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CAREFULLY SPEAKING®

CS 2018 ISSUE 1

Resident Care Planning: Avoid These Seven Common Deficiencies

The care plan is a communication tool designed to coordinate the efforts of the aging services facility care team and help staff meet the medical, nursing, mental and social needs of residents. Ideally, the plan helps ensure that residents receive the care and services required to achieve measurable, realistic, clearly articulated and agreed-upon goals. Because the care plan affects every aspect of the resident's experience in the facility, an inadequate or obsolete planning process can have major consequences in terms of outcomes, compliance and liability.

In 2016, as part of a larger aging services regulatory overhaul, the Centers for Medicare & Medicaid Services (CMS) implemented a new regulation known as Comprehensive Person-centered Care Planning. (See box on page 2 for details.) The CMS revisions support a more individualized, timely, interdisciplinary and dynamic care planning process, in which all parties – including residents, family members, facility staff, home care providers and healthcare professionals – come together upon admission to participate in assessing residents, setting goals and creating an action plan.

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The changes emphasize the importance of maximizing resident choice and eliciting personal preferences, rather than relying upon standard or template care plan language. Failure to satisfy the new planning process requirements may result in sanctions, including fines and other penalties.

Aging services leaders should also be aware that the resident care plan is often the first document requested and examined by the plaintiff attorney following a resident injury. Any shortcomings discovered in the development, execution and/or updating of the plan – e.g., belated or superficial assessments, insufficient staff input, lack of specific goals, delayed review or other lapses – can compound an underlying claim of substandard care.

To help staff comply with the updated regulatory directives and mitigate the risks associated with suboptimal care plans, this edition of *CareFully Speaking*® is divided into seven sections, each focusing on a common care planning deficiency. These sections include a range of practical compliance tips, which are intended to help aging services administrators expedite the baseline planning process, engage residents and family members, better manage expectations, strengthen intra-staff communication, prepare for transitions and keep plans current. A checklist of baseline and comprehensive care planning requirements begins on page 7.

1. DELAYED INITIAL PLANNING.

The intent of the interim baseline care plan is to increase resident safety and prevent or mitigate problems that tend to occur soon after admission, such as behavioral changes, elopement, falls and dehydration. (See the box at right for more details.) Many states already require a similar care plan within 24 hours of resident admission. For facilities in these states, the new regulation will not present much difficulty. For other organizations, however, the baseline care plan requirement – i.e., the mandate to produce a written plan within 48 hours – may necessitate conducting pre-admission resident appraisals, home visits and screening interviews, or otherwise expediting the process of compiling medical data and other information.

Compliance Tips:

- **View the baseline care plan as an initial set of written instructions** directed toward providers, facility staff, residents and families.
- **Draft short-term goals based upon physician, admitting and dietary orders,** as well as medication schedules, orders for therapy and social services, and Pre-admission Screening and Resident Review (PASRR) recommendations.[1]
- **Summarize the baseline care plan in writing for the resident and family,** noting initial goals, medications, dietary instructions, and facility and vendor services to be provided, as well as resident discharge objectives and needs, including community support.
- **Provide a written or electronic copy of the care plan to the family or representative** within two working days of its completion.
- **Revise the baseline care plan as needed** until the comprehensive care plan has been developed.

1 For details about PASRR regulations, see the Code of Federal Regulations, Title 42, Part 483, Sections 483.100-483.138. Under the new care planning regulations, if an aging services organization disagrees with the findings of a resident's PASRR, the dissent and its underlying rationale must be documented in the resident care record.

CMS CARE PLANNING REQUIREMENTS

Comprehensive person-centered care planning, as set forth in *the Code of Federal Regulations, §483.21,* is being put into effect incrementally between November 28, 2016 and November 28, 2019. As of November 28, 2017, aging services organizations must complete and implement an interim baseline care plan within 48 hours of a resident's admission, as well as provide a baseline care plan summary to the resident and/or resident's representative. Alternatively, the facility may draft a comprehensive care plan within 48 hours of admission, if it fulfills the baseline plan's stated requirements.

In the event that the resident experiences significant changes in physical, mental or psychosocial functioning, those changes and accompanying goals must be incorporated into an updated summary provided to the resident and/or resident's representative. Once the comprehensive care plan has been developed and a summary of the updates given to the resident, the facility is no longer required to update the written summary of the baseline care plan.[2]

Note that *§483.21* combines all of the new requirements for care planning in one location, replacing *§483.20(k)* for care planning and *§483.20(l)* for discharge planning.

