

Objectives:

- Understand about care plan process
- Addressing the care plan components
- Baseline care plan and comprehensive care plan
- Understand the regulations and surveys related to the care plan
- Discussing the different care plan models

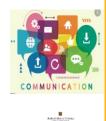
To promote communication and continuity of care by suggesting communication strategies, medical plans, and psychosocial resources

Problems
Goals
Approaches
Implementations
Evaluations

WHY CARE PLAN?

- · Identify the unique role of aspects of care
- · Provides direction for individualized care of the residents
- Think critically about each resident and to develop interventions that are directly tailored to the individual.
- · Continuity of care
- Communication
- Documentation
- · Guide for assigning a specific staff on specific tasks
- Support reimbursement





WHEN ... CARE PLAN?



- Within 48 hours of a resident's admission (baseline care plan)
- 21 days of a resident's admission (comprehensive care plans)
- When changes in conditions
- When having a new clinical concerns
- Revise at least every 3 months and anytime as needed



- A separate care plan is not necessarily required for each area that triggers a CAA
- The 7-day requirement for completion or modification of the care plan applies to the Admission, SCSA, SCPA, and/or Annual RAI assessments
- Do not need to be developed after each SCSA, SCPA, or Annual reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment (RAI Version 3.0 Manual CH 4: CAA Process and Care Planning October 2023 Page 4-12)
- The resident's care plan must be reviewed after each assessment, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions Reduction of North

CARE PLAN TIMING AND REVISION

- A comprehensive care plan must be:
- Developed within 7 days after completion of the comprehensive assessment
- Prepared by an interdisciplinary team, that includes but is not limited to-
 - The attending physician.
 - A registered nurse with responsibility for the resident.
 - A nurse aide with responsibility for the resident.
 - A member of food and nutrition services staff.
 - To the extent practicable, the participation of the resident and the resident's representative(s)
 - Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
- Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

CARE PLAN PROCESS

- Policy and process for successful care planning
- Base on MDS assessment and CAA analysis
- Identify the areas/problems/concerns for developing a plan of care
- · Interview the resident/family
- Team communication/Team discussion
- Further assessment/investigation
- Develop approaches/interventions
- Implementation
- Evaluation





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CARE PLAN: MEETING/CONFERENCE



- Must-have participants at a minimum, consist of the resident's attending physician, a registered nurse and nurse aide with responsibility for the resident, a member of the food and nurrition services staff, and to the extent possible, the resident and resident representative, if applicable.
- No requirements for members of the IDT 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 met in person, through email participation or written notes.
- 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, document explanations in a resident's medical record





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Invitation ser	t on:				O EMAIL O	POST MAIL	PHONE		
	Respond or/and return (date) Accept the schedule meeting (date)				ST MAIL O PHONE, ledule different time for conference. (date)				
Yes	No	Yes	N.	0	Via phone (dat	e) Req	est CPs	Different	meeting
Date of meet	in a c		_		Care plan d				
Partici	pants (staff)	Title	Partic (resi /fan		Relati	onship	·	Others	Title
	Major Diagr	noses				Overall	Goals		
# Date ID	Pr	obtems/conc	ems		Resolved	Reviewed		Plan	
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-						_	_	_	
								_	
NOTES									
TO LESI									
RESIDEN	T:			RO	OM:	PHYSIC	IAN:		

	Re: care plan meeting for:, will be held on in
	Dear
	I would like to invite you to a meeting with the care plan team of to discuss seem of the care plan to help higher health and conflictions and optimize higher tridgened and recovery.
	We would appreciate your input and feedbacks to help us to provide the test care for We expect the meeting may last lietween 30 minutes to an hour, and we would be glad to welcome any family
	members or friends who would wish to be involved in's care and in thinking ahead to tuture care.
	I look forward to meeting with you.
	In the case that you cannot attend at this above time and date, please call us to reschedule the meeting, or we can have the conference call with you.
	If you are not able to attend the meeting or to discuss with us via phone, please return this letter with your feedback below.
	Yours sincerely,
	Will affend the meeting on the above date and time.
	I cannot attend, nor to discuss on the phone, however, I have some inputs and feedback below and return into the provided envelop.
	PLEASE PROVIDE THE FEEDBACKS AND RECOMMENDATIONS BELOW: I have some concerns regarding the care for the resident.
	 I have some recommendations or/and information that the staff should pay attention to:
	I have some recommendations orland information that the staff should pay attention to:
	I have some recommendations orized information that the staff should pay attention to:
(Pa)	

