Person-Centered Comprehensive Care Plans

Crystal Plank, BSN, RN, RAC-CT
Clinical Consultant/Quality Educator
MU MDS and Quality Research Team
Sinclair School of Nursing
QIPMO

1

CEUs for Today!

Today's Webinar has been approved for CEU hour(s)

In order for MO LNHAs to get credit:

- **It is REQUIRED that you complete a brief survey/evaluation via:**
  - ✓ **A pop-up at the end of the webinar, or**
  - ✓ **An automated email from GoToWebinar that will be sent to attendees**
  - ✓ ***You only need to complete it once (either via the pop-up or the email)***
- **It is REQUIRED that you answer the question asking for your LNHA number.**

Please note: the certificate that will be linked in GoToWebinar's automated "thank you for attending" email is NOT YOUR CEU CERTIFICATE. Your official certificate will be sent out by QIPMO staff in approximately 2 weeks.

**The amount of your credit will be adjusted based on time spent on the webinar.*

2

Comprehensive Care Plan F656

§483.21(b)

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights.

This includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs.

QIPMO

Sinclair School of Nursing

3

F656-Comprehensive Care Plans

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.

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).

QIPMO

Sinclair School of Nursing

4

F656-Comprehensive Care Plans

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

QIPMO

Sinclair School of Nursing

5

F656-Comprehensive Care Plans

If a Care Area Assessment (CAA) is triggered, the facility must further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident.

Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered must be recorded in the medical record

QIPMO

Sinclair School of Nursing

6

F656-Comprehensive Care Plans—Survey Guidance

Does the care plan address the goals, preferences, needs and strengths of the resident, including those identified in the comprehensive resident assessment, to assist the resident to attain or maintain his or her highest practicable well-being and prevent avoidable decline?

Are objectives and interventions person-centered, measurable, and do they include time frames to achieve the desired outcomes?

Is there evidence of resident and, if applicable resident representative participation (or attempts made by the facility to encourage participation) in developing person-centered, measurable objectives and interventions?

Does the care plan describe specialized services and interventions to address PASARR recommendations, as appropriate?

QIPMO

Sinclair School of Nursing

7

F656-Comprehensive Care Plans Survey Guidance

- Is there evidence that the care plan interventions were implemented consistently across all shifts?
- Is there a process in place to ensure direct care staff are aware of and educated about the care plan interventions?
- **Determine whether the facility has provided adequate information to the resident and, if applicable resident representative so that he/she was able to make informed choices regarding treatment and services.**
- Evaluate whether the care plan reflects the facility's efforts to find alternative means to address care of the resident if he or she has refused treatment.

QIPMO

Sinc

8

F 656: Key Elements of Noncompliance

Facility failed to do one or more of the following:

Develop and implement a care plan that:

- Is comprehensive and individualized;
- Is consistent with the resident's goals and right to be informed and participate in his/her treatment;
- Meets each of the medical, nursing, mental and psychosocial needs identified on the resident's comprehensive assessment;
- Includes measurable objectives, interventions and timeframes for how staff will meet the resident's needs.

QIPMO

Sinclair School of Nursing

9

F 656: Key Elements of Noncompliance

Develop and implement a care plan that describes all of the following:

- Resident goals and desired outcomes;
- The care/services that will be furnished so that the resident can attain or maintain his/her highest practicable physical, mental and psychosocial well-being;
- The specialized services to be provided as a result of the PASARR evaluation and/or the comprehensive assessment;
- The resident's discharge plan and any referrals to the local contact agency;
- Refusals of care and action taken by facility staff to educate the resident and resident representative, if applicable, regarding alternatives and consequences.

QIPMO

Sinclair School of Nursing

10

F 656: DEFICIENCY CATEGORIZATION

Examples of Level 4, immediate jeopardy to resident health and safety, include, but are not limited to:

A resident has a known history of inappropriate sexual behaviors and aggression, but the comprehensive care plan did not address the resident's inappropriate sexual behaviors or aggression which placed the resident and other residents in the facility at risk for serious physical and/or psychosocial injury, harm, impairment, or death.

The facility failed to implement care plan interventions to monitor a resident with a known history of elopement attempts, which resulted in the resident leaving the building unsupervised, putting the resident at risk for serious injury or death.

QIPMO

Sinclair School of Nursing

11

F 656: DEFICIENCY CATEGORIZATION

Examples of Level 3, actual harm that is not immediate jeopardy include, but are not limited to:

The CAA Summary for a resident indicates the need for a care plan to be developed to address nutritional risks in a resident who had poor nutritional intake. A care plan was not developed, or the care plan interventions did not address the problems/risks identified. The lack of interventions caused the resident to experience weight loss.

Lack of care plan interventions to address a resident's anxiety, depression, and hallucinations resulted in psychosocial harm to the resident

QIPMO

Sinclair School of Nursing

12

F 656: DEFICIENCY CATEGORIZATION

Examples of Level 2, no actual harm, with potential for than more than minimal harm, that is not immediate jeopardy, include, but are not limited to:

During the comprehensive assessment, a resident indicated a desire to participate in particular activities, but the comprehensive care plan did not address the resident's preferences for activities, which resulted in the resident complaining of being bored, and sometimes feeling sad about not participating in activities he/she expressed interest in attending.

