Care Plan Meeting Tune-up

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The MDS Coordinator has a multitude of responsibilities, not just leading care plan meetings, but scheduling and structuring. Following an organized format can help make the meetings more enjoyable and productive. This guide outlines how to keep the meeting positive, efficient, improve quality of care, and increase participation of the resident, family, and staff members.

Start out on a positive note with good preparation and communication.

Bring the resident's chart, care plan, nursing assistant care form, and all pertinent documents to the meeting.

If family members and/or the resident are present, introduce yourself and all the care plan team members, and ask if there are any concerns, questions, or complaints they wish to discuss first.

Increase efficiency by staying on track.

Keep the care plan team members focused and from going off on tangents by leading them gently but firmly back to the matter at hand. If a member has a pattern of wasting time in the meeting, schedule a private conference to discuss the problem

Address family satisfaction issues immediately, and assure family members that information will be given to the Charge Nurse and/or Director of Nursing.

Make sure issues are followed up on as soon as possible.

Do a comprehensive assessment by involving each member of the team.

Review everything that's happened with the resident since the last assessment.

Go over all recent changes in medications and physician's orders.

Review the nursing care plan, reading each problem statement and discussing with the team, family, and resident as necessary.

Ask each care plan team member to review his or her department's care plan.

Increase quality of care by examining each issue.

Review the resident's Quality Indicator reports, and address any item that is flagged.

Especially focus on Late-loss ADLs.

Compare the care plan to the MDS 3.0 and Nursing Assistant care form to make sure it all matches. Resolve any conflicting information.

Make sure issues related to falls, restraints, skin breakdown, psychotropic medications, and weight loss are discussed, and that effective interventions are implemented and documented.

Give everyone a chance to participate.

Sum up the main points and changes that have been covered in the meeting, and discuss with the care plan team if additions or changes need to be made.

Ask if anyone present can think of anything else that could help the resident.

Take notes of the meeting on the care plan conference form, and when discussion of the resident's care plan is finished, pass the form around the table for signatures

Maintain the care plan according to documentation standards.

If changes to the care plan need to be made, cross through the old entries with a yellow marker, date, and initial. Date and initial new entries.

Care plans do not need to be completely rewritten with each assessment. They can be edited each time. A rational policy is to reprint the care plan once per year or when a great number of changes have been made. Surveyors like to see a care plan that has been worked on and used.

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