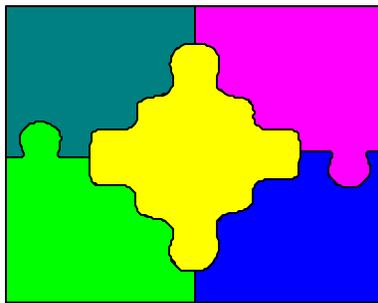


CARE PLANNING 2000 GUIDELINE



January 2000

**A Guideline for Efficient and Effective
Clinical Record Documentation and Care Planning jointly
developed by providers and provider associations in collaboration with
The Bureau of Quality Assurance and
The Wisconsin Board on Aging and Long Term Care**

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INTRODUCTION & ACKNOWLEDGEMENTS

Care Planning 2000 Guideline was generated from a concern that clinical records in nursing facilities were crowded with unnecessary documentation. After a number of meetings and discussions between the Department of Health and Family Services and provider groups, a work group was formed to address this issue. The Secretary of the Department of Health and Family Services directed the Bureau of Quality Assurance to gather input from provider and bureau representatives to address the issues. This **Care Planning 2000** Guideline is the result of that collaborative effort.

A steering-group identified the resident's care plan as a focus for this effort. Streamlining the assessment and care planning process and reducing the size of care plans should result in a reduced paperwork burden on facilities and improve the outcomes for the resident. The steering group also wanted to develop a useful tool for care planning and care delivery.

The steering-group was expanded to a core-group of provider and bureau representatives. This core group developed, distributed and analyzed a questionnaire sent out to all Wisconsin nursing homes. This enabled them to identify the vision, goals and objectives of Care Planning 2000 that are in the appendix of this guideline. The steering group then conducted various focus groups and presentations throughout the state to gather input for guideline development and to share the information. Volunteer facilities piloted the guideline prior to finalization to validate the concept.

Throughout this process, many persons have contributed to this guideline or supported its development. It would not be possible to mention them all by name. For everyone who assisted, the Bureau of Quality Assurance heartily thanks you.

Among those who contributed most significantly were the facilities who volunteered to pilot the guideline and reported their results. The Bureau of Quality Assurance recognizes these facilities and their staff and specifically the leaders listed here:

Cedar Campuses - West Bend

Skip Topel, R.N., Unit Manager, Dementia Unit

Dr. Kate Newcomb Convalescent Center - Woodruff

Maureen Rodzicak, R.N., Director of Nursing
Mary Staeben, Activities Director

Franciscan-Skemp Healthcare - Sparta

Mary Strok, Director of Nursing
Rhonda Sullivan, Social Services
Lisa Wenzel, Occupational Therapy

Good Shepherd Services - Seymour

Tom Lohuis, R.N., Director of Health Services

Please call the Provider Regulation & Quality Improvement (PRQI) section of the Bureau of Quality Assurance at (608) 266-3024 if you have questions about this guideline or would like additional training in implementation.

Reprint Permission Granted

INSTRUCTIONS FOR USING THIS GUIDELINE

The Care Planning 2000 Guideline is a resource that can be used for the care planning process. It is not regulation. This guideline may be integrated into your facility's policies, procedures and best practice guidelines. The guideline is compatible with the Resident Assessment Instrument and with quality indicators.

- **All disciplines can use the guideline**, and **it may be reproduced and shared**. Citing the source is appreciated. If you make any changes, please remove the reference to the Department, Division and Bureau.
- Please refer to the table of contents for specific topics.
- The last portion of the document addresses special resident populations and identifies resources for caring for those populations.
- Bibliographical references are interspersed throughout the guideline with the pertinent subject matter.

KEY POINTS

- **Nothing takes the place of critical thinking**. Each resident presents a unique set of strengths and problems, thus they need unique care and a unique care plan. Developing and implementing an effective care plan requires staff creativity and dedication.
- **The guideline is a tool**. You may use other specialized tools in conjunction with this guideline, including nursing diagnosis, critical pathways, clinical pathways, quality monitoring pathways, quality indicators, outcomes, goals, targets, etc. Please integrate this information with other successful tools.
- **Utilize other professional resource materials and practice guideline groups**. Specific clinical guidelines are available from a variety of professional resource groups for particular conditions and types of resident issues. Integrate these resources into your resident assessment and care planning process, which begins with an accurate, comprehensive assessment using the Resident Assessment Instrument.
- **Other tools are not contraindicated**. You can use other tools/methods if they are based upon sound clinical judgment and have been proven successful by clinical research.
- **Continue to enrich the guideline with research**. Please continue to seek and use other resources and up-to-date research-based information that becomes available after the publication of this guideline, as well as any new state or federal regulations that become effective.

*Obstacles Are What People See
When They Take Their Eyes Off The Goal*

Quality of Life

**Ensuring the Highest Quality of Life With a
Resident-Centered Focus**

ENSURING THE HIGHEST QUALITY OF LIFE WITH A RESIDENT-CENTERED FOCUS

Along with the quality of medical care residents receive, the quality of each individual's life is an important way to measure the success of a facility's care giving. The exact measurements for "quality of life" vary. The following is a perspective on defining quality of life that was developed by the American Association of Homes and Services for the Aging (AAHSA). For a complete reference, call AAHSA at (202) 783-2242.

Quality is also difficult to define because it is a concept that evolves with respect to the status of each person. Like most of us, recipients of long-term care services don't feel the same way about life from one period to the next. But unlike most of us, their source of quality may well depend on what people around them are willing and/or able to do, and how well they know the individual and what is meaningful to that person. In the world of long-term care, what is "quality" often reflects a judgment made by others for individuals who may not be able to communicate and whose condition is very fragile. This becomes particularly true as people approach the end of life.¹

In spite of the difficulty in defining quality, however, some have tried. The evolution of quality is subject to on-going research, which continues to demonstrate new levels of what is possible for the elderly people to achieve and maintain, even in a nursing facility setting.

...[Quality of care is] the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.²

...[Quality of life] includes a sense of satisfaction with oneself, the environment, the care received, the accomplishment of desired goals, and control over one's life.³

...Quality [is care that] meets the highest practicable physical, mental and psychosocial well being of each resident (OBRA '87).

...High quality nursing home care consists of the maintenance of a clean and pleasant environment, in which the food is good, that there is plenty to do, assistance is readily given with dressing and bathing, people are nice to each other and respect each other's privacy and personal dignity, and good medical and nursing services are provided to those who need them.⁴

...[Of highest importance to (nursing facility) residents are] the qualifications, competence, attitudes and feelings of staff and quality of interactions between residents and staff. Also important: improving function and greater independence.⁵

Some of the definitions demonstrate an increasing tendency to separate concepts of quality of clinical care and quality of life. This is appropriate. For the elderly, in particular, medical care can

¹ See, for example, Thomasma, David C., "Ethical Judgments of Quality of Life in the Care of the Aged," *Journal of the American Geriatrics Society*, 32:7, pp. 525-527, July 1984.

² US Government Accounting Office, Medicare: *Federal Efforts to Enhance Patient Quality of Care*, Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, April 1996, GAO/HEHS-96-20, citing, IOM 1990 "Medicare: A Strategy for Quality Assurance," Kathleen Lohr, ed. (Washington DC: National Academy Press).

³ IOM, Citing Lawton, M.P., 1982. Competence, Environmental Pressure, and the Adaptation of Older People. In *Aging and the Environment: Theoretical Approaches*. M. Lawton, P. Windley, and T. Tyerts (eds.). New York: Springer-Verlag.

⁴ Vladek, Bruce C., *Unloving Care*, Basic Books, New York (1980).

⁵ IOM, citing a study of nursing home resident preferences conducted by the National Citizens Coalition for Nursing Home Reform from 1984-85 and reported in Spalding, Joy. 1985. *A Consumer Perspective on Quality Care: The Residents' Point of View; Analysis of Resident Discussions*. National Citizens' Coalition for Nursing Home Reform, Washington, D.C.

be delivered at the highest levels of quality to individuals who are dissatisfied in every other sense. At the same time, individuals can be quite content with less than adequate medical care if the rest of their lives are satisfactory.

The distinction between quality of clinical care and quality of life also is appropriate because these aspects are monitored and assessed very differently. Measurement of clinical care, for example, tends to be a matter of objective observation and examination of the person and comparison of that person's data to an established clinical standard of practice over time. Quality of life, on the other hand, depends on the subjective view of the individual, a far more difficult phenomenon to measure.⁶

Both quality of clinical care and quality of life are the subject of intense efforts to measure and improve quality in long-term care.

THE FACILITY'S PHILOSOPHY OF CARE/ LIFE

The "quality of life" philosophy requires everyone in the facility, from the top management to the newest employee, to embody and enact genuine beliefs in quality care. Ensuring a quality life for elderly or disabled individuals who are entrusted to the care of a facility is a challenge. Residents are unique and the care of each of them requires a true commitment from everyone in the facility to establish and maintain each resident's individuality. Additionally, staff must continually see evidence, not just hear verbalizations, that the leadership staff at the facility exemplify a caring attitude at all times. When administrative and other leadership staff spend time with residents, giving bedside care, feeding residents, talking to residents and *doing* activities *with* them, an example is set for all facility staff to model. Quality of Life in a nursing home has less to do with what is on paper and a whole lot more to do with what is done *with* people. This is not to say that facilities should ignore documentation, but nursing homes that focus on residents' quality of life are homes that are going to succeed in meeting residents' desired outcomes. These are the homes that will be highly regarded in the community.

PROMOTING THE INDIVIDUALITY OF THE RESIDENT

Care plans constructed in "**first person**" format are very effective in highlighting a resident's individuality. As an example, the resident's care plan says "I prefer to lie down just before supper, I don't like to lie down after lunch." Or "I need the light left on in the bathroom at night." Care plans that focus on the residents' strengths or needs, rather than on "problems" in the traditional medical model format, can result in personalized, individualistic resident care.

Begin with a comprehensive assessment that focuses on the resident's individuality. To promote a quality life for each resident, it is necessary to determine what is meaningful to each person, such as:

STRENGTHS

- What are the strengths of this person (physical ability, cognition, and desire for rehabilitation)?
- How can we **maximize** those strengths?

⁶ Although family members' judgments often are substituted for those of the residents, their views seem more properly confined to perceptions of how the facility responds to families' needs, rather than residents'. Our members' experience is that families can be very helpful in determining what the resident's likes and dislikes were before he or she came to the nursing home setting; however, families' ability to interpret the resident's preferences in the context of the new environment is probably no more accurate than the ability of staff to do the same thing. Perhaps the most striking example is the situation where families must decide whether a resident would want life-sustaining treatment after a life-threatening incident. Cases where the resident recovered sufficiently to be asked about the family's decision on the resident's behalf demonstrated that the families guessed the resident's wishes correctly less than half the time.

PERSONALITY

- What was this person like before coming to a nursing home?
- How did the resident relieve stress?
- What did the person do previously for enjoyment?

ESTEEM

- What things were the most valuable to the individual?
- What caused them to smile or laugh?

ROUTINE

- How did he or she like to spend time?
- What was the "daily routine?"
- What did the resident enjoy? How did the resident relieve stress? Was music comforting/pleasing? What kind of music? What kind of chair was comfortable for the resident?
- How much walking was this person capable of before the most recent decline?

ENVIRONMENT

- What was the environment of the person like?
- Where did the person live?
- What physical aspects were most important?
- How can the person's nursing home environment be more homelike?
- How much walking was this person capable of before the most recent decline?

FOOD

- What role did food play in the person's life? What foods *really* pleased the resident? Go *beyond* simple likes and dislikes and realize that tastes can change; texture may be important; finger food may be best, etc.

RELATIONSHIPS

- Who are the other important people in the life of this individual?
- **How can we help them maintain that connection?** This includes family and friends who may be elderly, compromised or unable to easily travel to the nursing home, or those who are deceased. Encouraging positive reminiscing can be helpful in maintaining connections.

DIGNITY AND PRIVACY

Studies have shown that the two things people hold most dear are their dignity and their privacy. Only when these two basic human rights are respected and fostered will people be able to achieve higher levels of physical and psychosocial functioning.

THE IMPORTANCE OF A HOME-LIKE ENVIRONMENT

Creating a home-like environment is a challenge faced by institutions. Each nursing home facility is encouraged to be creative in using simple measures to make the resident's home away from home as pleasing as possible. Talk to residents and their families to find out what their previous environments were like. Treat each person as if he/she is a member of your own family and remember the same amenities you enjoy in your home are likely to be comforting to residents as well.

NOTE: One book that can give a lot of insight into quality of life issues in a nursing home is [A Life Worth Living](#) by Dr. William Thomas, ISBN # 096 410 8968, available at bookstores. This book tells about the popular "Eden Alternative." Other resources on this kind of environment that can be very helpful. For further information on the Eden Alternative, go to this web site: <http://edenmidwest.com>

THE POWER OF HUMAN TOUCH

Never underestimate the power of meaningful human touch to enhance a resident's quality of life. In America, we are primarily a non-touching culture. Inexperienced staff need a great deal of help in overcoming touch barriers and in learning *appropriate* touch techniques with residents. Sometimes confusion and behavioral symptoms in residents are very difficult to manage, and staff are often at odds to know how to approach individuals, especially residents who value and express their need for privacy and dignity. Yet staff members still need to attend to intensely personal interventions for residents, such as bathing and toileting. Therefore, staff to whom you delegate caregiving must also know how to share calming touch.

Facilities can utilize the power of simple, appropriate touching to enhance quality of life for residents. All humans have the basic need for human touch; however, many have not received *appropriate* touch for long periods of time, or they may have cognitive difficulty relating to the touch of people who seem like strangers. If staff say things like, "He doesn't like to be touched," there is a need to re-evaluate the approaches to giving that resident care. It can take a lot of effort to find the right caregiving approaches, but ensuring consistent use of these approaches will enable staff to have more success with residents. Professional massage therapists, or nurses and therapists who have had professional training in the use of appropriate touch techniques can be an excellent resource for the facility.

Many facilities are having success using Reiki, a technique for stress reduction and relaxation and other Eastern techniques that utilize the life-force energy of the person. The Reiki Web site (www.reiki.org) can provide more information. Other facilities find aromatherapy successful and beneficial for both residents and staff.

