"Age is opportunity no less than youth itself."

HENRY WADSWORTH LONGFELLOW

LONG-TERM CARE
Improvement Guide

picker INSTITUTE

PLANETREE

LONG-TERM CARE IMPROVEMENT GUIDE

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A Message from Picker Institute

While the promise of our future lies with our young, the wisdom that will guide that future lies with our elders. They are the great storehouse of the past, their own and our collective past, and in their hands lie the knowledge and experience that will inform many of the groundbreaking changes—as well as many of the smaller, quieter changes—that will profoundly affect the direction in which we travel and the way in which we go.

For years this population—and we are they and they we, our grandfathers and uncles and great-grandmothers and older siblings—has too often been relegated to what a prominent gerontologist and champion of elders has called a "time of failure," following childhood and adulthood. Now a movement is well under way, gaining adherents and strength daily, to change the culture of aging and create a third stage of life, elderhood, to which so many are entitled and to which all of us will someday belong.

Not all the improvements needed to make a watershed change in the culture of aging will be easy to bring about. But this change is supported by powerful champions—more and more every day—and it is becoming easier to imagine a not-too-distant future when it is no longer a dream, or a vision, or even a rare occurrence. As recognition grows of its importance, of the difference it can make to our elders as well as to ourselves and our young, it is moving onto a main line, gathering speed and visibility and demanding that its voice be heard everywhere people of all ages gather, a voice that speaks of the joys of growing old and the final years of lives that began with promise and will end with fulfillment.

The Long-Term Care Improvement Guide, which you are holding in your hands or reading on your Kindle or your computer screen, is a practical resource intended to support continuing care communities in their efforts to bring about culture change. Like its groundbreaking predecessor, the Patient-Centered Care Improvement Guide, published in 2008 by Planetree and Picker Institute, the Guide has been shaped by the perspectives of patients—in this case, patients in long- and short-term care—and their families, as well as those of the staff and leadership of the skilled nursing homes, independent and assisted living facilities and rehabilitation centers where so many of the elderly live.

But the Guide is not just for elders and their families and their caregivers. Old age is universal, and the drive to change the culture of aging is one in which we must all participate if we are to be assured that our lives will remain our own to the end of them.

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Picker Institute is an independent nonprofit organization dedicated to promoting the advancement of patient-centered care and improving the patient's experience with the healthcare system.

Established in Boston in 1993, Picker Institute led the way in creating scientifically valid nationwide surveys and databanks on patient-centered care that were designed to help educate doctors, hospital staff and other caregivers to the benefits of patient-centered care. The patient's perspective—"through the patient's eyes"—is now one of the standard metrics of performance routinely measured by healthcare organizations.

The Picker Surveys have become the world standard for measuring performance "through the patient's eyes," and the Picker family of patient experience surveys is used in quality-driven organizations throughout the world.

Over the past few years, Picker Institute has expanded its focus beyond just measuring the scope of the problem to actively seeking solutions. From its offices in Camden, Maine, the Institute seeks to advance excellence in patient-centered care through a wide range of educational and research programs and the dissemination of best-practices strategies, including the Picker Institute/Arnold P. Gold Foundation/ACGME Challenge Grant program, the Picker Institute Research program and the Picker Institute Long-Term Care program.

Launched in March 2008, and in keeping with the Institute's belief that quality of life is as important as quality of clinical care in all healthcare settings, the long-term care program awards grants to support initiatives aimed at improving the quality of life in all long-term care settings, and, through the annual Picker Awards, recognizes individuals who have made outstanding contributions to achieving this goal.

Most recently Picker Institute has introduced Always Events™, a national program aimed at identifying the elements of the patient experience that should be part of every encounter between a patient and the healthcare system, and championing their adoption on every occasion where a patient and the healthcare system interact.

THE PICKER PRINCIPLES OF PATIENT-CENTERED CARE

The eight Picker Principles of Patient-Centered Care embody Picker Institute's conviction that all patients deserve high-quality healthcare, and that patients' views and experiences are integral to improvement efforts. The Picker Principles were codified in 1989 in response to the qualitative patient research conducted in 1988 that led to the design of the first Picker inpatient survey and a national study of patients' experiences of care in U.S. hospitals in 1989. The principles of patient-centered care are:

Respect for patients' values, preferences and expressed needs

Patients want to be kept informed regarding their medical condition and involved in decision-making. Patients indicate that they want hospital staff to recognize and treat them in an atmosphere that is focused on the patient as an individual with a presenting medical condition.

- Illness and medical treatment may have an impact on quality of life. Care should be provided in an atmosphere that is respectful of the individual patient and focused on quality-of-life issues.
- Informed and shared decision-making is a central component of patient-centered care.
- Provide the patient with dignity, respect and sensitivity to his/her cultural values.

Coordination and integration of care

Patients, in focus groups, expressed feeling vulnerable and powerless in the face of illness. Proper coordination of care can ease those feelings. Patients identified three areas in which care coordination can reduce feelings of vulnerability:

- Coordination and integration of clinical care
- Coordination and integration of ancillary and support services
- Coordination and integration of front-line patient care

Information communication and education

Patients often express the fear that information is being withheld from them and that they are not being completely informed about their condition or prognosis. Based on patient interviews, hospitals can focus on three kinds of communication to reduce these fears:

- Information on clinical status, progress and prognosis
- Information on processes of care
- Information and education to facilitate autonomy, self-care and health promotion

Physical comfort

The level of physical comfort patients report has a tremendous impact on their experience. From the patient's perspective, physical care that comforts patients, especially when they are acutely ill, is one of the most elemental services that caregivers can provide. Three areas were reported as particularly important to patients:

- Pain management
- Assistance with activities and daily living needs
- Hospital surroundings and environment kept in focus, including ensuring that the patient's needs for privacy are accommodated and that patient areas are kept clean and comfortable, with appropriate accessibility for visits by family and friends.

Emotional support and alleviation of fear and anxiety

Fear and anxiety associated with illness can be as debilitating as the physical effects. Caregivers should pay particular attention to:

- Anxiety over clinical status, treatment and prognosis
- Anxiety over the impact of the illness on themselves and family
- Anxiety over the financial impact of illness

Involvement of family and friends

Patients continually addressed the role of family and friends in the patient experience, often expressing concern about the impact illness has on family and friends. These principles of patient-centered care were identified as follows:

- Accommodation, by clinicians and caregivers, of family and friends on whom the patient relies for social and emotional support
- Respect for and recognition of the patient —advocate's" role in decision-making
- Support for family members as caregivers
- Recognition of the needs of family and friends

Continuity and transition

Patients often express considerable anxiety about their ability to care for themselves after discharge. Meeting patient needs in this area requires staff to:

- Provide understandable, detailed information regarding medications, physical limitations, dietary needs, etc.
- Coordinate and plan ongoing treatment and services after discharge and ensure that patients and family understand this information
- Provide information regarding access to clinical, social, physical and financial support on a continuing basis

Access to Care

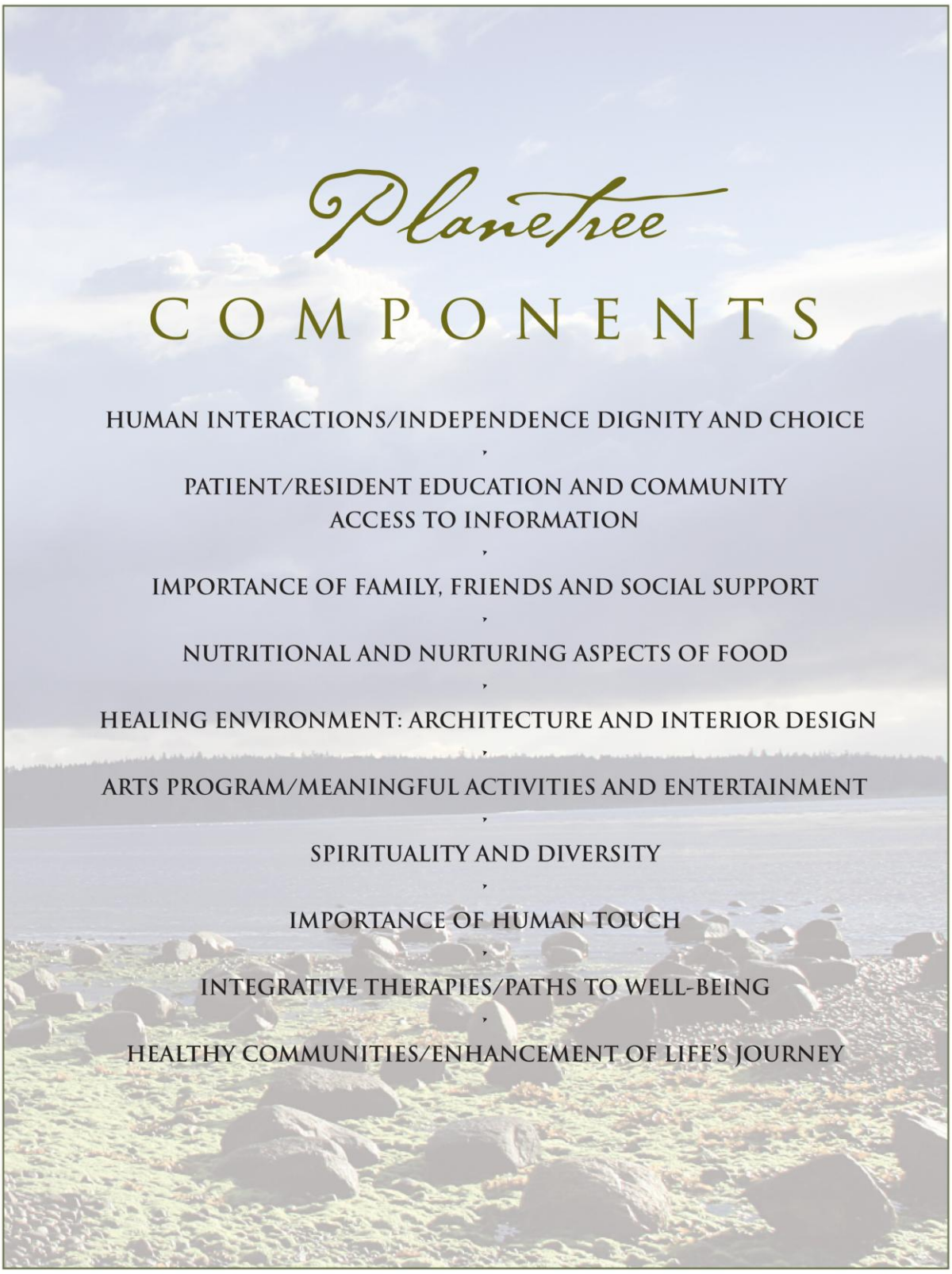
Patients need to know they can access care when it is needed. Attention must also be given to time spent waiting for admission or time between admission and allocation to a bed in a ward. Focusing mainly on ambulatory care, the following areas were of importance to the patient:

- Access to the location of hospitals, clinics and physician offices
- Availability of transportation
- Ease of scheduling appointments
- Availability of appointments when needed
- Accessibility to specialists or specialty services when a referral is made
- Clear instructions provided on when and how to get referrals

Named after the tree under which Hippocrates, the Father of Medicine, taught his students in Ancient Greece, Planetree, Inc. is a not-for-profit organization that provides education and information in a collaborative community of healthcare organizations, facilitating efforts to deliver patient-/resident-centered care in healing environments. Planetree was founded in the late 1970s by Angelica Thieriot, a patient whose experiences with hospitals led her to envision a different type of healthcare experience where patients could receive care in a truly healing environment that would also provide them with access to the information needed to become active participants in their own care.

Based on focus groups with thousands of patients, residents, family members and healthcare workers, Planetree defined what it means to be patient- and resident-centered by identifying core focus areas. Healthcare providers, including hospitals, long-term care communities and medical centers, which have adopted this approach strive to improve the patient/resident experience by partnering with those receiving care and their family members to identify and satisfy the full range of their needs and preferences. Patient-/resident-centered organizations also focus on supporting the professional and personal aspirations of their staff members, who can more effectively provide care when they feel cared for themselves. Planetree has documented the components of the model of patient-/resident-centered care more broadly in the book *Putting Patients First*, the second edition of which was released in October 2008.

Though the Planetree model was initially developed for acute care settings, the concepts and components have also helped to guide organizational transformation in continuing care settings. Focus groups with residents and their family members as well as staff and leadership from continuing care affiliates highlight the profound importance of relationships, community and supporting residents in living the lives they want to lead. These insights prompted the refinement of the components of the Planetree model to reflect the continuum of care. Today, Planetree is a growing global membership network of acute care hospitals, continuing care communities, VA medical centers, behavioral health facilities, ambulatory centers, community health centers and health libraries. There are Planetree sites in 35 U.S. states, Canada, Japan, Brazil and the Netherlands. A complete list of Planetree members is available at www.planetree.org.



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This Guide is a concrete expression of a vision shared by Planetree and Picker Institute for improving the delivery of patient- and resident-centered care across the healthcare continuum. The Guide would not be possible without the financial support of Picker Institute. This partnership, however, extends beyond funding; Picker Institute was a collaborator in every respect on this project. The thoughtful questions, inspired ideas and steady encouragement from the Institute are reflected throughout these pages.

