Reimagining the Plan of Care

Building a plan that supports strong clinical care in the home.

QUALIDIGM

Charlotte Steniger, RN MSN COS-C
CHAP/ACHC

- RN for 23 years, 18 in Home Health
- Educator in Home Health regulation and practice for 14 years
- COS-C since 2006
- Connecticut Association for Health Care at Home: Education Committee member since 2012

QUALIDIGM

Objectives

- Identify how critical elements in home care assessment, planning and documentation relate to the nursing process.
- Define the core assessment components related to care plan development.
- Discuss how clinical assessment documentation should drive plan of care elements.
- Identify key elements of successful plan of care implementation.

QUALIDIGM

Nursing Process in Home Health

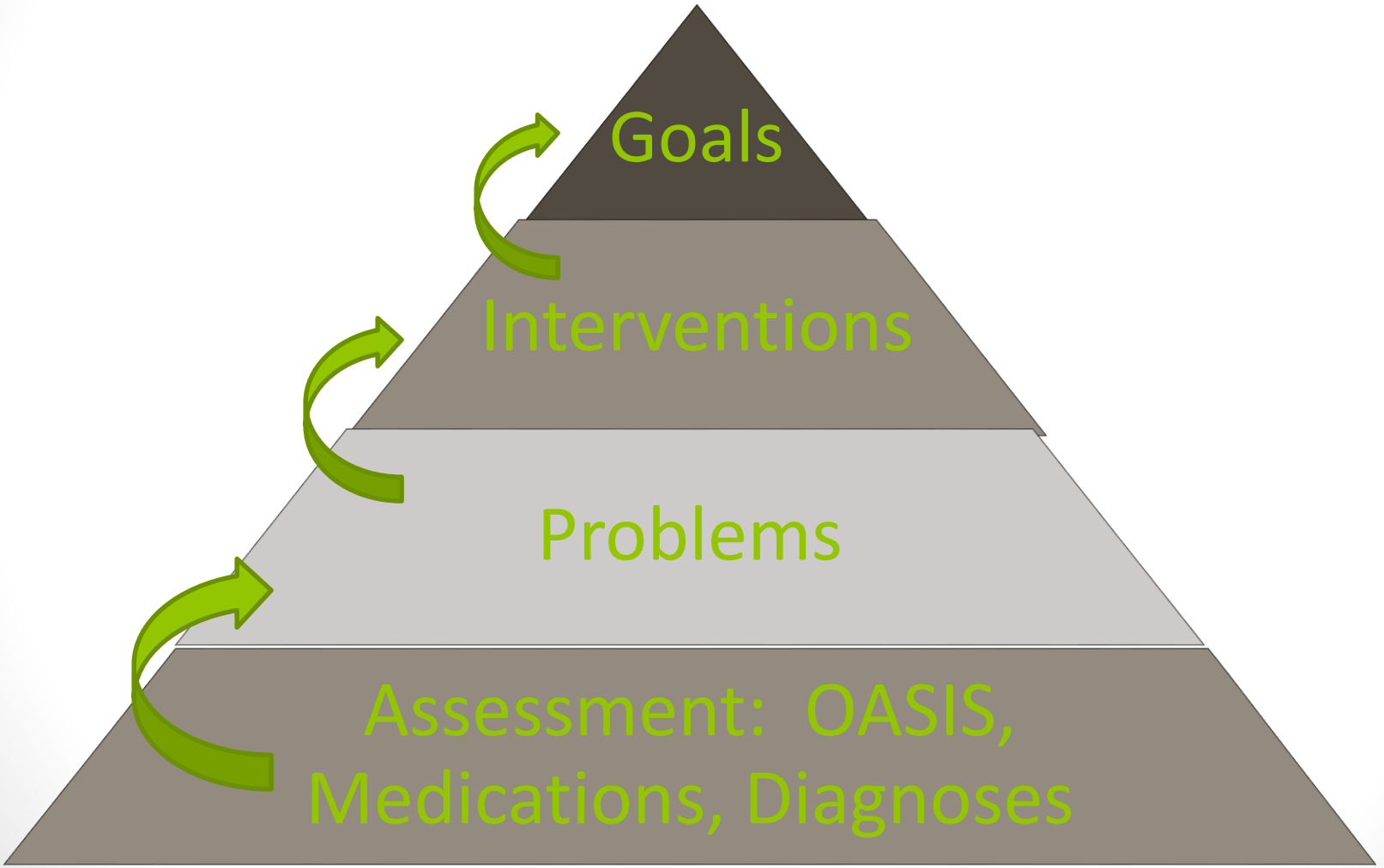
- Assess –OASIS
- Plan– Plan of Care/485
- Obtain the order—Verbal order
- Implement—Do and Document
- Evaluate—Routine Visit/discharge planning

The reality…

So how can we go at this in a more organized fashion?

