A2.2 – Educative resources for teachers

Basic principles of management

<< Lesson Materials>>

Module: 4

Sub-Module: 4.1

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Introduction

Module	4. MANAGEMENT IN CAREGIVING
Sub-module	4.1. Basic principles of management
Lesson nr.	#1
Duration (minutes)	45
Date	

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Lesson Outcomes

1. Define person-centered care.
2. Know the main characteristics of person-centered care.
3. Understand the philosophy of person-centered planning.
4. Describe the main stages of the person-centered care planning process.
5. Apply the principles of person-centered care to the processes developed by caregivers.

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What is person-centered care?

- ✓ **Individuals**' values and preferences are elicited and, once expressed, **guide all aspects** of their health/social care, supporting their realistic health and life goals.
- ✓ Person-centered care is achieved through a dynamic **relationship** among **individuals**, **others** who are important to them, and all relevant **providers.**
- ✓ This **collaboration** informs **decision-making** to the extent that the individual desires.

Person-Centered Care: A Definition and Essential Elements

The American Geriatrics Society Expert Panel on Person-Centered Care

DOI: 10.1111/jgs.13866

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Person-centered: essential elements

What are the ***essential elements*** *of this type of care?*

Reading and **discussion** ...

Person-Centered Care: A Definition and Essential Elements

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Person-centered: essential elements

- An **individualized**, **goal**-oriented care PLAN based on the person's preferences.
- Ongoing **review** of the person's goals and the care plan.
- Care supported by an **interprofessional team** in which the **person** is an integral team member.

Person-Centered Care: A Definition and Essential Elements

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DOI: 10.1111/jgs.13866

Person-centered: essential elements

- One primary or lead **point of contact** on the team.
- Active **coordination** among **all** service providers.
- **Continual** information **sharing** and integrated communication.
- **Education** of people receiving care and those important to them supports informed **decision-making** and **self-determination**.
- Performance measurement and quality improvement using **feedback** from the person and caregivers.

Person-Centered Care: A Definition and Essential Elements

The American Geriatrics Society Expert Panel on Person-Centered Care

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Person-centered planning

- ✓ A facilitated, ***individual-directed***, positive **approach** to the **planning** and **coordination** of a person's services and supports **based on individual** aspirations, needs, preferences, and values.
- ✓ Create a ***plan*** that would optimize the person's self-defined QoL, choice, and control, and self-determination through meaningful exploration and discovery of **unique** preferences/needs and wants in **areas** including …

Health and well-being, relationships, safety, communication, residence, technology, community, resources, assistance…

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Person-Centered Planning and Practice

FINAL REPORT
July 31, 2020

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Person-centered planning

Philosophy

- *Everyone has **preferences** that form the foundation for how they **want to live** their lives and achieve their dreams, goals, and desires.*
- *The **focus** is on these preferences, not on the person's conditions or cognitive level.*
- *Resources and informed **choices** that create freedoms.*
- ***Empowerment** of the person is foundational to the approach.*

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Person-Centered Planning and Practice

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Person-centered planning

Philosophy: reading and discussion …

- ***Cultural*** *perspective*
- *Effective* ***freedom***
- ***Empowerment***
- *Dignity of* ***risk***
- *Presumption of* ***competence***
- *Supported* ***decision*** *making*
- *Trauma-informed approach*

Person-Centered Planning and Practice

FINAL REPORT
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Person-centered planning

Philosophy: reading and discussion …

- ***Independent living*** *philosophy*
- *Understanding of living* ***best life***
- ***Recovery***
- ***Ableism and ageism***

Person-Centered Planning and Practice

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Person-centered plan and documentation

- The person's ***strengths, interests, and talents***.
- The person's **preferred** name and language.
- Frames **goal** statements using language that is **clear** and accessible while capturing ***what is important*** to the person **in their own words**.
- The **services and supports** (paid and unpaid) that will assist the person to achieve identified goals.

