Putting the Person in Person-Centered Care Plans

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Objectives

• Discuss person centered care plans as they relate to regulations and new rule

• Demonstrate the use of QI tools to develop person centered care plans

• State understanding of the need for ongoing evaluation of processes in developing and revising care plans
Person-Centered Care in the Care Planning Process

• Person-centered care is large focus of many regulatory changes within the final rule
• Expectation is to individualize all aspects of the care plan starting within 48 hours of admission
• Regulations such as F 242 Self Determination and F 248 Activities are extremely person centered in nature and speak directly to the care planning aspect of driving care
Standardized vs Person-Centered

• Generic care plan problems, goals and interventions are no longer acceptable

• Standard problem: Resident has diagnosis of DM
  – Current effort to personalize: Mary has a diagnosis of DM
  – Individualized: Mary has a diagnosis of DM and struggles to maintain a diabetic diet

• The progression from standardized to individualized brings Mary the resident with diabetes to the center of the dialogue vs. any resident with a diabetes diagnosis
Standardized vs. Person-Centered

• Standard goal: Will not have any episodes of hypo/hyperglycemia through next review
  – Current effort to personalize: Mary will not have hypo/hyperglycemia through next review
  – Individualized Goal: Mary will participate in making food choices that maintain FBS between 60 and 130 through next review (identified weakness)
  – Individualized Goal: Mary will continue to be able to verbalize food choices that will help her to maintain FBS between 60 and 130 through next review (maintain a strength)

• Goal is now two parts – focused on the strength and the weakness of the resident as it relates to how a diagnosis of diabetes effects her individually

• Goal is now measurable, based on data and specific...
Standardized vs. Person-Centered

- **Standard Interventions:**
  - Consult dietary
  - Accu checks before meals
  - Insulin as ordered

- **Current effort to individualize**
  - Mary will participate with dietary to maintain diabetic diet
  - Mary will allow accu checks before meals
  - Mary will be given insulin as ordered.

- **Individualized**
  - Mary will discuss her desire to eat chocolate cake and potato chips with the physician
  - Mary will enjoy one piece of chocolate cake each week as ordered by the physician
  - Dietary will substitute one starch per week with the equivalent in potato chips
  - Mary will make food choices that maintain her ordered diet
  - Mary will be able to verbalize the potential consequence to uncontrolled blood sugar levels if she engages in non-prescribed snacking
Individualized vs “I” Care Plan

• I care plans are designed to speak from the perspective of the resident, thereby ensuring the resident is the center of the care planning process
• Take a look at the example on the following slide
Individualized vs “I” Care Plan

- I have been a diabetic for 25 years now and, although I understand completely what I should and should not eat, and can tell you what might happen if I don’t follow my diet, sometimes I just have to have some chocolate cake or a little bag of potato chips. I talked to my doctor, and we have agreed that one piece of chocolate cake each week is a compromise we can both live with. He has also told me that I can have a small bag of potato chips instead of another starch once through out the week. I talked with dietary and they are going to help make sure that happens. Even though I have agreed to these compromises and agree to make food choices that adhere to my diet, sometimes I want to cheat! When I feel that craving, I call the nurse and we talk about my choices and the consequences of choices I make. I keep a food diary that helps me make the connection between what I eat and my blood sugar level. My blood sugar is taken every day before each meal, and my doctor and I like to keep it between 60 and 130. I do try my best to stick to the diet but I also think that at 82-years-old, everyone should have a piece of chocolate cake now and again!
Steps to Individualizing the Plan of Care

• Begin to know the resident immediately
  – Consider interview within 48 hours of admission to individualize the initial care plan with both resident and responsible party
  – Interview staff who have cared for resident in first 48 hours of admission and then ongoing input thereafter
  – Incorporate preferences
  – Incorporate individual reactions to disease processes
  – Incorporate behaviors that fall outside of the facility norm
Behavior and Preferences Outside of the Facility Expectation

• May or may not be related to disease process
  – Resident becomes combative at meal time with a dementia diagnosis
  – Alert and oriented resident chooses not to follow DM diet

• Need to determine cause of behavior
  – Root Cause Analysis

• Accommodate behavior if possible and not a threat to the safety of the resident, other residents or staff
Tools for Root Cause Analysis: 5 Whys and Fishbone Diagrams

