PEAK GUIDEBOOK

QUALITY IMPROVEMENT THROUGH PERSON-CENTERED CARE

2024-2025

PEAK is a Medicaid pay-for-performance program offered through the Kansas Department for Aging and Disability Services and administered by the Kansas State University Center on Aging.

Kansas
Department for Aging and Disability Services
PEAK

KANSAS STATE UNIVERSITY
College of Health and Human Sciences
Center on Aging

HOW TO USE THIS GUIDEBOOK

This guidebook is the primary resource for navigating the PEAK program guidelines and criteria. The guidebook is set up as a navigable PDF document so that with a click of a button you can jump to sections of the document as needed with ease. Utilize the table of contents to navigate to the sections of your choice. Navigation of the document works when used digitally, but the document can also be downloaded and printed if that is preferred.

The home button on the bottom left corner of each page will take you back to the table of contents for a fresh selection.

TABLE OF CONTENTS

TERMS OF USE

This handbook is intended for use by nursing homes in Kansas. The intent of this handbook is to communicate key program information.

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Mention of particular services, methods of operation or products does not constitute an endorsement, but are to be used for informational purposes only. Opinions expressed by individuals in this document do not necessarily represent the opinions of the KSU Center on Aging or the Kansas Department for Aging and Disability Services.

The development of PEAK materials was supported by the Kansas Department for Aging and Disability Services through a Title XIX contract and matching funds provided by Kansas State University.

THE TEAM

The Kansas Department for Aging and Disability Services partners with Kansas State University to administer PEAK. Listed below are key program staff and their contact information. The team is your partner to successfully navigate the PEAK program--use them!

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https://www.hhs.k-state.edu/aging/research/peak20/

HOW DO HOMES GET INVOLVED?

This program coincides with the fiscal year calendar, July to June. The enrollment deadline is April 15th of each year. New homes or homes that have been discontinued from the program must enroll (by following the instructions below) to participate. It is not necessary for current and active homes to re-enroll in the program. Homes may not enter the program mid-year.

To enroll simply visit the website below and enter the necessary information into the appropriate fields.

http://www.hhs.k-state.edu/aging/outreach/peak20/enroll/

Upon completing the online registration form, a conformation page with instructions and a link to complete the Kansas Culture Change Instrument (KCCI) will be displayed. Six people from your organization (the administrator OR director of nursing, 2 CNAs, and 3 others of your choice) must complete the Kansas Culture Change Instrument electronically. Only six individuals from your organization will be allowed to access the survey. All surveys must be completed by April 15, 2023.

Each person should fill out the survey independently. That means the responses of those taking the survey may be different. This is to be expected.

Disclaimer: KDADS views your KCCI score solely as a self-assessment tool and it is in no way representative of your level, performance, or success in the PEAK program. It is intended as a learning tool to determine how your organization perceives performance in key practice areas.

Once enrolled, you will begin PEAK activities July 1st of the enrollment year. If you are new to the program, you will spend the first year working on the Foundation, which involves a structured series of activities led by the PEAK team. (Refer to the “Timeline: The Foundation” for an outline of required activities of homes working on the Foundation.)

PEAK OVERVIEW

Background:

PEAK (Promoting Excellent Alternatives in Kansas) started in 2002 as a recognition and education program to encourage providers in Kansas to adopt culture change. Kansas State University's Center on Aging has a long history with PEAK. The Center was responsible for development of the culture change modules, some of the first written materials on culture change.

In 2011, PEAK was revised and became PEAK 2.0, a Medicaid pay-for-performance program to financially incent implementation of person-centered care. This change was made to quicken the adoption of person-centered care in the state. Participation in the program increased substantially with the shift to the pay-for-performance model.

PEAK Now:

In 2023, KDADS released a revision of the program. PEAK: Quality Improvement through Person-Centered Care, was born out of the PEAK Advisory Group and approved through multiple nursing home stakeholder groups. The program remains a Medicaid pay-for-performance program to incent person-centered care practices. The program now features faster escalating per diems and greater flexibility in moving through program levels. All program resources have a new look and are easier to navigate content.

Program materials now feature an interactive, navigable PDF that includes multiple resources in one document. The Kansas State University Center on Aging team continues to administer the program through a contract with the Kansas Department of Aging and Disability Services and is your partner to a successful person-centered care journey.

OVERVIEW OF INCENTIVE LEVELS

LEVEL & PER DIEM INCENTIVE	SUMMARY OF REQUIRED NURSING HOME ACTION	STATE ACTION	INCENTIVE DURATION
LEVEL 0: The Foundation $0.50 PMRPD	Home completes the KCCI evaluation tool according to the application instructions. Home participates in all required activities noted in "The Foundation" timeline and Workbook. Homes that do not complete the requirements at this level must sit out for the remainder of the program year. At successful completion of the Foundation level, homes move to Level 1.	Contracts with KSU to provide feedback on the KCCI evaluation and The Foundation activities. KDADS implements incentive payment for the enrolled fiscal year.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year, provided the home participates in program activities.* Homes' incentive can be dropped mid-year for non-participation.
LEVEL 1: 0-2 Cores $0.75 PMRPD	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 1 incentive by passing the Foundation level and/or sustaining practices in 1-2 cores. Level 1 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment.	Contracts with KSU to provide feedback on the KCCI, review action plans and provide feedback, education/consulting, and evaluate homes through Zoom calls and randomly selected on-site visits. KSU will make recommendations to KDADS following evaluation of homes. KDADS will make final decisions regarding the distribution of homes' incentive payment. Previously passed cores will be re-evaluated every 2 years for sustainability.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year.*

LEVEL 2: 3-4 Cores $1.00 PMRPD	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 2 incentive by passing and/or sustaining 3-4 cores. Level 2 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment.	Contracts with KSU to provide feedback on the KCCI, review action plans and provide feedback, education/consulting, and evaluate homes through Zoom calls and randomly selected on-site visits. KSU will make recommendations to KDADS following evaluation of homes. KDADS will make final decisions regarding the distribution of homes' incentive payment. Previously passed cores will be re-evaluated every 2 years for sustainability.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year.
LEVEL 3: 5-6 Cores $1.25 PMRPD	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 3 incentive by passing and/or sustaining 5-6 cores. Level 3 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment.	Contracts with KSU to provide feedback on the KCCI, review action plans and provide feedback, education/consulting, and evaluate homes through Zoom calls and randomly selected on-site visits. KSU will make recommendations to KDADS following evaluation of homes. KDADS will make final decisions regarding the distribution of homes' incentive payment. Previously passed cores will be re-evaluated every 2 years for sustainability.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year.*

LEVEL 4: 7-8 Cores $1.50 PMRPD	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 4 incentive by passing and/or sustaining 7-8 cores. Level 4 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment.	Contracts with KSU to provide feedback on the KCCI, review action plans and provide feedback, education/consulting, and evaluate homes through Zoom calls and randomly selected on-site visits. KSU will make recommendations to KDADS following evaluation of homes. KDADS will make final decisions regarding the distribution of homes' incentive payment. Previously passed cores will be re-evaluated every 2 years for sustainability.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year.*
LEVEL 5: 9-11 Cores $1.75 PMRPD	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 5 incentive by passing and/or sustaining 9-11 cores. Level 5 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment.	Contracts with KSU to provide feedback on the KCCI, review action plans and provide feedback, education/consulting, and evaluate homes through Zoom calls and randomly selected on-site visits. KSU will make recommendations to KDADS following evaluation of homes. KDADS will make final decisions regarding the distribution of homes' incentive payment. Previously passed cores will be re-evaluated every 2 years for sustainability.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year.*

LEVEL 6: 12 Cores Person-Centered Care Home $2.00 PMRPD	Demonstrates minimum competency as a person-centered care home (passes all 12 core areas or 90% of the PEAK practices). The home does this by passing a full on-site visit to evaluate all 12 PEAK core areas.	KSU will screen homes via Zoom conference with homes potentially eligible for level 6. KDADS and KSU will facilitate a full on-site visit to evaluate minimum competency in all PEAK cores. KDADS will make final determination of movement to level 6.	Available beginning July 1 following confirmed minimum competency as a person-centered care home. Incentive is granted for one full fiscal year.*
LEVEL 7: 12 Cores Sustained Person-Centered Care Home $2.50 PMRPD	Homes earn person-centered care home award two consecutive years.	Confirm achievement of person-centered care home status for two consecutive years. If so, KDADS applies level 7 incentive payment for two years.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies in all 12 PEAK cores. Incentive is granted for two fiscal years.* Renewable biannually.
LEVEL 8: 12 Cores Mentor Home $3.00 PMRPD	Homes earn sustained person-centered care home award and successfully engage in mentoring activities suggested by KDADS (see KDADS mentoring log form). Mentoring activities should be documented.	Confirm achievement of sustained person-centered care home status. Reviews and confirms documentation of mentoring activities. Apply level 8 incentive payment for two years.	Available beginning July 1 following confirmation of mentor home standards (upkeep of minimum person-centered care competencies in all 12 PEAK cores and mentoring points). Incentive is granted for two fiscal years.* Renewable bi-annually.

PMRPD: Per Medicaid Resident Per Day

*The survey and certification performance of each NF and NFMH provider will be reviewed quarterly to determine each provider's eligibility for incentive factor payments. To qualify for an incentive, factor a home must not have received any health care survey deficiency of scope and severity level "H" or higher during the survey review period. Homes that receive "G" level deficiencies, but no "H" level or higher deficiencies, and that correct the "G" level deficiencies within 30 days of the survey, will be eligible to receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level "F" will be eligible to receive 100% of the calculated incentive factor.

TIMELINE: THE FOUNDATION

April 15, 2023	• Enrollment Deadline
July 2023	• Incentive payment begins • Home receives correspondence from the PEAK team with instructions for the virtual Zoom meetings and scheduling instructions for training dates • Home participates in a technology test to prepare for 1st Zoom meeting
August 2023	• Home participates in 1st virtual meeting: Orientation to the program • Assignment #1 distributed
September 2023	• Home participates in Zoom meeting #2 • Assignment #1 due • Assignment #2 distributed
October 2023	• Home participates in One Day Mentor Home Experience • Assignment #2 due
November 2023	• Home participates in Zoom #3 • Assignment #3 distributed
January 2024	• Home participates in Zoom #4 • Assignment #3 due • Assignment #4 distributed
February- March 2024	• Work on assignment #4
March 2024	• Home participates in Action Plan Coaching Calls • Assignment #4 due • Assignment #5 distributed
April 15, 2024	• Home submits Action Plans to the PEAK team via email (Assignment #5- Action plans prepare your organization for the work in the next fiscal year of PEAK 2.0)

TIMELINE: LEVEL 1-5

April 15, 2023	• Action plan due to the PEAK team • Begin work on the action plan anytime
July 2023	• Incentive payment beings • Peak team returns feedback on submitted action plan
August 2023- April 2024	• Home continues to work on action plan
October- November 2023	• Home has to option to attend Peak Round Tables
January- March 2024	• Home participates in a site visit OR phone evaluation (Peak team will notify home with instructions for evaluation)
March 2024	• Evaluation results returned to homes with instructions for next steps
April 2024	• Action plan due to the Peak team
April- June 2024	• Level 3 full site (for those that qualify) conducted by the Peak team
July 2024	• New Peak fiscal year begins

- Correspondence about PEAK 2.0 will come primarily through email. Please be sure to keep the email contact for your home current.

TIMELINE: LEVEL 6, 7 AND 8

July 2023	• Incentive payment begins
June 2023- July 2024	• Work on sustaining practices in all 12 core areas. If any areas of weakness were identified in the evaluation, actively work on improvement in those areas. Use the Peak team as a resource. • Mentor level homes are required to do mentoring activities (see mentor home log) to maintain their status as a level 8 mentor home. Level 7 & 8, PCC & sustained homes are eligible to mentor (unless notified otherwise) to establish a pattern of mentoring and eligibility for mentor level.
October- November 2023	• Homes are encouraged to participate in Peak Round Tables
April or May 2024	• Participate in an evaluation as appropriate ◦ Note: Level 6 homes are evaluated annually; level 7 and 8 homes are evaluated biannually
April 15th, 2024	• Turn in mentor home log as appropriate. Contact the Peak team to determine if activities pass requirements

- Correspondence about PEAK 2.0 will come primarily through email. Please be sure to keep the email contact for your home current.

PEAK EVALUATION APPEAL PROCESS

Homes that have any grievance with their PEAK evaluation results should submit these in writing to the KSU PEAK team by email at ksucoa@gmail.com or by physical mail at:

PEAK Team
KSU Center on Aging
253 Justin Hall
1324 Lovers Lane
Manhattan, KS 66506

The appeal/grievance should be submitted within 10 working days of the participating home's receipt of the evaluation results. The KSU PEAK team will have 10 working days, upon receipt of the grievance to respond to the home in writing.

If the issue is not resolved to the home's satisfaction, the home may then schedule an evaluation review meeting, which will include representatives from the PEAK & KDADS teams. Based on the outcome of the above process, KDADS will make all final appeal decisions.

DOMAIN #1 : RESIDENT CHOICE

RESIDENTS DIRECT THEIR LIVES.

Food

GOAL: *Residents choose what, when, and where they eat.*

SP 1-What to Eat

- Enhanced dining program to increase menu options
- Resident Input in menu development

SP 2- When to Eat

- Food available 24/7
- Expand meal times of hot food availability to reflect resident eating habits
- Access to special food requests

SP 3- Where to Eat

- Residents are involved in décor changes and decisions
- Residents drive seating decisions
- Multiple options in where to eat

Sleep

GOAL: *Residents' individual sleep patterns are supported.*

SP 1- Individual Sleep Routines

- Individual sleep preferences are gathered, communicated, and supported
- No group sleep or wake-up program
- Individual sleep routines/schedules are in place
- Consistent Staffing

SP 2- Undisturbed Sleep Practices

- Individualized night care
- Care provided around preferred sleep
- Reduced noise and lighting conducive to sleep
- Resident bed choice

Bathing

GOAL: *Bathing practices support individual choice*.

SP 1- Bathing Choice

- Information about bathing preferences is gathered
- Multiple bathing options exist
- Residents have input in who assist them
- Residents have choice in when and where they bathe
- Practices accommodate daily preferences

SP 2- Bathing Alternatives

- Staff are trained on bathing alternatives
- Residents are supported in bathing alternatives

Daily Routines

GOAL: *Residents decide how they spend their day.*

SP 1- Move-In Assessment

- Gather information about routines and preferences PRIOR to move-in
- Caregivers have access to information
- Caregivers support daily routines from day 1

SP 2- PCC Care Plan Development

- 90% of care plans are attended by residents and/or family
- Residents and/or family participate in creation of the care plan
- 90% of care plan meetings are attended by direct caregivers
- Direct caregivers participate in the creation of the care plan

SP 3- Care Plan Delivery

- All caregivers have direct access to care plan information
- Direct caregivers have a system available to communicate care plan changes as directed by residents
- Daily routines are lived as outlined in the plan of care

DOMAIN #2: STAFF EMPOWERMENT

ALL STAFF ARE EMPOWERED TO SUPPORT RESIDENT CHOICES AND MAKE DECISIONS ABOUT THEIR WORK.

Relationships

GOAL: *Residents enjoy meaningful relationships with a small group of consistently assigned caregivers.*

1- Get Small

- Define physical locations
- No more than 30 residents live in each work area
- Necessary supplies/equipment available in each work area

2- Consistent Staffing

- A staff schedule is developed for each work area (required)
- Staff are assigned to a team in a defined work area (required)

Meet at least 2:

- Versatile workers
- No "scheduled" rotation
- No "scheduled" agency staff
- PRN staff are assigned to work areas

Decision Making Staff Work

GOAL: *Traditional top down hierarchy is replaced with self-led teams making decisions that affect their work.*

1- Staff Scheduling

- Direct care (DC) staff are self-scheduling OR
- The scheduling process includes:
  - DC staff input is gathered for staffing plans
  - DC staff arrange their own coverage
  - DC staff coordinate and negotiate time off with one another

2- Hiring and Orientation Practices

- DC staff receive training on homes' hiring practices
- DC staff involved in hiring process
- DC staff are involved in orientation of new staff

3- Leadership

- The home has a central leadership team that includes DC staff representation
- Each work area has a leadership team that includes DC staff representation
- DC staff serve on work groups addressing issues throughout the home

Decision Making Resident Care

GOAL: *The home supports resident decisions through a team approach.*

1- Shared Understanding

- Formal training on how to respond when residents make a risky decision

2- Access to Information & Resources

All team members have access to:

- Information about special health needs of each resident
- Access to contact information
- Access to transportation
- Access to resident funds

Career Development

GOAL: *Systems are in place to promote professional development.*

1- Professional Development

- Formal career advancement or skills enhancement program in place
- Versatile worker training opportunities

2- Outside Education

- At least 10% of non-managerial staff attend outside training of any kind

DOMAIN #3: HOME ENVIRONMENT

THE BUILT ENVIRONMENT IS RECOGNIZED AS THE RESIDENTS' HOME & RESIDENT COMFORT IS HONORED OVER STAFF CONVENIENCE.

Resident Bedrooms

GOAL: *Bedrooms in the home provide opportunities for privacy, personalization, and comfort.*

SP 1- Privacy

- Arranged to promote privacy
- Boundaries are respected
- Regular training on privacy expectations

SP 2- Personalization

Meet at least 2 of the following-

- Decor reflects preferences
- Choice of paint color
- Bed and furniture choices are supported
- Policy in place to encourage personalization

SP #3 Self-care & Mobility

- Adaptations to promote self-care
- Free of barriers to mobility and self-care

Resident Use Space

GOAL: *All spaces in the home are comfortable and accommodating.*

SP 1- Private Space

- Space is available to host and receive family and friends
- Bathing areas provide privacy and dignity
- Spaces for solitude
- Boundaries are respected

SP 2- Self-care and Mobility

- Free of barriers to mobility and self-care
- Adaptations to promote self-care

SP 3- Institutional Elements

- Overhead paging turned off (used only in emergencies)
- Equipment and carts not left in halls
- Nurse stations are eliminated

DOMAIN #4: MEANINGFUL LIFE

RESIDENTS HAVE OPPORTUNITIES AND ASSISTANCE TO PURSUE A PURPOSEFUL LIFE.

Supporting the Human Spirit

GOAL: *Team members work together to discover and support what gives each resident meaning and pleasure.*

SP 1- Day-to-Day Life

- Information is gathered about residents' routines, preferences, and daily pleasures
- Information is available to DC staff
- Residents live individualized daily routines supported by PCC care plan
- Individual spiritual and cultural preferences supported
- Residents are honored when they pass on

SP 2- Planned and Spontaneous Activities

- Residents are involved in planning formal activity schedules
- Residents involved daily in determining spontaneous activity

Community Involvement

GOAL: *Residents have opportunities to build and maintain existing connections.*

SP 1- Internal Community

- Residents participate in chores
- Residents have opportunities to help others
- Residents contribute to community decisions
- Residents have opportunities to express preferences and concerns

SP 2- External Community

- Home gathers information about residents' community connections
- PCC care plans address ways staff support community connections as desired by residents
- Outside community members are welcomed by the home
- Family and friends feel welcome
- Home engages in community projects/life

CORE: FOOD

FOOD

GOAL: *Residents choose what, when and where they eat.*

REQUIRED OUTCOMES:

1 - What to Eat

- Enhanced dining program with increased menu options
- Resident input in menu development

2 - When to Eat

- Food available 24/7
- Expanded meal times for hot food availability
- Access to special food requests

3 - Where to Eat

- Residents are involved in décor changes and decisions
- Residents drive seating decisions
- Multiple options in where to eat

GOAL: FOOD CORE

Residents choose what, when and where to eat.

Food is not only an essential part of maintaining health and life, it is also a key component of peoples' social life. Dining is a time people connect with others, and food smells and sights can elicit strong memories for people. Kitchen and dining areas are often the heart of our homes. The food core encourages getting food closer to residents and resident autonomy over food choices.

