Assessment and Care Planning: Compliance and Quality

Barbara Speedling - Quality of Life Specialist
SDAHO – February 2022

OBJECTIVES

- Describe the regulatory expectations for person-centered assessment and care planning;
- Develop improved non-pharmacologic interventions in addressing behavioral health needs;
- Describe the impact of the COVID-19 Pandemic relative to quarantine and social distancing on resident psychosocial well-being, mood, and behavior; and
- Develop improved methods for the assessment and person-centered care planning for residents with complicated behavioral health needs.

F656 Comprehensive Care Plans

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

F656 Comprehensive Care Plans

The comprehensive care plan must describe the following —

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

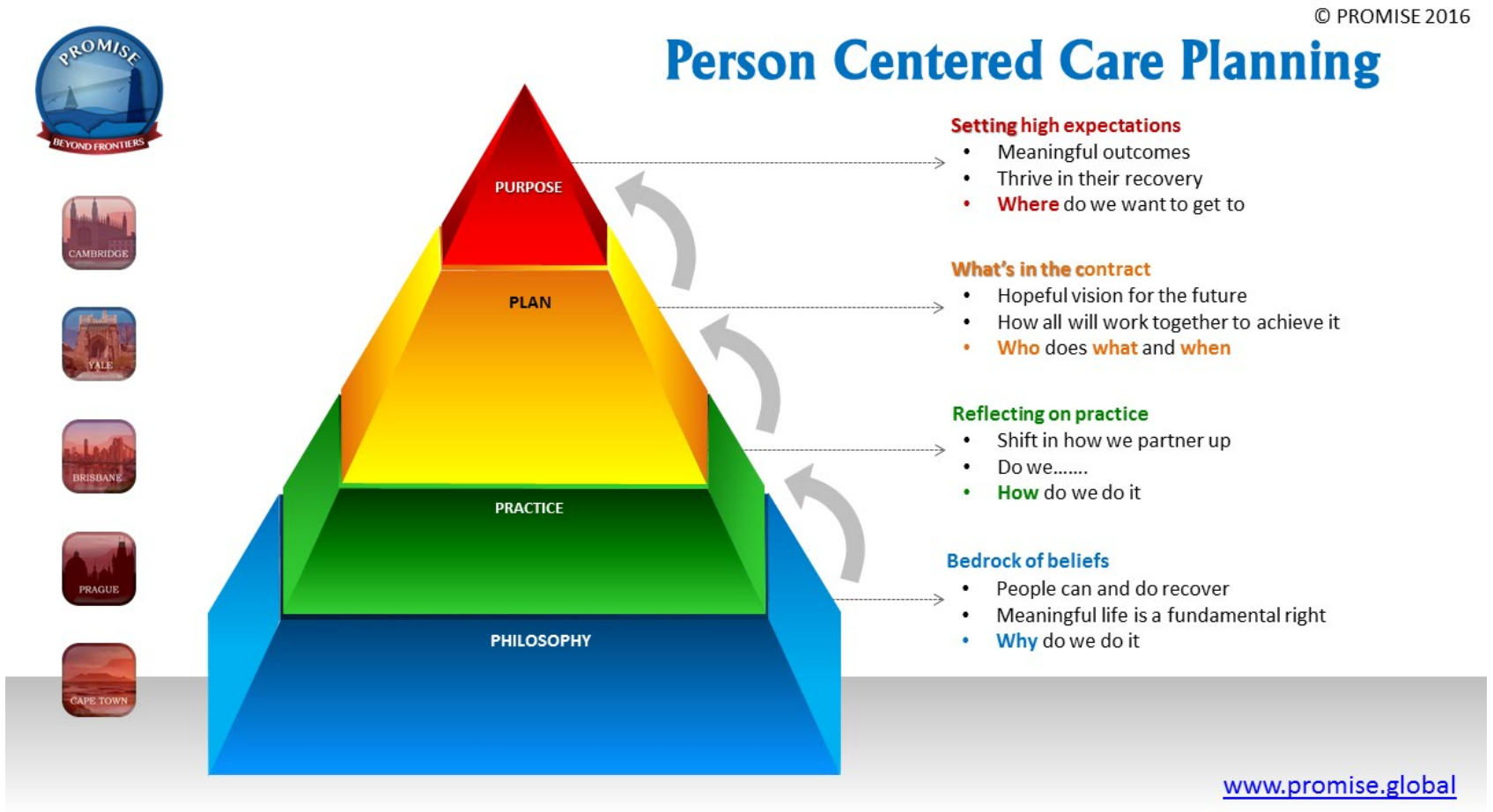
ii. Any services that would otherwise be required. but are not provided due to the resident's exercise of rights, including the right to refuse treatment.

iii. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations.

i. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

PROMISE Global aspires to set and break through frontiers of humane mental health care and eliminate reliance on force.

