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MONTANA SWING BED BULLETIN

Developing the Plan of Care

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Developing the Plan of Care

The multi-disciplinary plan of care is the roadmap for the care provided during a patient's stay in Swing Bed, for both the care team and the patient.

The requirements for the Plan of Care can be found in Appendix W, C-1620 §483.21(b) and Appendix PP.

Step 1: Develop a Baseline Plan of Care

Appendix PP requires that a baseline Plan of Care is developed within 48 hours of admission. Remember that Appendix W does not have any Interpretive Guidelines and refers back to Appendix PP.

Usually, admission orders and the nursing care plan will cover this requirement.

F655 §483.21(b)(3): "The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary.

Baseline care plans are required to address, at a minimum, the following: Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASARR recommendation, if applicable."

This issue:

Step 2: Schedule the Care Plan Meeting

As soon as possible after admission, it is important to schedule the first multi-disciplinary meeting. With an average length of stay of only 12 days, the meeting should be scheduled no later than 3 days after-admission and sooner if possible.

Plan on a sufficient amount of time at the first meeting to discuss and develop the comprehensive Plan of Care. This typically takes 30 – 45 minutes. Attendees must include: the attending physician, registered nurse with responsibility for the patient, CNA with responsibility for the patient, member of the food and nutrition services staff, others as appropriate (PT, OT, Speech, Pharmacy, etc.), and to the extent practicable the patient or representative.

Step 3: Review the Multi-Disciplinary Assessment

An accurate and comprehensive admission assessment is extremely important as the basis for developing a person-centered Plan of Care. All members of the team should take the time to review the assessment of other disciplines prior to the meeting. The components and timeframes for completing the admission assessment were covered in last month's newsletter.

Step 4: Develop a Person-Centered Plan of Care

The primary focus of the Care Plan meeting is to develop the multi-disciplinary Plan of Care. CMS requires that the Plan of Care *"includes measurable objectives and timeframes to attain or maintain the patient's highest practicable physical, mental, and psychosocial well being that were identified in the comprehensive assessment".*

Developing a person-centered Plan of Care means that the patient's goals for admission and desired outcomes, including preference for discharge are included. In some instances, the patient's goals may not appear to be realistic, such as wanting to go home and live independently. Regardless, the Plan of Care must represent the patient's wishes.

It's important to remember that the Plan of Care is not a duplicate of the nursing care plan. The Plan of Care should include only those focused goals specific to the Swing Bed stay.

Two examples are included on the next page that illustrate how to write goals that are measurable and time limited.

Step 4: Goal Examples

Example 1

Discharge Goal: Mr. Jones's goal is to be discharged home, with home health if needed. He will be living with his wife.

Long Term Goal *(to be achieved prior to discharge):*
Mr. Jones will be able to dress and undress independently prior to discharge.

Responsible Discipline(s): Occupational Therapy and Nursing

Short Term Goals

1. Mr. Jones will be able to put on shirt and pants independently within 5 days of admission.
2. Mr. Jones will be able to put on shoes independently within 7 days of admission.
3. Mr. Jones will undress and put on pajamas independently within 7 days of admission.

Example 2

Discharge Goal: Ms. Love's goal is to be discharged back to the Assisted Living where she resided prior to her Swing Bed stay.

Long Term Goal *(To be achieved prior to discharge):*
Ms. Love will check blood sugars and administer insulin independently prior to discharge.

Responsible Discipline(s): Nursing and Pharmacy

Short Term Goals

1. Ms. Love will demonstrate appropriate technique and times for checking blood sugar within 2 days of admission.
2. Ms. Love will identify correct dose of insulin based on blood sugar within 3 days of admission.
3. Ms. Love will demonstrate drawing up insulin and administering insulin using sterile technique within 5 days of admission.
4. Ms. Love will identify signs and symptoms of hypoglycemia and hyperglycemia and actions to take if either occur within 5 days of admission.

Step 5: Document Plan of Care in the Medical Record

The electronic medical record (EMR) does not usually have a template for documenting a Swing Bed Plan of Care. There are several options to consider, although I must admit none of them are ideal.

1. Document the Plan of Care in a progress note or other free form text.
2. Develop an EMR template.
3. Document on paper and scan in the medical record.

MT Flex Program provided a template that you may find useful. It can be found by accessing this link: Multi-Disciplinary Care Plan and IDT Note

Step 6: Post the Plan of Care in the Patient's Room

Posting both the long term goal, which must be achieved prior to discharge, as well as daily or weekly goals helps not only the patient but also the care team stay on track.

The goals should be updated at least every week, but more often if there are new goals or current goals are modified.

Remember to assign someone responsibility for updating the information in the patient's room so it doesn't get missed.

Step 7: Schedule Ongoing Multi-Disciplinary Meetings

Ideally, the multi-disciplinary meeting is held twice per week, but at a minimum should be scheduled once per week. The focus of the meeting should be on reviewing patient's progress and if goals have been achieved or need to be modified.

