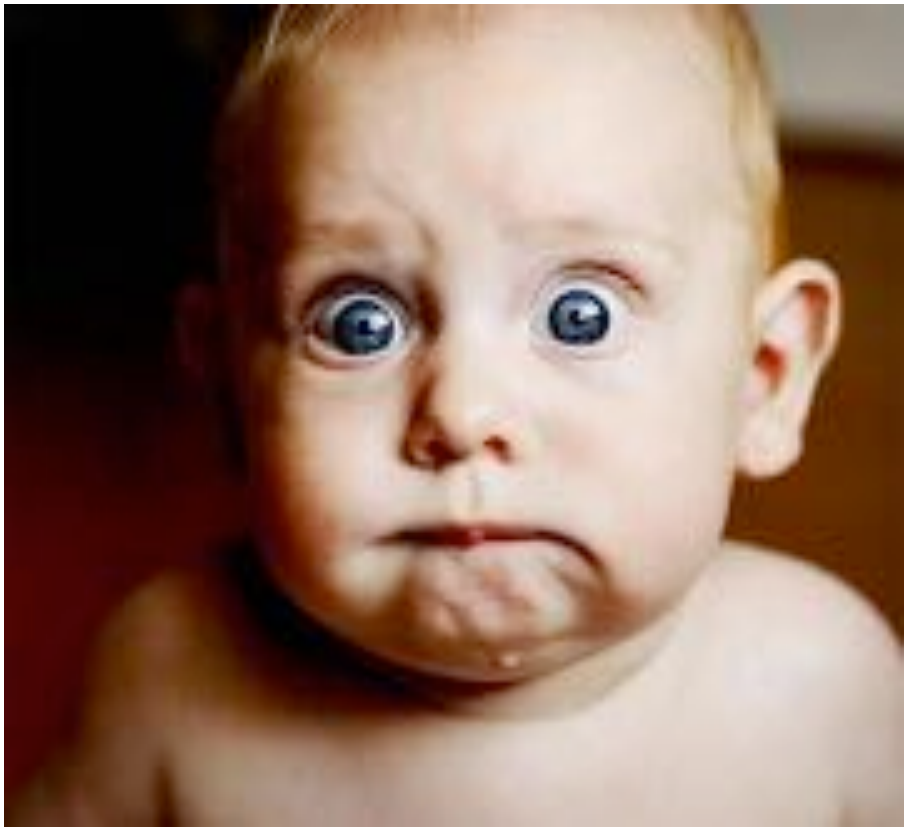
MDS 3.0 Care Plans

Cassie Crafton RN, CDP, RAC-CT

Objectives

- Review regulation requirements regarding Person-centered Care Plans
- Utilize resources in completing Person-centered Care Plans
- Review audit tools to assist in monitoring and evaluating Care plans

Person-Centered Care Plans



Person-Centered Care Planning

- Person-Centered Planning is a way for diverse people, who share a common need to align….
  - Their vision, purposes, and goals
  - Their understanding of the focus person's past, present and future life
  - Their actions for change, mutual support, personal and team development, and learning

Baseline Care Plan

- The requirements:
  - The facility is responsible for addressing the resident's needs from the moment of admission
  - Baseline care plan is developed within 48 hours of admission (including weekends and holidays)

Baseline Care Plan

- Includes the minimum healthcare information necessary to care for the resident, including but not limited to :
    - Initial goals
    - Physician orders
    - Dietary orders
    - Therapy services
    - Social services
    - PASARR recommendation, if applicable
    - Immediate health and safety needs
    - Instructions needed to provide effective and person-centered care that meets professional standards of quality care

Baseline Care Plan

- The requirements:
  - Baseline Care Plan was revised and updated to meet resident's needs until comprehensive care plan was developed
  - If an injury or adverse event occurred prior to the development of comprehensive care plan the baseline care plan identified the risk for the injury or event

Baseline Care Plan

- A written baseline care plan summary was delivered to the resident that includes:
  - Initial goals
  - Summary of medications
  - Dietary instructions
  - List of treatments to be administered
  - Any updated information, based upon details form the admission comprehensive assessment

Baseline Care Plan

- The written baseline care plan summary was in a language that the resident and/or representative could understand
- If noteworthy change occurred after baseline care plan summary was given, but prior to completion of comprehensive care plan, the baseline care plan summary was updated with the changes and given to the resident

Comprehensive Care Plan

- The requirements:
  - The care plan is developed within 7 days after completion of comprehensive assessment
  - Evidence exists that the care plan was developed by IDT
    - Provider involvement (MD, APN)
    - RN responsible
    - CNAs and LPNs (floor staff)
    - Dietary
    - Other IDT (Social Services, Activities, Therapy)
    - Resident and/or Representative

Comprehensive Care Plan

- Reviewed and revised after each comprehensive and quarterly assessment
- Triggered Care Area Assessments (CAAs) are addressed in care plan if decision is made to proceed to care plan
- If resident refuses services or treatment, evidence exists that risks were reviewed and alternative offered

Comprehensive Care Plan

- Does the care plan include the resident's needs, strengths, goals, life history, and preferences?
- Each problem, need, and/or strength has a measurable goal that is consistent with resident's or representative's choices and preferences
- Each goal has a determined target date for achievement

Comprehensive Care Plan

- The interventions or approaches are specific in helping resident achieve goal
- Care plan needs to stay current to assist in knowing resident's status
- Evidence exists that resident and/or representative are aware of care plan and goals
- Notes reflect resident's desire to participate in care planning

Person-Centered Care Plan

- Exactly as it sounds
- Resident is in control
  - Their wants, desires, strengths, and goals
- No more can care plans
- Individualize each care plan to reflect the resident and their assessment
  - Approaches should be unique to their problems and identified strengths or goals
- Knowing your residents beyond the usual

Resources

- The Well Being Model for Dementia Care
  - IPAGE (Getting to know your resident)
  - Domains of Well Being
- National Nursing Home Quality Improvement Campaign- Person-Centered Care
  - https://www.nhqualitycampaign.org/goalDetail.aspx?g=pcc
- AHRQ- Resident and Family Engagement

You Are the Expert!