

# CHAPTER 5: LINKING ASSESSMENT TO INDIVIDUALIZED CARE PLANS

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### 5.1 Overview of the RAI and Care Planning

Throughout this manual the concept of linkages has been stressed. That is, good assessment forms the basis for a solid care plan, and the RAPs serve as the link between the MDS and care planning.

This chapter provides a discussion of how the care plan is driven not only by identified resident problems, but also by a resident's unique characteristics, strengths and needs. When the care plan is implemented in accordance with standards of good clinical practice, then the care plan becomes powerful, practical and represents the best approach to providing for the quality of care and quality of life needs of an individual resident.

The process of care planning is one of looking at a resident as a whole, building on the individual resident characteristics measured using standardized MDS items and definitions. The MDS was designed to allow the interdisciplinary team to observe and evaluate the resident's status with these detailed, consistently applied definitions. Once the separate items in the MDS have been reviewed, the RAP process provides guidance to the staff on how to use this information to assess triggered problems and ultimately to arrive at a holistic view of the person.

Once the resident has been assessed using triggered RAPs, the opportunity for development or modification of the care plan exists. The triggering of a RAP indicates the need for further review, which is carried out utilizing the Guidelines that have been developed for each RAP. Staff use RAP Guidelines to determine whether a new care plan is needed or changes are needed in a resident's existing care plan. It is important to remember that even though a RAP may not have been "triggered" in the assessment process, the interdisciplinary team must address, in the care plan, a resident problem in that area if clinically warranted. (See Chapter 4 for additional information on the use and documentation of RAPs.)

The care-planning process in long term care facilities has been the subject of countless books, journal articles, conferences and discussions. Often this discussion has focused more on the structure or content of care plans than on the course of action needed to attain or maintain a resident's highest practicable level of well-being. It is not the intent of this chapter to specify a care plan structure or format. Rather the intent is to reinforce that the care plan is based on using fundamental information gathered by the MDS, further review and assessment "triggered" by the MDS, and distillation of all final assessment information, through the RAP Guidelines, into an appropriate blueprint for meeting the needs of the individual resident. An appropriate care plan results from analysis of the resident by the interdisciplinary team based on communication about the resident that is reliable, consistent and understood by all team members. This benefits the resident by ensuring that the entire interdisciplinary team and all "hands on" caregivers are following the same process based upon a common knowledge base.

Properly executed, the assessment and care planning processes flow together into a seamless circular process that:

- Looks at each resident as a "whole" human being with unique characteristics and strengths.
- Breaks the resident into distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS).
- Re-groups the information gathered to identify possible problems the resident may have (Triggers).
- Provides additional assessment of potential problems by looking at possible causes and risks, and how these causes and risks can be addressed to provide for a resident's highest practicable level of well being (RAP Guidelines).
- Develops and implements an interdisciplinary care plan based on the complete assessment information gathered by the RAI process, with necessary monitoring and follow-up.
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the resident's care plan as appropriate and necessary.

Care planning is a process that has several steps that may occur at the same time or in sequence. The following list of care planning components may help the interdisciplinary team finalize the care plan after completing the comprehensive assessment:

1. The RAI process (i.e., MDS and RAPs) is completed as the basis for care plan decision making. By regulation, this process may be completed solely by the RN Coordinator, but ideally the RAI is completed as a cohesive effort by the members of the interdisciplinary team that will develop the resident's care plan.
2. The team may find during their discussions that several problem conditions have a related cause but appear as one problem for the resident. They may also find that they stand alone and are unique. Goals and approaches for each problem condition may be overlapping, and consequently the interdisciplinary team may decide to address the problem conditions in combination on the care plan.
3. After using RAP Guidelines to assess the resident, staff may decide that a "triggered" condition does not affect the resident's functioning or well being and therefore should not be addressed on the care plan.
4. The existence of a care planning issue (i.e., a resident problem, need or strength) should be documented as part of the RAP review documentation. Individual staff members who have completed assessments using the RAP Guidelines or participated in care planning may do documentation. It may also be a joint note by members of the interdisciplinary team.

**5. The resident, family or resident representative should be part of the team discussion or join the care planning process whenever they choose. The individual team members may have already discussed preliminary care plan ideas with the resident, family or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches.**

6. In some cases a resident may refuse particular services or treatments that the interdisciplinary team believes may assist the resident to meet their highest practicable level of wellbeing. The resident's wishes should be documented in the clinical record.

