Swing Bed Quality Improvement Project
User Group Call

Swing Bed Plan of Care

Carolyn St. Charles, HealthTechS3
January 21, 2022

Welcome! We will begin shortly while everyone gets logged in!

Roll Call

Unmute and tell us your:

Name

Facility

In the chat box…

What is the most important question you hope to have answered today?

MHA MONTANA HOSPITAL ASSOCIATION

Advancing Health in Montana

Presenter

Carolyn St.Charles
Chief Clinical Officer, HealthTechS3

Carolyn began her career in healthcare as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative and consulting roles, and has been in her current position as Chief Clinical Officer with HealthTechS3 for the last 15 years.

In her role as Chief Clinical Officer, Carolyn conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, Long Term Care, Rural Health Clinics, Home Health and Hospice. Carolyn also assists in developing strategies for continuous survey readiness and developing plans of correction.

Carolyn has extensive experience in working with rural hospitals to both develop, and strengthen, Swing Bed programs.

carolyn.stcharles@healthtechs3.com
206-605-3748

Regulatory Requirements

CMS revised regulatory rules in October 2018, with additional changes in November of 2019. The rules were published in February of 2020 in the Conditions of Participation

1. Appendix W Critical Access Hospitals (Rev. 200, 02-21-20)

2. Appendix A PPS Hospitals (Rev. 200, 02-21-20)

Interpretive Guidelines are in Appendix PP – CMS has said they have no intention of writing interpretative guidelines for Swing Bed regulations

3. Appendix PP Long Term Care Facilities (Rev. 11-22-17)

Comprehensive Assessment

C-1620 §483.20(b)

A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. (**CAHs don't have to use RAI)** The assessment must include at least the following:

1. Identification and demographic information
2. Customary routine
3. Cognitive patterns
4. Communication
5. Vision
6. Mood and behavior patterns
7. Psychosocial well-being – HISTORY of traumatic events
8. Physical functioning and structural problems
9. Continence
10. Disease diagnoses and health conditions
11. Dental and nutritional status
12. Skin condition
13. Activity pursuit
14. Medications
15. Special treatments and procedures
16. Discharge potential
17. Review of PASSAR – if one has been done

Make sure all elements are assessed including History of Trauma and Review of PASSAR

Not everything has to be assessed by nursing!

Culturally Competent Trauma Informed Care

C-1620 §483.21(b)
(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(i) Meet professional standards of quality. (ii) Be provided by qualified persons in accordance with each resident's written plan of care.
(iii) Be culturally-competent and trauma-informed.

Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.

http://traumainformedcareproject.org/index.php

Goal: Eliminate or mitigate triggers that could cause re-traumatizing of the resident (F-699)

Sample Assessment Questions - *MY QUESTIONS – NOT FROM CMS*
1. Has there been anything within the last six months to a year that has caused you to be upset or very worried?
2. Have you experienced the loss of a close friend, relative or a pet that you loved recently?
3. Have you had any past trauma in your life that we should know about so we can better care for you?
4. If you have experienced some kind of trauma is there something that helps you feel better?
5. Is there anything we can do to help while you are in the hospital?

Include as part of Nursing or Social Work or Case Management Assessment

Comprehensive Assessment

Assessment	Components of Assessment	Primary	Secondary
Customary Routine	❑ Time wake up ❑ Time go to sleep ❑ Naps ❑ Time eat meals (Bkf / Lunch / Dinner ❑ Other	Activities Nursing	
Cognitive Patterns	❑ Cognition Measurement Tool at end	Provider	Nursing
Communication	❑ Ability to express ideas and wants, consider both verbal and non-verbal expression. ❑ Understood. ❑ Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time. ❑ Sometimes understood - ability is limited to making concrete requests. ❑ Rarely/never understood.	Nursing	Provider
Vision	❑ Corrective Lenses ❑ Cataracts ❑ Blind	Nursing	

Comprehensive Assessment

Assessment	Components of Assessment	Primary	Secondary
Mood	❑ Little interest or pleasure in doing things ❑ Feeling down, depressed or hopeless ❑ Trouble falling or staying asleep, or sleeping too much ❑ Feeling tired or having little energy ❑ Poor appetite or overeating ❑ Feeling bad about yourself – or that you are a failure or have let yourself or your family down ❑ Trouble concentrating on things such as reading the newspaper or watching television ❑ Moving or speaking so slowly that other people have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual ❑ Thoughts that you would be better off dead, or of hurting yourself in some way	Social Work or Nursing	
Behavior	❑ Hallucinations ❑ Delusions ❑ Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others) ❑ Verbal behavioral symptoms directed toward others (threatening, screaming, cursing) ❑ Other behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste	Nursing	Provider