An inaccurate or incomplete care plan resulted in facility staff providing one staff to assist the resident, when the resident required the assistance of two staff, which had the potential to cause more than minimal harm

QIPMO

Sinclair School of Nursing

13

F 656: DEFICIENCY CATEGORIZATION

An example of Level 1, no actual harm with potential for no more than a minor negative impact on the resident, includes, but is not limited to:

For one or more care plans, the staff did not include a measurable objective, which resulted in no more than a minor negative impact on the involved residents

QIPMO

Sinclair School of Nursing

14

Survey and Care Plans

- Does the Care Plan reflect what the surveyor is seeing from the activities the resident is doing?
- Does the Care Plan reflect what the surveyor is hearing from the resident and frontline caregivers?
- Does the Care Plan reflect what the surveyor is reading in the medical record?

QIPMO

Sinclair School of Nursing

15

- Assessment (MDS)
- Decision Making (CAA)
- Care Plan Development
- Care Plan Implementation
- Evaluation

QIPMO

16

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 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

17

The Interdisciplinary Comprehensive Care Plan

Serves as a road map that guides all staff involved in the resident's care

Communicates vital resident care information to the entire IDT team

Contains specific detailed instructions for achieving resident goals.

Person Centered Care

18

What is a Person-Centered Care Plan?

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

Sinclair School of Nursing

19

The Rothschild Person-Centered Care Planning process involves:

Identifying and clarifying the resident's choice

Discussing the choice and options with the resident

Determining how to honor the choice (and which choices are not possible to honor)

Communicating the choice through the care plan

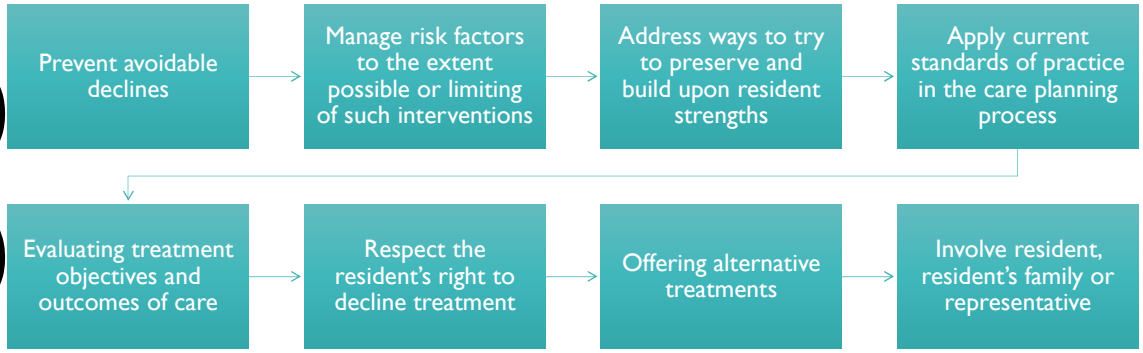
Monitoring and revisions to the plan of care

Quality Assurance and Performance Improvement

Sinclair School of Nursing

20

Overall Focus of the Comprehensive Care Plan



QIPMO

Sinclair School of Nursing

21

Care Plan Issues Based on Comprehensive Assessment

- ADLs (functional status/ Daily Care Needs)
- Pressure sores
- Urinary Incontinence
- ROM
- Mental/Psychosocial functioning
- N-G tubes
- Hydration
- Special needs

QIPMO

Sinclair School of Nursing

22

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

QIPMO

Sinclair School of Nursing

23

Care Planning List – Special Considerations/Strengths

- Dental care
- Bladder management
- Skin care
- Nutrition
- Fluid maintenance
- Pain management/comfort
- Activities
- Discharge plan
- Advanced Directive (DNR/Full Code)

QIPMO

Sinclair School of Nursing

24

Care Planning: Quality of Life

Security
Comfort
Enjoyment
Relationships
Dignity

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

QIPMO

Sinclair School of Nursing

25

Practical Thoughts

Medications:
- Care Plan
  - Common side effects
  - If seen, to whom is it reported
- MAR
  - Actual med
  - Dosage
  - Time
- POC or MAR
  - Diagnosis

QIPMO

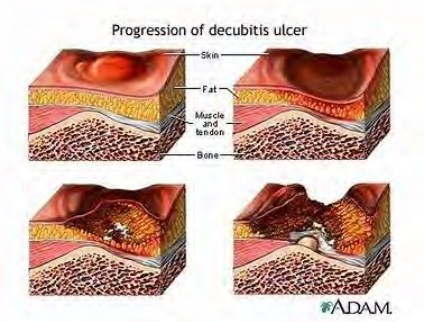
Sinclair School of Nursing

26

PRACTICAL THOUGHTS

Skin Care

- Care Plan
  - Dressing location
  - Specific interventions
  - To whom do they report problems
- TAR
  - Dressing specific details
  - Type of medication to be applied to wound
  - Wound documentation



QIPMO

Sinclair School of Nursing

27

HOW DO YOU FIND THIS INFORMATION?