A collaborative project between Yale and Cambridge on bringing to life recovery oriented care delivery in Mental Health through Person Centered Care Planning.



Person-Centered Care Planning

- Person-centered care means the facility focuses on the resident as the center of control;
- Supports each resident in making his or her own choices;
- Includes making an effort to understand what each resident is communicating, verbally and nonverbally;
- Identifying what is important to each resident with regard to daily routines and preferred activities; and
- Having an understanding of the resident's life before coming to reside in the nursing home.

Person-Centered Care Planning

- Measurable objectives describe the steps toward achieving the resident's goals, and can be measured, quantified, and/or verified.

- For example, "Mrs. Jones, who underwent hip replacement, will report adequate pain control (as evidenced by pain at 1-3, on a scale of 1-10) throughout her SNF stay."

Person-Centered Care Planning

- The comprehensive care plan must reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.
- Interventions for the example above, related to pain, may include, but are not limited to:
  - Evaluate pain level using pain scale (0-10) 45 minutes after administering pain medication;
  - Administer pain medication 45-60 minutes prior to physical therapy.

Person-Centered Care Planning

In some cases, a resident may wish to refuse certain services or treatments that professional staff believes may be indicated to assist the resident in reaching his or her highest practicable level of well-being or to keep the resident safe.

Person-Centered Care Planning

In situations where a resident's choice to decline care or treatment (e.g., due to preferences, maintain autonomy, etc.) poses a risk to the resident's health or safety, the comprehensive care plan must identify:

- ✧The care or service being declined;
- ✧The risk the declination poses to the resident;
- ✧And efforts by the interdisciplinary team to educate the resident and the representative, as appropriate.

✧The facility's attempts to find alternative means to address the identified risk/need should be documented in the care plan.

Person-Centered Care Planning

- The comprehensive care plan must coordinate with and address any specialized services or specialized rehabilitation services the facility will provide or arrange as a result of PASARR recommendations.
- If the IDT disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
- The rationale should include:
  - An explanation of why the resident's current assessed needs are inconsistent with the PASARR recommendations; and
  - How the resident would benefit from alternative interventions.
- The facility should also document a resident's the resident's preference for a different approach to achieve goals or refusal of recommended services.

Preadmission Screening and Resident Review (PASARR)

Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASARR requires that:

1) All applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability;
2) Be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and
3) Receive the services they need in those settings.

Preadmission Screening and Resident Review (PASARR)

The PASARR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they *might* have MI or MR.

- ✧This is called a "Level I screen."
- ✧Those individuals who test positive at Level I are then evaluated in depth, called "Level II" PASARR.
- ✧The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.

REGULATORY EXPECTATIONS
F645 PASARR Coordination

Coordination includes:

- Incorporating the recommendations from the PASARR Level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

- Referring all Level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for Level II resident review upon a significant change in status assessment.

PASARR
F646 Significant Change

A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.

PASARR

Significant Change in Status Requirements

Referrals for a Level II evaluation must be made as soon as the significant change is evident, but no later than 14 days after the change has been identified. The facility should not wait until the MDS significant change in status assessment is complete.

PASARR
Federal Regulations

"Significant Change" is a major decline or improvement in a resident's status that:

- Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered "self-limiting"
  - (**NOTE**: Self-limiting is when the condition will normally resolve itself without further intervention or by staff implementing standard clinical interventions to resolve the condition.);
- Impacts more than one area of the resident's health status; and
- Requires interdisciplinary review and/or revision of the care plan. This does not change the facility's requirement to immediately consult with a resident's physician of changes as required F580.

Significant Change

In instances where the individual was previously identified by PASRR to have mental illness, intellectual disability, or a related condition, the following conditions may be noted as the reason for referral:

- A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.
- A resident with behavioral, psychiatric, or mood-related symptoms that have not responded to ongoing treatment.
- A resident who experiences an improved medical condition—such that the resident's plan of care or placement recommendations may require modification.
- A resident whose significant change is physical, but with behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.
- A resident who indicates a preference to leave the facility. (This preference may be communicated verbally or through other forms of communication, including behavior.
- A resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASRR Level II evaluation and determination.

