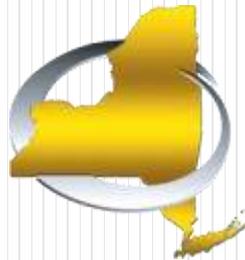


# What's In A Medical Record?

Records Access Training for the Ombudsman



# Goals

- Brief Case Study : Record Review ?
- Regulation
- Sections of the Chart
- MDS – minimum data set
- Care Plans
- Abbreviations

**POLICY AND PROCEDURE**  
**New York State Long Term Care Ombudsman Program**  
**New York State Office for the Aging**  
**2 Empire State Plaza**  
**Albany, NY 12223-0001**

Subject: Medical Records Access Training	Number: 07-PP-1	Effective Date: May 1, 2007
Reviewed/ Revised:	Contact Person(s): Ombudsman (518) 474-7329	
Applicable To: Certified Long Term Care Ombudsman		

**POLICY:** It is the policy of the New York State Long Term Care Ombudsman Program to recognize all persons who have completed the thirty-six (36) hour ombudsman certification training which includes the six (6) hours records access training segment and who have been subsequently appointed ombudsman by the New York State Long Term Care Ombudsman as meeting the minimum requirements necessary to access resident medical records for the purposes of complaint investigation.

**PROCEDURE:** New York State Rules and Regulations specifically defines the six (6) hours of record access training that is required to be included as part of the thirty-six (36) hour ombudsman certification training curriculum to meet the criteria necessary for an ombudsman to be deemed knowledgeable on the subject of records access.

The Assistant State Ombudsman (ASO) assigned to the local program will review all proposed record access training segments of each thirty-six (36) hour ombudsman certification training curriculum prior to the start of such training.

The required records access training sections and required teaching time for each section are as follows:

**1.Module 1: The Long Term Care Ombudsman Program**

*2 Hours*

- a.Ombudsman philosophy
- b.What is the Long Term Care Ombudsman Program
- c.The Role of the Ombudsman
- d.Record Access

**2.Module 2: Resident's Rights**                      *1 Hour*

- a.Nursing Home Resident's Rights
- b.Adult Home Resident's Rights
- c.Family Type Home Resident's Rights

**3.Module 3: Profile of the Long Term Care Residents**

*1Hour*

- a.Aging Process

**4. Module 4, The Long Term Care Setting**

*1.5 Hours*

- a.Regulations governing Long Term Care facilities
- b.Assessment and Care Planning

**5. Module 7, HIPAA**

*.5 Hours*

- a.HIPAA, The Privacy Rule and Ombudsman Access

**REFERENCES:**

- 1.New York State Elder Law §218(7)(a) and (b)
- 2.New York Code of Rules and Regulations: Title 9  
NYCRR §6660.11

# What is a medical chart?

The Medical Chart is a confidential document that contains detailed and comprehensive information on the resident and their care experience.



**Medical chart:** serves as both a medical and legal record of the residents clinical status, care, history, and caregiver involvement.

The record will have information regarding the resident .

- Diagnosis
- Tests
- Treatments
- Response to treatments.



- Prior to seeking access to medical or personal records of a resident an ombudsman must obtain the express written approval for access to those personal or medical records.
- The ombudsman shall not seek access to a resident's personal or medical record except for the purpose of investigating a complaint made by or on behalf of one or more residents.
- The Ombudsman shall not remove the original record from the premises of the facility. Any copies removed from the premises by the Ombudsman are subject to the confidentiality provisions of Ombudsman service.
- The Ombudsman shall not disclose to any person outside the Ombudsman program any information obtained from a medical record.

Generally, physicians and nurses write most frequently in the chart. Other staff health care professionals that have access to the chart include: physician assistants, social workers, psychologists, nutritionist (dietary department), physical and occupational therapists, speech or respiratory therapists and consultants.



**Documentation begins when the resident is admitted to the nursing home. The record may contain:**

- Information to identify the resident
- The comprehensive assessment
- The plan of care and services
- Results of preadmission screening
- Progress notes by all practitioners
- Results of tests and treatments and procedures
- Advance directives

## **The chart may also contain:**

- The immunization records
- MAR (Medication Administration Record)
- MDS Assessments
- Raps or triggers
- The care plan

Depending on the resident's complaint and the complaint code, chart review can be the best course of action for the investigation of the complaint. When reviewing a chart schedule enough time to read the entries, and to Xerox information if need be.

