Baseline Care Plan Policy

POLICY

It is the policy of the facility to develop a baseline care plan within 48 hours of admission. Along with the baseline care plan is a summary of care plan that is provided to the resident and representative in a language that can be understood.

OBJECTIVE OF THE BASELINE CARE PLAN POLICY

The objective is the completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

DEFINITIONS

"Resident's Goal": The resident's desired outcomes and preferences for admission, which guide decision making during care planning.

"Interventions": Actions, treatments, procedures, or activities designed to meet an objective.

"Measurable": The ability to be evaluated or quantified.

"Objective": A statement describing the results to be achieved to meet the resident's goals.

"Person-centered care": means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home

PROCEDURE:

1. Upon admission, the facility will begin the process of developing a baseline care plan and this care plan will be completed within 48 hours of admission.
2. Information for the baseline care plan will be based upon admission orders, information from the transferring provider and discussion with the resident and resident representative is applicable and the resident so chooses.
3. The care plan will include at the minimum the following information:
    a. Initial goals based on admission orders
    b. Physician orders
    c. Dietary orders
    d. Therapy services
    e. Social services
    f. PASARR recommendations, if applicable
    g. Instructions needed to provide effective and person-centered care that meets professional standards of quality care
    h. Address resident health and safety concerns to prevent decline or injury, such as:
        i. Elopement or
        ii. Fall risk
    i. Identify needs for supervision, behavioral interventions and assistance with ADLs as necessary
4. The care plan will reflect the resident's stated goals and objectives and include interventions that address his/her current needs.
5. The baseline care plan will include conditions and risks affecting the resident's health and safety. Examples include, but are not limited to:
    a. Infection(s)
    b. Cardiac diagnoses
    c. Neurological Impairments
    d. Alterations in skin integrity
    e. Mood and/or Behaviors
    f. Comfort Care Needs
    g. Discharge Care Planning Needs
6. Changes will be made as necessary, resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan.
7. The facility staff or those acting on behalf of the facility will implement the interventions to assist the resident to achieve care plan goals and objectives.

8. Direct care staff will be educated about the care plan interventions
9. The resident and representative will be provided with a written summary of the baseline care plan.
10. The baseline care plan summary will be in a language and conveyed in a manner the resident and representative, if applicable, can understand. The summary will include:
    a. Initial goals for the resident
    b. A list of current medications
    c. Dietary instructions
    d. Services (i.e. therapy) and treatments to be administered by the facility and personnel acting on behalf of the facility.
    e. Any updated information based on details of the admission comprehensive assessment as necessary.
11. This facility may decide to present the baseline care plan as the summary as long as it meets the requirements listed in #10.
12. There will be documentation in the clinical record that the baseline care plan summary was given to the resident and representative.
13. In the event that the comprehensive assessment and comprehensive care plan identify a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, these changes will be incorporated into an updated summary provided to the resident and his or her representative.
14. The facility has the option of completing a comprehensive care plan instead of a baseline care plan as long as the comprehensive care plan is completed within 48 hours and follows the RAI process/requirements. A written summary of the comprehensive care plan will be provided to the resident and resident representative in a language that they can understand.

References

CMS State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities:

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf