MDS 3.0 Care Plans made easy

Debbie Ohl, RN, M.Msc., PhD

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HCPro

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Introduction

The care plan is our opportunity to chart the course for a better quality of life and enhanced care for each person we serve. Over the past many decades, we have evolved from no care plans to paper compliant plans to creating discipline-integrated plans focused on obtaining the best quality of care. Care plans today reflect the individual resident's needs. Stated goals are being achieved, or care plans are modified accordingly. The long-term care professional has mastered the skills and mechanics of writing care plans.

Although we are proficient at developing care plans that address resident needs and sometimes their wants, with the implementation of the Minimum Data Set 3.0, we are charged with advancing our care planning skills yet again by giving residents a true voice in their care. Now we must honor the residents' perspectives and respect their desires if we are to promote the best quality of life they are capable of achieving. It may be helpful in understanding this by looking at the difference between the care provided and the life being lived. The care provided is a hands-on, best-practice approach to maintain and improve functional status and medical conditions. The life experienced is the manner and way the person is living. The emphasis on quality of life is designed to give residents a say in how they choose to live their lives. The intention is to place those people, the human beings we refer to as residents, in the driver's seat, giving them a meaningful voice in how they will live and be cared for (whether it be directly through them or through their significant others, and if neither of these options are available, using the staff as a resource to guesstimate resident preferences based on behavior and any history that is available). We are charged with the awesome task of enhancing the manner in which a person lives when in our care. Our new mission is person-first care planning. Keeping this in mind may lessen the frustrations, anxieties, and regulatory fears we will surely face as we transition into the next generation of care planning.

The intent of this manual is provide you with care plan essentials, allowing the care team more time to care and be with the resident rather than developing care plans.

This book has been designed to assist long-term care professionals in making the transition to *person-first* care plans. The content has been created to provide the user with the most up-to-date information available at the time of printing. The user assumes full responsibility for use of the manuwal. You are cautioned to stay abreast of regulatory changes and challenged to improve upon the ideas and content from your own experience.

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PART 1

Chapters

CHAPTER 1

The Evolution of Care Planning

Looking back in time can help us understand the significance of care planning. Federal involvement in nursing homes began with the passage of the Social Security Act in 1935. At the time, there were only public poor houses, which were dire at best; the majority of people in these poor houses were aged. The legislators, did not want these places used to care for the elderly.

The Social Security Act established a public assistance program for the elderly, which proliferated the growth of voluntary and proprietary nursing homes. Consequently, in 1950, the Social Security Administration required states participating in the program to establish licensing programs, although the requirement did not specify what the standards or enforcement should be; consequently, little changed.

Bureaucracy moves slowly and is fraught with roadblocks for change. In 1956, a study of nursing homes called attention to problems with the quality of care. Most facilities were found to be substandard; staff members were poorly trained or untrained, and few services were provided. In 1965, the Medicare and Medicaid federally funded programs for nursing homes were significantly expanded; standards were uniformly put in place for nursing homes participating in the federal program. Few nursing homes were capable of meeting the health or safety standards or providing the level of service expected under the program.

In 1970 and 1971, nursing home problems came to the forefront with front-page news stories, such as a fire killing more than 30 residents in Ohio, food poisoning in a Maryland home killing 36 residents, and numerous horror stories about care atrocities. As a result, in 1972, Congress passed a comprehensive welfare reform bill that funded state survey and certification activities in an effort to establish and enforce uniform standards and conditions for operating nursing facilities. The federal law required a single set of standards to be developed. The

emphasis was on the institutional framework rather than on the resident's care. Later in the 1970s and early 1980s, the Patient Care and Services Survey was created to rectify this problem. However, there was controversy over the legitimacy of this process, which had shifted the emphasis to the actual provision of care delivery using existing regulations. Very simply stated, having a policy was no longer enough, it had to be implemented, reviewed, and revised to get results; paper compliance in the form of policy and procedure was nearing its end.

The use of paper for care plans was the new gauge for ensuring resident care, although it would take another 20-plus years to achieve its intent. The move from paper to person in determining compliance has been a long road of transitions and lessons learned.

During the first phase of the care planning evolution, regulators demanded that each resident have a care plan that was multidisciplinary in nature. In other words, each discipline was required to have its own care plan. An unintended consequence of this approach was that each discipline became fearful of being cited if something was missing on its plans. Consequently, plans often contradicted one another and certainly missed the mark of being resident oriented (but the contradictions and omissions fueled survey deficiencies). This was particularly the case between nursing and dietary. The social services and activities departments generally looked at the nursing care plans and picked out some aspect to use on their plans. It took nearly a decade to move into the interdisciplinary care planning model. As with many changes in nursing homes, the transition to a unified care planning team began with the name change. We just started saying the care plan was interdisciplinary, but for the most part, things remained business as usual with care plans.

Intermixed during this period were other expectations (all designed to get us to pay attention and focus). Each diagnosis required a care plan, whether it was primary or secondary to the presenting problems or had no impact on current status. Surveyors told facilities that every medication was supposed to have a care plan (their interpretation). Once the industry got the hang of writing something on paper and calling it a care plan, regulators shifted the emphasis to phase two, which involved getting the writers to create measurable goals. It didn't matter that the goals did not measure anything meaningful in terms of functional status; they were measuring something (e.g., resident will be able to walk 4 ft. unassisted). The resident may have been able to walk 4 ft., but what did this actually mean for the resident? In retrospect, it

was a way of teaching us the basics: What are you trying to accomplish and how will you know if you do?

Historically, care plans were rarely if ever used as a working tool for resident care. There were major growing pains, a lot of misinformation, and misguided understanding of what should and should not be care planned that resulted from rumors (the he-said/she-said phenomena). Confusion reigned, and care plans were a burden facilities dealt with. The plans were used as a tool for surveyors more than for resident care. Our care plans were driven by what we thought surveyors wanted to see. The process was mechanically driven; nonetheless, certain expectations were in place, and care delivery and its quality improved.

