

Person-centered Care Planning



Themes in the New Regs

- ▶ Person-Centered Care
- ▶ Staffing & Competency
- ▶ Training and the need for competency specific skills and procedures
- ▶ Quality of Care & Quality of Life
- ▶ Care planning
- ▶ Emphasis on patient goals and their involvement in decision making
- ▶ Changing Patient Population
- ▶ Behavioral Health
- ▶ Focus on adverse events
- ▶ Medication related
- ▶ QAPI
- ▶ Infection prevention
- ▶ Increase monitoring of facility, staff and residents

3 Phase Implementation

Phase 1

Phase 1 (* this section is partially implemented in Phase 2 and/or 3)

- Resident Rights and Facility Responsibilities*	- Nursing Services*
- Freedom from Abuse Neglect and Exploitation*	- Pharmacy Services*
- Admission, Transfer and Discharge*	- Laboratory, radiology and other diagnostic services
- Resident Assessment	- Dental Services*
- Comprehensive, Person-Centered Care Planning*	- Food and Nutrition*
- Quality of Life	- Specialized Rehabilitation
- Quality of Care*	- Administration (Facility Assessment – Phase 2)*
- Physician Services	- Quality Assurance and Performance Improvement* - QAA Committee
	- Infection Control – Program*
	- Physical Environment*

Phases 2 and 3

Phase	Primary Implementation
Phase 2	<ul style="list-style-type: none"> Behavioral Health Services* Quality Assurance and Performance Improvement* - QAPI Plan Infection Control – Facility Assessment and Antibiotic Stewardship ** Physical Environment- smoking policies *
Phase 3	<ul style="list-style-type: none"> Quality Assurance and Performance Improvement* - Implementation of QAPI Infection Control – Infection Control Preventionist * Compliance and Ethics Physical Environment- call lights at resident bedside * Training *

*This section is partially implemented in other phases.

§483.5 Definitions



- Person-centered care - focus on resident as having control over their daily lives and supporting the resident in making those choices
- Resident representative - individual chosen by resident to act on behalf of resident; person authorized by State or Federal

4 Part Person-Centered Care Planning

- ▶ Resident Rights
- ▶ Care Plan Writing and Inclusion
- ▶ Discharge Care Planning
- ▶ Care Plan Meetings

Resident Rights

483.10 Resident Rights

- ▶ Right to request care plan conferences
- ▶ Right to request revisions to care plan
- ▶ Right to be informed in advance of changes in care plan
- ▶ Right to sign after significant changes in care plan
- ▶ Right to have personal and cultural preferences addressed in care plan.

483.10 Resident Rights

- ▶ Resident has right to be informed of total health status
- ▶ Right to request, refuse, or discontinue treatment
- ▶ Right to participate in care planning including the right to identify individuals or roles to be included in the care planning. Guardians, lawyers, friends, priests—whomever the resident requests.
- ▶ Right to participate in family groups and have family members participate as well.

483.10 Resident Rights

- ▶ A resident may not be able to identify a specific person they want included in the planning process, but that should not prevent the resident from including a role, such as someone to provide spiritual, nutritional or behavioral health input.

483.10 Resident Rights

- ▶ Right to choose his/her attending physician.
- ▶ If physician chosen refuses or does not meet LTC regulations, facility may seek alternate.
- ▶ Facility must discuss alternate physician issue with resident.

483.10 Resident Rights

- ▶ Right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with interests, assessments, and plan of care.
- ▶ Right to make choices about aspects of life in facility that are significant to resident.

Care Plan Writing and Inclusion

Comprehensive Care Plans, by CMS

- ▶ All services furnished to attain, maintain highest practicable well-being
- ▶ Any services required but not provided due to resident's exercise of rights
- ▶ Any specialized services or specialized rehab
- ▶ Resident goal for admission and desired outcome
- ▶ Resident preference for discharge
- ▶ Discharge plans

Comprehensive Care Plans, by CMS

- ▶ The resident and/or representative **MUST** participate in the interdisciplinary team that develops the resident's care plan.
- ▶ All physician orders **MUST** be documented in a care plan.
What's Your Policy? Phase 2 *waiting on details
- ▶ Facilities are required to provide written advance directive information to the resident and representative.

Comprehensive Care Plans, by CMS

- ▶ Reviewed and revised after each assessment
- ▶ Meet professional standards of quality
- ▶ Be provided by qualified persons
- ▶ Be culturally-competent and trauma informed

Comprehensive Care Plans, by CMS

- ▶ Resident has the right to see the care plan along with the right to sign it after significant changes.
- ▶ Encourage the facility to provide a copy of the comprehensive care plan upon request. Residents have right to review and obtain copy of their medical record, the care plan is a part of their medical record.
- ▶ FINAL, "FINAL" Appendix PP due out??

Care Plan Writing and Inclusion

- ▶ Person-centered, individual care plans are the key!!
 - ▶ Cultural preference
 - ▶ Spiritual preferences
 - ▶ Dietary preferences (see New Dining Standards at Pioneer Network Coalition for evidence-based practices)
 - ▶ Sleep/natural waking routine practices
 - ▶ Activity preferences
 - ▶ Clinical practices (pain management)

▶ GET RID of the "General" Practices—get specific and to the root cause

Traditional Example:
 Problem: Resident has a hx of falling d/t weakness and unsteady gate.
 Goal: Resident will remain free from falls for the next 90 days (don't we wish!)
 ...INSTEAD
 "Jim has a history of falling early in the morning. He enjoys warm milk at this time and tends to be unsteady. Staff will be present to assist Jim out of bed and/or milk will be available for him at this time. His goal will be to reduce is risk of falling."

Care Plan Writing and Inclusion

▶ Assessment

- ▶ Try interviewing over coffee instead a clipboard...why do think social services knows more than nurses do?!
- ▶ What was your normal routine?
 - ▶ Break it down---morning, noon, night
 - ▶ Relationships
 - ▶ Pleasures (church groups, clubs, veteran's networks, etc.)
 - ▶ Preferences on medication administration, lighting, noise

REMEMBER—this is their home and we all have things we're picky about!

What if they can't tell you what they want?

- Discuss with families what they think the person's goals would be now.
- If residents are unable and family is unavailable, then staff can step in and determine as best as they can from really knowing the person, what the person's goals might be.
- Talk to your CNAs and floor nurses!! They know this person's routine and what works and what doesn't better than you do!!

Care Plan Writing and Inclusion

Typical Care Plan

Problem	Goal	Intervention

Care Plan Writing and Inclusion

Category	Requirements	Preferences	Inclusion
Dental Care	Susan will maintain healthy teeth and gums.	Susan prefers to brush her teeth before breakfast and after supper. She likes mint toothpaste and she has a difficult time flossing on her own because of the arthritis in her fingers.	Staff will assist Susan with her dental care by following her routine and preparing her toothbrush if needed. Staff will assist her with flossing after supper at her discretion, and will offer professional dental services bi-annually or as needed.

Care Plan Writing and Inclusion

Narrative "I" Care Plan

COMMUNICATION/MEMORY: I have a little bit of trouble with my memory. I have been diagnosed with early Alzheimer's dementia. I am aware of my situation, my caregivers and my family.

Occasionally I am a little forgetful and confused. Be sure to orient me as part of our conversation while you are providing care. Remind me what is going to happen next. Introduce yourself every time you meet me until I am able to remember you. If I should be more confused than you normally see me, or I don't remember details about my day, notify the nurse. Often times this means that I am having health complications, which my nurse will be able to assess. I enjoy conversation about your family and your children. I have had a lot of experience raising kids. If you would like some advice on beauty, I love to share my opinion. Especially on how you should do your hair or what clothes look good on you. Being a model all those years has paid off.

GOAL: I want to remain oriented to my family and my caregivers. I want to be able to remember special events and holidays with your reminders.

Care Plan Writing and Inclusion

Possible "person-centered" categories for a care plan...

- Dental Care
- Bladder Management
- Skin Care
- Nutrition
- Fluid Maintenance
- Pain Management and Comfort
- Activities
- Discharge Plan

Care Plan Writing and Inclusion

Possible "person-centered" categories for a care plan...

- Social History
- Memory Enhancement & Communication
- Mental Wellness
- Mobility Enhancement
- Safety
- Visual function

It's not about leaving out the medical. Instead, it's about managing, educating, and living a normal life with that condition.

