ACTION PLAN WORKSHEET: DECISION-MAKING / RESIDENT CARE

INSTRUCTIONS:

Before scheduling a time to write the action plan:

- Gather the ***KDADS Criteria*** for Decision-Making/Resident Care: (pg. 6 and pgs. 16-17): http://www.he.k-state.edu/aging/outreach/peak20/2017-18/peak-criteria.pdf
- Gather the ***KDADS Core Considerations*** for Decision-Making/Resident Care: (pg. 16-17): 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 Decision-Making Resident Care core, supporting practice by supporting practice.
- Read the statement under the heading Core #2, "The home supports resident decisions through a team approach." (KDADS Criteria page 16)
- This is the **GOAL** for this core area. Have the scribe write or type that exact goal statement in the goal box of the Action Plan Template as seen below.

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

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

Supporting Practice #1: Shared Understanding

"The home provides formal training to all team members on what to do when a resident makes a risky decision. "

1. Has the home developed and implemented a formal training for ALL team members on risk? **Circle**: YES or NO
2. Does the Risk training clarify the organization's position on Risk? **Circle**: YES or NO
3. Does the Risk training address how to respond to a resident making a risky decision? **Circle**: YES or NO
4. Does the Risk training discuss the need to consider the severity of the risk involved in the decision being made by the resident? **Circle**: YES or NO
5. Does the Risk training address the need to discuss alternatives to mitigate risk with the resident? **Circle**: YES or NO
6. Does the Risk training address the need to educate residents about consequences of their decisions? **Circle**: YES or NO
7. Does the Risk training cover how to document these situations? **Circle**: YES or NO
8. Does the Risk training cover how to Care plan risky decisions? **Circle**: YES or NO
9. Does the Risk training encourage the team to make decisions based on individual needs and situation of each elder? **Circle**: YES or NO
10. Are you able to provide attendance records that reflect 90% attendance at this training? **Circle**: YES or NO
11. Are there systems in place to sustain this training and for training new employees? **Circle**: YES or NO

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

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

***Sample Objective*: "**Develop a formal training outline on Risky Decisions that will also address our home's position as it relates to organizational policy by January 15, 2018." (Implementing the training would be an additional objective with separate action steps)

***Sample Action Steps*:**

- "Determine what team members will be on the committee for developing the training outline."
- "Determine meeting date possibilities."
- "Confirm meeting dates."
- "Bring PEAK materials related to developing the training to the first meeting."
- Etc…

Supporting Practice #2: Access to Information and Resources

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

1. Is there a system in place for caregivers to access information (either electronically or on paper) of residents special health needs? **Circle**: YES or NO
2. Are all team members aware of and able to access this information? **Circle**: YES or NO

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

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

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

***Sample Action Steps*:**

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

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

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

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

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

***Sample Objective*: "**Direct caregivers will be trained in accessing contact information from both the residents' electronic medical record and paper chart. Training will include facilitating communication with the elders' support systems by October 31, 2017."

***Sample Action Steps*:**

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

"Staff has access to transportation as needed to support residents."

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

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

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

***Sample Objective*: "**Selected team members from each household will be trained to use the home's vehicle for transporting residents as requests are received by November 10, 2017. This will include evening and weekend staff."

***Sample Action Steps*:**

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

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

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

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

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

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

Sample Action Steps:

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

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

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