Foundations in Creating an Accurate Individual Service Plan

Prepared for:

Wisconsin Health Care Association

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Summary and Objectives

This discussion will provide attendees' with valuable recommendations to creating an accurate service plan. The accurate Individual Service Plan provides a clear understanding of each resident's needs and preferences. The Individual Service plan is a roadmap for nursing staff to deliver consistent quality care and service. The accurate, updated Individual Service Plan allows nursing staff to adjust to resident physical and or mental changes. An accurate, timely Individual Service plan can ensure facility reimbursement and avoid state regulatory penalties.

Presented by:
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About the Presenter

Jacqueline Arthur, RN, LNHA, Senior Consultant

She has over 12 years of experience in the health care industry as a registered nurse and licensed nursing home administrator. Eight of those years were spent working in direct patient care within a long-term care environment where she learned how to combat challenges both from an industry perspective as well as a regulation, compliance, and legal standpoint. Jacqueline's past experience includes roles as a regional director of health care services, director of nursing, corporate clinical project manager, corporate MDS supervisor, and registered nurse. She maintains membership in the Illinois Nurses Association. Jacqueline is also a legal nurse consultant, certified restorative nurse, and certified CNA instructor.

Power Point Slides

Foundations in Creating an Accurate Individualized Service Plan (ISP)

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Individual Service Plan Goal

The comprehensive Individual Service Plan should bring all the necessities of a resident's care needs together, so that anyone reading it can see the care the resident receives, who is responsible for providing the care, and how and when it will be delivered.

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Individual Service Plan Contents

The ISP addresses the resident's overall health status.

- *Physical health, vision and hearing, mental health, cognition and behaviors*

The ISP includes activities of daily living (ADLs).

- Eating, bathing, toileting, dressing, mobility and transferring, along with risks, such as falls, elopement, etc.

The ISP addresses the resident's personal interests, activity pursuits and desired community involvement.

- The ISP indicates whether the resident is still driving and will bring a car to the community.
- The ISP indicates whether the resident is employed or would like to be employed, vocational goals also are included.

Any changes to any one area should be updated on the ISP

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When Does Service Planning Start?

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Service Planning Starts During the Initial Inquiry

There will always be Initial Inquiry of a potential Resident…

If the initial inquiry is made by phone, invite the person and their family to tour the community.

Ask questions and document the response given. Share the responses at morning meeting.

Examples

- Why is the individual is seeking Assisted Living services?
- Where is the person currently living?
- What type of services does the person need?

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Preadmission Team Approach

The resident preadmission assessment and the overall admission process requires the cooperation of a team. Often several individuals from different service areas are involved.

Communication among team members is crucial to accurate service planning. All potential resident inquires, preadmit on-site/off-site assessments, admissions, and tour opportunities should be discussed and coordinated at morning meeting.

Be the proactive team! Plan ahead to conduct the preadmission screen while the person is visiting the community.

If scheduling the tour, inform the family of the preadmit screen opportunity, and ask the family to bring Medication list and/or actual medications; history and physical; medical evaluation from current physician; caregiver information, etc. Obtain as much information possible.

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Potential Resident Tour Opportunities

The tour allows the entire team to observe the potential Resident.

- Is the person independent with ambulation? Does the person use walker, w/c, scooter, or cane?
- If the person had lunch at the community during the visit, do they need assistance with meals (i.e., food cut, mechanically altered diet, adaptive eating utensils)?
- How does the person communicate? Is the person lucid? Is the family answering questions for him/her? Are there any noted hygiene issues? Are there any visible skin conditions?
- What is his/her mood? Does he/she appear anxious, fearful, or angry?

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Preadmission Assessment Interview

- After the tour, conduct the preadmission assessment interview. Any observations (i.e. cognitive deficits, assistance with eating etc.) made during the tour should be shared with the assessor.
- If the potential Resident has health care needs, the licensed nurse should complete the medical portion of the assessment.

