

# Considerations: Food

## Background:

- The food core is in domain #1- Resident Choice. The goal of this domain is “Residents *direct* their lives.”
- Promoting choice is the most basic and essential principle of person-centered care. Real choice is having the power to determine your options, whether good or bad. How many of us can honestly say that we have never made a decision that is bad for us? We must accept risk as a normal part of life while at the same time do what we can to mitigate risk.
- The bottom line, we must support residents in the decisions they make.

## The overall goal of this core: Residents choose what, when, and where they eat.

When working through this core keep in mind that the idea is that elders should **direct** the choices around food.

### Supporting Practice #1— “What to eat” required outcomes

**Enhanced dining program-** The intent of this requirement is for homes to move beyond the “pink-tray service” of days gone by, when each person was served the same plate of food at mealtime. Homes should implement a dining program that offers choice to each person **at the time of service**. Each home should select the style of dining that best meets the needs of the people who live there.

- Many styles of dining are currently being used to meet this requirement: restaurant style, buffets, alternative or “always available” menus, and cook to order programs, to name a few.
- Avoid a system that requires elders to make their selections hours or a day before the meal. (*Most of us don’t know what we want to eat tomorrow*).

**Menu options-** The home should make numerous food options available to elders. Current regulations require two food alternatives be available at each meal, however this will not meet the criteria of the PEAK program.

- Available food **options should be based on the preferences of the people living in the home**.
- Consider this example: *If a resident tells you he ate Bran flakes with dried cranberries every morning at home, every effort should be made to make Bran flakes with dried cranberries available. A home can offer fifteen different breakfast cereals but if the elder’s preferences are not among the options they are not “directing” their food choices.*

**Resident input-** Elders should be actively involved in **menu development on an on-going basis**. Think beyond elders simply giving feedback in Resident Council on seasonal menu changes prior to their implementation.

- Consider the difference between asking for feedback on a menu that has already been created and asking elders *upfront to help create a menu based on foods they want to see served in their home*.
- Talk to elders on an on-going basis. Ask them what they are hungry for., if there anything they want from the grocery store, or to test and share their favorite recipes.
- Homes have implemented a variety of systems to meet this requirement, among them: resident food councils, regular “Coffee with the Cook” activities, dining table rounds with elders, posted grocery lists, etc. However you choose to handle it, **the first step in the process of menu development should always be talking to elders**.

# Considerations: Food

## Supporting Practice #2— “When to eat” required outcomes

**Food available 24/7-** Food must be available to elders upon request at all times of the day and night. Effective August 2015, self-serve access is no longer considered a required outcome of the PEAK program. For homes wishing to maintain this practice, please refer to [Considerations for Food Accessibility](#).

**Expanded meal time of hot food availability to reflect resident eating habits-** As people move into your home, find out what time they eat their meals and work to accommodate their personal routine.

- *Consider this example: Prior to retirement an elder reported to his job as a milk truck driver every day at 4:00am. On his way to work each morning he stopped at this local café for a big breakfast of bacon and eggs with coffee. He continues to wake each morning at 3:00am. In a traditional nursing home he may be forced to wait until 7:30am or 8:00am for breakfast. A home providing person-centered care would find a way to make a hot breakfast available to him each morning upon rising at 3:00am. Some homes have made this possible by finding a way for the night shift team to access a kitchen, either the main kitchen or a smaller kitchenette somewhere. They have then trained team members outside of the kitchen staff about safe food preparation, storage, and service. By making a skillet, bacon, and a couple eggs available to the night team they have been able to support the elder’s personal routine.*
- Homes must find a way to make hot food available beyond the usual, limited meal times to accommodate resident schedules. Many homes have accomplished increased flexibility of mealtimes by training other team members to assist with resident food requests.

**Access to special food requests-** A system needs to be in place for residents to access reasonable special food items that are not normally available in the home. Residents should know how to access these special food requests.

# Considerations: Food

## Supporting Practice #3— “Where to eat” required outcomes

**Residents are involved in décor changes and decisions-** You are NOT required to make any changes in dining room décor. However, if you *do* make changes in décor, residents must to be involved in the process.

- Residents should be involved in all decisions related to their dining experience. Even simple things like re-arranging furniture should be discussed with them. Residents should be involved in decisions about table service, what condiments they want available on their tables, décor, music, etc. Homes should respond to resident requests for change in the dining experience as they are able.

**No assigned seats in dining the room-** All residents should decide where they want to sit in the dining room at mealtime. A person could select a seat based on their relationship with another resident, the proximity of a seat to the window,, an air-conditioning vent, noise from the kitchen, or the mood they are in that day.

- These decisions should not be based on staff convenience. Homes should avoid the practice of segregating people who need assistance at meals by seating them at special tables or even “assisted” dining rooms. Seating should always be based on the preference of the elder.
- *Consider this situation. A home in the past may have had residents who required assistance at mealtime eat in a segregated dining room. In one home such as this, a husband was not allowed to sit with his wife of 60 years at mealtime because he required assistance and therefore was seated in the Assisted Dining room. The wife, independent at mealtime, ate in the main dining room.*
- All elders should receive the assistance they need in the seat of their choice. Seating decisions for those elders who cannot verbalize their preference should be based on what we know about them.
- Keep in mind, we all know we tend to be creatures of habit. We often sit in the same place every day in our own homes. It is okay for elders to sit in the same place every day as long as the elder chooses the place.
- This will get easier as homes expand mealtimes and resident begin to eat at different times throughout the day. More than one resident may claim a seat as theirs.

**Multiple options in where to eat-** These can include places such as the elder’s bedroom, in front of the TV, the patio, a private dining room, conference room, activity room etc. Get creative!

- Nurses must assess elders to determine if they need supervision or assistance when eating. Systems should be in place that enable all team members’ access to information about these individual needs. The team is responsible for providing needed care while they support elder decisions.

# Considerations: Food Accessibility

## Things to consider when food is available to elders on a self-serve basis 24/7.

In August of 2015, KDADS issued a statement noting a change to the PEAK 2.0 criteria related to the Food core. **Self-serve access to food is no longer a requirement of the food core;** however 24/7 accessibility to food continues to be a required outcome.

**Residents have a right to access food anytime they wish 24/7 and homes should have staff available 24/7 that are trained to prepare and serve food. Preferred snacks should be stocked where residents live and should be available when residents want them.**

While it is not practical in most homes to have the main kitchen and dining team available 24/7, many homes have accomplished increased availability of food by training other team members to assist residents with food requests.

As team members outside of the dining team become more involved in food service, it is important to consider the following:

- **Training:** Nurse aides, nurses, housekeepers, social workers, activity personnel, administrative and maintenance staff may all be called upon to assist an elder with food when the dining team is not available. ALL team members should receive training to do this safely. Training needs could include: safe food handling practices, information about special diets, food service, proper food storage and where to find dining information about elders in the home. **Staff training should be done upon hire and then routinely throughout the year.**
- **Access to information:** As other team members become involved in assisting elders with food they will need access to the same information that has traditionally been provided to only the dining team. Information about all residents' food preferences, eating habits, special diets or concerns should be available for quick reference by ALL staff. **Systems should be in place to keep this information available and current at all times.** Some homes have created a dining "book" with quick reference information that is kept near the food that any team member can reference.

# Considerations: Food Accessibility

## Homes who wish to make food available on a self-serve basis to elders should also make the following considerations:

**Implement a consistent staffing model and “get small”:** Prior to making food accessible on a self-serve basis, homes are strongly encouraged to implement a consistent staffing model. A consistent staffing model is one that ensures the same small group of team members provide support to the same small group of elders every day. Team members in this model get to know a great deal about the people they work with, which enables them to better anticipate care needs, identify possible risks and implement needed precautions.

**Evaluate each resident:** Each elder in the home should be evaluated specifically for any risks the self-serve access of food may present to the individual. Things to consider might include: foods that may put the elder at risk, the severity of that risk, the elder’s mobility and ability to reach and access the food independently, cognitive functioning and decision making ability of the elder, as well as the elder’s eating routines and habits.

**Develop and individualized care plan:** When an elder has special considerations in relation to self-serve food accessibility it should be addressed in that individual’s care plan. Spell out what steps the team will take to mitigate risk to the elder while working to honor the elder’s choice. See “Considerations for Risk” for further information.

**Conduct routine and continuous assessment:** Homes must continually assess the acuity of the elders living in the home to be sure that self-serve access is still advisable in the current circumstances.

**Make on-going adjustments to self-serve food access as needed based on the risks and needs of the elders currently living in the home:** If it is determined that a resident is at risk due to self-serve food access in the home it may be advisable to make adjustments to the types of food available on a self-serve basis, the way in which food is made available to elders, or to suspend the self-serve access entirely for a period of time until the risk passes.

