"Documentation and Compliance" Supportive Documentation for the Comprehensive Care Plan

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What does CMS say?

The 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 as required under 483.25; and

(ii) Any services that would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10(b)(4).

Care Planning, Compliance & Quality Outcomes

- Is the care plan oriented toward preventing avoidable declines?
- How does the care plan manage risk factors?
- Does the care plan build on resident strengths?
- Does the plan reflect standards of current professional practice?
- Are there measurable goals and treatment outcomes?

Care Planning, Compliance & Quality Outcomes

- Is the resident/representative involved? How? Have wishes been honored? Has sufficient information been given so that an informed choice can be made?
- If resident refuses care, treatment, etc., does the plan reflect alternative means to address the problem?
- Is the Interdisciplinary Care Team expertise used to develop the plan?

Care Planning, Compliance & Quality Outcomes

- Are assessment and care planning needs met for new residents prior to MDS completion?
- Are direct-care staff informed and knowledgeable about the care planning goals and interventions? How? What process is used?

Care Planning

1. Identification of problems, needs, interests, strengths, preferences
2. Development of goals:
   a. Goal must deal with or address the "issue" that was identified;
   b. Goal must be resident-directed;
   c. Goal must be an observable action task;
   d. Goal must be measurable and quantifiable.
3. Development of interventions/approaches
   a. Must be individualized
   b. Must be specific; consider them specific "assignments" to a staff person

Easing into Care Plans

Choose an individual from your facility. Now, ask yourself the following three questions:

1. What do I do with and for this resident?
2. Why am I doing these things?
3. What outcome am I hoping to help the resident attain?

Easing into Care Plans

1. Question 1 = Staff interventions
2. Question 2 = Resident risks, issues, concerns or preferences
3. Question 3 = The resident's goal.

Ask yourself this question:

Could I use this same goal and/or interventions on other residents in my care?

If the plan can be applied to the majority of your residents, **THROW IT OUT AND START OVER!**

Outcomes

- What is the resident outcome that you want to occur as a direct result of the care that you have provided?
- Who accomplishes the goal? Resident or staff?

When documenting….

- Begin with the MDS 3.0
- Pay close attention to the codes on each resident.
- Make certain that any "risks," preferences, strengths, problematic areas identified on the MDS are first addressed on the comprehensive care plan.
- Make certain any documentation (progress notes, updates, reviews, etc.) reflects and supports the code that has been designated for a particular item or section.
- Make certain the documentation is interdisciplinary if appropriate or needed.

When documenting….

Next stop is the comprehensive care plan…

- Documentation should indicate the implementation, monitoring, and review of this plan.
- Progress notes, reviews, updates, etc. should address specific issues noted on the care plan.
- Progress notes, reviews, updates, etc. should indicate that specific interventions identified on the care plan have been carried out, or if not, why?
- Progress notes, reviews, updates, etc. should indicate the resident's response to identified interventions.

When documenting….

Next stop is the comprehensive care plan…

- Progress notes, reviews, updates should indicate who actually carried out the intervention.
- Progress notes, reviews, updates should indicate "follow-up" and "monitoring"
  - ✓ Why?
  - ✓ What?
  - ✓ How?
  - ✓ When?
  - ✓ By Whom?
  - ✓ Require any action?

When documenting….

Next stop is the comprehensive care plan…
Progress notes/documentation should reflect behavioral issues:

- Thorough investigation
- Tracking document
- Implementation of interventions
- Resident outcomes
- Education of staff

When documenting….

Next stop is the comprehensive care plan…
Progress notes/documentation should reflect mood state issues:

- Staff knowledge of resident's mood score and issues
- Implementation of identified interventions
- Resident outcomes

When documenting….PDPM

- While RUG-IV reduces everything about a patient to a single, typically volume-driven, case-mix group, PDPM focuses on the unique, individualized needs, characteristics, and goals of each patient
- PDPM advances CMS' goal of using standardized assessment items across payment settings, by using items in Section GG of the MDS as the basis for patient functional

Surveyor Instructions - General

- Review the care plan to identify whether the facility used the RAI to make sound care planning decisions.
- Determine whether the facility identified resident strengths, needs, and problems which needed to be addressed to assist the resident to maintain or improve his/her current functional status.
- Determine whether the facility identified resident-centered, measurable goals and specific interventions to achieve those goals.

