

A Process for

Care Planning for Resident Choice

ROTHSCHILD PERSON-CENTERED CARE PLANNING TASK FORCE



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OVERVIEW OF PROCESS FOR CARE PLANNING FOR RESIDENT CHOICE

The purpose of the Rothschild Person-Centered Care Planning process is to support long term care communities in their efforts to honor residents' choices that influence quality of care and quality of life, while mitigating potential risks associated with those choices. This process is specifically aimed at care planning when the choice carries sufficient risk, perhaps related to impaired cognition and inadequate decision-making capacity, and the community is considering not honoring the resident's wishes. Following the Rothschild Person-Centered Care Planning process will help the community work with the resident to understand and respect choices to the greatest extent possible, in line with CMS regulations.

The purpose of this process is to guide staff and clearly demonstrate to residents, state surveyors, family members, and others that a care community has done due diligence in:

- Assessing the resident's functional abilities and relevant decision-making capacity,
- Weighing, with the resident and his or her representative², the potential outcomes (positive and negative) of both respecting and aiding the resident in the pursuit of her or his choices, and
- Reviewing the potential outcomes (positive and negative) of preventing the resident from acting on his or her choices.

The assessment of risk in long-term care is often an unbalanced exercise. It generally only takes into consideration potential negative outcomes, primarily with respect to quality of care issues. Insufficient consideration is given to possible positive consequences or to how choices might impact quality of life. In the healthcare arena, safety – particularly physical safety and protection from illness – has generally been more highly valued than the positive psychological and emotional outcomes that may result from behaviors or activities which may have some level of risk attached. Traditionally, care communities consider risk management to mean keeping residents safe, but this view does not take into account that the potential loss of quality of life is equally important. CMS regulations, as well as Person-Centered Care approaches, recognize that the responsibility to respect resident rights for self-determination is equal to the responsibility for resident safety concerns.

2 In this document when we refer to representative, we mean any person who may, under State law, act on the resident's behalf when the resident is unable to act for himself or herself. Similarly, even if the resident has named a representative in a Durable Power of Attorney for Health Care or there is an applicable default representative statute in the particular jurisdiction, the resident's expressed preferences should prevail unless there has been a formal adjudication of incompetence or the resident's attending physician has documented in the resident's record the physician's professional judgment that the resident lacks decision making capacity. In all situations, the resident's expressed preferences should be duly considered and respected to the maximum extent possible.

According to CMS regulations, the resident has the right to:

- Choose activities and schedules (Tag F242).
- Interact with members of the interdisciplinary team, friends and family both inside and outside the care community (Tag F172 and Tag F242).
- Make choices about aspects of his or her life in the care community that are important to him or her (Tag F242).
- Participate in care planning (Tag F280).
- Refuse treatment (Tag F155).
- Both quality of care (Tag F309) and quality of life (Tag F240) that recognizes each individual and enhances dignity.
- Achieve the highest practicable level of well-being (Tag F309).
- The same rights as any resident of the United States (Tag F151).

The challenge in meeting all of these regulatory mandates is that, for so long, the focus has been on doing what is “in the best interest of the person” as defined by the healthcare professional staff, rather than as defined by the person. The whole process has been based on a historical medical model that assumes the “patient” is the passive and “compliant” recipient of care directed and provided by professionals. But person-centered care is based upon a fundamentally different perspective, which places particular value on a cognitively capable individual’s right to make decisions concerning every aspect of her or his life. In our society, people are not required to follow their health care provider’s advice, and many in fact choose not to do so. This right does not change just because care is being delivered in a care community instead of at home; in fact, CMS regulations require these rights be respected.

In order to optimize opportunities for resident choice and to mitigate risk, the interdisciplinary team along with the resident can use this care planning process to plan for each resident’s choice when that choice carries potential risk.

