MDS Care Plans

A Person-Centered, Interdisciplinary Approach to Care

Second Edition

Debbie Ohl, RN, NHA, M. Msc, PhD

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Downloadable Contents

Visit *www.hcpro.com/downloads/12703* to access more worksheets. Here's a list of what's included:

Bonus downloadable worksheets: Care area assessment worksheets from CMS, updated October 2018 with the latest RAI updates, addressing 20 care areas:

1. Delirium

2. Cognitive loss/dementia

3. Visual function

4. Communication

5. Activities of daily living

6. Urinary incontinence and indwelling catheter

7. Psychosocial well-being

8. Mood state

9. Behavioral symptoms

10. Activities

11. Fall(s)

12. Nutritional status

13. Feeding tube(s)

14. Dehydration/fluid maintenance

15. Dental care

16. Pressure injury

17. Psychotropic medication use

18. Physical restraints

19. Pain

20. Return to community referral

About the Author

Debbie Ohl, RN, NHA, M.Msc., PhD

Debbie Ohl, RN, NHA, M.Msc., PhD, is a successful consultant and author of more than 35 years. She is owner and senior consultant at Ohl and Associates, a consulting practice dedicated to promoting quality outcomes and professional excellence in nursing facilities. Ohl is a registered nurse, nursing home administrator, skilled geriatric clinician, nursing home consultant, educator, and author; she is an expert in nursing facility regulatory guidelines and clinical practice, specifically assessment and care planning.

About the Reviewer

Rosanna L. Benbow, RN, CCM, CIC, DNS-CT, RAC-CT

Rosanna L. Benbow, RN, CCM, CIC, DNS-CT, RAC-CT, offers MDS consultation and a variety of other consulting for post-acute care clients. Services for interim MDS and PRN MDS nurses are also available through Leading Transitions.

Benbow has over 22 years of experience in the long-term care industry, where she began as a certified nursing assistant. She has extensive experience in clinical reimbursement in roles such as director of nursing, MDS coordinator, case-mix auditor, clinical IT specialist, and MDS/reimbursement consultant. While focusing on MDS and case management, Benbow has been highly involved in accountable care organiztion partnerships, policy development, Interact 3.0 implementation, and QAPI program development.

Benbow is involved in several committees with AANAC and is also a Certified InterACT Champion. She was a presenter at the 2014, 2015, and 2018 AANAC conferences speaking on managed care. She also does routine presentations for LeadingAge Indiana and Hoosier Owners and Providers for the Elderly.

Foreword

This book is intended to simplify care plans for real-world use.

The government-designed Resident Assessment Instrument (RAI), consisting of the Minimum Data Set (MDS) and care area assessments (CAA), are critical tools used for care planning. The care plan is intended to reflect resident needs and wants, along with actions and timelines to address them. Care plans are intended to be used by caregivers to promote continuity of care and better outcomes. Unfortunately, most care plans are paper-compliant documents for surveyor use. They are not designed for routine use by caregivers.

The RAI not only drives care planning, but it also determines reimbursement rates, and generates quality measures used by regulators and multiple sources to assess facility status and outcomes.

The concept of a multifunctional, one-size-fits-all document sounds good. In a computerized environment, its utility for care plans has had unintended consequences. Computerized care plans capture data from the MDS and generate a care plan. A typical plan lacks individuality and is often 20 to 40 pages long. Day-to-day use is impossible. The quality of the reviews are compromised by the volume of the care plans and the number of reviews scheduled.

The regulatory and reimbursement pressure for timely completion and submission of the MDS tends to fall to a few people. The primary goal of the process is to gather and enter the data for transmission. The care plans that are generated have little to no utility for everyday use.

When there is work to be done on the unit, it's hard to access a care plan that reads like a novel. Most of the staff has a good general knowledge of who the resident is and what needs to be done for them. The intention of the care plan is to deliver resident-specific information that facilitates a hands-on, best-practice approach to maintaining and improving functional status, medical conditions, and quality of life for the individual. General knowledge ensures the basic needs are tended to and functional tasks completed. On the other hand, specific knowledge creates the best outcomes for quality of care and quality of life.