Ask the resident

Look at MDS Section F: Preferences for Customary Routine & Activities

Interview family members

Interview friends

Observe the resident with the staff

QIPMO

Sinclair School of Nursing

28

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!!

Sinclair School of Nursing

29

THE CARE PLAN MUST BE ORIENTED TOWARD

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

Sinclair School of Nursing

30

THE CARE PLAN MUST BE ORIENTED TOWARD

Offering	Offering alternative treatments
Approach	Using an IDT approach to care plan development to improve the residents' functional abilities
Involving	Involving family & other resident representatives
Assessing & planning	Assessing & planning for care sufficient to meet the care needs of new admission
Involving	Involving the direct care staff with the care planning process relating to the resident's expected outcomes

QIPMO

Sinclair School of Nursing

31

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
- 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

- 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
- 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

32

CARE PLAN AND RESIDENT'S RIGHTS

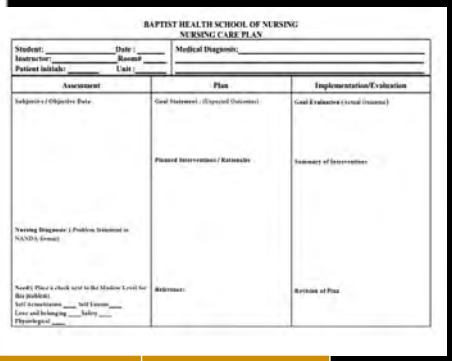
- Respecting resident's right to decline treatment
- Offer alternative treatments
- Educate
- Document refusals

QIPMO

Sinclair School of Nursing

33

Nurse Narrative Note: The patient is a 76 year-old female, admitted on 5-25-19 with a postoperative wound infection of the right hip. She is alert and oriented to person, place, time and situation. She reports no pain and 0 on a 0-10 pain scale.She states, "it only hurts to move my right foot and leg it aches every time I move it or add pressure." Heels are elevated and achy pain noted on right foot around heel.No edema noted on right foot. Baseline vital signs are: respirations-16, blood pressure 179/77, pulse ox- 92% with a blood sugar reading of 121.She is on 2L of oxygen via nasal cannula and slowly weaning off. Ortho came in to change her right hip dressing at 0730.It is covered with an ABD.She had a picc line placed in the upper right brachium at 1630. She will be discharging to therapy with the antibiotics prescribed with her. She has her SCD's on and urine output total is 600mL from 0700-1600.She voids in a brief with purewick provided. No ambulation during shift. She is on a 1800 diabetic diet, she ate 100% of her breakfast and 25% of her lunch. She has been using the incentive spirometer Q2h. She is cooperative and very pleasant.


BAPTIST HEALTH SCHOOL OF NURSING
NURSING CARE PLAN

Student: _____ Date: _____
Instructor: _____ Room# _____
Patient initials: _____ Unit: _____
Medical Diagnosis: _____

Assessment | Plan | Implementation/Evaluation

Category/ Problem	Requirements/ Goals	Preferences/ Goals	Inclusion/ Intervention
Dental Care	Susan will maintain healthy teeth and gums through next 90 days.	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.

FORMAT FOR CARE PLAN

34

Parts of the Care Plan Process

Assessment

Planning

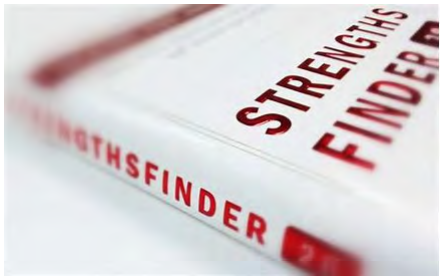
Implementation

Evaluation

35

Defining issues to be addressed in Care Planning

Problems
Potential Problems
Risks
Need
Strength



36

Care Plan Writing and Inclusion

Assessment

What was their normal routine?

- Break it down---morning, noon, night
- Relationships
- Pleasures (church groups, clubs, veteran's networks, etc.)
- Activities
- Preferences on medication administration, lighting, noise

Sinclair School of Nursing

37

3 Examples:
"Classic" Care Plan

Problem	Goal	Approaches
Alteration in thought process r/t History of CVA A/E by ST Memory loss.	Resident will be oriented to person, place, time and situation at all times.	1) Provide orientation w routine care. 2) Invite to RO Activ, ie current events, holiday parties, Resid Council. 3) Place calendar in rm
Self Care Deficit r/t Rt Sided paralysis A/E by need for assist with ADLs.	Resident will wash face and hands with limited assistance from staff.	1) Place resident in from of mirror for upper torso ADL care. 2) Place warm, wet wash cloth in lt hand. 3) Instruct resident to wash face and rt hand. 4) Complete portion of task left undone.

