Are You a Pioneer in the Care Planning Process?

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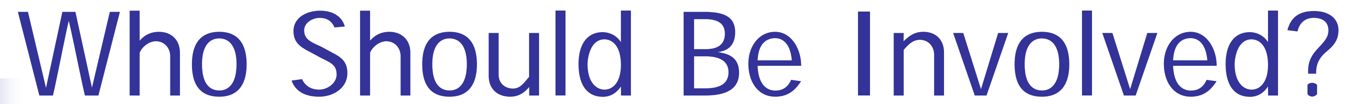
F 279 Comprehensive Care Plans

- The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

- Should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment.

Who Should Be Involved?



- Interdisciplinary team
- Resident
- Resident's family
- Surrogate or
- Representative

- Does the care plan address:
  - Needs
  - Strengths and
  - Preferences identified in the comprehensive resident assessment?

Probes

- Is the care plan oriented toward preventing avoidable declines in functioning or functional levels?
- How does the care plan attempt to manage risk factors?
- Does the care plan build on resident strengths?

Probes

- Does the care plan reflect standards of current professional practice?
- Do treatment objectives have measurable outcomes?

Probes

- Corroborate information regarding the resident's goals and wishes for treatment in the plan of care by interviewing residents, especially those identified as refusing treatment.

Probes

- If the resident has refused treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem?

Care Planning Guidelines

- The interdisciplinary team should show evidence in the Resident Assessment Protocol (RAP) summary or clinical record of the following:
  - **The resident's status in triggered RAP areas;**
  - **The facility's rationale for deciding whether to proceed with care planning; and**
  - **Evidence that the facility considered the development of care planning interventions for all RAPs triggered by the MDS.**

Care Planning Guides

- Monitor resident progress
- Prioritize interventions if appropriate
- Interdisciplinary means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident.
  - **Was interdisciplinary expertise utilized to develop a plan to improve the resident's functional abilities?**

Care Planning Guides

- Do staff make an effort to schedule care plan meetings at the best time of the day for residents and their families?
  - How do you communicate this information with the resident and their families?
- Is the ombudsman involved in the care planning meeting as a resident advocate?

Care Planning Guides

- Do facility staff attempt to make the process understandable to the resident and family?
- What happens if residents have brought questions or concerns about their care to the attention of facility staff?

Who Are the Pioneers?

- The Pioneers are a group of people who formed the Pioneer Network and simply want to make a difference for elders.
- They include: elders, family members, administrators, nurses, CNAs, physicians, social workers, recreation therapists, ombudsmen, advocates, educators, researchers, regulators and architects.

Pioneers

- Pioneers are creating a better culture in all settings where elders live, with the intention of building loving, elder-directed communities.

Pioneers

- Pioneers call their collective work culture change, the transformation of traditional institutions and practices into communities in which each person's capacities and individuality are affirmed and developed.
- They strive to transform the way people live and work throughout the continuum of aging.

Pioneer Values

- Pioneers commit to these values:
  - Know each person
  - Each person can make a difference
  - Relationship is the fundamental building block of a transformed culture
  - Respond to spirit, as well as mind and body
  - Risk taking is a normal part of life

Pioneer Values

- Put person before task
- All elders are entitled to self-determination wherever they live
- Community is the antidote to institutionalization
- Do unto others as you would have them to unto you

Pioneer Values

- Promote the growth and development of all
- Shape and use the potential of the environment in all its aspects: physical, organizational, and psycho-social/spiritual

Pioneer Values

- Practice self-examination, searching for new creativity and opportunities for doing better
- Recognize that culture change and transformation are not destinations, but a journey, always a work in progress

The Care Planning Process

- Can we apply common sense to this process?

