

Philadelphia Geriatric Center  
Administrative Manual

Administrative Manual	Policy No: AD97
Title: Interdisciplinary Care Planning	No. of Pages: 9
	Original Effective Date:
	Authorized Signature:

**I. Purpose:**

- A. To establish an interdisciplinary team care planning process to ensure that resident care and treatment is planned appropriately for the resident's needs and severity of condition, impairment, disability or disease.
- B. To assure a planning process that maximizes and maintains each resident's optimal physical, psychosocial, and functional status.
- C. To establish a care-management system in which the care and treatment planning process is timely, systematic, and comprehensive and incorporates input from all disciplines.
- D. To provide a mechanism for resident and family input to the care plan.

**II. Policy:**

- A. PGC utilizes an interdisciplinary team to provide an individualized comprehensive resident assessment and care planning process in order to maximize and maintain every resident's functional potential and quality of life.
- B. Based on a comprehensive interdisciplinary assessment, the care team will address individualized resident needs to include physical, psychosocial, functional, activities, emotional, spiritual, and communication needs. Care planning addresses needs resulting from the resident's condition and considers the resident's expectations, characteristics, and previous daily routines.
- C. An interim care plan is developed immediately after admission, based on information obtained during the admissions process. The interdisciplinary care plan is developed as soon as possible after admission, but no later than one week after completion of the comprehensive assessments.
- D. Individual care and treatment goals are identified. These goals are reasonable and measurable. Each resident's care plan identifies goals that:
  - reflect the resident's unique needs
  - are realistic and measurable
  - include a time frame for achievement, when appropriate
- E. Services and care are identified and planned to meet resident's care goals. The Interdisciplinary Care Plan team members to provide care or service are identified. The care plan indicates how frequently specific services will be provided.

- F. The care plan is revised when appropriate to reflect the resident's current needs, based on evaluation of:
- progress towards goals
  - response to care and treatment
  - significant changes in the resident's status
- G. An Interdisciplinary Care Planning Mentoring Team is responsible for the overall supervision, training, consultation, and evaluation of the individual team's process. They provide ongoing feedback to the teams and administrative staff.
- H. Any member of the unit care team may request that a process meeting be held to discuss improving procedures, problem solving, and/or resolution of differences among team members. The Interdisciplinary Care Planning Mentoring Team is available for consultation on these issues.
- I. The resident education process is interdisciplinary, as appropriate to the care plan.
1. As part of the care plan the resident is educated appropriate to his or her assessed needs, abilities, readiness, preferences, and length of stay.
  2. The care planning process incorporates information from the resident's assessment about his or her education needs.
- J. Team Membership: Care is planned by an interdisciplinary team representing all appropriate health care professionals.
1. Core Members:
    - Professional Nursing
    - Medicine
    - Social Work
    - Activities
    - Nutritional Services
    - Certified Nursing Assistants
    - Psychologist

2. Consultative Members:

As appropriate to the resident's needs, the team may include representatives from the following departments and services:

- Chaplaincy
- Psychiatry
- Administration
- Dental
- Pharmacy
- Physical Medicine and Rehabilitation (PM&R)

3. Residents and family are invited to attend the care planning conference and participate in developing and reviewing the care plan.

K. Roles and Responsibilities of team members:

1. All disciplines are responsible for adhering to Federal and State regulations, and JCAHO standards pertaining to their specialty.
2. Nurse Manager Responsibilities
  - a. To be responsible for the coordination of the care planning process and for the completion of the MDS per Federal regulations.
  - b. For the care planning meeting:
    1. To keep an updated listing of the schedule of care planning.
    2. To notify team members of that schedule.
    3. To assign CNA's to attend the care planning meeting as appropriate.
    4. To make sure a mechanism is in place for obtaining information from other shifts.
    5. To share the care planning information with appropriate nursing personnel not attending the meeting.
    6. To comply with all regulations pertaining to the timing and completion of the MDS.

3. Other Team Member Responsibilities:

In preparation for the care planning meeting, each member is responsible to:

- a. Conduct a review of the status of the resident, searching for problems, issues, concerns to address in the team meeting. This review includes a chart review and individual clinical experience with resident since last care planning session. This may include interview or observation of residents.
- b. Complete his/her MDS section(s) and input data into the computer system in a timely manner.
- c. Assess for changes since last MDS Quarterly, or at time of first Quarterly, since the last annual or readmission MDS.