Sinclair School of Nursing

38

"Individualized" CP

Problem	Goal	Approaches
Cognitive loss r/t history of CVA A/E: Joe is experiencing ST Memory loss	Joe will begin to learn how to orient himself to TOD and location of room	1) Remind Joe of day and time when providing care 2) Invite Joe to News Group, Resid Council and Holiday events to help with orientation. 3)Show Joe the calendar in his room and let him know the events of the day.
Self Care Deficit r/t Rt Sided paralysis A/E: Joe needs assist w morning care.	Joe will use a washcloth to wash his face and hands with your help to set him up.	1) Position Joe in front of mirror to observe himself while doing his morning grooming. 2) Put a washcloth in Joe's lt hand. 3) Ask Joe to wash his face and rt hand. 4) Offer to finish any portion Joe is unable to complete.

QIPMO

Sinclair School of Nursing

39

"Person Centered" CP

Background/ Info	Goal	Approaches
Memory: I have memory loss from a recent stroke which limits my ability to remember what used to be simple tasks.	I want to be able to figure out on my own how to find out the time of day and to find my own room. I want to increase my self reliance.	1) When talking to me point to the clock and help me to read the digital numbers. 2) Show me the calendar and read the activities for the day to me. 3) Help me choose what activities I want to go to and remind me when and where.
Care: Since my stroke I must relearn how to take care of myself.	I would like to wash my own face and hands each day. I want increased independence.	1) When I get ready to wash and shave in the AM, put me in front of the mirror so I can see myself. 2) Help me to wash my face and hands by handing me a wet wash cloth. I like it warm and I like to use "Irish Spring" 3) Remind me to follow the steps I learned in therapy to wash my face. 4) When I have done all I can, I will ask you to finish for me.

QIPMO

Sinclair School of Nursing

40

Forming the Problem/ Need Statement

A statement of an actual or potential health problem identified through the RAI process

Can use functional status or need (limitation or strengths) or Nursing Diagnosis

Resident centered, not staff centered

Should be written in simple terms, not medical terminology.

Should contain items related to factors, etiology and/or signs and symptoms

41

PROBLEM COMBINING

Often makes good clinical sense to combine problems

- They are interrelated
- They have related or similar goals
- The selected interventions are the same or related

42

Problem Statement Caution

Make sure to write the problem statement about the resident's problem and not the staff's problems

43

Goal Setting

Goals should target either improvement, prevention, maintenance or palliative outcomes.

They should be measurable and have a timeframe for completion or evaluation.

They should be person-centered (Resident centered).

What are the resident's goals?

44

What does the goal have to contain?

Who does the goal address?

What is the resident or staff demonstrate?

How often will the action will occur?

The amount of times or number of occurrences.

45

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

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

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

Problem: Always incontinent (no episodes of continent voiding)
- Goal: Will void on toilet at least once a day

Thru the next 90 days, next review, etc…..

46

INTERVENTIONS

Specific

Individualized approaches

Short and concise

47

REFUSALS

Respect	Respect the resident's right to refuse or decline treatment
Offer	Offer alternative treatments
Offer	Offer different times or days
Offer	Offer different caregivers

QIPMO

Sinclair School of Nursing

48

Comprehensive Care Plan Checklist

- Summary of comprehensive assessment of resident.
- Services to meet a resident's medical, nursing, mental and psychosocial needs.
- Person Centered Care.
- Did the care plan get completed within 7 days after completion of the comprehensive assessment?
- Is the care plan appropriately updated with date, line and signature?
- Is the care plan prepared and signed by IDT team?
- Review and updated after each Quarterly and Comprehensive MDS assessment.

QIPMO

Sinclair School of Nursing

49

Care Planning: Quality of Life

Security
Comfort
Enjoyment
Relationships
Dignity

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

QIPMO

Sinclair School of Nursing

50

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!)

More Person Centered:

I have a history of falling early in the morning. I enjoys warm milk at this time and tend to be unsteady. Staff will be present to assist me out of bed and/or milk will be available for me at this time. My goal will be to reduce my risk of falling for the next 90 days."

51

DOES EVERY SMALL DETAIL OF CARE 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

52

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. (time frame)

QIPMO

Sinclair School of Nursing

53

Sample "I" Care Plan

Hello my name is **John Doe**. I was admitted to Marshfield Care Center on 11-11-11 with the following diagnosis': Diabetes, Pressure Ulcer, Hypertension, UTI and Dementia.

I was born in Columbus, Ohio on 8-2-1937. We raised dairy cattle until 2000 when I retired and got the itch to move somewhere warmer. I married my high school sweetheart Jane in 1957. Together we had 6 children 4 boys and 2 girls. We have 7 grandchildren and 2 great grandchildren to date. My sons took over the farm when I retired and I and my wife moved to Columbia, Missouri to be closer to our daughter Jessica. My bride Jane passed away about a year ago. She will always be in my heart and I miss her dearly.

I have **dementia**, so sometimes I may say I need to go to the field and plow the back 40 or milk the cows. **Please reorient** me and remind me my sons now took over the farm and are doing a great job. I am so proud of them. And I will usually agree with your or you can engage me in an activity**. I enjoy** playing cards, doing hidden word searches and building things.