Comprehensive Assessment

Assessment	Components of Assessment	Primary	Secondary
History of traumatic events	❑ Has there been anything within the last six months to a year that has caused you to be upset or very worried? ❑ Have you experienced the loss of a close friend, relative or a pet that you loved recently? ❑ Have you had any past trauma in your life that we should know about so we can better care for you? ❑ If you have experienced some kind of trauma is there something that helps you feel better? ❑ Is there anything we can do to help while you are in the hospital?	Social Work	Nursing
Cultural Component	❑ Determine if there are any cultural beliefs / customs that will impact care.	Social Work	Nursing
PASRR	❑ IF patient has a PASRR (usually completed if patient was a resident of LTC) review PASRR	Social Work	Nursing
Physical functioning and structural problems	❑ Independent ❑ Setup or Clean-up Assistance ❑ Supervision or touching assistance ❑ Partial/moderate assistance ❑ Substantial/maximal assistance ❑ Dependent	PT	Nursing

Comprehensive Assessment

Assessment	Components of Assessment	Primary	Secondary
Continence, bladder and bowel	☐ Urinary incontinence ☐ Bowel incontinence	Nursing	
Active diagnosis		Provider	
Health conditions		Provider	
Dental	❑ Dentures (fitting / loose) ❑ Broken Teeth ❑ Overall dentation	Nursing	Dietician
Swallowing	❑ Loss of liquids/solids from mouth when eating or drinking ❑ Holding food in mouth/cheeks or residual food in mouth after meals ❑ Coughing or choking during meals or when swallowing medications ❑ Complaints of difficulty or pain with swallowing	Nursing	Dietician
Nutrition	❑ Nutrition Risk Assessment ❑ Loss of 5% or more in the last month or loss of 10% or more within last 6 months	Nursing	
	❑ Dietician Nutrition Assessment	Dietician	
Skin condition	❑ Braden Scale ❑ If pressure ulcers or skin breakdown, describe in nursing notes	Nursing	

Comprehensive Assessment

Assessment	Components of Assessment	Primary	Secondary
Activity pursuit	What do you like to do? ❑ Reading – print or audio books ❑ Puzzles ❑ Word games ❑ Watching TV ❑ Knitting / Crocheting ❑ Visiting with friends ❑ Other Remember – Formal activities program not required – but preferred activities are still is part of the comprehensive assessment	Activities or Nursing	
Medications	❑ Medication Reconciliation	Nursing	Pharmacy
Special treatments and procedures and programs		Provider Orders	
Restraints and alarms		Nursing	

Plan of Care

C-1620 §483.21(b) Comprehensive care plans

(1)The facility must develop and implement a **comprehensive person-centered care plan for each resident**, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive 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 §483.24, §483.25, or §483.40; and

(ii)Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of **PASARR** recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record

Plan of Care

C-1620 §483.21(b) Comprehensive care plans

(i)In consultation with the resident and the resident's representative(s)—The **resident's goals for admission and desired outcomes.**

(A) The **resident's preference and potential for future discharge**. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(B)Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

(C)Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section

APPENDIX PP F553: PARTICIPATION

GUIDANCE §483.10(c)(2)-(3)

Residents and their representative(s) must be afforded the opportunity to participate in their care planning process and to be included in decisions and changes in care, treatment, and/or interventions.

This applies both to initial decisions about care and treatment, as well as the refusal of care or treatment. Facility staff must 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.

A resident has the right to select or refuse specific treatments options before the care plan is instituted, based on the information provided as required under §483.10(c)(1), (4)-(5), F552.

While Federal regulations affirm a resident's right to participate in care planning and to refuse treatment, the regulations do not require the facility to provide specific medical interventions or treatments requested by the resident, family, and/or resident representative that the resident's physician deems inappropriate for the resident's medical condition.

A resident whose ability to make decisions about care and treatment is impaired, or a resident who has been declared incompetent by a court, must, to the extent practicable, be kept informed and be consulted on personal preferences.

The resident has the right to see the care plan and sign after significant changes are made.

Plan of Care

C-1620 §483.21(b)
(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) **Prepared by an interdisciplinary team**, that includes but is not limited to—
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

Too Long for Swing Bed -
Must be appropriate to the anticipated LOS

F553 §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care

Appendix PP F655: Baseline Care Plan

F655 §483.21(b)(3) Comprehensive Person-Centered Care Planning

The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

INTENT §483.21(a)
Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

Appendix PP F655: Baseline Care Plan

GUIDANCE §483.21(a)
Nursing homes are required to develop a baseline care plan within the first 48 hours of admission which provides instructions for the provision of effective and person-centered care to each resident. This means that the baseline care plan should strike a balance between conditions and risks affecting the resident's health and safety, and what is important to him or her, within the limitations of the baseline care plan timeframe.