Significant Change

In instances where the individual had not previously been found by PASRR to have a mental illness, intellectual disability/developmental disability, or a related condition, the following conditions may be noted as the reason for referral (note that this is not an exhaustive list):

- A resident who exhibits behavioral, psychiatric, or mood-related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR §483.102 (where dementia is not the primary diagnosis).
- A resident whose intellectual disability as defined under 42 CFR §483.102, or whose related condition as defined under 42 CFR §435.1010, was not previously identified and evaluated through PASRR.
- A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.

https://www.pasrrassist.org/resources

Section 1135 Waiver

- In response to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services (CMS) introduced several blanket waivers pursuant to its 1135 waiver authority
- The particular waivers issued in response to COVID-19 modify certain requirements for the provision or payment of care in an attempt to allow providers dealing with pandemic conditions to focus on patient care.
- While there are potential benefits to patients and providers by permanently waiving some requirements, loosening certain requirements could **negatively impact the quality of patient care or lead to potential abuse.**

Source: https://www.americanhealthlaw.org

Section 1135 Waiver

- The 1135 Waiver allows Level I and Level II assessments to be waived for 30 days.
  - All new admissions can be treated like exempted hospital discharges.
  - After 30 days, new admissions with mental illness (MI) or intellectual disability (ID) should receive a Resident Review as soon as resources become available.
- New preadmission Level I and Level II screens are not required for residents who are being transferred between nursing facilities (NF).
  - If the NF is not certain whether a Level I had been conducted at the resident's evacuating facility, a Level I can be conducted by the admitting facility during the first few days of admission as part of intake and transfers with positive Level I screens would require a Resident Review.

F745
Medically Related Social Services

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

Ethical Principles

Social Work's Core Values:

- Service
- Social Justice
- Dignity and Worth of the Person
- Importance of Human Relationships
- Integrity
- Competence

www.socialworkers.org

ADVOCATE
Assessment Considerations

Manifestations of mental and psychosocial adjustment difficulties that may occur over a period of time:

- Impaired verbal communication;
- Social isolation (e.g., loss or failure to have relationships);
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);
- Spiritual distress (disturbances in one's belief system);
- Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

ADVOCATE
Assessment: When, Where, and How…

A Changing Demographic

Important demographic shifts include:

- The **aging** of the population and the **projected growth** of the oldest old (those 85 years of age or more);
- The **changing racial and ethnic composition** of the population resulting from immigration and the rapid growth rates of the minority populations, especially those of Hispanic and Asian origin;
- The **shifts in family patterns** (particularly the trend toward smaller family size, childlessness, and divorce); and
- Increasing **poverty**.

Source: Institute of Medicine (US) Committee on the Adequacy of Nursing Staff in Hospitals and Nursing Homes; Wunderlich GS, Sloan F, Davis CK, editors. Nursing Staff in Hospitals and Nursing Homes: Is It Adequate? Washington (DC): National Academies Press (US); 1996. 2, Implications of Population Change. Available from: https://www.ncbi.nlm.nih.gov/books/NBK232661/

A Changing Demographic

The growing elderly population will be a major determining force in the next century for the demand and supply of health services and, therefore, for the type of resources needed to provide those services.

Accommodation of a Fading Personality

New Considerations

- Capacity determinations for medical and psychosocial decision making;
- Medical Marijuana;
- Pain management – opioids and addiction;
- Sexuality/LGBT populations;
- Short-term vs. Long-term needs and practices;
- Complicated discharge planning/housing/financial concerns.

F842 Medical Records

The clinical record must contain—

- ✧Sufficient information to identify the resident;
- ✧A record of the resident's assessments;
- ✧The plan of care and services provided;
- ✧The results of any preadmission screening conducted by the State; and
- ✧Progress notes

Critical Thinking

Documentation should describe the nurses' critical thinking process:

- ✧Assessment of resident conditions, causative factors, and/or risk factors
- ✧Analysis of potential outcomes or consequences
- ✧Plan of action
- ✧Evaluation of resident response to the plan

What is Cultural Competency?