I **wear glasses** please assist me in keeping them clean and remind me to wear them daily. I am slightly **hard of hearing**. Please speak directly to me and face me when talking. You may have to reduce background noise if it is interfering with my hearing what you're saying. I also have **upper and lower dentures**. I need your assistance in keeping them clean please soak them nightly and assist me in putting them in each morning. I am **able to tell you** most of my needs but please assist me if you see me and I appear confused.

QIPMO

Sinclair School of Nursing

54

Activities/Well-Being

I have suffered with Anxiety and Depression for most of my adult life. I have periods of being tearful, crying, feeling down, depressed and hopeless. I also get tired easily and it take a lot of effort for me to concentrate when there is a lot of noise and activities going on. I do not like talking about my medical condition. I may also get upset and tearful when there are attempts to clean my room. I am attached to everything in my room and do not care about the clutter. It is very important to me to be able to care for my own belongings. I am more comfortable with some CNA's but I can let you know if I prefer to have someone else care for me. I like having to option to keep things locked up but I do not currently have anything to lock up. I do not sleep well so I take medication to help with this.

I have a history of refusal of care such as refusing therapy, showers, treatments and medications.

I enjoy watching TV such as the news and cooking shows. I like embroidering, crocheting, puzzle books and bingo. I like listening to the radio especially "the oldies". I prefer individual activities. I keep in contact with my friends and family with my cell phone. I like to wear lipstick anytime I leave my room. Please offer to take me on outings but I usually do not go. I also have a tablet that I can take care of and keep charged myself. I like to read Magazines, newspaper and books. I do like animals.

Goals: I want to continue to make simple daily decisions about my activities through the next 90 days.
I want to have less than 2 episodes of tearfulness a week through the next 90 days.

Interventions: Talk to me while providing care about my life.
Let me know what activities there are so I can make a decision if I want to attend or not.
Encourage me to attend special events.
SSD to contacted if I am inconsolable.
Encourage me to express my feelings and allow me time to do so.
If I am tearful, please listen to me and do not offer solutions. I just want to be heard.
If my room gets too clutter, please assist me in prioritizing what I need right now and what can be put in totes for later use.
Monitor for falls especially at night because I take "sleep" medication.
Let me know if any animals visits the facility.
Let my nurse know when I refuse care.
Offer me alternates options when I refuse.
Educate me in possible complications that could result in my refusals.

QIPMO

Sinclair School of Nursing

55

CARE PLAN

PROBLEM

- I am confused and have refusal behaviors due to my disease progression of 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

QIPMO

Sinclair School of Nursing

56

CARE PLAN

PROBLEM

- I was admitted to hospice and am a DNR due to end-stage bone cancer and unavoidable weight loss.

GOALS

- I will approach end stage life with dignity and comfort measures that allow for a natural death and observation/provision of my end-of-life goals to the fullest extent able through this review period.
- OR
- I have made my end-of-life goals know to hospice, facility staff, and care plan team to allow for a comfortable and dignified natural death through this review period.

INTERVENTIONS

- Encourage loved ones to visit
- Provide dignity and respect through my dying process
- If I appear uncomfortable in my w/c, during a meal, or activity assist me back to bed
- Acknowledge my choice not to eat

Sinclair School of Nursing

57

CARE PLAN SAMPLES

I am 88-year-old (male) with dementia. I have a short attention span. I am very pleasant most of the time. I likes to walk around the facility a considerable amount of his waking hours. I am unable to distinguish between areas that I am welcomed to enter and those where I am not welcomed.

My walking ability is excellent, and I can walk without assistive devices. Some residents are disturbed by me because I may enter their rooms against their wishes. I prefer to be with staff at all times as I do not want to be alone. My wife and I raised 11 children who all live in different states. I owned a hardware store and was a respected businessman in town.

Sinclair School of Nursing

58

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. I like to use different tools and put things together. I enjoy talking about my children and what they doing. My photo album is very important to me and I like looking at it especially when I am restless.

59

Rose's Care Plan

Problem: Rose 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).

60

Rose's Care Plan

Rose's Story: I worked in the animation design world for 20 years. I never married but have many friends who are my family. I love animals and always had a cat or dog and I enjoy watching BBC and National Geographic.

61

Rose's Interventions

I am an early riser so do not be surprised if I am up by 5am and want to get my day started

I prefer showers before breakfast, and I like yogurt or a smoothie and a granola bar for breakfast

Known behavior triggers:

- Looking for animals to love
- Not getting up early

When she becomes upset

- Ensure her safety and leave the room and return in 5-10 minutes

62

ROSE'S INTERVENTIONS

Redirection suggestions

- Take her to see MOQI (facility dog)
- Play "Bing Crosby & Frank Sinatra" Christmas music year round
- Talk about her art and friends
- Offer a snack of chocolate ice cream or some Indian food
- Gently rub her back

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

63

THOUGHTS

Care plan state: Rose has dementia and wanders throughout the facility.

