Using outputs for care planning

This diagram illustrates the sequence of steps taken to arrive at a care plan, beginning with the completion of the interRAI assessment . Once the assessment is complete, 2 types of clinical outputs are generated: outcome scales and CAPs.

The assessor should **review the outputs and flag adverse outcome scale scores and triggered CAPs**, which indicate where the person may be at a risk of decline or have a potential for improvement. If a previous assessment is available, the assessor should compare current and previous outputs to provide insight into areas of change.

Next, the assessor should **determine actions for the flagged outputs:** address them in the current care plan, defer them to a future care plan or not address them in the care plan (e.g., because the person declined intervention). The assessor should consider the person's input and use clinical judgment in making their determination.

The next step is to create or revise the care plan . The assessor should determine goals for each problem area, suggest interventions to achieve the goals and describe expected outcomes of these interventions. The assessor should consider the individual's strengths, preferences and needs; and information from other sources, including clinical assessments and documentation, and family and other team members.

Implementing the care plan may include the initiation of programs and services, referrals or discharge plans.

The person should be reassessed at routine intervals (per jurisdictional policies) or when there is a significant change in status. The updated clinical outputs will be used to revise the current care plan accordingly.