MDS Alert

In The Spotlight: Let The I's Have It In Your Facility By Crafting The Right 'I Care Plan'

How to navigate the ins and outs of this person-centered care approach.

In the quality-of-life realm, the MDS is your friend -- and a resident's, too -- when you use the tool to prepare an "I Care Plan" that fits only him.

Know the definition: An "I Care Plan" is one developed "through the mind and hands of the resident," says **Diana Waugh, RN**, of **Waugh Consulting** in Waterville, OH. For example, you can ask cognitively intact residents to actually write down their needs, strengths -- and what they expect to happen, says Waugh.

Collect Info About Personal Preferences

Eunice C. Smith Home uses an I Care Plan that has a section about a resident's preferences and habits. And they start collecting that information before admission, offers **Hazel Morgan**, coordinator for the Alzheimer's unit at the Alton, IL-based facility.

Examples: One lady wants showers about three times a week, "so we care plan that," says Morgan. The I Care Plan states: "I will let you know when I want my showers."

Other examples: One resident's care plan says: "I want two shots of Schnapps before bed," relays **Joyce Barr, RN, RAC-C**, MDS coordinator for the facility.

One woman admitted to the facility from home had been sleeping in a recliner in her home for 10 years. Her family had removed the bed from her house, in fact, because she never slept in it. So the facility checked with the department of health and asked if they could provide a recliner in lieu of a bed for the resident. "They said yes, so the care plan says: 'I sleep in my recliner at home and I sleep in one here. Please keep my call light within reach,'" relays Barr.

I Care Planning the Cognitively Impaired Resident

What if the person has cognitive impairment and communication problems coded on the MDS (Sections B and C)? In that case, the I Care Plan would say, "Give me time to find the words to tell you what I need. And give me time to process what you say" and "by the way, I have a hearing deficit and wear a hearing aid in my left or right ear or both," says Barr.

For someone on the Alzheimer's wing who isn't eating well, the care plan might say: "I have a short memory and don't always sit still, so please make sure you have foods that I can carry around with me -- small sandwiches and finger foods."

Critical point: "The care plan should try to sound like the person is giving" staff the directions, says Barr. You try to "get the language in a conversational mode."

The facility consulted with attorneys about using that approach for someone with cognitive impairment who can't say a sentence, relays Barr. They said that's OK if you let the staff and resident's decision-makers know that the care plan instructions are presented in a way that you think the person would say them if he's unable to do so, Barr adds.

Digging deeper: But to be able to speak for someone, you really have to get to know the person, adds Waugh. And that

includes "talking to the family about what the person was like before she developed cognitive decline -- and how the person behaves now and seems to like and dislike." For example, "you may find out the person doesn't like to sit still for long."

Caregivers will update the I Care Plan as they recognize how the resident communicates wants and dislikes.

Individualize ADLs in Section G

At Eunice Smith Home, the I Care Plan addresses the resident's preferences for meeting basic activities of daily living coded in Section G.

For care planning purposes, Barr separates mobility from personal care because those are two different things.

"Mobility includes bed mobility and transfer status -- for example, what apparatus the person uses to get out of bed like a walker or quad cane and how many people are required to help him transfer."

For instance: To meet a resident's preferences for transferring out of bed, the care plan might state: "I have a new hip fracture, so I am not able to bear weight. Two people must help me get in and out of bed. My goal is to get up every day and go to my therapy. They put a belt around my waist and give me my walker. Then I stand up, pivot, and sit," explains Barr.

"For bathing and grooming and dressing, if the person can do any part of their care in that area, the care plan might say: 'I can complete my upper body care but can't do my back and lower body, so I will need help,'" says Barr. "Please allow me to pick out my clothes, and toilet me when I ask."

Home In on Clinical Issues, Risk Management

Once the care plan addresses ADLs and basic care, it goes into the person's disease processes.

Clinical examples: Say the resident has diabetes mellitus. The care plan may say: "I am diabetic and at risk for hypo- or hyperglycemia. Watch me for signs and symptoms of those." The care plan then lists what to look for.
If the team has identified a resident at risk for falls, the care plan might state: "I can't say that I won't fall, but my goal is to not get hurt if I do. Please let me know if you move my furniture around. Wipe up any spills off the floor, etc.," says Barr.

Key Implementation Tip

A facility has to undergo a "philosophical change in implementing" the I Care Plan format, advises **Cheryl Boldt, RN, NHA**, senior consultant with **Maun-Lemke LLC** in Omaha.

Otherwise, "someone will just go through and change the terminology to 'I' statements, which doesn't really mean they are providing person-centered care," she cautions.