MDS Competency
Person-Centered Care Planning
and
Care Area Assessments (CAAs)
Module 4

Harmony Healthcare International (HHI)

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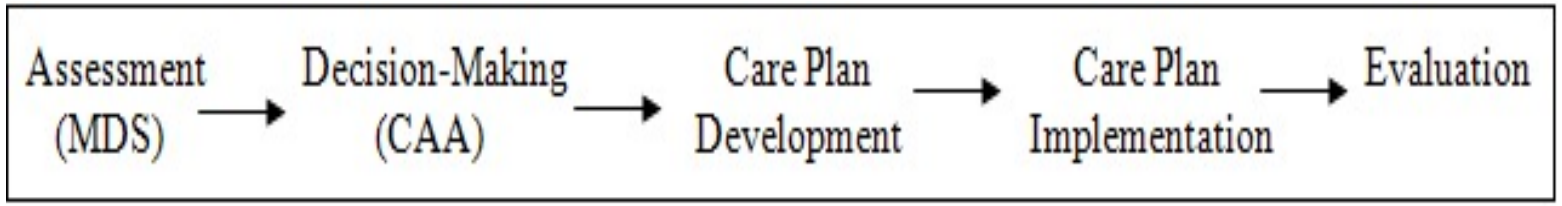
Learning Outcomes

1. The learner will be able to identify the RAI Process for CATs, CAAs and Care Planning.
2. Define the purpose of the Care Plan.
3. Identify the correlation between the MDS, CAAs, and the Care Plan.

The Resident Assessment Instrument (RAI) Process

- Similar to the nursing process
- Goal: Care delivery aimed at meeting resident's goals and desired outcomes based upon the completion of a comprehensive interdisciplinary assessment, Care Plan development and ongoing evaluation



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The Resident Assessment Instrument (RAI) Process

- Assessment:
  - The Minimum Data Set (MDS 3.0) assessment is an initial core set of screening, clinical and functional status elements which forms the foundation of a comprehensive assessment process known as the Resident Assessment Instrument (RAI) process

The Resident Assessment Instrument (RAI) Process

- Assessment:
  - The MDS is merely a starting point in the comprehensive RAI process
  - MDS accuracy leads to identifying areas that impact resident care
  - Accurate completion of the MDS assessment is critical to Care Plan development

The Resident Assessment Instrument (RAI) Process

- Decision-Making (CAA Process):
  - Care Area Assessments (CAAs) are the link between the problem identification and the Care Plan development
  - Use the CAA process as a guide to expand your assessment findings from the MDS, and then "chart your thinking"
  - Care Areas triggered during the RAI process must be reviewed to determine Care Planning needs

Care Area Assessments

- CAAs are required only for comprehensive clinical assessments:
  - Annual
  - Significant Change
  - Admission
  - Significant Correction of a Prior Full Assessment
- Use the CAA process as a guide to expand your assessment findings from the MDS, and then “chart your thinking”

Care Area Assessment Problem

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. Activity of Daily Living (ADL) Functional/Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being
8. Mood State
9. Behavioral Symptoms
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration/Fluid Maintenance
15. Dental Care
16. Pressure Ulcer
17. Psychotropic Medication Use
18. Physical Restraints
19. Pain
20. Return to Community Referral

V0200AA: CAA Triggered

- The triggered CAAs checked in Column A (Care Area Triggered):
  - For each area triggered, use the CAA process and current evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area

V0200C: Care Plan Completion

- Signature of the staff person completing the Care Plan:
  - Person signing does not need to be an RN
- The Care Plan must be completed within 7 days of the CAA completion date

V0200AB: CAA Results

- Check Column B (Addressed in Care Plan) for each triggered care area that a Care Plan is necessary to address the problem:
  - New Care Plan
  - Care Plan revision
  - Continuation of current Care Plan is necessary

Care Area Assessment

- Care Area Trigger (CAT):
  - Specific MDS response indicates that clinical factors are present that may or may not represent a condition that should be addressed in the Care Plan
  - Triggers “flag” conditions for the interdisciplinary team to consider in making Care Plan decisions

Care Area Assessment

- The Guidelines:
  - The interdisciplinary team reviews the conditions under the CAA guidelines (and other assessment information as needed) to:
    - Determine the nature of the problem
    - Understand the cause specific to the resident
  - To get a better understanding of the relationship between the problem conditions and their effects on the resident
  - Keep asking: How, when and why?