**The resident will have a variety of assessments made. These assessments are done to provide for the safety, wellbeing and individual care that each newly admitted resident needs.**



The assessments include:

- Social History (a brief synopsis of the resident's life story)
- Discharge plans and any individual special considerations.

## Other assessments include



- Nursing assessments (such as falls risk)
- Nutrition, physical and occupational therapies
- Therapeutic recreation (activities) and medical services –care giver assessments such as vital signs, I/ O, skin
- Even a pain assessment may be done on the resident.

# Admission Check List

ADMISSION CHECK LIST	INITIAL	N/A
1. Clothing and personal belonging sheet		
2. Nursing Admission Assessment		
3. Admission Orders(include all Dx. for meds)		
4. Physician History and Physical		
5. Notify Pharmacy re: Meds		
6. Medication Sheet		
7. Treatment Sheet		
8. Order labs		
9. Order X-rays		
10. Nursing 48 hr Notes including v/s		
11. Identification Bracelet and Room tags		
12. Wheelchair (from Rehab if necessary)		
13. Bowel and Bladder Assessment		
14. Restraint and Bedrail Assessment		
15. DNR/Health Care Proxy Info and Consent forms		
16. Photo ID		
17. Turning and Positioning Sheet		
18. CNA ADL sheet		
19. MDS+		
20. Norton Skin Assessment		
21. Psychoactive Meds Consents		
22. Behavior Monitoring Flow Sheet		
23. Diet and Diet slip to Dietary		
24. Interim Care Plans(completed in 48 hrs)		

**WINGATE AT DUTCHESS**

**Nutritional Assessment Form**

NAME \_\_\_\_\_ Room# \_\_\_\_\_

Adm Date \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Diagnoses \_\_\_\_\_

MDS	AREA OF ASSESSMENT - Data	ASSESSMENT
L 4 e	DIET ORDER	
L2C	Height _____ Weight _____ IBW _____ UBW _____	
L2C	% WEIGHT CHANGE 5% LAST 30 DAYS OR 10% LAST 180 DAYS	
	ESTIMATED NUTRIENT NEEDS: Kcalories/day _____ Protein/day _____ gm/d Fluids/day _____ cc	
L 4 f	NOURISHMENTS AM _____ PM _____ HS _____	
	DINING LOCATION	
III h j	USUAL EATING PATTERNS: Distinct food preferences Y N Between meal snacks all or most days Y N Use of alcoholic beverages _____ Ethnic considerations _____ Religious considerations _____	
B1-5	COGNITIVE PATTERNS OR COMMUNICATION PROBLEMS ALTERING FOOD PREFERENCES/TOLERANCES	
D 11-3	VISION PROBLEMS	
E2a	FEEDING ABILITY	
K1 a-c	HEALTH CONDITIONS AFFECTING NUTRITIONAL STATUS	
L 1	ORAL PROBLEMS a. chewing b. swallowing c. mouth pain	

## WINGATE HEALTH CARE

## BOWEL AND BLADDER ASSESSMENT

AGE :	GENDER :	FEMALES : # OF CHILDREN :				
DIAGNOSIS			GU / ABDOMINAL SURGERY			
PRIMARY			DATE :	TYPE :		
SECONDARY			DATE :	TYPE :		
CHRONIC ILLNESSES	CHF	HYPERTENSION	DIABETES	OSTEOARTHRIT	DEPRESSION	ENLARG PROST
(X ALL THAT APPLY)	CVA	HYPERCALEMIA	CARDIAC	RHEUM ATHRIT	PEDAL EDEMA	CA SITE :
GENERAL EVALUATION (X ALL APPROPRIATE RESPONSES)						
FUNCTIONAL	INDEPENDENT		WALKS SHORT DISTANCES ONLY		USES URINAL/BEDPAN	
MOBILITY	AMBULATES c ASSIST		NON-AMBULATORY		USES COMMUNE	
MENTAL STATUS	DEPRESSED		COOPERATIVE		COGNIZANT OF NEED TO VOID/DEFECATE	
	ANGRY		PASSIVE		MOTIVATED TO BE CONTINENT	
	FORGETFUL		CAN LOCATE BR		FOLLOWS DIRECTIONS	
SENSORY DEFICIT	HOH	POOR VISION	DECREASED TACTILE SENSES		POOR DEPTH PERCEPTION	
MEDICATION	DIURETIC		ANTIPSYCHOTIC			
FACTORS	HYPNOTIC / SEDATIVE		ANTIHISTAMINE			
(LIST BY NAME)	ANTIDEPRESSANT		ANTIHYPERTENSIVE			
DIETARY	TURGOR REFLECTS DEHYDRATION			DIET CONSISTENCY		
FACTORS	CONSUMES CAFFEINE _____ AMT.		REGULAR	PUREE	LIQUID	
(FILL AS APPROPRI- ATE)	SUFFICIENT INTAKE _____ ML/DAY		THERAPEUTIC DIET : TYPE			
CONTINENCE (X APPROPRIATE AREAS)						
CONTINENT OF :	BLADDER	BOWEL	INCONTINENT OF :		BLADDER	BOWEL