# Considerations: Sleep

## Background:

- The sleep core is in domain #1- Resident Choice. The goal of this domain is “Residents *direct* their lives.”
- Promoting choice is the most basic and essential principle of person-centered care. Real choice is having the power to determine your options, whether good or bad. How many of us can honestly say that we have never made a decision that is bad for us? We must accept risk as a normal part of life while at the same time do what we can to mitigate risk.
- The bottom line, we must support residents in the decisions they make.

## The overall goal of this core: Residents’ individual sleep patterns are supported.

When working through this core keep in mind we want to find ways to support the life-long sleep patterns established by elders before moving into the nursing home and improve their quality of sleep.

### Supporting Practice #1— “Individual sleep routines” required outcomes

**Individual sleep preferences are gathered, communicated, and supported-** When possible, gather information about sleep routines *before* people move in. If it is not possible to do this before a person moves in, talk with them as soon as possible upon move in. It is important to get off to a good start and support the persons’ sleep routine from the beginning.

- Most homes meet this requirement by developing an interview tool that includes various questions about the residents’ sleep patterns. Think beyond what time a person likes to get up and go to bed. Consider their daily routine as well.
- *For example: Caregivers often describe this common morning practice: get someone up, take them to the bathroom, help them get dressed and take them to the dining room for breakfast. What if the resident prefers to have a quiet cup of coffee in their pajamas while sitting in their recliner watching the news for a few minutes before they go to breakfast?*
- When gathering sleep preferences, consider including information such as what time they prefer to get up in the morning, what their morning routine looks like, when they like to nap, where they like to nap, what time they like to go to bed, what their bedtime routine looks like, what they like to wear to bed, favorite blankets and pillows, things that help them sleep, and things that interfere with their sleep. The more you know about a person the easier it will be to support their personal sleep routine.
- Don’t forget to ask if a person wants a courtesy wake-up each morning or if they prefer to call for help when they wake up naturally. Even residents who are unable to call for help can be allowed to wake up naturally.
- *Consider this: One resident may prefer assistance setting their own alarm clock to wake them in the morning while another may prefer they are greeted in bed with a cup of coffee each morning. Still others may want to be left alone until they put their call light on in the morning and request assistance.*
- Once the sleep information is gathered, decide how it will be communicated to the care team. Implement a formal system so all caregivers know where to find this important information when someone new moves into the home.

# Considerations: Sleep

## Supporting Practice #1— “Individual sleep routines” required outcomes (continued)

**No group sleep or wake-up programs-** Everyone should direct their own individual routine.

- Caregivers working in traditional nursing homes often describe a “group” wake-up or sleep program. It looks something like this: The team starts their day at one end of the hall. They help an elder get up and ready for the day and then move next door to help the next elder. The team continues to work their way down the hall until everyone is up and ready for breakfast.
- *Consider this: If person centered-care were being provided the team would know the sleep and wake preferences of the elders they care about. People would be assisted at the time of their choice as they live their preferred daily routine. One elder may be up dressed and done with breakfast before a neighbor is even out of bed.*

**Individual sleep routines/schedules are in place-** Think about how your care systems support individualized sleep routines. For example: Does your practice of medication administration support the resident’s sleep routine? Medication schedules should be determined only after talking to the resident to find out when they usually take their medication and when they want to take it here.

- Mealtimes must also support the resident sleep routine. If a person usually gets up around 10am the team will need to implement systems that allow this person to eat a hot breakfast upon rising if preferred.
- Keep in mind that resident preferences can change from day to day. While we gather information about the usual sleep routine, we know our daily routines can vary depending on our plan for the day. If a resident has stayed up late at night, they may want to sleep later the next day. If they have special plans in the morning, they may need to get up earlier. Be sure practices in the home support these day to day changes.
- Residents should not be awakened by staff unnecessarily unless requested by the resident.

**Consistent staffing-** PLEASE NOTE: The RELATIONSHIP Core which addresses consistent staffing must be in place to successfully meet the criteria for the SLEEP CORE. (See criteria for the Relationship core and the Considerations: Relationships document).

# Considerations: Sleep

## Supporting Practice #2— “Undisturbed sleep practices” required outcomes

**Individualized night care-** Homes are encouraged to develop a specific nighttime plan of care for each individual rather than relying on a system of 2 hour “rounds” for each and every resident. Individualized night care plans should be based on a thorough assessment of each resident. Consideration should be given to: Voiding patterns, continence, bed mobility and skin integrity.

- The use of night time incontinence products designed to wick moisture away from skin could also be considered.

**Care provided around preferred sleep-** Research indicates that many residents living in nursing homes suffer sleep deprivation. Undisturbed sleep should be given high priority. Necessary care should be provided around sleep whenever possible. If care is needed during the night, caregivers should work with the elder to determine the frequency of the care and the preferred time for this care. These preferences should be outlined in individualized care plans that are readily available for reference by direct caregivers.

- Residents should NEVER be awoken for routine nursing assessments or treatments that could be provided at a time when the resident is awake.
- *Consider this: It is helpful to think ahead about accountability. Determine how leadership will follow up for accountability of night care support. For example: Is person-centered night care being appropriately implemented? Do night care staff need more education? Resources? Support? Also, determine if organizational policy and procedures need to be updated to support person-centered night care practices.*
- While navigating the area of sleep the considerations for addressing risk may be helpful, as well.

**Reduced noise and lighting conducive to sleep-** Look for ways to reduce noise at night. Consider re-assigning certain cleaning duties, stocking supplies in resident bedrooms and other noisy tasks to other times of day.

- Think of ways to reduce noise from alarms and call lights.
- Work to adjust lighting to be more conducive to sleep. Consider using bedside lamps and flashlights to provide care rather than bright overhead lights. Also dim all lights during night time hours.

**Resident bed choice-** Encourage residents to bring personal bedding and pillows from home when they move in. Nursing teams should also determine if care can be safely provided in the elder’s personal bed. Support residents in bringing personal beds from home if deemed safe and space allows. Think about how elders will be made aware of this option.



# Considerations: Bathing

## Background:

- The bathing core is in domain #1- Resident Choice. The goal of this domain is “Residents *direct* their lives.”
- Promoting choice is the most basic and essential principle of person-centered care. Real choice is having the power to determine your options, whether good or bad. How many of us can honestly say that we have never made a decision that is bad for us? We must accept risk as a normal part of life while at the same time do what we can to mitigate risk.
- The bottom line, we must support residents in the decisions they make.

## The overall goal of this core: Bathing practices support individual choice.

When working through this core keep in mind that you want to find ways to support life-long bathing patterns established by elders before moving into the nursing home. It also needs to be understood that the goal is to maintain good hygiene which can be done using a number of alternative bathing methods.

### Supporting Practice #1— “Bathing choice” required outcomes

**Information about bathing preferences is gathered-** When possible, gather information about a person’s bathing preferences and routines *before* they move in. If it is not possible to do this, talk with them soon after move-in. It is important to honor their preferences from the start.

- Most homes meet this requirement by developing an interview tool that includes various questions about the residents’ bathing routines and preferences.
- In gathering bathing preferences, consider including information such as what time they like to bathe, how often, how they bathe (see alternative bathing methods), where do they like to bathe, their routine for bathing, preferred shampoos, and soaps and other skin products. Do they like music while bathing? Do they have any preferences in who assists them?
- *For example: Someone who likes to bathe in the evening may prefer to do so right before they go to bed so they can get out of the bath, put on their pajamas and watch TV for a few minutes in their room before going to bed. Another person may like an “evening bath” but may prefer to take it after supper and then get dressed for a while before changing into night clothes. Someone may like to soak in the tub for a time, while someone else may prefer to get “in and out.”*
- Once the bathing information is gathered, decide how it will be communicated to the care team. Implement a formal system so all caregivers know where to find this important information when someone new moves into your home.

**Multiple bathing options exist-** While baths and showers are certainly the most common means of providing hygiene care, many other methods are considered effective alternatives. Caregivers should know how to assist with sink baths, bed baths, towels baths, segmented bathing, alternative haircare with dry shampoo products, and other alternative methods.

- We are aware of no regulation that requires nursing home residents to submerge in water on a regular basis. Therefore, people who fear water or just prefer not to take a bath or a shower should never be forced to do so. Hygiene needs should be met with effective alternative methods.

# Considerations: Bathing

## Supporting Practice #1— “Bathing choice” required outcomes (continued)

**Residents have input in who assists them with bathing-** Decisions about who will help with maintaining hygiene should be based on the elders’ relationship with caregivers and their preferences rather than staff convenience.

