Care plan preparation, long-term care

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Introduction

A care plan is an individualized, written action plan for a resident's care, treatment, and services that is based on the resident's medical, nursing, physical, mental, and psychosocial needs and preferences. The care plan must be person-specific and include measurable objectives and time frames in order to reflect the resident's progress toward goals. An interdisciplinary team works together to create a comprehensive care plan that guides a resident's care from admission to discharge.[1] A care plan can also serve as a database for planning assignments, conducting handoff communication during change-of-shift reports, conferring with the practitioner or other members of the health care team, planning the resident's discharge, and documenting the resident's care. (See *Elements of a care plan*.) In addition, a care plan can serve as a management tool for determining staffing needs and assignments.

A review of the resident's medical history and condition should occur before planning the resident's care. The resident (if able) or someone acting on the resident's behalf has the right to be included in the care planning process, along with the members of the long-term care facility's staff.[1]

ELEMENTS OF A CARE PLAN

Care planning is driven by a resident's conditions and issues as well as a resident's unique characteristics. Each resident's care plan should be based on an assessment of the resident and effective clinical decision making. The plan must also be compatible with current standards of clinical practice. These three pillars can provide a strong base for quality of care and quality of life for residents. Per CMS, each care plan should:

- evaluate the resident as an individual and include unique characteristics and strengths
- use the Minimum Data Set to evaluate distinct functional areas to elucidate knowledge regarding functional status
- provide a strong understanding of the resident to the interdisciplinary team
- organize information to identify potential issues or conditions, such as triggers, for the resident
- clarify potential issues by looking at causes and risks using the care area assessment process
- be based on assessment information with necessary monitoring and follow-up
- include information regarding ways to address causes and risks associated with issues and conditions to allow for the resident's highest level of well-being
- include a timeline for modification of the care plan and re-evaluation of the resident's status in a prescribed interval, as appropriate.[2]

The resident's interdisciplinary team must develop a baseline care plan within 48 hours after the resident's admission to the facility.[1] On completion of the comprehensive care plan, the facility must provide the resident and the resident's representative, if applicable, with a written summary of the baseline care plan.[1] The interdisciplinary team then collaborates with the resident and reviews and revises the care plan, as necessary, to meet the resident's needs throughout the stay in the facility. This document becomes part of the resident's permanent medical record.

The care plan for each resident must include:

- resident's goals, expressed in measurable objectives with timetables to meet the resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment
- interventions describing the services the interdisciplinary team employs to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being
- evaluation of the fulfillment of goals, as planned.

Some health care facilities use standardized care plans that the interdisciplinary team can modify to serve individual residents. Others use computer programs to facilitate care plan development.[3]

Equipment

- Interdisciplinary care plan form or computerized care plan
- Resident's medical record

Implementation

- Gather and prepare the necessary equipment and supplies.
- Review the resident's medical record, including the interdisciplinary team assessments completed on admission. Review diagnostic test results, the medical treatment plan, and other information that may affect the resident's care. If the resident has just been admitted, complete a nursing history and physical assessment, and add it to the resident's medical record.
- Perform hand hygiene.[4] [5] [6]
- Confirm the resident's identity using at least two resident identifiers.[7]
- Provide privacy.[8]
- Obtain any additional subjective or objective information necessary to complete your assessment from the resident or the resident's representative (if applicable).
- Based on an analysis of the data, determine the nursing diagnoses that will guide the resident's care.[9] Be sure to address all the resident's significant needs when determining the person-centered care plan.[1] [10]
- Collaborate with the resident or the resident's representative (if applicable) to identify individualized short- and long-term goals (expected outcomes) for each nursing diagnosis. The resident should be able to achieve short-term goals quickly; long-term goals take more time to achieve and usually involve prevention, resident teaching, and rehabilitation. A correctly written outcome expresses the desired resident behavior, the criteria for measurement, and the appropriate time and conditions under which the behavior will occur. For example, an outcome containing all these elements might read, "By Monday, using crutches, Mary Ballin will walk 100 feet twice per day." *Expected outcomes serve as the basis for evaluating the effectiveness of your nursing interventions*.
- Select interventions that will help the resident achieve the stated outcome for each goal. Include specific information, such as the frequency or particular intervention technique.

Outcomes establish criteria against which you'll judge further actions. (See *Tips for writing an effective resident care plan*.)

TIPS FOR WRITING AN EFFECTIVE RESIDENT CARE PLAN

Listed below are guidelines to help compose a care plan that's systematic, realistic, clear, specific, and brief.