Tondora et al., 2020

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Person-centered plan and documentation

- Solicits ongoing **feedback from the person** and their supporters on progress and concerns and **revises** the plan as needed in an expedient manner.
- **Monitors** the **implementation** to ensure that services are delivered both in accordance with the person's preferences and in accordance with the type, amount, and frequency of supports as specified in the plan.

Tondora et al., 2020

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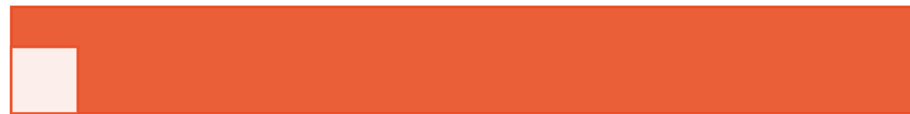
Person-centered management

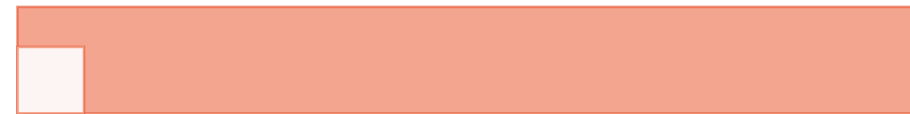
Based on the person's preferences

A process …



- Dynamic
- Holistic
- Comprehensive
- Follow-up

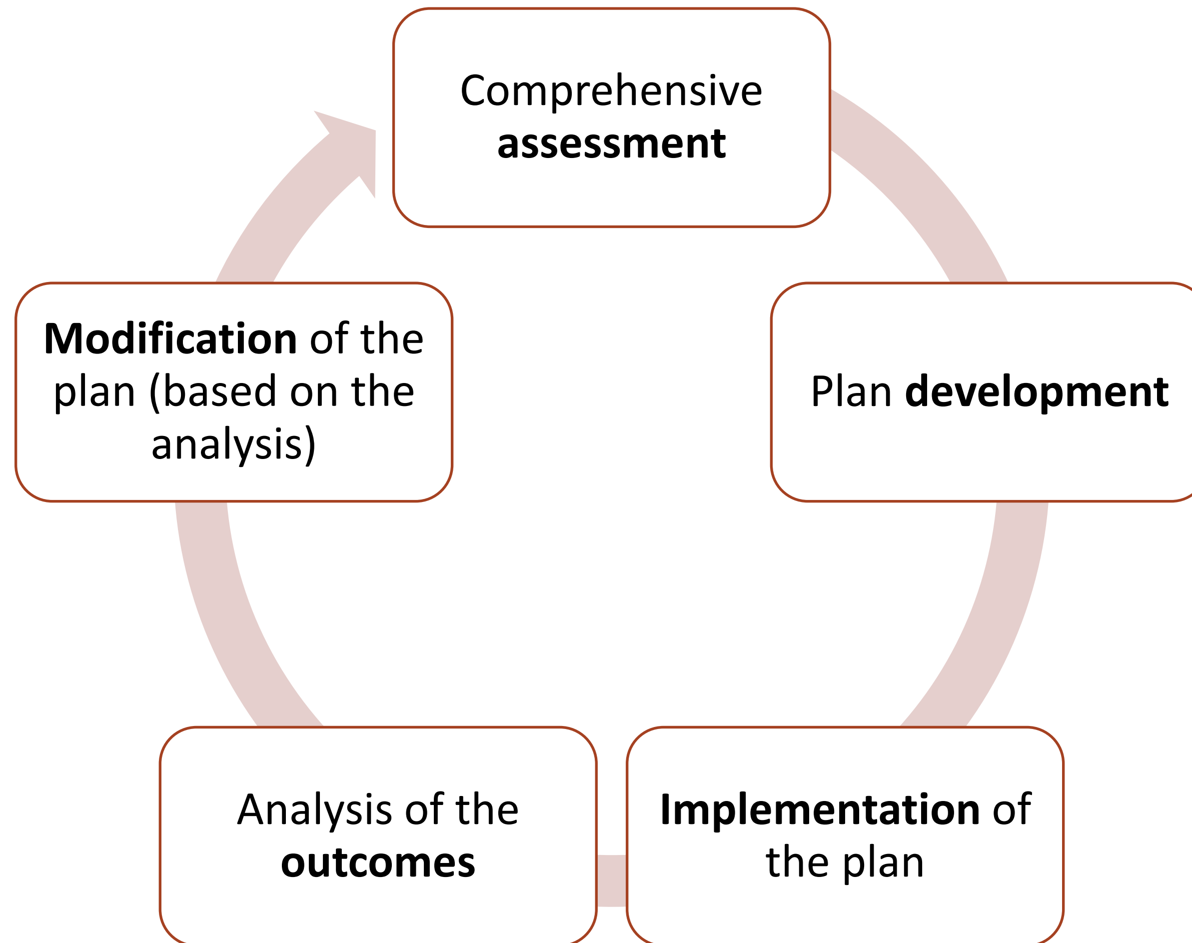
A plan …



- Co-created
- Writing
- Revised: "a living document"
- Monitoring of the plan´s implementation

Tondora et al., 2020

Person-centered: work plan



Introduction

Module	4. MANAGEMENT IN CAREGIVING
Sub-module	4.1. Basic principles of management
Lesson nr.	#2
Duration (minutes)	45
Date	

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Lesson Outcomes

1. Identify the relevant information according to a holistic view of the person.
2. Understand the importance of documenting the information collected for the development of the plan.
3. Describe tools and methods to determine the functional needs of the person.
4. Apply standardized evaluation instruments aimed at the person and self-assessment instruments.

Information and documentation

- ✓ **Holistic** care

*Care to the "whole person" that considers **psychological, social and environmental** factors rather than just the symptoms of disease or ill-health.*

World Health Organization, 2015

- ✓ All activities focus on the person as **a whole …**

(*not just their diagnosis or disability*)

Tondora et al., 2018

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Information and documentation

✓ **Documentation** of the person-centered plan:

The plan is written down.

A copy is provided to the person, and a copy is retained within the person's record.

✓ **Updating** of the person-centered plan:

Most people will have plans that change over time.