QUALIDIGM

Plan of Care Pyramid



QUALIDIGM

Start at the very beginning…

- Assessment—OASIS
- Why
  - Mandated by CMS
  - Drives Outcome and Process measures
    - What are those?
      - Outcome: did you make your patient better?
      - Process: did you follow evidence-based practices when you cared for your patient?
  - Determines agency reimbursement

What is are the elements of your assessment?

QUALIDIGM

Core elements of the assessment that drive the POC

- Assessment
  - Recent PMH: recent in patient discharge details, or physician report, or recent changes
  - Cardio/pulmonary status, including vital signs, pulse oximetry (if appropriate), edema
  - GI/GU: appetite, nutrition, bowel/bladder function, continence
  - Sensory: Pain, vision, sensory elements
  - Skin: surgical/wound/cellulitis or other skin integrity issues
  - Medications: reconciliation and review with MD
  - Neurologic/MS: weakness, moving, coordination, falls
  - Mobility/ADLs: ability to meet personal care needs
  - Mental: Orientation, Cognitive, Behavioral abilities

Important assessment tools**

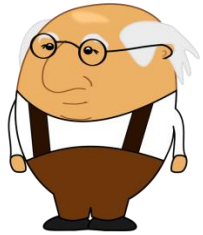
- Fall Risk Assessment: MACH 10/ TUG
- Risk for Skin Breakdown Assessment: BRADEN SCALE
- Depression Risk: PHQ2 / PHQ9, the Cornell Scale
- Patient's defined risk for hospitalization assessment: Patient Self- Hospitalization Risk Assessment
- Risk for Re-hospitalization Assessment: Hospitalization Risk Assessment

** CoP reg: 484.50 Patient Rights, 484.55 Comprehensive Assessment, 484.60 Care Planning, Coordination of Services and Quality of Care,

QUALIDIGM

Meet Jim Smith

- 78 year old male, lives alone. 5’ 5’’, 230 lbs.
- Diagnoses: CHF, HTN, unsteady gait, fall, OA, Glaucoma



Just came home after a recent fall and hypotensive episode related to a recent medication change. SN and PT services were ordered.

What targeted assessment activities will you perform?

QUALIDIGM

Jim Smith's Assessment

- Assessment:
  - A&Ox5, able to follow direction and pleasant
  - C/P: no chest pain, +2 pitting edema to BLE, Lung sounds diminished, B/P 102/66, P: 66, Resp.: 22, temp 99.0 <3 sec cap refill.
  - GI/GU: Appetite good, not compliant with NAS diet, reports moving bowels QD, +BS to all quads. Continent of urine, output unremarkable.
  - Sensory: C/o pain to lower back 5/10, worse since hospitalization takes Motrin, poor vision, HOH, no swallowing or speech issues
  - Skin: skin tear on left forearm that is covered with band aid
  - Medications: Lasix 20mg or 40 mg (Jim is not sure) QD, Losartan 25mg QD, MVI 1 tab QD
  - Neuro/MS: C/o dizziness when standing, denies decreased sensation to extremities or peripheral neuropathy noted
  - Mobility: Ambulates with cane, gait unsteady, poor balance with transfers. Unable to shower by himself,
  - Mental: denies anxiety or confusion. Reports that he takes his Paxil.

But what about the patient

- So how to do you help Mr. Smith be an active participant in his care?
  - Define his goal
    - He states: “I don’t want to fall anymore and wind up in the hospital.”
  - Develop a patient specific problem list for him (worded at patient’s learning level)
    - Mr. Smith: “I don’t understand my medications and can’t seem to keep my balance.”
  - Define what things does he want to do/learn to help him meet his goal. (again worded at his learning level)
    - “I want to learn more about my medications and ways I can keep from falling”.