This spirit of cooperation and collaboration has characterized the year-long process of developing the Guide. With a goal to create an improvement resource that transcends specific models, we relied heavily on the involvement and generosity of long-term care communities across the United States, in Quebec and in the Netherlands. These communities shared their approaches to organizational transformation—how they have worked to engage all members of the community in the change and how they have measured success. Ultimately, this Guide is rich with practical strategies and implementation tools to support change because of their commitment to expanding the adoption of a resident-directed, relationship-centered approach. They welcomed us into their settings, shared their accomplishments and challenges, and responded enthusiastically to our requests for additional information. They are listed on page xi.

The extraordinary progress reflected in this Guide is a testament to the passionate individuals and organizations that have been advocating for change and providing roadmaps for how to achieve it long before "culture change" became mainstream. The development of the Long-Term Care Improvement Guide has been informed and influenced by these innovators and enduring champions of the movement. In particular, we would like to acknowledge the support and involvement of Bonnie Kantor, Amy Elliot and The Pioneer Network, Barbara Frank of B&F Consulting, Dr. Bill Thomas, Chris Condeelis and American Health Care Association (AHCA), Marguerite McLaughlin and Quality Partners of Rhode Island, American Association of Homes and Services for the Aging (AAHSA), Wellspring, Eden Alternative, The Green House Project, Mary and Vivian Tellis-Nayak and My InnerView; Kimberly Nelson Montague, Betsy Brawley, Nancy Fox, Dr. John Wasson, Mary Jane Koren, Maggie Calkins, Reverend Jim Stinson, Raymond Rusin, David Green, Cheri Lattimer, Alicia Goroski, and Carol Benner and the Advancing Excellence in America's Nursing Homes Campaign. We are also indebted to those "in the field" who reviewed early versions of the Guide and provided constructive feedback that helped us remain on course to provide a resource that meets organizations where they are at in their improvement efforts. They included Ken Arneson, Lonnie Bisbano, Dustin Dodson, Gary Johnson and Kenda Spaulding.

We are most proud to call the leaders who participated in the Long-Term Care Leadership Roundtable in February 2010 our partners. A list of those who participated in that meeting is included as Appendix A. The Guide is definitively better for their input.

In order to create a resource that would suit the needs and proactively address the common questions of long-term care executives, we knew it was essential to include them in the process. We are deeply grateful to the following executives who carved time out of their schedules to share their insights about organizational transformation in long-term care: Lane Bowen of Kindred Healthcare; Robert Chur of Elderwood Senior Care; Larry Deans of Golden Living; Patrick Fairbanks of Vetter Health Services; David Farrell of SnF Management; Rick Fisk of Covenant Retirement Communities; Stephen Fleming of Well Spring; Nancy Fox and Jeff Jerebker of Piñon Management; David Horazdovsky of the Evangelical Lutheran Good Samaritan Society; Neil Kurtz, MD of Golden Living; Tim Lukenda of Extendicare Health Services; Bill Mathies of Sun Healthcare; Joseph Murphy of Masonic Villages of the Grand Lodge of Pennsylvania; and Danny Sanford of Still Hopes Episcopal Retirement Community.

Special thanks as well to the Planetree Continuing Care Advisory Council, supported by the Rothschild Foundation, and our Planetree colleagues, in particular, Christy Davies, who tended to a myriad of details and helped to keep this project on track.

We will end these acknowledgments where the development of the Guide began – with long- and short-term residents and their family members. We start with Robert Dalton, Arline Robinson and Doris Thorn, three residents of Wesley Village in Shelton, Connecticut, whose faces grace the cover of this Guide. In their images, photographer Annie Levy has beautifully captured all the possibility and promise that exemplify residents' lives in culturally transforming long-term care communities. Robert, Arline and Doris are just three of the hundreds and hundreds of residents, short-term patients and family members whose experiences and insights have been woven together to create the framework of this Guide. Their personal stories of what goes well and what could be improved about their living and care experience is the foundation for this project, and their voices have guided us every step of the way.

We would like to acknowledge the following organizations for inviting us to their communities and/or sharing the implementation tools that populate this Guide:

Augsburg Lutheran Home and Village (Baltimore, Maryland)
Azura of Lakewood (Lakewood, Colorado)
Bethel Health Care Center & The Cascades Assisted Living (Bethel, Connecticut)
Brewster Village (Appleton, Wisconsin)
Central Connecticut Senior Health Services (Southington, Connecticut)
Arbor Rose · Jerome Home · Mulberry Gardens of Southington · Southington Care Center · The Orchards at Southington
Delnor Glen Senior Living (St. Charles, Illinois)
Evergreen Retirement Community (Oshkosh, Wisconsin)
Fairacres Manor (Greeley, Colorado)
Holbrook Health Center at Piper Shores (Scarborough, Maine)
Kennon S. Shea & Associates (San Diego, California)
California Special Care Center · Cloisters of La Jolla · Cloisters of Mission Hills Lo-Har Gardens · Magnolia Special Care Center · Parkside Special Care Center Somerset Special Care · Victoria Special Care Center
Landis Homes Retirement Community (Lititz, Pennsylvania)
Magnushof, Schagen (part of Woonzorggroep Samen) (The Netherlands)
Maimonides Geriatric Centre (Quebec, Canada)
Messiah Village (Mechanicsburg, Pennsylvania)
Middlewoods of Farmington (Farmington, Connecticut)
Rivas Zorggroep (The Netherlands)
Saint Elizabeth Home (East Greenwich, Rhode Island)
Sharon Health Care Center (Sharon, Connecticut)
St. John‘s Lutheran Ministries (Billings, Montana)
Wesley Village (Shelton, Connecticut)
Bishop Wicke Health Center · Crosby Commons · Wesley Heights
Toonladder, Almere (part of Zorggroep Almere) (The Netherlands)

In addition to these sites, we acknowledge the collective wisdom of the entire Planetree community of continuing care organizations, hospitals, ambulatory care centers, health resource libraries and VA medical centers and community living centers, each of which serves as a living laboratory where innovation in patient- and resident-centered care thrives, and whose focus groups informed the creation of this Guide.

FOREWORD

By Bonnie Kantor, Executive Director
Pioneer Network

Many of you will remember the classic line from the children's story, "The Little Engine that Could." I certainly remember reciting "I think I can, I think I can," over and over again as the engine climbed the hill. Then Shel Silverstein came along with a slightly different take on the task at hand. In his poem, "The Little Blue Engine," he wrote about how hard the engine was trying, how it hoped and pulled and puffed and coughed and then . . .

> He was almost there, when — *CRASH! SMASH! BASH!*
> He slid down and mashed into engine hash
> On the rocks below... which goes to show
> If the track is tough and the hill is rough,
> THINKING you can just ain't enough![1] (Silverstein)

We all want to improve long-term care for our elders—you have indicated your desire to implement change just by picking up this Long-Term Care Improvement Guide. And in this era of healthcare reform, when we now have the support of policy makers and the strength of policy to further change the culture of care, the opportunities before us are unprecedented. However, thinking we can, or even wanting to do so, just isn't enough. We need tools and guidance and assistance from each other along the way.

This Guide is intended to do just that—supply providers with tools, data and practical resources so they can make informed decisions as they consider implementing culture change initiatives in order to deliver person-centered care.

What Will it Take to Make Person-Centered Care the Norm?

For many years now, pioneers nationwide have championed the idea that those receiving long-term care in nursing homes and other settings are best served by what has become known as "person-centered care." To fulfill this aspiration will require a sea-change in the way this country thinks about long term care—a broad and deep change in our mindset and in the way we lead and deliver these services. In short, a substantial change in the culture of long-term care. Through the innovation and hard work of the early adopters of such culture change, we know that it is possible to deliver person-centered care that is both cost-effective and highly satisfying to those receiving the care and to their families and caregivers. While many specific approaches have been developed, the **core values that unite them are choice, dignity, respect and self-determination.**

These values are reflected in key aspects of the care setting's physical environment and in the philosophy and practices of leaders and caregivers. There is no single or simple change that will

[1] Silverstein, Shel. *Where the Sidewalk Ends*. 1st ed. Harper Collins, 1974. Print.
[2] Rogers, Everett M. Diffusion of Innovations, Fifth Edition. New York: Free Press, A Division of Simon &

create an environment in which people have meaningful choices, are treated with dignity and respect and where they themselves make important decisions about their care and their day-to-day lives. It's hard work.

But, given the benefits, especially for the recipients of care, a large and growing number of providers, consumers, policy makers, professional associations, and long-term care leaders believe ***we must move from the demonstration stage that has characterized the last decade to the broad-scale spread of this compelling innovation.***

Culture Change as Innovation: Toward Defining Terms

Before an innovation can spread, it must be clearly defined and understood. "Culture change" is an innovation anchored in values and beliefs that return the locus of control to elders and those who work closest with them. Its ultimate vision is to create a culture of aging that is inclusive, life-affirming, satisfying, humane, and meaningful. Long-term care environments become places where elders can continue to live and, most importantly, make their own choices and have control over their daily lives. The transformation accompanying culture change requires changes in organizational practices, physical environments, workplace practices, and relationships.

Culture change refers to the progression from institutional or traditional models of care to more individualized, consumer-directed practices that embrace choice and autonomy for care providers and recipients. For example, residents living in nursing homes that provide resident-centered care go to bed and wake when they want, eat what they want when they want and create their own living spaces in the rooms. This kind of care not only enhances quality for consumers and staff but also creates opportunities for the organization to improve operational benchmarks in areas such as quality of care, efficiency of operation, revenue generation and stabilized staffing.

Because we now are able to articulate operational linkages between person-centered care, quality of care and financing, culture change has progressed from a grassroots movement to one that is embraced and supported by policymakers, providers, national and state associations and, more importantly, CMS.

CMS has been supportive of culture change since the beginning of the movement in 1997. A good recent example of this commitment is the national symposium CMS co-sponsored with the Pioneer Network in 2008. *Creating Home in the Nursing Home: a National Symposium on Culture Change and the Environment* was intended to promote discussion, dispel barriers and coordinate action that supports culture change in nursing home environments. This was a groundbreaking effort to broaden and deepen the discussion of the connections between resident-centered implementation and the regulatory environment. Chief among the substantive outcomes are the 2009 revision to the CMS interpretive guidelines. The new interpretive guidelines enhance instructions to surveyors on how to evaluate compliance with areas such as resident choices about daily schedule (including when to get up, got to bed, eat and bathe.) Throughout this Guide you will see tips for responding to the new opportunities CMS has provided us to further ensure that elders live self-directed and meaningful lives as their care needs change.

Toward Diffusion of Innovation: Spreading the Good Word and Work

In the classic work, *Diffusion of Innovations*[2], Everett Rogers categorizes five attributes of innovation as a theoretical framework for the essential elements of diffusion (Institute for Healthcare Improvement, 2009). When measured, these attributes determine the level of difficulty inherent in broad-scale adoption, build specificity around change, and illustrate how it can be carried out. These are:

- **Relative Advantage**
  The degree to which an innovation is perceived as better than the idea or practice it supersedes
- **Simplicity**
  The degree to which an innovation is perceived as simple to understand, apply, and use
- **Compatibility**
  The degree to which an innovation is perceived as being consistent with the existing values, experiences, beliefs, needs, and practices of potential adopters
- **Trialability**
  The degree to which an innovation can undergo a trial and be tested on a small scale
- **Observability**
  The degree to which the use of an innovation and the results and impacts it produces are apparent and/or visible to those who should consider it

To achieve maximum impact this Guide prioritizes projects and resources that fulfill each of the five attributes. The examples include both the "before and after" approach and allow the reader to think critically about the comparative advantage of the intervention. Both quantitative and qualitative indicators and results are included whenever possible. You will also note that the models proposed are ones that can be applied or adopted with some ease; major capital outlays are not necessary. Especially exciting is the opportunity the Guide provides for you to think about "trying on culture change" on a small scale in a way that is compatible with your organization's values and needs. Finally, the style of the Guide is meant to help the examples "come alive" and be observed in the reader's mind. And nothing could make the examples come alive better than "hearing" directly from the residents and their families. As you read, please "listen carefully" to the residents' voices. They are powerful reminders that in resident-centered care, it is the resident who directs his or her life and daily routine wherever they call home.

On behalf of these elders, our most valued and deserving citizens, please join us on this journey. The hill before us is indeed a steep one. The load is a heavy one. But through the sharing of knowledge, experience, examples and resources, this Guide will lighten the load and help us all enhance our long-term care system. Can we create a more cost-effective and responsive system that meets the need of our elders and those who serve them? Can we do it? I don't just think we can, I know we can.

[2] Rogers, Everett M. Diffusion of Innovations, Fifth Edition. New York: Free Press, A Division of Simon & Schuster, Inc. 2003.

How to Use the Long-Term Care Improvement Guide

Funded by Picker Institute, the Long-Term Care Improvement Guide was created to propel long-term care communities in their improvement efforts by presenting a collection of concrete strategies for actualizing a resident-directed, relationship-centered philosophy. Ultimately, the aim of this Guide is to encourage communities to *take action*.

