Care Planning Consultation

State Licensing Consultative Section (SLCS)

2024

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Learning Outcomes:

Participants will be able to identify the regulations related to care plan documentation.

Participants will be able to adopt best practices and examples outlined in the session in the nursing facility to enhance the care planning process through policy development, implementation and review.

Participants will be able to successfully audit care planned interventions for accuracy and effectiveness.

About Our Team - SLCS

- We complete non-punitive, on-site, consultative visits under the authority granted by the Public Health Code and Administrative Rules.

Contact assigned SLCS team member or email LARA-BCHS-SLICS@michigan.gov

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SLICS to SLCS

2020

SLICS created by legislation to help nursing homes with infection control and prevention during the pandemic.

2021

Non-punitive infection control consultations. CRF and CRC evaluations in collaboration with MDHHS

2022

Continued infection control consultations with follow ups from initial visits.

Officially a permanent BCHS Team!

2023

Team name changed to SLCS to allow for adaptability in topics offered.

A variation in consultation subject to Wound Care and Falls Prevention.

2024

Continuing to grow with the needs of nursing homes and presenting Care Planning as our focus topic. Follow up as needed on Infection Control.

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Care Planning Rules and Regulations

MICHIGAN PUBLIC HEALTH CODE

Article 17; Part 201; Section 333.20201

THE ADMINISTRATIVE RULES

R 325.45131 Discharge; transfer; policy; procedure; planning

R 325.45379 Nursing care services

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Michigan Public Health Code

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BCHS – Nursing Care Facilities

Michigan Public Health Code – Article 17; Part 201; Section 333.20201

1)A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization that is subject to chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3573, the health facility or agency shall post the policy at a public place in the health facility or agency and shall provide the policy to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.

(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:

BCHS – Nursing Care Facilities

Michigan Public Health Code – Article 17; Part 201; Section 333.20201

2)(e) A patient or resident is **entitled to receive adequate and appropriate care**, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, **in terms that the patient or resident can understand**, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.

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BCHS – Nursing Care Facilities

Michigan Public Health Code – Article 17; Part 201; Section 333.20201

(2)(j) A patient or resident is **entitled to know who is responsible for and who is providing his or her direct care**, to receive information concerning his or her continuing health needs and **alternatives for meeting those needs**, and to be **involved in his or her discharge planning**, if appropriate.

BCHS – Nursing Care Facilities

Michigan Public Health Code – Article 17; Part 201; Section 333.20201

(2)(o) A patient or resident is **entitled to adequate and appropriate pain and symptom management** as a basic and essential element of his or her medical treatment.

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BCHS – Nursing Care Facilities

Michigan Public Health Code – Article 17; Part 201; Section 333.20201

(3) The following additional requirements for the policy described in subsection apply to licensees under parts 213 and 217:

3)(d)A nursing home patient or home for the aged resident is **entitled to the opportunity to participate in the planning of his or her medical treatment**. The attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse, shall fully inform the nursing home patient of the patient's medical condition unless medically contraindicated as documented in the medical record by a physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse. Each nursing home patient shall be afforded the opportunity to discharge himself or herself from the nursing home.

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THE ADMINISTRATIVE RULES
for
Nursing Care Facilities

R 325.45131 Discharge; transfer; policy; procedure; planning

(1) A health facility or agency shall have a written discharge policy and procedure that is provided to the patient or any other person or agency responsible for the patient upon request.

(2) A health facility or agency shall have a written transfer policy and procedure that is provided to the patient or any other person or agency responsible for the patient upon request.

(3) In addition to subrule (2) of this rule, a nursing care facility shall have a written involuntary transfer policy and procedure in compliance with R 325.45385.

(4) Discharge or transfer planning must be provided for each patient in conjunction with patient care planning.

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R 325.45379 Nursing care services

(1) Nursing care services must be based on assessment of the patient through a person-centered approach. Nursing care services must include, but are not limited to, personal care, restorative services, and patient treatments.

(2) Personal care must be provided in accordance with the patient's preferred schedule and meet all of the following patient needs:

(a) **Hygiene** through washing, bathing, oral care, and application of hygiene products.
(b) **Grooming** through haircare, shaving, and application of cosmetic products.
(c) **Mobility** through walking and propelling, including transfer assistance and use of ambulation devices, if needed.
(d) **Incontinence and perineal care**.
(e) **Clothing** that is clean and appropriate for the season, temperature, and activity, including undergarments and proper footwear.
(f) **Nourishment** provided through meals and supplementary fluids with the proper consistency and texture.

