

# Have a Good Life.™

## Person-Centered Care in Assisted Living

Preparing for the New, Informed Consumer: *Transforming Your Service Model by Bringing Well-Being to Assisted Living*

### RESOURCES

#### Handouts

Part 1: Person-Centered Care in Assisted Living Preparing for the New Informed consumer with Caregiver Crash Course™ and Culture Change Crash Course™

<https://www.dropbox.com/s/jqbct3azgdgl7o/OK%20PART%201%20HANDOUTS%20Person-Centered%20Care%20in%20Assisted%20Living%20%20Preparing%20for%20the%20New%20Informed%20Consumer%20with%20Caregiver%20Crash%20Course%20and%20Culture%20Change%20Crash%20Course.pdf?dl=0>

Part 2: Transforming Your Service Model by Bringing Well-Being to Assisted Living

<https://www.dropbox.com/s/46uua7qw9ct24tr/OK%20PART%202%20HANDOUTS%20Transforming%20Your%20Service%20Model%20by%20Bringing%20Well-Being%20to%20Assisted%20Living.pdf?dl=0>

Part 3: National Efforts and Best Practices to Transform Dementia Care including Dementia Crash Course™

<https://www.dropbox.com/s/rwpzwljpdvgo6n1/OK%20PART%203%20HANDOUTS%20National%20Efforts%20and%20Best%20Practices%20to%20Transform%20Dementia%20Care%20%20including%20Dementia%20Crash%20Course.pdf?dl=0>

Part 4:4; Ageism and Language that Shifts Perceptions of Aging

<https://www.dropbox.com/s/05g7cbk8jlelo1q/OK%20PART%204%20HANDOUTS%20Ageism%20and%20Language%20that%20Shifts%20Perceptions%20of%20Aging.pdf?dl=0>

## Other Resources

Culture Change Network of Georgia website ~ check out the videos!  
[www.CultureChangeGA.org](http://www.CultureChangeGA.org)

Culture Change Network of Georgia Facebook Page ~ “Like” it!  
<https://www.facebook.com/CultureChangeNetworkOfGeorgia/>

Timeline of the Culture Change Movement  
[https://www.dropbox.com/s/2expfz1ysp5z68y/BriefHistoryOfCultureChangeMovement\\_FINAL%20wc%20071318.pdf?dl=0](https://www.dropbox.com/s/2expfz1ysp5z68y/BriefHistoryOfCultureChangeMovement_FINAL%20wc%20071318.pdf?dl=0)

Definition of an Elder  
<https://www.dropbox.com/s/zu02tmjerok1bop/ELDER%20DEFINITION.pdf?dl=0>

Relationships Quote  
<https://www.dropbox.com/s/fjw0kx5m2ytmoml/Relationships%207152011.pdf?dl=0>

Learning Circle  
<https://www.dropbox.com/s/h4q5c3nza4drhzh/LEARNING%20CIRCLES%20new.pdf?dl=0>

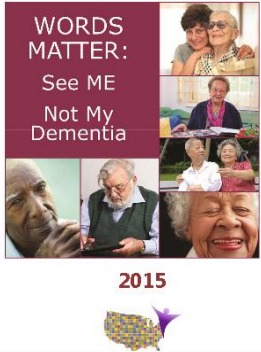
The Eden Alternative® Domains of Well-Being White Paper  
<https://www.dropbox.com/s/qatlqpvq0ynhjgq/Eden%20DOMAINS%20of%20Well-BeingWhitePaperv5.pdf?dl=0>

ARE YOU READY? Key Questions That Consumers Will Be Asking to Find Out if a Nursing Home or Organization is Doing Person-Directed Care  
<https://www.dropbox.com/s/136w1e4kvfz145k/Key%20Questions%20Consumers%20Will%20Be%20Asking%20%20ARE%20YOU%20READY.pdf?dl=0>

WHAT ARE KEY QUESTIONS TO ASK the STAFF in NURSING HOMES to FIND OUT IF THEY PROVIDE PERSON-DIRECTED CARE? (And the answers to listen for)  
<https://www.dropbox.com/s/urfsypmtudex41d/Key-Questions-to-Ask-Nursing-Home-Staff.pdf?dl=0>

