Introduction

The ninety-five care plans in this book cover every nursing diagnosis and care plan problem that may be generated from the OASIS-C form. Terminology is based on OASIS-C language and nursing diagnosis definitions and classifications as outlined by the North American Nursing Diagnosis Association (NANDA). The care plan format follows the care plan standards from the American Nurses Association.

The first section of the book covers regulations and standards for care planning, care plan components, and Quality Measures and Outcome Measures.
Because the terminology of the care plans is based on OASIS-C language, it is very easy to see which care plans are triggered by the OASIS-C entries.

The care plans can be used for outlines of care, and are also extremely useful for teaching patients and caregivers.

Care plans are placed in the book alphabetically by problem title, and follow the list given in the Table of Contents.
All of the care plans and forms in the book are also on the CD.
When the CD is placed in a computer, the care plans can be opened in a word processor. Entries can be added or deleted to individualize the care plans.

Care Plan Standards and Regulations

Excerpts from OASIS-C Guidance Manual, September 2009 for 2010 Implementation, Appendix A, Centers for Medicare & Medicaid Services:

The comprehensive assessment must (1) identify the patient's continuing need for home care; (2) meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs; and (3) for Medicare patients, identify eligibility for the home health benefit, including the patient's homebound status.

It should be noted that the data items in OASIS-C are not, in and of themselves, a complete or comprehensive assessment. Home health agencies will need to supplement the OASIS-C data items with others necessary for a full assessment. For example, the OASIS-C items do not include vital signs, assessment of breath sounds, or collection of data on fluid intake, which are part of a more complete assessment. Each agency will be expected to incorporate the OASIS-C items into its own comprehensive assessment documentation and related policies and procedures.

The care plan is the blueprint for the patient’s entire care needs, and directs the actions of all health care team members. A new caregiver should be able to know everything essential about the patient by reading the care plan.

The care plan is a measure of quality of care. It gives a comprehensive picture of where the patient is at present and what is hoped to be achieved in the future, and is a guide for daily charting and care.

The care plan:

Increases consistency of care

Focuses all interdisciplinary team members on the same problems

Describes the patient’s functional abilities and needs

Sets goals to maintain the patient’s highest level of functioning

Addresses the patient’s physical, mental, emotional, and social needs

Provides a reference to measure progress or decline in the patient’s condition

The Medicare Benefit Policy Manual (CMS Pub. 100-2, Ch.7 §30.2) states that:
The term "plan of care" refers to the medical treatment established by the treating physician with the help of the home health care nurse.
The plan of care must address the following:

- All pertinent diagnoses
- The beneficiary's mental state
- The types of services required
- Supplies and equipment required
- Frequency of visits
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- Medications
- Treatments
- Safety measures to protect against injury
- Discharge plans
- Any additional items which the HHA or physician want to include

Excerpts from the State Operations Manual, Appendix B - Guidance to Surveyors: Home Health Agencies, §484.18, 2005:

The plan of care must be established and authorized in writing by the physician based on an evaluation of the patient's immediate and long term needs.

The HHA staff, and if appropriate, other professional personnel, shall have a substantial role in assessing patient needs, consulting with the physician, and helping to develop the overall plan of care.

The patient has the right, and should be encouraged, to participate in the development of the plan of care before care is started and when changes in the established plan of care are implemented.

1. How does an HHA evaluate whether the plan of care, and the coordination of services, help the patient attain and maintain his or her highest practicable functional capacity based on medical, nursing, and rehabilitative needs?

2. How does the HHA monitor the delivery of services, including those provided under arrangement or contract, to ensure compliance with the specificity and frequency of services ordered in the plan of care?

"Professional standards of quality" means services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired patient outcomes may also be found in clinical literature.

Possible reference sources for standards of practice include:

Current manuals or textbooks on nursing, social work, physical therapy, etc.

Standards published by professional organizations such as the American Dietetic Association, American Medical Association, American Medical Director's Association, American Nurses Association, National Association of Activity Professionals, National Association of Social Work, etc.

Clinical practice guidelines published by the Agency of Health Care Policy and Research

Current professional journal articles.