Conducting Successful Care Plan Meetings

2.0 Contact Hours

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Conducting Successful Care Plan Meetings

By Carrie L. Hill

Objectives:

At the completion of this course, the learner will be able to:

1. Define a care plan meeting and describe its purpose.
2. Explain why interdisciplinary care planning is important.
3. Identify the key players on a care plan team.
4. Delineate the six principles of effective care plan meetings.

What is a Care Plan Meeting?

Federal law requires long term care facilities to create individual care plans for its residents. Care plans address a resident's medical, psychological, and social needs through measurable goals and objectives. Care plans are developed during care plan meetings by a team of professionals familiar with the residents. While communication between care plan team members occurs outside of care plan meetings, the majority of formal care planning takes place during these regularly scheduled meetings.

Care plan meetings present an opportunity for health care professionals from multiple disciplines to cultivate an interdependent system of addressing the needs of residents through shared decision making. Ideally, care plan meetings are characterized by a high level of trust, effective communication, high productivity, and interdisciplinary collaboration. This course (a) explains why interdisciplinary care planning is important, (b) describes the key players on a care plan team, and (c) discusses the principles of effective care plan meetings that care plan teams are encouraged to adopt.

Why Is Interdisciplinary Care Planning Important?

Older adults in long term care settings often present with a multitude of issues requiring a range of skills and knowledge not encompassed by any individual discipline. Residents often need the expertise of multiple disciplines such as medicine, nursing, and social work. Also, many older adults with medical issues have concurrent mental health issues and vice versa, so professionals from the fields of psychiatry, geropsychology, and neuropsychology also provide valuable contributions to the care plan team.

Interdisciplinary collaboration is particularly important when caring for residents who have Alzheimer's disease or a related dementia. These residents pose behavioral challenges that can only be successfully addressed if all staff members understand how to respond to the resident and how to manage specific behaviors. In a sense, every member of the care plan team, from CNAs to nurses to social workers, must "buy in" to the proposed behavioral strategy in order for it to work.

The Key Players on Care Plan Teams

Ideally, all of the following people should be part of a care plan team, but this is not always possible due to scheduling conflicts, workload, and other issues. Still, here are the key players on a care plan team whose inclusion can optimize the development of a comprehensive, well-targeted care plan.

- *Activity director.* The activity director can provide valuable information to the care plan team about how a resident is functioning socially. If the resident has recently become more withdrawn and less interested in previously enjoyed activities, the activity director will often be the first to notice this change, which could signal depression or another medical, cognitive, or mental health issue.

- *Certified Nursing Assistant (CNA).* Although several CNAs interact with each resident, it is ideal to get some input from the CNA who spends the most time with the resident and witnesses his or her functioning during activities of daily living (ADLs). Not only can the CNA expand the team's understanding of the resident's day-to-day abilities and behavior; he or she can also provide clues about environmental factors that may be impacting the resident's well-being.
- *Consultants/contracted health care providers.* Many long term care facilities contract with psychiatrists, psychologists, mental health counselors, rehabilitation specialists, physical therapists, and others for consultative or direct services. These are key people to include in care plan meetings so they can report on progress toward targeted treatment goals. Additionally, if a mental health consultant helps design and implement a behavioral intervention for a resident, it is important for the consultant to continue attending care plan meetings to motivate other team members to continue implementing the strategy or to help them revise it if problems arise.
- *Dietician.* All care plans include goals and objectives related to the resident's nutritional status, so it is crucial to have a registered dietician on the care plan team that has evaluated the resident and can provide ongoing feedback about the person's dietary needs, preferences, and challenges.
- *Nurses.* The Director of Nursing (DON) and other nurses regularly involved in the person's care should be part of the care plan team; the DON often leads the care plan meetings and may be responsible for the formal written care plan. Although several nurses are involved in a resident's care, the ones who have the most contact with the resident should be encouraged to participate when possible.

- *Physician(s).* The resident's primary physician should be part of the care plan team; this person may be the facility's regular doctor or an outside physician who also treated the resident prior to admission. If specialists are involved in the resident's care, such as a cardiologist or a neurologist, it would be ideal to have them participate as well.
- *Primary caregiver.* The family member or friend most involved in the person's care should be involved in care plan meetings because this person (usually a spouse or adult child) can provide valuable information about the person's current medical and psychosocial functioning, even though the resident is no longer living at home. Caregivers have a unique window through which they can detect subtle changes in someone they have probably known for decades. Caregivers can also supply key information about the resident's cultural identity, values, and religious or spiritual practices that may be difficult to uncover through typical staff-resident interactions. Unfortunately, some health care settings perceive caregivers and other family members as nuisances who take up precious time; however, treating these people as valued members of the care plan team often results in more appropriate care plans for the residents.
- *Resident.* According to a study by the Geriatric Interdisciplinary Team Training Program, 9 out of 10 health care professionals fail to list the patient as a key member of the care planning team. Unless the resident is too cognitively impaired to participate, it is the resident's right to attend care plan meetings and have a say in his or her care regimen. It is also extremely beneficial for other care plan team members to hear concerns, questions, preferences, and updates directly from the resident. One of the many advantages of assembling an interdisciplinary team with several kinds of professionals is that some members will be more experienced in communicating with residents (and

family members) than others. Residents and caregivers will exhibit a wide range of health literacy skills, so care plan team members who can communicate complicated health information with less technical jargon will be extremely beneficial.