Person-centered care means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home.

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.

Plan of Care - Measurable Objectives and Timeframes

C-1620 §483.21(b) Comprehensive care plans.

(1)The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

F656 §483.21(b) Comprehensive Care Plans

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

.

.

Example Plan of Care & IDT Notes

Patient Discharge Goal: Home with family
Long Term Goals (to be met prior to discharge)

Example Goal 1: Patient will be able to dress independently within 2 weeks and prior to discharge

Example Goal 2: Patient will receive 14 days of antibiotic therapy

Example Goal 3: Patient will improve nutritional status as evidenced by an increase in BMI to ____within 2 weeks and prior to discharge

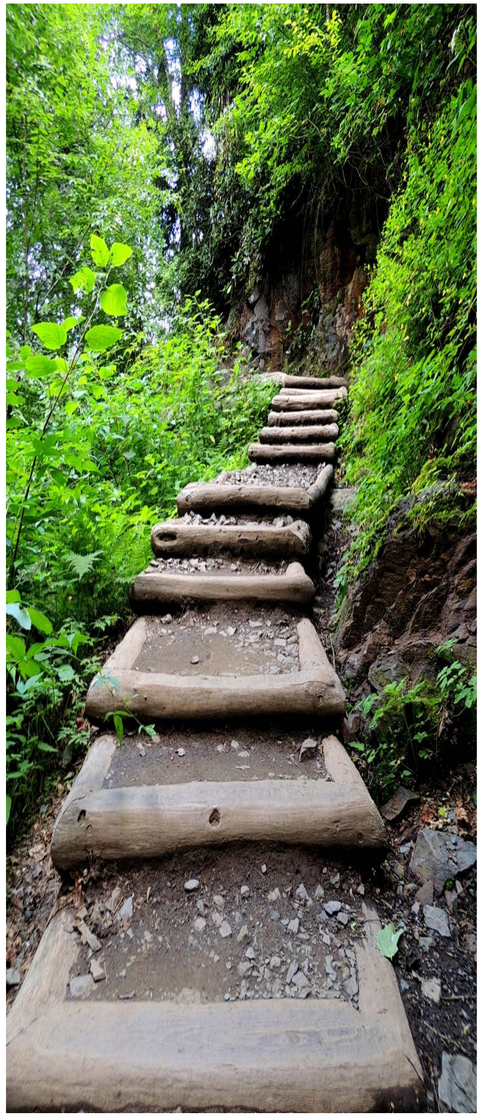
Example Goal 4: Patient will give insulin independently including accurately checking blood sugar, understanding dose based on blood sugar, when to administer, how to administer within 2 weeks and prior to discharge

EXAMPLE PLAN OF CARE & IDT NOTES

EXAMPLE: MULTI-DISCIPLINARY CARE PLAN and IDT Note

Long Term Goal	Short Term Goals	Interventions	Discipline Responsible	Date	Date	Date	Date
Goal 1: Patient will be able to dress independently within 2 weeks (April 10)	Patient will be able to put on shirt and pants independently within 5 days (April 1)	1. OT will que patient to dress each morning with increasing independence Monday – Friday	Occupational Therapy	☐ Met ☐ Not Met ☐ Modified	☐ Met ☐ Not Met ☐ Modified	☐ Met ☐ Not Met ☐ Modify	☐ Met ☐ Not Met ☐ Modified
		2. Nursing will que patient to dress each morning Saturday - Sunday	Nursing				
	Patient will be independently put on shoes within 7 days (April 3)	1. OT will que patient to put on shoes each morning Monday – Friday	Occupational Therapy				
		2. Nursing will que patient to put on shoes each morning Saturday – Sunday	Nursing				
	Patient will undress independently within 7 days and put on pajamas (April 3)	1. OT will que patient to undress and put on pajamas each evening Monday - Friday	Occupational Therapy				
		2. Nursing will que patient to undress and put on pajamas each evening Saturday – Sunday	Nursing				

Comprehensive Plan of Care – Step by Step



Step 1: Review the assessment

The plan of care starts with the comprehensive assessment!