***Best practice would be to interview the resident without family present. During the interview, family members may not give correct information and most likely will attempt to answer for the Resident.**

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Key Areas for Service Plan Need Considerations

Area of Assessment	Examples
Physical health Including identification of chronic, short-term, and recurring illnesses	Diabetes, Alzheimer's, dementia, COPD, strokes, aphasia, arthritis, CHF, TBI, MS, Parkinson's, HIV/Aids, HTN, seizures, lower body weakness, edema, SOB, dizzy/vertigo, wounds
Oral health	Mouth pain, chewing/swallowing problems, dentures, broken teeth, bridge work
Physical disabilities Any limitation on a person's physical functioning, mobility, dexterity, or stamina	Respiratory disorders, Oxygen use, pacemakers, blindness, epilepsy, sleep disorders, RA, OA. etc.
Mobility status	Unsteady gait, balance problems while standing, limits activities r/t fear of falling, prosthetic limb(s)
Need for any restorative or rehabilitative care	Physical Therapy, Occupational Therapy, Speech Therapy (i.e., multiple falls, lower body weakness, strokes)

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Key Areas for Service Plan Need Considerations (Continued)

Area of Assessment	Examples
Medications The resident medications the resident takes and the resident's ability to control and self-administer medications.	List allergies, list pills, patches, injections, accu-checks, nebulizers treatments, eye drops, ointments, liquids and powders, OTC drugs, etc. List commonly associated side effects, risks, and potential complications (e.g., Coumadin risk for bleeding, Lasix risk for dehydration and falls) List MD orders, such as pulse or blood pressure reading, before meds are taken, and sliding scale insulin **Conduct a self-administration of medication assessment to determine the level of assistance needed.*

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Key Areas for Service Plan Need Considerations (Continued)

Area of Assessment	Examples
Presence and intensity of pain	Pain site, acute/chronic, constant or intermittent, mild to moderate, severe/excruciating. Has pain caused a decrease in ADL function or disruption in daily routine. List pain medications and ask does the med relieve the pain.
Nursing procedures What the resident needs and the number of hours per week of nursing care the resident needs	A person who needs more than 3 hours of nursing care per week except for a temporary condition needing more than 3 hours of nursing care per week for no more than 30 days. ***Per DHS 83.27(2)(d) Limitations on admissions and retentions.***

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Key Areas for Service Plan Need Considerations (Continued)

Area of Assessment	Examples
Mental and emotional health Including the resident's self-concept, motivation and attitudes, symptoms of mental illness, and participation in treatment and programming.	**Observe for wandering** (i.e., moving with no rational purpose, seemingly oblivious to safety) **Verbal expressions of distress** (i.e., nothing matters, I'd rather be dead, I am no use to anyone, persistent anger with others or self) **Observe for sleep cycle issues** (i.e., insomnia/change in usual sleep pattern) **Observe for sad, apathetic, anxious appearance** (i.e., sad, pained, worried facial expressions, crying/tearful, pacing, hand wringing, fidgeting) **Loss of interest** (i.e., withdrawal from longstanding activities or being with family/friends)

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Key Areas for Service Plan Need Considerations (Continued)

Area of Assessment	Examples
Behavior patterns That are or may be harmful to the resident or other persons, including destruction of property	**Observe for verbal abuse** (i.e. others threatened, screamed at, cursed at) **Observe for physically abusive behaviors** (i.e. others hit, shoved, scratched, sexually abused) **Observe for socially inappropriate disruptive behavior** (disrobing in public, smeared feces, throwing food, hoarding, rummaging through others belongings) **Observe for resisting care** (resists taking meds/injections, ADL assistance or eating **Observe for intimidating behavior** (made others feel unsafe, at risk, privacy invaded)

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Key Areas for Service Plan Need Considerations (Continued)

Area of Assessment	Examples
Risks Including choking, falling, elopement	**Look for history for swallowing/chewing difficulties,** (inability to swallow pills, difficulty eating) **Look for history of falls** (i.e., fall in past 30-180 days, hip fracture in last 180 days, unsteady gait, medications) **Look for history of elopement/exit seeking behaviors** (i.e., resident has diagnosis of Alzheimer's or dementia and is observed with cognitive decline, confusion)

