Care Plans…

The Instruction Manual

OBJECTIVES

- Participants will verbalize an understanding of the intent and probes for F279 and F280
- Participants will verbalize an understanding of the purpose of a comprehensive, individualized care plan
- Participants will verbalize an understanding of the steps of the care plan process
- Participants will verbalize an understanding of recent survey findings for F279 and F280 in Kansas re-surveys

F279 Comprehensive Care Plans

- Facility must use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care
  - Develop CP 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 including:
    - Services that are to be furnished to attain or maintain resident's highest practicable physical, mental & psychosocial well-being
    - Any services that would otherwise be required but are not provided due to resident's exercise of rights including right to refuse treatment

F279

- Interdisciplinary team, IN CONJUNCTION WITH THE RESIDENT, RESIDENT'S FAMILY, SURROGATE OR REPRESENTATIVE AS APPROPRIATE, should develop quantifiable objectives for highest level of functioning the resident may be expected to attain based on comprehensive assessment
- Evidence must be present in CAA summary or clinical record:
  - Resident's status in triggered CAA areas
  - Facility's rationale for deciding whether to proceed with care planning
  - Evidence that facility considered development of care planning interventions for all CAAs triggered by MDS

F279 Probes

- Does the CP address the needs, strengths & preferences identified in the comprehensive assessment?
- Is the CP oriented toward preventing avoidable declines in functioning or functional levels?
- How does the care plan attempt to manage risk factors?
- Does the CP build on resident strengths?
- Does CP reflect standards of current professional practice?
- Do treatment objectives have measurable outcomes?
- Has facility provided adequate information to res so resident able to make an informed choice of treatment?
- If resident refused treatment, does CP reflect facility's efforts to find alternative means to address problem?

F280 Resident Participation in Care Plans

- Resident has right to-unless adjudged incompetent or otherwise found to be incapacitated under law, participate in planning care and treatment or changes in care and treatment
  - Resident is afforded opportunity to select from alternative treatments
  - Impaired resident must be kept informed & be consulted on personal preferences
  - If conflict between resident's right and resident's health or safety, determine if facility attempted to accommodate both exercise of resident rights and resident's health, including exploration of care alternatives through thorough care planning process including resident participations

F280 Requirements

- Comprehensive care plan must be:
  - Developed within 7 days after completion of the comprehensive assessment
  - Prepared by interdisciplinary team that includes attending physician, a registered nurse with responsibility for resident, and other appropriate staff in disciplines as determined by resident's needs with participation of resident, resident's family or legal representative
  - Periodically reviewed and revised by team of qualified persons after each assessment

F280 Probes

- Was interdisciplinary expertise utilized to develop plan to improve resident's functional abilities?
  - Is there evidence of physician involvement in development of care plan?
    - Presence at care plan meetings, conversations with team members about care plan, conference calls
- In what ways do staff involve residents & family members in care planning?
- Do staff make an effort to schedule meetings at best time of day for residents and family members?
- Is Ombudsman involved?
- Do staff attempt to make process understandable to resident/family?
- Did residents get questions answered adequately?
- Is care plan evaluated and revised as the resident's status changes?

How Do We Get It Right?

- Thorough……but brief enough to be useful
- Comprehensive
- Individualized
- Current
- Comply with standards of practice and regulations

Purpose-Organized Instruction Manual of Care and Services of Individual Resident

- Care plan creates an organized approach to meeting the resident's needs
- "Organizing is what you do before you do something, so that when you do it, it's not all mixed up."- A.A.Milne
- Staff working without a plan can easily get care processes mixed up or miss important issues critical to successful care of the physical, mental, and emotional health of the resident
- There is no prescribed format, only required types of information in a care plan
- EVERY care plan will be different, reflecting the individual needs and personality of the resident
  - It's a problem for care plan libraries

Goals of a care plan

- Care plan is driven by resident's unique characteristics, strengths & needs
- Preventing avoidable declines
- Managing risk factors
- Preservation of resident's strengths
- Use current standards of practice
- Evaluate treatment of measurable goals, timetables & outcomes
- Respect resident's right to refuse interventions
- Offer alternative and education as needed
- Use entire interdisciplinary team approach
- Involve the resident & family
- INVOLVE DIRECT CARE STAFF

Overall care plan approaches

- Look at each resident as unique with strengths
- Include distinct functional areas of each resident to gain knowledge about functional status
- Give the entire IDT a common understanding of resident
- Identify possible unique issues/needs of each resident
- Provide clarity of potential issues/conditions by addressing causal factors
- Based on assessment information
- Reflect resident/representative input & goals
- Focus on "highest practicable level of well-being"
- Evaluate and re-evaluate routinely
- Revise as changes occur
- COMMUNICATE, COMMUNICATE, COMMUNICATE with resident, representative, direct care staff about resident

What should be included in a Care Plan Problem?

