



# CARE PLANNING FOR BASIC CARE

April 29, 2010

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NORTH DAKOTA  
DEPARTMENT *of* HEALTH

# Care Plan Truths or Fallacies

- It only applies to nursing
- It is a waste of time
- It is not necessary because we know our residents so well
- We need one because the regulations say we do
- It applies more to skilled nursing homes.

# RESIDENT ASSESSMENT AND CARE PLAN TAG #'S

- B1210 – Required timeframes for completing assessments
- B1220 – What assessment must include, and who must complete
- B1230 – Care plan development and implementation.
- B1240- Updating of the careplan.

# TEN MOST COMMONLY CITED TAGS (04/01/04 - 03/31/10)

- B1800 – DIETARY SERVICES – 34
- B1240 – RESIDENT CARE PLANS - 30
- B1540 – PHARMACY/MED ADM – 30
- B1220 – RESIDENTASSESSMENT - 26

# MOST COMMONLY CITED CONT.

- B1700 – NURSING SERVICES – 24
- B1230 – RESIDENT CARE PLANS – 20
- B1320 – RESIDENT RECORDS – 20
- B1120 – EDUCATION PROGRAMS – 19
- B1840 – DIETARY SERVICES – 18
- B0924 – GOVERNING BODY – 18
- (B1210 – RES ASSESSMENT – 15)

# 33-03-24.1-12. RESIDENT ASSESSMENTS and CARE PLAN

- B1210 - An assessment is required within 14 days of admission and as determined thereafter, but no less frequently than quarterly.
- B1220 – The assessment must be completed in writing by an appropriately licensed professional, and

# THE ASSESSMENT MUST INCLUDE:

- A review of health, psychosocial, functional, nutritional, and activity status
- Personal care and other needs
- Health needs
- The capability of self-preservation
- Specific social and activity interests
- (Discharge planning)
- Identification of the residents problems, needs and strengths.



# The problem/need/strength list

- Once completed, look at each problem/need and ask:
  - “Will this problem get better?” or
  - “Can we make this problem better?” or
  - “Can we prevent this problem from getting worse?”

If the answer is “yes”, it is time to develop your goal(s) for the resident. Use resident strengths to help set problem related goals.

# When problem is not likely to improve or resolve:

- Ask, “Can we keep this from getting worse, or developing complications?”
- “How might worsening or complications affect the resident’s overall well-being?”

# When deterioration is inevitable:

- Ask “What can we do to provide optimal quality of health, quality of life and personal dignity for this person?”

# Goals should be:

- Designed to show resolution, or improvement, of the problem (or maintaining the resident's current status) within a specified period of time, and
  - Be specific
  - Be measurable
  - Be attainable

## B1230 - A care plan must:

- Be based on the assessment, and input from the resident or responsible person.
- Address identified problems/needs/strengths.
- Be developed within 21 days of admission.
- And consistently implemented in response to the individual resident's problems, needs and strengths.

## B1240 – The care plan must cont.:

- Be updated as needed, but no less than quarterly.
- Must include dates for when problem/need/strengths are added to the care plan, approaches/interventions are added to the care plan, dates problems/needs are resolved, and when changes/revisions are made.

# Interventions/Approaches

- Must reflect steps to enhance the resident's ability to meet his/her objectives/goals.
- Must allow for, and be used to, monitor the resident's progress towards meeting objectives/goals.
- May be physician ordered, facility protocol, or accepted standard of practice/care.
- Must incorporate the resident's strengths, wishes and preferences.

# Care Planning Truths and Facts

- The care plan is individualized.
- The care plan addresses the needs, strengths and preferences identified in the assessment.
- The care plan builds on resident strengths.
- The care plan is oriented toward preventing avoidable decline in functioning or functional levels.
- Goals/objectives have measurable outcomes.



# Truths and Facts continued:

- Any caregiver, regardless of familiarity with the resident, should have all information needed to care for the resident in the resident's plan of care.
- Care planning is never completed until the resident is discharged or deceased.

# WHAT'S BEING CITED??

- Decline in physical and mental condition resulting in need for more/additional care/services.
- Falls (recurring) – without assessment of contributing factors and preventative care planning.

# WHAT'S BEING CITED CONT.

- Incontinence – without assessment of cause/type/reason for incontinence and potential for improved continence, and individualized plan of care to promote increased continence.
- Self-administration of medications – without assessment and ongoing monitoring of safety and capability.

# WHAT'S BEING CITED CONT.

- Behavior (aggression, wandering, elopement, anxiety, etc.) – without assessment of factors contributing to the behavior, associated patterns/trends, and care planning to minimize/improve behavior through use of non-pharmacological approaches/interventions.
- Assessments and care plans not completed within required timeframes.

I Have A Question



If 4 out of 5 people SUFFER from diarrhea.....  
Does that mean that one out of five enjoys it?

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