NOTE: References in the section on Dementia are useful for those who have touch issues.

HAVE FUN IN YOUR HOME

When staff have success and fun with residents and with each other, they are happier. Happiness is contagious and will enhance the quality of life, the quality of resident care, staff satisfaction and staff retention. In today's world, where nearly everyone works, many staff spend far more time with residents in the facility and with each other than they do with their own family members. When staff have training and assistance in team-building techniques, including the ability to have fun, the benefits can far outweigh the expense of training.

Making Documentation Work for You

**Taking a Critical and Team Approach to
Streamlining Care Plans**

MAKING DOCUMENTATION WORK FOR YOU

This section lists resources and suggestions to help you develop a clinical records program that:

- Promotes standardization of form design and development, including computer forms;
- Eliminates duplicate documentation; and
- Utilizes current research and resources.

One of the primary purposes of this guideline is to give ideas that will help facilities streamline paperwork. No magic set of instructions for reducing paperwork exists; you will need to reassess documentation methods with a **proactive, take charge, and teach approach**. Taking stock of what you *have* and what you *do* in your medical record system with a critical eye will help you gain control.

When facilities piloted the use of this streamlining process, they were pleased with the results. They discovered that it really is possible to go from a 25-page care plan to a 5-page care plan and that over 100 computer screens could be reduced to 25. One facility streamlined the documentation forms for the four providers on their campus. They went from 102 forms down to 54 forms for the four types of providers, including nursing home, hospital, etc.

REMEMBER THESE IMPORTANT POINTS WHEN STREAMLINING DOCUMENTATION:

- ❑ ***FOCUS ON QUALITY OF CONTENT RATHER THAN QUANTITY OF WORDS; MAKE IT USEFUL.***
- ❑ ***DOCUMENT TO SUPPORT CLINICAL CARE, NOT FOR SURVEYORS.***
- ❑ ***USE MDS LANGUAGE AND DEFINITIONS WHEN DOCUMENTING IN THE CLINICAL RECORD.***
- ❑ ***WHEN YOU COLLECT DATA, USE IT TO TAKE APPROPRIATE ACTION BASED ON YOUR ASSESSMENT OF THAT DATA. DO NOT MERELY OBSERVE AND RECORD. WHEN YOU COLLECT DATA, YOU ARE OBLIGATED TO USE IT.***
- ❑ ***REDUCE BLANK SPACE ON COMPUTER AND PAPER FORMS.***

GETTING STARTED:

1. **Inventory all forms, paper and computer forms.**

Thoroughly review the purpose of each form, who completes each form, and how the information is used. Be sure those who *use* these forms or computer screens are involved.

2. **Know state and federal requirements.**

Each discipline needs to familiarize themselves with federal and state regulatory requirements for their discipline and establish how they will meet those requirements, how they will document their practice, and how they will communicate with the other disciplines on a resident's team. Eliminate duplicate documentation that may have become a habit as a result of academic education but is beyond the requirements.

A. The only assessment forms required by regulation are the federal Health Care Financing Administration (HCFA) specified Minimum Data Set (MDS) forms, which include:

- i. Basic Assessment Tracking Form
- ii. Background (Face Sheet) Information
- iii. Full Assessment Form, Sections A - S
- iv. Section T - for Medicare PPS
- v. Section V, Resident Assessment Protocol Summary
- vi. MDS Quarterly Assessment Form (2 pages)
- vii. Discharge Tracking Form
- viii. Reentry Tracking Form

NOTE: Keep up to date with future MDS changes on the HCFA Web site:

<http://www.hcfa.gov/medicare/hsqb/mds20>

NOTE: Bureau of Quality Assurance Memos on MDS are available on the DHFS Web site:

http://www.dhfs.state.wi.us/rl_DSL/Publications/BQAnodMems.htm

B. The Federal Regulations effective March 12, 1998 at Code of Federal Regulations 42 (CFR) 483.20 (b)(1) require the facility to make a comprehensive assessment that includes at least the following:

- Identification and demographic information
- Customary routine
- Cognitive patterns
- Communication
- Vision
- Mood and behavior patterns
- Psychosocial well being
- Physical functioning and structural problems
- Continence
- Disease diagnoses and health conditions
- Dental and nutritional status
- Skin condition
- Activity pursuit
- Medications

- Special treatments and procedures
- Discharge potential
- Documentation of summary information regarding the additional assessment performed through the resident assessment protocols
- Documentation of participation in assessment
- Documentation for the assessment process includes direct observation and communication with licensed and non-licensed direct care staff members on all shifts. This is documented on the MDS Section R.1.
- A facility must maintain all resident assessments (MDSs) completed within the previous 15 months in residents' active records and use the results of the assessments to develop, review, and revise the resident's plan of care.
- A facility must coordinate assessments with the Preadmission Screening and Resident Review program (PASRR) under Medicaid part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

C. The Federal Nursing Home Requirements at 42 CFR 483.75(1) (F514 to F516) also state that the facility must:

1. **Maintain clinical records on each resident in accordance with accepted professional standards and practices that are:**

- a) Complete;
- b) Accurately documented;
- c) Readily accessible; and
- d) Systematically organized.

2. **The clinical record must contain:**

- a) Sufficient information to identify the resident;
- b) A record of the resident's assessments;
- c) The plan of care and services provided;
- d) The results of any preadmission screening conducted by the state; and
- e) Progress notes.

NOTE: The Resident Assessment Instrument User's Manual provides guidance in documentation. The RAI Manual and up-to-date state and federal regulations can be obtained from the Bureau of Quality Assurance at (608) 267-1446.

3. **Establish facility standards using a team approach.**

Involve all disciplines when looking for ways to streamline records and eliminate duplication. This may mean learning new and unfamiliar documentation styles. The entire staff must decide:

- a) **What** must be documented,
- b) **How** it is to be documented,
- c) **Who** is to document it,
- d) **When** it will be documented,
- e) **Where** it will be documented (strive for only once) so that it is available when and where others will need it, and
- f) **How** it will be evaluated in your quality assurance or quality improvement efforts.

4. Avoid repeating information/data that is documented elsewhere in the medical record.

- Evaluate how many places you record things like vital signs or weights, and limit the documentation to one place if at all possible. Be sure all staff can access vital information; *unnecessary repetition is not the most effective way to assure access*. Halting repetition may involve breaking old habits, but it is the only way to streamline.
- Avoid repetition by not repeating the same information in the weekly narrative note.
- Use reference notes to other parts of the medical record, if needed, to avoid repetition, especially when the information is already clearly documented.
- Refer to pertinent baseline data rather than rewriting it, such as historical or diagnostic information, to establish background information upon which your documentation is "grounded."
- Document a specific goal; this may help to avoid duplication.

5. Establish a forms approval process.

Once you have established what documentation is needed in your facility, establish a process for reviewing and approving all new forms or computer screens before they are implemented. Resist the temptation to solve each problem in your facility by creating a new form or "tool". Avoid the "Resistance to Giving Up Forms" (R.G.U.F.) syndrome in your facility. Sharing information with computer vendors and from other providers who are happy with their designs can be very helpful in this area.

6. Eliminate and consolidate wherever possible within the regulations and your interdisciplinary clinical practice needs. The interdisciplinary team needs to integrate the interdisciplinary process and documentation in a way that is reflected in the record and tells an accurate story of the resident.

7. Develop a clinical record documentation system that works for you.

Be sure your system also meets Medicare documentation requirements. Many systems of documentation are available, including focused documentation, problem oriented documentation, documentation by exception, etc. These systems may help save resources if they are used correctly. The two most important factors in developing a documentation system are to enable staff to effectively provide resident care and to meet the regulatory requirements.

One principle necessary for documentation by exception is that everyone who charts knows the individual well, including all their baseline norms and any pre-established protocols or parameters. For example, documentation by exception for the long-term care resident may only be appropriate during an acute episode when specific parameters are established for the resident or it may not be appropriate in this setting at all. Legal ramifications must be considered if you make this process part of your system. This system also relies a great deal on strictly following assessment and documentation protocols, very specific policies and procedures, specific staff training, follow-through, supervision and ongoing quality assurance.

Whatever the documentation system used, it must clearly document the resident's condition and also how the staff implements care (the facility's actions), as well as the resident's response to care.

8. Make documentation clear, concise and accurate.

9. Reduce the blank space on each sheet of paper.

- a) *Work with computer software vendors and information technology staff to develop efficient electronic and printed documents that use all document and page space efficiently.* If there is only one resident problem or one discipline's interventions on a page, only a few lines of the page are used. This results in a *lot* of blank paper in each clinical record, easily contributing to *doubling* the size of an ordinary clinical record.
- b) Choose computer systems that are flexible. For instance, there does not have to be a "hard page break" in a care plan after each problem, each set of approaches or sections of discipline-specific information.
- c) Care plans do not have to be in columns like they were years ago unless you choose that format and you can use it efficiently, such as for updating the care plan. This format can potentially lead to unnecessary "blank space" in the clinical record when columns on the left have very little documentation in them.
- d) Most approaches or interventions on the care plan should be maintained across disciplines. Transdisciplinary care needs to be integrated as part of the interdisciplinary process.
- e) Document on both sides of the paper in the clinical record. Two sided printers are now available. Work with your computer vendors to upgrade technology.
- f) Many facilities systematically organize the clinical record with tabs or dividers. You might also use a chart table of contents list in the front of the record or on each unit that tells the reader exactly where to find a particular item.

10. Develop a quality improvement program to evaluate the effectiveness of your clinical records system.

In order to achieve continuing quality improvement you need to ensure the utilization of these three things:

1. **Structure** - The structure for assessment begins with the MDS and the comprehensive assessment using the Resident Assessment Instrument structure.
2. **Process** - The process you have in place should ensure the correct use of the structure.
3. **Outcome** - The outcomes of care are measurements of success, failures and identifiers of needed improvements.

Carefully evaluate the information staff need in the record and ensure that the thinning process does not remove critical information. A facility must decide what information staff members need to care for the resident and ensure that it is readily accessible when they need it.

ADDITIONAL SUGGESTIONS FOR MAKING DOCUMENTATION WORK FOR YOU

- Establish an organized, efficient flow of the clinical records system in the facility. Remember the facility's policies, procedures and use defines the clinical record; the regulations are broad.
- Let the assessment and care planning process drive the documentation system, not the reverse. Be certain that a streamlined, resident focused assessment process is in place.
- **Integrate any assessment processes or assessment tools with the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) process** to avoid duplication of effort and/or paper. Don't do everything that you used to do plus the MDS requirements and the RAI process; develop a fully-integrated procedure, if you have not already done so.
- Using forms with **checkboxes** for hard data collection rather than narrative may save some time. This is okay **if the holistic clinical picture of the resident** can still be gleaned from the combination of hard data, assessment and evaluation of the resident's condition and the clinical picture related to that data, as well as the documentation of that assessment and evaluation process.
- When using flow sheets to record repetitious data, **the assessment and evaluation of the data** will probably need to be narrative. A flow sheet that only records observations will not stand alone in documenting the assessment, action (selection and implementation of interventions) and the evaluation of the effects of your interventions. Do not leave out conclusions drawn based on critical thinking from clinical records. It is up to the facility to establish the policies and procedures and to train staff on how this is to be accomplished. Then it is up to the individual professional to use his or her clinical expertise to carry out the care plan, evaluate the results and ensure accurate documentation. The more simple documentation is, the more useful it is for all staff and for anyone who would later read the record.

GETTING THE COMPUTER TO WORK FOR YOU

A SUPPORTIVE ADMINISTRATIVE PHILOSOPHY IS ESSENTIAL

***Staff training time on computers is essential for success.
It takes time for computer fears to be overcome
and for people to realize that they can't do anything
that the computer experts can't undo.***

1. When converting from a paper system to an electronic clinical record system, be certain that your computer system meets all the Federal MDS Data specifications. All clinical records must meet archival and legal requirements, such as the retention of clinical record information. See Federal regulation at 42 CFR 483.
2. **Conduct Daily computer back up** to avoid loss of information.
3. Design electronic clinical record systems that avoid duplication of data and data entry. Computerization can certainly help, but unless great thought is put into a program design that avoids duplication, it will be no different, and may be worse than paper.
4. Choose and contract with vendors that emphasize research and development and who will provide system support and upgrades. Then work with them for continued adherence.
5. Consider choosing one person in your facility who has a "can do", positive approach and who is skilled at assertive communication to be the primary vendor contact person.
6. Be sure that when a failure within the computer program occurs, you are prepared to bypass the customer relations representative and ask to speak directly with a programmer to resolve your issue.
7. Be sure the computer vendor support can accommodate all shifts, evenings, nights, and weekends.
8. Choose a vendor who has remote access and can interact with your computers and programs via a modem.
9. Resist the tendency to chart outside your computer system. Train staff to accurately and effectively use the electronic clinical record.
10. Look for opportunities to migrate what you now do on paper into your computer system.
11. Develop a system that includes sufficient hardware and computer workstations to enable staff to use the system efficiently, then provide training, both initial and ongoing, and frequent encouragement.
12. Build on software provided by HCFA.

CLINICAL RECORD RESOURCES

Wisconsin Health Information Management Association (WHIMA)

Address: 2350 South Avenue, Suite 212
La Crosse, WI 54601-6272
Phone: (608) 787-0168
Fax: (608) 787-0169
Web site: www.whima.org
E-mail: whima@execpc.com

Written resources available:

- "Professional Practice Standards for Health Information Management Services in Long-Term Care Facilities"
- "Legal Resource Manual for Patient Health Care Information," updated annually

Contact the WHIMA association to obtain names of Health Information Management Consultants for LTC facilities or to verify resource content, pricing, and ordering information.