Be systematic.

Avoid setting an initial outcome that's impossible to achieve. For example, suppose the outcome for a newly admitted resident with a stroke is *Resident will ambulate without assistance.* Although this outcome is certainly appropriate in the long term, the resident must first achieve several short-term outcomes, such as *Resident maintains joint range of motion.*

Be realistic.

The nursing intervention should match staff resources and capabilities. For example, *Passive range-of-motion exercises to all extremities every 2 hours* may not be reasonable, given the unit's staffing pattern and care requirements. The goals you set to correct a resident's problem should reflect what is reasonably possible in your setting—for example, *Passive range-of-motion exercises with a.m. care, p.m. care, and once at night.*

Be clear.

Remember, you'll use goals to evaluate the effectiveness of the care plan, so it's important to express them clearly. For example, stating a goal as *Resident will regularly ambulate* lacks clarity and can be interpreted differently by different people. Stating the goal *Resident will walk 50 feet, three times daily, using a walker* is clearer and enables any nurse to determine whether the resident met the goal.

Be specific.

A directive that isn't specific—for example, *Give plenty of fluids*—is ineffective. In contrast, an intervention that reads, *Encourage fluids—1,000 mL/day shift, 1,000 mL/evening shift, 500 mL/night shift* allows another nurse to carry out the step with some assurance of having adhered to the planned interventions.

Be brief.

Provide necessary details without extraneous information. An intervention that reads *Follow turning schedule* is more readable and useful than having the entire schedule written on the resident care plan.

- Review the care plan with the resident and resident's representative (if applicable) to validate the resident's agreement and to elicit suggestions.[1]
- Evaluate the resident's progress, and revise the care plan, as appropriate.[9]
- Perform hand hygiene.[4] [5] [6]
- Complete documentation of the care plan.[11]

Special Considerations

- If your facility doesn't have an electronic medical records system, fill out the care plan in ink *because the document is part of the permanent medical record.* If you must revise your plan as the resident's condition changes, fill out a new care plan and add it to the medical record.[9] [12] Write the care plan clearly and concisely so that it can be understood by other members of the health care team.[3]
- Sign and date the care plan whenever you make new entries *to keep the plan current and to maintain accountability for planning the resident's care.*[11]
- Customize a standardized care plan *to avoid "standardizing" the resident's care and to enable you to address individual resident concerns.*[3]
- Note that the resident might not meet long-term goals during a stay at your facility. Thus, ensure that your planning addresses postdischarge and home care needs. Interventions may include coordinating home care services.
- Some facilities use critical pathways to address standardized, desired outcomes of care. Critical pathways are interdisciplinary documents that some view as replacements for care plans.[3] If the plan includes nursing diagnoses, these facilities use only the most common diagnostic statements.
- The care plan should reflect elements of person-centered care, make every effort to understand what each resident is communicating verbally and nonverbally, and identify what daily routines are important to each resident.[1]
- For residents who have experienced trauma, the care plan should ensure that residents receive culturally-competent, trauma-informed care that accounts for the resident's experiences and preferences *to eliminate or mitigate triggers that may retraumatize the resident.*[1] (See the "Trauma-informed care, long-term care" procedure.)

Documentation

Documentation associated with care plan preparation includes:

- all pertinent resident problems
- expected outcomes
- interventions
- evaluations of expected outcomes
- progress (or lack of progress) toward meeting set goals.[9]

Related Procedures

- Care plan preparation

References

(Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions)

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Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions

The following leveling system is adapted from *Evidence-Based practice in nursing & healthcare: A guide to best practice,* Fifth edition, by Bernadette Mazurek Melnyk and Ellen Fineout-Overholt (2023).

Level I	Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs)
Level II	Evidence from well-designed single RCTs (experimental)
Level III	Evidence from well-designed nonrandomized controlled trials (quasi-experimental), systematic reviews of a complete body of evidence, and intervention studies using mixed methods

Level IV	Evidence from well-designed case-control and cohort studies (observational)
Level V	Evidence from systematic reviews of qualitative and descriptive studies
Level VI	Evidence from single descriptive and qualitative studies, evidence-based practice implementation, and quality improvement projects
Level VII	Evidence from expert opinion, expert committee reports, and literature reviews

Data from Gyatt, G., & Rennie D. (2002). Users' guides to the medical literature. American Medical Association; Harris, R. P., et al. (2001). Current methods of the U.S. Preventative Services Task Force: A review of the process. American Journal of Preventative Medicine, 20, 21-35.