4-7-2025 Weekly Clinical Update

Based on recent identified issues, the subject of care plans came up. Exactly who "owns" a resident's care plan…the facility or the resident? And what happens when a resident "objects" to something in the care plan and demands that it be removed? For example, what if the resident has a diagnosis of substance use disorder and the resident denies that diagnosis and wants it removed from the care plan even if the physician has documented the diagnosis in the resident's record?

The purpose of comprehensive care plans is to make sure that residents receive care tailored to their own specific, individualized situations, conditions, identified needs (physical, mental, and psychosocial), with the purpose of improving the resident's quality of care and quality of life. Care plans promote coordinated efforts among nursing home staff and provide clarity about individual responsibilities. In other words, they are the "instruction manual" for the staff to care for each individual resident. Care plans also empower residents and their families by involving them in decision-making processes, and providing identified care needs to foster a sense of dignity and respect.

An effective, individualized, person-centered care plan requires constant communication between staff, practitioners, the resident and family members of the resident. It is often a challenge. Key components of a comprehensive, individualized, timely, and person-centered care plan requires the components of: medical needs, daily living assistance, psychological and emotional support, social interactions, dietary and nutritional needs, and safety measures including identified risks.

So, what should happen if a resident objects to something included in his/her care plan? First, they have the right to voice concerns and request changes and the facility is required to address those concerns and make reasonable accommodations, but remember the purpose of the care plan is to provide direction to each staff member caring the resident with a COMPREHENSIVE guide to caring for the resident. Some sort of accommodation or compromise has to be reached in the process.

Every resident residing in a facility has Resident Rights. Each resident has the right to participate in the development of his/her own care plan and they have the right to express preferences and concerns, and those should be documented in the care plan and the care plan notes. Staff MUST actively encourage open communication with all residents and family members related to the care plans.

When a resident objects to something in his/her care plan, staff should take the following steps:

- Listen to the resident's concerns and try to understand his/her perspective. Practice active listening skills and empathy
- Explain the rationale behind the care plan and the reasons for the specific focuses and interventions
- Consider the resident's objections and explore alternative approaches or modifications to the care

If the resident's concerns are valid and a modification is needed, the care plan should be revised to reflect the resident's preferences and needs. Perhaps changing the wording is all it will take to provide all staff the information. Staff should make sure that the information in the care plan is, indeed, factual and not judgmental in any way. The care plan is a CLINICAL, legal document that is regulatorily required. Always remember, the care plan is a function of the ENTIRE interdisciplinary team (IDT)…not just the RAI Coordinator. The resident's practitioner is a vital part of that IDT, and can be an asset in explaining the components of the resident's care plan to the resident and/or family members. The same concept applies to any/all behavioral health providers caring for the resident. Social Service staff are also important in assisting the resident in adjustment issues to specific diagnoses.

If disagreements persist, the facility may consider mediation or dispute resolution processes to reach a mutually agreeable compromise.

The resident and/or family member and the staff may reach out to the State LTC Ombudsman if no resolution can be reached.

Resident involvement in the care planning processes ensure that each resident's needs and preferences are met, leading to improvement in quality of care and quality of life.