Discharge Planning in Care Planning

Discharge Planning (in Care Plans)

- ▶ § 483.21(b)(1)(iv)(B) requires that discharge assessment and planning to be a part of developing the comprehensive care plan.
- ▶ They want you looking at discharge as early as admission so they are given "every opportunity to attain their highest quality of life."
- ▶ § 483.21(b)(1)(iv) facilities should document whether a resident's desire for information regarding returning to the community is assessed and any referrals that are made for this purpose. *"This goes along with Section O."*

Discharge Planning (in Care Plans)

- ▶ § 483.21(c) Facilities must develop and implement an effective discharge planning process.
 - ▶ Identify discharge goals and needs
 - ▶ Develop a discharge plan, including referrals to local agencies, etc. for returning to the community.
- ▶ We note that in compliance with the Supreme Court *Olmstead* decision (*Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 119 S. Ct. 2176 (1999)), we encourage facilities and their community partners to strive to serve individuals in their preferred settings, when feasible.

Discharge Planning (in Care Plans)

- Information provided to receiving provider (another home, resident's home, etc):
 - Contact information of practitioner
 - Resident representative information
 - Advance Directive information
 - All special instructions or precautions
 - Comprehensive care plan goals
 - All other necessary information and any other documentation

Coming Up With Care Plans

- ▶ ...require regular re-evaluation of residents to identify changes that require modification of the discharge plan and update the care plan to reflect these changes. **MAKE SURE YOU DATE AND INITIAL ANY CHANGES.**
- ▶ And, they want the MDS (or care plan coordinator) involved in the discharge planning process.

Care Plan Meetings

Care Plan Meetings...§ 483.21(b)

- ▶ Must-have participants
 - ▶ CNA who provides care
 - ▶ Dietary staff
 - ▶ For those facilities that do not hire nursing assistants, as indicated by the commenter, we note that the regulation at § 483.21(b)(ii) also requires a RN with responsibility of the resident to participate on the IDT as well. We expect that these facilities will meet these additional requirements for IDT members and be able to demonstrate their lack of nursing assistants on staff.



Care Plan Meetings...§ 483.21(b)

- ▶ No members of the IDT are required to participate in person.
- ▶ Facilities have the flexibility to determine how to hold IDT meetings whether in person or by conference call.
- ▶ The facility may determine that participation by the nursing assistant or any member, may be best met through email participation or written notes. We believe that this added flexibility will help to alleviate concerns of shortage and availability.
- ▶ **BEWARE of HIPPA violations!**

Care Plan Meetings...§ 483.21(b)

- ▶ § 483.21(b)(2)(ii)(F), to provide that *to the extent practicable*, the IDT must include the participation of the resident and the resident representatives.
- ▶ An explanation must be included in a resident's medical record if the IDT decides not to include the resident and/or their resident representative in the development of the resident's care plan or if a resident or their representative chooses not to participate.

Care Plan Meetings

- ▶ CMS encourages facilities to explore ways to allow residents, families and representatives to access care plan on a routine basis using technology solutions that enable real time access for authorized users.
- ▶ Face-time, Skype

Person-centered Care Plan Meetings

1. Ask yourself: Are you having a conversation about someone's care in their home or are you coming to a meeting because you have to, holding a clipboard, and checking off a list?
2. Are the various disciplines rattling off their speels then walking out of the room?
3. What is the ratio of staff to resident and family? Remind you of a firing squad? Think about who REALLY needs to be present.
4. Is it too cold, too hot, distracting, private, comfortable for the resident and family?

Coming Up

Phase 2

- ▶ Baseline care plans (within 48 hours of entering the home)
 - ▶ § 483.21(a)(1) & § 483.21(a)(2)
 - ▶ All physician orders in the careplan *Details to come!*

Facility required to provide resident and representative with a summary of baseline care plan including initial goals, medications and dietary instructions, services and treatments, and any updated information based upon the comprehensive care plan.

Phase 2

- ▶ Baseline care plans (within 48 hours of entering the home)
- ▶ a new § 483.21(b)(1)(iii), requiring that any specialized services or specialized rehabilitation services that a nursing facility provided pursuant to a PASARR recommendation be included in the resident's care plan.

Phase 3

- ▶ Care that addresses unique needs of Holocaust survivors, war survivors, disasters, and other profound trauma are important aspect of person-centered care.
- ▶ Requirement for Trauma-informed care has delayed implementation of 3 years.

Resources

- ▶ DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services, 42 CFR Parts 405, 431, 447, 482, 483, 485, 488, and 489, [CMS-3260-F], Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, <https://federalregister.gov/d/2016-23503>
- ▶ Carmen Bowman, Edu-catering, *Individualized Care Planning*

Don't Get Excited ☺

- ▶ Appendix PP guidelines are supposed to be out eventually.
- ▶ Don't make any big changes to your care plan meetings, social services, care plans, or discharge until we know the specifics.
