Nursing Care Plans

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Nursing Care Plans

Foundation and Expectations

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Objectives

- Describe the purpose of the Nursing Care Plan
- Define the fundamentals of a Nursing Care Plan
- Explain the roles and responsibilities of the Interdisciplinary Team
- Outline when to update the Nursing Care Plan
- Provide guidelines for proper documentation
- Provide an overview of common Nursing Care Plan citations

Nursing Care Plan Purpose

- Nursing is a profession in which nurses are responsible for all aspects of nursing care, from the time a resident is admitted to their care until they are discharged from it.

- The purpose of nursing care plans is to facilitate communication between nurses, residents, caregivers, and all members the interdisciplinary team to provide optimal care to the resident.

- **A Nursing Care Plan is a written record of the care planning process.**

Facilities Responsible For Nursing Care Plans

- Adult Care Facilities-
  - Adult Home
  - Enriched Housing Program
  - Assisted Living Program
  - Assisted Living Residence

There may not be a registered nurse on staff at the above facilities, but the knowledge of the Nursing Care Plan process is valuable, especially when it comes to admissions, retention, and case management. For success, it's crucial to understand your licensing and certification levels and care boundaries.

- Nursing Homes
- Home and Community Based Services

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Adult Care Facilities Definitions

Adult Home – a facility established and operated for the purpose of providing long term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the operator. Limited to 200 beds. (18 NYCRR Part 487)

Enriched Housing Program – a facility established and operated for the purpose of providing long term residential care to five or more adults, primarily persons aged 65+, in community-integrated settings resembling independent housing units. Such program shall provide or arrange for the provision of room, and provide board, housekeeping, personal care and supervision. (18 NYCRR Part 488)

Assisted Living Program (ALP) – provides long-term residential care, room, board, housekeeping, personal care, and supervision, and provides for or arranges home health services. The ALP must be an Adult Home or Enriched Housing Program. (18 NYCRR Parts 487 or 488 and 494)

Assisted Living Residence – provides or arranges for housing, onsite monitoring and personal care services and/or home care services in a home-like setting to five or more adult residents unrelated to the operator. The ALR must be an Adult Home or Enriched Housing Program. (Public Health Law, Chapter 10; 10 NYCRR Part 1001)

Nursing Care Plan Fundamentals

- Nurses must initially and continually *assess* the patient's needs to plan the patient's care in a Nursing Care Plan.

- Nurses must also be able to demonstrate the ability to work in partnership with all members of an interdisciplinary team to implement and evaluate care on behalf of residents and their families.

- **Nursing and the interdisciplinary team are responsible for providing comprehensive, compassionate, and ethical care to residents and document this in the Nursing Care Plan.**

Interdisciplinary Team Members

Dietary professionals

Social workers

Physical therapists and Occupational therapists

Speech language pathologists

Pharmacists

Activities professionals

Nursing Care Plans Types

- **Standardized -** Providing nursing care to groups of patients with basic expectation for care of daily needs.
- **Individualized -** An individual care plan that is tailored to the specific needs and **preferences** of the resident.
- **Informal -** An action plan created by the nurse using nursing judgment and includes what should be accomplished during the shift.
- **Formal -** This is an organized and coordinated plan of care for a resident that is written or charted in an electronic medical record.

Standardized Care Plans

- Standardized care plans do not take into consideration the specific needs and goals of a patient, but they can be used as a starting point for the development of individualized care plans.

- They can be informal or formal.

Individualized Care Plans

For individualized care plans, standardized care plans are tailored to meet the specific needs, preferences, and goals of the individual resident. They are developed using approaches shown to be effective for the resident.

They can be informal or formal.

Formalized Individualized Nursing Care Plans are expected for all residents.

Individualized Nursing Care Plans

- Start by performing a comprehensive assessment.
- The resident, family members or care givers, and all members of the interdisciplinary team can and should be involved in the comprehensive assessment.
- Ask the resident to contribute and document answers in quotes when possible.
- The attendance, the time, and the place of the comprehensive assessment should be documented.
    - **Resident participation increases likelihood of adherence to Nursing Care Plans.**

Individualized Nursing Care Plans

Assess and evaluate the resident on a regular basis as the patient's health and goals may change and adjust the Nursing Care Plan, as necessary.

The resident should be always be an active participant in this process.

Nursing Care Plan Review

The nursing care plan should be reviewed regularly or whenever there is a **change in status**.

The status of a patient may change, and a diagnosis may change if the condition improves, worsens, or presents in a different manner.