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R 325.45379 Nursing care services continued…

(3) Restorative services must focus on maintaining a patient's optimum level in the activities of daily living by providing all of the following:

(a) **Range of motion** exercises.

(b) **Positioning and body alignment**.

(c) **Preventative skin care**.

(d) **Transfer and ambulation training**.

(e) **Bowel and bladder training**.

(f) **Training in activities of daily living**, including eating, dressing, personal hygiene, and toilet activities.

(4) Patient treatments must be modified in accordance with the response or request of the patient consistent with physician orders and in consultation with the nursing staff.

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Hospice and Hospice Residence

Administrative Rules

R 325.45345 General services
R 325.45353 Nursing services
R 325.45355 Hospice residence; additional staffing requirements
R 325.45359 Spiritual services
R 325.45361 Volunteer services

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R 325.45345 General services.

(1) As the needs of the hospice or hospice residence and its patient and family units dictate, the services of qualified personnel, who need not be an employee, must be made available in all the following disciplines:

(a) Physician services.

(b) Nursing services.

(c) Social work services.

(d) Counseling services, including spiritual, dietary, and bereavement counseling.

(e) Hospice aide services.

(f) Volunteer services.

(g) Therapy services, including physical, occupational, and speech therapy.

(h) Short term inpatient care.

(i) Pharmaceuticals, medical supplies, and durable medical equipment services.

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R 325.45353 Nursing services

(1) A hospice shall assure that a registered professional nurse completes an **initial assessment** of the patient's condition **within 48 hours after the election of hospice care**, unless sooner as requested by the physician, patient, or patient representative.

(2) A **comprehensive assessment** of the patient must be completed by the hospice interdisciplinary care team **no later than 5 calendar days after the election of hospice care**. The comprehensive assessment must identify the patient's immediate physical, psychosocial, emotional, and spiritual needs related to the terminal illness.

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R 325.45353 Nursing services

(3) The patient care plan must be established by the hospice interdisciplinary care team. The patient care plan must include problems, interventions, and goals specific to the patient and family unit and all medications, medical equipment, and other pertinent items used by the patient. The patient care plan **must be revised or updated every 15 days or as the needs of the patient/family unit change**.

(4) A staff member, as designated in the patient's record, is responsible for the coordination, implementation, and ongoing review of each plan. The plan must be recorded and maintained as part of the patient and family unit record.

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R 325.45353 Nursing services

(5) The patient care plan must give direction to the care given in meeting the physical, psycho-social, and spiritual needs of the patient and family unit. The plan **must be personalized to meet the individual's needs and treatment** decisions.

(6) Resource materials relating to the administration and untoward effects of medications and treatments used in pain and symptom control must be readily available to hospice personnel.

(7) The hospice shall arrange for the availability of nursing services 24 hours a day, 7 days a week.

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R 325.45359 Spiritual services

The hospice shall offer spiritual services to the patient and family. Services will be provided, if accepted, based upon an assessment of spiritual needs in accordance with beliefs and choices, and will be delivered as directed within the plan of care developed by the interdisciplinary care team, which includes a pastoral or other counselor. When identified as beneficial to the patient or family, local clergy and others may be sought to assist with meeting the patient and family needs.

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R 325.45361 Volunteer services

(1) The hospice shall utilize lay or professional volunteer services to promote the availability of care, meet the broadest range of patient and family unit needs, and affect financial economy in the operation of the hospice.

(2) A volunteer services director shall develop and implement a program that meets the operational needs of the hospice, coordinate orientation and education of volunteers, define the role and responsibilities of volunteers, recruit volunteers, and coordinate the utilization of volunteers with other program directors.

(3) The hospice shall provide each volunteer with the information the volunteer needs to know to protect the patient's and the volunteer's health and safety.

(4) Services provided by volunteers must be in accordance with the written plan of care.

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Certified Nurse Aides

Administrative Rule

R 400.320 Nurse aide requirements

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R 400.320 Nurse aide requirements

Once issued a certificate, a nurse aide shall do all of the following:

(a) Practice only with a valid and active certificate.

