Writing “I” Format Care Plans: The “Common Sense” Approach to Meeting Resident Needs

Catherine R. Selman, BS
The Healthcare Communicators, Inc.
Person-centered Care

- Care providers who truly offer a person-centered approach focus on the individual.
- They spend a great deal of time getting to know who the person is and who the person was.
Person-centered Care

- Care-givers demonstrate a respect for each person.
- They believe each person still makes a difference in the world.
- They look at themselves not simply in a caretaker role of keeping someone safe and dry.
- They want to enable each person to use all their God-given abilities that remain.
- They believe that with proper support, people can enjoy a relatively high level of well-being throughout the course of their illness or situation.
Why Person Centered Care?

• It's the right thing to do!
• Reduction in turnover
• Reduction in job injuries
• Consumer perception of better care
• Reduction in abuse/neglect
• Reduction in litigation
• Increased resident census
• Financial growth
• Improved workplace satisfaction
Definitions

“Person Appropriate” refers to the idea that each resident has a personal identity and history that involves more than just their medical illnesses or functional impairments. Activities, care & services should be relevant to the specific needs, interests, culture, background, etc. of the individual for whom they are developed.
The National Alzheimer’s Association has changed from endorsing the idea of “age-appropriate” activities to promoting “person-appropriate” activities.

One person may care for a doll or stroke a stuffed animal. Another person may be willing to reminisce about dolls or stuffed animals they once had, while a third person may enjoy petting a dog but want nothing to do with anything that isn’t “real.”
Consider person directed care plans to enhance residents’ highest physical, psychosocial well-being.

Changing the style of care plan documentation assists to reflect the emphasis on the resident’s care from their personal perspective:

1. The care plan is written from the resident’s point of view.
2. Document assessments of the resident’s social history, communication ability, mobility, activities of daily living etc. as though the resident was talking.
Changing the Culture of Care Planning

Medical Model:
- Staff know you by diagnosis
- Staff write care plan based on what they think is best for your diagnosis
- Interventions are based on standards of practice per diagnosis

Community Model:
- Staff have personal relationship with resident and family
- Resident, family, and staff develop care plan that reflects what resident desires for himself/herself
- Unique interventions which meet the needs of that resident
Medical Model
- Care plan written in third person
- Care plan attempts to fit resident into facility routine
- Nursing assistants not part of interdisciplinary team
- Care plan scheduled at facility convenience

Community Model
- Care plan written in first person "I, myself"
- Care plan identifies resident's lifelong routine and how to continue it in the nursing home
- Nursing assistants vary and present at each care plan conference
- Care conference scheduled at resident and family convenience
“I” Care Plans

- Care plans should be written in simple language that all caregivers can understand.
- It will be written in the “I” format. It is as though the resident is speaking directly to us via the care plan.
- The use of nursing diagnosis is discouraged as other disciplines are not trained to understand this.
- Care plans shall be accessible to all staff at all times.
Care Plans

- The care plan is made up of problem statements or needs as identified by the resident.
- Resident centered goals
- Time frames for meeting the goals
- Interventions designed to assist the resident in meeting the goals
- Facilitates communication among members of the IDT as well as members of different shifts.
What does CMS say?

F279 – Comprehensive Care Plans

(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental & psychosocial needs that are identified in the comprehensive assessment.
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 483.14(b)(4).
What does CMS say?

F280 (2) A comprehensive care plan must be—
(i) Developed within 7 days after the completion of the comprehensive assessment;
(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs, and, to the extent practicable, the participation of the resident, the resident’s family or the resident’s legal representative; and
(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.
What does CMS say?

Surveyor Guidance:

> As used in this requirement, “interdisciplinary” means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident.

> It does not mean that every goal must have an interdisciplinary approach.

> The mechanics of how the interdisciplinary team meets its responsibilities in developing an interdisciplinary care plan is at the discretion of the facility.
From the Director of CMS... 

