



Assessment and Care Planning

Assessment, sometimes called appraisal in Residential Care Facilities for the Elderly, is a process to gather information about a person's life, functional abilities and needs in order to develop an individualized plan of care. The plan of care describes the strategies that the facility and staff will use to enhance, restore or maintain a person's optimal physical, mental and psychosocial well-being.

What Kind of Information Does the Facility Want to Know About a Resident?

The Residential Care Facility (RCFE) is required to complete a pre-admission appraisal that evaluates a prospective resident's functional capabilities, mental condition and such social factors as likes, dislikes and interests. A medical assessment must also be conducted if one hasn't been completed in the past year. Prior to a person's acceptance as a resident, the facility should obtain a medical assessment, signed by a physician. This assessment includes a diagnosis, examination for TB and other contagious diseases, medical history, record of medications, and identification of physical and mental limitations that might prevent a person from receiving adequate care at RCFE level. Note: For residents with dementia, there must also be a written plan of care by the resident's doctor to minimize the use of psychoactive medications.

Why Does the Facility Need to Know All This Information?

The detailed and comprehensive information provided in the assessment gives the facility a "whole picture" of the resident. The information helps tell a person's story, giving insight into their strengths, interests, likes and dislikes, routines, habits and patterns of daily living. For example, this type of information can transform a resident with a diagnosis of dementia in room 12 into a real person. Facilities can then create an individualized plan that will provide good quality of care and enhance the resident's quality of life.

When Will the Facility Want to Obtain This Information?

The RCFE is required to obtain most of this information before admitting someone as a resident. Either prior to admission or within 2 weeks after being admitted, the facility must meet with the resident and his/her family, agent or legal representative to develop a care plan.

What is the Role of the Resident and Family Members or Representatives in the Assessment & Care Planning Process?

The resident, family and legal representatives have the right to participate in the assessment, reassessment and care planning process. Their role is essential to providing a complete picture of the resident. Note: The resident also has a right to refuse treatment and services, once advised of their benefits and risks, and the offer of alternative treatment approaches.

How Often Will the Care Plan Be Reviewed?

RCFEs are supposed to make a reassessment and care plan revisions at least annually. However, a reassessment and care plan update are required whenever there are significant changes in the resident's physical, medical, mental, and/or social condition. Ask for a quarterly review. This allows for mutual feedback, adjustments in the care plan and preventive intervention.

What Happens at a Care Plan Meeting?

The Care Plan meeting provides an opportunity to see if the plan is meeting the needs of the resident by reviewing what strategies are working and which ones are not. It can identify changes in the resident's condition or behavior that will require revisions of the care plan. The meeting also gives residents, family members or representatives, as well as facility staff, a chance to discuss and resolve problems and concerns.

How Will I Know if the Care Plan is Working?

The true measure of a good care plan is the degree to which it meets the person's care needs and enhances the quality of life. Other important criteria for evaluating a care plan are:

- Is the plan resident-centered and individualized?
- Is it understandable to the resident, family and to the staff?
- Does it clearly indicate what is to be done, by whom, how and by when?
- Is staff consistently following the plan?

If the care plan is not working, request a meeting to review the care plan. Also ask that other persons with expertise be consulted, (e.g., doctor, nurse, social workers, Ombudsman, etc.), and be involved in the care planning process.

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The most pertinent laws and regulations are found in California Health & Safety Code Section 1569.80 and in California Code of Regulations, Title 22, Sections 87458, 87608, 87219, 87457 through 87505.