American Health Information Management Association (AHIMA); (National Organization)

Address: 919 North Michigan Avenue, Suite 1400
Chicago, IL 60611-1683
Phone: (312) 787-2672
Web site: www.ahima.org
E-mail: info@ahima.org

Written resources available:

- "Professional Practice Standards for Long-Term Care," Product No. 15104
- "Security and Access, Guidelines for Managing Electronic Patient Information" by Sandra R. Fuller, MA, RRA, Product No. AB101797
- "Information Security: Protecting Paper and Computer-Based Health Information" by Sandra R. Fuller, MA, RRA, and Mary Brandt, MBA, RRA, CHE; this is referred to as a "Program in a Box," Product No. 6160101

Contact AHIMA to verify resource content, pricing and ordering information at:

Address: P.O. Box 75438
Chicago, IL 60675-5438
Phone: (800) 335-5535
Fax: (847) 364-1268

Overcoming Obstacles in the Care Planning Process

**Realistic, Prioritized, Streamlined, Useful
Outcome-Based Care Plans**

CORRECTING MYTHS

This section clarifies requirements and dispels myths that can obstruct the care planning process. The facility leadership from the facilities who piloted this guideline did not previously think that their staff subscribed to the myths identified here. However, when they reviewed them with their staff, they discovered that many staff *did* base their practice on some of these myths. Reviewing them and making corrections through inservices and staff meetings proved very worth while for the piloting facilities.

Making The Care Plan Realistic

MYTH 1 We can't be creative in caring for residents and still meet the regulations.

FACT: The resident assessment and care planning process is focused on the individual resident and offers many opportunities for creativity. The regulations contain very basic requirements, and it is imperative that the interdisciplinary team works together to gain a better understanding of these minimum requirements. Focusing the resident assessment and care planning process on quality of life issues, as identified in the first section of the guideline, will open more doors to creativity in caring for residents.

If you find specific regulations preventing you from being creative with resident care, please address these issues to the Bureau of Quality Assurance. Your input about regulations is valuable, and the Bureau will respond to your inquiries and assist you in your efforts to meet resident's needs while still meeting the regulations.

MYTH 2 We need to use "Reality Orientation" for residents with dementia.

FACT: Reality orientation was a very popular care plan intervention in the past; however, experts now know that reality orientation is only effective when dementia is early and/or mild. For many residents, reality orientation only serves to frustrate and confuse. Listen to your residents and relate to their reality, not yours. For example, if they are worried about whether or not the chores have been done or the children have been fed, reassure them that someone has taken care of those things or use another equally comforting statement. Such reassurances are not lies; usually, it is true that someone is taking care of whatever they are worried about, or it may no longer be a relevant issue. Help them overcome anxieties upon which they have become fixated and provide them with reassurance.

Review the techniques described in the Ombudsman or Alzheimer's Association's resources that are mentioned in the Special Resources section of this guideline. Many facilities have said that the main thing the reality orientation board does in their facility is help the staff to chart the right dates. So, you don't have to take your board down if it helps the staff, visitors and cognitively intact folks, and if people enjoy using it. However, realize that actually *understanding* reality is not realistic for many residents, especially those with advanced dementia.

MYTH 3 We have to get the whole team to meet and that is sometimes impossible.

FACT: A care planning conference where all staff must be present is not a regulatory requirement. If necessary, choose and facilitate other effective means to work as an interdisciplinary team. Use of conference calls, fax machines and E-mail may be more realistic to enhance interdisciplinary communication and foster the decision making

process. Be sure that essential coordination and interdisciplinary communication is made part of the clinical record and is not just on your E-mail system alone.

The most important person to include in the decision making process is the resident. Some ways to facilitate participation are listed below.

- Invite residents and schedule care conferences at their convenience.
- Help residents participate in decision-making at the care conference to the fullest extent possible.
- If the resident chooses not to attend the care conference, obtain his or her input and the family's input prior to the conference.
- Include family members the resident wants in attendance. Be sure the time is right for the family, that they can find a convenient place to park, and so on.
- Follow-up with the resident and family to discuss progress and changes in the care plan.

The federal nursing home regulations require that: "...the facility must develop a COMPREHENSIVE care plan for each resident, ...that is based upon a comprehensive assessment, and ...conducted or coordinated with the appropriate participation of health professionals." The facility determines how to accomplish this task using the right people with the right expertise. Many professionals feel that meeting face to face is the most efficient and effective way to plan care and you have this option.

To stay in compliance, the interdisciplinary assessment and care planning PROCESS must be functional and intact so that care meets the needs of the residents and helps them achieve their highest practicable level of functioning.

At one of the Care Planning 2000 focus groups, a provider reported that their interdisciplinary team has daily "stand-up" meetings that last no longer than one half hour. At these short meetings, each staff member can highlight a specific resident's issues to the entire team and suggest any immediate changes needed in care. Not every resident will need a care plan change each day, but if they do, staff can quickly and efficiently consult the resident and implement changes with the stand-up method, while still maintaining resident involvement.

The documentation should reflect the participatory process, and the care plan document should facilitate the delivery of individualized, interdisciplinary care. Everyone needs to be working IN CONCERT to provide individualized, comprehensive care for residents.

Prioritizing The Care Plan

MYTH 4 Care plans only focus on medical/nursing issues and does not need to include quality of life issues.

FACT: Focusing the care planning process and the care plan document primarily on physical, medical and nursing care is no longer a standard of practice. The care planning process and the resulting document need to focus on things that are most important to the resident including quality of life issues. The care plan is to be used as a tool to meet all the resident's needs holistically, recognizing the whole person; body, mind and spirit. This is

critical if your care planning efforts are to yield the outcome you and the resident want. Medical and nursing issues should be included when needed.

MYTH 5 Everything triggered on the MDS needs to be on the care plan.

FACT: Use sound clinical decision making and the resident assessment protocols to make care planning decisions for items triggered on the MDS. Items triggered need a comprehensive assessment. Whether or not they are addressed on the plan of care is a clinical decision. Triggered areas on the MDS help focus the comprehensive assessment process using the Resident Assessment Protocols. Decisions about what care the resident needs and what is on the resident's care plan are clinical decisions based on the comprehensive assessments. Just because something is triggered does not necessarily mean it must be on the care plan, unless it is a problem or strength for the resident and requires attention. For example, the concern may have been resolved, or it is not a problem/concern that needs to be addressed at this time.

MYTH 6 You must be able to resolve every problem on the care plan.

FACT: Evaluate what you put on the care plan based upon what you are going to be able to resolve or at least have some impact on for the resident.

Residents' problems cannot always be solved. The assessment and care planning process must focus on the **STRENGTHS** of the resident if it is to address any of the resident's resolvable issues and help them maintain an acceptable quality of life.

A resident's care plan may reflect any of the following:

1. You are going to **rehabilitate** the resident,
2. You are going to **prevent complications** for which risk factors are present,
3. You are going to **prevent current problems** from **worsening**, and/or
4. You are going to provide **palliative care** as the resident completes the life span.

With some residents you are going to do more than one, but decide on a **PRIMARY FOCUS** for a resident so that you concentrate in one direction, without ignoring other areas if they need to be addressed. Having a primary focus makes your care plan more precise and streamlined.

Do not forget their psychosocial needs, especially behaviors, pain, depression, etc.

MYTH 7 All goals need to be reached in three months.

FACT: Times for achieving care plan goals will vary; some goals should be met in a few days or weeks. Not every goal can be reached within three months. The nursing home regulations require that a team of qualified persons must periodically review and revise the comprehensive care plan. The more the goals focus on the resident's strengths, the more likely the goals can be achieved.

"Interim" goals enable staff to see benchmarks of achievement toward measurable goals after three months (small victories, if you will) and can help staff see that their caregiving **DOES** make a difference. Long range goals are often unrealistic, and staff may then lose

the determination to make the goals happen. The more specific and measurable the goal is, the more likely success is.

For example, we may not be able to cure anyone's COPD (Chronic Obstructive Pulmonary Disease), but perhaps we can keep them out of the hospital or off antibiotics for a certain period of time.

Streamlining The Care Plan

MYTH 8 We cannot have a streamlined system that establishes, delivers and documents the standard care given to everyone in a standard of practice protocol. Every small detail of care given to the resident must be on the care plan.

FACT: It is acceptable if your facility utilizes facility "standards of practice" in caring for all residents. Having standard interventions (care provided as routine) on the care plan creates unnecessary length. The information on care plans should be *individualized* as to resident's needs that are *different from or in addition to* facility standards of practice or protocols.

Concerns and problems related to the use of standard care practices that definitely need to be avoided:

- Direct care staff need to be aware of these standards and standard care practices according to the facility protocols. If they do not follow standards of practice there can be problems, including potential negative effects on the resident, as well as potential for citations, especially if the resident *needs* the care and *does not* receive it. The Bureau of Quality Assurance observes resident care during survey activities to determine if residents receive the care they need to enable them to achieve or maintain their highest practicable level of functioning.
- The facility cannot merely write standards of care in a policy or procedure book. Staff need to participate in the development of what is "standard." Then the staff needs to ***consistently provide care in accordance with the identified standards AND the resident's individualized care plan.*** Both staff training and ongoing supervision are critical if this type of system is to succeed. **If residents do not receive needed care, residents will not progress, and this may result in citations regardless of whether it is a standard facility practice or an individual resident intervention.**
- A suggestion was made at one of the Care Planning 2000 focus groups that sub-groups of providers could get together and establish some standard care protocols rather than each one doing it on their own. This sounded like a good idea to most participants. The critical issue is that *direct caregiving staff must participate in this process* so that everyone "buys in" to what the standards of care are and how they are implemented.

MYTH 9 The more information in the record, the better it is.

FACT: You must examine your record system and determine whether or not you are avoiding duplication of information in the record.

There is no federal or state regulation that requires duplication of the same information, for example, lab data, weights, etc. Staff members who need the information can

reference and use the information from a single place in the record when they need to for resident care or documentation.

Avoiding duplication in clinical records is a big challenge that only a team approach can accomplish. What is very workable for one facility may be a nightmare for another. Again, be sure to avoid R.G.U.F. (Resistance to Giving Up Forms) in your facility. Look carefully at where you are recording information and take a comprehensive look at how to eliminate unnecessary duplication. Everyone needs to be involved in this process.

NOTE: Refer to the "[Making Documentation Work For You](#)" section of this guideline.

There is a requirement in HFS 132 **for a weekly narrative note that documents the resident's condition**, but it does not require a RAP Summary. The required RAP Summary is Section V of the Resident Assessment Instrument. Currently, HFS 132 is under revision. Be sure to adjust your facility documentation requirements to the final version of HFS 132 when it is passed.

Some providers at Care Planning 2000 focus groups reported that they document regarding one of the resident's goals on the care plan for weekly narrative documentation, especially when the resident's condition is stable.

MYTH 10 We cannot combine problems on the care plan.

FACT: You can combine problems when it makes good clinical sense to do so. There are no regulations that prohibit combining problems on the care plan document if that facilitates the delivery or the documentation of the care. You are not even required to use the problem-oriented format. Decisions about the structure of the care plan document are determined by facility policies and procedures. The more focused the care is and the more focused the care plan document is, the more effective it will be for the resident, and the more user friendly it will be for staff.

If the whole care plan is channeled into one problem, it is probably not going to work for the typical nursing home resident who has multiple issues. However, to address every problem in a document when it does not significantly relate to the resident's care only creates unnecessary length and redundancy in the resident's care plan.

Most residents' MDS assessments will trigger multiple concerns/problems. Combining related issues on the care plan makes good clinical sense if:

- They are interrelated;
- They have related or similar goals; and/or
- The selected interventions are the same or related.

Do not depend solely on MDS to identify everything that should be addressed on the care plan. The Resident Assessment Instrument identifies *almost all* of the resident's needs because it focuses on functional capacity; however, you are not prohibited from addressing other areas of the resident's needs or strengths, such as a particular medical problem if it needs attention.

MYTH 11 All potential problems must be on the care plan.

FACT: There is no requirement that all potential problems be addressed on the care plan.

A potential problem is a concern if it could become an *actual problem if you do not take preventive action* and it *should* be on the care plan in that case. One example: monitoring for Tardive Dyskinesia when the resident is on an antipsychotic medication. Address only those potential problems you need to *do* something to prevent, or *do* something to closely monitor.

Ask yourself this question: *If we do nothing, and the resident continues on their current path, is there likely to be a problem?*

If your response is "Yes", because you need to institute preventative actions, you will probably want to address this on the plan even if your goal is to postpone or slow the inevitable. In the long run, this will only make your job and the resident's life easier.

MYTH 12 We need extensive care plans for every problem, even if the resident is only here for a "short stay."

FACT: Make the care plan for a short-stay resident very *focused* on what you expect the resident to achieve. The short-stay resident still needs a *comprehensive* care plan that is focused on:

- Problems of the resident that need attention during his/her stay;
- Strengths of the resident upon which you can capitalize;
- Actions you need to take to help the resident achieve goals; and
- Methods to measure progress and readiness for discharge.

Use the standards explained above regarding potential problems and your expertise to **focus your efforts and care plan on what the resident needs during the stay.**

Making The Care Plan Useful

MYTH 13 We can't keep information at the bedside where it will be useful.

FACT: Some facilities do find it helpful to keep care plan information at the bedside where it can be used; this is allowed, **if done correctly.**

If written resident information, such as the care plan, portions of the care plan or other instructions for the resident's care ARE left or posted in the resident's room; it is critical that:

- The *confidentiality* and *privacy* of the information is maintained by how the facility manages this information, such as it being concealed from vision and protected and secured in whatever way is effective in your institution.
- The *privacy* and *dignity* of the resident is maintained and their environment is homelike. Having pictures of wounds or medical looking pictures hanging at the bedside does not uphold the resident's dignity or home-like environment. Having age

and weight listed on a clipboard which hangs at the foot of a resident's bed for all to see is *not* homelike.

Whether or not information is at the bedside of a resident is a decision that each facility must make on its own, based upon on what is feasible in the particular setting. However, it is *not* prohibited *if* it is done correctly.

Many providers at focus groups meetings have identified that keeping bedside information updated is the most difficult part of this system. Check with other facilities in your network that have done this successfully and find out what works for them.

MYTH 14 The care plan must be together in one location.

FACT: Your care plan can consist of multiple documents in several different locations or formats if this is workable for *all staff* who need to use the care plan.

The structure of the care plan document is a facility decision. It needs to function in a way that the Resident Assessment and Care Planning process is supported and facilitated. The documents must work for the staff to facilitate the delivery of care that meets the resident's needs.