Care Area Assessment

- Decision-making:
  - Determining the severity, functional impact and scope of a resident's problems
  - Understanding the causes and relationships between a resident's problems
  - Discovering the "what's" and "why's" of resident's problems

CAA Documentation

- While reviewing each CAA consider:
  - What MDS responses caused this to trigger?
  - What issues or conditions contributed to those MDS responses?
  - Were those issues or conditions addressed in the MDS?
  - Is there a new onset of a problem that the resident did not previously have?

CAA Documentation

- CAA documentation helps to explain the basis of the Care Plan by showing how the IDT determined that the underlying causes, contributing factors and risk factors were related to the care area condition for a specific resident

CAA Documentation

- Documentation for **each triggered CAA** should describe:
  - The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, **what is the problem for this resident**?
  - **Causes** and **contributing factors**
  - **Complications** affecting or caused by the care area for this resident

CAA Documentation

- **Risk factors** that arise because of the presence of the condition that **affect the staff's decision to proceed to Care Planning**
- **Factors** that must be considered in developing **individualized** Care Plan interventions, including appropriate documentation to justify the **decision to plan care or not to plan care** for the individual resident
- **Need for referrals** or further evaluation by appropriate health professionals

Care Plan Development

- Care Planning:
  - Establishing a course of action that moves a resident toward a specific goal, utilizing resident strengths and interdisciplinary expertise
  - Defining the “how” of resident care

Care Planning: Beyond The RAI

- The Care Plan should address the following special considerations/strengths, which may or may not be indentified through the CAAs:
  - Social history
  - Cognitive status and communication
  - Mental well-being, including mood and behavior issues
  - Mobility issues
  - Safety
  - Vision
  - Dental
  - Improving continence
  - Skin care
  - Nutrition/hydration
  - Comfort
  - Activities
  - Discharge planning

Care Plan Development

- The facility must develop a Care Plan that meets these guidelines:
  - Comprehensive
  - Focused on meeting a measurable goal identified by the resident
  - Developed with individualized Interventions honoring resident preferences and aimed at achieving the desired outcome
  - Timetable for completion

Linking Assessment and Care Plan

- The Care Plan is driven by:
  - Resident goals and desired outcomes
  - Resident preferences
  - Resident issues and/or conditions
  - Resident unique needs
  - Resident strengths
  - Each resident's unique characteristics

Linking Assessment and Care Plan

- The Care Plan must be reviewed after each OBRA assessment (except the discharge assessment) and be revised based on the changing goals, preferences and needs of the resident in response to the current interventions
- Resident's goals may change throughout their stay, so it is necessary to have ongoing discussions with the resident and address the changes in the comprehensive care

Linking Assessment and Care Plan

- The Care Plan must be based on a thorough assessment, effective clinical decision-making, and must be compatible with current standards of clinical practice
- Looks at the resident as a whole with unique characteristics and strengths

Care Planning Process

- Interdisciplinary Team includes:
  - Resident and Family
  - Nursing
  - Physician
  - Activities
  - Dietary
  - Social Services
  - Therapy
  - Direct Care Staff
  - Other disciplines as appropriate based on the resident's individual need, strengths, and preferences

Four Parts of the Care Plan Process

1. Assessment – problem identification through RAI process and in-depth review of clinical data
2. Planning – goal setting, development of individualized interventions
3. Implementation – putting plan into place
4. Evaluation – periodically review progress to goals and revision of established goals or interventions as indicated

Assessment

- Collecting, organizing and analyzing data:
  - Pre-admission information
  - Hospital Discharge Summary
  - Resident's medical record
  - Staff observations
  - Shift to shift report
  - Interviews

Care Planning

- Defining the Issue to be Care Planned:
  - Problems - condition, diagnosis, situation, or behavior that negatively impacts the person, requiring assistance, intervention or correction by the staff
  - Need (Psychosocial) – an emotion, feeling, or social interaction that is important to the person and should be recognized
  - Strength – an ability, skill, characteristic or trait a person possesses that should be recognized, encouraged and/or promoted

Issue Statement

- Forming the Problem/Need Statement:
  - A statement of an actual or potential health problem identified through the RAI process
  - Can use functional status or need (limitations or strength) or Nursing Diagnosis
  - Resident-centered, not staff-centered
  - Should be written in simple terms, not medical terminology

Problem Statement

- Sample Problem Statements:
  - Requires assistance when ambulating due to gait disturbance resulting in frequent falls
  - Pain related to recent hip fracture interferes with ADL participation
  - Poor appetite due to mouth pain related to poorly fitting dentures