1 WHAT TO EAT

CRITERIA: Menus include numerous options and are developed with on-going resident input.

REQUIRED OUTCOMES:

- An enhanced dining program to increase resident menu selection has been implemented, such as restaurant or buffet style.
- Residents are involved in menu development on an on-going basis.

CORE: FOOD

FURTHER GUIDANCE:

Enhanced dining options

Homes implementing enhanced dining work to individualize the meal and dining experience for residents in ways that demonstrate resident autonomy around eating. Dining should offer options 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 dining styles are currently being used to meet this outcome such as:

- Restaurant Style
- Buffets
- Cook to Order

Menu options

The intent of this outcome is that numerous food options are available to individuals. Regulations require alternatives be available at each meal, but enhanced dining goes above and beyond regulatory compliance. This outcome is about offering numerous options based on current residents' input and preferences. Homes meet this in a variety of ways:

- Always Available Menus
- Alternative Menus
- Cook to Order Options
- Daytime Menu

Resident input

To meet this core, residents must be actively involved in menu development on an on-going basis. Think beyond residents 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 individuals upfront to help create a menu based on foods they want to see served in their home. However you choose to handle it, *the first step in the process of menu development should always be talking to residents*.

action planning: Enhanced dining

Consider this Example:

Mary arrives in the dining room at 12:30 pm. Most of her friends are already eating but she likes to catch the weather on channel 13 news everyday in her room before lunch. She sees an open seat next to a friend and sits down. Jennifer, a CNA, sees Mary enter the dining room and greets her as she sits down, ready to take her order for lunch.

Jennifer shares the specials of the day and points out the alternative menu that sits on the table. She already knows Mary is trying to gain weight and does NOT like peanut butter. She has referenced an individualized card kept in the dining room with resident likes, dislikes, food allergies, nutritional information, and goals. She reminds Mary that the cake flavor today is peanut butter but points out the ice cream flavors and other desserts available on the alternative menu.

Mary makes her selections and Jennifer delivers her order to the kitchen to be prepared and served.

action planning: What to eat

Resident input can be accomplished in many ways. In fact, the best input happens by not relying on a single approach. Homes that have successfully implemented this requirement have used a variety of effective strategies that have included (but are not limited to):

- Resident food councils
- Regular "coffee with the cook"
- Dining round tables
- Posted grocery lists
- Favorite recipes

BASIS FOR EVALUATION:

- The home has implemented one or more of the enhanced dining programs or an equivalent option. Evidence will include:
  - Two weeks worth of food menus and an always available or alternative menu.
  - Staff and residents describe how numerous food options are made available to residents.
- The home describes formal systems for gathering resident input on main and alternative menus.

2 WHEN TO EAT

CRITERIA: Food and drinks are available 24 hours a day and staff are empowered to provide food when a resident desires it.

REQUIRED OUTCOMES:

- A system to make food and drinks available to residents 24 hours a day has been implemented and staff are empowered to serve residents in accordance with their individualized plan of care.
- Meal times are expanded to be more flexible in offering hot options and reflect residents' eating habits.
- Residents are able to access special food and drink requests and/or items not normally stocked by the home.

CORE: FOOD

FURTHER GUIDANCE:

Food available 24/7

The intent of this requirement is to further support the residents' access to food. Food and beverage options must be available to residents either by self-service OR upon request at all times of the day and night. Current residents' preferred snacks should be stocked and available in proximity to where the residents live. For homes wishing to provide self-serve access please read **Guidance for Self-Service Food** to identify ways to do this and meet regulatory guidance.

action planning: When to eat

Consider this example:

Prior to retirement a gentleman reported to his job as a milk truck driver every day at 4:00 a.m. On his way to work each morning he stopped at a local café for a big breakfast of bacon and eggs with coffee. Although he has moved into a nursing home, he continues to wake each morning at 3:00 a.m. In a traditional nursing home, he may have to wait until 7:30 a.m. or 8:00 a.m. 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 3:00 a.m.

Some homes have responded to situations like this by finding a way for the night shift to access a kitchen, either the main kitchen or a smaller kitchenette somewhere in the home. They have then trained team members outside of the kitchen staff about safe food preparation, storage, and services. By making supplies available that are regulatory compliant, the night team is able to support the residents' preferences.

Expanded mealtime for hot food availability

This requirement is to respect the residents' eating habits by expanding the regular mealtime offerings for hot food. To meet this, homes must have a meal schedule that is not limited to a single serving time for breakfast, lunch, and dinner, but rather the home should implement a scheduled service time for each meal (approximately 2 hours) within which residents can be served their meal. These mealtimes should be set based on current residents' personal routines and habits and with their input.

Access to special food requests: A system is implemented for residents to access reasonable special food items that are not normally available in the home. Residents should know how to request and access these special food preferences.

BASIS FOR EVALUATION:

- The home will describe the procedures related to 24-hour food and beverage access.
  Evidence will include:
  - Staff and residents describe how to access food and beverage between meals.
  - Evaluators can observe where food and beverages are accessed (self-serve or with assistance)
- The home will describe the scheduled mealtimes for serving hot meals and how these times are determined.
  Evidence will include:
  - Staff and residents describe mealtimes.
  - Specials should be available for at least 2 hours for each meal.
  - Evaluators observe mealtimes and any posted signs related to mealtimes.
- The home will describe how they handle special food requests.
  Evidence will include:
  - Staff and residents describe how to get access to special food items not normally stocked.

3 WHERE TO EAT

CRITERIA: Resident preferences are reflected in the dining atmosphere and residents determine where they eat meals.

REQUIRED OUTCOMES:

- Resident are involved in decisions to change the dining room décor or arrangement and placement of dining room furniture.
- Residents have the freedom to sit at any table in the dining room at any meal.
- Residents have multiple options in where to eat and are supported in eating where they are comfortable.

FURTHER GUIDANCE:

Resident involvement in decisions about the dining room

The intent of this requirement is that residents are involved in all decisions related to their dining experience. Because it is the residents' home, even simple adjustments should be discussed with residents as it fosters control and ownership of their space. Homes should also respond to resident requests for changes in the dining experience when these changes are feasible. Examples of changes can include, but are not limited to:

CORE: FOOD

- Re-arrangement of seating and table layouts
- Decisions about table service and table decorations
- Options for condiments residents want available on their tables
- Options for music or other entertainment during meals
- Decorations for holidays or other special occasions
- Paint color

Keep in mind, changes in dining areas are not required, but if done, changes and decisions should be directed by residents.

Freedom to sit at any table in the dining room at any meal

To further support resident autonomy, all residents should decide where they want to sit in the dining room at mealtime. Residents should also be able to sit at different tables on different days or times if they choose (see also multiple options in where to eat). If a resident requires assistance with their meal, this support should come to them; they should not be relegated to a separate “assisted dining room.” If a resident chooses to sit in a regular place, that choice should also be supported. Having expanded mealtimes so residents can dine at different times will also allow multiple residents to “claim” a seat as theirs (See When to Eat).

example: Residents drive seating

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.

Eating together, especially with our loved ones is one of the most fundamental acts of social engagement. Supporting these activities contributes to the vibrance of life.

Multiple options in where to eat

This requirement supports the idea that each resident should be able to decide to eat their meal in a location other than the dining room and have the support to do so. This fosters opportunities for resident engagement with entertainment and/or visitors they may enjoy. It may also support needs for privacy. Options for other dining locations could include:

- Their room
- In front of the TV in a social space
- On the patio or other outdoor space
- In a private dining space, conference room, and/or activity room

CORE: FOOD

action planning: Where to eat

"Where to eat" requires thinking through the details of the rooms, the actions of the staff, and the individual needs of residents. First, consider how the furniture and its location in various spaces supports options for residents to choose what is comfortable for them. Some residents may want a view outside, others do not like the glare created by the windows at certain times of the day. Thermal comfort can be impacted by the location of air conditioning vents. The ability to hear table conversation may be impacted by kitchen noise or other background sounds. Asking residents about the reasons for their choices can also help in planning out better options with them.

Next, staff must consider how they support the needs of residents during mealtimes especially if residents require assistance. These decisions should not be based on staff conveniences. Practices that group residents together based on their assisted dining needs is not person-centered. Having flexible dining times can also be helpful for staff so they can better manage the number of residents who might need help at one time.

BASIS FOR EVALUATION:

- Home will describe dining room enhancements made within the last year and how residents were involved in the changes.
- Home describes how decisions are made around where people sit in the dining room.
  Evidence will include:
  - Staff and residents describe how seating decisions are made in the dining room.
  - Evaluators observe mealtimes.
- Home describes practices around supporting residents in eating where they are comfortable outside the dining room.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET	CORE AREA AUDIT
GUIDANCE FOR SELF-SERVICE FOOD	TRAINING VIDEO: (0:00-5:57)

CORE: BATHING

BATHING

GOAL: *Bathing practices support individual choice.*

REQUIRED OUTCOMES:

1 - Bathing Choice

- Information about bathing preferences is gathered
- Multiple bathing options exist
- Residents have input in who assists them
- Residents have choice in when and where they bathe
- Practices accommodate daily preferences

2 - Bathing Alternatives

- Staff is trained on bathing alternatives
- Residents are supported in bathing alternatives

GOAL: BATHING CORE

The goal of the bathing core is that the home's bathing practices support individual choice.

This core is all about supporting life-long bathing patterns established by residents before moving into the nursing home. The goal is to maintain good hygiene, which can be accomplished in a variety of ways including alternative bathing methods that do not require submersion in water.

1 BATHING CHOICE

CRITERIA: Residents have a choice in how, when and where they bathe, as well as who assists them with bathing.

REQUIRED OUTCOMES:

- Information about bathing preferences is gathered.
- Multiple bathing options exist.
- Residents have input in who assists them with their preferred method of keeping clean.
- Residents choose when and where they bathe.
- Bathing practices accommodate daily preferences.

CORE: BATHING

FURTHER GUIDANCE:

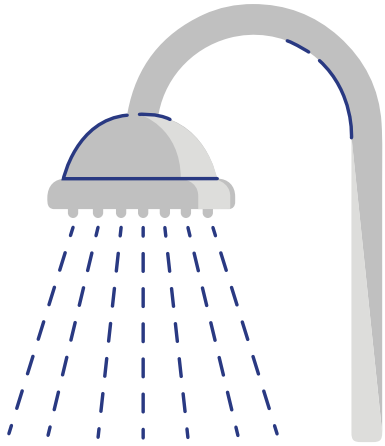
Gathering bathing preferences

The intent of this outcome is to gather information about an individual's bathing preferences and routines *before* they move in and as you begin to know them more. This is best done by developing an interview tool to gather information used to communicate to the care team.

action planning: Gathering bathing preferences

Potential questions to consider when developing a tool:

- What were your bathing routines at home?
- What time did you take your bath/shower at home?
- How did you keep clean at home?
- Where do you like to bathe (shower, bath, sink, etc.)?
- Do you prefer any specific products (shampoos, soaps, etc.)?
- Are there any other important things we should know about your bathing routines/habits (music, temperature, types of assistance, etc.)?



Once the bathing information is gathered, decide how it will be communicated to the care team. Implement a formal system so that all caregivers know where to find this important information when someone new moves into your home.

action plan: Bathing choice

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 television in their room for a bit before going to bed.

Another person may like an evening bath but may prefer to take it after supper and then get dressed for awhile before changing into night clothes.

Someone may like to soak in the tub for a time, while someone else may prefer to get in, get done and out quickly.

The tool developed to gather information and communicate it to caregivers should support this level of detail and nuance.

CORE: BATHING

Multiple bathing options exist

While baths and showers are certainly the most common means of providing hygiene care, many other methods, when done correctly, are considered effective alternatives. There is not a regulation that requires nursing home residents to submerge in water on a regular basis, however, residents are to be kept free of odor and skin breakdown. People who fear water or just prefer not to take a bath or a shower should never be forced to do so. Residents should always drive decisions about their own bodies. Effective alternative methods are:

- Sink Bath
- Bed Bath
- Sponge Bath
- Basinless Bath
- Toilet or Commode Bath
- Singing Bath
- Seven-Day Bath
- Under-the-Clothes Bath
- Intimate Partner Supported Bath
- Segmented Bathing
- Dry Shampoo Products to Support Waterless methods

When discussing bathing options with an individual, keep your interview tool questions broad enough to capture different methods for keeping clean. Check out the **Guide to Alternative Bathing** for a full description and basic instructions for each of these methods.

Input in who assists with bathing

In person-centered care, decisions about who will help with baths should be based on the resident's relationship with caregivers. Team members should talk with the resident at the time of the bath (or preferred method of cleaning) to see who they would like to assist them based on who is working. Assignments are made based on the preference of each resident rather than which staff member has not yet given a bath on that day.

The use of designated bath aides is discouraged for the same reason. Team members working in homes using designated bath aides often report an unspoken expectation among the team that if the bath aid is doing a good job they will complete all the baths on the shift they work. Therefore, there is also some unspoken expectation that the resident takes their bath when the bath aide is in house. The likely result is the bath aide's work schedule dictates when baths get done rather than resident preferences setting the bath aide's schedule.

CORE: BATHING

example: Choice in who

Two nurse aides are reviewing the bath schedule and see that Lee is on the schedule and prefers to get his bath before lunch today. As the nurse aides talk, one says to the other, "You've already given two baths today so I will give this one."

While this conversation reflects a good effort to "evenly" distribute the work load, it does not take into consideration Lee's preference in who assists him with his bath.

One person-centered approach may be for the nurse aids to consider Lee's preferences as they decide who will provide the bath. For instance, when the nurse aide's talk, one may say, "We know Lee likes you the best, so why don't I answer call lights while you give him his bath?"

Another approach could be to ask Lee who he wants to give a bath based on who is working.

Residents always decide when and where they bathe

Based on the information gathered, residents have identified their preferred routines, including when and where they typically bathed at home. The intent of this practice is to translate preferences into reality for the resident by supporting this routine in their new home.

Use the preferences gathered to work around other residents' preferences to offer their preferred method of bathing when they would prefer to do it.

example: Choice in when and where

When Mary moved in, she indicated that she wanted a shower three times a week at 8:00 a.m. This preference was then put on the caregiver daily sheet.

As Melissa begins to organize her work for the day, she reviews the caregiver daily sheet and sees that it is Mary's shower day. When Melissa sees Mary's call light, she offers Mary a shower.

Mary decides Melissa should assist her, but asks if she could do a whirlpool instead because her joints are sore. Melissa checks the whirlpool. Finding it vacant, she prepares it for Mary and assists Mary with her bath.

Practices accommodate residents' daily preferences

While most of us probably have a fairly consistent bathing routine, occasionally we may vary our choices depending on what is going on that day. For example, a resident may want to alter their normal bath schedule on a day that they are going out for a planned appointment. Individuals should be given this opportunity to change their routine from as they prefer. It is important that the team understands the expectation to adapt bathing schedules as requested by residents on a daily basis.

BASIS FOR EVALUATION:

- The home will describe how they gather information about residents' bathing preferences.
  Evidence will include:
  -A sample(s) of tool(s) used to gather information about bathing preferences.
- Direct caregivers will describe bathing options available to residents.
- Direct caregivers will describe how they decide who will assist each resident with bathing.
- Direct caregivers will describe how bathing practices accommodate the daily preferences in when and where baths are taken.

2 BATHING ALTERNATIVES

CRITERIA: Team members receive training on and offer alternative bathing options to residents.

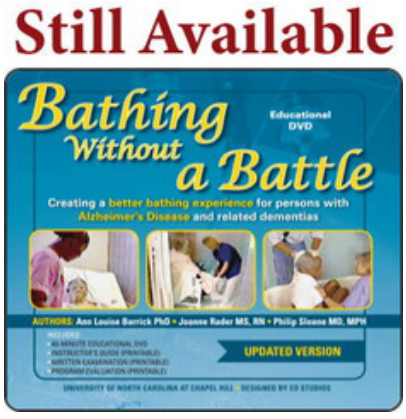
REQUIRED OUTCOMES:

- Staff are trained in bathing alternatives such as *Bathing Without a Battle* or an equivalent option.
- Residents are supported in alternative bathing options.

FURTHER GUIDANCE:

Bathing alternative training

As mentioned earlier, there are many alternative methods to maintain hygiene outside of the traditional tub or shower options. Staff in your home should know how to assist residents 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*, an older training video, is still 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 all caregivers are trained periodically on an on-going basis.

CORE: BATHING

Residents are supported in bathing alternatives

Supporting resident preferences for bathing requires two key components. First, you must know what the resident's preferences are, and second, staff must be trained to provide bathing options that can meet these preferences. It is also important to recognize how preferences might change in different situations. Staff who pay attention to how residents are feeling and how individuals are responding to the bathing experience can make appropriate adjustments to the choices residents are provided.

Sometimes it is easy to miss opportunities to support residents in an alternative bathing method when it might be helpful. If you have a resident who consistently refuses a shower, bath or whirlpool, suggest or try an alternative method. If you have a resident who does not verbalize clearly but who hollers, screams, or becomes combative and tense during bathing, try an alternative method. Keep in mind, no one should be forced into the tub or shower, and alternative bathing methods are a great tool to maintain hygiene when used appropriately.

example: Supporting bathing alternatives

Grace recently moved into Maridale Nursing Home when her husband of 65 years could no longer manage her dementia care at home. Grace is usually happy and shows it by singing quietly. However, when caregivers have attempted to provide bathing care based on her stated preferences, she says no and becomes fearful and anxious. After weeks of attempting baths using different caregivers, approaches, and times of day, caregivers continue to struggle. Grace is beginning to experience redness and signs of urinary infection.

Grace's care team brainstorms and begins to try some alternative methods and work with Grace's husband, Bob on the issue. Bob agrees to help a caregiver with her baths. He thinks she is very modest and that might be why she is having trouble. Bob also suggests music to play while she is bathing. Grace loves music and he believes it may calm her or take her mind off of the bath.

The team tries these new methods for three weeks. The first week was tough. Bob and the caregivers learned that the bathing area needs to be warmer and the music needs to be on when Grace gets to the bathing room. Involving Bob in assisting with the bath made a huge difference. Her anxiety was reduced tremendously. By the end of the third week, Grace was developing comfort with the bath and even sang during them, which is a sign that she is happy. Grace began trusting caregivers, even without her husband being present. The team updated her care plan and to continue to support these methods.

CORE: BATHING

BASIS FOR EVALUATION:

Evidence will include:

- Sample of the interview tool used to gather resident bathing preferences.
- The training curriculum used to train staff on bathing alternatives.
- Attendance records of the bathing alternative trainings. Include the total number of direct care staff members employed by the home. (90% of all staff involved in bathing should be trained excluding PRN staff)
    - A sample of an individual resident care plan that includes bathing alternatives as an approach.
- The home will describe how the alternative bathing training will be maintained.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET

CORE AREA AUDIT

ALTERNATIVE BATHING METHOD DESCRIPTION & INSTRUCTIONS

TRAINING VIDEO: (11:30-17:29)

ALTERNATIVE BATHING METHOD POST CARD FOR CAREGIVERS

SLEEP

GOAL: *Residents' individual sleep patterns are supported.*

REQUIRED OUTCOMES:

1 - Individual Sleep Routines

- Information about sleep preferences are gathered, communicated, and supported
- No group sleep or wake-up programs
- Individual sleep routines/schedules are in place
- Consistent staffing (see Relationships core)

2 - Undisturbed Sleep Practices

- Individualized night care
- Care provided around preferred sleep
- Reduced noise and lighting conducive to sleep
- Resident bed choice (See Resident Bedroom Core)

GOAL: SLEEP CORE

The goal of the sleep core is that residents' individual sleep patterns are supported.

Residents in nursing homes are considered sleep deprived, which can lead to increased falls, behaviors, and other negative outcomes. This core asks homes to find ways to support life-long sleep patterns established by residents before moving into the nursing home and improve the quality of sleep they receive.

