This newsletter is brought to you by the Kansas State University Center on Aging through a grant from the Kansas Department for Aging and Disability Services.
This newsletter includes a feature of two different homes’ approach to the subject of risk. The core area Decision-Making Resident Care has an objective of training staff to support resident choices, which inherently involve risky choices, at times. This is a tough area for many nursing homes across the U.S. The term “surplus safety,” a term Bill Thomas introduced me to at a Pioneer Network Conference. It was coined by, Bill Thomas, a physician and Judah Ronch, a psychiatrist, who noted that risk is the possibility of an unanticipated outcome.

There are two kinds of risk, upside and downside. In long-term care we have focused on the downside risk, which is an outcome that is worse than expected rather than the upside risk which is an outcome that is better than expected. In other words, when a resident makes a choice that has an uncertain outcome, we often jump to protection against potential downsides (ex. physical harm, disappointment) but often do not consider the potential upsides associated with the choice (ex. Psychological benefits, physical benefits, accomplishment of life goal). The decision-making resident care area pushes us to consider BOTH the upside and downside risk associated with resident choices. I’m excited for you to hear about Evergreen and The Shepherd’s Center’s approach to this core area.

I am also elated to share two new resources that were developed by our team but informed by the input of a variety of stakeholders including YOU! This is so exciting! Enjoy this issue of our newsletter and don’t hesitate to contact us for assistance in using the new resources.

“The dangers of life are infinite, and among them is safety.”
– Goethe

Laci J. Cornelison,
PEAK 2.0 Project Coordinator
Evergreen Community of Johnson County is in Olathe, KS. ECOJC is one of three branches of Evergreen Living Innovations, Inc. ECOJC is a not-for-profit for 112 individuals, PEAK mentor home with 59% of the population we serve being Medicaid.

Wikipedia defines risk as the potential of gaining or losing something of value. Values, such as physical health, social status, emotional well-being, or financial wealth can be gained or lost when taking risk resulting from a given action or inaction (planned or unplanned, foreseen or unforeseen). Risk can also be defined as the intentional interaction with uncertainty. Uncertainty is a potential, unpredictable, and uncontrollable outcome; risk is a consequence of action taken despite uncertainty (Retrieved on October 30, 2017 from https://en.wikipedia.org/wiki/Risk).

Risks are taken in everyday life. We take risks all the time and don’t even really think about it. Interesting though, when it comes to a person living in a nursing home, suddenly we must call a meeting to discuss it. A team of professionals come together, often for several hours to discuss if they should “let” the resident do something risky. Why do we do this?

Risk is scary. As the definition reads above, risk is entered into with uncertainty. Uncertainty is tough for caregivers. They often feel out of control. So, this is when we must remind ourselves it’s not about our control. It’s about the residents being in control.

One of the first things that needs to happen, to create an environment where risk happens every day, is that staff are empowered to make decisions that ensure the resident is in control.

How that is accomplished is to change your organizational chart. Put the residents at the top, where they belong. Next comes the staff members that work the closest to the residents (CNAs/Care Partners).

Implementing and then educating the entire organization on this new practice is very important.

We have also worked very hard on educating staff about taking risks. This starts during the hiring process and should be repeated often. Education is provided through conversation in our weekly neighborhood meetings in our annual in-services and then 1:1 with individuals that are struggling with it or question how to approach a risky situation. It is also necessary to support team members when they are struggling with risky decisions. Leaders, informal and formal, must help staff, especially the staff closest to the resident, with support when making decisions to ensure residents get what they want. So, the people who are now lower on the organizational chart must make sure they do not override those decisions or put them down.

There is no evidence to support the long term use of pureed diets for people living in long-term care communities, but pureed diet orders are quite common.

How did we get here? It goes something like this:

1) A resident chokes while eating in the dining room.
2) The CNA, being a good CNA, reports it to the neighborhood nurse.
3) The neighborhood nurse, being thorough, contacts the doctor to tell them that the resident choked while eating.

4) The doctor, having been trained in acute care, orders a swallow study.

5) The swallow study shows that there is a risk of aspiration.

6) The doctor orders a pureed diet.

