# Person-Centered Comprehensive Care Plans


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# Objectives

1. Identify F656 Requirements for Comprehensive Care Plan from the State Operations Manual.
2. Know different person-centered individual care and services that need to be care planned.
3. Understand Person-Center Care Plans components and what makes a care plan person-centered.
4. Will be able to formulate a care plan with the problem, goal and interventions.

# 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.

# 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).

# F656-Comprehensive Care Plans

Specialized services or specialized rehab services that are provided as a result of the PASARR recommendations. Rationale must be provided if facility disagrees with PASARR findings.

Care plans must be person-centered and reflect the resident's goals for admission and desired outcomes.

Resident's preference and potential for discharge including the resident's desire to return to the community, any referrals to the local contact agencies and/or other appropriate entities.

Be culturally-competent and trauma-informed.

A Treatment Improvement Protocol Improving Cultural Competence
https://library.samhsa.gov/sites/default/files/sma14-4849.pdf

Concepts of Trauma and Guidance for a Trauma-Informed Approach
https://library.samhsa.gov/sites/default/files/sma14-4884.pdf

# Culturally Competent Care

(Cultural responsiveness, Cultural awareness, Cultural sensitivity)

Interacting effectively with persons of cultures different from his/her own.
Being respectful and responsive to health beliefts, practices and cultural and linguistic needs of diverse populations such as racial, ethnic, religious or social groups.
Care Plan interventions reflect the individual needs/preference and align with the resident's cultural identify.

# Trauma-Informed Care

Individualized trauma experience and need to utilize person centered trauma-informed approaches.
Recognize the effects of past trauma includes resident, family, and friends input to identify and implement individual interventions. 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.

# F656-Comprehensive Care Plans

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 and has control over their daily lives.

Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home

# What 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

# GUIDANCE

Measurable objectives describe the steps toward achieving the resident's goals, and can be measured, quantified, and/or verified.

> For example, "Mrs. Jones, who underwent hip replacement, will report adequate pain control (as evidenced by pain at 1-3, on a scale of 1-10) throughout her SNF stay." Facility staff will use this objective to monitor the resident's progress.

The comprehensive care plan must reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. Interventions for the example above, related to pain, may include, but are not limited to:

> • Evaluate pain level using pain scale (0-10) 45 minutes after administering pain medication; • Administer pain medication 45-60 minutes prior to physical therapy.

# 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

# F656 Comprehensive Care Plans

## Section V - Care Area Assessment (CAA) Summary

**V0200. CAAs and Care Planning**

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

| Care Area — Check all that apply | A. Care Area Triggered | B. Care Planning Decision | Location and Date of CAA Documentation |
|---|---|---|---|
| 01. Delirium | ☐ | ☐ | |
| 02. Cognitive Loss/Dementia | ☐ | ☐ | |
| 03. Visual Function | ☐ | ☐ | |
| 04. Communication | ☐ | ☐ | |
| 05. ADL Functional/Rehabilitation Potential | ☐ | ☐ | |
| 06. Urinary Incontinence and Indwelling Catheter | ☐ | ☐ | |
| 07. Psychosocial Well-Being | ☐ | ☐ | |
| 08. Mood State | ☐ | ☐ | |
| 09. Behavioral Symptoms | ☐ | ☐ | |
| 10. Activities | ☐ | ☐ | |
| 11. Falls | ☐ | ☐ | |
| 12. Nutritional Status | ☐ | ☐ | |
| 13. Feeding Tube | ☐ | ☐ | |
| 14. Dehydration/Fluid Maintenance | ☐ | ☐ | |
| 15. Dental Care | ☐ | ☐ | |
| 16. Pressure Ulcer | ☐ | ☐ | |
| 17. Psychotropic Drug Use | ☐ | ☐ | |
| 18. Physical Restraints | ☐ | ☐ | |
| 19. Pain | ☐ | ☐ | |
| 20. Return to Community Referral | ☐ | ☐ | |

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# F656-Comprehensive Care Plans—Survey Probes

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?

For residents with a history of trauma, does the care plan describe corresponding 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 re-traumatization of the resident?