# TIMELINE: A Brief History of the Culture Change Movement

[https://www.dropbox.com/s/2expfz1yp5z68y/BriefHistoryOfCultureChangeMovement\\_FINAL%20wc%20071318.pdf?dl=0](https://www.dropbox.com/s/2expfz1yp5z68y/BriefHistoryOfCultureChangeMovement_FINAL%20wc%20071318.pdf?dl=0)



**WORDS MATTER:**  
See ME  
Not My  
Dementia

2015

**Preference Based Living**  
DEVELOPING PERSON-CENTERED SERVICE AND CARE PLANS |  
HONORING CHOICE WHILE MITIGATING RISK

The purpose of this process is to support long-term care communities in their efforts to honor residents' choices and preferences that influence quality of care and quality of life, while mitigating potential risks associated with those choices and preferences. This process is specifically aimed at care planning when an individual's choice carries sufficient risk that the community is considering not honoring the person's wishes. The documentation of this process is critical, as it is related upon should an unforeseen event occur. Having the documentation that shows all the steps taken, who was involved in the conversations, what options were discussed, which were or were not acceptable, and why is what regulations and others will expect to see. This document is a brief summary of the care planning/advance care development tool. For the complete toolkit and documentation forms mentioned below, please go to [Dementia.org/2015/03/04/](http://Dementia.org/2015/03/04/).

**STEP 1: IDENTIFY AND CLARIFY CHOICES AND PREFERENCES FOR RESIDENCE**  
The intent of this step is to identify and clarify choices and preferences that are associated with risk. Interview the person using the FICU and observe the person. Review the person's history to obtain detailed information about the nature and extent of the choice that the person wishes to make.


- ✓ Interview the individual and the staff who are most familiar with the individual.
- ✓ Identify the request. Determine if the choice is a one-time request or a long-term preference. Is it a repeated preference over time or perhaps a brief reaction to some other concern?
- ✓ Report back to the person your understanding of what she or he desires to choose or refuse, to confirm both parties understand each other.
- ✓ Ask to involve the person's representative in the discussion.
- ✓ Record the nature and extent of the choice(s) the person wishes to make on the Documentation Form and place in the written or electronic medical chart or health record.

**STEP 2: DISCUSS THE CHOICE AND OPTIONS WITH THE RESIDENT**  
The intent of this step is for the team and person to explore options that might be mutually acceptable. This is an opportunity for the person and multidisciplinary care team to engage in dialogue so that the person can explain what is important to him or her.

- ✓ Discuss with and educate the person about the potential outcomes, both positive and negative, of requesting and acting on the part of her or his choice and preferences, as well as the potential negative or positive outcomes of preventing the person from acting on his or her choice.
- ✓ Offer ways to accommodate the choice which also mitigate potential negative consequences as much as possible.
- ✓ After learning of and considering the potential consequences and positive outcomes, the person may decide not to take his or her initial requested action, to consult his Preference, or to select an alternative with fewer potential adverse consequences, or may continue to desire the original choice.
- ✓ Explain why a requested choice cannot be honored if posed significant danger to others.
- ✓ Record the conversations with the person and representative on the Documentation Form and place it in the medical chart/health record. Describe the discussion of the risks and benefits and whether the person exhibited adequate decision-making capacity related to the choice in question. Provide a record in writing about what was presented to the person and what the person's response was.

**WORDS MATTER: See ME Not My Dementia**  
[https://daanow.org/wp-content/uploads/2016/03/Words\\_Matter-See-Me-Not-My-Dementia.pdf](https://daanow.org/wp-content/uploads/2016/03/Words_Matter-See-Me-Not-My-Dementia.pdf)

## DEVELOPING PERSON-CENTERED SERVICE and CARE PLANS: HONORING CHOICE WHILE MITIGATING RISK



*Knowing the person.  
Honoring preferences.  
Improving quality of life.*

**Honoring preferences when the choice involves risk:  
A process for shared decision making and care planning**

Prepared for:  
Maryland, Illinois,  
Ohio, and Wisconsin  
Dementia Round  
Table Forum  
July and 2015

**Preference Based Living**

## HONORING PREFERENCES WHEN THE CHOICE INVOLVES RISK: A PROCESS FOR SHARED DECISION MAKING AND CARE PLANNING

Richard Taylor, Phd ~ “I have Alzheimer’s” ~ clip from *“Be with me TODAY.”™*



LINK HERE: <https://youtu.be/lHQfc3KJ9qE>



LINK HERE: <https://www.pioneernetwork.net/conference/>