Plans need to be clear, effective, and used. The formats in this manual are a stepping stone to transitioning care plans to workable tools.

The user assumes full responsibility for use of this manual. You are cautioned to stay abreast of regulatory changes and challenged to improve upon the ideas and content from your own experience.

Section 1:

Care Area Assessments: Culture Change for Process and Outcome Improvement

Transforming Our Mindset

The RAI Clinical Assessment Process

The Resident Assessment Instrument (RAI) is an amazing tool. First and foremost, it enables clinicians to look at and evaluate the functional status of a person physically, mentally, and psychosocially. The RAI uses three specific mechanisms: the Minimum Data Set (MDS), care area triggers (CAT), and care area assessments (CAA). These tools facilitate the critical thinking necessary to develop a plan that preserves the integrity and uniqueness of the individual, while addressing the challenges that confront them.

The MDS is a multipurpose tool. It captures the big picture. It underpins the clinical assessment process. It serves as a benchmark, reflecting the resident's overall functional stability, improvement, or decline over time. It lays the foundation for survey activities. It acts as a reimbursement tool. It converts data into quality indicators used by surveyors, consumers, and long-term care facilities and community living centers.

The MDS is designed to recognize patterns through a combination of item responses. These patterns of response point to specific areas referred to as CATs. These triggers demand a thorough review of the targeted care area. There are 20 areas that fall into the triggered categories or CATs. The specified care areas are known as the CAAs. Facilities have been instructed by the Centers for Medicare & Medicaid Services (CMS) to complete CAAs by identifying and using current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and other resources. This directive leaves the onus on the facility to decide what tools and resources to use.

The RAI User's Manual, Appendix C, Care Area Resources, offers assessment tools for each of the 20 care areas. It is important to note that the resources provided in the appendix, as stated by CMS, "[A]re provided solely as a courtesy for use by nursing homes, should they choose to, in completing the RAI CAA process. It is also important to reiterate that CMS does not mandate, nor does it endorse, the use of any particular resource(s), including those provided in this appendix."

CMS offers an additional disclaimer: "The list of resources in this appendix is neither prescriptive nor all-inclusive. References to non-U.S. Department of Health and Human Services (HHS) sources or

sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or HHS. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication."

The bottom line

It is the nursing facility's responsibility to determine what resources it uses and how it chooses to use them. It is important to use assessment tools that allow for CAAs in a comprehensive, usable, and thought-provoking format that helps with the decision-making process. The final section of this manual contains specific CAA guidelines for each of the 20 CAAs and is presented in a format designed to facilitate clinically appropriate decision-making.

Culture Change

Government edicts and industry response have created change bit by bit. If we look at where we began and where we have come to, the progress is remarkable, and the culture changes are significant. Our industry roots began in the mid-1900s by literally warehousing people and putting little more than a roof over their heads—no standards, no requirements, and little expectation for anything else. For all intents and purposes, nursing homes have gone from providing food and shelter, to meeting basic physiological needs, to providing for medication and physical care needs, to delivering care and services that make life a little better for those in our charge. Nursing homes have moved from treating the occupants as a group of people first referred to as indigent, then as patients, then as residents, then more recently, as individuals, and finally as persons (as in unique human beings with their own story). If this isn't culture change, then what is?

Transformation

Transforming what we do and how we do it is the essence of culture change. Transformation has been occurring for decades. Culture change is simply the politically correct, cutting-edge buzz word that depicts this process. Nursing home culture is a result of an evolutionary process driven by regulatory demands, consumer desires, ever-advancing technology, and new knowledge. It is an ongoing process, not an end result.