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# F656-Comprehensive Care Plans
# survey guidance

Does the care plan describe interventions that reflect the resident's cultural preferences, values and practices?

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 alternati to address care of the resident if he or she has refused treatment.

# 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?

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

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# Updating Care Plan

is

**ON-GOING**

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

# The Interdisciplinary Comprehensive Care Plan

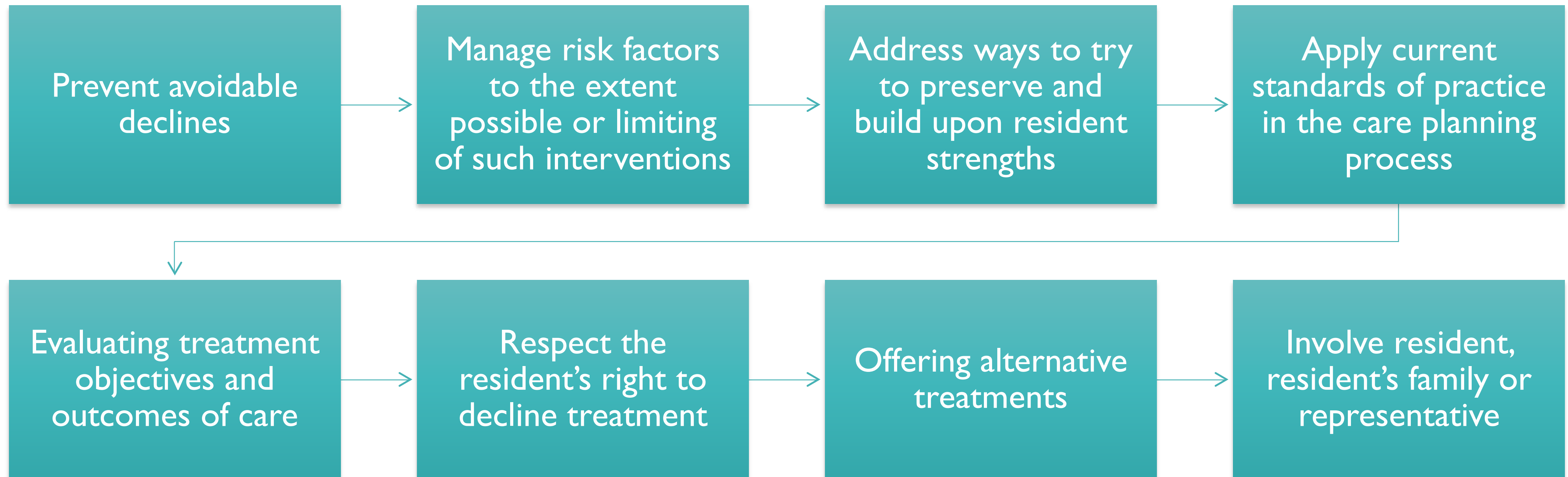
Serves as a road map that guides all staff involved in the resident's care

Communicates vital resident care information to the entire IDT team

Contains specific detailed instructions for achieving resident goals.

Person Centered Care

# Overall Focus of the Comprehensive Care Plan

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# Care Plan Issues Based on Comprehensive Assessment

ADLs (functional status/ daily care needs/ section GG) & ADL goals

Pressure injuries (Skin)

Bladder Management (Toileting Programs-Urinary/Bowel)

ROM

Mental/Psychosocial functioning

N-G tubes/G-tubes/Catheters/Ostomies

Nutrition/Hydration/Fluids

Special needs & services

Specialized Equipment

# Care Plan Writing and Inclusion

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

Social History

Memory Enhancement & Communication

Mental Wellness

Mobility Enhancement

Safety

Visual & Hearing function

# Care Planning List – Special Considerations/ Strengths

Dental care

Pain management/comfort

Discharge plan

Advanced Directive (DNR/Full Code)

Medications: High Risk/Black Box Medication

Cultural preference

Trauma-Informed Care

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# Care Planning: Quality of Life

Security

Comfort

Enjoyment

Relationships

Dignity

Meaningful activity

Functional competence

Individuality

Privacy

Autonomy/choice

Spiritual well-being

# Care Plan

How much assistance
Anything unique to the individual
Assistive devices used
Therapy interventions
Restorative interventions
Strengths, preferences
Functional status for Improving, maintaining &/or Preventing

# How Do You find this Information?

Ask the resident

Interview family members

Interview friends

Observe the resident with the staff

IDT Team

Use the MDS as a tool

Medical records

# 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!!

# 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 |

# 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 |

# 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 (Person-Centered) 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 or persons name.
- 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

# Care Plan and Resident's Rights

- Respecting resident's right to decline treatment
- Offer alternative treatments
- Educate
- Document refusals
- Notify
  Appropriate staff (physician etc.)

