



## ASSESSMENT AND CARE PLANNING: THE KEY TO QUALITY CARE

Every person in a nursing home has a right to good care, under the law. The law says the home must help people "attain or maintain" their highest level of well-being - physically, mentally and emotionally. To give good care staff must assess each resident and plan care to support each person's life-long patterns, and current interests, strengths and needs. Resident and family involvement in care planning gives staff information they need to make sure residents get good care and the care they deserve.

### WHAT IS A RESIDENT ASSESSMENT?

Assessments gather information about how well residents can take care of yourselves and when you need help in "functional abilities" -- how well you can walk, talk, eat, dress, bathe, see, hear, communicate, understand and remember. Staff also ask about residents' habits, activities and relationships so they can help residents live more comfortably and feel more at home. The assessment helps staff look for what is causing a problem. For instance, poor balance could be caused by medications, sitting too much, weak muscles, poor-fitting shoes, a urinary infection or an ear ache. Staff must know the cause in order to give treatment.

### WHAT IS A PLAN OF CARE?

A plan of care is a strategy for how the staff will help a resident. It says what each staff person will do and when it will happen (for instance—The nursing assistant will help Mrs. Jones walk to each meal to build her strength). Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel like they meet your needs and must be comfortable with them. Care plans can address any medical or non-medical problem (example: incompatibility with a roommate).

### WHAT IS A CARE PLANNING CONFERENCE?

A care planning conference is a meeting where staff and residents/families talk about life in the facility-- meals, activities, therapies, personal schedule, medical and nursing care, and emotional needs. Residents/families can bring up problems, ask questions, or offer information to help staff provide care. All staff who work with a resident should be involved--nursing assistants, nurse, physician, social worker, activities staff, dietician, occupational and physical therapists.

### WHEN ARE CARE PLANNING CONFERENCES HELD?

Care planning meetings must occur every three months, and whenever there is a big change in a resident's physical or mental health that might require a change in care. The care plan must be completed within 7 days after an assessment. Assessments must be completed within 14 days of admission and at least once a year, with reviews every three months and when a resident's condition changes.

### WHAT SHOULD YOU TALK ABOUT AT THE MEETING?

Talk about what you need, how you feel; ask questions about care and the daily routine, about food, activities, interests, staff, personal care, medications, and how well you get around. Staff must talk to you about treatment decisions, such as medications and restraints, and can only do what you agree to. You may have to be persistent about your concerns and choices. For help with problems, contact your local ombudsman, advocacy group or others listed on the next page.

## HOW RESIDENTS AND THEIR FAMILIES CAN PARTICIPATE IN CARE PLANNING

Residents have the right to make choices about care, services, daily schedule and life in the facility, and to be involved in the care planning meeting. Participating is the only way to be heard.

### Before the meeting:

- Tell staff how you feel, your concerns, what help you need or questions you have; plan your agenda of questions, needs, problems and goals for yourself and your care.
- Know, or ask your doctor or the staff, about your condition, care and treatment.
- Ask staff to hold the meeting when your family can come, if you want them there.

### During the meeting:

- Discuss options for treatment and for meeting your needs and preferences. Ask questions if you need terms or procedures explained to you.
- Be sure you understand and agree with the care plan and feel it meets your needs. Ask for a copy of your care plan.
- Ask with whom to talk if you need changes in it.

### After the meeting:

See how your care plan is followed; talk with nurse aides, other staff or the doctor about it.

### Families:

- Support your relative's agenda, choices and participation in the meeting.
- Even if your relative has dementia, involve her/him in care planning as much as possible. Always assume that s/he may understand and communicate at some level. Help the staff find ways to communicate with and work with your relative.
- Help watch how the care plan is working and talk with staff if questions arise.

### A Good Plan Should:

- Be specific, individualized and written in common language that everyone can understand;
- Reflect residents' concerns and support residents' well-being, functioning and rights; Not label residents' choices or needs as "problem behaviors;"
- Use a multi-disciplinary team approach and use outside referrals as needed;
- Be re-evaluated and revised routinely - Watch for care plans that never change.

For more information and resources on assessment and care planning,  
go to [www.theconsumervoic.org](http://www.theconsumervoic.org)

*National Consumer Voice for Quality Long-Term Care (formerly NCCNHR) is a nonprofit organization founded in 1975 by Elma E. Holder to protect the rights, safety and dignity of American's long-term care residents.*

©2017 The Consumer Voice for Quality Long-Term Care, 1001 Connecticut Ave, NW, Suite 632, Washington, D.C. 20036  
Tel. 202. 332.2275, Fax 202.3322949, email: [info@theconsumervoic.org](mailto:info@theconsumervoic.org), website: [www.theconsumervoic.org](http://www.theconsumervoic.org)