Sound familiar? What is missing in this scenario? The resident! If no one explained the likely outcome of a swallow study (a pureed diet order until they die), but the resident states they do not want to eat “baby food”, why subject them to the testing to begin with? There are many foods that are easier to chew than others. Perhaps the resident will consent to texture modified meats, but wants “real green beans” and thin liquids. The question for your community is: how do we make that happen? When physicians and nurses become aware that there is no evidence to support long term use of pureed foods or thickened liquids, they should be much more comfortable advocating for the wishes of the resident. Providing physicians, nurses, caregivers and families with the 2011 Dining Practice Standards approved by CMS will help the community do a better job of honoring resident choice related to nutrition. It may feel risky when a resident wants to eat something and there is a chance of them choking but if we educate everyone involved it feels more like a group decision than a risk.

Happy hour is another one of those practices that is often frowned upon by outsiders. As I am out speaking to groups about what we do at Evergreen, people are so shocked when I say we have Happy Hour. The residents are over 21 and not driving anywhere! Some clinical staff will question the safety of residents drinking alcohol and taking prescribed medications. Upon move in and throughout the time the resident lives at Evergreen we are discussing resident choice. Staff get to know the residents very well. They have conversations about the risk of drinking alcohol and interactions with medications. This is done as a conversation though. Not as a demeaning interaction where staff is telling the resident what they should and shouldn’t do. There are certain things the community has to do: we must care plan the desires of the resident, document education has been provided to resident and family about possible negative impact, and caregivers are educated about what to look for regarding negative interactions. Look at the face of the resident enjoying her Coors and tell me Happy Hour shouldn’t happen at nursing homes.

Sure, there are risky things about ensuring people get to enjoy the food they want, knowing it’s not good for them. We all do it! I have always said if I am diagnosed with Diabetes, death by chocolate cake is how I want to go. Our job, as long-term care professionals, is to educate the resident about the risks, document those conversations in line with our organization’s approach and then honor their choices.

Risk is scary and the results are uncertain, but that doesn’t mean we shouldn’t try. Things that are important to remember are to re-think your organizational chart, empower the staff closest to the resident and put the resident in the driver seat. Taking risks is worth it!
The Shepherd’s Center

The Shepherd’s Center began its PEAK journey in 2014. We are a 28 bed, not-for-profit, long-term nursing care home, located in Cimarron, KS. At this time, we are 66% Medicaid. To date, we have passed 8 out of 12 PEAK 2.0 cores and are at level 2 in the program. We recently passed Core 2, Decision-Making Resident Care in Domain 2: Staff Empowerment. One of the requirements to pass this core is to hold a training on Risk and discuss ideas as to how to support elders to make choices, while keeping them and those around them safe.

Resident choice is highly encouraged and respected by our staff. We take risks in our lives every day by the choices we make. As adults, we have the freedom to make choices about how we want to live our life, whether they are good for us or not. Our elders, as adults, should also have the right to make decisions about how they want to live their lives, whether we agree with them or not. It is our responsibility to know and understand our elder and why they make the choices they do. It is our responsibility to know their medical conditions, allergies, etc. and how their decisions will affect them. Where do we find this information? Their Care Plan. It is our job to be familiar with their care plans and even to help form them. Our direct caregivers are the ones who are on the front line taking care of our elders. They know our elder’s wants and preferences, as well as their dislikes. Direct caregivers are the ones the elders ask to bring them something or make something happen. It is very important that they feel equipped and able to support the elder’s needs and wants and that they feel empowered to give their elder what they want.

In the Risk training that we held, we introduced our Risk Management Tool; some “Best Practices” or tips to follow in order to help support our elder’s choices and preferences for daily routines. Here are the things we included:

1. **Use the care plan** as your tool to help support the elder’s preferences and decisions. The care plan will drive what they are doing and the choices they make. Is this a new behavior? Is this a chronic behavior? If it is chronic, then it is something that should be care planned. If it is a new behavior, then we need to navigate and take a step by step, situation by situation approach in handling it.

2. **Know the elder.** Do not give a “blanket” response, meaning we need to evaluate each situation and person individually.

3. **Educate the elder** and let them know if the decision they are making has risk tied to it what the consequences could be. Will their choices make them sick? Is immediately life threatening to them or others? If not, then why can’t he/she have what they want? Remember, it is not our job to tell them “No” or judge their decisions when we feel they are not making the best choices. It is our job to evaluate each situation and educate our elders on how their choices could affect them or others around them. They are adults and should have the freedom and right to make daily choices, whether we agree with them or not.

