The Surveyor's Approach to Care Planning

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You are going to come and live with me for the rest of your life. I am going to take care of you.

What are 5 things that you would want me to know about you? Make a list.

What does CMS say?

F656 – Develop/Implement Comprehensive Care Plan

(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 time*frames* 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 —

What does CMS say?

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 483.24, 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(b)(4).

What does CMS say?

The care plan must describe the following:

(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.

What does CMS say?

The care plan must describe the following: (all new…)

(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.

What does CMS say?

- ✓ In addition to addressing preferences and needs assessed by the MDS, the comprehensive care plan must coordinate with and address any specialized services or specialized rehabilitation services the facility will provide or arrange as a result of PASARR recommendations.
- ✓ If the IDT disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. The rationale should include an explanation of why the resident's current assessed needs are inconsistent with the PASARR recommendations and how the resident would benefit from alternative interventions.
- ✓ The facility should also document a resident's the resident's preference for a different approach to achieve goals or refusal of recommended services.

What does CMS say?

- "Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline.
- Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

What does CMS say?

- 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.

What does CMS say?

- 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).

What does CMS say?

- 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.

What does CMS say?

- 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.
- When developing the comprehensive care plan, facility staff must, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services.

What does CMS say?

- In situations where a resident's choice to decline care or treatment (e.g., due to preferences, maintain autonomy, etc.) poses a risk to the resident's health or safety, the comprehensive care plan must identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate.
- The facility's attempts to find alternative means to address the identified risk/need should be documented in the care plan.

What does CMS say?

F657 Care Plan Timing and Revision

(i) Developed within 7 days after the 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.

General Critical Element Pathway

Observations Across Various Shifts:

- Does staff consistently implement the care-planned interventions? If not, describe.
- Ensure interventions adhere to professional standards of practice.
- What is the resident's response to interventions? Is the resident's response as intended?
- Do observations of the resident match the assessment? If not, describe. Are there visual cues of psychosocial distress and harm?

General Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- Will you describe your current condition or history of the condition, or diagnosis?
- How did the facility involve you in the development of the care plan and goals?
- How effective have the interventions been? If not effective, what alternate approaches have been tried?
- What are your goals for care? Do you think the facility is meeting them? If not, why do you think that is?
- For newly admitted residents, did you receive a summary of your (or the resident's) baseline care plan? Did you understand it?

General Critical Element Pathway

Staff Interviews (Nursing Aides, Nurse, DON, Therapist, Attending Practitioner):

- Will you describe specific interventions for the resident, including facility-specific guidelines/protocols?
- How, what, when, and to whom do you report changes in condition?
- How does the interdisciplinary team monitor for the implementation of the care plan and changes in condition?
- How is information passed across shifts, and between all disciplines?

General Critical Element Pathway

Staff Interviews (Nursing Aides, Nurse, DON, Therapist, Attending Practitioner):

- How are revisions to the comprehensive care plan communicated to staff?
- How was it determined that the chosen interventions were appropriate?
- Did the resident have a change in condition that may justify additional or different interventions?
- How does staff validate the effectiveness of current interventions?

General Critical Element Pathway

Record Review:

- Review relevant information such as medication and treatment administration records, interdisciplinary progress notes, and any facility-required assessments that may have been completed. Does the information accurately and comprehensively reflect the resident's condition? If not, describe.
- Are federally required RAI/MDS assessments completed according to required time frames?
- For newly admitted residents, is there a baseline care plan, and does it describe the instructions necessary to meet the resident's immediate needs? Does it address the resident's clinical and safety risks?

General Critical Element Pathway

Record Review:

- Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, preferences, and behaviors? Does it include goals for admission, measureable objectives, timetables, and desired outcomes? How did the resident respond to care planned interventions? Was the care plan revised if interventions weren't effective, the desired outcome was achieved, or if there was a change in condition?

General Critical Element Pathway

Record Review:

- Is there evidence of resident or resident representative participation in developing resident-specific, measureable objectives, and interventions? If not, is there an explanation as to why the resident or representative did not participate?
- Is there evidence that the resident has refused any care or services that would otherwise be required, but are not provided due to the resident's exercise of rights, including the right to refuse treatment? If so, does the care plan reflect this refusal, and how has the facility addressed this refusal?

General Critical Element Pathway

Record Review:

- Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

General Critical Element Pathway

Record Review:

- Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

CMS Requirement - F655

- 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:
  - Be developed within 48 hours of a resident's admission.
  - Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
    - ✓ Initial goals based on admission orders.
    - ✓ Physician orders.
    - ✓ Dietary orders.
    - ✓ Therapy services.
    - ✓ Social Services.
    - ✓ PASARR recommendations, if applicable.