- *Consider this situation: Two nurse aides are reviewing the bath schedule and see that there is a resident who prefers to get her bath before lunch today. As the nurse aides talk, one says to the other, “You’ve already given 2 baths today so I will give this one.” While this conversation reflects a good effort to “evenly” distribute the workload it does not take into consideration the resident’s preference.*
- In person-centered care, resident choice is always given priority over staff convenience. Team members should talk with the elder at the time of the bath to see who they would like to assist them. Assignments are made based on the preference of each elder rather than which staff member has not yet given a bath today.
- The use of assigned bath aides is discouraged for the same reason. Team members working in homes using assigned bath aides often report an unspoken expectation among the team that if the bath aid is doing a good job they will complete all of the baths on the shift they work. Therefore, there is also some “unspoken” expectation that the elders take their bath when the bath aide is in house. Though these homes report others team members *can* give a bath if the elder requests, they also report that it rarely happens. The likely result is the bath aides work schedule dictates when baths get done.

**Residents have choice in when and where they bathe-** Not only should elders have a choice in *when* they bathe, but *where* they bathe as well. Remember, no one should be forced into the tub or shower if alternative bathing methods are available and being used effectively.

**Practices accommodate daily preferences-** While most of us probably have a fairly consistent bathing routine (some of us prefer bathing in the morning and others at night) occasionally we may vary our routine depending on what is going that day. Elders should be given this same opportunity to change their routine from day to day as they prefer. It is important that the team understands the expectation to adapt the bathing schedule as requested by elders on a daily basis.

## Supporting Practice #2— “Bathing alternatives” required outcomes

**Staff are trained on bathing alternatives-** As mentioned earlier, there are many alternative methods to bathing in a tub or shower to maintain hygiene. Staff in your home should know how to assist elders with alternative bathing methods. Homes may select or develop their own training material, however the material the home uses for this training should include instruction on how to use a variety of alternative bathing methods. ([Bathing Without a Battle](#) is considered by many in the field to be among the best available).

- To meet this requirement make sure all new direct caregivers receive training on these alternative methods upon hire and are then trained periodically on an on-going basis. 90% of all staff certified to give baths (CNA's, CMA's and Nurses) who are scheduled weekly should be trained. Seasonal and PRN staff are excluded.

**Residents are supported in bathing alternatives-** These alternatives are available in the home and they are offered to elders and those who prefer bathing alternatives to baths and showers are supported by the team.

# Considerations: Daily Routines

## Background:

- The Daily Routines core is in domain #1- Resident Choice. The goal of this domain is “Residents *direct* their lives.”
- Promoting choice is the most basic and essential principle of person-centered care. Real choice is having the power to determine your options, whether good or bad. How many of us can honestly say that we have never made a decision that is bad for us? We must accept risk as a normal part of life while at the same time do what we can to mitigate risk.
- For example: Your home prides itself on the many different services it provides and you are always excited to share them with new residents. You notice a new resident who is very well-kept with red hair, red manicured nails and sharp clothes. You are excited to introduce her to the on-site stylist, however you quickly learn that the resident has her own stylist that she has gone to for many years. Supporting resident in directing their lives means thinking outside of the box and avoiding assumptions.
- The bottom line, we must support residents in the decisions they make.

## The overall goal of this core: Residents decide how they spend their day.

When working through this core think in terms of how to support the life-long daily routines established by elders before moving into the nursing home. While there will be new opportunities available to elders in the home, elders should decide how they will spend their time each day and how the care provided by you fits into their preferred daily routines.

## Supporting Practice #1— “Move-in assessments” required outcomes

**Gather information about routines and preferences PRIOR to move in-** When possible, gather information about personal routines and preferences *before* people move in. If it is not possible to do this before a person moves in, talk with them as soon as possible upon move in.

- Many homes already work to gather *clinical* information during a “screening process” before a person moves in. Homes are now gathering personal routine and preference information at this time as well.
- To meet this requirement add questions about daily routines and preferences to the interview tool you are using to screen people before they move in.

**Caregivers have access to information-** Decide how the information will be communicated to the care team once it is gathered. Implement a formal system so all caregivers know where to find this important information when someone new moves into your home.

**Caregivers support daily routine from day one-** It is important to get off to a good start and support the person’s daily routine from the beginning. With the right information caregivers can support the elder’s routine from their first day in the home.

# Considerations: Daily Routines

## Supporting Practice #2— “Person-centered care plan development” required outcomes

**90% of care plans are attended by residents (family)-** Residents (or their representatives) must be actively involved in the care plan process. Think about what you can do to increase their attendance of care plan meetings.

- How do you currently handle care plan invites? Are residents encouraged to attend? Are they told how important their attendance is or is it simply mentioned in passing? Are family members given adequate notice or offered to participate via phone or internet? Is flexibility in scheduling being offered?
- Consider the difference in the following two resident invites: “Your care plan meeting is at 2pm on Thursday. Would you like to come to the meeting or do you want to go to the ice cream social?” OR “We would like to visit with you soon about your health and your care here. We need your help to review your care plan. Is there a time you could join us for a few minutes in the next week?”
- To figure the percentage of care plans attended by a resident or their representative: Divide the number of care plans meetings that were attended by either the elder or a representative in a certain period of time by the total number of care plan meetings that were held in that same period of time. For example: Of 10 care plans held in the month of May, 9 were attended by the resident OR their representative.  $9 \div 10 = 90\%^*$

**Residents (family) participate in the creation of the care plan-** It is impossible to create a true person-centered care plan without the active involvement of the person. We typically think of a care plan meeting as being a formal meeting in the conference room, but it does not matter where this involvement takes place as long as the elder (or representative) is actively involved in the development of the care plan. Team members can talk with the elder in his room or a family member can talk with the team over the phone. However this interaction happens it is important that the team hear about the elder’s goals for life and care. A person-centered care plan can only be developed at the direction of the elder.

**90% of care plan meetings are attended by direct caregivers-** A nurse aide actually involved in providing direct care to the elder on a regular basis should participate in the care plan process. You will likely need to look at ways to support schedule coverage to allow direct caregivers time to attend these meetings.

- To figure the percentage of care plans attended by a direct caregiver: Divide the number of care plans meetings that were attended by a direct caregiver in a certain period of time by the total number of care plan meetings that were held in that same period of time. For example: Of 15 care plans held in the month of June, 14 were attended by a direct caregiver.  $14 \div 15 = 93.3\%^*$

**Direct caregivers participate in the creation of the care plan-** Think of your nurse aides as a valuable resource in the care planning process. Who knows your elders better?

\*To calculate Care plan attendance, look at attendance records for the past 3 months and report on your best month.

**Review our [April 2016 newsletter](#) and the [Rothchild Foundation Care planning guide](#) for more information on care planning and care plan meetings.**

# Considerations: Daily Routines

## Supporting Practice #3— “Care Plan Delivery” required outcomes

**All caregivers have direct access to care plan information-** The people who provide direct care to elders need access to the care plan. Be sure all caregivers know how to find the information they need to do their jobs. Many homes have met this requirement through care plan “books” or folders, “pocket” care plans, or via electronic kiosks.

**Direct caregivers make revisions to care plans as directed by residents-** Develop a system for all caregivers to make changes to the care plan as directed by the resident. When a resident voices a change in their routine or preferences, direct caregivers should be empowered to reflect these changes in the plan of care. Educate direct caregivers about the type of changes they can make on the care plan, how to make these changes, and how to communicate these changes to other team members.

- While these changes can be made on the original care plan itself, many homes have met this required outcome by implementing a formal written process to record this information on a log, care sheet or various types of communication forms. These are reviewed daily by the team in brief huddles and changes are then made to the original care plan.
- Please note: Simply reporting these changes to a nurse on duty will NOT meet the required outcome of direct caregivers making revisions to care plans.

**Daily routines are lived as outlined in the plan of care-** Each person should live a daily routine of their choosing that reflects their own preferences and goals for life. The care that is necessary to support the resident’s goals should be spelled out in the care plan to support their preferred routine.

- *Consider this: By reviewing a care plan in your home could you tell which elder the care plan belonged to without their name appearing on it?*
- It is important that elders actual *live* the life and daily routines they have described to you.

# Considerations: Relationships

## Background:

- The Relationship core is in domain #2- Staff Empowerment. The goal of this domain is “direct care staff must be empowered to support residents in the decisions they make.”
- The goal is to keep decisions as close to the elders as possible because direct caregivers know the elders on a more personal level. They are together day and night. Empowered direct caregivers have the latitude and authority to support resident decisions on the spot without being required to run basic decisions through organization leaders.
- Direct care staff understand they are expected to support resident decisions and they know they will be supported by leaders in the organizations when they do so. They have access to information necessary to support resident decisions and have the necessary training and flexibility to respond to resident needs.
- Direct care staff are valued and involved in decisions affecting their work.

## **The overall goal of this core: Residents enjoy meaningful relationships with a small group of consistently assigned caregivers.**

When working through this core, keep in mind that the idea behind this core is to better support resident choice. Be consistently assigning caregivers to the same small group of elders every day, an environment is created that fosters meaningful relationships between the caregivers and the elders. As they get to know one another, caregivers learn what is important to each elder and are then in a better position to support the preferences and daily routines of the elders they know and love.

