Exceptional Care Planning DOH Presentation

Project Funded by

The New York State Health Foundation

Project Managed by

The Foundation for Long Term Care

Project Period: January 1, 2012 –June 30, 2013 (grant extended!)

Introductions

Your presenters are:

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LeadingAge NY ProCare Consultant

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FLTC Project Manager

ECP Demonstration Project

- **Success in the original grant was the basis for new grant, *Replicating Exceptional Care Planning in New York State Nursing Homes***
  - **FLTC's ECP demonstration project aimed to replicate the project initiated by the Bureau of Quality Assurance and the Wisconsin Board on Aging and Long Term Care (more on ECP origins later) and evaluate it more rigorously.**
  - **The FLTC was able to conduct research and spread the word about ECP with funding from the New York State Health Foundation (2008-2010).**

ECP Demonstration Project continued

- **This project was conducted at nine diverse New York State not-for-profit and governmental nursing homes:**

Coler-Goldwater Specialty Hospital and Nursing Facility, Fred & Harriet Taylor Health Center, Isabella Geriatric Center, Menorah Home for Rehabilitation and Nursing Care, Otsego Manor, Robinson Terrace, Saratoga County Maplewood Manor, Teresian House, Center for the Elderly, Unity Living Center

ECP Demonstration Project Results

- **ECP significantly reduced nurses' time spent in documenting care plans as much as half- 50 percent!**
- **Freed up time was spent with "people, not paper."**
- **Qualitative findings include improvement in communication between staff and family members, within the interdisciplinary team, and with aides.**
- **Shorter, clearer care plans were less intimidating for families to provide input.**
- **Interdisciplinary teams helped identify overlap in care and helped see all facets of a person.**

ECP Demonstration Project Results continued

- **Analysis of monthly floor event reports showed that the intervention was associated with positive trends in reducing falls and hospitalizations.**

- **All the participating facilities indicated that staff enjoyed participating in, creating and using the Standards of Care and are very positive about the ECP process.**

ECP 2012: Replicating Exceptional Care Planning in NYS Nursing Homes

- **Success of demonstration project led to additional funding by the NYSHF to disseminate ECP to new eldercare organizations. ECP goes hand in-hand with the personalized approach of MDS 3.0.**
- **Four free regional trainings were held this spring across NYS: Rochester, Capital Region, Queens, Westchester. 168 professionals representing 81 nursing homes attended.**
- **Attendees now have the opportunity to officially join the replication project by beginning the ECP implementation process in the summer and fall 2012. They receive continued support through monthly conference calls facilitated by Nurse Educator, Ann Marie Bradley, with ProCare Consultant, Barb Bates.**

History of ECP

What is it?

- **A guideline for efficient and effective clinical record documentation and care planning.**

Who developed this initiative?

- **The Bureau of Quality Assurance and The Wisconsin Board on Aging and Long Term Care.**

Why was it developed?

- **Out of concern that clinical records in nursing facilities were crowded with unnecessary, duplicative documentation that makes personal care information hard to find and takes too much time to complete.**

The Outcome

- **Resident Centered Care Plans**

Working with Department of Health
(Advice Given to ECP Implementation Sites)

- **The Department of Health (DOH) has supported this project from the beginning.**
- **Since DOH does not mandate a specific care plan format, you do not need prior approval to implement ECP.**
- **Your facility should notify DOH surveyors of your care planning format when they arrive for survey.**
- **Standards of Care should be on-hand for surveyors to review**

and most importantly…

Standards of Care (SOC)

Staff must know the

Standards of Care,

know where they are found,

how to implement them correctly and follow them.

Focus of ECP

Documentation that serves a useful purpose

- **Eliminates duplicate documentation**
- **Utilizes current research and resources**
- **Focus on quality (not quantity) of content**
- **Documentation to support clinical care (not perceived surveyor needs)**
- **Use of MDS language and definitions, improving consistency in the medical record**

Care Plan Myth?

CMS states you must use a specific format.