The Self-Assessment Tool on page 10 was developed to support users in this aim by helping you to navigate to the content in the Guide most pertinent to your organization. Completion of the tool is a good starting point for identifying and prioritizing opportunities for improvement and enhancement. The findings can be used to inform a site-specific implementation plan and to guide the trajectory of the change effort. Involving all stakeholder groups in completing the tool and broadly sharing the findings positions any subsequent actions for greater success by establishing the change efforts as community-driven.

For communities in the early stages of the change process, creating a sense of urgency for why business as usual will no longer suffice is essential. Section One, *Making the Case for Change* uses outcomes data to demonstrate that improving the long-term care experience for those who live and work in our communities is not merely a moral imperative, but increasingly a financial one. The data presented here may be useful in creating a platform from which to launch improvement efforts. This section also tackles twenty of the most persistent myths that have long curtailed change efforts and demonstrates why they need not stand in the way of improvement. Read more about these myths beginning on page 34.

In Section Two, *Building Community*, we explore a defined process for engaging all stakeholders in creating, implementing and anchoring a comprehensive vision for change. Consistent with the aim of the Guide to transcend specific models, the change process defined here is not specific to any one philosophy. The description of the change process is complemented with specific tools individual sites have used related to the different steps.

Section Three, *Practical Approaches for Building a Resident-Centered Culture*, is organized around aspects of life in long-term care communities identified as priorities by residents and staff. Topics covered include: Systems for Getting to Know Residents; Resident-Centered Staffing Approaches; Maximizing Independence; The Move-In Experience; Understanding Community Norms; Focusing on Possibilities, Not Limitations; Supporting the Community Through Grief and Loss; Spirituality; Managing Risk; Culinary Engagement; an Environment of Living; Authentic Experiences that Promote Well-Being; Community Connections and Transitions of Care.

Here we present tangible resident-centered practices in place within a diverse set of culturally transforming long-term care communities. Many of the strategies featured are relatively simple changes that can be implemented quickly and at little cost to the organization. The sequencing of

the sections within this Guide, though, is very intentional. The long-term success of every practice in Section Three (even those that, on the surface, appear basic) is contingent upon them being implemented as part of a comprehensive and inclusive process for change (as described in Section Two.)

To further illustrate the connection to process, a number of the practices are accompanied by a *Focus on Process* sidebar that explores in depth one organization's approach to implementation. Also included throughout this section are sample policies, implementation tools and Web resources to support you in crafting an implementation approach tailored to your setting. To help connect the dots between practices and outcomes, we have also included outcomes data for a number of the featured practices.

It is important to note that though the aim of this Guide is to spur action, the intended audience is not limited to those organizations yet to embark on a journey of transformation. It is equally relevant to those long guided by a resident-centered philosophy who may be feeling stalled in their effort, or who may be exploring what *more* can be done to cement and strengthen an already well-established culture. For communities that fall into this latter category, we have included a number of *Stretch Goals*. These goals are advanced practices that may require even settings well along on their journey to extend themselves further, taking change efforts to even greater heights within their organization.

Additional Resources

In addition to the resources made available by Picker Institute **(www.pickerinstitute.org)** and Planetree **(www.planetree.org)**, the following Web sites provide valuable information and further guidance for any organization endeavoring to improve the experiences of residents and staff.

Action Pact, Inc.
www.culturechangenow.com

Advancing Excellence in America's Nursing Homes
www.nhqualitycampaign.org

Almost Home: Changing Aging in America
www.almosthomedoc.org

American Association of Homes & Services for the Aging
www.aahsa.org

American Health Care Association
www.ahcancal.org

Artifacts of Culture Change
www.artifactsofculturechange.org

B&F Consulting, Inc.
www.bandfconsultinginc.com

Better Jobs, Better Care
www.bjbc.org

Center for Excellence in Assisted Living
www.theceal.org

The Eden Alternative
www.edenalt.org

The Green House Project
www.thegreenhouseproject.org

IDEAS Institute
www.ideasinstitute.org

Institute for Caregiver Education
www.caregivereducation.org

It's Never 2 Late™
www.in2l.com

Life Bio
www.lifebio.com

Live Oak Institute
www.liveoakinstitute.org

Mather Lifeways
www.matherlifeways.com/re_leap.asp

My InnerView
www.myinnerview.com

National Alliance of Small Houses
www.smallhousealliance.org

National Center for Assisted Living
www.ahcancal.org/ncal

National Consumer Voice for Quality Long-Term Care
www.theconsumervoice.org

National Transitions of Care Coalition
www.ntocc.org

NHRegsPlus
www.sph.umn.edu/hpm/NHRegsPlus

Palliative Care in Nursing Homes
www.scherviercares.org

Paraprofessional Healthcare Institute(PHI)
www.phinational.org

Pioneer Network
www.pioneernetwork.net

Quality Partners of Rhode Island
www.qualitypartnersri.org

Society for the Advancement of Gerontological Environments
www.sagefederation.org

Wellspring
www.lifespan-network.org/beacon_wellspring.asp

The following terms will appear throughout this Guide. The following definitions are provided to facilitate a consistent understanding of each term.

Artifacts of Culture Change: A tool developed by Carmen Bowman, consultant-owner of EduCatering and Karen Schoeneman, Deputy Director of the CMS Division of Nursing Homes. Based on the items that are most significant to changing a home's culture, the tool can be used to assess an organization's current status and to determine areas that still need to be addressed.

Case for Adoption: As defined by the Pioneer Network, the case for adoption is the articulation of the operational linkages between person-directed care, quality of care and financing.

Community: Unless otherwise noted, *community* will refer to the collective population of a long-term care organization.

Culture: How different aspects of human conduct—roles, norms, values, customs, likes, dislikes, symbols, language, priorities and more—dovetail and turn a group of disparate individuals into a community with a distinct identity.

Culture Change: A quality improvement approach for shifting from an institutional model characterized by top-down power structures and a medical orientation to a person-centered one distinguishable by smaller self-contained living areas, the blurring of staff roles and a flattened organizational structure in which those who work closest to residents are empowered with decision making authority.

Practices and Implementation Tools At a Glance

Building Community: A Process for Transformation

Practical Approaches for Building and Sustaining a Resident-Directed, Relationship-Centered Culture

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LONG-TERM CARE IMPROVEMENT GUIDE SELF-ASSESSMENT TOOL

This self-assessment tool is provided as a resource to assist users in navigating through the Long-Term Care Improvement Guide, particularly those struggling with where to begin. The assessment tool is organized around important aspects of a resident-centered culture, each of which is addressed in-depth in its own section of the Guide. Completing the self-assessment may help to identify important opportunities for improvement or to prioritize a list of initiatives your organization may be eager to undertake. The process of completing the tool and using the findings is an opportunity for modeling organizational values. Including stakeholders from throughout the organization in the assessment process is important, as perceptions may differ across the organization. Sharing the findings in a transparent manner builds trust and helps to create urgency for change, and incorporating the identified priorities into the goals of the coalition/steering team will be important for maintaining momentum. Change is dynamic; accordingly, it will be important to revisit this tool routinely as part of the process for sustainable improvement.

INSTRUCTIONS:

1. Complete the table below by marking the box that most appropriately captures the current status of the described practice in your organization.
2. Tally up your score for each section using the following scale:
   2 points for every practice that is **fully implemented.**
   1 point for every practice that is **partially implemented.**
   0 points for every practice that there is **no activity** or it is **not applicable.**
3. Calculate your organization's performance in each area, and refer to the section of the Guide addressing those areas which your performance indicates as the greatest opportunities for improvement. (low percent score=opportunity for improvement)
4. Use the **Prioritization Tool** to prioritize the implementation of the initiatives.
5. Take the time to celebrate your accomplishments! (high percent score=areas of achievement)

	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas)*	*No activity*	*Not applicable*
***Building Community: Establishing Urgency*, pg. 51**				
We routinely use an internal assessment and/or measurement system for developing goals.				
We have a process in place to listen to the stakeholders of our organization. (Examples: focus groups, learning circles)				
We have a process to routinely communicate our organizational challenges, financial, clinical, operational and cultural goals and vision to stakeholders. (Examples: community meetings, town hall meetings, daily stand-ups)				
Total Score out of a Possible of 6		**Percent of Total:**		**%**

	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas)*	*No activity*	*Not applicable*
Building Community: Creating a Coalition, pg. 56				
We have a guiding coalition that meets routinely.				
Our coalition has a process in place to identify new members.				
Our coalition has representation from all stakeholder groups, such as residents, families, and staff.				
Our coalition has a charter to guide its work.				
Total Score out of a Possible of 8		**Percent of Total:**		**%**
Building Community: Developing a Vision and Strategy, pg. 59				
Our vision for resident-centered care is clear, concise and understandable.				
Our organization has identified values to support our vision.				
Total Score out of a Possible of 4		**Percent of Total:**		**%**
Building Community: Communicating the Change, pg. 62				
We routinely do leadership assessments with input from community stakeholders. (Examples: 360 degree evaluation, self-assessment, staff feedback)				
Leadership models the expected behaviors of the change vision. (Examples: rounding with reason, coaching supervision, immersion leadership)				
Leadership regularly models the vision through routine participation in the community. (Examples: all hands philosophy, dialogue days, visual displays)				
Stakeholders‘ ideas and suggestions are welcomed and responded to.				
We empower neighborhoods/households to conduct internal audits and create performance improvement plans.				
We are transparent with the development of goals and the progress of those goals.				
Total Score out of a Possible of 12		**Percent of Total:**		**%**

	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas)*	*No activity*	*Not applicable*
***Building Community: Empowering Others*, pg. 68**				
Feedback from staff validates that the organizational culture allows for the celebration of mistakes as a mechanism for learning.				
Our organizational chart and other documents reflect our change vision. (Example: resident placement on org. chart and resident involvement in job description development)				
We routinely offer education and development to our staff, residents, and family to understand the change vision.				
Our organizational culture allows for honest dialogue about barriers to change, even when those barriers are human.				
We have a process to drive accountability and address poor performance in the organization. (Example: job coaching)				
We dialogue regularly with our Department of Health field office to build an understanding of our change vision.				
Total Score out of a Possible of 12		**Percent of Total:**		**%**
***Building Community: Aligning Human Resources*, pg. 73**				
Our hiring practices include the use of behavioral based questions.				
Our interview process includes interviews with staff.				
Our interview process includes interviews with residents.				
Our job/role descriptions reflect the standards of behavior expected and the decentralization of departments.				
Our employee evaluations include peer and resident input. (Examples: anonymous contribution, learning circle feedback)				
We use a mentoring program for all new employees.				
We have a career ladder in place for all employees.				
Total Score out of a Possible of 14		**Percent of Total:**		**%**
***Building Community: Aligning Work Design with Vision*, pg. 77**				
Our teams are self-managed and self-directed.				
Our teams use a consistent or personal assignment format.				
Our teams use self-scheduling.				
Nursing assistant education is provided for all positions.				
We routinely provide continuing education to all stakeholders (residents, family, and staff).				
Total Score out of a Possible of 10		**Percent of Total:**		**%**

	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas)*	*No activity*	*Not applicable*
Building Community: Building an Appreciative Culture, pg. 80				
Our organization provides support services for staff and solicits staff input into the services that would be most meaningful to them.				
We have a consistent recognition program for all stakeholders, including employees, volunteers, private caregivers and families.				
We have an active employee wellness program.				
Total Score out of a Possible of 6		**Percent of Total:**		**%**
Building Community: Generating Short-Term Wins, pg. 83				
Our organization routinely identifies and responds to short term goals/wins.				
Our organization celebrates short-term wins.				
Total Score out of a Possible of 4		**Percent of Total:**		**%**
Building Community: Consolidating Improvements and Sustaining Momentum for Change, pg. 88				
We have an active continuous quality improvement (CQI) process in our organization.				
Our CQI process is directly aligned with our coalition/steering committee.				
We create annual goals through the evaluation of data from surveys, focus groups/learning circles,and family concerns.				
Residents, family and front line staff are decision-makers and are included in the improvement process.				
Total Score out of a Possible of 8		**Percent of Total:**		**%**
Building Community: Anchoring the Change, pg. 92				
We share data with stakeholders to foster dialogue about their priorities.				
We use an external evaluator on a routine basis.				
We post/display our organizational data in a public place. (Includes quality indicators, financial goals, and organizational goals)				
The common language of the community reflects the values of resident-centered care.				
A process is in place for succession planning.				
Total Score out of a Possible of 10		**Percent of Total:**		**%**