# Considerations: Relationships

## Supporting Practice #1— “Get small” required outcomes

**Defined physical locations-** To reduce the number of elders each caregiver works with start by dividing the home into smaller work areas. Some homes call these work areas pods, units, halls, households, neighborhoods, or families. While this “division” does not require the construction of walls or other physical barriers to define the area, it should be clearly defined on paper so all team members understand where the small work areas are and who lives in them.

- Chances are the caregivers in your home have already “informally” identified some work areas or natural divisions of the workload. *For example: Nurse Aides can often be heard having conversations like this: “Today I’ll take the North side of the hall. Tomorrow you can take it.” Or “I have the residents in the front hall, you take the residents in the back hall”.*
- Homes will likely find it helpful to involve direct caregivers when making these decisions because they have firsthand information about the daily work flow in the home. Strive to identify and formalize these smaller work areas. Once identified these work areas do not change from day to day.

**No more than 30 residents live in each work area-** Note: **If 30 or less elders** live in your home there is no need to divide your home into smaller work areas to meet the program criteria. You currently meet this required outcome. **If more than 30 elders live in your home,** the team needs to work together to identify smaller work areas.

- “Getting Small” will take variables into consideration such as the number of elders in your home and the staffing levels you have available and the physical layout of your home. Think about the proximity of the elder bedrooms to one another and to living spaces in each work area as well as access to supplies and work spaces. “Getting Small” will look different in every home.
- *Consider this: One home with 60 residents may decide to divide into 2 work areas of 30 residents while another decides to split into 3 work areas of 20 elders. Depending on the layout of the building another may decide it makes more sense in their building to have one work area of 15 elders, another of 22 elders and a third of 23 elders. Depending on the physical layout of the home, available nursing coverage etc. homes must decide what will work best for them.*
- While these work areas are then formalized and do not change, it is understood that homes do not always have the same staffing levels during nighttime hours. Teams should keep assignments as consistent as possible during night time hours but evaluation of nighttime hours is less stringent.

**Necessary supplies and equipment are available in each work area-** Once clear work areas have been identified, the team should work together to assure caregivers have what they need in each work area to do their job. Some relocation of supplies and equipment may be necessary if one work area is too far away from supplies.

# Considerations: Relationships

## Supporting Practice #2— “Consistent staffing” - The following two outcomes MUST be met

**A staff schedule is developed for each work area (required)**- Once work areas have been defined a work schedule should be developed for *each* work area. Homes are encouraged to create new schedule templates for each work area rather than trying to make current schedule templates fit your new situation.

- *Consider this: Once work areas are defined it will be necessary to look at each area and decide what staffing levels and schedule rotations will be necessary to meet the needs of the elders living in that work area. These staffing levels and rotations often begin to look much different than before the home was divided into small areas. Sometimes trying to “adapt” a traditional work schedule is more difficult than creating a new template that fits the new situation. Try to look at each small work area through a different lens. What will it take to meet the needs of the people living in this area? Look closely at your total staffing budget and determine where the staffing dollars and hours best fit. The schedule templates in each work area may also look different based on the elders who live in each area and their personal routines.*
- When creating new schedule templates it is also important to think beyond CNAs. Social service designees, activity staff, housekeeper and food service roles to name a few, can all be blended and distributed among the work areas as consistent staff.

**Staff are assigned to a team in a defined work area (required)**- Team members should be assigned to the same work area each day they come to work. A few exceptions will apply, but overall team members will work with the same elder's every day they work.

- Depending on the situation exceptions could include: A nurse who covers more than one work area or a person who holds two part-time positions in two different work areas.

## Supporting Practice #2— “Consistent staffing” - In addition to the two required outcomes previously listed, homes must also meet at least 2 of the following 4 outcomes

**No “scheduled” rotation**- This means team members are not scheduled to rotate from one work area to another. They work in the same work area each time they come to work.

- Homes have occasionally presented staffing plans that involve team members working in one area for a couple weeks then moving to another area to “prevent burnout”. This plan does not meet the required criteria for consistent staffing.
- Occasionally it will be necessary for a person to help in another work area due to illness or times of great staff turnover. This should be the exception rather than the rule. Consideration should be given to the process used to cover unplanned open shifts on the schedule.
- Many homes have created good consistent staffing plans but are unable to realize true consistent staffing because of the process they use to cover unplanned open shifts. Think about the steps you take when someone calls in. Put priority on covering these open shifts with team members from the same work area before looking to another work area. This is evaluated by calculating the total number of staff on the schedule (excluding overnight and PRN) and then determining how many of them work in more than one work area. The home must have 75% of their staff work in the same work area and only 25% working in more than one area to meet the criteria.
- *Consider these things: Are team members in one work area expected to trade days and cover for one another? Could someone from a different shift in the same work area cover before asking for help outside of the work area? Does the work area have any PRN team members available?*



# Considerations: Relationships

**Supporting Practice #2 (cont...)— “Consistent staffing” - In addition to the two required outcomes previously listed, homes must also meet at least 2 of the following 4 outcomes**

**No “scheduled” agency staff-** The use of agency staff undermines consistent staffing models and should be avoided. If a home uses any agency staffing they will not be able to count this as one of the two required outcomes to be met in this area.

**PRN staff are assigned to specific work areas-** Consistently assigned PRN staff will help support your consistent staffing model. It is recommended that each work area develop their own PRN team to help when needed.

**Versatile workers-** Versatile workers are team members who are expected to perform duties outside their “traditional” role on a regular basis. Some refer to this as “blended roles.”

- In traditional models of care it is common for nurses to provide nursing care, dining teams to handle the food requests, housekeepers to do the cleaning, and activity staff to facilitate most of the activities.
- When versatile workers are used, everyone is responsible for supporting elders in their daily routine **to the extent allowed by their license or certification**. Homes that are actively using versatile workers provide additional training and make information available to team members that allows them to safely help with tasks outside of the traditional roles described above.
- *For example: A home may train all team members in the area of safe food handling so they can help prepare and serve meals or snacks as requested by elders. They would put systems in place to assure necessary nutritional information about each elder is easily accessible to team members outside of the kitchen staff. Homes might provide training to all team members on cleaning techniques so all team members can help maintain the living areas of elders without waiting on a housekeeper. All team members might be considered responsible to support elders in the things that bring them pleasure such as spontaneous and planned activities.*
- The Versatile worker concept goes beyond a person who can work in more than one position. *For example, a CNA who may fill in for a housekeeper occasionally or the dining aide who becomes a CNA and covers CNA shifts from time to time.*
- With versatile workers the positions *themselves* are blended and any person working is expected to serve in multiple functions on any given day. Versatile workers are expected to support elders in any way they can, working outside their traditional work “silos” regularly to meet the needs of the elders. *In a home using versatile workers, a caregiver could be expected to assist an elder with personal care, fix a snack or serve their meal, clean their bedroom and enjoy a game of Scrabble in the same day.*

# Considerations: Decision Making - Resident Care

## Background:

- The Decision Making-Resident Care core is in domain #2- Staff Empowerment. The goal of this domain is “direct care staff must be empowered to support residents in the decisions they make.”
- The goal is to keep decisions as close to the elders as possible because direct caregivers know the elders on a more personal level. They are together day and night. Empowered direct caregivers have the latitude and authority to support resident decisions on the spot without being required to run basic decisions through organization leaders.
- Direct care staff understand they are expected to support resident decisions and they know they will be supported by leaders in the organizations when they do so. They have access to information necessary to support resident decisions and have the necessary training and flexibility to respond to resident needs.
- Direct care staff are valued and involved in decisions affecting their work.

## The overall goal of this core: the home supports resident decisions through a team approach.

When working through this core keep in mind that the idea behind this core is elders are ultimately in charge of their own lives. ALL caregivers should be empowered to support elders in the decisions they make on the spot without seeking approval from team members serving on a higher level of the staff hierarchy. This will require additional training. Caregivers should also have direct access to the resources that are necessary to support elders in the decision they make.

## Supporting Practice #1— “Shared understanding” required outcomes

**Formal training on how to respond when residents make a risky decision-** We all make decisions from time to time that are not in our best interest. As adults we have the right to make both good and bad decisions for ourselves. Elders do not lose this right when they move into a nursing home. Risk is a normal part of life.

- As providers of person-centered care, you support the idea that elders are in charge of their lives and that they are able to make their own decisions. We believe it is the job of direct caregivers to support elders in the decisions they make. At the same time, caregivers have an obligation to keep elders safe and to provide what is best for them. These conflicting roles can put direct caregivers in a very difficult position.
- So what do you do when a resident makes a decision we believe is not in their best interest? All too often direct caregivers immediately defer to the nurse on duty. This can inadvertently give the elder the idea that the nurse must “approve” their decision, which can lead to an unspoken understanding that the nurse is ultimately in charge of them.
- All team members should understand their role in supporting elders’ decisions while at the same time mitigating risk as much as possible. Homes are required to conduct formal training on how to support residents when they make risky decisions. It is important to give team members a “framework” to make decisions in. Nurses and direct caregivers alike should understand the principles of person-centered care, how they relate to risk, and what is expected of them when elders make a risky decision.
- Trainings should be completed with each team member as they are hired and again periodically. Please review the “[Considerations: RISK](#)” document. This is evaluated by looking at the % of staff that have been trained in the last year on the topic of risk. 90% of ALL Full-time and Part-time staff, who are on the schedule every week, should be trained. Seasonal and PRN staff are excluded.