Surveyor Instructions - General

- With observations, interviews, and record review, determine if the facility implemented the interventions defined; and
- Determine whether the facility documentation and resident status as observed indicate the decision to proceed or not to proceed to care planning was appropriate.
- This information will assist in determining whether a resident's decline or failure to improve was avoidable or unavoidable.

General Investigative Protocol Components

Care Plan Revision:

- Determine whether staff have monitored the resident's condition and effectiveness of the care plan interventions and revised the care plan with input by the resident and/or the representative to the extent possible, or justified the continuation of the existing plan based upon the following:

General Investigative Protocol Components

Care Plan Revision:

- ✓ Achieving the desired outcome;
- ✓ Resident failure or inability to comply with or participate in a program to attain or maintain the highest practicable level of well-being; and/or
- ✓ Change in resident condition, ability to make decisions, cognition, medications, behavioral symptoms or visual problems.

Surveyor Instructions

- If the care plan refers to a specific facility care protocol, determine whether interventions are consistent with that protocol.
- If a resident's care plan deviates from the protocol, determine through staff interview or record review the reason for the deviation.

Surveyor Instructions

- The surveyor will determine if the facility's comprehensive care plan for the resident included measurable objectives, time frames, and specific interventions/services to meet the resident's needs, consistent with the resident's specific conditions, risks, needs, goals, and preferences and current standards of practice.

Care Plan Revision Surveyor Instructions

- Determine if the staff have been monitoring the resident's response to interventions and have evaluated and revised the care plan based on the resident's response, outcomes, and needs.

Care Plan Revision Surveyor Instructions

Determine if the facility revised the care plan when:

- ✓ Achieving the desired outcome;
- ✓ Resident failure or inability to comply with or participate in a program to attain or maintain the highest practicable level of well-being; and/or
- ✓ Change in resident condition, ability to make decisions, cognition, medications, behavioral symptoms or visual problems.

Progress notes, updates, reviews, daily entries….

1. Carry out the interventions that were identified on the Comprehensive Care Plan.
2. Note the resident's response to each intervention. If evidence cannot be found to support that the plan was actually implemented, it appears to surveyors that the plan was not implemented.

Progress notes, updates, reviews, daily entries….

3. Update information regarding identified problems/needs/strengths/preferences and goals:
   - If the problem/need has been resolved or met, and the goals have been attained, state as such.
   - If the problem/need has not been resolved and you would like to continue the present goal and "plan of action," state as such. Reminder: before you can continue a goal for another time period, your progress note must indicate evidence of some progress towards the attainment of the goal, or resolution of the problem/need. Surveyors wonder why plans are continued when no progress has been noted.

Progress notes, updates, reviews, daily entries….

3. Update information regarding identified problems/needs and goals:
   - If the problem has not been resolved, or the need not met, and the goal is not feasible, state this and develop a new plan of action.
   - If there is a new problem or need, identify those issues. Develop an appropriate plan of action to be incorporated into the Comprehensive Care Plan.

Progress notes, updates, reviews, daily entries….

4. Comment on problems/needs as they arise and note the outcome or resolution.
5. Note the frequency and level of resident's involvement in community life.
6. Note the frequency of family contact, visits, and community visitors.
7. Note referrals and follow-ups.
8. Note resident's mental, physical, emotional, and psychosocial well-being during the past time period that you are reflecting in the progress note.
9. Pay special attention to cognition deficits, behavioral symptoms and symptoms of depression.

Progress notes, updates, reviews, daily entries….

10. Document deliverance of services or care. While it is virtually impossible to document every little service that you provide to each individual resident, it is important to document the services that reflect implementation of the care plan.
11. Note any changes in the resident's condition (improvement or decline/deterioration) and hospital stays.

The Total Team Concept for Documentation

Ask yourself these questions:

- Do I know what is required to meet the intensity level?
- Have I supported services in my notes?
- Are all relevant disciplines consistent in their documentation, or is there contradiction?

Teamwork

Physician

- The physician is seen by the resident and family as having the most medical authority/knowledge.
- Physician comments in progress notes are relied upon by expert reviewers to verify whether the physician was aware of the comprehensive care plan or whether other practitioners were aware of the physician's diagnoses and plan.

