Care Plan Setup

1. General Guidance

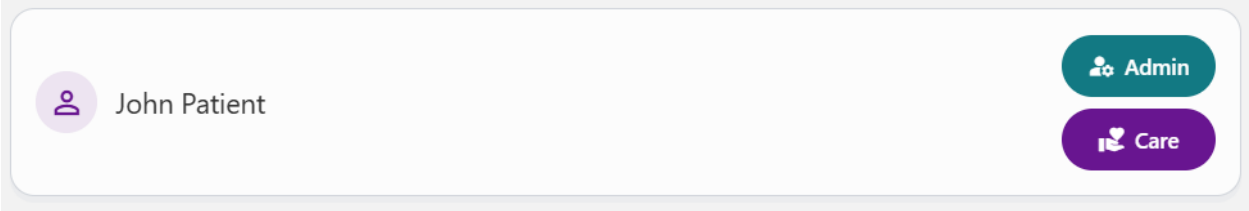
Thank you for being part of the CareCorner community. Our platform is designed to make care coordination simpler, more connected, and truly centred around the person receiving care. As the Administrator, you play a key role in ensuring information is accurate, timely, and accessible to the whole team.

- We strongly **recommend completing this process on a desktop / laptop** or maybe a tablet as it is easier to also copy and paste from existing documents.
- When you initially sign up as a new user, you will have to verify your account via a link sent to your email address.
- You can setup multiple patients under your account and invite dedicated team members.
- Ensure that the “updated” command appears at the bottom of the screen when you make changes to the care plan.
- Always double check in the Care taker mode (e.g. in the Care Plan) that the changes have come through successfully and that the care plan is written in a way that works for the team and that there are no errors.
- You can make another person an “Admin” for your account. You are able to remove them as well. The person initially setting up can never be removed as the admin.

2. Initial Patient Setup

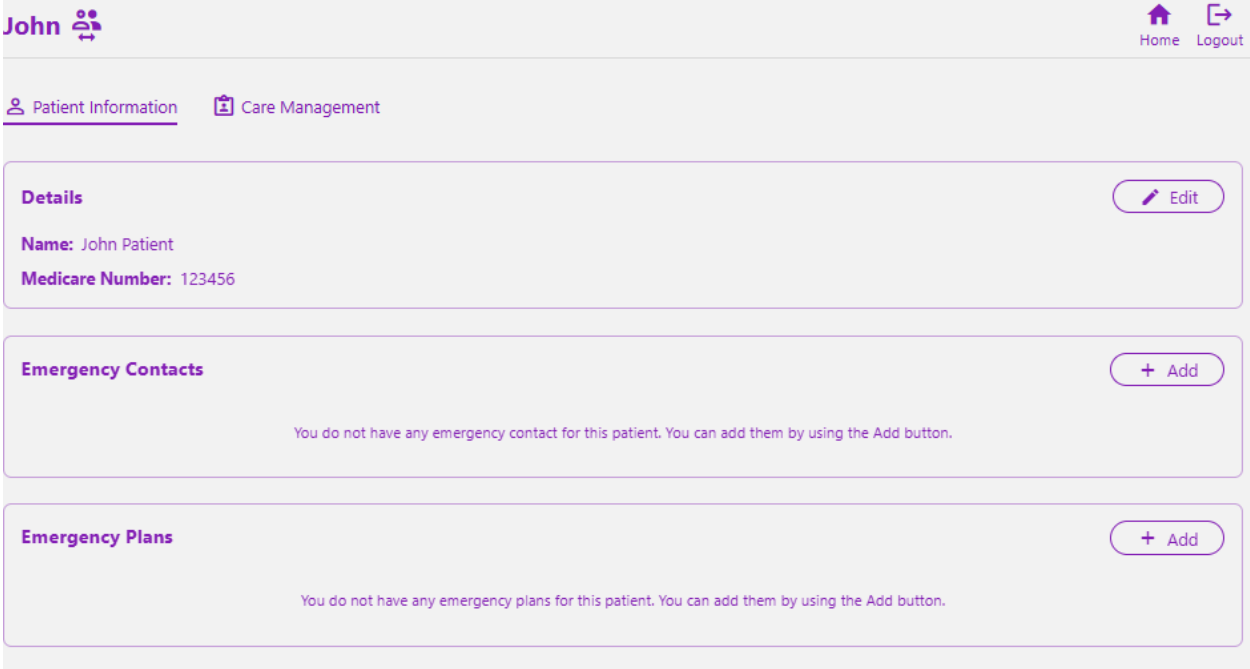
You will be asked some generic information about the patient you are setting up. This data can be edited at a later stage and the fields are not mandatory.

Editing information is always possible via the Admin button for each patient on your login screen.



3. Patient Information

The Patient information tab includes generic info about the person, their Emergency contacts and customised Emergency Plans.

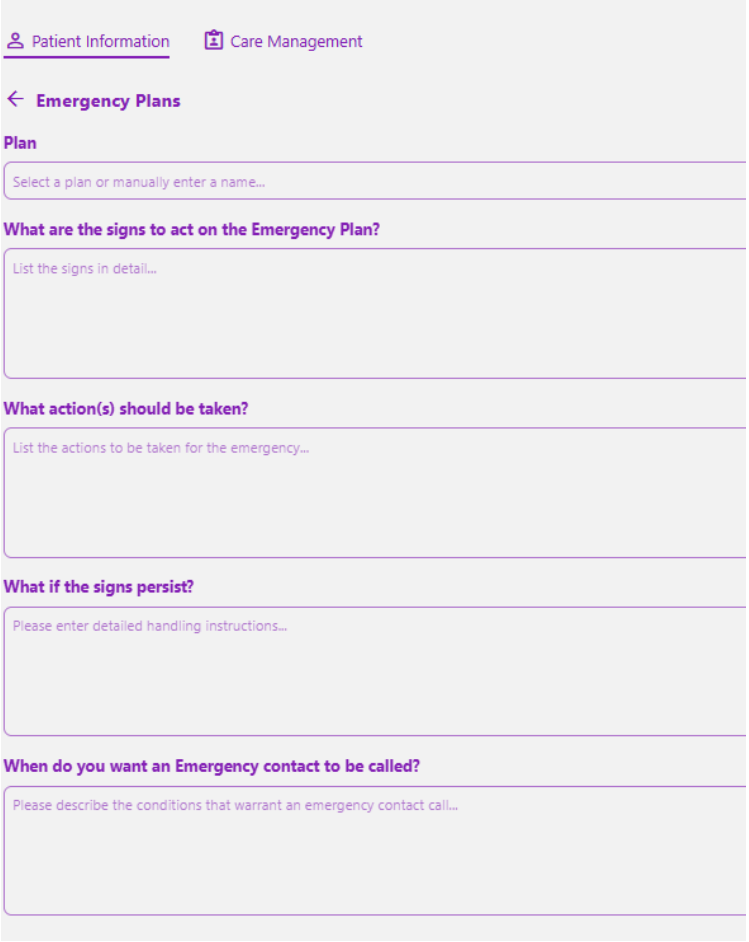


3.1 Emergency Plans

The Admin can create as many Emergency plans as they wish and they can be labelled in customised ways.

Each Emergency Plan follows the same pattern:

- Title of the Plan
- Signs in the patient indicating to act on the Emergency Plan
- Actions to be taken
- Actions is symptoms persist
- When to contact an Emergency contact



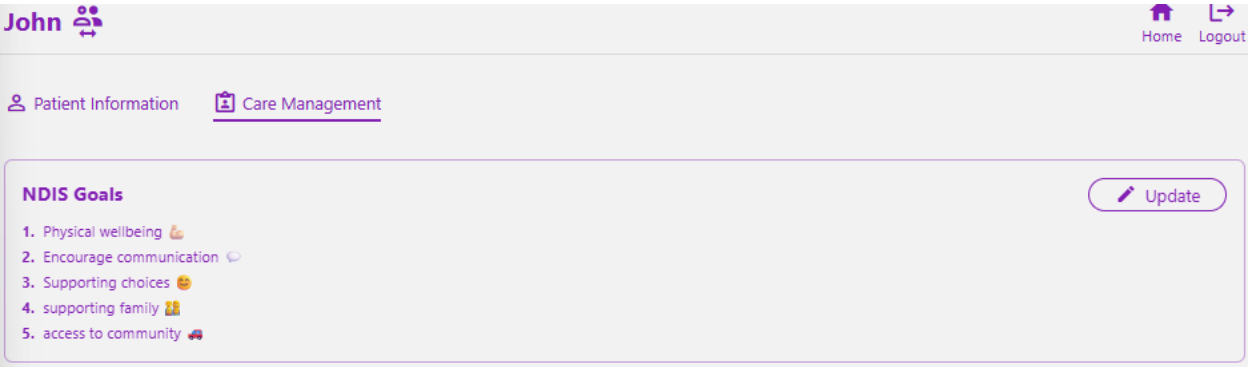
4. Care Management

4.1 Care Goals

This allows the admin to define the patient's Care goals. Those goals can be aligned with NDIS plans or as discussed with the wider Care team.

It is recommended to use short description for the Care Goals as they will appear in the Progress notes and act as reminders for the team to consider the Care Goals on every shift.

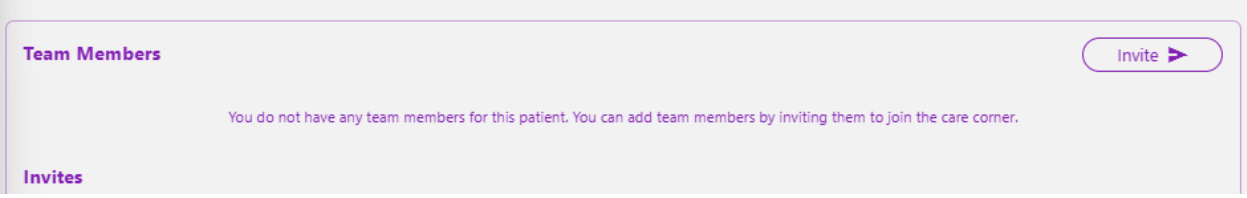
The Admin might choose to set one goal as "NONE" or "NA" to enable the care takers to select this option if they have not been able to work on any goals in the shift.



