CareCertify LLC

Assisted Living Training Series

AL-10

Person-Centered Service Planning & Documentation

Participant Guide

Assisted Living Training Series · Audience: HHAs · CNAs · PCAs · DSPs · AL Staff · CE Hours: 1.0

The Plan Is the Promise; the Record Is the Proof

Every resident's care runs on two things: a service plan that says what care they need and want, and documentation that records what actually happened. Minnesota's Chapter 144G requires assessing each resident's needs and maintaining an up-to-date service plan, and it makes accurate records part of safe care.

This guide shows how assessment becomes a plan, how you follow and inform that plan, and how to document well. Your observations and your charting are the link between front-line care and the clinical decisions that follow.

Learning Objectives — by the end of this module you will be able to:

- Describe how a resident's needs are assessed and planned
- Explain person-centered service planning and your role in it
- Report and chart changes in a resident's condition
- Document care clearly, accurately, and on time
- Protect resident confidentiality and privacy

Section 1: Assessing Resident Needs

Under Chapter 144G, each resident's needs are assessed — their health, functional abilities, preferences, and risks — and that assessment drives the services the facility provides. Assessment is ongoing because needs change over time.

You contribute to the picture every day. What you observe about a resident's abilities, mood, and changes helps keep the assessment and plan accurate.

Section 2: The Service Plan

The service plan is the individualized, up-to-date roadmap for a resident's care, built from the assessment and the resident's own goals and preferences. It tells you what services to provide and how the resident wants them provided.

Always follow the current plan rather than a generic routine. When the plan and a habit conflict, follow the plan and raise the question with your supervisor or the nurse.

Section 3: Person-Centered Planning

Person-centered planning puts the resident at the center. Residents have the right to actively participate in planning, modifying, and evaluating their care (Minn. Stat. 144G.91). The plan should reflect their goals, routines, and preferences.

Your daily care delivers this by honoring choices — when to wake, what to eat, how to dress, how to spend the day — within the plan.

Section 4: Following and Informing the Plan

Your role is twofold: deliver care according to the current service plan, and inform the plan by reporting what you observe. When a resident's condition or needs change, report it — the change may trigger a reassessment and an updated plan. You are the eyes and ears of the care team.

Section 5: Reporting Changes in Condition

Report new or worsening symptoms, falls, behavior or mood changes, skin changes, refusals of care, and anything that seems 'not right' for that resident. A sudden, new change in confusion can be a medical emergency and must be reported immediately. Report to the nurse per facility policy so care and the plan can respond.

Section 6: Documenting Care

Documentation is the record that care happened and keeps the team coordinated. Good documentation is accurate (what actually happened), objective (what you saw and heard, not opinions or labels), timely (recorded promptly, not from memory hours later), complete (care given, refusals, and changes), and legible and signed.

Never document care before it happens or chart something you did not do. The record is a legal document that protects the resident, you, and the facility.

Section 7: Confidentiality and Privacy

A resident's health and personal information is private. Share it only with those who need it to provide care, and never discuss residents in public areas or on social media. Protect paper records and computer screens from unauthorized viewing. Confidentiality is part of the resident's right to privacy and dignity.

> **Records are a legal document**
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> Service plans and your charting can be reviewed by surveyors, families, and courts. Accurate, honest, timely records protect everyone — most of all the resident.

Section 8: Bringing It All Together

Everything in this course connects here. The service plan turns a resident's rights and needs into a concrete plan; your care delivers it; your documentation proves it and keeps the team coordinated. Reporting changes keeps care safe and current. When the plan reflects the resident's goals and your records are honest and timely, dignity becomes daily practice — and you are central to making it happen.

Key Terms

Term	What it means
Assessment	The evaluation of a resident's needs, abilities, preferences, and risks.
Service plan	The individualized, up-to-date roadmap that directs a resident's care.
Person-centered planning	Planning driven by the resident's goals, routines, and preferences.
Change in condition	A new or worsening sign that should be reported and may update the plan.
Documentation	The accurate, timely record of care provided and changes observed.
Confidentiality	Keeping a resident's information private and shared only as needed for care.

Check Your Understanding

1. What does an assessment capture, and how does it relate to the service plan?
2. What does it mean to follow and to inform the service plan?
3. Give three things you should report as a change in condition.
4. List four qualities of good documentation.
5. How do you protect a resident's confidentiality?

What's Next

> **Looking ahead**
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> This completes the Assisted Living & Residential Care course. Keep each lesson's completion record in the employee file, and pair these courses with your facility's required drills and competency checks.