For more information about current and pending CMS revisions, see the *Federal Register*. Scroll down to the implementation time frames section for a summary of regulatory changes scheduled for 2019.

2 Source: Wilhide, J. "Discussion of the Interpretative Guidelines for F655, Baseline Care Plan," *LeadingAge*®, July 6, 2017.

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2. FAILURE TO ENGAGE RESIDENTS AND FAMILY MEMBERS.

The revised CMS regulations emphasize the right of residents and their representatives to be informed and in control of decisions involving care. In order to broaden their understanding of residents' needs and desires, aging services facilities are required to encourage residents and family members to participate in the care planning process on an ongoing basis. If the team determines that participation by either the resident or authorized representatives is impractical, this decision and its rationale must be documented in the resident care record.

Compliance Tips:

- **Obtain the resident's written consent for family participation in care planning interviews,** as well as related assessments, conferences and consultations.
- **Schedule the first care planning conference with family members and others as soon as possible after admission,** and meet at least every three months thereafter to review and update the plan.
- **Review every aspect of the plan during quarterly care conferences,** including, but not limited to, the resident's medical condition, rehabilitation progress, diet, medications and activities.
- **Encourage direct care staff to attend care planning conferences,** which will help strengthen relationships between staff and residents and families, while underscoring the need to include all relevant parties in the planning process.
- **Request that residents and family members prepare a list of questions, needs and concerns prior to meetings,** and invite them to suggest and refine goals.
- **Distribute a copy of the existing care plan to conference attendees,** in order to ensure that all parties – including relatives and other resident representatives – are aware of current provisions and can participate knowledgeably in the discussion.
- **Allocate sufficient time for care plan meetings** and schedule them at convenient times for working family members, such as early mornings, evenings and weekends.
- **Email or otherwise distribute revised care plans to family members after conferences,** thus keeping all participants in the loop.

3. OVER-RELIANCE ON GENERIC CARE PLAN PROVISIONS.

A comprehensive person-centered care plan – one that reflects individual residents' needs and preferences, and permits them to participate in day-to-day decision-making – must be developed and implemented within seven days of the initial assessment. Effective November 28, 2018, care plans also are expected to be culturally competent and trauma-informed – i.e., they must reflect residents' linguistic and cultural preferences and address the unique care needs of trauma survivors by avoiding stress triggers that could cause re-traumatization.

For a sample worksheet designed to help providers clarify resident preferences and identify associated risks, see "A Process for Care Planning for Resident Choice," issued by the Hulda B. & Maurice L. Rothschild Foundation, February 2015. (Scroll to page 31.)

Compliance Tips:

- **Obtain a copy of the resident's advance healthcare directive,** durable power of attorney for healthcare, physician's order for life-sustaining treatment and/or conservatorship papers; secure the documents in the resident care record; and consult them when drafting the care plan.
- **Draft care plans in the first person,** as if the resident were speaking directly to staff. (For example, "I need to walk three times a day around the recreational center," instead of "Mary has dementia and needs to walk frequently.")
- **Clearly and thoroughly record the resident's medical needs and personal preferences in the care plan,** and note the name and contact information of the designated healthcare agent.
- **Periodically review the care plan,** assessing whether the services being furnished are likely to help the resident attain the highest practicable level of physical, mental and social well-being.
- **Identify and present alternative care approaches,** and honor the right of legally competent residents to refuse care plan provisions. (See "When Residents Refuse Care," page 5.)
- **Avoid the temptation to rely on computer-generated care plans,** which tend to lack individualization and may focus on core problems only, e.g., activities of daily living, pressure ulcers, nutritional deficits, falls.

For additional recommendations, see "Drafting Tips for Care Plans" on page 4.

4. INSUFFICIENT INTERDISCIPLINARY INPUT.

The CMS regulations require multidisciplinary input during the care planning process. In addition to an attending physician and a registered nurse with responsibility for the resident, the revised regulations call for the addition of two new members to the interdisciplinary team (IDT): a nurse aide with responsibility for the resident and a member of the food and nutrition staff. Additional staff members – such as a social worker or physical therapist – may participate, if dictated by the resident's needs or requested by the resident or a representative.

Compliance Tips:

- **Be flexible in arranging IDT meetings,** using electronic technology (e.g., teleconference or Skype) if necessary. The CMS regulations do not require in-person participation by all members.
- **Invite direct care providers to attend care conferences** and share their experiences and observations with other members of the IDT.
- **Solicit resident input about planning conferences,** asking them what staff members and others should participate in the meetings.
- **Encourage all conference participants to share their views on basic care plan issues,** including the following:
  - What are the resident's overall goals, and how can the care plan best achieve them?
  - What kind of personal or healthcare services are needed?
  - What type of staff should provide the services?
  - How often are the services required?
  - What type of equipment or supplies are needed?
  - What food choices should be offered, in light of ordered dietary restrictions and expressed food preferences?
  - Does the resident intend to return to the community and, if so, when?
- **Monitor every element of the care plan,** noting which strategies are working and which are not, based upon staff and resident/family feedback.