# Considerations: Decision Making - Resident Care

## Supporting Practice #2— “Access to information and resources” required outcomes

### **All team members have access to information about the special health needs of each resident-**

It is important that all team members have access to the information they need to do their jobs. Some homes gather excellent information from elders about their preferences and routines but then place the information in medical records or other areas of restricted access to direct caregivers. Be sure that once information is gathered everyone knows where to find it.

**All team members have access to contact information-** Direct caregivers should be empowered to contact family members at the request of elders. Be sure direct caregivers know what they can discuss with family members and how to access their contact information.

**All team members have access to transportation-** Be sure direct caregivers have the resources they need to follow up with resident requests that may involve transportation. The key here is to be sure that if direct caregivers themselves are unable to drive facility vehicles there is a driver available to them on short notice. Team members should be able to support spontaneous resident requests in real time rather than waiting until the next morning or after the weekend when members of the administrative team are available to provide transportation.

- Keep in mind we are not asking homes to drop everything immediately at every request. The expectation is that there are resources available such as transportation and funds for self-led teams to work together to coordinate solid resident care while accommodating individual requests as they are able.
- *For example: An elder has expressed a craving for an ice cream. The self-led team talks about how the day is going and comes up with a plan for a CNA to take the elder to the Dairy Queen after lunch. The nurse agrees she will have her charting caught up by then and will be available to assist with any direct care that may be needed while she is out.*

**All team members have access to resident funds-** Put systems in place that assure direct caregivers can assist elders in accessing personal funds without calling a superior. Again, team members should be able to support spontaneous resident requests.

- Homes have implemented various systems to meet this outcome. Among the most common is cash boxes that a nurse can access at resident request.

# Considerations: RISK

## Things to consider when developing your training on how to respond when residents make a risky decision

We do not have a formal training developed for you. Each home must look at their own practices and expectations re: Risk and build a training around that. The training should be specific to your home.

There are some things we encourage you to consider when developing your training:

Before developing the training it will be helpful for the team to get together and try to **clarify your position on risk**. What do you expect of your staff? How do you want the team to respond when a resident makes a risky decision? What kinds of situations do you want the nurse to be directly involved with? What kind of situations do you just want the team to tell the nurse about later?

For example: I might be comfortable with a direct caregiver giving an elder with Diabetes a piece of pie and then informing the nurse that she has done so, so blood sugar can be monitored.

I might be comfortable with a direct caregiver supporting a resident in the request to skip breakfast because they are not hungry. I would want that communicated to the team so everyone would know to offer the resident something to eat again in a little while.

However, I might not be comfortable with a direct caregiver giving a requested steak to a person with a diet order for Pureed foods due to a high risk of choking. In that case I may want the nurse involved before the steak is served.

As a team, talk through possible situations and think about how you want your team members to respond.

**Teach your team how to respond to an elder making a risky decision.** Be sure your team understands that all residents have the right to make their own decisions and the right to make what may seem like risky decisions. Your goal is to accommodate resident decisions while mitigating risk. We can no longer simply tell a resident that they cannot do something.

Encourage your team not to respond with “I need to ask the nurse” as this indicates to the resident that the nurse has the final say instead of the resident. If nurse support is needed it may be better to respond, “OK, let me see what I can do about this”.

As a team you will **consider the severity of risk** to self and others as you decide what your expectations are. Will the choice place the elder or others in immediate jeopardy or a life-threatening situation? How will you train your team to think through this?

All team members should be expected to **determine exactly why a person is choosing not to follow a physician order while they are directing their own life**. Train caregivers to ask questions of elders and try to work through the elders concerns. Caregivers should understand that they are expected to talk with elders about these things.

**Talk about available alternatives and staff approaches to mitigate risk.** Talk about alternatives your direct care staff can offer and different staff approaches that a nurse might use. Can you train your direct caregivers to offer these alternatives rather than immediately saying “I’ll go ask your nurse”?

**We are required to educate elders about the consequences of their decisions.** All team members should understand that while they are expected to support resident decisions, they are also responsible to educate residents of any potential consequences or health risks that might result from their decision. Keep in mind that if a person makes *the same* risky decision over and over, we are not required to provide them “a lecture” each time they make the same decision. For example: If a person with Diabetes has decided that they are going to have a serving of regular dessert each day at lunch, this can be addressed in the Care plan. Educate the elder about the potential health risks of their decision and offer healthy alternatives. If they continue to state that they plan to eat a dessert each day at lunch the team should document this and address it on the care plan. They do not need to re-educate the elder every day at lunch. However, is recommended that on-going assessment should be done to determine the resident’s wishes have not changed. The subject should be revisited again at each Care plan meeting and if the elders condition changes.

**Consider where/how you want these things documented.** Team members should understand that all efforts made by the team to mitigate risk need to be documented. Take credit for what you have done to try to keep the elder safe. Discussions you have had about why the resident is making the decision, alternatives you have offered, and education you have provided to the elder about the risks of their decision should all be documented. Team members need to understand the documentation process in your home and what is expected of them.

**Person-centered care plans should address risk.** If a resident consistently makes decisions that are not in line with physician orders this should be addressed on the care plan. Involving direct caregivers in the care plan process can go a long way in empowering them to support resident decisions and to know how to respond when a resident makes a risky decision.

**Encourage team members to make decisions on an individual basis.** Avoid “blanket policies”. For example: It may not be safe for a person with Dementia to sit outside alone and watch the cars go by, so a “blanket policy” would say that no one will be allowed to do so.

# Considerations: Decision Making - Staff Work

## Background:

- The Decision Making - Staff Work core is in domain #2- Staff Empowerment. The goal of this domain is “direct care staff must be empowered to support residents in the decisions they make.”
- The goal is to keep decisions as close to the elders as possible because direct caregivers know the elders on a more personal level. They are together day and night. Empowered direct caregivers have the latitude and authority to support resident decisions on the spot without being required to run basic decisions through organization leaders.
- Direct care staff understand they are expected to support resident decisions and they know they will be supported by leaders in the organizations when they do so. They have access to information necessary to support resident decisions and have the necessary training and flexibility to respond to resident needs.
- Direct care staff are valued and involved in decisions affecting their work.

## **The overall goal of this core: The traditional “top-down” hierarchy is replaced with self-led teams making decisions that affect their work.**

When working through this core keep in mind that in person-centered care, daily decisions are made by the elders and supported by those closest to them. Those closest to the elders are the small group of consistently assigned caregivers working directly with them every day. This group of caregivers must be **directly** involved in decisions that will affect their work to empower them with latitude and authority they will need to truly support elder decisions.

### **Supporting Practice #1— “Staff scheduling” required outcomes**

#### **Direct care staff are self-scheduling**

OR

#### **The scheduling process includes the following:**

**-Direct care staff input is gathered for staffing plans**

**-Direct care staff arrange own coverage**

**-Direct care staff coordinate and negotiate time off with one another**

- In an ideal situation, the direct caregivers working in each small work area are empowered to develop and manage their own work schedule. Caregivers working consistent assignments often report they get to know the elders they care for on a more personal level. Relationships are often strengthened between these caregivers and the elders. As this happens, team members often feel an increased sense of ownership and responsibility for the elders they work with. Direct caregivers are in a much better position to develop staffing plans that will meet the needs of the elders. This increased ownership can lead to better staffing coverage with reduced call-ins and increased staff retention.
- If the work team has not evolved to the point they are self-scheduling, at a minimum they must be actively involved in the process to meet program criteria for this core. The direct caregivers must be involved in the process of determining the staffing patterns that are needed to meet the needs of the elders in each area. They must assume responsibility for arranging their own coverage with co-workers when unable to work as scheduled and coordinate and negotiate time off with each other. In homes that meet this requirement it is usually an expectation that caregivers find their own replacement when they are unable to work.

# Considerations: Decision Making - Staff Work

## Supporting Practice #2— “Hiring and orientation practices” required outcomes

### Direct care staff receive training on the homes’ hiring practices

- Direct care staff must receive training to be involved in the hiring process. If employees are going to be involved in the interview process, teach them about the types of questions they can and cannot ask an applicant as well as what your team is looking for in a good candidate.

