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Strategies for Translating the Resident Care Plan into Daily Practice

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Abstract

The Omnibus Budget Reconciliation Act of 1987 required nursing facilities to complete a standardized comprehensive assessment known as the Resident Assessment Instrument (RAI) and to formulate a plan of care from the RAI to guide nursing care. The purpose of this retrospective case study was to examine the issues around the translation of nursing facility resident care plans to documents that guide daily care. Data were obtained by auditing 96 resident care plans in 10 nursing facilities in two states. Despite the importance of the resident plan of care, the audit revealed the provider approaches to resident problems varied appreciably in nursing facilities. The results of this study support the need for further research to assist in the development and implementation of strategies in nursing facilities that focus on standardized practices. Consistent systems can be promoted that translate the resident care plan into daily practice.

Care planning is the foundation of the nursing process and is a federally mandated regulatory function in all American nursing facilities (Omnibus Budget Reconciliation Act, 1987 [OBRA '87]). Compared with residents served by nursing facilities in 1998, today's average resident is older, more frail, more acutely ill, and more impaired (Harrington, Carrillo, & Crawford, 2006). Comprehensive assessments and individualized, interdisciplinary care plans are essential in meeting the needs of these vulnerable older adults. Each resident's care plan is composed of a set of problems derived from the assessment and the associated interventions for each problem. Nursing facilities use a variety of strategies to move information from the care plan into daily operations.

The study reported in this article was designed to examine the communication of the interventions from the care plan to staff who provide daily care to residents. Two research questions addressed gaps in the existing literature:

- How are the interventions in the written care plan translated to documents used by nursing staff to guide resident care?
- What are the issues surrounding the translation of the written care plan?

This project was part of a larger study to explore the relationship between care planning integrity and nursing facility resident outcomes (Taunton et al., 2007).

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Background

OBRA '87 required nursing facilities to adopt the Resident Assessment Instrument (RAI), a system of recurring standardized assessment and care planning for each resident. A written interdisciplinary care plan based on the assessment and Resident Assessment Protocols was also required. The process of communicating the resident care plan to direct care staff was not addressed in reports related to nursing homes by the Institute of Medicine (IOM) (1986, 2001) or Centers for Medicare & Medicaid Services (CMS) (2001).

Quality of care, poor or incomplete resident assessment, and failure to provide a comprehensive interdisciplinary care plan have remained among the top 10 deficiencies cited by state surveyors in their reviews of nursing facilities (Harrington et al., 2006). A series of reports (CMS, 2001; Office of the Inspector General, U.S. Department of Health and Human Services, 2001) indicated that one fourth of nursing facilities in the United States have had serious deficiencies that caused harm to residents or placed them at risk for serious injury or death since the implementation of OBRA '87 regulations.

Several nursing publications provide interesting historical perspective about care planning (Ackerly, 1939; Dellefield, 2006). Researchers have focused on the RAI and the care planning process and its relationship to improvement in both quality of care and quality of life in nursing facilities (CMS, 2001; Cox, 1998; Dellefield, 2006; Fries et al., 1997; Harrington et al., 2006; Hawes et al., 1997; Rantz, Popejoy, Zwygart-Stauffacher, Wipke-Tevis, & Grando, 1999).

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Daly, Buckwalter, and Maas (2002) evaluated the effect of paper versus computerized care plans on resident outcomes and found no differences. They reported that nurses and nursing assistants often do not know what is on each resident's individualized plan of care. Daly et al. (2002) concluded that “residents cannot receive effective, quality care unless the interventions on the care plan are conveyed to and implemented by front line staff” (p. 22). Taunton, Swagerty, Smith, Lasseter, and Lee (2004) described variability in the involvement of direct care staff with the care planning process, as well as in use of the care plan by nursing staff.

Dellefield (2006) conducted a critical review of the literature related to the care planning process in nursing homes and concluded that “strategies are needed to integrate the process and written care plan into daily operations” (p. 132). No studies were found describing or evaluating the documents used in translating the resident care plan, and the issues surrounding communication of the care plan remain uninvestigated.

Method

Design and Sample

The study involved a retrospective case review of a purposive sample of 96 residents in 10 Midwestern nursing facilities selected to represent state and size. Most of the nursing facilities in the sample were located in rural areas, and most were certified for both Medicare and Medicaid. Six facilities were for profit and 4 were not for profit. Licensed beds ranged from 54 to 147 across facilities, with the average daily census ranging from 47 to 123 residents.

Consents were obtained onsite from the residents or their guardians from the larger sample ($N = 245$) for multiple research activities. The sub-sample of 96 residents for this study was drawn randomly by unit within each facility to explore the communication of interventions in the resident care plan to direct care staff who provide daily care.