Person centered way: Sometimes I feel all alone, and I forget who you are. I like to walk. At home I walked with my dog Kimba. Please walk with me & let's take MOQI, the dog with us. I like looking at cute baby animals. I like to rearrange it in my drawers. Make sure I am part of any animals that visit the facility.

Or Sometimes Rose feels lonely & will forget where she is at. She does like to walk. She had a dog Joey & would walk him. Ask her to walk with you with Duke the facility dog. Rose likes to be a part of all animal activities.

64

Hospice Care Plan Samples

Items to consider including in a Hospice care plan:

Resident and Family coping

Activity intolerance

Anticipatory Grieving

Pain

65

Hospice Care Plan Samples

Resident and family coping concerns:

Related to:

Unrealistic expectations
Family unable to manage motional conflicts/sufferings and is unable to perceive or act effectively with residents needs.
Prolonged disease progression that exhausts supportive capacity of significant persons
Highly ambivalent family relationships, feel stress or nervousness in their relationship with facility staff

Evidenced by:
History of poor relationship been family and resident
Resident expresses despair about family's lack of involvement
Family displaying intolerance, family not ready for caregiver role
Withdrawal, limited communication with family

66

Hospice Care Traditional Plan Samples

Outcomes:
Visit regularly and participate positively in resident care within limits of ability.
Express more realistic understanding of resident's disease progression/status
Provide opportunities for resident to deal with situation in own way

Interventions:
Assess level of anxiety
Evaluated illness and current behaviors that are interfering with the care of the resident
Assess residents emotional and behavioral response from resulting from increasing weakiness and dependeny
Assist family and resident to understand "who owns the problem" and who is responsible for resoluation.
Avoid placing blame or guidlt
Involve family in information
Include all family members as appropriate in discussions.
Provide/reinforce info about terminal illness and/or death and future family needs.

QIPMO

Sinclair School of Nursing

67

Person Centered Hospice Care Plan Samples

My family and I have not been close in years. As my terminal illness has progressed, this has placed more strain on our emotional stability and my family has expressed guilt, anxiety, and hostility. This has also made my family withdraw and when they are involved, they are overbearing, and their expectations are not reasonable. They expect more of me than what I can do physically and emotionally.

I want to die with dignity and respect and just want to be listened to for what I want through my dying process.

Please include my family and provide as much information about the care that I need and where I am at in my dying process. Reinforce information about terminal illness and/or death and on-going family care. I have always gone to church and never said a cuss word in my entire life, however I am starting to say words that people would consider inappropriate, help my family to deal/accept my unusual behaviors. Evaluate if there are any other underlying reasons for me to behave this way, like infection or cognitive changes. Let my nurse know if this increases. Encourage virtual visits until an improved family dynamic is established and then encourage in-person visits as appropriate. Offer supportive family and resident groups that may assist in development of rapport with hospice chaplain and social services.

QIPMO

Sinclair School of Nursing

68

End of Life Person Centered Care Plan Sample

I am a Do not Resuscitate, If my heart and breathing stop- respect my choice and maintain my dignity. Offer my family the opportunity to see me before I am taken to the funeral home. Make sure that my dentures are in and my glasses are on my face when my family see me. Send my blue dress to the funeral home with me.

My family and I have discussed wt loss as a natural process. I do not wish for extraordinary emphasis or measures to be taken to insure wt maintenance. I wish to choose to eat or not eat as I please. I wish to be weighed according to routine weights per PCP order but not specifically to monitor loss/gain.

Some days I do not feel like showering or changing from my pajamas. Staff to acknowledge and provide for my preference.

I am not verbal but am known to turn my head to the side when I am not interested in my meal. My family would like staff to acknowledge this my choice not to eat at this time.

I can not longer express my preferences or needs. Above all my family has voiced end of life goals are for makes me most comfortable. At any time I appear uncomfortable in my w/c, during a meal, or activity , etc, my family wishes staff to assist me to bed

69

CHF Traditional Care Plan

Problem: Risk for cardiac overload due to CHF related to edema

Goal: I will not have any S&S of CHF through the next 90 days.

Interventions:

Assess/document for s/sx of malnutrition. Do not force me to eat but encourage my intake of adequate nutrition. Offer me small frequent feedings. Assess/document food preferences.

Assess/document/report to MD PRN any s/sx of hypokalemia because I take diuretics. These may include: Fatigue, muscle, weakness, diminished appetite, nausea and vomiting and dysrhythmias, Monitor potassium levels.

Assess/document/report to my MD PRN any s/sx of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, SOB upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, Orthopnea, weakness and/or fatigue, increased heart rate (Tachycardia) lethargy and disorientation.

Assess/document/report to my MD PRN any s/sx of digitalis toxicity: Fatigue, muscle weakness, anorexia, nausea, yellow halos around objects.

Check my breath sounds and Assess/document for labored breathing. Assess/document for the use of accessory muscles while breathing.

QIPMO

Sinclair School of Nursing

70

CHF Person Centered Care Plan

I have trouble with my heart and can get swelling of my feet, ankles and legs. Encourage me to keep my feet and legs propped up when I am in my recliner. Remind me not to add any salt to my food.