The Rothschild Person-Centered Care Planning process involves:

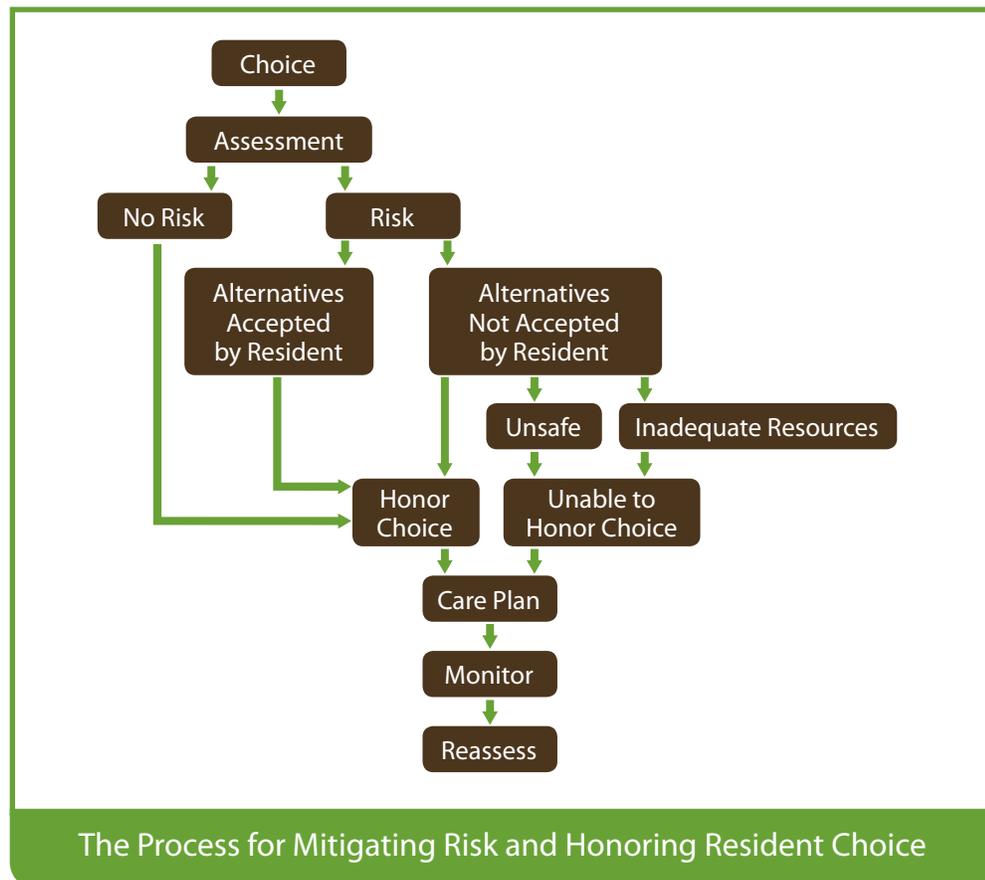
- I Identifying and clarifying the resident’s choice
- II Discussing the choice and options with the resident
- III Determining how to honor the choice (and which choices are not possible to honor)
- IV Communicating the choice through the care plan
- V Monitoring and making revisions to the plan
- VI Quality Assurance and Performance Improvement

The process is outlined in the following flow-chart, which can be used as a quick check by a community as it implements the Rothschild Person-Centered Care Planning process with a resident. The next sections of this document describe each step of the process in greater detail. There is also a documentation form that can be used to document all of the steps of the process, which should be included in the

resident's chart or care plan. Finally, there are several sample scenarios that show how the process is implemented.

The following are resources for implementing this process:

1. Detailed description of the process for mitigating risk and honoring resident choice
2. Flow chart of the process for mitigating risk and honoring resident choice
3. Blank form a care community can use to document the process
4. Sample completed forms documenting the process