	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas)*	*No activity*	*Not applicable*
***Individual and Community Life*, pg. 129**				
A process is in place to identify, communicate and honor resident preferences.				
Residents, families and front line staff participate in the care planning process.				
Resident care plan goals are reflective of resident preferences and are interdependent on each other.				
A resident-directed medication pass process is in place.				
Our teams are taught to focus on strengths and how to maximize independence for all residents.				
Residents have access to a full array of concierge and on-site services.				
Our teams are taught conversational assessment techniques.				
We manage our move-in process to decrease the stress related to the resident being overwhelmed.				
Our teams use life stories and responses to care to individualize care for persons with cognitive impairment.				
Our community has a process and ritual that celebrates life when each resident dies.				
Our community has a process in place that supports residents and staff through grief and loss.				
A process is in place for residents to proactively make their preferences known about sharing information with others in the community about a hospitalization.				
Total Score out of a Possible of 24		**Percent of Total:**		**%**
***Culinary Engagement*, pg. 189**				
Residents‘ dining choices are supported and honored.				
Our speech pathologists support a resident‘s choice as it relates to texture.				
Residents have access to food and beverages 24/7.				
Residents are offered a variety of menu choices at each meal.				
Tray style dining has been eliminated, except for room service.				
We have implemented restaurant style dining, family style dining, or buffet style dining.				
Residents are involved in menu planning.				
Residents assist with the chores associated with dining. (Example: setting the table, clearing plates, etc.)				
Our community has a garden for fresh vegetables and fruit. (Examples: wheelchair gardens, cart gardens, box gardens)				
Total Score out of a Possible of 18		**Percent of Total:**		**%**

	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas)*	*No activity*	*Not applicable*
Authentic Experiences that Promote Well-Being, pg. 216				
We celebrate individual birthdays with our residents.				
We have cultural norms that support holiday celebrations on the holiday.				
Residents have opportunities in the community to teach and to learn.				
All stakeholders in the community have opportunities to share passions and lead activities.				
Residents have access in the community to technologies that support cognitive fitness, wellness, and communication with families and each other.				
Holistic and alternative therapies such as massage, aromatherapy, chiropractic care, and healing touch are offered.				
Total Score out of a Possible of 12		**Percent of Total:**		**%**
An Environment of Living, pg. 237				
We have implemented a self-directed living environment. (Examples: neighborhoods and/or household models)				
Our community culture supports the self-expression of our residents in their personal spaces.				
Our community/public spaces are decorated to the preferences of our residents.				
Icons of institutionalization have been eliminated. (Examples: nurses stations, medication carts, and institutionalized bathing rooms)				
We use lighting sources that decrease glare and enhance visual acuity.				
Our olfactory environment is pleasing to the residents, families and staff.				
Our feedback from residents indicates an environment that is respectful of the amount of noise in the neighborhood/households.				
Outdoor spaces are conducive to safe ambulation and visitation.				
We have private areas for family members and friends to visit with the resident.				
Staff has access to comfortable and private break rooms that meet their needs.				
We have identified and integrated into our strategic plan a vision for renovation.				
Total Score out of a Possible of 22		**Percent of Total:**		**%**

	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas)*	*No activity*	*Not applicable*
***Community Connections*, pg. 252**				
Our community stakeholders represent the organization at events such as walk-a-thons, health fairs, volunteering at food banks/soup kitchens, and other social service organizations.				
Our residents and other stakeholders actively recruit for our volunteer program.				
We have a volunteer program that is responsible for ____% of our engagement and social functions. (as determined through committee)				
We provide outreach and education to the public-at-large.				
We encourage active participation of external community members in social events, activities and daily life. (Examples: through book clubs, art shows, or entertainment)				
Total Score out of a Possible of 10		**Percent of Total:**		**%**
***Transitions of Care*, pg. 261**				
Our community tracks readmission rates.				
Our organization is working with the local hospital and other providers across the continuum of care to improve the patient experience and enhance transitions of care.				
Total Score out of a Possible of 4		**Percent of Total:**		**%**

INITIATIVE PRIORITIZATION TOOL:

Instructions:

1. From the completed assessment, fill in those initiatives that you rated either **partially implemented** or **no activity.**
2. Tally up the number of ―Yes" responses to identify top initiatives. Items with the greatest number of Yes responses = higher priority.
3. Refer to the Guide sections that correlate to the top priorities for your organization.
4. Empower the Guiding Coalition or Steering Team to use these priorities to set organizational goals and work groups.

Assessment Item	Does this initiative satisfy an expressed resident, family and/or staff need?		Does this initiative support our organizational goals and priorities?		Does this initiative present an opportunity for a high-impact, short-term win?		Do our organizational resources allow for the implementa-tion of this initiative?		# of Yes Resp-onses
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	

—I dwell in possibility."
Emily Dickinson

CREATING DWELLINGS OF POSSIBILITY

Improving the Long-Term Care Experience

Defining culture change begins with defining culture. Culture is how different aspects of human conduct—roles, norms, values, customs, likes, dislikes, symbols, language, priorities and more—dovetail and turn a group of disparate individuals into a community with a distinct identity.

To transform a culture is a momentous undertaking; the word "change" almost doesn't suffice. We change our clothes, change our minds, have a change of heart—all fleeting, often insignificant adjustments. *Culture change* is anything but fleeting and insignificant. It is deep, systemic and enduring. Since the fairly generic term has been adopted for the very specific purpose of representing a transformation of long-term care culture, the implications are even more profound. Now, we are talking about the lives and experiences of society's most vulnerable citizens and those who have dedicated their professional lives to working with them.

There are numerous variations on the definition of culture change. Fundamentally, though, it is a quality improvement approach for shifting from an institutional model characterized by top-down power structures and a medical orientation to a person-centered one distinguishable by smaller self-contained living areas, the blurring of staff roles and a flattened organizational structure in which those who work closest to residents are empowered with decision making authority. The changes that take root to reflect these values are attitudinal, operational and environmental, and they occur at an individual and organizational level. Common elements of culture change include resident-direction in care and daily activities, a home atmosphere; close relationships between residents, family members and staff; staff empowerment; collaborative decision-making; and quality improvement processes.[3]

With the aim of defining culture change by classifying long-term care communities intently focused on it, a number of efforts have been made in recent years to create a more concrete framework for evaluating communities' progress in their change journeys. The Culture Change Staging Model identifies four stages: the institutional model, transformational model, neighborhood model and household model, with the most advanced stage being defined more specifically by:

- Resident-directed decision-making
- Universal workers who function in multiple roles
- Self-contained living areas with 24 or fewer residents

[3] Koren, MJ "Person-Centered Care for Nursing Home Residents: The Culture-Change Movement," *Health Affairs* Web First, Jan. 10, 2010.

- Decentralized core services
- Decentralized, autonomous and multidisciplinary teams
- Leadership practices supportive of change and process management.[4]

A subsequent study classified 16 practices commonly associated with culture change based on their level of complexity and correlated the adoption of the more complex practices with homes self-characterized as –eomplete" culture change adopters. These practices include:

- Including direct care workers and residents as a regular part of the senior management team
- Involving residents in decision-making, including creating calendars for social events, activities and outings
- Creating self-managed work teams, and
- Involving residents in decisions about who provides their hands-on care.[5]

Though the term culture change has tended to be associated with nursing homes, more recently the definition has broadened to include the full continuum of long-term care; in other words, ―the place wherever one lives." Ultimately, at the core of any definition of culture change are the same attributes: choice, dignity, self-direction, relationships and an emphasis on possibilities versus limitations.

Transforming Philosophy into Tangible Change

This definition of culture change represents a colossal shift for a field whose institutional-orientation has long prioritized efficiency, productivity and profits, resulting in a focus on quality of care over quality of life, decisions being made *for* residents rather than *with* them, and in a general reputation as places people go to die rather than places people go to live out a rich and full chapter of their lives.

This highly institutionalized model that has guided long-term care organizations for decades has bred dependence, indignity and relinquishment of much that is inspiring, enjoyable and stimulating in life. How could we possibly expect people to want to make such places home? For that matter, how can we expect to attract and retain staff with the skills and character to be effective caregivers in settings where rules and rigidity can quickly burnout even the most devoted employees?

When it comes to culture change in long-term care settings, the prevailing wisdom from a philosophical standpoint is that, of course, it is the *right* thing to do. Where the breakdown occurs is in efforts to actualize these concepts in day-to-day operations, given the mighty pressures applied by state and federal regulations, narrow operating margins and a pervasive attitude within the field that is both change and risk averse.

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[4] Grant LA, Norton L. A Stage Model of Culture Change in Nursing Facilities; Paper presented at the Symposium: Culture Change II: Theory and Practice, Vision and Reality, The 56th Annual Scientific Meeting of the Gerontological Society of America; San Diego. 2003.

[5] Sterns, S. Miller S C., & Allen, S. (2010) The Complexity of Implementing Culture Change Practices in Nursing Homes. *Journal of the American Medical Directors Association.*

A growing number of organizations are breaking the mold that for far too long has sustained an unacceptable status quo for long-term care. These pioneering organizations represent the full continuum of long-term care—skilled nursing, independent and assisted living, sub-acute and short-term rehabilitation. They are for-profit and not-for-profit, religiously-affiliated and not, with diverse payer mixes. In the day-to-day ways that each is building community, cultivating relationships, engaging all stakeholders in decision-making and personalizing support and services for those who live there, these communities are modeling what is possible. The emergence of data correlating these efforts with lower staff turnover, improved clinical outcomes, higher occupancy rates, and improved resident, family and staff satisfaction is steadily converting culture change from a moral imperative to a financial one. *The business case for culture change is explored more fully starting on page 25.*

Nonetheless, the question lingers for many communities of how to translate philosophical alignment with the values of culture change into tangible and sustainable transformation.

About the Long-Term Care Improvement Guide

The Long-Term Care Improvement Guide has been developed as a response to this ongoing challenge. A compendium of more than 250 specific changes a long-term care community can make to move toward a more resident-directed, relationship-centered approach, the Guide's focus is on the practical more so than the philosophical. These are not "pie in the sky" ideas; every process and practice spotlighted in these pages has been implemented in a real setting. They are presented here as tools for you to use in your organization's ongoing improvement efforts.

What the Guide is *not* is a step by step recipe for culture change. Such a "recipe" is inconceivable because there truly is no one size fits all approach. While some concepts are fundamental, how those concepts manifest within an organization requires the influence of the staff who work there, the residents who live there, the board

A Note on the Patient-Centered Care Improvement Guide

The genesis of the Long-Term Care Improvement Guide was the release in 2008 of the Patient-Centered Care Improvement Guide (**www.patient-centeredcare.org**), an unprecedented compendium of practical strategies for transforming patient-centeredness from a nebulous concept into a concrete one. Developed by Planetree and Picker Institute, the Patient-Centered Care Improvement Guide has been downloaded more than 57,000 times. Strategies highlighted have been realized in acute care hospitals, ambulatory centers, physician practices, and even long-term care settings.

While many of the patient-centered practices and resources featured in the Patient-Centered Care Improvement Guide are certainly pertinent to long-term care providers, the focus of the Guide was definitively on acute care hospitals. This companion Long-Term Care Improvement Guide explores the experiences of residents, their families and their caregivers in greater depth. Here we explore approaches for meeting needs in a setting where expectations, preferences and priorities differ from those of hospital patients and staff. However, just as a number of long-term care communities turned to the Patient-Centered Care Improvement Guide as a resource for their culture change journeys, acute care providers are encouraged to look to the innovations that have burgeoned in long-term care to further advance hospital efforts to support patient autonomy, dignity, and privacy, preserve patients' personal routines and promote healing in a supportive and comfortable environment.

members who govern, the volunteers who provide support and others.

Nor is the Guide a checklist of strategies for an organization to work its way through, one at a time, section by section. In fact, on its own, such an inventory of practices can, at best, result only in superficial and short-lived change. While some would argue even short lived improvements are beneficial, there is an important counterpoint to raise. A sporadic, bits and pieces approach to change may actually do more harm than good by raising and then dashing expectations and undermining stakeholders invested in creating a different kind of experience. Ultimately, a poorly thought out approach will fail not only in the short term, but may stymie future efforts by fueling attitudes of skepticism and disengagement.

The seeds for deep, systemic change are not isolated interventions, but rather a comprehensive approach for nurturing a collective vision, engaging stakeholders, breaking down barriers to challenge even the most steadfastly held conventions; and expanding the accepted definition of leadership and community. For this reason, the *process* for how opportunities are identified; how goals are set, implemented and sustained; how all members of the organization contribute to problem-solving; and how success is measured is the crux of the matter. In the absence of such processes, the strategies highlighted in these pages will be without the essential roots that transform discrete practices into an all-embracing culture. *A framework for these processes is the focus of the Building Community section beginning on page 49.*

Strategies that Transcend Specific Models and Span Settings

Through her research, Dr. Robyn I. Stone has concluded that ―organizations interested in radically transforming their care, work and residential environments should begin with a living template that has successfully implemented and sustained one or more dimensions of culture change."[6] A number of models provide such a ―living template" to guide long-term care communities in this process of improvement, among them Green House®, Eden Alternative®, Wellspring and Planetree. While each has distinct elements, what they have in common is far more profound than what sets them apart. With this Guide, we look beyond any specific model, letting the voices of residents, staff and thought leaders in the field guide us to approaches that address universal desires for living and working in long-term care settings. With a goal of creating a resource that is broadly applicable, the intent is that regardless of what model is guiding your organization's efforts, this Guide will support you in putting in place the necessary groundwork and building on progress to date.

