Care Plans: Is your facility going in the right direction?

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It seems that long-term care providers are struggling to stay the course in developing thorough, comprehensive, "Person-Centered Care" plans. Amid all the numerous regulatory changes, nursing and rehabilitation facilities are attempting to find a balance between shifting the care model while also maintaining regulatory compliance.

In an effort to move care to a more "individualized" approach, The Centers for Medicare & Medicaid Services (CMS) has issued new regulations to guide facilities in Comprehensive, Person-Centered Care Planning (483.21). Let's first explore Person-Centered Care as it is defined by CMS.

Definitions 483.21(b) "Person–centered care": to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

Baseline Care Plan

As stated in 483.21(a)(1) 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 recommendations, if applicable

Baseline Care Plan Summary

483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The Initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. The summary must be in a language and conveyed in a manner the resident and/or representative can understand. The format and location of the summary is at the facility's discretion; however, the medical record must contain evidence that the summary was given to the resident and the resident representative, if applicable.

Comprehensive Care Plans

483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at 483.10(c)(2) and 483.10(c)(3) that includes measurable objectives

and timeframes to meet a resident's medical, nursing, and mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

i. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.24,483.25 or 483.40; and

ii. Any services that would otherwise be required under 483.24,483.25 or 483.40 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10(c)(6)

iii. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

iv. In consultation with the resident and resident representative(s)

   a. The resident's goals for admission and desired outcomes.

   b. The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or appropriate entities, for this purpose.

   c. Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirement 483.21(c)(1).

Comprehensive Care Plans: Part Two

483.21(b)(2) lists the conditions in the development of the comprehensive care plan. A comprehensive care plan must be:

i. Developed within seven (7) days after completion of the comprehensive assessment.

ii. Prepared by the interdisciplinary team, that includes but is not limited to:

   a. The attending physician

   b. A registered nurse with responsibility for the resident

   c. A nurse aide with responsibility for the resident

   d. A member of food and nutrition services staff

   e. To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their representative is determined not practicable for the development of the resident's care plan

   f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident

iii. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

Where to go from here?

First, ask questions … then, ask more questions! Last but not least, *listen*. What matters most to the resident can best be explained by him/her or their caregivers. The goals of the residents are most often not medically related, but personal to that individual. Residents want to continue their life just as they did in their own home — something we would all want. A key item that will help in the development of the care plan is getting to know your resident. Are you asking them about hobbies they enjoy, or important events they may want to continue to take part in? Are you asking for their advice on activities or holiday planning? Do you know which residents like outdoor activities and which residents like quiet time alone? Who wants to go to church or hear musical entertainment? Are you checking to see what the preferred bath time is for each resident? If not, you should be!

In allowing the resident to be involved in making choices, facilities will be changing the narrative from what the staff believes is prudent to what the resident actually desires. Rather than using form care plans, individualized plans of care will be implemented, providing greater independence for a resident and a better quality of life. On paper, this shift in the regulation certainly benefits the resident. However, the documentation required prior to, during, and following care plan meetings will create a burden on the facility at the outset. Additionally, inclusion of the resident's representative in the care plan meeting and the resulting resident-centered care plans will also be essential to fulfilling these new requirements. The representative's expectations may need to be realigned with the resident's goals and desires. This documentation will become important should there be an unfortunate incident that results in litigation.

Once pertinent personalized information has been gathered, you will be on the right path in putting together a plan of care that is customized, thorough, and easily understood by all who are providing care. Remember, the care plan is a *working* document; a continuum of trial and error. If something doesn't work, simply change it.

We all want our voices heard — that doesn't change as we age. The Person-Centered Care model is a platform that will change our thinking, and ultimately improve quality of care and life.

Resources:

- Centers for Medicare & Medicaid Services (CMS)
- State Operations Manual (SOM)
- *Person-Centered Care Planning: Identifying Goals and Developing Care Plans*, by Jessica Briefer Fiend
- *What's Wrong with Care Plans — and how to Get it Right*, by Holly F. Sox, RN, BSN,RAC-CT
- Clinical Editor — Careplans.com
- *The Surveyor's Approach to Care Planning*, by Cat Selman, BS
- The Healthcare Communicators, Inc.

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Kerri also held a position as a committee member for the Memory Walk for the Alzheimer's Association. She has also been an educational training provider for nurses, social worker's, and administrators in the Senior Living Industry as well as Primary and Specialty Physician Offices.

Kerri is Certified as a Resident Assessment Coordinator, and Risk Manager Certified. Kerri is Licensed in Tennessee as a Residential Home for the Aged Administrator/Assisted Care Living Facility Administrator and in 2017, she received her certification as a Certified Dementia Practitioner from the National Council of Certified Dementia Practitioners

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