It took the Omnibus Budget Reconciliation Act of 1987 (OBRA) requirements to solidify the survey standards and process and to provide a framework for continuous improvement. The Minimum Data Set (MDS) 2.0 process has been a big help in the unification of the care team and including the resident as the primary player in the process and not just on paper. Formalizing the assessment process, expecting more in terms of care planning and care delivery, and outcome measurements, such as the quality indicators and quality measures, are now essential tools to meet regulator, consumer, and professional expectations. In retrospect, job one was to improve the quality of care, which has absolutely occurred. Job two is to improve the quality of life for residents, seeing them as unique individuals with lives and dreams. Since the year 2000, this transition has been in process. The MDS 3.0 promises to take the industry to the next level, past quality of care and toward improved quality of life and a person-centered (person-first) approach to care planning.

CHAPTER 2

MDS 3.0 Implications for Care Planning

Section A: Identification Information

Collect key information on resident age, marital status, prior living arrangements, reasons for the assessment, etc.

Care planning implications

A1100: Language

If language barriers are present, care planning is essential. Barriers can create isolation, depression, and unmet needs. Alternative methods of communication, such as picture boards, should be planned to help ensure that basic needs can be met at all times.

Section B: Hearing, Speech, and Vision

- Assess communication skills, speech clarity, and ability to understand and be understood
- Assess the resident's ability to interact with people and the environment and to make needs known
- Ensure that the resident is not misdiagnosed with other problems and conditions
- Ensure that the resident receives appropriate care and services

Note: When mood, behavior, and well-being issues are present, always consider compromised speech, hearing, and vision as possible causes or contributors. If these issues exist, can the problem(s) be corrected, improved, or kept from getting worse, or must the complications and risk be managed to minimize negative outcomes?

Care planning implications

B0100: Comatose

- Verify the medical record documentation of comatose or persistent vegetative state
- Assess for a risk for skin breakdown and joint contractures

B0200 and B0300: Hearing and Hearing Aid

- Deficits can be mistaken for confusion or cognitive impairment.
- Is there a risk or presence of sensory deprivation, social isolation, or mood or behavior disorders?

B0600: Speech Clarity

- Quality of speech, not content or appropriateness.
- Is there a risk or presence of compromised communication, frustration, unmet needs, depression, or social isolation?

B0700: Making Self Understood

- Deficits include reduced voice volume and difficulty with expression or producing sounds.
- Is there a risk or presence of frustration, social isolation, or mood or behavior disorders?

B0800: Ability to Understand Others

- Deficits include decline in hearing, comprehension, recognizing facial expressions
- Results in limited association with others and inhibiting the ability to follow health and safety needs

B1000 and B1200: Vision and Corrective Lenses

- Does the resident have or need lenses; can they be obtained?
- Deficits result in or create the risk for falls and impede hobbies and activities, performance of activities of daily living (ADL), or the management of personal affairs and contribute to sensory deprivation, social isolation, and depressed mood.

Section C: Cognitive Patterns, Staff Assessment, and Delirium

Assess memory, recall, and cognitive skills for decision-making; utilize the confusion assessment method to determine the presence of four signs and symptoms of delirium and if there has been a sudden onset of mental status changes in past seven days.

Care planning implications

Cognition is the ability to think and know the world; it includes memory, recall, and decision-making. Some cognitive conditions are reversible, others are improvable, and some can only be managed to minimize negative outcomes. Recognizing the ways in which cognition is compromised promotes effective care planning. These include:

- **Amnesia:** Loss of ability to learn new information. Manifests as forgetfulness. Behavior problems may occur from frustration and the insensitivity of others.
- **Aphasia:** Difficult comprehension; unable to follow instructions; unable to participate in conversation; unable to express need. Behaviors that may be exhibited include uncooperativeness, withdrawal, frustration.
- **Apraxia:** Loss of ability to do learned motor skills, such as using eating utensils, dressing, and toileting. Misinterpretation by the staff can result in labeling the resident as uncooperative. Behavior problems tend to occur when there is conflict between what the staff expects and what the resident can actually do.
- **Agnosia:** Loss of ability to recognize objects (e.g., staff member names, faces, where they are, what belongs to them). Problems occur when others believe the person should know or remember. Picking up or taking another person's belongings is a common occurrence. Admonishments are of no use and often precipitate acting-out behaviors.

Caregivers must have a realistic idea of what the individual's ability level is in each of these four areas of cognitive compromise. The risk for catastrophic reactions or task failure can be high. It results from frustrating or confusing aspects of the environment that cause the person to decompensate. Staff training, understanding, and appropriate care planning of these losses is critical to improving quality of life and minimizing behavior outburst.

Cognitive syndromes of an altered mental status

An altered mental status can be caused by:

- **Delirium:** An acute confusional state that is reversible and occurs in varying degrees. Illusions, delusions, and hallucinations are common. It is always accompanied by a decreased ability to focus.
- **Dementia:** A decline in multiple cognitive functions, orientation, attention, memory, and language, occurring in clear consciousness.

Confusion can occur without dementia, but dementia is always accompanied by confusion. Confusion is a symptom that demands evaluation for causative factors.