If different locations for parts of the document facilitate care, then that is where they should be located. It is up to the facility to structure the system so that duplication is avoided.

Constructing a care plan documentation system with information in multiple places requires looking at your system with a team approach. The outcome of the care that is given and the content and usefulness of the care plan document is what is most important, not the format of the care plan document.

Explaining how your care plan format works to anyone who is not familiar with it, including surveyors, will facilitate good understanding.

MYTH 15 Therapy notes must be on the care plan and in the clinical record.

FACT: If the therapy notes are to be considered part of the care plan, it is important that all staff who care for the resident have access to information they need about the resident in order to provide the proper care (weight-bearing status progression, for instance).

If the care plan identifies a reference to the therapy notes and the staff needs to read them in order to provide consistent, individualized, coordinated care, then they need to be where the staff person can read them. *However, there is no need for duplication if they are always readily accessible to those who need them.*

The interdisciplinary team must work together to identify what will work for them in the delivery of the resident's care. There should not be a situation where one discipline is doing one thing or using one approach, and another discipline is counteracting with another approach or intervention, including the nurse aide staff. Communication, written and verbal, is *very* important.

Making The Care Plan Outcome-Based

MYTH 16 **Computerized, outcome-based care plans are going to be required soon.**

FACT: The only computerization requirement is the requirement to submit computerized MDS data.

MYTH 17 **We should document more to ensure fewer citations and less litigation.**

FACT: More precise quality documentation is what is needed, not a greater volume of documentation.

MYTH 18 **The "MDS and Care Plan Nurses" should do this process.**

FACT: The resident assessment and care planning process is interdisciplinary and requires the participation of multiple professional and paraprofessional people from all shifts who are familiar with the resident. One discipline or one person should not create the care plan alone; rather, the care planning process is best done by, or in conjunction with, those individuals who know the resident best. They are the ones most likely to be able to predict what outcomes the resident can achieve and to recommend the interventions that will work for the resident.

The requirement is that the Resident Assessment process be conducted or coordinated by a registered nurse, who signs and certifies the completion of the assessment. The federal requirements do not restrict this to just one RN, and many facilities use multiple nurses like "case managers" or "primary nurses" for this process, with selected groups of residents for whom each registered nurse is responsible.

The Assessment and Care Planning Process

**Communication and Critical Thinking for a
Holistic Care Plan**

THE ASSESSMENT AND CARE PLANNING PROCESS

This section shows you how to make sure that the assessment and care planning process flows for each resident and all staff members. The assessment and care planning process should be seamless and ongoing; it is not a series of events. Even though you are going to document some data at critical points in time (admission, change of status, etc.), your assessment and care planning process is continuous. Your documentation system needs to allow you to meet the minimum requirements but still be flexible enough to allow for your creativity. That is why the documentation requirement is broad and open.

EXTERNAL COMMUNICATION

INFORMATION NEEDS

Collaboration with other referral sources besides hospitals in your community is important. Let other providers, such as physicians, practitioners, discharge planners, etc., know what information you need and work to gather all the pertinent information from the referral source.

Clearly identify how your system meets the minimum requirements, then add only what you need that is above and beyond the minimum requirements. *More* is not necessarily what is needed, just **better, focused documentation**. Example: the regulations require infection control and tuberculosis screening, not a chest X-ray.

Examples of information that you may need from external sources:

1. Tuberculosis screening status
2. Infectious status -- to get accurate information, you may need to talk to the infection control person at the referring institution if the social worker or discharge planner is unable to answer your questions.
3. Behavioral status, level of staff supervision needed
4. What works for this person to avoid using restraints
5. Diagnoses, treatments, medication orders, ADL needs, etc.
6. The care plan from the previous provider
7. What this person's hopes and long range plans are after nursing home care; what support systems does the resident have?

REFERRALS

In addition to communicating with each referral source on a one-to-one basis about each resident coming to your facility, it is also critical that you contact, and perhaps meet with, all the common referral sources in your community. Establishing in advance what information you need about each person ensures smoother transition and better continuity of care. Positive, proactive dialogue and communication with these providers can help eliminate many confusing issues before the resident ever comes to you.

Uniformity within a community of care providers is extremely beneficial if it can be worked out. If all the nursing homes and hospitals and other providers in a community could meet and agree on a single approach or a list of information that they all want to have, it can go a long way toward establishing and

maintaining continuity of care in a community. The trend in regulation now is not to be prescriptive about standards of practice, rather to just identify basic minimum standards.

FAMILY

Contact family and other close friends who know the resident well and thoroughly interview them, even if it needs to be done **on the phone**.

FACILITY

Facility policies and procedures may exceed regulations if they are needed to meet the needs of the residents or if you want to provide services that are above the minimums. Facility administration, the medical director and/or board, and the interdisciplinary team must work together to make informed decisions about exactly what additional information is needed. You must communicate this clearly to your referral sources to maintain good continuity of care.

ORGANIZATION TIPS

- Consider keeping all your regulations in one place, e.g., a tabbed notebook.
 - Having an Admissions Notebook to guide staff during the admitting process can be very helpful.
- When your work *feels* organized, it *feels* easier.**

ASSESSMENT

The *Resident Assessment Instrument User's Manual* is your primary resource for this process. Many resources exist regarding the assessment process. Here are some key points to help you focus on streamlining the process.

RESIDENT INVOLVEMENT

- The participation of the resident and significant others is an easy thing to say, but not always easy to do. It requires focus and determination by staff to ensure that this takes place. This is documented in Section R.1. in the MDS.
- Often residents and families *assume* (and may have even been told) that "the facility was sent all the information they need." However, sometimes other care providers, such as hospitals and physicians, may not have sufficient insight into what a facility specifically wants/needs to know about a resident. It is critical that the facility develop an initial care plan that enables them to meet the resident's needs upon admission while the comprehensive care plan is being developed.
- The participation of residents in decision making about their lives and their care is critical. Each resident must be invited to care planning conferences, and the facility needs to provide him or her with choices during the process. This is true even though the resident may have a guardian or an activated Power of Attorney for Health Care (POAHC) agent; these residents still participate to the greatest extent possible. The legal authority of residents to make as many of their own decisions as possible must not be circumvented. Only those individuals who have previously executed a POAHC instrument and who have been determined in writing by two physicians or a physician and a psychologist to be incapacitated are to have full assistance with their decision making regarding health care matters.
- Individuals who have merely executed a POAHC document and have not yet been determined in writing to be incapacitated, are their own decision makers. Even individuals with guardians *or* activated POAHC agents must participate in decision making to the fullest extent possible within their limitations.

NOTE: The booklet "**Your Right to Direct Your Future Health Care**" (PSL-2025, revised 3/98) addresses the formulation of advance directives and is available from the Department of Health and Family Services by calling (608) 267-1446. They come in packages of 50 for a nominal printing fee or you may receive 1 or 2 booklets at no cost and reproduce them.

NOTE: The Ombudsman in your area may be of great assistance for resolving any issues that come up with families. They can answer questions, work with families, and they have resource materials that can provide clarification. Ombudsmen are spread around the state in regional offices. In the "Special Resources" section the regional offices are listed along with the toll free number that you can call for more information: 1-800-815-0015.

- Family members who have close relationships with residents need to be kept involved as a part of the resident's decision making if that is what the resident wants. Keep in mind the family's wishes do not supersede the decisions made by the resident together with the interdisciplinary team. Providing an invitation to family members that includes the specific issues that are going to be discussed at care conferences aids in their understanding and heightens their interest in attending.
- Ensuring the highest quality of life requires a complete focus on the resident. **The admission physician's orders and the initial care plan need to be individualized and specific enough to meet the initial needs of the resident.** Many facilities at focus groups have reported that a hand written initial care plan is the most efficient way to ensure prioritized, focused care while the comprehensive assessment and care plan process is in progress. However, this is a facility decision; *no* requirements specify the *format*.
- Integrate the Resident Assessment Instrument (RAI) into the facility's comprehensive assessment and care planning process. Prior to the RAI, nurses and other disciplines did "their own" assessments. The RAI/MDS process was never intended to be just added on top of those processes. Other professional assessments that a resident needs should be integrated with the RAI/MDS process.
- Each team of provider staff needs to look at their assessment process and streamline so there is no unnecessary duplication of work or documentation, excluding what is needed for resident progression and re-enforcement. This will ensure a comprehensive, effective process that looks at the resident holistically.
- The assessment process must be resident focused:
 - Gather accurate resident-specific information.
 - Identify and evaluate real issues and strengths of the resident.
 - Establish desired and realistic outcomes/goals with the resident.
 - Develop a plan of care to achieve goals that establishes:
 - What specifically needs to happen? Be resident specific, beyond "standards of care."
 - Who is to make it happen?
 - When does this need to happen and how often?
 - What does the plan indicate about how the resident's outcome will be evaluated?
 - Specialized assessments and other complementary assessment tools are acceptable, if they are needed for resident assessment and if they avoid duplication or repetition.

NOTHING TAKES THE PLACE OF CRITICAL THINKING

WORKING AS AN INTERDISCIPLINARY TEAM

The most critical people on the interdisciplinary team are the resident and family members or significant others.

- Work together as an interdisciplinary team by sharing all information anyone may receive from the referral source or the resident and family. Information from hospital discharge planners, nurses, family members, therapists, etc., is critical for the success of the resident.

NOTE: Also see the section in the guideline on "[Making Documentation Work for You](#)" in the area that addresses the team working together.

- Ensure common use information that everyone needs is collected only once and that it is accessible to all staff. Each discipline should not needlessly repeat collection efforts. For example, is objective data readily available? i.e., weights, labs, medications, medical, and therapy orders.
- A good, internal communication system is critical because it enables all staff to quickly familiarize themselves with the residents. Professionals and paraprofessionals working together can produce far more outstanding results than any one discipline working alone.
- Advance preparation is crucial before coming together for decision making as a team, whether or not it is in person or on a phone conference.
- Meeting on a regular basis promotes sharing but also using other modern communication tools such as faxes, phone conferences, E-mail and **especially the clinical record** aids in communication about the resident. The resident record creates a permanent legal, retrievable record of your assessments, plans and actions related to the resident, whereas your E-mail is not part of the clinical record unless it is specifically added by someone. If you use e-mail for communication, be sure facts that are communicated by phone or e-mail are documented in the clinical record.
- Be familiar with the current federal and state regulations required for each provider and each discipline. Knowing the minimum standards can help you avoid needless repetition in documentation.

NOTE: Current regulations are available by calling the Bureau of Quality Assurance at (608) 267-1446.

- Ensure that the interdisciplinary approach assigns responsibility for a resident's continued rehab interventions when therapy "discharges" a resident from services.
- Here are some things you can do if/when care conferences/ meetings become difficult:

1. *Staffing Minutes.*

Some providers find it helpful to keep care conference summaries or "staffing minutes."

Establish how this information gets shared with those who were not at the meeting and how the critical information gets into the clinical record. You must also be sure any changes in resident care are implemented and documented (clear definition of how, when and by whom, etc.).

Staffing summaries can be recorded directly in the chart of the resident who is being discussed in order to prevent recording twice.

2. *Accommodations.*

Establish who takes responsibility for resident and family participation in "staffings." Have meetings in the evenings or on weekends if family members work. However, if family members, friends or advocates do not drive at night, be sure to schedule them for daytime hours. Also ensure ample and close parking spaces for family members.

3. *Assign Responsibility.*

Establish who takes responsibility for implementation and changing the written action plan, as well as communicating and implementing the interventions at the level of direct resident care.

4. *Communicate to the "Pool."*

Be sure there is a method in place for everything to be communicated to hands-on direct caregivers including any "pool" people so that they know exactly what to help a resident with. This usually requires a briefing of the pool person by the supervising staff at the beginning of each shift. They do not usually have time to do extensive reading about resident care. Verbal instructions are often the best way to communicate with direct care staff.

CARE PLANNING WITH SUCCESS

Goals for care are established based upon the comprehensive, interdisciplinary assessment of the resident. Goals will only be successful if they are realistic and if they are the goals the resident is interested in achieving. Utilize the RAI manual, Chapter 4 as a reference for goal setting

- Determine the over-all focus of the plan. In guiding the goal setting process there are four basic choices. While you may do a little of each of these with each resident, pick one direction and focus on it. You can always change the focus if the resident "rallies" or heads in a different direction. Choose one from the following four basics of care planning goals:
 1. Focus on improvement - When the resident needs to focus on rehabilitation and improvement toward a previous functional level;
 2. Focus on prevention - When the plan needs to prevent or slow the resident's decline in functional level, health deterioration, etc.;
 3. Focus on maintenance - When the resident needs supportive care that enables him or her to maintain functional capacity and health status; or
 4. Focus on palliation - When the resident needs to be provided with comfort and symptom control as they approach the end of their life.
- Focusing on the resident will likely need to include interviewing family members face-to-face or by phone if necessary. Be creatively and gently assertive, but sincerely sensitive to their extreme stress if speaking to them on the phone. You will not be able to read family member's non-verbal distress signals when they are not in front of you.
 1. Evaluate what the resident's life was like prior to admission or prior to the most recent decline.
 2. Build goals around resident's strengths by listing the strengths of the resident at the beginning of a care plan. To help facilitate a resident's independence, considering all types of strengths; do not ignore inner strengths and spiritual strength.

3. Then focus on these identified strengths, making the best of every opportunity.
 4. Use the strengths of the resident to help in reaching the highest practical level of well-being.
 5. Strengths are especially important for short term residents and discharge planning.
 6. Using the strengths of the resident can help define realistic goals in care planning and motivate the resident towards independence.
 7. The following are some examples of some "strengths":
 - a) The resident who previously lived alone and wants to go back home.
 - b) The resident who is energized or soothed by music.
 - c) The resident who is cognitively intact.
 - d) The resident who is strengthened by prayer.
 - e) A resident who used to enjoy reading may no longer be able to do so, but may be comforted by holding books, hearing books on tape and/or being read to by a volunteer or family member.
 - f) The resident with strong family support.
 - g) Resident has good communication skills, listens to them and then use the information.
- It is important that this process is holistically based.
 - Care plan documentation needs to reflect the following:
 1. If your approach is to define the standards for resident care in your facility, then identify what is not done for the individual resident, or what is done for the resident that is different, or in addition to the standards. **Be sure individualized care is conveyed in your care plan documents.**
 2. Frequently teach established standards, especially to new staff and to any pool staff that you use. Update standards often and ensure that supervisory staff follow all practices to set an example.
 3. Interventions on the resident-centered care plan should be different than, or in addition to, your established standards of care. Ensure that all staff recognize variations from standards and that they understand and implement standards *and* individual variations.
 4. Use clear, concise documentation, using fewer words to convey a point. Streamlining takes practice and staff can help each other with this process.
 - Care planning for the resident taking medications.

