CARE PLANNING: THE BLUEPRINT FOR CARE

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OBJECTIVES

◦ Provide an understanding of the revised regulations related to Care Planning

◦ Provide methods for meeting the regulations

◦ Define Person/Resident Centered Care Plans

◦ Provide examples of Resident Centered Care Plan
CARE PLANNING: A BLUEPRINT FOR CARE

STATE OPERATIONS MANUAL
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§483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person–centered plan of care.
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(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.
(iii) The right to be informed, in advance, of changes to the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

§ 483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must—

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident’s strengths and needs.

(iii) Incorporate the resident’s personal and cultural preferences in developing goals of care.
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§483.21 Comprehensive Person–Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person–centered care of the resident that meet professional standards of quality care. The baseline care plan must—
(i) Be developed within 48 hours of a resident’s admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—

(A) Initial goals based on admission orders.

(B) Physician orders.

(C) Dietary orders.

(D) Therapy services.

(E) Social services.

(F) PASARR recommendation, if applicable.
§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—

(i) Is developed within 48 hours of the resident’s admission.

(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).
§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

(i) The initial goals of the resident.
(ii) A summary of the resident’s medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
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- §483.21(b) Comprehensive Care Plans
- §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following —
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.
(iv) In consultation with the resident and the resident’s representative(s)—

(A) The resident’s goals for admission and desired outcomes.

(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
(iv) In consultation with the resident and the resident’s representative(s)—

(A) The resident’s goals for admission and desired outcomes.

(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b) Comprehensive Care Plans

§483.21(b)(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to—

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident’s care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(i) Meet professional standards of quality.
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§483.21(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(iii) Be culturally–competent and trauma–informed.

[§483.21(b)(iii) will be implemented beginning November 28, 2019 (Phase 3)]
§483.21(c)(1) Discharge Planning Process

The facility must develop and implement an effective discharge planning process that focuses on the resident’s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility’s discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—

(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.

(iv) Consider caregiver/support person availability and the resident’s or caregiver’s/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident’s goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident’s comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post–acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post–acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident’s goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident’s needs, and include in the clinical record, the evaluation of the resident’s discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident’s representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident’s discharge or transfer.
(b) Comprehensive care plans
   ◦ Must describe the following:
     • Any specialized services or specialized rehab services the facility will provide as a result of PASARR recommendations
     • In consult with the resident and the resident’s representative:
       • Resident’s goals for admission and desired outcomes
       • Resident’s preference and potential future discharge
         • Must document desire to return to the community was assessed, referrals to local agencies, etc..
       • Discharge plan in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in §483.21(c) Discharge planning
(b) Comprehensive care plans
- Developed within 7 days after completion of the comprehensive assessment
- IDT involvement with preparation
- Reviewed and revised by IDT after each assessment
- Services provided must:
  - Meet professional standards of quality
  - Be provided by qualified persons
  - Be culturally-competent and trauma-informed
    - More information will be available at a later date—phase 3
(c) Discharge Planning

Process:
- Must develop and implement an effective discharge planning process that focuses:
  - On the resident’s discharge goals
  - The preparation of residents to be active partners and effectively transition to post-discharge care
  - The reduction of factors leading to preventable readmissions
- Must be consistent with discharge rights set forth under §483.15(b)
(c) Discharge Planning

- Ensure the discharge needs are identified and result in development of a discharge plan
- Include regular re-evaluation of residents to identify changes, which may result in modification of the discharge plan; plan needs to be updated as needed to reflect changes
- IDT involvement – ongoing process of developing the discharge plan
- Consider caregiver/support person availability and the resident’s or caregiver’s/support person(s) capacity and capability to perform required care; this is part of the identification of discharge needs
(c) Discharge Planning