IF INDIVIDUAL IS CONTINENT OF BOTH - DO NOT PROCEED FURTHER

SIGNATURE : \_\_\_\_\_ DATE : \_\_\_\_\_

BLADDER ASSESSMENT (X APPROPRIATE AREAS)						
ONSET OF INCONTINENCE / DATE :						
SIGNS / SYMPTOMS	URGENCY		NOCTURIA		DRIBBLING	
	FREQUENCY		HEMATURIA		ODOR	
	HESITANCY		DYSURIA		DIFF c STREAM	
(X ALL THAT APPLY)					TEMP ELEVATION	
					Hx OF UTIs	
					RECENT CATHETER	
PATTERNS OF	DAY	INCONTINENT EPISODES ONCE A WEEK			INCONTINENT DAILY; SOME CONTROL	
INCONTINENCE	NIGHT	INCONTINENT 2 OR MORE X A WEEK BUT NOT DAILY			MULTIPLE DAILY EPISODES	
(X ALL THAT APPLY)	BOTH					
VA RESULTS IF DONE	EMPTY	OVERFLOW INCONTINENCE			RETENTION / AMOUNT	

RESIDENT : \_\_\_\_\_ ROOM : \_\_\_\_\_ PHYSICIAN : \_\_\_\_\_

REVISED 07/03/98

B&BFORM

M 1 b- E	ORAL DENTAL STATUS Own teeth _____ Dentures _____	
L 3	NUTRITIONAL PROBLEMS A. complains of taste of foods B. insufficient fluid, dehydration C. did Not consume most liquids last 3days D. regular complains of hunger E. leaves 25% foods uneaten most meals Significant Food Allergies:	
L 3 Bce	CONSUMPTION %Food _____ %Fluid _____	
L 3 b N K 1	HYDRATION STATUS _____ SKIN CONDITION intact edema _____ Pressure Ulcers 1-4 _____	
L 4 a- h	NUTRITIONAL APPROACHES a. parenteral or IV b. feeding tube c. mechanically altered diet d. therapeutic diet e. adaptive equipment f. dietary supplements g. none of the above	
P 2	LABORATORY VALUES: FBS _____ hct _____ ALB _____ hgb _____ Total Protein _____ Na _____ K _____ BUN _____ other: _____	
Q	MEDICATIONS: Vitamin/Mineral supplement _____ Insulin/oral _____ Bowl Mgmt _____ Diuretic/Potassium _____ Other: _____	
	FOOD PREFERENCES: Likes _____	FOOD PREFERENCES: Dislikes _____

Educational Needs Identified \_\_\_\_\_

Risk Assessment Level Assigned: Level 1 \_\_\_\_\_ Level 2 \_\_\_\_\_ Level 3 \_\_\_\_\_

Notes: \_\_\_\_\_

Dietetic Technician/ Date \_\_\_\_\_

Dietitian/Date \_\_\_\_\_

WINGATE HEALTH CARE

FALL RISK ASSESSMENT

**INSTRUCTIONS :** Upon admission and quarterly (at a minimum) thereafter, assess the resident status in the eight clinical condition parameters listed below (A-H) by assigning the corresponding score which best describes the resident in the appropriate assessment column. Add the column of numbers to obtain the Total Score. If the Total Score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the Care Plan.