Syndromes are classed as two types. Although not mutually exclusive, they can provide a framework for thinking about the underlying disease. The types are:

- **Cortical:** Fine-motor skills persevere; cognitive compromise is prominent, indicating wide areas of dysfunction in the cerebral cortex: amnesia, apraxia, agnosia, aphasia. Motor skills are maintained until late in the course of the disease. Conditions include Alzheimer's, Pick's, and Jacob-Creutzfeldt, and cortical syndromes often occur following a stroke.
- **Subcortical:** Characterized by amnesia, slow thought, apathy/indifference, and a lack of initiative in all cognitive areas of orientation, attention, memory, and language without aphasia (difficulty comprehending), apraxia (loss of ability to do learned motor skills), and agnosia (loss of ability to recognize objects). Conditions include Parkinson's, Huntington's, and hydrocephalus.

Other syndromes include:

- **Focal cognitive syndrome:** Isolated deficits in memory, language, and other cognitive functions occurring in clear consciousness.
- **Schizophrenia:** An infrequent cause of altered mental status in the elderly. Should always be considered when prominent delusions and hallucinations are present.

Other considerations include:

- **Delusions:** Fixed, false beliefs. They must be distinguished from overvalued ideas that preoccupy the person to the exclusions of other activities, cultural or religious beliefs, superstitions or magical ideas, and obsessions or preoccupations.
- **Hallucinations:** False perceptions. They can be visual, auditory, olfactory, or sensory. They are prominent in delirium, dementia, and schizophrenia. They can also occur in late-life depression and occasionally bereavement.
- **Obsessions:** Unwanted, recurring thoughts.
- **Compulsions:** Unwanted, recurring behaviors.
- **Phobias:** Irrational fears of certain places, things, or situations severe enough to cause avoidance of them. In the elderly, phobias and obsessive compulsive behavior can be the first sign of severe depression.
- **Depression:** Particularly in the elderly can present as confusion and assumptions of dementia.
- **Confusion:** A symptom that demands evaluation for causative factors.

Section D: Mood

Assess for undiagnosed, untreated, and undertreated mood problems using the PHQ-9© resident interview or staff assessment tool.

Care planning implications

Mood problems can be associated with psychological and physical distress; decreased, little, or no participation in therapy and activities; reduced functional status; and poorer-quality outcomes. If any of these conditions are present, always consider the possibility that mood problems can be the causative or contributing factor and should be care planned accordingly.

Care planning strategies need to be built around addressing and managing the causative factors and how the symptoms of mood disturbance present.

The causative factors can be:

- **Physiological:** deregulated systems
  - Chemical
  - Hormonal
  - Circadian rhythm
- **Psychological**
  - Loss of valued objects
  - Exit events
  - Negative distortions of life experiences
  - Automatic negative thinking
- **Psychosocial**
  - Weak support system
  - Poor health

Occurrence of mood disturbances

Mood is short lived, lasting seconds to hours. It is sometimes precipitated by thoughts or circumstances. Mood disturbances can be characterized by the following:

- **Pathological emotions.** These are involuntary outbursts that are not congruent with mood. The person does not know why they are laughing or crying. It can occur with multiple sclerosis, strokes, etc. The care planning strategies need to be built around how the disturbance impacts the resident and those around them.
- **Catastrophic reactions.** These are the outcomes of task failure created by cognitive compromise. When the person cannot translate or understand, they may become frustrated and confused, resulting in acting-out behaviors such as combativeness and care refusal. Catastrophic reactions need to be anticipated and circumstances for occurrences minimized when possible.

Occurrence of depression

1. **Reactive syndromes or adjustment disorders.**
   - Most common in the elderly. Results from certain personality traits that cause a person to be vulnerable to particular environmental stressors.

Management: Very individualized. Review personal history, habits, coping mechanisms. Develop trust with key caregivers. Put things in perspective, redirect. Convey a sense of hope and support.

2. **Affective disorders**
   - A recurrent mood disorder which begins earlier in life. Usually a history of previous episodes. Primary traits: change in mood and accompanying sense of hopelessness, worthlessness. Often described as dark clouds, usually appearing out of the blue sometimes related to life events. Symptoms include loss of vital energy, irritability, change in appetite, bowel function, sleep pattern.
     Management: Develop empathetic relationship that elicits cooperation. Built by spending time listening to details of life. Tricyclic antidepressants, lithium, and neuroleptics are typical medication choices.

3. **Secondary or Symptomatic Depression**
   - Associated with neurological diseases (Stroke 30%, Alzheimer's 20%, Huntington's 40%, Parkinson's 40-60%). May or may not be precipitated by environmental events. Symptoms same as affective disorder but are harder to elicit due to memory and language problems.
     Management: Symptomatic. May be treated with antidepressants, but use is inconclusive.

Section E: Behavior

Assesses variety of behavioral symptoms, problematic behaviors, and changes in behavioral symptoms

1. Determine frequency of symptoms in last seven days
2. Determine impact of behavior on resident and others
3. Determine if risks are present for resident safety or safety of others

Care planning implications

Behavior symptoms may be related to delirium, dementia, adverse drug reactions, psychiatric disorders, hearing or vision problems. Behavioral symptoms may also be indicators of unmet needs or resident preferences, or illness. Ultimately, connection to the underlying source for the symptoms drives the direction, goals, and expected outcomes of the care plan.

What causes behavior symptoms? Is behavior reactive having a clear precipitant or endogenous having no precipitant?

- **Altered cognition:** Delirium, dementia, catastrophic reactions/task failure, schizophrenia, and mental illness/retardation.
- **Altered emotions:** There are different types of depression: reactive, the most common; affective, a recurrent mood disorder; symptomatic/secondary, related to neurological disease.

Disturbances of mood: Emotional labiality precipitated by thoughts, and/or circumstances; or pathological, related to disease processes such as multiple sclerosis or strokes.

Physical illness altering level of consciousness, infection, pain or disfigurement can create behavioral disturbances. The key question: Is the behavior change consistent with physical illness?

Drug toxicity: Is the behavior drug induced? Can you make a correlation with drug use and onset of behavior? Don't be fooled by a lab test that indicates drug is within therapeutic range. Drug toxicity can be present in the elderly despite "normal" lab reports.