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Key Areas for Service Plan Need Considerations (Continued)

Area of Assessment	Examples
Capacity for self-care Including the need for any personal care services, adaptive equipment, or training needs	**Observe for needs with**: bed mobility, transfers, dressing, eating, personal hygiene, toilet use (i.e. incontinent of b/b independently manages or needs help), and locomotion out of apartment. **Observe for needs with:** laundry (i.e. resident washed clothing, folded clothing), light housework, transportation (will resident bring a car), how does resident use the phone, does resident manage their finances? **Observe for:** Visual impairments (glasses, blindness), hearing impairments (hearing aids present and worn, deadness; communication boards), modes of locomotion (i.e. walker, cane, crutch, wheeled self, other person wheeled, scooter; braces, prosthesis, etc.)

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Key Areas for Service Plan Need Considerations (Continued)

Area of Assessment	Examples
Capacity for self-direction Including ability to make decisions, act independently, and to make wants or needs known.	Observe if the resident can: choose clothing, know when to go to scheduled meals, show ability to use environmental cues (i.e., clocks, calendars, etc.); in the absence of environmental cues, do they seek information, ask when they need help, acknowledge need to use a walker consistently, show ability to make consistent concrete decisions regarding likes/dislikes, wants, needs, etc.
Social participation Including interpersonal relationships, communication skills, leisure time activities, family and community contacts, and vocational needs.	Activity Pursuits (e.g., spiritual/religious, attending church services or watching on TV, trips/shopping cards, games, crafts/arts, exercise/sports dancing, music, reading writing, walking or wheeling outdoors, watching TV, gardening, talking or conversing, helping others)

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Evaluating Needs vs. Staffing

Always consider the level of assistance required for the potential resident and your staffing ratio

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Examples of Care Need vs. Staffing Considerations

Visual Impairment

- How are ADLs performed? Set up only? Verbal cues? Hands-on assist?
- If the Resident is diabetic, how are blood glucose checks completed? If insulin dependent who will administer?
- Is there a licensed nurse to administer? Has the medication aide been trained to administer injections?

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Examples of Care Need vs. Staffing Considerations (Continued)

ADLs

- How much assistance needed with ADLs?
- Bathing
- Ambulation
- Transferring
- Incontinence management
- Eating (feeder, mechanically altered meals, etc.)

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Examples of Care Need vs. Staffing Considerations (Continued)

Medications

- How much assistance needed with medications?
- Types: patches, insulin injections, eye drops, suppositories, ointments
- Frequency: daily, weekly, monthly
- Physician's orders: B/P checks prior to medication, sliding scale insulin
- Residents ability to use adaptive equipment: insulin pens, glucometers, etc.

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Examples of Care Need vs. Staffing Considerations (Continued)

Medical Equipment

Oxygen

- Can the person turn the O2 concentrator on and off and apply tubing?
- Can the person change the tank and set the regulator?

Bi-pap or C-pap

- Can the person turn the machine on/off and apply the mask?

Nebulizer

- Can the person turn the machine on/off, and can they fill the medication container?



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Care Need vs. Staffing Consideration *Reminder*

Injections, medications administered via a tube, nebulizer treatments, and oxygen routes have not been evaluated as part of the medication aide curriculum; therefore, the above-mentioned must be administered by an RN, an LPN, or as a delegated act under N6.03(3).

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Common Significant Changes in Resident Condition

Conditions that result in revisions to the ISP

- Behaviors
- Cognition change (decline)
- Falls
- New diagnosis (e.g., dialysis)
- New/discontinued psychotropic medication or MD order for care
- Home health care service
- Hospice services
- PT/OT
- Health status decline

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Common Service Plan Errors

- Missing signatures
- Missing dates/initials
- Completed late
- Services supplied from an outside provider not included (most commonly home health care)
- Refusals and non-compliance patterns
- Not revised to reflect significant changes in condition or MD orders
- PRN/scheduled psychotropic Medications not on service plan
- Risk factors not included (fall, elopement, choking)

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Service Plan Example (Falls)

