July 28, 2025 Weekly Clinical Update

In preparation for a future presentation on Writing Effective, Innovative Care Plans. During research and review of care plan deficiencies cited for nursing homes, it is apparent a common issue that frequently isn't but should be included on a resident's comprehensive care plan…and that is refusals of care and how to effectively include the issue in the comprehensive care plan.

Refusals of care are common in long term care settings and those refusals are not necessarily a deficient practice but the facility is responsible for "digging deeper" into the root cause of those refusals. Often refusals reflect deeper concerns, unmet needs or personal preferences. Development of a care plan that addresses the refusals, along with identified causal factors, and instructions to staff on interventions to implement at the time of refusals is key to regulatory compliance. That process also demonstrates the facility is honoring resident autonomy and ensuring dignified care.

The methods for creating care plans and working through those refusals while still providing needed care must be a planned, structured process and included in the resident's individualized, person-centered, comprehensive, timely care plan.

- Identify the type of refusal and carefully document the refusal clearly & objectively
    - What is being refused?
        - Bathing, medication, turning/repositioning, non-pharmacological interventions?
    - How often does it occur?
    - Who reports it?
- Assess the Causal Factor(s) for the Refusal: ASK THE RESIDENT WHY; Gather information from multiple disciplines
    - Medical factors
        - Pain
        - Fatigue
        - Cognitive status
    - Psychosocial causes
        - Cultural background
        - History of trauma
        - Behavioral health issues
        - Lack of privacy
    - Environmental issues
        - Room temperature
        - Staff approach
        - Timing
    - Communication barriers
        - Language impairment
        - Sensory impairments

- Include the Resident's Voice
    - Care planning must be person-centered, meaning:
        - Quoting resident's reason when possible
        - Documenting resident's preferences and goals
        - Involving resident in designing alternatives
- Craft SMART goals and interventions
    - SMART goals:
        - S: Specific: goal should be clearly defined. What EXACTLY do you want to be accomplished?
        - M: Measurable: Process to measure progress or completion. How will you know when goal is achieved?
        - A: Achievable: Goal should be realistic given resources & time. Can it actually be done?
        - R: Relevant: Goal must align with priorities. Is it meaningful & connected to larger goals?
        - T: Time-bound: goal should have a deadline or timeframe. When will it be completed?
    - Ensure all direct care partners know the components of the care plan and the approaches to take and alternatives to offer if/when resident refuses a specific care/intervention
- Monitor & evaluate regularly
    - Include in the care plan:
        - Who will monitor
        - How frequently
        - What constitutes success or change in status
    - Document outcomes
        - Did refusals decrease?
        - Is resident more engaged?
        - Were alternative interventions successful?
        - Are additional interventions needed?
- Integrate with regulatory requirements
    - Ensure the care plan:
        - Aligns with F656 (develop care plans), F657 (revise care plans), and F684 (quality of care)
        - Demonstrates interdisciplinary input and person-centered approach(es)
        - Uses language that supports survey-readiness & defensibility

Refusals can and should be considered opportunities to know more about the resident and honor the resident's autonomy and quality of life.