The meeting is not a nursing report but should be focused specifically on the goals established for the Swing Bed stay.

The individual leading the meeting, typically the Case Manager or a provider, can facilitate the discussion by asking:

- Discharge Plan: Any update on discharge plans? Has anything changed? Does the discharge place or timeline need to be modified?
- Long Term Goals. Has the goal been met? Does the goal need to be modified?
- Short Term Goals. Are the goals being met? Do the goals need to be modified?
- Additional Goals: Are there any additional goals that need to be added
- Weight: Has the patient experience a weight loss or gain since the last meeting and if so how much as the weight changed? If more than 5% has the dietician assessed the patient, and what are the recommendations?
- Patient Input: Does the patient agree with the goals and plan? Any patient issues or feedback?

If the patient does not attend, review the Care Team's recommendation and document concurrence with the plan after the meeting.

Step 8: Reassess and Modify the Plan of Care after Significant Change

If the patient experiences any significant change, there must be a comprehensive reassessment and the Plan of Care modified.

The CMS definition of a significant change includes:

- *Deterioration in two of more activities of daily living (ADLs), or any combination of deterioration in two or more areas of ADLs, communication, or cognitive abilities that appear permanent.*
- *Loss of ability to ambulate freely or to use hands to grasp small objects to feed or groom oneself, such as spoon, toothbrush, or comb.*
- *Deterioration in behavior or mood, to the point where daily problems arise or relationships have become problematic and staff conclude that these changes in the resident's psychosocial status are not likely to improve without staff intervention.*
- *Deterioration in a resident's health status, where this change places the resident's life in danger (e.g., stroke, heart disease, metastatic cancer); where the change is associated with a serious clinical complication (e.g., initial development of a stage III pressure sore, prolonged delirious state, or recurrent decline in level of consciousness); or change that is associated with an initial diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time (e.g., Alzheimer's disease or diabetes); or the onset of significant, unplanned weight loss (5% in the last 30 days, 10% in the last 180 days).*

Special Considerations and Challenges

Scheduling the Care Plan Meeting

Scheduling the meeting so that the Care Team and the patient can attend can be challenging. The time of day will vary by facility, but communicating the importance of the meeting and requesting leadership support may sometimes help. In some facilities, the CEO, CFO and/or CNO attend the meetings, which reinforces the importance of the meeting.

Appendix PP §483.10(c)(2)-(3) includes language regarding involvement of the patient:
"staff support and encourage participation in the care planning process. This may include ensuring that residents, families, or representatives understand the comprehensive care planning process, holding care planning meetings at the time of day when a resident is functioning best, providing sufficient notice in advance of the meeting, scheduling these meetings to accommodate a resident's representative (such as conducting the meeting in-person, via a conference call, or video conferencing), and planning enough time for information exchange and decision making".

Nutrition

The hydration and nutritional status of the patient must be closely monitored. There should be a dietician assessment at admission, even though the patient may not have any nutritional risk factors at the time of admission, and then weekly thereafter. Since the dietician is not always able to attend the Care Plan meetings, the representative from dietary must be able to address any recommendations from the dietician, and provide an update on any goals related to nutrition or hydration.

Special Considerations and Challenges (continued)

Intermediate Swing Bed

Some Swing Bed programs provide care for Medicaid patients that require long term care, when a long term care facility is not available.

All of the Swing Bed regulations apply. However, after the initial development of the Plan of Care, a review every thirty (30) days is more appropriate than weekly given the length of stay.

Intermediate Swing Bed patients will benefit from implementing many of the Long Term Care regulatory requirements such as Psychotropic Drug Review.

Trauma Informed Care

As outlined in the December newsletter, the facility is required to assess for trauma, and if identified include strategies as part of the Plan of Care to prevent re-traumatization. Trauma may be long-standing such as PTSD, or more recent such as loss of a family member, friend or pet.

PASARR

The Plan of Care must include any specialized services or specialized rehabilitative services that will be provided as the result of PASARR recommendations. A PASARR is not required for Swing Bed patients, unless required by the State (typically for Medicaid patients). However, if the patient has a PASARR then the findings must be taken into consideration and included in the Plan of Care.

Test Your Knowledge

Answer each T (true), F (false), M (maybe).

1. A baseline care plan must be developed within 48 hours of admission.
2. The goal for discharge should be developed by the care team.
3. It's not a problem if the physician can't attend the Care Plan meeting.
4. It's not a problem if the patient can't attend the Care Plan meeting.
5. The Plan of Care must include measurable objectives and timelines.
6. The Plan of Care must be updated after a significant change in the patient's condition.

Answer Key

1. True
2. False
3. Maybe
4. Maybe
5. True
6. True

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February Issue
Discharge Processes