and how they participate with each support activity.	**How often?**
Mary is monitored for pain and interventions are in place to address pain and decrease the duration. Skill-building: ☐ *Yes* ☒ *No*	Mary is able to reposition herself, relieving pressure areas. Nursing assessment for pain is not required because Mary is able to vocalize pain, location, intensity.	1. RN will develop a Pain protocol and provide training to staff to identify symptoms of pain. Nurse will provide Mary and her family with education on pain to ensure Mary is aware of how to alert caregivers. 2. Nurse will provide the on call number to staff and family so that upon identifying symptoms of pain nurse can be notified. 3. Nurse will be provided a set of baseline vital signs. 4. Nurse will follow-up with staff one hour after pain medication is administered to ensure relief. 5. Nurse will provide a pain assessment in the event that non-pharmacological interventions are not successful. 6. Nurse will attend appointments and ensure that physician orders are obtained, staff trained, and implemented.	32 units for assessment and development of protocol. 32 units for education of Mary and staff. 8 units for monitoring per week.

LIFE AREA **Healthy living**	Mary eats preferred foods in order to remain free from choking/aspiration.
Key steps and services to get there……	***Develop nutrition and hydration protocols (SN), follow nutrition and hydration protocols (CE, GH), Develop G-tube care protocol (SN), follow G-Tube care protocol (CE, GH), provide options each day for food by mouth (CE, GH),***

	provide training and oversite (SN).

Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for their person to be successful and how they participate with each support activity.	**How often?**
Mary is well hydrated and has good nutrition. Skill-building: ☐ *Yes* ☒ *No*	Mary receives all nutrition by mouth and does not require a G-Tube for supplementation. Mary stays well hydrated and is not at risk for dehydration. Mary eats without being monitored for choking or aspiration. Mary can eat foods without modification (pureed).	A nutritional and hydration program will be developed, and education will be provided to Mary and the staff. The nurse will closely monitor the implementation of the Nutritional protocols. 1. Nurse, Mary, her Speech Therapist, and Nutritionist will develop a Nutritional Protocol which will be followed so that appropriate positioning, food consistency including food options that meet her dietary needs as prescribed by her PCP. Mary has a diagnosis of dysphagia and requires that food by mouth be pureed consistency. Nurse will monitor meal times to ensure staff are preparing food to orders. 2. Nursing will provide education to Mary, her family and the staff at all of her programs on the importance of good nutrition, fluids intake and regular bowel movements and the implementation of the Nutritional Protocol and all tracking forms. 3. The RN assesses weekly fluid intake and urine output. If fluid intake is significantly behind recommendations, notify the PCP and implement all orders.	32 units for assessment and development of protocol. 32 units for education of Mary and staff. 8 units for monitoring per week.

Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for their person to be successful and how they participate with each support activity.	**How often?**
Mary will receive medication and nutrition via G-Tube in order to maintain good hydration, nutrition status and	Mary takes all nutrition and medication by mouth and no longer requires a G-Tube. Mary is no longer at risk	1. Nursing will write protocols and educate all Medication Aides on the use and care of her G-tube. The RN will reinforce how to determine when oral intake needs to be supplemented by G-tube feedings and water boluses.	32 units for assessment and development of protocol.

receive medication. Skill-building: ☐ *Yes* ☒ *No*	for complications associated with G-Tube.	2. Nursing will inspect all equipment and order supplies weekly to assure equipment is clean and in good working order and supplies are available. 3. RN will provide G-tube training per curriculum and provide staff competencies every 6 months to ensure staff are following protocols and meet requirements to perform G-Tube feedings and medication administration. 4. RN will assess Mary's weight monthly to ensure she is maintaining weight as identified by Nutritionist, Nurse will notify PCP and nutritionist if Mary has unexpected weight loss of 5 pounds or more. If there are weight changes noted, nurse will have weight taken more frequently. 5. Nursing will be available via phone to discuss with staff and family if Mary's status changes or is Mary is showing signs of pain, discomfort, signs of infection, her abdomen is hard or distended. 6. Consult with PCP, PT, Gastroenterologist, and other specialist to ensure that orders are obtained and followed, contact when health issues arise, attend appointments as needed. 7. Nurse will assess Mary's stoma weekly and more frequently if issues arise, to ensure free from infection or complications. 8. Nurse will develop a G-Tube Care protocol to ensure the stoma is being cleaned and staff are trained on signs and symptoms when the nurse needs to be notified.	32 units for education of Mary and staff. 8 units for monitoring per week.

