Care Plans:
What do we need to know?

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The MDS: the first assessment

- Federally required set of questions for every resident in a certified bed in the nation
- Several different types of assessments
- Required at regular intervals
MDS

• Mandated to be electronically submitted to CMS
  – Surveyors can view MDS’ on ASPEN
    • Discharged residents stay under the facility unless transferred to another facility (then all MDS’ move with the resident to the new facility)
    • Call MDS unit if you cannot find the resident in ASPEN
The CAAs: the second assessment

- Triggered responses to items coded on the MDS
- Framework for guiding the review of triggered areas, and clarification of a resident’s functional status and related causes of impairments
- Provides a basis for additional assessment of potential issues, including risk factors
- Only the CAA summary in Section V is transmitted
  - Surveyor will need to look at documentation in the facility to verify that the CAAs were completed
The Care Plan: the communication tool

• Development
  – IDT meets to discuss and write problems/needs, goals and interventions (instructions for the staff)

• Implementation
  – Staff following the instructions

• Evaluation
  – IDT meets again (regular intervals) to discuss and revise as needed
The Resident Care Plan vs. the Nursing Care Plan

• Person Centered Care, Individualization of Care, Culture Change all = to really knowing the resident and then work towards communicating and implementing their preferences and plan
  – MDS 3.0 has scripted resident interviews in order to hear the “resident’s voice”. It is how we get to know the resident
  – The resident has the right to participate in planning care and treatment or changes in care and treatment
  – Resident preferences ( & what is unique for them) should be incorporated into and communicated through the care plan
Care Planning: the primary intent of RAI process

• Since OBRA 87 the primary legislative intent of the RAI process was to lay the foundation for a person centered, individualized care plan
So why are we discussing Care Planning today?

• 1) July 6, 2012 OIG report:

   Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs

   – 99% failed to meet one or more Federal requirements for resident assessments and/or care plans
Why are we discussing? Antipsychotics and Care Planning

• 2) CMS initiative: Partnership to Improve Dementia Care in Nursing Homes (S & C March 29, 2012 and May 24, 2013)
  – It has been a common practice to use various types of psychopharmacological medications in nursing homes to try to address behaviors without first determining whether there is a medical, physical, functional, psychological, emotional, psychiatric, social or environmental cause of the behaviors
Antipsychotics and Care Planning

• The concern is that nursing homes may use medications as a “quick fix” for behavioral symptoms or as a substitute for a holistic approach that involves a thorough assessment of underlying causes of behaviors and individualized, person-centered interventions.

• Utilizing a process that focuses on individual needs and tries to understand behavior as a form of communication may help reduce distress.
Antipsychotics and Care Planning

– One of the primary ways to reduce AP use is to observe and get to know the resident (through the MDS), further assess (CAAs) and evaluate (care plan development, implementation and evaluation) to determine why a behavior is occurring

– Direct care staff need specific, detailed individual instructions (the written care plan)
Why are we discussing?
Second OIG Report

3) February 2013 OIG Report
Skilled Nursing Facilities Often Fail To Meet Care Planning And Discharge Planning Requirements

Why they did the study:
– Part of a larger body of work about SNF payments and quality of care
OIG Report

What was found:

• For 37% of stays, SNF’s did not develop care plans that met requirements or did not provide services in accordance with care plans

• For 31% of stay, SNF’s did not meet discharge planning requirements
OIG Report

Recommendations:

• Strengthen the regulations on care planning and discharge planning

• Provide guidance to SNF’s

• Increase surveyor efforts to identify SNF’s that do not meet care planning and discharge planning requirements and to hold these SNF’s accountable
OIG Report

- Link payments to meeting quality-of-care requirements
- Follow up on the SNFs that failed to meet care planning and discharge planning requirements or that provided poor quality of care
Third OIG Report

• 4) Released Sept. 30, 2013
• OIG continues to see insufficient care plans and their impact on residents as a risk area for nursing facilities
Why are we discussing?