Conflict with resident wants and preferences. This can minimized or eliminated with a person-centered approach to the care plan.

Clarifying questions for care planning:

1. What is the specific behavior and how long does it lasts?
2. Are psychoactive medications being used? Are there supporting criteria for the drug category being used? As example, are antipsychotics used in the absence of

supporting diagnosis coupled with absence of symptoms that are harmful to self or others? Is behavior a threat, distressing or harmful to self or others?

3. Are physical restraints in use? Why? Did the behavior problems emerge after initiation of use? How long have they been used? Is there a change in any area of their functional status since implementation?
4. Has the behavior worsened? Could it be related to transfer, change in room, or change in roommate, different personnel, change in medication, decline in cognition?
5. Is behavior creating care resistance or is care creating behavior problem? What do you believe are the potential causes or contributors to the behavior problem?
6. Is there a pattern to the occurrence such as time of day, activity, event(s), or what others are or aren't doing?

Can the behavior be easily altered? If not, why not, and has the use of medication been considered?

E0100: Potential Indicators of Psychosis (Hallucinations and Delusions)

- Identify the source: delirium, dementia, adverse drug reactions, psychiatric disorders, or hearing or vision problems.
- Is there a risk for harm to self or others or are symptoms so distressing that they interfere with quality of life and the ability to function? (May require medication in addition to nonmedical interventions.)

E0200, E0500, and E0600: Behavior Symptoms (Presence/Frequency/Impact)

- Rule out physical or medical causes.
- Rule out environmental causes.
- Is the behavior serious enough to warrant medications; in other words, is the resident or caretaker at risk of injury?
- Is the behavior responsive to medications? In general, wandering and vocal and nuisance behaviors do not improve with drug therapy unless doses are high enough to cause sedation, which in turn can cause falls and the need for more physical care.

- Manipulate the environment to be consistent and supportive and have the right amount of stimuli. This is different for each resident and will take trial and error to determine what the correct amount of stimuli is.

Define the specific behavior(s) and frequency and intensity of occurrence. Types of behavior are as follows:

- **Physical/aggressive behaviors:** Hitting, kicking, grabbing, biting, pushing, scratching, etc.
- **Physical/nonaggressive behaviors:** Pacing, wandering, inappropriate dressing, disrobing, general restlessness, hiding, hoarding, etc.
- **Verbal/aggressive behavior:** Screaming, cursing, negativism, constant request for attention, verbal sexual advances
- **Verbal/nonaggressive behaviors:** Repetition, strange noises, complaining

Define the impact on the resident, others, and the environment. Consider the following:

- **Risk to resident:** Illness; injury; interference with care needs, participation in activities, and social interaction; affront to autonomy and respect for preferences
- **Risk to other:** Injury, intrusion of privacy and activities
- **Risk for disruption of the environment**

E0800: Rejections of Care (Presence and Frequency)

Is it related to matters of resident choice (will be noted on the initial assessment). Is it related to underlying neuropsychiatric, medical, or dental problems? Can it be corrected, improved, controlled?

E0900: Wandering (Presence, Frequency, and Impact)

- Wandering can be defined as locomotion with no discernable, rational purpose. It may be manifested by walking or movement in a wheelchair. A wanderer may be oblivious to physical or safety needs.

- Is there a risk for elopement, potential harm from dangerous places like stairwells, etc., or is the resident intruding on the privacy or activities of others? Identifying the actions that may appear to be wandering can be valuable in shaping the direction of the care plan. Consider the following:
  - **Exit seekers:** Attempting to leave the premises
  - **Self-stimulators:** Manipulate doors as an activity
  - **Akathesiacs:** Wander due to restlessness, may be perceived as agitation by others
  - **Modelers:** Follow other people around in an imitative fashion
- Wandering must be differentiated from purposeful movement (e.g., searching for food, need to toilet, etc.). Wandering may appear aimless only because the sufferer cannot express him- or herself.

E1000: Change in Behavior or Other Symptoms

No change or improved or worsened behavior indicates care plan modifications need to be considered related to goals, interventions, and/or timelines.

Section F: Preferences for Customary Routines and Activities

Assess the importance of activities and routines to the resident, such as bathing, dressing, eating, and activities such as being outdoors, reading, and participating in activities.

Care planning implications

If the resident is experiencing boredom, a depressed mood, or behavioral disturbances, it is imperative to determine whether there is or has been a lack of attention to the resident's preferences regarding routines and activities. Enhancing the quality of life requires attention to the resident's preferences in developing a person-centered care plan.

Section G: Functional Status

Assess activities of daily living, balance, limitations in range of motion, and resident improvement potential. This section does not assess what the resident's capabilities are.

G0110A: Bed Mobility; G0110B: Transfer; G0110H: Eating; and G0110I: Toileting

These four ADLs are a significant part of the resource utilization groups' reimbursement equation. Accuracy of the assessment is paramount.

Care planning implications

Typically, care planning efforts have centered on meeting the ADL needs for the resident. Person-centered care planning broadens the scope and elevates the standards to incorporate the use of resident preferences and the remaining strengths to increase self-sufficiency and improve the person's quality of living. The care plan must include the resident's strengths, with the plan geared to improve on the existing strengths when possible. This line of thinking can result in a specific nursing restorative program to maximize strengths and increase gains for the resident.

The use of devices and aids, allowing adequate time for the resident to perform, the use of task segmentation and verbal prompts, as well as staying alert for condition changes that may point to an opportunity for increased self-sufficiency or risk for increased dependency should be actively pursued.

Always consider that dependency on others may create additional risk for the person, including psychosocial and physical difficulties. Using your knowledge of each resident as an individual with unique habits, preferences, and personalities can go a long way in developing a plan that centers on what is best for that particular person and improving his or her quality of life.