- Resident and resident representative involvement in developing the discharge plan, must be informed of final plan
- Address resident’s goals of care and treatment preferences
- Resident interests in receiving information regarding returning to the community must be documented that the resident was asked
(c) Discharge Planning
   ◦ Return to the community
     • If resident is interested in returning to the community, documentation must be present of any referrals to local contact agencies, etc.
     • Comprehensive care plan and discharge must be updated to reflect responses from referrals
     • If return to community is not feasible, must document who made the decision and why
(c) Discharge Planning

Summary:

- Must include, but not limited to:
  - Summary of the resident’s stay: dx, course of illness/treatment or therapy, pertinent labs, radiology, consults results
  - Include items from §483.20(b)(1)
    - (i) Identification and demographic information
    - (ii) Customary routine
    - (iii) Cognitive patterns
    - (iv) Communication
    - (v) Vision
    - (vi) Mood and behavior patterns
    - (vii) Psychological well-being
(c) Discharge Planning

**Summary:**

- Must include, but not limited to:
  - Include items from §483.20(b)(1)
    - (viii) Physical functioning and structural problems
    - (ix) Continence
    - (x) Disease diagnosis and health conditions
    - (xi) Dental and nutritional status
    - (xii) Skin Conditions
    - (xiii) Activity pursuit
    - (xiv) Medications
(c) Discharge Planning

Summary:
- Must include, but not limited to:
  - Include items from §483.20(b)(1)
    - (xv) Special treatments and procedures
    - (xvi) Discharge planning.
    - (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS)
    - (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.
(c) Discharge Planning

**Summary:**
- Must include, but not limited to:
  - Reconciliation of all pre–discharge medications with resident’s post–discharge medications (both prescribed and over the counter)
  - Post–discharge plan of care – developed with resident, must include where the resident plans on residing, any arrangements that have been made for follow up care and post discharge medical and non–medical services
Intent of Baseline Care Plans

- Completion and implementation of the baseline care plan within 48 hours of a resident’s admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.
The baseline care plan should strike a balance between conditions and risks affecting the resident’s health and safety, and what is important to him or her, within the limitations of the baseline care plan timeframe.

Person-centered care means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices.

Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident’s life before coming to reside in the nursing home.
The baseline care plan must reflect the resident’s stated goals and objectives, and include interventions that address his or her current needs.

It must be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable.

Because the baseline care plan documents the interim approaches for meeting the resident’s immediate needs, professional standards of quality care would dictate that it must also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan.

Facility staff must implement the interventions to assist the resident to achieve care plan goals and objectives.
Baseline Care Plan Summary

- The facility must provide the resident and the representative, if applicable with a written summary of the baseline care plan by completion of the comprehensive care plan.
- The summary must be in a language and conveyed in a manner the resident and/or representative can understand.
Baseline Care Plan Summary

- The format and location of the summary is at the facility’s discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable.
- The facility may choose to provide a copy of the baseline care plan itself as the summary, as long as it meets all of the requirements of the summary.
Baseline Care Plan Summary

- Given that the baseline care plan is developed before the comprehensive assessment, it is possible that the goals and interventions may change.
- In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident’s goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable.
Intent of the Comprehensive Care Plan

- Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident’s medical, physical, mental and psychosocial needs.
Definitions

- **Resident’s Goal:** The resident’s desired outcomes and preferences for admission, which guide decision making during care planning.
- **Interventions:** Actions, treatments, procedures, or activities designed to meet an objective.
- **Measurable:** The ability to be evaluated or quantified.
- **Objective:** A statement describing the results to be achieved to meet the resident’s goals.
- **Person-centered care:** means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.
Through the care planning process, facility staff must work with the resident and his/her representative, if applicable, to understand and meet the resident’s preferences, choices and goals during their stay at the facility.

The facility must establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life.

Care planning drives the type of care and services that a resident receives.

If care planning is not complete, or is inadequate, the consequences may negatively impact the resident’s quality of life, as well as the quality of care and services received.
Facilities are required to develop care plans that describe the resident's medical, nursing, physical, mental and psychosocial needs and preferences and how the facility will assist in meeting these needs and preferences.

