PCA CARE PLAN

POLICY

A complete and appropriate Care Plan, identifying duties to be performed by the PCA, shall be developed by an Agency Registered Nurse/Qualified Professional. The Care Plan services are based on the PCA Assessment and Service Plan (DHS-3244) that is completed by the Public Health Nurse, and sent to the agency within the first week following an assessment.

PURPOSE

To provide a means of assigning duties to the PCA that are clear to the RN/QP, PCA, and the client/caregiver being served.

To provide documentation that the assigned PCA is oriented to the client's care prior to initiating the cares.

To provide documentation that the client's care is individualized to his/her specific needs, and utilizes the data from the Assessment and Service Plan.

SPECIAL INSTRUCTIONS

1. Following the initial assessment and consultation with the client/caregiver, instructions for home care are prepared by a Registered Nurse, as appropriate.
2. The PCA Care Plan must be completed or updated:
   - Within the first seven days of starting services with an agency
   - When there is a change in condition, tasks, procedure, living arrangements, responsible party or month to month plan
   - Annually at the time of reassessment
3. The PCA Care Plan can only include services that are allowable as covered services and cannot include services identified as non- covered.
4. A copy of the most current care plan must be in the client's home, in the client file in the agency, and individual PCAs must know the location of the care plan. For shared services, a copy of the care plan must be at the location where shared services are being delivered.
5. PCA provider agencies must have a care plan template. The PCA care plan must contain the following required components:
   - Client name, address and phone number
   - Responsible party and delegated responsible party name, address and telephone numbers
   - Start and end date of the Care Plan
   - Dated signatures of client/responsible party and qualified professional (QP)
   - A month-to-month plan for the use of personal care assistance services
6. The Care Plan must include a description of the individualized needs of the client, the services to be provided by the PCA and special instructions or procedures. Covered services

include:

- Assistance with activities of daily living (ADLs)
- Assistance with health related tasks, including assistance with self administered medications
- Observation and redirection of behaviors
- Instrumental activities of daily living (IADLs) (age 18 and older)
- IADLs needed for health and hygiene reasons integral to PCA services (age 0-17 years)

7. The Care Plan must include an Emergency Plan that has the following:
   - Emergency telephone numbers
   - Emergency procedures for serious, unexpected, dangerous situations that require immediate actions
   - Descriptions of measures to address identified safety and vulnerability issues
   - Back-up staffing plan
8. The initial care plan development for clients receiving traditional PCA services must include a face to face meeting with the client/responsible party and the QP at the location where services will be delivered
9. PCA Choice client/responsible party is responsible to develop the care plan using the provider agency care plan template. Clients can request assistance from their PCA Choice provider agency's QP
10. Lead agencies must send a completed PCA service plan to the recipient and to the provider selected by the recipient **within the first week** following an assessment for PCA services.
11. The care plan must be updated to reflect changes in needs of the client.
12. A new PCA care plan is required annually at the time of reassessment.