Medications are usually an intervention. The facility may have standardized procedures, protocols or practice guidelines for medication administration. Therefore, the care plan should identify specialized interventions or monitoring that are resident specific and change the standard of practice to meet resident's needs.

Some good reasons are listed below.

1. When you are concerned about the specific side effects or untoward effects of a particular drug on a resident.

2. When you are monitoring for specific behaviors, symptoms, or lab values, etc., or for titration of a drug.
3. You do not need to include "medications as prescribed" on your care plan if it is your policy, procedure and/or protocol for each resident to receive prescribed medications unless refused. You can eliminate this redundancy if all staff correctly implement this as a "standard of care."
4. You may consider the Medication Administration record (MAR) part of the clinical record and also part of the care plan in your facility.
5. Medications do not have to have a separate care plan problem; most are interventions and may be related to a resident's functional abilities.
6. Monitoring for side effects that can adversely impact functional capacity **may** need to be on the care plan, especially if there is a potential for problems to develop or escalate if you do **not** do preventative care or monitoring.

IMPLEMENTING SELECTED INTERVENTIONS OR THE DELIVERY OF INDIVIDUALIZED, HOLISTIC CARE

Now that you are familiar with the resident and have established a resident-centered plan of care, you must establish how to provide that care on a consistent basis.

- **STAFF ASSIGNMENTS**

One way providers have found particularly gratifying for both residents and staff is providing consistent staffing assignments, such as permanent "wing" assignments, or permanent "case loads", etc. These providers can provide you with information on the successes and barriers to implementing staffing changes.

- **SUPERVISION OF CARE DELIVERY** is critical to ensure that no one forgets any of the following, including how to do it correctly. It is extremely important that key "front line" staff know:
 - **What** needs to be done;
 - **How** it should be done which will require direct care staff training and in-service;
 - **Who** is to do it;
 - **What, exactly**, are they to do;
 - **When, how often, and for how long** are they to do it; and
 - **How** they are to use the documentation and communication system.

- **ADVOCATE FOR THE BENEFIT OF THE RESIDENT**

Residents expect and need to have their needs met, regardless of whether interventions are written on the care plan, in a facility or corporate protocol, or not written at all. Surveyors also expect residents' needs to be met. Surveyors observe the outcomes of care. They will observe care and evaluate the care plan document to identify what the resident wants and needs according to the resident's assessment. Standards of practice and established protocols for resident conditions that are similar will also be used for comparison. What the resident wants and expects, and how the facility goes about achieving this, is also significant in the evaluation of direct care.

- **CONFERENCES**

Ask staff at care plan conferences what changes they think will help the resident. Direct care staff usually know how to solve the resident's issue or will know if the care plan or the facility "protocol" needs to be changed for this resident.

- **ACCESSIBILITY**

Make the care plan information available at the site of the care if it can be done while still protecting the privacy and dignity of the resident. An example: specialized feeding techniques are needed in the dining room; however, they should not make the dining experience for the resident too "medically" oriented. Information should be available but discreet.

POOL HELP

Assure that pool staff have the knowledge skills and abilities to provide individualized results. Proper utilization of pool help, if it is necessary, is critical in avoiding "downfalls."

1. Consider developing your own pool staff. Facilities usually pay these people 10-20% higher salaries without guaranteed hours or benefits but require certain weekend and holiday commitments to ensure adequate staffing.
2. Establish what the method is for informing the pool person *exactly* what to do for a resident and how to foster the resident's independence. For example, how to get the resident to participate in feeding themselves.
3. Establish how the written care plan tool can be combined with any one-to-one briefings that are done.
4. Determine and instruct the pool staff about who handles any encountered problems. Be certain that they know who is in authority and to whom they need to report concerns and to whom to address questions about resident care.
5. Be sure they are adequately supervised.

If you use "pool" help, that will probably test the functionality of your care plan tools.

EVALUATING THE OUTCOME OF CARE AND THE CARE PLAN

Establishing a facility continuous quality improvement system that is focused on the outcomes of the resident is critical. Quality indicator reports based on MDS are now available for all facilities, but that is not the only information you should use. Direct care staff are an excellent resource to identify other issues about resident care that present an opportunity for improvement.

- Use the HCFA guidelines, but also identify other quality issues to evaluate and track care outcomes.
- Develop a system in which the interdisciplinary team identifies what the quality indicators are in your facility, incorporating the HCFA quality indicators as well.
- Remember personal indicators as well as medical ones when measuring quality of life of the residents. **Ask residents and family members** about what **they** use to measure the quality of the care and customer satisfaction.

- Any quality assurance or continuous quality improvement system must enable you to:
 1. Reevaluate the resident and his/her direct care and care plan document.
 2. Revise the care plan to change focus, interventions and/or goals.
 3. Adjust the care plan delivery, documentation and communication.
 4. Provide alternatives to care that will work on one shift but need some alteration for another.
Keep in mind this is the same resident and consistency is important. Be sure that differences in resident care are because the resident's needs differ, not because of the work style/habits of particular staff or the amount of available staff.
 5. Individualize the care plan for the resident who "waxes and wanes" so that the care plan accommodates both extremes of the resident's predictable changes.
 6. Promote TEAMWORK across shifts.

DEVELOPING DISCHARGE PLANS WITH THE RESIDENT

Upon admission, you need to predict the measurable, optimal functional level for each person in order to develop discharge plans. The assessment for discharge potential should focus on what needs to happen before the resident can be safely discharged. The assessment process must take the resident's desires seriously. In order for residents to move along the continuum of long-term care, the facility must:

1. Use an interdisciplinary approach to discharge planning.
2. Use the assessment data to creatively plan for each resident's discharge. (Virtually everything that is done in a facility can be done in a resident's home, or another type of less restrictive setting, when the right resources are available.)
3. Work with residents, family, and physicians with inertia and lack of insight:
 - a) Residents - Assertively work with residents who lack motivation or goals for the future, yet remain tender in your approach.
 - b) Family - Seek ombudsman involvement when needed.
 - c) Physicians - Build rapport and trust with physicians by providing them with accurate, meaningful information.
4. Use TEAMWORK, including collaborating with other types of providers in your community.
5. Be objective, especially if the resident wants to go home, even though it may initially seem impossible. Establish a care plan that rehabilitates the resident who insists on going home however unrealistic it may *seem to staff*. This is one of the greatest challenges in long-term care and problems are bound to develop for both the resident and the staff if interdisciplinary efforts are not devoted to resolving the issues that seem to be barriers to discharge back home.
6. Involve the resident and family in meeting targeted goals that will enable them to develop strengths and resources for going home.
7. Remember that creating unrealistic expectations for a resident can be cruel. Listen to what the resident wants and capitalize on trying to help him/her make it happen.
8. Help residents become more independent in the activities of daily living (ADL's) and the instrumental activities of daily living (IADL's), and maintain a consistent staff approach.

9. Conduct, or arrange for, home evaluations and creatively overcome seemingly insurmountable barriers. Seriously consider what can be done, or what can be aggressively and objectively explored. Almost any kind of care can be done in people's homes if the right resources are mobilized.
10. Coordinate discharge with the community services needed by the resident when they are discharged.

THE CARE PLAN AND DOCUMENTATION

Some providers find a checklist that establishes the presence or absence of certain components can be used and it can be individualized for each facility. The true evaluation of the resident outcomes related to the care they receive should be done through ongoing re-evaluation and the facility's continuing quality improvement process, whatever label you use to identify that process (Quality Assurance, Continuous Quality Improvement, etc.). A facility may find that they want to develop their own checklist ensuring proper assessment and care planning.

- Some of the components of a checklist could be:
 - ❑ Continuity from other providers - do we have what we need?
 - ❑ Participation of resident
 - ❑ Participation of family
 - ❑ Interdisciplinary assessment and planning being done?
 - ❑ Is goal setting appropriate?
 - ❑ Is correct use of standards of care in the facility being individualized and applied to resident?
 - ❑ Are RAI requirements are met; coding is accurate?
- Some other key elements to include in a checklist (content is the focus):
 - ❑ Comprehensive
 - ❑ Holistic
 - ❑ Identification of significant and potential issues that need interventions
 - ❑ Resident-centered specific interventions beyond standards of care
 - ❑ Assignment of care and supervision of implementation
 - ❑ Evaluation process
- Establishing goals -- The "basic 4" of Care Planning Goals
 - ❑ Improvement - Rehab to improved or previous functional level
 - ❑ Prevention - Halt or slow decline of functional level, health deterioration, etc.
 - ❑ Maintenance - Supportive care to maintain functional capacity and health status
 - ❑ Palliation - Comfort and symptom control as functional level and health declines.
- Meeting federal and state requirements:

Also keep in mind inter-provider responsibilities for the resident who has two providers (Hospice and Nursing Home, or ESRD (End State Renal Disease) and Nursing Home, resident who goes to a pain clinic, mental health professionals or skin care specialists, etc.).

 - ❑ What are the other providers doing?
 - ❑ How is this communicated?
 - ❑ What is the impact upon the resident?
 - ❑ Who is accountable for problems and issues?
 - ❑ Who is making sure the resident's holistic outcomes are targeted and that everyone is on "the right sheet of music?"

Utilizing Resources for Special Resident Populations

**Terminal Illnesses, Pain Management, Incontinence,
Pressure Ulcers, Diabetes, Behavior Issues, Short-Stay,
Traumatic Brain Injuries, Infections, Dementia,
Developmental Disabilities, Mental Illness, Renal Disease**

UTILIZING RESOURCES FOR SPECIAL RESIDENT POPULATIONS

This section of the guideline provides you with information and resources that are *unique* to some specialized types of resident issues. It enables you to find creative and helpful caregiving ideas for residents with specific health characteristics/issues that may cause you to do some things differently for particular residents that you might not do for everyone. The first part of each section contains some specific considerations for this population, and the second part gives you resources and resource documents you can obtain for additional assistance. The Care Planning 2000 Guideline is intended to be used for all types of residents. The assessment and care planning process is the same for all types of residents with various problems, strengths and goals, but some specialized resources may be helpful for special concerns.

Guidelines That Cover Multiple Issues

AHCPR Guidelines

Agency for Health Care Policy and Research now known as Healthcare Research and Quality (AHRQ, pronounced “arc”)

Executive Office Center, Suite 501

2101 East Jefferson Street

Rockville, MD 20852

1-800-358-9295 – Publications

Web sites: <http://www.ahrq.gov> and www.guideline.gov

E-mail: info@ahrq.gov

Guideline topics include:	Acute pain management	Alzheimer's disease
	Benign prostate hyperplasia	Cancer pain
	Cardiac rehabilitation	Cataract
	Depression	Heart failure
	Low back problems	Otitis Media
	Post-stroke rehabilitation	Pressure ulcers
	Sickle cell disease	Urinary incontinence
	Unstable angina	

These guidelines represent excellent standards of practice, are developed by clinicians, not government officials, and are based on extensive literature review and clinical research. Many states highly recommend these guidelines for use in nursing homes, as well as other health and residential care providers. AHRQ (formerly AHCPR) also has a free newsletter that is very helpful for keeping up to date on new research findings to use in resident care.

The American Medical Directors Association (AMDA)

10480 Little Patuxent Parkway, Suite 760

Columbia, MD 21044

1-800-876-2632 or (410) 740-9743

Web site: <http://www.amda.com>

Multiple topics are available and are continuously updated. Their quarterly newsletter “Reports” provides you with additional information.

Guideline topics include:	Depression	Pressure Ulcers
Altered Mental Status	Falls and Fall Risks	Pressure Ulcer Therapy Companion
Chronic Pain Management in the	Guideline Implementation	Urinary Incontinence
Long-Term Care Setting	Heart Failure	
Dementia	Osteoporosis	

These guidelines represent clinical practice standards for persons with these issues. The guideline on implementation provides insight into how to utilize guidelines. The guidelines and a newsletter subscription can be ordered through their web site or by calling either phone number.

The Wellspring Program

P.O. Box 620556
Middleton, WI 53562-0556
E-mail: Wellspring@prodigy.net

Modules available:	Physical assessment	Elimination/continence
	Skin care	Behavior management
	Falls	Restorative care
	Nutrition	

These modules have been developed by clinical experts and have produced excellent results in many nursing homes in Wisconsin.

**OBTAINING REGULATORY RESOURCES AND
THE RESIDENT ASSESSMENT INSTRUMENT USER'S MANAUL**

Copies of certain important regulatory and clinical documents are necessary for a nursing home to function within the regulations:

- Wisconsin Administrative Code, Chapter HFS 132, Nursing Home Rules
- Wisconsin Administrative Code, Chapter HFS 134, Facilities for the Developmentally Disabled Rules
- Federal Code of Regulations for Nursing Homes (includes Guidance to Surveyors)
- Chapter 50, Wisconsin Statutes, Uniform Licensure
- Long-Term Care Resident Assessment Instrument User's Manual
- Minimum Data Set (MDS) System - Long-Term Care Facility User's Manual

If you do not already have these resources in your facility, they are available from the Bureau for a nominal printing and mailing cost. Please write or phone Quality Assurance for ordering information:

Division of Supportive Living
Bureau of Quality Assurance
P.O. Box 2969
Madison, WI 53701-2969
(608) 267-1446

Information is also available on the Department of Health and Family Services (DHFS) Web site:

http://www.dhfs.state.wi.us/rl_DSL/Publications/BQAnodMems.htm

This site contains links to BQA memos so that you can read the documents on line.