LIFE AREA **Healthy Living**	Mary has smooth, healthy and fragrant skin.

Key steps and services to get there……	***Develop ROM protocol (SN), follow ROM protocol (GH). Provide training and oversight.***		
Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for their person to be successful and how they participate with each support activity.	**How often?**
Mary will follow the ROM protocol and repositioning protocol to ensure her skin is healthy and injury free. Skill-building: ☐ *Yes* ☒ *No*	Mary's skin is healthy and has no risks for breakdown. Mary is able to care for her skin by applying lotion and gentle massage. Mary repositions herself to avoid pressure injuries.	1. The RN will obtain a PT consult as needed to obtain recommendations for repositioning. Obtain orders from her PT/PCP for the lotion and ROM exercises to keep Mary's joints moving. Gentle massage helps to facilitate ROM and also provides hydration to the skin. 2. The RN will educate the staff on ROM protocol and model how to provide this care. Nurse will follow PT recommendations for ROM. 3. The RN completes a comprehensive health assessment at least once a week and more often to identify any change in her skin to prevent complications from breakdown and pressure injury and the RN reports any issues to the PCP and implements all new orders as prescribed. If skin breakdown or pressure injury occurs nurse will consult with PT to make adjustments to repositioning and seating protocols. 4. Mary will put her hands in her mouth when upset or bored. This causes them to stay moist and contributes to breakdown. Staff will be instructed to gently remind Mary to take her hands out, wipe clean with a moist wipe then dry. Keeping her hands busy will decrease the frequency. Ensure that Mary's favorite items are taken with her in community and encourage her to use them. 5. Develop a protocol for daily exercises that Mary enjoys, consulting with her PT. Incorporate activities such as reaching for the bell to ring, kicking at a large ball, dancing to her favorite music with staff support, lying on her large body pillow while staff assist with leg exercises (ROM).	32 units for assessment and development of protocol. 32 units for education of Mary and staff. 8 units for monitoring per week.

		6. Once staff are trained and demonstrate competence on exercises, observe staff as they begin to work with Mary. Re-certify staff every 6 months or as needed to ensure exercises are being completed correctly. 7. Research best practices and evidenced based educational materials for staff training on reducing the risk of immobility induced health problems, especially those associated with skin integrity.	

LIFE AREA **Healthy Living**	Mary is healthy, safe, and a valued member of her community.		
Key steps and services to get there……	***Follow daily routines (GH), identify changes in status (GH, CE, SN), maintaining a healthy and safe home and community environment (GH, CE), receiving routine supports and assessments to keep Mary healthy and safe (GH, SN).***		
Support Activities (action steps)	**I no longer want/need supports when…**	**Support Instructions** (Describe the steps, what's needed for their person to be successful and how they participate with each support activity.	**How often?**
Mary receives weekly assessments and oversight in order to be healthy. Skill-building: ☐ *Yes* ☒ *No*	Mary is healthy and has no need for nursing assessment and monitoring. Mary communicates with her physicians regarding health issues.	1. The RN completes a comprehensive health assessment once a week and more often when Mary is not feeling well Mary receives a full assessment to identify any change in her bowel function, respiratory status and other medical conditions before they lead to an emergency level and her medical care will be coordinated to prevent complications. 2. The RN reports any issues to the PCP and implements all new orders as prescribed. (Be alert to signs of bowel problems and pneumonia unique to Mary such as her reduced response to pain (if she is grimacing in response to palpitation alert PCP immediately or transfer Mary to the E.R.) her curvature which reduces the ability to accurately hear bowel sounds, may need an x-ray to confirm reduced sounds.	32 units for assessment and development of protocol. 32 units for education of Mary and staff. 8 units for monitoring per week.

