Care Plans that Support Living

Pioneer Network Annual Conference
8/4/15

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THE PLAN
IS NOT THE
OUTCOME

THE OUTCOME IS
A LIFE
WORTH LIVING

Steps to plans that know each person

1. Reframe perspective
2. Change the conversation
3. Act on what you learn

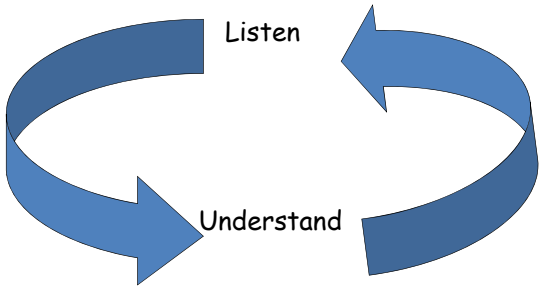
Traditional Approach

- **Start with what is "wrong" with the person**
  - **Assess issues of health and safety**
  - **Determine what the person can/cannot do**
  - **Strengths and needs lists**
  - **Plans that describe how to keep the person healthy and safe and that "make" them more independent**

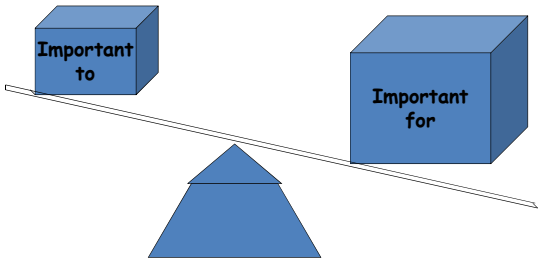
An Alternate Approach

- **Start with how the person wants to live**
  - Learn what is important to the person in everyday life
  - Assess issues of health and safety

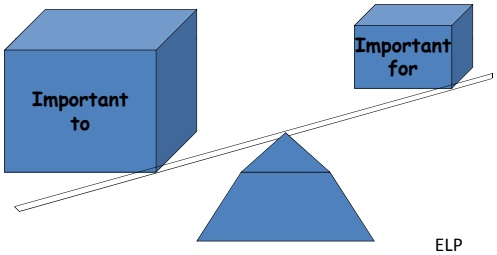
What you hear depends on what you're listening for



Health and Safety Dictates Lifestyle

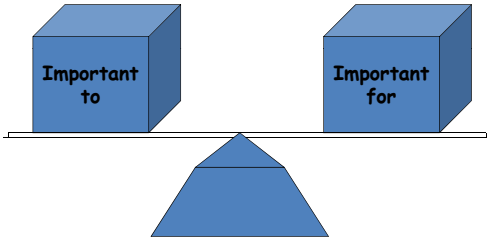


All Choice, No Responsibility



ELP

Balance



ELP

Begin with

Important to (person's name) | **Important** for (person's name)

What else do you need to learn/know?

Person centered planning is…

- Finding out what is important to someone
- Learning about what health, safety and risk mean to the person and those who know and care about him/her
- Figuring out how he/she can be supported in having a balance between happy and safe

Person-centered planning becomes

person-directed care

1. Guess

1. Ask

1. Write

Who should be involved?

Beyond paid staff

- Who could/should be included in the process?
- When could/should planning occur in order to accommodate everyone?
- At what point do regulations play a role?

Does setting make a difference?

- Comprehensive assessment
- Comprehensive care plan
- Evaluation

You Need a Direct Caregiver

Engaging Staff in Individualizing Care:

It started with staff training

•The Care Conference Team met with both day and evening shifts

•The Team role played a care conference to give the C.N.A.s an idea of what is discussed in care conferences

•Questions/thoughts were shared among the C.N.A.s and the rest of the team

•This training will be offered to C.N.A.s twice a year

Pioneer Network

Material developed by B&F Consulting for Pioneer Network's National Learning Collaborative on Using the MDS 3.0 as the Engine for High Quality Individualized Care funded by the Retirement Research Foundation

Engaging Staff in Individualizing Care:

Next came scheduling

- The social worker and the medical records specialist coordinate the order of care conferences each week
- Care conferences are offered in the morning to those families that are able to attend. Other care conferences are offered in the later afternoon to accommodate the schedules of family members who are working

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Communicating the schedule to the C.N.A.s each week

- Schedule of care conferences is placed in breakroom each week. Also includes list of suggested topics for C.N.A. to discuss at care conference.
- Care conference schedule is also noted on the C.N.A. daily assignment sheet.
- Each C.N.A. works with their hall partner to communicate what time they will be away at the care conference.

Care Conferences for this week:
Thursday, January 31st :
10:00am Mrs. A
10:20am Mrs. B
3:30pm Mr. C

If you are the caregiver for any of these residents, please meet us in #41 Friendship Room at the designated time.

In the last 3 months, have you noticed:

Activities of daily living—any change in the person's ability to participate in care?

Mood & Cognition—does the resident seem content? Agitated? More or less confused?