Integrate that plan in your POC that is sent to the patient’s physician AND communicate that with other health care team members

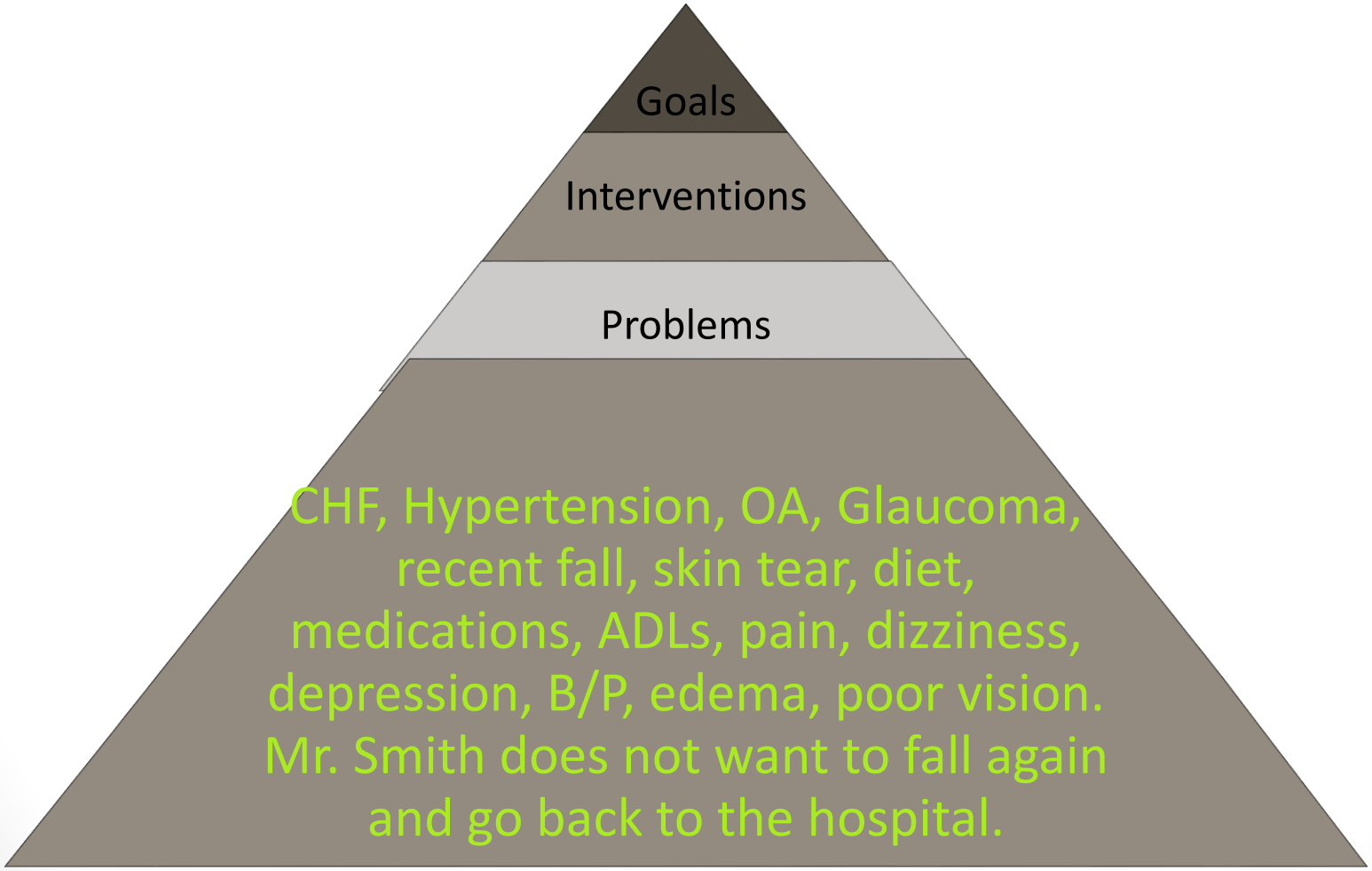
QUALIDIGM

So did you capture it?

