

ASSESSMENT AND CARE PLANNING

Every resident of a nursing home has the right to good care under the 1987 Federal Nursing Home Reform Law. The law states that a nursing home must help residents attain or maintain their highest level of well-being - physically, mentally and emotionally. To give good care, the nursing home staff must assess and plan care to support each resident's life-long patterns, current interest, strengths and needs. Resident and family involvement in the care planning will give the staff information needed in order to insure that the resident gets good care.

Assessment

Assessments gather information about how well a resident can take care of themself.

This includes assessing when help may be needed in functional abilities (walking, eating, dressing, bathing, seeing hearing, communication, understanding and remembering). Assessments allow the staff to know about a resident's habits, activities and relationships in order to help the resident live more comfortably and to feel at home.

The assessment also helps the staff when trying to solve difficulties. An example of when a good assessment helps would be when a resident begins to have poor balance. This could be the result of medications, sitting too much, weak muscles, poor fitting shoes, a urinary infection or an ear ache. Staff must know the cause in order to give good treatment and to figure out the cause is much easier with a good assessment.

Assessments must be done within 14 days of entering a nursing home and at least once a year. Reviews are held every three (3) months and when a resident's condition changes.

Plan of Care

A plan of care is a strategy for how the staff will help a resident every day and addresses both medical and non-medical issues. This plan of care says what each staff person will do and when it will happen (e.g., a nursing assistant will help the patient walk to each meal to build strength). Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel they meet their needs and must be comfortable with them.

Care Planning Conference

A care planning conference is a meeting where staff and a resident and/or family members talk about life in the facility, including meals, activities, therapies, personal schedules, medical and nursing care and emotional needs. Residents and family members can talk about problems, ask questions and offer information to help the staff provide better care. All staff who work with a resident should be involved in the conference, i.e., nursing assistants, nurse, physician, social worker, activities staff, dietician, occupational and physical therapists.

Care Planning conferences must be held every three (3) months and whenever there is a big change in a resident's physical or mental health. The actual plan of care must be done within seven (7) days after an assessment.

A good care plan should be specific to that resident and should be written so that everyone can understand it. The plan should also reflect the resident's concerns and support their well-being. The plan should use a team approach with a wide variety of staff (i.e., multi-disciplinary team) and outside referrals as needed. This plan should be re-evaluated and revised routinely.

Steps for Residents and Families to Participate in Care Planning

Residents and family members have the right to be involved in the care plan conference to make choices about care, services, daily schedules and life in the nursing home. Even if a resident has dementia, involve them in care planning as much as possible. Be aware that they may understand and communicate at some level and help the staff to find ways to communication and work with them.

Participating is a way to be heard.

Before the meeting, ask staff to hold the meeting at a convenient time. Ask the doctor and the staff about the condition of the resident, the care and treatment. Make a list of your questions, problems, goals, etc.

During the meeting discuss options for treatment and for meeting the needs and preferences of the resident. Ask questions if you need terms or procedures explained. Be sure that you understand and agree with the care plan and feel that it meets the resident's needs. Get a copy of the care plan and get the name of the person to talk to if changes need to be made in the care plan at a later time.

After the meeting, see how the care plan is being followed and talk with the nurse, nursing aides, or the doctor about the care plan.

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