CMS Requirement - F655

- The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—
  - ✓ Is developed within 48 hours of the resident's admission.
  - ✓ Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

CMS Requirement - F655

- Considerations for NOT doing this…
  - ✓ The resident you see within the first 48 hours is NOT going to be the resident you see 21 days later.
  - ✓ Resident interviews can be negatively impacted when doing them within the first 48 hours: specifically the PHQ9, BIMS, and Section F of the MDS 3.0.
  - ✓ Any significant changes would require an immediate update of both the MDS 3.0 and the Comprehensive Care Plan

CMS Requirement - F655

- The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
  - ✓ The initial goals of the resident.
  - ✓ A summary of the resident's medications and dietary instructions.
  - ✓ Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
  - ✓ Any updated information based on the details of the comprehensive care plan, as necessary.

Considerations…

- Discuss format of Baseline Care Plan with software vendor. If care plans are handwritten, ensure required components are addressed.
- Assign IDT accountability, with backup, for portions of the baseline care plan. Items to take into consideration:
  - ✓ Size of community
  - ✓ Number of admissions/readmissions
  - ✓ Staff available and competent to formulate required portions of plan.
  - ✓ Who should be responsible for obtaining resident's stated goals and objectives?
  - ✓ Who will formulate social services, therapy, dietary portion of care plan if those IDT members are not available within 48 hours (weekend admissions)? (BCP can be begun prior to admission as long as findings are verified upon admission.)
  - ✓ Who will be responsible for providing the written summary of the baseline care plan?

Surveyor Guidance

- Health information and services must be provided in ways that are easy for the resident and/or the resident's representative to understand. This includes, but is not limited to:
  - ✓ communicating in plain language,
  - ✓ explaining technical and medical terminology in a way that makes sense to the resident,
  - ✓ offering language assistance services to residents who have limited English proficiency, and
  - ✓ providing qualified sign language interpreters or auxiliary aids if hearing is impaired.
  - ✓ This does not mean that a facility is required to supply and pay for hearing aids.

Surveyor Guidance

- The physician or other practitioner or professional must inform the resident or their representative in advance of treatment risks and benefits, options, and alternatives.
- The information should be communicated at times it would be most useful to them, such as when they are expressing concerns, raising questions, or when a change in treatment is being proposed.
- The resident or resident representative has the right to choose the option he or she prefers.

Surveyor Guidance

- Care Plans should provide instructions for the provision of effective and person-centered care to each resident.
- This means that 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.

Surveyor Guidance

- 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.

Surveyor Guidance

- The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address:
  - ✓ resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and
  - ✓ would identify needs for supervision,
  - ✓ behavioral interventions, and
  - ✓ assistance with activities of daily living, as necessary.

Surveyor Guidance

- Baseline care plan must reflect the resident's stated goals and objectives, and include interventions that address his or her current needs.
- 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.
- Since this is an interim document, 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 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.
- Since the baseline care plan is developed before the comprehensive assessment, it is possible that the goals and interventions may change.
- Those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable.

Baseline Care Plan Summary

- As the resident remains in the nursing home, additional changes will be made to the comprehensive care plan based on the assessed needs of the resident, however, these subsequent changes will not need to be reflected in the summary of the baseline care plan.
- Once the comprehensive care plan has been developed and implemented, and a summary of the updates given to the resident, the facility is no longer required to revise/update the written summary of the baseline care plan.

Make certain…

- Does the BCP include, at a minimum:
  - ✓ Initial goals based on admission orders
  - ✓ All physician orders, which includes medications and administration schedule
  - ✓ Dietary orders
  - ✓ Therapy services
  - ✓ Social services
  - ✓ PASARR recommendation(s), if PASARR was completed

Make certain…

- Are the discharge needs of the resident identified (that help develop the discharge plan)?
- Is it completed within 48 hours of admission?
- Did resident (and their representative) receive at least the summary of the Baseline Care Plan that included:
  - ✓ The initial goals of the resident
  - ✓ A summary of the resident's medications and dietary instructions
  - ✓ Any services and treatments to be administered by the facility and personnel acting on behalf of the facility
  - ✓ Any updated information based on the details of the comprehensive care plan, as necessary

BCP Considerations for Inclusion

- What was resident admitted for?
  - ➞ Skilled services due to post-surgery? Others?
  - ➞ LTC due to safety, require daily nursing care?
  - ➞ Disease/illness management?
- Admission goals? (Need to be stated in "specifics.")
  - ➞ Participate in treatment for ____?
  - ➞ Participate in therapy for ____?
  - ➞ Display progress in ____?