Care plans must include person-specific, measurable objectives and timeframes in order to evaluate the resident’s progress toward his/her goal(s).
Care plans must be person-centered and reflect the resident’s goals for admission and desired outcomes.

Person-centered care means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices.

Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident’s life before coming to reside in the nursing home.
Residents’ goals set the expectations for the care and services he or she wishes to receive.

For example, a resident admitted for rehabilitation may have the following goal – “Receive the necessary care and services so that I may return to independent living.”

Another resident may have a goal of receiving the necessary care and services to meet needs they cannot independently achieve, while maintaining as much independence as possible.

And yet another resident or his or her representative, if applicable, may have a goal of receiving the necessary care and services to keep the resident comfortable and pain-free at the end of their life.

Each of these examples would be supported by measurable objectives, interventions and timeframes designed to meet each specific resident goal.
Measurable objectives describe the steps toward achieving the resident’s goals, and can be measured, quantified, and/or verified.

For example, “Mrs. Jones, who underwent hip replacement, will report adequate pain control (as evidenced by pain at 1–3, on a scale of 1–10) throughout her SNF stay.” Facility staff will use this objective to monitor the resident’s progress.
The comprehensive care plan must reflect interventions to enable each resident to meet his/her objectives.

Interventions are the specific care and services that will be implemented.

Interventions for the example above, related to pain, may include, but are not limited to:
- Evaluate pain level using pain scale (0–10) 45 minutes after administering pain medication;
- Administer pain medication 45–60 minutes prior to physical therapy.
If a Care Area Assessment (CAA) is triggered, the facility must further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident.

Documentation regarding these assessments and the facility’s rationale for deciding whether or not to proceed with care planning for each area triggered must be recorded in the medical record.
There may be times when a resident risk, weakness or need is identified within the context of the MDS assessment, but may not cause a CAA to trigger.

The facility is responsible for addressing these areas and must document the assessment of these risks, weaknesses or needs in the medical record and determine whether or not to develop a care plan and interventions to address the area.

If the decision to proceed to care planning is made, the interdisciplinary team (IDT), in conjunction with the resident and/or resident’s representative, if applicable, must develop and implement the comprehensive care plan and describe how the facility will address the resident’s goals, preferences, strengths, weaknesses, and needs.
Residents’ preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

The comprehensive care plan must address a resident’s preference for future discharge, as early as upon admission, to ensure that each resident is given every opportunity to attain his/her highest quality of life.

This encourages facilities to operate in a person-centered fashion that addresses resident choice and preferences.
Intent of Discharge Planning

- This requirement intends to ensure that the facility has a discharge planning process in place which addresses each resident’s discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.
Definition

- **Discharge Planning:** A process that generally begins on admission and involves identifying each resident’s discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident’s stay to ensure a successful discharge.
Discharge planning is the process of creating an individualized discharge care plan, which is part of the comprehensive care plan. It involves the interdisciplinary team (as defined in §483.21(b)(2)(ii) working with the resident and resident representative, if applicable, to develop interventions to meet the resident’s discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting.

Discharge planning begins at admission and is based on the resident’s assessment and goals for care, desire to be discharged, and the resident’s capacity for discharge.
It also includes identifying changes in the resident’s condition, which may impact the discharge plan, warranting revisions to interventions.

A well executed discharge planning process, without avoidable complications, maximizes each resident’s potential to improve, to the extent possible, based on his or her clinical condition.

An inadequate discharge planning process may complicate the resident’s recovery, lead to admission to a hospital, or even result in the resident’s death.
The discharge care plan is part of the comprehensive care plan and must:
- Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative;
- Address the resident’s goals for care and treatment preferences;
- Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education;
- Be re-evaluated regularly and updated when the resident’s needs or goals change;
- Document the resident’s interest in, and any referrals made to the local contact agency;
- Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance.
Discharge planning must include procedures for:

- Documentation of referrals to local contact agencies, the local ombudsman, or other appropriate entities made for this purpose;
- Documentation of the response to referrals; and
- For residents for whom discharge to the community has been determined to not be feasible, the medical record must contain information about who made that decision and the rationale for that decision.
Discharge planning must identify the discharge destination, and ensure it meets the resident’s health and safety needs, as well as preferences.