7. When the interdisciplinary team has identified problems, conditions, limitations, maintenance levels or improvement possibilities, etc., they should be stated, to the extent possible, in functional or behavioral terms (e.g., how is the condition a problem for the resident; how does the condition limit or jeopardize the resident's ability to complete the tasks of daily life or affect the resident's well-being in some way).

#### EXAMPLES

- Mr. Smith cannot find his room independently.
- Mrs. Jones slaps at the faces of direct care staff while they are giving personal care.
- Mr. Brown is unable to walk more than 15 feet because of shortness of breath.

8. The interdisciplinary team agrees on intermediate goal(s) that will lead to an outcome objective.

9. The intermediate goal(s) should be measurable and have a time frame for completion or evaluation.

10. The parts of the goal statement should include: The Subject - the Verb - Modifiers - the Time frame.

#### EXAMPLE

| Subject | Verb | Example Modifiers | Time Frame |

|-----|-----|-----|-----|

| Mr. Jones | Will walk | Up and down 5 stairs With the help of one nursing assistant | Daily for the next 30 days |

11. Depending upon the conclusions of the assessment, types of goals may include improvement goals, prevention goals, palliative goals or maintenance goals.

12. Specific, individualized steps or approaches that staff will take to assist the resident to achieve the goal(s) will be identified. These approaches serve as instructions for resident care and provide for continuity of care by all staff. Short and concise instructions, which can be understood by all staff, should be written.

13. The final care plan should be discussed with the resident or the resident's representative.

14. The goals and their accompanying approaches are to be communicated to all direct care staff not directly involved in the development of the care plan.

15. The effectiveness of the care plan must be evaluated from its initiation and modified as necessary.

16. Changes to the care plan should occur as needed in accordance with professional standards of practice and documentation (e.g., signing and dating entries to the care plan). Communication about care plan changes should be ongoing among interdisciplinary team members.

## 5.2 The Care-Planning Process

In order to provide a backdrop for understanding care planning, how it is supported by the RAI process, and what is required by the regulations, this section has been organized around a Question and Answer format based on the interpretive guideline probes for the care planning requirements at 42 CFR 483.20. The appropriate F Tags have been added to the end of each question to guide the reader back to the regulation. The regulatory language and associated probes may be found in Appendix P of the

State Operations Manual (SOM).

42 CFR 483.20 (d)(1)

Is the care plan oriented toward preventing avoidable declines in functioning or functional levels? - F 279

The care plan is a guide for all staff to ensure that decline is avoided, if possible. Not only is the resolution of clinical problems important (e.g., treatment of a pressure ulcer), so is the prevention of further decline. For example, for the resident with pressure ulcers, a program of bed mobility as well as efforts at improving the resident's mood to increase willingness to get out of bed, will improve chances for slowing decline. There must be a realistic, directed effort to provide quality care in addressing immediate concerns while, at the same time, attempting to ensure that functional decline does not occur. This is "proactive" involvement by the interdisciplinary team to make sure that declines in resident functioning are avoided if possible.

How does the care plan attempt to manage risk factors? - F 279

The RAPs are excellent identifiers of resident factors that may increase the chance of decline or for a problem to develop. Risk factors must not be overlooked when designing an effective care plan. Through the RAP review, the interdisciplinary team can identify certain resident characteristics that put the resident at risk for problems. For example, a resident may suddenly become at risk for falls when a change is made to certain medications. The team should identify this potential risk and identify the necessary precautions as part of the care plan (e.g. orthostatic blood pressure checks for a period of time).

Does the care plan build on resident strengths? - F 279

Care planning is usually thought of as a facility staff effort to solve or eliminate resident problems. While this view is often valid, it is also important for the interdisciplinary team to carefully look at the resident's strengths and use them to prevent decline or improve the resident's functional status. The RAI process not only identifies concerns but also pinpoints areas of resident vitality. These strengths or areas of vitality should be used in the care planning process to improve resident quality of care and quality of life through improved functional ability and self-esteem.

Does the care plan reflect standards of current professional practice? - F 279

It is important for all facility staff to be aware of and utilize current standards of professional practice. This can be accomplished through a routine, up-to-date in-house training program or through the use of qualified external training resources. New and more effective treatment modalities, resident activities, etc. are continually being identified which will benefit residents if built into their care plans.