BCP Considerations for Inclusion

Disease/Illness Management (Examples…)

- Diabetic
- Hypertension
- Post-surgical care
- Respiratory
- Pain
- Quadriplegia
- Weight Loss
- Nutrition
- Alzheimer's/Dementia
- Post CVA
- Infection
- Wound/Pressure Injury
- Psych Med
- Psychiatric Illness

BCP Considerations for Inclusion

- ADLs - Problems/Needs
  - Requires assistance
    - ✓ Grooming
    - ✓ Hygiene
    - ✓ Toileting
    - ✓ Bathing
    - ✓ Dressing
    - ✓ Eating

BCP Considerations for Inclusion

- Dietary
  - Tube Feeding
  - Regular Diet
  - Mechanical Diet
  - Therapeutic Diet
  - NAS
  - NCS
  - Other

BCP Considerations for Inclusion

- Physician's Orders
  - CPR, DNR, Advanced Directive
  - Admitting Diagnosis
  - Allergies
- Order for Therapy
  - PT, OT, ST, RT
- Order for Dietary
  - Regular, Mechanical Soft, Pureed, Bland, Renal, Thicken liquid, etc.

BCP Considerations for Inclusion

- Order for Activity/Mobility/Labs:
  - Activity/Mobility: bed rest, up ad lib, up with assistance, weight bearing, as tolerated, comfort/end of life care, etc.
  - Labs: CBC, Chemistry panel, Metabolic panels, EKG, Finger stick, etc.

BCP Considerations for Inclusion

- Order for Special Nursing Care:
  - Oxygen therapy, immunizations, TB test, PEG tube, Ostomy, Tracheostomy, Colostomy, Foley catheter, etc.
- Order for Medications
  - Medications, dosage, route, frequency, diagnosis

BCP Considerations for Inclusion

- Safety Care:
  - Fall
  - Elopement/Wandering
  - Ambulation
  - Transfer
  - Balance
  - Locomotion
  - Using brace/splint
  - Using mobility device
  - Others

BCP Considerations for Inclusion

- Psychosocial Well-Being Care:
  - Sad/crying
  - Aggression
  - Resists care
  - Verbal abuse
  - Physical abuse
  - Agitation
  - Combative
  - Blind
  - Deaf
  - Non-English
  - Confused
  - Sexual Inappropriate
  - Others

BCP Considerations for Inclusion

- Medically-related social needs:
  - Advocating/assisting in assertion of rights
  - Grievances - treatment, living conditions, visitation rights, accommodation of needs
  - Communication needs
  - Clothing/personal items
  - Education regarding healthcare
  - Referrals to outside entities
  - Transitions of care
  - Counseling
  - Preferences/choices
  - Advance Care Planning
  - Others

Surveyor/Compliance

- Was the baseline care plan developed and implemented within 48 hours of admission to the facility?
- Does the resident's baseline care plan include:
  - ✓ The 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;
  - ✓ PASARR recommendations, if applicable; and
  - ✓ Therapy and social services.

Surveyor/Compliance

- Was the baseline care plan revised and updated as needed to meet the resident's needs until the comprehensive care plan was developed?
- If the resident experienced an injury or adverse event prior to the development of the comprehensive care plan, should the baseline care plan have identified the risk for the injury/event (i.e., if risk factors were known or obvious)?

Surveyor/Compliance

- Did the facility provide the resident and his or her representative, if applicable, with a written summary of the baseline care plan that contained at least, without limitation:
  - ✓ 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; and
  - ✓ Any updated information based on details of the admission comprehensive assessment.

Areas of Survey Focus

- Physical/Medical Care
- Pain
- Palliative/End of Life/Hospice
- Behavior
- Cognitive losses/impairments
- Resident Choices
- Communication
- Psychosocial Well-Being
- Activities
- Symptoms of Depression
- Risks (Falls, accidents, elopement, etc.)

Physical/Medical Care

- Skin conditions, e.g., excessive dryness, wetness;
- Skin tears, bruising, or evidence of fractures that warrant investigation;
- Dehydration risk factors including availability of water for most residents, and other indicators or factors, e.g., the amount and color of urine in tubing and collection bags, dependence on staff, the presence of strong urinary odors, and resident complaints of dry mouth and lips;

Physical/Medical Care

- Clinical signs such as edema, emaciation and contractures;
- Functional risk factors such as poor positioning and use of physical restraints;
- Side effects of antipsychotic drug use such as tardive dyskinesia, e.g., lip, tongue or other involuntary abnormal movements;

Physical/Medical Care

- Presence or prevalence (numbers) of infections including antibiotic resistant strains of bacteria (e.g., Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), Clostridium Difficile (C-Diff) or other infections: Urinary tract infections, draining wounds, eye infections, skin rashes (especially if spreading, undiagnosed, and/or not responding to treatment), respiratory infections, gastroenteritis including diarrhea, etc.

Physical/Medical Care

- Pressure sores, old scars from pressure sores or evidence of surgical repair of pressure sores;
- Amputation;
- Significant weight loss;
- Feeding tubes and/or improper positioning while feeding is infusing; and
- Ventilators, oxygen, or intravenous therapies.

General

- Review the care plan to identify whether the facility used the RAI to make sound care planning decisions.
- Determine whether the facility identified resident strengths, needs, and problems which needed to be addressed to assist the resident to maintain or improve his/her current functional status.
- Determine whether the facility identified resident-centered, measurable goals and specific interventions to achieve those goals.