Tips

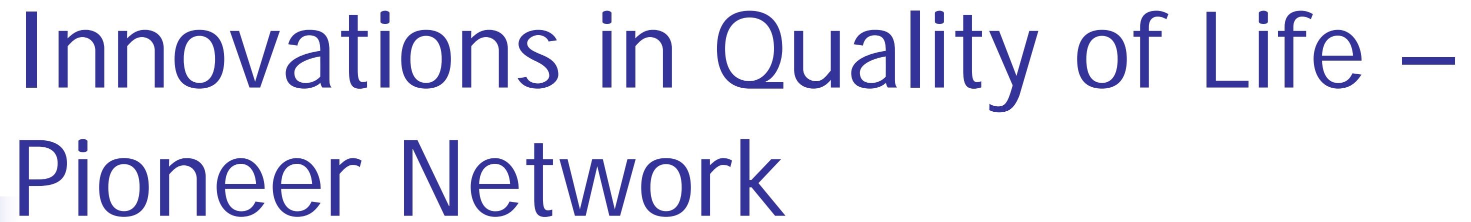
- Simplify and individualize the process
- Involve all staff
- Develop a functional elder centered care plan that is actually used by staff
- How well do staff know the elders?
- How do staff know what to do?

Tips

- How do you refer to elders in care plans?
  - For example, does your care plan state: Mrs. Jones is combative at bath time.
  - Or does your care plan state in a more elder centered way: I am afraid of water hitting me in the face and it frightens me to be totally undressed in a cold room that is unfamiliar.

Tips

- **Does your care plan state: Mrs. Jones has dementia and wanders throughout the facility.**
- **Or does your care plan state in a more elder centered way: Sometimes I feel all alone and I forget who you are. I like to walk. At home I walked with my dog Joey. Please walk with me and let's take Sam, the dog with us. I like looking at and wearing jewelry. I like to rearrange it in my drawers. Please take me to the jewelry chest.**



Innovations in Quality of Life – Pioneer Network

- The following information about care plans was presented at the CMS satellite broadcast presented on Friday, September 27, 2002.

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
- Community Model
  - Staff have personal relationship with resident and family
  - Resident, family, and staff develop care plan that reflects what resident desires for him/herself
  - Unique interventions which meet the needs of that resident

Changing the Culture of Care Planning

- Medical Model
  - 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
  - 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

Before and After Care Plan Samples

- Joe is an 88 year old man with dementia. He has a short attention span. He is very pleasant most of the time. Joe likes to walk around the facility a considerable amount of his waking hours. He is unable to distinguish between areas he is welcomed to enter and those where he is not welcomed.

Sample Care Plan

- His ambulation skills are excellent; no assistance is required. Some residents are disturbed by him because he may enter their rooms against their wishes. He prefers to be with staff at all times as he does not tolerate being along. He and his wife raised 11 children. Joe owned a hardware store and was a respected businessman in town.

Traditional Care Plan

- Problem
  - Wanders due to dementia
- Goal
  - Resident will not wander into other rooms

Traditional Care Plan Interventions

- Redirect resident to appropriate areas of the facility
- Praise for cooperation
- Teach resident not to enter rooms with sashes across door
- Encourage resident to sit in lounge and other common areas

Resident Directed Care Plan

- Needs
  - I need to walk
- Goal
  - I will continue to walk freely throughout my home

Approaches

- After I eat breakfast and get dressed, I want to walk with staff. I will accompany you anywhere. I like to help while we are together. I can fold linen and put things away with you. I do not like to nap. If weather permits, please walk outside with me. I like to keep walking in the evening until I go to bed. I sit when I am tired, so don't fuss over asking me to sit.

Traditional Care Plan

- Problem
- Non compliant with 1800 cal ADA diet

- Goal
- Resident will eat only foods approved in ordered diet

Interventions

- Educate resident regarding diabetes, her diet, and impact to her health if non-compliant
- Notify nurse of foods hidden in room
- Monitor for s/s hypo and hyper glycemia
- Check blood sugar 6 am and 8 pm
- Administer insulin as ordered

Resident Directed Care Plan

- Needs
  - 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.
- Goal
  - **I will enjoy moderate foods of my choice.**

Approach

- Please provide me with a diet with no concentrated sweets. Ask me prior to each meal what I would like. Honor my requests. Daily arguments about food will anger me. Check my blood sugar daily at 6 am and 8 pm. If it is too low or too high, I will discuss with the nurse what I ate that day, and will take responsibility to make better choices. Administer my insulin as ordered.

How Would You Know This Information?