- In your SOC assessment documentation
  - Ensure that you don't miss important components
    - Physician notification of patient's condition
    - Documentation of what you did, what skill you performed?
      - Teaching? What, who, how was it received? Did patient verbalize understanding of everything you taught?
    - Documentation of continued skilled need, why do you still need to be involved?
      - What is your plan, what else do you plan to teach?
    - Drug Regime Review: Are the medications listed on the discharge paperwork MATCH what the patient is taking at home and MATCH what the patient reports he/she is taking?

DOCUMENT DOCUMENT DOCUMENT

Building the Foundation



QUALIDIGM

10 day summary/Narrative

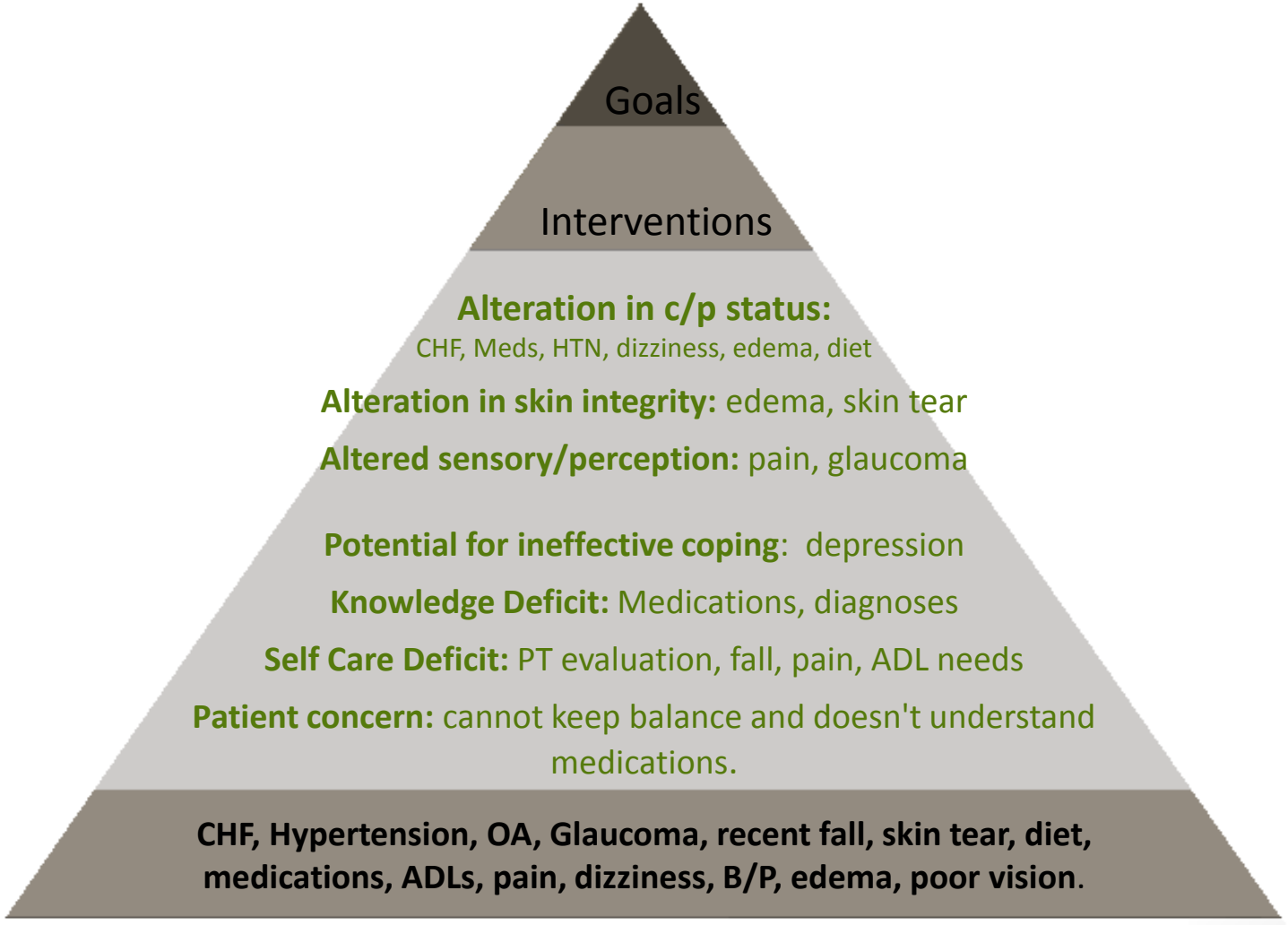
- Patient was recently referred to ABC Home Health for SN and PT services following recent hospitalization for Hypotension and recent fall. Patient's PMH includes: CHF, OA, HTN and glaucoma. Patient presents alert and oriented x5, receptive to interview and SN visit. Patient c/o pain to lower back and has a skin tear on his left forearm 3cm x 1cm x 0.2cm. The skin tear was found covered with a band aid wound bed is pink and moist, with moderate serous draining. It was cleansed with soap and water and DCD applied.