- Must include all elements
- Must include discussion with patient

All members of the team should take the time to review the assessment of other disciplines

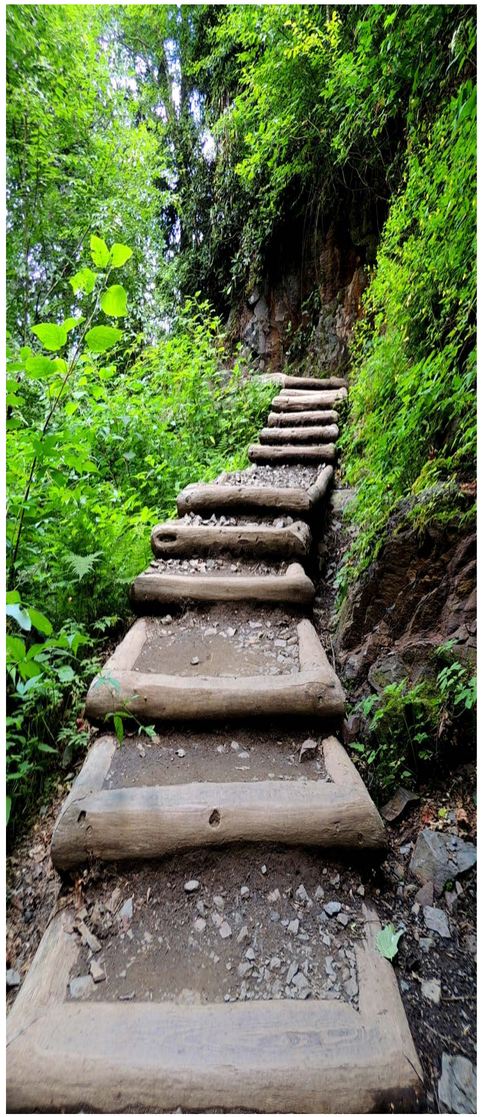
Step 2: Determine patient's goals

- Determine the patient's goals for admission and desired outcomes
- Determine the patient's preference and potential for future discharge
- Document as part of the comprehensive care plan

It's not the teams' goals – it's the patients goals

Decide who will gather this info – RN / Case Manager / Social Work

Comprehensive Plan of Care – Step by Step



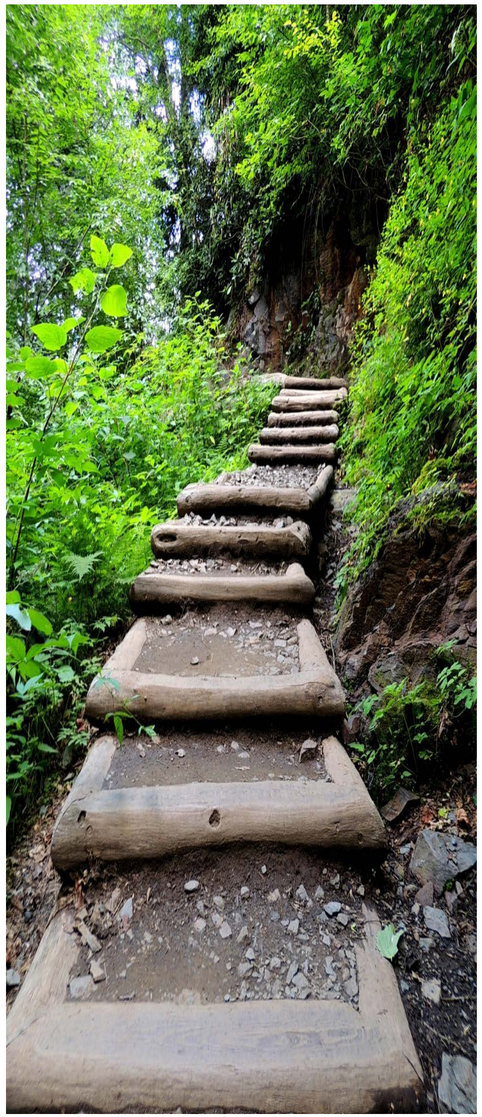
Step 3: Schedule INITIAL multi-disciplinary team meeting

- Initial meeting usually takes 30 – 45 minutes
- Invite patient and/or family
- Attendees: Provider, RN caring for patient, CNA caring for patient, Representative from dietary, Others as appropriate (PT, OT, Speech, Pharmacy, etc.)

