**Person-Centered Care**

**Competency**

General Information

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Centering care and services around the resident’s goals and preferences are best practices for the long-term care provider and are an expectation of residents, families, and regulatory agencies. All aspects of care are to involve input from the resident, who participates in the development of an individualized plan for care beginning with the baseline care plan and throughout the resident’s stay at the health center. As care needs evolve and the comprehensive care plan is updated, the resident and their family and/or significant other are consulted, and goals and approaches are updated with the resident’s choices followed.

The Requirements of Participation have integrated person-centered care philosophies throughout the updated regulations, demonstrating the resident’s right to choose and directly oversee the care that they receive to meet their goals.

F655- The following requirement is presented in the State Operations Manual under Baseline Care Plans:

“§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must—

1. Be developed within 48 hours of a resident’s admission.
2. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—

* Initial goals based on admission orders.
* Physician orders.
* Dietary orders.
* Therapy services.
* Social services.
* PASARR recommendation, if applicable.

Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident’s life before coming to reside in the nursing home.”[[1]](#footnote-1)

It is further directed in 483.21(a)(2) that:

“The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—

* (i) Is developed within 48 hours of the resident’s admission.”[[2]](#footnote-2)

The facility must also provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

* “(i) The initial goals of the resident.
* (ii) A summary of the resident’s medications and dietary instructions.
* (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
* (iv) Any updated information based on the details of the comprehensive care plan, as necessary.”[[3]](#footnote-3)

F656: “§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following —

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
2. Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
3. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record. (iv)In consultation with the resident and the resident’s representative(s)—
   1. The resident’s goals for admission and desired outcomes.
   2. The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
   3. Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.”[[4]](#footnote-4)

“INTENT: Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident’s medical, physical, mental and psychosocial needs.”[[5]](#footnote-5)

Competency in skills and techniques necessary to provide person-centered care include but are not limited to:

* Person-Centered Care
* Resident Rights
* Communication
* Assessment- Interdisciplinary
* Care Plan development and implementation
* Meeting psychosocial needs
* Nursing skills
* Basic Care skills
* ADLs
* Activities to meet preferences and needs
* Environmental
* Sensory and Communication deficits
* Cultural Competency
* Baseline and Comprehensive Care Planning
* Hospice and End of Life Care
* Restraint Use and Reduction
* Medication Management
* Pain Assessment and Management
* Psychoactive Medication

**Suggested Staff Competencies**

Interview with the resident, family, and other significant persons is critical to learning about the resident and their perceptions about entry into the health center, goals for treatment, and preferences regarding the ways they desire cares and treatment be provided. Through competence in communication and assessment, the health center is able to determine individualized approaches to meet the resident’s care needs while ensuring that preferences are followed.

Communication of approaches to be followed need to be shared with other health center staff to provide individualized care, promote involvement in health center programming such as therapy and life enrichment, and document care and services provided clearly to demonstrate resident status. Residents remain involved and their input sought with changes in treatment needed, and to provide feedback regarding preferences being followed, as directed in 483.10, Resident Rights.

**Suggested Competencies for Staff**

* **All Staff**
  + Communication skills
  + Recognizing and communicating with residents who have sensory/communication deficits
  + Observational skills
  + Recognition and reporting of changes
  + Understanding of Resident Abuse policies and reporting of abuse
  + Understanding of Resident Rights and the right of residents to self-determination, be informed of changes, accommodation of needs, make decisions and choices, etc.
  + Provide privacy, dignity, and respect for each resident
  + Understanding of the grievance policies and ability to assist residents to file a grievance as needed
  + Ability to develop and follow comprehensive plans of care that include resident preferences
  + Flexibility in providing alternatives to residents who refuse or state other preferences
  + Ability to encourage and assist residents to participate in activities of preference
  + Understanding of person-centered and directed care
  + Role with Person-Centered Care Plan development, implementation and revisions
  + Documentation

**F-Tag Reference for General Information:**

Some examples of potential citations which may be identified during survey include:

F540 Abuse

F550 Resident Rights/Exercise Rights

F551 Rights Exercised by a Representative

F552 Right to be informed & Make Treatment Decisions

F553 Right to Participate in Planning Care

F555 Right to Choose and Be Informed of Attending Physician

F558 Accommodation of Needs and Preferences

F584 Safe and Homelike Environment

F604 Right to be Free from Physical Restraints

F605 Right to be Free from Chemical restraints

F636 Comprehensive Assessments and Timing

F637 Comprehensive Assessment after Significant Change

F641 Accuracy of Assessments

F655 Baseline Care Plan

F656 Develop and Implement the Comprehensive Care Plan

F657 Care Plan Timing and Revision

F658 Services provided to meet Professional Standards

F659 Qualified Persons

F675 Quality of Life

F677 ADL Care Provided for Dependent Residents

F679 Activities to Meet Interests and Needs

F684: Quality of Care

F694 Parenteral Fluids

F696 Protheses

F697 Pain Management

F698 Dialysis

F740 Behavioral Health Services

F741 Sufficient and Competent Staff

F742 Treatment/Services for Mental/Psychosocial Concerns

F744 Treatment/Services for Dementia

F758 Free from Unnecessary Psychotropic Medication

F838 Facility Assessment

F849 Hospice Services

F942 Resident Rights and Facility Responsibilities

F943 Abuse, Neglect, and Exploitation Training

**Critical Element Pathways:**

There are no specific pathways for person-centered care as this care philosophy is integrated across most critical element pathways. The resident’s preferences are to be considered and included as part of assessment and when planning and implementing individualized resident care and services to meet resident-centered goals. The resident and representatives are to be consulted for their input when addressing changes of status and treatment.

Related Critical Element Pathways may include:

**CMS- 20067 “General”.** During review of this element, wide ranging areas of resident care is reviewed through observation, interview, and medical record review. The Resident’s preferences are to be included in the comprehensive care plan and their goals and preferences are to be followed during development of plans to meet their needs and implementation. Person-centered care is a requirement of care encompassing all aspects of the resident’s experience at the health center.

**CMS-20067 “Behavioral/Emotional”.**  Residents are interviewed to identify that their preferences are followed and alternative attempted during care and treatment. Staff knowledge of interventions to be followed when assisting a resident who has the potential for behavioral/emotional outbursts is identified through interview. Alternative approaches, interactions following the resident’s preferred method to minimize emotional stress, and review of the medical record and care plans are completed to determine that person-centered approaches are established, and alternative intervention are attempted to meet the needs of the resident, and minimize or eliminate the need for psychoactive medication. The Comprehensive Care Plan is reviewed for use of consistent approaches which meet the resident needs and follow preferences, and documentation audited.

**CMS- 20073 “Hospice and End of Life”.** The resident’s goals and preferences for palliative treatment and end of life care are evaluated through interview, observation, and review of the medical record and care plan. If Hospice is a partner in care, the collaboration between the health center and hospice staff are determined and evaluated.

**References**

Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>

Centers for Medicare & Medicaid Services. LTC Survey Pathways (Download):

<https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes.html>

1. 1,2,3 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)
4. 4,5 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-4)
5. [↑](#footnote-ref-5)