Nursing facilities have continually been changing, though the progression has been slow. In terms of the RAI process, we initiated the transition using outdated systems and practices. Although the nature of the assessment process changed, our thoughts and behaviors surrounding the activity lagged behind. We have been reactive to the change, looking for short cuts, trying to spread the increased workload around, getting irritated with one another when we didn't match up items on the MDS, and so on. Our attention was focused on the task. In most ways, our attention is still focused on the task. The RAI is not a task; it's a process (just like culture change). The trouble is that the number and degree of tasks it requires to get the job done creates a start/stop action, rather than a continuous flow.

We have shifted from the MDS 2.0 RAI paradigm, where we had 15+ years to be accustomed to more in-depth and individualized assessment and care planning to the next phase of culture change, the MDS 3.0 RAI. The substantive shift requires increased resident voice and involvement, and critical thinking in triggered care areas, exploring the resident's connection to his or her desires and

Completing the CAAs uses a combination of data obtained from Appendix C in the *RAI User's Manual*, a review of various Omnibus Budget Reconciliation Act requirements, as well as a review of expert resources in a format to promote critical thinking and good decision-making. Ultimately, the facility must make the decisions and take the responsibility for what tools it uses and how it will use them.

Figure 3.1

CAA Resources

RAI	Expert Resources	Facility Guidelines	Care Plan

• MDS 3.0 tools
 	
  BIMS
 	
  PHQ-9©
 	
• Chapter 4
 	
  Process steps 4–9
 	
  POC focus   4–12, 20
 	
  CAAs   4–17
 	
• Appendix C
 	
  CAA resources
	• CPGs
	
	• EBPs
	
	• SOP
	
	• Decision trees
	
	• Care paths
	
	• Journals, etc.
	
	• QMs
	
	• ROPs
	
	• This manual
		• Policy: A general plan to guide decisions
		
		• Procedure and protocols: Fixed, step-by-step sequence of activities or course of action
			• Baseline
			
			• Review and revisions
			
			• SMART goals
			
			• Timelines
			
			• Resident preferences

Terms

BIMS: Brief inventory of mental status

PHQ-9©:   Patient Health Questionnaire

CPG: Clinical practice guideline

EBP: Evidence-based practices

SOP: Standard of practice

ROP: Rules of participation

QM: Quality measures

SMART: Specific, measurable, attainable, realistic, timed

CAA process steps

1. Identify relevant triggers. What is the relationship of these triggers? Are they related and why? Assess; do not assume.

2. Identify the type of trigger: potential problem, broad screen, prevention of problem, or rehabilitation potential.

3. Identify the possible causes, contributing factors, risks, conditions, and strengths the resident may draw upon. Think holistically.

4. Correlate the relationships of the CAAs to one another. Is one the cause and another the outcome? Is it a stand-alone issue? Considering these factors will more clearly focus your care plan.

5. Analyze and draw conclusions. Think critically! What are the cause-and-effect relationships? Can they be changed or eliminated? How can they best be addressed? Think in terms of if/then.

6. Validate rationale for decisions in the resident record.

7. Develop a personalized, resident-specific, person-centered care plan based directly on conclusions, including insight of interdisciplinary team (IDT) members, the resident, and significant others.

CAAs are an opportunity to problem solve rather than problem manage.

Analyzing the information, thinking critically about what it means, and determining cause-and-effect relationships are the essence of the process. Reviewing a resident critically is always a team effort and responsibility. Different viewpoints and perspectives ensure the best possible plan.

Critical review

- Sorting out conflicting claims

- Weighing the evidence for the claims

- Letting go of personal biases

- Arriving at reasonable views

- Being willing to change views

How the CAA Process Is Designed to Work

Self-completion of the MDS 3.0

Although completing an MDS on yourself may not have the same complexities of using an actual resident, doing so helps you to become more familiar with the document and allows you to more clearly see the relationships and correlations from one section to the next. It also provides a different

perspective and reveals nuances within the MDS that can facilitate correct action. Once completed, you may or may not trigger CATs. (Though that is unlikely; or is it?)