If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility must treat this situation similarly to refusal of care, and must:
Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location;

Document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed;

Document that despite being offered other options that could meet the resident’s needs, the resident refused those other more appropriate settings;

Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary.

- The referral should be made at the time of discharge.
Intent of Discharge Summary

- To ensure the facility communicates necessary information to the resident, continuing care provider and other authorized persons at the time of an anticipated discharge.
The discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident’s plans for care after discharge.

A discharge summary must include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another.

The discharge summary may help reduce or eliminate confusion among the various facilities, agencies, practitioners, and caregivers involved with the resident’s care.
CARE PLANNING: A BLUEPRINT FOR CARE

- Was the baseline care plan developed within 48 hours of admission?
- Does the baseline care plan include:
  - Resident’s initial goals for care
  - The instructions needed to provide effective and person centered care that meets professional standards of quality care
  - The resident’s immediate health and safety needs
  - Physician and dietary orders
  - PASARRR recommendations, if applicable
  - Therapy and social services
Was the baseline care plan revised and updated as needed until the comprehensive care plan was developed.

If the resident experienced an injury or adverse event prior to the completion of the comprehensive care plan, should the baseline care plan have identified the risk of injury/event?
Did the facility provide the resident and his/her representative, if applicable, with a written summary of the baseline care plan that contains:

- Initial goals of the resident
- A summary of current medications and dietary instructions
- Services and treatments to be provided or arranged by the facility and personnel acting on behalf of the facility
- Any updated information based on details of the admission comprehensive assessment
Does the care plan address goals, preferences, needs and strengths of the resident including those identified in the comprehensive resident assessment, to assist the resident to attain or maintain his or her highest practicable well-being and prevent avoidable decline?

Are objectives and interventions person-centered, measurable, and do they include time frames to achieve the desired outcomes?

Is there evidence of resident and, if applicable resident representative participation (or attempts made by the facility to encourage participation) in developing person-centered, measurable objectives and interventions?
Does the care plan describe specialized services and interventions to address PASARR recommendations, as appropriate?

Is there evidence that the care plan interventions were implemented consistently across all shifts?

Is there a process in place to ensure direct care staff are aware of and educated about the care plan interventions?
Determine whether the facility has provided adequate information to the resident and, if applicable resident representative so that he/she was able to make informed choices regarding treatment and services.

Evaluate whether the care plan reflects the facility’s efforts to find alternative means to address care of the resident if he or she has refused treatment.
Was a comprehensive plan of care developed within seven days of completion of the resident’s comprehensive assessment?

• Is there evidence of participation in the care planning process by required IDT members?

• Ask required members of the IDT how they participate in the development, review and revision of care plans.

• Based on the resident’s goals and needs, were other appropriate staff or professionals’ expertise utilized to develop a plan to improve the resident’s functional abilities?
Did an occupational therapist recommend needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability?

b. Did the dietitian and speech therapist determine the optimum textures and consistency for the resident’s food that is nutritionally adequate and compatible with the resident’s oropharyngeal capabilities and food preferences?

Is there evidence of attending physician involvement in development of the care plan (e.g., presence at care plan meetings, conversations with team members concerning the care plan, conference calls, written communication)?
How do staff make an effort to schedule care plan meetings at the best time of the day for residents and if applicable, the resident representatives?

How do staff make the care plan process understandable to the resident and resident representative, if applicable?