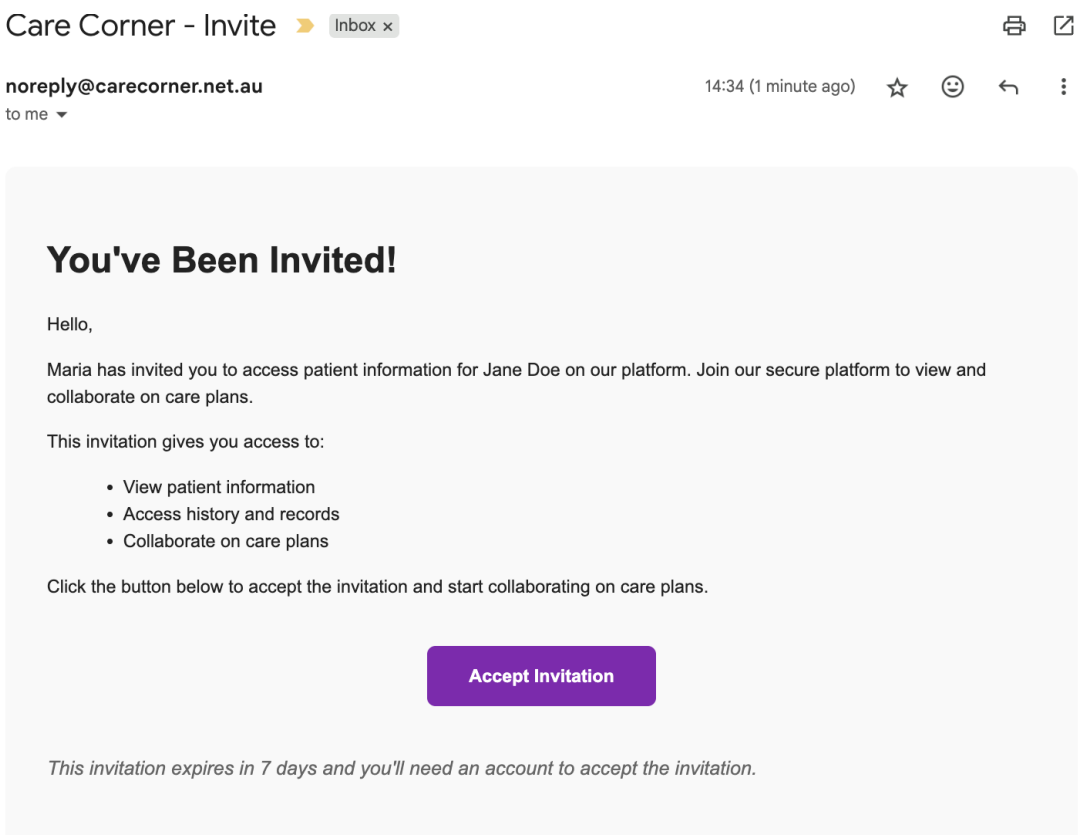
4.2. Team Members

The Admin invites the whole care team via entering their email addresses. Please be mindful that these email addresses are case sensitive.

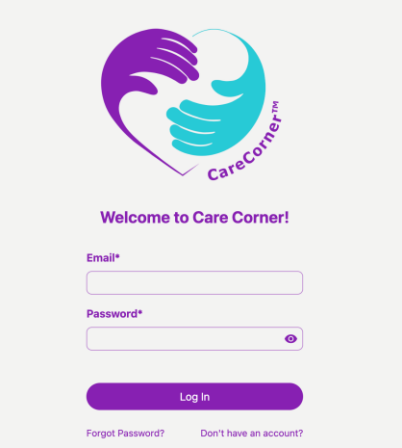
Depending on the approach taken by the Admin, you might want to invite family members, Allied Health professionals, medical progressionals or anyone else involved in the Care of the care recipient.



Team members such as family members, allied health professionals, and medical professionals receive an invitation to CareCorner.



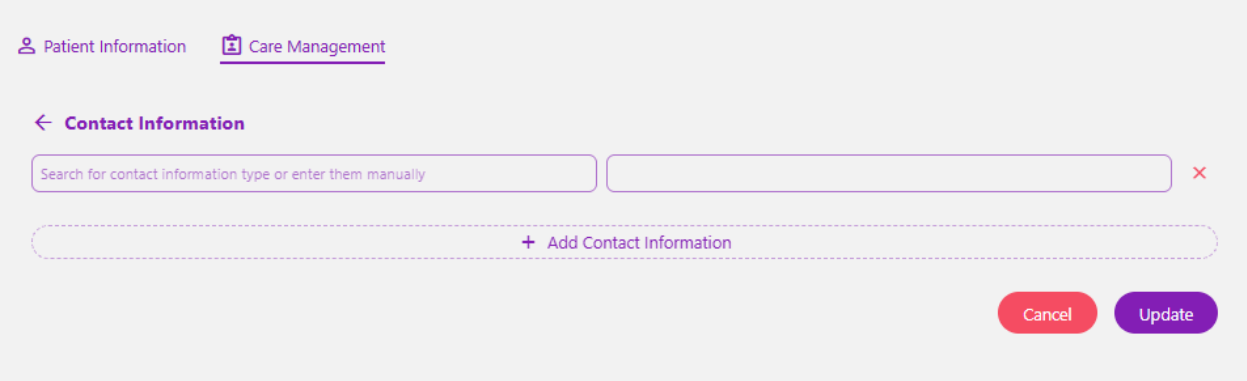
To access the patient's CareCorner profile, they click *Accept Invitation*, which takes them to the CareCorner login page. Team members then select *Don't have an account* and complete the details to view and access the patient they are caring for.



Once a Team member has accepted, you can make them an Admin to the account. This will allow them to make changes to the Care Plan.

4.3 Contact Information

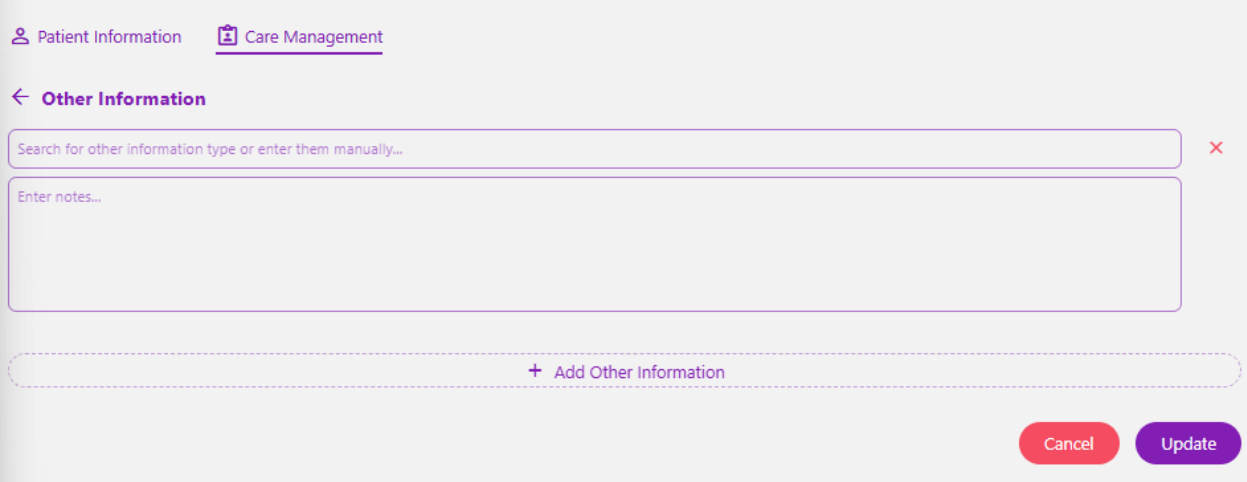
In this section the Admin can provide details for anyone relevant in the Care team. This could be Medical Specialists, Family members etc. You can add contact details such as office addresses, email addresses or phone numbers etc.



4.4. Other information

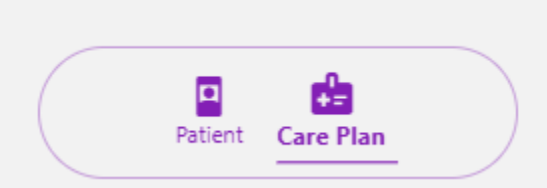
This section is highly customisable and it is up to the user to add in as many or as few sections as they want. Some categories are recommended but this area is fully customisable by creating titles and entering into a free text field.

All the information entered here will be visible on the Care Plan in the Caretaker mode.


Patient Information
Care Management
Other Information
Search for other information type or enter them manually...
Enter notes...
Add Other Information
Cancel
Update

5. Care Plan setup

The Care Plan setup can be entered via the controls at the bottom selecting the “Care Plan” section. It is the programming of the care taker mode in the app/platform.



5.1 General Observations

General observations allow the user to make free text entries that will appear in the Care Plan. The admin can also select all relevant data points for the vitals.

5.1.1 Temperature

It is recommended to note the patient’s baseline temperature and other relevant notes.

5.1.2 Pain

The Admin can note what signs of pain are and what the response actions are. This is particularly helpful for non-verbal patients who might not be able to express and explain their pain as easily.