Do treatment objectives have measurable outcomes? - F 279

Measurable outcomes require current knowledge about the resident to establish a baseline (e.g. how many times does a resident behavior or symptom occur in a certain time frame or how does a resident experience pain). Next, a target, goal, or outcome is required (e.g., reduction of behaviors to a certain level or reduction of pain). Finally, some way of measuring if the care plan has moved the resident from the baseline to the target outcome is needed. Without measurable outcomes there is no way to truly identify that a care plan has been successful. The care plan is a dynamic document that needs to be continually evaluated and appropriately modified based on measurable outcomes. This continual evaluation takes into consideration resident change relative to the initial baseline-in other words, if the resident has declined, stayed the same, or improved at a lesser rate than expected, then a modification in the care plan may be necessary.

Has information regarding the resident's goals and wishes for treatment been obtained -especially if a resident wishes to refuse treatment? Has the resident been given sufficient information about his or her treatment so that an informed choice can be made? - F 279

Residents should, if possible, be involved in planning their treatment. This means that staff must talk to the resident about what goals the resident would like to achieve and whether they believe these goals can be achieved. Residents also have a right to refuse treatment. The interdisciplinary team should ensure that the resident has all of the necessary information about how a particular treatment will affect the care they receive and their general well-being so that the resident can make an informed choice about whether or not they wish to receive treatment.

If a resident refuses treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem? - F 279

If a resident refuses treatment, the team should seek options with the help of the attending physician, resident and family. Often one method of treatment may not be acceptable to a resident, but another choice of treatment may. For example, a resident may refuse to take a prescribed anti-depressant medication for treatment of depression. Alternative courses of action could be explored with the resident that would use the expertise of mental health professionals. Consequently, rather than a care plan which indicates only that a resident refused treatment, the care plan would reflect other goals and methods of addressing the problem(s). Involve staff who have regular, first hand knowledge of the resident (e.g., nursing or activity assistants) in reviewing possible options. They can provide insights on why the resident may be refusing care and how to devise a better approach to the problem.

42 CFR 483.20 (d)(2)

Was interdisciplinary expertise utilized to develop a care plan to improve a resident's functional abilities? - F 280

It is of the utmost importance that the staff most knowledgeable about the resident, in coordination with staff having the most expertise in a given resident problem area, work with the resident and their family or other representative in the care planning process.

The medical model of care, while most common in the acute care setting, should not necessarily be the driving force in planning the resident's care unless the resident's medical condition is unstable and needs continuous clinical monitoring. The key is to identify those needs which affect the resident's day-to-day well-being. Such needs cover a broad range of areas and may vary among residents.

Although nursing staff are usually the "first responders" to resident problems and are responsible for the heaviest burden of documentation, each member of the interdisciplinary team brings a unique perspective and body of knowledge to the care planning process. As such, each members' contribution should be sought and valued.

In what ways do staff involve residents, families, and other resident representatives in care planning? - F 280

As emphasized in the Federal regulations as well as throughout this manual, the resident, resident's family or other resident representatives should be involved in the care planning process. The resident is the most appropriate individual to describe what is meaningful in his or her life. Family and friends may also contribute in a very meaningful way in describing what is important to a resident, especially for those residents who cannot speak for themselves. Although they may be knowledgeable about the resident and care practices, interdisciplinary team members do not know all of a resident's life history and experience which may affect his or her individual needs or dictate approaches.

It is important for the interdisciplinary team members to speak directly with the resident and the resident's family, friends and representatives during both the assessment and care planning process if an appropriate care plan is to be developed which will address all of the resident's individual quality of life and quality of care needs. If there is a legally designated proxy, staff should be aware of this fact and that individual should be given the opportunity to participate in the assessment and care planning process.

Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to the completion of the first comprehensive assessment? - F 282

Some care planning needs to occur for immediate care of the resident after admission or after a significant change in status. Physician orders for immediate care (42 CFR 483.20 (a)/F 271) are the written orders facility staff need in order to provide essential care to the resident, consistent with the resident's physical and mental status at admission. These orders, at a minimum, should include dietary, medication (if necessary) and routine care instructions to maintain or improve the resident's functional abilities until facility staff can conduct a comprehensive resident assessment and develop an interdisciplinary care plan.

The interdisciplinary team may wish to conduct an initial RAP review for any identified problem or potential problem even before the MDS is completed. This review can be documented at the time, and a written update completed when the interdisciplinary team completes the RAI process and documents final care plan decisions.

For example, if a resident was re-admitted from the hospital with a physical restraint but the resident was not previously restrained, the interdisciplinary team should immediately assess the resident for the need for a restraint. Since the team would know that the Physical Restraint RAP would be triggered by the MDS, they would use the RAP to guide their assessment of the resident and make preliminary plans about how to handle the restraint issue. When the comprehensive assessment is completed, the interdisciplinary team would then make a final decision regarding the resident's current status and need for a restraint.