General

- With observations, interviews, and record review, determine if the facility implemented the interventions defined; and
- Determine whether the facility documentation and resident status as observed indicate the decision to proceed or not to proceed to care planning was appropriate.
- This information will assist in determining whether a resident's decline or failure to improve was avoidable or unavoidable.

Activities of Daily Living (ADLs)

- What risk factors for decline of bathing, dressing, and/or grooming abilities did the facility identify?
- What care did the resident receive to address unique needs to maintain ADL abilities? (i.e. adaptations/modifications, adaptive equipment, relearning skills, resident education, staff assistance, cueing, etc.)
- Were individual objectives of the plan of care periodically evaluated, and if the objectives were not met, were alternative approaches developed to encourage maintenance of ADLs?

Accidents and Falls

- Behavior such as unsafe wandering, elopement, ingesting nonfood items, altercations with others;
- Hearing, visual, and sensory impairments;
- Impaired physical functioning, balance, or gait problems;
- Diagnoses that could relate to safety awareness and safe practices, such as Alzheimer's and other dementias, arthritis, Parkinson's disease, seizure disorder, osteoporosis, cardiovascular/ cerebrovascular diseases, depression/ psychosis;

Accidents and Falls

- Symptoms/conditions that could affect safety risk, such as vertigo, postural hypotension, or acute illness;
- Use of physical restraints and/or other devices that might limit movement;
- Medications that could affect function, level of consciousness, gait, balance, visual acuity, or cognitive ability, use such as antidepressants, anticholinergic medications, anti-hypertensives, diuretics, psychotropic medications, or initiation of new medication therapy; and

Accidents and Falls

- History of falls.
- Plan of Care: Review the plan of care to determine if the facility developed interventions based on the resident's risks to try to prevent avoidable accidents, and if the plan was modified as needed based on the response, outcomes, and needs of the resident.

Pressure Ulcers

For the resident at risk for developing or who has a pressure ulcer, determine:

- If the facility developed an individualized care plan that addresses prevention, care and treatment of any existing pressure ulcers, including specific interventions, measurable objectives and approximate time frames.
- If the facility's care of a specific resident refers to a treatment protocol that contains details of the treatment regimen, the care plan should refer to that protocol. The care plan should clarify any major deviations from, or revisions to, that protocol in a specific resident.

Pressure Ulcers

For the resident at risk for developing or who has a pressure ulcer, determine:

- A specific care plan intervention for risk of pressure ulcers is not needed if other components of the care plan address related risks adequately.
- For example, the risk of skin breakdown posed by fecal/urinary incontinence might be addressed in that part of the care plan that deals with incontinence management.
- If the resident refuses or resists staff interventions to reduce risk or treat existing pressure ulcers, determine if the care plan reflects efforts to seek alternatives to address the needs identified in the assessment.

Unnecessary Drugs

Review whether the resident's comprehensive care plan:

- was based on the assessment of the resident's conditions, risks, needs, and behavior;
- was consistent with the resident's therapeutic goals;
- considered the need to monitor for effectiveness based on those therapeutic goals and for the emergence or presence of adverse consequences; and
- was revised as needed to address medication-related issues.

Urinary Continence and Catheters

Determine if the plan:

- Identifies quantifiable, measurable objectives with time frames to be able to assess whether the objectives have been met;
- Identifies interventions specific enough to guide the provision of services and treatment (e.g., toilet within an hour prior to each meal and within 30 minutes after meals, or check for episodes of incontinence within 30 minutes after each meal or specific times based upon the assessment of voiding patterns);

Urinary Continence and Catheters

Determine if the plan:

- Is based upon resident choices and preferences;
- Promotes maintenance of resident dignity;
- Addresses potential psychosocial complications of incontinence or catheterization such as social withdrawal, embarrassment, humiliation, isolation, resignation;
- Includes a component to inform the resident and representative about the risks and benefits of catheter use, on continence management approaches, medications selected, etc.;

Urinary Continence and Catheters

Determine if the plan:

- Addresses measures to promote sufficient fluid intake, including alternatives such as food substitutes that have a high liquid content, if there is reduced fluid intake;
- Defines interventions to prevent skin breakdown from prolonged exposure to urine and stool;
- Identifies and addresses the potential impact on continence of medication and urinary tract stimulants or irritants (e.g., caffeine) in foods and beverages;

Urinary Continence and Catheters

Determine if the plan:

- Identifies approaches to minimize risk of infection (personal hygiene measures and catheter/tubing/bag care); and
- Defines environmental approaches and devices needed to promote independence in toileting, to maintain continence, and to maximize independent functioning.

Pain

The surveyor will determine if the facility's comprehensive care plan for the resident included measurable objectives, time frames, and specific interventions/services to meet the resident's pain management needs, consistent with the resident's specific conditions, risks, needs, goals, and preferences and current standards of practice.