(b) Provide nursing or nursing-related services pursuant to facility policies and procedures, a patient plan of care or other related care plans, and other delegated duties unless superseded by a verifiable written or verbal order or direction from a licensed health care professional.

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R 400.315 Certificate duration; renewal process.

(4) **The department shall renew a certificate when the individual submits all of the following:**

(a) Electronic payment of the fee.

(b) An attestation that within the last 24-consecutive-month renewal period the individual worked a minimum of 40 hours as a certified nurse aide providing nursing or nursing-related services for monetary compensation.

(c) Beginning not less than 12 months after the effective date of these rules, an **attestation that the individual has completed at least 12 hours annually of continuing education within the renewal period**.

(5) **Continuing education** must ensure the continuing competence of the nurse aide and **must include abuse, neglect, and care plan training.**

CMS
Care Plan Regulations

Disclaimer – SLCS Scope is Public Health Code and Administrative Rules. For specific information and guidance please contact Bureau of Survey and Certification

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CMS – Care Plan Regulations

483.21	Comprehensive Resident Centered Care Plan
F655	Baseline Care Plan
F656	Develop/Implement Comprehensive Care Plan
F657	Care Plan Timing and Revision
F658	Services Provided Meet Professional Standards
F659	Qualified Persons
F660	Discharge Planning Process
F661	Discharge Summary

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F655 - Baseline Care Plan

- Baseline care plan **completed within 48 hours of admission**

- Provide the resident and his/her representative, if applicable, with a written summary of the care plan

- Care plan includes:
  - Resident's initial goals
  - Instructions needed to provide effective and person-centered care that meets professional standards of quality care
  - Resident's immediate health and safety needs
  - Physician and dietary orders; PASRR recommendations, if applicable
  - Therapy and social services

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F656 - Develop/Implement Comprehensive Care Plan

Interventions implemented consistently across all shifts

Objectives and interventions are person-centered, measurable, have time frames for desired outcomes; and reflect the resident's cultural preferences, values and practices

Resident/resident representative participation (or attempts made by the facility to encourage participation) in developing objectives and interventions

Care plan reflects the facility's efforts to find alternative means to address care of the resident if he or she has refused treatment

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V0200: CAAs and Care Planning

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature

2. Date ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature

2. Date ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

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F657 - Care Plan Timing and Revision

<u>Comprehensive care plan completed within seven days of the comprehensive assessment</u>

Care plan is reviewed/evaluated for effectiveness and revised following each required assessment, and as needed

Participation in the care planning process by required IDT members; appropriate professionals' expertise utilized to develop a plan

Attending physician involved in developing the care plan (e.g., presence at meetings, conversations with team concerning the care plan, conference calls, written communication)

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F660 - Discharge Planning Process

- Identified and addressed the resident's goals and discharge needs

F661 - Discharge Summary

Prepared a discharge summary that includes:

- A recapitulation of the resident's stay
- A final summary of the resident's status
- A reconciliation of all pre and post discharge medications
- A discharge plan of care
- Reconcile the resident's pre-discharge medications with his/her post-discharge medications
- Convey the discharge summary to the continuing care provider or receiving facility at the time of discharge

General Critical Element Pathway

Use this pathway to investigate quality of care concerns that are not otherwise covered in the remaining tags of §483.25, Quality of Care, and for which specific pathways have not been established. For investigating concerns regarding care at the end of life, use the Hospice/End of Life CE Pathway.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for areas pertinent to the concern.
- ☐ Physician's orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan.

Observations Across Various Shifts:

- ☐ Does staff consistently implement the care-planned interventions? If not, describe.
- ☐ Ensure interventions adhere to professional standards of practice.
- ☐ What is the resident's response to interventions? Is the resident's response as intended?
- ☐ Do observations of the resident match the assessment? If not, describe. Are there visual cues of psychosocial distress and harm?

Resident, Resident Representative, or Family Interview:

- ☐ Will you describe your current condition or history of the condition, or diagnosis?
- ☐ How did the facility involve you in the development of the care plan and goals?
- ☐ How effective have the interventions been? If not effective, what alternate approaches have been tried?
- ☐ What are your goals for care? Do you think the facility is meeting them? If not, why do you think that is?
- ☐ For newly admitted residents, did you receive a summary of your (or the resident's) baseline care plan? Did you understand it?