Nor is the Guide specific to the nursing home setting, often thought of as the focus of culture change efforts. The concepts of resident-centeredness span the full continuum of care, which is all the more relevant as an emphasis on aging in place intensifies. Elders' desires to age in place compel us to consider how best to support resident independence, dignity and choice in a way that optimally meets their evolving needs and preferences—regardless of the setting they're in or the degree of support and level of care they are receiving. Accordingly, the Long-Term Care Improvement Guide features innovations from nursing homes, assisted living and short-term

[6] Stone, Robyn I. (2003). Selecting a Model or Choosing Your Own Culture. In A.S. Weiner, J.D. Ronch (eds.) *Culture Change in Long-Term Care*. Binghamton, NY: The Haworth Social Work Practice Press. pp.411-422

rehabilitation settings. In the spirit of being guided by individual needs versus a specific setting, these innovations are co-mingled throughout these pages, and the majority of them are portable across environments. Users of the Guide are encouraged to think beyond the perceived limitations to change efforts for specific populations or settings (e.g. the shorter length of stay for short-term rehab patients or the challenges of providing resident-directed care for individuals with cognitive functional loss), to instead focus on the possibilities and to learn from innovations from across the continuum.

Listening to the Voices of the Community

The Resident Perspective

It has been established that the content of this Guide was driven not by a specific model for change, nor by a specific setting. Rather, the foundation for this work—and truly for any endeavor toward organizational transformation—is the voices of those who live and work in long-term care communities. The first step in developing the Long-Term Care Improvement Guide was an analysis of qualitative data collected through focus groups with long- and short-term residents in settings across the long-term care continuum. A team from Brown University's Center for Gerontology and Health Care Research analyzed transcripts from 39 focus groups facilitated by Planetree in 19 Planetree-affiliated long-term care communities. Collectively, the focus groups captured the voices of 340 residents from skilled nursing homes, assisted living communities and short-term rehabilitation centers. Out of this analysis emerged core thematic areas about the resident perspective on living in these settings, as well as challenges or barriers that have hindered their preferences from being met. These themes have framed every aspect of the development of this Guide. In each section, residents' perspectives—in their own words—will underscore their priorities, a demonstrated connection back to why each of the strategies included here is important.

The Community Perspective

This focus group work was also the basis for a series of site visits to numerous culturally transforming long-term care communities. On these site visits, we were able to thoroughly explore how the resident priorities that emerged from the focus group analysis have been addressed in meaningful and effective ways in the field. Leadership, staff and residents graciously welcomed us to their settings, and candidly shared with us both their triumphs and struggles in shifting attitudes and operations. Sites visited represented a variety of settings implementing different culture change models in regions across the country.

The Staff Perspective

The experiences of those who live and work in these settings are intricately interwoven, and there is no greater influence on the life of a long-term care community than the relationships between residents and staff. Findings from a subsequent analysis of staff focus groups have also been incorporated into the Guide to showcase the all-important staff perspective.

The Leadership Perspective

Change efforts relocate the locus of decision-making power to residents and to those closest to residents (family members and staff who work most directly with them.) This is not to minimize, however, the role of leadership. Leaders both galvanize the organization around a

shared philosophical vision and also must ensure on a practical level that operational priorities, expectations and policies are consistent with that vision. Given this, the leadership perspective was an essential component to the development of this Guide.

In February 2010, guided by the resident and staff focus group findings, Planetree and Picker Institute convened a Long-Term Care Leadership Roundtable to engage leaders in the culture change movement in a dialogue about their experiences, barriers to advancement and next steps. Participants included leaders from such esteemed models as Eden Alternative, Green House, Wellspring and Planetree, as well as long-term care administrators, nurses, gerontologists, researchers, funders and representatives from trade associations. This dialogue significantly influenced this Guide, particularly in underscoring the importance of connecting practices to process and outcomes. *A list of participants is included as Appendix A.*

Another important outcome from the meeting was the recommendation to more deeply examine the perspectives of long-term care executives to explore how the definition of quality and incentives can be realigned to drive more widespread adoption of culture change principles. A series of interviews with 15 senior executives provided fascinating insight into these questions. The findings from those interviews are captured in Section I, *Making the Case for Change* which begins on page 25.

The Importance of Language

It is fitting that this section includes definitions and a discussion of language. Language is an important, but often overlooked, component of change. Examples abound of ways that language can either reinforce change efforts or, more commonly, undermine them.[7] It is virtually impossible for concepts of personalization and relationship-building to take root in an organization where a resident requiring assistance at mealtime is referred to as a ~~"f~~eeder." Authenticity is immediately lost when the act of walking is referred to as ~~"a~~mbulation," and spontaneity suffers when the only space for an impromptu get-together is the ~~"m~~ulti-purpose room." Purposeful lives unfold in communities, not in ~~"f~~acilities," which is why throughout this Guide, unless explicitly clarified as referring to the external community, the term *community* alludes to the collective population of a long-term care organization.

The widely-used language of long-term care continues to reflect an institutional orientation, and part of any change effort must be thoughtful consideration of the words and expressions we use to describe the work we do, and the people and spaces that make up our communities. For instance, the term ~~"r~~esident" emphasizes the special relationships between person and place and person and community that the term ~~"p~~atient" fails to evoke. But those in short-term rehab anticipating a return home may not identify as being a resident; for them ~~"p~~atient" may be more appropriate. Throughout this Guide, special effort has been made to use language that is consistent with the values of deep and sustainable change.

A discussion of terminology goes beyond the mixed messages sent when there is a disconnect

[7] See ~~"M~~ayday" by Karen Schoeneman for examples of ~~"p~~erson-centered" language. Available at http://www.pioneernetwork.net/CultureChange/Language/ (Accessed 7.1.10)

between language and values. Change can also be stalled when the language used to describe the vision fails to strike a chord. Throughout this Guide, we refer to "culture change." It is important to acknowledge, though, that this terminology may not resonate for all readers. Some organizations may eschew culture change as an industry buzz word that lacks broad appeal and understanding; others take offense that the terminology implies there is something wrong with their culture that needs to be fixed. Some recognize in the core aims of culture change what is commonly referred to as continuous quality improvement. Others, though, argue that it is a transformation process, one of growing and becoming something new and different, not just improving what exists. Most important is that each community finds the language that works best for them and not let the lack of consensus on what to call "it" delay change efforts.

Similarly, approaches are commonly characterized as "person-centered," "resident-directed," "resident-centered," and "relationship-centered." Despite the differences in terms used, all have as common threads the core values of meaningful change identified at the start of this section. In the absence of a singular, all-encompassing and widely accepted term, for the purposes of this Guide the term *resident-centered* will be used most prevalently.

The First Step: Harnessing the Power of Community

We hope this Guide will be a useful resource in helping you to frame your organization-specific approach for transforming attitudes, operational priorities and the environment to best meet the needs of those in your long-term care community. Specific ways to put it to use include providing sections for staff to read and discuss. A candid dialogue about the similarities and differences between your organization and those profiled in these pages may yield some interesting ideas for improvement. Invite residents, family members and volunteers into these discussions as well. Post the priorities that emerge from the self-assessment for all to comment on and offer suggestions for how they may be addressed.

The most powerful resources available for those on a journey of organizational transformation are not guides, Web sites or lecture series; they are the individuals who make up the heart and soul of a community. Involving residents, families, administrators, direct care workers, staff, volunteers, medical staff, the governing board, and other partners in defining a vision and establishing goals exponentially expands the potential for profound and sustainable change.

WE WANT TO HEAR FROM YOU!

Please let us know how you have used the Long-Term Care Improvement Guide and what changes you have implemented as a result. What barriers have you encountered and what successes have you realized? How are you evaluating your results?

To share your experiences, please email us at feedback@residentcenteredcare.org

MAKING THE CASE FOR CHANGE

In an increasingly competitive marketplace and with the emergence of an ever-more discerning consumer base, economics and resident-centered philosophies are driving forces for any long-term care community. Today, all long-term care leaders are obliged to consider any investment in quality improvement through the lens of the potential impact on the bottom line. Despite widespread consensus that culture change is the *right* thing to do, until the business case is compellingly demonstrated, economics will continue to trump philosophical perspectives.

Whereas subsequent sections of this Guide focus explicitly on *how* to adopt change principles and implement transformative practices, this section explores *why* such change is imperative from a clinical, financial and operational perspective. Until recently, these correlations between culture change and quality outcomes have been tenuous at best. The multi-dimensionality and complexity of comprehensive transformation of an organization's culture has long made it difficult to isolate the direct effects of culture change efforts.

"From my perspective, when culture change becomes one of an organization's 'guiding principles' it becomes difficult to assign an outcome to a specific action."
(Long-Term Care Executive)

With heightened interest in and adoption of resident-directed, relationship-centered approaches, however, the body of research demonstrating the value proposition is growing. As illustrated by the quantitative and qualitative data presented in this section, today culture change is understood by a growing number of executives to be a foundational element of successful long-term care business performance.

THE CASE FOR ADOPTION:
Leadership

A growing, critical mass of long-term care leaders is recognizing that the adoption of culture change serves to improve a broad base of key performance measures. More and more long-term care leaders are changing their workplace practices, de-institutionalizing their physical environments, and embracing resident-directed care in order to achieve an innovative, 21st century organization capable of sustainability in the current economic climate. To document this transition, leaders of national long-term care organizations were asked about the value of investing in resident-directed care and each reported many beneficial organizational outcomes from culture change activities, including decreased staff turnover, increased customer satisfaction (residents, families, staff), improved Minimum Data Set Repository (MDS) accuracy (better reimbursement), a positive reputation in the community, and an overall stabilization to occupancy (Farrell & Elliot, 2008).

Farrell, D., & Elliot, A. (August, 2008). Investing in culture change: Long-term care leaders speculate why it works. *Provider*, 18-30.

Source: Pioneer Network, 2010

Business Effects: Strengthening Viability, Building Reputation and Accruing Savings

From an economic perspective, in interviews with 15 executives at both for-profit and not-for-profit long-term care communities, culture change was consistently depicted as "good business."

A number emphasized that the application of these principles has been essential to maintaining the viability or relevance of a long-term care business. With an emphasis on individualizing support and services, these communities have positioned themselves to more effectively meet the needs of all types of residents, including both short- and long-term, which has proven to be a viable strategy for maintaining high occupancy levels.

As one example, in 2008 Piñon Management's average occupancy rate was 90.9%, compared to a Colorado state average of 82.3% and a national average of 84.2%. These results are not exclusive to nursing homes. Crosby Commons, an assisted living community in Shelton, Connecticut with a well-established relationship-centered culture, has maintained a 100% occupancy rate for more than ten years, compared to a national average occupancy rate of 88.3% for assisted living properties as of the second quarter of 2010.[8]

—Our [occupancy] has remained stable at around 95%. We've taken little dips here and there…with the great recession. For the most part we've been able to keep our census up. We believe that part of it is the culture change and the quality health care product we offer that makes the demand for our independent living unit so great because really that's the only way to get into our skilled nursing unit.
(Long-Term Care Executive)

A number of the executives also attributed their change effort to strengthening the reputation of their organization, including performance on the Five-Star Program. In terms of reputation, however, there is perhaps no more effective tool at an organization's

THE CASE FOR ADOPTION:
Occupancy

Organizations implementing a resident-directed approach find that consumers prefer to be living in long-term care environments that respect individual choice. Improvements to occupancy provide a concrete measurement of this outcome.

- A recent study examined 185 "adopter" homes and a comparison group of non-adopters. The sample of adopter and comparison homes both maintained the same occupancy rate of 86% in 2004. By 2008, occupancy of adopter homes increased to 89%. The result was a three percent significant increase for adopter homes not present in the comparison sample (Elliot, 2010).
- In an additional analysis, homes with a sustained level of culture change between 2004 and 2009 maintained, on average, occupancy rates that were seven points higher than the national mean (Pioneer Network cited by La Porte, 2010).
- In research of nursing homes with culture change improvements underway, 60% of homes with a high number of initiatives reported that culture change had a positive impact on occupancy (Doty, Koren & Sturla, 2008).

Doty, M., Koren, M., & Sturla, E. (May, 2008). *Culture change in nursing homes: How far have we come?* Findings from the Commonwealth Fund: 2007 National Survey of Nursing Homes. New York: Commonwealth Fund.

Elliot, A. (2010). Occupancy and Revenue Gains from Culture Change in Nursing Homes: A Win-Win Innovation for a New Age of Long-Term Care. *Seniors Housing & Care Journal,* 18.

La Porte, M. (May, 2010). Culture Change Goes Mainstream. *Provider*, 23-33.

Source: Pioneer Network, 2010

[8] —Assisted Living Occupancy Rises, Seniors Housing Rent Growth Slows." NIC Map. 12 August 2010. < http://www.nicmap.org/Resources/ShowNewsItem.aspx?id=23>. Accessed 31 August 2010.

disposal than word of mouth. Executives extolled their resident-centered cultures for delivering positive resident and family experiences which subsequently translated into referrals. The power of word of mouth is substantiated by data. According to survey vendor My InnerView, more than 60% of families choose a nursing home based on the recommendation of others.