MDS Findings

Section B:	Hearing/Speech/Vision	No concerns
Section C:	Cognitive Pattern	BIMS score: 15 (cognitively intact)
Section D:	Mood	PHQ-9© score: 9 (must be 10 to trigger)
Section E:	Behavior Symptoms	None
Section F:	Activities	Daily preference indicate autonomy is very important Activity preference indicate somewhat important
Section G:	Functional Status	Fully independent
Section GG:	Functional Abilities and Goals	None
Section H:	Bladder/Bowel	Continent
Section I:	Active Disease	None (history of attention deficit/hyperactivity disorder [ADHD]/episode of past depression)
Section J:	Health Conditions	Occasional mild pain; rate scale: 2
Section K:	Nutrition	No concerns, weight within ideal body weight
Section L:	Oral/Dental	No concerns
Section M:	Skin	No concerns
Section N:	Medications	Antianxiety, antidepressant, hypnotic use
Section O:	Special Treatments	None
Section P:	Restraints	None
Section Q:	Participation	Self-completion

CATs triggered

- Psychotropic drug use
- Mood and well-being did not trigger

The patient scored 9 on the PHQ-9© and the trigger point is 10. Issues are present that indicate a need for further analysis: trouble falling asleep and feeling tired with little energy nearly every day warrant further analysis.

Note: If a clinician believes other issues are present and a CAA is available for further review, it is highly recommended that it be reviewed, even though it did not meet trigger criteria. It is important to remember that the MDS 3.0 is a starting point and that any concerns arising from the assessment should be investigated.

Figure 3.2

Suggested CAA Assignments for IDT

Dietary	Social Service	Activities	Nursing
Dehydration/fluid maintenance* **Feeding tubes*** **Nutritional status***	*Behavior symptoms* *Cognitive loss/dementia* *Mood state* *Psychosocial well-being* **Return to community referral***	**Activities***	**Communication*** **Dental care*** **Catheters*** **Pressure ulcer*** **Pain*** **Vision*** **Falls*** **ADLs** **Delirium** **Incontinence** **Physical restraints** **Psychotropic medication**
Most nutritional assessments already contain CAA-related data. Compare your current assessment to the CAA highlights. There would be no reason to complete a separate CAA if the nutritional assessment contains the facts for analysis.	The use of the BIMs and PHQ-9 from the MDS provide a reasonable baseline for all disciplines to gain consensus.	*The importance of activities and their relationship to a person's quality of life goes without saying.* *The CAA, along with information collected on the MDS, could potentially serve as the professional assessment.* *The benefit is that the CAA is then always reviewed.*	CAAs focal point <u>ADLs</u> will always trigger if the patient experiences anything less than independence. The sooner this CAA is completed, the sooner the tailored plan can be put into place.
<u>Nutrition/hydration CAA focal point</u> • Weight status and history • Current eating pattern • Functional problems impeding ability to eat/drink	<u>Mood CAA focal point</u> • *Psychosocial influencing factors/changes* • Clinical/functional changes affecting self-worth • Presentation of mood disturbance	<u>Activity CAA focal point</u> • Strengths to draw upon physically, mentally, psychosocially • Physical factors to consider: medical, treatment times, psychoactive medication use, functional status,	

Figure 3.4

CAA and Care Plan Focus

Delirium

CAA Focus	Care Plan Focus
• Are there underlying acute health conditions?	• Resolve underlying clinical issues/conditions creating the problem

Cognitive Loss/Dementia

CAA Focus	Care Plan Focus
• Intercept declining or worsening cognitive abilities threatening independence and *increasing the risk for long-term nursing home placement* • Identify any related possible contributing and/or risk factors	• Address underlying clinical issues/conditions such as relieving pain and depression, managing medications, and ensuring optimal sensory input • Promoting as much social and functional independence as possible while maintaining health and safety • Address any underlying clinical issues/conditions

Visual Function

CAA Focus	Care Plan Focus
• Identify treatable conditions • Identify conditions that place the patient at risk of permanent blindness • Determine if quality of life might be improved with the use of appropriate visual appliances • Identify any related possible contributing and/or risk factors	• Develop plan based on conclusions from CAA • Prevent decline when possible • Enhance vision when return of visual acuity is not possible • Address any underlying clinical issues/conditions