L. Standards of Practice:

1. There are 3 designated roles on each team that may be rotated among selected members:
  - a. Leader
  - b. Recorder
  - c. Member

2. The Nurse Manager brings the MDS, RAP's and care plan draft to the care planning meeting.
3. Attendance and Participation:
  - a. All core team members are expected to attend weekly care planning meetings and actively participate.
  - b. In the event of absence from IDCP meeting, the member should:
    1. Notify the team leader.
    2. Relay pertinent information regarding specific residents to another team member or the leader of the team prior to the absence.
    3. Obtain a copy of the care planning notes form/tracking intervention list to get updates on any new plan of action care planned for residents.

M. Time Frames:

1. Each unit's care planning meeting occurs once a week at a mutually agreed upon time.
2. Scheduling residents for care planning conference is as follows:
  - a. Within 21 days post-new admission to Nursing Home.
  - b. On a 12 week (quarterly) schedule with annual MDS due 12 weeks after 3<sup>rd</sup> Quarterly review.
  - c. After significant change in resident status.

**III. Procedure:**

- A. MDS based assessments and RAPS are completed prior to the care planning meeting by designated team members.
- B. The Medical Record should be available at the care planning meeting.
- C. Leadership of the interdisciplinary team meeting rotates weekly among the following disciplines: psychology, nursing, social work, activities and nutrition.

The responsibilities of the leader are to:

1. Come prepared:
  - Find a substitute leader if unable to attend the IDCP meeting.

- Review the residents' charts prior to the meeting.
  - Bring the charts to the meeting.
2. Keep track of time:
    - Make sure the meeting starts and ends on time.
    - Discussion for each resident should not go more than 20 minutes (except in crisis situations).
    - Allow time for follow-up of residents discussed the week before.
    - Allow time for discussion of emergent issues on the unit.
    - Announce who will be care planned the next week.
  3. Follow the enhanced care planning format. (See format section)
  4. Use good leadership skills:
    - Solicit input from each discipline.
    - Refocus team members who get off track.
    - Encourage problem solving. If there are no specific "problems", focus discussion on how to enhance quality of life for a resident.
    - Use good listening skills – reflect back what you hear other team members saying.
    - Summarize the plan of action for each resident.
- D. The Team Recorder can be rotated among disciplines or assigned to a given individual on the team. It is the Team Recorder's responsibility to:
1. Take notes on each resident's plan of action.
    - After the leader summarizes each resident's plan of action, the Recorder notes the information including a clear specification as to which discipline(s) are taking responsibility for implementation.
    - The information is given to the Nurse Manager at the end of the meeting. It is the Nurse Manager's responsibility to ensure that this information is shared with appropriate nursing personnel not at the meeting.
  2. Update the status of suggested interventions from notes of previous meetings.
    - When an intervention from the previous week's care planning session has not been implemented by the following week, the resident and the suggested intervention should be indicated on a tracking intervention list.
    - Difficulties in implementing the prescribed intervention are discussed and solutions offered.

- The listing will remain and be discussed each week until the appropriate implementation of the plan has occurred or the intervention has been modified as approved by the team.

E. The Team Member is defined as anyone who is not leading the meeting. It is the Team Member's responsibility to:

1. Come prepared.

- Review charts of residents to be care planned ahead of time if possible.
- Make sure designated section(s) of the MDS are completed prior to the meeting and entered into the computer.
- Be courteous to other team members, be on time.

2. Participate.

- Members are expected to participate in the discussion of the resident.
- Provide information about the resident specific to your own discipline's expertise.
- Ask questions if you do not understand what a certain word or diagnosis means.
- Disagree (respectfully) if you do not believe that another person's perspective is accurate.
- Brainstorm approaches to care within or outside your own discipline's traditional scope (e.g., Social Work suggests a nursing intervention, Nursing suggests an activity intervention, etc.)

3. Follow through on assigned tasks.

- When accepting responsibility for the implementation of a specific plan of action for a resident, try to follow through on the plan within one week's time.
- Report the results of your efforts to the team at the next week's care planning meeting. If you are experiencing difficulties, ask the team to assist you in rethinking the plan of action for that resident.