		ASSESSMENT DATE >				
PARAMETER	SCORE	RESIDENT STATUS / CONDITION	1	2	3	4
A	0	ALERT (ORIENTED X 3) OR COMATOSE				
	2	DISORIENTED X 3 at all times				
	4	INTERMITTENT CONFUSION				
B	0	NO FALLS in past 3 months				
	2	1-2 FALLS in past 3 months				
	4	2 OR MORE FALLS in past 3 months				
C	0	AMBULATORY / CONTINENT				
	2	CHAIR BOUND (Requires restraints and assist with elimination)				
	4	AMBULATORY / INCONTINENT				
D	0	ADEQUATE (With or without glasses)				
	2	POOR (With or without glasses)				
	4	LEGALLY BLIND				
K		To assess the resident's gait / balance, have him/her stand on both feet without holding onto anything, walk straight forward, walk through a doorway, and make a turn.				
	0	GAIT / BALANCE NORMAL				
	1	Balance problem WHILE STANDING				
	1	Balance problem WHILE WALKING				
	1	DECREASED MUSCULAR COORDINATION				
	1	Change in gait pattern WHEN WALKING THROUGH DOORWAY				
	1	Jerking or unstable WHEN MAKING TURNS				
1	Requires USE OF ASSISTIVE DEVICES (canes, wheelchair, walker)					
F	0	NO NOTED DROP between lying and standing				
	2	Drop LESS THAN 20mm Hg between lying and standing				
	4	Drop MORE THAN 20mm Hg between lying and standing				
G		Respond below based on the following types of medications : Anesthetics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Sedatives/Hypnotics.				
	0	NONE OF THESE MEDICATIONS TAKEN currently or within last 7 days				
	2	TAKES 1-2 of these medications currently or within last 7 days				
	4	TAKES 3-4 of these medications currently and/or within last 7 days				
1	HAS HAD CHANGE IN MEDICATION AND/OR CHANGE IN DOSAGE in past 7 days					
H		Respond below based on the following predisposing conditions : Hypotension, Vertigo, CVA, Parkinson's Disease, loss of limb (e), seizures, Arthritis, Osteoporosis, fractures.				
	0	NONE PRESENT				
	2	1-2 PRESENT				
	4	3 OR MORE PRESENT				
TOTAL SCORE		TOTAL SCORE ABOVE 10 REPRESENTS HIGH RISK				

SIGNATURE :	SIGNATURE :
SIGNATURE :	SIGNATURE :

# Advance Directives

- The residents chart also contains information regarding their wishes for end of life care.
- Many homes have moved to the MOLST format.



SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

**MOLST**

**Medical Orders for Life-Sustaining Treatment  
Do-Not-Resuscitate (DNR) and  
other Life-Sustaining Treatments (LST)**

This is a Physician's Order Sheet based on this patient/resident's current medical condition and wishes. It summarizes any Advance Directive. If Section A is not completed, there are no instructions for this section. When the order expires, first follow these orders, then contact physician. Review the entire form with the patient. Any section not completed requires full treatment for that section. **WARNING:** If patient lacks medical decision-making capacity as a result of mental retardation or developmental disability or has a legal guardian, specific resuscitative procedures must be followed. Review information and seek legal counsel.

Local Council on the Quality of Patient-Care  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Patient/Resident Date of Birth \_\_\_\_\_  
(mm/dd/yyyy)  
Gender  M  F  
Unique Patient Identifier (Last 8 0000) \_\_\_\_\_

This form should be reviewed and renewed periodically, as required by New York State and Federal law or regulations, and/or if:

- \* The patient/resident is transferred from one care setting to care level to another, or
- \* There is a substantial change in patient/resident health status (improvement or deterioration), or
- \* The patient/resident's current preferences change.

**Section A** **RESUSCITATION INSTRUCTIONS (ONLY for Patients in Cardiopulmonary Arrest)**  
 (If patient/resident has no blood pressure, no pulse and no respiration) This form can be used in all settings, including emergency.  
 **Do Not Resuscitate (DNR)/Allow Natural Death** (No CPR, mechanical ventilation or mechanical chest-thrust)  
 **Full Cardio-Pulmonary Resuscitation (CPR)** (No Limitation: accepts intubation and mechanical ventilation)  
 \* For emergency code, advise the diagnostic or medical facility acceptance, advise for provision of DNR, DNR/DI or cardiopulmonary status, also complete advance version of Supplemental DNR Documentation Form for facility. For situations of DNR/DI without capacity in the community, also indicate NY State's designated DNR form. For severe patients, also complete Supplemental DNR Documentation Form for transport.