• 5) Care plan citations frequently make the Top 10 List in Missouri

• 6) Resolve any discrepancies as to what is expected about care planning in Missouri homes
Regulations

• F279

§483.20(d) (A facility must...) use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care

§483.20(K) Comprehensive Care Plans

(1) 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.
Regulations

The 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 §483.25 and

(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).
Regulations

• F280

§483.10(d)(3) The resident has the right to – unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment
§483.20(k)(2) A comprehensive care plan must be—

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

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs, and, to the
Regulations

extent practicable, the participation of the resident, the resident’s family or the resident’s legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment
Regulations

• F284
  §483.20(1)(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment
Care Plans
Realistic and Functional

Carol Siem - QIPMO
Culture Change Influences

– Began in 1980s
  • Autonomy
  • Choice
  • Homey personal spaces
  • Valued staff
– Current Battle Cry – Person Centered Care
– Now impacting how facilities do Care Plans
  • Individualized Care plans
  • Narrative Care plans
  • “I” Care plans
2006 Study – “Connection, Regulation and Care Plan Innovation”

- Staff Connection = higher care plan specificity and innovation
- Connection of frontline nursing staff are crucial for:
  - Implementation of the formal care plan.
  - Spontaneous informal planning responsive to changing resident needs.

2007 – CMS committed support to Culture Change

“...the Agency has become a part of a national movement known as ‘culture change.’ (Other terms include ‘resident-directed care, ‘person-centered care,’ and ‘individualized care.’)

Culture change principles echo OBRA principles of knowing and respecting each nursing home resident in order to provide individualized care that best enhances each person’s quality of life....”

• “...The OBRA regulations are not, as is commonly perceived, a barrier to culture change, but in fact support it as an optimum implementation of the law that mandates resident dignity, autonomy, and quality of life. The concept of culture change encourages facilities to change outdated practices to allow residents more input into their own care and encourages staff to serve as a team that responds to what each person wants and needs.”
Care Planning
Quality of life is just as important as health and safety

- Security
- Comfort
- Enjoyment
- Relationships
- Dignity

- Meaningful activity
- Functional competence
- Individuality
- Privacy
- Autonomy/choice
- Spiritual well-being

- Quality of life is just as important as health and safety
Pioneers

- Pioneers are creating a better culture in all settings where elders live, with the intention of building loving, elder-directed communities.
Pioneers

- Pioneers call their collective work culture change, the transformation of traditional institutions and practices into communities in which each person’s capacities and individuality are affirmed and developed.

- They strive to transform the way people live and work throughout the continuum of aging
Pioneer Values

Pioneers commit to these values:

– Know each person

– Relationship is the fundamental building block of a transformed culture

– Each person can make a difference

– Respond to spirit, as well as mind and body

– Risk taking is a normal part of life
Pioneer Values

– Put person before task
– All elders are entitled to self-determination wherever they live
– Community is the antidote to institutionalization
– Do unto others as you would have them do unto you
Pioneer 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
Pioneer Values

– 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
RAI Process

Yields information on the resident’s

– Functional status
– Strengths
– Weaknesses
– Preferences
Assessment (MDS) → Decision Making (CAA) → Care Plan Development → Care Plan Implementation → Evaluation
CAA Goals

Promote the highest practicable level of functioning for a resident through an assessment of triggered care areas from the MDS

- Determine if there is a problem and understand the causes & contributing factors
- Triggered care areas form a critical link between MDS and care planning decisions
Triggering a CAA

• Care Area Triggers (CAT)
  – Alerts assessor to problems/needs/strengths
  – Directs assessor to conduct assessment activities
  – Based on specific MDS item(s) and response(s)
Triggering a CAA

• All triggering care areas are available on the MDS 3.0 item set except for
  – Delirium
  – Mood State
• These 2 compare scores from a previous assessment (CAM & PHQ9)
• MDS items target (trigger) care areas for additional assessment & review
Types of CATs

