Care Plans

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• Required by the federal and state government
• Are considered the “road map” for resident care
• Used in the survey process

Federal Requirements

483.20(d) Care Plans
• F 279  A facility must use the results of the assessments to develop, review and revise the resident’s comprehensive plan of care
483.20(k) Comprehensive Care Plans
The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment
• Care plan must describe:
  1. Services that are furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being

2. Any services that would otherwise be required under 483.25 (Quality of Care) but are not provided due to resident’s exercise of rights under to refuse treatment

Interpretive Guidelines
Interdisciplinary team, in conjunction with resident, resident’s family, surrogate, or representative should develop objectives for highest level of function
• Should show evidence in the Care Area Assessments (CAA) summary or clinical record of:
  – Resident’s status in triggered CAA areas
  – Rationale for deciding to proceed with care planning, and
  – Evidence that facility considered the development of care planning interventions for all CAA’s triggered by the MDS
• Does the care plan address the needs, strengths and preferences identified by the MDS?
• Is the care plan oriented toward preventing avoidable declines and build on resident strengths?
• Does it reflect current standards of professional practice?
• If resident refuses, is there adequate information that the resident was able to make an informed choice

483.10(d)(3)

F 280 Resident has a right (unless adjudged incompetent or incapacitated under laws of the State) participate in planning care and treatment or changes in care and treatment

• Documentation that resident, family, etc. were invited to care plan meeting
• Resident is afforded opportunity to select from alternative treatments
  – Includes initial decisions and right to refuse

483.20(k)(2)

Comprehensive Care plan must be:
1. Developed within 7 days after the completion of the MDS 3.0
2. Prepared by an interdisciplinary team
3. Periodically reviewed and revised by team after each assessment
Interdisciplinary

- Means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident
  - Does not mean each goal must have an interdisciplinary approach
  - Mechanics on how this is done is at discretion of the facility

Facility Responsibility

- Resident and/or family do not have the right to demand the facility use specific medical interventions or treatments that the facility deems inappropriate
- Statutory requirements hold the facility ultimately accountable for resident’s care and safety, including clinical decisions

483.20(k)(3)

F 281 The services provided or arranged by the facility must:

- Meet professional standards of quality
  - Does staff notify physician as appropriate on acute medical problems?
  - Are there errors in techniques of medication administration?
  - Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to completion of first MDS and care plan?
483.520(K)(3)(ii) F 282  Be provided by qualified persons in accordance with each resident’s written plan of care
• Can direct care staff describe the care, services, and expected outcomes of the care they provide?

State Laws
• States may have laws or regulations requiring care plans be developed on admission
• Skilled level of care, needs a care plan on admission to support need for skilled services

Now What?
Care Plans often paper compliance

• Does staff know where the care plan is?
• Have CNA's been encouraged to assist with development and update of care plans?
• Are care plans truly used as “Road Map” for care of each individual resident?
• How do new staff know how to care for residents?

New Admission

• Even if know the resident could have condition change
• Resident at higher risk for falls in new environment
• Must provide for safety
• Must encourage resident to participate in cares and decisions as much as possible

How does staff know how to care for new admission?

• Report
• Communication book
• Resident list in room
• Graphics
Road Map

A facility must use the results of the assessments to develop, review, and revise the resident’s comprehensive plan of care

- Must have measurable objectives and timetables to meet a resident’s
  - Medical, nursing, and mental and psychosocial needs
  - Resident’s/families must be allowed to participate if so desire

Each Resident is Unique

- Directions for taking a trip must be clear
- Directions for caring for residents must be clear
  - Need to be aware of unique characteristics, strengths, and needs
  - Must represent good clinical practice
  - Look at the resident as a “whole”
- Conference is held to develop a care plan
  - Need to include the whole team (CNA’s)

Components of the Care Plan

- Problem
  - What is the problem
- Goal
  - Resident centered, not staff goal
  - Must have time table
  - Must be realistic
  - Must be measureable
- Interventions
  - What are the specifics for the resident
So, we have our MAP...

Now What??