Of the 96 residents selected for document review, most were Caucasian (98%) women (79%). Half of the residents had lived in the facility for less than 2 years, and more than half were age 85 or older. Medicaid was the primary payer for 42% of the sample.

Five of the nursing facilities in the sample used a centralized RAI/Care Planning coordination model led by one designated RN. The remaining facilities used a decentralized model in which multiple RNs were responsible for coordination of the care planning process for specified groups of residents.

Procedure

An investigator-developed Resident Record Audit was used to extract clinical problems and interventions from the current resident care plan and to seek evidence of translation of the interventions to documents used by direct care staff to guide daily care. The Resident Record Audit included the following demographic information: birth year, gender, payer, length of stay, race, care plan review date, kind of Minimum Data Set assessment completed, and diagnoses. Each resident problem and three or more of the associated interventions were listed from the care plan. Spaces were provided to record translation of the interventions to commonly used forms such as a certified nursing assistant (CNA) assignment sheet, CNA care plan, activities of daily living (ADLs) sheet, medication record, treatment record, meal monitor, or 24-hour log. Space was also available to record translation to more unique documents and for comments.

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Two research staff members, a senior investigator (R.L.T.), and one of several trained research assistants (L.A.W.) conducted the record audits in each facility. The translation of an intervention was noted as each document was reviewed. Interventions that were not identified on any of the documents guiding daily care were classified as *not translated*. Consistency was the deciding criterion for interventions identified in multiple documents. For example, finding the intervention "1-person assist for transferring from bed to chair" in multiple places was classified as *translated*, whereas finding "1-person assist" in one document and "2-person assist" in another was *not translated*.

Interrater Reliability

The senior investigator (R.L.T.) provided seasoned oversight in the data collection process. Emerging problems and inconsistencies were clarified and resolved onsite, with input as needed from facility staff. The documents guiding daily care varied in name, number, and location from unit to unit within the same facility, as well as among facilities. Thus, the risk to reliability of the data lay in the diversity of documents and the possibility of research staff not finding all of the relevant pieces of information used for translation. Only factual data were collected, so there was no risk regarding differences in ratings on the basis of subjective interpretation of data.

Data Analysis

Summary descriptive statistics were used in analyzing and reporting facility and resident characteristics. The quantitative data extracted via the Resident Record Audit were examined using SPSS, version 10, descriptive statistics.

Qualitative content analysis of the Resident Record Audit data was also performed using a case study methodology (Creswell, 1998). The principal investigator (R.L.T.) and one research assistant (L.A.W.) read through the Resident Record Audit data multiple times to identify and/or determine recurring patterns on how care plan translation fit into the nursing facility setting. Finally, from the case review, the investigators determined generalizations (issues) related to nursing facility resident care plan translation from which nursing and all disciplines can learn.

RESULTS

The residents presented complex scenarios for planning and delivering care. Findings revealed a median of six diagnoses per resident (range = 4 to 11). The top five diagnoses listed in descending order for the sample were hypertension, depression, arthritis, diabetes, and Alzheimer's disease. The median number of problems incorporated into resident care plans was seven (range = 3 to 18). The 10 most common problems were alteration in nutrition/nutritional status, self-care deficit in ADLs, falls, alteration in bowel and bladder function, alteration in comfort, ADL functional rehabilitation potential, alteration in physical mobility, psychotropic drug use, communication or cognition alterations, and dehydration or alteration in fluid maintenance.

Translation of Care Plan Interventions (Approaches)

Less than half (mean = 47%, range = 27% to 68%) of the interventions extracted by research staff were communicated to direct care staff through documents that guided daily care. Four facilities translated 52% to 68% of the interventions, whereas the remaining six facilities translated only 27% to 49% of the interventions.

The four nursing facilities that translated more than 50% of the interventions to direct care staff through daily care documents used a CNA care plan or a combination of a CNA care

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plan and kardex. These four nursing facilities were structured with a decentralized model in which multiple RNs were responsible for coordination of the care planning process for a specified group of residents.

Interventions commonly communicated through daily care documents included medication administration, ADL assistance, weights, treatments, and therapies—with the medication administration record, CNA assignment sheet, and treatment record used most frequently. Examples of interventions less likely to be found on daily care documents were assessments related to symptoms and medical diagnoses. Quality of life interventions such as explaining procedures, using approaches to residents (e.g., eye contact, use of the call light, ways to calm an agitated resident), offering choices, encouraging activity participation, and monitoring adverse effects of medications also were less likely to be documented.

Care Plan Translation Issues

From the cases reviewed, five generalizations (issues) emerged from the Resident Record Audit data related to translation of the written interdisciplinary resident care plan to nursing facility daily care documents. These issues included:

- Length of the care plan (e.g., 15 to 20 pages).
- Listing of routine assessment parameters or describing fundamental elements of nursing practice in the care plan.
- Redundancy in interventions relevant to multiple problems.
- Appreciable variability in the language used for care plan problems.
- Fragmentation in location of daily care documents.