• Potential Problems
  – Restraint use

• Broad Screening Triggers
  – Delirium and Dehydration may have false positives

• Prevention of Problems
  – Risk for falls or developing a pressure ulcer

• Rehabilitation Potential
  – Falls
  – ADL’s

  » RAI Manual 4-7
Documentation of CAA

• PCR
  – Problem description
  – Causes and contributing factors
  – Risk factors related to the care area
CAA & Care Planning Documentation Criteria

- Nature of issue/condition
- Causes, contributing risk factors, complications
- Need for referrals and/or further evaluation
- Consideration factors in developing care plan

  » RAI Manual 4-5
CAA & Care Planning Documentation
Criteria

• May occur anywhere in medical record
  – RAI Manual Page 4-7

• Resources used – Facilities may have written policies/protocols/standards of practice

• Appendix C – Sample of web based resources

  » RAI Manual 4 6-7
Sample CAA

- **P: Carol is on antipsychotic**
- **C: See Behavior Team report 9/22/13 regarding behaviors and GDR progress. No adverse SE noted. Carol does have heart disease**
- **R: Risk of side effects such as: sedation, falls, increase cardiac problems, weight loss**
Behavior Team Report

• Carol was admitted to the facility on Risperdal 2.5 mg bid. At previous facility physical & verbal aggression (hitting at staff, & verbally abusive during personal care) was noted on a daily basis. Since admission this behavior has occurred 4-6 days a week but not daily. The short term goal is to reduce the behavior to 1-3 days a week to be reviewed in 1 month & long term goal is no further behaviors in 3 months.
Behavior Team Report

• GDR to be initiated after one month
• See care plan for non-pharmacological approaches
• Social Service to interview family for life history & communicate findings to rest of team & initiate care plan interventions as appropriate
Sample CAA: Delirium

• Problem: Mrs. M’s BIM score has decreased from previous assessment.

• Causes: Low grade fever, multiple medical diagnoses including CHF, CVA, hypothyroid, and anemia. Recent hospitalization with surgery.

• Risk factors: Increased confusion may interfere with providing care, and put Mrs. M at risk for further injury such as another fall, skin breakdown, weight loss, etc.
Sample CAA: Cognitive Loss

• Mrs. M does show signs of delirium, see Delirium CAA 12/30/10. She does have a history of a CVA with new onset of changes in behavior in inattention and altered levels of consciousness. Her PHQ-9 also shows an increase in depression from her previous assessment. Medically she does have a thyroid disorder, ASHD, Hx of MI and GI Bleed/Ulcer, CHF, SOB with activity and inability to lie flat, and depression. Pain control has also been an issue since readmission but better participation noted in therapy over the last several days. Due to her recent surgery she does require more assistance with her ADL’s. In the last week she has also had several environmental changes between the hospital and the nursing home which may also impact her cognition. Speech therapy to see. Will care plan to minimize further decline and to possibly improve her cognitive ability with continuity of care and pain management.
Sample CAA: ADL Decline & Falls

- See PT eval 12/21/10 and OT eval 12/21/10
- Vision/Communication CAA 12/30/10 and Urinary incontinence CAA dated 12/30/10
- Mrs. M triggered for the above CAAs due to her need for limited to extensive assistance with ADLs and a recent fall resulting in a fracture. PT and OT have addressed recommendations for Mrs. M’s ADL status.
- In addition to a recent history of falls, Mrs. M is at fall risk due to possible medication side effects, urinary incontinence; weakness requiring limited to extensive staff assist at times because of fatigue, and sensory deficits. Medications that contribute to fall risk include Prozac, Bumex, Calan, NTG (PRN) and Digoxin. Pharmacy review to be done per facility protocols to determine further recommendations at this time. Urinary incontinence is related to urgency secondary to diuretics and is likely to be exacerbated by recent catheter insertion.
CAA Tips & Clarifications

• It is **NOT** necessary to always review and document findings on subsequent assessments the way performed on the initial assessment...but you must validate that the status has not changed as compared to the initial assessment
  » RAI Manual 4-12