Change in Status

- Changes in any of the following symptoms should be reported to the primary care provider **immediately** and **the appropriate changes made to the care plan:**
  - Frequent urination or changes in bowel movements
  - Itching, wounds, or new skin problems
  - Changes in balance, coordination, or strength
  - Indigestion or nausea
  - Thirst, increased hunger, or loss of appetite
  - Fever
  - Drowsiness, fatigue, or insomnia
  - Headaches or body aches
  - Dizziness, restlessness, or a tendency to stumble or fall
  - Changes in mental status

Change in Status

- A common example of a change in status in the elderly that requires a change in the care plan is the treatment of a UTI outside a facility and the return to the facility after treatment**:**
- **Why?**
  - There was a **change in condition** that required the hospitalization.
  - As a result of a readmission, a care plan change is likely because **assessment** is required.

Using best practice related to **antibiotic stewardship**, any changes related to antibiotic administration should be evaluated, such as decreased renal function, measuring appropriate intake and output, monitoring for Clostridium difficile, and preventing recurrence.

Nursing Care Plan Updates

- The frequency of evaluation depends largely on the nature of a recipient's medical conditions and the level of assistance they require.
- Medicare requires home health agencies to review each client's care plan **at least once every 60 days**.
- In Medicare-certified nursing homes, full health assessments and appropriate care plan updates must be made **at least once every 90 days**.

Impact on Care

- There are some observations that can quickly make a huge impact for residents related to intake and output. For example, when a resident misses two meals or drinks 50% or less of their daily intake requirement. They may develop a urinary tract infection (UTI). Staff observations and recording is needed as part of the care plan monitoring process and can be an early detection of care concerns.
    - ***Assessment is key***
    - **Proper documentation is essential**
    - **Refer to the Critical Element Pathways**

Nursing Care Plan

Process

Developing Nursing Care Plans

This is a five-step process

1. Assessment
2. Diagnosis
3. Planning
4. Implementation
5. Evaluation

ADPIE

Step 1-Assessment

- The process of systematically gathering data, sorting and organizing the collected data, and documenting the data in a retrievable format.

- Consider all observations, information, and knowledge about a resident. Finding out about a resident's strengths and limitations and discovering what makes him or her unique.

Assessment-Data

- General Information
  - Demographics
  - Admission Date
  - BIMS score
- Subjective Information. Information that is reported by the resident.
  - Cultural Concerns
- Objective Information. Information that is exhibited by the resident.
  - Review of Systems

Assessment-Review of Systems

- Neurological
- Cardiovascular System
- Respiratory System
- Musculoskeletal System
- Gastrointestinal (GI)
- Genitourinary (GU)
- Skin
- Pain
- Safety
- Discharge Plan
- Additional Assessment for appropriate level of care

Step 2: Diagnosis

- A nursing diagnosis systematically gathering data, sorting and organizing the collected data, and documenting the data in a retrievable format.
- It uses the common terminology or standardization of the nursing language, NANDA-I nursing diagnoses.
- NANDA-I nursing diagnoses provide a standardized language for identifying and categorizing health problems that nurses encounter. This language also helps nurses to develop individualized care plans and provide more effective patient care.

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Step 3:Planning-Person Centered Care

As part of **Person Centered Care planning**, priorities are established, goals are identified, desired client outcomes are identified, and specific nursing interventions are determined.

Using resident strengths and interdisciplinary expertise, the plan of action should move the resident towards personal goals by **comparing and contrasting preferences**.

Personal preferences and goals should be reflected **specifically and accurately** in the documentation.

Step 4: Implementation

Implementation involves putting the plan of care into action and performing the planned interventions.

Putting this course of action into action using specific interventions on the care plan by interdisciplinary team members who are familiar with the resident's care goals and approaches

Step 5: Evaluation

- Evaluation determining the client's progress toward attaining the identified outcomes and monitoring the client's response to and effectiveness of the selected nursing interventions.

There are three possible outcomes:

- Met
- Ongoing
- Not Met

- Based on the evaluation, it can determine if the goals and interventions need to be reassessed and if the Nursing Care Plan needs modification.

Proper Documentation

- When written and applied properly, care plans can save time by facilitating communication between nurses and other caregivers and providing direction for continuity of care.

- By writing and implementing a care plan correctly, nurses and other caregivers will save time by facilitating communication between each other and providing a common direction for continuity of care and care for the patient as much as possible.

Best Practice for Proper Documentation

- Put all relevant facts in chronological order.
- Keep sentences short.
- Use simple sentence structure.
- Use the active voice (e.g. “The DON reprimanded the CNA” not “the CNA was reprimanded by the DON.”).
- Avoid undefined abbreviations, initials and technical jargon.
- Write in layman’s terms.
- Write to inform, not impress.
- Avoid unnecessary words.
- Avoid vague terminology (such as, seems, appears, did not always).
- Avoid words that imply or state conclusions without including the facts to support them (e.g., “only,” “just,” “unsatisfactory,” “unnecessary,” or “inadequate”).
- Ensure the accuracy of quoted material.