Problem Statement

- Sample Problem Statements:
  - Strong identification with past occupation as a nurse resulting in desire to attempt to assist fellow residents
  - Finds strength in Scientology faith and relies on faith to resolve health concerns
  - Self-conscious about appearance due to new colostomy resulting in decreased activity participation

Problem Statement

- May be linked to related factors, etiology, and signs/symptoms:
  - Problem statement related to (r/t) associated with (etiology related factors) as evidenced by (signs and symptoms)
- Ex: Left hip pain r/t L hip fracture/surgery as evidenced by:
    - Resident reports of pain which worsens with movement
    - Facial grimace

Problem Statement

- Ensure problem statements are written to identify problems for the resident, not the staff
- For example: “Resident strikes out at the staff during care”
  - The problem for the staff is that the resident is striking out at them, but what is the problem for the resident?
  - The resident’s problem can often only be identified by doing a “root cause analysis”

Problem Statement

- To identify and address the resident's problem in this case the IDT must ask "why" until they are able to identify the reason the resident is striking out during care:
  - Is the resident experiencing pain?
  - Is the resident cold?
  - Fearful?
  - Modest?
- The problem statement should be written to address the resident's issue

Goal Setting

- Goals established must be pertinent to the resident's desired outcome
- Set goals that target either improvement, prevention, maintenance or palliative outcomes
- Develop goals that are measurable and have a time frame for completion or evaluation (the subject, the verb, the modifiers and time frame)

Goal Setting

- Elements of a Goal:
  - Goals should be resident-focused
  - Goals established should be a priority for the resident, not just the staff
  - It is important to ask the resident what their goals are
  - Ask about their goals for quality of life and activity involvement
  - If resident is unable to participate involve the family by asking them to identify what they believe the resident goals would be

Goal Setting

- Elements of a Goal:
  - Who:
    - Resident, caregiver, staff
  - What:
    - The action the resident/caregiver/staff will demonstrate or state
  - Frequency:
    - How often this action will occur
  - Qualifier – amount of times or number of occurrences:
    - How far will the resident ambulate
    - How many activities will the resident participate in

Goal Setting

- Functional Goals:
  - Should clearly identify who will do what, with how much assistance, and why this is important
  - Should contain a qualifier to define when the goal has been met
  - Unmet goals at the time of Care Plan review should be evaluated for their continued appropriateness and updated as needed

Goal Setting

- Sample Goals:
  - The resident will be able to eat 50% of each meal without assistance within two weeks
  - The resident will be able to ambulate 25 feet to the dining room for lunch with rolling walker and staff supervision within 30 days
  - Mrs. Jones will report pain relief to level of no greater than “2”, 30 minutes after pain medication is given

Goal Setting

- Objective Goals:
  - Activity related goals tend to be related to attending a specified number of activities per week:
    - Resident will participate in activities of preference daily through next review
    - Resident will participate in 2 - 3 activities for mental stimulation and socialization through next review
  - These goals may be measurable but do not focus on the highest practicable level of well being
  - The interpretive guidelines for F248 related to Activities indicates that goals such as those above that merely identify how many group activities a Resident will attend are “old and outdated”

Goal Setting

- Examples of poorly written goals:
  - Resident's needs will be met
  - Resident will maintain current functional level
  - Resident will maintain independence
  - Resident will continue to ambulate daily
  - Resident will participate in ADLs as able
  - Resident will communicate wants/needs
  - Resident will consume diet served

The Care Planning Process

- Examples of poorly written goals:
  - Psychosocial conditions tend to be more difficult to establish appropriate goals:
    - Resident will show decreased signs of depression
    - Resident will not hit more than one staff member per week
    - Resident will express satisfaction with social interaction
    - Allow resident to verbalize feelings

Care Plan Interventions

- Specific, individualized approaches must then be developed
- Serve as instructions for resident care and promote continuity of care by all staff
- These instructions should be short and concise so they can be easily understood by all staff

Care Plan Interventions

- Developed in accordance with the MD orders
- Consistent with current standards of practice
- Goal-directed

Care Plan Interventions

- Precise approaches help the staff to understand and implement interventions successfully
- Goals and approaches should be communicated to any staff members who may not have a direct role in developing the Care Plan

Sample Interventions

- Pain medications per orders Scale (3-10)
- Tylenol 325mg 2 tabs po q4hrs PRN for mild pain (2 or less on pain scale)
- Medicate 1/2hr prior to therapy using pain scale
- Assess pain level utilizing pain scale every shift

