



Presents

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Individualized Care Planning

Getting to Know the Person

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Handouts for this presentation
are available on the CD,
which is included

Please print out, share and enjoy!



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The Softer Side of the MDS

- AANAC grant project – the American Association of Nurse Assessment Coordinators
- Manual available from AANAC at www.aanac.org
- Explores the MDS and culture change.
 - The Softer Side of the MDS - interviewing ideas
 - Making the most of RAPs
 - Riverview’s progression from nursing care plans to individualized care plans to 1 care plans to narrative care plans
 - Regulatory support for innovative care planning
 - Getting to Know You
 - Communicating the Care Plan



Comprehensive Assessment

F Tag 272

Comprehensive Assessment/MDS

From the IGs:

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



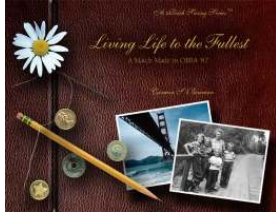
Are you doing a comprehensive assessment?

- Do you really *get to know the person*?
- First, do you ask questions about his/her routine and preferences?
- Second, if you ask, do you honor them?
- Or, is it more like “well, that’s nice but this is our schedule...”

**Living Life to the Fullest:
A Match Made in OBRA '87**

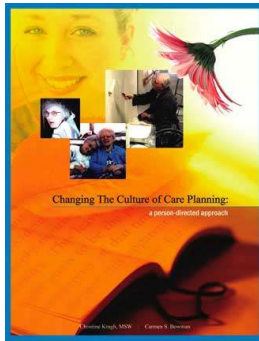
**Assessment and Care Planning
Resources**

- Getting to Know You assessment
- Assessing Psychosocial Needs
- Assessing a person's ethnic culture
- Assessing highest practicable level of well-being
- Activity programming according to **interests, not "problems"**



Available from Action Pact at www.culturechangenow.com

New Care Plan Resource



**Changing the Culture of
Care Planning:
a person-directed
approach**

- Covers:
- Regulations
 - Individual Care Planning
 - I Care Plans
 - Narrative Care Plans

Includes:

- Sample IN2L VIP "Visual Information Profile"

Available from Action Pact at www.culturechangenow.com

**Assessment and Care Planning
Resources**

- Transformational Assessments: Resident Assessment Tools based in Person-Directed Care
- Available from the Institute for Caregiver Education
- www.caregivereducation.org

The “Assessment Process”

- What does the institutional “assessment process” look and feel like?
- What are your ideas for improvement?

“Over coffee or over a form?”

- How do you get to know residents who are new to you?
- How do you get to know a new neighbor?

Welcoming New Residents

- How are new residents welcomed?
- What are your ideas for improvement?

What would caregivers need to know about you now to better care for you later?

- Examples
- Exercise

What's your ethnicity?

- What are some ethnic characteristics someone would need to know about you?

Your Residents' Ethnicity

- What is a well known ethnic trait of one of your residents?
- Can you think of a "behavior" that might be ethnicity related?
- Are you assessing ethnic characteristics?
- Resource: *Living Life to the Fullest: A Match Made in OBRA '87* by Action Pact available at www.culturechangenow.com

Care Planning Quality of Life

- Consider adding a “quality of life” section to every person’s care plan
- Prompt yourselves to find out:
 - What brings meaning and purpose to his/her life?
 - Boredom, Loneliness, Helplessness
The Three Plagues of Institutionalization
 - What quality of life means to them

What else?

- What else should we be assessing to get to know our residents better?
 - Daily routine
 - Daily pleasures
 - Relationships
 - How should we be assessing medical conditions better/softer?



**AANAC Free Manual
Softer Side of the MDS**

**PRINCIPLES OF EXCELLENCE
IN ASSESSMENT AND CARE
PLANNING**



Comprehensive Care Plan

F Tag 279

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



Measurable Objectives

Medical conditions

- Tend to be easier to measure
- Examples:
 - No skin breakdown (measure = zero)
 - Blood sugars in the range of ...