- **No specific care plan format or structure is mandated.**
- **Format should be efficient and user-friendly.**

Care Plan Myth?

Care Area Triggers all need to be addressed on the care plan.

- **Staff may decide that a triggered condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan. CAA analysis and documentation supports this decision-making.**
- **Conversely, staff may decide that items not triggered do affect the resident's functioning or well-being and therefore should be addressed on the care plan.**

Care Plan Myths?

All goals need to be reached in three months.

- **Time frames will vary**
- **Range from few days to weeks to months to ongoing**
- **The more specific and measurable the goal is, the more likely success will occur.**
- **Be realistic!**

Care Plan Myths

Every detail of care given to the resident must be written on the care plan.

- **Standards of practice are acceptable**
- **Standard interventions (routine care approaches) on the care plan create unnecessary length and defeat the purpose of an individualized care plan**

Care Plan Myth?

All potential problems must be on the care plan.

- **There is no requirement for all potential problems to be addressed on the care plan.**
- **CAA process requires us to ask the resident/family their thoughts on the problem/issue.**
- **Ask yourself, *If we do nothing additional, and the resident continues on his/her current path, is there likely to be a decline in the resident's quality of life?***

Care Plan Myths?

All documentation that supports the care plan must be in one location.

- **The care plan details can consist of multiple documents in several different locations or formats that is workable for all staff who need to use the care plan**
- **The outcome of care is the most important factor, not the format**
- **Explain the care plan format to all users, including surveyors**

Care Plan Myth?

A Specific Care Plan intervention is still needed if other components of the care plan address related risks adequately.

Ex. Risk of nutritional compromise for resident with Diabetes Mellitus might be addressed in part of the plan that deals with nutritional management.

No need to repeat the same information multiple times in the plan. Cross reference where to find.

Care Plan Myth?

If the Care Plan refers to a specific facility treatment protocol, these protocols need to be available for the direct care staff.

As per the Operational Manual – Staff must be familiar with the protocols and used.

Any deviation from the standard is specified in the care plan.

This is very similar to what ECP does.

Exceptional Care Planning

Steps to Success

Step 1-- how to get “buy-in” for making a change

Access your facility’s current care plan system.

	Yes	No
Are the care plans lengthy?	x	
Are Care plans repetitive from one resident’s plan to another?	x	

Step Two of Buy-In

Determine ways to demonstrate support for buy in:

EXAMPLES

- **Audit time spent by each discipline in completing care plans or length of care plan meetings.**
- **Audit number of incidents of care plans not being followed related to missing or unseen information.**
- **Audit the amount of repetitive or duplicative documentation related to care plans.**
- **Audit staff use of care plans.**

Step Three

- **Establish an Interdisciplinary Team to develop facility Standards of Care based on current, accepted clinical guidelines.**
- **Design an implementation plan.**
- **Develop a care model that establishes the standards as the building blocks to the resident centered care planning process.**
- **Review all of your facility's current policies within the context of new facility SOC.**

ECP Training Excerpt

Only professional level staff should be involved in developing standards of care.

Answer: FALSE

Nurse Aides involvement assists the SOC development process by:

- **Accepting buy in to the ECP process from the very beginning**
- **Assist in developing user friendly SOC**
- **Provide feedback on SOC**

Step Four

- **Review regulations, both federal and state, with respect to care plan requirements.**
- **Ensure the interdisciplinary team understands what must be included in the care plan process.**
- **Establish how compliance will be achieved.**

Step Five

- **Establish policies and procedures followed by development of facility Standards of Care.**
- **Utilize published guidelines (i.e., AMDA, AANAC, ANA, GNA, Hartford Foundation for Geriatric Nursing, RAI manual, etc.) as references for the standards.**
- **Review/revise all corresponding policies/procedures related to each standard.**
- **Interdisciplinary Team may consider linking the Standards of Care to the Care Area Assessments (CAAs).**

ECP Training Excerpt

A policy and/or procedure is needed to document how the SOC are integrated into the care plan.