- Ask the resident
  - Build a relationship with the resident
- Customary routine section of the MDS
- Interview family members
  - Build a relationship with the resident
- Interview friends
- Observe the resident

Web Sites

- Pioneer Network
- http://pioneernetwork.net

- Eden Alternative
- http://edenalt.com

Narrative Care Planning

- The following slides about narrative care planning were authored by Christine Krugh, MSW, LICSW, Riverview Lutheran Care Center, Spokane, Washington

Narrative Care Planning

- Person centered
- Written in language everyone understands
- Focuses on elder strengths
- Incorporates Pioneer principles

Standard Care Plan

- Problem: Alteration in thought process
- Goal: Resident will be oriented to person, place, time and situation at all times.
- Goal date: 11/16/03
- Approaches:
  - Provide orientation with routine care
  - Invite to R.O. activities, i.e., current events group and resident council
  - Place facility calendar in room

Individualized Care Plan

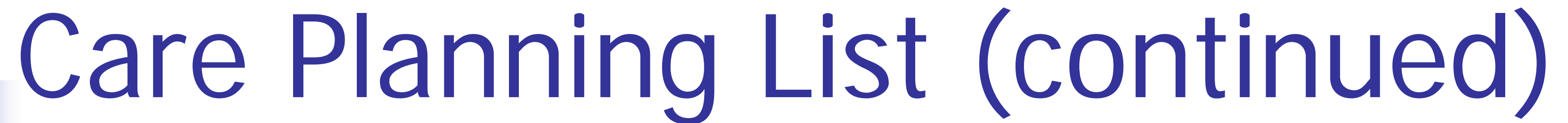
- Problem: Cognition
- Goal: Frank will use the activity calendar to remind himself of daily activities.
- Goal date: 11/16/03
- Approaches:
  - Place weekly calendar in Frank's room on the small bulletin board
  - Assist Frank to choose activities he is interested in for the day before he goes to breakfast
  - Remind Frank throughout the day of the group activities coming up.

Narrative Care Planning

- Person-Centered Care Planning

Care Planning List – Special Considerations/Strengths

- Social history
- Memory enhancement & communication
- Mental wellness
- Mobility enhancement
- Safety
- Visual function



Care Planning List (continued)

- Dental care
- Bladder management
- Skin care
- Nutrition
- Fluid maintenance
- Pain management/comfort
- Activities
- Discharge plan

Resident Care Plan

- Social History:
  - **I am Frankford Fox. My friends call me “Frank”. I was born in Fargo, North Dakota way back in 1910. My parents were farmers. They raised my six older brothers and worked very hard. My parents valued a good education. All of us boys graduated from Washington High School in Fargo. Shortly after graduation, I hopped a train to Colorado. I got off in a town called Marble, way up in the Rockies . . .**

Memory Enhancement/Communication

- My memory is pretty good. I had a stroke about a year ago which affected my ability to remember things which happen day to day. I love to attend groups and am a very social guy. I appreciate it if you show me the weekly calendar in my room near the sink every morning. Review with me what is going on for that day.

Memory Enhancement

- I will tell you what I am interested in. You can remind me during the day when an activity I enjoy is going to occur.
- Goal: I want to work with you daily to learn my calendar so that will be able to be independent in getting to the group activities which I enjoy.

Comfort

- Back in 1935, I fell while taking a climb up a mountain. I cracked a vertebrae in my upper spine. Later I developed Arthritis in this area. My pain worsens as the day wears on. Please remember that I start getting irritable it is because my back hurts. Ask me about it. Let the nurse know I am having trouble.

Comfort

- I take regular medication for pain. Sometimes I need an extra boost of medication. I also benefit from stretching so I like to attend the morning exercise group. The massage therapist sees me every Friday for an hour. Massage makes all the difference. Goal: To be free from breakthrough pain in my back.

Nutrition

- Ever since my stroke, my appetite just hasn’t been the same. I have been losing weight since July. It helps to have my special adaptive silverware at the table when I eat. I eat better when I sit with Joy. Make sure we have our special table set up so we can eat together at every meal.

Nutrition

- I have always been a snacker since my hiking days. I especially enjoy Almond Joy's, chocolate milkshakes and burgers from McDonald's which my daughter brings in for me. Offer me a snack between meals and before bed. Also invite me to join in the cooking group. "Food always tastes better when you make it yourself".