Sample Interventions

- Offer relaxation music of choice, resident prefers Yanni or Classical
- Offer whirlpool bath for comfort
- Educate resident for potential side effects of Percocet, light-headedness, upset stomach, vomiting, sedation, constipation

Implementation

- Put your Care Plan into action
- Communicate Care Plan goals and interventions to resident and responsible staff on all shifts
- Update CNA assignment sheets
- Provide feedback during Care Plan meeting

Evaluation

- Critically reviewing Care Plan goals, interventions in terms of achieved resident outcomes
- Assessing the need to modify the Care Plan
- Periodically review goals, approaches and staff/resident adherence to the Care Plan
- Monitor the resident's response to care daily
- Reassess Quarterly, Annually and when the resident has a Significant Change

Evaluation

- Evaluate your interventions
- Determine whether goal has been met
- If the goal has not been met:
  - Were approaches appropriate?
  - Were the approaches carried out?
  - Was the goal appropriate?
  - Was the time frame realistic?
  - Was this really a problem for this resident?

Person-Centered Care

- Theme of RoP
- Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices
- Resident is involved, informed and in control
- Resident's right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the Plan of Care
- The right to receive the services and/or items included in the Plan of Care

Person-Centered Care

- Person-centered care means residents of post-acute centers are supported in achieving the level of physical, mental and psychosocial well-being that is individually practicable:
  - Honoring choices
  - Actively participate in their Care Plan development
- Care Plans are living, breathing documents with the person at the center reflecting their changing needs

Person-Centered Care Plan

- Comprehensive Care Plan Developed by an interdisciplinary team that includes:
  - The attending physician
  - RN with responsibility for the resident
  - Nurse with responsibility for the resident
  - Member of the food and nutrition staff
  - Social services staff
  - Other staff as determined by the resident's needs
- In consultation with the resident and the resident's representative(s) and include:
  - Resident's goals for admission and desired outcomes
  - Resident's preference and potential for future discharge

Person-Centered Care Plan

- The comprehensive Care Plan must address:
  - Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations

Person-Centered Care

- Staff focus on **active listening and observing** to meet the changing needs of the person and prevent adverse events
- The Care Plan provides additional clarity of potential issues and actual conditions by linking possible causes and risks:
  - Person-centered goals
  - Prevent avoidable decline
  - Manage risk factors
  - Preserve and build upon the resident's strengths

Person-Centered Care

- The planning process must:
  - Facilitate the inclusion of the resident and/or resident representative
  - Include an assessment of the resident's strengths and needs
  - Incorporate the resident's personal and cultural preferences in developing goals of care

Baseline Care Plan

- Effective November 28, 2017 the Revised Requirements of Participation (RoP) mandate the development of a **Baseline Care Plan**
- Baseline Care Plan must include **very specific information**
- Must be developed within 48 hours of admission, regardless of the day or time the resident admits

Baseline Care Plan

- Required elements of the Baseline Care Plan include:
  - The minimum healthcare information necessary to properly care for a resident
  - Initial goals based on admission orders
  - Physician, therapy, dietary, social services and PASRR (if applicable)

Baseline Care Plan

- Resident must be provided a summary of the Baseline Care Plan in a language he/she can understand that includes:
  - Initial goals
  - Summary of medications and dietary instructions
  - List of services and treatment to be administered by personnel of the facility/on the facility's behalf
  - Notification of updated information based on the details of the comprehensive Care Plans as necessary

The Care Planning Process

- Traditional Care Plans:
  - Diagnosis-focused using nursing diagnosis format
  - Written by the staff based on what they believe is best for the resident
  - Interventions focus on standards of practice for diagnosis
  - Care Plan written in third person – “Resident will…”
  - Care Plan focuses on adapting the resident to facility routine

The Care Planning Process

- Resident-Directed Care Plans:
  - Resident-focused
  - Resident, family, and staff develop a Care Plan that focuses on the resident's wishes
  - Individualized interventions to meet the resident's needs and desires
  - Care Plan written in the first person
  - Care Plan focuses on continuing the resident's lifelong routines during the nursing home stay

Traditional Care Plan

Problem/need	Goal	Intervention
Alteration in thought process r/t history of CVA and short-term memory loss	Resident will be oriented to person, place, time, and surroundings at all times	Introduce self during care Provide orientation to day of week and surroundings with all daily care Place facility calendar in room Invite resident to attend activities daily provide reminders to attend prior to scheduled activity Encourage attendance at the current events activity