- **Cultural competence** is the ability to understand, communicate with and effectively interact with people across **cultures**.

- **Cultural competence** encompasses. being aware of one's own world view. developing positive attitudes towards **cultural** differences, gaining knowledge of different **cultural** practices and world views.

Source: makeitourbusiness.ca/blog/what-does-it-mean-be-culturally-competent

REGULATORY EXPECTATIONS

The facility must have ***sufficient staff*** who provide direct services to residents with the appropriate ***competencies and skills sets*** to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident…***considering the number, acuity and diagnoses*** of the facility's resident population.

REGULATORY EXPECTATIONS

These competencies and skills sets include knowledge of and appropriate training and supervision for:

- Caring for residents with mental and psychosocial disorders, as well as residents with a history of ***trauma and/or post-traumatic stress disorder***; and

- ***Implementing non-pharmacological interventions.***

REGULATORY EXPECTATIONS

A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

REGULATORY EXPECTATIONS

A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder ***does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors,*** unless the resident's clinical condition demonstrates that development of such a pattern was unavoidablE.

REGULATORY EXPECTATIONS

F740 Behavioral Health

Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

REGULATORY EXPECTATIONS

F699 Trauma-informed care

The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

REGULATORY EXPECTATIONS

Trauma can be defined as a psychological, emotional response to an event or an experience that is deeply distressing or disturbing.

What is Trauma-Informed Care?

Trauma-Informed Care understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize.

The Relationship Between Trauma and Grief

Trauma is an event.

The result of a traumatic event is **grief**.

Source: https://www.griefrecoverymethod.com/blog/2015/02/what-difference-between-trauma-and-grief

Stages of Grief

- Denial
- Anger
- Bargaining
- Depression
- Acceptance

A Trauma-informed Approach (The 4 R's)

- Realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices
- Resists re-traumatization

https://www.integration.samhsa.gov/clinical-practice/trauma-informed

The **Five Principles of Trauma-Informed Care**

- The **Five Guiding Principles** are;
  - Safety;
  - Choice;
  - Collaboration;
  - Trustworthiness; and
  - Empowerment.

- Ensuring that the physical and emotional safety of an individual is addressed is the first **important** step to providing **Trauma-Informed Care**.

http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

What Does Trauma-informed Care Look Like?

- Explain why you're asking sensitive questions.
    - "I need to ask you about your sexual history, so I know what tests you may need."
- Explain why you need to perform a physical exam, especially if it involves the breasts or genitals. If someone is nervous, you can let them bring a trusted friend or family member into the room with them.
- You can tell them that if they need you to stop at any time, they can say the word.
- If someone refuses outright to have a certain exam or test, or if they're upset about something (like having vaccinations), you can respond with compassion and work with them, rather than attempting to force them or becoming annoyed.

https://www.health.harvard.edu/blog/trauma-informed-care-what-it-is-and-why-its-important-2018101613562

Primary Care PTSD Screen

- The Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5) is a 5-item screen that was designed to identify those with probable PTSD.

- Those screening positive require further assessment from a mental health professional.

- The results of the PC-PTSD-5 should be considered "positive" if a client answers "yes" to any three of the five items about experiences in the past month related to an event.

Source: https://www.ptsd.va.gov

Primary Care PTSD Screen

- **Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:**
  - A serious accident or fire
  - A physical or sexual assault or abuse
  - An earthquake or flood
  - A war
  - Seeing someone be killed or seriously injured
  - Having a loved one die through homicide or suicide

- **Have you ever experienced this kind of event? YES or NO**
  - If no, screen total = 0. Please stop here.
  - If yes, please answer the questions below.

- **In the past month, have you ...**
  - **Had nightmares about the event(s) or thought about the event(s) when you did not want to?** YES or NO
  - **Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?** YES or NO
  - **Been constantly on guard, watchful, or easily startled?** YES or NO
  - **Felt numb or detached from people, activities, or your surroundings?** YES or NO
  - **Felt guilty or unable to stop blaming yourself of others for the event(s) or any problems the event(s) may have caused?** YES or NO

Anticipating Extreme Emotion

Changes in mood and behavior may occur in residents, staff and families in response to the social distancing and moratorium on visitation initiated to prevent the spread of COVID-19.