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# FORMAT FOR CARE PLAN

**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.

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NURSING CARE PLAN

| Student: ____ Date : ____<br>Instructor: ____ Room# ____<br>Patient initials: ____ Unit : ____ | Medical Diagnosis: ____ | |
|---|---|---|
| **Assessment** | **Plan** | **Implementation/Evaluation** |
| Subjective / Objective Data<br><br>Nursing Diagnosis: ( Problem Statement in NANDA format)<br><br>Need:( Place a check next to the Maslow Level for this problem)<br>Self Actualization ___ Self Esteem ___<br>Love and belonging ___ Safety ___<br>Physiological ___ | Goal Statement : (Expected Outcomes)<br><br>Planned Interventions / Rationales<br><br>Reference: | Goal Evaluation (Actual Outcome)<br><br>Summary of Interventions<br><br>Revision of Plan |

| 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. |

# Defining issues to be addressed in Care Planning

Problems
Potential Problems
Risks
Need
Strength

# Care Plan Assessment

Assessment

What was/is 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, temperature, meals

# 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.<br>2) Invite to RO Activ, ie current events, holiday parties, Resid Council.<br>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.<br>2) Place warm, wet wash cloth in lt hand.<br>3) Instruct resident to wash face and rt hand.<br>4) Complete portion of task left undone. |

# "Individualized" Care Plan

| 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<br>2) Invite Joe to News Group, Resid Council and Holiday events to help with orientation.<br>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.<br>2) Put a washcloth in Joe's lt hand.<br>3) Ask Joe to wash his face and rt hand.<br>4) Offer to finish any portion Joe is unable to complete. |

# “Person Centered” Care Plan

| 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 through this review period. | 1) When talking to me point to the clock and help me to read the digital numbers.<br>2) Show me the calendar and read the activities for the day to me.<br>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 through this review period. | 1) When I get ready to wash and shave in the AM, put me in front of the mirror so I can see myself.<br>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”<br>3) Remind me to follow the steps I learned in therapy to wash my face.<br>4) When I have done all I can, I will ask you to finish for me. |

# 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 (language that a 4$^{th}$ grade level can understand)

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

# 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

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# 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?

# What Does the Goal Have to Contain?

Who does the goal address?

What is the resident or staff going demonstrate?

How often will the action will occur?

The amount of times or number of occurrences.

# 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: Pressure Injury of R hip

Goals:

Decrease in size by next quarter

No signs of infection

No slough or eschar on wound bed

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: 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…..

# INTERVENTIONS

Specific

Individualized approaches

Short and concise

What do CNAs/staff need to do to assist the resident to reach their goal

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# Refusals

| | |
|---|---|
| Respect | Respect the resident's right to refuse or decline treatment |
| Offer | Offer alternative treatments, non-pharmacological interventions |
| Offer | Offer different times, shift or days |
| Offer | Offer different caregivers |

# What is Part of the Care Plan?

Many different items are used as part of the Care Plan

- For example:
  - MARs
  - TARs
  - Closet information
  - Notes within the Care Plan Book
  - Kardex

What does your care plan policy include?

# 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

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*Intervention should not say "See Skin Protocol or Policy".