• Upon admission an initial plan of care needs to be implemented

• Annual and SCSA the care plan can be updated with the new information and does not have to be rewritten
  » RAI Manual 4-12

• The RAI will not identify every conceivable problem
  – Ex: “chewing problem” = no CAA but do we need to care plan? It depends on the resident
Care Plan

• PROBLEM
  – Confusional state characterized by disorientation, environmental awareness, behavior r/t progression of disease processes associated with Alzheimer’s

• GOALS
  – Respond to questions or statement with appropriate verbalization
  – Show positive interest in activities
  – Bases statements/behavior in reality

• INTERVENTIONS
  – Observe/report changes in mental status
  – Encourage participation in activities
  – Reality orientation/verbal reminders during care
  – Encourage loved ones visitation
What is a Care Plan?

• Written Communication
• Paints picture of resident
• Foundation for care/treatment
It’s the resident’s care plan

Does the facility know who their residents are ???
Video

• [http://www.youtube.com/watch?v=cDDWvj_q-o8&feature=youtu.be](http://www.youtube.com/watch?v=cDDWvj_q-o8&feature=youtu.be)
The Key is....

It takes a team!!!
Who Should Be Involved?

- Interdisciplinary team
- Resident
- Resident’s family
- Surrogate or
- Representative
RAI – Care Plans

• Cost-effectiveness
• Staffing needs
• Legal documentation
• Team evaluation
• Guides surveyors
RAI – Care Plan

• The care plan is the ultimate product of the RAI process...start with the MDS, progress to CAAs, result is the plan of care

• The care plan is designed as a COMMUNICATION TOOL to all staff about care needs for the resident

• Important to think of the resident as a whole person...remember this is ONE resident with ONE plan of care that is made up of various problems/goals/approaches
How did we get where we are?

In the beginning:
• Direct descendent from hospital care plans
• Handwritten or typed using carbon paper
• “Nursing Care Plan” – directed medical care
• Nursing Diagnoses – “professionals only”
  – Non-descriptive list of care tasks
• Advent of the computer
• OBRA 87
• HIPAA
Changing the Culture of Care Planning

• 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 of Care Planning

• 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 valuable part of team and present at each care plan conference
  – Care conference scheduled at resident and family convenience
General Care Planning Areas

- Functional Status
- Rehabilitation/Restorative nursing
- Health Maintenance
- Discharge Potential
- Medications
- Daily care needs

» RAI Manual 4-14
RAI – Care Plans

Interdisciplinary care conference

• Assimilate data

• Pool ideas to ID problems/needs/strengths

• Determine long/short-term goals with resident

• Determine actions to meet goals
Traditional Before Care Plan

• Problem
  – Wanders due to dementia

• Goal
  – Resident will not wander into other rooms
Traditional Care Plan Interventions

• Redirect resident to appropriate areas of the facility
• Praise for cooperation
• Teach resident not to enter rooms with sashes across door
• Encourage resident to sit in lounge and other common areas
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.
Sample Care Plan

• 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 along. He and his wife raised 11 children. Joe owned a hardware store and was a respected businessman in town.
Resident Directed Care Plan

• Needs
  – I need to walk

• Goal
  – I will continue to walk freely throughout my home
Approaches

• 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 6 am and 8 pm
- Administer insulin as ordered
Resident Directed Care Plan

• 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.
Approach

• Please provide me with a regular diet (Follows recommendations from New Dining Standards). Ask me prior to each meal what I would like. Honor my requests. Daily arguments about food will anger me. Check my blood sugar fasting twice weekly and Hgb A1-C every 3 months. Administer my insulin as ordered
Carol’s Care Plan

- Problem: Carol is both physically and verbally abusive during personal care 4-6 days per week
- Goal:
  - Short term: Behaviors are noted 1-3 days per week (1 month)
  - Long Term: Behaviors no longer occur (3 months)
Carol’s Care Plan