1 INDIVIDUAL SLEEP ROUTINE

CRITERIA: Residents wake, nap and go to bed when they choose.

REQUIRED OUTCOMES:

- Residents' individual preferences around sleep are gathered, communicated, and supported by the home.
- There are no group wake-up, nap or bedtime routines or schedules.
- Individual sleep schedules are determined by each resident.
- Consistent staffing is in place (See the **Relationships Core**)

FURTHER GUIDANCE:

Gathering sleep preferences

When possible, gather information about sleep routines *before* people move in (See Daily Routines Core). 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 person's 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. The more you know about a person, the easier it will be to support their personal sleep routine. Even residents who are unable to call for help should be supported to wake up naturally.

action planning: Gathering sleep preferences

Potential questions to consider when developing a tool:

- What time do you prefer to get up in the morning?
- What does your morning routine look like?
- Do you nap? If so, what time do you usually nap?
- What time do you like to go to bed?
- What does your bedtime routine look like?
- What do you like to wear to bed?
- Do you have favorite blankets and/or pillows?
- Are there things that help you sleep?
- Are there things that interfere with your sleep?
- Would you like a courtesy wake-up each morning?
- OR Do you prefer to call for help when you wake up naturally?

Once sleep information is gathered, decide how it will be communicated to the care team. Implement a formal system so that all caregivers know where to find this important information when someone new moves into your home.

CORE: SLEEP

examples: Sleep preferences

Jane is a night owl, she likes to stay up late and watch television until about midnight, and then she wakes naturally at around 8:30 to 9:00 am. She enjoys a nap after lunch, but insists that someone roust her in time to enjoy afternoon activities.

Rebecca was a farm girl and is still very connected to the rhythm of "early to bed, early to rise." She has not taken a nap in her life and does not intend to start now.

Frank's sleep clock has become closely connected to the sunrise and sunset. Once it starts to get dark, he starts to feel sleepy. Once the sun comes streaming through his window, he tends to wake naturally. His bedtime adjusts with the season.

No group sleep or wake-up programs

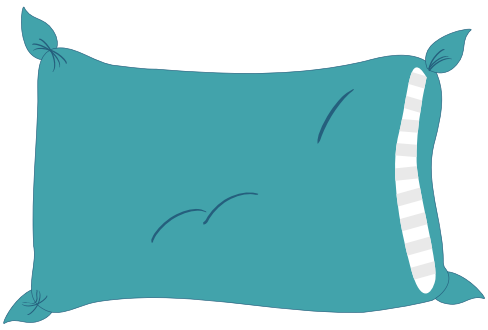
Everyone should direct their own individual routine rather than the routines of staff determining residents' routines. Caregivers working in traditional nursing homes often describe a “group” wake-up or sleep program. It looks something like this: The team starts their day at one end of the hall. They help a resident get up and ready for the day and then move next door to help the next person. The team continues to work their way down the hall until everyone is up and ready for breakfast.

example: No group wake-up

Consider this:

If person-centered care were being provided, the team would know the sleep and wake up preferences of the residents in their care. People would be assisted at the time of their choice as they live their preferred daily routine.

One resident may be up, dressed, and done with breakfast before another neighbor is even out of bed.



CORE: SLEEP

Individual sleep routines/schedules are in place

Think about how your care systems support individualized sleep routines. 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 now. Mealtimes must also support the resident sleep routine. 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. Be sure practices in your home support these day-to-day changes. Residents should not be awaken by staff unnecessarily unless requested by the resident.

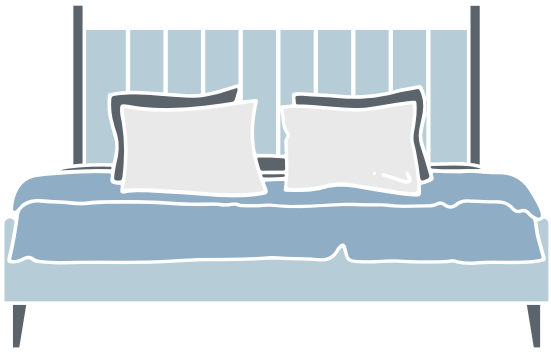
example: Individual sleep routines

- If a person usually gets up around 10:00 a.m., the team will need to implement systems that allow this person to eat a hot breakfast upon rising.
- If a resident has stayed up late at night, he/she may want to sleep later tomorrow. Or if a resident has special plans in the morning, he/she may want to get up earlier than usual.

John has an order for a fasting blood sugar with sliding scale for insulin every morning. When staff gathered John's information, they found out that John usually gets up at 9:00 a.m. They developed a care plan for the day nurse to implement the treatment plan, upon John arising. In a traditional care model, a night nurse might gather blood sugars at 6 a.m. before she goes off duty disrupting John's sleep unnecessarily.

Consistent staffing

To meet this portion of the Sleep Core, homes must meet the criteria for the **Relationships Core**. It is helpful and recommended to work on the Relationships Core *before* working on the Sleep Core.



BASIS FOR EVALUATION:

- The home will describe how they gather information about residents' sleep preferences.
- Direct caregivers will describe how residents' sleep preferences are made available to them.
- Direct caregivers will describe their morning and evening routines.
  Evidence will include:
  - A sample(s) of tool(s) used to gather information about sleep preferences.
  - Provide weekly, two week, or monthly staff schedules for each work area that have been filled out.
  - Provide a building floor plan (can be the fire evacuation plan) with work areas identified, including the number of residents who live in each work area.

2 UNDISTURBED SLEEP PRACTICES

CRITERIA: Residents enjoy restful, undisturbed sleep.

REQUIRED OUTCOMES:

- Residents receive individualized night care to support restful sleep.
- Resident care is provided around residents' preferred sleep routine.
- Noise at night is reduced and lighting is conducive to restful sleep.
- Residents have choice of the bed they sleep in.

FURTHER GUIDANCE:

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 preferences and a thorough clinical assessment of each resident.

CORE: SLEEP

Clinical considerations for the individualized night plan

- Voiding Patterns
- Level/Type of Incontinence
- Bed Mobility
- Skin Integrity

Note: The use of nighttime incontinence products designed to wick away moisture from skin can be helpful to extend uninterrupted sleep.

example: Individualized night care

Shirley, who experiences dementia, moved into your home. In the first two weeks, Shirley's nurses do clinical assessments to include a voiding study, incontinence assessment and skin and bed mobility assessments, to develop an individualized night care plan. Shirley's skin is intact, she can reposition herself in bed on her own, and is incontinent. Based on the clinical assessment and considering Shirley's preferences, the nurse team determines that helping Shirley toilet at 2 a.m. and 5 a.m. would help her stay clean and dry while supporting restful sleep. The individualized care plan reflects going in to help Shirley tot he bathroom at these specific times. Shirley, like most residents, also needs monitoring, which staff do by going to her door regularly to peek in on her to ensure she is in her bed and asleep with minimal disruption.

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 directly with the resident to identify 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 awaken for routine nursing assessments or treatments that could be provided at a time when the resident is awake.

CORE: SLEEP

action planning: Individual night care

It is helpful to think ahead about accountability. Determine how leadership will monitor and support night care support.

Consider these questions:

- Is person-centered night care being appropriately implemented?
- Do night care staff need more education or training? Resources? Support?
- Does organizational policy and/or procedures need updated to support person-centered night care practices?

Reduced noise and light to be conducive to sleep

Look for ways to reduce noise and light levels at night. Consider re-assigning certain cleaning duties, stocking supplies in resident bedrooms and other noisy, or light dependent tasks to other times of day.

REDUCE NOISE AT NIGHT:

- Avoid stocking in resident rooms at night.
- Avoid cleaning tasks in or near resident rooms.
- Avoid use of body or bed alarms.
- Work to eliminate audible call lights.
- Minimize staff talking, especially near resident spaces.
- Encourage headphones for residents up watching television or listening to music in the middle of the night with roommates.
- Encourage residents up at night to be in spaces away from other resident rooms.

REDUCE LIGHT AT NIGHT:

- Lower public lighting during overnight hours.
- Consider using bedside lamps or flashlights to provide care overnight rather than overhead lighting.
- Avoid doing even "quiet" tasks in or around resident room that require light.
- Consider use of amber colored light rather than white or blue colored lights at night.
- Consider window coverings and light coming in from outside, including parking lot or street lights.

CORE: SLEEP

Supporting resident bed choice

Encourage residents to bring personal bedding and pillows from home when they move in. When people want to bring their own personal bed, have a process in place to assess the personal bed to ensure care can be supported safely from it. Think about how residents and their families will be made aware of this options (See Resident Bedroom Core).

example: Resident bed choice

Jake is moving into your home. When gathering personal preferences before moving in, you discover Jake sleeps in an electric lift recliner all the time at night. Special arrangements are made to remove the traditional bed out and to assist Jake to move in his recliner after assessing that it is clean and mechanically safe.

BASIS FOR EVALUATION:

- The home will describe how nighttime care needs are assessed.
- Direct caregivers will describe nighttime job responsibilities and routines.
- The home will describe their practices around reducing disruptive noise and light at night.
- The home will describe their practices for addressing resident choices of bed.
  Evidence will include:
  - Provide the overnight CNA and nurse mini care plan sheets that outline resident overnight care instructions for incontinence care and reposition needs. Some homes call these different things. Following are some examples of what they are called but this is not meant to be an exhaustive list. Example: jot sheet, team sheet, Kardex, QI sheet, pocket care plan, CNA sheets, CNA task sheet, etc.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET	CORE AREA AUDIT
DREAM TOOLKIT: SLEEP HANDBOOK	TRAINING VIDEO: (5:58-11:29)

CORE: DAILY ROUTINES

DAILY ROUTINES

GOAL: *Residents decide how to spend their day.*

REQUIRED OUTCOMES:

1 - Move-In Assessment

- Gather information about routines and preferences PRIOR to move-in
- Caregivers have access to information
- Caregivers support daily routines from day 1

2 - PCC Care Plan Development

- 90% of care plans are attended by residents and/or family
- Residents and/or family participate in creation of the care plan
- 90% of care plan meetings are attended by direct caregivers
- Direct caregivers participate in the creation of the care plan

3 - Care Plan Delivery

- All caregivers have direct access to care plan information
- Direct caregivers have a system available to communicate care plan changes as directed by residents
- Daily routines are lived as outlined in the plan of care

GOAL: DAILY ROUTINES CORE

The goal of the daily routines core is to support life-long daily routines established by individuals before moving into the nursing home.

The habits and routines that have transcended an individual's lifestyle will remain important even after they move into your nursing home. This core focuses on the resident driving their own care through establishing their goals and the support they will need to meet these goals. It will be important for your teams to identify current practices that get in the way of this and build new systems that support the resident to be the driver of their care and support with your team being partners with them to achieve their desired goals.

1 MOVE-IN ASSESSMENT

CRITERIA: Residents will continue to live their personal daily routine when they move-in.

REQUIRED OUTCOMES:

- Information is gathered about daily routines and preferences PRIOR to the resident moving in (at the time of move-in for emergency situations).
- Caregivers have access to information and preferences PRIOR to the resident moving in (at the time of move-in for emergency situations).
- Caregivers support personal daily routines and preferences from day one.

FURTHER GUIDANCE:

Move-in assessment

It is important to get to know individuals in order to meaningfully support them when they move into their new home. Screening assessment tools traditionally focus on clinical information to know if a home can medically take care of an individual. While this is important, person-centered care demands that we know more. Pre-screening tools, done prior to move-in, should include questions and probes to learn about residents' daily routines, preferences and habits in addition to the other information you need to provide quality care. Here are some sample questions:

- What does your typical day look like at home?
- What time do you like to get up in the morning?
- What time do you typically go to bed at night?
- What are your routines around bathing?
- What do you enjoy doing in your free time?
- What is one thing you do daily that you wouldn't want to live without? (i.e. drink coffee, feed the birds, pray)

Caregivers have access to information

With a system in place to gather information about residents BEFORE they move-in, it is then essential that caregivers, who work closely with the new resident, have access to this information. Having access to information prior to move-in, gives caregivers vital information to start building rapport and trust with new residents. It can also help people feel more comfortable with the new environment.

*Collecting information on the day a person moves in should only happen in emergency situations.

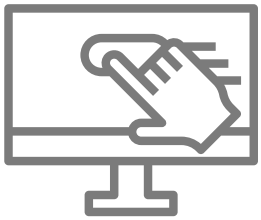
CORE: DAILY ROUTINES

Move-in information should:

- Be located in a consistent place or access point

Caregivers should:

- Know where and how to access the information



Examples of ways homes have accomplished access to information include, but are not limited to:

- Post a welcome paragraph about the new resident in the break room
- Welcome information in the kiosk with notifications to caregivers
- Transferred to a resident preference notebook and updated
- On the spot huddles, in addition to written information to go over key information

Caregivers support daily routines from day one

It is important to get off to a good start and support new residents' daily routines from the beginning. With the right information, caregivers and all staff can tangibly support and foster the residents' routines from their first day in the home.

action planning: Supporting daily routines from day one

As Layla arrives at Sunnydale Living, Melanie, a CNA greets her warmly. Melanie leads Layla to Chimney Rock household and to her new living area there and shows her to her room. Prior to Layla moving in, two other staff members met with Layla and her daughter at the hospital. During this visit, they learned that Layla likes to use a commode at night, watches Chiefs football regularly, and has Carmex Chapstick with her at all times. When Layla enters her new room, she sees her own comforter on her bed, her favorite chair, a commode by the bed, and a small welcome basket sitting on the night stand. She smiles from ear to ear to see something familiar.

Melanie encourages Layla to look in the welcome basket. "Oh, my goodness!" Layla announces as she discovers three tubes of Carmex Chapstick and a note from Judy, another resident who lives in Chimney Rock household. Melanie had read about the Carmex on Layla's welcome sheet and again in the pre-move-in staff huddle, so she knew why Layla was so thrilled. Judy then enters the room to greet Layla and invites her to go meet some of the other residents.

BASIS FOR EVALUATION:

- The home describes how they gather information about personal routines and preferences before residents move into the home.
  Evidence will include:
  - A sample of the interview tool(s) used to gather information about personal routines and preferences before move-in.
- The home describes how preference information is made available to caregivers before residents move into the home.

2 PERSON-CENTERED CARE PLAN DEVELOPMENT

CRITERIA: Residents, family, and caregivers collaborate to develop a plan of care that is based on each individual's personal daily routine and preferences.

REQUIRED OUTCOMES:

- 90% of care plan meetings are attended by a resident (family members or designated decision makers may represent a resident at the resident's request or if the resident is unable to communicate in any way).
- Residents and/or family members participate in the creation of the individualized plan of care.
- 90% of care plan meetings are attended by a direct caregiver.
- Direct caregivers participate in the creation of the individualized plan of care.

FURTHER GUIDANCE:

90% of care plans attended by residents and/or family

For care plans to be truly resident driven or person-centered, residents should be involved in developing care plan goals and desired supports. With residents' permission, family and/or representatives can also be involved. Attendance at care plans is essential to accomplishing this outcome. Consider the format of your current care plan meetings. Homes with high engagement in care plans invest time in making the meeting format easy to attend, stay focused on the resident, are action-oriented, and include the right people in discussions and decisions.

CORE: DAILY ROUTINES

Residents (and/or family) participate in the creation of the care plan
Resident and/or family attendance at the care plan is essential. Equally important is active involvement in the development of the care plan. We typically think of a care plan meeting as being a formal meeting in a conference room, but we should challenge this notion. It does not matter where this involvement takes place as long as the resident (and/or representative) is actively involved in the development of the care plan. Team members can talk with residents in his/her room or a family member can talk with the team over the phone. The key is that the team hear the resident's goals for life and care and professional opinion does not dominate over the resident's goals. A person-centered care plan can only be developed at the direction of the resident.

90% of care plan meetings are attended by direct caregivers
Nurse aids involved in providing direct care are critical to include in the care planning process. Direct caregivers have the most one-on-one interaction with residents on a day-to-day basis and thus know them better than anyone in the home. Involving caregivers in care plan meetings facilitates direct communication between caregivers, the resident, and their families. It increases the value of the conversation and the follow through (action items) from the meeting.

Direct caregivers participate in the creation of the care plan
Think of nurse aides and other support staff as valuable resources in the care planning process. This goes beyond caregivers' attendance at care plan meetings. Nurse aides and other support staff are filled with knowledge and information about residents. Work to ensure direct caregivers in attendance at care plan meetings have an active role in and are consulted during the meeting. Caregivers and other support staff not attending the meeting can also provide information in other ways that contribute to the care plan.

action planning: Direct caregivers attending care plans

Successful homes:

- Work out coverage for direct caregivers attending the care plan meetings.
- Provide guidance for direct caregivers attending care plan meetings for the first time.
- Dedicate the first part of the care plan meetings to actively talk about day-to-day care topics to maximize the direct caregiver's time in the meeting.
- Provide caregiver worksheets available to all caregivers from all shifts to gather input on care and brought to the care plan meeting by the attending caregiver.

CORE: DAILY ROUTINES

STRIVE TO:

- Have flexible scheduling
- Ask residents about their personal goals
- Make formatting and location flexible (phone, video chat, email)
- Concentrate on what is most important to the individual resident and/or family
- Emphasize the value of participation
- Hold care plans with the consistent staff that cares for the resident regularly

BE CAUTIOUS OF:

- Downplaying resident participation in the care plan
- Holding care plans in spaces far from resident rooms
- Holding care plans during activity heavy times of day
- Staff dominating the care plan conversation
- Scheduling care plan meetings on the same day back-to-back

BASIS FOR EVALUATION:

- Staff will describe the process used to invite and encourage resident and family involvement in the care plan process.
- Homes will describe how they support direct caregivers to attend and participate in care plan meetings. Evidence will include:
- Care plan attendance records:
  - Number of care plan meetings in one of the last three months (choose one full calendar month) Number attended by resident AND/OR family or designated decision-maker (from the month chosen above)
  - Number attended by a direct caregiver (from the month chosen above) These records can include attendance by conference call, Skype, or other technology. If you have a process for meeting with families that is non-traditional be sure to capture this in your attendance records. We will ask you to explain your approach.

CORE: DAILY ROUTINES

example: Care plan meeting

It is time for Jerry's care plan meeting. In preparation for the meeting, the household nurse collects information from Jerry and the interdisciplinary team. The household social worker, Melissa, with Jerry's consent, works with Jerry's son to schedule the care plan meeting at a time that works for him and the team. Prior to the meeting, Melissa provides Jerry and his son a copy of the current care plan and some questions:

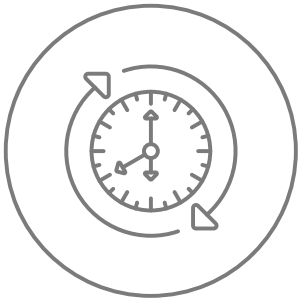
- Has Jerry experienced any changes that would be important for us to know?
- How do you feel about progress toward the goals in the current care plan?
- Are there new goals or concerns you would like to see addressed?
- What are we doing well? What could we do better?

On the day of the care plan meeting, the interdisciplinary team, including a CNA, Jerry, and his son meet in Jerry's room for the meeting. Angie, the dietary manager, brings up a change in Jerry's weight. She tells Jerry that he has gained 10 pounds since the last care plan meeting. Angie asks Jerry what his thoughts are about the change.

Jerry replies, "I've never been able to gain weight. The food must be good here. I could stand to have a little more meat on me anyway."

Jerry's son agrees that he is not concerned about the weight change but would like to keep monitoring it. Dan, the household nurse, notes that the clinical team will keep monitoring his overall health to make sure the weight gain is not a sign of something else going on. Dan reports that it is not a worry at this time based on their assessments. Nancy, Jerry's caregiver notes that the weight gain has not impacted his ADLs and his clothing are still fitting at this time.