- Patient is SOB with 50 feet ambulation, denies chest pain, +2 bilateral pedal edema, <3 second cap refill. Reports good appetite, however verbalized needing more information about low salt diet. Moving bowels QD with + bowel sound to all 4 quadrants. Continent of bowel and bladder, states urine output has been unremarkable. Patient demonstrated ambulation from living room to bedroom, on and off bed and on and off toilet. Gait is unsteady with cane, PT evaluation warranted. Able to meet personal care need with assist from neighbor; refused HHA services. Pain to lower back rated at 5/10 at worst and completely subsides with Motrin, which he takes 600mg BID, PRN. Patient's B/P 102/66 (sitting) 88/50 (standing), pulse 88, resp 22, and temp 99.0. Reports compliance with medication regime from hospital, however was confused about which does of Lasix to take as he reports dosage decreased when in hospital. Patient also mentioned taking Paxil prior to his recent hospitalization. When asking Mr. Smith about his goal for care he stated, "I don't want to fall anymore and wind up in the hospital."

10 day summary/Narrative continued

- TC to Dr. Morgan to report SOC findings, patient's goal for care, verify the POC and for medication reconciliation/review. MD ordered soap and water wash, f/b antibiotic ointment and a DCD to skin tear QD, which was taught to patient; returned demonstration proficiently. MD confirmed patient to take 20mg Lasix daily, restart his Paxil and has a confirmed diagnosis of Depression. He wants him to schedule an appointment with him next week for the Face-to-Face appointment. Patient verbalized understanding of the appointment instructions, however requires follow up for medication, fall prevention and cardiac disease management teaching and assessment. Plan to see patient 2x week for 3 weeks then 1 x week for 6 week. Next SN appointment is scheduled with the patient for early next week to review medication regime, c/p status and diet teaching. A PT evaluation ordered by Dr. Morgan to be completed by next Friday. Report left for Physical Therapist. Patient is considered homebound as she leaves the house only 1-2x a month to seek medical care/appointments for only 2-3 hours. His taxing effort include his inability to ambulate >50 feet safely requiring assistance to negotiate stairs and steps due to pain and decreased endurance.

Defining your focus



QUALIDIGM

So what are you going to do?

QUALIDIGM

How to write goals

Writing SMART goals…

- S= Specific: should relate directly to your intervention.
- M= Measurable: should be clearly measurable.
- A= Achievable: considerate of limitations and constraints
- R= Realistic: considerate of the patient's skills, abilities and reflective of the resources you have.
- T=Timeframe: can be achieved in the time you have to provide care for the patient. Need both short term and long term goals defined.

What is wrong with this goal?