Anticipating Extreme Emotion

Be prepared for extreme emotion:

- Where can residents and staff express their stress and frustration safely?
- Will a resident’s emotional expression be dismissed as "behavior” or understood as resulting from the impact of the Pandemic?
- What plans have been developed to ensure families and friends of residents are provided accurate and timely information?

Preventing Abuse and Neglect

- Being aware of how emotions can escalate during stressful events;
- Discuss abuse prevention with your team;
- Be alert to disagreements between staff, or staff and residents and ensure quick resolution of grievances; and
- Be open and honest with staff, residents and families regarding the stress everyone is feeling during this time and that there help is available for anyone feeling overwhelmed.

Helping Residents With Mental Disorders

- Anxiety
- Major Depression
- Schizophrenia
- Schizoaffective Disorder
- BiPolar Disorder
- Obsessive Compulsive Disorder

Mental Disorders and Related Conditions

Residents diagnosed with a mental disorder may have additional illnesses:

- Anxiety disorder
- Post-traumatic stress disorder (PTSD)
- Attention-deficit hyperactivity disorder (ADHD)
- Substance abuse

Contents of the Medical Record

The clinical record must contain:

- ✧Detailed descriptions of changes in condition
- ✧Unusual occurrences
- ✧Evidence of physician and responsible party notification
- ✧**Proof of care provided**

Proof of Care Provided: COVID-19 Vaccinations

- The medical records reviewed lacked care plan documentation for the administration of the SARS-COV-2 (COVID-19) vaccine.
- Documentation in the immunization section of the medical record is not always completed in its entirety.
- There are no progress notes reflecting administration of the vaccine or observations of the resident over the next 24 hr. period.
  - The immunization record sometimes offers a statement regarding the resident's condition, but not consistently.
  - In the absence of a chronological progress note entry or a care plan, the documentation is often insufficient to validate that the care has been provided.

Care Plan Evaluations

Evaluation is required:

- ✧Following an accident or incident, whether or not it results in injury;
- ✧Following a significant change in function or treatment;
- ✧Following determination of a new or revised diagnosis;
- ✧Upon transfer/discharge; and
- ✧Upon readmission.

Care Plan Evaluations

DX: Anxiety, Dementia

- SS – 5/28/21: Resident's behaviors continue, she remains non- compliant with requests, continues with attention seeking. She is minimally responsive to individual music and has a short attention span.
  - **No revision to interventions that have proven unsuccessful.**
- Behavior CCP Interventions: 4/26/21
  - Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.
  - **Provide a program of activities that is of interest and accommodates residents status. (Such as?)**

What to Document

- **Assessment**—data collection
  - Auscultate, palpate, inspect, percuss
- **Action**—what did you do with the findings?
  - Physician/family notification?
- **Response**—how did the resident react?
- **Evaluation**—were the actions effective? Does the plan need re-evaluated?

How to Document

- Documentation should include **correct anatomical terms***:
  - Buttocks, sacrum, coccyx - **NOT** butt crack!

- Superior, inferior, anterior, posterior, medial, lateral, proximal, distal— use the correct terminology.

- **ICD-10 - documentation must include correct anatomy or questions regarding reimbursement claims will arise.**

Coordination of Care

- Admitting dx: **l97.429 non-pressure chronic ulcer of left heel** and midfoot with 03/24/2021 diagnosis l admitting dx (#69) unspecified severity
- Face sheet - **dx: l89.623 pressure ulcer of left heel, stage 3**
- CCP for limited mobility: the resident has limited physical mobility r/t l heel ulcer, weakness date initiated:
  - Interventions: Activities: invite the resident to activity programs that encourage physical activity, physical mobility, such as exercise group, walking activities to promote mobility.
  - Activity CCP does not correspond to the interventions noted here.

How to Document

- The following terminology **does not** sufficiently describe the reaction of the resident to his/her skilled care:
  - Tolerated treatment well
  - Continue with POC
  - Remains stable
  - This type of documentation does not provide a clear picture of the results of the treatment, nor the “next steps” that are planned.

How to Document

- **If you document information such as:**
  - "wound healing" or
  - "condition improved"
- Be sure to state facts that support your documentation.
- Give exact measurements and state the observations supporting the opinion.
  - "As evidenced by..."

COVID-19 Pandemic Response - Care Planning
Psychosocial Well-Being and Infection Control

Psychosocial Considerations:

- ✧Lack of family or social support;
- ✧Inability to communicate anxiety/stress verbally; and
- ✧Depression and trauma

What is Quality of Life?