No new goals were added to Jerry's care plan and all other plans were reviewed with no changes.



3 CARE PLAN DELIVERY

CRITERIA: Residents live a daily routine of their choice supported by a person-centered plan of care.

REQUIRED OUTCOMES:

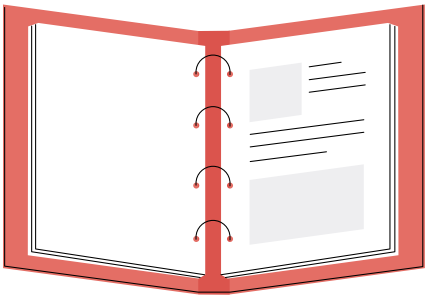
- All caregivers have direct access to care plans and information about resident preferences.
- Direct caregivers have a system available to communicate care plan changes as directed by residents.
- Daily routines are lived as outlined in the person-centered plan of care.

FURTHER GUIDANCE:

All caregivers have direct access to care plan information

The intent of this requirement is that the people who provide direct care to residents have access to the care plan, both the full and condensed care plan information. Be sure all caregivers know how to find the information they need to do their jobs and support residents' daily routines. Many homes have met this requirement through:

- Care Plan Books/Binders
- Pocket Care Plans
- Electronic Kiosks
- Care Plan Folders
- Jot Sheets
- Resident Care Sheets



CORE: DAILY ROUTINES

Direct caregivers make revisions to care plans as directed by residents

The intent of this requirement is to develop a system for all caregivers to make changes to the care plan as directed by residents in real time. When a resident voices a change in their routine or preferences, direct caregivers should be empowered to reflect these changes to the plan of care right away through more than a verbal exchange with a nurse. Educate caregivers on the types of changes they can make to the care plan, how to make these changes, and how to communicate these changes to other team members.

When developing a system for caregivers to communicate care plan changes, consider two key elements:

1. The system does not rely on verbal communication only; include written/electronic communication methods.
2. The system includes prompt follow-up on the caregiver's input to make official changes to the care plan, care sheets, and electronic care information.

example: Direct caregivers make revisions to care plans as directed by residents

When Anthony was caring for Marjorie, he learned that she no longer wants her fan going at night. It has been too chilly for her lately.

To communicate this change, Anthony makes a note on the 24 hour nursing notes, tells his charge nurse, and creates an alert on the Point Click Care system. Georgia, the night nurse, who has been designated to review and make official changes on the care plan between care plan meetings, sees the alert and updates Georgia's ADL care information in Point Click Care and updates and prints new Resident Care Sheets.

Daily routines are lived as outlined by the plan of care

The intent of this outcome is that residents actually live the life and daily routines they have described to you with the support of your team. The care that is necessary to support the resident's goals should be spelled out in the care plan to support their preferred routine.

CORE: DAILY ROUTINES

BASIS FOR EVALUATION:

- The home describes how they make care plan information available to care teams.
- Direct caregivers describe how they access care plan information.
- The home describes their system for direct caregivers communicating changes to the care plan.
- Direct caregivers describe non-verbal ways they communicate care plan changes.

  Evidence will include:
  - 2-3 current residents' deidentified, comprehensive care plans.

example: Routines are supported by PCC care plan

Care Plan Challenge:
Georgia is requiring more assistance with ADLs due to increased weakness.

Care Plan Goal:
Georgia wants to maintain her current level of self-care so that she is able to care for herself as long as possible.

Interventions:

- Georgia independently brushes her teeth several times a day and flosses.
  - Monitor her ability to complete this task. Assist her as needed.
  - Complete oral assessments quarterly or as needed.
- Ensure Georgia's hand grabber is available and accessible for her use.
- Georgia wears soft slipper like shoes for comfort. Assist her in putting these on as needed.
- Georgia prefers a tub bath with no jets, once a week on Wednesday afternoons around 2:00 p.m.
  - Encourage her to wash areas she can reach.
  - Place a towel on the bath chair and a cushion between the back of the bath chair and her back for comfort.
  - Take your time with Georgia and provide assurance, as she gets nervous about falling off of the bath chair.
  - Georgia likes to use Irish Spring body wash during baths and Jergens lotion applied after her bath. Ensure she is supplied with these items and that they are used during her showers.
  - Wash Georgia's hair in the bath.
  - Georgia occasionally declines her preferred baths. She will often participate in a sponge bath at her sink instead. Be sure to offer this alternative.
- Georgia is independent with dressing with set up assistance.
  - Assist Georgia to lay out chosen clothing the night before at the foot of her bed for the next day.
- Provide standby assistance with transfers for balance support.

CORE: DAILY ROUTINES

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET	CORE AREA AUDIT
ROTHCHILD FOUNDATION CARE PLANNING GUIDE	TRAINING VIDEO: (17:30-23:18)

CORE: RELATIONSHIPS

IMPORTANT MESSAGE FOR NFMH HOMES:
The criteria for this core have been modified for your home. Click here to go to your criteria.

RELATIONSHIPS

GOAL: *Residents enjoy meaningful relationships with a small group of consistently assigned caregivers.*

REQUIRED OUTCOMES:

1 - Get Small

- Defined physical locations
- No more than 30 residents live in each work area
- Necessary supplies/equipment available in each work area

2 - Consistent Staffing

- A staff schedule is developed for each work area (required)
- Staff are assigned to a team in a defined work area (required)

Meet at least 2:

- Versatile workers
- No "scheduled" rotation
- No "scheduled" agency staff
- PRN staff are assigned to a work areas

RELATIONSHIPS CORE GOAL:

Residents enjoy meaningful relationships with a small group of consistently assigned caregivers.

The principle idea behind this core is to better support resident choice. By consistently assigning caregivers to the same small group of residents every day, an environment is created that fosters meaningful relationships between the caregivers and the residents. As they get to know one another, caregivers learn what is important to each person and are then in a better position to support the preferences and daily routines of the people they know and care about.

1 GET SMALL

CRITERIA: The team identifies small areas of the home as work areas.

REQUIRED OUTCOMES:

- Work areas are defined by specific physical locations.
- No more than 30 residents live in each area.
- Necessary supplies and equipment are convenient and available in each work area.

FURTHER GUIDANCE:

Defined physical locations

To reduce the number of residents each caregiver works with, start by dividing the home into smaller work areas. Some homes call these work areas halls, households, pods, neighborhoods, or families. This "division" or distinction 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 and works in them.

No more than 30 residents live in each work area

If more than 30 residents live in your home, the team should work together to identify smaller work areas. If 30 or less residents live in your home, there is no need to divide your home into smaller work areas to meet this program criteria. With 30 or less resident capacity, you already meet this required outcome.

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 jobs efficiently. Some relocation of supplies and equipment may be necessary if one work area is too far away from supplies.

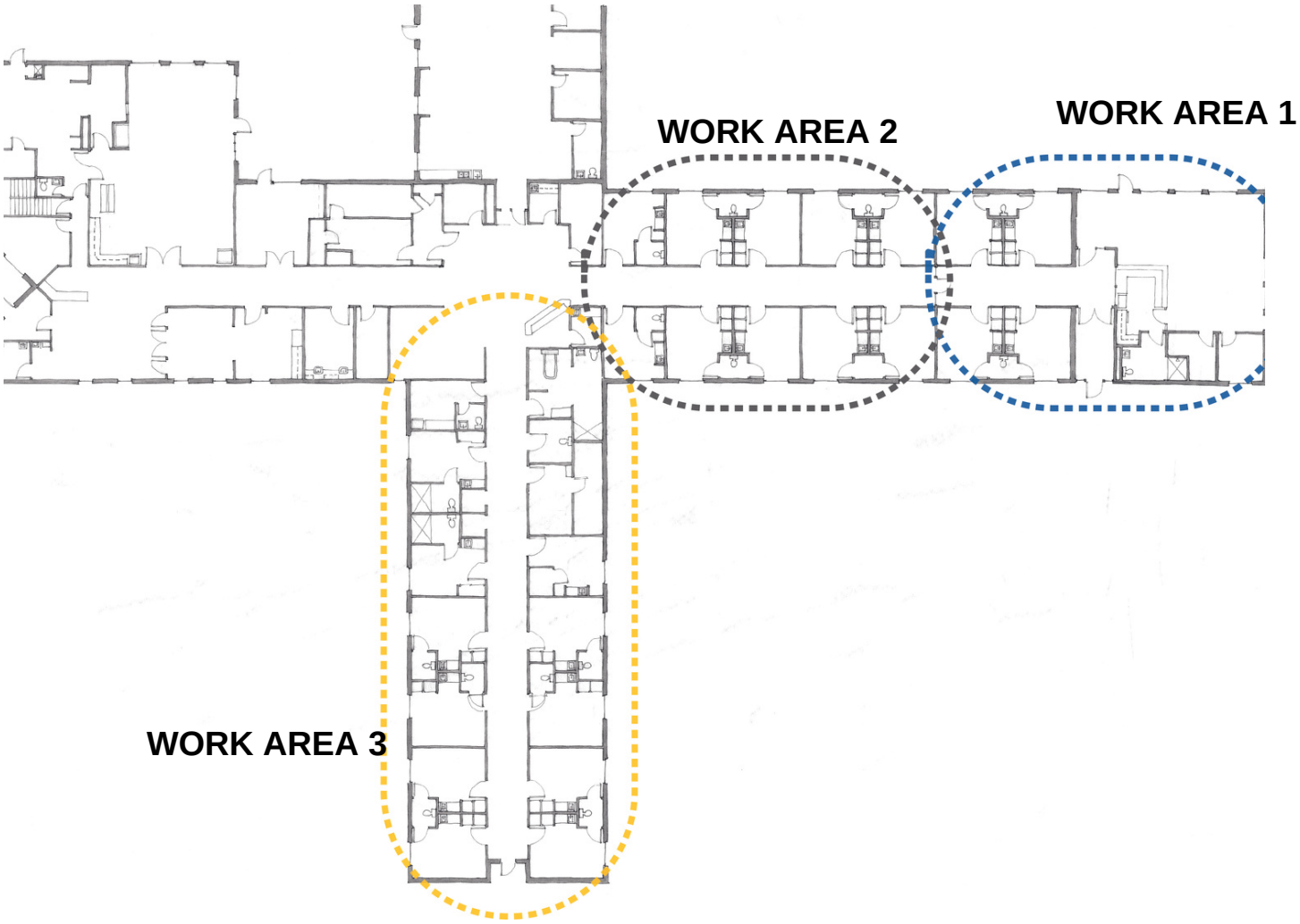
CORE: RELATIONSHIPS

EXAMPLE #1:

WORK AREA 1: 8 Residents

WORK AREA 2: 10 Residents

WORK AREA 3: 12 Residents



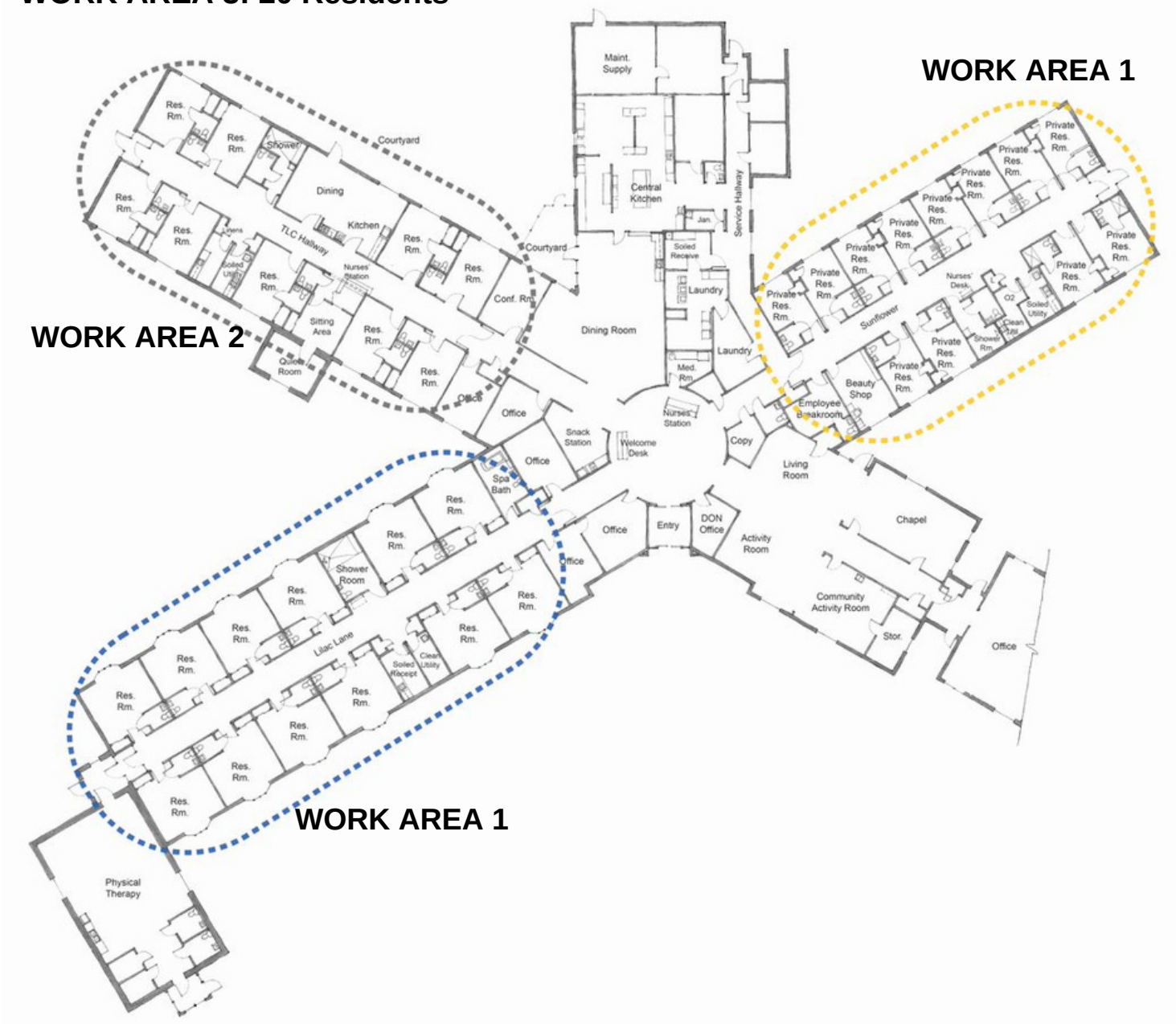
CORE: RELATIONSHIPS

EXAMPLE #2:

WORK AREA 1: 12 Residents

WORK AREA 2: 10 Residents

WORK AREA 3: 20 Residents



CORE: RELATIONSHIPS

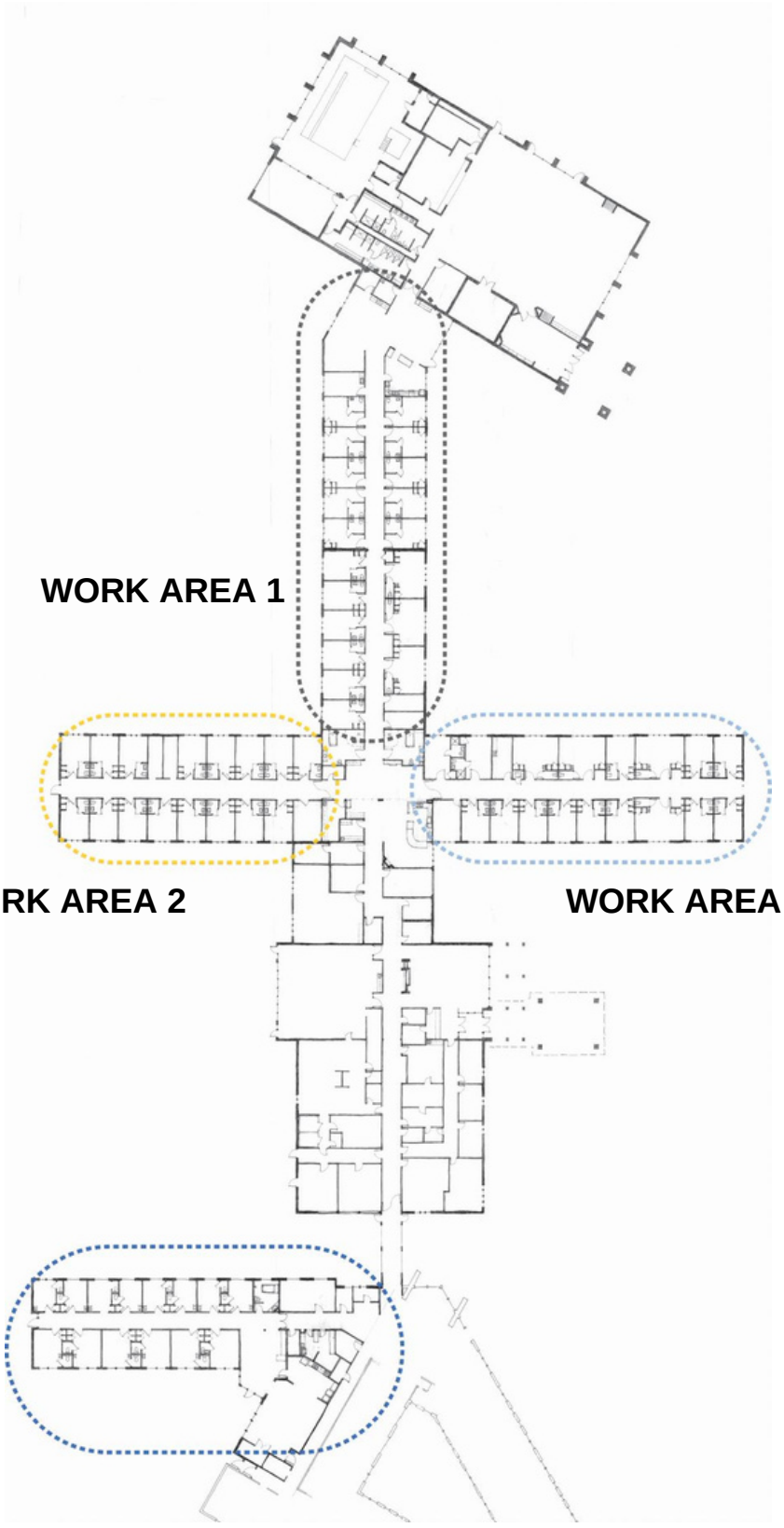
EXAMPLE #3:

WORK AREA 1: 22 Residents

WORK AREA 2: 18 Residents

WORK AREA 3: 20 Residents

WORK AREA 4: 14 Residents



WORK AREA PICTURE EXAMPLES:

Snack/dining area in former large living area

Staff work area and living space where the former large nurse's station was located

Closet converted to a staff work space.

Eliminating the traditional nurses' station requires that you recreate other areas where staff can complete similar tasks.

These images are examples of how homes were creative in solving this problem.

BASIS FOR EVALUATION:

Evidence will include:

- The home will provide a building floor plan (can be a fire evacuation plan) with work areas identified, including the number of residents who live in each work area.
- The home describes how supplies and equipment are reallocated to support each work area.

2 CONSISTENT STAFFING

CRITERIA: Teams are identified to consistently support people living in each work area.

REQUIRED OUTCOMES:

- A staff schedule is developed for each work area. (Required)
- Team members are assigned to a team in a defined work area. (Required)

AND Meet 2 of the following 4 options:

- Versatile workers are utilized in each work area.
- There is no "scheduled" staff rotation between work areas
- There is no "scheduled" agency staffing.
- PRN staff are recruited and designated for each work area.

FURTHER GUIDANCE:

A staff schedule is developed for each work area (required)

Once work areas are defined, a work schedule should be developed for each work area. It is recommended that these be separate from one another, even if you have a master schedule where you can see all schedules at one time. Homes are also encouraged to create new schedule templates (what it takes to staff each work area within budget parameters) rather than attempting to make current templates fit your new situation.