Ask the resident and resident representative, if applicable if he or she actively participates in the care planning process? If not, what have been the barriers to participation?
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- Ask the resident and if applicable, the resident representative if he or she has requested the participation of additional individuals care planning process. If so, was the request respected?
- In what ways does staff involve the resident and if applicable, the resident representative in care planning? If staff determine that the resident and/or resident representative involvement in care planning is not practicable, is the reason and the steps the facility took to include the resident and/or resident representative documented in the medical record?
- Is there evidence that the care plan is evaluated for effectiveness and revised following each required assessment, except discharge assessments, and as needed?
TYPES OF CARE PLANS
CARE PLANNING: A BLUEPRINT FOR CARE

TRADITIONAL
- Clinically driven
- Lack personalization
- Difficult to read
- Difficult to understand
- Difficult to formulate

INDIVIDUALIZED
- First attempt by LTC to personalize the care plan
- Clinically driven
- Difficult to read
- Easier to formulate

“I”/Resident Centered CARE PLAN
- Requires more time spent with the resident
- More informative to all staff
- Easier to read and understand
- Easier to formulate
- Resident driven – tells a story
# CARE PLANNING: A BLUEPRINT FOR CARE

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<thead>
<tr>
<th>TRADITIONAL CARE PLANNING</th>
<th>PERSON CENTERED CARE PLANNING</th>
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<tbody>
<tr>
<td>The professional assesses the person’s needs</td>
<td>Care and support plans are developed with the person. The conversation is led by the person who knows best about their needs and preferences</td>
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<tr>
<td>Care planning follows a medical model</td>
<td>Care planning follows a social model</td>
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<tr>
<td>There is a focus on what the person is unable to do</td>
<td>There is a focus on goals and aspirations, what the person would like to achieve with their care and support</td>
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<tr>
<td>There is a static view of the person’s ability or capacity</td>
<td>Care planning explores potential for change, opportunities to develop capacity and ability</td>
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<td>The professional writes the care plan with little or no input from the person or their representative</td>
<td>The person is supported to express how they would like their care and support to be delivered. The professional provides information about what the service can offer. They agree what will be in the care plan. A copy of the care plan is made available to the resident and their representative.</td>
</tr>
<tr>
<td>The emphasis is on protecting the person from risk</td>
<td>The emphasis is on safe care that respects a person’s right to take risks that they understand</td>
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<tr>
<td>The process takes place when it is convenient for the professional</td>
<td>The care planning conversation takes place at a time when the person is most or more likely to participate</td>
</tr>
<tr>
<td>Power is with the professionals</td>
<td>Power is equally shared</td>
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Medical Model
- Staff know you by diagnosis
- Staff write care plan based on what they think is best for your diagnosis
- Interventions are based on standards of practice per diagnosis

Community Model
- Staff have personal relationship with resident and family
- Resident, family, and staff develop care plan that reflects what resident desires for him/herself
- Unique interventions which meet the needs of that resident
CARE PLANNING: A BLUEPRINT FOR CARE

- **Medical Model**
  - Care plan written in the third person
  - Care plan attempts to fit resident into facility routine
  - Nursing assistants not part of interdisciplinary team
  - Care plan scheduled at facility convenience

- **Community Model**
  - Care plan written in first person “I” format
  - Care plan identifies resident’s lifelong routine and how to continue it in the nursing home
  - Nursing assistants very and present at each care plan conference
  - Care conference scheduled at resident and family convenience
CARE PLANNING: A BLUEPRINT FOR CARE

What is ‘Resident Centered Care Plan’

- The resident and family are the primary decision makers as to the goals of care and how these needs are to be met
- Creating a home-like environment where residents, family, staff members can achieve their highest potential
- Responding to the needs of the resident, family, staff in a timely manner
- Enhancing communication between all members of the ‘team’, including the resident and family
CARE PLANNING: A BLUEPRINT FOR CARE

WHO SHOULD BE INVOLVED?

- Resident
- Resident’s family
- Surrogate or Representative
- Interdisciplinary Team including the nursing assistant – most important that those “responsible for providing care" to the resident are included in the care planning process
The interdisciplinary team should show evidence in the Resident Assessment Protocol (RAP) summary or clinical record of the following:

- The resident’s status in triggered RAP areas;
- The facility’s rationale for deciding whether to proceed with care planning; and
- Evidence that the facility considered the development of care planning interventions for all RAPs triggered by the MDS.
Monitor resident progress
Prioritize interventions if appropriate
Interdisciplinary means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident.
  - Was interdisciplinary expertise utilized to develop a plan to improve the resident’s functional abilities?
Do staff make an effort to schedule care plan meetings at the best time of the day for residents and their families?
  ◦ How do you communicate this information with the resident and their families?

