Individualized Care Planning

Getting to Know the Person

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Regulator Turned Educator

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

Please print out, share and enjoy!
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
    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…”
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?
**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?
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"

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**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.

**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:  
- **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?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Approaches</th>
</tr>
</thead>
</table>

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.

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.

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.
**Care Planning Activities**

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

<table>
<thead>
<tr>
<th>INTERESTS</th>
<th>Goal</th>
<th>Approaches</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>INTERESTS and NEEDS</th>
<th>Goal</th>
<th>Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are strengths the same as interests?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INTERESTS and NEEDS</td>
<td>Goal</td>
<td>Approaches</td>
</tr>
<tr>
<td>---------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>Carmen loves to scrapbook</td>
<td>Carmen will scrapbook daily over the next 90 days</td>
<td>Left handed scissors, Occupational Therapy, C Clamps, Suction Vise, Volunteer to assist, Staff to assist</td>
</tr>
</tbody>
</table>

Now, let’s say I do not have the use of my right arm…

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!)
Interest and Needs
Carmen loves to scrapbook

Goals
Carmen will scrapbook daily over the next 90 days

Approaches
Additional Info
Carmen’s daughter scrapbooks several times a week with her Mother
Carmen has a bright lamp

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

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

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<td></td>
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</table>

No! Look back at the text of the regulation
What are the two, the only two things required?
So, as far as style or format, we have choices!
### Common Care Planning

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult behavior: Resident wanders into others rooms at night</td>
<td>Resident will sleep 5 hours during the night by next RCC</td>
<td>Sleep medication PRN, Discourage napping during the day, Side rails up if unable to sleep, place in geri-chair</td>
</tr>
</tbody>
</table>

### “I” Care Plan

<table>
<thead>
<tr>
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<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>I like to walk during the night</td>
<td>I will ambulate freely throughout my home daily at times of my choice over the next quarter</td>
<td>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.</td>
</tr>
</tbody>
</table>

### Common Care Planning

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<th>Intervention</th>
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<tbody>
<tr>
<td>Non compliant with 1800 cal ADA diet</td>
<td>Resident will eat only foods approved in ordered diet</td>
<td>Educate resident regarding diabetes, her diet, and impact to her health if non-compliant. Notify nurse of food hidden in room. Monitor for u/v hypo and hyper glycemia. Check blood sugar 6 am and 8 pm. Administer insulin as ordered.</td>
</tr>
</tbody>
</table>
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

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

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<thead>
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<th>Institutional Model</th>
<th>Community Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care plan written in the third person.</td>
<td>Care plan written in first person “I” format.</td>
</tr>
<tr>
<td>Care plan attempts to fit resident into facility routine.</td>
<td>Care plan identifies resident’s lifelong routine and how to continue it in the nursing home.</td>
</tr>
<tr>
<td>Nursing assistants not part of the interdisciplinary team.</td>
<td>Nursing assistants very valuable part of IDT and present at each care plan conference.</td>
</tr>
<tr>
<td>Care plan scheduled at facility convenience.</td>
<td>Care conference scheduled at resident and family convenience.</td>
</tr>
</tbody>
</table>

**RIVERVIEW CARE CENTER**

**RESIDENT CARE PLAN**

**NAME:** Anne Jones  
**ROOM:** 344  
**ADDRESS ME AS:** Anne or Mrs. Jones  
**BIRTHDATE:** 11/12/15  
**ADMIT DATE:** 11/01/00

**SOCIAL HISTORY:** I was born in Minnesota in 1915. At a young age I moved west with my family. We settled in Tekoa, Washington where we lived on a large farm. My mother and father managed the farm while my brother and I attended school. My parents always valued a good education. I graduated from high school in Tekoa and moved to the “big city” which was Seattle back then. I went to work as a model and enjoyed my career for 5 years. After moving to Spokane to be closer to my family, I worked as a model for “Bernard’s” which was a big department store. In 1940 I married my first husband. He was an established dentist in the Spokane community. We raised two children, a boy and a girl. After my husband’s death in 1955, I remarried. My second spouse was a land developer. We enjoyed our life together until his death two years ago. My 2 children, 3 grandchildren and seven great grandchildren all live nearby. They visit often and I enjoy their companionship.

**COMMUNICATION/MEMORY:** I have a little bit of trouble with my memory. I have been diagnosed with early Alzheimer’s dementia. I am aware of my situation, my caregivers and my family. Occasionally I am a little forgetful and confused. Be sure to orient me as part of our conversation while you are providing care. Remind me what is going to happen next. Introduce yourself every time you meet me until I am able to remember you. If I should be more confused than you normally see me, or I don’t remember details about my day, notify the nurse. Often times this means that I am having health complications, which my nurse will be able to assess. I enjoy conversation about your family and your children. I have had a lot of experience raising kids. If you would like some advice on beauty, I love to share my opinion. Especially on how you should do your hair or what clothes look good on you. Being a model all those years has paid off.

**GOAL:** I want to remain oriented to my family and my caregivers. I want to be able to remember special events and holidays with your reminders.
**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

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**Riverview’s Care Planning List**

**Special Considerations/Strengths**
- Social History
- Memory Enhancement & Communication
- Mental Wellness
- Mobility Enhancement
- Safety
- Visual function

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**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?

Edu-Catering
Catering Education for Compliance and Culture Change
303-988-7228 edu-catering.com
carmen@edu-catering.com
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EDU-CATERING
Catering Education for Compliance and Culture Change in LTC

Special thanks to Jack York

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John Clower
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