5.1.3 Height and Weight

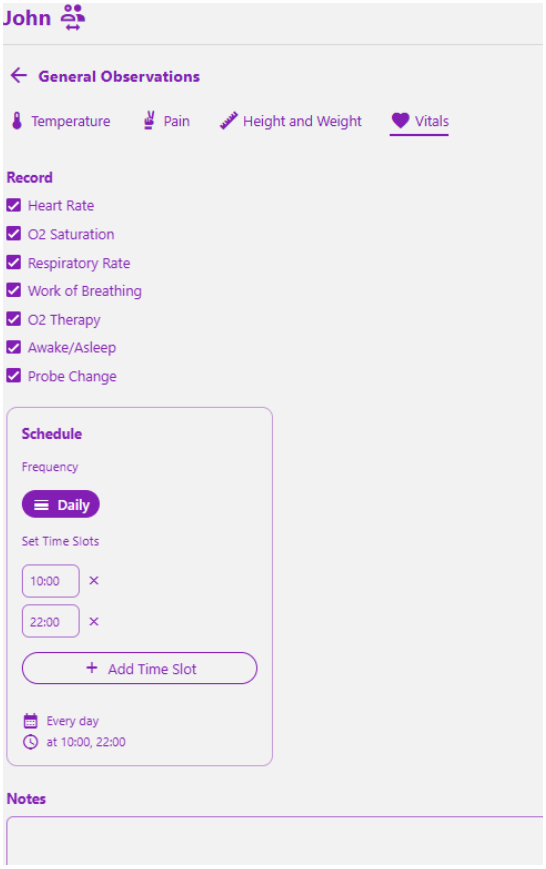
This is a free text field where the user might note recommended intervals of height and weight checks or where a goal weight is added.

5.1.4 Vitals

The admin can select which data points they would like record routinely for the patient.

The possible data points include:

- Heart rate
- O2 Saturation
- Respiratory Rate
- Work of Breathing
- O2 Therapy
- Awake/Asleep
- Probe changes



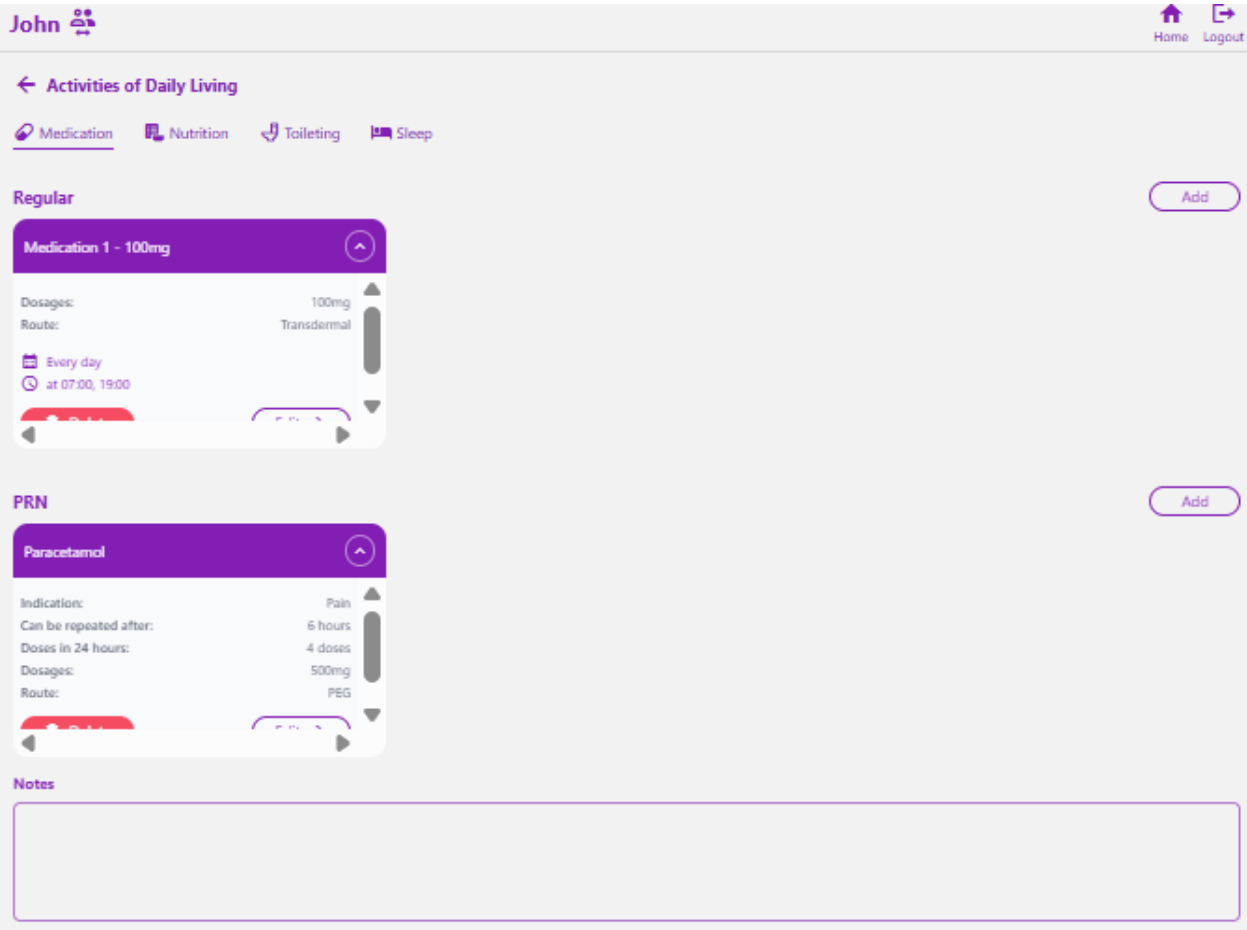
The admin can also create a schedule on how regular they would like to take vitals. These times will appear in the schedule. The care takers can however take vitals more frequently then this.

The admin can also add additional notes in the Free text field that will the appear in the Care Plan.

4.2 Activities of Daily Living

4.2.1 Scheduled and PRN Medications

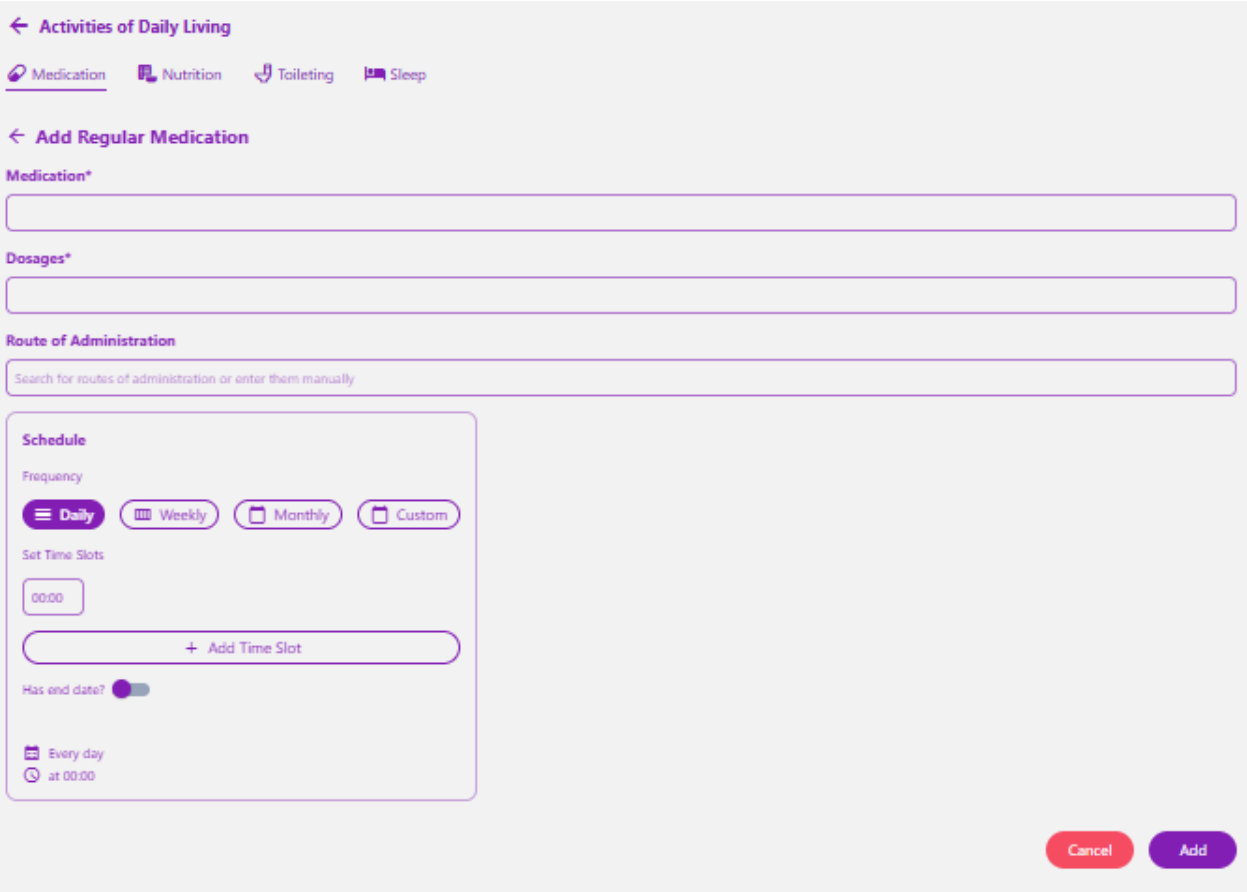
The Admin can setup Regular Medications as well as PRN Medications for each patient. A generic notes section give room for general rules around Medication administration.



Regular Medications

For each regular medication the Admin enters the name of the medication, the dosage, the Route of Administration and the schedule.