Cost savings are another established financial outcome of resident-centered care. Savings can be accrued through reduced turnover, decreased use of agency labor and decreased worker compensation costs.

THE CASE FOR ADOPTION:
Revenue

As consumers progressively choose long-term care options that are person-directed, organizations are able to calculate the return on investment of implementation. This type of bottom line return is often evident from increases to revenue.

Major findings of a recent study indicate that adopter homes achieved an additional $11.43 per bed per day revenue over a comparison group of homes from 2004-2008. Thus, on average and with other factors accounted for, implementing culture change resulted in an additional $1,600 per day ($584,073 per year) for a 140-bed nursing home over the comparison group from a pre- to post-time frame (Elliot, 2010).

Research of a large nursing home chain found that homes implementing resident-centered care had higher profits per resident day and higher earnings before interest, taxes, depreciation, and amortization (EBITDA) per resident day than those homes not engaging in implementation efforts (Grant, 2008).

Another study comparing nursing homes participating in the Pioneer Network with non-participating homes found that homes participating with Pioneer Network outperformed comparison homes in the financial outcomes of per bed net income and improved operating margins (Pioneer Network, 2007).

Elliot, A. (2010). Occupancy and Revenue Gains from Culture Change in Nursing Homes: A Win-Win Innovation for a New Age of Long-Term Care. *Seniors Housing & Care Journal, 18.*

Grant, L. (February, 2008). *Culture change in a for-profit nursing home chain: An evaluation.* Commonwealth Fund, pub. no. 1099. New York: Commonwealth Fund.

Pioneer Network. (2007). *Preliminary Research Supports Nursing Home Culture Change Movement*. Retrieved August 26, 2010, from www.pioneernetwork.net/Data/Documents/PNPreliminaryResearch.pdf.

Source: Pioneer Network, 2010

—I think you'll have a very successful Living Center if you embrace culture change and live it every day. You will be viewed as the preferred provider in your community. It will build the Living Center's reputation, resulting in positive word-of-mouth—and that is incredibly powerful in terms of getting continued referrals of patients or residents who need the services you offer. Embracing culture change is key to becoming a successful community-based health care provider, and there is nothing more important than that."
(Long-Term Care Executive)

Cultural Change Customization for Short-Term Residents and Dementia Care

Long-term care executives appreciate that culture change is customizable for diverse resident groups across settings. A prominently discussed driver of such customization is the need to provide services that meet the needs of each organization's unique resident populations, including individuals with dementia, and both long- and short-term residents.

> *"So nursing homes should be person-directed—just like home health should be person-directed, or, just like assisted living, just like all of them—they all need to be person-directed. It just depends on what level of frailty or condition you're in to get best served and have the most rehabilitative potential, to the extent that there is rehabilitative potential."* (Long-Term Care Executive)

Culture change is important across long-term care settings, and residents and staff in all types of settings could benefit from culture change initiatives. However, culture change also requires customization for distinct groups of residents. In assisted living, for instance, culture change initiatives could be customized for residents with dementia. Such customization could valuably enrich residents' lives.

> *"We have seen our residents more engaged and behaviors are better and they seem to be more pleased about where they are in the assisted living dementia care neighborhood."* (Long-Term Care Executive)

Furthermore, long- and short-term residents are recognized to have different experiences and needs, which drive customized approaches to quality improvement.

> *"We serve two very distinct customer groups; one that 'stays' with us for approximately 30 days and goes home and one that 'lives' with us thru end of life. These two customer groups have unique sets of needs and expectations; both from an environmental and experience standpoint."* (Long-Term Care Executive)

> *"If somebody's coming in for short-term rehab, many of them don't want to bring in a lot of furniture; they don't want to make a big move. We work to create an environment where we have the quality furnishings, a quality flat screen TV on the wall, telephone service at their fingertips, to have all of these amenities there for them when they move in so they don't have to move these kind of furnishings in for their short-term stay"* (Long-Term Care Executive)

The Clinical Perspective

> *"The quality of care goes up substantially and our outcomes are just phenomenal, and I believe that comes back specifically to culture change. We have a professional team—from our hands-on caregivers, our nursing assistants, to our housekeepers—that know our residents so well because our turnover is so low, that they can immediately spot something changing to bring it to the attention of the nurse…I chalk that up to culture change, thinking about doing something in a different way."* (Long-Term Care Executive)

Providing personalized care, empowering frontline staff and creating a comfortable and supportive built environment cannot come at the expense of excellent clinical care. In fact, as captured in the quote above, clinical quality is enhanced through a resident-centered approach. There are numerous examples of culturally transforming long-term care communities whose improvements in clinical outcomes tell a compelling story about the profound implications of culture change on resident well-being at the most basic level. During the ten year period of 2000 through 2010, Masonic Villages of the Grand Lodge of Pennsylvania reported a 44% decrease in falls and injuries, a 13% decrease in the use of psychotropic drugs and a 30% decrease in weight loss—all attributed by CEO Joseph Murphy to the adoption of culture change principles. Piñon Management in Colorado manages 13 homes, each at different stages in their change journeys. As a rule, those homes more advanced in their implementation exhibit better outcomes than those that have more recently initiated the change process.

Data from the Advancing Excellence in America's Nursing Homes Campaign further corroborates that culturally transforming homes that participated in the campaign have improved faster in clinical areas than non-participating homes. In Phase One of the Advancing Excellence Campaign, nursing homes committed to working on at least three goals, generally in areas where they most needed improvement. Evidence indicates that nursing homes which registered for the Campaign and set specific goals improved faster in clinical areas than homes that did not participate. Indeed, utilization of the free Setting Targets-Achieving Results (STAR) Web-based tool, which was released by Quality Partners of Rhode Island, has been associated with significantly higher performance on a variety of clinical outcomes (see table).[9] Campaign members demonstrated measurable progress toward reducing the prevalence of pressure ulcers, reducing the use of physical restraints, and improving pain management.

Baseline to Remeasurement Performance for the High-Risk Pressure Ulcer Quality Measure, by Target Setting Status

Performance	Target Setters (N=7019)	Non-Target Setters (N=9727)
	%	
Baseline	13.2	14.0
Remeasurement	12.3	13.1
Mean absolute improvement*	0.9	0.8
Mean relative improvement†	7.0	5.9

* Difference in mean absolute improvement, $P = .0440$.
† Difference in mean relative improvement, $P = .0004$.

Baseline to Remeasurement Performance for the Physical Restraints Quality Measure, by Target Setting Status

Performance	Target Setters (N=7030)	Non-Target Setters (N=9716)
	%	
Baseline	6.5	6.8
Remeasurement	5.7	6.4
Mean absolute improvement*	0.8	0.4
Mean relative improvement†	11.9	6.5

* Difference in mean absolute improvement, $P = .0190$.
† Difference in mean relative improvement, $P < .0001$.

[9] Baier RR, Butterfield K, Harris Y, Gravenstein S. (2008) Aiming for star performance: the relationship between setting targets and improved nursing home quality of care. *Journal of the American Medical Directors Association,* 9(8), 594-9. Epub 2008 Sep 7.

Building on this successful foundation of (1) choosing meaningful goals, (2) examining data, and (3) setting meaningful targets, the Advancing Excellence Campaign has proceeded to Phase Two. In Phase Two, the Campaign has re-ordered goals. Reducing turnover and establishing consistent assignment are the primary goals. These goals, it is believed, must b
e addressed before organizations can achieve clinical goals or enhance resident or staff satisfaction. Accordingly, two new and very important tools have been added to the resources section of the Campaign's Web site:

- **A Staff Turnover Calculator**
  www.nhqualitycampaign.org/files/Calculation%20of%20turnover.xls
- **Consistent Assignment Tool**
  www.nhqualitycampaign.org/files/ConsistentAssignment.xls

Providers can use these tools to collect data, set targets, and monitor progress in minimizing staff turnover and increasing the use of consistent assignment.

THE CASE FOR ADOPTION: *Quality*

There are ongoing and substantive conversations regarding the differences in measurement and outcomes of quality of care and quality of life. The systemic nature of culture change in long-term care environments bridges these outcomes by focusing on the residents.

- One study of Green House homes found more direct care time per resident day and increased engagement for residents, less job-related stress experienced by direct care staff, and fewer acquired pressure ulcers (Sharkey, Hudak & Horn cited by La Porte, 2010).
- Another example of this type of interconnected perspective can be illustrated through the use of antipsychotic medications in treating dementia. The relationships established through resident-directed care allow for the involvement of the residents and family in care planning to find ways to address agitation outside of antipsychotic drug use. Dr. Al Power, a national expert and author, suggests that the use of antipsychotic medications can decrease to as low as 7% to 8% through culture change and resident-directed care (compared to 40% nationwide). When residents are not sedated, their ability to interact and engage increases. Side effects such as falls also decrease. As a result, the costs for homes from medication side effects and re-hospitalizations also decreases by as much as $2 for every $1 spent by the home on medications (Kaldy, 2009). The result is a win-win for the resident and the home.

La Porte, M. (May, 2010). Culture Change Goes Mainstream. *Provider*, 23-33.

Kaldy. J. (February, 2009). Putting a New Face on Depression Treatment. *Provider*, 29-35.

Source: Pioneer Network, 2010

—We are trying to build into our organization a culture of excellence and realizing that those that are entrusted to our care and how we deal with them is a sense of pride…We want to make sure that the experience of receiving care in any one of our living centers, that our residents and patients and family members rate us that the care was excellent, not just in terms of quality outcomes as measured by CMS, but the actual experience of receiving care."
(Long-Term Care Executive)

The Resident and Family Experience: Improving Quality of Care and Quality of Life

Correlations between clinical quality improvement and culture change efforts highlight only a narrow slice of the value proposition. For residents and family members, "excellent care" extends far beyond the quality outcomes reported by CMS.

Research from My InnerView demonstrates that what residents and families prize highly and yearn for most are those features of nursing home living that support and promote the quality of life of residents. A quality of life culture is one that subordinates institutional efficiency to person-centered caregiving. It affirms the individuality of residents and staff, maximizes their choice and privacy, promotes their physical and social well-being, and helps them grow spiritually and intellectually. Residents, families and staff agree that a good nursing home is one that honors every individual as a person, and values and promotes relationships, mutual concern, and personal bonds. Ultimately, these approaches, though, set the stage for the more traditional definition of clinical quality. According to My InnerView, long-term care settings consistently rated highly by customers are bound to measure up as high quality operations on any criterion. In other words, surveys mirror quality.

The Staff Experience: Establishing a Satisfied and Stable Workforce

> *"To date I have seen a tremendous change in the attitudes of the staff that work in the neighborhood where we have fully engaged culture change. They are definitely way more bought-in to their job at a way higher level. They are more like partners in this than I have ever seen line staff be here in the ten years I've been here. There is an excitement beginning to grow from some of the other staff in the other units about 'When do we get to do that?' Now that's a change."*
> (Long-Term Care Executive)

In reflecting on the priorities identified by residents and families in satisfaction surveys, the importance of supporting a loyal and engaged workforce cannot be overstated. At its most basic level, how one experiences the "human side" of the long-term care living experience is a reflection of the staff who works most closely with the resident and his/her family. A concurrent focus on both the experience of residents and families *and* the experience of staff positions communities to improve staff satisfaction, decrease turnover, increase retention and enhance recruitment. Numerous executives interviewed for this Guide highlighted staff-specific effects of their change efforts.

At Extendicare Health Services, Inc., for instance, turnover has dropped from 73% to 43% in a two year period. Even more significant, turnover in the often unstable first 90 days of employment when turnover tends to be highest dropped from 35% to 29%. At Evergreen Retirement Community in Oshkosh, Wisconsin, staff turnover overall dropped from 24.6% in 2005 to 13.1% in 2009. Of particular note is that during that same time period, CNA turnover dropped from 42.7% to 13.5%. The connection between the resident and staff experience is further illustrated in that as turnover at Evergreen went down, resident satisfaction increased.

On a broader scale, in 2004-2005, four corporations representing 51 nursing homes participated in the Improving Nursing Home Culture (INHC) Workforce Retention (WFR) special study. For

the duration of the study, these homes implemented a number of strategies to combat the ongoing challenge of high turnover that plagues this country's long-term care providers and is a barrier to improved quality outcomes. In a seven-month period, these homes realized a 5.6% decline in their annualized turnover rates (55.2% to 49.6%). They also experienced 196 fewer terminations (annualized), saving them approximately $490,000.[10]

Pay for Performance

Quality improvement becomes all the more consequential as states increasingly turn to pay for performance (P4P) programs in an effort to improve the quality of nursing home care. Such programs provide financial rewards to nursing homes that provide high quality services, and some explicitly reward nursing homes for adopting culture change and supporting person-centered care. Currently, fourteen states have implemented or plan to implement a P4P program for nursing homes, including Oklahoma, Colorado, Vermont, Ohio, Georgia, Minnesota, Iowa, Kansas, Utah, Arizona, Texas, Indiana, Virginia, and Maryland[11], but it should be noted these policy developments are in flux.