• Carol’s Story: Carol worked in LTC for 25 years doing the MDS. She has 3 daughters who visit when they can, although Carol sometimes forgets they have come to visit which upsets her. She raised cocker spaniels for many years
Care Plan Interventions

• Interventions
  – Carol likes to sleep in, do not awaken before 9 AM
  – Carol prefers her showers before breakfast of yogurt and a granola bar
  – Known behavior triggers:
    • Moving arms too quickly which causes pain
    • Looking for daughters
  – When she becomes upset
    • Ensure her safety and leave the room and return in 5-10 minutes
Care Plan Interventions

• Redirection suggestions
  – Take her to see Duke (facility dog)
  – Play “Jersey Boys” music
  – Talk about her sewing and quilts
  – Offer a snack of chocolate or a popsicle
  – Gently rub her shoulders
  – Assist to recliner
Care Plan Interventions

- Carol is on a pill for her behaviors, let the nurse know if you see any of the following side effects: tremors, facial twitching, jerking of the arms or legs, difficult to arouse
MAR

• Risperdal 2.5 mg upon arising and at supper
Behavior Monitoring Sheets

• Physical aggression

• Verbal outbursts
The Care Planning Process

• Can we apply common sense to this process?
Goals of Care Planning

• MDS identified actual or potential problem areas
• CAA process provides further assessment of triggered areas
• Important that CAA documentation include causal/unique risk factors for decline/lack of improvement
• Plan of care then addresses these factors
• Goal is to promote resident’s highest practicable level of functioning
• Improvement when possible
  – Maintenance/prevention of avoidable decline
Care Planning Guidelines

- The interdisciplinary team should show evidence in the Care Area Assessment (CAA) summary or clinical record of the following:
  - The resident’s status in triggered CAA 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 CAAs triggered by the MDS.
Care Planning Guides

• 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?
How Does the Facility Know this Information?

- Ask the resident
- Look at the customary routine section of the MDS
- Interview family members
- Interview friends
- Observe the resident with the staff
- Listen to what is being said & discussed with the residents
Orientation of Care Plan

• Preventing avoidable declines in functioning or functional levels
• Managing risk factors
• Addressing resident strengths
• Using current standards of practice in the care planning process
• Evaluating treatment objectives and outcomes of care
• Respecting the resident's right to refuse treatment
• Offering alternative treatments
• Using an interdisciplinary approach to care plan development

» RAI Manual 4-13
Orientation of Care Plan

• Family and other resident representatives need to be involved
• Assuming & planning for care sufficient to meet the care needs of new admissions
• Involving the direct care staff
• Addressing additional care planning areas that could be considered in LTC

» RAI Manual 4-13
General Care Planning Areas

• Functional Status
• Rehabilitation/Restorative Nursing
• Health Maintenance
• Discharge Potential
• Medications
• Daily Care Needs

» RAI Manual 4-14
RAI – Care Plans

Interdisciplinary Care Conference

• Assimilate data
• Pool ideas to ID problems/needs/strengths
• Determine long/short-term goals with resident
• Determine actions to meet goals
MYTH: CNAs cannot have access to the chart or care plan

- FACT:
  - HIPAA does not apply to those who have direct care responsibility for a resident.
  - RAI Manual pp 4-26/27 – “An appropriate care plan results from analysis...based on communication...that is...understood by all team members....ensuring that the entire interdisciplinary team and all ‘hands on’ caregivers are following the same process based upon a common knowledge base.”
  - RAI Manual pg 4-32 – “Direct care staff (e.g., nursing assistants, aides) must be directly involved in the care planning process.” “Direct care staff [not in the formal CP process] must be informed about how the care and services they provide is intended to improve, maintain or minimize decline in the resident’s condition and well-being.
MYTH: Every small detail of care must be on the Care Plan

• Utilize:
  – Standards of Practice (Clinical Practice Guidelines)
  – Facility Care Protocols

• Individualize - what is
  – Different from,
  – In addition to, or
  – Not done
Facility Care Protocols

- Morning routine
- Evening routine
- Peri Care
- What other routines do you have???