Clinical Problem Solving and Decision-Making Process Steps and Objectives

PROCESS STEP / OBJECTIVES	KEYTASKS				
RECOGNITION / ASSESSMENT	 Identify and collect information that is needed to identify an individual's 				
Gather essential information about the	conditions that enables proper definition of their conditions, strengths, needs,				
individual	risks, problems, and prognosis				
	Obtain a personal and medical history				
	Perform a physical assessment				
PROBLEM DEFINITION	 Identify any current consequences and complications of the individual's situation, 				
Define the individual's problems, risks,	underlying condition and illnesses, etc.				
and issues	 Clearly state the individual's issues and physical, functional, and psychosocial 				
	strengths, problems, needs, deficits, and concerns				
	Define significant risk factors				
DIAGNOSIS / CAUSE-AND-	 Identify causes of, and factors contributing to, the individual's current 				
EFFECT ANALYSIS	dysfunctions, disabilities, impairments, and risks				
Identify physical, functional, and	 Identify pertinent evaluations and diagnostic tests 				
psychosocial causes of risks, problems,	 Identify how existing symptoms, signs, diagnoses, test results, dysfunctions, 				
and other issues, and relate to one	impairments, disabilities, and other findings relate to one another				
another and to their consequences	 Identify how addressing those causes is likely to affect consequences 				

IDENTIFYING GOALS AND		Clarify prognosis
OBJECTIVES OF CARE		Define overall goals for the individual
Clarify purpose of providing care and of		
specific interventions, and the criteria		Measurables
that will be used to determine whether		l'leasur ables
the objectives are being met	+	
SELECTING INTERVENTIONS/		Identify specific symptomatic and cause-specific interventions (physical, functional, and
APPROACHES/ PLANNING CAR		psychosocial)
Identify and implement interventions and	d •	Identify how current and proposed treatments and services are expected to address
treatments to address the individual's		causes, consequences, and risk factors, and help attain overall goals for the individual
physical, functional, and psychosocial	•	Define anticipated benefits and risks of various interventions
needs, concerns, problems, and risks	•	Clarify how specific treatments and services will be evaluated for their effectiveness
		and possible adverse consequences
MONITORING OF PROGRESS	•	Identify the individual's response to interventions and treatments
Review individual's progress towards	•	Identify factors that are affecting progress towards achieving goals
goals and modify approaches as needed	•	Define or refine the prognosis
	•	Define or refine when to stop or modify interventions
		and the second s
		Identify when care objectives have been achieved sufficiently to allow for discharge,
		transfer, or change in level of care

BASELINE CARE PLAN (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—
- (i) Be developed within 48 hours of a resident's admission.
- (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
 - (A) Initial goals based on admission orders.
 - (B) Physician orders.
 - (C) Dietary orders.
 - (D) Therapy services.
- (E) Social services.
 (F) PASARR recommendation, if applicable.



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BASELINE CARE PLAN

- I. Be developed within 48 hours of a resident's
- Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—
- 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;

 - PASARR recommendations, if applicable; and
 - Therapy and social services.

- - I. Is developed within 48 hours of the resident's admission.
 - 2. Comply with the requirements for a comprehensive care plan
- The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
 - 1. The initial goals of the resident.
 - 2. A summary of the resident's medications and dietary instructions.
 - 3. 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.

