Meeting Residents' Needs: How Nursing Home Care Plans are Developed

How do nursing homes decide what care a resident needs?

A nursing home must complete a full evaluation of the resident's condition within 14 days of admission and at least once every 12 months after that. A new assessment should be done within 14 days of any significant change in the resident's physical or mental condition. An assessment should evaluate the resident's physical and mental condition as well as the person's functional ability to care for himself (so-called activities of daily living or ADL's such as walking, eating, dressing, toileting, bathing, etc.). The assessment should include the resident's strengths and should also identify the reasons for problems the resident is having so that things can be done, where possible, to correct problems. For example, a resident may suddenly be more confused - is the confusion the result of too many medications, a urinary tract infection, disorientation from the recent move, or some other reason? A good assessment may help identify the cause of the problem and find a way to solve the problem.

Nursing Home Care Plans

Once the assessment is completed, the facility must develop a care plan for each resident. The care plan is supposed to identify the services the resident needs each day to be in the best possible physical and mental condition. The care plan should be developed by a team, including the attending doctor, the registered nurse responsible for the resident, the certified nursing assistant (CNA) and other facility staff. The resident and the resident's family or legal representative are also important members of the team and should have input into the care planning process.

Care Planning Meetings

The care planning meeting is a good way for the family to let the facility know what the resident likes and dislikes, his habits and lifestyle before he moved to the

nursing home. If the staff knows the resident's background, they can better meet his preferences and can make the nursing home more like home. For example, if the resident has always been a night person and hates getting up early, the care plan may include later times for getting up, bathing and dressing. If a resident is unsteady on her feet but has always done lots of walking, the care plan may include a daily walk with an aide.

Each person's care plan should be different, reflecting that person's needs. The care plan should be designed to meet the individual resident's needs and preferences. Once the care plan is in place, the resident and family should check to be sure the staff follows the care plan. If the facility is not following the care plan, bring this up with staff - talk to them respectfully but firmly and without delay. For example, if the care plan provides for the resident to go to activities every day, but they do not have staff to take the resident to the activities, the family can point to the care plan and ask that arrangements be made to get the resident to the activities each day. Talk with the aides and nurses about your loved one so they understand her and know her history, interests, and daily routines. If the staff knows what your resident needs, they will be better able to help her. Use the care plan to be sure that the resident gets the best possible care.

Resolving Behavioral Issues

If the facility complains that the resident has difficult behaviors and/or the facility is threatening to transfer or discharge the resident because of something he is doing, the resident or family may want to request a care planning meeting. At the meeting, ask about the behaviors and try to suggest other approaches that might be better for your loved one and which might reduce the behavioral symptoms. The goal of the care planning meeting should be to discover what the symptoms mean (what needs of the resident aren't being addressed) and to find ways to help the resident. For example, if a resident is wandering into other residents' rooms, maybe the staff needs to take more time to walk with her or to offer other activities the resident enjoys. If the resident is striking out at staff, maybe there is another way to approach the resident which will not be threatening to her and will not cause her to strike out. The focus of the care planning meeting should be on the resident and on finding the best approaches for the resident.

For More Information

For additional information on assessment and care planning, click on this link to the National Citizens' Coalition for Nursing Home Reform (NCCNHR) fact sheet: https://theconsumervoice.org/uploads/files/issues/assessment__care_planning-final.pdf and for additional information about individualized assessment with behavioral symptoms, see NCCNHR's fact sheet at this link: https://theconsumervoice.org/uploads/files/issues/individualized-assessment-with-behavioral-symptoms-factsheet-1.pdf

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Article Source
Virginia Poverty Law Center
Source URL
https://vplc.org
Last Reviewed
Thursday, December 12, 2019