Clinical Practice Guidelines

- Turning at least every 2 hours
- Do not rub redden areas
- Post fall monitoring for 72 hours
- What else???
MYTH: If it doesn’t say Care Plan and in one place then it is not a Care Plan

• FACT: Many different items are used as part of the Care Plan.
  – For example:
    • MARs
    • TARs
    • Closet information
    • Notes within the Care Plan Book
    • Kardex

• Fact:
  – Structure of the care plan document is a facility decision
What is a Person Centered Care Plan?

- A Person Centered Plan is a means and not an end
- The life that the resident wants is the outcome, not the plan that describes it
- It’s the process of learning how a resident wants to live
- It describes where the resident wants his or her life to go and what needs to be done to get there
- It emphasizes the goals, desires and dreams of the individual served
TIPS

• How does the facility refer to elders in care plans?
  – For example, does the care plan state: Mrs. Jones is combative at bath time.
  – Or does the care plan state in a more elder 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.
Tips

– Does the care plan state: Mrs. Jones has dementia and wanders throughout the facility.

– Or does the care plan state in a more elder centered way: Sometimes I feel all alone and I forget who you are. I like to walk. At home I walked with my dog Joey. Please walk with me and let’s take Sam, the dog with us. I like looking at and wearing jewelry. I like to rearrange it in my drawers. Please take me to the jewelry chest.
MDS 3.0 = Resident Voice

• Increase resident centered care:
  – Respect for individual
  – Fundamentals to high quality & culture change
  – Residents & Families want care to be individualized & accurate
Person Centered Care

• Staff have a 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
Person Centered Care

• Care plan written in first person “I” format or by name “John”
• Care plan identifies resident’s lifelong routines & how to continue it in the nursing home
• Nursing assistants very valuable part of team & present at each care plan conference
• Care conferences scheduled at resident and family convenience
The care plan must be oriented toward

- Preventing avoidable declines in functioning or functional levels
- Managing risk factors
- Addressing resident strengths
- Using current standards of practice in the care planning process
- Evaluating treatment objectives and outcomes of care
- Respecting the resident’s right to refuse treatment

- RAI Manual 4-13
The care plan must be oriented toward

• Offering alternative treatments
• Using an IDT approach to care plan development to improve the residents’ functional abilities
• Involving family & other resident representatives
• Assessing & planning for care sufficient to meet the care needs of new admission
• Involving the direct care staff with the care planning process relating to the resident's expected outcomes
Mandated CP issues “as based on comprehensive assessment” – (CFR §483.25):

- ADLs
- Pressure sores
- Urinary Incontinence
- ROM
- Mental/Psychosocial functioning
- N-G tubes
- Hydration
- Special needs -
Care Planning List – Special Considerations/Strengths

- Social history
- Memory enhancement & communication
- Mental wellness
- Mobility enhancement
- Safety
- Visual function
- Dental care
- Bladder management
- Skin care
- Nutrition
- Fluid maintenance
- Pain management/comfort
- Activities
- Discharge plan
Discharge Planning

• Is this the resident’s forever home

• OR

• Is there a discharge plan in progress and what is the basic plan: home alone, home with family, hired caregivers, assisted living, etc
Advance Care Planning

• Each facility should have a policy/procedure on determining who is a full code vs. DNR.
• All staff should be aware of where the information is
Measurable Goals

• Problem: Daily crying
  – Goals:
    • Episodes will decrease to 4-6 days but not daily
    • Episodes will decrease to 1 to 3 days
    • No further episodes
Measureable Goals

• Problem: Falls on average of 10 times per month

• Goals
  – No major injury as defined by MDS
  – Reduce average of falls to 5 per month by next quarter
Measurable Goals

• Problem: Pressure Ulcer of R hip
• Goals:
  – Decrease in size by next quarter
  – No signs of infection
  – No slough or eschar on wound bed
Measurable Goals

• Problem: Always incontinent (no episodes of continent voiding)
• Goal: Will void on toilet at least once a day
The Process is to....