Section H: Bladder and Bowel

Assess residents who are incontinent or are at risk of developing incontinence. Include:

- Continence status
- Bowel patterns
- Use of appliances
- Use and response to toilet programs

Care planning implications

H0100: Appliances

- **Indwelling catheter:** Address medical justification, anticipated duration, potential risk, benefits, and complications (potential risks include urinary tract infection [UTI], blockage, expulsion, pain, discomfort, leaking, and bleeding); promote comfort and maintain dignity
- **External catheter:** Address comfort, fit, leakage, skin integrity, and resident dignity (potential risks include UTI, pain, discomfort, bleeding); promote comfort and maintain dignity
- **Ostomy:** Address the risk for the presence of redness, tenderness, excoriation, skin breakdown; promote comfort and maintain dignity

H0200: Urinary Toilet Programs

Documented requirements must be present in the following three areas:

- Individualized care plan
- Resident-specific program
- Documentation of communication with caregivers, notation of resident response to program

Consider:

- **Habit training:** Resident is cooperative, no discernable voiding pattern, able to be mobilized with or without assistance.

- **Training assistance:** Schedule is fixed. Expected outcome is partial continence (reduction in frequency of incontinence) or social continence (dry and odor free).
- **Scheduled training:** Resident is cooperative, discernable voiding pattern, voiding frequency is greater than two times per day.
- **Toileting hours training:** Able to be mobilized with or without assistance. Schedule is tailored to individualized voiding patterns. Dependent continence (results from staff intervention). Expected outcome is dependent continence (results from staff intervention) or partial continence (reduction in frequency of incontinence). Interventions may include modification of medication or administration time, environmental adaptations, or an exercise program to strengthen the pelvic floor muscles.
- **Bladder training:** Resident has the ability to be taught to consciously delay urinating or resist the urgency to urinate.
- **Retraining void:** Schedule voiding on a predetermined basis. Expected outcome is the control of bladder function. The schedule may be established by the facility policy in conjunction with individual needs of the resident.
- **Prompted training:** Resident is cooperative. Ambulatory or able to transfer his- or herself without assistance.
- **Voiding training:** Can recognize some degree of bladder fullness or the need to void. Schedule prompts to use the toilet at regularly identified intervals (based on what you know of habits and routines). Expected outcome is dependent continence (results from staff intervention) or partial continence (reduction in frequency of incontinence). Interventions may include asking the resident at regular intervals about wetness and giving feedback on the accuracy of his or her response, modification of the medication regimen or administration time, environmental adaptations, and an exercise program to strengthen the pelvic floor muscles.
- **Check training:** Resident does not respond to other behavioral interventions or may be unable to cooperate. With toileting, a check is scheduled on a regular basis; it may be set by facility policy. Outcomes include comfort, good hygiene, and intact skin.

H0300: Urinary continence

- Seven-day look-back period, determined by medical record and interviews
- Risk for skin rashes, skin breakdown, repeated UTIs, falls with injury, embarrassment, and interference with activities

Care planning implications

Determine what quality indicator risk category the resident falls into.

Severe cognitive impairment and dependence in mobility

The chance of lessening the occurrence of incontinence episodes is very minimal. The most likely program, if the resident is cooperative, will be habit training. That is, a regular toileting schedule (like every 3–4 hours during waking hours). If you decide on this approach, determine whether waking to toilet at night is in the best interest of the resident. If not, plan concerns accordingly.

Severe cognitive impairment

If the resident is cooperative, your best bet will be habit training. If the resident is not cooperative, you might find that a check-and-change program is a better option than toileting a resistive, cognitively impaired resident. Always remember to look at the complications and risks that attend your choices and plan accordingly.

Mobility dependent

Revisit the incontinence Care Area Trigger (CAT). Can the resident cooperate? Is there a pattern to voiding times? Have you identified the type of incontinence? Is the high frequency of incontinence a possible result of the lack of timely attention from the staff?

Cognitive compromise

Too often, mental status is used to "blow off" incontinence as a not correctable or improvable condition. Very often, the cause for incontinence in the cognitively impaired has more to do with the inability to get to the toilet or express the need to toilet than it does with lack of awareness of the need to void.

Reinstating or improving continence for the cognitively impaired can be accomplished via habit training, scheduled toileting, or prompted voiding. The only question is which to use when. Of course, the ability to cooperate is essential for all three of these programs. If there is resident resistance, the first challenge is to determine whether the resistance has been staff induced. An evaluation of cognitive loss and communication status can help determine the answer.

- Review the MDS coding for frequently or always incontinent residents. Residents coded as frequently incontinent may be able to improve this status. Determine when the resident is continent (regardless of who toileted him or her) and build the care plan from there.
- Be realistic about factors that can be addressed.

Urinary incontinence is the inability to control urination in a socially appropriate manner. Consider:

- **Bladder retraining.** The resident is the primary player. Retraining demands that the resident has the ability to consciously delay urinating or resist the urgency to void.
- **Scheduled toileting.** The staff is the primary player. A staff member takes the resident to the bathroom, hands him or her a urinal, or reminds him or her to go to the toilet. This includes habit training and prompted voiding.