P4P PROGRAMS REWARD CULTURE CHANGE

—Oklahoma evaluates each facility based on a culture change component of the employee satisfaction surveys. Colorado includes measures of resident autonomy, employee satisfaction, and home environment. Through on-site examinations, evaluators will examine factors that are frequently used in culture change, including resident privacy, use of flexible dining schedules, and the presence of children, pets, and plants in the nursing home."

Source: Werner, R. M., Konetzka, R. T., & Liang, K. (2009). State adoption of nursing home pay for performance. *Medical Care Research and Review*, 67(3), 364-377.

Though some P4P programs support resident-centered care, many states' programs remain based on measures of very specific aspects of clinical care—such as the percentage of residents with pain, pressure sores, or infections—which do not broadly reflect nursing home quality.[12] Though not yet supported by all state reimbursement systems, the culture change movement has been endorsed by CMS, which has directed states' Quality Improvement Organizations to work with nursing homes to improve organizational culture.[13]

Several states also are utilizing My InnerView to assess the adoption and provision of person-centered care or to examine specific issues related to culture change, and more states are including related issues in their requests for proposals from vendors to assist with their P4P programs. In Oklahoma, for instance, My InnerView includes 17 items in its employee satisfaction survey to assess *System-wide Culture Change,* including items related to

[10] Individualized Care Training Curriculum, The Holistic Approach to Transformational Change (HATCh), Quality Partners of Rhode Island - Nursing Home Quality Improvement Support Center (NH QIOSC), Contract #: HHSM-500-2006-RI002C, October 6, 2005

[11] Werner, R. M., Konetzka, R. T., & Liang, K. (2009). State adoption of nursing home pay for performance. *Medical Care Research and Review*, 67(3), 364-377.

[12] Werner, R. M., Konetzka, R. T. (2010). Advancing nursing home quality through quality improvement itself. *Health Affairs, 29(1), 81-86.*

[13] Ibid.

organizational and leadership practices, innovation, quality management, and resident directedness. Under Iowa's P4P program, qualification for additional reimbursement is based on measures in four domains, one of which is resident-directed care. Furthermore, Colorado's P4P program strongly supports several components, including resident-directed care, creating a home environment, and empowering staff.

Conclusion

The communities spotlighted throughout this Guide have individually reported a host of operational, financial and clinical-level benefits as a result of a comprehensive effort toward cultural, operational and environmental transformation. Each has demonstrated, then, that economics need not stand in the way of embracing resident-centered approaches to care.

WE ARE GRATEFUL TO THE FOLLOWING EXECUTIVES FOR THEIR PARTICIPATION IN THE TELEPHONE INTERVIEWS THAT LARGELY INFORMED THIS SECTION:

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Additional insights shared during these phone interviews are captured in executive quotes that appear throughout this Guide.

In addition, we acknowledge Mary Tellis-Nayak and Vivian Tellis-Nayak, PhD for their contributions to this section.

COMMON MYTHS AND MISCONCEPTIONS

Throughout the country and world, many long-term care communities forge ahead on the culture change journey despite any number of obstacles that may obstruct their path. They challenge regulations, financial limitations and non-believers in the name of empowered residents and employees. For others, the journey has not yet started or is being embarked upon with skepticism that changing the culture of long-term care is a futile endeavor.

In this section, we address some common reasons cited for not embracing this transformation. Collectively, these false impressions and misinterpretations have been powerful deterrents to change. Even organizations that have been on their way with the best of intentions can be side-tracked by some of these myths. As demonstrated, though, by the growing number of long-term care communities that are steadily prevailing over these perceived stumbling blocks, these beliefs—persistent as they may be—need no longer be barriers on the road to resident-centeredness.

MYTH #1: PROVIDING RESIDENT-CENTERED CARE IS TOO COSTLY.

While the financial outlook of each long-term care community is unique, it is rare to come across one that is not facing some type of financial challenge. A common misconception is that embarking on a journey of transformation will only increase the financial pressure on the organization, and that changes such as major structural renovations, increased staffing levels and 24-hour dining will place an even bigger burden on already strained finances. While these changes can certainly enhance a resident-centered approach, there are many low-to-no cost changes that can make a significant impact without a considerable financial investment. A community becomes resident-centered, not through a fancy building or extravagant programs, but through the attitudes and engagement of its people.

In resident-centered settings, residents and staff are empowered through education and information and supported in making their own decisions. They are encouraged to be creative and spontaneous. Individuals are respected for their unique perspectives. All of these attributes are not only free, but also integral to sustaining change for the long term. One key to change that was identified by Crandall et al. in their research on initiating person-centered care practices is establishing steps ~~to~~ institutionalize practice change."[14] This includes updating documents and forms such as mission statements, policies and procedures and job descriptions. Revising these is not a guarantee that change will be sustained, but in the research were found to set a strong foundation for how things are done and to provide structure such that ~~p~~practice changes are not

[14] Crandall, L.G., White, D.L., Schuldheis, S., & Talerico, K.A. Initiating Person-Centered Care Practices in Long-Term Care Facilities. *Journal of Gerontological Nursing*, 2007, 33(11), 47-56.

lost when key staff leave." These changes, while requiring some commitment of staff's time, do not require a significant financial commitment. The Orchards at Southington, an assisted living community in Southington, Connecticut, not only updated job descriptions and evaluations but is now involving staff and residents in helping to ensure these key documents adequately reflect what traits and skills are important to them.

Beyond the ability to make no-to-low cost changes, resident-centered care may even serve to have a positive financial impact. As part of its change effort, one nursing home in Rhode Island endeavored to reduce noise in support of residents' sense of peace and well-being. In the course of the process, the study group discovered numerous issues, including open telephone lines that were being paid for monthly. When the committee finished its work, they reported a savings of $2,500 a month. Another organization working on the same issue went on to realize a decrease in psychotropic drug use—a significant savings to the organization. The Pioneer Network has found communities that participate in their network have achieved better differences in per bed net income and operating margins than comparable non-participant homes.

The experience of SnF Management further showcases the fallacy of this myth. Building on a cost-effective process of evaluating all staff for reliability, clinical competence, and having a loving attitude toward elders, the company realized substantial business improvements in terms of both financial and survey performance. By replacing staff who rated lowly on the three criteria with staff selected through a new hiring methodology, the organization went from a loss of $95,000 in November to a gain of $85,000 within just four months. At the same time, it experienced a 70% improvement in deficiencies in the course of one year. *Other financial outcomes identified by long-term care executives are discussed in the Making the Case section, beginning on page 25.*

MYTH #2: RESIDENT-CENTERED CARE IS NICE, BUT NOT NECESSARY.

Given the limited staff, budgets and space that most long-term care communities operate with, the day-to-day focus is often on what *needs* to be done versus what would be *nice* to do. Unfortunately, this pervasive myth relegates resident-centered care into the category of endeavors that are taken on only if sufficient resources are available after all the other "essential" aspects of operations are covered. In essence, resident-centered care is often perceived as a luxury, not a necessity.

This line of thinking, though, fails to connect the dots between how a resident-centered approach is, in fact, directly tied to those aspects of operations universally considered top priorities—quality of care, safety, finances and occupancy. For instance, at Brewster Village in Appleton, Wisconsin, residents and staff have benefited from "personal assignments," a hallmark of resident-centered care where staff consistently cares for the same residents for many years. Knowing each other well helps residents and staff form relationships that result not only in better satisfaction in both groups, but also in better quality of care, which is undeniably *not* a luxury. As evidence of the high quality care at Brewster Village, only 2% of Brewster residents with high risk of wounds experience wounds, compared to 9% in the state and 11% nationally, and no

Brewster residents with low wound risk experience wounds, compared to 2% in the state and nationally. At Wesley Village in Shelton, Connecticut, within two years of introducing a comprehensive approach to resident-centered care, no certified nursing aides had left due to dissatisfaction with their jobs, and turnover (all involuntary) decreased to 18%, compared to a national average of 70%. At Holbrook Health Center at Piper Shores in Scarborough, Maine, agency utilization went from 2100 hours to zero hours in just seven months, a decrease attributed to its adoption of a resident-centered approach. Piper Shores' survey results also showed marked improvement. A five star community with zero deficiencies in its two most recent surveys, Piper Shores had five deficiencies in the prior survey and nine in the survey prior to that.

The Centers for Medicare and Medicaid Services (CMS) has recognized the importance of culture change in improving quality of care and quality of life. Through its work with the Minimum Data Set (MDS) 3.0, the QIS state survey process, and recent changes in the Interpretive Guidelines, CMS has joined a growing chorus of voices identifying resident-centered care as an absolute necessity.

MYTH #3: A RESIDENT-CENTERED APPROACH WON'T WORK FOR US…WE ARE IN A UNIQUE SITUATION.

The second part of this myth is not a myth at all. Every long-term care community is unique; there are no two exactly alike. Even communities in the same town, of the same size, under the same parent organization are completely different. Nonetheless, whatever it is that distinguishes a community as distinctive (a majority of individuals with dementia or mental illness, patients that stay for short-term care, communities with strong cultural influences, city locations that allow for limited outdoor space, or rural areas that make staff recruitment difficult) has long been the rationale for why the concepts of culture change won't work in any number of unique communities. What makes each community unique, though, need not be a barrier to culture change; in fact, it can be a springboard for innovation.

The key to implementing and sustaining a resident-centered care philosophy is recognizing that there is no "cookie-cutter" approach to culture change. Each community must customize its implementation efforts to meet the specific needs and desires of its own residents, staff and other stakeholders. Sites can, and should, learn from each other by sharing best practices and lessons learned. The creation of this Guide is based on the benefit of such sharing. Ultimately, however, the uniqueness of the community must be respected, and changes implemented must be reflective of the individual community rather than following a specific process that worked elsewhere.

MYTH #4: WE ARE EMBARKING ON THIS CHANGE JOURNEY *FOR* OUR RESIDENTS.

The language of culture change is an important component of the journey. It is nuanced and carries profound messages. In this myth, we see an example of just how important this language can be in reflecting a community's outlook. Culture change is not something done *for* residents,

but rather *with* them. The difference here is considerable, and recognizing the distinction is essential for positioning an organization for success in its transformation efforts.
After learning about resident-centered care, many communities want to "do it" and they want to "do it" fast! With the best of intentions, leadership implements a flurry of significant changes—from starting consistent assignments to removing a nurses' station. Unfortunately, such quickly implemented changes are often not well received and residents, as well as staff, may yearn to return to the old way of doing things. Not only does this affect the current effort, but it may also make it difficult to implement future changes. This then perpetuates another myth that commonly fuels leadership teams' resistance to culture change—that staff and residents do not want to be part of change or decision-making.

Resident-centered communities have found that a slow but steady and intentional approach to change works best for sustainability and engagement. The Eden Alternative describes readying the organization for change as "warming the soil." Preparing the community for a significant change in philosophy is vital and should occur prior to implementation of a certain program or process. Planetree affiliates take part in focus groups that capture the voices of those who work, live and visit there. Changes are made based on feedback received, rather than just what the leadership team believes to be best.

Engaging residents in culture change efforts takes commitment from leaders who must constantly encourage, nurture and support the input of residents who may not be used to providing such input. This support must go beyond a request for input at a resident council meeting. Participating in brainstorming sessions, designing activities, serving on hiring committees—these are a just a few of the ways that residents and family members can become active decision-makers within the organization. Barbara Habekost, a resident of Bethel Health Care in Bethel, Connecticut, encouraged the Director of Nursing to have residents be part of the interview process for new nursing assistants. Who better than the residents themselves to choose the people who will be part of the Bethel team? Today, Bob Murray, a fellow resident and others are present at interviews and because of the support they received for their initial idea, the residents have initiated involvement in staff training and educational processes. *For more on including all stakeholders in quality improvement, see the Building Community section, beginning on page 49.*

MYTH #5: RESIDENT-DIRECTED CARE MAKES SENSE IN THEORY, BUT NOT ALL RESIDENTS HAVE THE ABILITY TO DIRECT THEIR CARE.

This concern is often raised in long-term care settings that care for residents with cognitive impairments. Fundamentally, resident-centered care is about recognizing and respecting each resident for the unique person that they are. Beth Baker, in her book *Old Age in a New Age* refers to her once vibrant grandmother morphing into a "generic old person" once she moved into a skilled nursing community. Resident-centered communities refuse to accept that all residents fit into this haunting description. A focus on staff education and empowerment is especially important in settings where residents with dementia receive care. A study published in *The Gerontologist* found that "workers who perceive themselves to be better trained in dementia

care are more likely to espouse person-centered care and report more satisfaction."[15] The National Center for Assisted Living in its paper *Guiding Principles for Dementia Care in Assisted Living* states that resident-centered care for those with dementia focuses on meaningful relationships with residents and their family members. Examples of implementation include focusing on the resident, not the task and encouraging personal development based on the individual. *These are explored in more depth beginning on page 149.*

MYTH #6: OUR RESIDENTS AREN'T COMPLAINING, SO WE MUST BE DOING A GOOD JOB.