Information from the federal Health Care Financing Administration (HCFA) can be obtained on the World Wide Web at:

<http://www.hcfa.gov/medicare/hsqb/mds20>

BOARD ON AGING AND LONG-TERM CARE

THE OMBUDSMAN PROGRAM

AND VOLUNTEER OMBUDSMAN PROGRAM

1-800-815-0015

Regional Ombudsman staff are frequently out of the office. Calls are taken at the 800 number and are relayed to the appropriate regional Ombudsman office.

Southwestern Regional Office

214 N. Hamilton Street
Madison, WI 53703-2118

Fax: (608) 261-6570

George Potaracke, Executive Director
Claudia Stine, Ombudsman Supervisor

Regional Offices

Central Office

5424 U.S. Hwy 10 East, Suite F
Stevens Point, WI 54481-8560

Southeastern Regional Office

819 North 6th Street, Room 520
Milwaukee, WI 53203-1664

Northeastern Regional Office

812 South Fisk Street, 2nd Floor
Green Bay, WI 54304-2269

Northwestern Regional Office

4330 Golf Terrace #211
Eau Claire, WI 54701-3823

Northcentral Regional Office

1853 North Stevens Street
Rhineland, WI 54501-2129

THE RESIDENT WHO HAS A TERMINAL ILLNESS

The resident with a terminal illness is the ultimate challenge for the interdisciplinary team. The approach for each person will be as unique as that individual. Participation of the entire team, along with the resident and his/her family, facilitates the highest quality of life and care while the person completes their life cycle in the facility. The individualized approach that you use for every resident is even more important for the person with a terminal illness. Additionally, you will want to be certain everyone on the team has the training and skills to provide comprehensive palliative care, including any necessary pain control, symptom management, psychosocial and spiritual support. Local palliative care resources in your community provide training and resources about caring for the person with a terminal illness. Investing in learning the basics of caring for people with a palliative care concept is possible in any setting when the appropriate resources are mobilized.

NOTE: The resources listed in the section on pain management will also be helpful if you are caring for persons in your facility who have a terminal illness.

An individual residing in a nursing facility who also meets eligibility criteria for hospice services can elect to receive hospice services in the nursing home. The hospice agency becomes the *primary provider* of services, while the nursing facility staff function within the capacity of the *caregivers* for the person, much like family members would do if the resident were in a private residence.

Both federal and state laws require that the hospice agency maintain the overall professional management responsibility for the hospice services. The professional management responsibilities of hospice are described within the formal contractual agreement between the hospice agency and the nursing facility. Within this formal agreement, the guidelines and protocols define the role of each provider in education of caregivers, and in the development, implementation, evaluation and updating of the care plan.

Quality of care depends on individualized care planning and effective communication among the resident, family, physician, hospice and nursing home staff. In collaboration with the nursing facility, the hospice provider conducts an assessment of the resident and their family/caregiver needs as a whole. The information contained in the resident assessment instrument (RAI), completed according to the nursing home requirements, needs to be considered in the assessment process. Care planning and care delivery should flow together like a seamless circular process that includes assessment, needs identification, plan development, implementation, evaluation and modification of the plan as needed.

Nursing home staff have a critical role, working in concert with the hospice interdisciplinary group, the resident, family and physicians to ensure that the services provided through the care plan are meeting resident needs.

In providing for the needs of the person who elects to have hospice care and their family within this unique living situation, both providers need to consider the following areas:

- The hospice and nursing home staff must communicate, establish and agree upon a coordinated plan of care, identifying what services and care the hospice and the nursing facility will each administer.
- The plan of care **must** be consistent with the hospice philosophy of palliative care.
- The plan of care must address the physical, mental, spiritual and psychosocial needs of the resident as well as the psychosocial needs of the family and caregivers.

- The nursing facility staff **must** provide input and/or participate in the Interdisciplinary Group meetings at a minimum of every two weeks. Reviews may be conducted more frequently as outlined within the plan of care or with a change of condition or needs.
- The plan of care must always reflect current resident needs and wishes.
- Standardized plans of care are not acceptable. Each coordinated plan of care needs to be individualized to meet the specific needs of the resident and caregiver.
- A copy of the coordinated plan of care must be present within the clinical record of both providers.

In providing for the needs of the resident who does not elect hospice services but desires a palliative approach to care, consider the following:

- The nursing home must establish and implement a plan of care *with* the resident that reflects a palliative philosophy and the resident's desires.
- The plan of care should address the physical, mental, spiritual and psychosocial needs of the resident and should also consider the psychosocial needs of the family.
- Implementation of plans of care and continual reevaluation is critical in order to meet resident's needs as conditions decline.

RESOURCES FOR CARING FOR A PERSON WHO HAS A TERMINAL ILLNESS:

- **Wisconsin Administrative Code**, Chapter HFS 131, hospice licensure rule, dated June 1, 1992 or a subsequent version when any revisions occur.
- **42 CFR 418**, Medicare Conditions of Participation for hospice providers, State Operations Manual for Provider Certification, transmittal no. 265, dated December, 1994, or a subsequent version when any revisions are made.
- **Medical Guidelines for Determining Prognosis in Selected Non-cancer Diseases (Second Edition)**, 1996, The National Hospice Organization, 1901 North Moore Street, Suite 901, Arlington, VA 22209.
- **Nursing Home/Hospice Interface**, "Guidelines for Care Coordination for Hospice Patients Who Reside in Nursing Facilities," Wisconsin Hospice Organization of Wisconsin (HOW), Wisconsin Health Care Association (WHCA) and Wisconsin Association for Homes and Services for the Aging (WASHA), October 1995. The Interface document is also available through the Bureau of Quality Assurance memo BQC #96-002, dated January 19, 1996, or subsequent versions when any revisions are made.
- **Waiver of Chapter HSS 132**, Wisconsin Administrative Code, for nursing home residents electing hospice services, BQC memo #96-025 dated May 2, 1996.
- **Wisconsin Cancer Pain Initiative** - See section on pain management.
- **Wisconsin Hospice Organization**
P.O. Box 259808
Madison, WI 53725-9808

- **The National Hospice Organization**
1901 North Moore Street, Suite 901
Arlington, Virginia 22209-1714
Phone: (703) 243-5900
Fax: (703) 525-5762
<http://www.nho.org/>
- **Cancer Information Service** - 1-800-4 CANCER
- **Cancer Response Service** - 1-800-ACS-2345
<http://cis.nci.nih.gov/>
- **The Good Death**, a book by Marilyn Webb, explains what makes a death bad and what can make it good. She is a journalist who traveled the country for six years interviewing persons with terminal illnesses and their families. Bantam Books - ISBN# 0553379879.
- **Dying Well**, a book by Ira Byock, M.D., President of the American Academy of Hospice and Palliative Care, Riverhead Books, New York, 1997, ISBN# 1-57322-051-5.
- **Hard Choices for Loving People, CPR, Artificial Feeding, Comfort Measures Only and the Elderly Patient**, by Hank Dunn, Chaplin, Hospice of Northern Virginia, ISBN# 1-928560-00-8.

A & A Publishers, Inc.
P.O. Box 1098
Herndon, VA 20172-1098
E-mail: AAPublish@aol.com
<http://www.hardchoices.com>
- **American Academy of Hospice and Palliative Care:**
<http://www.aahpm.org>
- **The University of Ottawa Institute of Palliative Care:**
<http://www.pallcare.org>
- **The American Dietetic Association position paper on Issues in Feeding the Terminally Ill Adult**, *Journal of the American Dietetic Association*, August, 1992, Volume 92, Number 8
- **American Dietetic Association**
<http://www.eatright.org>

THE RESIDENT WHO NEEDS PAIN MANAGEMENT

The resident who needs pain management could have a terminal illness or could also have acute or chronic pain problems not related to a terminal illness.

- Pain assessment and re-assessment is essential.
 1. BELIEVE WHAT RESIDENTS SAY ABOUT THEIR PAIN.
 2. Develop, and be sure staff consistently carry out, **pain assessment skills for the cognitively impaired person, the non-verbal resident, and the resident who denies pain.** Professionally developed pain control resources are available that address the assessment of those who cannot express pain.
 3. Measurable goals for comfort are essential and they must be established with the resident.
 4. Consistent application of interventions is essential in order to truly evaluate the results.
- Residents can have verbal or psychological denial of their pain yet give non-verbal pain signals, i.e., not eating, not sleeping, not taking fluids, not interacting normally, etc. These individuals need consistent skilled assessment and must develop trust in caregivers in order for them to "open up" about their actual pain. Some may even never be able to verbally "admit" to pain, but may accept treatment for it in the interest of improving their **functional** level. Example: "Mr. Jones, I think that if we use this MS Contin on a regular basis, you may be able to sit up in the chair and go out on the patio when your grandchildren visit."

RESOURCES

- **The Wisconsin Center Pain Initiative**
3675 Medical Sciences Center
1300 University Avenue
Madison, WI 53706
Phone: (608) 262-0978
Fax: (608) 265-4014

Ask to be put on the mailing list for the newsletter "Cancer Pain Update."

They can also supply you with many clinical and educational resources, including a laser printed copy of a pain assessment form that is designed to be made into a notepad for staff convenience and ready availability.

- **Hospice and Palliative Nurses Association**
www.hpna.org/publ.htm

ADDITIONAL INTERNET RESOURCES:

- **Cancer Pain Release**
ISSN 1013-3097, is published quarterly by the World Health Organization (WHO) Collaborating Center for Policy and Communications in Cancer Care.
<http://www.medsch.wisc.edu/WHOCancerpain>

- **Agency for Health Care Policy Research (AHCPR – now known as the Agency for Healthcare Research and Quality - AHRQ) Pain Guidelines:**
<http://www.ahrq.gov>
(Clinical Practice Guidelines - can also be obtained by calling 1-800-358-9295)
- **American Cancer Society:**
<http://www.cancer.org>
- **American Medical Association (JAMA):**
<http://www.ama-assn.org>
- **Arthritis Foundation:**
<http://www.arthritis.org>
- **National Library of Medicine:**
<http://www.nlm.nih.gov>

THE RESIDENT WITH INCONTINENCE

The interdisciplinary assessment and care planning process is essential for the resident with incontinence. The primary focus is on urinary incontinence, although many of the same concepts can also be applied to bowel incontinence.

Begin with the MDS and the urinary incontinence resident assessment protocol to do your comprehensive assessment; then care plan accordingly. The following list of resources may also be helpful to you.

- **AHCPR Clinical Practice Guideline No. 96-0682:**
"Urinary Incontinence in Adults: Acute and Chronic Management", Number 2, 1996 Update
Note: See page 41 of this guideline for details about contact and ordering.
- **American Medical Directors Association (AMDA) Guideline:**
"Urinary Incontinence," Clinical Practice
Note: See page 41 for details about contact and ordering.
- **Wellspring Program:**
"Elimination/Continence Module"
Note: See page 42 for details about contact and ordering.
- **Diagnostic Ultrasound Corporation:**
Diagnostic Ultrasound Bladder Scan - a tool for fast, non-invasive bladder volume measurement
18109 N.E. 76th Street
Redmond, WA 98052
<http://www.dxu.com>
1-800-331-2313

THE RESIDENT WITH, OR AT RISK FOR A PRESSURE ULCER

RESOURCES:

The resources here provide clinical practice information for both prevention and treatment of pressure ulcers.

- **AHCPR Guidelines**

- "Pressure Ulcers in Adults: Prediction and Prevention," No. 92-0047
- "Treatment of Pressure Ulcers," No. 95-0652

Note: See page 41 for details about contact and ordering.

- **Pertinent Wellspring Modules**

- Skin Care
- Restorative Care
- Nutrition

Note: See page 42 for details about contact and ordering.

- **AMDA Guidelines**

- Pressure Ulcer

Note: See page 41 for details about contact and ordering.

THE RESIDENT WITH DIABETES

RESOURCES:

The following document provides comprehensive, valuable information about managing diabetes. It is in the public domain and may be used and reprinted. The Wisconsin Diabetes Control Program appreciates citation and notification of its use.

- **Essential Diabetes Mellitus Care Guidelines**

Developed by the Wisconsin Diabetes Advisory Group, January, 1998

Wisconsin Diabetes Control Program
Chronic Disease Prevention & Health Promotion
One West Wilson, Room 233
Madison, WI 53701
Phone: (608) 261-6871
Fax: (608) 266-8925

- **Guidelines for Diabetes in Long-Term Care Facilities**

A collaborative effort of Minneapolis/St. Paul diabetes educators, gerontology practitioners, long term care organizations and the Minnesota Diabetes Control Program is available from:

Minnesota Diabetes Control Program
Martha Roberts, Coordinator
Minnesota Department of Health
PO Box 64882
St. Paul, MN 55164-0882
(651) 281-9842

THE RESIDENT WITH BEHAVIORAL SYMPTOMS:

Behavior is everything a person says and does. Some people living in a nursing home exhibit behaviors that cause them to be difficult to care for. Working with challenging behaviors is the responsibility of all facility departments.

When care planning and implementing care for challenging behaviors, prevention is the desired outcome. The following are features to consider when care planning for challenging behaviors.

- A thorough on-site preadmission behavioral assessment may be needed for all potential admissions. This assessment should include at least the following:
 1. A comprehensive history of the resident's behaviors, including what preventive actions have been effective, and medication history.
 2. Any attempted behavioral interventions, when and how they were attempted, and whether or not they were successful.
 3. Input from a reliable reporter (such as a relative or former caregiver) who is knowledgeable about the resident, including communication style, past successes, etc.
- A preventive care plan is needed when a potentially challenging behavior is identified through assessment. Before developing a care plan address the following questions.
 1. Is the behavior a problem? For whom?
 2. What are the underlying causes of the behavior? What triggers it? Rule out physical causes via assessment, labs, etc. Is the behavior part of the disease process?
 3. What life experiences may have led to the behavior?
 4. Is there a need for behavior management or behavior treatment?
 5. Is the behavior likely to be short term (transfer stress, illness, adjustment, etc.)?
 6. What has been tried? What has been effective or ineffective? (Don't forget, interventions that have not worked before *sometimes* can work even though they did not in the past, especially if something is now different about the person or the environment, or if time has passed.)
- Consider the following when care planning
 1. Determining the cause or trigger of the behavior is necessary to adequately develop approaches for dealing with the behavior (dementia vs. mental illness, etc.).
 2. **Be proactive.** Recognize behavioral symptoms **before** they develop into aggressive behavior and plan to eliminate/reduce symptoms. Evaluate and seek to eliminate antecedents, or triggers, for the symptoms and change.
 3. "Redirection" *after* behavior occurs is not a success, but a reaction due to a failure to predict antecedents and provide preventative intervention.
 4. Care plans should have measurable goals related to anticipating, minimizing or extinguishing challenging behaviors.