Is the ombudsman involved in the care planning meeting as a resident advocate?
Do facility staff attempt to make the process understandable to the resident and family?

What happens if residents have brought questions or concerns about their care to the attention of facility staff?
Before and After Care Plan Samples
Joe is an 88 year old man with dementia. He has a short attention span. He is very pleasant most of the time. Joe likes to walk around the facility a considerable amount of his waking hours. He is unable to distinguish between areas he is welcomed to enter and those where he is not welcomed.
His ambulation skills are excellent; no assistance is required. Some residents are disturbed by him because he may enter their rooms against their wishes. He prefers to be with staff at all times as he does not tolerate being alone. He and his wife raised 11 children. Joe owned a hardware store and was a respected businessman in town.
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Traditional Care Plan

- **Problem**
  - Wanders due to dementia

- **Goal**
  - Resident will not wander into their rooms
Redirect resident to appropriate areas of the family
Praise for cooperation
Teach resident not to enter rooms with sashes across door
Encourage resident to sit in lounge and other common areas
Resident Directed Care Plan

- Needs
  - I need to walk

- Goal
  - I will continue to walk freely throughout my home
After I eat breakfast and get dressed, I want to walk with staff. I will accompany you anywhere. I like to help while we are together. I can fold linen and put things away with you. I do not like to nap. If weather permits, please walk outside with me. I like to keep walking in the evening until I go to bed. I sit when I am tired, so don’t fuss over asking me to sit.
Traditional Care Plan

- Problem
  - Non compliant with 1800 cal ADA diet

- Goal
  - Resident will eat only foods approved in ordered diet
Interventions

- Educate resident regarding diabetes, her diet, and impact to her health if non-compliant
- Notify nurse of foods hidden in room
- Monitor for s/s hypo and hyperglycemia
- Check blood sugar 6am and 8pm
- Administer insulin as ordered
Needs
- I have diabetes and take insulin. I am aware of recommended dietary restrictions and I choose to exercise my right to eat what I enjoy.

Goal
- I will enjoy moderate foods of my choice.
Problem: Alteration in thought process
Goal: Resident will be oriented to person, place, time and situation at all times
Goal date: 11/16/03

Approaches:
- Provide orientation with routine care
- Invite to R.O. activities, i.e., current events group and resident council
- Place facility calendar in room
Problem: Cognition
Goal: Frank will use the activity calendar to remind himself of daily activities.
Goal date: 11/16/03

Approaches:
- Place weekly calendar in Frank’s room on the small bulletin board
- Assist Frank to choose activities he is interested in for the day before he goes to breakfast
- Remind Frank throughout the day of the group activities coming up.
CARE PLANNING: A BLUEPRINT FOR CARE

Care Planning List – Special Considerations/Strengths

- Social history
- Memory enhancement & communication
- Mental wellness
- Mobility enhancement
- Safety
- Visual function
CARE PLANNING: A BLUEPRINT FOR CARE

Care Planning List – Special Considerations/Strengths

- Dental care
- Bladder management
- Skin care
- Nutrition
- Fluid maintenance
- Pain management/comfort
- Activities
- Discharge plan
Social History:

I am Frankfort Fox. My friends call me “Frank”. I was born in Fargo, North Dakota way back in 1910. My parents were farmers. They raised my six older brothers and worked very hard. My parents valued a good education. All of us boys graduated from Washington High School in Fargo. Shortly after graduation, I hopped a train to Colorado. I got off in a town called Marble, way up in the Rockies...
My memory is pretty good. I had a stroke about a year ago which affected my ability to remember things which happen day to day. I love to attend groups and am a very social guy. I appreciate it if you show me the weekly calendar in my room near the sink every morning. Review with me what is going on for that day.
Memory Enhancement