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Information and documentation

- ✓ **Records** of the person-centered plan:
  - Concise and accurate
  - Participation of the **caregiver** ?

- ✓ **Discussion:**

In the plan documentation ...

*What significant **life areas** should be included?*

*What **information** is important?*

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Person-centered plan: information

The **relationships** that are the most important to you and **who** you want to spend time with

The best ways to talk or write to you

Where you want to live and what you want your home to be like

The **community** that you want to be in

Activities or hobbies you would **like to do**

Help that you might need

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Person-centered plan: information

Finances and **budget**

People and resources in **your community** that are important to you

Jobs and **education**

Challenges to your **goals**, including your health

Things that are **important** for your health, safety, and overall quality of life

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Person-centered plan: content

- The plan meets the person's expressed **needs and desired outcomes**.
- The **services and supports** that are important for the individual to meet the **needs** identified (paid and unpaid supports).
- An assessment of **functional** needs.
- Identify **goals** to support and address the person's needs and desired outcomes.
- **Barriers** to the person's goals must be identified.
- **Strengths**
- **Community**

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Comprehensive needs assessment

Activity: Reading and discussion …

- Demographics
- History
- Functionality
- Nutrition
- Developmental concerns
- Support/community resources
- Psychosocial history

FUNCTIONALITY	
1	Do you have a problem with any of these? (Select: independent as age appropriate; dependant as age appropriate; requires assistance; completely dependant)
	Ambulation/Walking
	Bathing with sponge, bath, shower
	Oral health (brushing, flossing, chewing)
	Dressing
	Toilet Use
	Transferring (in and out of bed or chair)
	Eating
	Continence (controls bowel and bladder by self)
	Shopping
	Cooking
	Using the telephone
	Housework