### Direct care staff are involved in the hiring process

- You may wonder why it is important to involve direct care staff in the hiring process. *Consider this: Traditionally, the nursing home industry has been challenged by an extremely poor rate of staff retention. Homes must get creative in their efforts to minimize turnover by creating a supportive work environment. Including direct care staff in the hiring process gives them a vested interest in the success of the new hire. If they have chosen a person to be their co-worker they may be more likely to help them succeed.*
- This can happen in a number of ways. Some homes involve direct care staff in the interview itself, using a group interview process. Other homes have direct caregivers meet with each potential candidate after the formal interview to visit individually with them. However you involve direct care staff it is important that they have an opportunity to weigh in on the final decision of who is hired.
- Potential applicants can be screened by managers to assure they meet all of the required qualifications for the position. Then qualified candidates can be turned over to the team to make final selections.

### Direct care staff are involved in orientation of new staff

- Whenever possible direct caregivers should be involved in the orientation process of new team members.
- Traditionally, caregivers are trained by an appointed trainer and then turned over to the “floor” to begin work. It is more effective to involve the team the new hire will actually be working with from the beginning. This group can better teach the “real” job as well as how the team handles the work flow together. The team can begin to build important relationships with one another from the start.

# Considerations: Decision Making - Staff Work

## Supporting Practice #3— “Leadership” required outcomes

### The home has a central leadership team that includes direct care staff representation

- Think about where decisions are made in your home. Traditionally, the central leadership team consists of some combination of the department heads in your home. Thinking back to the idea of keeping decisions as close to elders as possible. What changes can you make in your “top-down hierarchy” to achieve this goal? Since direct caregivers have more daily contact with the elders in your home invite representatives from that team to join your central decision making team. Your leadership team will benefit from the insight and ideas of those who work more closely with the elders.

### Each work area has a decision-making team that includes direct staff representation.

- As your home works through the process of “getting small” as outlined in the Relationship core, the elders living in each work area are ultimately responsible for the day to day decisions in that area. Direct caregivers are responsible for supporting these resident decisions and must be empowered to do so. Form a leadership team in each work area to address day to day decisions that affect the area and provide support to the elders living there. Be sure direct caregivers are represented on this team.

### Direct care staff serve on workgroups addressing issues throughout the home.

- There are numerous opportunities in your home to involve direct care staff in work groups. Teams such as QAPI, Clinical Review, Safety and Fall committees all offer opportunities for your home to benefit from the knowledge of those working closest with the elders.
- You will find many additional opportunities to use work groups as you begin working through the PEAK criteria. As these teams are formed be sure to involve direct caregivers in the process. All team members should have opportunities to voice their opinions and make decisions about their work.



# Considerations: Career Development

## Background:

- The Career Development core is in domain #2- Staff Empowerment. The goal of this domain is “direct care staff must be empowered to support residents in the decisions they make.”
- The goal is to keep decisions as close to the elders as possible because direct caregivers know the elders on a more personal level. They are together day and night. Empowered direct caregivers have the latitude and authority to support resident decisions on the spot without being required to run basic decisions through organization leaders.
- Direct care staff understand they are expected to support resident decisions and they know they will be supported by leaders in the organizations when they do so. They have access to information necessary to support resident decisions and have the necessary training and flexibility to respond to resident needs.
- Direct care staff are valued and involved in decisions affecting their work.

## **The overall goal of this core: Systems are in place to promote professional development.**

When working through this core keep in mind the focus is on enhancing professional development while retaining quality caregivers. Caregiving is a very tough job and we know good direct caregivers possess a very special skill set. This skill set should be recognized as valuable to the organization and rewarded with opportunities to enhance these skills.

## **Supporting Practice #1— “Professional development” required outcomes**

The Career Development core must consist of Versatile Worker training opportunities and EITHER a Formal Career Ladder OR Skills Enhancement Program. We do not have formal training guidelines developed for you. Each home must look at their own practices and expectations involving Career Development and build trainings around those. The trainings should be specific to your home. The following are guidelines we encourage your team to follow when developing your Career Development core.

# Considerations: Career Development

**Versatile worker training opportunities-** To meet the criteria in this area it is first important to have a clear understanding of versatile workers.

- Versatile workers are team members who are expected to perform duties outside their “traditional” role on a regular basis. Some refer to this as having “blended roles.”
- In traditional models of care it is common for nurses to provide nursing care, dining teams to handle the food requests, housekeepers to do the cleaning, and activity staff to facilitate most of the activities in the home. When versatile workers are used, everyone is responsible to support elders in their daily routine **to the extent allowed by their license or certification**. Homes that are actively using versatile workers provide additional training and make information available to team members that allow them to safely help with tasks outside of the traditional roles described above.
- *For example: A home may train all team members in the area of safe food handling so they can help prepare and serve meals or snacks as requested by elders. They would put systems in place to assure necessary nutritional information about each elder is easily accessible to team members outside of the kitchen staff. Homes might provide training to all team members on cleaning techniques so all team members can help maintain the living area of elders without waiting on a housekeeper. All team members might be considered responsible to support elders in the things that bring them pleasure such as spontaneous and planned activities.*
- The versatile worker concept goes beyond a person who can work in more than one position.
- *For example: A CNA who may fill in for a housekeeper occasionally or the dining aide who becomes a CNA and covers CNA shifts from time to time.*
- With versatile workers the positions themselves are blended and any person working is expected to serve in multiple functions on any given day. Versatile workers are expected to support elders in any way they can, working outside their traditional work roles regularly to meet the needs of elders. In a home using versatile workers, a caregiver could be expected to assist an elder with personal care, fix a snack, serve their meal, clean their bedroom, and enjoy a game of Scrabble in the same day.
- All new hires are provided formal orientation and training to prepare them to safely respond to elder requests within their capacity and certification.
- *Examples of orientation and training could include: Safe food handling, preparation and service, special dietary needs, housekeeping and laundry functions and assisting with daily activity programs to name a few.*

# Considerations: Career Development

## Formal career ladder OR skills enhancement program is in place

**Formal career ladder-** To meet the PEAK program definition of a formal career ladder the program must address the following:

- The home must develop curriculum or identify approved outside educational opportunities for each level of the career ladder.
- The career ladder must provide opportunities for **lateral** advancement in the organization and must be available for all non-licensed staff.
- *The traditional career ladder in nursing homes often looks like this: the CNA becomes an LPN, then an RN, then possibly an MDS nurse or Assistant Director of Nurses and then the Director of Nursing. In this example, direct caregivers who want to advance their career must leave the position of direct caregiver to do so. This ladder places little value on the position of Direct Caregiver itself. A career ladder with opportunities for **lateral** advancement provides the chance for direct caregivers to learn new skills and advance their careers while continuing to serve as valued direct caregivers.*
- Employees must receive incremental pay increases **or** title or position recognition for completing various levels of the career ladder as well as a certificate of completion.

## OR

**Skills enhancement program-** To meet the PEAK program definition of a skills enhancement program the program must include the following:

- Educational opportunities to enhance skills for all non-licensed staff.
- Strong coaching, mentoring and goal setting opportunities for all non-licensed staff.
- Regularly scheduled meetings between non-licensed staff and leaders to establish individual development plans.
- Development plans that are created through a collaborative effort with each employee and reflect their personal career goals.
- Active leadership involvement in the search for training opportunities to achieve staff goals.

## **Policy is in place-**

- The formal career ladder or skill enhancement program must be outlined formally in writing. This can be done in a policy, employee handbook or other written document and must be available and communicated to all team members.
- Give some thought as to how you will assure all team members learn of the opportunities available to them upon hire.

# Considerations: Career Development

## Supporting Practice #2— “Outside education” required outcomes

**At least 10% of non-managerial staff attend outside training of any kind-** Start by identifying your non-managerial staff.

- *To further clarify: Management is considered the traditional department heads, such as the Administrator, Director of Nursing, Director of Social Service, Activity Director, Director of Maintenance, Director of Food Service, etc. Non-managerial staff would be everyone else employed by the home. A charge nurse is considered non-managerial staff, but the Director of Nursing is considered a manager.*
- 10% of these non-managerial staff must attend some sort of outside training.
- *To calculate this: A home employees 55 total team members. 5 of these 55 total team members are department heads or managers. That means the home employees 50 non-managerial team members. 10% of 50= 5. Therefore, 5 different non-managerial team members must receive some sort of outside training during your PEAK year.*
- This can include conferences, classes, or training of any kind. You may also include trainings that are provided inside your home IF the trainer is not an employee of your organization.
- *For example, you could count in- house trainings provided by a local Hospice or other outside agency as long as the trainer does not work for your company.*
- Homes will be required to provide supporting documentation of attendance. It is recommended that homes track this attendance by maintaining records with sign-in sheets or certificates of course completion.