Bladder continence refers to the ability to control bladder function. Influencing factors for bladder continence are:

- A bladder that can store and expel urine
- A urethra that can open and close appropriately
- Fluid balance, integrity of spinal cord, integrity of peripheral nerves
- Timely toilet access with or without assistance
- Dexterity to adjust clothing
- Cognitive and social awareness
- Individual motivation

H0400: Bowel Continence

- Seven-day look-back period, determined by medical record and interviews
- Risk for skin rashes, skin breakdown, repeated UTIs, falls with injury, embarrassment, increased dependency, and interference with activities

H0500: Bowel Toilet Programs

Documented requirements must be present in the following three areas:

- Individualized care plan
- Resident-specific program
- Documentation of the communication with caregivers, notation of resident response to program

H0600: Bowel Patterns

- Constipation caused or exacerbated by a lack of physical activity and immobility, inadequate fluid or food intake, medication side effect, disease process, and neurological, metabolic, or endocrine disorders.
- Constipation will produce or create the risk for pain, discomfort, nausea, vomiting, and loss of appetite, fecal impaction, hemorrhoids, anal fissures, bowel incontinence, and delirium. If these occur on the MDS in concert with the code for constipation, develop the care plan accordingly.

Section I: Active Diagnosis

Assesses documented diagnosis 60-day look-back and diagnosis status (active/inactive in the seven-day look back). Other than noting diagnosis on a problem list, additional indicators of an active diagnosis must be reflected in the medical record to support it.

Care planning implications

Active diagnosis will always have a relationship to the care plan. The resident may require a specific plan due to the medical and nursing implications required to manage the condition.

Active diagnosis may also be addressed from the standpoint of a causative or contributing factor to other problems or needs the resident has that interfere with functional status, mood, behavior, well-being, or end-of-life care.

Section J: Heath Conditions

Assess conditions that can affect functional status and quality of life, including pain, shortness of breath, tobacco use, vomiting, fever, dehydration, internal bleeding, falls, and prognosis.

Care planning implications

J0700 to J0850: Pain

Pain is an unpleasant sensory or emotional experience which is primarily associated with tissue damage or described in terms of tissue damage. Pain is a complex perception that takes place only at higher levels of the central nervous system; pain is whatever the person says it is.

Types of pain include:

- **Bone, muscle, skin pain:** Relatively well localized, worse on movement, tender to pressure over the area, often accompanied by a dull background aching pain.
- **Visceral:** Often poorly localized, deep and aching, usually constant, often referred (e.g., diaphragmatic irritation may be referred to the right shoulder, pelvic visceral pain is often referred to the sacral or perineal area).
- **Neuropathic:** Burning, deeply aching quality that may be accompanied by some sudden, sharp, searing pain, often a nerve path radiation, numbness, or tingling over the area of skin, skin sensitivity over the area, severe pain from even slight pressure from clothing or light touch.
- **Acute:** Alerts that something has gone wrong in the body. Can be the result of a trauma, broken bone, or some form of disease. Pain is temporary; can last a few seconds or longer but wanes as healing occurs.
- **Persistent or chronic pain:** Any pain lasting longer than six months or that occurs beyond the usual course of a disease, or beyond reasonable time for an injury to

heal; can be caused by diseases, syndromes, injuries, or surgeries. Seen in people with osteoarthritis and rheumatoid arthritis, ranges from mild to severe and can last weeks, months, and years to a lifetime.

- **Breakthrough pain (BTP):** A sudden flare-up of pain that "breaks through" the pain medication taken for a persistent pain. A typical episode may peak in as little as three minutes and last 30 minutes. Up to 86% of people with persistent pain also experience BTP, which is different from persistent pain and requires different treatment.
- **Severity of pain:** Mild, moderate, severe, horrible/excruciating pain.
- **Frequency of pain:** Occasional, frequent, intermittent, constant.

For each type of pain, include the location, frequency, severity, and impact on function. Approaches should include timelines to assess the effectiveness of the pain management program routinely and periodically. Incorporate both the specific medical interventions and nonmedical interventions to be employed (including service providers and/or a particular discipline).

The Quality Improvement Organization program for the Centers for Medicare & Medicaid Services' NHQ have made the following recommendations:

- **Pharmacological management:**
  - Use the simplest dosage schedule and least-invasive treatment modalities first (oral medication vs. IV medications).
  - Management of mild to moderate pain may include an NSAID or acetaminophen, unless they are contraindicated.
  - When pain persists or increases, an opioid is recommended. The treatment of persistent or moderate to severe pain may be based on increasing the opioid.
  - It is recommended that medication be administered around the clock with additional "as-needed doses."
  - The oral route is the preferred route of analgesic administration; if residents cannot take them orally, then rectal and transdermal routes may be considered.
  - Monitor for side effects of the medication.

  - Since constipation is an anticipated problem with the use of pain medication, it is recommended that it be treated prophylactically and monitored constantly.
  - When a resident is transferred from one setting to another, communication about pain management history is recommended.

- **Adjuvant medication:**
  - Corticosteroids provide a range of effects, including anti-inflammatory and antiemetic activity, appetite stimulant, and mood elevation.
  - Anticonvulsants are used to manage neuropathic pain, especially when the resident complains of burning pain.
  - Tricyclic antidepressants are useful as adjuvant analgesics in the management of neuropathic pain, as well as potentially enhancing opioid analgesia and elevating mood. Monitor carefully for anticholinergic adverse effects.
- **Physical nonpharmacological management** (may be used as a complimentary treatment and is not recommended to replace medication):
  - Cutaneous stimulation techniques: hot/cold, massage, pressure, or vibration
  - Exercise
  - Immobilization
  - Transcutaneous electrical nerve stimulation
  - Acupuncture
- **Psychosocial interventions:**
  - Relaxation and imagery
  - Distraction and reframing
  - Psychotherapy
  - Hypnosis
  - Peer support groups
  - Pastoral counseling
- **Routine care:**
  - Positioning
  - Frequent oral care

- Prevention of pressure ulcers and contractures
- One-on-one visits
- Emotional support to the resident and family
- Review advanced directives

Care planning implications

J1700: Falls

Falls and other injuries are a common occurrence. They typically happen within the first 10 days of admission for a variety of reasons. Because of this, determining risk from the outset can minimize occurrence and improve resident outcomes. Information collected from the nursing admission assessment and MDS 3.0 can be applied to easily determine whether a risk is present.