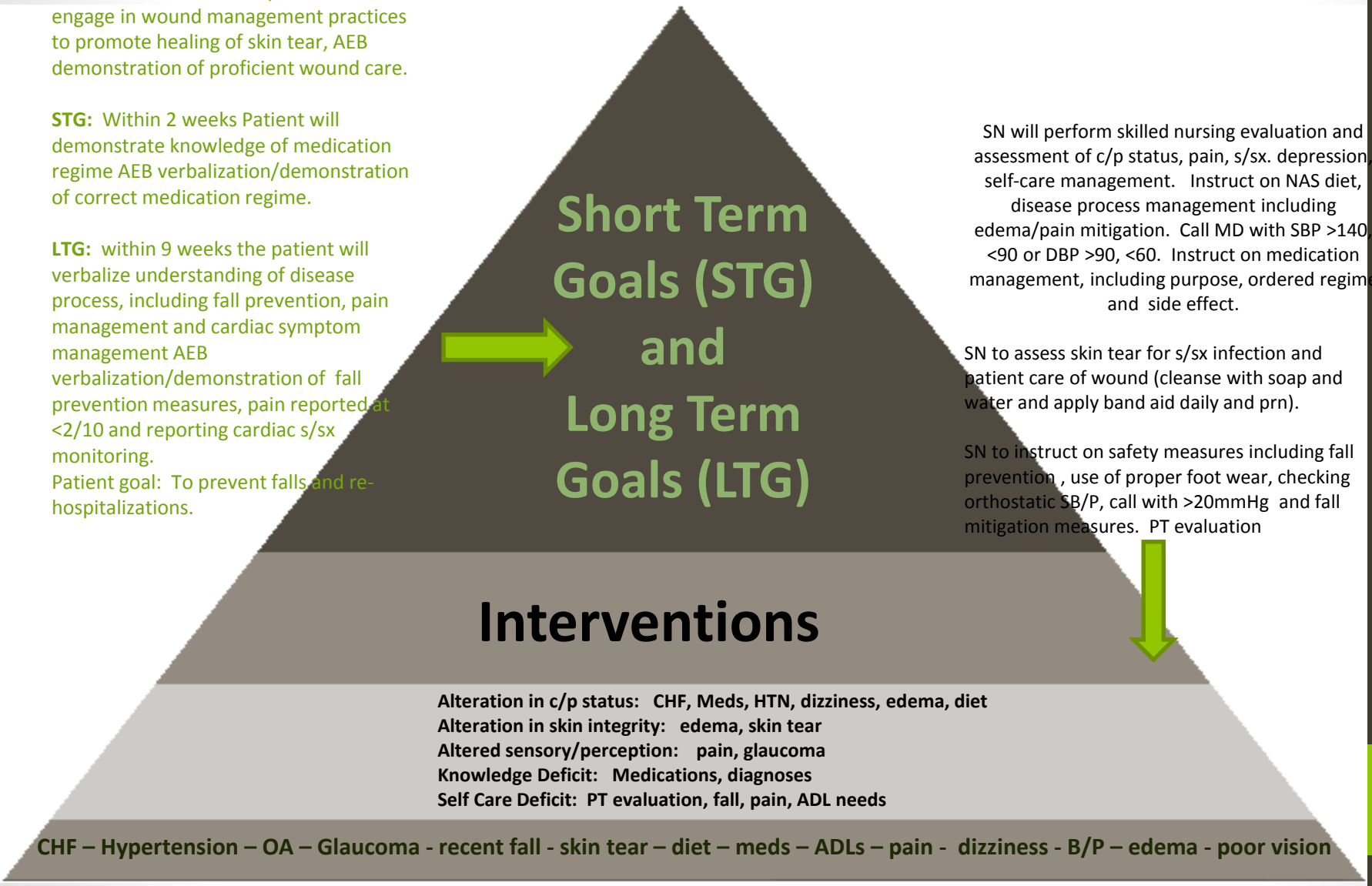
***Patient will be free from falls

What is your goal?

STG: Within 1 week the patient will engage in wound management practices to promote healing of skin tear, AEB demonstration of proficient wound care.

STG: Within 2 weeks Patient will demonstrate knowledge of medication regime AEB verbalization/demonstration of correct medication regime.

LTG: within 9 weeks the patient will verbalize understanding of disease process, including fall prevention, pain management and cardiac symptom management AEB verbalization/demonstration of fall prevention measures, pain reported at <2/10 and reporting cardiac s/sx monitoring.
Patient goal: To prevent falls and re-hospitalizations.



SN will perform skilled nursing evaluation and assessment of c/p status, pain, s/sx. depression, self-care management. Instruct on NAS diet, disease process management including edema/pain mitigation. Call MD with SBP >140, <90 or DBP >90, <60. Instruct on medication management, including purpose, ordered regime and side effect.

SN to assess skin tear for s/sx infection and patient care of wound (cleanse with soap and water and apply band aid daily and prn).