CMS Requirements for Nursing Care Plans

- (i) All pertinent diagnoses;
- (ii) The patient's mental, psychosocial, and cognitive status;
- (iii) The types of services, supplies, and equipment required;
- (iv) The frequency and duration of visits to be made;
- (v) Prognosis;
- (vi) Rehabilitation potential;
- (vii) Functional limitations;
- (viii) Activities permitted;
- (ix) Nutritional requirements;
- (x) All medications and treatments;
- (xi) Safety measures to protect against injury;
- (xii) A description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors.
- (xiii) Patient and caregiver education and training to facilitate timely discharge;
- (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;
- (xv) Information related to any advanced directives; and
- (xvi) Any additional items the HHA or physician may choose to include.

Sample Nursing Care Plan

- **Assessment:** Resident was newly admitted to facility from the hospital for frequent falls and failure to thrive. Resident is refusing to ambulate to the dining area to eat and states “I want to stay in my bed and eat. Nobody will help me out there if I fall anyways.”
- **Diagnosis:** 1. ineffective coping
- **Plan:** Consult the Activities Coordinator for the initial assessment to review resident preferences. **Review Critical Element Pathways for Dining Observation**.
- **Implementation:** The Admission coordinator will provide the admission assessment and the interdisciplinary team will use it to identify likes and dislikes to acclimate the resident to the new facility.
- **Evaluation:** By the end of the shift ,the resident will demonstrate the ability to safely ambulate to the dining area to eat meals.

Sample Nursing Care Plan

- **Assessment:** Resident returned from the hospital for the treatment of a UTI. Resident now requires droplet precautions for c diff and must be moved to a different room. Resident states “I am not moving rooms! Move someone else!”
- **Diagnosis:** 2. knowledge deficit
- **Plan:** Nursing will educate the client on required room change and precaution status. **Review Critical Element Pathways for Infection Control.**
- **Implementation:** Nursing will use referenceable hand outs and displays in the resident's language and ability by referencing the admission assessment and activities evaluation form to create a 15-minute teaching session on c diff and droplet precautions.
- **Evaluation:**. By the end of the shift, the resident will participate and verbalize understanding of the need for the room change and successfully change rooms.

Sample Nursing Care Plan

- **Assessment:** Resident is admitted to a facility for placement. Resident is homeless and has a substance use disorder-alcohol, and a diagnosis of paranoid schizophrenia. Resident is refusing to take all prescribed medications and states “I am only taking medication that I can keep in my own room and take myself.”
- **Diagnosis:** 1. Anxiety
- **Plan:** Nursing staff will review the care plan for interventions that have helped reduce anxiety and will provide the resident with education about need for prescribed medications. **Review Critical Element Pathway for Behavioral- Emotional.**
- **Implementation:** Social work will be consulted and will work with the prescriber to review the medication administration record and consult with the client about preferences of administration and will create a mutually agreed upon plan.
- **Evaluation:**. By the end of the shift, the resident will take medications as prescribed by the provider at the prescribed times and days and verbalize understanding of medication administration.

Nursing Care Plan

Common Citations

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Common Nursing Care Plan Citations

- An **incomplete assessment at the start of care** and therefore the initial plan of care is lacking items- diagnosis, treatments, safety measures.

For example,

- A resident was recently admitted to facility for frequent falls and failure to thrive. Resident is refusing to ambulate.
- A resident came to facility by ambulance and no paperwork. Resident states he weighs 425 lbs and cannot use the bed provided by the facility. Resident placed in facility bed and supervisor notified of resident request.
- Resident unable to communicate verbal needs due to newly placed tracheostomy. No family is present for admission assessment. Resident given communication board to communicate needs.

Common Nursing Care Plan Citations

- **Care plans are not implemented** – visit frequency not provided as ordered, wound care performed incorrectly, or wound care not ordered and should be.
- Unable to obtain the ordered supplies for ostomy change. Supplies used from generic supply to change ostomy appliance. Ostomy continues to leak stool and resident states “This is fine.” Dry 4x4 gauze placed at the leaking site and resident informed to change gauze when saturated.
- Skin check performed on resident’s shower day and 3x5 open area is noted to right heel. Area cleaned and Opti foam placed over area.
- CNA did not complete turn and position orders.

Common Nursing Care Plan Citations

- **Care plans are not patient specific** – use a somewhat cookie cutter approach as opposed to individualized care plans – (not as common but occurs regularly enough)

- Resident will attend activities as ordered.
- Resident will participate in care.
- Resident will not fall this shift.
- Resident will not express suicidal ideation this shift.
- Resident will remain safe this shift.

Common Nursing Care Plan Citations

- **Care plans are not done on time and not updated** to reflect the changing needs of the patients between certification periods.