Communication

CAA Focus	Care Plan Focus

• Characteristics of the problematic issue/condition
 	
• Success of any attempted remedial actions, the person's ability to compensate with nonverbal strategies
 	
• Willingness and ability of caregivers to ensure effective communication
 	
• Identify any related possible contributing and/or risk factors
	• Address verbal and nonverbal strategies to improving quality of life, health, and safety in the presence of reduced language skills
	
	• Caregivers and the resident must expand their nonverbal communication skills:
	  – Touch
	  – Facial expression
	  – Eye contact
	  – Hand movements
	  – Tone of voice
	  – Posture

Section 2:
MDS Care Plans

Chapter 4

The Evolution of Care Planning

Federal involvement in nursing homes began in 1935. At the time, public poor houses cared for the majority of older people when they had nowhere else to go. Recognizing the growing needs of this population, the government established the Social Security Act, which created a public assistance program for the elderly and led to the proliferation of voluntary and proprietary nursing homes. These facilities had no regulations or guidelines for the delivery of care and services, so in 1950, the Social Security Administration required states participating in the program to establish licensing requirements. Because the requirements did not specify standards for care or enforcement remedies, however, little changed.

Bureaucracy moves slowly and is full of roadblocks to change, and nursing homes are no exception. In 1956, a study of these facilities called attention to problems with quality of care. Most were found to be substandard; their staff members were poorly trained or untrained, and they provided few services. In an attempt to address these issues in 1965, the Medicare and Medicaid federally funded programs for nursing homes were significantly expanded, and uniform standards were put in place for those participating in the federal program. Still, it was essentially an unfunded paper requirement system, and it had little to no effect on the delivery of care.

In 1970 and 1971, nursing home problems escalated into front-page news stories, like a fire that killed more than 30 residents in Ohio, food poisoning in a Maryland home that killed 36 residents, and numerous other horror stories about care atrocities. As a result, in 1972, Congress passed a comprehensive welfare reform bill that funded state survey and certification activities to establish and enforce uniform standards and conditions for operating nursing facilities. The new law required a single set of standards to be developed for these facilities, with an emphasis on the institutional framework used to deliver resident care.

Later in the 1970s and in the early 1980s, the Patient Care and Services Survey was created to rectify problems with quality of care. However, there was controversy over the legitimacy of this survey's process. Having a policy was no longer enough; that policy had to be implemented, reviewed, and revised to get results. The era of paper compliance in the form of policies and procedures was nearing its end.

The care plan's content should address the following:

- The specific problem, needs, and risks. Plans for patients at risk need to reflect the areas of concern and the risk factors present, as well as the strengths/capabilities on which the resident can draw. When ulcers are present, the plan should reflect the site, scope, and severity of the problem; presence or absence of pain; the strengths/capabilities on which the resident can draw; and the stability of the condition. Do not overlook the need for pain management preceding treatment and other activities that allow the resident to be more comfortable.

- Reasonable, measurable goals that consider rehab/restorative potential. Can the areas be resolved and improved and/or complications minimized? When will the goal be met and/or when will the plan be reviewed for effectiveness?

- Person-centered approaches that address their particular holistic needs and reflect accepted standards of practice.

M1030: Venous or Arterial Ulcers

- Most common vascular ulcers
- May occur on and off for several years
- May occur after relatively minor trauma
- Common after thrombophlebitis
- Often referred to as chronic venous stasis
- Usually occurs on the inner aspect of the lower leg or around the ankle
- Ulcer may have a moist, granulating wound bed, may be superficial, and may have minimal to copious drainage
- Pain may increase when the foot is in the dependent position (i.e., seated with feet on the ground)

Arterial/ischemic ulcers

- Occurs with non-pressure-related disruption or blockage of the arterial blood flow to an area, causing tissue necrosis
- May present in residents with moderate to severe peripheral vascular disease, generalized arteriosclerosis, inflammatory or autoimmune disorders, or significant vascular disease elsewhere, such as:
  - Stroke, heart attack, etc.
  - Ulcers are painful
  - Occur in the lower extremities
  - May occur on top of foot, over ankle, and bony areas of feet
  - Wound bed is usually dry and pale with minimal to no exudate
  - May exhibit no pedal pulse
  - Coolness to touch

doing your quarterly resident reviews. Be sure that you have effective care plans in place and documented rationale for the resident's status.