- "We believe these innovations culture change more fully implement the Nursing Home Reform provisions of the OBRA of 1987."

- The CMS has been participating in a variety of efforts to engage in communication with culture change innovators and to inform our survey agencies of how these innovations can comply with Federal requirements.

- Our survey and certification staff have been pursuing various culture change initiatives, with more planned for the next year."

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Joanne is an Alzheimer’s resident who has her days and nights mixed up. She wanders into other residents’ rooms at night which has resulted in several resident and family complaints. The following care plan was developed.
1. Make a list of 5 things that a person would need to know about you, if they were going to take care of you for the rest of your life.

2. What would you say to this person?
<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident wanders into other rooms at night</td>
<td>Resident will sleep 5 hours during the night by next RCC</td>
<td>Sleep medication PRN; Discourage napping during the day; Side rails up if unable to sleep; place on geri-chair</td>
</tr>
<tr>
<td>Problem</td>
<td>Goal</td>
<td>Intervention</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>I like to walk during the night.</td>
<td>I will ambulate freely throughout my home at times of my choice through next RCC.</td>
<td>If I'm walking at night, please offer to walk with me. Place stop signs on the doorways of the residents who are disturbed by my presence at night. Offer snacks and preferred activities when I'm unable to sleep. I like to read the sports section of the newspaper, play solitaire, watch old movies.</td>
</tr>
</tbody>
</table>
The Way We've Always Done It

Sally is a resident who hits and screams when receiving her weekly shower. The facility has tried a variety of interventions to calm her, but she continues to hit and scream. Two CNA’s have received injuries during showers, they are afraid of her. The following care plan was developed.
<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident displays combative behavior during shower</td>
<td>Resident will not hit CNA's during shower through next RCC</td>
<td>2-3 CNA's for showers. Calm, gentle approach. Shower weekly. Pre-medicate with Xanax prior to shower</td>
</tr>
<tr>
<td>Problem</td>
<td>Goal</td>
<td>Intervention</td>
</tr>
<tr>
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</tr>
<tr>
<td>I dislike to be showered.</td>
<td>Can enjoy a &quot;comfort bath&quot; as evidenced by no hitting and screaming through next shift.</td>
<td>Provide me with a &quot;comfort bath&quot; by Sue Jones (my primary CNA), every other week. Please offer me daily hygiene as usual. If I start to raise my voice, please try again after keeping me warm during the bathing process.</td>
</tr>
</tbody>
</table>
Joe is an 88 year old man with dementia. He has a short attention span. He is very pleasant most of the time. Joe likes to walk around the facility a considerable amount of his waking hours. He is unable to distinguish between areas he is welcomed to enter and those where he is not welcomed.
Sample Care Plan

- His ambulation skills are excellent; no assistance is required. Some residents are disturbed by him because he may enter their rooms against their wishes. He prefers to be with staff at all times as he does not tolerate being alone. He and his wife raised 11 children. Joe owned a hardware store and was a respected businessman in town.
Traditional Care Plan

- Problem
  - Wanders due to dementia

- Goal
  - Resident will not wander into their rooms
Traditional Care Plan

Interventions

- Redirect resident to appropriate areas of the facility
- Praise for cooperation
- Teach resident not to enter rooms with sashes across door
- Encourage resident to sit in lounge and other common areas
Resident Directed Care Plan

- Needs
  - I need to walk

- Goal
  - I will continue to walk freely throughout my home
Approaches

- After I eat breakfast and get dressed, I want to walk with staff. I will accompany you anywhere.
  I like to help while we are together. I can fold linen and put things away with you. I do not like to nap. If weather permits, please walk outside with me. I like to keep walking in the evening until I go to bed. I sit when I am tired, so don’t fuss over asking me to sit.
Traditional Care Plan

- Problem
  - Non compliant with 1800 cal ADA diet

- Goal
  - Resident will eat only foods approved in ordered diet
Interventions

- Educate resident regarding diabetes, her diet, and impact to her health if non-compliant
- Notify nurse of foods hidden in room
- Monitor for s/s hypo and hyper glycemia
- Check blood sugar 6am and 8pm
- Administer insulin as ordered
Resident Directed Care Plan

Needs
- I have diabetes and take insulin. I am aware of recommended dietary restrictions and I exercise my right to eat what I enjoy.