• ID Resident’s Strengths, Needs and Problems
• Set Priorities for the Problems
• Determine Realistic Resident Centered Goals
• Specify Tasks to Achieve Goals
Process (cont)

- Establish facility Standards of Care
- Establish policies/procedures to support each standard.
- Teach and re-teach
- Care plan approaches include:
  - deviations from,
  - deletions or additions to established standards.
- Clear, concise documentation
Tips we give to Providers:

• Notify surveyors when you begin the change to a more person centered care plan format.
  – Provide them with pertinent resources

• Develop protocol for regular goal reviews.
  – Include statement at bottom of CP that “All goals will be reviewed and updated as needed every 90 days unless otherwise stated in the individual goal.”
Tips we give to Providers:

• Simplify and individualize the process
• Involve all staff
• Write the resident’s care plan for the CNA (4th grade level)
• Avoid medical terminology
• Develop the entire care plan during the meeting, rather than starting with pre-developed sections.
Practical Thoughts

Medications

- Care Plan
  - Common side effects
  - If seen who does it get reported to

- MAR
  - Actual med
  - Dosage

- POC or MAR
  - Diagnosis

Skin Care

- Care Plan
  - Dressing location
  - Specific interventions
  - Who do they tell if there is a problem

- TAR
  - Dressing specific details
  - Type of medication to be applied to wound
Tips we give to Providers:

• Separate sections for different departments are not necessary or advisable. Rather, focus on how the departments can provide for meeting the identified need(s).

• Urge daily, routine use of care plan by staff

• Remember, the care plan should focus on improving or maintaining the resident’s ability to *function* and how the home can intervene to accomplish that.
Tips we give to Providers:

• Develop staff into teams. Consider the buddy system so elders will be more familiar with care givers.
• Empower staff at all levels. Staff work more effectively if they control work responsibilities.
• Care teams having knowledge of the CAA guidelines will be better prepared to give individualized care and to chart meaningful CAA assessment documentation
Care Plan Meeting Objectives

• Review Diagnoses
• Review for the group any major changes
• Discuss with the resident/family any changes
• Review the QI report Resident Level Summary
• Review triggered CAA sections
• Review the overall care plan
• Obtain signatures on the MDS and care plan
Surveying for Care Plans

• V0200
  – Can you find the CAA documentation where the facility tells you it is located in Section V under “Location And Date Of CAA Documentation”?
    • It is permissible to combine CAAs
  – Does every area triggered in the column V0200A have documentation?
Surveying for Care Plans

- CAAs signature and completion date: RN must sign in V0200B1 and date in V0200B2 that the CAAs were completed
  - For admission assessments: CAAs must be signed by Day 14 (not necessarily same as Z0500B MDS completion date...MDS completion date will be before or same date as CAAs)
  - For annual assessments: CAAs must be signed by 14 days from ARD (again, MDS completion date could be before this and not necessarily same date)
Surveying for Care Plans

• For significant change in status assessments: The CAAs must be completed by 14\textsuperscript{th} calendar day after \textit{determination} that change occurred (again, MDS must be completed by day 14 also, but it will be completed before the CAAs...could be completed on a date before the CAA ...not necessarily same date as CAA
Surveying for Care Plans

- Refer to OBRA Required Assessment Summary for handy tool on when all completion dates are required:
  
  Chapter 2, page 15 and 16 of RAI Manual
Surveying for Care Plans

• V0200C Care Plan Decision Date must be signed by the person completing the care plan decision (does not have to be an RN)
  – Must be signed by 7 days after the CAAs completion date
Surveying for Care Plans

• The Care Plan:
  – Is there a care plan for each CAA the team said they would develop a care plan for (those with a “yes” in decision column V0200A)?
  – Does each care plan area state the
    • Problem/need
    • *Measurable* goal
    • Intervention
Surveying for Care Plans