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Resident-Focused Care Plan

Problem/need	Goal	Intervention
Short-term memory problem due to recent CVA	Paul will use the activity calendar to select activities of choice daily	Place the monthly activity calendar in Paul's room on the wall near his bed During am care please show him the calendar of events for the day and assist in selecting some that will interest him Throughout the day remind Paul of the activities that he plans to attend for the day and assist with finding event Paul enjoys most activities that offer refreshments but he does not enjoy attending activities that involve music of any kind Religion is very important to Paul – be sure to invite him to the Sunday service

Traditional Care Plan

Problem/need	Goal	Intervention
Resident wanders due to dementia	Resident will not wander into other residents' rooms	Redirect to appropriate area within facility Encourage resident to remain in common areas Teach resident not to enter other residents' rooms Praise for appropriate behaviors

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Resident-Focused Care Plan

Problem/need	Goal	Intervention
I like to walk throughout the home and sometimes wander into other residents' rooms	I will continue to ambulate freely throughout the home daily through the next review	I like to walk with the staff. I will walk with you anywhere. If the weather is nice please take me outside for walks after lunch. I do not like to take naps and I will not sit even when I am tired unless you sit with me for a while. I like to play cribbage and checkers – help me find someone who will sit and play with me after dinner.

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Traditional Care Plan

Problem/need	Goal	Intervention
Potential for Impaired social interaction r/t adjustment to unit	Resident will participate in 2 - 3 activities weekly for mental stimulation and socialization through next review	Introduce to roommate and fellow residents. Provide access to a monthly activity calendar. Encourage and assist resident to 2 – 3 activities for mental stimulation and socialization. Provide 1:1 visits as needed. Praise for appropriate behaviors and offer opportunities for success. Encourage rest periods.

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Resident-Focused Care Plan

Problem/need	Goal	Intervention
Maureen enjoys knitting and needle crafts	Maureen will continue to knit daily	Encourage family to bring in items from home that Maureen has been working on Provide craft box for storage Invite Maureen to attend activities that involve crafts Introduce to residents with similar interests and encourage them to meet daily with small group knitting clutch

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Traditional Care Plan

Problem/need	Goal	Intervention
Potential for alteration in nutrition and hydration	Resident will maintain adequate nutrition and hydration as evidenced by stable weight (+/-4%) and no s/s of dehydration	Diet and consistency as ordered Set up assist prn Monitor weights prn Supplements and fortified food as ordered Labs and meds as ordered Monitor for signs and symptoms of dehydration Offer HS snack Encourage fluids daily Report any significant wt changes to RD

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Resident-Focused Care Plan

Problem/need	Goal	Intervention
Since my recent CVA I have being experiencing a decreased appetite resulting in 10 lb weight loss this month	To maintain my current weight and regain 5 lbs	It helps to have my special adaptive silverware provided by OT at the table during meals I eat better when I sit with my friends Sally and Sue I do not like to brush my teeth prior to eating since the toothpaste alters the taste of my meal, instead just assist me to rinse my mouth prior to meals and brush them after Weigh me once weekly in the am prior to my bath

Resident-Focused Care Plan

Problem/need	Goal	Intervention
Since my recent CVA I have being experiencing a decreased appetite resulting in 10 lb weight loss this month (Cont'd)	To maintain my current weight and regain 5 lbs	Keep my physician informed of any significant changes in my weight I prefer not to get up too early for breakfast – I like to eat hot cereal and eggs with coffee around 9:30 am If you notice I am not eating offer me snacks- chocolate is my favorite and I always have M&M's from my family in my room. I also like chocolate protein shakes. My daughter often brings in my favorite foods from home please remind me they are available and assist with prep

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The Care Planning Process

- Quality Probes:
  - Does the Care Plan address the needs, strengths, and preferences identified in the comprehensive resident assessment?
  - Is the Care Plan oriented toward preventing avoidable declines in functioning or functional status?
  - How does the Care Plan attempt to manage risk factors?
  - Does the Care Plan build on the resident strengths?
  - Does the Care Plan reflect standards of current professional practice?

The Care Planning Process

- Quality Probes:
  - Do the treatment objectives have measureable outcomes?
  - Corroborate information regarding the resident's goals and wishes for treatment in the Plan of Care by interviewing residents, especially those identified as refusing treatment
  - Determine whether the facility has provided adequate information to the resident to enable the resident to make informed choices regard their treatment
  - If the resident has refused treatment, does the Care Plan reflect the facility's efforts to find alternative means to address the problem?