# Considerations: Resident Bedrooms

## Background:

- The Resident Bedroom core is in domain #3- Home Environment. The goal of this domain is, “bedrooms in the home provide opportunities for privacy, personalization, and comfort.”
- The environment is recognized as the residents’ home and resident comfort is honored over staff convenience. This domain speaks to creating a home rather than a work place.
- While the home should be homey and comfortable the program focus goes beyond the building and furnishings and looks at the practices of the team around boundaries in the elders bedrooms.
- When creating resident environments areas of focus should include:
  - True privacy and control
  - Supporting choices for solitude
  - Personalization of living space
  - Accommodating and promoting self-care and independence

## The overall goal of this core: Bedrooms in the home provide opportunities for privacy, personalization, and comfort.

When working through this core think about what “home” means to you. What are the things that make your home important to you? What would you miss most if you were to move into the nursing home?

### Supporting Practice #1— “Privacy” required outcomes

**Bedrooms are arranged to promote privacy-** While there is often little that can be done in a small semi-private room, sometimes rearranging furniture can help promote privacy.

- *For example: Something as simple as moving a bed from one location to another can make it less visible from the hallway.*

**Boundaries are respected-** Think beyond knocking on doors and privacy curtains to promote privacy. Think about the boundaries you enjoy in your own home.

- *Consider this: Do people come into your home when you are out? Would a repair man come into your home to make repairs if you weren’t there? Would a laundry service deliver clothes to your closet when you are not home?*
- How can you change your practices around boundaries to better support the privacy of elders?

**Regular trainings on privacy expectations-** Once the team has identified practices that will support resident privacy it is important that all team members understand what is expected of them. This will involve training all new team members as they are hired and a team review at least annually.

# Considerations: Resident Bedrooms

## Supporting Practice #2— “Personalization” required outcomes

Homes are only required to meet **TWO OF THE FOUR FOLLOWING OUTCOMES**. Homes are **NOT** required to meet all 4 of the required outcomes.

**(1) Décor in resident bedrooms reflect the preferences of the elder living there-** Bedrooms should be personalized with décor and belongings of the elder(s) occupying them. Homes should do what they can to assist elders as needed to make this happen.

**(2) Residents choose paint color in bedrooms-** To meet this required outcome elders must be able to select a paint color of their choice for their bedroom. This choice cannot be limited to a color palette pre-selected by the home.

- *Consideration must be given to how this can be done in the semi-private room situation. Homes have taken a variety of approaches to address this. Some homes work to find roommates who can agree on a color. Other homes paint an accent wall on each side of the room. Whatever approach you take in the semi-private room it will certainly involve facilitation on the part of the staff in negotiating between roommates.*
- It is important for homes to clearly communicate their practices around paint color with elders. Elders should be aware of their options.
- Homes may charge a fee for painting bedrooms to accommodate a personal color preference.

**(3) Bed and furniture choices are supported-** When addressing resident bedrooms, teams should support residents who wish to bring personal beds and other furniture from home. Elders should also be aware that this is an option for them.

- Elders should be supported in bringing personal beds and furniture from home. At the same time, all items brought into the home should be evaluated for potential safety hazards they may present to any elder or staff in the home.
- Be sure your practices around bed and furniture choices include informing elders of their opportunity to bring personal furniture from home as well as monitoring potential safety hazards.

**(4) A policy is in place to encourage personalization-** Homes create a formal policy around their practices in this area and make this policy available to all elders moving into the home.

## Supporting Practice #3— “Self-care and mobility” required outcomes

**Adaptations are made to promote self-care-** These are changes made specific to an individual to make it easier for them to function independently.

- *Examples might be moving a towel bar or shelf so an elder can reach it or lowering a closet bar so the elder can select their own clothing.*

**Bedrooms are free of barriers to mobility and self-care-** It is necessary to work with each elder to discover any barriers that may exist in their bedroom that prevent their ability to complete tasks without assistance. Then adaptations are made to overcome the barrier. These are made on an individual basis because not everyone will need the same things. Ask yourself, could a person do more for them self if adaptations were made in their room or things were rearranged?

- *For example, could a person comb their own hair if the mirror was lowered so they could use it?*

# Considerations: Resident Use Space

## Background:

The Resident Use Space core is in Domain #3- Home Environment. The goal of the Domain is “the built environment in the home is recognized as the resident’s home and resident comfort is honored over staff convenience in the workplace”.

- This Domain speaks to placing priority on creating home over creating an efficient work space.
- While the home should be homey and comfortable the program focus goes beyond the building and furnishings and looks at the practices of the team around respecting boundaries in resident use spaces.
- When creating resident environments, areas of focus should include:
  - True privacy and control
  - Supporting choices for solitude
  - Personalization of living space
  - Accommodating and promoting self-care and independence.

## The overall goal of this core: All spaces in the home are comfortable and accommodating.

The core addresses all of the “common areas” that elders may use in the home outside of their bedroom.

- When working through this core, keep in mind the idea that a personalized, homelike environment recognizes the individuality and autonomy of the elder, provides an opportunity for self-expression and encourages links with the past and family members.
- The intent of the word “homelike” in this Core is to support the state and federal regulation that the nursing home should provide an environment as close to that of the environment of a private home as possible.

## Supporting Practice #1— “Private space” required outcomes

**Space is available to host and receive family and friends-** It is understood that many homes have limited space. Often homes find themselves using a single space for multiple purposes.

- *For example: An activity room or a conference room may be converted to a private dining room when an elder has company.*
- Get creative and do what you can to accommodate elders hosting family and friends.

**Bathing areas provide privacy and dignity-** Work to provide a comfortable atmosphere in the bathing areas of your home.

- *What can you do to ensure the privacy of elders while taking a bath? What items are stored in your bathing areas that might increase traffic in this private care area? Are team members going in and out of the bathing areas for supplies? What can you do to ensure other people cannot walk into the bathing area while it is in use?*
- No more than one elder should ever use any bathing area at one time.
- Also think about the practices in your home for taking a person to the bathing area. Elders should be fully clothed when being assisted to and from the bathing area. Most of us would feel uncomfortable strolling down the hallway in a bath towel or blanket.

**Space for solitude-** Space and solitude is often limited in the nursing home. Do you have a space where elders can go to be alone? What is this space? Do what you can to accommodate each individuals’ need for time alone. Often this can be supported simply by respecting boundaries.

# Considerations: Resident Use Space

**Boundaries are respected-** As mentioned above, often space in the nursing home is used for multiple purposes. It is important that you consider the “common areas” in your home primarily as resident use space, being careful not to interrupt elders while you do your work. Think about how the staff functions in these spaces in the home.

- *For example: Are staff quiet when passing through an area where a resident is watching a TV program? Would staff interrupt an elder visiting with company to take their blood pressure?*
- Spend some time brainstorming with your team to develop standards for interacting in these spaces in your home and then be sure everyone on the team understands the expectations.

## **Supporting Practice #2— “Self-care and mobility” required outcomes**

**Resident use space must be free of barriers to mobility and self-care-** Have there been any areas in your home the elders have reported as being hard for them to navigate independently? If so, what have you done to address it?

- *Maybe a door is especially heavy and hard to pull open. Could this barrier be addressed with the installation of a different door, or an automatic door opener? Maybe the transition from one type of flooring to another creates a “bump” that is hard to get over in a wheelchair. Could this barrier be eliminated with a different transition material?*

**Adaptations are made to promote self-care-** Talk to the elders living in your home. If they report any area of concern see if you can make any adaptations to eliminate the barriers.

## **Supporting Practice #3— “Institutional elements” required outcomes**

This concept of creating a home setting includes the elimination of institutional odors and practices to the extent possible. Institutional elements are things that look like they belong in a hospital setting rather than in a home. Look for things in your home that look institutional and work to replace them with more home-like alternatives.

Some practices that can be eliminated to decrease the institutional character of the environment include, but are not limited to the following:

**Overhead paging is turned off and is only used in emergencies-** Overhead paging (including frequent announcements and piped in music throughout the building) is a convenience for staff, but can be very disruptive to the living environment in the elder’s home. Work to create a peaceful environment.

As you work to meet this required outcome, remember this will require advanced planning to maintain regulatory compliance. See 483.90 (g) Resident call system.

**Equipment and carts are not left in the halls-** Often hallways in nursing homes are littered with lifts, wheelchairs, scales and medication and treatment carts needed to do your work. Get creative and look for alternatives. Some innovative homes now store medication in locked areas in resident rooms and other secured areas eliminating the need for a cart. Strive to create a homey environment for the elders living in your home.



# Considerations: Resident Use Space

**Nurse stations are eliminated-** Think about the work spaces in your home and how they are used. Often homes have large, centrally located nursing stations, including those with barriers (such as Plexiglas or tall cabinets/desks) that prevent staff from interacting with elders. Strive to eliminate barriers between working staff and elders living in the home. The goal is to have team members work where people live. Nurses can step into an office to make private phone calls, but should spend most of their time among the people they support.

Homes have met this required outcome by tearing down the traditional nurse stations and creating small home-like den areas in hallways and living areas of the home. As you work to “Get Small” in the Relationship core and define small work areas (units, pods or neighborhoods) in your home, think about strategic placement of nurse work areas in each.