DISCUSSION

The results of this study are consistent with previous authors' work related to the lack of effective communication of the basic care needs of nursing facility residents (Rantz et al., 2004). In addition, the findings provide additional evidence to support the fragmentation of communication and lack of efficiencies inherent in current organizational systems and processes in U.S. nursing facilities (Bott, Gajewski, Lee, Piamjariyakul, & Taunton, 2007; Dellefield, 2006; Swagerty, Lee, Smith, & Taunton, 2005; Taunton et al., 2004; Taunton, Coffland, Pedram, Piamjariyakul, & Bott, 2006).

Length of the Care Plan

As identified in this study, the length of the care plan may make it difficult and inefficient for caregivers, especially CNAs, to find the essentials of care the residents should receive.

> An accurate document that provides a complete picture of the basic care information for each resident must be readily available to all clinical staff caring for each resident.

Length, combined with the task-focused approach to care delivery commonly found in nursing facilities, may also contribute to the proliferation of communication documents and inconsistencies across them in regard to the current intervention.

Routine Assessment Parameters and Fundamental Nursing Practice Elements

Routine assessment parameters and fundamental nursing practice elements were found on every care plan reviewed. For example, for the problem of chronic obstructive pulmonary disease, listed routine assessment parameters included respirations, color, cyanosis, dyspnea,

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and wheezing, rather than as “assess respiratory status” (RN/licensed practical nurse [LPN] approach) or “monitor respiratory status” (CNA approach). Examples of fundamental nursing practice elements or standards listed in detail on the care plan were: (a) keep the resident call light within reach (regulatory standard), (b) call the resident by name (regulatory standard), and (c) rotate insulin injection sites (standard nursing procedure).

The findings support Dellefield's (2006) recommendations that standard interventions are best described in policies and procedures or in job descriptions with staff education, rather than incorporated into the resident care plan. Implementing evidence-based protocols and competencies specific to nursing facilities would allow the elimination of standard procedures from the written resident care plan. In addition, staff would more likely respond appropriately in common situations, such as calming an agitated resident or communicating with a resident with hearing or visual impairment (Krichbaum, Pearson, & Hanscom, 2000).

Redundancy in Interventions

Redundancy in interventions was prevalent throughout the record review. An example is the repetition in detail of “observe for signs and symptoms of hypoglycemia or hyperglycemia” for three different problems (e.g., diabetes, nutrition, falls) on the same resident care plan.

Variability in Language

Findings regarding the variability in language to label problems on the care plans support previous findings recommending that standard language be used in the resident care plan (Daly, Maas, & Buckwalter, 1995; Dellefield, 2006). Variations identified in the study document review ranged from the formal North American Nursing Diagnosis Association taxonomy (Wilkinson, 2005) (e.g., self-care deficit: bathing/hygiene) to an informal statement of the problem (e.g., poor hygiene).

Fragmentation in the Location of Daily Care Documents

Fragmentation in the location of daily care documents was a dominant pattern in the nursing facilities. It was difficult to find a total picture of the resident's needs in one location. Multiple notebooks were used to direct and record much of the daily care, such as medications, treatments, ADL assistance, elimination, food intake, skin assessment, and pain assessment. In addition, elements of daily care were posted in resident rooms or on the door and may or may not have been found in the RAI system care plan, on assignment sheets, or in other important places. Given the high staff turnover and the rotation of staff from unit to unit, the inconsistency in names for basic care documents (e.g., CNA care plans, CNA books, CNA assignment sheets) within and among facilities was also a concern.

A strategy is needed for clinical staff to obtain a complete picture of a resident's care, which may include centralization of resident care information, including translation documents. The authors believe considerable resistance can be expected to centralization of the resident record in a nursing facility setting. As reported by nursing facility nursing staff during this study, separating parts of the record makes it easier for multiple staff to access different forms at the same time, for example, the medication, treatment, and ADL forms. Separation also facilitates the survey process by allowing the examination of documentation of care (e.g., skin assessments) for a group of residents in one notebook, rather than having to review each individual resident's entire open record.

Updating the documents that guide daily care to incorporate changes in the care plan would be easier with a minimum number of forms in fewer locations. The IOM (2004) reported that disconnects and omissions of care occur when directives for nursing care must be replicated in multiple forms and locations. Staff may be more willing to use fewer

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documents if the forms are accurate, and it would be easier to hold them accountable for the content.