- Must include "focus", "problem"
- Objectives, goals with reasonable MEASURABLE timetables CONSISTENT WITH THE GOALS OF THE RESIDENT/RESPONSIBLE PARTY
- Comprehensive, individualized interventions, approaches

Recognition and Assessment

- Identify & collect information that is needed to identify an individual's conditions that enables proper definition of conditions, strengths, needs, risks, problems, and prognosis
- Obtain personal and medical history
- Perform physician assessment

Assessment-The Care Plan Foundation

- For facility to develop a well-founded care plan, resident's condition must be established-MUST INCLUDE RESIDENT & FAMILY INTERVIEWS
- The MDS is only the starting place; the MDS does not constitute the entire assessment needed to address all issues to manage the care of individual residents
  - Bowel & bladder control
  - Nutritional issues, chewing, swallowing issues
  - Activities of daily living functionality
  - Psychosocial needs, interests, prior routines
  - Hearing, speech, vision, dental/oral issues
  - Health conditions
  - Comprehension and thought process
  - Mental health status
  - Special treatment procedures
  - Rehab potential
  - Pain
  - Fall risks
  - Skin condition
  - Advance directives
  - Medication review/assessment
  - Mood, behaviors, & cognition
  - Etc, etc, etc

Problem Definition

- Define the resident's individual problems, risks and issues
  - Identify any current consequences & complications of the resident's situation, underlying conditions & illnesses
  - Clearly state the resident's issues & physical, functional & psychosocial strengths, problems, needs, deficits & concerns
  - Define significant risk factors

Identification of Causal Factors

- Identify causes of and factors contributing to the resident's current dysfunctions, disabilities, impairments and risks
- Identify pertinent evaluations and diagnostic tests
- Identify how existing symptoms, signs, diagnoses, test results, dysfunctions, impairments, disabilities & other findings related to one another
- Identify how addressing those causes is likely to affect consequences

The CAA Process Framework

- Consider each resident as a whole, with unique characteristics and strengths that affect the resident's ability to function
- Identify areas of concern that may warrant interventions
- Develop interventions to improve, stabilize or prevent decline in physical, functional & psychosocial well-being, in the context of the resident's condition, choices, & preferences for interventions
- Address the need & desire for other important considerations including advance care planning & palliative care including symptom relief & pain management

Identifying Goals and objectives of care

- Clarify purpose of providing care & of specific interventions & the criteria that will be used to determine if the objectives are being met
  - Clarify the prognosis
  - Define overall goals for the resident
  - Identify criteria for meeting goals

Measurable Goals

Measurable Verbs (Use)

- Identify
- Describe
- Perform
- Relate
- State
- List
- Verbalize
- Communicate
- Hold
- Demonstrate
- Stand/sit
- Share
- Express
- Will loose
- Will gain
- Has absence of
- Exercise
- Cough
- Walk

Non Measurable Verbs (Do not use)

- Know
- Understand
- Appreciate
- Think
- Accept
- Feel
- Appear

Selecting interventions and plan care

- Identify & implement interventions & treatments to address the resident's physical, functional, and psychosocial needs, concerns, problems & risks
  - Specify individualized interventions including physical, functional & psychosocial interventions based on identified causal factors of the needs
  - Identify how current & proposed interventions & services are expected to address causes, consequences & risk factors & help attain overall goals for the resident
  - Define anticipated benefits & risks of interventions
  - Clarify how specific treatments & services will be evaluated for effectiveness & possible adverse consequences

Monitoring of progress

- Review resident's progress towards goal(s) & modify approaches as needed
  - Identify resident's response to interventions & treatments
  - Identify factors that are affecting progress towards achieving goals
  - Define or refine the prognosis
  - Define or refine when to stop or modify interventions
  - Review effectiveness & adverse consequences related to treatments
  - Adjust interventions as needed
  - Identify when care objectives have been achieved

The Care Plan Meeting

- Residents have the right to make choices about care, services, daily schedule and life in the facility and to be involved in the care planning meeting
- PARTICIPATING IS THE ONLY WAY TO BE HEARD
- During the meeting:
  - Discuss options for treatment, needs, preferences and prior routines
  - Encourage the resident and family to ask questions
  - Make sure the resident and family understand and agree with the care plan & feel it meets their needs
  - Encourage the resident & family to ask questions after the care plan meeting

Access to the Care Plan

- Part of the clinical record
- Resident has the right to limit access by others to both the care plan and the care plan meeting
- Who "needs to know" care plan information?
  - EVERYONE who provides any care or services to the resident
  - Not only need access but need to read contents of the care plan…how can someone provide care without knowing the interventions included in the care plan?
  - Let's talk about CNA care plans, "jot sheets" "cardex", etc…
    - What's included?
    - What's not included?
    - What are the barriers to getting the information to the staff who need it?
      - Time
      - Language
      - Staff-empowerment to understand the need

Recent F279 Findings

- Failed to develop CP for unnecessary meds & catheter use
- …bruising, catheter needs, pressure ulcers
- …alternatives for refusing bathing
- …behaviors, coordination of hospice
- …dialysis, urinary incontinence, anxiety
- …constipation, weight loss
- …wake & sleep times, cognitive impairment, current interests
- …bathing preferences, shaving & nail care instructions, dental status/oral care
- …activity preferences
- …elopement risk & interventions
- …restorative program, devices
- ...restraints (perimeter mattresses, side rails)

Recent F280 Findings

- Failed to revise care plans for falls, weight loss, pressure ulcers
- …fluid restriction, incontinence (how often, incontinence products used), supplements recommended
- …accidents with bruising & skin tears
- …medication changes
- …chronic skin conditions
- …spiritual/emotional support during end of life & integration of hospice services
- …ER visit interventions
- …ophthalmology recommendations/conditions
- …post op interventions
- …repositioning

A "Good" Care Plan

- Be specific, individualized and written in common language that everyone can understand
- Reflect resident's concerns and support resident's well-being, functioning and rights; not label resident's choices or needs as "problem behaviors" or "non-compliant"
- Use a multi-disciplinary team approach and use outside referrals as needed
- Be revised and re-evaluated continuously to ensure it is current and timely
- Tell the resident's story…the whole story

Thank you for all you

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