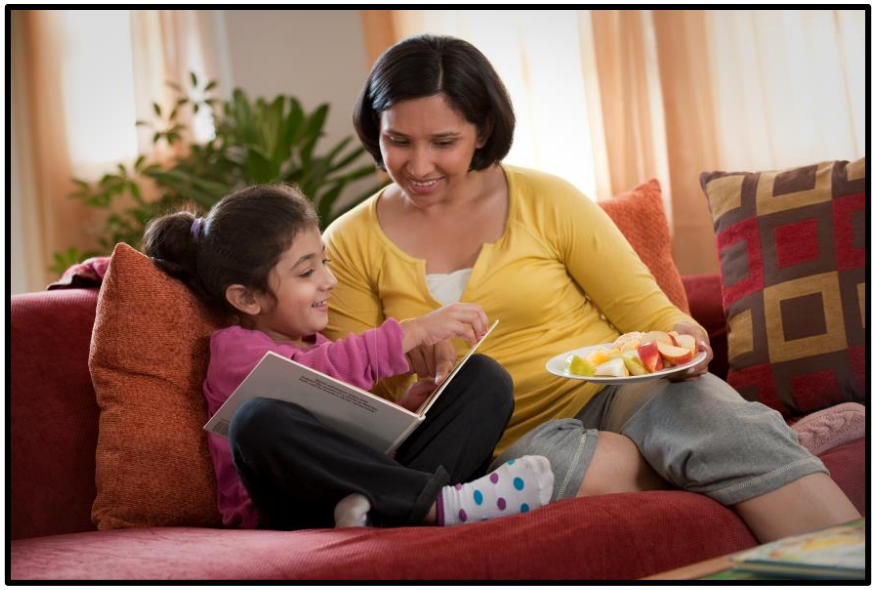
IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Idaho WIC Training

Care Plan



What Will You Learn?

Developing a care plan allows WIC staff to evaluate the information collected during the nutrition/health assessment and document the participant's risks, needs, changes expected, and strategies to achieve the participants' desired health outcomes from those changes. Staff will learn how to a write a well-developed care plan and have the opportunity to practice within this course.

Instruction Level

Prerequisite for taking the course: Health and Nutrition Assessment course

Items Needed for This Course

- Access to WISPr
- *Care Plan Samples Appendix* document
- No Idaho TRAIN LMS online course exists for this guidebook

Recommended Time

- Approximate time it takes to complete the care plan course: 1-2 hours
- Approximate time to complete the face to face activities and discussion: 2-3 hours

Module 1: Care Plan Introduction

What Is a Care Plan?

To understand a care plan, let's breakdown the words "care" and "plan."

Care: The provision of what is necessary for the health, welfare, maintenance, and protection of someone or something

Plan: A detailed proposal for doing or achieving something

In essence, a care plan is the record (documentation) of and proposal for achieving what is necessary for the health and welfare of a participant.

Why Do We Write Care Plans?

Care plans give a clear "snapshot" description (documentation) of what occurred during the participant interaction related to their individual nutrition risk(s). The care plan should reflect clearly (explain) information discussed, risk factors, concerns, questions, education, referrals, handouts, and goals reviewed during the appointment. Well-written care plans provide accountability, verify the delivery of appropriate services, and support decisions. A well written care plan will allow future staff member that interact with the participant to understand and have a clear picture of what was discussed at prior appointments.

When Should a Care Plan be Completed?

Complete a care plan when:

- Staff provide services/care specific to a participant (i.e. Certification, Health Screen, high risk individual nutrition education, etc.)
- Staff make plans to follow-up with the participant regarding the services/care provided
- A care plan should always be completed with certification and health screen appointments

Complete Activity 1 in your Activities Packet

Description of Care Plan Types

Care plans are labeled by "type" within WISPr. At the top of the care plan, there will be a drop down to select from the following list:

- **Certification:** Certification done by a para-professional, Clinical Assistant

