

Basics and Standards of Care Planning

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In a skilled nursing facility, the care plan is the blueprint for the resident's entire care needs, and directs the actions of all health care team members. A new staff member should be able to know everything essential about the resident by reading the care plan. The care plan is a measure of quality of care, and gives a comprehensive picture of where the resident is at present and what is hoped to be achieved in the future.

The care plan is not only a guide for daily charting and care; it is also examined by surveyors to assess whether the resident's needs are being adequately met by the facility. The care plan:

Increases consistency of care

Focuses all interdisciplinary team members on the same problems

Describes the resident's functional abilities and needs

Sets goals to maintain the resident's highest level of functioning

Addresses the resident's physical, mental, emotional, and social needs

Provides a reference to measure progress or decline in the resident's condition

Standards of Care Planning

A number of clear guidelines and resources outline the basic components of a care plan for long term care.

Being familiar with regulatory and industry standards helps to increase quality of care and assure good survey outcomes.

The RAI MDS 3.0 User's Manual is a reliable source of basic care-planning principles. In Chapter 5 of the manual, Linking Assessment to Individualized Care Plans, it states that: "The process of care-planning is one of looking at the resident as a whole, building on the individual resident characteristics, measured using standard MDS 3.0 items and definitions."

The care plan should focus on the course of action needed to attain or maintain a resident's highest practicable level of well-being.

It should be based on communication about the resident that is reliable, consistent, and understood by all team members.

Good assessment forms the basis for a solid care plan. The Care Area Assessments and Triggers (CAAs and CATs) serve as the link between the MDS 3.0 and care planning.

The care plan is driven by the resident's problems, unique characteristics, strengths, and needs.

Code of Federal Regulations (CFR) 42, Subpart E, Part 483.20 Guidelines:

The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS 3.0 or Care Area Assessments.

The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident.

Furthermore, the facility is responsible for addressing the resident's needs from the moment of admission.

F279 (k)Comprehensive Care Plans:

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

The care plan must describe the following:

- (i) The services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under 483.25; and
- (ii) Any services that would otherwise be required under 483.25 but are not provided due to the resident’s exercise of rights under 483.10, including the right to refuse treatment under 483.10(b)(4).

The American Nursing Association’s Standards of Clinical Practice outline the Nursing Process.

This framework of critical analysis and planning is used universally by nurses in all areas of health care. Its six basic parts form the actual structure of the care-planning process:

Assessment - data collection from the chart, physical nursing assessment, observation, interview of resident, family, and staff, review of the MDS 3.0 data

Diagnosis – stating the individual problems as nursing diagnoses

Outcome Identification / Planning– formulation of the desired goal for resolution of the problem, setting priorities, identifying nursing interventions

RAI Manual updates of October 2011 were very specific about the structure of goal statements, stating that care plan goal statements should include: The subject (first or third person), the verb, the modifiers, the time frame, and the goals.

Implementation – putting the care plan into action

Evaluation – analyzing, assessing the success and appropriateness of the care plan

The written care plan is usually arranged into the four parts of Problem, Goal, Interventions, and Assessment.

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