Step 4: Develop Plan of Care

- Review / Discuss
  - Patient's goals for admission and desired outcomes
  - Patient's preferences for discharge
  - Each discipline's assessment (Focus on those areas specific to why the patient has been admitted to Swing Bed)
- Develop Goals
  - Long Term Goals (measurable objectives and timeframes
  - Short Term / Intermediate Goals (measurable objectives and timeframes)
  - Document patient's concurrence with goals

Comprehensive Plan of Care – Step by Step



Step 5: Document Plan of Care in Medical Record (This is not a nursing care plan)

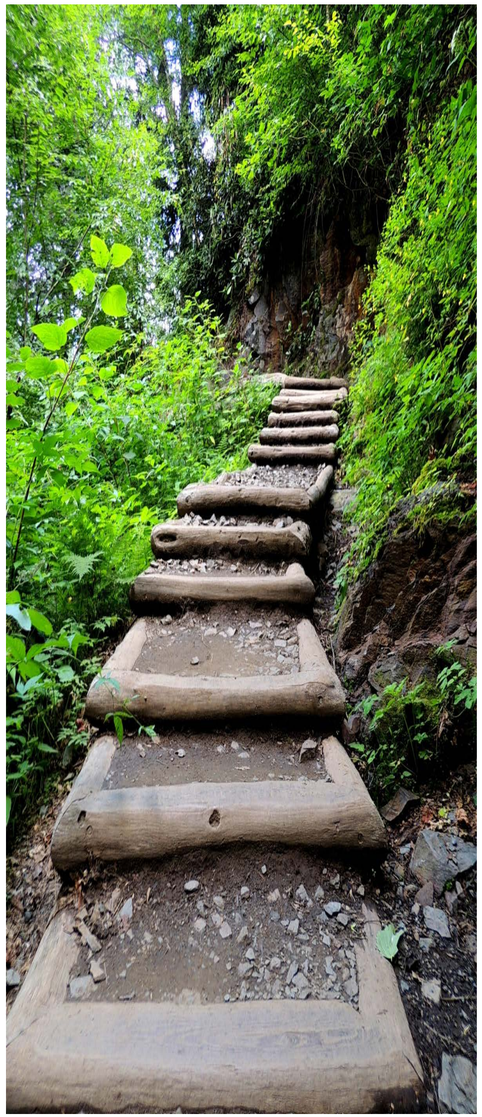
Step 6: Post Plan of Care in Patient's Room

- Include both Long Term Goal and Short Term Goals for day or week

Step 7: Schedule at least weekly multi-disciplinary meetings (better if twice per week)

- Review Long Term Goal(s)– has anything changed? – does the long term goal need to be modified?
- Review Short Term Goals – has anything changed? - do any goals need to be modified?
- Review with patient if not in attendance at meeting – ensure documentation of patient's concurrence with goals

Comprehensive Plan of Care – Step by Step



Step 8: Discharge Plan of Care

- Review all goals
- Document if met or not met and if not met – why?
- Provide plan of care to next post-acute provider (Home Health, Long Term Care, etc.)

Plan of Care: Assessment of Compliance

	Yes - Always	Sometimes	Never
❑ Baseline care plan within 48 hours of admission that includes initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASARR recommendations if applicable			
❑ Comprehensive person-centered plan of care developed and implemented to meet preferences and goals, and address resident's medical, physical, mental and psychosocial needs			
❑ Plan of Care includes any specialized services as result of PASARR			
❑ Plan of Care includes Resident's goals for admission and preferences for discharge			
❑ Plan of Care completed within the timeline established by Facility Policy			
❑ Plan of Care prepared by interdisciplinary team that includes: Attending physician, RN with responsibility for resident, NA with responsibility for resident, Member of food and nutrient staff, To the extent practicable, the resident and resident's representative.			
❑ Resident involvement in Plan of Care including establishing goals, outcomes of care, type, amount frequency and duration of care.			
❑ Resident informed of any changes to Plan of Care including the right to sign after significant changes			
❑ Care Planning meetings held at a time Resident of family or representative can attend			
❑ Care Plan includes Person-specific, measurable objectives and timeframes in order to evaluate resident's progress toward his/her goals			
❑ Care Plan updated as applicable.			

Next Up

Date	Activity	Notes
February 5, 2021	December 2021 Discharges SWB Data Due	Enter/Upload to QHi
February 18, 2021	User Group Call	
Schedule records review and site education		

MHA MONTANA HOSPITAL ASSOCIATION
Advancing Health in Montana

Contact

Jennifer Wagner**, CPHQ**	**Carolyn St. Charles, RN, BSN, MBA**
MT Flex Program/MHA	HealthTechS3
Rural Hospital Improvement Coor.	Chief Clinical Officer
Jennifer.wagner@mtha.org	carolyn.stcharles@healthtechs3.com
406-457-8000	360-584-9868

Project Website - https://mtpin.org/swbqip/

MHA MONTANA HOSPITAL ASSOCIATION
Advancing Health in Montana