37 Plan of Care

TEACHING PLAN

As a home health clinician or aide, you are responsible for following the plan of care. That means you follow through with requested duties within the plan of care. You communicate with other team members to identify changes in the patient condition and additional needs the patient may have that impact his or her care.

LEARNING OBJECTIVES

A participant in this lesson will be able to:

- Identify the components of a plan of care
- Define the purpose of a plan of care
- Understand the aide's role in the plan of care

LESSON ACTIVITY

Review actual plan of cares from patient documentation, and discuss as a group how that plan of care could be honored through the nurse or aide role, and how it could change.

THE LESSON

Review the material in the lesson with participants. Allow for discussion.

CONCLUSION

Have participants take the test. Review the answers together. Award certificates to those who answer at least seven (70%) of the test questions correctly.

TEST ANSWERS

1. True
2. False
3. c
4. d
5. False
6. False
7. a
8. c
9. d
10. d

PLAN OF CARE

Overview

A patient's plan of care is like a road map. It provides instructions and directions on items that need to be completed in order for the patient to have improved health and positive outcomes. Each patient has an individualized plan of care that is developed in collaboration with the patient, clinician, and physician. The goals included in the plan of care should be developed with input from the patient regarding his or her personal goals to be obtained during the home health episode of care; the plan should include all orders for care and goals of care during the home health care episode. According to CMS, 30.2.1, the content of the plan of care includes items such as:

- Pertinent diagnosis
- Medication list
- Allergies
- Safety precautions
- Medical supplies and equipment
- Discipline (nursing, therapy, aide) visit frequency
- Orders for care and treatment
- Prognosis
- Mental status
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutrition requirements
- Therapy course of treatment
- Expected duration of services
- Discharge plan
- Identified risk for emergency department or acute care hospitalization and interventions to decrease risk
- Patient and caregiver education needs for discharge
- Advance directives

Coordinating the Plan of Care

Having a plan of care for each home health patient is very important in home health, especially since patients are often cared for by a team of providers, including aides, nurses, therapists, etc., at different times (often by themselves). Coordinating the care with all team members will lead to improved outcomes. Uncoordinated care could result in additional cost and have limited impact on outcomes. An analogy is adding more players to the football game without having a game plan and without knowing the role for each player. When there is one quarterback (coach, care manager) and each team member has a specific role (nursing, therapy, personal care, aide) that is driven by the game plan (care plan), then the focus shifts from the provider to the patient and from activity to productivity.

Although the plan of care is initiated on the first visit, it is an active document that may change over the course of treatment based on the patient's condition. This involves input by all team members. In home health, this is called coordination of care. A case manager (coach) is assigned to oversee the entire plan of care for the patient. The case manager coordinates care of all team members through communication with the team members and the physician. The case manager facilitates communication among all team members and the physician to ensure that the best plan is in place in order for optimal outcomes to be achieved. The plan of care must include all current orders for care and be followed by all disciplines.

Home Health Aide Care Plan

The home health aide will have a separate aide care plan developed by the clinician that identifies all tasks to be completed. The clinician will discuss the patient's personal care needs and preferences (with the patient) when developing the aide care plan. The care plan is developed with an understanding of the patient's physical limitations, which may be due to a medical condition or safety issues.

The home health aide plan must include specific tasks and state the frequency the task is to be completed. The care plan should not include vague frequencies such as "PRN" (as often as needed) or "by caregiver preference." Any changes to the care plan must be made by the clinician prior to the aide performing the new task.

The care plan should also include items to be observed or reported to the clinician or case manager. Observable items include:

- Changes in skin condition—new reddened areas, new skin openings, changes in prior skin condition, itching, scratches.
- Changes in mental process—patient confusion, increased sleeping, restlessness, sadness.
- Changes in physical condition—unsteadiness when walking, more difficulty walking, changes in bowel elimination, changes in urinary elimination, changes in eating habits.

- Vital signs—if vital signs are assigned, the aide should have normal ranges of findings for the patient, and any findings outside of those ranges should be reported to the clinician.
- Medications—based on agency and state regulations, the aide's involvement in administering medications will vary. The aide is allowed to remind a patient to take medications and alert the nurse if there are indications the patient is not doing so. Indications of medication not being taken include pills found lying around the house, pills from prior days still in the patient's daily pill sorter, and (of course) if the patient states he or she is not taking medications.

Each visit, the aide should complete all tasks assigned on the care plan. If the patient requests changes to the plan of care, the aide should notify the case manager or clinician for permission to perform the requested tasks. If the patient refuses to have a task performed, the aide should notify the case manager or clinician. The aide should clearly document all care provided and any communication with the clinician per agency policy.

The aide is required to have a supervisory visit by a clinician at least every 14 days. During this supervisory visit, the clinician should:

- Review the aide's documentation of care provided
- Discuss with the patient any concerns with the care the aide has provided
- Discuss if the patient's rights are being honored
- Ensure that infection control practices are followed
- Ensure that communication between the patient and the aide is adequate
- Ensure that any changes in patient care or condition are reported to the nurse

During the supervisory visit, the clinician should evaluate the continual need for aide services and if there are any changes needed in the aide plan of care. Changes in the aide plan of care could include reduction in visit frequency or changes in tasks, such as giving the patient a shower instead of a bed bath.