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# Practical thoughts

Medications:

MAR
- Actual Medication
- Dosage
- Frequency/Time

POS
- Diagnosis

Care Plan
- Common side effects
- Whom to report it to

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# Practical thoughts

Skin Care

TAR

Dressing specific details

Type of medication to be applied to wound

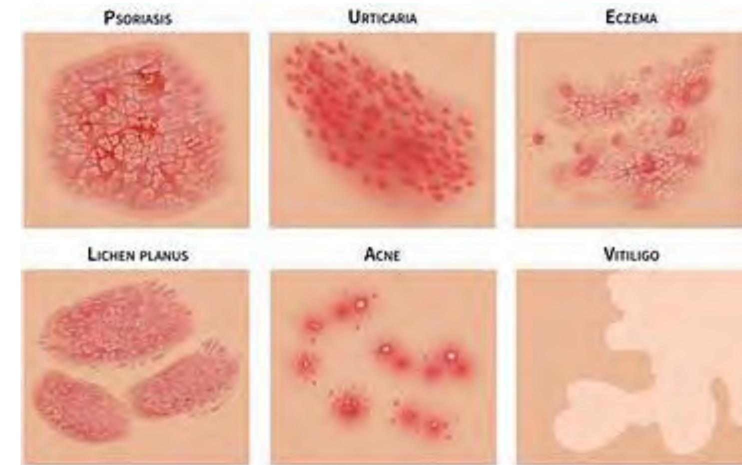
Wound documentation

Care Plan

Dressing location

Specific person-centered interventions

To whom do they report problems



## Traditional Example:

Problem: Resident has a hx of falling d/t weakness and unsteady gait.

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 using my walker to steady myself. My goal will be to reduce falling to 1-2 falls without major injury for the next 90 days."

# 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)

# 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.

# 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.

# Hospice 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 known 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 (comfort with care, privacy)
- If I appear uncomfortable in my w/c, during a meal, or activity assist me back to bed
- Acknowledge my choice not to eat after offering alternates
- Hospice Chaplain to see weekly to provide spiritual support
- Hospice Social Services as needed
- Do not perform CPR

# 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.

# 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

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# Hospice Care Plan Samples

Items to consider including in a Hospice care plan:

Resident and Family coping

Activity intolerance

Anticipatory Grieving

Emotional/Religious beliefs

Feelings: hopelessness, isolation, weakness. Loss of control, unrealistic perceptions

Pain

Person Centered goals & intervention especially when different then standard care practices.

Hospice Care Staff: and care Chaplain, CNA etc.

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# 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.

# 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. Weigh me before and after dialysis treatment.

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. Let my nurse know if I have any swelling in my left arm, or bleeding from my dialysis site.

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.

# 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 through this illness (14 days).

# 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.

# Communication Care Plan Example

Problem:

I have dementia and have difficulty communicating my needs.

Goal:

I will speak yes or no every shift through this review period.

Intervention:

Allow me time to communicate needs
Don't assume you know what I want
Ensure I can see your face to read lips or direct voice to right ear that has better hearing
Use gestures, communication board when I do not respond verbally
Use simple instructions- break up into one or two steps, yes or no
Include me in conversations
Limit length of activities based on my short attention span

# Care Plan Example

Rose is at risk for decline in activities participation since she does not like large groups and has dementia. Rose would like to participate in 1 small group activity weekly and activities in her room daily through this review period.

Rose's favorite TV shows is NCIS, BBC, National Geographic, and anything that has animals in it. Rose likes science fiction movies like Star Trek Trilogy, Star Wars movies and any movies from the 80's. Rose does not like westerns or the news. Rose enjoys music especially when she has difficulty sleeping. My favorite is Christian and instrumental music. I like quiet areas of the building and do not like BINGO or puzzles. Rose has to have her ipad on her night stand and in reach when in bed.

Rose loves chocolate ice cream or any activities that involve food. Rose is a vegetarian.

# Behavior Care Plan Example

Problem: What is the behavior (possible causes, exacerbation factors, diagnosis)

Goal: Will not interrupt the environment of others due to "whatever behavior" less than daily thru this review period.