- **Certification/RD:** Certification done by a Registered Dietitian
- **Temp Certification:** Temporary certification
- **Category Change:** An appointment to change a participant's category (changing a breastfeeding woman to non-breastfeeding post-partum; or changing a non-breastfeeding post-partum woman to breastfeeding)
- **Health Screen:** A health screen done by a para-professional, Clinical Assistant
- **Health Screen/RD:** A health screen done by a Registered Dietitian
- **Registered Dietitian:** An appointment with a Registered Dietitian
- **Breastfeeding:** A breastfeeding appointment (not with a Registered Dietitian)
- **Breastfeeding/RD:** A breastfeeding appointment with a Registered Dietitian (who may or may not also be an International Board Certified Lactation Consultant)
- **Nutrition Education:** An appointment for the primary purpose of providing nutrition education
- **VOC:** An appointment to add an out-of-state transfer to ID WIC

Module 2: Components

What Belongs in a Care Plan?

WIC has given you a care plan form in WISPr with specific sections. WISPr will automatically populate some information in the care plan. Information that is populated (based on the type of appointment and what was entered during the assessment) includes:

- **Goal** from the previous appointment (if it's not the very first appointment)
- **Age**
- **Blood work results** (most recent hemoglobin or hematocrit)
- **Anthropometric measurements** (most recent height, weight and body mass index)
- **Pregnancy information** (delivery date; if multi-fetal; weight gained/lost; outcome)
- **Infant feeding information** (if breastfed; if formula – age introduced; if no longer breastfeeding – age stopped; reason for stopping breastfeeding)
- **Immunization** status
- **Nutrition risk criteria** assigned during the most recent certification (and health screen for that certification period)
- **Mandatory referrals** required for certification and nutrition risks

Descriptions of Care Plan Components (WISPr Screenshots)

The following describes what type of information you may want to enter in each care plan section.

Subjective:

- Previous goal (populated)
- Follow-up information about how the participant is doing with any previous goal(s) set during the last appointment/certification
- Participant's concerns, interests, questions
- Relevant information the participant told you that's not already documented in the assessment interview section and/or will be of benefit to the staff seeing the participant at the next appointment. It is recommended to use concise, brief statements or defined abbreviations for your local agency. Ask your trainer for a list of common abbreviations used in your clinic.

Objective:

Factual information (all populated)

- Age
- hemoglobin/hematocrit
- height
- weight
- BMI
- delivery date
- multi-fetal
- prenatal weight gained/lost
- pregnancy outcome
- immunizations
- breastfeeding status

The objective information provides the documentation for nutrition risks assigned.

Assessment:

- Health care provider medical diagnosis (stating whether self-reported or confirmed with MD) if required for a nutrition risk
- Nutrition risk criteria identified (populated) and explained (for example, no intake of fruits/veg)
- Brief overview of participant's health situation if relevant (for example, hgb WNL)
- Participant's level of interest, readiness to make changes towards a next step/goal (willingness of participant: *not ready, unsure, ready)*
- *See below in Example Care Plans for further examples.*

Education Topics:

- Nutrition education topics discussed
- This should reflect actual participant education discussed and should be related to RA/Participant's nutrition/health concerns & risks. In general, limit the education topics to 1-3 points to help focus and limit key topics.

Referrals:

- Referrals made (mandatory referrals are populated)

Handouts:

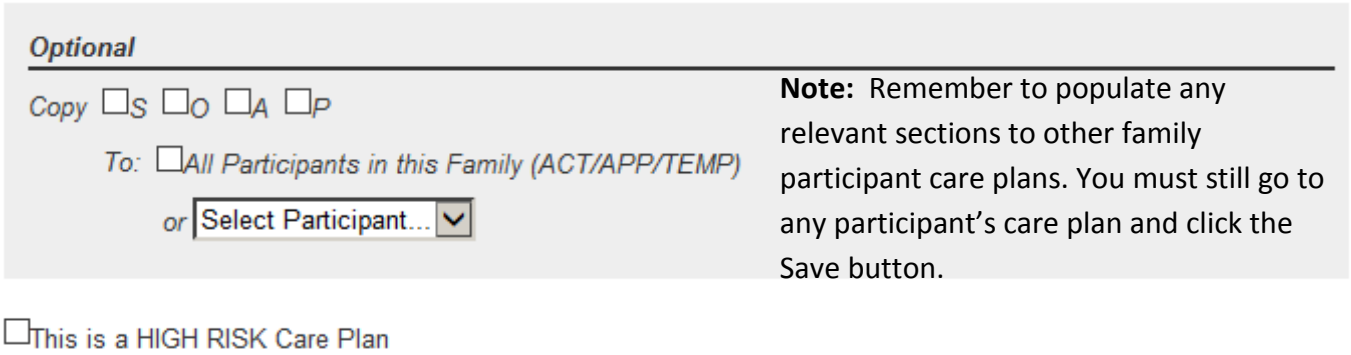
- Handouts, if any, given to the participant. Identify if "none" were given.
- Handouts should be limited to 1-2.