- Subjective, multidimensional, encompassing positive and negative features of life.

- A dynamic condition that responds to life events

http://www.forbes.com/sites/iese/2013/09/04/quality-of-life-everyone-wants-it-but-what-is-it/

COVID-19 Pandemic Response

Manifestations Of Mental And Psychosocial Adjustment Difficulties

- Impaired verbal communication;
- Social isolation (e.g., loss or failure to have relationships);
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);

COVID-19 Pandemic Response

Manifestations Of Mental And Psychosocial Adjustment Difficulties

- Spiritual distress (disturbances in one's belief system);
- Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

Care Planning in COVID-19

- Infection Control:
  - COVID-19 Status
  - Symptom management/observations
  - Treatment interventions
- Psychosocial Well-being:
  - Trauma-Informed Care
  - Grief Response
  - Behavioral Assessment and Interventions
- Discharge Planning

CARE PLAN SAMPLE COVID-19 Infection Risk

RESIDENT:					
DATE	PROBLEM	GOAL	REVIEW DATE	INTERVENTIONS	RESPONSIBLE DISCIPLINE
	Resident is at risk for COVID-19 viral infection.	The resident will remain afebrile x14 days. or The resident will verbalize signs and symptoms of infection x 30 days.		❑ Assess the amount and characteristics of sputum. ❑ Auscultate breath sounds as ordered for changes in baseline. ❑ Monitor vital signs as ordered for changes in baseline. ❑ Review with the resident the signs and symptoms of infection; discuss preventive methods to reduce the risk for infection. ❑ Tell the resident and family to use disposable gloves and household disinfectant to clean any surface that might have been exposed to the resident's body fluids. ❑ Administer prescribed medications, and monitor for effect. ❑ Encourage incentive spirometry hourly while the resident is awake. ❑ Maintain infection control precautions according to the Centers for Disease Control and Prevention's latest recommendations ❑ Monitor IV sites; follow facility protocol for changing IV tubing and sites. ❑ Monitor laboratory values. Obtain specimens for culture, as ordered.	Nursing, RT Nursing, RT Nursing Nursing, RT Nursing, SW Nursing, Nursing MD, Nursing Nursing Nursing

CARE PLAN SAMPLE - COVID-19 Respiratory

RESIDENT:					
DATE	PROBLEM	GOAL	REVIEW DATE	INTERVENTIONS	RESPONSIBLE DISCIPLINE
	Resident has tested positive for COVID-19 and presents with s/s of respiratory distress.	The resident will maintain adequate ventilation x 14 days.		❑ Assist the resident with activities of daily living. ❑ Auscultate breath sounds every: (i.e., 1 hour) _____ ❑ Monitor respiratory rate, depth, and effort every: (i.e., 1hour) _____ ❑ Perform chest physiotherapy every: (i.e., 1hour) _____ ❑ Perform suctioning, as needed, and monitor response. ❑ Place the resident in a position that best facilitates chest expansion. ❑ Schedule care activities to allow the resident uninterrupted periods of rest. ❑ Teach the resident to cough and deep-breathe, and encourage the resident to do so hourly while awake. ❑ Administer prescribed medications, and monitor for effect. ❑ Administer nebulizer treatments, as ordered, and monitor the resident's response. ❑ Administer oxygen, as ordered, and monitor the resident's response. ❑ Monitor pulse oximetry every: (i.e., 1 hour) _____	Nursing Nursing, RT Nursing, RT Nursing, RT Nursing, RT Nursing, RT Nursing, Activities Nursing, RT Nursing Nursing, RT Nursing, RT Nursing, RT

CARE PLAN SAMPLE - COVID-19 Discomfort

RESIDENT:					
DATE	PROBLEM	GOAL	REVIEW DATE	INTERVENTIONS	RESPONSIBLE DISCIPLINE
	Resident has tested positive for COVID-19 and expresses discomfort related to flu-like body aches and respiratory symptoms.	The resident will notify the practitioner of discomfort x 30 days. Or The resident will verbalize or demonstrate feelings of comfort x 30 days.		❑ Acknowledge the resident's feelings of discomfort. ❑ Observe for nonverbal cues of discomfort, such as restlessness, muscle tension, or altered vital signs. ❑ Assess the degree of the resident's discomfort (characteristics, severity, location, onset, type, precipitating factors, and duration). ❑ Educate the resident on ways to decrease factors that precipitate the discomfort, as appropriate. ❑ Assist the resident in developing a plan to reduce discomfort; include the resident to facilitate independence and control. ❑ Instruct the resident to notify the health care practitioner if control measures are inadequate. ❑ Modify control measures based on the resident's response. ❑ Provide non-pharmacologic comfort measures. Adjust the environment, as necessary, and position the resident for comfort. ❑ Administer prescribed medications, and monitor for effect.	