F. Format of Care Planning Meeting

1. For Each Annual or new MDS:

- a. Identify your purpose of review:
  1. Yearly review

2. Change in status
  3. Return from hospitalization for treatment of \_\_\_\_\_
- b. Provide description of resident including diagnoses and brief psychosocial history.
  - c. Review of triggers indicated on MDS.
  - d. Discuss problems, issues, interventions related to triggers and any other concerns raised at last care planning. If relevant, review previous issues raised at last care planning.
  - e. Review behavior monitoring/side effect forms for residents receiving psychotropic medication or those who are on behavior monitoring plans to assess effectiveness of nonpharmacologic interventions and potential to reduce or eliminate psychotropic medications.
  - f. Review residents using restraints for restraint reduction or elimination potential. Document discussion on the care plan.
  - g. Review the medication plan for polypharmacy and opportunities for medication dosage reduction and/or elimination.
  - h. Leader obtains feedback from each team member regarding how the resident is functioning per that discipline and suggested interventions for targeted problems.
  - i. Leader summarizes problems, approaches and goals. Identify who is responsible for implementation of interventions and how frequently interventions will be provided.
  - j. Consider quality of life issues in the following areas:
    1. Social/Spiritual Needs
    2. Physical Health
    3. ADL Functioning
    4. Emotion/Affect
  - k. Incorporate interventions in care plan, making additions or modifications as necessary.
  - l. Team recorder documents relevant information on care planning notes form for communication to other staff.
1. For Each Quarterly Review:
    - a. Identify 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> quarter.
    - b. Review list of diagnoses.

- c. Leader obtains feedback from each team member about how the resident is functioning per that discipline, any changes since last review, and suggested interventions for targeted problems.
  - d. Review behavior monitoring/side effect forms for residents receiving psychotropic medication or those who are on behavior monitoring plans to assess effectiveness of nonpharmacologic interventions and potential to reduce or eliminate psychotropic medications.
  - e. Review residents using restraints for restraint reduction or elimination potential. Document discussion on the restraint order form.
  - f. Review the medication plan for polypharmacy and opportunities for medication dosage reduction and/or elimination.
  - g. Leader summarizes problems, approaches and goals. Identify who is responsible for implementation of interventions and how frequently interventions will be provided.
  - h. Consider quality of life issues in the following areas:
    - 1. Social/Spiritual Needs
    - 2. Physical Health
    - 3. ADL Functioning
    - 4. Emotion/Affect
  - i. Incorporate interventions in the care plan, making additions or modifications as necessary.
  - j. Team Recorder documents relevant information on care planning notes form for communication to other staff.
- G. Residents and family participate in developing and reviewing the care plan.
- 1. To the extent they are able, residents participate in care planning. Residents are asked to express their preferences about care, which are respected and incorporated into care decisions. The interdisciplinary team and the resident work together to make clinically sound care decisions.
  - 2. Residents and families are invited to care planning meetings by the social worker. The social worker informs families of time constraints and monitors time during the care planning session. When families are unable to attend, the social worker elicits their input and keeps them informed of all care plan issues.
  - 3. The care plan sign off form and progress notes document how residents and families are included in the care plan process.
- H. When a resident is receiving hospice services, care planning is coordinated with the interdisciplinary hospice team. Hospice staff are invited to care planning meetings.

1. A bereavement care plan is developed to address any risk factors identified in the bereavement assessment. The bereavement care plan describes:
  - family needs
  - specific services to be provided for up to one year following the resident's death
  - referrals for additional counseling when appropriate
2. When a hospice is not involved in provision of bereavement services directly, referrals to appropriate services are documented in the bereavement care plan.

I. Advance directives are reviewed in the care planning process annually.

#### IV. **Documentation :**

1. MDS
2. RAPS
3. Care Plans
4. Care Plan sign-off form
5. Care Planning notes form/Tracking Intervention list
6. Progress Notes
7. Order Sheets
8. Kardexes

#### V. **References:**

1. Angermeyer, K., Clark, D., Connelly, T., Ellenor, G., Marion, R., Mitchell, C. & Walsh, T. (1980). A Guide to Team Development. University of Kentucky: College of Allied Health Professions.
2. Campbell, Lyla J. & Kenneth D. Cole (1987). Geriatric Assessment Teams. Clinics in Geriatric Medicine 3, (1) Feb.: 99-110.
3. Feiger, Shelia M., & Madeline H. Schmidt (1979). "Collegiality in interdisciplinary health team: Its measurement and effects."