Interventions: promotes/stirs it up and what calms the behavior
Prefers quiet and not loud noises
Does not get along with John, don't sit them together
Does not liked to be rushed
If upset remove from situation and return to room to watch old movies and offer chocolate ice cream
Was a nurse in long term care likes to organize papers and fill out forms
Watch your body language, can sense if staff is becoming frustrated, leave room and return later after ensuring my safety

# Weight Loss Care Plan

Rose is at risk for weight loss because Rose does not like to sit long to eat. Offer snacks while she is walking like granola bars, chocolate chip cookies, and goldfish crackers. Nutritional supplement drinks chocolate or strawberry when walking. Does not like water, so offer lemonade, and fruit flavored teas or chicken broth. Finger foods are easier for Rose while she away from the dining table.
Rose is to eat at a table by herself facing the wall to decrease distractions when she chooses to sit down for a meal. Rose is able to get up and move at her own will. Rose does not have any teeth but is able to eat a regular consistency diet.

# Wound Care Plan

Rose has a dressing on her right hip. If it is missing, wet or soiled, let the nurse know immediately.

Rose can only be turned from her back to left side.

Please use a wedge to keep Rose on her left side.

Be sure alternating pressure mattress is working and has not bottomed out.

Apply barrier ointment after each incontinent episode.

Rose likes to be up in w/c with roho cushion after breakfast, lunch and supper for 1 hour at a time.

# Restraint care plan

Restraint: Belt that is fastened in the rear of the wheelchair

Family is aware and in favor of the practice, fearing further injury. Does not want any further hospitalizations.

Attempted: High visibility, toileting, pain management, self release seat belt, resident centered activities, had two major injury falls in the last 4 months

Removed every 2 hours and when in the dining room under the direct care of staff

Plan to remove restraint and go to a broda chair or tilt in space wheelchair once resident is no longer able to self propel the wheelchair

# PTSD/ Trauma

| Problem | Goals | Interventions |
|---|---|---|
| I have experience trauma and have PTSD as a result. | I do not want to experience re-traumatization through this review period. | Let me know when there is going to be a fire drill if possible. Have me use my headphones to listen to 80's music during fire drills. |
| I have been in a flood and fire when I was younger and I have been physically assaulted and threatened with a knive. | I can have 2 glasses of wine weekly through this review period. | Provide me with meaningful activities like listening to 80's music, watching the news, men's small groups and any activity that has food. I enjoy drinking wine with special occasions. |
| | | I like to keep my door open even at night. |
| | | Monitor for signs and symptoms of depression, anxiety, sleep disturbances or physical aggression. If any noted- let my nurse know. |
| | | Encourage me to talk about my feelings, thoughts and concerns. Reassure me that I am in a safe space. |
| | | I use telehealth for my mental health provider monthly. |
| | | Explain all procedures and care prior to initiating them. |

# Discharge Plan

| Problem | Goal | Intervention |
|---|---|---|
| Rose wants to go home and live with her husband who has dementia and is elderly and unable to assist in caring for her. Rose does agrees at other times that placement is long-term here. Rose's husband visits with the assistance of their daughter frequently and both agree long term care is appropriate. Rose nor family want the local contact agency contacted. | Plan is for long term care through this review period. | Review discharge plans annually and prn. Encourage Rose to talk about feelings when she is upset about not living at home with husband and about her long term placement. Assist Rose in using Facetime/Skype or other virtual means to see/communicate with husband when he is unable to visit weekly. Involve Rose in activities of choice like any activity with food, watching soap opera from 1pm-3pm uninterrupted, animal visits especially dogs, and tea time. Rose does not like Bingo or puzzles. |

# Anti-depressant Care Plan

Rose is on a medication for depression and at high risk for side effects. Alert the nurse if she has nausea, diarrhea, dry mouth, insomnia, nervousness.

Alert the nurse if a change in mood (increase time in her room or not coming to activities)is noted.

Rose does not like loud noises or being in large groups.

Encourage Rose to attend small group activities and to come out of her room when animals or children are visiting.

Rose sees a psychologist on a regular basis. Rose prefers to be notified before the psychologist visits. Rose likes to see the beautician before the visit.