Goals:

- Measurable next step/goal(s) with timeframes chosen by participant (facilitated during nutrition education)
- For example:
    - Infant Goal – Add 1 new veg/fruit every 3 days
    - Child Goal – Limit juice to ¼ cup per day
    - Pregnant Goal- Add 1 veg to dinner everyday
    - Breastfeeding Goal- Breastfeed on demand
    - Non-Breastfeeding Goal- Walk 20 min per day
- **Staff must still document if the participant is not ready to set a goal.**

Counseling / Plan:

- Key point(s) of nutrition education discussed
- Rational for food package prescribed if different from the standard package for category
- Follow-up plan (when and what needs to happen at the next appointment?)
- If a nutrition risk(s) was not addressed, what is the plan to address nutrition risk(s) in the future?



The *Optional* section has check boxes that are designed to populate sections from the care plan to another participant(s) care plan within the same family.

'S' is for the subjective section
'O' is for the objective section
'A' is for the assessment section
'P' is for the plan section

Only sections that are relevant to the other participant's category and nutrition or health needs (i.e. risks, concerns, interests and/or questions) should be populated. If the information isn't relevant, then new information needs to be entered into the other participant's care plan regarding what was done specific to them. *See the two examples below for further details*.

Example 1:

Scenario: A child is certified and has nutrition risk *201 Low Hemoglobin*. The family doesn't eat red meat, but eats mainly chicken, eggs and turkey for protein sources. You explain the hemoglobin results and finish the assessment. You respect the family's decision not to eat red meat and ask the mom if she's interested in knowing more about other iron-rich foods. She says yes and you review an iron-rich foods handout with her circling the foods she says could fit into her family's meals and snacks.

Staff Action: After you finish the appointment, you write the child's care plan. The mom is a WIC participant too – category: pregnant. Since pregnancy is a condition causing iron needs to increase and she doesn't eat red meat either, the counseling provided was relevant for both family members. You populate sections S and P. You don't populate the O and A sections since that information was populated from information already entered while she was being certified.

Example 2:

Scenario: An infant is seen for an individual education appointment at age 4 ½ months and has nutrition risk *702 Breastfeeding Infant of Mom at Nutritional Risk.* The infant is breastfeeding. Breastfeeding is going very well and you ask the mom what information she's received so far about

how to introduce baby foods starting at age 6 months. She says she hasn't received anything from her doctor and isn't really sure which foods are safe to use when making baby food. You review a handout with the mom about how to introduce and progress with baby foods, using a highlighter to highlight the food safety information (discussing how to safely make and store baby food). The mom is a WIC participant – category: breastfeeding. Since the mom won't be eating baby food, you discuss a different topic that is relevant to her for her nutrition education (increasing walking towards returning to her pre-pregnancy weight).

Staff Action: After the appointment, you write the infant's care plan. Since none of the information is relevant to the mom's nutrition and health needs, you don't populate any of the sections. You write a separate care plan for the mom.

Complete Activity 2 in your Activities Packet

Module 3: Practice Activities

This Module provides a variety of activities with opportunities to practice and review care plan writing. This section includes the following care plan samples.

- Sample 1: Breastfeeding Woman, Registered Dietitian
- Sample 2: Child, Nutrition Education
- Sample 3: Infant, Certification

As you review the samples, keep in mind these samples and related activities are designed to have you think about what might be missing or how these care plans could be improved.

For additional samples to reference, please see the *Care Plan Samples Appendix* document.