Similarly, if a resident is incontinent of urine at the first admission, or newly incontinent at readmission, good practice would dictate that 14 days is too long to wait for completion of an initial assessment of the incontinence. Again, the Urinary Incontinence RAP can be used to guide the immediate care plan intervention. The documentation of the RAP review would then be updated following the completion of the comprehensive assessment.

Are direct care staff fully informed about the care, services and expected outcomes of the care they provide? Do direct care staff have general knowledge of the care and services provided by other staff and the relationship of those services to the resident's expected outcomes? - F 282

Direct care staff (e.g., nursing assistants, aides) must be directly involved in the care planning process. The importance of the communication between direct care staff and the interdisciplinary team cannot be overstated. Since direct care staff have the most frequent contact with residents, they may be the most knowledgeable about a resident's daily life, needs, problems and strengths.

Direct care staff who have not participated in the formal care plan decision-making process must be informed about how the care and services they provide is intended to improve, maintain or minimize decline in the resident's condition and well-being. Without knowing the reasons they are performing particular tasks, direct care staff may not understand the relationship between the care and services they provide for a resident and the expected outcomes for that resident. Similarly, for nursing staff to understand how the resident is responding to a plan of care, the input of direct care staff is crucial. In many ways, they are the best source of information on how the program has been implemented, how the resident has responded, and whether specific program variations might be useful.

What are some general care planning areas that could be considered in the Long Term Care setting? - F 280

The following are six general care planning areas that are useful in the long term care setting. This list is not prescriptive or all-inclusive. Ultimately the resident's status determines what should be addressed on the care plan.

- Functional Status

Functional status limitations are identified using the MDS and triggers. All conditions determined to need care plan intervention, after using the RAPs to guide further assessment, must appear on the care plan. The conditions identified by the RAI should be clearly linked to the problems addressed on the care plan.

#### - Rehabilitation/Restorative Nursing

A resident's potential for physical, occupational, speech, psychological and other types of rehabilitation needs to be assessed and care planned. The risk of immobility, for example, should be assessed, and restorative nursing interventions planned accordingly. Complications of immobility, such as damage to the muscular system as indicated by weakness, difficulty walking, posture problems, foot drop, contractures, edema, constipation, calcium depletion, depression, agitation, etc., should be assessed as appropriate. These assessments may include causes, particular risk factors, clinical impressions and the need for referrals.

#### - Health Maintenance

Health maintenance includes monitoring of disease processes that are currently being treated. These would include both stable and unstable conditions that need monitoring such as a history of cardiac problems, hypertension, CHF, pain, dehydration, mental illness, etc. If a resident is taking medications for conditions, regular monitoring of edema, vital signs, blood glucose, etc., may be appropriate.

The interdisciplinary team may also decide whether or not to list problems on the care plan that no longer affect the resident, are controlled or need no monitoring. This will depend on the team's decision about how a given problem affects the resident's overall functioning or well-being.

Other areas of health maintenance may include terminal care, and special treatments such as peritoneal dialysis or ventilator support.

#### - Discharge Potential

Discharge potential for each resident needs to be assessed at admission, annually, and as needed. The assessment for discharge potential should focus on what needs to happen before the resident can safely be discharged. If the resident has discharge potential or if discharge is actively being pursued, documentation should appear in the resident's plan of care.

#### - Medications

On at least a yearly basis, a comprehensive assessment of drug therapy should be completed (See 483.20 (b)(1)(2)(xiii)). This assessment can be documented anywhere in the resident's record and should include dose, frequency, existing and most likely side effects, relevant lab results, parameter comparisons, and justifications for use. Pharmacists review the drug regimen and discuss irregularities with appropriate facilities staff using Appendix N of the State Operations Manual on a monthly basis.

It is the interdisciplinary team's decision whether medications need to be addressed in the care plan. For example, consideration might be given to recent changes in medications, the use of multiple medications, or medications which may put the resident in jeopardy for a decline in functional status. The care plan should alert the staff to medication side effects for which the resident is at particular risk. The interdisciplinary team may decide to identify a drug(s) as an approach to meeting a goal. The interdisciplinary team should determine if any medications that the resident is taking are listed in a triggered RAP. If so, use of the medication needs to be assessed as a potential contributing cause to the RAP concern.

#### - Daily Care Needs

Some facilities put all resident daily care needs and standard practice approaches on the care plan. Daily care needs that are specific to the resident and are out of the ordinary must be addressed on the

care plan. Facility staff must use their professional judgment when making these decisions.