- I will tell you what I am interested in. You can remind me during the day when an activity I enjoy is going to occur.
- Goal: I want to work with you daily to learn my calendar so that will be able to be independent in getting to the group activities which I enjoy.
Back in 1935, I fell while taking a climb up a mountain. I cracked a vertebrate in my upper spine. Later I developed Arthritis in this area. My pain worsens as the day wears on. Please remember that I start getting irritable it is because my back hurts. Ask me about it. Let the nurse know I am having trouble.
I take regular medication for pain. Sometimes I need extra boost of medication. I also benefit from stretching so I like to attend the morning exercise group. The massage therapist sees me every Friday for an hour. Massage makes all the difference.

Goal: To be free from breakthrough pain in my back
Nutrition

- Ever since my stroke, my appetite just hasn’t been the same. I have been losing weight since July. It helps to have my special adaptive silverware at the table when I eat. I eat better when I sit with Joy. Make sure we have our special table set up so we can eat together at every meal.
I have always been a snacker since my hiking days. I especially enjoy Almond Joy’s, chocolate milkshakes and burgers from McDonald’s which my daughter brings in for me. Offer me a snack between meals and before bed. Also invite me to join in the cooking group. “Food always tastes better when you make it yourself”.

Goal: I want to keep my current weight and maybe even gain five pounds.
Questions to ask ourselves

- If an elder is declining, have we asked the question, why did this happen?
- Are we assessing outcomes?
- Are we assessing why elders don’t improve?
- Are we assessing why elders are not reaching their highest practicable physical, mental, and psychosocial well-being?
- Are we truly assessing the elder’s functional status in a holistic manner and making a difference for that person?
CARE PLANNING: A BLUEPRINT FOR CARE

HOW DO WE SURVIVE THE CHANGE?
How do we survive the change!

- Know the regulations and the interpretations
- Educate yourself, educate administration, educate the staff
- Who are the gatekeepers of the Care Plan?
- Focus on resident’s voice and participation
- Include the resident representative
- Look at the resident holistically
- Assess your team’s care planning work flow
- Teach the team on person centered care plans, including the Nursing Assistants
How do we survive the change!

- Reinforce more time will need to be spent on care planning
- Look at how the baseline care plan is documented – does it meet the definition of a care plan i.e. not simply a cardex listing what the resident does or requires
- Answer the who, what, where, when how, why questions
- Is a ‘summary’ provided or a copy of the care plan – is it in layman’s terms
Watch your ‘time savers’ i.e. forms and tools – be sure they meet the intent of the regulations and the definition of a care plan

Team Communication is key!

MDS Coordinator communication to DON and vice versa is critical

All must be on the same page

Review the policy for care planning – does it address how the care plan is structured and if yes, does it reflect resident centered care plans
How do we survive the change!

- Is your discharge planning adequate?
  - Looking for evidence of your decision making process
  - Documentation needs to be clear and concise
  - Why did you make the discharge plan decision that you did?
  - Care Plan structured note with critical thinking
- Incorporate the Nurse Aide into discharge planning – responsible for the resident
- Focus is still “Person-Centered Care”
Large portion revolves around the Care Plan
Review the documentation provided to the resident at discharge (planned discharges)
Be sure all appropriate information data elements are addressed
Be sure it is in “layman’s” terms
CARE PLANNING: A BLUEPRINT FOR CARE

Resources

Centers for Medicare and Medicaid Services – Nursing Homes
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

Long Term Care Ombudsman; Person Centered Care
http://ltco.org/personcentered_care0.aspx

NCQA
http://blog.ncqa.org/person-centered-care-planning/

Alzheimer’s Association
https://alz.org/
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Resources

CarePlans.com

Pioneer Network
https://www.pioneernetwork.net/person-centered-care-care-planning-makes-new-cms-regulations-part/