State of New Jersey
Department of Human Services

Care Management Workbook

Comprehensive needs assessment

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Examples

DEMOGRAPHICS	
1	What is your name (member)?
2	What is your primary telephone number?
3	What is a secondary telephone number we could use?
4	In case of an emergency, what is the name and telephone number of a person we can contact?
5	What is the primary language spoken in the home?
6	What is your current address?
7	Who is providing the information to complete the assessment (include name and relationship to member)?
8	Is there a guardian involved?
HISTORY	
1	Who is your current primary care provider or family doctor? (Provide name and telephone number)
	What was the date of last appointment?
2	Do you see any specialists? (Provide names and telephone numbers)
	What was the date of last appointment?
3	Do you see a dentist? (Provide name and telephone number)
	What was the date of last appointment? Routine or emergency care?
4	Which of the following medical conditions do you/have you had? (Select: Asthma, Chronic Obstructive Pulmonary Disease, Tuberculosis, Seizures, Memory Problems, Depression, Schizophrenia, Congestive Heart Failure, Heart Disease, Hepatitis, Diabetes, Kidney Failure, On Organ Transplant List, Paralysis, Multiple Sclerosis, HIV/AIDS, Stroke, Lead Poisoning, Sickle Cell disease, Cancer w/treatment, Hemophilia, Other)
5	On a scale of 1 to 5, with 1 being "poor health"; 2 being "fair health"; 3 being "good health"; 4 being "very good health"; and 5 being "excellent health", how would you rate your overall health during the past three months, including medical, dental and mental health?
6	Which medications are you taking, including over-the-counter medications and supplements?

State of New Jersey
Department of Human Services

Comprehensive needs assessment

Reading and discussion: Paralyzed Veterans Association, 2000

Need	Frequency	Time Needed	AM	PM
ADLs				
Bathing				
Dressing				
Grooming (shaving, hair care, makeup)				
Meal preparation				
Eating				
Bowel care				
Bladder care				
Turning in bed				
Transferring				
Other:				

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Caregivers: records and documentation

Information relevant to the plan: how can the **caregiver** participate?

- Service **referral** sheets
- **Health** reports: primary care and specialized care
- **Social** reports: social services
- **Needs assessment**:
    - Observation records
    - Records of the application of standardized instruments
    - Interview records

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Caregivers: records and documentation

Information relevant to the plan: how can the **caregiver** participate?

- **Formulation** of the plan:

  Individualized goal sheets

  Work team involved and distribution of tasks / Time and shift records

- **Implementation** of the plan:

  Daily records of hours of work and tasks performed

  Daily incident records

  Observation records

  Barriers and facilitators for the implementation of the plan

- **Review** meetings: records and modifications of the plan
- Records of **results**

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Comprehensive needs assessment

Standardized assessment instruments

Activity: Reading and group discussion:

- What **domain** does it evaluate?
- What are your **strengths and weaknesses**?
- Is it **easy** to use?
- Grade of **recommendation** (0 – 10)

Comprehensive needs assessment

Standardized assessment instruments: activity (group discussion)

- Functional Independence in **ADLs**

  The Barthel Index: ***Mahoney & Barthel****, 1965*

- Functional Independence in **IADLs**

  The Instrumental Activities of Daily Living Scale: ***Lawton & Brody****, 1969*

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Comprehensive needs assessment

Standardized assessment instruments: activity (group discussion)

- **Cognitive** status

  Short Portable Mental Status Questionnaire: ***Pfeiffer***, 1975

  Informant Questionnaire on Cognitive Decline in the Elderly: ***Jorm & Jacomb***, 1989

  The set Test: ***Isaacs & Akhtar***, 1972

- **Mood** status

  Anxiety and depression: ***Goldberg*** *et al., 1988*

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Caregivers: self-assessment

Standardized assessment instruments: group discussion

- ❑ **Continuous** self-assessment: why is it important to the caregiver?
- ❑ Perception of **burden**: self-assessment of caregiver's burden

Caregiver Burden Interview: ***Zarit, Reever & Bach-Peterson***, 1980

Thank you!

Teachers' name

Teachers' e-mail

Date of the session