4. **Offer alternative choices that may be healthier or negotiate and make compromises,** such as half of something. But in the end, understand that the choice is theirs to make. If it is not illegal, or harmful to those around them, give them what they want.

5. **Do not tell them, “I have to ask the nurse”.** This may make them feel like they are not in control. Instead, if you are unsure, tell them, “OK, I’ll see what I can do” and get back with them.

6. **If the Elder is refusing something they need, such as meds, bathing, eating, etc., can you try again later?** Again, know each elder and what will upset them. Do not get into an argument with the elder. Can someone else get them to accept whatever it is they need? Evaluate the situation and ask yourself, “Is this something that can wait or be delayed another day?” Is this an issue where the family needs or wants to be called? If they adamantly refuse, find out why and document their why.
7. **Document the efforts taken by you and the team to try and keep the elder safe.** Document why the elder is making the choices they are making, the alternatives you have offered, and the education you provided to the elder about the risks of their decisions.

8. **Communicate with other staff and other departments about the elder’s choices.** For example, make sure the nurse and oncoming shifts know that a diabetic elder has eaten 2 pieces of pie during a shift, so that blood sugar levels can be accounted for and if desserts for the next shift should be adjusted, if possible.

9. **Know that if an elder’s decisions impedes other’s rights or endangers others, or if what they want is illegal, then it is not a right that staff can grant.**

10. **Come to care plan meetings and advocate for elders.** This is the best way to help the elders you care for get what they want when they want it.

Our Risk Management Tool was handed out to every employee at the training and is included in our New Employee Packet. Our Risk training will be held annually.

Here is a great example of how this training has paid off for a resident. Tom has been a resident here for many years and due to health concerns, we have been told that he should not go on outings. His daughter, Tammy, found out that Kenny Rogers was going to perform in concert in Dodge City and she called to ask if it would be alright to take him.

Kenny Rogers has always been Tom’s favorite singer. Tom does not speak much, but he can sing every word to any Kenny Rogers song. We helped his daughter give Tom and his wife, Debbie, a date night that they would never forget by working through the different elements of our training guide (listed previously). He was so happy; he smiled all night long. Tom did great on the outing, and that night opened the door to other outings for him, as well.

*The Shepherd’s Center PEAK Team: Amy Berry, SSD/AD, Nanci Lacy, RA/CNA, Debra Voeltz, Housekeeping/Laundry Manager, Kathryn Daley, CMA/RA/CNA*
New Resources Available

We are excited to announce the release of two new resources that were developed to aid in your success in the PEAK 2.0 program. The PEAK 2.0 advisory team, PEAK 2.0 Experience Survey feedback, and the PEAK 2.0 team's experience in talking with PEAK participants lead to the development of these resources. We thank all of those who were involved in the development and revisions of these resources. It takes everyone to continue to improve and help each other on the journey to improved quality for residents in Kansas through person-centered care provision. Without further ado-- introducing…

Action Plan Development Worksheets:

Have you struggled to develop a quality action plan for the core areas you have worked on? Have you struggled to aid your teams in developing quality action plans? Does the action planning process overwhelm you? Well, this resource is for you! The worksheets provide a step-by-step guide for each PEAK 2.0 core area for writing an action plan. We recommend printing the worksheet for each of the core areas you select to work on and providing it to the team charged with writing the plan. It walks the team through writing the action plan by core area. You can find this resource at: http://www.he.k-state.edu/aging/outreach/peak20/2017-18/

PEAK 2.0 Core Area Audits:

Are you preparing for a PEAK 2.0 evaluation? Do you want to know what type of progress you have made in implementing a particular PEAK 2.0 core area? Do you feel like your organization has struggled to sustain a core area? Do you suspect a particular area of your organization has backslid in a particular core area? This resource is for you! This was designed to help teams identify areas that are working well within each core area and areas where there might be signs of trouble. We encourage teams to perform the audits and not managers “inspecting” others. This will help the process be informative and develop awareness rather than accusatory or punitive. We welcome calls to aid in instruction of the tools so feel free to contact us with questions. You can find this resource at: http://www.he.k-state.edu/aging/outreach/peak20/action-planning/