When I have breathing trouble, I do not eat well so encourage me to eat but do not force me. I may need more frequent snacks and offer me fluids throughout the day. I also have difficulty breathing and sleep in my recliner to help me breath better. I have shortness of breath when I walk distances outside of my room. Let my nurse know if any of these signs occur. I may get confused or talk about things that are not there when I have trouble breathing. Check my oxygen saturations if I get confused or talk about things that are not there. Let my nurse know if I am confused or talk about things that are not there.

I sometimes take off my oxygen and I cannot reach it if it falls on the floor. So you may need to remind me to put it back on or get it for me if it is on the floor. I am a do not resuscitate and do not want to go to the hospital for any interventions.

Sinclair School of Nursing

71

Dialysis Traditional Plan

Assess me for dry skin and apply lotion as needed.
Assess my intake and output.
Assess/document for peripheral edema.
Assess/document report to my MD s/sx of depression. Obtain order for mental health consult if needed.
Assess/document/report to my MD PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage.
Assess/document/report to my MD PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds.
Assess/document/report to my MD PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia, septic shock.
Check and change dressing daily at access site or per orders. Document.
Do not draw blood or take B/P in arm with graft.
Encourage me to go for the scheduled dialysis appointments. I usually receive it on Monday, Wednesday and Friday.
Obtain labs and report to doctor as needed.
Obtain my vital signs and weight per orders and prn. Report significant changes in pulse, respirations and BP immediately.
Work with me to relieve discomfort for side effects of the disease and treatment. (Cramping, fatigue, headaches, itching, anemia, bone demineralization, body image change and role disruption.)

72

Dialysis Person Centered Care Plan

I have damage to my kidneys that requires dialysis on Monday, Wednesday and Fridays. I like to take a packed lunch with an extra snack in it. Please make sure that one of the snacks is chocolate.

I get ankle and feet swelling at times and this is normal for me. You can remind me to elevate them, but I prefer to leave them down. I cannot wear regular shoes due to the swelling, so I wear slippers with rubber soles on them. Make sure to get my weight before dialysis three times a week and let my nurse know if it is increases or decreases by 5 or more pounds. If I start coughing, please let my nurse know because I may have to much fluid in my lungs and I may have breathing difficulty.

My dialysis site is on my left arm so do not take my blood pressure or draw blood in this arm.
Let my nurse know if this site is bleeding or turns red or purple.

I get depressed very easily and on my dialysis days I cry frequently. I am not looking for answers, just someone to listen. If I cry or am sad on non-dialysis days, let my nurse know.

QIPMO

Sinclair School of Nursing

73

Care Planning COVID

COVID	
Any age are at increase risk of severe illness	Following conditions might be at increase risk for severe illness
Cancer	Asthma
Chronic kidney disease	Cerebrovascular disease
COPD	Cystic fibrosis
Immunocompromised	HTN
Obesity	Immunocompromised
Heart disease	Neurological conditions
Sickle cell disease	Liver disease
DM Type 2	Pregnancy
	Pulmonary fibrosis
	Smoking
	Thalassemia
	DM Type 1

QIPMO

Sinclair School of Nursing

74

COVID Person Centered Care Plan

I have tested positive for Coronavirus but am not showing any symptoms at this time. I will be in droplet isolation for the next 14 days. Assess for COVID symptoms like fever, cough, shortness of breath or trouble breathing, headache, loss of taste or smell, congestion or runny nose, nausea or vomiting, new confusion or diarrhea. Please let my nurse know if any of these occur.

Re-educate me on why I am in isolation and remind me on how long I must be in isolation. I have a history of depression and feel like I am heading down that road again. Please provide virtual opportunities for me to visit with my family. I need assistance on putting on my mask and washing my hands. I like to keep busy with watching TV shows like NCIS and mystery shows. Christian and instrumental music helps me cope with COVID. I do enjoy 1:1 visits for conversation, manicures and reading with staff.

I hope not to have to be hospitalized or have symptoms related to COVID.

75

COVID Person Centered Care Plan

I have COVID-19 and am experiencing respiratory complications that requires oxygen right now. I do not feel like drinking much right now so I am at risk for dehydration. I want to be comfortable and will not have pain above a 4 and maintain my oxygen saturation above 90%.

I am on droplet isolation precautions. Encourage me to turn, cough and deep breath and use my incentive spirometer. I do use a CPAP at night and will need assistance with putting on and off the face mask and turning on the machine. Check my oxygen saturation at least every 4 hours. Let my nurse know if it falls below 90%. Encourage me to drink plenty of water with each staff interaction. I prefer to drink hot chocolate, apple juice and water.

I have chest and lung pain and can do the pain scale of 1-10. It has been about a 3-4 most of the time. I do not like to take medication so I may like a steam shower because this makes me feel better. I need extra rest right now so do not be surprised if I am in bed more often right now.