CORE: RELATIONSHIPS

action planning: Staff schedule for each work area

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 residents 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 or rethinking a schedule all together.

When creating new schedule templates, it is important to think beyond CNAs. Social service designees, activity staff, nursing, housekeeping and food service roles to name a few can all be blended and distributed among the work areas as consistent staff. With this in mind, ask questions like, "What will it take to meet the needs of the people living in this area?" Look closely at your total budget and determine where the staffing dollars and hours best fit. Schedule templates in each work area may look different based on the residents who live in each area and their personal routines and needs.

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 residents every day they work.

Meet 2 of 4 Options
In addition to the two required outcomes (a staff schedule for each work area and staff assigned to a team in a defined work area), homes must also meet at least 2 of the following outcomes:

1. No scheduled agency staff
2. No scheduled rotation
3. Versatile Workers
4. PRN staff assigned to a work area

CORE: RELATIONSHIPS

Click the options below to explore and learn how to meet these criteria:

NO SCHEDULED AGENCY	**VERSATILE WORKERS**
NO SCHEDULED ROTATION	**PRN STAFF ASSIGNED TO A WORKER AREA**

No scheduled agency staff
The use of agency staff undermines consistent staffing 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.

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. 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. Work to cover open shifts with work area staff first before considering staff from other work areas.

action planning: No scheduled rotation

To meet this criteria, the evaluation team uses the 75% rule. Keeping the 75% rule in mind as you set up your work area teams, can help you make decisions about how you staff work areas and how you cover open shifts.

No scheduled rotation is evaluated by calculating the total number of staff on the schedule (excluding overnight and PRN staff) and then determining how many of them work in more than one work area. The home must have 75% of their staff working in the same work area and only 25% working in more than one area to meet the criteria. Check out the **Consistent Staffing Tool** or **Consistent Staffing Printable Tool** to assist you in calculating the 75% rule.

CORE: RELATIONSHIPS

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". When versatile workers are used, everyone is responsible for supporting residents 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 their traditional roles.

With versatile workers, the positions themselves are typically blended and any person working is expected to serve in multiple functions on any given day. Versatile workers are expected to support residents in any way they can, working outside their traditional work "silos".

example: Versatile worker

Often, there is confusion about the versatile worker. For example, a CNA who fills in for a housekeeper occasionally or the dining aide who becomes a CNA and covers CNA shifts from time to time are NOT versatile workers and do not count as as one of the two required outcomes to be met in this area.

A versatile worker is someone whose daily job includes a variety of job duties that may cross over traditional departments. For example, in a home using versatile workers, a caregiver might routinely assist a resident with personal care, fix a snack or serve their meal, clean their bedroom, and enjoy a game of Scrabble in the same day.

PRN staff are assigned to specific work areas

Consistently assigned PRN staff will help support your consistent staffing model. To meet this area, homes develop their own PRN team for each work area to help when needed in that area.

BASIS FOR EVALUATION:

Evidence will include:

- The home will provide the last two weeks - one month of staff schedules for each work area that are completed. Include a key or directions on how to read the schedules (ex. abbreviation key) and include a designation of the schedule area not separated by work area that lets us know who works where.

- For the criteria with 4 options, the home will identify the 2 areas to be evaluated and then will be asked to describe practices related to the 2 they have selected.

CORE: RELATIONSHIPS

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET	CORE AREA AUDIT
CONSISTENT STAFFING IMPLEMENTATION A "HOW TO" GUIDE	TRAINING VIDEO: (0:00-6:14)

NFMH RELATIONSHIPS

GOAL: *Residents enjoy meaningful relationships with caregivers.*

REQUIRED OUTCOMES:

1 - Consistent, Well-Trained Staff

- Staff members receive training on PCC care plans for each resident upon hire.
- There are no scheduled agency staffing.
- Versatile workers are assigned in the home.

GOAL: RELATIONSHIPS CORE

Residents enjoy meaningful relationships with caregivers.

Keep in mind that the idea behind this core is to better support resident choice through staff empowerment. When caregivers know more about the people they serve, it develops an environment that fosters meaningful relationships between the caregivers and clients. As they get to know one another, caregivers learn what is important to each client and how to best support their needs, preferences, and daily routines.

1 CONSISTENT, WELL-TRAINED STAFF

CRITERIA: Residents enjoy meaningful relationships with consistent, well-trained caregivers who support individual care needs and preferences.

REQUIRED OUTCOMES:

- Every staff member receives training on the person-centered care plan for each client/resident upon hire.
- There is no scheduled agency staffing.
- Versatile workers are assigned in the home.

FURTHER GUIDANCE:

Training on person-centered care plan for each client/resident

It is important for new team members to get to know each person they have been hired to support in order to create meaningful relationships with them. As new team members are hired, it is essential that they quickly become familiar with the individual care plan for each client/resident, including any specific therapeutic or behavioral interventions. It is important that each team member understands the purpose and intended benefit of these interventions so they can monitor their effectiveness. This empowers team members to contribute to decisions as they relate to needed changes in the plan of care for the clients/residents they support.

To do this, create an orientation process that includes a review of these care plans and discussion with experienced team members on their approach to care. Many homes have included this discussion in their orientation checklist to assure completion.

example: Orientation on individual care plans

Beth has recently joined the team at Englewood Nursing Facility for Mental Health. After her first few days of general orientation, she is paired with Michael, an experienced health aide at Englewood, for her on-the-job training. On the orientation checklist, Michael references the item that states, "Review individual care plans for all clients, including behavior plans and interventions." Michael shows Beth where to find the plans and decides to have Beth read five care plans per shift they work together. After she has read the plans, they review them together and Michael offers tips he has learned working with each client.

No scheduled agency staff

The use of agency staff undermines consistent staffing and should be avoided. If a home uses any agency staffing, they will not meet the criteria in for consistent staffing.

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".

When versatile workers are used, everyone is responsible for supporting clients 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 their traditional roles.

CORE: NFMH RELATIONSHIPS

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 clients in any way they can, working outside their traditional work "silos" on a daily basis to meet the needs of residents.

example: Versatile worker

Versatile workers are those who can (and do) perform different roles fluidly during their regular shifts. Individuals who take on different shifts in different roles, or who "step in to cover" for someone else because they are qualified to do so, is certainly helpful, but not really being "versatile."

A versatile worker IS someone who's daily job includes a variety of job duties that may cross over traditional departments. For example, in a home using versatile workers, a caregiver might routinely assist a client with personal care, fix a snack or serve their meal, clean their bedroom, and enjoy a game of Scrabble in the same day.

BASIS FOR EVALUATION:

Evidence will include:

- Home will provide samples of new orientation checklists that include person-centered care plan training.
- Direct caregivers will describe how they find and use individual person-centered care plans.
- The home will describe their use of agency staff during the last PEAK year.
- Direct caregivers will explain their job duties.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET

CORE AREA AUDIT

CORE : DECISION-MAKING RESIDENT CARE

IMPORTANT MESSAGE FOR NFMH HOMES:
The criteria for this core have been modified for your home. Click here to go to your criteria.

DECISION-MAKING RESIDENT CARE

GOAL: *The home supports resident decisions through a team approach.*

REQUIRED OUTCOMES:

1 - Shared Understanding

- Formal training on how to respond when residents make a risky decision

2 - Access to Information and Resources

All team members have access to:

- Information about special health needs of each resident
- Access to contact information
- Access to transportation
- Access to resident funds

GOAL: DECISION-MAKING RESIDENT CARE CORE

The goal of the decision-making resident care core is for the home to support resident decisions through a team approach.

The idea behind this core is that residents are ultimately in charge of their own lives. All caregivers should be empowered to support residents in the decisions they make, on the spot, without seeking approval from team members from a higher level on a staff hierarchy. Additional training is important to accomplish this along with caregivers having access to the resources that are necessary to support residents in their decisions.

1 SHARED UNDERSTANDING

CRITERIA: Team members are prepared and expected to support resident decisions.

REQUIRED OUTCOME:

- The home provides formal training to all team members on how to support resident decisions, including those that could be considered risky. (The training must include the position of the organization as it relates to decision-making when the choice of the resident may not be in agreement with policy, may pose a risk to the resident, or does not agree with the caregivers' personal value set.)

FURTHER GUIDANCE:

Formal training to respond to resident decisions

We would all likely agree that from time to time we make decisions that are not in our best interest. We may occasionally over-eat, skip exercise or not get enough sleep. Maybe we do not always follow our physician's recommendations to the letter. Person-centered care providers understand that risk is a normal part of life and people who live in nursing homes should continue to enjoy the right to make decisions for themselves.

example: Supporting resident decisions

Warren loves ice cream. He is diabetic, but insists life is not worth living without ice cream. He says he is more concerned about the quality of his life than the length of his life and believes there is no quality in a life without ice cream. After supper, he asks his caregiver for a triple scoop of Rocky Road in a bowl with chocolate syrup. His caregiver reminds him of his high blood sugar reading earlier in the day and asks if he wants a smaller serving. With a smile, he answers, "Absolutely not!" His well-trained caregiver brings the ice cream without argument then quietly lets the nurse know so she can keep an extra eye on his blood sugar and adjust his medication if necessary. Warren enjoys his ice cream but more importantly he enjoys his autonomy.

CORE: DECISION-MAKING RESIDENT CARE

Direct caregivers are often put in a very difficult position by the conflicting responsibility they have to support resident decisions while at the same time keeping residents as safe and healthy as possible. Homes are required to conduct formal training on how to support residents when they make decisions that may not be in their best interest. (Referred to here as a risky decision.) A one size fits all training is not possible for this subject; homes must look at their own practices and expectations related to risk and build a training around that. The training should be specific to your home. There are some subjects that should be included in your training. Refer to the **Guide to Developing Risk Training** for assistance in developing your organization's training.

example: Supporting resident decisions

Consider this Situation:

Norma is 84 years old with progressing dementia. Her increased weakness affects her ability to safely move about in her room by herself. She wants to be independent with ADLs and prefers to have the door shut when she is in her room. She had several falls and her family wants her to have a personal alarm to alert staff when she is up. Personal alarms cause her anxiety and limit her mobility, which would continue to increase her weakness.

Traditional Approach:

- Staff continue to use the alarm on Norma and the alarm acts as a personal restraint.
- The alarm goes off regularly and causes Norma anxiety that escalates into anger.
- Norma becomes anxious and aggressive toward others, so she is prescribed medication. The medication makes her balance worse and the falls continue.

Person-Centered Approach:

- Norma and her family are invited to a care plan with caregivers, who are consistently assigned to her care.
- The care team, including a direct caregiver, discuss situations surrounding her falls and review current best practices to minimize her falls.
- Together, Norma and her family along with her caregivers develop a plan aimed to reduce falls and minimize the risk for injury when Norma does fall.
- Norma and her family choose not to use the personal alarm. She experiences less anxiety and does not require medication.
- Norma receives restorative nursing to build her strength to the extent possible.

Key subjects to include in risk training:

- Clarify your organization's position on risk.
- Teach your team how to respond to a resident making a risky decision.
- Teach the team to consider the severity of risk.
- Teach the team to determine exactly why a person is choosing not to follow a physician order.
- Teach the team to talk about and offer available alternatives.
- Teach the team to educate residents about consequences of their decisions.
- Teach the team where and how to document.
- Teach the team to create person-centered care plans.
- Encourage team members to make decisions on an individual basis.

BASIS FOR EVALUATION:

- The home provides this formal training to all employees upon hire and again annually. 90% of ALL full-time and part-time staff, who are on the schedule every week, should be trained. Seasonal and PRN staff are optional.
  Evidence will include:
  - A copy of the risk training outline used by the home.
  - Records of attendance maintained for the risk training.
  - The home describes how they plan to keep new and current employees trained.

2 ACCESS TO INFORMATION AND RESOURCES

CRITERIA: Team members have direct access to information and resources to support resident decisions.

REQUIRED OUTCOMES:

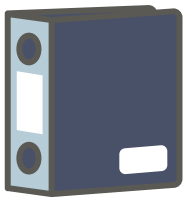
- All team members have access to information about the specific health needs and preferences of each resident in their work area.
- Direct care staff have access to contact information and facilitate communication between residents and their support system.
- Staff have access to transportation as needed to support residents.
- Staff have access to petty cash or resident funds to support resident requests.

CORE: DECISION-MAKING RESIDENT CARE

FURTHER GUIDANCE:

Access to information

Homes are gathering excellent information from residents about their health needs, personal preferences, daily routines and things that make them happy. It is important that all team members have access to this information so they can respond to residents' requests appropriately. Homes meet this in a variety of ways:



- Kiosks
- Pocket Care Plans
- About Me Binders

Access to contact information and communication

Empower direct caregivers to contact family members or loved ones at the request of residents. Maybe a resident needs some socks, wants a special snack or just wants to let their family know of an upcoming event. Be sure direct caregivers know they are expected to make the contact as requested by residents and that caregivers know what they can discuss with contacts and how to access their contact information.

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 a week day when members of the administrative team are available to provide transportation.

Homes have accomplished this in ways such as (but not limited to) training all staff to drive facility vehicles, creating on-call driving rotations among administrative staff, or purchasing tickets with a community transportation company.

example: Access to contact information and communication

While Shanna is providing care for Fred, he mentions that his cell phone has not been working properly. He would like his son to come help him with it or take it in for repair. Because Fred's phone does not work, he asks Shanna to reach his son.

Shanna is happy to help him. She goes and gets the house phone and looks up Fred's son's number on his face sheet on the Point Click Care kiosk. She dials the number and gives the phone to Fred to talk with his son. Fred was grateful to get that task off his "to do" list with Shanna's help.

CORE: DECISION-MAKING RESIDENT CARE

example: Access to transportation

Marjorie has a grandson getting ready to graduate from college. She wants to go downtown and select a greeting card to send him. The self-led team for the living area talks about how the day is going and comes up with a plan for a CNA to take Marjorie downtown 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 the CNA is out with Marjorie.

Access to petty cash

The home has a system in place to assure residents have access to their own petty cash 24/7 without waiting for a member of the administrative team to arrive at the building. Homes have implemented various systems to meet this outcome. Among the most common is a cash box that a nurse can access at resident request.

BASIS FOR EVALUATION:

- Direct caregivers will explain how they access specific health needs and preference information of residents.
- Direct caregivers explain how family contact and communication is handled.
- Direct caregivers will describe transportation options available to them to meet resident requests.
- Direct caregivers will explain how they access petty cash at the request of residents.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET	CORE AREA AUDIT
GUIDANCE FOR DEVELOPING A RISK TRAINING	TRAINING VIDEO: (6:15-11:17)

NFMH DECISION-MAKING RESIDENT CARE

GOAL: *The home supports resident decisions through a team approach.*

REQUIRED OUTCOMES:

1 - Shared Understanding

- The home has developed a formal process to evaluate, address, and plan responses to risky decisions.
- Home provides formal training to all team members on the process for all decision-making.
- Home addresses risk on an individual basis rather than with blanket policies.

2 - Access to Information and Resources

All team members have access to:

- Information about special health needs of each resident
- Access to contact information
- Access to transportation
- Access to resident funds

DECISION-MAKING RESIDENT CARE CORE GOAL:

The home supports resident decisions through a team approach.

We would all likely agree that from time-to-time we make decisions that are not in our best interest. We may occasionally over-eat, skip exercise, or not get enough sleep. Maybe we do not always follow our physician's recommendations to the letter. Person-centered care providers understand that risk is a normal part of life and people who live in nursing homes should continue to enjoy the right to make decisions for themselves.

CORE: NFMH DECISION-MAKING RESIDENT CARE

The idea behind this core is the we acknowledge that residents are ultimately in charge of their own lives. This can be complicated in the NFMH setting as many residents have additional challenges related to their mental health issues. All caregivers should be empowered to support residents in the decisions they make, on the spot, while mitigating risk to the extent possible. Additional staff training is important to prepare team members and empower them to respond in these situations. Caregivers must also have access to the resources that are necessary to support residents in their decisions.

1 SHARED UNDERSTANDING

CRITERIA: Team members understand what is expected of them and are prepared to mitigate risk and support client choice to the extent possible. Care and behavioral plans established in the home will be determined on an individual basis taking into consideration the therapeutic needs and personal preferences of each individual.

REQUIRED OUTCOMES:

- The home has developed a formal process to evaluate, address, and plan responses to risky decisions.
- Home provides formal training to all team members on the process for all decision-making.
- Home addresses risk on an individual basis rather than with blanket policies.

FURTHER GUIDANCE:

Formal process to evaluate, address, and plan responses to risk.
Direct caregivers are often put in a very difficult position by the conflicting responsibility they have to support resident/client decisions while at the same time keeping residents/clients as safe and healthy as possible.

The home should develop expectations as they relate to staff response to individuals who make decisions that are not in their best interest (referred to here as risky decisions).

Create a training outline that describes your expectations of staff in responding to these situations. A one-size-fits-all training is not appropriate for this subject; homes must look at their own practices and expectations related to risk and build a training around that. The training should be specific to your home.

CORE: NFMH DECISION-MAKING RESIDENT CARE

Guide to developing a formal process to evaluate, address and plan responses to risk.

Subjects that should be addressed in your formal process include, but are not limited to:

- Consider the severity of 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?
- Consider available alternatives and staff approaches to mitigate risk and support resident choice.
- Direction on how and where to document these situations.
- Person-centered care plans addressing risky decisions are reviewed regularly and issues revisited on an on-going basis.

Formal training to all team members

All team members working in the home should receive this training upon hire and again annually. Homes often add this training to their new employee orientation checklist to assure it is covered during the initial orientation and training period.

Homes include a review of this training annually in a number of ways including, but not limited to:

- Annual in-services schedules
- Competency fairs
- Electronic training programs
- Discussions in huddles and stand-up meetings

Address risk on an individual basis rather than with blanket policies

Here again, work to keep your focus on individual decisions. A blanket policy creates a single response to a behavior regardless of the individual's capacity to manage the outcomes of their decision.

***Example:* Individualized Solutions**

Work to create and implement policies that always focus on assessment of each individual and what best meets the needs of each person.

For example, Mary has a long history of compulsive spending and is unable to carry her petty cash on her person. An individualized care plan would address why her money is kept at the desk and how she is to access it. In contrast, a blanket policy would state that no resident carries their own spending money and would create restrictions for everyone even if they do not have the same challenges.

BASIS FOR EVALUATION:

- Home will explain the process used to evaluate, address, and plan responses to risky decisions
- Review of training outline used to train on this process
- Direct caregivers will explain this process.
- Home will explain how they plan to keep new employees trained.
- Review of individualized care plans

2 ACCESS TO INFORMATION AND RESOURCES

CRITERIA: Team members have direct access to information and resources to support resident decisions.

REQUIRED OUTCOMES:

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- Staff have access to transportation as needed to support residents.
- Staff have access to petty cash or resident funds to support resident requests.

FURTHER GUIDANCE:

Access to information

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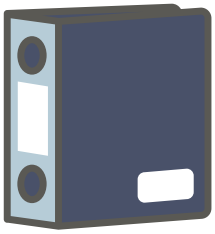

- Kiosks
- Pocket Care Plans
- About Me Binders

CORE: NFMH DECISION-MAKING RESIDENT CARE

Access to contact information and communication

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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.

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example: Access to contact information and communication

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example: Access to transportation

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BASIS FOR EVALUATION:

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- Direct caregivers will describe transportation options available to them to meet resident requests.
- Direct caregivers will explain how they access petty cash at the request of residents.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET

CORE AREA AUDIT

DECISION-MAKING STAFF WORK

GOAL: *Traditional top-down hierarchy is replaced with self-led teams making decisions that affect their work.*

REQUIRED OUTCOMES:

1 - Staff Scheduling

- Direct care (DC) staff are self-scheduling

OR

- The scheduling process includes:
  - DC staff input is gathered for staffing plans
  - DC staff arrange their own coverage
  - DC staff coordinate and negotiate time off with one another

2 - Hiring and Orientation Practices

- DC staff receive training on homes' hiring practices
- DC staff involved in the hiring process
- DC staff are involved in orientation of new staff

3 - Leadership

- The home has a central leadership team that includes DC staff representation
- Each work area has a leadership team that includes DC staff representation
- DC staff serve on work groups addressing issues throughout the home

GOAL: DECISION-MAKING STAFF WORK CORE

The goal of the decision-making staff work core is that the traditional top-down hierarchy is replaced with self-led teams making decisions that affect their work.