Drafting Tips for Care Plans:

- **Ensure that the plan is readable both on-screen and in printed versions,** selecting a white background and a font size of 12 points or larger.
- **Select a plain, highly legible typeface,** such as Calibri, Arial or Times New Roman.
- **Keep sentences short,** generally no more than 15 to 20 words long.
- **Avoid jargon and acronyms,** and define any medical or technical terms referred to in the plan.
- **Assign tasks to named staff members,** in order to clarify responsibilities, personalize the care plan and promote continuity of care.
- **Use the present tense and active voice for clarity,** e.g., "I do physical therapy at 10:00 a.m. every Monday, Wednesday and Friday in the therapy room."
- **Employ bulleted or numbered points, rather than long paragraphs,** to present lists or multi-step processes.
- **Boldface text for emphasis** rather than using italics or all capitals, which may impair legibility.

QUICK LINKS

- "A Closer Look at the Revised Nursing Facility Regulations: Assessment, Care Planning, and Discharge Planning." *Justice in Aging Issue Brief*, a publication of the National Consumer Voice for Quality Long-Term Care.
- Davis, C. "Baseline Care Plans: How NACs Can Prepare." *LTC Leader*, July 26, 2017, from the American Association of Nurse Assessment Coordination.
- "Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements." Department of Health and Human Services, Office of Inspector General, February 2013.
- Wilhide, J. "Discussion of the Interpretative Guidelines for F655, Baseline Care Plan," *LeadingAge®*, July 6, 2017.

5. LACK OF MEASURABLE AND ACHIEVABLE GOALS.

Too often, resident care plans reflect family desires or staff convenience at the expense of resident wishes. At the time of admission, residents should be asked in writing, when possible, about their personal goals and desired outcomes. Their responses, as well as physical and mental assessment findings, form the basis of a problem list, which may include medical diagnoses, physical weaknesses, family problems, social withdrawal or any other issue potentially affecting their health and well-being. For each identified problem or need, establish one or more reasonable goals and determine the actions and/or services required to achieve them.

Compliance Tips:

- **Indicate in the care plan all goal-directed care to be provided,** as well as needed services that the resident has refused, such as bathing, repositioning in chair or bed, wound care and supplemental feedings. (See "When Residents Refuse Care" at right.)
- **State goals in relation to a specific, detailed action plan,** e.g., "To increase weight by 5 pounds in one month, I will supplement my daily lunch and dinner with a 6-ounce protein shake."
- **Supplement care plan goals with clinical information** collected during interviews, assessments and planning conferences, e.g., "To reduce overreliance on a walker due to a past ankle injury, I will ambulate with one-person assistance 20 feet per day for one week," rather than, "I will ambulate on my own to the end of the hallway by discharge home."
- **Thoroughly document all actions taken – such as restorative nursing services, toileting programs and preventive wound care – to meet resident goals,** even if these efforts are already included in the care plan, as written plans do not supplant formal documentation requirements.
- **Regularly audit resident care records and compare them with care plans** to ensure that all needed services are actually being provided and that progress is being made toward accomplishing agreed-upon goals.

When Residents Refuse Care

Residents in aging services settings have the right to decline any care – including medications, therapies, dietary recommendations, medical treatments and physician's orders – if they are legally competent and able to make decisions. The right to refuse is explicitly provided for by the Centers for Medicare and Medicaid Services in F tag 155.

Organizations should develop a written protocol for responding to refusals of care, which includes the following risk management measures, among others:

- **Ascertain the resident's continued ability to make independent decisions** by completing a baseline mental health examination and documenting the results in the resident care record.
- **Offer the recommended service or intervention twice,** attempting at each encounter to discern why the resident is refusing – e.g., water pressure hurts the skin, medications taste bad, exercise is painful.
- **Explain to the resident the potential ramifications of declining care,** including a worsening of physical and mental conditions.
- **Attempt to accommodate the resident's preferences, desires and needs,** including changes in schedules, staff assignments and therapy arrangements.
- **Document the resident's reason(s) for refusal in the resident care record** and summarize all efforts undertaken to inform the resident of the need for the recommended care.
- **Inform family members and other representatives in writing that the resident declines ordered services and/or treatments,** clearly conveying to them both the stated reason for refusal and the possible consequences.