Nutrition

- Goal: I want to keep my current weight and maybe even gain five pounds.

How Can You Accomplish Pioneer Care Planning?

- Know your resident
- Team effort
- Involves all staff at all levels
- Honors each resident's life
- Continues the resident's life
- Makes life worth living
- Develops relationships between residents, families and staff
- Helps create a home
- Take time with the resident
  - Many times we become so task oriented, so focused, that we miss what is really important to the resident

Other Tips

- Develop staff into teams. Consider the buddy system so elders will be more familiar with care givers.
- Empower staff at all levels. Staff work more effectively if they control work responsibilities.
- Care teams having knowledge of the RAP guidelines will be better prepared to give individualized care and to chart meaningful RAP assessment documentation.

Questions

- Are we talking to elders and to families?
  - **Are you listening?**
  - **What are their concerns?**
  - **How do they feel about quality of care and quality of life?**
  - **Are they included in the assessment process?**
  - **What is the elder's functional status?**
  - **Have you given the elder the opportunity to demonstrate their abilities?**

- If an elder is declining, have we asked the question, why did this happen?
- Are we assessing outcomes?
- Are we assessing why elders don’t improve?
- Are we assessing why elders are not reaching their highest practicable physical, mental, and psychosocial well-being?
- Are we truly assessing the elder’s functional status in a holistic manner and making a difference for that person?

The RAI User's Manual

- The goal of the RAPs is to:
  - Guide the interdisciplinary team through a structured, comprehensive assessment of an elder's functional status.
- Functional status differs from medical or clinical status in that the whole of a person's life is reviewed with the intent of assisting that person to function at his/her highest practicable level of well-being.

The RAI User's Manual

- Going through the RAI process will help staff set elder-specific and elder-centered objectives in order to meet the physical, mental and psychosocial needs of elders.

Culture Change Documentation

- On the care plan, use words like loneliness, helplessness and boredom if you are stating a problem.
  - **For example, in an elder centered care plan, the elder states: I feel bored on Saturdays. On Saturdays at home, I played games with my great great grandchildren. Please make sure I am ready to greet the children when they arrive. I am looking forward to telling them stories.**

Culture Change Documentation

- The immediate plan of care for Mrs. Smith is to talk to her about selecting a parakeet for her room. Show her parakeets in other elder's rooms. Elder wishes to select bird and cage. This will occur in 2 days. Also due to her love of roses, involve her in the garden club where a helpful tips gardening book is being written by elders. Utilize Mrs. Smith knowledge of caring for roses. Discuss with her planting a flower box for her room.

Culture Change Documentation

- Contact with the bird, children, plants and utilizing her knowledge will help provide the companionship she needs and will help minimize the helplessness she feels. Include in this plan her functional ability to care for the bird and plants.

Culture Change Documentation

- In progress notes, document what is occurring. Document that the bird and plants were placed in Mrs. Smith's room and that Mrs. Smith is writing helpful tips about the care of roses. Document how Mrs. Smith interacts with the bird, children and plants. What is Mrs. Smith telling you in conversations? Is she still lonely? Is she still calling for help every 5 minutes? Is progress being made? Take some pictures.

Example of RAP Assessment Documentation

- Problem: Activity
- In what activities is the elder involved?
- Issues to be considered as the activity plan is developed:
  - Is the elder suitably challenged?
  - Is the activity program improving the elder's functional abilities?

RAP Assessment Documentation (continued)

- Focus to right side extremities
  - On 10/01/02 at 10:00 am, Mrs. Smith, known in her neighborhood as Nan, was interviewed about her life at Edenwood (refer to activity progress note of same date for detailed interview information). She responded to questions with clear yes and no answers. She communicated that she is bored and wants to try different things. On 10/03/02 we went with Nan

RAP Assessment Documentation (continued)

- to a small group exercise with first graders in the courtyard at 2:00 pm. She was able to move her right arm and hand to bat a brightly colored beach ball to one of the children and do stretching exercises to music. She was able to do 3 of 5 exercises with her right extremities for about 5 minutes and laughed with the children as they played. She tires easily but readily tries to participate. Nan and caregivers