76

TIPS:

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

77

TIPS:

Any changes to the care plan need to be dated and initialed

Post fall the care plan needs to be reviewed, dated and initialed

- Look outside the box for possible interventions
- If the resident rolled out of a low bed to the mat, ask your self why??
  - Bed was wet
  - Tired of laying in the bed
  - Was an early riser before admission

78

TIPS:

Separate	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	Urge daily, routine use of care plan by staff
Remember	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.

QIPMO

Sinclair School of Nursing

79

TIPS:

Develop	Empower	Care	Post	Review
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	Post a new care plan every week without the name and reward the staff who knows whose care plan it is.	Review care plans with the staff who work the closest with the resident

QIPMO

Sinclair School of Nursing

80

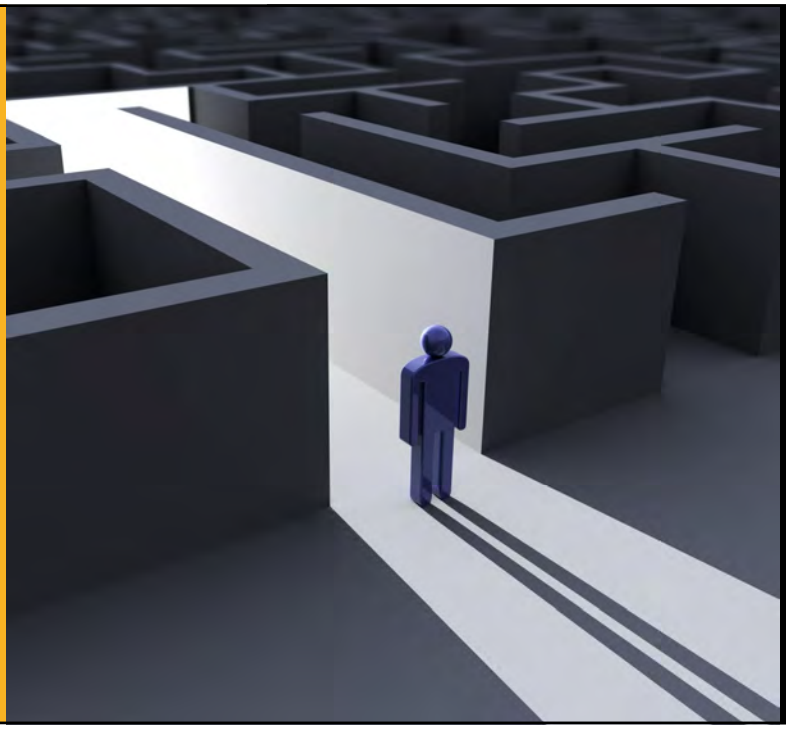
Your Daily Pleasures

Think about one thing that you always do during the course of the day that brings you pleasure and without it would your day be a little worse?

How would you feel if you could no longer experience that daily pleasure?

Do you think our residents are missing any of their daily pleasures?

81



Challenge!!!

Choose one resident to start with.

Identify what one daily pleasure was for them all their life.

Make it happen for that Person!

82

Look in the Mirror

What would you like people to know about you??

What will make or break your day??

Who is your favorite person??

83

CEUs for Today!

Today's Webinar has been approved for CEU hour(s)

In order for MO LNHAs to get credit:

- **It is REQUIRED that you complete a brief survey/evaluation via:**
  - ✓ **A pop-up at the end of the webinar, or**
  - ✓ **An automated email from GoToWebinar that will be sent to attendees**
  - ✓ ***You only need to complete it once (either via the pop-up or the email)***
- **It is REQUIRED that you answer the question asking for your LNHA number.**

Please note: the certificate that will be linked in GoToWebinar's automated "thank you for attending" email is NOT YOUR CEU CERTIFICATE. Your official certificate will be sent out by QIPMO staff in approximately 2 weeks.

**The amount of your credit will be adjusted based on time spent on the webinar.*

84

Resources

State Operations Manual

RAI Manual

Quality of life is just as important as health and safety source: Kane, R.A, (2001). Long term care and a good quality of life: Bringing them closer together *the Gerontologist, 41 (3), p. 293*

Krugh, C. & Bowman, C. "Changing the Culture of Care Planning: A person-directed approach" www.culturechangenow.com (Workbooks); 414-258-3649.

Newell, S; Rauscher, R; Virgil, R. "Care Plans for Culture Change. (Workbooks); 712-322-0026.

https://www.aapacn.org/wp-content/uploads/2020/04/AADNS_Individualized-Care-Plan-Development-Guide-for-Residents-with-COVID-19_FIN_V.1.2.pdf

https://www.pioneernetwork.net/wp-content/uploads/2016/10/Process-for-Care-Planning-for-Resident-Choice-.pdf

Quality of life is just as important as health and safety source: Kane, R.A, (2001). Long term care and a good quality of life: Bringing them closer together *the Gerontologist, 41 (3), p. 293*

Adapted from "The Softer Side of the MDS," Bowman, Cucinelli, Krugh, Arellano. 2008. aanac.org.

https://nurseslabs.com/4-end-of-life-care-hospice-care-nursing-care-plans/#nursing_care_plans

85