CORE: DECISION-MAKING STAFF WORK

When working through this core keep in mind that in person-centered care, daily decisions are made by the resident and supported by those closest to them. Those closest to the individual 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 the latitude and authority they will need to truly support individual decisions.

1 SELF-SCHEDULING

CRITERIA: Direct care staff are directly involved in staff scheduling.

REQUIRED OUTCOMES:

- Direct care staff participate in self-scheduling.

  OR

- The scheduling process includes the following three outcomes:
  - Direct care staff input is gathered for staffing plans.
  - Direct care staff arrange coverage when they are unable to work.
  - Direct care staff coordinate and negotiate time off with one another.

FURTHER GUIDANCE:

Self-scheduling

Direct caregivers are in a much better position to develop staffing plans that will meet the needs of the residents than leaders who are more removed from direct care. With guidance and direction from leaders, self-scheduling can benefit all parties by better meeting resident needs and empowering staff to determine and negotiate their own schedules. This increased ownership can lead to better staffing coverage with reduced call-ins and increased staff retention.

The self-scheduling outcome can be met in one of two ways. Select one of these options to implement:

DC STAFF SELF-SCHEDULE	SCHEDULING PROCESS INCLUDES THREE OUTCOMES

CORE: DECISION-MAKING STAFF WORK

Self-scheduling
If your team selects this option, direct care staff actively develop and manage the schedule based on resident needs. Leaders provide guidance on required staffing levels, budget parameters, and individual human resource issues that may impact benefits (ex. staff person must work at least 32 hours per week to maintain full-time benefit eligibility unless taking PTO time). It is also helpful to create some guidelines for the self-scheduling process and an agreed upon schedule selection process so that there is a level playing field for all staff. From there, direct care staff work together as a team to develop the schedule.

OR

Scheduling process includes the following three outcomes

1. Direct care staff has input in the plans for staffing.
2. Direct care staff arrange coverage when they are unable to work.
3. Direct care staff coordinate and negotiate time off with one another.

If the team is not self-scheduling, they must be actively involved in the process through the three outcomes listed above 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 residents 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.

For additional guidance on self-scheduling, see the **Guide to Self-Scheduling**.

action plan: Self-scheduling and electronic scheduling systems

Many homes have moved to electronic scheduling systems that not only display schedules but also allow for notifications when a shift is open. If you are considering these types of technologies, shop for those that allow for interactivity and some division between work areas of the home. It is important to be able to have separate or distinct schedules for each work area (consistent staffing) so work area teams know what is schedule gaps are in their work area to maintain consistent staffing.

Example: One way to gather input on scheduling when people are not able to meet in person at the same time is by using a Google document. A digital template could be shared among team members to fill in their desired schedule. Others on the team can see entries from other team members. A designated person can then lock the document after the schedule is finalized.

BASIS FOR EVALUATION:

- Homes will describe their scheduling process.
- Direct care staff will explain how they have input into the scheduling process.
- Direct care staff will explain how they handle call-ins and arrange their time off.

2 STAFF HIRING AND ORIENTATION

CRITERIA: Direct care staff are involved in the selecting and training of new staff.

REQUIRED OUTCOMES:

- Direct care staff receive training on the homes' hiring practices.
- Direct care staff are involved in the selection process of all new hires.
- Direct care staff are responsible for portions of the orientation of new employees.

FURTHER GUIDANCE:

Direct care staff receive training on hiring practices

As direct care staff become involved in hiring, teach them about the do's and don'ts of interaction with potential employees. Some examples might be what can and cannot be asked during an interview and what qualities to look for in a good employee. If direct caregivers are involved in interviews, it can also be helpful to develop a list of agreed upon questions that are used used as the main questions during interviews. Individual work areas or neighborhoods may want to develop some specific questions for applicants based on their specific hiring needs and preferences.

Direct care staff are involved in the hiring process

Traditionally, the nursing home field has been challenged by extremely poor staff retention rates. Homes must get creative in 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 a new hire. If they have chosen a person to be their coworker, they may be more likely to help them succeed. With direct caregivers involved in the selection process, be sure to actively involve them in the decisions about whether to hire or not. It can be disempowering to ask for input and then ignore the input you requested. Keep communication lines open as your teams make decisions.

action plan: **Involving direct care staff training on hiring practices**

One way homes have done training related to hiring is creating a one-pager than includes the dos and don'ts of interviewing. This is provided and gone over with individuals involved in interviews. In some homes, residents are also involved in interviewing potential employees and they need training, too! The one-pager is a great way to communicate these essentials to anyone involved in interviews.

examples: Direct care staff involvement in hiring

There is an opening for a day shift CNA in Harvest House. The team posts their job opening on the employee communication board and to Human Resources. After initial screening, the Human Resource leader brings the application to the team, who they would be working with, for review. The Human Resource leader works with the Harvest House team to set up a time to do an interview with applicants. The team uses an interview tool with a grid that was developed by the Harvest House team to help them determine if this applicant meets the expectations of the team. The decision is made by consensus of the team and Human Resources as to whether a job offer is extended.

Direct caregivers responsible for portions of new employee orientation

Traditionally, caregivers have been trained by an appointed trainer and then turned over to the "floor" to begin work. PCC recognizes the value of an empowered team. Empowering staff is achieved by high engagement and relationship development. Homes are encouraged to involve peers from the very beginning of a new team member's orientation. Connecting new hires to their actual work and the people they will be working with directly, begins the relationship development process. It personalizes the experience, offers better support to new team members and gives peers a vested interest in their success.

Required trainings and skills work can be done away from the new hire's work area, but direct care training should be done by competent peers. This group can better teach the hands on, day-to-day aspects of the job, as well as how the team handles the work flow together. The team will begin to build important relationships with one another from the start.

BASIS FOR EVALUATION:

- The home describes how they prepare direct care staff to be involved in interviewing.
  Evidence will include:
  - Home provides any training outlines or documents used to train on interviewing.
  - Home provides attendance records for interview training if applicable.
- Direct caregivers will explain how they are involved in new hires and the orientation process.

3 LEADERSHIP

CRITERIA: Direct care staff participate in leadership throughout the organization.

REQUIRED OUTCOMES:

- Direct care staff are actively involved in the home's central leadership team.
- Direct care staff serve on leadership teams in each work area of the home.
- Direct care staff serve on various work groups addressing the issues throughout the home.

FURTHER GUIDANCE:

Direct care staff are actively involved in the central leadership team

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. To support resident decisions, it is important to keep decisions as close to residents as possible by including direct care staff in central leadership decisions. What changes can be made to a top-down hierarchy to achieve this goal? Since direct caregivers have more daily contact with residents in your home invite representative(s) from that team to join your central decision making team. It is important that the direct care representation be consistent, meaning that once a direct caregiver is asked to participate on the central leadership team that they are the one that attends regularly. Your leadership team will benefit from the insight and ideas of those who work more closely with the residents.

example: Direct care staff involved in central leadership

Jerrie has served in her CNA role for 24 years. She is a natural leader and other team members look to her for guidance, though she has not served in an official supervisory role. In an effort to flatten the hierarchy, the department head team invited Jerrie to serve on the central leadership team. She serves as the CNA mentor and her role on the team is to represent the other CNAs and the residents whom she interacts with every day.

Jerrie attends the meeting each week. As decisions are made, the team discusses situations in a learning circle format, giving each team member the opportunity to express their thoughts and opinions. In the learning circle, Jerrie has the opportunity to weigh in with her thoughts and opinions. Her input and opinions are given the same value as those of the other members. The home has found that giving consideration to her point of view as a direct caregiver, who spends most of each day with the residents, has helped them to better support the resident perspective.

CORE: DECISION-MAKING STAFF WORK

Direct caregivers serve on leadership teams in each work area
Homes are encouraged to form self-led leadership teams in each work area to address day-to-day decisions that affect the area and provide support to the people living in the work area. Be sure direct caregivers are included on this team.

Decisions that the self-led leadership team would be responsible for include but are not limited to:

- Team staffing decisions
- Coaching team members
- Conflict resolution
- Scheduling and attendance tracking
- Budget management
- Activity plans
- Addressing environmental issues
- Targeted quality improvement initiatives

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. Here are some examples:

- QAPI Committee(Quality Assurance Performance Improvement)
- Safety Committee
- Fall Committee
- Party Planning Work Groups

This gives your home opportunities to benefit from the knowledge of those working closest with the residents. 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. High levels of engagement have demonstrated greater success in outcomes and improved staff retention.

CORE: DECISION-MAKING STAFF WORK

BASIS FOR EVALUATION:

- The home describes the different teams in their home and who serves on them.
  Evidence will include:
  - Homes provide a list of individuals on the leadership team(s) and their title (role they serve in the organization).
  - Home provide minutes from leadership or work team meetings held in the last two months.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET	CORE AREA AUDIT
CONSISTENT STAFFING TOOL	TRAINING VIDEO: (11:18-15:35)

CAREER DEVELOPMENT

GOAL: *Systems are in place to promote professional development.*

REQUIRED OUTCOMES:

1 - Professional Development

- Formal career advancement OR skills enhancement program in place
- Versatile worker training opportunities

2 - Outside Education

- At least 10% of non-managerial staff attend some form of outside training

GOAL: CAREER DEVELOPMENT CORE

Systems are in place to promote professional development.

Enhancing professional development can be fundamental to retaining quality caregivers. Caregiving is a tough job and we know good direct caregivers possess a very special skill set. These skills should be recognized as valuable to the organization and rewarded with opportunities professional development even if it does not mean changing positions in the organization.

1 PROFESSIONAL DEVELOPMENT

CRITERIA: Formal opportunities are provided for staff to develop professionally.

REQUIRED OUTCOMES:

- A formal career advancement OR
- A skills enhancement program is in place.
- In-house training is available for versatile workers to learn new job duties and skills outside their traditional roles.

CORE: CAREER DEVELOPMENT

FURTHER GUIDANCE:

Formalized professional development program
As mentioned in the criteria, homes have two pathways to meet the criteria. They can create and implement a formal career advancement program OR they can create and implement a formal skills enhancement program. The program homes implement must be outlined formally in writing.

Click on your preferred option to see the full criteria:

FORMAL CAREER ADVANCEMENT	SKILLS ENHANCEMENT PROGRAM

OPTION #1 FORMAL PROFESSIONAL DEVELOPMENT PROGRAM:

FORMAL CAREER ADVANCEMENT
To meet the PEAK program definition of a formal career advancement, the program must address the following:

- The home must develop curriculum or identify approved outside educational opportunities for each level of the career advancement program.
- The career advancement program must provide opportunity for lateral advancement.
- The opportunities must be available for all non-licensed staff.
- The career advancement program must involve incremental pay increases OR title or position recognition for completing various levels of the career advancement program.
- It must include recognition for completion.

Educational opportunities
The program should clearly spell out the requirements to complete each level of the advancement program. Be specific about what the education requirements are at each level so each participant is expected to meet the same requirements. The education can be created by the home or you may use outside material that would be beneficial to your team.

CORE: CAREER DEVELOPMENT

example: Option #1 Formal Career Advancement Program - Education

One home has implemented a career advancement program that offers further education on various topics of care. When a direct caregiver has completed a level of the program, they are prepared to serve the home as a competency guide in different subject areas such as:

- Orientation guides- lead the training of new team members
- Hiring guides- assist with interviews and selection of new team members
- Dining guides- oversee the household in areas of food and food service
- Grief guides- step up during residents' dying process to assure resident and family needs are met
- Activity guides- take the lead in the house to assure residents leisure interests are being supported
- Dementia guides- help with team discussions and care planning of challenging dementia care issues

Other levels of the program may offer specialized training in leadership subjects, preparing caregivers to serve on neighborhood leadership teams or as household leaders.

- Coaching
- Offering feedback
- Conflict Resolution
- Organization policies
- Team evaluation

Lateral advancement

The traditional career advancement program (ladder) in nursing homes often looks like this. The CNA becomes a CMA, then 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 advancement program (ladder) places little value on the position of direct caregiver itself. Career advancement 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 caregiver.

example: Lateral Advancement

Jamie is a very talented CNA and loves her job. She is motivated, wants to learn and grow at her job, but just can't see herself working all day as a nurse. The nurses she knows are required to spend so much time on paperwork and MDS. She signs up for the formal career advancement program and learns she can complete training to serve as a dementia guide, a special area of interest for her. Upon completion of the training she is recognized with a new title, dementia guide. While continuing to provide daily direct care to the residents she loves, she takes on the new responsibility of training others to provide solid dementia care and thus contributes more directly to care planning issues. The new role has helped her build confidence in her work and she feels valued and appreciated by the leaders at work.

CORE: CAREER DEVELOPMENT

Available for all non-licensed staff
Be sure that opportunities are available to those working outside of the nursing department. Work to create opportunity for all staff, including, but not limited to:

- Kitchen staff
- Housekeepers

Incremental pay increases or title or position recognition
While some homes are able to award participants small incremental pay raises for working through the career advancement program, this is not required. Recognition of a title or position change will meet criteria. For example, maybe a team member becomes an orientation guide, a member of the leadership team, or a CNA mentor through the program.

Recognition
Upon completion of each level of the career advancement program the participant receives a certificate of completion or comparable recognition for their accomplishment.

OPTION #2 FORMAL PROFESSIONAL DEVELOPMENT PROGRAM:

FORMAL SKILLS ENHANCMENT PROGRAM

To meet the PEAK program definition of a formal skills enhancement the program should address the following:

- Educational opportunities to enhance skills for all non-licensed staff
- Strong coaching, mentoring and goal setting opportunities
- 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 participant that reflect their personal career goals
- Active leadership involvement in the search for training opportunities to achieve staff goals

Opportunities for all non-licensed staff
Make sure the Skills Enhancement program is available to all team members. Remember to include those outside of the nursing department.

- Kitchen staff
- Housekeepers
- Laundry team
- Clerical/Support staff
- Maintenance
- Grounds

CORE: CAREER DEVELOPMENT

Strong coaching, mentoring and goal setting opportunities
A coach or leader should be assigned to take an active role in guiding each participant and serving as their career mentor. Assigning a specific mentor to each participant allows them to build a relationship as they work to identify interests and find opportunities appropriate for the participants' needs. The mentor is someone the participant can talk with about their goals and dreams to receive guidance and support.

Regularly scheduled meetings
The idea is to create regular, on-going discussion. The needs of the participant cannot be met in one session. The mentor and participant should schedule regular meetings at agreed upon intervals to check in and discuss progress towards goals.

Development plans
Unlike the career advancement program, which outlines the curriculum of each level, the skills program focus is on setting individualized goals and a plan to attain them. The mentor and participant create a development plan that identifies the goals of the participant and steps they will take to reach their goals.

Active leadership involvement in the search for opportunity
The leader/coach is actively involved in finding resources or creating training opportunities for the participant. Once goals have been identified the leader will take time to look for trainings and/or experiences that will help the participant reach their goal.

example: Leaders involved in searching for opportunities

Perhaps a housekeeper is interested in becoming a Certified Dining Manager. The leader would research the requirements of that certification, maybe arrange some time for the housekeeper to shadow the current CDM, and find funding to enroll the participant in the course.

example: Option #2 Skills Enhancement Program

Emily has just returned to work after raising her children. She accepted a job as a housekeeper to get back into the workforce. While she loves working at the nursing home, she finds the work tedious to her. She has become friends with some of the team in the kitchen and really thinks she would enjoy working in that area.

She signs up for the home's skills enhancement program. She is assigned a mentor named June. June currently serves as the Director of Nursing. She has lots of experience leading others. As they meet the first time Emily shares that she might enjoy food service. June mentions that she has recognized strong leadership potential in Emily and asks about her interests. During one of their sessions June learns that Emily works as a volunteer to oversee the food production and kitchen at their church-run day care. Together, they decide the Certified Dietary Manager (CDM) program might be a good fit for Emily. June does some research to find out the requirements of the CDM program and arranges a day of shadowing for Emily with the current CDM. After Emily spends a day with the CDM she is even more excited about the possibility. June works with the administrator to find some financial support for Emily to enroll in a class to earn her CDM.

SUMMARY: FORMALIZED PROFESSIONAL DEVELOPMENT PROGRAM

To successfully pass this area, homes should outline their program (either option #1 or #2) in writing providing a description and the requirements of the program. This description should include, but is not limited to: who can enroll in the program, how to sign-up or enroll in the program, and how the program works. Describe the various levels of the career advancement program or how the skills enhancement program works.

Some homes create a formal policy to outline their career development program while others spell this out in a staff orientation manual or a special brochure about the program. There is no requirement about how this is done but it needs to be written and easily reproduced for sharing with the evaluators.

COMPLEMENTARY PRACTICES

While policies about hiring and promoting from within and paying for trainings and certifications are excellent complementary practices to career development, they alone do not address the criteria fully. Think about incorporating these great practices into your career advancement or skills enhancement program.

FURTHER GUIDANCE:

In-House training for versatile workers

Homes should have additional training available to versatile workers to learn new job duties and skills outside of their traditional roles. Make information available and create opportunities that allow team members to safely help with tasks outside of the traditional role they fill to the extent allowed by their license or certification.

Homes that have passed this core have created orientation programs that address different areas such as:

- Safe food handling
- Cleaning techniques
- Leisure activities

Team members learn to help prepare and serve food, clean the residents' home and assist in planning and supporting the residents in the pursuit of their leisure interests. These trainings are made part of the overall orientation of all new team members and further training is made available to those who are interested.

Think about how your team members find out about these opportunities. They could be spelled out in new employee handbooks, advertised in regular staff newsletters, or discussed in staff meetings.

example: Versatile worker training

Jane was just hired into a CNA position. She read about versatile workers in the New Employee Handbook and then she received an orientation checklist and a schedule of training times with various people in the organization. She notices that one day she is scheduled to train with a dietary manager, another with the housekeeper and yet another day with the activity director. At first, she thinks she has the wrong orientation checklist. After working with the home a while, she begins to understand what a special place she has found. The dietary manager had her watch a training video on serving food safely. She taught her how to find a dining book that outlines all of the special dining needs of each resident. She taught her how to find snacks and how to use some of the cooking equipment to make quick snacks in the neighborhood for the resident. The housekeeper taught her where to find cleaning supplies and how to use them safely. During her time with the activity director, she grew to understand her role in supporting leisure requests, learned how to access resources and began to recognize she could spend time doing fun things with the people she was hired to care for.

BASIS FOR EVALUATION:

- The home has implemented a Formal Career Advancement Program OR a Formal Skills Enhancement Program.
  Evidence will include:
  - The home will provide a written description of the program outlining it for review.
  - Staff describe how they were made aware of opportunities available to them.
- The home provides in-house training for versatile workers to learn new job duties and skills outside their traditional roles.
  Evidence will include:
  - Staff describes the versatile workers training opportunities available to them.

2 OUTSIDE EDUCATION

CRITERIA: Opportunities are provided for non-managerial staff to attend outside training.

REQUIRED OUTCOMES:

- 10% of non-managerial staff attend outside training of any kind during the PEAK year.