**Section B** **DNR (CPR) CONSENT OF PATIENT/RESIDENT WITH DECISION-MAKING CAPACITY**  
 Section A reflects my treatment preferences.  
 Patient/Resident Signature \_\_\_\_\_ Check if verbal consent \* \_\_\_\_\_ Print Patient/Resident Name \_\_\_\_\_ Date \_\_\_\_\_  
 Witness of Patient/Resident Signature or Verbal Consent \_\_\_\_\_ Print Witness Name \_\_\_\_\_ Date \_\_\_\_\_  
 Witness of Patient/Resident Signature or Verbal Consent \_\_\_\_\_ Print Witness Name \_\_\_\_\_ Date \_\_\_\_\_  
 \*Patient with capacity can provide verbal consent in the presence of two other witnesses. Repeat consent requires only one witness signature. If verbal consent, one witness must be a physician. In facility, physician must be affiliated with the facility, e.g. resident physician on-site.

**Section B** **DNR (CPR) CONSENT OF HEALTH CARE AGENT (HCA) OR SURROGATE DECISION-MAKER FOR PATIENT/RESIDENT WITHOUT DECISION-MAKING CAPACITY** This document reflects what is known about the patient/resident's treatment preferences. For Patient/Resident without decision-making capacity, or when medical facility or diagnostic exception is used, Supplemental MOLST Decision-making Form MUE1 to be completed and should always accompany this MOLST Form. If patient/resident has a legal and valid DNR previously completed while patient/resident had capacity, attach to MOLST.  Prior DNR form attached  Supplemental Documentation Form completed.  
 HCA/Surrogate Signature \_\_\_\_\_ Check if verbal consent \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_  
 Relationship to Patient/Resident \_\_\_\_\_  
 Witness Signature \_\_\_\_\_ Print Witness Name \_\_\_\_\_ Date \_\_\_\_\_  
 \*Other witnesses: All 3 witnesses must be present for verbal and written consent.

**Section C** **Physician Signature for Sections A and B**  
 Physician Signature \_\_\_\_\_ Print Physician Name \_\_\_\_\_ Date \_\_\_\_\_  
 (Other Witness: Patient/Resident Signature or verbal consent. Resident physician signature must be recognized by licensed physicians.)  
 Physician License #: \_\_\_\_\_ Physician Phone/Fax #: \_\_\_\_\_  
 It is the responsibility of the physician to determine, within the appropriate period, (see below) whether this order continues to be appropriate, and to indicate this by a note on the person's medical chart. The issuance of a new form is NOT required, and under the law, this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been renewed within the appropriate time period. The physician must review these orders as follows: Hospital: at least every 7 days; Nursing Home/ skilled Nursing Facility: at least every 60 days; Nonhospital/Community Setting: at least every 60 days.

**Section D** **ADVANCE DIRECTIVES:** Patient/Resident has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity:  
 Health Care Proxy  Living Will  Other Written Documentation or Oral Advance Directive

**Section E**

Physician may complete form with patient who has capacity or with Health Care Agent. Include Section E consent.

Physician may complete form for incapacitated patients without Health Care Agent only with clear and convincing evidence. Include Section E consent.

Physician should consult legal counsel for MR/D patients without capacity. See Surrogate's Court Procedure Act § 1750-b.

**Section E Consent**

HIPAA Permits Disclosure of MOLST to Other Health Care Professionals & Electronic Registry as necessary for treatment.

**ORDERS FOR OTHER LIFE-SUSTAINING TREATMENT AND FUTURE HOSPITALIZATION: (If patient/resident has pulse and/or is breathing)**

Review patient's goals and patient's choice of interventions and then complete orders for appropriate subsections. Blank subsections can be completed at a later date. If patient has decision-making capacity, patient should be consulted prior to treatment or withholding thereof. After confirming consent of appropriate decision-maker, obtain signature or verbal consent and complete the consent section of Section E, at the bottom of this page. Physician must sign and date each subsection at the time of completion.