Problem/Need	Service/Assistance Provided	Outcome Expected
Ruth is at risk for falls r/t unsteady gait and a history of falls. DX: Seizure Dis., osteoarthritis, lower extremity weakness, HTN Appliances: Seated wheeled walker Non-skid mat Shower chair	Ensure call system in reach Ruth will ambulate using seated walker inside and outside apartment. Ruth will wear shoes when ambulating outside the apartment. Ruth will ask for assistance when feeling weak. Staff will provide escort to meals and activities as needed. Staff will provide supervision during bath time and upon request . Staff will provide education and safety reminders .	Ruth will be at reduced risk for falls through next review.

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Service Plan Example (Noncompliance)

Problem/Need	Service/Assistance Provided	Outcome Expected
Noncompliance Services needed, yet Bob often refuses to take his Remeron 30mg at bedtime *(include the dates)* Bob refuses to shower on Mon-Fri *(Include the dates)*	Staff will document and report refusals onto report sheets and to supervisor. Nurse will report to refusals attending physician and family. Staff will ask reason for Bob's refusal of service and try to resolve any problems Staff will offer refused services at least 2 – 3 times at different times. Nurse will request family assistance as needed. Nursing staff to monitor for any negative outcomes and report to nurse. If refusals continue, nurse or appropriate supervisor will attempt a conference 1:1 and resolve.	Bob will resolve issues for refusing services needed, and service will be provided to promote optimal health.

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Service Plan Example (Home Health Care)

Problem/Need (Concern)	Service/Assistance Provided (Approach)	Outcome Expected (Goal)
Home Health Care: Physical Therapy Provider Choice: Sunshine Homecare 10 West Kline Street Madison, Wisconsin (414) 551-7713 office (414) 551-7714 Fax	Nurse will seek home health care order from MD as needed. Nurse will notify home health care service upon receiving order from MD. Home health Care nurse or therapist will evaluate Ruth and provide treatment as indicated. Ruth will have 2 visits per week on Mon/Wed for 12 weeks starting Sept 15, 2016.	Ruth will participate in home health care program and benefit either with physical improvement or comfort. Treatment completed, visits D/C on_____.

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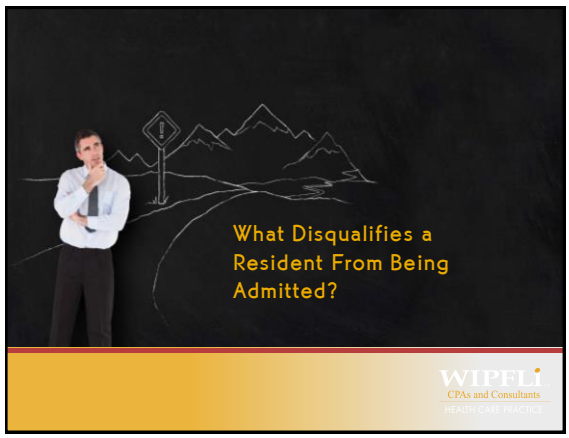

Disqualifiers - Admission and Retention Limitations DHS 83.27(2)

A CBRF may not admit or retain any of the following persons:

- (a) A person who has an ambulatory or cognitive status that is not compatible with the license classification under s. DHS 83.04 (2).
- (b) A person who is destructive of property or self, or who is physically or mentally abusive to others, unless the CBRF has sufficient resources to care for such an individual and is able to protect the resident and others.
- (c) A person who has physical, mental, psychiatric or social needs that are not compatible with the client group as described in the CBRF's program statement.
- (d) A person who needs more than 3 hours of nursing care per week except for a temporary condition needing more than 3 hours of nursing care per week for no more than 30 days.

If the CBRF requests a waiver or variance, the department may grant a waiver or variance to this requirement, as described under s. DHS 83.03, if the following conditions are met:

- ✓ 1. The resident's clinical condition is stable and predictable, does not change rapidly, and medical orders are unlikely to involve frequent changes or complex modifications and the resident's clinical condition is one that may be treatable, or the resident has a long-term condition needing more than 3 hours of nursing care per week for more than 30 days.
- ✓ 2. The resident is otherwise appropriate for the level of care provided in the CBRF.
- ✓ 3. The services needed to treat the resident's condition are available in the CBRF.