# Antidepressant Medication

| Problem | Goal | Intervention |
|---|---|---|
| I am on a medication for my depression. I am at risk for this to worsen in the winter and tend to see the negative side of all things. | My depressive symptoms (such as sad facial expressions, or verbalized that I am depressed) wil not occur daily through these period | Praise accomplishments and reinforce positive interactions. Allow Rose to talk about negative side, but remind the resident of the positive side without judgement. Encourage contact with daughter via phone. Encourage comedy shows and movies. |
| | | Assist resident to church services on Sunday. |
| | | Assess for suicidal tendencies like statements that Rose wants to die or feels hopeless, extreme mood swings, eating or sleeping more or less, agitated, anxious, extremely sad, or withdrawal. Notify the Nurse and Social Services. |
| | | Encourage me to talk about my feelings and reinforce positive talk. |
| | | Encourage me to walk in the courtyard on days that are appropriate (not when it is raining, snow or extreme high temp/humid). |
| | | Assess for side effects due to my medication for depression such as diarrhea, constipation, weight gain, upset stomach, headache, trouble sleeping, dry mouth or blurred vision. Let my nurse know if any of these occur. |
| | | Encourage me to watch comedy TV and movies, books, comics, magazines that are humorous. |
| | | My daughter has a "knack" for making me feel better about things. Call her if nothing else seems to work. |
| | | Contact geri-psych as needed. |
| | | Chocolate ice cream, chocolate pudding, pink lemonade, and mint tea are my favorite and always makes me feel better. |
| | | Sit me with Terry or Alex during activities and meals when I am having a "down" day. |

# 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 and medication names |
| Develop | Develop the care plan with IDT involvement. |

# 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 (computerized make sure to revise and not delete).

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

# 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 on-going. |

# Comprehensive Care Plan Audit Check List

- Diagnosis: Are diagnosis that require special care listed on the care plan with the care requirements? (Ex., anticoagulants, orthotic devices, pacemaker checking, dialysis)
- ADLs: What can they do for themselves? What do they need assistance with (and how much)? Are there any parts of tasks they can complete but perhaps not all? (Ex., can button shirt but cannot pull up pants)
- Communication: Do they have dentures, hearing aids, glasses? Does this affect their communication and ADLs? Do they have dementia or another kind of cognitive deficit that impairs their communication? How is this compensated? What other areas of the resident's care plan does this affect?
- Routines/Religious or Cultural Preferences: What are their personal preferences related to when they are awake versus when they prefer to go to bed (night owl or early bird)? Are there any religious or cultural routines or preferences related to activities or foods that should be mentioned?
- Trauma-informed care: Is there anything you need to address here? What are their triggers? What calms them down?
- Medications: Do they take any medications that require special monitoring? (Ex, Coumadin, antiseizure meds, diuretics). Are the frequency of lab draws in the physician's orders or in the care plan?
- Pain/Behaviors: (Pain) What is the source of pain? Does anything make it worse or better? Is there dietary and/or pharmacological interventions in place for side effects of the prescribed pain meds if opioids? What nonpharmacological interventions should be tried first? (Behaviors) Does the resident have a diagnosis related to psych? Are there specific things that trigger their symptoms? What nonpharmacological interventions help those symptoms? How often is the psych med evaluated?
- Discharge plans: What are the resident's discharge goals?
- Person-centered: Is the care plan individualized? Are the goals applicable to the resident's capabilities and wishes? Does the dietary section reflect likes and dislikes? Does the care plan distinguish itself by resident or is it cookie-cutter?

# 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.

# 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?

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# Challenge!!!

Choose one resident to start with.

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

Make it happen for that Person!

# 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??

# Clinical Education Nurses

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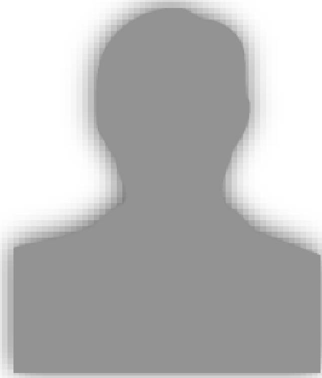

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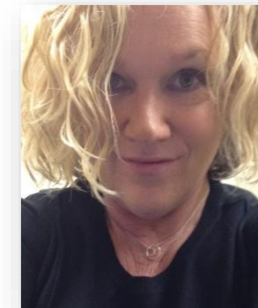

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# Evaluation

Please take a few minutes to fill out the evaluation for this training:

EVALUATION

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