Answer: TRUE

Policy should document the following:

- How SOC, Facility P & P, and Care Plans are integrated
- Who and how developed
- What references are used
- How reviewed and frequency
- Staff education and accountability
- How compliance monitored

Sunny Acres N.H. Standards of Care Policy and Procedure

(Based on Fred & Harriett Taylor Health Center and Amsterdam Memorial P & P)

Policy: It is the policy of Sunny Acres N.H. to develop resident centered individualized care plans focused on quality of life, maintaining each resident's dignity, and confidentiality. Specific standards of care (SOC) will be followed on all residents and incorporated into the interdisciplinary care plans. The SOC are based on current research, Care Area Assessments (CAAS) guidelines, and Federal/State regulations. Facility policies and procedures will be integrated into the SOC and the comprehensive care planning process.

It is the facility's policy that our residents will be provided with the necessary care and services to attain or maintain the highest practicable, physical, mental, and psychosocial well being in accordance with the comprehensive assessment and the plan of care.

Before and After Exceptional Care Planning Examples

Before Care Plan– Skin Integrity

Problem	Goal	Approaches
Resident is at risk for skin break down due to history of pressure ulcer on coccyx, recent weight loss , recent decline in mobility, and incontinence of bladder. Strengths: Resident is cooperative with care and is cognitively intact. Family very supportive.	Resident's skin integrity will remain intact as evidenced by no pressure ulcer development through next review period.	1. Monitor skin each shift 2. Report changes in skin immediately to charge nurse 3. Use pressure relieving devices 4. Apply A & D ointment after each episode of incontinence 5. Reposition resident with lift sheet 6. Encourage resident to turn self as able 7. Monitor resident for incontinence and change at least every 2 hours 8. Encourage meal completion 9. Encourage fluids 10. Encourage between meal nourishments 11. Monitor weight monthly

Skin Integrity /Pressure Ulcer Prevention
Standard of Care

Every Resident's skin will be assessed for potential problems, appropriate treatments provided, and pressure-relieving equipment utilized to promote healing and to prevent skin breakdown.

1. **Skin will be observed daily during care routines. Any changes will be reported to the charge nurse.**
2. **Pressure reduction will be achieved by using pressure reduction mattress, cushions, and pressure point protectors as needed.**
3. **Protective creams/lotions will be applied as needed for dry skin. Apply barrier cream after each incontinent episode.**
4. **Lifting sheets will be used to reposition residents to reduce shearing.**
5. **Use only one large incontinent pad under resident.**

After – Skin Care Plan

Problem	Goal	Approaches
I, James Right am at risk for skin break down due to a past pressure ulcer on my coccyx, a recent weight loss of 20 lbs, a decline in my mobility, and an increase in urinary incontinence. Strength: I like to participate with my care and am very clear in my decision making and surroundings.	My skin integrity will remain intact as evidenced by no pressure ulcer development through next review period	1. Follow Skin Care Standard of Care 2. Roho cushion in wheelchair 3. Low air loss mattress on bed 4. Apply Aloe Vesta lotion to elbows and heels with am and pm care 5. Follow nutrition/hydration standards of care 6. Follow toileting standards 7. Follow mobility standards

“Before “ Nutrition Care Plan

Problem	Goal	Approaches
Resident has poor nutritional status. Is not completing meals, has had recent weight loss, and general decline in overall health condition – labs show elevated BUN, low albumin, and total protein. Strength: Resident has a good family support system	Resident will increase weight by 3-5 pounds in the next 30 days.	1. Assess for physical assistance with eating 2. Serve meal tray promptly 3. Encourage meal completion 4. Encourage between meal nourishments 5. Encourage fluid consumption 6. Monitor weight weekly 7. Obtain food preferences and provide foods of choice 8. Monitor labs 9. Monitor for s/sx of dehydration 10. Provide water at bedside 11. Investigate with MD for appetite stimulant 12. Meals in dining room 13. Encourage family to bring home made foods 14. OT/SLP evaluation

Nutrition/Hydration *Standard of Care*

Every resident shall receive suitable and sufficient hydration, nutrients, and calories to maintain health.