BASELINE CARE PLAN

- If a comprehensive care plan is completed in lieu of the baseline care plan, a written summary
 of the comprehensive care plan must be provided to the resident and resident representative, if applicable, and in a language that the resident/representative can understand. $\label{eq:condition}$
- The facility must provide the resident and the representative, if applicable with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary must be in a language and conveyed in a manner the resident and/or representative can understand. This summary must include:
 - · Initial goals for the resident;
 - · A list of current medications and dietary instructions, and
 - Services and treatments to be administered by the facility and personnel acting on behalf of the facility





BASELINE CARE PLAN: COVID 19

Goal: recovery?

- What precautions are being taken due to COVID-19
- Isolation precautions, special dining considerations, therapy considerations, ma
- Signs & Symptoms
- Fever, Cough, SOB, Respiratory problems like difficulty breathing
- rever, Colgn.Jub., Respiratory processins use amounty oreating.
 Sore throat, general feeling of unwell (body/muscle chest, chills). Diarrhea, Nausea or vomiting, headache, congestion or runny nose, new loss of sate or smell
 Emergency warning signs. Trouble breathing, persistent pain or pressure in the chest, new confusion, inability to wake or stay awake, blushed lips or face
 You also want to look for signs and symptoms of DVT & PE (these have been a clinical manifestation during and post COVID-19 residents).

- Special Precautions due to COVID-19
- CPAP/BiPAP, Respiratory treatments, dialysis



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			VANCED DIRECTIVE
	Admitting diagnos	15	Aftergies (including food, medications)
		PHYSICIAN ORDER	THE PARTY OF THE P
• PT D sower	ing D Evaluation C		special Discreening DiSolution Different
		PROVINCIANI ORDER	H FOR DETATY
C Regular C Maintanios soft	C Penal dist		O his concentrated seems.
C Bland diet	© Others		D Ruid restriction
	ACTIVITY/MORIL	CHAR ORDER FOR AC	CENTYMOBELTYTABL
Placement Pills and			
	C) broked weight bearing	ig on L R	
C As townsted C Confot (are) end			Anticohyuluant Ci Culture for
LI COMPOSITION, WILL	COLUMN TWO	TAN ORDER FOR RE	PCIAL MURSING CARP
Follow the nursing can			
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O TR Inci	G Tradestons		D Paracials D
		CIAN ORDER FOR ME	
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F 656: COMPREHENSIVE CARE PLAN



- 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.
- 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 personspecific, measurable objectives and timeframes in order to evaluate the resident's progress toward his/her goal(s).
- Care plans must be person-centered and reflect the resident's goals for admission and desired outcomes.

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COMPREHENSIVE CARE PLAN

- Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.
 - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being
 - Any services that would otherwise be required but are not provided due to the resident's exercise of rights
 - Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations
 - The resident's goals for admission and desired outcomes
 - The resident's preference and potential for future discharge
 - Discharge plans





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COMPREHENSIVE CARE PLAN

- Culturally Competent Care: The interventions in the resident's care plan must reflect the individual resident's needs and preferences and align with the resident's cultural identity.
- Trauma-Informed Care: Interventions for trauma survivors should recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, aggression, depression, anxiety, and withdrawal or isolation from others. Concerns related to culturally-competent, trauma-informed care
 - F656:For concerns related to development or implementation of culturally competent and/or traumainformed care plan interventions;
 - F699: For concerns related to outcomes or potential outcomes to the resident related to culturallycompetent and/or trauma-informed care;
 - F726: For concerns related to the knowledge, competencies, or skill sets of nursing staff to provide care
 or services that are culturally competent and trauma-informed.
 - F742:For concerns related to treatment and services for resident with history of trauma and/or history
 of post-traumatic stress disorder (PTSD)







CARE PLAN COMPONENTS

- · Data Collection or Assessment. ...
- Data Analysis
- Formulating the Problems or concerns using Diagnoses and impacts of the problems
- Outcomes Identification
- Planning for formatting the plan of care
- Establishing Goals and Desired Outcomes. ...
- Selecting Interventions, approaches
- · Planning for implementation
- Implementation: communication
- · Evaluation: if the care plans work?. Make decision to change, modify or remove



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CARE PLANS ADDRESS....