General Critical Element Pathway

Staff Interviews (Nursing Aides, Nurse, DON, Therapist, Attending Practitioner):

- ☐ Will you describe specific interventions for the resident, including facility-specific guidelines/protocols?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How does the interdisciplinary team monitor for the implementation of the care plan and changes in condition?
- ☐ How is information passed across shifts, and between all disciplines?
- ☐ How are revisions to the comprehensive care plan communicated to staff?
- ☐ How was it determined that the chosen interventions were appropriate?
- ☐ Did the resident have a change in condition that may justify additional or different interventions?
- ☐ How does staff validate the effectiveness of current interventions?

Record Review:

- ☐ Review relevant information such as medication and treatment administration records, interdisciplinary progress notes, and any facility-required assessments that may have been completed. Does the information accurately and comprehensively reflect the resident's condition? If not, describe.
- ☐ Are federally required RAI/MDS assessments completed according to required time frames?
- ☐ For newly admitted residents, is there a baseline care plan, and does it describe the instructions necessary to meet the resident's immediate needs? Does it address the resident's clinical and safety risks?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, preferences, and behaviors? Does it include goals for admission, measureable objectives, timetables, and desired outcomes? How did the resident respond to care planned interventions? Was the care plan revised if interventions weren't effective, the desired outcome was achieved, or if there was a change in condition?
- ☐ Is there evidence of resident or resident representative participation in developing resident-specific, measureable objectives, and interventions? If not, is there an explanation as to why the resident or representative did not participate?
- ☐ Is there evidence that the resident has refused any care or services that would otherwise be required, but are not provided due to the resident's exercise of rights, including the right to refuse treatment? If so, does the care plan reflect this refusal, and how has the facility addressed this refusal?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?

General Critical Element Pathway

Critical Element Decisions:

1) Did the facility ensure that the resident received treatment and care in accordance with professional standards of practice, their comprehensive, person-centered care plan, and the resident's choice?
If No, cite appropriate outcome tag or F684

2) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

4) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

5) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

General Critical Element Pathway

7) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Notification of Change F580, Admission Orders F635, Professional Standards F658, Qualified Staff F659, QOL F675, Foot Care F687, Colostomy/Urostomy/Ileostomy Care F691, Prosthesis F696, Sufficient and Competent Staffing (Task), Physician Services F710, Facility Assessment F838, Medical Director F841, Resident Records F842, QAA/QAPI (Task).

General Critical Element Pathway (cmscompliancegroup.com)

Care Planning Process

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What is a Care Plan?

A formal written **individualized plan of treatment and activities**, based upon comprehensive assessments performed by an appropriately-comprised interdisciplinary team of qualified professionals that:

a) identifies the **goals and wishes** of the individual

b) describes the **medical, nursing, and psychosocial needs** of each individual consistent with the individual's stated goals and wishes

c) describes **how such needs will be met**

d) sets **timetables for meeting those needs** in order that each individual attains or maintains the highest practicable physical, mental, and psychosocial well-being

e) is **periodically reviewed and revised** as appropriate

https://www.lawinsider.com/dictionary/care-plan

What are the Standards of Care?

Standards of care in nursing are guidelines that provide a foundation as to how a nurse should act and what they should and should not do in their professional capacity. These guidelines establish a baseline of quality patient care and provide an objective standard of accountability within the profession.

Standard of Practice

https://pubmed.ncbi.nlm.nih.gov/32202397/

https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf

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Who Participates in Care Planning?

- RESIDENT/REPRESENTATIVE

- Interdisciplinary Team
  - Physician
  - Nurse
  - CNA
  - Therapy
  - Social Work
  - Dietary
  - Activities

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3 KEY COMPONENTS

The care plan must contain at a minimum the following three areas.

1. Nursing diagnosis identifying the problem or concern

2. Resident's goal

3. Interventions to meet goal and care for resident

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How to get started?

- Resident assessment
  - Pain evaluation and implementation
  - Clinical Condition
  - Cognitive and Functional Status
- Activities
- Nursing services
- Food and nutrition services
- Cultural competence and trauma-informed care
- Treatment/Services for mental/psychosocial concerns
- Use of Services
  - Physical therapy, pharmacy and other rehabilitation therapies
- Discharge planning

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INVOLVE THE RESIDENT

Work collaboratively with the resident or the responsible party.