Pain

Care Plan:
- Care plan
- Clinical Standards of Practice
- Responsibility

Interventions
- Resident's needs/goals
- Source, type and severity of pain;
- Available treatment options

Approaches
- Address underlying cause, when possible
- Target strategies to source, intensity, nature of symptoms
- Prevent/minimize anticipated pain

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Pain

- Review the care plan and orders to identify any current pain management interventions and to focus observation. Corroborate observations with interviews and record review.
- Determine who is responsible for providing and implementing pain management interventions, for example, level of staff or other entities such as therapists, certified hospice, or anesthesiology consultants.

Pain

Review
- Pain management goals
- Interventions
- Monitoring
- Facility specific pain management protocol, if being used
- Revised as necessary

Pain

- If the care plan refers to a specific facility pain management protocol, determine whether interventions are consistent with that protocol.
- If a resident's care plan deviates from the protocol, determine through staff interview or record review the reason for the deviation.

Pain

- The surveyor will determine if the facility's comprehensive care plan for the resident included measurable objectives, time frames, and specific interventions/services to meet the resident's pain management needs, consistent with the resident's specific conditions, risks, needs, goals, and preferences and current standards of practice.

Dehydration

- Determine if the resident was assessed to identify risk factors that can lead to dehydration, such as those listed above and whether there were abnormal laboratory test values which may be an indicator of dehydration.

Dehydration

- Determine if an interdisciplinary care plan was developed utilizing the clinical conditions and risk factors identified, taking into account the amount of fluid that the resident requires.
- If the resident is receiving enteral nutritional support, determine if the tube feeding orders included a sufficient amount of free water, and whether the water and feeding are being administered in accordance with physician orders?

Nutrition

- Based on information generated by the comprehensive assessment and any pertinent additional nutritional assessment, the interdisciplinary team (including a physician or other licensed health care practitioner and the resident or the resident's representative) develops an individualized care plan.
- The care plan addresses, to the extent possible, identified causes of impaired nutritional status, reflects the resident's goals and choices, and identifies resident-specific interventions and a time frame and parameters for monitoring.

Nutrition

- The care plan is updated as needed; e.g., as conditions change, goals are met, interventions are determined to be ineffective, or as specific treatable causes of nutrition-related problems (anorexia, impaired chewing, etc.) are identified.
- If nutritional goals are not achieved, different or additional pertinent approaches are considered and implemented as indicated.
- Pertinent documentation can help identify the basis (e.g., current resident status, comorbid conditions, prognosis, and resident choices) for nutrition-related goals and interventions.

Nutrition

- The care plan includes nutritional interventions that address underlying risks and causes of weight loss (e.g., the need for eating assistance, reduction of medication side effects, and additional food that the resident will eat) or unplanned weight gain.
- It is important that the care plan address insidious, abrupt, or sudden decline in intake or insidious weight loss that does not trigger review of the Nutritional Status Resident Assessment Protocol (RAP); for example, by intensifying observation of intake and eating patterns, monitoring for complications related to poor intake, and seeking underlying cause(s).

Nutrition

- Many risk factors and some causes of weight loss can be addressed, at least partially, while others may not be modifiable. In some cases, certain interventions may not be indicated or appropriate, based on individual goals and prognosis.
- Weight stability, rather than weight gain, may sometimes be the most pertinent short-term or long-term objective for the nutritionally at-risk or compromised resident.

Nutrition

- Care plan interventions for a resident who has a wound or is at risk of developing a wound may include providing enough calories to maintain a stable weight and a daily protein intake of approximately 1.2-1.5 gm protein/Kg body weight.

Nutrition

If a resident has poor intake or abnormal laboratory values related to fluid/electrolyte balance, the care plan addresses the potential for hydration deficits.

Examples of interventions include:

- adjusting or discontinuing medications that affect fluid balance or appetite;
- offering a variety of fluids (water, fruit juice, milk, etc.) between meals,
- and encouraging and assisting residents as appropriate.

Nutrition

Surveyor is to determine:

- Whether the facility identified a resident's desirable weight range, and identified weight loss/gain;
- Whether the facility identified the significance of any weight changes, and what interventions were needed;
- Whether there have been significant changes in the resident's overall intake;

Nutrition

Surveyor is to determine:

- Whether the reasons for the change were identified and if appropriate interventions were implemented;
- Whether the facility has calculated nutritional needs (i.e., calories, protein and fluid requirements) and identified risk factors for malnutrition;
- Whether the facility met those needs and if not, why;
- Whether the resident's weight stabilized or improved as anticipated;

Nutrition

Surveyor is to determine:

- Whether a need for a therapeutic diet was identified and implemented, consistent with the current standards of practice;
- Whether the facility indicated the basis for dietary restrictions;
- Whether the reasons for dietary changes were identified and appropriate interventions implemented;

Nutrition

Surveyor is to determine:

- Whether the facility accommodated resident choice, individual food preferences, allergies, food intolerances, and fluid restrictions and if the resident was encouraged to make choices;
- Whether the facility identified and addressed underlying medical and functional causes (e.g., oral cavity lesions, mouth pain, decayed teeth, poorly fitting dentures, refusal to wear dentures, gastroesophageal reflux, or dysphagia) of any chewing or swallowing difficulties to the extent possible;

Nutrition

Surveyor is to determine:

- Whether the facility identified residents requiring any type of assistance to eat and drink (e.g., assistive devices/utensils, cues, hand-over-hand, and extensive assistance), and provided such assistance;
- Whether the facility has identified residents receiving any medications that are known to cause clinically significant medication/nutrient interactions or that may affect appetite, and determined risk/benefit;
- Whether the facility identified and addressed to the extent possible medical illnesses and psychiatric disorders that may affect overall intake, nutrient utilization, and weight stability;

Nutrition

Surveyor is to determine:

- Whether the facility identified residents requiring any type of assistance to eat and drink (e.g., assistive devices/utensils, cues, hand-over-hand, and extensive assistance), and provided such assistance;
- Whether the facility has identified residents receiving any medications that are known to cause clinically significant medication/nutrient interactions or that may affect appetite, and determined risk/benefit;
- Whether the facility identified and addressed to the extent possible medical illnesses and psychiatric disorders that may affect overall intake, nutrient utilization, and weight stability;

Nutrition

Surveyor is to determine:

- Whether the facility reviewed existing abnormal laboratory test results and either implemented interventions, if appropriate, or provided a clinical justification for not intervening (see note in Laboratory/Diagnostic Evaluation);
- Whether the resident's current nutritional status is either at or improving towards goals established by the care team; and
- Whether alternate interventions were identified when nutritional status is not improving or clinical justification is provided as to why current interventions continue to be appropriate.

Activities Care Planning

- Care planning involves identification of the resident's interests, preferences, and abilities; and any issues, concerns, problems, or needs affecting the resident's involvement/engagement in activities.

Care Planning

The surveyor will review the comprehensive care plan to determine if that portion of the plan related to activities is based upon the goals, interests, and preferences of the resident and reflects the comprehensive assessment.

Care Planning

In addition to the activities component of the comprehensive care plan, information may also be found in:

- a separate activity plan,
- on a CNA flow sheet,
- in a progress note, etc.

Care Plan Content

- Includes participation of the resident (if able) or the resident's representative;
- Considers a continuation of life roles, consistent with resident preferences and functional capacity;
- Encourages and supports the development of new interests, hobbies, and skills;
- Identifies activities in the community, if appropriate;
- Includes needed adaptations that address resident conditions and issues affecting activities participation; and
- Identifies how the facility will provide activities to help the resident reach the goal(s) and who is responsible for implementation (e.g., activity staff, CNAs, dietary staff).

Care Plan Goals

Should be based on measurable objectives and focused on desired outcomes (e.g.,

a. engagement in an activity that matches the resident's ability,
b. maintaining attention to the activity for a specified period of time,
c. expressing satisfaction with the activity verbally or non-verbally),

Not merely on attendance at a certain number of activities per week.

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Care Planning

The care plan should also identify the discipline(s) that will carry out the approaches. For example:

- Notifying residents of preferred activities;
- Transporting residents who need assistance to and from activities (including indoor, outdoor, and outings);
- Providing needed functional assistance (such as toileting and eating assistance); and
- Providing needed supplies or adaptations, such as obtaining and returning audio books, setting up adaptive equipment, etc.

Care Planning

Concepts the facility should have considered in the development of the activities component of the resident's comprehensive care plan include the following, as applicable to the resident:

- **A continuation of life roles, consistent with resident preferences and functional capacity (e.g., to continue work or hobbies such as cooking, table setting, repairing small appliances);**
- **Encouraging and supporting the development of new interests, hobbies, and skills (e.g., training on using the Internet); and**
- **Connecting with the community, such as places of worship, veterans' groups, volunteer groups, support groups, wellness groups, athletic or educational connections (via outings or invitations to outside groups to visit the facility).**

Social Services

- How do facility staff implement social services interventions to assist the resident in meeting treatment goals?
- How do staff responsible for social work monitor the resident's progress in improving physical, mental and psychosocial functioning?
- Has goal attainment been evaluated and the care plan changed accordingly?

Social Services

- Has goal attainment been evaluated and the care plan changed accordingly?
- How does the care plan link goals to psychosocial functioning/well-being?
- Have the staff responsible for social work established and maintained relationships with the resident's family or legal representative?

Mental and Psychosocial Adjustment Difficulties

- How are mental and psychosocial adjustment difficulties addressed in the care plan?
- Were individual objectives of the plan of care periodically evaluated, and if progress was not made in reducing, maintaining, or increasing behaviors that assist the resident to have his/her needs met, were alternative treatment approaches developed to maintain mental or psychosocial functioning?