QUALITY OF CARE: clinical care /medical conditions 9ADLs, PU, PR, incontinence, PEG tube, etc. Prevent avoidable declines Safety • Manage risk factors to the or the safety of the safe

- QUALITY OF LIFE:
- Security;
- Comfort;
- Enjoyment;
- Relationships;
- Meaningful activity;
- Topspiritual well-being

- Manage risk factors to the extent possible or limiting of such interventions
- Address ways to try to preserve and build upon resident strengths
- Apply current standards of practice in the care planning process
- Evaluating treatment objectives and outcomes of care Offering alternative treatments
- Involve resident, resident's family or representative
- Functional competence; Individuality;
 Privacy, Autonomylchoice
 Spiritual well-heine
 Spiritual well-heine

WHAT THE CARE PLAN SHOULD REFLECT

- · The goals, preferences, needs and strengths of the resident
- The interventions person-centered measurable and time frames to achieve the desired outcomes
- Evidence of resident and, if applicable resident representative participation
- Specialized services and interventions to address PASARR recommendations
- Interventions that reflect the resident's cultural preferences, values and practices
- Interventions for care that are in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause retrammatization of the resident
- Interventions were implemented consistently across all shifts
- A process in place to ensure direct care staff are aware of and educated about the care plan interventions
- Adequate information provided to the resident and, if applicable resident representative to help 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

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ASSESSMENT

- Background information or Health history
- Current health status
- Self-care skills/needs
- Psychosocial status
- · Health issues related to learning
- Diagnoses and clinical judgment about the client's response to actual or potential health conditions or needs.
- The care plan should reflect the MDS assessment coding and CAA analysis
- Reasons for care plan or not





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PROBLEMS

- Diagnosis
- · Impacts of health issues or wellbeing
- Concerns
- What the problem is a problem?
- Different problems in the same diagnoses
- Combine problems if they are interrelated, similar goals or/and interventions are the same or related
- Make sure the problem statement about the resident's problem and not the staff's problems or facility's practices





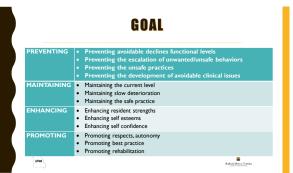


CARE PLAN GOALS

- Care Plan goals should be $\underline{\textit{measurable}},$ and have a timeframe for completion or evaluation
- The IDT may agree on intermediate goal(s) that will lead to outcome objectives. Intermediate
 goal(s) and objectives must be pertinent to the resident's goals, preferences, condition, and
 situation (i.e., not just automatically applied without regard for their individual relevance),
 measurable, and have a time frame for completion or evaluation.
- Goals should target either improvement, prevention, maintenance or palliative outcomes. They
 should be person-centered (Resident centered). What are the resident's goals? Not the staffs' goals
- Care plan goal statements should include the subject (first or third person), the verb, the modifiers, the time frame, and the goal(s).

Subject	Verb	Modifiers	Time frame	Goal	
Resident Jones OR I	will walk	fifty feet daily with the help of one nursing assistant	the next 30 days	in order to maintain continence and eat in the dining area	
					Substitution Nation

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Clear. Concise Realistic descriptions of desired outcomes. Reflect the problems/concerns They may be short-term or long-term, but they must be measurable. SMART Goal: SMART Goal: Specific The goal should be specific to the resident's situation and focused on one desired outcome. Measurable The goal must be a measurable, evidence-based outcome. Achievable: The goal must be reasonably achievable based on patient's condition Relevant: The goal must be individualized to the patient, based on stated needs, desires, and assessment findings Time Specific Goals need to include a target date that is achievable.

APPROACHES - How and what to reach to the goal? Practical approaches - Process of cares - Specific approaches/interventions - Is the approach worked for - particular concerns? - Problem? - Staff and the available recourses - Who carries out the tasks?



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Evaluation—Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, goals, or improvement or decline. Care plan meeting discusses: Resident's status and the effectiveness of the care plans Goal accomplishment. Partial? Full? Care plans will be modified as needed in goals, approaches and concerns Communication of changes

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F656: SURVEY GUIDANCE



- Does the care plan <u>address the goals, preferences, needs and strengths</u> 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 <u>specialized services and interventions to address PASARR</u> recommendations, as appropriate?