CORE: CAREER DEVELOPMENT

FURTHER GUIDANCE:

10% of non-managerial staff

Management is considered the traditional department heads, such as Administrator, Director of Nursing, Director of Social Service, Activity Director, Director of Maintenance, Director of Food Service, etc. Non-managerial staff is everyone else employed by the home. A charge nurse is considered non-managerial staff but the Director of Nursing is considered a manager. Identify your non-managerial staff and then determine how many must receive outside training to meet your 10%.

example: 10% of Non-managerial staff

A home has 55 total team members. 5 of the 55 are department heads or managers. That means the home has 50 non-managerial team members. 10% of 50 = 5. Therefore, 5 different non-managerial team members must receive some sort (does not have to be person-centered care content) of outside training during your PEAK year.

Work to assure 5 different individuals have the opportunity of some sort of outside training rather than sending 1 team member to 5 different trainings.

Outside training

Outside training can include any organized activity that provides staff with new information or a learning experience. Conferences, webinars, and/or other classes are common examples of activities that count towards the 10% completion requirements.

You may also include training that is 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 or organization.

It is recommended that homes track attendance by maintaining records with sign-in sheets and/or copies of certificates of course completion.

CORE: CAREER DEVELOPMENT

BASIS FOR EVALUATION:

- The home describes outside training opportunities available for non-managerial staff. Evidence will include:
  - Home provides information about number of non-managerial staff working in the home.
  - Review of sign-in sheets, certificates of course completion, copies of registrations for conferences, webinars, etc.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET

CORE AREA AUDIT

TRAINING VIDEO: (15:36-19:39)

CORE: RESIDENT BEDROOMS

RESIDENT BEDROOMS

GOAL: *Bedrooms in the home provide opportunities for privacy, personalization, and comfort.*

REQUIRED OUTCOMES:

1 - Privacy

- Arranged to promote privacy
- Boundaries are respected
- Regular trainings on privacy expectations

2 - Personalization

Meet at least 2 of the following:

- Décor reflects preferences
- Choice of paint color
- Bed and furniture choices are supported
- Policy in place to encourage personalization

3-Self-care and Mobility

- Adaptations to promote self-care
- Free of barriers to mobility and self-care

GOAL: RESIDENT BEDROOMS CORE

The goal of the resident bedrooms core is that bedrooms in the home provide opportunities for privacy, personalization, and comfort.

When working through this core, think in terms of creating a home rather than a work place. The priority is recognizing the environment as the resident's home. Resident choice and comfort is honored over staff convenience.

CORE: RESIDENT BEDROOMS

While the environment should be homey and comfortable, the program focus goes beyond the building and furnishings and looks at the practices of the team around boundaries related to privacy in resident bedrooms.

When creating resident environments, areas of focus should include:

- Privacy: visual and auditory
- Supporting choices for solitude
- Personalization of the resident bedroom space
- Accommodating and promoting self-care and independence

1 PRIVACY

CRITERIA: The sanctity of home is acknowledged and respected by all.

REQUIRED OUTCOMES:

- Furnishings in rooms are arranged to promote privacy.
- Staff recognize boundaries and are respectful of resident space.
- Staff receive regular training on privacy expectations.

FURTHER GUIDANCE:

Furnishings in rooms 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. Additionally, consider how public circulation occurs around private spaces and keep the circulation limited and controlled.

Boundaries are respected

The resident's bedroom space should be considered an area that is under the complete control of the resident. Permission to enter the space should be granted by the resident, even when they are not in the room. The delivery of supplies and/or maintenance should be completed with the knowledge and agreement of residents.

Consider this: A repair man or delivery man does not come into my home when I am not there. In fact, most companies require someone be home before they will come.

CORE: RESIDENT BEDROOMS

Gather a group of staff and residents working in the home and talk about boundaries.

- What boundaries did you enjoy at home?
- How is that different here?
- How can we change our practices related to boundaries to better support your privacy?

example: Respecting boundaries

Rosie does laundry for the residents in the home. As new people move in, she makes sure she introduces herself to them. She talks about her job, visits about any special clothing care instructions they may have, the laundry schedule options available to them, and their preference on laundry delivery.

Grace lives in room 101. When Rosie has her laundry ready for delivery she finds Grace, usually drinking coffee in her favorite spot. They go to Grace's room together so Grace can assist in putting her clothing away where she wants it.

Fred lives just down the hall. He has asked Rosie not to bother him when his laundry is ready. “My wife always put my clothes in the closest after she washed them. I trust you are better at it than me”.

Regular training on privacy expectations

Once the residents and staff have 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 conducting a team review annually. Homes usually include this training in their orientation materials and then include it in trainings and discussions again throughout the year. This discussions can be included in:

- Annual in-service schedules
- Monthly staff meeting agendas
- Occasional huddles
- Electronic training programs

CORE: RESIDENT BEDROOMS

BASIS FOR EVALUATION:

- The home will describe room arrangements that have been made to promote privacy.
- Direct care staff explain their practices around resident privacy and boundaries.
- The home explains how they handle training around privacy expectations.

2 PERSONALIZATION

CRITERIA: Residents are encouraged and actively assisted in creating personalized space.

REQUIRED OUTCOMES:

Select 2 of the following 4 to implement:

- Resident room décor reflects resident preference.
- Residents have the ability to choose paint color for their room.
- Bed and furniture choices are supported.
- A policy is in place to encourage personalization of resident rooms.

FURTHER GUIDANCE:

Homes are only required to meet two of the four choices in outcomes. Homes are NOT required to meet all four of the required outcomes in this area.

Click the options below to explore and learn how to meet these criteria:

ROOM DECOR REFLECTS RESIDENT PREFERENCE	CHOICE OF PAINT COLOR
BED AND FURNITURE CHOICES ARE SUPPORTED	PERSONALIZATION POLICY IN PLACE

CORE: RESIDENT BEDROOMS

Décor in bedrooms reflect resident preference
Homes should work with residents and families at the time of move-in to create a plan to personalize the resident's bedroom. Do what you can to assist residents as needed to implement the plan. Talk with them about the things they would like to bring with them. Find out if they will need help moving, hanging, or installing any personal items.

Items to be considered (but are not limited to) include:

- Personal bedding
- Lamps
- Photos
- Art
- Small furniture
- Computer/electronics
- Flooring choices
- Window coverings
- Light fixtures
- Radios/TVs
- Decorative items
- Knickknacks
- Sewing machine or hobby items

CORE: RESIDENT BEDROOMS

Choice of paint color
It is important for homes to clearly communicate their practices around paint color with residents. Be sure residents are aware of their options when they move in.

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 involve facilitation on the part of the staff in negotiating between roommates.

To meet the criteria for choice of paint color, residents 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. Homes MAY charge a fee for painting bedrooms to accommodate a personal color choice.

example: Choice of Paint Color

I met Edna in a nursing home in Southeast Kansas. When I met her, I couldn't help but notice her brilliant teal blue sweater, matching earrings, and fingernail polish. After we visited awhile she took me to her room. There I saw the brightest teal blue I had ever seen on a wall--EVERY wall! The bedspread and lampshade were the same bright teal blue. As we talked, she laughed and asked why I hadn't asked about her favorite color. She told me the exterior of her home had been painted the same color before she moved in. She proudly said to me, "Everyone who knows me, knows it's my thing."

Bed and furniture choices are supported
Homes who choose to meet this required outcome have implemented practices around supporting residents in bringing personal beds and furniture from home. These practices include a plan to evaluate the items for potential safety hazards they may present to any resident or caregiver.

Be sure your practices around bed and furniture choices include informing residents of their opportunity to bring personal furniture from home, as well as, monitoring potential safety hazards.

CORE: RESIDENT BEDROOMS

examples: Bed and furniture choice

Russell:
As Russell is moving into the nursing home, the Social Worker talked with his family about their policy regarding personal beds and furniture. Russell's son mentioned he had a new memory foam mattress at home that he just loved. His personal bed is King sized and everyone realized it wouldn't fit in the bedroom here. The Director of Nursing met with Russell to show him some options of mattresses available in the home. He selected a memory foam topper and was pleased with it.

Artie:
When Artie planned to move in, his family asked if he could bring his personal bed from home. A nurse went to his home to check out the bed. It sat somewhat low to the ground which initially concerned her, but the nurse determined that Artie is independent with mobility and bed transfers. She talked with Artie and his family and let them know that he could bring the bed, but also discussed the idea that if his condition were to change it may be necessary to find something not as low to the ground as a caregiver could get injured during transfers.

Policy in place
Homes must put their practices as they relate to personalization of resident space in writing. This can be done in a number of ways, including but not limited to:

- A formal policy
- Written in a New Resident Handbook
- A marketing brochure that offers suggested items to bring and options available to residents

The important part of this required outcome is that residents and their family members know their options about personalizing their bedrooms from the point they are considering moving in.

BASIS FOR EVALUATION

- A minimum of 2 of the 4 outcomes must be met.
- The home will describe their efforts to assist residents with personalization.
  Evidence will include:
  - The home will provide copies of written practices on personalization of resident space.
  - The home will provide pictures of resident bedroom spaces.

3 SELF-CARE AND MOBILITY

CRITERIA: The environment is adapted to promote self-care and mobility.

REQUIRED OUTCOMES:

- Adaptations are made to promote self-care
- Rooms are free of barriers to mobility and self-care.

FURTHER GUIDANCE:

Adaptations to promote self-care

Every resident will have their own strengths and weaknesses so changes in their rooms and bathrooms should be targeted to individualized needs. Not everyone will need (or want) the same thing. This criteria exceeds the minimum requirements for standardized placement of grab bars mandated by the Americans with Disabilities Act (ADA).

example: **Adaptations to promote self-care**

Ben is 6' 6", stands independently but does not bend easily. Mable is 4'11" and in a wheelchair. They can both wash their face if they can access their washcloth and see into the mirror. They will need towels stored at a different height, and their mirrors mounted (or tilted) so they can see their faces as they use the sink. Raising the height of the towel rack for Ben, and lowering the towel rack and tilting hte mirror forward for Mable is an example of promoting self-care.

Work to implement a process that involves talking with EACH resident in their bedroom about changes that could be made to make it easier for them to function independently.

Examples might be moving a towel bar or shelf so a resident can reach it or raising or lowering a closet bar so the resident can select their own clothing.

It may be helpful to have the therapy team help create a simple assessment tool to be used by the team. Look at the person's ability to perform daily tasks and how the environment could make it easier for them.

Keep in mind that people change over time. It may be helpful to identify team members to work with residents upon move-in and then again at care plan time to assure nothing has changed.

CORE: RESIDENT BEDROOMS

Free of barriers to mobility and self-care

Again, think in terms of individualized needs. Work with EACH resident 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. Here are some things to consider:

SUPPORTING INDEPENDENCE:

- Locate self-care items within reach
- Locate switches within reach
- Make clothing and personal items accessible
- Ensure people can reach and access the sink and see in mirrors

SUPPORTING MOBILITY:

- Determine optimal bed placement to support transfers
- Arrange furniture and other items to reduce barriers in the room
- Utilize supports for visually impaired residents such as high contrast color cues on the floor or guide ropes.

BASIS FOR EVALUATION:

- Homes will describe their practices to evaluate resident bedrooms for barriers to mobility and self-care.
- Home will give examples of adaptations they have made to promote self-care and mobility.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET

CORE AREA AUDIT

PERSONALIZATION TOOL

TRAINING VIDEO: (0:00-5:36)

CORE : RESIDENT USE SPACE

RESIDENT USE SPACE

GOAL: *All spaces in the home are comfortable and accommodating.*

REQUIRED OUTCOMES:

1 - Private Space

- Space is available to host and receive family and friends
- Bathing areas provide privacy and dignity
- Space for solitude
- Boundaries are respected

2 - Self-Care and Mobility

- Public spaces are free of barriers to mobility and self-care
- Adaptation to promote self-care

3-Institutional Elements

- Overhead paging turned off
- Equipment and carts are not left in halls
- Nurse stations are eliminated

GOAL: *RESIDENT USE SPACE CORE*

The goal of the resident use space core is that all spaces in the home are comfortable and accommodating.

When working through this core think in terms of creating a home rather than a work place. The priority is recognizing the environment as the resident's home and focusing on resident comfort over staff convenience. This core addresses all of the common areas of the building that individuals may use outside of their bedroom.

While the environment should be homey and comfortable, the focus goes beyond the building and furnishings and looks at the practices of the team around boundaries and use of the public spaces in the home.

CORE: RESIDENT USE SPACE

When creating and arranging public spaces, areas of focus should include:

- Creating intimate spaces within larger spaces
- Creating options for residents to host and gather with loved ones
- Reducing the mark of institutional equipment and postings
- Accommodating and promoting self-care and independence

1 PRIVATE SPACE

CRITERIA: Private space is available for resident use.

REQUIRED OUTCOMES:

- Space is available to host and receive family and friends.
- Bathing areas provide privacy and dignity.
- There is space available for solitude.
- Boundaries are respected by staff in these spaces.

FURTHER GUIDANCE

Space available to host and receive family and friends

Resident rooms are often not conducive to entertaining family and friends. Many homes are also space challenged making dedicated space for entertaining challenging. Getting creative as a team can help to identify spaces that could be used for multiple functions. Many homes use spaces like an activity room or conference room to double as entertaining spaces when they are needed. If your home has spaces that could be dedicated for entertaining, think about how these spaces can be enhanced for entertaining and hosting people.

Bathing areas provide privacy and dignity

Personal hygiene upkeep through bathing in a public use area is one of the most intimate, vulnerable personal care activities a person experiences in the nursing home. It is important to work to provide a comfortable, private atmosphere for residents in public bathing areas.

CORE: RESIDENT USE SPACE

Consider this practice from the perspective of a resident. If you were bathing in the public bathing area of your home, what would it be like? How might you feel if you were the one in the whirlpool, tub, or shower? Here are some questions to think about carefully:

- Are there any items or bins stored in the bathing areas that are used for purposes outside of bathing? (ex. soiled bins or biohazard, lifts)
- Are there reasons other staff members might need to enter bathing areas when it is in use? (ex. storage in the area that other staff members might need to access while a bath is occurring)

When space challenges are present, people get creative and sometimes bathing areas are used for additional storage. Unintentionally, these spaces become *less private* for residents because other staff may have a greater need to enter these spaces when they are in use. Avoid using public bathing areas for additional storage.

Beyond the bathing area itself, think about the bathing experience holistically. From the time staff get a resident for their preferred bathing method to getting dressed afterward, the resident should experience privacy and dignity. Elders should be fully clothed when being assisted to and from bathing areas, even if they need total assistance with a full lift.

example: Bathing areas promote privacy and dignity

Sarah is new to Sunshine Home and today she has an appointment to get her first whirlpool bath in the main bathing area. She is excited for the whirlpool because she believes the warm water and jets will help her arthritis pain. Sarah's favorite caregiver, Shaniqua, takes her to the whirlpool and Sarah gets in the tub. As Sarah is relaxing, she hears someone knock on the door and holler to Shaniqua. Soon, another caregiver is in the whirlpool room and Sarah becomes uncomfortable. The other caregiver tosses some items in a soiled utility area and collects some items out of a cupboard in the whirlpool room and walks out. Sarah suddenly feels exposed and nervous that someone else will come in without much warning while she is bathing. What started out relaxing suddenly became anxiety producing.

Space for solitude

Space and solitude is often limited in the nursing home, especially when residents are in a semi-private room with a roommate. Given this, it is important to have alternative spaces where individuals can go for quiet and solitude. This can be enhanced by respecting residents' boundaries for privacy. Individuals who need monitoring due to their health or cognitive impairment can be supported in this by unobtrusive check ins. Here are some ideas of resident use spaces that can be conducive to supporting privacy and solitude:

- Quiet rooms
- Chapel spaces
- Sun room
- Conference rooms
- Library space

BASIS FOR EVALUATION

- Homes will describe the spaces available to residents to entertain friends and family. At on-site visits, evaluators will observe these space(s).
- Homes will describe how privacy is handled in bathing areas. At on-site visits, evaluators will observe the bathing areas and how staff use these spaces.
- Homes will describe their practices and boundaries around entering social areas when in use by residents.

2 SELF-CARE AND MOBILITY

CRITERIA: The environment is adapted to promote independence.

REQUIRED OUTCOMES:

- Resident use space is free of barriers to mobility and self-care.
- Adaptations have been made to promote self-care.

CORE: RESIDENT USE SPACE

FURTHER GUIDANCE

Resident use space is free of barriers to mobility and self-care
As your team works through this practice, it is a great opportunity to explore your home from the resident's point of view and interview residents. This practice is all about how the space is experienced by residents. What works well? What isn't working well? Based on what you learn, you can problem solve about how to make spaces function well for residents. Get residents involved in the solutions!

Adaptations are made to promote self-care
This practice is very closely related to spaces being free from barriers to mobility and self-care. One of the key differences with this practice is that it requires proactivity to address rather than response to something not working well. Consider the needs of the individuals that use your spaces. What adaptations have been helpful to residents in their bedrooms/private spaces? Can these adaptations be translated into public spaces without impeding other residents?

example: Free of barriers

The possibiliies for removing environmental barriers are endless. Some barriers homes have shared include (but are not limited to):

- Installation of an electric door to outdoor patio areas to reduce barriers for residents with wheelchairs or walkers exiting on their own.
- Changing out doorway thresholds to make them easier for residents in wheelchairs to get over on their own.
- Chairs placed in long hallway alcoves to provide resting spaces for residents.

BASIS FOR EVALUATION

- Homes will describe the efforts they have made to support independence in resident use spaces.

3 INSTITUTIONAL ELEMENTS

CRITERIA: Key institutional elements have been eliminated.

REQUIRED OUTCOMES:

- Overhead paging has been turned off and used only in emergencies.
- Equipment and carts are not left in hallways.
- Nurse stations have been eliminated.

FURTHER GUIDANCE

Institutional elements are things that look like they belong in a hospital setting rather than in a home. Look around your home from that perspective. Identify items that look hospital like and work to replace those items with homelike alternatives.

Overhead paging is turned off and used in emergencies only

Noise pollution is unwanted or disturbing sound in the environment that affects the health and well-being of people in the environment. Work to create a peaceful living and work environment. Eliminating overhead paging is essential to meet this practice area. While overhead paging is convenient for staff, it is very disruptive to the living environment. Use overhead paging for emergency purposes only. If your home has adopted a call light pager system, consider any noise pollution pagers are contributing to the environment and work to reduce it.

Equipment and carts are not left in the halls

Equipment such as lifts, wheelchairs, blood pressure machines, and scales, as well as, carts for laundry, medications, and housekeeping are essential to the work you do in your home. Many times these equipment become prominent features of hallways and other spaces contributing to the institutional feel of the environment. As you work on this area, get creative to look for alternative storage possibilities for equipment. Consider ways to tuck these needed items away when not in use and update equipment that cannot be removed completely with more residential items.

- Converting small closets into open alcoves.
- Create built in storage for medications instead of medication carts.
- Evaluate all spaces in the home to determine what could renovated or repurposed for another use.

CORE: RESIDENT USE SPACE

CLUTTERED HALLWAY

CLEAR HALLWAY

Nurse stations are eliminated

Think about the work spaces in your home and how they are used. Strive to eliminate barriers between working staff and the residents 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 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 your work through your plan.

It is suggested that you review your plan with the PEAK team prior to renovation to assure it 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 if applicable, 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.

CORE: RESIDENT USE SPACE

TRADITIONAL NURSE STATION

DECENTRALIZED NURSE WORK AREA

BASIS FOR EVALUATION

- Homes will describe what has been done to eliminate overhead paging. At on-site visits, evaluators will listen and observe for overhead noise.
- Home will describe how equipment storage is handled. At on-site visits, evaluators will observe hallways and main areas for equipment and carts.
- Homes will provide a picture(s) of nurse work areas. At on-site visits, evaluators will observe nurse work areas looking for evidence that traditional nurse's stations are eliminated.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET

CORE AREA AUDIT

TRAINING VIDEO: (5:37-8:59)

SUPPORTING THE HUMAN SPIRIT

GOAL: *Team members work together to discover and support what gives each resident meaning and pleasure.*

REQUIRED OUTCOMES:

1 - Free Time

- Information is gathered about residents' routines, preferences, and daily pleasures.
- Information is available to DC staff.
- Residents live individualized daily routines supported by PCC care plans.
- Individual spiritual and cultural preferences are supported.
- Residents are honored when they pass on.