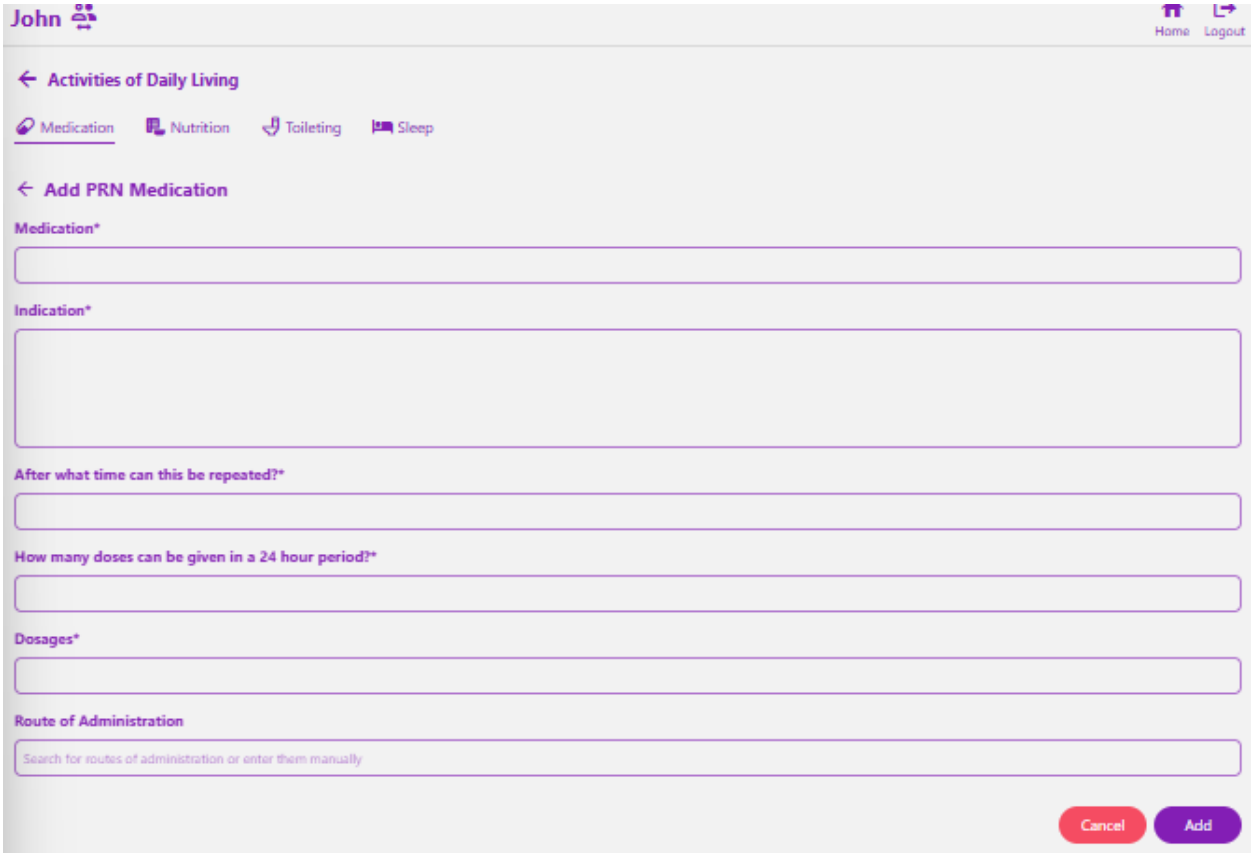
The schedule can be daily, weekly, monthly or otherwise in a custom manner. In addition the admin selects the time(s) when each medication is due. The admin can select an optional end date for the medication.



The regular medications will appear in the Daily schedule as well as part of a medication chart in the Care Plan.

PRN Medications

For PRN Medications the Admin selects the Medication name, the indication of when to administer the medication, the amount of time when the PRN medication can be repeated, how many doses can be given in a 24 hour period, the dosage and the Route of Administration.

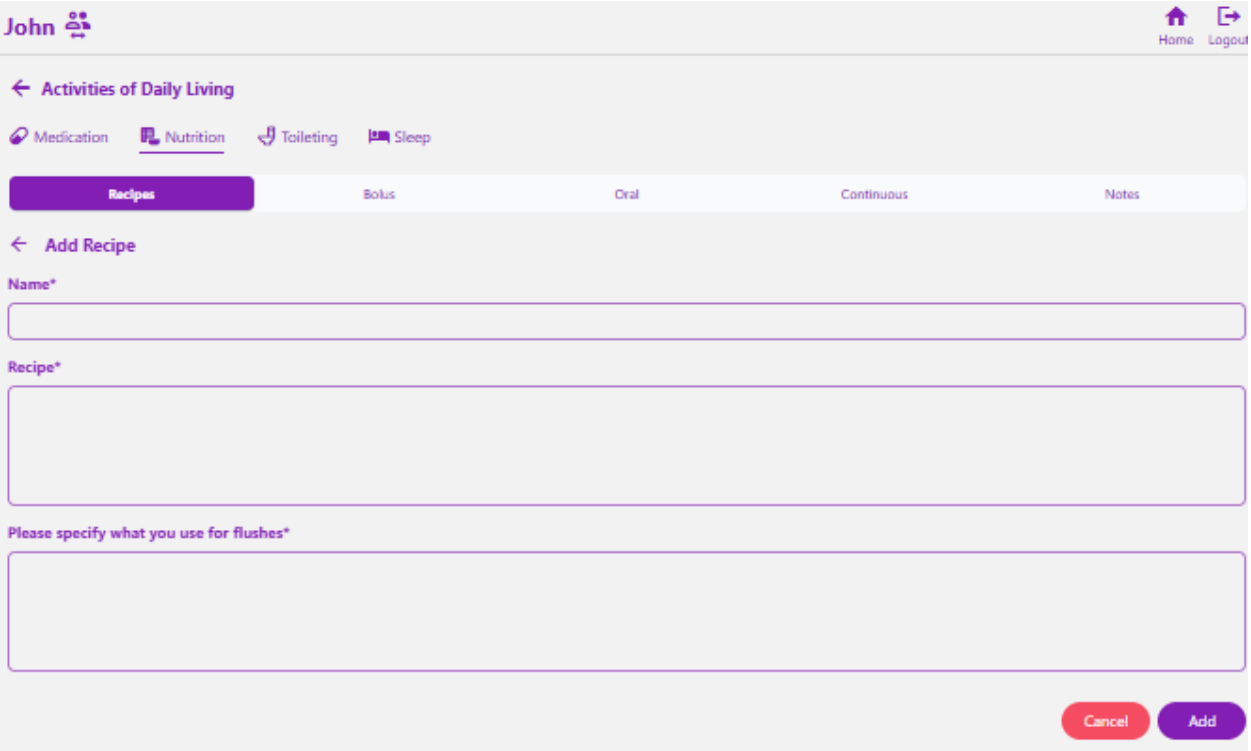


The PRN medications will appear in the Care Taker view as a list of medications, the information entered for each Medication will appear in the entry screen and also in the Care Plan.

4.2.2 Nutrition

The nutrition section is mostly targeted towards patients who rely on tubefeeding. An oral option is also available for users that can eat or drink orally. The admin can also add general notes regarding nutrition in the Free text field for notes which will appear in the Care Plan.

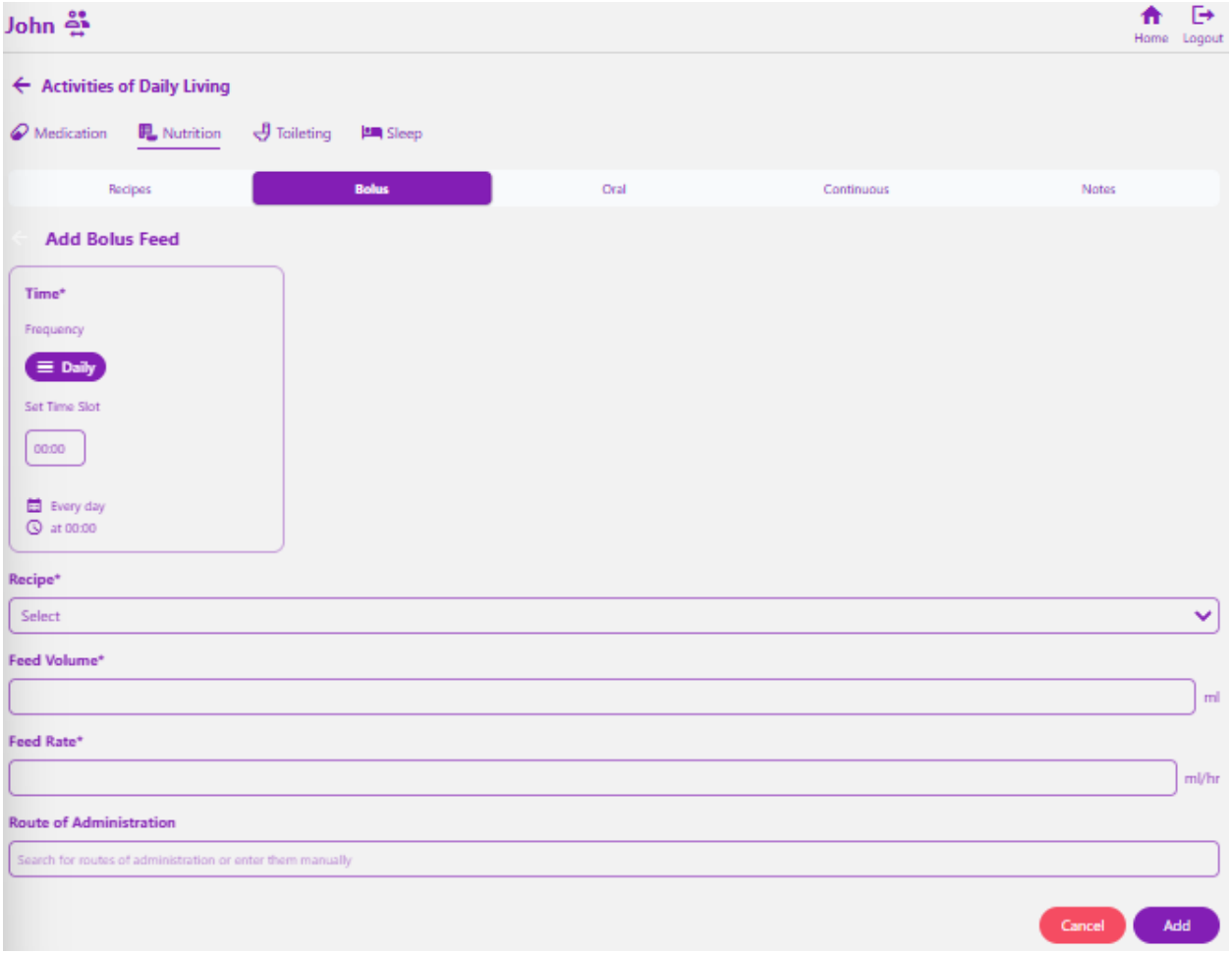
As a first step, the Admin should setup one or multiple Recipes:



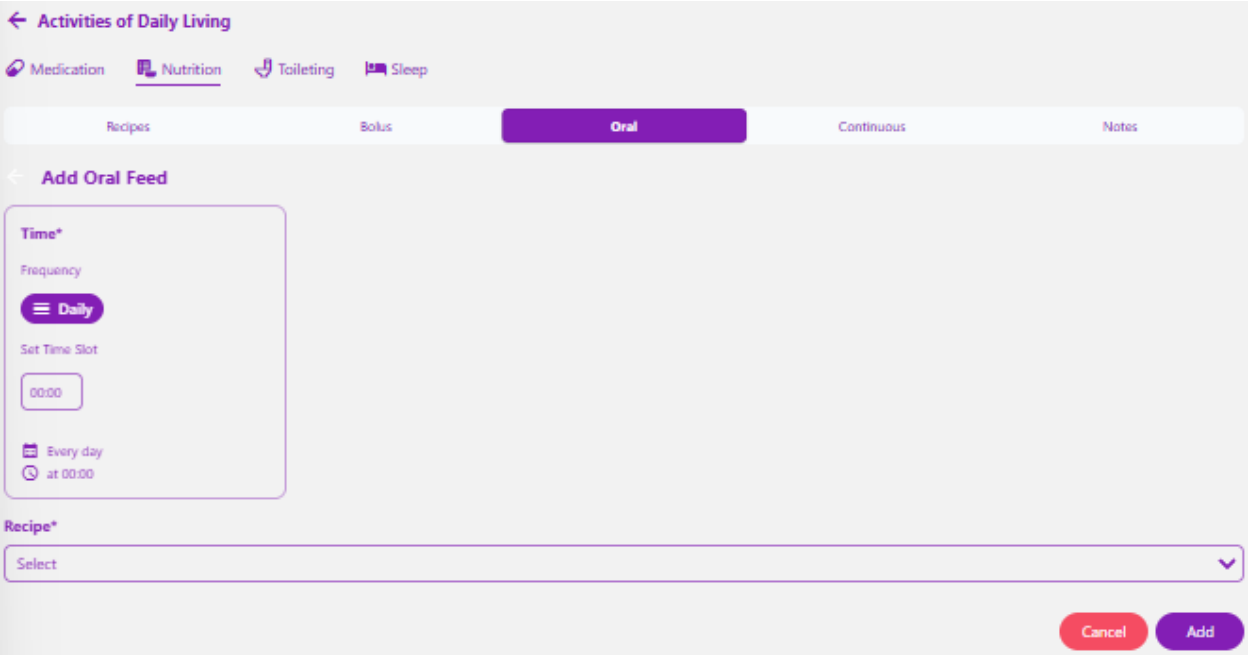
Then the user selects which feed regime the patient follows - Bolus Feeds, Continuous Feeds oral intake.

For Bolus feeds the Admin needs to select one or multiple timeslets for each recipe, the feed volume, the feed rate and the Route of Administration.

This will create tasks in the scheduler and will also appear in the Nursing Care Plan.

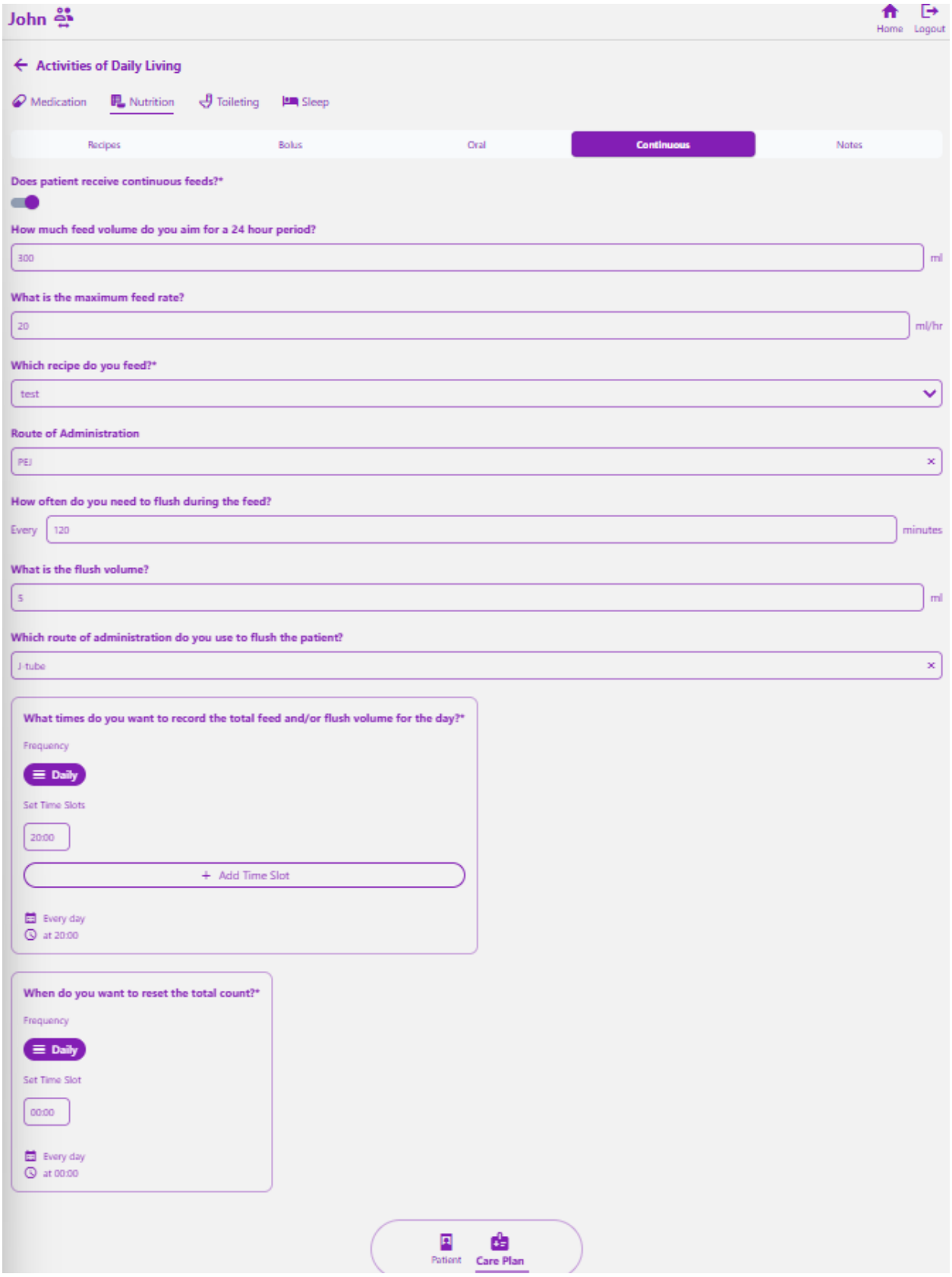


For an oral feeding regime, the Admin can select timeslots and recipes.



For a continuous feeding regime the admin is required to fill in a form regarding the continuous feed regime, including the following:

- total Feed volume in a 24 hour period
- Maximum Feed rate
- Recipe
- Route of Administration for feeds
- Interval of Flushes in minutes
- Flush volume
- Route of Administration for flushes
- Times to record feed and flush volume for the day.
- Time to reset the feed count.


John
Home
Logout
Activities of Daily Living
Medication
Nutrition
Toileting
Sleep
Recipes
Bolus
Oral
Continuous
Notes
Does patient receive continuous feeds?*
How much feed volume do you aim for a 24 hour period?
300
ml
What is the maximum feed rate?
20
ml/hr
Which recipe do you feed?*
test
Route of Administration
PEJ
How often do you need to flush during the feed?
Every
120
minutes
What is the flush volume?
5
ml
Which route of administration do you use to flush the patient?
J-tube
What times do you want to record the total feed and/or flush volume for the day?*
Frequency
Daily
Set Time Slots
20:00
+ Add Time Slot
Every day
at 20:00
When do you want to reset the total count?*
Frequency
Daily
Set Time Slot
00:00
Every day
at 00:00
Patient
Care Plan