• Does the care plan show:
  – Initial signature and dates of the IDT and then the review signatures and dates?
  – Appropriate review/revision of goals and interventions?
  – That the resident/family provided input (or not?)
Surveying for Care Plans

• Through observation, interview and record review determine if the facility’s assessment of the resident *coincides* with the information gathered

DOES THE CARE PLAN MAKE SENSE WITH WHAT YOU ARE SEEING, HEARING AND THE MEDICAL RECORD SHOWS?
Surveying For Care Plans

• In Summary:
  – Determine if the facility used the CAA process in developing an individualized care plan for the resident
  – Determine if the care plan states the appropriate needs, goals and interventions.
  – Evaluate if the resident’s care plan is consistently implemented by all personnel at all times of the day, and assess through interviews and record review the resident’s response to care provided
Surveying for Care Plans

– Confirm that the facility evaluates the effectiveness of the goals and interventions identified for the resident and that changes or revisions are made as necessary and appropriate
• Interpretive Guidelines
  – The resident’s status in triggered CAA areas
  – The facility’s rationale for deciding whether to proceed with care planning
  – Evidence that the facility considered the development of care planning interventions for all CAAs triggered by the MDS
F279

• Consider a citation when there is not adequate documentation of CAAs
• Consider a citation when goals/objectives are not measurable
• Consider a citation when timetables (dates) are not met for completion
F279

• Consider a citation when the care plan does not match what you observe
• Consider a citation when the care plan does not reflect standards of current professional practice
F280

• Interpretive guidelines
  – IDT works together to provide the greatest benefit to the resident
  – Physician is part of the IDT but does not have to attend CP meetings (alternate methods: one-on-one discussions and conference calls)
  – Facility has a responsibility to assist residents to participate
  – The resident has the right to refuse treatment
F280

- Consider a citation when the resident was not allowed (invited) to participate in care planning
- Consider a citation when not developed within 7 days after the comprehensive assessment
- Consider a citation when not prepared by an IDT team (no signatures or dates)
- Consider a citation when not periodically (every quarter) reviewed and revised
F281

• Consider a citation when care plan was not implemented
• Interpretive guidelines:
  – The discharge planning process includes:
    • Assessing continuing care needs and developing a plan designed to ensure the individual’s needs will be met after discharge from the facility into the community
There is no requirement as to where the post discharge plan of care needs to be written; however, it makes sense to put it with the care plan.
F284

- Consider a citation when the facility did not do a *discharge assessment*
  - Also F278 and F287
  - Is it used to develop the discharge plan?
- Consider a citation when there is no evidence that the facility helped to make arrangements for a *planned discharge*
  - Medications
  - Contacted home health
  - Education of resident and family
F284

- Consider a citation when the resident has answered “yes” to Section Q0500 “Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community” but the facility did not make the referral.
F284

• Surveyors need to understand that if *no active discharge planning* is occurring (QO400) then the facility must proceed to ask the resident (or guardian/invoked DPOA) *on every comprehensive assessment* if they want to talk to someone about options

• The expectation is that if the resident (or guardian/invoked DPOA) wants to talk to someone, then the facility must make the online referral
Conclusion

• The care plan is for and about the resident
• The care plan must be individualized in order to capture the resident’s voice and preferences
• The care plan is a communication tool
• Through observation, interview and record review the surveyor must determine if the care they are seeing and hearing matches what the care plan says and if the facility is providing the highest Quality of Care and Quality of Life
Suggested Resources

• RAI User’s Manual, Chapter 4
• CAA General Resources, RAI Manual Appendix C-1-84
• AHRQ Clinical Practice Guidelines
  – www.guideline.gov
• AMDA Guidelines - www.amda.com
• NPUAP (Nat’l Pressure Ulcer Advisory Panel) www.npuap.org
• Pioneer Network: http://pioneernetwork.net
• Eden Alternative: http://edenalt.com
• Nursing Home Help: www.nursinghomehelp.org
• State Operations Manual, Appendix PP
State MDS Unit Contacts

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