CARE PLAN SAMPLE – TRAUMA/DISCHARGE

RESIDENT:					
DATE	PROBLEM	GOAL	REVIEW DATE	INTERVENTIONS	RESPONSIBLE DISCIPLINE
	Due to the facility closure, the resident will be discharged to: _____ A comprehensive discharge plan has been developed with a focus on minimizing the impact of the transfer on the resident's psychosocial well-being. The individualized plan incorporates current behavioral health care and treatment, as well as projected needs that may occur post-discharge. The resident, to the extent possible, and the resident's family have been involved in this planning.	Resident will not exhibit s/s of trauma x 30 days; Or Resident will respond positively to transfer as evidenced by not exhibiting s/s of depression or withdrawal x 30 days. Or Resident will adjust to relocation as evidenced by saying he/she is satisfied with the placement x 30 days.		❑ Notify resident and family of the d/c plan; ❑ Notify facility Ombudsman of d/c plan; ❑ Meet with resident and family to discuss d/c procedures and respond to any questions or concerns; ❑ Assist resident and family in identifying the most appropriate d/c destination; ❑ Provide emotional support and reassurance; ❑ Prepare interdisciplinary d/c plan and review with resident and family; ❑ Prepare medical records, all required documents and resident profile for d/c; ❑ Arrange d/c liaison with receiving facility and organize d/c details and plan for 30-day follow-up; ❑ Pack resident's personal belongings and arrange transport to receiving facility; ❑ Arrange for d/c send-off with resident and family; ❑ Prepare/provide d/c information packet to resident and family.	

CARE PLAN SAMPLE
POST TRAUMATIC STRESS DISORDER (PTSD)

RESIDENT:					
DATE	PROBLEM	GOAL	REVIEW DATE	INTERVENTIONS	RESPONSIBLE DISCIPLINE
	1. Resident has a diagnosis of post-traumatic stress disorder and depression. Reports/displays the following signs and symptoms: ❑ Has nightmares about the event(s) or thoughts about the event(s) when he/she does not want to ❑ Tries hard not to think about the event(s) or goes out of his/her way to avoid situations that remind him/her of the event(s) ❑ Feels constantly on guard, watchful, or easily startled ❑ Feels numb or detached from people, activities, or your surroundings ❑ Feels guilty or unable to stop blaming his/herself or others for the event(s) or any problems the event(s) may have caused 2. Resident expresses his depression by withdrawing from social activity and meals. 3. Resident identifies the past trauma as the primary source of his depression. He admits to having a short temper when he feels most depressed. He will generally raise his voice when angry, but feels it takes a lot to get him to that point.	The resident's will not experience s/s of PTSD as evidenced by reporting that s/s have diminished x 30 days. Or The resident will demonstrate fewer episodes of depression as evidenced by his attendance at social activities and meals over the next quarter. Or The resident will achieve better control over his anger as evidenced by not raising his voice to staff and peers x 30 days.		❑ Meet with resident to identify topics and/or events that may trigger s/s of PTSD ❑ Identify what interventions the resident currently practices to minimize the s/s of PTSD ❑ Psychology/mental health services ❑ Therapeutic activity to improve social comfort and interest in conversation with peers (i.e. roundtable discussions, social events, educational programs) ❑ Offer social dining with a small group of peers to help reduce anxiety relative to eating in the large dining room ❑ Medications, as indicated	MD, Nursing, SW IDT MD/Psych/SW TR/SW/Rehab RD/SW/TR/Nursing MD, Nursing, SW