Measurable Objectives

Psychosocial issues

Tend to be harder to measure

- Reduced signs and symptoms of depression such as...
- Measurable but do you have a system for monitoring that indeed certain signs/symptoms are less?

Measurable Objectives

Activity related goals

- Traditionally have used attendance at so many activities per week
- Indeed measurable BUT is not meaningful nor does it have anything to do with a person's highest practicable level of well-being
- New CMS interpretive guidelines for Tag F248 **Activities**, state that goals identifying how many group activities one will attend are "outdated and old fashioned"

Tips on creating measurable outcomes/goals

Frequency

- Lucky will assist in the maintenance department at least once a week.
- Conrad will read to fellow residents once a week.

Tips on creating measurable outcomes/goals

Numbers/totals

- Lucky will complete one project per week.
- Conrad will read at least one book out loud to a volunteer weekly.

Tips on creating measurable outcomes/goals

Duration

- Lucky will work with the maintenance department at least an hour a week.
- Conrad will read out loud to an activity staff member for at least 5 minutes during 1:1 visits.

Back to Tag 279 – Measurable Timetable

- Most common:
 - Over the next 90 days
 - Until the next care conference
 - Through XX/XX/XX (date 90 days out)
- Shorter timetables too

Highest Practicable

F Tag 279 - “the second paragraph”

The care plan must describe the following:

- o *The services that are to be furnished to attain or maintain the resident’s **highest practicable** physical, mental and psychosocial well-being.*



Highest Practicable

- We're good at addressing "highest practicable" for **physical** needs
- We lack at identifying and addressing "highest practicable" for **psychosocial and activity** needs
- Examples
- Exercise
- Tag 169

Families

- Think of them as a resource.
- Invite them to write the book/story/care plan.
- "Will you help us?"
- They are there to help you.

Add "Highest Practicable" to Care Plan?

- I think it's a good idea.
- It is a **regulation**.
- It's an honor to figure out someone's "highest practicable."
- CMS is an ally.
- CMS satellite broadcasts – check them out.

“A Goal is a Goal”

- “What if a goal is not met?”
- “What will the surveyors say?”
- “What kind of documentation is needed?”
- We all need to remember, surveyors included, that a goal is a goal.
- There is no guarantee that a goal will ever be met and surveyors cannot hold a person or a facility to making sure goals are met.
- A goal is a goal.
How many of us have goals we have not met?
- What a surveyor can hold us to is that there is a goal and that it is measurable and fits the person.

Who’s goals are they anyway?

- Really, who are we to set goals for other people?
- The goals are to be the resident’s, not ours.
- Again, medical condition goals are usually clear cut. However, what would be more self-directed?
- And what about psychosocial/activity related goals?

Ask residents!

- Ask residents what their goals are.
- Prompt them, help them think about it.
- What would you say your goals are for your life right now?
- What are your goals related to your quality of life?
- What are your goals related to your activity interests?
- Examples
 - Exercise

What if residents cannot tell you?

- Discuss with families what *they* think the person's goals would be now.
- If residents are unable *and* family is unavailable, *then* staff can step in and determine as best as they can *from really knowing the person*, what the person's goals might be.

Resident Participation

- PLUS, it's required!!!
- Tag F280
- *A comprehensive care plan must be prepared by an interdisciplinary team ... and to the extent practicable, the **participation of the resident, the resident's family or the resident's legal representative.***

Let's talk about care conference

- Describe it – a typical care conference looks like...
- Do you really, truly support the person in guiding his/her life?
- Does the resident sit in the driver's seat of their life?
- Do you make that happen?

Your Care Conferences

- What do your care conferences look like?
- What do your care conferences feel like?
- What are your ideas for improvement?
- How can you begin to ask residents their goals?

The Care Conference Environment

- What is the atmosphere of your care conference environment?
- Warm or cold?
- Inviting or sterile?
- At *home* feeling or institutional?