Care Plan Should Always…

- Be a working tool with highlighted areas of discontinued goals with signatures and date changes as they occur
- Address ways to try to preserve and build on the resident's strengths
- Apply current standards of practice in the Care Planning process
- Evaluate treatment of measureable objectives, timetables and outcomes of care

Care Plan Should Always…

- Respect the resident's right to refuse or decline treatment
- Offer alternative treatments, as applicable
- Use an appropriate interdisciplinary approach to Care Plan development to improve the resident's functional abilities
- Involve the resident and/or representative

Surveyors Will Probe…

- Can the staff describe the care, services and expected outcomes of the care they are to provide?
- Do the staff have a general knowledge of the care and services being provided by other team members?
- Does staff understand the relationship of these expected outcomes to the care they provide?
- Is the staff actually doing what the Care Plan says?

Discharge Planning

- When the SNF anticipates the discharge of a beneficiary to another care setting or home it must plan for the discharge
- As part of this planning the SNF must develop a Discharge Care Plan to help ensure coordination of care and safe transition to the new setting

Discharge Planning

- The Discharge Care Plan should include:
  - A summary of the beneficiary's stay
  - A summary of the beneficiary's status at the time of discharge
  - A post-discharge Plan of Care, including:
    - Beneficiary's and family's preferences
    - How the beneficiary will access services
    - How care will be coordinated among caregivers
    - Discharge education and instructions

Discharge Planning

- The discharge summary should provide an adequate clinical picture of the beneficiary and detailed individualized care instructions to ensure that care is coordinated and that the beneficiary transitions safely from one care setting to another
- The interdisciplinary team, including the physician, should participate

Final Thoughts

- Care Plans ensure that the resident's needs are met throughout their stay and after discharge
- Increased scrutiny on the quality and content of Care Plans, as well as resident outcomes, can be anticipated
- The SNF is required to develop a Plan of Care in accordance with the resident's individualized needs

Self-Audit Baseline Care Plan

- The baseline Care Plan was developed within 48 hours of admission to include weekends and holidays
- The baseline care plan includes the minimum healthcare information necessary to properly care for the resident, including but not limited to:
  - Initial goals for care based on admission orders
  - Physician orders
  - Dietary orders
  - Therapy services
  - Social services
  - PASARR recommendations, if applicable
  - Immediate health and safety needs
  - Instructions needed to provide effective and person-centered care that meets professional standards of quality care

Self-Audit Baseline Care Plan

- Baseline care plan was revised and updated to meet the resident's needs until the comprehensive care plan was developed
- If an injury or adverse event occurred prior to the development of the comprehensive care plan, the baseline care plan identified the risk for the injury or event
- A written baseline care plan summary was delivered to the resident that includes:
  - Initial goals
  - Summary of medications
  - Dietary instructions
  - List of services to be administered
  - List of treatments to be administered
- Any updated information, based on details from the admission comprehensive assessment

Self-Audit Baseline Care Plan

- The written baseline Care Plan summary was in a language that the resident and/or representative could understand
- The written baseline Care Plan summary was provided to the resident and/or representative by completion of the comprehensive Care Plan (V0200C2)
- If a noteworthy change occurred after the baseline Care Plan summary was presented to the resident, but prior to completion of the comprehensive Care Plan, the baseline Care Plan summary was updated with the changes and given to the resident

Self-Audit Comprehensive Care Plan Process

- The care plan addresses the **goals, preferences, needs and strengths** of the resident.
- The care plan includes areas identified in the comprehensive resident assessment.
- The care plan assists the resident to **attain or maintain his or her highest practicable well-being.**
- **The care plan focuses on interventions to prevent avoidable decline.**
- The objectives and interventions are resident-centered, measurable, and include **time frames** to achieve the desired outcomes.

Self-Audit Comprehensive Care Plan Process

- There is evidence of resident (or representative) **participation in developing person-centered, measurable objectives and interventions**
- The care plan describes **specialized services** and interventions to address **PASARR** recommendations, as indicated.
- There is a process in place to ensure **direct care staff are aware of and educated** about the care plan interventions.
- There is evidence that the facility has provided adequate information to the resident or resident representative to make **informed choices regarding treatment and services**.

Care Plan Process Self-Audit

- The care plan reflects the facility's efforts to find **alternative means** to address care of the resident if he or she has refused treatment.
- There is evidence that the care plan interventions were **implemented consistently across all shifts**