Mental and Psychosocial Adjustment Difficulties

- Review whether the facility had identified, evaluated, and responded to a change in behavior and/or psychosocial changes, including depression or other mood disturbance, distress, restlessness, increasing confusion, or delirium in relation to potential medication adverse consequences.

Emotional & Behavioral Symptoms

- Resident behaviors such as crying out, disrobing, agitation, rocking, pacing; and
- The manner in which these behaviors are being addressed by staff, including nature and manner of staff interactions, response time, staff availability, and staff means of dealing with residents who are experiencing catastrophic reactions.

Palliative Care

- Conduct observations to verify that palliative interventions, as described in the plan of care, are being implemented and revised as necessary, to meet the needs/choices of the resident in order to maintain the resident's comfort and quality of life.
- Determine if the care plan is evaluated and revised based on the response, outcomes, and needs of the resident.

Palliative Care

- Decreased appetite and altered hydration are common at the end of life, and do not require interventions other than for comfort.
- Multiple organ system failure may impair the body's capacity to accept or digest food or to utilize nutrients.
- Thus, the inability to maintain acceptable parameters of nutritional status for someone who is at the end-of-life or in the terminal stages of an illness may be an expected outcome.

Surveyor Instructions
Palliative Care

- If the resident has elected a hospice benefit, determine whether the care plan reflects coordination by all providers regarding aspects of pain management, such as choice of palliative interventions, responsibility for assessing pain and providing interventions, and responsibility for monitoring symptoms and adverse consequences of interventions and for modifying interventions as needed.

Surveyor Instructions
Palliative Care

- The facility and hospice are jointly responsible for developing a coordinated and compatible plan of care based upon their assessment and the needs and goals of the resident.
- The plan of care must be consistent with the hospice philosophy of care, include directives for managing pain and other uncomfortable symptoms, and be revised and updated as necessary to reflect the resident's current status.

Surveyor Instructions
Palliative Care

If the resident has elected the Medicare hospice benefit, the providers may:

1. Develop one common care plan to be utilized by both providers, or
2. Two care plans following the documentation policies for each provider.

Surveyor Instructions
Palliative Care

The care plans should reflect:

1. The identification of a common problem list,
2. Palliative interventions,
3. Palliative outcomes,
4. Responsible discipline and
5. Responsible provider.

Use of "Monitoring" on care plans

- Why
- What
- How
- When
- By whom

Care Plan Revision

- Determine if the staff have been monitoring the resident's response to interventions and have evaluated and revised the care plan based on the resident's response, outcomes, and needs.

Care Plan Revision

Determine if the facility revised the care plan when:

- ✓ Achieving the desired outcome;
- ✓ Resident failure or inability to comply with or participate in a program to attain or maintain the highest practicable level of well-being; and/or
- ✓ Change in resident condition, ability to make decisions, cognition, medications, behavioral symptoms or visual problems.

Current Facility Care Plans

Concerns:

1. Give the impression that plans are "multidisciplinary" as opposed to "interdisciplinary" (can result in contradictory & repetitious information on the care plan)
2. Goals at times appear to be staff-directed, rather than resident-directed
3. Interventions appear generic in nature, geared to the "elderly in LTC" as opposed to being truly individualized
4. Interventions are not "shared"

Current Facility Care Plans

Sample of Reviewed Goals:

- Will accept assist as needed from staff for ADLs
- Will have needs met daily
- Will have needs met daily with staff support
- Provide food and fluid for comfort and to aid in maintaining skin integrity
- Will be provided with encouragement from staff members to attend out of room activities that she states she enjoys
- Sad/anxious mood will decrease as evidenced by being OOR on daily basis
- Will be provided with daily sensory stimulation in room and out of room with staff members' assistance.
- Staff to anticipate and meet all needs.

Current Facility Care Plans

Sample of Reviewed Interventions:

- Call light close and answer promptly.
- Call light within reach
- Encourage adequate fluid intake
- Encourage frequent ambulation
- Encourage good intake of diet, supplements, fluid
- Provide monthly activities calendar
- Encourage out of room activities
- Requires assistance with all transfers and locomotion (assigned only to Rec.)
- Inform daughter if resident is refusing to attend activities for extended periods of time
- Respect resident's right to refuse

Current Facility Care Plans

Sample of Reviewed Interventions:

- Check frequently when not in sight
- Encourage resident to stay in area of high visibility to staff when OOB
- If restless or agitated, increase staff supervision
- Use calm approach
- 1:1 short visits
- Reassure needs will be met
- Resident is bedbound

Advanced Directives

Goal:
Health care wishes will be respected and maintained

Interventions:

- Educate support systems
- Review choices with resident and family
- Provide support around concerns and ethical decisions
- Support ethical decision-making
- Ensure proper documentation in chart

Symptoms of Depression

Will be redirected from signs and symptoms of depression with staff support

- Provide support as needed
- Monitor for decline/change in mood
- Family to provide support
- 1:1 visits as needed
- Enjoys walking and going outside
- Reassure needs will be met
- Meet with resident on a regular basis to establish trust

End of Life

Terminal prognosis r/t: End stage Alzheimer's dementia failure to thrive with poor intakes.