5. Describe the behavior, don't label it.
6. All levels and types of staff from all shifts should be involved in the development, implementation and reevaluation of the care plan, especially direct caregivers.
7. The facility should identify a staff person or a small interdisciplinary team as the facility's behavioral experts, who keep apprised of current resources and research regarding behavioral issues.
8. A copy of the resident's previously established care plan may prove useful.
9. Psychotropic medications should be reviewed and the care plan should identify any special monitoring of the resident and/or the effects or side effects for a medication, if needed.

TO REVIEW:

1. Remember that behavior is ever changing. Caregivers need to be creative in finding solutions for each unique resident. Anticipate and plan for *prevention*.
2. A change in a resident's behavior should be comprehensively evaluated, including the determination if this change is due to a change in a physical condition, requiring assessment and care planning.
3. The effects of a resident's behavior on peers should be evaluated and planned for as needed to protect the resident, other residents and staff.

RESOURCES FOR BEHAVIORAL ISSUES:

1. **"Choice and Challenge: Caring for Aggressive Older Adults Across Levels of Care"**
This video has been used with good success in Wisconsin nursing homes. It is available for \$30.00 from:

Choice and Challenge
Abbe, Inc.
3150 E. Avenue NW
Cedar Rapids, Iowa 52405
2. **"From the Family's Perspective"**
This is a training video that was developed to help nursing home staff understand family expectations for caregiving. It is available for \$69.95 from:

The Advocacy Center for Long-Term Care
2626 E. 82nd Street, #220
Bloomington, MN 55425-1381
(612) 854-7304
3. **"Managing Behavior Problems in Nursing Home Residents"** A Manual for Nursing Home Staff. (Revised in 1995.) This manual can be obtained for \$10.00 printing and mailing costs and Vanderbilt will readily grant you permission to recopy for nursing home training.

By Jo A. Taylor RN, MPH and Wayne Ray, Ph. D.
Continuing Education for Nursing Homes in Tennessee

Department of Preventative Medicine
Vanderbilt University School of Medicine
A1124 Medical Center North
Nashville, TN 37232-2637
Phone: (615) 322-5000

4. **"Information and Referral Directory Assisting Persons with Behavior Symptoms"**

Developed by the regulations sub-group of the "Adults With Behavioral Symptoms in Long-Term Care - A Wisconsin Workgroup." Copies can be obtained from:

Provider Regulation and Quality Improvement
Bureau of Quality Assurance
One West Wilson Street
P.O. Box 2969
Madison, WI 53701-2969
Phone: (608) 266-2966

5. **Alzheimer's Association**

Internet information: <http://www.alz.org>

6. **WI Audiovisual Resource in Geriatrics and Gerontology.**

For publications:
Marquette University, WI Geriatric Education Center
WI Audiovisual Resource in Geriatrics and Gerontology
P.O. Box 1881
Milwaukee, WI 53201-1881
Phone: (414) 288-3712
E-mail: wgecnet@vms.csd.mu.edu
<http://www.mu.edu/wgec/wgecpubs.htm>

7. **The Wisconsin Alzheimer's Association Chapter Network** offices are listed in the section on dementia. They have many excellent resources that can be used for residents with behavioral symptoms.

8. **"Understanding Difficult Behaviors. Some Practical Suggestions for Coping With Alzheimer's Disease and Related Illnesses."** The cost is \$15.00.

By Anne Robinson, Beth Spencer, Laurie White, Geriatric Education Center of Michigan -
Ypsilanti, Michigan
Phone: (734) 487-2335

9. **"Aging in the News"** is a newsletter publication issued by the State Bureau of Aging and Long-Term Care Resources, Division of Supportive Living, Wisconsin Department of Health and Family Services. It is available at no charge to residents of Wisconsin. If you, or your organization would like to be placed on the mailing list, please write to:

Bureau of Aging and Long-Term Care Resources
c/o Monica Snittler
P.O. Box 7851
Madison, WI 53707

10. **"Elder Abuse, Neglect and Family Violence: A Guide for Health Care Professionals"**

PSL-3077. This booklet may be ordered without a charge from:

Division of Supportive Living
Attn: Publications Order
P.O. Box 7851
Madison, WI 53707-7851

Since elderly persons with behavioral issues are at high risk of abuse and neglect, additional resources are available on this subject from the following two sources:

11. **Wisconsin Coalition Against Domestic Violence**

1400 E. Washington Ave., Suite 232
Madison, WI 53703
Phone: (608) 255-0539
Fax: (608) 255-3560
wcadv@inxpress.net

12. **Bureau of Aging and Long-Term Care Resources**

One West Wilson Street, Room 450
Madison, WI
Phone: (608) 266-2568
Fax: (608) 267-3203
E-mail: raymoja@dhfs.state.wi.us

13. **Mendota Mental Health Institute**

General phone: (608) 243-2500
Gero-Psych Unit phone: (608) 243-2623

14. **"Geriatric Care"** is an excellent monthly newsletter that contains many helpful clinical articles.

The cost for 25 to 75 subscriptions is \$3.50 per subscription, per year with a minimum of 25 subscriptions.

Geriatric Care
Box 3577
Reno, NV 89505
Phone: 1-800-354-3371
Fax: (702) 358-1476
E-mail: order@care4elders.com
<http://www.care4elders.com>

Other publications by the same publisher:

"Activity Directors Guide"

"Remembering Yesterday, Mini-Lessons in the Care of the Aging"

"Here's Help, Great Ideas for Long-Term Care"

"Nurse Aide/VIP"

"Alzheimer's Care Guide"

"Volunteer and Visitors Guide"

"Alzheimer's Home Companion"

15. **"Solving Bathing Problems in Persons With Alzheimer's Disease and Related Dementias -A Training and Reference Manual for Caregivers"** from Departments of Family Medicine and Psychiatry, University of North Carolina at Chapel Hill.

Order from:
Dr. Phillip Sloane, M.D.
Campus Box #7595
University of North Carolina
Chapel Hill, NC 27599

THE RESIDENT WITH DEMENTIA

Many resources are available about providing for the specialized needs of the resident with dementia. It is extremely important to tailor the care planning process to them, including interviewing others who know the resident and can provide you with valuable details specific to the person. The most critical need is to provide meaningful interventions and activities, a home-like environment and a quality life.

If the person has behavioral symptoms, the section on behavioral symptoms can be useful. Information from the Alzheimer's Association will probably be of the most help in caring for these individuals.

Web site: <http://www.alz.org>

The Wisconsin Dementia Services web site from the Wisconsin Alzheimer's Institute of the Wisconsin Medical School has resources: www.wisc.edu/dementia

WISCONSIN ALZHEIMER'S ASSOCIATION CHAPTER NETWORK

Indianhead Chapter

1227 B Menomonie Street
Eau Claire, WI 54703

(715) 835-7050

(800) 499-7050

Fax: (715) 835-0597

Lake Superior Chapter

201 W. Main Street, Rm. 105A
Ashland, WI 54806

(715) 682-6478

(800) 682-6478

Fax: (715) 682-6561

Midstate Wisconsin Chapter

3000 Cleveland Ave.
Plover, WI 54467

(715) 342-4747

Fax: (715) 342-4770

North Central Wisconsin Chapter

203 Schiek Plaza
Rhineland, WI 54501

(715) 362-7779

(800) 220-1221

Fax: (715) 362-1879

Northeastern Wisconsin Chapter

2900 Curry Lane, Suite A
Green Bay, WI 54311

(920) 469-2110

(800) 360-2110

Fax: (920) 469-2131

Riverland Chapter

115 5th Avenue S., #421
La Crosse, WI 54601

(608) 784-5011

(800) 797-1656

Fax: (608) 784-4428

South Central Wisconsin Chapter

517 N. Segoe Road, Suite 301
Madison, WI 53703

(608) 232-3400

(800) 263-4859

Fax: (608) 232-3407

Southeastern Wisconsin Chapter

6130 W. National Ave., Suite 200
West Allis, WI 53214

(414) 479-8800

(800) 922-2413

Fax: (414) 479-8819

THE "SHORT STAY" RESIDENT

Critical factors for the short term resident are as follows:

- Planning for discharge prior to admission;
- Resident and family involvement;
- Maintenance or improvement of functional level;
- Utilizing background information;
- Focusing on strengths;
- Streamlining the assessment and care planning process/documentation;
- Prioritizing care; don't focus on areas that are stable;
- Providing for continuity of care.

For a short term resident:

- Use standards of practice efficiently;
- Efficient and effective medication teaching is important;
- Be knowledgeable and accurate regarding diet progression;
- PT and OT involvement may be helpful;
- If discharged home, arrange a "home evaluation" in order to ensure a safe environment;
- Set up community services; and
- Using an interdisciplinary approach is extremely important.

THE RESIDENT WITH A TRAUMATIC BRAIN INJURY

The resident with a brain injury must have all the components that are described for all residents in the nursing home. Additionally, everything that is important for everyone is magnified with the brain-injured person due to his or her special condition. A holistic and consistent approach is necessary. Each resident's problems are unique to the portion of the brain that is injured and the amount of injury, but some of the common problems that make their care needs special are:

- Lack of safety awareness;
- Visual deficits;
- Cognitive deficits;
- Proprioceptor deficits;
- Lack of impulse control (anger, aggression); and
- Communication deficits.

RESOURCES

- **The Brain Injury Association of Wisconsin, Inc.**
3505 North 124th Street, Suite 100
Brookfield, WI 53005
Phone: (414) 790-6901
Fax: (414) 790-6824
Help line: 1-800-882-9282
<http://tbilaw.com/BIAW.html>
- **The National Brain Injury Association**
Phone: (703) 236-6000
<http://www.biausa.org>
- **The Wisconsin Association of Rehabilitation Nurses**
Karen Bernard
2605 Cedar Point Dr.
Janesville, WI 53546
Phone: (608) 364-5215
- **Rehabilitation Accreditation Commission (CARF)**
4891 East Grant Road
Tucson, Arizona 85712
(520) 325-1044 - Voice/TDD
Fax: (520) 318-1129
E-mail: webmaster@carf.org
<http://www.carf.org>
- **National Family Caregivers Association**
10605 Concord Street, Suite 501
Kensington, MD 20895-2504
Phone: 1-800-896-3650
<http://www.info.nfcacares.org>

THE RESIDENT WITH A KNOWN OR SUSPECTED INFECTION

Federal and state regulations do not directly speak to specific organisms that cause infections or exactly identify how a specific type of isolation or infectious care is to be done. The regulations primarily require facilities to manage a program that prevents the spread of infections and treats any infectious illnesses according to current professional principles and with proper precautions. The actual language in the federal and state requirements does contain more detail, and all long-term care providers need to be familiar with that language; however, it is not disease-specific or resident-specific. The provider has a great deal of flexibility within the regulations to provide up-to-date care of residents with infections. Further clinical research will continue to define clinical practice guidelines as new infection control concepts and treatments emerge.

Long-term care providers will want to have policies, procedures and standards of clinical practice to enable all staff to provide resident care using sound infection control practices. This will require ongoing education, training and supervision of staff to ensure that the program is carried out. If

residents have particular care needs beyond these established standards, they may need to be spelled out in the residents' individualized care plans.

Maintaining a collaborative relationship with the **infection control practitioners in the community** and with the **city/county public health agency** will greatly enhance the nursing home's ability to deliver quality care. These individuals and programs are excellent resources for guidance in the principles needed to manage residents' infection control needs. They do not always have familiarity with nursing home regulations, but are excellent resources for specific disease information.

RESOURCES

- **Bureau of Quality Assurance Memos** # 96-022, dated May 6, 1996 and #96-034, dated June 26, 1996. Internet site: http://www.dhfs.state.wi.us/rl_DSL/Publications/BQAnodMems.htm

Bureau of Quality Assurance
Department of Health and Family Services
One West Wilson Street, P.O. Box 2969
Madison, WI 53701-2969
Phone: (608) 266-8847

These memos include the Centers for Disease Control (CDC) guidelines for isolation precautions. These guidelines are written with the acute care hospital in mind, but the same principles of infection control and disease epidemiology apply no matter where the resident lives, and the transmission of organisms is the same, regardless of the environment.

- **Association for Professionals in Infection Control and Epidemiology**
1275 K Street NW, Suite 1000
Washington, DC 20005-5703
Phone: (202) 789-1890
<http://www.apic.org/>
- **Centers for Disease Control (CDC) resources**
<http://www.cdc.gov>
- **American Journal of Infection Control (AJIC)**
The December 1997 issue contains a very good article on infection control, pages 488 to 508. It is titled, "Special Communication, Infection Prevention and Control in the Long-Term Care Facility." This is not regulation but gives sound guidance on infection control principles in long-term care.
- **Distance Learning Courses and Resources**
The Public Health Service at the CDC offers videoconferences and resources on infection control and related issues. They produce a catalog entitled "PHTN" (Public Health Training Network) that outlines their programs and resources. One of the topics that may be of interest is the information on tuberculosis, including an interactive CD-ROM program for clinicians.

They can be reached at: 1-800-41-TRAIN or <http://www.cdc.gov/phtn>

THE RESIDENT WITH A DEVELOPMENTAL DISABILITY

Nursing homes who care for residents with developmental disabilities have separate regulations and guidelines for caring for these individuals. However, the assessment and care planning process should still be intact and focus on the individual needs of the person. Person-centered planning is essential for all persons, especially for persons with developmental disabilities, regardless if they reside in a facility for the developmentally disabled, a nursing home or in the community.