6. LAPSES IN TRANSITIONAL PLANNING.

The CMS regulatory changes reflect the updated discharge planning requirements of the Improving Medicare Post-acute Care Transformation Act of 2014 (IMPACT Act). In order to comply with the revised rules, organizations must ask residents whether they wish to be transferred from the residential care setting into the community, document their response and note efforts made to facilitate the transition, such as referral to appropriate local agencies. If discharge to the community is not feasible, the organization must indicate the rationale for this determination and the name of the individual who made it.

Compliance Tips:

- **Develop and implement an effective discharge planning process,** which emphasizes ascertaining and meeting residents' expressed discharge goals, as well as reducing preventable readmissions.
- **Include discharge goals in the comprehensive resident care plan,** and outline discharge needs, crisis and contingency arrangements, transfer details and the date of the next planned review.
- **Draft a formal discharge plan** that prominently notes the resident's post-discharge care goals and treatment preferences.
- **Prior to discharge, contact agencies that assist with transitions,** and incorporate any information received into both the care plan and discharge plan.

7. OBSOLETE PLAN PROVISIONS.

Aging services organizations must review resident care plans on a quarterly basis, at a minimum. Updates also are required following significant changes in a resident's physical, medical, mental and/or social condition. Both residents and family members or other representatives should actively participate in the care plan review and updating process, to the extent possible.

Compliance Tips:

- **Ensure that all key disciplines are represented at care plan conferences,** including staff members from nursing, therapy, dietary services, recreational activities and social work.
- **Ask residents and/or family members to prepare a list of questions and concerns to be addressed at care plan conferences,** in order to maximize the meetings' usefulness and efficiency.
- **Begin care plan conferences by reviewing resident and staff concerns expressed during the prior meeting** and verifying that remedial action has been taken and documented.
- **Request that all conference attendees report on resident status and needs** in relation to their area of expertise and section of the care plan.
- **Provide care plan conference participants with access to the resident care record,** as required by the Resident Bill of Rights.
- **Conclude conferences with a summary of identified care plan deficits,** as well as remedial action plans and anticipated dates by which time the noted deficits will be corrected.
- **Draft a meeting summary,** distribute it to participants and place a copy in the resident care record.
- **Encourage the care plan review team to consult with professional advisors** – such as geriatric care managers, discharge coordinators, elder law attorneys and financial planners – whenever questions arise.

Sound care planning can be a powerful tool to enhance residents' health and quality of life, as well as to strengthen the relationship between providers and residents and their families. An inadequate care plan, however, can lead to conflict and dissatisfaction, unrealistic expectations, poor care outcomes, regulatory and reimbursement complications, and impaired defensibility in the event of a claim. By reviewing the organization's planning process on an ongoing basis, leaders can identify potential deficiencies and implement corrective measures to ensure that resident care plans are compliant, comprehensive, current and clearly written, and that they reflect and support each resident's unique needs, goals and preferences.

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Developing Quality Care Plans: A Process Enhancement Checklist

Care planning is a complex process, requiring continuous, wide-ranging feedback and a team approach. The following list is designed to help focus leadership attention on care planning methods and protocols, and to encourage internal discussion about how the planning process can be strengthened and updated.

CARE PLANNING ACTIVITIES	STATUS: YES/NO	COMMENTS
PRE-ADMISSION SCREENING		
The organization's admission procedures are evaluated for compliance with applicable state and federal regulations, reviewed annually and revised, if necessary, as legal requirements and accreditation standards evolve.		
The applicant's written permission is obtained to conduct third-party interviews, with the understanding that all information compiled during the admissions process remains a part of the application record and will not be shared with unauthorized individuals.		
Family members, former and present providers, case workers, attending physicians and other knowledgeable parties are consulted prior to admission, ideally in person, so that staff can gain a more complete, balanced and accurate view of the applicant's deficits, treatment needs and goals.		
A pre-admission screen is performed to assess care needs, determine the suitability of the setting, and compile and document the following information:		
- Overall health status.		
- Dietary restrictions.		
- Physical limitations, especially vision, hearing and speech deficits.		
- Mental/cognitive impairments, such as symptoms of confusion, forgetfulness and social withdrawal.		
- Emotional state, e.g., mood swings, depression, anger.		
- History of major illnesses, surgery, communicable diseases, accidents and hospitalizations during the past five years.		
- Functional capability, including mobility, energy level and overall awareness.		
- Ambulatory status, focusing on the need for human or mechanical assistance, wandering tendencies and amount of time spent out of bed each day.		
- Currently prescribed medications, as well as their indication and dosage.		
- Social/recreational/spiritual needs and preferences, noting individual pleasures and interests as well as cultural/religious/ethnic identity.		
- Necessary services, e.g., assistance with bathing, dressing, feeding, toileting, transferring, ambulation, medication administration, and household and financial tasks, as well as nighttime observation and continence-related care.		
- Advance directives, living wills and power of attorney documentation, or lack of same.		
Screening findings are translated into actionable care recommendations, such as, "Evidence of dementia, necessitating 1:1 mealtime supervision."		