Dining—change in appetite? Change in the amount of assistance needed for dining

Actual Data from C.N.A.s

- Surveyed C.N.A.s that have been attending the care conferences
- The results.
- 78% feel fully supported by their supervisor when scheduling and attending a care conference
- 100% of those surveyed have attended a care conference in the past 3 months
- 68% feel the meeting times are convenient
- 75% felt their presence and input was valued during the care conference
- 75% felt heard by family and staff during the care conference
- 75% enjoyed attending the care conference

CNA survey

On a scale of 1-4, with 1 being "strongly disagree" and 4 being "strongly agree", please indicate your response by picking the score that most accurately reflects your feelings about the following statements.

CNA participation in care conferences:

I felt supported by my supervisor when scheduling and attending care conferences for resident(s) :
☹ 1 2 3 4 ☺

I have attended a recent (past 3 months) a care conference for a resident:
Yes No

Attending the care conference meetings was convenient.
☹ 1 2 3 4 ☺ n/a

I felt my presence and input is valuable during the care conference meetings:
☹ 1 2 3 4 ☺ n/a

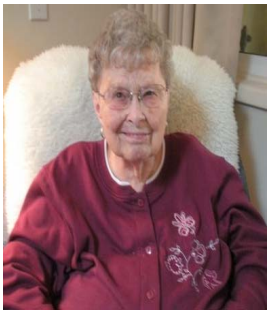
I felt heard, by family and staff, during care the conference meetings:
☹ 1 2 3 4 ☺ n/a

I enjoyed attending the care conference meeting:
☹ 1 2 3 4 ☺

Any additional comments: `

Thank you for your feedback!
-Rose Villa Staff

The Residents' and Families' Responses have been positive



"I was so relieved when I saw Jackie in the group that I was meeting with. She knows me best and always knows just what to do."

Doris, a Health Center Resident

Actual Data from Family Members

- We surveyed the residents and families that participate in care conferences
- The results show:
- 100% feel the assigned CNA cares well for the resident
- 100% participation in care conferences by CNAs
- 90% of families appreciate the CNA joining the care conference meetings
- 75% gain new knowledge from the CNA
- 100% feel the CNA presence is valuable and should be a part of future care conferences
- 100% support the CNA discussing the resident's progress with the team

Family feedback survey of CNA.

Rose Villa would like your input regarding CNA attendance at quarterly care conference meetings with you and other members of the care team.

On a scale of 1-4, with 1 being "strongly disagree" and 4 being "strongly agree", please indicate your response by picking the score that most accurately reflects your feelings about the following statements.

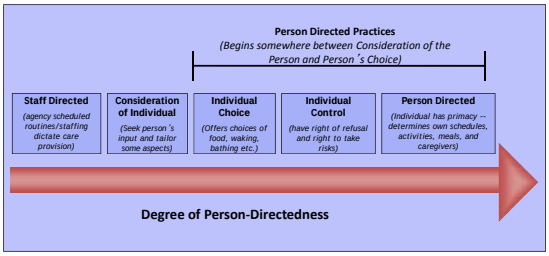
CNA participation in care conferences:

I feel the assigned CNA (Certified Nursing Assistant) cares well for my loved one:
☹ 1 2 3 4 ☺
A CNA has been present at a recent care conference for my loved one:
Yes No
I appreciate the CNA joining in care conference meetings for my loved one:
☹ 1 2 3 4 ☺ n/a
I gain new knowledge of my loved from CNA input:
☹ 1 2 3 4 ☺ n/a
CNA presence is valuable and I feel they should be a part of future care conferences:
☹ 1 2 3 4 ☺
If a family member is not able to attend a care conference, I would like the CNA present to discuss the progress of my loved one with other members of staff:
☹ 1 2 3 4 ☺

Any additional comments:

Thank you for your feedback!
-Rose Villa Staff

Person Directed Practices Overlap with Varying Degrees of Choice and Autonomy



Developed by the Lewin Group

"We know who makes the rules here, and it's not us"

Nursing Home resident

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Self determination is what life is about

Choice is about:

- **Preference** (things you like to do)
- **Opportunity** (to do those things)
- **Control** (of when, where and with whom those opportunities will occur)

Smull & Allen

Language makes a difference

Some examples:

• Planning for someone	Planning with someone
• Others are "in charge"	Power is shared
• Person is admitted/placed	Person moves in
• Care for a person	Support a person
• Alzheimer's patient	Person living with Alzheimer's
• Bedbound person	Person in bed
• Wheelchair bound	Person in wheelchair
• Health and safety dictate where you live	Health and safety are addressed where you want to live

In the person's own words

- Use 1st person only if:
  - He/she actually wrote it
  - He/she dictated it to you
  - You wrote it and he/she checked it over and approves of the wording

Care/Service Plan Meetings 7 questions

1. Does the plan identify what's important **to** the person?
2. Does the plan identify what's important **for** the person?
3. Is what's impt **for** him being addressed within the context of what's impt **to** him?
4. Is there a good balance between impt **to** and impt **for**?
5. What else do we need to learn about him/her?
6. What needs to stay the same on the plan
7. What needs to change?

Should end with a plan that…

- Is better than what you had
- Describes what has been learned about:
  - What is important to the person in just proportion to what is important for the person
  - What others need to know or do to support the person