1. **Residents shall be offered balanced meals three times a day with supplements offered as need arises**
2. **Obtain resident preferences for food likes/dislikes, customary times for meals, food preparation, etc.**
3. **Fresh water is provided each shift, as appropriate**
4. **Food and fluids provided at meals will be encouraged and monitored via consumption records.**
5. **Residents will be offered 120 cc of fluids with each medication administration.**
6. **Residents shall be offered snacks and fluids three times per day between meals as appropriate**
7. **Residents will be weighed monthly, with closer monitoring as needed.**
8. **Monitor labs as available**
9. **Meal tray will be served promptly upon arrival to the unit**
10. **Monitor and report S/Sx of dehydration (dry/cracked lips, dry oral mucosa, rapid unplanned weight loss, weakness/lethargy, sudden onset of confusion, elevated temperature and the absence of infection, hard stools/increased constipation, concentrated urine/UTI).**

“ After” Nutrition Care Plan

Problem	Goal	Approaches
I, James Right have difficulty with my nutrition due to not wanting to finish my meals, a recent weight loss of 20 lbs, and a decline in my overall health. My lab work shows an elevated BUN, low albumin, and total protein which places me at high risk for dehydration, skin breakdown and falls Strength: I have a very caring and supportive family	I want to increase my weight by 3-5 pounds in the next 30 days. My BUN, albumin, and total protein lab values will be within acceptable range per my physician in 60 days.	1.See Nutrition /Hydration SOC 2.Obtain weekly weights 3. Encourage my family to eat dinner with me in small dining room and to bring in homemade foods I like. (Nursing, SW, Dietary) 4. I prefer to sit at table 7 in the main dining room for breakfast and lunch meals to socialize with my tablemates (Nursing, Dietary) 5. OT/SLP evaluations to r/o feeding, ADL, swallowing problems. 6. Consider appetite stimulant after discussing with the me and investigating with the MD.

SOC Documentation Format

- **Definition of Standard**
- **Risk Factors**
- **Standard of Care (Interdisciplinary)**
- **CNA Considerations**
- **Reference(s) used to develop standard**

Example SOC from ECP Demonstration Project

Standard of Care: Falls (Based on Isabella)

- **Identify and document for falls risk as needed**
- **Identify current weight-bearing status**
- **Position safely in bed and chair**
- **Maintain clutter-free and safe environment**
- **Ensure adequate lighting and safety**
- **Encourage use of call bell and keep within reach**
- **Educate resident and family about falls risk**
- **Encourage use of recommended mobility and assistive devices**
- **Place resident's personal items in familiar places and within reach**
- **Monitor during group activities**

Example SOC from ECP Demonstration Project

Standard of Care: Falls (Based on Isabella) Continued

- Provide eyeglasses and hearing aids, as indicated
- Ensure that assistive devices are in good working order
- Monitor activities
- Ensure that bed and chairs are locked when in use
- Ensure that resident has appropriate footwear
- Medication review
- Develop and evaluate interventions status post fall
- Network with interdisciplinary team for interventions that ensure individualized care

Step Six

- **Educate all staff on the standards.**
- **Ensure ongoing education is provided for all current staff, on orientation for newly hired staff, when revisions occur to the standards or policies, and PRN.**
- **Attendance records need to be maintained, systems developed to ensure training is ongoing, and decisions as to where records will be stored.**

ECP Training Excerpt

A plan to educate staff on Standards of Care is only needed when new standards are developed.