There are reasons or circumstances that create the risk for fall or injury. Be sure to identify the specific risk. Can they be reversed or minimized? If not, what are the implications for goal setting and interventions? Identify the resident's strengths/capabilities that can be used to minimize occurrence.

Measurable goal(s) are those that consider rehab/restorative needs as well as what is reasonable and attainable in the way of prevention. Individualized approaches are those that address the holistic needs of the individual and reflect accepted standards of practice.

Section K: Swallowing and Nutritional Status

Assess conditions that can affect the resident's ability to maintain adequate nutrition and hydration. These include:

- Swallowing disorders
- Weight changes
- Nutritional approaches
- Intake of calories or fluid by parenteral or tube feeding

Care planning implications

K0100: Swallowing Disorders

Swallowing problems have and can create risk for malnutrition, dehydration, and aspiration pneumonia. Determine the extent and severity of these risks, as it will determine the intensity of oversight. Does the potential for improvement exist? Always address presented risks as part of the care plan.

Dental problems, including missing and ill fitting dentures, tooth decay, mouth sores, or pain with food consumption, can add additional care plan concerns. Consider collateral concerns that may affect care planning, such as loss of food or liquid while eating, cheeking foods, and complaints of problems with swallowing the food. Determine whether there is a connection that affects well-being, mood, and/or behavior.

K0300: Weight Loss

In evaluating weight loss, consider the resident's usual weight through his or her adult life, the assessment of potential for weight loss, and care planning for weight management. Was the resident on a calorie-restricted diet? If newly admitted, obese, and on a normal diet, are fewer calories provided than prior to admission? Was the resident edematous when initially weighed? Does he or she no longer have edema after treatment? Has the resident refused food? Parameters of nutritional status which are unacceptable include unplanned weight loss as well as other indices, such as peripheral edema, cachexia, and laboratory tests indicating malnourishment (e.g., serum albumin levels).

K0500: Nutritional Approaches

Although these may be the indicated approaches to nutritional management, the holistic impact must be considered for care planning. Parenteral or IV feedings or tube feedings may create the need for restraint, cause behavior issues, and mood or other concerns. The key to an effective care plan is to identify the root problem and how it is affecting the resident overall. When considering the resident as the central player, the use of nutritional approaches in concert with what the resident wants is a key element in the care plan.

Section L: Oral/Dental Status

MDS 3.0 demands an oral assessment and directs caregivers to refer residents for dental evaluation if they are uncooperative and do not allow the exam or if there are dental or oral issues or mouth pain present.

Care planning implications

Oral care must be part of the ADLs. Oral and dental problems can have significant implications related to quality of life, general health, and nutrition. To generate a person-centered care plan, do not underestimate the possible role oral and dental problems can contribute to the residents' self-esteem, in addition to health and nutrition concerns. Consider routine oral checks as part of care approaches.

Section M: Skin Conditions

M0300—Current number of unhealed pressure ulcers
M0610—Dimensions of unhealed stage 3 or 4 pressure ulcers or eschar
M0700—Most severe tissue for any pressure ulcer
M0800—Worsening of pressure ulcer since admission
M0900—Healed pressure ulcers

Care planning implications

The most important external factors in the development of pressure ulcers are unrelieved pressure. Primary contributing factors include compression, maceration, immobility, pressure, friction, and shear. These elements should be considered for each individual resident and addressed accordingly on the care plan. Intrinsic or secondary factors adding to the risk and as well as compromising healing include fever, anemia, infection, ischemia, hypoxemia, malnutrition, spinal cord injury, neurologic disease, decreased lean body mass, and increased metabolic function.

Agency for Healthcare Research and Quality prevention guidelines identify prime candidates for pressure ulcers as chronically ill (e.g., patients with cancer, a history of a stroke, or diabetes),

immobile (e.g., due to fracture, arthritis, or pain), being in a weak or debilitated state, having an altered mental status (e.g., under the effects of narcotics, anesthesia, or coma), as well as decreased sensation and/or paralysis. Secondary factors elevating risk include illness or debilitation increasing pressure ulcer formation, fever increasing metabolic demands, predisposing ischemia, diaphoresis promoting skin maceration, incontinence causing skin irritation and contamination, as well as other factors such as edema, jaundice, pruritus, and dry skin.

Osteomyelitis should be considered whenever an ulcer does not heal, especially if the ulcer is over a bony prominence.

For more comprehensive guidelines and intervention strategies, visit *http://emedicine.medscape.com/article/319284-overview* (Pressure Ulcers and Wound Care).

The care plan content should address:

- The specific problem, needs, and risks. At-risk plans need to reflect the areas of concern and the risk factors present, as well as the resident's strengths/capabilities to draw on. When ulcers are present, the plan should reflect the site, scope, and severity of the problem, presence or absence of pain, as well as the resident's strengths/capabilities to draw on and the stability of the condition. Do not overlook the need for pain management preceding treatment and other activities that allow the resident to be more comfortable.
- Reasonable, measurable goals that consider rehab/restorative potential. Can the areas be resolved and improved and/or complications minimized? When will the goal be met and/or when will the plan be reviewed for effectiveness?
- Person-centered approaches that address their particular holistic needs and reflect accepted standards of practice.

