Individualizing a Plan of Care Guiding Principles

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Upcoming changes to the Medicare Benefit Policy Manual bring greater focus to individualizing plans of care. While it seems natural to assume that individuals have unique needs and therefore plans of care would have to be customized in order to be effective, the reality is that trying to achieve efficiencies in health care documentation has led to the use of generic or stock plans in many facilities. The new requirements stipulate that an individualized, overall plan of care will need to be developed for each patient. Each discipline that comprises the rehabilitation team is also responsible for developing a plan of care that guides their processes. That sounds like a lot of care planning and a lot of time. Meeting this requirement is not an option; it's an obligation, so the question is... how will it be accomplished?

Sometimes the best way to solve a problem is to start by assessing the current situation and comparing it to the desired outcome. A reality check will help to discover discrepancies between the two processes; weaknesses can be identified, priorities set and a course of action will evolve. In many facilities, logistics create barriers to effective communication, which is necessary to evaluate a patient's individual needs and create an interdisciplinary plan of care. Pre-admission screeners are pressured to collect data quickly to get an admission decision and avoid causing too much interruption for the referring facility. Nurses receive verbal reports prior to the patient's transfer and often begin assessments without having read a prescreening form. History and physicals are usually dictated and appear on the chart the following day. Typically, therapists begin their assessments the day after admission. Documentation from each discipline's initial evaluation is placed on the chart, but plans of care are often abbreviated to check lists such as gait training, transfer training and ADLs; or for nursing - safety, skin integrity and pain management. Plans of care such as these could apply to almost all patients.

To develop a plan of care that integrates information from the various perspectives of a group of clinicians that addresses a patient's individual needs requires a systematic approach that is used by all clinicians. Documentation methods require guiding principles. Each discipline has a process by which objective and subjective data are collected and analyzed, problems are identified, goals or outcomes are determined, interventions are planned and effectiveness of the plan is evaluated. The nursing process is intended to guide the provision of nursing care. In the United States and Canada, nursing care plans sometimes include nursing diagnoses. The North American Nursing Diagnosis Association (NANDA - currently NANDA International) was founded in 1982 and developed a standardized nursing terminology. They continue to refine the nomenclature, criteria and taxonomy of nursing diagnoses. This process is sometimes seen as too academic for many nurses working in clinical settings. However, in relation to the topic of this article, it contains a very useful element referred to as the PES (problem, etiology, signs and symptoms) system. It is a method to document relating factors and evidence that support diagnoses. By supplying at least the etiology, the problem or diagnosis is focused on the patient's clinical presentation. Signs and symptoms can also be used. Using both would be ideal, but may be too time consuming.

PES offers a guiding principle for documenting individualized plans of care. While most patients in rehabilitation have impaired physical mobility and self-care deficits, the problems can be related to many different factors or combination of factors. By stating the factors in our problem lists, we make great strides toward individualizing plans of care. Physical mobility may be impaired from many causes, such as activity intolerance, perceptual or cognitive impairment, musculoskeletal impairment, neuromuscular impairment, limited strength, pain or lack of coordination, just to name a few. By documenting the etiology of the problem, each problem list becomes unique to the patient's set of deficits. An easy way to put this documentation principle into practice is to write "related to" statements, e.g., impaired physical mobility related to (r/t) neuromuscular impairment or self-care deficit r/t musculoskeletal impairment. The more specific the statements, the more individualized the problem lists, goals and interventions.

Another similar strategy is to add "secondary to" statements. For example, a clinician may write: impaired physical mobility r/t neuromuscular impairment secondary to right hemiparesis or self-care deficit r/t musculoskeletal impairment secondary to cervical vertebra fracture and CTLSO. By consistently using these principles across disciplines, the team ties their assessment findings directly to their problem lists. As an added bonus, it also serves to promote evidence-based practice.

An additional guiding principle is to rate the severity of impairments. Speech language pathologists seem to routinely document in that manner. For example, speech noted "that the patient demonstrated mild to moderate cognitive linguistic deficits with slow processing and thought generation. The patient also demonstrated moderate oropharyngeal dysphagia and was eating a pureed diet with nectar thick liquids." Classifying the severity of impairments is another way to connect assessment data to a problem list. A simple scale such as mild, moderate, severe or complete provides very useful information. Rating the extent of impairments is also a component of the International Classification of Functioning Disability and Health (WHO, 2002) and is consistent with the theoretical framework for functional assessment.

If the plan of care is a component of the initial evaluation form, then another guiding principle is to provide a narrative summary that presents the clinician's overall impression of the patient's clinical picture. For example, a physical therapist may write, "The patient has significant impairments characterized by dense hemiparesis, severe uncompensatory right neglect, flaccid right upper and lower extremities, aphasia which appeared global and apraxia. He was dependent for transfers including wheelchair to bed. He was able to maintain unsupported upright sitting balance for short periods of time. There was a subluxation palpable in the right shoulder." A speech language pathologist may conclude, "The patient presented with mild dysarthria, dysphagia and moderate receptive expressive aphasia. Verbal expression was characterized by decreased word finding, slow rate and semantic paraphasias. Patient was inconsistent in naming, requiring phonetic cues, written cues or open ended questions approximately 50% of the time. Patient perseverated at times and was noted with some self-monitoring/correction. Patient was accurate in yes and no questions and one step commands, but demonstrated increased difficulty with increased length and complexity. Mild apraxia of speech was suspected. She was also noted to have mild oral pharyngeal dysphagia." An occupational therapist may report: "Patient evidenced fatigue-induced decrease in cognitive skills, recent memory and functional activities. She had impaired proprioception, balance, bilateral integration and decreased sensory motor functioning of the right side. Also noted was decreased endurance, decreased vision and decreased right attention." A nursing initial assessment should culminate in an overall impression that details both health-related and functional issues. It may be written on the initial assessment form or appear as an

admission progress note. A rehabilitation nurse may document, "Patient admitted with pelvic fracture from fall. She has mild residual left hemiparesis and dysphagia from previous stroke. She experienced aspiration pneumonia during her acute hospital stay. Lungs currently clear to auscultation. Patient was incontinent of bowel x 1; staff cleaned patient and changed adult brief, no accident occurred. She complained of left hip pain and leg pain at level 8/10; four milligrams of dilaudid was given with relief. Stage one ulcer on the left heel noted. Patient required maximum assistance for stand pivot transfer and maximum assistance for turning and positioning. She was oriented x4, cooperative and able to discuss both complex and routine information. Her speech was somewhat slurred, but understandable without cuing. She is at high risk for falls."

The above summaries were taken from different records for illustrative purposes, but as physicians (or designees) begin to implement an individualized overall plan of care with input from the team, discipline specific summaries and care plans will be a vital source of information. The guiding principles of: 1) relating a problem to its etiology; 2) rating severity of impairment and; 3) writing an overall impression will provide a systematic approach to documenting discipline-specific problem lists and individualized plans of care. These documents will form the basis of the overall plan of care, which will be grounded by findings from initial assessments. In order for the guiding principles to work successfully, the entire team has to accept their usefulness and begin to implement the approach consistently. So the answer is... that's how it can be accomplished.

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