Care Planning for Activity Professionals

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1

1

Objectives – Participants will:

- Explore new regulations regarding care planning
- Explore critical components of care planning process
- Explore techniques to ensure person-centered care plans that are responsive to need and choice
- Explore strategies for keeping care plans current and useful

2

2

Overview

- Nursing facilities and assisted living faculty regulations require that a plan of care be developed for each resident.

Nursing Facilities call them care plans

Assisted Living Facilities call them ISP [Individualized Service Plan

3

3

Commonalities

NF

- Baseline & developed after completion of the MDS
- Reviewed after the completion of each MDS
- Updated when there is a change in resident status or preference or when the original plan is no longer effective or needed

ALF

- Developed after completion of the UAI
- Reviewed at least annually
- Updated when there is a change in resident status or preference or when the original plan is no longer effective or needed

4

4

Person - Centered

means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices

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.

5

5

Comprehensive Plan of Care must include:

1. services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being
2. services that would otherwise be required but are not provided due to the resident's exercise of right
3. any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASSAR
4. Discharge plan

6

6

Key definitions

- **"Resident's Goal"**: The resident's desired outcomes and preferences for admission, which guide decision making during care planning.
- **"Interventions"**: Actions, treatments, procedures, or activities designed to meet an objective.
- **"Measurable":** The ability to be evaluated or quantified.
- **"Objective":** A statement describing the results to be achieved to meet the resident's goals.

7

7

Resident / Resident Representative Participation

- **The facility must provide the resident and resident representative, if applicable with advance notice of care planning conferences to enable resident/resident representative participation**
- Facilities are **expected to facilitate the residents' and if applicable, the resident representatives' participation in the care planning process**.
  - **NF** – document initiation and who participated in the development and care plan meeting
  - **ALF** – ISP must be signed by staff, resident and/or resident representative following each revision

8

8

Plan of Care Basics

- Content
- Statement of risk or opportunity
- Goals / Expectations
- Interventions / Approaches
- Responsibility
- Review / Evaluation

- Expectations
- S – specific
- M – measurable
- A – achievable
- R -- realistic
- T -- Timely

9

9

Statement of risk or opportunity

Must be based from assessment

MDS / CAA or UAI

Departmental assessments [i.e. social work, dietary, mental health, etc..

Risk assessments [i.e. falls, pressure ulcer, etc.

Should be summary of rationale – explain why and what is important

Should incorporate resident / resident representative decisions or choice.

Statement can be predictive or reactive

10

10

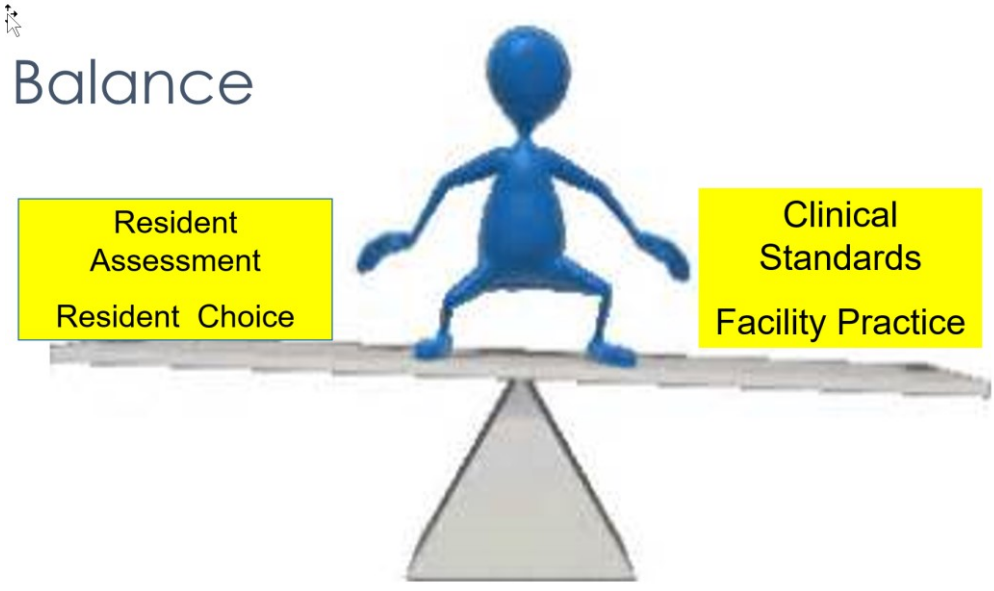
Goals / Expectations

- What is the expected outcome
  - Improvement
  - Decline
  - Stabilization
- Is it measurable
- Is it realistic for the resident

11

11

Interventions / Approaches



12

12

Interventions / Approach's

- ✓ Are they responsive to opportunity or risk
- ✓ Are they reflective of resident choice
- ✓ Are they "do-able" by the team

13

13

Person-Centered Plan of Care Considerations

- Ethnicity
- Cultural values
- Lifelong interests
- Spirituality
- Life roles
- Support systems
- Resident / representative choice or preference
- Advanced directive decisions