M1030: Venous or Arterial Ulcers

- Most common vascular ulcers
- May occur on and off for several years

- May occur after relatively minor trauma
- Common after thrombophlebitis
- Often referred to as chronic venous stasis
- Usually occurs on the inner aspect of the lower leg or around the ankle
- Ulcer may have a moist, granulating wound bed, may be superficial, and have minimal to copious drainage
- Pain may be increased when the foot is in the dependent position seated with feet on the ground

Arterial/ischemic ulcers

- Occurs with non-pressure-related disruption or blockage of the arterial blood flow to an area, causing tissue necrosis
- May present in residents with moderate to severe peripheral vascular disease, generalized arteriosclerosis, inflammatory or autoimmune disorders, significant vascular disease elsewhere, such as:
  - Stroke, heart attack, etc.
  - Ulcers are painful
  - Occur in the lower extremities
  - May occur on top of foot, over ankle, and bony areas of feet
  - Wound bed is usually dry and pale with minimal to no exudate
  - May exhibit no pedal pulse
  - Coolness to touch
  - Decreased pain when hanging down (dependent)
  - Increased pain when elevated
  - Blanching when elevated
  - Delayed capillary refill

Section N: Medications

Identify the frequency of injections and the types of selected medication the resident received. This section has a seven-day look-back period. Medication codes are as follows:

- N0350: Insulin
- N0400A: Antipsychotics
- N0400B: Antianxiety
- N0400C: Antidepressant
- N0400D: Hypnotic
- N0400E: Anticoagulant
- N0400F: Antibiotic
- N0400G: Diuretic

Care planning implications

Medication issues are placed in the framework of the care process and the medication framework. The care process includes assessment, problem identification, development of a treatment plan, and implementation. It also includes monitoring for medication side effects and effectiveness. The medication framework entails indications for use, effectiveness, and safety. Incorporate criteria into the care plan. Incorporate nonmedical and team interventions, such as behavioral approaches, weight monitoring, and education as part of your plan in addition to the following.

Excessive doses

Know per-dose and cumulative-dose ranges; reflect exceptions and rationale as part of the care plan.

Excessive doses means those given at one time, those given over a period of time greater than what the manufacture recommends, those given beyond the stop date, those given for temporary problems and continued after the problem is resolved, those given for sleep induction for more than 14 days, or PRN MEDS QD x15 days or QOD x30 days without clinical justification.

This also includes multiple medications of the same class and any medication that duplicates effect without increased benefit.

Excessive duration

Know the expected timeline for medication use (this should be reflected in the goal date) and document exceptions and rationale.

Gradual reduction means tapering—more than one attempt in a short span of time. Timing for reductions needs to be consistent with the condition being treated (e.g., delirium-induced psychosis from a few days to a few weeks; psychotic depression from two to six months); most psychotic symptoms related to the dementia process usually are reduced, and attempts to improve can be successful in four to six months.

If adequate monitoring is not taking place, identify what needs to monitored, how often, and by whom.

If adequate indications for use are not present, incorporate the clinical rationale for use in the care plan use (secure documented physician support).

Adverse consequences

Identify the specific adverse consequence known to occur and establish timelines and frequency for monitoring as part of the care plan.

The rationale for use of medication is to:

- Cure acute illness
- Arrest or slow the disease process
- Decrease or eliminate symptoms
- Prevent a disease or symptom
- Provide therapy for a resident with chronic mental or physical problems

Section O: Special Treatments, Procedures, and Programs

Identify special treatments, procedures, or programs that the resident is receiving.

Care planning implications

O0400: Therapies

Planning goals typically will include one or more of the following goals:

- Stabilize the primary problem
- Prevent secondary complications, such as anorexia, deconditioning, contractures, blood clots, depression, psychological dependency, confusion, incontinence, pressure ulcers, and pneumonia
- Restore lost functional ability
- Promote adaptation of the person to the environment
- Adapt the environment to the person
- Promote family adaptation

Nursing should be addressing its role in the rehab program, both pre- and post-therapy. This might include preparation for therapy, pain management, and support following therapy.

O0500: Restorative Nursing Programs

Restorative goals are designed to:

- Emphasize ability, de-emphasize disability, and focus on what is left, not what is missing
- Promote self-care responsibility
- Foster independence
- Reinforce skills learned in formal therapy
- Teach functional adaptation when complete recovery is not possible

The difference between a formal, documented restorative nursing program and expected standard-of-care nursing actions is that more deliberate and focused efforts beyond routine care interventions are necessary to achieve desired goals.

Section P: Restraints

The intent is to determine whether a restraint was used at any time over the look-back period. The focus is not on the purpose of the restraint. This will require more in-depth assessment.

Care planning implications

A comprehensive review of the resident must be done to determine the problem or issue, needs, and disabilities necessitating the use of a restraint as well as capabilities, and then these must be weighed against the potential benefits and risks of the chosen course of action.

Restraint use is not business as usual. Do not bury the problem in the care plan. Treat the use as seriously as you would an acutely ill resident requiring constant monitoring. Care plan content will include:

- Problem need statement
  - Identifies specific medical symptoms/problems
  - Reflects the type of restraint to be used
  - Identifies strengths and capabilities to draw on
  - Notes potential risk factors and negative outcomes
- Goal(s)
  - Measurable goal(s) to prevent negative outcomes associated with restraint use
  - Planned goal(s) for progressive removal
- Interventions
  - Define a specific schedule or plan of rehab/restorative training to enable progressive use of less-restrictive devices
  - Reflect measures to prevent decline
  - Address actions to prevent risk from materializing
  - Reflect the specific plan of activities and/or social interventions as appropriate, to aid in reduction, elimination, and prevention of decline
  - Clearly identify responsible disciplines
- Target dates based on the degree of risk and aggressiveness of the plan

Section Q: Participation in Assessment and Goal Setting

Addresses the role of the resident, family, and significant others in the assessment and discussion of goals for the residents' care.

The emphasis and standard of care is to place the resident at the center of all care planning decisions as much as possible. For those residents with diminished capacity, a thorough assessment of who they were and what they wanted, expressed or implied, should be considered in creating a person-centered care plan. The emphasis is on quality of life.

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