

## ACTION PLAN WORKSHEET: RELATIONSHIPS (Δ NFMH)

### INSTRUCTIONS:

#### Before scheduling a time to write the action plan:

- Gather the **KDADS Criteria** for Relationships Δ NFMH: (pg. 6 and pg.15-16 ): <http://www.he.k-state.edu/aging/outreach/peak20/2017-18/peak-criteria.pdf>
- Gather the **KDADS Core Considerations** for Relationships: (pg. 12-15): <http://www.he.k-state.edu/aging/outreach/peak20/2017-18/Core-Considerations.pdf>
- Gather a team together (approximately 5-6 people) who are interested in working on this topic. Include a couple members of your PCC change team.
- Have all the team members read through the KDADS Criteria and Core Considerations for Relationships before meeting together.
- Bring copies of the KDADS Criteria and Core Considerations for everyone on the team when you meet to start writing the action plan.

#### At the time of the meeting:

- Make sure everyone has a copy of the Criteria and the Core Considerations.
- Have several hard copies or an electronic copy of the Action Plan Template. These can be found in both Word and PDF formats at: <http://www.he.k-state.edu/aging/outreach/peak20/action-planning/>
- Ask for a volunteer to scribe for the group. This person will record items on the Action Plan Template.

#### Now it is time to start action planning:

- Your team will work through the Relationship (Δ NFMH) core, supporting practice by supporting practice.
- Read the statement in orange under the heading Core #2, “Residents enjoy meaningful relationships with a small group of consistently assigned caregivers.” (KDADS criteria page 15)
- This is the **GOAL** for this core area. Have the scribe write or type that exact goal statement in the goal box of the Action Plan Template as seen below.

Goal: Residents enjoy meaningful relationships with a small group of consistently assigned caregivers.
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Now everyone is aware of the goal for this core area. Next, review the Replacement Supporting Practice for Δ NFMH’s.

### **Replacement Supporting Practice for Δ NFMH's:**

***“Every staff member receives training on the person-centered care plan for each resident upon hire.”***

1. Does each resident living in the home have a person-centered care plan outlining the routine and care preferences of that individual? **Circle:** YES or NO
2. Are these person-centered care plans reviewed with each new team member upon hire?  
**Circle:** YES or NO

If you answered YES to any of the questions above, write a detailed description of what you are currently doing to satisfy that question in the NARRATIVE BOX of the action plan template. Again, if your home has been recently evaluated on this area and passed it, note this and the evaluation date in the narrative box. Do this for all questions answered with “yes.”

If you answered NO to any of the questions above, you need to write an OBJECTIVE about this area on the action plan template and ACTION STEPS to meet the OBJECTIVE. Do this for all questions answered with “no.”

**Sample Objective:** “Review of each person-centered care plan will be included in new employee orientation by January 1, 2018.”

**Sample Action Steps:**

- “Care plan team will review each care plan over next 90 days to assure they include rich personal information about routines and preferences.”
- “Review of current care plans will be added to new employee orientation checklist.”
- “Team will determine trainers that will review care plans with new hires.”
- Etc...

***“There is no “scheduled” agency staffing.”***

1. The home has covered the staff schedule in the past PEAK year WITHOUT the use of agency staff? **Circle:** YES or NO

If you answered YES to the question above, write a detailed description of what you are currently doing to satisfy that question in the NARRATIVE BOX of the action plan template. Again, if your home has been recently evaluated on this area and passed it, note this and the evaluation date in the narrative box.

If you answered NO to the question above, you need to write an OBJECTIVE about this area on the action plan template and ACTION STEPS to meet the OBJECTIVE.

**Sample Objective:** “No agency staff will be used during the next PEAK year.”

**Sample Action Steps:**

- “Discuss expectation with all team members.”
- “Gather the Relationship team to discuss alternative coverage strategies.”
- Etc..

**“Versatile workers are assigned in the home.”**

1. Are workers in each area expected to perform duties outside their “traditional” role on a regular basis to the extent allowed by their license or certification? For example, serve food, assist with cleaning, facilitate activities, etc. **Circle:** YES or NO
2. Do workers routinely receive additional training to allow them to safely help with tasks outside their traditional roles? **Circle:** YES or NO

If you answered YES to any of the questions above, write a detailed description of what you are currently doing to satisfy that question in the NARRATIVE BOX of the action plan template. Again, if your home has been recently evaluated on this area and passed it, note this and the evaluation date in the narrative box. Do this for all questions answered with “yes.”

If you answered NO to any of the questions above, you need to write an OBJECTIVE about this area on the action plan template and ACTION STEPS to meet the OBJECTIVE. Do this for all questions answered with “no.”

**Sample Objectives:** “All neighborhood teams will be cross trained to support a versatile worker model of care by January 1, 2018.”

**Sample Action Steps:**

- “Make a list of each team member in each work area.”
- “Create a training for serving food safely, neighborhood cleaning, and assisting with activities and life enhancement.”
- “Identify training needs.”
- “Recruit trainers for each competency identified, Include trainings in New Employee orientation.”
- Etc...

Now that you have Objectives and Action Steps for each supporting practice within the Relationship (Δ NFMH) core,

- Go back to your action plan and have members volunteer to take the lead on the action steps and **write/type their name as Responsible person**. Work to spread out the work load among the team.
- Go through and identify deadlines for each action step. Get the person that volunteered to lead the step involved in setting the date. **Write this as the target date on the plan.**
- Review the action plan to make sure it makes sense, and compare the timeline with the other cores you are working on. Try not to overload your schedule with too many activities at one time.
- Once the plan is complete, turn it in to the KSU Center on Aging for feedback and get started on your plan. The feedback you will receive from KSU are suggestions to aid in your success in the

program. You do NOT need to submit any changes or revisions you make to the action plan. Make changes internally and continue using the plan as a working document.

- The feedback you will receive on your action plan has no impact on your PEAK 2.0 level but a submitted action plan is required for receipt of your Medicaid financial incentive. We see a strong correlation between homes that invest time in the action planning process and success at evaluation time. Feel free to contact the PEAK 2.0 team anytime for consultation on your work.