2 - Planned and Spontaneous Activities

- Residents are involved in planning formal activity schedules.
- Residents are involved daily in determining spontaneous activity.

SUPPORTING THE HUMAN SPIRIT CORE GOAL:

Team members work together to discover and support what gives each resident meaning and pleasure.

Supporting the human spirit is all about making life meaningful. This shifts the focus from traditional activity programming and calendars to a focus on supporting life to happen in our nursing homes. 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 a meaningful way, participate in decisions, help other people, and engage in life. This core helps us to come alongside residents in their personal pursuit of meaningful living.

1 FREE TIME

CRITERIA: ***Residents determine how their leisure time is spent each day.***

REQUIRED OUTCOMES:

- Information is gathered about resident routines, preferences, and personal pleasures.
- Information about resident leisure preferences is shared with direct caregivers.
- Residents live individualized daily routines supported by a person-centered care plan.
- Individual spiritual and cultural preferences are supported and accommodated.
- Residents are honored when they pass on.

FURTHER GUIDANCE:

Information gathered about resident routines, preferences, and personal pleasures

To support someone in living a meaningful life, we must first get to know them well. Develop an interview tool to gather substantial information about the normal daily routines residents lived before moving into the nursing home. The **Daily Routines Core** criteria asks that homes gather information prior to a resident moving in. Often, this is done through a brief interview tool done to get things started. For the meaningful life criteria, the interview tool should be robust and should become a living document that all staff members can add to or modify as staff get to know individuals more and residents become more comfortable to share.

action plan: Information gathering tool development

As you develop a tool to gather preference and routine information, think about tools you already have that include some of these questions. Your goal is to have one solid, robust tool OR tools that come together in one place that all staff can access. Eliminate duplicate questions on tools you are already using.

Here are some sample questions to consider as you develop your tool:

- Describe a typical day when you lived at home.
  - Morning routines/activities
  - Afternoon routines/activities
  - Evening and overnight routines/activities
- Any special diet, food allergies, or specific preferences?
- Favorite foods
- What are your hobbies?
- What specific spiritual or religious preferences do you want us to know about?

CORE: SUPPORTING THE HUMAN SPIRIT

Information is available to direct care staff

Once you have developed and begin using a tool to gather preference information, the next step is to make sure that direct caregivers can access the information, know how to find it, and can make changes to it as needed. This can be done in a variety of ways. Here are some ideas (but not limited to):

- Kiosks or Point of Care programs
- Notebooks or Binders
- Pocket care plans
- One Page Descriptions

Residents live individualized daily routines supported by person-centered care plans

Once information has been gathered, the resident's care team should strive to support the individual in continuing the daily routine of their choosing. Daily routine information, preferences, and personalized interventions should be spelled out in the care plan and updated as your knowledge of each individual grows and changes.

example: Person-centered care plan

Lisa's usual time to awaken is 8 a.m. After putting on her robe, she needs a one person assist to use the restroom. When done in the bathroom, she enjoys sitting in her recliner where she read the news and drinks a cup of coffee with cream. Next, she finishes dressing and putting on makeup so she can meet her three friends at breakfast in the dining room at 9:30 a.m. One of Lisa's favorite parts of the day is her bacon, egg, and cheese biscuit made to order with cranberry juice. One Monday, Wednesday, and Friday, she joins the exercise class before returning to her room to use the restroom and rest until lunch at 12:30 p.m. Occasionally, Lisa prefers pancakes for breakfast and at times she does not attend exercise class. She enjoys having the structure, but also the flexibility to change it up when she feels like it.

The individual spiritual and cultural preferences of each resident are supported

We often think about making sure our organizations offer religious services and that community clergy come to visit. This is an important and valuable aspect of serving residents. To meet this criteria, however, we must think more individually about how each person wants their culture and spirit supported. Ask each person what you can do to support their preferences and then develop a care plan to support it.

CORE: SUPPORTING THE HUMAN SPIRIT

example: Supporting spiritual and cultural preferences

An elder named Joseph moved into a nursing home. Staff learned that Joseph lived in an Amish community. The team began learning about how Joseph wanted to live out his religion in the nursing home. They discovered that Joseph prefers to get up at 6:00 a.m. each morning for quiet, undisturbed time to read his bible and pray. His bishop comes and visits him weekly on Thursday in his room. As is custom in the Amish faith, Joseph does not trim his beard. The pants Joseph wears are homemade, another important tradition in the Amish culture, and have a button flap, which he needs help fastening. These two preferences are listed in his care plan and caregivers' notes, so that all caregivers know how to best support him. Joseph also pauses quietly before each meal to say a silent prayer. Individual support and respect of these preferences around his religion and culture are important to him.

Residents are honored when they pass on

Residents who live in our homes are people that we develop relationships with and they have developed friendships with other residents. Take a moment to think about what happens in your home when a resident dies. It is important to honor each individual at the time of their death. When a resident is honored, it not only pays tribute to the person who has died, but it also provides a form of healing to staff and other residents who had a relationship with that person. As you brainstorm how this will be implemented in your home, consider individual ways to honor residents rather than group memorials.

action plan: Information gathering tool development

Homes have embraced the idea of honoring residents when they die, especially as consistent staffing has lead to deeper relationship development with residents. Here are some examples that PEAK homes have implemented:

- Placing a single stem flower on the resident's bed once the body is gone.
- Placing a photo of the resident on a designated memorial table with a basket to collect sympathy cards that residents can sign and send to the resident's family.
- Designating a special quilt that covers the resident's body as it leaves the home.
- Staff and residents escorting the body out of the home.
- Holding a community circle the day after a death to share stories of the resident.
- Serving the resident's favorite food or doing their favorite activity in honor of them.

BASIS FOR EVALUATION:

- Homes describe how information is gathered and shared with staff.
  Evidence will include:
  - The home provides interview tools(s) used to gather information about routines, preferences, and daily pleasures.
  - The home provides 2 sample care plans that address daily routines and leisure preferences.
- Homes describe how they support spiritual/cultural preferences.
- Homes describe their practices around honoring residents at the time of their death.

2 PLANNED AND SPONTANEOUS ACTIVITIES

CRITERIA: Individual and group activities reflect the interests of current residents.

REQUIRED OUTCOMES:

- Residents are involved in planning formal activity schedules.
- Residents are involved daily in determining spontaneous activity.

FURTHER GUIDANCE:

Residents are involved in planning formal activity schedules

Events and activities in your home should reflect the interests of the people currently living in your home. One way to do this is to involve residents in planning the activity calendars. Whatever strategy you use, residents should be able to talk about how they participate in this process. Activity professionals should also use the information they gather from residents through assessments in activity calendar planning.

action plan: Planning activities

As you develop a strategy for engaging residents in activity planning, think about tools you already have that gather this type of information. The information about daily preferences and routines in each of the resident's care plans can provide some starter ideas that you can build on in more organized discussions with groups like the examples here.

- Community Circles
- Activity Planning Committees

CORE: SUPPORTING THE HUMAN SPIRIT

Residents are involved daily in determining spontaneous activity

In homes providing person-centered care all team members understand their role in supporting residents in the daily life they want to live. That means we can no longer think in terms of the activity director taking sole responsibility for residents' daily agendas. All team members must be empowered to make spontaneous things happen as they have the opportunity. Activity directors or leaders take on the new role of making sure team members have access to the knowledge and resources they need to support spontaneous life and play a key role in organizing and supporting larger event or activity planning.

example: Spontaneous activity

Jayne and Rhonda were sitting on the patio on a nice morning reminiscing about going for rides in the country with their husbands to check crops and how much they enjoyed those quiet moments. Barb, the homemaker in the neighborhood, asked if she could take them for a ride after she cleaned up from lunch. After lunch, Barb checked out the facility van and the three went on a country cruise. She did not pass this ride on to the activity director to schedule for a later date. Instead, she was empowered by previous training on the use of the facility vehicles and was able to support their idea on the day she learned of their interest.

BASIS FOR EVALUATION:

- Homes describe the process used to plan formal activity schedules.
- Homes will give examples of spontaneous activity that is resident driven.
  Evidence will include:
  - During on-site visits, evaluators will look at posted activity calendars.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET

CORE AREA AUDIT

TRAINING VIDEO: (0:00–5:26)

CORE : COMMUNITY INVOLVEMENT

COMMUNITY INVOLVEMENT

GOAL: *Residents have opportunities to build and maintain existing connections.*

REQUIRED OUTCOMES:

1 - Internal Community

- Residents participate in chores.
- Residents have opportunities to help others.
- Residents contribute to community decisions.
- Residents have opportunities to express preferences and concerns.

2 - External Community

- Home gathers information about residents' community connections.
- PCC care plans address ways staff support community connections as desired by residents.
- Outside community members are welcomed by the home.
- Family and friends feel welcome.
- Home engages in community projects/life.

GOAL: COMMUNITY INVOLVEMENT CORE

Residents have opportunities to build and maintain existing connections.

The community involvement core focuses on supporting meaningful life for those living in your home. To thrive, people need opportunities to contribute in meaningful ways, to help other people, to participate in community decisions, and to maintain their ties to the community. These are basic human needs, but they look a little different to each of us. It is essential that we strive to discover what this looks like to each individual. What is important to them? What brings meaning to their life? What are their community connections, and how can we help them to maintain these relationships?

CORE: COMMUNITY INVOLVEMENT

Community Involvement helps us shift our priority from taking over residents' lives with our plans to keep residents engaged in life. As you plan activities with residents, facilitate care planning, and make daily decisions, think in terms of supporting life to happen in your home. When we plan and make decisions for residents, we can unintentionally put residents in the position of being bystanders in their own home rather than active participants.

1 INTERNAL COMMUNITY

CRITERIA: Residents have opportunities to be contributing members in the home.

REQUIRED OUTCOMES:

- Residents participate in chores or tasks as they desire.
- Residents have opportunities to help others.
- Residents contribute to community decisions through formal decision making processes.
- Residents have regular opportunities to express preferences and concerns.

FURTHER GUIDANCE:

Participation in chores

Much of the work we each do as individuals each day has a way of bringing us satisfaction and a sense of purpose and accomplishment. Often, our well-intentioned attempt to care for people can actually prevent them from feeling this sense of purpose and accomplishment.

Here are some ways to determine what residents want to do:

- Talk to people about what tasks they want to help with
- Ask what they prefer to do themselves
- Look for opportunities for residents to do things independently
- Provide the support they need with portions of the task they may need help with
- Look for opportunities in the home for residents to contribute with chores, maybe something they enjoyed at home. Cooking, housework, laundry, party planning, mail sorting and delivery, plant and pet care are all opportunities to get people involved in the life of the home and to give them a sense of purpose and accomplishment. Get creative!

CORE: COMMUNITY INVOLVEMENT

example: Participation in chores

Violet has always been known to keep a great house. When she moves into the nursing home the staff learns this is important to her. Violet says she can make her bed on her own since she can support herself on it while she works. She can dust her knick-knacks on her dresser but cannot reach the shelves on her walls. The homemaker, Mary, talks with Violet and agrees that she will clean the shelves but will not disturb the items on Violet's dresser or make her bed, except when it is time for a total bedding change.

Now, when Violet wakes in the morning, she relaxes a minute in her chair before getting dressed for the day. After she gets dressed, she makes her bed before going to breakfast. Most mornings after breakfast she spends some time straightening her room and dusting her precious keepsakes. Once a week she waters her houseplants with water Mary leaves in a pitcher for her. Much of her day is spent doing what she did at home; caring for her home.

Opportunities to help others

For many of us, the ability to help other people is an important key to living a meaningful life. Work to create volunteer opportunities for residents. Look for opportunities for residents to help others and avoid residents observing staff do the volunteer work. Some homes have become very creative in meeting this outcome. Here are some examples:

- A group of residents make and sell craft items and then donate the proceeds to community causes of their choosing.
- A resident, who is a retired minister, leads a Bible Study in his home.
- Residents volunteer to serve on a welcome committee in one home and greet and support new people moving into the home.
- A resident teaches other residents how to use email and Facebook on the home's computer.

Residents contribute to community decisions

This outcome is all about creating a culture where individuals are involved daily in deciding what is going on in their home. That means we must look beyond monthly Resident Council meetings to get residents involved in decisions. Decisions about hiring, purchasing, staffing, décor, furniture placement, menus, activities and how to celebrate holidays are all great examples (but don't feel limited by our list).

CORE: COMMUNITY INVOLVEMENT

example: Resident involvement in decisions

Valerie is a CNA in Sunflower House. She is sitting with a group of residents after breakfast drinking coffee. Each morning she starts her day by asking, "Well, it's a beautiful day. What do you want to do today?" She lets them know that the staff are interviewing a potential new team member at 10:00 a.m. The group then talks about the activity calendar but decides it's much too nice outside to stay indoors and watch the *Price is Right* today. They decide to move to the patio where they talk about the garden. Margaret mentions that the roses need to be dead-headed. Valerie gets the garden tools, gloves, and a second cup of coffee for everyone as they work together to clean up the roses.

At about 10:30 a.m. the DON joins the group on the patio with a new applicant. The residents offer the applicant a cup of coffee and they visit as they work. After the applicant leaves, Valerie asks them all what they think. They all agree they like this applicant better than the one they met yesterday.

Opportunities to express preferences and concerns

As we create a culture of resident involvement, people will naturally be more willing to share their thoughts, opinion, and concerns. To develop this type of culture, we must be intentional about asking residents for their input and valuing it. Regular impromptu discussions give residents opportunity to voice ideas and participate in decisions made in the home. Ask for this input and opinions and support resident decisions.

Think of ways to engage people who are less likely to open up in an meeting or a group setting. Some intentional strategies used by homes to gather input outside of group settings include but are not limited to:

- Suggestion boxes
- Periodic satisfaction questionnaires
- Assigning a single staff member to check in individually with residents at regular intervals to discuss the daily happenings of the home and gather input
- Individual regular visits to residents by dining and activity staff

BASIS FOR EVALUATION:

- The home describes individual examples of residents contributing to the home in meaningful ways.
- The home provides individual and collective examples of residents who help others.
- The homes describes examples of residents involved in decisions about day-to-day life in the home.
- The home describes formal opportunities and strategies used to encourage residents to voice opinions, concerns, and preferences.

2 EXTERNAL COMMUNITY

CRITERIA: Residents have opportunities to remain active members of the broader community.

REQUIRED OUTCOMES:

- Home gathers information about resident's current community connections.
- Care plans address ways staff support connections as desired by the residents.
- Outside community members and groups are welcomed by the home.
- Family and friends feel welcome in the home.
- Home engages in community projects and life outside the home in the surrounding community. (e.g., community projects, civic organizations, festival and fairs)

FURTHER GUIDANCE:

Gather information about resident's current community connections

Ask questions. Find out who the resident has relationships with in the external community and which of those relationships they wish to maintain. Possible connections to consider but are not limited to include:

- Family
- Friends
- Neighbors
- Civic groups
- Organization memberships

CORE: COMMUNITY INVOLVEMENT

Care plans address ways the staff can support community connections
When asking questions be sure to also ask how you can support them in maintaining their connections in the community. What do they need from you? Then be sure this support is clearly spelled out clearly in the person-centered care plan.

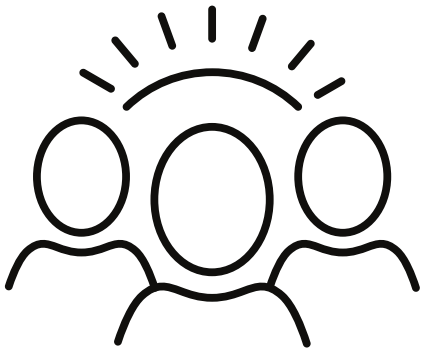
example: Care plan supports community connections

Rick's sample care plan:
CNA will assist Rick with a phone call to his daughter in Texas each Sunday after lunch. The phone number is kept in Rick's book by his phone.

Bob's sample care plan:
Bob attends the United Methodist Church in town each Sunday with his daughter. Assist Bob each Sunday morning to be sure he is dressed and ready for his daughter to pick him up at 8:30 a.m.

Gayla's sample care plan:
Gayla has participated in a Bridge club for over 20 year with women from her neighborhood. She no longer feels comfortable going out but still loves to play Bridge. She will host her Bridge club the first Friday of each month in the community room. The dining team will meet with Gayla each month to plan a menu for refreshments.

Outside community members and groups are welcomed by the home
Think in terms of the residents currently living in the home and the relationships they have with the outside community. Using that as your starting point, what can you do to encourage outside community members and groups to visit? Who do they want to host? Who would they like to see drop by? Groups to consider would have some connection to the people who live in your home.



CORE: COMMUNITY INVOLVEMENT

example: Community members welcomed

Marjorie is a member of the Red Hat Society. She has made a move to the nursing home in her local community and assumes she will not be able to continue going to the Ret Hat Society meetings. As Joe, a life enhancement coordinator, talks with Marjorie, he learns she is a member of the group. It becomes evident to Joe that the group is important to Marjorie. Joe encourages Marjorie to invite the group to meet in one of the available rooms in the nursing home. The Red Hat Society group accepts the invitation and meets in the conference room monthly now. Marjorie reserves the space in the nursing home, sends out invitations, and arranges the snacks and drinks for each meeting.

Family and friends feel welcome

Think of ways to support residents in your home in hosting their guests. Are there quiet, private, comfortable places for them to visit? Are refreshments easily accessible? Are staff respectful of visits and work to avoid interruptions?

This is an area homes can get really creative with. Some examples we have seen include:

- One home gathers a group of residents each Friday afternoon to bake cookies for the weekend. The cookie jars in the neighborhoods are the stocked and residents have them available to share with guests over the weekend.
- Another home purchased some games and children's toys for younger guests. They created both an indoor play area and one outside.
- One home has been known to support residents in hosting sleepovers with their grandchildren spending the night in sleeping bags in their room. The neighborhood team provides snacks, rents movies, and plays games during the visit.

The home engages in community projects and life

Talk to residents regularly about what is going on in the outside community. Look for areas of interest for people currently living in the home and engage them where possible. Remember that observing community is different than being a part of it. Many volunteer opportunities can be found with a little effort and creativity. Once residents have identified community projects and events that interest them, talk about how they can participate. Have residents help with all aspects of the event or project.

CORE: COMMUNITY INVOLVEMENT

example: Community projects and life

Hillside Nursing Home is situated in a small community that hosts an annually festival in the early fall. The whole town in involved in making the festival happen. The Hillside residents are excited to contribute to the event. Dan, a resident at Hillside, and Samantha, a household coordinator, attend the festival planning committee meeting and learn how they can be involved. Dan volunteers Hillside residents to be on the parade float judging team and Samantha volunteers residents to donate pies and baked goods for the community bake sale.

As the festival day approaches, Dan and two other residents are set to judge the floats. Another group of residents have worked all week to prepare pies and baked goods for the sale and plan to go deliver them in the Hillside van. Nancy, a CMA, has organized a group of residents interested in hosting a lemonade stand in the Hillside parking lot to raise money for a staff member's daughter, who had a kidney transplant. The whole day is filled with opportunities to actively participate in the festival and community happenings.

BASIS FOR EVALUATION:

- The home will describe how they gather information about residents' current community connections. Evidence will include:
  - A sample(s) of questions and/or tool(s) used to gather information about community connections.
  - A care plan that demonstrates community involvement.
- The home describes specific examples of outside community members being welcomed by the home.
- The home describes things they intentionally do to make visitors feel welcome.
- The home gives specific examples of resident involvement in life outside the home in the surrounding community and how these examples were initiated.

ADDITIONAL RESOURCES

ACTION PLAN WORKSHEET

CORE AREA AUDIT

TRAINING VIDEO: (5:27-10:14)