As you work to meet this required outcome, remember this will require advanced planning to maintain regulatory compliance. See Guidance on 483.12 (a) 1 and 483.10 (h) as you work through your plan.

It is suggested that you review your plan with the PEAK team *prior* to renovation to assure the plan will meet program criteria.

Anytime a change is planned to a required room use, homes are required to submit a copy of the final plan, signed by an architect, to KDADS. KDADS has recommended the home send a letter of intent including your plans ***prior to making any changes***. After review they may approve moving forward without the involvement of an architect. Decisions are made on a case by case basis.

Feel free to contact the KSU PEAK office for guidance through the process.

# Considerations: Supporting the Human Spirit

## Background:

- The Supporting the Human Spirit core is in domain #4- Meaningful Life. The goal of this domain is, “opportunities and assistance exist for elders to pursue a purposeful life.”
- This domain speaks to making life meaningful rather than focusing on traditional activity programs and calendars. We tend to view activity planning as a way to solve a problem instead of supporting a life. Homes must change the focus from activity programs to life in the community.
- Elders need opportunities to contribute in a meaningful way, be *engaged* in life, participate in community decisions, help other people, and maintain their ties to the community. These are basic human needs.
- Your teams need to find out what matters to each elder. What brings them meaning and purpose. How do they want to spend their time, and how can you best support them in living the life of their choosing?

## The overall goal of this core: Team members work together to discover and support what gives each resident meaning and pleasure.

We all have different things that are important to us but we all share the basic human need to be involved in things that matter to us. We need to contribute in some meaningful way, participate in decisions, help other people, and engage in life.

### Supporting Practice #1— “Day to day life” required outcomes

**Information is gathered about resident routines, preferences and daily pleasures-** The home should develop interview tools to gather substantial information about the normal daily routine the elder lived before moving into the nursing home. What are the small daily pleasures the elder enjoys? How do they choose to spend their time? Ask as much as you can about what a typical day looks like for them.

- Be sure your practice of gathering information continues beyond the time of move-in. The depth and type of information a person is willing to share may change as relationship develop with caregivers.

**Information is available to direct care staff-** Be sure direct caregivers know how to find this information once it is gathered.

- Homes have made this information available in a number of different ways: Kiosks, notebooks, and pocket care plans to name a few. Decide what method works best in your home. Make sure all care plan information matches the original full care plan and is updated accordingly.

**Residents live individualized daily routines supported by person-centered care plans-** Once this information has been gathered the care team should strive to support the elder in continuing the daily routine of their choosing. The care plan should spell out these preferences and describe the individual daily routine preferred by the elder. These should be updated as your knowledge of the elder grows and changes.

**The individual spiritual and cultural preferences of each elder are supported-** Simply put, ask each elder what you can do to support their preferences and then care plan and do it.

- *For example: Could the home arrange transportation to the elder’s church on Sunday? Maybe the elder does not eat fish on Friday or requests quiet time each morning for personal devotions.*
- Person-centered care plans will include approaches to support these spiritual and cultural preferences.

**Residents are honored when they pass on-** What happens when an elder passes away in your home? Think of ways that you can honor each individual in some way at the time of their death. How do residents and staff become aware of deaths in your home? It is important for residents and staff to have the opportunity to grieve these losses.

# Considerations: Supporting the Human Spirit

## Supporting Practice #2— “Planned and spontaneous activities” required outcomes

**Residents are involved in planning formal activity schedules-** Formal activity schedules should be based on the interests of the elders currently living in the home. The calendars should change as people come and go from the home. Homes that have met this required outcome have a system in place where elders are directly involved in developing activity schedules.

- The system is much different than simply asking elders each month in Resident Council if there is anything they want to do. These homes engage elders in daily conversations about their interests and respond by supporting elders in things they like to do. Activity staff work to bring elders together to develop the calendars based on their ideas and areas of interest.

**Residents are involved daily in determining spontaneous activity-** How does your team talk to elders about what they want to do each day? You can no longer think in terms of the activity director taking sole responsibility for elders' lives. All team members must be empowered to make spontaneous things happen as they have the opportunity. Our expectations of one another can prevent spontaneity in life if you are not careful.

- *Consider this: How does the team respond when a caregiver is seen sitting and visiting with an elder? Maybe enjoying a cup of coffee together. We frequently hear, “well that would be ok as long as their work was done.” What does a response like that say about the culture of an organization? Does it imply that only certain tasks are considered important? What is work? What is our responsibility as caregivers? Are we not responsible to meet the needs of elders beyond their clinical needs?*
- In homes providing person-centered care all team members understand their role in supporting elders in the daily life they want to live. These efforts are supported by the team. Activity directors make sure team members have access to the knowledge and resources they need to support spontaneous life.

# Considerations: Community Involvement

## Background:

- The Community Involvement core is in domain #4- Meaningful Life. The Supporting the Human Spirit core is in domain #4- Meaningful Life. The goal of this domain is, “opportunities and assistance exist for elders to pursue a purposeful life.”
- This domain speaks to making life meaningful rather than focusing on traditional activity programs and calendars. We tend to view activity planning as a way to solve a problem instead of supporting a life. Homes must change the focus from activity programs to life in the community.
- Elders need opportunities to contribute in a meaningful way, be *engaged* in life, participate in community decisions, help other people, and maintain their ties to the community. These are basic human needs.
- Your teams need to find out what matters to each elder. What brings them meaning and purpose. How do they want to spend their time, and how can you best support them in living the life of their choosing?

## The overall goal of this core: Opportunities exist for elders to build new and maintain existing community connections.

Think in terms of engaging people in a new life while doing what you can to maintain their current ties to the external community.

### Supporting Practice #1— “Internal community” required outcomes

**Residents participate in chores-** Talk to people about what they want help with and what they prefer to do themselves. Many of the tasks we do each day bring us satisfaction and a sense of accomplishment. Be careful not to take this away from elders in an attempt to care for them. Look for opportunities for elders to make a contribution to others.

- Some elders may like to make their own bed or help with their personal laundry. Cooking, cleaning, activity planning, mail sorting and delivery, and plant and pet care all provide opportunities to get elders involved.

**Residents have opportunities to help others-** Homes have become very creative in meeting this required outcome. Look for opportunities for elders to actually help others, instead of watching the staff provide help. Some general examples include groups of elders making and selling craft items and donating the proceeds to community causes, elders serving on a welcome team to greet and support people moving into the home, and elders volunteering at on-site snack and gift shops.

**Residents contribute to community decisions-** Look for ways to involve elders in daily decisions in the home. This will become more natural as you work to “get small” and develop closer relationships through consistent staffing. Keep in mind, daily type decisions cannot be made at a monthly meeting. Look beyond monthly Resident Council meetings to meet this required outcome. Talk with elders daily about what is going on in their home. Seek the opinions of elders when making decisions and look for ways to actively engage them in all decisions.

- *For example: Decisions about hiring, purchasing, staffing, décor, furniture placement, menus, activities, and how to celebrate holidays should be discussed with elders.*

**Residents have opportunities to express preferences and concerns-** Again, look beyond monthly Resident Council meetings. Regular learning circles provide excellent opportunities for elders to voice ideas, opinions and concerns. Also, think of ways to engage the elders who are less likely to open up in meetings or group settings.

# Considerations: Community Involvement

## Supporting Practice #2— “External community” required outcomes

**The home gathers information about the community connections-** Ask questions. Find out who the elder has relationships with in the external community and which of those relationships they wish to maintain.

**Person-centered care plans address ways the staff support community connections as desired by residents-** As you talk with elders find out what you can do to support them in maintaining these relationships and then include this in their person-centered care plan.

- *Could you help an elder with a weekly phone call to their daughter out of state? Maybe staff could help write letters, email, Skype or Facebook family members and friends?*
- *You might help with transportation to outside events or even help the elder host groups in the home that they wish to maintain ties with.*

**Outside community members are welcomed by the home-** Think in terms of outside community members who have relationships with the elders rather than a random 4H club. What can you do to encourage people who are important to the elders to visit the home?

**Family and friends feel welcome-** Think of how you can help the elder “host” others in their home. Something as simple as making beverages or snacks available to the elder to share with company could make a difference.

- *Elders living in one home have been known to host sleepovers with their grandchildren spending the night in sleeping bags in their room. The neighborhood teams provide snacks, rents movies, and plays games during the visits.*

**The home engages in community projects and life-** Talk to the elders regularly about what is going on in the outside community. Look for areas of interest for your current elders and engage them where possible. Many volunteer opportunities can be found with a little effort and creativity.

- *Observing community is different than being part of it. For example: Think about the common Easter egg hunt at the nursing home. Often these events are planned and carried out by staff with elders as spectators. Why not have elders help with all aspects of the event and be the host/ hostess they would have been at home?*