CARE PLAN SAMPLE - DEPRESSION

RESIDENT:					
DATE	PROBLEM	GOAL	REVIEW DATE	INTERVENTIONS	RESPONSIBLE DISCIPLINE
	1. Resident has a diagnosis of depression. Reports/displays the following signs and symptoms: ❑ Little interest/pleasure in doing things ❑ Feeling down, depressed, hopeless ❑ Trouble falling/staying asleep; sleeping too much ❑ Feeling tired /having little energy ❑ Poor appetite/overeating ❑ Feeling bad about him/herself; a failure ❑ Trouble concentrating, e.g. reading, watching TV ❑ Moving/speaking so slowly others noticed; or opposite ❑ Thoughts he/she would be better off dead; or hurting him/herself 2. Resident expresses his depression by withdrawing from social activity and refusing ADL care. 3. Resident admits to having a short temper when he feels most depressed. He will generally raise his voice when angry, but feels it takes a lot to get him to that point.	The resident's will not experience s/s of depression as evidenced by reporting that s/s have diminished x 30 days. Or The resident will demonstrate fewer episodes of depression as evidenced by his attendance at social activities and acceptance of ADL care over the next quarter. Or The resident will achieve better control over his anger as evidenced by not raising his voice to staff and peers x 30 days.		❑ Meet with resident to identify topics and/or events that may trigger s/s of depression ❑ Identify what interventions the resident currently practices to minimize the s/s of depression ❑ Psychology/mental health services ❑ Therapeutic activity to improve social comfort and interest in conversation with peers (i.e. roundtable discussions, social events, educational programs) ❑ Develop an ADL care routine that resident accepts; record in writing and review daily to minimize the potential for refusals ❑ Medications, as indicated	MD, Nursing, SW IDT MD/Psych/SW TR/SW/Rehab SW/TR/Nursing MD, Nursing, SW

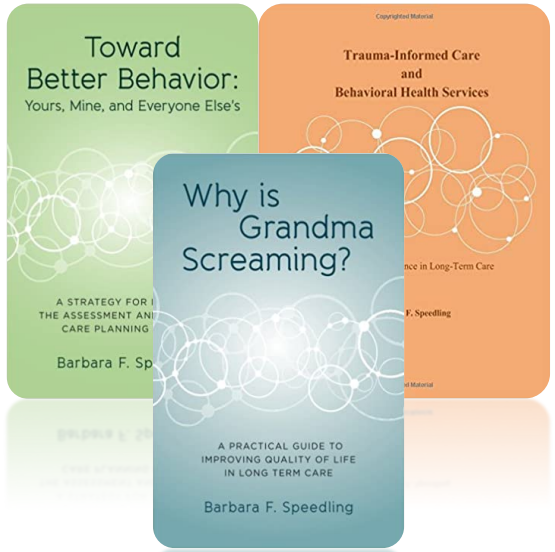
CARE PLAN SAMPLE - DEMENTIA

RESIDENT:					
DATE	PROBLEM	GOAL	REVIEW DATE	INTERVENTIONS	RESPONSIBLE DISCIPLINE
	Resident has a diagnosis of dementia with behavioral symptoms. The behavior is generally limited to calling out and restlessness when not engaged. The resident is able to communicate verbally with prompts and word suggestions to complete thoughts. She is able to follow directions that are segmented into small steps and encouraged verbally with demonstration. Her ambulation is supported by a rolling walker. She is able to feed herself with initial demonstration of how to use utensils and explanation of what is on the plate. Intermittent verbal cuing and encouragement help her to complete her meal. She is generally cooperative with ADL care if ample information is given and tasks demonstrated.	The resident will not experience a decline in intellectual and physical function over the next quarter. Or The resident will successfully participate in the daily therapeutic activity structure without becoming restless or calling out over the next quarter.		Provide with word/picture cues to facilitate understanding of instructions and information. Provide ADL care in keeping with resident's needs and preferences. Please refer to ADL CCP. Provide preferred activities. Please refer to Activities CCP. Provide preferred meals and snacks with assistance, as needed. Please refer to Nutrition CCP. Provide emotional support and medically related social services, as indicated. Please refer to Social Service CCPs on Advance Directives, Discharge Planning and Psychosocial well-being. Provide medical services as indicated. Please refer to CCPs addressing diagnosis and treatment.	All Nursing, Rehab, Nutrition Recreation, Nursing, Social Services Nursing, Nutrition Nursing, Medicine, Psych, Social Services, Recreation Medicine, Nursing, All

Barbara Speedling

Innovations for Quality Living

Bspeedling@aol.com 917.754.6282 www.barbaraspeedling.com



Creating Meaningful, Satisfying Lives One Person at a Time