CMS: Best Practices in Care Planning Compliance

Care planning is a complex and vital process that can seriously impact a patient's health. Therefore, it is important that organizations have a robust care planning process.

Joint Commission surveyors have reported seeing the following issues during hospital surveys:

- Wide variations within/between institutions and systems
- Processes not clearly defined
- "Point and click" and generic care plans
- No evidence of interdisciplinary care team involvement
- Inability of caregivers to articulate the plan of care
- Inability of caregivers to locate where the different elements are documented in the electronic medical record
- Lack of patient and/or family involvement in care planning

A Model Care Planning Process

Barb Buturusis, RN, MSN, director of Field Staff Education and Development, Accreditation and Certification Operations, The Joint Commission, and Joanne Salsgiver, RN, MHA, CMS Consultant, Joint Commission Resources, suggest the following model care planning process. This process can be used to help organizations develop their own policies and processes that reflect compliance with both the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) and Joint Commission standards (*see* the sidebar begining on page 8 for an outline of related CoPs and standards).

Survey Tips

- Staff must be able to speak to the care planning process and know where the different elements are located in the patient medical record.
- Staff must be able to speak to the organization's policy and know where it is located.
- Organizations must have a process for ensuring that specified time frames are met (for example, electronic reminders).
- Staff must know how to make revisions to the care plan in the patient record.
- All components of the care planning process must be documented in the patient record.

A meticulous care planning process can make a huge difference in patient safety and patient outcomes.

Components of the Care Planning Process

A good care planning process should include the following elements:

- An organizational policy for care planning
- The components of a comprehensive patient assessment
- Patient-specific goals
- Interventions that will help reach the desired goals
- Time frames for the patient's achievement of goals
- Regular reassessment and revision of the plan of care with changes in patient condition

The Care Planning Policy

We suggest organizations consider addressing the following in their care planning policy:

- Who will develop the care plan
- Who is allowed to access the care plan
- A time frame for initiating the care plan
- Elements of the comprehensive patient assessment
- How the patient and/or family will be involved in

(continued on page 8)

the care planning process, including development of goals
- How the interdisciplinary team will be involved in the care planning process, including development of goals
- A time frame for reassessment and updating
- Where the different elements of the care plan will be documented and when
- How discharge planning will be addressed

The Comprehensive Patient Assessment

It is up to the individual organization to determine what will be included in its comprehensive patient assessment. Staff must be familiar with what should be included in the patient assessment, per the organization's policy, and the time frame in which the assessment must be completed.

Establishing goals and outcomes

When establishing goals and outcomes, some suggestions for organizations include the following:

- Involve all related disciplines.
- Involve the patient and/or family. It is up to the individual organization to determine how patients and families will be involved in the care planning process. Potential strategies may include the following:
  - Conducting bedside rounds
  - Using whiteboards as a visual cue
  - Involving patients in care team planning meetings
- Document goals and anticipated outcomes in the patient record.

Developing Interventions to Help Reach Desired Goals

When developing interventions, organizations should do the following:

- Involve all related disciplines.
- Individualize interventions to the specific patient.
- Document interventions, including time frames.
- Document any changes based on reassessments or new findings.

Establishing Time Frames

When establishing time frames, organizations should do the following:

- Establish time frames for patient care based on the type of intervention and the patient's condition.
- Develop time frames for reassessment and revise the care plan as appropriate to changes in the patient's condition.
- Document time frames in the patient record.

(continued on page 15)

CMS and Joint Commission Care Planning Requirements

CMS addresses care planning compliance in the following CoPs:

- **A-0395**
  42 CFR §482.23(b)(3) NURSING SERVICES: STAFFING AND DELIVERY OF CARE
  A registered nurse must supervise and evaluate the nursing care for each patient.
- **A-0396**
  42 CFR §482.23(b)(4) NURSING SERVICES: STAFFING AND DELIVERY OF CARE
  The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.
- **A-0397**
  42 CFR §482.23(b)(5) NURSING SERVICES: STAFFING AND DELIVERY OF CARE
  A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available.
- **A-0438**
  42 CFR §482.24(b) MEDICAL RECORD SERVICES: FORM AND RETENTION OF RECORD
  The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.
- **A-0449**
  42 CFR §482.24(c) MEDICAL RECORD SERVICES: CONTENT OF RECORD

(continued on page 9)

CMS and Joint Commission Care Planning Requirements (continued)

The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

- **A-0467**
  42 CFR §482.24(c)(4)(vi) MEDICAL RECORD SERVICES: CONTENT OF RECORD
  All records must document the following, as appropriate: All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.
- **A-0273**
  42 CFR §§482.21(a) & 482.21(b) QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM: DATA COLLECTION AND ANALYSIS
  (a) QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM: PROGRAM SCOPE
  (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes. . . .
  (2) The hospital must measure, analyze, and track quality indicators . . . and other aspects of performance that assess processes of care, hospital service and operations.
- **A-0309**
  42 CFR §482.21(e) QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM: EXECUTIVE RESPONSIBILITIES
  The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:
  (1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
  (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.
  (5) That the determination of the number of distinct improvement projects is conducted annually.
- **A-0315**
  42 CFR §482.21(e)(4) QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM: EXECUTIVE RESPONSIBILITIES
  The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients.
- **A-0043**
  42 CFR §482.12 CONDITION OF PARTICIPATION: GOVERNING BODY
  There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. . . .
- **A-0049**
  42 CFR §482.12(a)(5) GOVERNING BODY: MEDICAL STAFF
  The governing body must ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.

Care planning compliance is addressed in the following Joint Commission standards:

- Nursing (NR) Standard **NR.02.03.01**, EP 2: The nurse executive implements nursing policies, procedures and standards that describe and guide how the nursing staff provides nursing care, treatment and services. (*See also* LD.04.01.07, EP 2)
- Provision of Care, Treatment, and Services (PC) Standard **PC.01.02.03**, EP 3: Each patient is reassessed as necessary based on his or her plan for care or with changes in condition.
- **PC.01.02.03**, EP 6: A RN completes a nursing assessment within 24 hours after the patient's admission. (*See also* RC.02.01.01, EP 2)
- **PC.01.02.05**, EP 1: Based on the initial assessment, a RN determines the patient's need for nursing care, as required by hospital policy, law and regulation.

(continued from page 8)

Reassessing and Revising

When reassessing and revising the care plan, organizations should do the following:

- Revise according to new laboratory or diagnostic findings.
- Reassess and revise at specified intervals.
- Document revisions in the patient record.

Educating Staff and Monitoring the Care Planning Process

Salsgiver says that those who are involved in care planning should be educated during their initial orientation and at least annually.

"Care planning should be part of the organization's QI [quality improvement] process and should be continuously monitored to see if improvements are needed," Salsgiver says. "Organizations can also do a postdischarge review to see if the care plan matches the patient's diagnosis and to see if it was updated during the patient's stay."

"You not only want to be compliant with the Joint Commission standards and the CoPs, but you also want to focus on quality of care for patients," Buturusis says. "If you focus on that, you can't go wrong." TS