Teamwork

Nurses

- Nurses keep the team focused and usually provide the majority of the care noted in the medical record.
- The words that the nurse chooses to formulate the content of an entry, and the items she/he chooses to add to the record will often decide whether the record can be defended.
- The most important consideration for a nurse is to determine why she/he is making the entry.

Teamwork

Some questions to ask:

1. Is the information for other caregivers for continuity of care? Continuation of care notes should be specific so the next professional/caregiver can take the information and decide on the next action.
2. Does it call for you to take action? If the notation requires another step or action, note the next step.
3. Does it require others to take action? If the notation requires others to take action, outline the need for interventions and follow-up with a specific caregiver.
4. Is it a special focus entry? (Reporting a fall or an elopement.)

Teamwork

Dietary
The Registered Dietitian may complete a nutritional assessment on a new resident and calculate the resident's needs – 2,000 calories per day and 1,900 cc of fluid. While this may be an appropriate calculation, what is reality?
Dietary notes should recommend:

- the level of calories and fluid needed by the resident
- state what obstacles, if any, might be encountered in meeting these levels, and
- what efforts will be required of caregivers to reach the goals.

Teamwork

Social Services
Social service staff are usually the first contact with residents and families. Examples of support for other disciplines in regard to resident issues:

- Symptoms of depression/mood state
- Behavior
- Psychosocial well-being
- Cognitive status
- Family concerns
- Complaints/grievances
- Room transfers
- Dietary restrictions/concerns

Teamwork

Activities/Recreation
Although it is often thought that the activity/recreation department simply provides entertainment and diversional activities; these disciplines can contribute significantly to resident issues involving, but not limited to:

- Malnutrition (encouragement of refreshments at specific activities)
- Dietary restrictions/concerns
- Dehydration (encouragement of liquids at specific activities)
- Constipation (involvement in exercise)
- Behavior
- Symptoms of depression
- Psychosocial well-being
- Cognitive status

Teamwork

Certified Nursing Assistants
CNAs are often described as the "eyes and ears" of nurses. The CNA notices subtle changes in the resident. The CNA can:

- report to nurses when they notice changes in appetite, elimination, sleeping and communication.
- report resident and family comments/questions that need to be addressed by other team members.
- offer information that can assist in providing the best care approach for documented interventions.

Teamwork

Physical Therapist
The PT's detailed assessment of the resident's functional abilities and limitations make her/him a valuable team member. The clinician should review:

- both abilities and limitations so that documentation can support independent functioning.
- PT notes for inconsistencies between them and other discipline notes. PT should notify nursing of any change in resident condition as soon as that change occurs.
- Comments such as "needs to be supervised" or "needs to be monitored" should not be put in general notes if there has been a change in the resident's abilities. The care plan team should be alerted.
- If consideration is not given to the notes of others so that follow up and supporting documentation can take place, it may be hard to explain an event at a later date.

Teamwork

Physical therapy notes should include:

- the number of times the resident went to therapy;
- how well the resident understood and can recall what was learned;
- conversations with family members and the resident (especially in regard to expectations);
- if a resident is uncooperative, is impulsive, lacks safety awareness and how this is being addressed, along with staff teaching efforts.

Teamwork

Occupational Therapist

The OT works closely on aspects of activities of daily living (ADLs) and in collaboration with nursing assessments. It is very important to capture how receptive the resident is to care approaches and to established goals.

Speech Therapist

The ST's notes should reflect:

- swallowing protocols, but also success or lack of success the staff has in carrying out such techniques;
- discussions with family members
- collective goals and reassessments to ensure continuity of care (dietary should also address this);
- the reality of what the resident can actually do (i.e., the resident may swallow functionally during the bedside evaluation and coaching, but can he/she do so during day-to-day meal services?)

Final Thoughts…

- What is the resident outcome that you want to happen as a direct result of the care that you provide?
- Does your team's documentation reflect their actions and the outcome?

Final Thoughts…

Your documentation is the only source for the surveyor to actually see the development of an area of care/service delivery, your response to it, and the resident's outcome. What does *your* documentation say?

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