4.2.3 Toileting

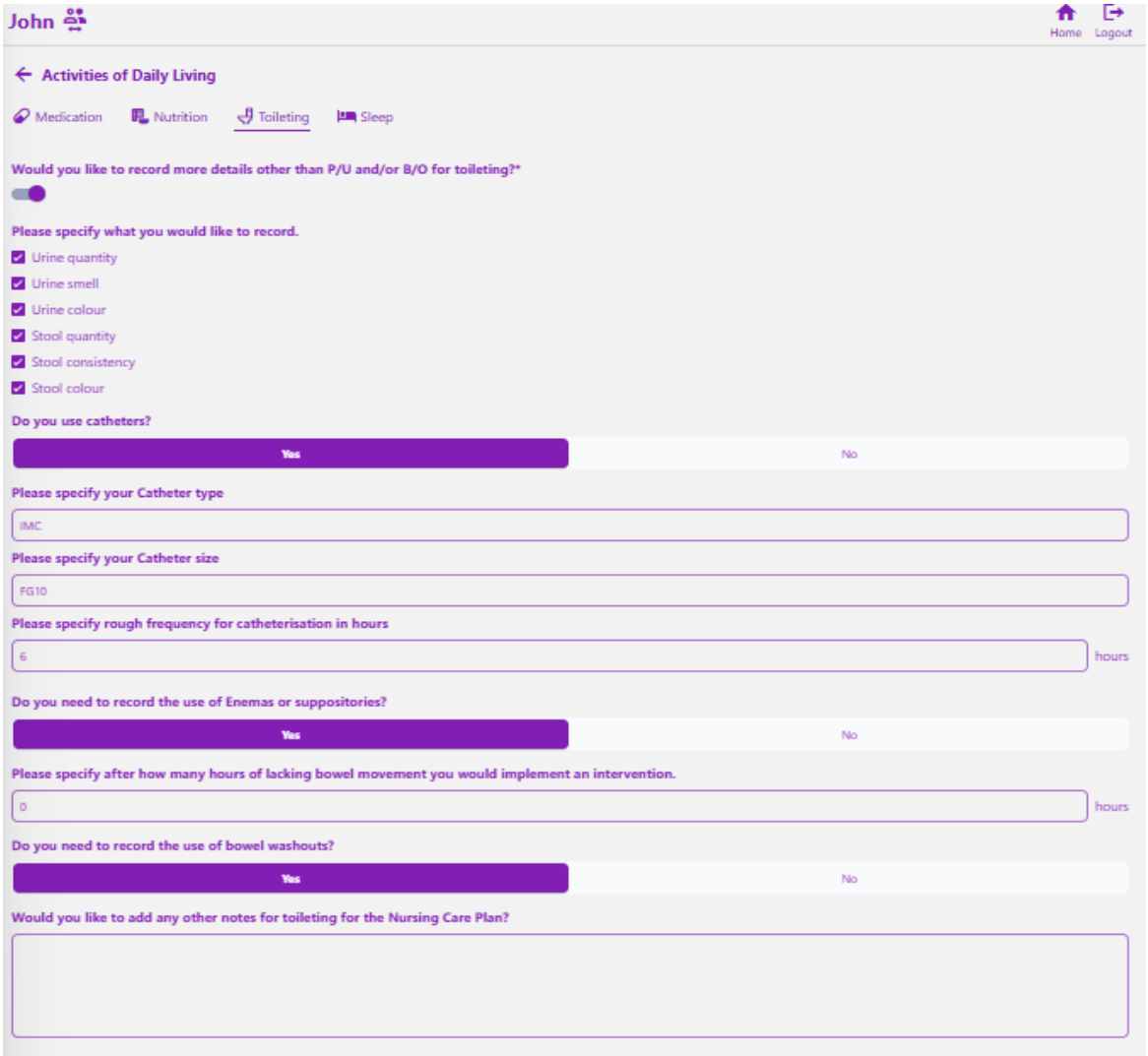
Recognising that some patients need more information on toileting habits than others, the toileting section can be customised to the patients needs. The following data points can be selected for the observation entry form in addition to passed urine and bowels open:

- Urine quantity
- Urine smell
- Urine colour
- Stool quantity
- Stool consistency
- Stool colour

The Admin can also advise if the Patient requires catheters, which type and size and the frequency for catheterisation.

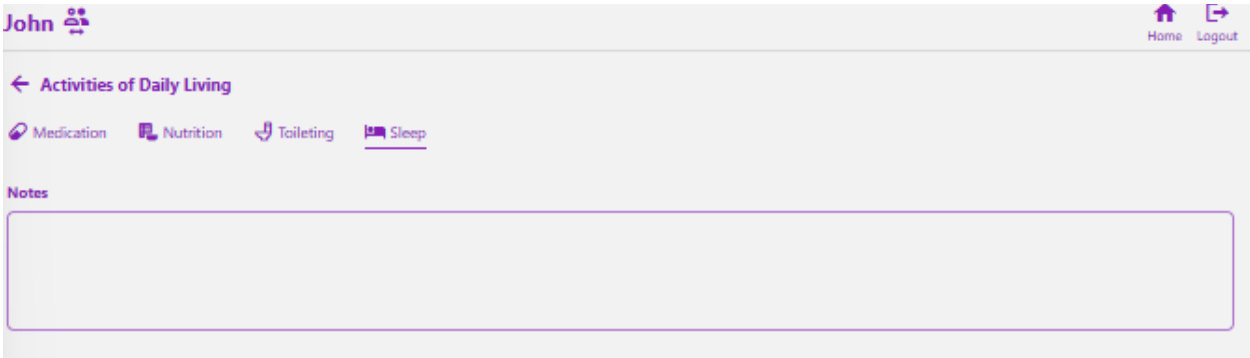
You can select of suppositories and enemas need recording as well as bowel washouts and what the time of intervention would be when there is lack of bowel movements.

At the end of the setup is a Notes section that allows the user to enter any additional information.



4.2.4 Sleep

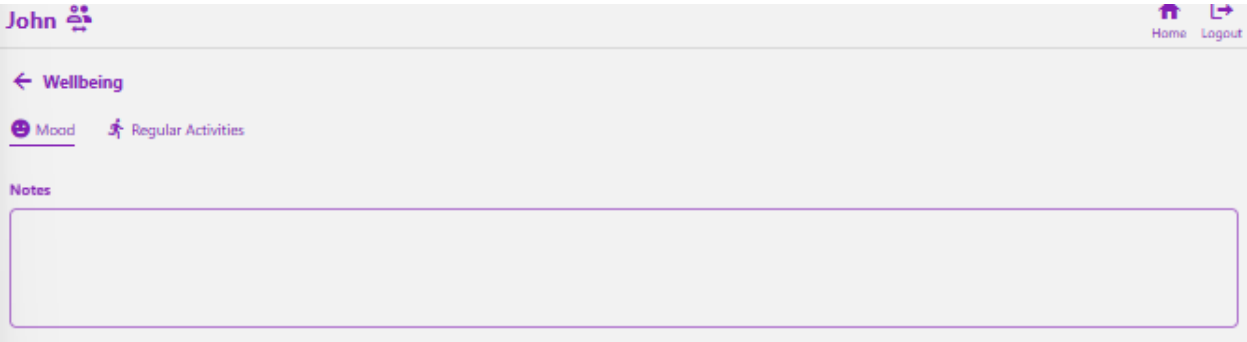
It is recommended to describe the patient's normal sleep routine in the Notes section. This will display in the Care Plan.



4.3 Wellbeing

4.3.1 Mood

It is recommended to describe the patient's normal mood as well as signs to look out for with regards to their mood in the Notes section. This will display in the Care Plan.



4.3.2 Regular Activities

Regular activities can be set up in the same way as Medications. The user selects or describes the Activity and chooses a frequency (daily, weekly, monthly custom) as well as (multiple) timeslot. Typical activities can be matters of daily hygiene or regular cleaning of equipment, changes of filters on equipment or bedsheets. This is highly customisable to the person's needs.

In the notes section the Admin can leave additional information or instructions that will appear in the Care Plan.

