

ACTION PLAN WORKSHEET: NFMH DECISION- MAKING / RESIDENT CARE

INSTRUCTIONS:

Before scheduling a time to write the action plan:

1. Gather the ***KDADS Criteria/Guidance*** found in the PEAK Guidebook on the PEAK website.
2. Gather a team together (approximately 5-6 people) who are invested and interested in working on this topic. Include a couple members of your PCC change team.
3. Have all the team members read through the KDADS Criteria and Core Considerations for Daily Routines before meeting together.
4. Bring copies of the KDADS Criteria and Core Considerations for everyone on the team when you meet to start writing the action plan.

At the time of the team meeting:

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

Now it is time to start action planning:

- Your team will work through the NFMH Decision-Makin/Resident Care core, supporting practice by supporting practice.
- Read the statement under the heading Core #2, “The home supports resident decisions through a team approach.” (KDADS Criteria page 16)
- This is the **GOAL** for this core area. Have the scribe write or type that exact goal statement in the goal box of the Action Plan Template as seen below.

Goal: The home supports resident decisions through a team approach.

Now everyone is aware of the goal for this core area. Next, go through each of the supporting practices and consider the following questions as a team.

Replacement Supporting Practice for NFMH's

Start with the replacement supporting practice for Δ NFMH's:

"The home has a formal process in place to evaluate, address and plan responses to risky decisions. The process gives consideration to:

A: The severity of the risk to self and others. Does the choice place the client or others in immediate jeopardy or a life-threatening situation? Will the choice impede the client's treatment process and hopes to return to independent living?

B: Available alternatives and staff approaches to mitigate risk and support resident choice.

C: Considerations are documented.

D: Person-centered care plans addressing risky decisions are reviewed regularly and issues revisited on an on-going basis."

1. Does the home have a formal process in place to evaluate, address and plan responses to risky decisions made by residents? **Circle:** YES or NO
2. Does the home provide training on this formal process to all team members?
Circle: YES or NO
3. Do person-centered care plans address risky decisions? **Circle:** YES or NO
4. Are care plans reviewed regularly and issues revisited on an on-going basis?
Circle: YES or NO

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

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

Sample Objective: "All care plans will be reviewed and revised as needed to ensure that the approaches and interventions are person-centered and individualized in addressing risky decisions by January 31, 2018."

Sample Action Steps:

- "MDS coordinator will meet with neighborhood coordinators to update the care plan library in PCC with various individualized approaches and interventions that can be personalized/customized for each client on a regular basis for risky decisions."
- Etc...

“Home provides formal training to all team members on this process.”

1. All team members have received formal training on the process for evaluating, addressing and responding to risky decisions and are able to support client choice to the extent possible? Team members are also trained in documenting considerations? **Circle:** YES or NO
2. All team members are empowered to support clients in their decisions/choices in accordance with the direction of the training and pcc care plan after they have received the formal training? **Circle:** YES or NO

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

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

Sample Objective: “Develop a formal training outline for all team members on Risky Decisions that encompasses our process of evaluating, addressing and planning responses for clients on an individual basis that will be presented to the PEAK group by January 15, 2018.” (Implementing the training would be an additional objective with separate action steps)

Sample Action Steps:

- “Determine what team members will be on the committee for developing the training outline.”
- “Contact PEAK NFMH homes to ask about their formal training methods.”
- Etc...

“Home addresses risk on an individual basis rather than with ‘blanket policies.’”

1. We have eliminated ‘blanket policies’ for addressing risk and client choices/decisions are evaluated on an individual basis? **Circle:** YES or NO
2. Our clients’ care plans are person- centered in addressing risky decisions and are reviewed regularly with issues revisited individually on an ongoing basis? **Circle:** YES or NO

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

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

Sample Objective: “Review current policies with corporate education director and eliminate all policies that pertain to clients behaviors as they relate to risky decisions and choices by January 1, 2018.”

Sample Action Steps:

- “Replace eliminated policies with the Risky Decision formal training outline.”
- Etc...

Supporting Practice #2: Access to Information and Resources

“All team members have access to information about special health needs of each resident in their work area.”

1. Is there a system in place for direct caregivers to access information about special health needs of each resident in their work area? **Circle:** YES or NO
2. Are all team members aware of and able to access this information (either electronically or in print)? **Circle:** YES or NO

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

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

Sample Objective: “Team members will be educated in how to access special health needs of the clients in their work area by October 1, 2017.”

Sample Action Steps:

- “Household coordinators and IT support staff will provide appropriate computer access and login information to team members in each household.”
- Etc...

“Direct care staff has access to contact information and facilitate communication between residents and their support systems.”

1. Do direct care staff have access to contact information for residents’ loved ones?
Circle: YES or NO
2. Staff are empowered and trained to access this information as needed? **Circle:** YES or NO
3. Direct care staff is at ease with handling communication between clients and their support systems? **Circle:** YES or NO

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

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

Sample Objective: “Direct caregivers will be trained in accessing contact information from both the clients’ electronic medical record and paper chart. Training will include facilitating communication with the clients’ support systems by October 31, 2017.”

Sample Action Steps:

- “Household coordinators will work with the IT department to ensure training for accessing the electronic medical record contact information is completed in their areas.”
- Etc...

“Staff has access to transportation as needed to support residents.”

1. Are there transportation methods that are easily accessible for direct caregivers to support client requests? **Circle:** YES or NO
2. Staff is aware of and empowered to access transportation for client requests?
Circle: YES or NO
3. Direct caregivers are able to access transportation for clients on the evening and on weekends?
Circle: YES or NO

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

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

Sample Objective: “Selected team members from each household will be trained to use the home’s vehicle for transporting clients as request by November 10, 2017. This will include evening and weekend staff.”

Sample Action Steps:

- “Look for direct caregivers from various shifts to recruit as drivers.”
- “HR staff to verify current drivers’ license with the selected team members.”
- “Administration will check with the insurance company on logistics of adding drivers.”
- “Develop a policy.”

“Staff has access to petty cash or resident funds to support resident requests.”

1. There are systems in place for staff to access petty cash or client funds as requests/needs arise (including evenings & weekends)? **Circle:** YES or NO
2. Staff is aware of and trained in the home’s protocols for accessing petty cash or client funds?
Circle: YES or NO

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

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

Sample Objective: “Establish and implement a petty cash fund in each household by November 10, 2017.”

Sample Action Steps:

- “Business office manager and household coordinators will meet and draft a petty cash protocol.”
- “Staff will be trained on the use of petty cash and how to access it for resident needs.”

Now that you have Objectives and Action Steps for each supporting practice within the NFMH Decision-Making Resident Care core,

- Go back to your action plan and have members volunteer to take the lead on the action steps and **write/type their name as Responsible person**. Work to spread out the workload among the team.
- Now go through and identify deadlines for each action step. Get the person that volunteered to lead the step involved in setting the date. **Write this as the target date on the plan.**
- Review the action plan to make sure it makes sense, and compare the time line with the other cores you are working on. Try not to overload your schedule with too many activities at one time.
- Once the plan is complete, turn it in to the KSU Center on Aging for feedback and get started on your plan. The feedback you will receive from KSU are suggestions to aid in your success in the program. You do NOT need to submit any changes or revisions you make to the action plan. Make changes internally and continue using the plan as a working document.
- The feedback you will receive on your action plan has no impact on your PEAK 2.0 level but a submitted action plan is required for receipt of your Medicaid financial incentive. We see a strong correlation between homes that invest time in the action planning process and success at evaluation time. Feel free to contact the PEAK 2.0 team anytime for consultation on your work.