14

Responsibility

- Who will be responsible for completing each intervention or approach

Think "TEAM" not individual discipline/department

15

Review / Evaluate

- **Review to determine the effectiveness of the plan; were expectations met?**
  - Continue
  - Modify
  - Eliminate

FOCUS

There may be differing perspectives

16

CARE PLAN MODEL

Opportunity	Goals or Expectations	Approaches Interventions
4 R's ➢Reason ➢Risk ➢Related Condition ➢Resident preference	Expected Outcome that is specific to the resident & time frame and that is measurable	➢What team will do in response to the 3 R's ➢Resident choice & preference ➢Are they responsive to expectations

They must be responsive and compliment each other

17

Opportunities for Successful Use of Plan

- Write in "layman's terms"
- Keep it short & concise
- Explain what the issue is and what others will do to:
  - Facilitate improvement
  - Minimize decline or slow progression
  - Minimize risk or adverse outcome
  - Maintain stability
  - Meet resident expectations

18

Respect resident choice / decision

- When a resident / resident representative makes a decision that you believe is not in the best interest of the resident:
  - Document education to the resident / representative that includes the rationale for your recommendations and risk/benefits of their decision
  - Document all considerations of alternative treatment and/or compromise
  - Keep resident / representative and physician informed of on-going discussions
  - Validate presence of and/or scope of any Advance Directives
  - Review, update or modify care plan timely
  - Consider need to refer to Ethics Committee

19

19

When a "risk" turns into a "reality"

- Risk care plan may fail because
  - Incomplete or inaccurate assessment of risks at time
  - Interventions were not responsive to the identified risks
  - Interventions were not consistently carried out or accepted by resident
  - Resident risks changed – new risks developed or probability of other risks increased
- Investigate to understand the "root cause" of the decline or adverse outcome – what was different; why did this occur
- Modify plan to address
  - Response / treatment to new condition
  - Prevention of recurrence

20

20

Opportunities for Successful Use of Plan

- Involve key stakeholders
  - All levels staff
  - All departments
  - Resident/family
  - Contract consultants
    - Pharmacy, wound care consultant, hospice, mental health, etc..

21

Systems to Keep Plan Current

When modifying plan of care because of new incident –

develop both treatment and preventive components

Why did it occur
How can we treat
How can we prevent recurrence

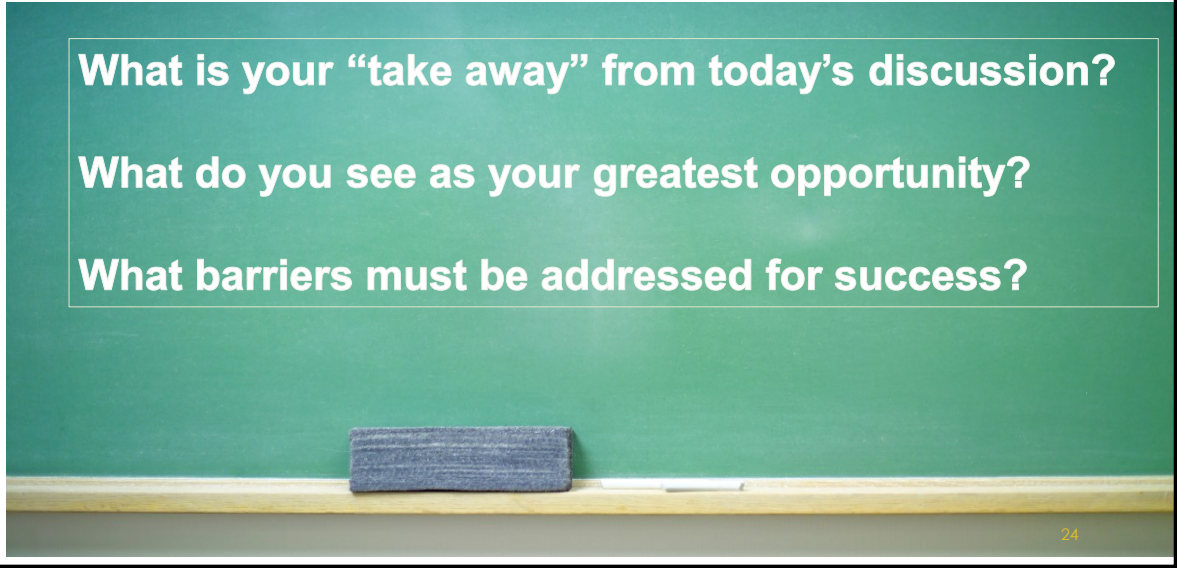
22

Systems to Keep Plan Current

- Share responsibility
  - Create "ownership" by the team, not by department
- Evaluate efficiencies
  - Computer v. hand written plans
- Take a "pulse check"
  - Does it represent the resident
  - Is it acceptable to resident
  - Is initiation do-able / demonstratable

23

Lessons Learned



24

Plan of Care for Activity Professionals

Thank you for this opportunity; I will gladly try to answer your questions or research those that I cannot answer.

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25