DOCUMENTATION FORM FOR HONORING RESIDENT CHOICE AND MITIGATING RISK

Resident Name: Elaine Murtha

I. IDENTIFY AND CLARIFY THE RESIDENT'S CHOICE		Date	Date	Date	Initials
What is resident's preference that is of concern?	Mrs. Murtha states that she prefers to eat foods of regular texture rather than the recommended puree texture. She would rather risk choking than "have to eat pureed foods the rest of my life".	9/5			RM
Why is this important to the resident?	The texture and taste of the pureed food is unappealing. Especially since she retired, having healthy, nicely prepared and presented meals has been a high priority for her. Pureed foods do not fit into that preference.	9/5			RM
What is the safety/risk concern?	Mrs. Murtha has choked once (needing a Heimlich maneuver), takes a very long time to chew her food, and often coughs after swallowing.	9/5			RM
Who representing the resident was involved?	Mrs. Murtha, son and daughter-in-law. Son has a durable Power of Attorney for health care, and feels his mother should follow the advice of the professionals.	9/5			RM
Who on care team was involved in these discussions?	R. Moody-DON, T. Caffot, daytime RN, P. Porter, primary CNA, J. White, SLP, G. Ford, dietician	9/5			RM
II. DISCUSS THE CHOICE AND OPTIONS WITH THE RESIDENT		Date	Date	Date	Initials
What are the potential benefits to honoring the resident's choice?	Increased caloric consumption, greater satisfaction, higher quality of life, and liberalization conforms to current standards of practice.	9/5			RM
What are the potential risks to honoring the resident's choice?	Risk of choking during meals.	9/5			RM
What alternative options were discussed?	<ol style="list-style-type: none"> 1) Working to improve the flavor and presentation of pureed foods 2) Trying a modified texture vs pureed process level 3) Working with Speech Language Pathologist and Dietician to identify: preferred foods that are safer without being pureed; which foods are deemed very unsafe if the texture is not modified; and foods that Mrs. Murtha prefers from these options. 4) Teach Mrs. Murtha the universal signal for choking, so she could get help quickly if needed 5) Mrs. Murtha will participate in dysphagia therapy to improve chewing and swallowing as indicated 6) Always having at least one soft "preferred" food, such as a creamed soup, available. 	9/5			RM
What education about the potential consequences of the choice alternative actions/ activities was provided?	Asked Mrs. Murtha to discuss with the staff the risks of eating regular textured foods, so they can be sure she understands. Social Worker explained to son that PoA for HC doesn't allow him to make choices for his mother while she is still capable of making decisions. The care community has the responsibility to determine and meet the resident's own preferences. Social worker explained to the son that Mrs. Murtha still retains decision-making authority and she is working with the staff to come up with a diet that honors most of her choices while eliminating the most dangerous foods. The son agreed it is important to honor choices as long as the staff think their mutually-agreed plan will be ok.	9/5			RM
Who was involved in these discussions?	Son, R. Moody-DON, T. Caffot, daytime RN, P. Porter, primary CNA, J. White, SLP, G. Ford, dietician	9/5			RM

III. DETERMINE HOW TO HONOR THE CHOICE		Date	Date	Date	Initials
Of all options considered, is there one that is acceptable to the resident /representative and staff? Which one?	Options #3 and #5 were most preferred by Mrs. Murtha. First, staff will identify the foods that are considered to be most high risk, and make sure that on the days when that food is being served, the alternate menu option was something Mrs. Murtha liked and could eat with a regular or soft texture with less risk. Second, the dietician agreed to try to make her plate more appealing in its presentation — recognizing that this was something they should do for everyone. Finally, the family was asked to bring in some of her favorite foods that are naturally soft.	9/5			RM
If no option is acceptable to both the resident /representative and staff, what is the reason for the denial of resident choice? And what is /are the consequences or actions that will be taken?					
Who was involved in these discussions /decisions?	Mrs. Murtha, Son, Sally, Dietician, SLP, CNA	9/5			RM
IV. CARE PLANNING THE CHOICE		Date	Date	Date	Initials
What specific steps will be taken to assure both the resident and the staff follow the agreed to option? Document a brief summary of the plan here and put the detailed goal and approaches in the care plan.					
Was care plan updated?	Yes	9/5			RM
V. MONITORING AND MAKING REVISIONS TO THE PLAN		Date	Date	Date	Initials
How often will this decision be formally reviewed (recognizing that informal monitoring may take place on a daily basis)?	Plan is to spend 1 week going through the menus to identify high risk foods and acceptable alternates for Mrs. Murtha. This coincided with the beginning of the next 5 week menu rotation. Primary CNA will document Mrs. Murtha's comments regarding food, in addition to their routine caloric assessment. SLP and dietician will meet with Mrs. Murtha and CNA each week for the 5 weeks to see how the new menu is working. A Speech-language pathology treatment plan for dysphagia will be initiated.	9/5			RM
Who has primary responsibility for monitoring the implementation?	CNA will track Mrs. Murtha's comments. Dietician to track consumption.	9/5			RM
Was there another option considered to be the "next best step" that would be implemented next?					

Other comments _____