Short-stay quality measures

1. Self-reported moderate to severe pain
2. Residents with pressure ulcers that are new or worsened*
3. Residents assessed and appropriately given the seasonal influenza vaccine
4. Residents assessed and appropriately given the pneumococcal vaccine
5. Residents with new antipsychotic medication

Long-stay quality measures

1. Residents experiencing one or more falls with major injury*
2. Residents who self-report moderate to severe pain
3. High-risk residents with pressure ulcers
4. Residents assessed and appropriately given the seasonal influenza vaccine
5. Residents assessed and appropriately given the pneumococcal vaccine
6. Residents with a urinary tract infection
7. Low-risk residents who lose control of their bowels or bladder
8. Residents who have/had a catheter inserted and left in their bladder
9. Residents who were physically restrained
10. Residents whose need for help with ADLs has increased
11. Residents who lose too much weight
12. Residents who have depressive symptoms
13. Residents who have received an antipsychotic medication

* *This measure is underscored in the IMPACT Act of 2014.*

Improving Medicare Post-Acute Care Transformation Act of 2014

Additional quality measures have been implemented, and continue to develop and evolve, in accordance with this act. The IMPACT Act was enacted in response to issues found by the Office of Inspector General in the 2013 study titled "Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Needs." If your assessment and care planning are on track, and if you properly utilize your CAAs and create an effective care plan, you should experience little difficulty with these additions. The *Skilled Nursing Facility Quality Reporting Program Measure Calculations and Reporting User's Manual* offers additional guidance on these quality measures.

Care Plan Index – More than 100 modifiable care plans in 25 categories

Appendix 1

Active Disease Diagnosis

CANCER *(1 of 3)*

Resident name _____ Date_____

Problem/need	Related to	Risks/challenges
Reduce or eliminate adverse effects of cancer treatment problems that may occur during and after treatment.	❏ Chemotherapy ❏ Radiation ❏ Surgery ❏ Immunotherapy ❏ Other _____	❏ Nutritional compromise ___ Loss of appetite ___ Taste changes ___ Dry mouth ___ Nausea ___ Vomiting ❏ Quality of life compromised

In My Own Voice: Specific wishes and preferences about this particular area   ❏ N/A ❏ None ❏ Already noted

_____

_____

_____

_____

_____

CANCER

Goal(s)	Freq.	Interaction and approaches	Disc.	Target date
Resident nutritional compromise will be lessened and/or eliminated by maintaining hydration, stabilizing weight, and promoting the enjoyment of meals.		❑ Eat small meals and healthy snacks several times per day that contain plenty of calories and protein, including cheeses, milkshakes, puddings, ice cream, etc. ❑ Add extra calories and protein to food (such as butter, skim milk powder, honey, or brown sugar). ❑ Substitute poultry, fish, eggs, and cheese for red meat; add spices and sauces to foods. ❑ Eat meat with something sweet, such as cranberry sauce, jelly, or applesauce. ❑ Provide liquid supplements, such as soups, milk, juices, shakes, and smoothies, when eating solid food is a problem. ❑ Clean teeth (including dentures) and rinse mouth after each meal and before bedtime. Avoid mouth rinses containing alcohol. ❑ Use sugar-free lemon drops, gum, or mints if there is a metallic or bitter taste in the mouth. ❑ Use plastic utensils if foods taste metallic. ❑ Offer foods and drinks that are very sweet or tart to stimulate saliva. ❑ Encourage resident to drink even if not thirsty; drink 8–12 cups of liquids per day. This includes water, juice, milk, or foods that contain a large amount of liquid, such as puddings, ice cream, ice pops, flavored ices, and gelatins. ❑ Limit drinks that contain caffeine, such as sodas, coffee, and tea (both hot and cold).		