Following Care Plans

- All nursing staff must be aware of what is on the care plan
  - How is everyone updated with changes?
  - Whom do staff go to with changes that might be needed?
  - CNA's must be part of the process

Care Plans

- Format can vary from facility to facility
- Must be user friendly
- Staff must be able to read them
- Must be accessible to all nursing department and others as needed
- Must be current and updated
  - Sometimes this means almost daily
Detours do occur

• CNA’s usually know the resident the best
  – If they find something that works well with the resident, SHARE THIS with others
• CNA’s must report to charge nurse/designee when changes do occur
  – ADL’s
  – Behavior
  – Pain
  – Restorative

Specific care plans

• Care plans don’t need to list the things you do for all residents
  – Call light within reach
  – Bath/shower 2X a week
Are You Getting the “I” in Your Resident’s Care Plan?

Putting the “I” into your resident’s plan of care makes everything you do personal for each and every resident. Person-directed care holds true when you write your care plans to be specific to each resident’s needs.

Care Plans

- Should be able to determine which resident’s care plan you are reading without a name on it
- Is a working document
- Should not be generic
- Everyone’s should not read the same
Care planning pieces...

Traditional Care Plans
- Difficult to read
- Difficult to understand
- Clinically driven
- Without personalization are “canned”
- Difficult to formulate

Individualized Care Plans
The industries first approach to become more personalized with plans of care...
- Difficult to read
- Clinically Driven
- Easier to formulate

Computerized versions “canned” approaches
Putting the “I” into it.....

• Interview the resident, spend time getting to know them...
• More informative for all staff
• Easier to read and understand
• Easier to formulate
• Tell a story
• Directs the plan of care by various staff members

The Care Planning Process

• Can we apply common sense to this process?

YES WE CAN.....!!!

• Simplify and individualize the process
• Involve all staff
• Develop a functional resident centered care plan that is actually used by staff
• How well do staff know the residents?
• How do staff know what to do?
Residents, or “I”....

• How do you refer to residents in care plans?
  – For example, does your care plan state: Mrs. Jones is combative at bath time.
  – Or does your care plan state in a more resident centered way: I am afraid of water hitting me in the face and it frightens me to be totally undressed in a cold room that is unfamiliar.

How Would You Know This Information?

• Ask the resident
  – Build a relationship with the resident
• Customary routine section of the MDS
• Interview family members
  – Build a relationship with the resident
• Interview friends
• Observe the resident

Are we talking to residents and to families?

– Are you listening?
– What are their concerns?
– How do they feel about quality of care and quality of life?
– Are they included in the assessment process?
– What is the resident’s functional status?
– Have you given the resident the opportunity to demonstrate their abilities?
If a resident is declining, have we asked the question, why did this happen?
• Are we assessing outcomes?
• Are we assessing why residents don’t improve?
• Are we assessing why residents are not reaching their highest practicable physical, mental, and psychosocial well-being?
• Are we truly assessing the resident’s functional status in a holistic manner and making a difference for that person?

Commit to these values:
– Know each person
– Each person can make a difference
– Relationship is the fundamental building block of a transformed culture
– Respond to spirit, as well as mind and body
– Risk taking is a normal part of life

Values
– Promote the growth and development of all
– Shape and use the potential of the environment in all its aspects: physical, organizational, and psychosocial/spiritual
— Practice self-examination, searching for new creativity and opportunities for doing better
— Recognize that culture change and transformation are not destinations, but a journey, always a work in progress

Changing the Culture...

• 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

Changing the Culture...

• The Process
• Takes time
• Can cause some confusion
• Can be hard to remain on track
• Don’t give up!
Benefits continued....

- ALLOW your staff to become more familiar with your residents
- Remind your staff the resident is a person not a diagnosis down the hall!!!
- Increased autonomy of the resident
- Improved Survey results

MDS 3.0 gives us a unique opportunity to make the changes, all of us together residents, facilities and regulators!

We need to be “thinking outside the box” on how to make your resident’s journey more resident centered!
The irony is...

the “I” never left,
we just got caught up in being
“institutionally” correct!