RAP Assessment Documentation (continued)

  - will further discuss how to involve her in an exercise program that will encourage the use of her right side and increase her tolerance level.
- Confounding Problems to be considered:
  - There is a decrease in energy due to her recent acute illness. We expect to see her energy level and tolerance increase over

RAP Assessment Documentation (continued)

- the next 2 to 3 weeks as the elder recuperates and spends less time in bed. All staff should observe Nan closely for shortness of breath, dizziness, pallor (refer to current diagnoses). We will be evaluating and modifying her current activity program according to past interests and life styles and will focus on her functional ability.

RAP Assessment Documentation - Example 2

- Problem: Elder is not satisfied with current activities
  - On 11/12/02 based on an interview with Mrs. Smith, known in her neighborhood as Nan, and her daughter, Nan is interested in exercise, gospel and country music, baseball (the Braves), going outside, conversation, and being with her new life friend and companion, Joey, the Australian

Example 2 - Documentation

- **Shepherd. When Nan attended the exercise class, in the outside courtyard, with the children, she was able to bat a brightly colored beach ball with her right hand, even though she has glaucoma. Exercises will be conducted 3 x a week to strengthen her right hand and arm to increase function. One exercise will include petting and brushing Joey. Due to her poor vision, television has not been successful and has**

Example 2 - Documentation

- become an annoyance to her. A junior volunteer will read a short devotional to Nan daily and Nan enjoys telling the teenager fond stories of old. On 11/13/02, I observed the devotional and following the completion, Nan embraced the junior volunteer. When CNAs are in her room providing care, they will encourage her to independently brush her hair and do as many ADL tasks as possible independently. CNAs will also ask Nan about her interest in listening to her gospel tapes or

Example 2 - Documentation

- the sermons from her church. On the evening of 11/14/02, the CNA told me that Nan listened to the Statler Brothers before going to sleep. Several residents listen to the Braves games in the parlor on Sundays. It is our plan for Nan to attend the Sunday afternoon Braves game wearing her favorite ball cap. This plan will help decrease Nan's boredom and will also improve her social and functional levels.

RAP Assessment Documentation – ADLs – Functional Rehab. Potential

- Social Services Progress Note:
  - On 11/16/02, Mia Sadler, CNA, told me that Mrs. Smith (Nan) tried to help dress herself this morning, but could not manage the buttons with her right hand. This evening, I talked to Nan about her clothing and showed her an outfit that had been modified with velcro fasteners. Through yes and no questions, it was clear that Nan

RAP Assessment - ADL

- wanted to try on this dress. Nan was able to fasten the dress independently with her right hand. Upon completion, Mr. Smith came in for a visit and complimented her on the beautiful floral dress. Nan smiled widely upon demonstrating her newly found success.

RAP Assessment Documentation - Vision

- Visual Function – Social Services Progress Note
  - On 11/17/02 I talked with Mrs. Smith about her eyes. Mrs. Smith has severe loss of vision due to the diagnosis of glaucoma. In my hand was a large red ball. Mrs. Smith was not sure that the object was a ball, but as I moved the ball from left to right, her eyes followed the object.

RAP Documentation - Vision

- An interview with her oldest daughter, Mrs. Hill, indicated Mrs. Smith has had this eye condition for years. When her mother was younger, she used to wear glasses, but after the CVA, the glasses bothered her. Mrs. Smith verified she was not interested in wearing glasses. The television was on in the room, but Nan asked that it be turned off since she couldn't see the picture.

RAP Assessment Documentation - Vision

- I have asked staff to speak to Mrs. Smith immediately after knocking on her door to reassure her of who they are and what they are about to do. Consistency of the same staff is critical to success. Two bright floral pictures of large yellow daises and purple pansies brought from home have been placed in the room. Mrs. Smith and I visited every part of her room, touching

RAP Assessment Documentation - Vision

- and identifying objects with her right hand. Telephone, hand bell and water have been placed on the right side of the bed on the table for easy access. On visits outside, staff will assure that Mrs. Smith is close to the roll up garden so she can feel and better see her favorite plants.