CANCER

Goal(s)	Freq.	Interaction and approaches	Disc.	Target date
Quality of life will be enhanced through supportive care.		❏ Eliminate or control pain at a level tolerable for the resident. Refer to the pain care plan. ❏ Encourage and provide opportunities to share thoughts and feelings during individual contacts. ❏ Provide opportunities to share via support groups. ❏ Promote participation and/or completion of activities of daily living as the resident feels able. ❏ Provide and encourage leisure pursuits and distraction, including: _____ _____ ❏ Medicate for naseau/vomiting as ordered. Monitor for efficacy. Report adverse effects to MD.		

DIABETES   *(2 of 2)*

Goal(s)	Freq.	Interaction and approaches	Disc.	Target date
❏ Maintain blood sugar levels between _____ and _____. ❏ Prevent crises from inade-quate control of blood sugar levels, hypoglyce-mia, hyperglycemia		❏ Diet modifications as planned. See the nutrition plan. ❏ Exercise type: _____ ❏ _____ ❏ Exercise frequency: _____ _____ ❏ Timely administration of diabetic medicine. ❏ Monitor blood sugar; if outside of acceptable range, give sliding scale insulin and/or contact the physician as indicated. *hyper-/hypoglycemia* ❏ Be alert to signs of low blood sugar: sweating, nervous-ness, faintness, confusion, fatigue, weakness, headaches, inappropriate behavior, visual problems, inability to concentrate, seizures, increasing stupor. *hypoglycemia* ❏ Immediately check blood sugar. Give juice. If unable to drink, give instant glucagon. Reassess blood sugar in 10 minutes. ❏ Be alert to signs of high blood sugar: flushed, dry skin, drowsiness, nausea/vomiting, abdominal pain, soft sunken eye balls, red lips, decreased blood pressure, acetone breath, and increased respirations. Contact physician immediately. *hyperglycemia* ❏ Increase monitoring during periods of stress, such as any signs/symptoms of infection to prevent hypoor hypergly-cemia and dehydration. ❏ Encourage consumption of diet and snacks as recom-mended. If intake changes or the resident is noncompliant with intake, increase observation for diabetic reaction.		

Palliative Care and Hospice

HOSPICE CARE (1 of 2)

Resident name _____ Date _____

Problem/need	Related to	Risks/challenges
Palliative care, supportive and comfort care as a result of: ❑ Persistent pain ❑ Anxiety ❑ Failure to thrive ❑ Serious chronic illness ❑ End of life	❑ Rapid disease progression ❑ Cancer nonresponsive to treatment ❑ Dementia, end stage with medical complications ❑ ALS or Lou Gehrig's disease: critical nutrition impairment, rapid disease progression in the past six months ❑ Chronic cerebrovascular accident: severe functional disability, difficulty swallowing with risk of aspiration or recurrent infection	❑ Pain ❑ Fatigue ❑ Appetite loss ❑ Dehydration ❑ Dry mouth ❑ Skin problems ❑ Anxiety ❑ Psychosocial distress ❑ Constipation ❑ Fecal impactions

In My Own Voice: Specific wishes and preferences about this particular area ❑ N/A ❑ None ❑ Already noted

_____

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PALLIATIVE CARE

Resident name _____ Date _____

Problem/need	Related to	Risks/challenges
Needs supportive and comfort care	❏ Persistent pain ❏ Anxiety ❏ Failure to thrive ❏ Serious chronic illness ❏ End of life	❏ Pain ❏ Fatigue ❏ Appetite loss ❏ Dehydration ❏ Dry mouth ❏ Skin problems ❏ Anxiety ❏ Psychosocial distress ❏ Constipation ❏ Fecal impactions

In My Own Voice: Specific wishes and preferences about this particular area   ❏ N/A ❏ None ❏ Already noted

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PALLIATIVE CARE (2 of 3)