Complete Activities 3, 4 & 5 in your Activities Packet after you have reviewed the sample care plans

Sample 1: Breastfeeding Woman, Registered Dietitian

Care Plan	2/25/2015	Staff:	Clinic:

Print Preview

Care Plan Type: Registered Dietitian

Subjective:

12/23/2014 Previous Goals: Skin to Skin. Watch for feeding cues and nurse frequently. Call if she has any concerns.

States working out daily since baby turned 2 months old. Is eating all food groups daily. Drinks lots of water.

Objective:

Age:	28 y
Bloodwork:	Date: 12/15/2014 Hemoglobin: 12.8
Anthropometrics:	Date: 12/15/14 Height: 63 in Weight: 157 lbs BMI: 27.8
Pregnancy:	ADD 12/2/2014 Multi-Fetal: N Wt Gained/Lost: 24 lbs Outcomes: 1 alive

Assessment:

Certification Risks:

Risk 111: Overweight woman

Risk 332: Closely Spaced Pregnancy

Hgb WNL

Intake low for frt/veg

Education Topics:

Healthy balanced eating (specific to category)

Breastfeeding Management

Referrals:

Handouts:

1: After Baby

2:

3:

Goals:

1: Add 1-2 more servings of frt/veg a day.

2:

Counseling/Plan:

Discussed intake,bf; wt on baby in May.

☐ This is a HIGH RISK Care Plan

Sample 2: Child, Nutrition Education

Care Plan	2/9/2015	Staff:	Clinic:

Print Preview

Care Plan Type: Nutrition Education

Subjective:

11/26/2014 Previous Goals: will try/work on offering child milk in a small cup at mealtime.

Doing hgb today that was not done back in Nov due to child being at home sick with bronchitis. Mom states [*Name*] has a good appetite. Has 3 well-balanced meals and a few snacks. Eating a variety. Drinking water, milk and juice. States she's not a fan of green beans. Mom states she has been offering small amounts of milk and other liquids in a small reg cup, and that she's doing good drinking from it. Asks for more. No concerns.

Objective:

Age: 1 y 9 m

Bloodwork: Date: 2/9/2015
Hemoglobin 11.9

Anthropometrics: Date: 11/26/14
Height: 33 in
Weight: 24 lbs
BMI: 15.5

Feeding: Date: 11/26/2014
Ever BF: Yes
Age formula started: 0 wks
Age stop BF: 12 wks
Why stop BF: Other, too busy

Immunizations: Yes

Assessment:

Certification Risks:

Risk 428: Dietary Risk Associated with Complementary Feeding Practices

Hgb good today, 11.9 WNL

Education Topics:

Healthy balanced eating (specific to category)

Referrals:

Immunizations

Handouts:

1: None
2:
3:

Goals:

1: None today
2:

Counseling/Plan:

Continue to offer healthy food choices, good job with offering her a reg cup at mealtimes. RC in May.

☐ This is a HIGH RISK Care Plan

Sample 3: Infant, Certification

Care Plan	1/23/2015	Staff:	Clinic:

Print Preview

Care Plan Type: Certification

Subjective:

Mom says she is exclusively BFing with no problems. Plans to BF as long as she can. BF her other child for nine months.

Objective:

Age: 0 y 0 m

Anthropometrics Date: 1/23/2015
Height: 20 in
Weight 7.25 lbs
BMI: 12.7

Feeding: Date: 1/23/2015
Ever BF: Yes
Age formula started: Not started
Age BF stopped: Not stopped

Immunization: No

Assessment:

Certification Risks:
Risk 411.11: Not feeding recommended dietary supplements
Risk 702: Breastfeeding Infant of a Woman at Risk

Mom is ready to set a goal

Education Topics:

Healthy Balanced eating (specific to category)

Referrals:

Immunizations
Medicaid/Chip
SNAP
Substance Abuse
TANF/Cash Assistance

Handouts:

1: TTk, RCH
2:
3:

Goals:

1: Exclusively BF for 6 months
2: Talk to doctor about vitamin D supplements for baby at next well baby check

Counseling/Plan:

Praised for BF. Reviewed My Plate for BF moms. Offered PC services for help with BF. Nutrition Education appointment in April.

☐ This is a HIGH RISK Care Plan