Care Conference Environment Considerations:

- Lighting/natural light?
- Refreshments?
- Artwork or blank walls?
- Temperature?
- Plants?
- Animals?
- Other?

So, what does a typical care plan look like?

Problem	Goal	Approaches

Problem	Goal	Approaches
<p>Where does this style of care plan come from? This is a Nursing Care Plan, taught in nursing school In regards to medical problems, it has a place It sometimes fails us, however, regarding activities, quality of life and strong identification with past roles</p> <p>Goals come naturally for us Whether measurable, is an issue Over the next 90 days – some homes have made it policy Approaches come naturally, are for staff Feel free to add pertinent information</p>		

Activities



F Tag 248 Activities

- The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the _____ and the physical, mental, and psychosocial well-being of each resident.

Activities



F Tag 248 Activities

- The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

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Problem	Goal	Approaches

Care Planning Activities

- Traditional Care Plan = Problems
- Medical/nursing care plan model
- The regulation requires activities be based on INTERESTS!
- Free your recreation/activity staff!
- Time to get beyond 3 activities a week!
- New interpretive guidelines even say so!



A NEW DAY!

INTERESTS	Goal	Approaches

INTERESTS and NEEDS	Goal	Approaches
<p>Are strengths the same as interests?</p>		

INTERESTS and NEEDS	Goal	Approaches
Carmen loves to scrapbook		

Interests and Needs	Goal	APPROACHES
Carmen loves to scrapbook Now, let's say I do not have the use of my right arm...	Carmen will scrapbook daily over the next 90 days	

Interests and Needs	Goal	APPROACHES
Carmen loves to scrapbook <i>We DO NOT need to make the disability the focus. Tag 248 says to base activity programming on INTERESTS! We've been doing it the "wrong" way Focusing on and creating problems (when often they don't even exist!)</i>	Carmen will scrapbook daily over the next 90 days	Left handed scissors Occupational Therapy C Clamps Suction Vise Volunteer to assist Staff to assist

Interests and Needs	Goal	Approaches
Carmen loves to scrapbook	Carmen will scrapbook daily over the next 90 days	<p>Additional Info</p> <p>Carmen's daughter scrapbooks several times a week with her Mother</p> <p>Carmen has a bright lamp</p>

So, must a care plan be written in the third person?

Or must a care plan be in the three column style?

Problem	Goal	Approaches
<p>No! Look back at the text of the regulation What are the twb, the only two things required? So, as far as style or format, we have choices!</p>		

Common Care Planning

Problem	Goal	Intervention
Difficult behavior: Resident wanders into others rooms at night	Resident will sleep 5 hours during the night by next RCC	Sleep medication PRN Discourage napping during the day Side rails up If unable to sleep, place in geri-chair

"I" Care Plan

Problem	Goal	Intervention
I like to walk during the night	I will ambulate freely throughout my home daily at times of my choice over the next quarter	If I'm walking at night, please offer to walk with me. Place sashes on the doorways of the residents who are disturbed by my presence at night. Offer snacks and preferred activities when I'm unable to sleep. I like to read the sports section of the newspaper, play solitaire, watch old movies.

Common Care Planning

Problem	Goal	Intervention
Non compliant with 1800 cal ADA diet	Resident will eat only foods approved in ordered diet	Educate resident regarding diabetes, her diet, and impact to her health if non compliant. Notify nurse of food hidden in room. Monitor for s/s hypo and hyper glycemia. Check blood sugar 6 am and 8 pm. Administer insulin as ordered.

“I” Care Plan

Problem	Goal	Intervention
I have diabetes and I take insulin. I am aware of recommended dietary restrictions and I choose to exercise my right to eat what I enjoy.	I will enjoy moderate foods of my choice.*	Please provide me a regular diet with no concentrated sweets. Ask me prior to each meal what I would like. Honor my requests. Daily arguments about food will anger me. Check my blood sugar daily at 6 am and 8 pm. If it is too low or too high, I will discuss with the nurse what I ate that day, and will take responsibility to make better choices. Administer my insulin as ordered.