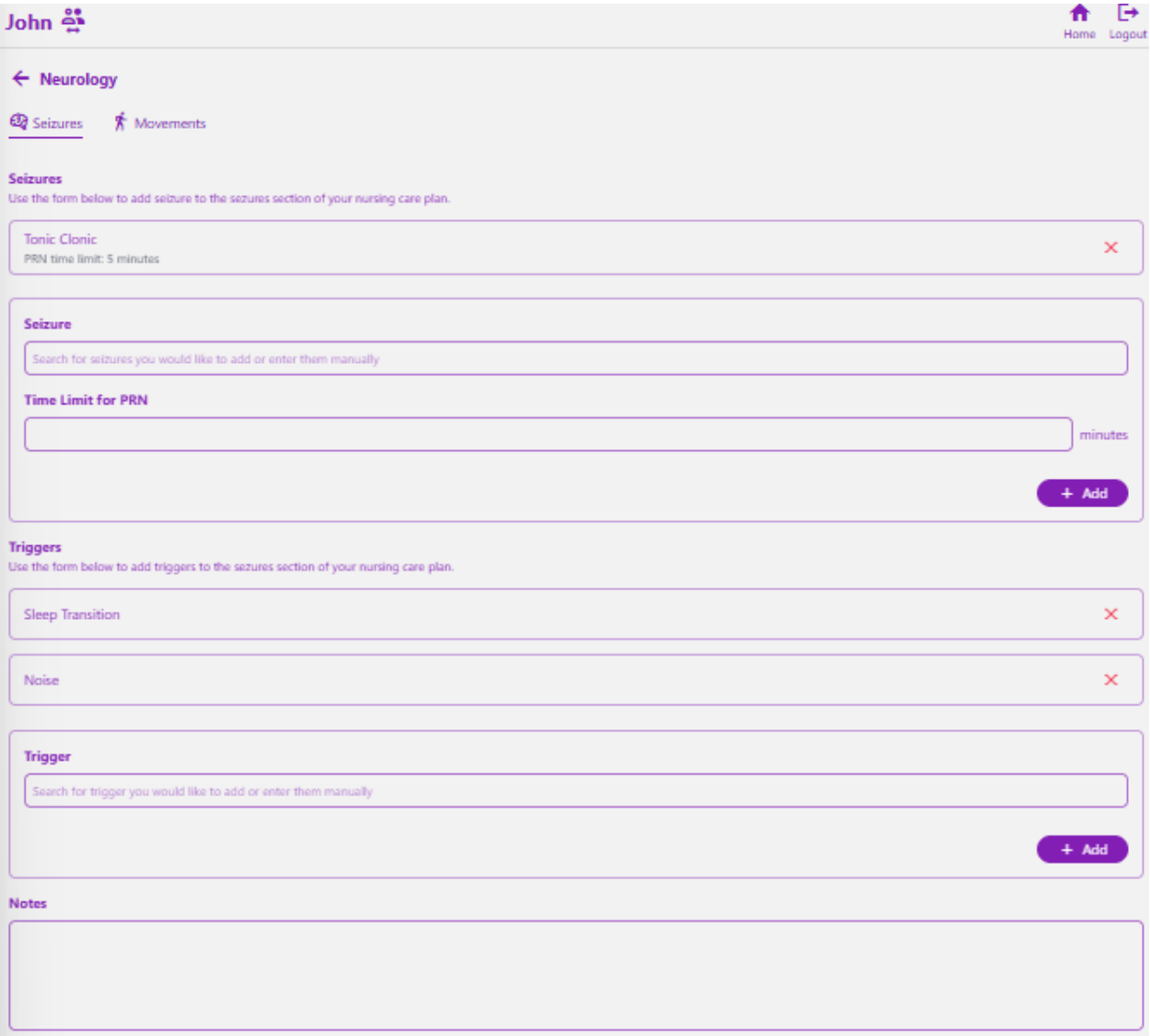
4.4 Neurological

4.4.1 Seizures

In order to customise the seizures entry form, the Admin needs to select the types of seizures and what the PRN time limit is for each seizure type. When the care taker enters a seizure and selects the seizure type the PRN time limit will display.

The Admin can also select various Triggers for seizures to display on the entry form. It is recommended to create a “NA” or “unsure” option when the trigger cannot be identified.

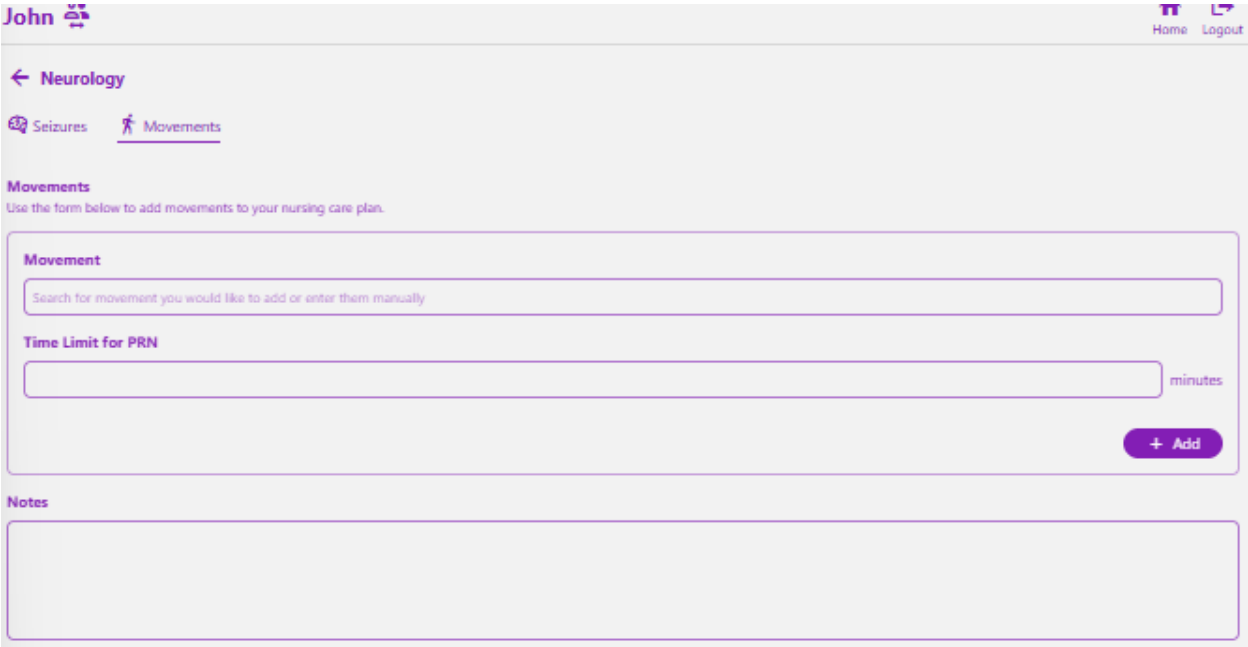
The notes field allows the admin to enter any additional information relating to seizures, such as how to comfort the person during a seizure or how to support in the post ictal phase.



4.4.2 Movements

For movements the Admin adds any movement types that the patient is known to experience and also a time limit for PRN medications.

The notes field allows the admin to enter any additional information relating to movements, including but not limited to on how to comfort during movements.

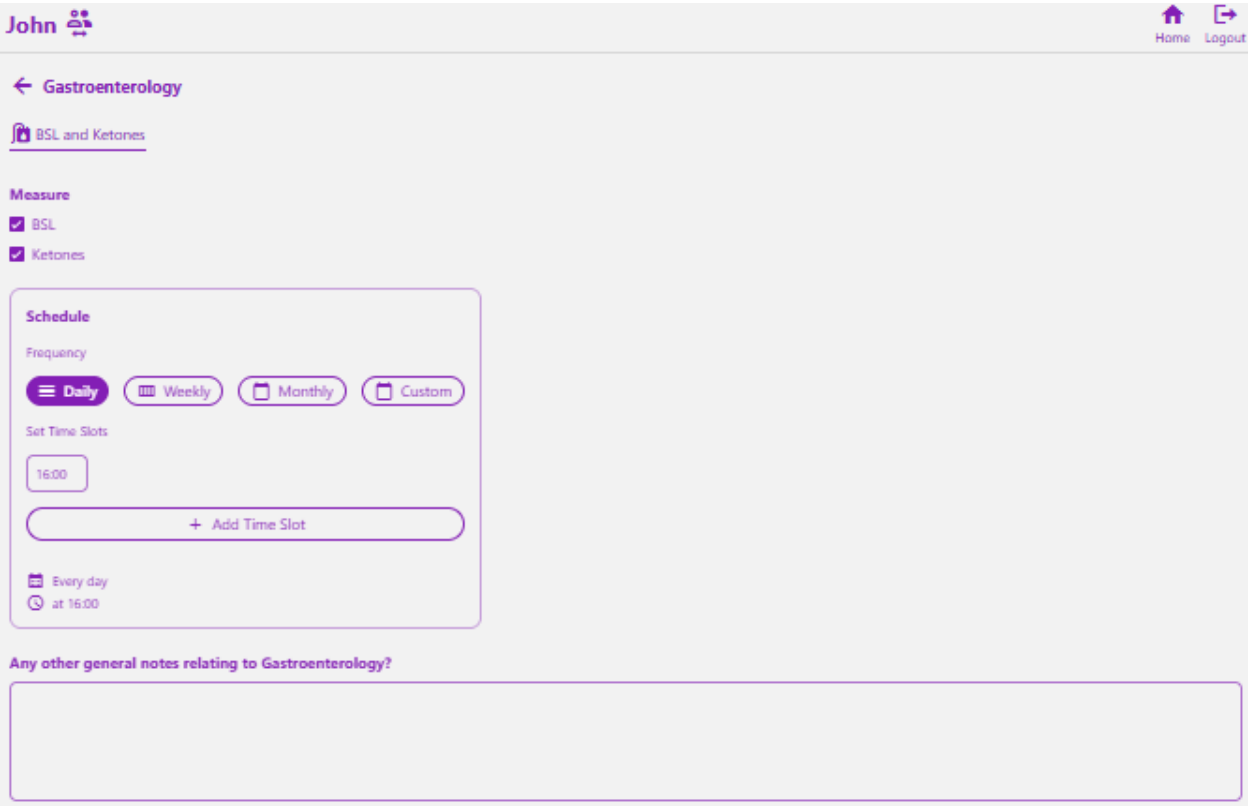


4.5 Gastroenterology

4.5.1 BSL & Ketones

If the patient needs tracking of BSL and/or Ketones, the Admin can select one or both of them and also select the intervals of routine tracking in the scheduler. The scheduled times will appear in the scheduler in the Care taker mode ensuring that BSL and/or Ketones are tracked routinely.

In the notes section the Admin should outline additional information such as the equipment to use for checks, highlight possible sensitivities and state the values to aim for.