- Both methods rely on a clear problem statement
- For our purpose we will examine the 5 Whys approach
- Occasionally the 5 Whys will not identify a root cause, when this happens moving to the Fishbone Diagram will force all areas of the problem area to be explored
- Requires the person administering the analysis to keep the questions on track without leading the response
- Individual administering the test must remain non judgmental and operate with a “Just Culture” mind set
- Can be administered to a group or to individuals
Tips for completing 5 Whys:
1. Develop clear problem statement
2. With each response ask, “If the most recent response were corrected is the problem likely to reoccur?” If the answer is “yes” the response is most likely a contributing factor and not the root of the problem. Continue to question
3. Most likely will require 3 to 5 Why cycles
4. Many problems will have more than one root cause
Common Barriers to Root Cause Analysis

• Problem statement is not clear
  – Example: Why do people fall vs. Why do people on the dementia unit fall in the hour before dinner

• Root Cause dialogue does not keep problem statement as focus
  – Can not allow the Why path to stray to a different problem. Example: People fall because night shift doesn't check on them.
  – In this case the RCA should be directed back to the problem statement while mentally recording the potential of a separate issue.
  – Remember not to discourage people from contributing when this happens. In this case no response is “wrong” but explain the need to keep to the problem statement as written.

• Responses to general
  – Example: People fall before dinner because they are old and can't walk vs People fall before dinner because staff is toileting and they are bored.

• Remember that with practice this process becomes easier.
Interventions and PDSA Cycles

• **Step 1: Plan**
  – Plan the test or observation, including a plan for collecting data
  – State the objective of the test.
  – Make predictions about what will happen and why
  – Develop a plan to test the change. (Who? What? When? Where? What data need to be collected?)

• **Step 2: Do**
  – Try out the test on a small scale
  – Carry out the test.
  – Document problems and unexpected observations.
  – Begin analysis of the data.
Interventions and PDSA Cycles, cont.

• **Step 3: Study**
  – Set aside time to analyze the data and study the results
  – Compare the data to your predictions
  – Summarize and reflect on what was learned

• **Step 4: Act**
  – Refine the change, based on what was learned from the test
  – Determine what modifications should be made
  – Prepare a plan for the next test
What changes are we going to make based on our findings?

What exactly are we going to do?

When and how did we do it?

What were the results?

Plan

What change are you testing with the PDSA cycle(s)?

What do you predict will happen and why?

Who will be involved in this PDSA? (e.g., one staff member or resident, one shift). Whenever feasible, it will be helpful to involve direct care staff.

Plan a small test of change.

How long will the change take to implement?

What resources will they need?

What data need to be collected?

Do

Carry out the test on a small scale.

Document observations, including any problems and unexpected findings.

Collect data you identified as needed during the “plan” stage.

List your action steps along with person(s) responsible and timeline.

Study

Study and analyze the data.

Determine if the change resulted in the expected outcome.

Were there implementation lessons?

Summarize what was learned. Look for: unintended consequences, surprises, successes, failures.

Act

Based on what was learned from the test:

Adapt — modify the changes and repeat PDSA cycle.

Adopt — consider expanding the changes in your organization to additional residents, staff, and units.

Abandon — change your approach and repeat PDSA cycle.

Describe the measured results and how they compared to the predictions.

Describe what modifications to the plan will be made for the next cycle from what you learned.

Disclaimer: Use of this tool is not mandated by CMS, nor does its completion ensure regulatory compliance.
Individualized Care Plan Exercise

• Ima Newgal was admitted 48 hours ago
• Social Service completed an admission interview with the resident, who has moderate dementia and her son Macon Thedecisons.
• Interview results include
  – Grew up on a farm, raised her family on a farm
  – Homemaker by trade
  – Family focused, took care of everyone first, herself last
  – Lost a child in a fire
  – Husband worked from sunrise to sunset then came home for big family meal
  – Made all of the children's clothes and was well known for her baking skills
Care Plan Exercise

• You are doing a chart review on the dementia unit and observe the following interaction between staff and Ima. You are paying particularly close attention as this is her second day of admission and you will be generating her initial care plan this afternoon.

• Devise a Problem Statement, Goal Statement and Interventions based on the scenario you are about to see.

• You may ask questions, but during the skit we will only respond in character. So ask your questions to either Ima or her nurse aide Vanna Bethebest.
Summary

• Individualized, specific, person centered care plans are required; ‘I’ care plans are not required
• A good plan should reflect residents’ concerns and support residents’ rights; not label residents’ choices or needs as “problem behaviors”
• Use a multi-disciplinary approach and QI tools to help develop individualized care plans
• The care plan is a living document that requires ongoing evaluation and revision as the needs of the resident change
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