SN to instruct on safety measures including fall prevention , use of proper foot wear, checking orthostatic SB/P, call with >20mmHg and fall mitigation measures. PT evaluation

QUALIDIGM

Key elements of the Plan of Care

- Was the assessment comprehensive, addressing all the factors impacting the patients current health status? **YES**
- Did those assessment findings define the problems identified on the plan of care, including at least one patient identified problems? **YES**
- Are the interventions that were included on the plan of care defined to meet the patients specific needs that were identified in the assessment? **YES**
- Are the goals designed to be objective and measurable, defining the specific **patient desired** outcomes that are related to the assessment, problems and interventions defined on the plan of care? **YES**

QUALIDIGM

Routine visits: What's in Your Notes?

- **Assess**
  - Physical status
  - Knowledge status
  - Available supports/resources
- **Intervene**
  - Physician contact/response
- **Educate**
  - Medication/Diet instruction
  - Patient self-management actions
  - The teach-back model
- **Plan**
  - Learning needs/ What comes next

QUALIDIGM

How about for Jim Smith?

- **Assess**
  - Physical status: weight gain? diet? c/p status?
  - Knowledge status: What does Jim know? What does he want to know?
  - Available supports/resources: Does he have community support?
- **Intervene**
  - Physician contact/response: Did you call the MD?
- **Educate**
  - Medication/Diet instruction: What did you teach?
  - Patient self-management actions: What is Jim doing to stay on the road to recovery?
  - The teach-back model: How did Jim do with the instruction?
- **Plan:**
  - Learning needs/ What comes next: What is your plan for the next visit?

Addressing Interventions

- What did you do? Is it clearly captured in your documentation?
  - Notifying the physician
  - Case conferencing with other disciplines
  - HHA orientation and supervision to the care plan.
  - Defining evidence of measurable patient progression (learning)

Documentation of Teaching/Instruction

- If more teaching or reinforcement is needed then state that in your documentation.
- Each note should identify what the teaching plan for the next visit is based on your negotiation of that instruction with your patient.
- If patient verbalized understanding, then close or end date that intervention.
  - If all interventions are end dated, then consider discharge.

Communicating the plan in writing is a professional responsibility that not only transfers knowledge but also protect the practice of the nurse.

QUALIDIGM

How are you doing with the GOALs?

- Part of discharge planning is reviewing the goals of care at each visit.
  - Focus on the patient
  - Document changes
  - Get your orders
  - Document progression

Discharge may be coming sooner than you think!

QUALIDIGM

Planning your Discharge

- Communicate and Document your plan
  - To the patient/caregiver
  - To other disciplines (including your LPNs)
  - To the physician
  - To the facility (if applicable)
- Did you do your notices?
  - Notice of Medicare Non-Coverage (at least 2 days prior to DC)
  - HHCCN (discipline DC)

Transfer/Discharge Summaries

Reason for referral	Services provided; span of care (admit/dc Dates	Status on admission (clinical, mental, cognitive, social, functional)
Care provided	Status on discharge (all spheres)	Final drug profile
Recommendations for ongoing care	Current individualized plan after discharge	Narrative documentation (additional information)

QUALIDIGM

Discharge Summary for Jim Smith

- Mr. Smith was referred to ABC Home Health on 12/1/17 for SN and PT services following recent hospitalization for Hypotension and recent fall. In addition, he presented with CHF, OA, Glaucoma, a skin tear and needed teaching on diet, medications, ADLs, pain and disease process management. He received SN assessment, monitoring, wound care and instruction and PT established a HEP to build strength and endurance. His VSS and wound is healed and he demonstrates increased knowledge of self health management activities. Mr. Smith is being discharged from all services on 1/8/18 with all goals met. He received an updated medication profile to promote his continued understanding of his medication regime. It was recommended that he schedules a f/u with Dr. Morgan in two weeks for re-evaluation. Mr. Smith agrees to discharge at this time and verbalized agreement to continued health monitoring measures (B/P and weight) in addition to continued engagement in his HEP established by the physical therapist.

Questions?

QUALIDIGM

Thank You!

Charlotte Steniger, RN, MSN, COS-C, CHAP, ACHC

Qualidigm Home Health Consultant

Phone: 860-990-6553

Fax: 860-632-5865

Email: csteniger@qualidigm.org

QUALIDIGM