4.6 Respiratory

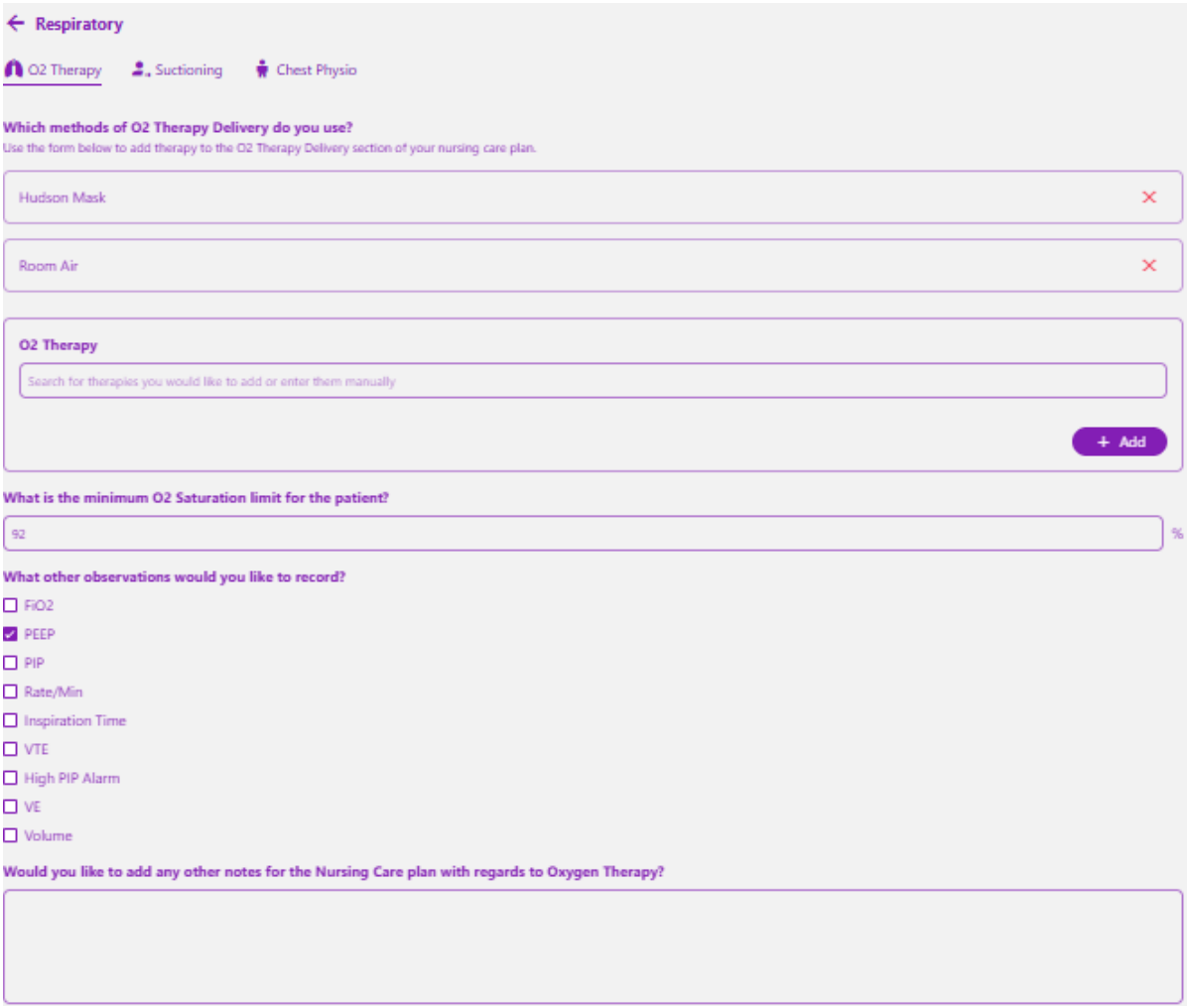
4.6.1 O2 Therapy

On O2 Therapy the Admin can select which methods of O2 Therapy are being used for the patient. The setup form also asks for the minimum O2 Saturation for the patient.

The Admin can also select multiple optional data points for the O2 Therapy that need tracking:

- FiO2
- PEEP
- PiP
- Rate/Min
- Inspiration Time
- VTE
- High PIP Alarm
- VE

- Volume



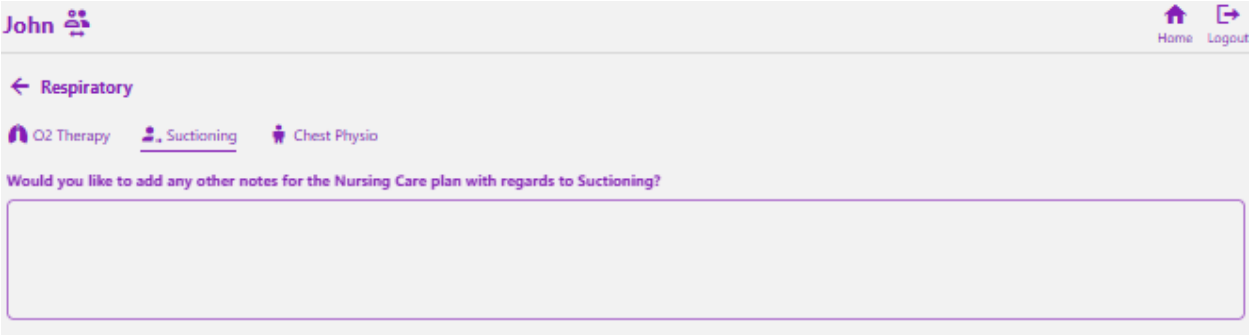
As a standard the Care taker Observation form requests the Flow rate.

In the Notes and additional information can be entered.

Tip: The Admin might want to create the O2 Therapy Method “RoomAir” to allow the Caretakers in the observation mode to indicate when other O2 Therapies are removed.

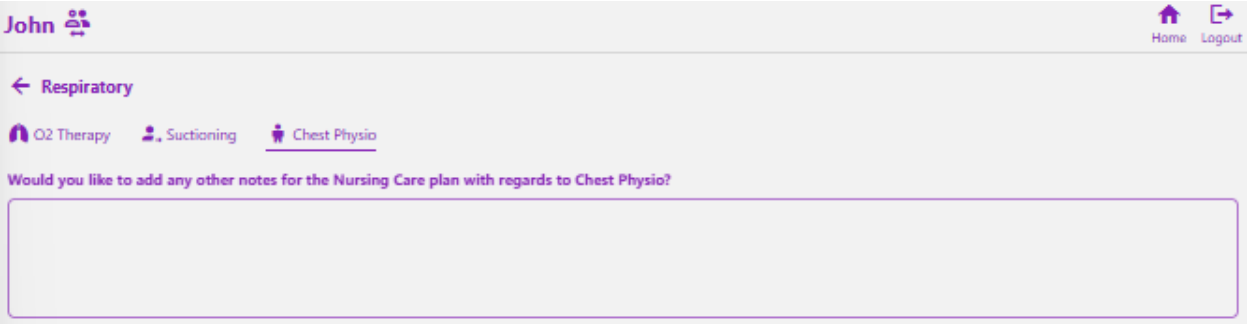
4.6.2 Suctioning

In the notes section for suctioning the Admin should outline additional information such as the equipment to use, how to use deepsuction, e.g. oral or nasal, any other preferences, brand of suction catheters etc.



4.6.3 Chest Physio

In the notes section for Chest Physio the Admin should outline information such as duration of chest physio sessions, regularity, indications when to use Chest Physion etc.

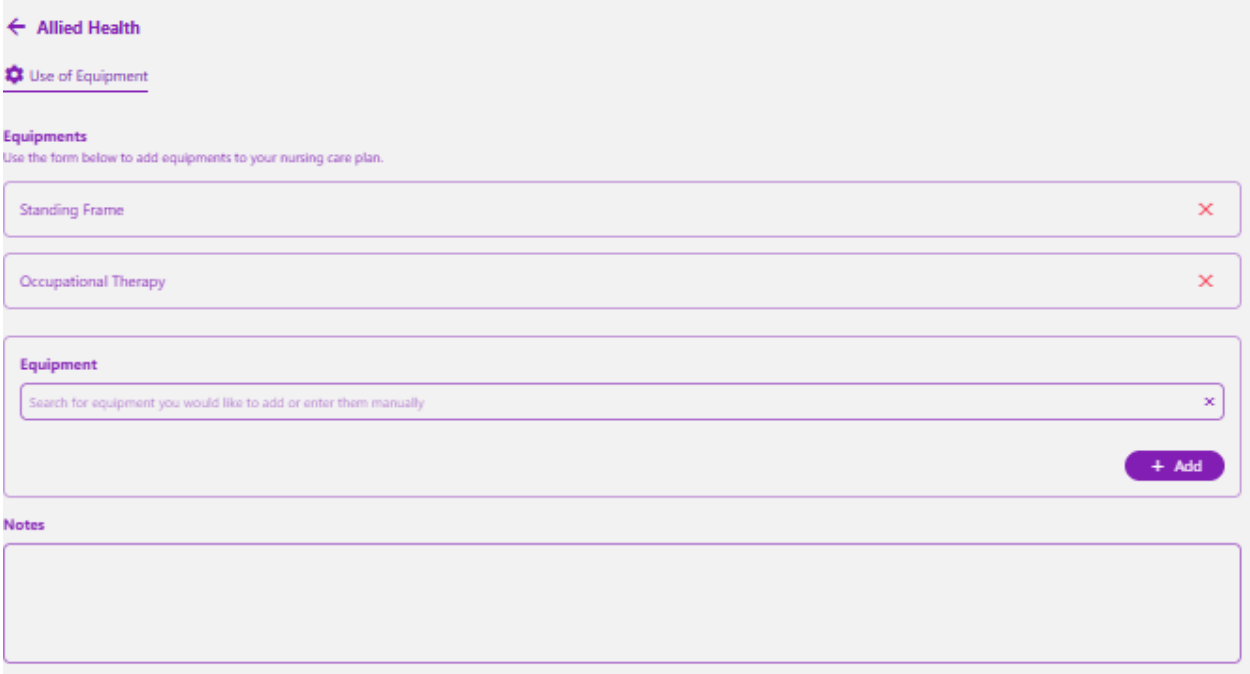


4.7 Allied Health

4.7.1 Equipment

The Admin can specify any equipment that is being used for Allied Health purposes, e.g. Standing Frames, walkers, alternative seating options, speech therapy tools like eye gaze or Podds etc. The equipment added will appear in a selection box for the observation entry.

The notes section should contain information such as duration of recommended use, intervals for use or other instructions. This information will appear in the Care Plan.



4.8 Positive Behaviour Supports

4.8.1 Positive Behaviour Supports

The Admin can make some notes on the Positive Behaviour supports in place. The following selections can be made:

Selection of the PBS Phase:

- Interim Behaviour Support Plan
- Comprehensive Behaviour Support Plan
- Maintenance Behaviour Support Plan

Selection of Risk Markers (Low - Moderate - High)

Restrictive Behaviours in use (Optional).

The Admin can then provide some generic guidance on Positive Behaviour Supports which will appear in the Care Plan.

Tip: It is strongly recommended to upload the full Behaviour Support Plan in the File section.