Goal
- I will enjoy moderate foods of my choice.
Standard Care Plan

- Problem: Alteration in thought process
- Goal: Resident will be oriented to person, place, time and situation at all times
- Goal date: 11/16/03

Approaches:
- Provide orientation with routine care
- Invite to R.O. activities, i.e. current events group and resident council
- Place facility calendar in room
Individualized Care Plan

- Problem: Cognition
- Goal: Frank will use the activity calendar to remind himself of daily activities.
- Goal date: 11/16/03

Approaches:
- Place weekly calendar in Frank’s room on the small bulletin board.
- Assist Frank to choose activities he is interested in for the day before he goes to breakfast.
- Remind Frank throughout the day of the group activities coming up.
Care Planning List – Special Considerations/Strengths

- Social history
- Memory enhancement & communication
- Mental wellness
- Mobility enhancement
- Safety
- Visual function
Care Planning List (continued)

- Dental care
- Bladder management
- Skin care
- Nutrition
- Fluid maintenance
- Pain management/comfort
- Activities
- Discharge plan
Resident Care Plan

Social History:

I am Frankfort Fox. My friends call me “Frank.” I was born in Fargo, North Dakota way back in 1910. My parents were farmers. They raised my six older brothers and worked very hard. My parents valued a good education. All of us boys graduated from Washington High School in Fargo. Shortly after graduation, I hopped a train to Colorado. I got off in a town called Marble, way up in the Rockies.
My memory is pretty good. I had a stroke about a year ago which affected my ability to remember things which happen day to day. I love to attend groups and am a very social guy. I appreciate it if you show me the weekly calendar in my room near the sink every morning. Review with me what is going on for that day.
Memory Enhancement

- I will tell you what I am interested in. You can remind me during the day when an activity I enjoy is going to occur.
- Goal: I want to work with you daily to learn my calendar so that I will be able to be independent in getting to the group activities which I enjoy.
Back in 1935, I fell while taking a climb up a mountain. I cracked a vertebrae in my upper spine. Later I developed Arthritis in this area. My pain worsens as the day wears on. Please remember that if I start getting irritable it is because my back hurts. Ask me about it. Let the nurse know I am having trouble.
Comfort

- I take regular medication for pain. Sometimes I need an extra boost of medication. I also benefit from stretching so I like to attend the morning exercise group. The massage therapist sees me every Friday for an hour. Massage makes all the difference.

Goal: To be free from breakthrough pain in my back.
Ever since my stroke, my appetite just hasn’t been the same. I have been losing weight since July. It helps to have my special adaptive silverware at the table when I eat. I eat better when I sit with Joy. Make sure we have our special table set up so we can eat together at every meal.
Nutrition

I have always been a snacker since my hiking days. I especially enjoy Almond Joy’s, chocolate milkshakes and burgers from McDonald’s which my daughter brings in for me. Offer me a snack between meals and before bed. Also invite me to join in the cooking group. “Food always tastes better when you make it yourself.”
Goal: I want to keep my current weight and maybe even gain five pounds.
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?
Questions

- If an elder is declining, have we asked the question, why did this happen?
- Are we assessing outcomes?
- Are we assessing why elders don’t improve?
- Are we assessing why elders are not reaching their highest practicable physical, mental, and psychosocial well-being?
- Are we truly assessing the elder’s functional status in a holistic manner and making a difference for that person?
Contact Information:

Catherine R. “Cat” Selman, BS
The Healthcare Communicators, Inc.
(610) 497-9837
HealthcareComm@aol.com
www.catselman.com
www.thehealthcarecommunicators.com