But what about persons with dementia?

- Isn't it like "putting words in their mouths?"
- If you know your residents well, *you know* what they would say if they could!
- *You know* what they are saying!

Changing the Culture of Care Planning

Institutional Model	Community Model
Staff know you by diagnosis.	Staff have personal relationship with resident and family.
Staff write care plan based on what they think is best for your diagnosis.	Resident, family, and staff develop care plan that reflects what resident desires for him/herself.
Interventions are based on standards of practice per diagnosis.	Unique-to-the-person interventions are developed together which meet the needs and desires of that person.

WELL-BEING: Most of the time my mood is very pleasant. I enjoy people, I enjoy talking, and I look forward to the daily visits from my daughter. The thing that makes me happiest is when I feel in control of the things going on around me. You can help by offering me choices in my care. Encourage me to get out and be with others. It is important that I get to all three meals in the dining room because my table companions count on me to be there. If I appear grouchy, really listen to me. I like to have things done my way so follow my directions. I also get grouchy if I am hurting in my back, hip or shoulder. I take medication that helps me with pain and with depression. Let my nurse know if I am grouchy, I don't want to get out of bed, I don't feel like eating, or I don't bother to put on my make-up. These are signs that I am not quite myself.

GOAL: I want to make decisions in my daily care. I want to get out of my room for meals three times a day. I want my mood to improve with your helping interventions.

Only part of a narrative "I care" plan from Riverview Retirement Center, Spokane, WA
Refer to *Changing the Culture of Care Planning* workbook

Riverview's Care Planning List

Special Considerations/Strengths

- Social History
- Memory Enhancement & Communication
- Mental Wellness
- Mobility Enhancement
- Safety
- Visual function



Riverview's Care Planning List

- Dental Care
- Bladder Management
- Skin Care
- Nutrition
- Fluid Maintenance
- Pain Management and Comfort
- Activities
- Discharge Plan



More about the Riverview narrative care plan system can be found in *Changing the Culture of Care Planning: A Person-Directed Approach* Published by Action Pact at www.culturechangenow.com

A simple place to start

- Can the person's name be used in the care plan?
- Well, whose name is written on the bottom of every page of the care plan?
- Of course, the person's name can be used and should be.
- A simple place to start...

Whose care plan is it?

- Remember this is a plan reflecting the care for a *person*, not disciplines or departments!
 - Not, “the social service care plan.”
 - The section of Frank's care plan that identifies Frank's depression, etc.

Communicating the Care Plan

- How does all staff know the “all staff” approaches?
- How does appropriate staff come to know changes to the care plan?

Communicating the Care Plan

- Cardex system
- Adding to CNA flow sheets but what about all staff?
- Closet system
- *Route care plans to staff, resident and family for changes, inputs and needs*



IN2L.com

- Personal page
- Flight/driving simulation
- Stimulation
- Therapy applications and reimbursement
- Wireless systems
- Teaching technology for staff
- Training in varied languages
- **Visual Information Profiles***
- Hands on teaching and ongoing support
- Leasing options



Meeting the new Tag F248
Interpretive guidelines:
• "Connection with community"
• "Past roles"
• "New interests/skills"



*Who isn't a
Future Elder
of
America?*

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**Thank you to
Healthcare Research, Inc.
for their generous support**

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**Special thanks to
Carmen Bowman**


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**Special thanks to
Jack York**

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Special thanks to
Walter Coffey and
Georgia Institute on Aging



Special thanks to
Kim McRae
Co-Founder
Culture Change Network of Georgia

Founder, Have a Good Life, LLC

Have a Good Life.™

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Special thanks to
Frank Zamor
Producer/Editor

Original Music/Guitar

Co-Founder, Have a Good Life Media, LLC



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Special thanks to
John Clower
Audio/Video

Clower & Associates

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