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F656: 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.





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CARE PLAN COMPLIANT WITH REGULATORY REQUIREMENTS



- Is comprehensive and individualized and centered care
- 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.
- · 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
 Secremon:
- 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.

Types of care plans

Medical models

- Standardized care plan
- · Medical-Procedure care plans
- · Are based on diagnosis
- Interventions/Approaches 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 (Individualized care plans
- 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
- Sometimes 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

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Traditional Care Decisions about policies, procedures, and work environment are made exclusively by management. Frontline staff are not involved in the decision-making process. Traditional medical model where care is driven by diagnosis, care tasks, and the individuals who perform the tasks.

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PERSON CENTERED CARE PLANS

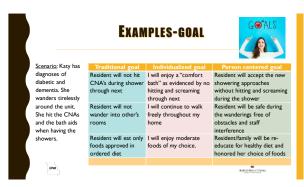
- A philosophy that keeps the person, the resident and their family, at the center of every decision-making process
- A focus assuring residents' preferences are valued and respected
- Care that reflects dignity and respect, information sharing, participation and collaboration
- Eliminating the assembly-line approach to care and embracing a philosophy of residents as individuals
- Improving the quality of care and quality of life for residents by accommodating resident choices and preferences
- Equipping staff with relevant knowledge and decision-making authority so they can effectively engage residents as partners in safety
- Collaborating with resident advisors, advocates, and long-term care ombudsman programs at all levels

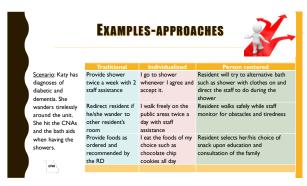
 | Resident advisors | Resident advisors

PERSON GENTERED CARE PLANS - 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 trying to understand what each resident is communicating, verbally and noverbally, identifying what is important to each resident regarding daily routines and preferred activities, and understanding the resident's life before coming to reside in the nursing home - Social History - Memory Enhancement & Communication - Mental Wellness - Mobility Enhancement • Safety - Visual function



PROBLEM	Exai	MPLES-PROBL	EM
	Traditional problem		
Scenario: Katy has diagnoses of diabetic and dementia. She wanders tirelessly	Behavioral issue: Resident displays combative behavior during shower	I dislike to be showered	High risk for hygiene problem Resident does not like the shower or bath due to be being afraid of the shower chair and water splash resulted in many combative episodes with the CNAs during the showers
around the unit. She hit the CNAs and the bath aids	Wanders due to dementia	I need to walk	Resident has risk of fall and elopement due to often wanders around the unit due to dementia, attempted to get close to the door and walk very fast
when having the showers.	Noncompliant with 1800 cal ADA diet	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.	Resident is at risk for medical complication due to resident refuses diet restrictions, choosing the rights to decline the medical advice for 1800 cal ADA diet





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Katy has memory loss
due to her CVA. She
nas left side paralysis
and needs ADL

Problem:

- Memory loss related post CVA. Episode of alteration in
- though process

 2. Need for assist
 with ADLs due to
 L side paralysis.

GO	ALS	AND	AP	PRO <i>l</i>	ACHES			
	Class	ic care p	olan	Individ	dual care p	ans	Person-centered care	

			plan
Goal:	Resident will be oriented to person, place, time, and situation most of the time. Resident will eat with limited assistance from staff.	Resident will remember her room and her seat in the dining room. Resident will comb her hairs with her R hand.	Resident will recognize the day from the personal calendar in her room. Resident will ask to participate into the shower by putting the soap on her arms and neck.
Approache s:	Provide orientation with routine care. Provide activities. Provide assistance with meals:cut meat and butter bread	Provide activity calendar and remind the events. Position the resident in front of mirror and setup the comb and hair accessories while doing her morning grooming	Provide clock and calendar at her bed side stand. Prompt her to date and time when provide morning care. Resident preferred liquid soap when washing her face. Provide the scent that she likes (Dove)