- **Care plans should be completed upon admission and comprehensive assessments no more than 14 days from date of admission.**

Nursing Home Regulations

- 42 CFR § 409.43 - Plan of care
- eCFR :: 42 CFR 409.43 -- Plan of care requirements.

- § 484.60 Condition of participation: Care planning, coordination of services, and quality of care
- eCFR :: 42 CFR 484.60 -- Condition of participation: Care planning, coordination of services, and quality of care.

Nursing Home Regulations

- 42 CFR § 483.21 - Comprehensive person-centered care planning
- eCFR :: 42 CFR 483.21 -- Comprehensive person-centered care planning.

Adult Care Facility Regulations

- § 763.6**(Adult Care Facilities)**
- (a) A comprehensive interdisciplinary patient assessment shall be completed, involving, as appropriate, a representative of each service needed, the patient, the patient's family or legally designated representative and patient's authorized practitioner. Such assessment shall address, at a minimum, the medical, social, mental health and environmental needs of the patient
- (b) A plan of care shall be developed within 10 days of admission to the agency and approved by the patient based on the comprehensive interdisciplinary patient assessment. The plan shall designate a professional person employed by the agency to be responsible for coordinating care which includes but is not limited to:
- (1) coordination of all services provided directly or by contract to the patient by the agency, informal supports and other community resources to carry out the agency's plan of care;
- (2) cooperation with other health, social and community organizations providing or coordinating care;
- (3) consultation with the patient's authorized practitioner, the local social services representative and discharge planner, if applicable. If an authorized practitioner has referred a patient under a plan of care that cannot be completed until after an evaluation visit, the authorized practitioner shall be consulted to approve additions or modifications to the original plan; and
- (4) responsibility for maintaining current clinical records, conducting case reviews and completing required patient-specific records and reports, as appropriate.
- (c) The plan of care shall cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, need for palliative care, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.
- (d) Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency and duration of such services.
- (e) The plan of care shall be reviewed as frequently as required by changing patient conditions but at least every 60 days.
- (1) Each review shall be documented in the clinical record; and
- (2) Agency professional personnel shall promptly alert the patient's authorized practitioner to any significant changes in the patient's condition that indicate a need to alter the plan of care

Adult Home Regulations

Part 485 – General Provisions
https://regs.health.ny.gov/volume-b-1-title-18/2004847564/part-485-general-provisions

Part 486 – Inspection and Enforcement
https://regs.health.ny.gov/content/part-486-inspection-and-enforcement

Part 487 – Standards for Adult Homes
https://regs.health.ny.gov/volume-b-1-title-18/content/part-487-standards-adult-homes

Enriched Housing Program Regulations

Part 485 – General Provisions
https://regs.health.ny.gov/volume-b-1-title-18/2004847564/part-485-general-provisions

Part 486 – Inspection and Enforcement
https://regs.health.ny.gov/content/part-486-inspection-and-enforcement

Part 488 – Standards for Enriched Housing
https://regs.health.ny.gov/volume-b-1-title-18/content/part-488-adult-care-facilities-standards-enriched-housing

Assisted Living Program Regulations

Part 487 – Standards for Adult Homes
https://regs.health.ny.gov/volume-b-1-title-18/content/part-487-standards-adult-homes

Part 488 – Standards for Enriched Housing
https://regs.health.ny.gov/volume-b-1-title-18/content/part-488-adult-care-facilities-standards-enriched-housing

Part 494 and Part 505, Section 505.35 – Assisted Living Program
https://regs.health.ny.gov/content/part-494-assisted-living-program
https://regs.health.ny.gov/content/section-50535-assisted-living-programs

Assisted Living Residence Regulations

Part 487 – Standards for Adult Homes
https://regs.health.ny.gov/volume-b-1-title-18/content/part-487-standards-adult-homes

Part 488 – Standards for Enriched Housing
https://regs.health.ny.gov/volume-b-1-title-18/content/part-488-adult-care-facilities-standards-enriched-housing

Part 1001 – Assisted Living Residences
https://regs.health.ny.gov/content/part-1001-assisted-living-residences

Home Health Regulations

- §484.60 Condition of Participation: Care Planning, Coordination of Services, and Quality of Care Standard: Plan of care.
- eCFR :: 42 CFR 484.60 -- Condition of participation: Care planning, coordination of services, and quality of care.

- (1) Each patient must receive the home health services that are written in an ***individualized plan of care*** that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration.

- (2) All patient care orders, including verbal orders, must be recorded in the plan of care.

Hospice Regulations

- § 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services
- eCFR :: 42 CFR 418.56 -- Condition of participation: Interdisciplinary group, care planning, and coordination of services.

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References

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Doenges, M. E., Moorhouse, M. F., & Murr, A. C. (2022). *Nursing diagnosis manual: Planning, individualizing, and documenting client care* (7th;1; ed.). F. A. Davis Company