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Disqualifiers - Admission and Retention Limitations DHS 83.27(2) (Continued)

- (e) A person whose condition requires 24-hour supervision by a registered nurse or licensed practical nurse.
- (f) A person whose condition requires care above intermediate level nursing care.
- (g) A person who requires a chemical or physical restraint except as authorized under s. 50.09 (1) (k), Stats.
- (h) A person who is incapacitated, as defined under s. 50.06 (1), Stats., unless the person has a health care agent under a valid and properly activated power of attorney for health care under ch. 155, Stats., or a court appointed guardian under ch. 54, Stats., except for the admission of an incapacitated individual who does not have such a legal representative, and who is admitted directly from the hospital according to the provision of s. 50.06, Stats.
- (i) A person who resides in a CBRF licensed for 16 or more residents, and has been found incompetent under ch. 54, Stats., and does not have a court-ordered protective placement under s. 55.12, Stats.

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Recommendations

- *Ensure all resident assessments and ISPs are current and up to date. Don't forget to update residents' ISPs when any change occurs and at least annually.*
- *Ensure that all identified needs and abilities from the comprehensive assessment are addressed in the ISP, including goals, services to be provided, the frequency of the service, and the service provider.*
- *Identify in the ISP each resident's supervision needs and specific approaches to meet the needs (risk for elopement, falls, swallowing difficulties, etc.).*
- *Routinely assess residents for any change in condition. Provide staff training in recognizing and responding to changes in condition.*

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Recommendations (Continued)

- Ensure staffing levels are adequate to provide supervision for high-risk residents. Communicate and instruct staff about the residents level of risk for falls, etc.
- Ensuring (PRN) psychotropic medication is part of the resident's supportive behavior program. Document the need and reason for PRN psychotropic medications.
- Identify in the individual service plan the rationale for use and a detailed description of the behaviors which indicate the need for PRN psychotropic medication.
- Routinely audit resident records to ensure compliance with regulatory standards. Use results of the audit to institute quality improvement activities.

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Avoid "Cookie Cutter" ISPs

Every resident is different, and his/her Individual Service Plan should be personalized to reflect individual needs, strengths, and goals.

Residents may have many of the same disease processes or needs, but presentations and manifestations generally vary from person to person.

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Benefits of Accurate Service Planning

- Provides documentation to determine whether the community can or continue to meet the resident's needs.
- An accurate Service Plan serves as a roadmap that aids staff to provide quality care.
- The Individual Service Plan defines the services delivered in addition to the costs associated with services.
- An accurate individualized Service Plan helps the facility to avoid deficiencies during state survey.

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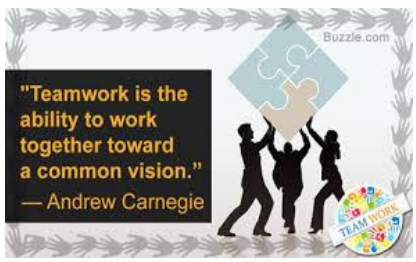
Go Team!



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Conflict of Interest

Neither Jacqueline Arthur nor the education planning committee has an affiliation or relationship of a financial nature with a Commercial Interest Organization that might bias a person's ability to objectively participate in the planning, implementation, or review of a learning activity.

Consultant Information

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Assessment DHS 83.35(1)(a)(b)

(a) Scope. The CBRF shall assess each resident's needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.

(b) Information gathering. The CBRF shall base the assessment on the current diagnostic, medical and social history obtained from the person's health care providers, case manager and other service providers. Other service providers may include a psychiatrist, psychologist, licensed therapist, counselor, occupational therapist, physical therapist, pharmacist or registered nurse. The administrator or designee shall hold a face-to-face interview with the person and the person's legal representative, if any, and family members, as appropriate, to determine what the person views as his or her needs, abilities, interests, and expectations.

