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 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 their rooms

Traditional Care Plan Interventions

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

- 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 6am and 8pm
- 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.

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

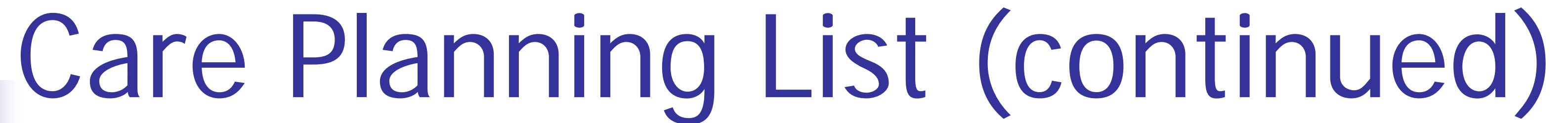
- Approaches:
  - Place weekly calendar in Frank's room on the small bulletin board
  - Assist Frank to choose activities he is interested in for the day before he goes to breakfast
  - Remind Frank throughout the day of the group activities coming up.

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 Frankfort 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 vertebrate 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 extra boost of medication. I also benefit from stretching so I like to attend the morning exercise group. The massage therapist seems 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 silverwear 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.

Questions

- 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?

This material was prepared by the Rhode Island QIO and shared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.
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