CARE PLANNING ACTIVITIES	STATUS: YES/NO	COMMENTS
INTERIM BASELINE CARE PLAN		
A baseline care plan is drafted within 48 hours of admission, containing the instructions needed to provide the resident with professional, effective and person-centered care.		
The baseline care plan is compiled using a variety of sources, e.g., transfer documentation, pre-admission screening, admission assessment, interviews with resident and family/representative.		
Initial goals – such as tapering off medications or ambulating without assistance – are contained within the baseline care plan, as are key medical orders, medications and administration schedule, dietary orders, therapies, social services and other recommendations.		
Pre-admission screening and resident review (PASRR) recommendations are optimally included in the baseline care plan. If it is impractical to do so, the rationale for omitting PASRR recommendations is documented in the resident care record.		
The resident's discharge goals are prominently noted in the baseline care plan and resident care record.		
The baseline care plan is filed and made available to relevant staff members, and a summary is given to residents and/or their representatives.		
Feedback is solicited from residents and/or family members, and a formal policy is developed for managing any disagreements that may arise concerning the plan.		
The baseline care plan is revised as needed until the comprehensive care plan is developed.		
COMPREHENSIVE CARE PLAN		
A comprehensive person-centered care plan is completed within seven days of the initial post-admission resident assessment by an interdisciplinary team. The team reflects the resident's needs and wishes and includes, at a minimum, the following individuals:		
- Attending physician.		
- Registered nurse who has responsibility for the resident.		
- Nurse aide with responsibility for the resident.		
- Member of food and nutrition services staff.		
- Other staff members or outside professionals, reflecting the resident's range of needs and expressed wishes.		
A summary of the initial resident assessment is entered in the care plan, emphasizing the following information:		
- Physical and emotional needs.		
- Resident strengths.		
- Identified goals.		
- Life history.		
- Personal and cultural preferences.		
- Minimum Data Set findings.		
- PASRR findings.		

CARE PLANNING ACTIVITIES	STATUS: YES/NO	COMMENTS
COMPREHENSIVE CARE PLAN (CONTINUED)		
The comprehensive care plan is carefully reviewed to ensure that it …		
▪ **Contains measurable, realistic goals that relate to residents' medical, nursing, social and psychological needs** and are consistent with the *Code of Federal Regulations* addressing quality of life (*§483.24*), quality of care (*§483.25*) and behavorial health (*§483.40*), as well as PASRR recommendations, if adopted.		
▪ **Notes residents' desired outcomes,** as well as their wishes with respect to returning to the community.		
▪ **Specifies transitional and/or discharge goals and criteria, if feasible.** If discharge is not practical, the reasons are noted in the resident care record, together with the names and titles of the individuals making this decision.		
▪ **Includes referrals to local support agencies and/or other appropriate entities,** in order to facilitate eventual discharge to the community, if applicable.		
Any refusal of recommended services or therapy by the resident is noted in the care plan and documented in the resident care record.		
CARE PLAN REVIEW		
Comprehensive care plans are reviewed and updated after each quarterly MDS assessment or sooner if there is a change in the resident's physical or mental condition.		
Quarterly care plan review meetings are scheduled at convenient times – such as evenings and weekends – for residents' family members or other representatives.		
Every effort is made to include residents in care planning meetings. If they cannot participate, the reasons – e.g., cognitive impairment, illness, hospitalization – are noted in the resident care record.		
Current care plans are distributed to all care plan conference attendees, including residents and their representatives, prior to meetings.		
Residents and their representatives are asked to submit a list of questions, concerns and suggestions well in advance of scheduled conferences.		
Identified care plan deficits are noted in the resident record, as are steps taken to address these issues.		
Changes made to previous care plans are noted in newly issued plans, including modifications in the type, intensity, frequency and duration of care.		
Residents and/or their representatives are given a copy of the revised care plan after it has been finalized and formally drafted.		
The resident care record is audited on an ongoing basis, in order to assess documentation and overall compliance with the care plan.		

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