IMPLICATIONS FOR NURSING PRACTICE

As noted at the beginning of this article, the quality of both care planning and care delivery continues to leave nursing home residents at risk for harm, despite the OBRA '87 mandates. As reported in 2005 in the CMS Nursing Home Compare national database for the survey period, 40% of the facilities in this sample have quality of care deficiencies in federal tag F-309, and 30% have deficiencies in providing comprehensive care plans to meet resident needs in federal tag F-279. The literature reflects skepticism about whether written resident care plans guide daily care in nursing facilities (Cox, 1998; Dellefield, 2006; Schnelle, Bates-Jensen, Chu, & Simmons, 2004). However, the findings of this study related to lack of translation of the written resident care plan and the issues around translation of the resident care plan may help explain why nursing facilities continue to be noncompliant with resident care planning and quality of care regulations.

The dynamics of communicating resident needs and the associated interventions of the written resident care plan to direct caregivers confound the effectiveness of care planning and delivery (Bott et al., 2007; Dellefield, 2006; Rantz et al., 1999; Swagerty et al., 2005; Taunton, 2005; Taunton et al., 2004, 2006). With the implementation of mandated electronic medical records on the horizon (targeted for the year 2014), technology has been identified as a strategy to facilitate the quality of care and life of individuals (Lunney, Delaney, Duffy, Moorhead, & Welton, 2005; National Institutes of Health, National Center for Research Resources, 2006; Rantz et al., 2006). However, if the use of technology is to be an important strategy in assisting with the translation of the resident care plan to direct care staff, organizational systems (standard terminology and processes) need to first be present. To date, automation of the resident care plan has only increased the length of the care plan without empirical evidence to support improvement in resident outcomes (Cox, 1998; Daly et al., 1995, 2002).

With this in mind, although translating the written message of the resident care plan to frontline nursing facility staff does not mean the intervention will always be done or that this is the ultimate in caregiving, effective translation of the written message must be a first step. Adequate RN leadership and efficient care planning models must be present for effective communication and to provide direction to integrate the resident care plan into daily nursing facility operations (Dellefield, 2006; Forbes-Thompson, Gajewski, Scott-Cawiezell, & Dunton, 2006; Taunton et al., 2004, 2006)

Foremost, the focus of care planning should be meeting the residents' basic needs. Rantz et al. (2004) reported that “in order for nursing facilities to achieve positive resident outcomes processes must be in place to ensure that the basics of care delivery are done for the residents” (p. 24). Effective communication of the interventions on the written resident care plan is essential to ensure the basics of care delivery are accomplished by direct care nursing facility staff. To highlight the issues around communication of the care plan, nursing facility leaders must listen to the “voice” of frontline CNAs, LPNs, and RNs about processes that are the most effective in exchanging resident care information (Dellefield, 2006; Pillemer, 1996; Rantz et al., 2004).

CONCLUSION AND RECOMMENDATIONS

Adequate RN leadership combined with efficient organizational systems are essential for effective translation of the resident care plan into nursing facility daily operations. Although limited in generalizability, several strategies to address translation of the written resident

care plan, whether hand written or automated/electronic, are supported by the results of this study. In summary, the written care plan should be concise and use consistent terminology that is understood by all clinical staff. The written care plans in this study could be streamlined by implementing evidence-based protocols and completing annual competency evaluations with all clinical staff. This approach provides continuity in the delivery of care and eliminates the need to outline procedural steps in the resident care plan. Nursing facilities need to eliminate duplicative documentation on multiple forms by identifying a minimal number of centrally located daily care documents to which the written care plan should be translated. An accurate document that provides a complete picture of the basic care information for each resident must be readily available to all clinical staff caring for each resident.

Further research with a larger sample, focusing on ownership/payer differences and expansion of urban nursing facilities, is required to explore the most efficient care plan models, staffing patterns, and issues around translation of the care plan into daily operations in relation to resident outcomes. Ways to reduce redundancy and integrate interventions that address multiple problems in the care plan should be explored. Further research is warranted to explore whether the interventions (tasks) that are currently translated to daily operations in nursing facilities are at the expense of resident autonomy and, ultimately, quality of life. Finally, additional research is needed to evaluate the strategies suggested in this article to help communicate the resident care plan to direct care staff, with the goal of improved quality of resident care and quality of resident life.

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keypoints

1. This study examined a sample of 96 resident care plans in 10 nursing facilities to evaluate how interventions in the written resident care plan are translated to documents used by nursing staff to guide resident care and the issues around the translation of the written care plan to direct care nursing staff.
2. The results revealed that less than half of the interventions evaluated were communicated to direct care staff via daily care documents. Facilities with the greatest translation had decentralized RN leadership and care planning models.
3. Five generalizations emerged related to translation of the resident care plan: length of the care plan, listing of routine assessment parameters or fundamental elements of nursing practice, redundancy in interventions related to multiple problems, variability in the language used for care plan problems, and fragmentation in location of daily care documents.
4. The focus of resident care planning must be on meeting residents' basic needs. Adequate RN leadership and effective resident care plan models must be present for effective communication and, ultimately, quality outcomes for nursing facility residents.