- *Social worker.* The facility's social worker is a key member of the care plan team because this person is skilled in coordinating services and locating additional resources to address the resident's psychosocial needs when onsite staff members are unable to accommodate. Social workers often act as a liaison between the resident, the caregiver, and the rest of the care plan team.

Principles of Effective Care Plan Meetings

Every facility has specific rules and formats for developing care plans, but the following principles are offered as a more overarching philosophy with which to approach the task of interdisciplinary collaboration.

- *Biopsychosocial approach.* Care plan meetings should include discussions about the biological/medical, psychological, and social needs of the resident. Though the biopsychosocial approach has long been heralded as the best way to ensure the total well-being of patients, care plan meetings often run the danger of focusing heavily on medical issues at the expense of other dimensions. Obviously, each member of the care plan team will bring unique skills and areas of expertise that will then translate to targeted services for the resident, but each team member should also recognize how services affect multiple dimensions of the resident's health and well-being.
- *Sensitivity to ageism.* Even in settings where most patients are older (e.g., nursing homes), some members of the care plan team might exhibit ageist views. Assuming that older adults are naturally frail, rigid, asexual, alike, and/or cognitively impaired will not

result in a care plan that enhances a resident's quality of life. For example, research indicates that adults enjoy sexual intercourse and other forms of intimacy throughout the lifespan, including old age. Unless a resident is cognitively impaired to the degree that he or she is not competent to give consent, it is the resident's right to be provided the privacy and respect to engage in intimate relations. Be sure to recognize the strengths of each individual as well as problems in order to create a balanced care plan.

- *Cultural sensitivity.* As the older population becomes more diverse, it will be crucial for care plan meetings to address the cultural needs and values of each resident. Cultural sensitivity involves an awareness of culture and its relevance to health and well-being, knowledge of one's own cultural identity, an awareness of one's own biases and stereotypes, and knowledge of other cultures. Incorporating culture into care plan meetings will require an increase in cultural knowledge through in-services and continuing education. More importantly, however, it will require care plan teams to take the time to learn about and consider the unique cultural identity of each resident, including the person's racial/ethnic background, religious or spiritual orientation, sexual orientation, beliefs about illness and death, and perceptions about the health care system. Cultural sensitivity is critical to creating appropriate and achievable care plan goals and objectives. For instance, a resident may want to practice a cultural custom that is unfamiliar to the care plan team, but if the practice does not violate resident rights, safety codes, or infection control standards, it should be documented in the care plan as a way of enhancing the person's psychosocial well-being. While cultural sensitivity is vital to successful care plan meetings, tolerance of cultural insensitivity exhibited by residents and family members is also necessary. Just like the clientele, the health care profession is

becoming increasingly diverse, and older residents and caregivers may exhibit racism or other biases toward health care providers based on long-held beliefs rooted in their upbringing. While tolerating cultural insensitivity may be difficult, it is not realistic to try to change these beliefs or challenge them, and doing so may compromise care plan progress and collaboration between professionals, residents, and family members.

- *Respect for each team member's role.* As stated earlier, a well-functioning, interdisciplinary team is essential to conducting successful care plan meetings. This involves respecting each team member's role and understanding that different disciplines will offer unique – and sometimes conflicting – perspectives about treatment. Unfortunately, theoretical or practical differences between disciplines can sometimes fracture a care plan team because professionals are often trained to practice autonomously within their area of expertise. When a different point of view is expressed, team members not accustomed to working with those outside of their discipline may become defensive or resistant to the collaborative process. However, differences and conflicts should be seen as an opportunity to explore all possible solutions to a resident's presenting medical and psychosocial issues. On a related note, if two members of the team offer similar services (e.g., a psychologist and a social worker each offer grief counseling), they should work together to find the best way to serve the resident, rather than become territorial over who will provide the service.
- *Creative communication methods.* Ideally, all members of a care plan team will be physically present at scheduled meetings, but this is rarely possible. Team members should be prepared to communicate through teleconferencing, video conferencing, and other electronic methods in order to work together and keep everyone on the same page.

This is especially true with the rise of telehealth services in rural areas. When care plan team members are in different locations, the transfer of resident care plans, files, and records must be accomplished carefully in order to preserve confidentiality.

- *Flexible care planning approach.* Care plans must change over time to reflect the changing medical and psychosocial needs of the resident. Beware of rigidly adhering to an original care plan when the person's status has clearly changed. A flexible approach to care planning works better, where each care plan meeting includes an evaluation of each care plan goal and whether it is still appropriate in its current form.

Conclusion

While this course specifically dealt with care plan meetings within long term care settings, many of the principles and recommendations apply to the care plans and treatment plans that need to be developed in other settings, such as primary care, specialized medical clinics, and community social services agencies.

Many issues related to conducting successful care plan meetings are beyond the scope of this course. In an effort to improve geriatric care planning and interdisciplinary care, the John A. Hartford Foundation created the Geriatric Interdisciplinary Team Training Program, which offers a wealth of training tools, information, and resources for interdisciplinary health care teams that want to more effectively work together to serve their patients. If you are interested in learning more about factors that can affect care plan team development, the culture of interdisciplinary team care, how to foster leadership during care plan meetings, or how care plan teams have handled a variety of ethical or treatment dilemmas, see http://www.gittprogram.org.

Interdisciplinary care plan teams are not really optional in today's health care arena – instead, care plan teams composed of professionals from multiple disciplines are considered the standard of care for long term care facilities and other health care settings that serve older adults. Hopefully, this course will help long term care facilities foster greater collaboration and effectiveness within their care plan teams so that the health and well-being of residents are ultimately enhanced.

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