RESOURCES

The HCFA web site contains information on regulations, standards, guidelines and training resources. It also has tapes of multiple excellent videoconferences that can be obtained at reasonable costs. Providers may be able to share these videotapes with other facilities in their network to reduce the expense to each provider. Listed below are two examples. More information is available at:

<http://www.hcfa.gov/medicaid/icfmr/licftrg.htm>

- **Person-Centered Planning**

A tape and materials are available that defines Person-Centered Planning. It also describes the similarities and differences between Person-Centered Planning and Active Treatment.

National Technical Information Services (NTIS)
Order number: AVA20271VNB5
Phone: (703) 605-6186

- **Ageing And People With Developmental Disabilities**

NTIS order number: AVA20264VNB2

Additional helpful information is available from the following organizations.

ARC - Wisconsin

Contact: Jackie Becker
121 Hancock Street
Madison, WI 53703
Phone: (608) 251-9272
Fax: (608) 251-1403
E-mail: arcw@danenet.wicip.org
<http://danenet.wicip.org/arcw>

The ARC of the United States

500 East Border Street, Suite 300
Arlington, TX 76010
Phone: 800-433-5255 or (817) 261-6003
Fax: (817) 277-3491
E-mail: thearc@metronet.com
<http://thearc.org>

THE RESIDENT WITH A MENTAL ILLNESS

The care of residents with mental illnesses is a challenge for the long-term facility. In addition, depression is common in the elderly and often goes undiagnosed. Finding the right resources to enable them to return to a community or less restrictive setting is an important focus. This is especially true when they have good physical functioning that allows them to be independent and not need physical nursing care. Many residents with mental illnesses can be assisted in living outside institutional settings with care in their home in combination with other outpatient and community support services. Residents with mental illnesses are only to be in nursing homes if they have a need for nursing care.

RESOURCES

- **NAMI Wisconsin Inc.** (Formerly the Alliance for the Mentally Ill of Wisconsin, Inc.)
4233 W. Beltline Highway
Madison, WI 53711
Phone: (608) 268-6000 or 1-800-236-2988
Fax: (608) 248-6004
E-mail: amiwisc@aol.com
<http://namiwi.nami.org/namiwi/>
- **National Alliance for the Mentally Ill (NAMI)**
200 North Glebe Road, Suite 1015
Arlington, Virginia 22203-3754
Phone: (703) 524-7600 or 1-800-950-NAMI
Fax: (703) 524-9094
www.nami.org
- **Agency for Health Care Policy Research (AHCPR) (now AAHRQ)**
"Depression in Primary Care: Volume 1 - Detection and Diagnosis," No. 93-0550
"Depression in Primary Care: Volume 2 - Treatment of Depression," No. 93-0051
Phone: 1-800-358-9295, or see page 41 for contact and ordering details
- **American Medical Directors Association Clinical Practice Guidelines**
"Depression"
Phone: 1-800-876-2632, or see page 41 for contact and ordering details
- **National Alliance for Research on Schizophrenia and Depression**
www.mhsource.com/narsad.html
- **U.S. Department of Health and Human Services**
www.hhs.gov
- **Dana Brain Web**
Dana Brain Web is the web site of The Dana Alliance for Brain Initiatives which is a nonprofit organization supported by the Charles A. Dana Foundation and is made up of more than 185 neuroscientists. The organization's goal is to provide information about the benefits of brain research: www.dana.org/brainweb

THE RESIDENT WITH A NEED FOR SPECIALIZED SERVICES

Specialized services are those services the state is required to provide or arrange for that raise the intensity of services to a higher level that is based on the needs of that resident. Specialized services are an "add on" to nursing facility services. They are of a higher intensity and frequency than specialized rehabilitation services, which the nursing facility provides.

In the Federal Conditions of Participation at 483.45 (F406), the Guidance to Surveyors area provides detail about how this is interpreted. This requirement and related rehabilitation requirements apply to the resident who needs physical therapy, occupational therapy, psychiatric therapy and rehabilitation, vocational rehabilitation, sheltered workshops, schooling, services for the blind, consultation with an organization such as the Multiple Sclerosis Society, etc. These needs should be provided or arranged for by the facility so that the resident's need for these, or any other rehabilitative care, is met. These needs should be identified during the admission and ongoing assessment process, decisions made about what and how to provide the services and when. These services must then be implemented and evaluated and re-evaluated through the ongoing comprehensive assessment, as well as during the quarterly review or with any change of status or condition.

A Pre-admission Screening and Resident Review (PASARR) is mandated by federal law for all persons with mental illness (MI) or mental retardation (MR) who apply for admission to a nursing facility, regardless of the applicant's source of payment unless:

- A physician certifies prior to admission that they require a nursing facility stay of less than 30 days.
- They require care at the nursing facility for the same condition for which they were hospitalized.

When a resident is determined by the PASARR screen to be in need of specialized services for their mental illness or mental retardation, the facility is required to provide or arrange for these services to be provided. Each facility will need to utilize the resources within their community.

Typical services that are necessary are listed; however, the requirements are not limited to these. They are determined based upon resident assessment/need. They may be provided or arranged for.

- Drug therapy monitoring, including efficacy, side effects, etc.;
- Adjust individual, group and family therapy psychotherapy programs;
- Other specialized services required to provide for the residents needs.

THE RESIDENT WHO ALSO RECEIVES RENAL DIALYSIS SERVICES (ESRD – END STAGE RENAL DISEASE)

Caring for the nursing home resident who receives renal dialysis services requires extremely skilled coordination and communication between the provider of the dialysis services and the nursing facility. That dialysis unit is the best resource for the facility. Set up regular and resident-specific communication systems that enable both providers to be very clear about the resident's condition and care.

Resources:

National Renal Diet Professional Guide

A Clinical Guide to Nutritional Care in End State Renal Disease includes six client diet booklets with food choice lists that are for either the person with diabetes or the person without diabetes:

- a pre-ESRD diet
- a diet for persons receiving peritoneal dialysis
- diet information for those receiving hemodialysis

The above resources are available from the National Kidney Foundation, Inc.

National Kidney Foundation

30 East 33rd Street
New York, NY 10016
Phone: 1-800-622-9010
<http://www.kidney.org>

Internet Resources

Medicare
<http://www.medicare.gov>

The Nephron Information Center
<http://nephron.com>

Colorado Health Net
<http://www.coloradohealthnet.org>

National Institute of Diabetes and Digestive and Kidney Diseases
<http://www.niddk.nih.gov>

Annalink, the official web site of American Nephrology Nurses Association, ANNA
<http://anna.inurse.com>

Appendix A

DEFINITIONS RELATED TO CARE PLANNING

Many other pertinent definitions are contained in the references listed in this guideline and can enhance the use of this guideline.

Authenticated	Established or proven authentic.
Chemical restraint	A psychopharmacological drug that is used for discipline or convenience and not required to treat a medical symptom.
Electronic signature	Each person who makes an entry in the electronic clinical record has a completely private, confidential, password protected "signature" that they enter electronically when "documentation" in the clinical record. No one else ever uses that password.
Highest practicable level of functioning	Resident is functioning at their optimum potential in multiple ways; physical, mental, psychosocial and spiritual.
Interdisciplinary	Cooperative involvement of disciplines in an integrated process.
Interdisciplinary Care Plan	Document or documents that identify the care for a resident that has been established by using the interdisciplinary assessment and care planning process, including the involvement of the resident.
Interdisciplinary Care Planning Process	Integrated process through which a comprehensive care plan is developed by the interdisciplinary team who know the resident best, as a result of their comprehensive assessments and the resident's involvement in the process.
Multidisciplinary	Two or more disciplines are involved.
Physical restraint	Any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.
Policy	Written, established way in which something will be handled.
Procedure	Step-by-step process that will be carried out to accomplish a particular task.
Professional standards of care	Standards developed by professional groups and organizations and are based upon valid research and clinical studies and appear in accredited health care journals and publications.
Protocol	Written, established method, guideline or standard that is followed under certain specific circumstances or for certain events.
Quality of life	State of being that results from the reconciliation of one's abilities and resources with their collection of perceptions and beliefs that define meaning and purpose for their life.

Standards of care in a facility Specific written care interventions using protocols, policies, and/or procedures that are established by an interdisciplinary team of professionals for implementing resident care delivery.

Specialized services Those services the state is required to provide or arrange for that raise the intensity of services to the level needed by the resident. That is, specialized services are an "add-on" to nursing facility services; they are of a higher intensity and frequency than specialized rehabilitation services, which are provided by the nursing facility.



VISION / GOALS

CARE PLANNING - 2000

VISION

**A resident-centered, interdisciplinary care planning system that provides for quality of care/life services that are:
Realistic, Prioritized, Streamlined;
Useful, and Outcome-based**

GOALS

1. Develop a care planning process through a state-wide collaborative approach involving care providers and Wisconsin State Bureau of Quality Assurance with significant contributions from consumers, computerization support-vendors, Board on Aging and Long Term Care, other interested parties including both proprietary and not-for-profit long-term care organizations.
2. Develop a care planning process that meets the needs/requirements of the consumers, providers and regulatory agencies.
3. Develop a care planning process that reduces paperwork in both paper and computerized systems.
4. Develop a written guideline and instructions for the use of the **Care Plan 2000** process.
5. Receipt of potential waivers (if needed) from state and HCFA to implement the **Care Plan 2000** process.
6. Contribute recommendations to the legislative process regarding revisions for **HFS 132**.

OBJECTIVES

1. Develop, distribute, collect and collate a questionnaire to identify care planning issues and recruit volunteers and ideas.
2. Analyze data to integrate and prioritize objectives that will guide the process.
3. Analyze state citation data with an emphasis on care planning citations.
4. Share analysis with core groups and provider groups.
5. Target statewide volunteers for participation in focus group type meetings to be held at a variety of locations around the state.
6. Correlate results of individual project teams.
7. Create initial **Care Plan 2000** guideline and instructions for providers to facilitate piloting the process.
8. Identify criteria to be used for the pilot project.
9. Identify and request any needed waivers to pilot the process.
10. Identify pilot study groups.
11. Educate and collaborate with the pilot groups.
12. Implement the trial process with the pilot groups.
13. Analysis and evaluation of results.
14. Identify recommendations to be made to the legislative process for change in **HFS-132**.
15. Inclusion of evaluation in final **Care Plan 2000** guidelines and instructions.
16. Develop a method of evaluation of the process that reflects the vision and goals of the project.

The plan for evaluating Care Planning 2000 may involve one or more of the following (subject to change):

- Piloting the guideline in a variety of types of facilities;
- Re-evaluation of the changes in care planning citations after the implementation of the guideline;
- *Possible* follow-up questionnaire for providers; and
- *Possible* series of follow-up focus group meetings to gather input post-guideline about whether or not it is helpful.

ENSURING SURVEY AND ENFORCEMENT CONSISTENCY

Resident Care Review Section And Provider Regulation And Quality Improvement Bureau Of Quality Assurance

1. The Bureau of Quality Assurance (BQA) targets individuals with relevant work experience in the hiring process. As a result, the majority of surveyors within the Resident Care Review Section (RCRS) have had hands-on experience working in long-term care facilities.
2. The Bureau has a six month training process that focuses on accurate use of the survey process. This training is coordinated by the Provider Regulation Quality Improvement (PRQI) Section and is given to all new surveyors, Regional Field Operations Directors (RFODs), Field Operations Supervisors (RFOSs), Administrative Assistants, and many other bureau staff.
3. Wisconsin conducts weekly statewide "grid calls." Citations that have been placed at level "F" or higher are reviewed by the grid call team to determine if the proper federal or state regulation has been cited, and if the citation is appropriately placed on the federal enforcement grid.
4. Resident Care Review Section has quality assurance staff reviewing data and monitoring citing patterns with the purpose of identifying inconsistencies from region to region within the state, identifying variation from the state to HCFA Region V (Indiana, Michigan, Minnesota, Ohio, and Illinois) and any variations by the state compared to nationwide citing patterns.
5. Monthly scheduling and team meeting days are provided in each regional office. Supervisors use these meetings to update staff on changes in the survey process, to address and discuss inconsistencies that have been identified, to discuss changes in procedures, to discuss case-specific situations and citations, etc., and to provide training and inservice.
6. Monthly meetings of Regional Field Operations Directors and quarterly meetings of Regional Field Operations Supervisors are conducted to discuss citing issues, new procedures and policies, and to ensure consistency with federal and state regulations and Bureau and Department policies.
7. BQA provides ongoing training for all long-term care surveyors (e.g., changes in the survey process, care issues, case-specific issues, etc.).
8. Memos from both the Resident Care Review Section and BQA management update staff regularly and provide standard information and instructions to all staff.
9. HCFA conducts monitoring/partnering surveys. They use these surveys to evaluate team performance and adherence to federal survey and decision-making protocols. They provide feedback to the survey team. Quality assurance staff in central office to identify recurring issues and trends monitors federal reports from each of these surveys and, consequently, training needs.
10. BQA is working with HCFA in the State Agency Quality Improvement Program (SAQIP). Together, quality improvement goals in 13 standard areas (IQIPs) are being identified, and approaches are being developed and implemented to improve overall performance within BQA, particularly in the areas of survey and enforcement.
11. Individual regional offices have established quality assurance review teams to review the documentation on the federal work sheets from selected surveys and provide feedback to the individual members of the survey team.

12. Regional Field Operations Supervisors (RFOS) provide on-site monitoring of the survey process and team decision-making. On-site presence enables them to identify inconsistencies or variations among survey teams/surveyors, which can then be discussed at monthly team meetings. Findings from each RFOS will be analyzed on a statewide basis to identify inconsistencies/variation between regions, and to identify statewide training needs.
13. The **Care Planning 2000** effort has included surveyors from every region throughout the development of the guideline drafts. Surveyors have contributed to the content all along and continue to be involved. When the guideline is "semi-final", they will re-look and re-discuss it at their team meetings and provide any input prior to and after the piloting process. Therefore, all surveyors will be aware of the guideline content. This does not provide "an insurance policy" against care plan citations, however. **It is still critical that residents receive the care they need, regardless of any changes made, or not made, in the facility's care planning process or documents.**