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The Key Areas of Assessment DHS 83.35(1)(c)

1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care.
2. Medications the resident takes and the resident's ability to control and self-administer medications.
3. Presence and intensity of pain.
4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs.
5. Mental and emotional health, including the resident's self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming.

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The Key Areas of Assessment DHS 83.35(1)(c) (Continued)

6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property.
7. Risks, including, choking, falling, and elopement.
8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training.
9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known.
10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs.

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Temporary Service Plan DHS 83.35(2)

(2)Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented.

Comprehensive Individual Service Plan DHS 83.35(3)(a)(b)

(a) Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following:

1. Identify the resident's needs and desired outcomes.

2. Identify the program services, frequency and approaches under s. DHS 83.38 (1) the CBRF will provide.

3. Establish measurable goals with specific time limits for attainment.

4. Specify methods for delivering needed care and who is responsible for delivering the care.

(b) Development. The CBRF shall involve the resident and the resident's legal representative, as appropriate, in developing the individual service plan and the resident or the resident's legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. DHS 83.38 (2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. DHS 83.38 (2) (b). The resident's case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.

Implementation of the Service Plan DHS 83.35(c)

(c)The CBRF shall implement and follow the individual service plan as written.

Individual Service Plan Review DHS 83.35(d)

(d) Individual service plan review. Annually or when there is a change in a resident's needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident's legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

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Documentation of Review DHS 83.35(e)

(e) Documentation of review. The CBRF shall document any changes made as a result of the comprehensive individual service plan review.

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Availability DHS 83.35(f)

(f) Availability. All employees who provide resident care and services shall have continual access to the resident's assessment and individual service plan.

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Satisfaction Evaluation DHS 83.35(4)

(4) Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident's legal representative the opportunity to complete an evaluation of the resident's level of satisfaction with the CBRF's services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department.

Limitations on Admissions and Retentions DHS 83.27(2)(a)(b)(c)

(2) Admission and retention limitations. A CBRF may not admit or retain any of the following persons:

(a) A person who has an ambulatory or cognitive status that is not compatible with the license classification under s. DHS 83.04 (2).

(b) A person who is destructive of property or self, or who is physically or mentally abusive to others, unless the CBRF has sufficient resources to care for such an individual and is able to protect the resident and others.

(c) A person who has physical, mental, psychiatric or social needs that are not compatible with the client group as described in the CBRF's program statement.

Limitations on Admissions and Retentions DHS 83.27(d)

(d) A person who needs more than 3 hours of nursing care per week except for a temporary condition needing more than 3 hours of nursing care per week for no more than 30 days. If the CBRF requests a waiver or variance, the department may grant a waiver or variance to this requirement, as described under s. DHS 83.03, if the following conditions are met:

1. The resident's clinical condition is stable and predictable, does not change rapidly, and medical orders are unlikely to involve frequent changes or complex modifications and the resident's clinical condition is one that may be treatable, or the resident has a long-term condition needing more than 3 hours of nursing care per week for more than 30 days.

2. The resident is otherwise appropriate for the level of care provided in the CBRF.

3. The services needed to treat the resident's condition are available in the CBRF.

Limitations on admissions and retentions DHS 83.27(e)(f)(g)(h)(i)

(e) A person whose condition requires 24-hour supervision by a registered nurse or licensed practical nurse.

(f) A person whose condition requires care above intermediate level nursing care.

(g) A person who requires a chemical or physical restraint except as authorized under s. 50.09 (1) (k), Stats.

(h) A person who is incapacitated, as defined under s. 50.06 (1), Stats., unless the person has a health care agent under a valid and properly activated power of attorney for health care under ch. 155, Stats., or a court appointed guardian under ch. 54, Stats., except for the admission of an incapacitated individual who does not have such a legal representative, and who is admitted directly from the hospital according to the provision of s. 50.06, Stats.

(i) A person who resides in a CBRF licensed for 16 or more residents, and has been found incompetent under Ch. 54, Stats., and does not have a court-ordered protective placement under s. 55.12, Stats.

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Questions?

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Thank you!

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