Answer: FALSE

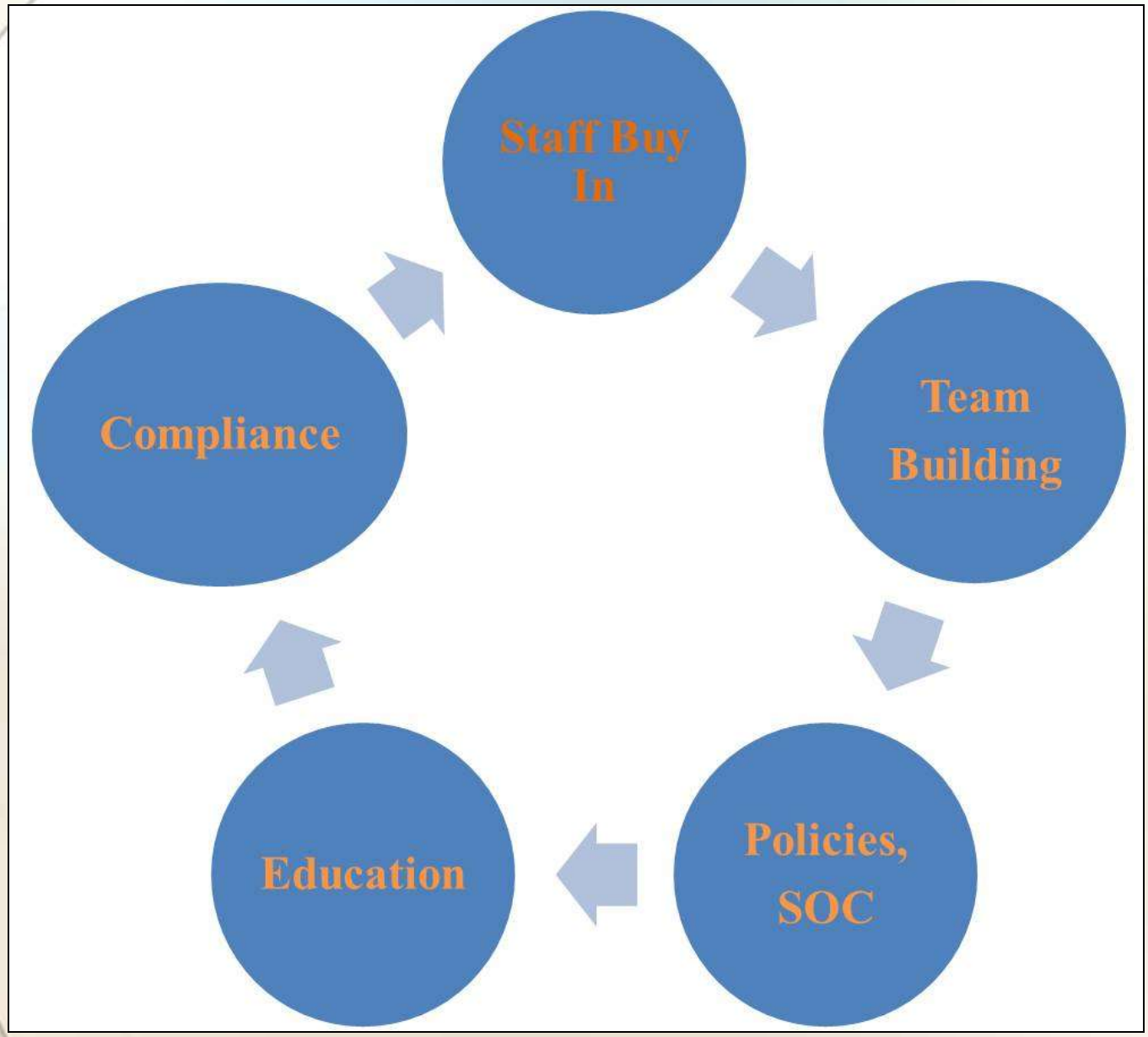
Education plan is needed:

- **On implementation**
- **Each time a standard is revised**
- **For all new hires**
- **When compliance issues are identified**
- **As needed**

Step Seven

- **Audit and Evaluate Outcomes.**
- **Audit compliance of staff with the standards – Are they following?, Using?**
- **Evaluate the effectiveness of the standards in meeting regulatory requirements and are up-to-date.**
- **Evaluate the effectiveness of the standards in delivery of quality of care and life for the residents.**

Best Practices

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