Goal:
Symptoms relieved within 1 hour of interventions, care provided in accordance with advanced directives.

All identified interventions were the responsibility of the Social Worker

Person-centered Care

- Care providers who truly offer a person-centered approach focus on the individual.
- They spend a great deal of time getting to know **who the person is and who the person was**.

Person-centered Care

- Care-givers demonstrate a respect for each person.
- They believe each person still makes a difference in the world.
- They look at themselves not simply in a caretaker role of keeping someone safe and dry.
- They want to enable each person to use all their God-given abilities that remain.
- They believe that with proper support, people can have a relatively high level of well-being throughout the course of their illness or situation.

Why Person Centered Care?

- It's the **RIGHT** thing to do!
- Reduction in turnover
- Reduction in job injuries
- Consumer perception of better care
- Reduction in abuse/neglect
- Reduction in litigation
- Increased resident census
- Financial growth
- Improved workplace satisfaction
- IT'S REQUIRED!!!

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 and present at each care plan conference
- Care conference scheduled at resident and family convenience

"I" Care Plans

- Care plans should be written in simple language that all care givers can understand.
- It will be written in the "I" format. It is as though the resident is speaking directly to us via the care plan.
- The use of nursing diagnosis is discouraged as other disciplines are not trained to understand this.
- Care plans shall be accessible to all staff at all times.

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"I" Care Plans

- The care plan is made up of problem statements or needs as identified by the resident
- Resident centered goals
- Time frames for meeting the goals
- Interventions designed to assist the resident in meeting the goals
- Facilitates communication among members of the IDT as well as members of different shifts

"I" Care Plans

The Way We've Always Done It

Joanne is an Alzheimer's resident who has her days and nights mixed up. She wanders into other resident's rooms at night which has resulted in several resident and family complaints. The following care plan was developed.

The Way We've Always Done It

Problem	Goal	Interventions
Difficult behavior: Resident wanders into others rooms at night	Resident will sleep 5 hours during the night by next RCC	Sleep medication PRN Discourage napping during the day Side rails up If unable to sleep, place in geri-chair

New and Improved

Problem	Goal	Interventions
I like to walk during the night	I will ambulate freely throughout my home at times of my choice through next RCC	If I'm walking at night, please offer to walk with me Place stop signs on the doorways of the residents who are disturbed by my presence at night Offer snacks and preferred activities when I'm unable to sleep. I like to read the sports section of the newspaper, play solitaire, watch old movies

The Way We've Always Done It

Sally is a resident who hits and screams when receiving her weekly shower. The facility has tried a variety of interventions to calm her, but she continues to hit and scream. Two CNA's have received injuries during showers, they are afraid of her. The following care plan was developed.

The Way We've Always Done It

Problem	Goal	Interventions
Resident displays combative behavior during shower	Resident will not hit CNA's during shower through next RCC	2-3 CNA's for showers. Calm, gentle approach Shower weekly Pre-medicate with Xanax prior to shower

New and Improved

Problem	Goal	Interventions
I dislike to be showered	I will enjoy a "comfort bath" as evidenced by no hitting and screaming through next RCC	Do not shower me Provide me with a "comfort bath" by Sue Jones (my primary CNA), every other week. Please offer me daily hygiene as usual, if I start to raise my voice, please try again later Keep me warm during the bathing process.

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.

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 alone. He and his wife raised 11 children. Joe owned a hardware store and was a respected businessman in town.

Traditional Care Plan

Problem	Goal
1. Wanders due to dementia	Resident will not wander into their 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

Resident Directed Care Plan

Needs	Goal
1. I need to walk	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	Goal
1. Noncompliant with 1800 cal ADA diet	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 hyper glycemia
- Check blood sugar 6am and 8pm
- Administer insulin as ordered

Resident Directed Care Plan

Needs

1. 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.

Standard Care Plan

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

Individualized Care Plan

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 List – Special Considerations/Strengths

- Social history
- Memory enhancement & communication
- Mental wellness
- Mobility enhancement
- Safety
- Visual function

Care Planning List (continued)

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

Resident Care 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…

Memory Enhancement/Communication

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 I will be able to be independent in getting to the group activities which I enjoy.

Comfort

- 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 if I start getting irritable it is because my back hurts. Ask me about it. Let the nurse know I am having trouble.

Comfort

- I take regular medication for pain. Sometimes I need an 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.

Nutrition

- 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

- **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?**

C

Resources

- Centers for Medicare and Medicaid Services (CMS), State Operations Manual (SOM) http://www.cms.hhs.gov/SurveyCertificationGenInfo
- "Changing the Culture of Care Planning," Jalene White, Pleasant View Home, Inman, KS

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