		3. Nurse will need to request assistance from a DSP that Mary trusts to assist with the exam. Mary will hold her abdominal muscles tightly and move about until she is distracted, then an assessment can be completed. (Have a DSP provide soothing music and hold her hand during the exam; this helps Mary feel more comfortable and it assists the nurse to obtain an accurate assessment). 4. RN communicates with PCP, PT, Nutritionist and other physicians to maintain orders and ensure that protocols are up to date. Nurse provides oversight, consultation and training for staff.	

Signatures:

Nurse: _____ Date: _____

Individual: _____ Date: _____

Substitute Decision Maker: _____ Date: _____

Medical Provider: _____ Date: _____

Outcome changes approved by Support Coordinator:

_____ _____

Support Coordinator Date

General Schedule of Supports Provider: Nursing Services, Inc. Service: Nursing

Instructions: The **General Schedule of Supports** is a general blueprint of activities and supports, based on the person's preferences and routine. The authorized support time allotted to each group of activities is included in the **authorized hours and totals sections**. The **General Schedule of Supports** can be developed in various ways, but must include: support activities and outcome numbers, timeframes for activities, as well as authorized totals.

	Outcomes	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
morning	1,3,7,8,9,10	800am to 1200pm	[from/to]	[from/to]	[from/to]	6am to 8 am	[from/to]	[from/to]
		Prepare Protocols	[activities]	[activities]	[activities]	Assessment, oversight, consultation, training Modeling of morning routine	[activities]	[activities]
	Authorized	32 units	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]
afternoon	1,3,7,8,9,10	12-2pm	[from/to]	**11am to 3pm**	[from/to]	[from/to]	[from/to]	[from/to]
		Prepare protocols	[activities]	Educate day Support staff with Mary on Protocols	[activities]	[activities]	[activities]	[activities]
	Authorized	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]
evening	1,3,7,8,9,10	**2pm to 4pm**	[from/to]	[from/to]	**3pm to 8 pm**	[from/to]	[from/to]	[from/to]
		Meet with Mary and review all Protocols	[activities]	[activities]	Provide staff education on protocols	[activities]	[activities]	[activities]
	Authorized	8 units	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]
overnight	[outcome numbers]	[from/to]	[from/to]	[from/to]	[from/to]	[from/to]	[from/to]	[from/to]
		[activities]	[activities]	[activities]	[activities]	[activities]	[activities]	[activities]
	Authorized	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]	[enter support hours total]
Authorized Totals		***32***	***[Enter daily***	***16 units***	***16 units***	***8 units weekly***	***[Enter daily***	***[Enter daily***

		authorized total]				*authorized total]*	*authorized total]*
Comments:							
Authorized hours per week:		***[Enter weekly authorized total]***		***Authorized periodic support hours per week:***			***[Enter weekly periodic supports authorized total]***

Safety Restrictions

As your provider, we have identified something you want to do that might create a risk. We need your input to develop a plan that supports you to have what you want in a safe way. We have determined that ther restriction is necessary to achieve a therapeutic benefit, maintain a safe and orderly environment or to intervene in an emergency and that all possible less restrictive options have been tried. [12VAC35-115-100].

The following is completed with the **individual**:	
I understand that I will not:	[Enter description of restriction]
Ther is necessary because:	[Enter description of the reason for the restriction]
The outcomes in my plan related to ther restriction include:	[Enter the outcomes from the person's ISP related to the restriction]
The following is completed by a qualified professional:	
Describe your assessment, to include all possible alternatives to the proposed restriction that take into account the individual's medical and mental condition, behavior, preferences, nursing and medication needs, and ability to function independently.	[Enter assessment results]
Describe other less restrictive, positive approaches that have been attempted to meet safety needs based on the person's medical and mental condition, behavior, preferences, nursing and medication needs, and ability to function independently:	[Describe other less restrictive, positive approaches attempted]
Is ther proposed restriction necessary for effective treatment of the individual or to protect him or others from personal harm, injury, or death?	☐ *Yes* ☐ *No*
Describe how progress toward resolving the restriction(s) will be measured:	[Describe how progress will be measured]
Describe how often restriction(s) will be reviewed:	[Enter frequency of review]
Describe conditions for removal of restriction(s):	[Describe conditions for removal of restriction]