**ADDITIONAL TREATMENT GUIDELINES: (Comfort measures are always provided.)**

- Comfort Measures Only** - The patient is treated with dignity and respect. Reasonable measures are made to offer food and fluids by mouth. Medication, positioning, wound care, and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction are used as needed for comfort. *Do Not Transfer to hospital for life-sustaining treatment. Transfer if comfort care needs cannot be met in current location.*
- Limited Medical Interventions** - Oral or intravenous medications, cardiac monitoring, and other indicated treatments are provided except as specified in Sections A or E. Guidance about acceptable/unacceptable interventions relevant to this patient/resident may be written under "Other Instructions" below. May consider less invasive airway support (e.g. CPAP, BIPAP). *Transfer to the hospital as indicated.*
- No Limitations on Medical Interventions** - All indicated treatments are provided except as specified in Sections A. *Transfer to the hospital is indicated, including intensive care.*

MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ADDITIONAL INTUBATION AND MECHANICAL VENTILATION INSTRUCTIONS: (If patient/resident chooses DNR, review all options if patient/resident has progressive or impending pulmonary failure without acute cardiopulmonary arrest. If patient chooses full CPR, review options of trial and long-term intubation & mechanical ventilation.)**

- Do Not Intubate (DNI)**  
(Review available symptomatic treatment of dyspnea: oxygen, morphine, etc.)
- A trial period of intubation and ventilation**     **A trial of BIPAP**     **A trial of CPAP**  
(Discuss duration of trial and document in other instructions.)
- Intubation and long-term mechanical ventilation, if needed**

MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FUTURE HOSPITALIZATION / TRANSFER: (For long-term care residents and home patients)**

- No hospitalization unless pain or severe symptoms cannot be otherwise controlled.**
- Hospitalization with restrictions outlined in Sections A and E.**

MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: (If Health Care Agent makes decision, it must be based on reasonable knowledge of patient/resident's wishes.)**

- No feeding tube** (offer food/fluids as tolerated)     **No IV Fluids** (offer food/fluids as tolerated)
- A trial period of feeding tube**     **A trial of IV fluids**
- Long-term feeding tube, if needed**

MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ANTIBIOTICS:**

- No antibiotics** (except for comfort)
- Antibiotics**

MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OTHER INSTRUCTIONS: (May include additional guidelines for starting or stopping treatments in sections above or other directions not addressed elsewhere.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR SECTION E OF PERSON NAMED IN SECTION B:** Significant thought has been given to life-sustaining treatment. Patient/resident preferences have been expressed to the physician and this document reflects those treatment preferences. As the medical decision-maker, I confirm that the orders documented above in Section E reflect patient/resident's treatment preferences.

Signature     Check if verbal consent    \_\_\_\_\_    Print Name    \_\_\_\_\_    Date    \_\_\_\_\_

Assessments must be done within 14 days of the residents admission to a nursing home ( or 7 days for Medicare residents, )\* and at least once a year after that.

Reviews are held every three months and when a residents condition changes.

The MDS (minimum data set) is the universally used form for the assessments.

- After the assessment-- the MDS is completed, the information is analyzed and a care plan is developed to address all the needs and concerns of the resident.

# What is a Care Plan?

## **A Care Plan is:**

- Developed to address individual needs of resident
- A fluid document that reflects changing needs of resident
- Usually developed by nursing home staff
- Should include input from resident and/or family
  - Primary focus of survey team

# What Does A Care Plan Look Like?

- Regulation States:

*Facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs as identified in the comprehensive assessment*

- Standard Format =

Problem, Goal, Approaches, Outcome

- Preferred format = Strengths Based

# Ombudsman Role

- Educate resident/family on care planning process
  - empower them to become involved
- Represent resident/family at care plan meetings (when invited by the resident)
- Bring resident focus to the care planning process:
  - resident history
  - resident routine/preferences
  - input for interventions and approaches
- Observe to be sure care plan is being followed

# Bloopers

- Nonverbal, noncommunicative and offers no complaints
- Unresponsive and in no distress
- Reason for leaving AMA – “pt wants to live”
- “Pleasant man lying comfortably in bed. Appears somewhat uncomfortable”
- Pt. expired and was dc’d home
- “We will watch her diarrhea closely”
- Order “ Please feed patient only when awake”
- “He is allergic to Wives.”