Goal(s)	Freq.	Interaction and approaches	Disc.	Target date
❏ The resident will experience the best possible quality of life, maintaining autonomy and decision-making ability as long as able ❏ The resident's pain will be controlled		❏ Enable the resident/family to make informed decisions about their care by educating them on the process of the resident's disease, prognosis, and the benefits and burdens of potential interventions. *Psychosocial distress* ❏ Assess and manage the psychological reactions of the resident and family (including stress, anticipatory grief, and coping) in a regular, ongoing manner to address emotional and functional loss. *Psychosocial distress* ❏ Convert the resident's treatment goals into medical orders, and ensure that the information is sent upon transfer across care settings. ❏ Support the resident to give as much self-care as desired, avoid overtiring, and care for the resident at his or her pace and on his or her terms. *Psychosocial distress. fatigue* ❏ Provide spiritual counseling to address questions of hope, meaning, despair, fear of death, relationship with divine, need for forgiveness, and loss of life purpose. *Psychosocial distress* ❏ Explore issues of separation, loss, and the unknown that arise when facing death. *Psychosocial distress* ❏ Provide interpreter services and culturally sensitive materials for the resident and family in their preferred language. ❏ Make advance directives and surrogacy designations available across care settings.		

PALLIATIVE CARE (3 of 3)

Goal(s)	Freq.	Interaction and approaches	Disc.	Target date
❑ Dry mouth will be alleviated. ❑ The resident will experience comfort and pleasure from food and drink. *Appetite loss, dehydration* ❑ Prevent pain, stiffness in muscles and joints		❑ Offer frequent sips of water, ice chips, and swabbing of the mouth with a moist sponge on a stick. *Appetite loss, dehydration* ❑ Provide meticulous mouth care that includes combinations of cleaning, swabs, ice chips, hard candy, and lubricants. *Appetite loss, dehydration* ❑ Provide salivary stimulants, oral moisturizers, and salivary substitutes as ordered. ❑ Provide small, frequent meals that are calorically dense foods to slow weight loss. *Appetite loss, dehydration* ❑ Encourage the resident to "indulge" by eating small amounts of favored foods simply for the pleasure of taste and allowing a nurturing opportunity for others and the resident, but never force feed. *Appetite loss, dehydration* ❑ Encourage movement; guide the resident to do range-of-motion movements as far as able and assist the rest of the way. *Pain, fatigue, skin problems* ❑ If the resident is too weak or fatigued, do simple range-of-motion exercises to wrist, knee, elbow, ankle, shoulder, hip, neck; protect joints by holding the limb above and below it; bend, straighten, and move joints as far as the resident normally goes. *Pain, fatigue, skin problems*		

Bonus Care Plans

Appendix 24

Discharge Planning

DISCHARGE PLANNING

Resident _____   ☐ Admission   ☐ Re-admission

Problem/Need	Related to:	Risks/Challenges	Goals	Interactions and approaches	Disc.	Target date
Resident desires to discharge home to: ☐ Home ☐ Assisted living With: ☐ Spouse ☐ Family ☐ Alone ☐ Caregiver ☐ _____	☐ _____ _____	☐ Confusion ☐ Limited ROM ☐ Needs assist with ADLs ☐ Needs assist with medications ☐ _____	Will improve in _____ and experience a safe discharge: ☐ Eating ☐ Oral hygiene ☐ Toilet hygiene ☐ Shower/Bathe self ☐ Upper body dressing ☐ Lower body dressing ☐ Toilet transfer ☐ Car transfer ☐ Walk: 10ft/50ft/150ft	☐ Therapy screening/treatment ☐ Staff support provided for safety ☐ Restorative nursing ☐ Encourage resident to familiarize self with facility ☐ Encourage resident to be more independent ☐ Verbal cues for safety ☐ Educate family/caregivers on: _____ ☐ Coordinate home health care ☐ _____ ☐ _____	PT/OT All N All All All	
					PT/OT All N All All	

Nurse's Signature/Title _____   Date _____

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