I understand that taking the actions listed can create a safety risk. I understand the reason for the restriction, the criteria for removal, and my right to a fair review of whether the restriction is permissible. When utilized, I understand that the proposed restriction will not cause harm and give my consent to participate:

_____ _____

Individual **Date**

_____ _____

Substitute Decision Maker **Date**

_____ _____

Responsible provider (NURSE) **Date**

Ther ISP belongs to:_____ID# _____ISP Start: _____End: _____ Revision: _____

STATUS UPDATE

The Status Update form is available for sharing status changes directly with the Support Coordinator and others.

Information Element	**Update:** *Describe changes to any of the listed elements in the spaces below for sharing with others.*
Contact Information	
Emergency Contacts/Representation	
Psychological/Developmental Evaluation	
Current Level of Functioning Survey	
Support Coordination and Provider Contacts	
Communication and Sensory Support	
Adaptive Equipment, Assistive Technology and Modifications	
Health, Medications, Physicals	
Summary of Social/Developmental/ Behavioral/Family Hertory	
Summary of Employment and Educational Background	
Exceptional Support Needs/ Risk Assessment (SIS Section IV)	
Ability to Access Services and Supports	
Legal, Financial and Advocacy Issues	
Back-up, Discharge and/or Self-Sufficiency Plan	
Personal Profile/Planning Meeting/Plans for Support	

Effective date of change: _____
Update completed by (print name): _____
Signature: _____Date: _____

Ther ISP belongs to:_____ID# _____ISP Start: _____End: _____ Revision: _____

1. Specialized Protocols to cover Bowel Movement Recording, Intake &Output Recording, Positioning, Skin and personal Care, ROM, Seizures, Nutrition and Hydration, transferring and lifting, Pain, Protocols are developed and implemented. Mary and her staff are educated on their use and the results are reviewed weekly. The RN shall:
2. Write protocols to reflect the information from the visit and have the PCP sign these protocols.
3. Educate and ensure staff is competent on the implementation of protocols. Implement Protocols as needed.
4. Provide input and consultation to Case Management, Mary's Residential and Day support providers and other members of Mary's support team as they develop their Part V Support Plans to ensure all health and medical issues are addressed and care is consistent when out in community.
5. Provide ongoing guidance and support to Mary, her family and her staff as needed.
6. Consult with PCP, PT, Neurologist, Gastroenterologist, and other specialist to ensure that orders are obtained and followed and that protocols reflect those orders.

PAIN

Mary alerts staff through non-verbal ques or through other means of communication that she is uncomfortable or having pain in order for her daily routine to be uninterrupted.
Skill-building:

☐ *Yes* ☒ *No*

Mary is not at risk for pain due to immobility and muscle atrophy. Mary is able to turn and reposition herself relieving pressure on boney prominences. Mary communicates well and alerts staff to pain and discomfort. Mary has a communication device in which she can express herself.

7. Provide training to staff and family regarding best practice and evidence based interventions for pain. Research and provide handouts.
8. Obtain and appointment with PCP and Mary to discuss pain interventions, obtain orders for pain relief medications.
9. Develop a Pain protocol for Mary, identifying ways that she communicates pain (Grimacing, humming, rocking, crying, sad facial expression, face becomes red, screaming), and non-pharmaceutical interventions that offer her choice. Incorporate PCP orders into Pain protocol.
10. Train staff on Mary's Pain protocol.
11. Nurse will be available by phone to consult with staff if Mary is exhibiting signs of pain and interventions are not successful.
12. Monitor Mary's use of PRN medications for Pain, where she is experiencing pain, and how often. If frequency increases nurse will address with PCP. Discuss with Mary and staff on which interventions seem to work best for her.

Nurse will provide a Pain Assessment if interventions are not successful and determine if contacting the PCP or going to the ER is warranted.