- Identify goals that are specific, measurable, and time bound (documented target completion date)
- Start small and build on success
- Provide regular feedback: phone follow-up, email, and face-to-face
- Goal-setting discussions and follow-up can be conducted by care team members
- Identify external supports as needed, e.g. community programs, family members

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S.M.A.R.T Goals

- Patient goals should be S.M.A.R.T.
  - **S**pecific: Well defined, clear, and unambiguous
  - **M**easurable: With specific criteria that measure patient's progress towards the accomplishment of the goal
  - **A**chievable: Attainable and not impossible to achieve
  - **R**ealistic: Within reach, realistic, and relevant to patient's functional/lifestyle
  - **T**imely: With a clearly defined timeline, including a starting date and a target date
- Interventions and goals should be prioritized based on specific patient assessment and identified needs

PERSON CENTERED CARE PLAN

Identified Care Gaps/ Needs

- Have you learned about the patient's personal habits, likes and dislikes, daily routines, baselines?
- Have you identified barriers to care? Gaps in care? If there are any, how will you handle them?
- Who will you collaborate with from other specialties in order to provide the patient with the best possible care?
- Are there any acute needs to be addressed with the care team?
- Are there any emergent needs to be addressed with the PCP or ED?

Addressing barriers supports successful completion of the goals stated in the care plan.
Barriers may include physical, emotional or social barriers.

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WHO AM I?

Care plans should include statements that describe the patient in their own words, such as:

- I prefer to be addressed as ….(Mrs. Jones, Kathy)
- I want the person working with me to know…
- The most important information you need to know about me…
- I have a challenge with…
- My religion/spirituality is important to me …
- I learn best by…
- Where I am (concerns)…
- Where I want to be (goals)…

Common Care Plan Issues

- Length
- Missing problems/interventions
- Redundancy
- “Fluff”/Routine Practices
- Practicing outside of scope
- Timely resolution/revision
- Timely identification, implementation, and review
- Communicating changes

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Length

Care plans are a supposed to be a blueprint, not a novel.

Length does not equal complete.

If care plan is person-centered, measurable, realistic and includes all required and pertinent areas then it is complete.

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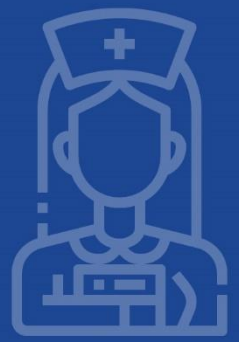

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Missing Problems/Interventions

An audit of the care plan and/or Kardex can remedy this.

Does the written care plan match the physical environment and vice versa?

Is the care plan specific for the resident?

If there are adaptive devices, level of transfer assistance, mattress settings, etc., are those specified within care plan?

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Redundancy

If an intervention is being continued or needs to be re-emphasized, then document that.

If the current intervention is appropriate and there is not a need for a new intervention, then also document that.

Is the same intervention listed in multiple different problems?

“Fluff” / Routine Practices

Are standards of care defined?

Are all staff educated on standards of care?

If so, standards do not need to be re-stated in the care plan unless there is a deviation from normal.

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Practicing Outside of Scope

Ensure ALL staff are practicing within their scope.

Are Kardex items appropriate for CNAs?

Are care plan items appropriate for the discipline specified?

What can be delegated appropriately to activities, or support staff?

Timely revision / resolution

How timely do new interventions get entered onto the care plan?

How often are care plans:

- ✓ audited
- ✓ reviewed
- ✓ irrelevant or completed interventions resolved

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Identification, implementation and review

Are staff involved in creating the care plans?

When are staff reviewing care plans?

Do they understand how to implement the interventions?

How is completion of tasks being captured?

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Communicating Changes

How are staff notified of changes?

Is there a consistent process?

Are you using consistent verbiage when communicating?

Has staff been educated on the process of communicating changes?

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Auditing Considerations

Make sure the picture the care plan reflects matches the resident's room and the care being provided to the resident.

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Care Plan Review

- Do each of the residents reviewed have a baseline and comprehensive care plan?
- Does the care plans address all the resident's care needs?
- Are the care plans person/resident centered?
- Does the facility/staff provide care as described in the care plan?
- Does the care plan make sense when you read it?
- Does the care plan address discharge/transfer planning?

- **Does your facility have a good auditing process in place?**

Questions?

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Resources

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