

ACTION PLAN WORKSHEET: DAILY ROUTINES

INSTRUCTIONS:

Before scheduling a time to write the action plan:

- Gather the **KDADS Criteria** for Daily Routines: (pg. 5 and pgs. 13-14): <http://www.he.k-state.edu/aging/outreach/peak20/2017-18/peak-criteria.pdf>
- Gather the **KDADS Core Considerations** for Daily Routines: (pg. 9-11): <http://www.he.k-state.edu/aging/outreach/peak20/2017-18/Core-Considerations.pdf>
- Gather a team together (approximately 5-6 people) who are invested and interested in working on this topic. Include a couple members of your PCC change team.
- Have all the team members read through the KDADS Criteria and Core Considerations for Daily Routines before meeting together.
- Bring copies of the KDADS Criteria and Core Considerations for everyone on the team when you meet to start writing the action plan.

At the time of the team meeting:

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

Now it is time to start action planning:

- Your team will work through the Daily Routines core, supporting practice by supporting practice.
- Read the statement under the heading Core #4, “Residents decide how they spend their day.” (KDADS Criteria page 13)
- This is the **GOAL** for this core area. Have the scribe write or type that exact goal statement in the goal box of the Action Plan Template as seen below.

Goal: Residents will decide how they spend their day.

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

Supporting practice #1: Move in Assessment

“Information is gathered about daily routines and preferences PRIOR to the resident moving in.”

1. Is the information you are gathering about residents’ routines and preferences adequate? See the Core Considerations to verify. **Circle:** YES or NO
2. Is the information you gather about residents’ routines and preferences gathered PRIOR to move in? **Circle:** YES or NO

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

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

Sample Objective: “Information will be gathered about residents’ daily routines and preferences by adding questions to our screening tool done prior to move in by September 21, 2017.”

Sample Action Steps:

- “Each daily routines team member will review the current screening tool.”
- “Look for sample screening tools from upper level PEAK homes for ideas.”
- Etc...

“Caregivers have access to information and preferences PRIOR to the resident moving in.”

1. Do direct caregivers report they have adequate preference information to enable them to meet resident preferences from day one? **Circle:** YES or NO
2. Is the information about resident routines and preferences given to caregivers PRIOR to the resident moving in? **Circle:** YES or NO

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

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

Sample Objective: “By September 30, 2017, the household coordinator will write up a summary of preferences and routine information gathered about new residents and make it available to caregivers prior to them moving in.”

Sample Action Steps:

- “Once new screening tool is determined, meet with the household coordinators to determine what information will be provided to direct caregivers.”
- “Household coordinators will determine the format in which it will be provided.”
- Etc...

“Caregivers support daily routines and preferences from day 1.”

What intentional things do caregivers do to make new residents feel welcome?

1. Do these intentional welcoming actions incorporate each new residents’ stated preferences and routines? **Circle:** YES or NO

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

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

Sample Objective: “Caregivers will use the preference and routine information provided by the resident to direct the resident’s day starting on the day of move in.”

Sample Action Steps:

- “Provide education to direct caregivers about how to use preference and routine information.”
- Etc...

Supporting Practice #2: PCC Care Plan Development

“90% of care plan meetings are attended by a resident (family members or designated decision makers may represent a resident at that resident’s request or if the resident is unable to communicate in any way).”

1. In the last three months, has attendance by residents AND/OR family members been 90%?
Circle: YES or NO

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

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

Sample Objective: “Care plan attendance by residents and/or family will be 90% for three months starting in February 2018.”

Sample Action Steps:

- “Determine our current care planning practices: How are meetings scheduled? Who is involved? How long are the meetings? Are they at set times/days of the week?”
- “Talk to residents and families about what they like and dislike about current care plan format.”
- “Call mentor homes and find out what they do to get increased care plan attendance.”
- “Review PEAK 2.0 webinar on daily routines to learn other best practices.”
- Etc...

“Residents and family member participate in the creation of the individualized care plan.”

1. Are residents and/or family members (legal representative) involved in setting care plan goals?
Circle: YES or NO

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

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

Sample Objective: “Residents and/or their family member(s) will be involved in setting their care plan goals by October 31, 2017.”

Sample Action Steps:

- “Determine our current care planning meeting format: What is the agenda of the care plan meeting? Who is involved? Do residents and/or families share their goals for care? Are these goals set as care plan goals?”
- Etc...

“90% of care plan meetings are attended by direct caregivers.”

1. In the last three months, has attendance by direct caregivers at care plan meetings been 90%?
Circle: YES or NO

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

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

Sample Objective: “Care plan attendance by direct caregivers will be 90% for three months starting in February 2018.”

Sample Action Steps:

- “Gather direct caregivers and gather input about what support they would need to attend care plan meetings and the role they see themselves playing in the meeting.”
- “Daily Routines team will develop an action plan based on direct caregiver input.”
- “Determine role of the direct caregiver in the meetings.”
- “Train direct caregivers to be prepared to participate in care plan meetings based on the role description developed by the team.”
- Etc...

“Direct caregivers participate in the creation of the individualized care plan.”

1. Are direct caregivers involved in creating resident care plans? **Circle:** YES or NO

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

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

Sample Objective: “Direct caregivers will be involved in creating care plans for residents within their work area by October 31, 2017.”

Sample Action Steps:

- “Meet with direct caregivers to brainstorm about how they will be involved in creating resident care plans.”
- “Daily Routines team will develop an action plan based on direct caregiver input.”
- Etc...

Supporting Practice #3: Care Plan Delivery

“All caregivers have direct access to care plan information.”

1. Are direct caregivers able to access the care plan (interview several staff members old and new)? **Circle:** YES or NO

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

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

Sample Objective: “Direct caregivers have access to the care plans by November 15, 2017.”

Sample Action Steps:

- “Contact mentor homes to learn ways they are making care plans available to d/c staff.”
- “Discuss with nursing staff ideas for making care plan information available.”
- “Decide on a way that care plans will be made available.”
- Etc...

“Systems are in place for direct caregivers to make on-going revisions to the care plans as directed by residents.”

1. Is there a way (not verbal) that direct caregivers can make changes to the care plan? **Circle:** YES or NO

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

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

Sample Objective: “Direct caregivers will be able to create alerts in Point Click Care to notify the nurse to review for changes to the care plan by December 15, 2017.”

Sample Action Steps:

- “Determine what software changes need to be made to enable alerts.”
- “Make Point Click Care updates to enable alerts.”
- “Develop education for direct care staff on how and when to use alerts.”
- “Schedule trainings.”
- “Set implementation date.”
- Etc...

“Daily routines are lived as outlined by the plan of care.”

1. Are you regularly checking with residents/family/designee to see if daily routine preferences are being met? **Circle:** YES or NO

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

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

Sample Objective: “During MDS assessment, direct caregivers will ask residents about their daily routines and if they have been supported in the last month by October 10, 2017.”

Sample Action Steps:

- “Develop a check-in questionnaire.”
- “Test the questionnaire.”
- “Revise the questionnaire.”
- “Implement the questionnaire.”
- “Meet with direct caregivers to see how the questionnaire has worked.”
- Etc...

Now that you have Objectives and Action Steps for each supporting practice within the Daily Routines core,

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