No long-term care community is too good a place to live, work or visit. Opportunities always exist for communities to improve, even in those that pride themselves on high satisfaction scores and strong census numbers. The culture change journey is never ending, an ongoing path of continuous improvement guided in large part by the experiences of residents. Whether complaints, compliments, ideas for enhancement, or encouragement to continue moving in a certain direction, residents' feedback comprises the building blocks for continuous improvement.

In many ways, a lack of feedback may be symptomatic *not* that everything is ~~"g~~reat the way it is," but rather of a need to look inward at an organizational culture that may be stifling an open dialogue about community improvements. Residents who are not complaining may be intimidated to do so, despite the community's attempts to encourage them. Often in focus groups held by a neutral party, residents will share that they don't bother speaking up because their feedback is not truly listened to and suggestions are not acted upon. This is difficult for staff to identify with, as most feel that they are receptive to residents' concerns. Mulberry Gardens, an assisted living community in Southington, Connecticut, supports a philosophy of ~~"T~~he answer is yes; now what is the question?" Instead of approaching a resident suggestion with why it *can't* be done (regulations, budget, lack of staffing, etc.), each suggestion is approached from a positive standpoint of what needs to be done so that it *can* be made to happen.

It is not uncommon for residents who have been living in a long-term care community for a significant length of time to become ~~"in~~stitutionalized." They become used to doing things how they are done, used to rigid schedules and used to accepting that this is now their reality. This obliges organizations committed to values-based change to find ways to overcome this barrier to candid and constructive feedback. Approaches for doing so may include expanding the repertoire of questions posed to residents beyond the simple ~~"H~~ow are we doing?" A bulletin board can become an area where individuals can post concerns or suggestions. And providing disposable cameras to residents with the request that they take snapshots of aspects of the setting that create a feeling of home and those that do not could yield some surprising insights. Resident empowerment needs to be supported at all levels and the tendency to make decisions *for* residents resisted as described in Myth # 4 above.

[15] Zimmerman S, Williams CS, Reed PS, Boustani M, Preisser JS, Heck E, Sloane PD. ~~"A~~ttitudes, stress, and satisfaction of staff who care for residents with dementia." *Gerontologist*. 2005 Oct;45 Spec No 1(1):96-105.

MYTH #7: RESIDENT-CENTERED CARE CONFLICTS WITH REGULATIONS.

Contrary to this myth is the fact that the intent of The Federal Nursing Home Reform Act, from the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), was to promote an individualized approach to care to enhance quality of care and quality of life in skilled nursing communities. More recently, changes have been made to the Interpretive Guidelines, the directives that indicate to surveyors how to assess compliance with the OBRA regulations. These changes were made to support resident-centered approaches to care and further stress the importance of resident choice and decision-making. The survey process itself was reviewed in the Individualized Care Pilot (ICP). This project of the Rhode Island Department of Health, partially funded by The Commonwealth Fund and supported by CMS, examined ways to promote individualized care through the regulatory process. One lesson learned during the pilot was that providers' *misperceptions* of certain federal regulations—not the regulations themselves—were obstacles to resident-centered care. Among the most commonly misinterpreted regulations pertained to frequency of meals, approved food sources, staff and residents dining together, food temperatures, refrigerators in residents' rooms, nurses' stations, and medication times.[16]

[16] Rhode Island Department of Health Office of Facilities Regulation. "Individualized Care Pilot Toolbox Module 1 Recommendations and Dilemmas." Rhode Island Department of Health. November 2008. Accessed 7.19.10 at www.health.ri.gov/programs/facilityregulation/individualizedcarepilot /Module1Recommendationsdilemmas.pdf>.

THE CASE FOR ADOPTION: *Regulations*

Effective June 12, 2009, CMS released revisions to 11 Interpretive Guidelines. This issuance was a major initiative for CMS to redefine nursing home culture, by revising guidelines that specifically relate to resident-directed care, needs and preferences. The revisions include both environmental and systemic nursing home components, and require institutionalized nursing homes that have not yet adopted person-directed practices to create the look and feel of a real home in which dignity and respect are presumed and are further promoted by striving to accommodate individual resident choices and needs (Pioneer Network, 2010a). Despite this national initiative, regulations are often incorrectly perceived as barriers to resident-directed care. In fact, many nursing homes experience positive outcomes in the survey process.

- A Kansas Department of Aging study established that homes engaged in extensive culture change had consistently lower deficiencies than homes not engaging in implementation (Bott, et al., 2009).
- A study of homes participating with the Pioneer Network found that length of time participating with the network was positively associated with fewer survey citations (Pioneer Network, 2007).
- An evaluation of adopter homes found that performance on state surveys improved significantly over comparison homes (Stone et al., 2002).

Bott, M., Dunton, N., Gajewski, B., Lee, R. Bonnell, W. & Averett, A. (2009). *Culture Change and Turnover in Kansas Nursing Homes*. Kansas Department of Aging. Retrieved August 30, 2010, from www.nursingoutcomes.org/documents/Year5Report_000.pdf.

Pioneer Network. (2007). *Preliminary Research Supports Nursing Home Culture Change Movement*. Retrieved August 26, 2010, from http://www.pioneernetwork.net/Data/ Documents/PNPreliminaryResearch.pdf

Pioneer Network. (2010a). *Promising Practices*. Retrieved August 25, 2010, from http://www.pioneernetwork.net/Providers/PromisingPractices/CMSGuidelines/

Stone, R., Reinhard, S., Bowers, B., Zimmerman, D., Phillips, C., Hawes, C., et al. (August, 2002). *Evaluation of the Wellspring Model for Improving Nursing Home Quality,* No. 550. New York: Commonwealth Fund.

Source: Pioneer Network, 2010

MYTH #8: PROVIDING RESIDENT-CENTERED CARE IS ONE MORE THING TO DO BY STAFF WHO ARE ALREADY STRETCHED THIN AS IT IS.

This myth also takes on the form of "This is not my job" and "We can't do this with current staffing levels." These attitudes perpetuate the notion of resident-centered care as a task, e.g. *one more thing to do*, when in fact, it is an overarching philosophy of care that connects all the day-to-day aspects of living and working in a long-term care community. Resident-centered communities find that it is not staffing levels that need to change to support the effort, but instead the *way* in which staff approaches their work. A housekeeper at one community describes how she dances for residents as she cleans the floor. This takes no extra time but brings joy to the residents and staff.

When staff is asked why they went into this work, rarely is the answer to complete paperwork or routine tasks. For most, the reason is to interact with and provide caring support to residents and their families.[17] A transforming community encourages staff members to recall their personal vision and helps them to bring it alive, resulting in staff discovering a renewed passion for their work that transcends specific job duties and task lists.

At Bishop Wicke Health Center, a skilled nursing community in Shelton, Connecticut, staff has blurred the lines of their jobs and supports each other when an extra hand is needed. Strong relationships have been built through a variety of examples included in this Guide and the blurring of roles is modeled by the leadership team. Staff is cross-trained for jobs such as helping to transport residents and clearing food service items, and policies support this teamwork rather than discourage it.

MYTH #9: A DEFICIENCY FREE SURVEY MEANS THAT WE ARE ALREADY DOING A GREAT JOB.

While it is commendable to have a deficiency free survey, it is shortsighted to consider any singular measure as a "be-all and end-all" measure of excellence.

Although a shift is occurring in how the regulations are interpreted by surveyors, often the focus of the survey is on the outcomes of services provided versus on *how* the services were delivered. The way in which staff interact with residents, family members and each other is the root of resident-centered care, and is just as, if not more, important than the tasks carried out. Those who live, work and visit the community may be the most appropriate people to decide if standards are being met.

[17] Lepore, M., Ball, M. M., Perkins, M. M., & Kemp, C. L. (2010) "Pathways to Caregiving," in *Frontline Workers in Assisted Living*, Mary M. Ball and Molly M. Perkins (Eds). Baltimore, MD: Johns Hopkins University Press.

MYTH #10: IF WE FOCUS ON QUALITY OF LIFE, WE WILL COMPROMISE QUALITY OF CARE.

While assisted living in some cases may provide an environment for enhanced quality of life, maintaining quality of care is a challenge as individuals age in place. Conversely, nursing homes have long been focused on providing quality of care while often missing opportunities to support quality of life. In both settings, within the context of relationship- and community-building, there are important aspects of care and life that have to take place. One, though, need not trump the other. These are not competing aims; and in fact, a dual focus on quality of care and quality of life has the potential to ultimately enhance both. The Pioneer Network discovered in its research that homes that were on the culture change journey achieved better differences in quality of care outcomes (as measured by survey citations) than comparable non-participant homes in the seven year timeframe that was reviewed.[18]

Of course, though, family members and residents think beyond data and clinical outcomes when choosing a community in which to live. Very often they tour a number of environments and make their decision based on how it ―feels" despite the quality of care information that is available through CMS's Nursing Home Compare. The human side of receiving and directing their own care is most important to them. This is not to minimize the supreme importance of appropriate, safe delivery of care. A resident-centered approach can help to make it a reality. Residents and family members who are empowered to ask questions, share what they believe is the best approach, and are engaged in the community can be the greatest resource that a community has for improving outcomes.

MYTH #11: UNTIL WE CAN INVEST IN SIGNIFICANT RENOVATION TO OUR BUILT ENVIRONMENT, TRUE CULTURE CHANGE IS AN ELUSIVE AIM.

A built environment that is not institutional is an important part of a resident-centered approach, but not the only part. Innovations in design, such as neighborhoods and small houses, help to foster and support resident-centered care in organizations that have the ability to renovate or rebuild. For those that are currently unable to undertake major environmental changes, however, transformation can still take place in settings of older, out-dated buildings. Low or no cost changes such as eliminating overhead paging, introducing healing art and redecorating bathing areas can have a major impact on the atmosphere.

At Maimonides Geriatric Centre in Quebec, various collections of donated art are displayed on the walls along with a history of their connection to the community. Evergreen Retirement Community is designated as a stop on a local art walk through the city of Oshkosh, Wisconsin and also displays a collection of photos of individual residents' hands with a quote of what those

[18] Pioneer Network. (2007). *Preliminary Research Supports Nursing Home Culture Change Movement*. Retrieved August 26, 2010, from http://www.pioneernetwork.net/Data/ Documents/PNPreliminaryResearch.pdf

hands have done. In some communities, residents choose the color to paint their room. At Victoria Special Care Center in El Cajon, California, animals are able to move into the community with residents and share their room.

In fact, focusing on the more foundational (but less tangible) aspects of culture change, such as creating a receptive environment where residents, staff and family members are encouraged to speak up with concerns and ideas, sets the stage for wise investment in environmental changes once construction or major renovation is an option. As with any change within a resident-centered community, the changes to the built environment are not made *for* residents, but *with* them, and their involvement in the process builds ownership and pride in the community. *See An Environment of Living on page 237 for more no- and low-cost strategies for enhancing the built environment.*

MYTH #12: WE CAN'T PLEASE ALL OF THE RESIDENTS ALL OF THE TIME. PROVIDING EXPANSIVE CHOICE TO OUR RESIDENTS WILL WREAK HAVOC AND SET US UP FOR NOT BEING ABLE TO MEET THEIR DEMANDS.

This myth can be a perilous one that allows organizations to accept the status quo. It stems from fear that allowing one resident to direct his/her experience will open up the floodgates for more and more demands. Fear can be a powerful motivator—or de-motivator, in this case. For many communities, it is easier to not set this precedent and do things like they have always been done.

With the advancement of resident-direction in care in recent years, one would think this myth would be dispelled, but the perception that anarchy will rule once choices are expanded remains rampant. Transforming communities know that the opposite is actually true. Anecdotal evidence abounds that when offered choice and the ability to make decisions about their daily lives, residents actually become *less* demanding. The feeling of control that they have replaces the need for continuous demands on staff. Many examples exist of residents whose personalities completely transformed once they formed strong relationships with staff and were encouraged to make decisions.

MYTH #13: AS A STAFF MEMBER, I'D LOVE TO DO THIS, BUT I DON'T HAVE PERMISSION.

Support from all levels is imperative for achieving deep, systematic change throughout the organization, and the importance of leadership in transforming a community cannot be overstated. At the same time, each individual within the community must take personal ownership for their behavior and ~~–~~walk the talk." It is sometimes too easy to place blame on someone else for the inevitable challenges that await on the culture change journey. The Board of Directors, corporate office, CEO, supervisor, and fellow staff members can easily become scapegoats for why a change has not been implemented or sustained.

This is not to suggest that staff do not encounter real barriers as they attempt to bring about change. However, every employee must be encouraged to consider what aspects of community life and the work environment they can control, and to take responsibility within that scope for making the vision of resident-centered care come alive. Every community has champions or cheerleaders they can point to as a shining example of the difference that one person can make. "Johnny the Bagger," a story about an individual with Down syndrome who is "just a grocery bagger yet transforms the culture of an entire store, is a wonderful one to inspire staff. A number of communities share this very brief video during orientation, retreats or staff meetings and challenge staff to think about how they can "be a bagger" in their own job.

MYTH #14: RESIDENT-CENTERED CARE IS JUST A RE-PACKAGING OF ANOTHER INITIATIVE WE'RE ALREADY DOING OR ONE WE TRIED BEFORE.

This myth also takes on the form of "We've tried this once and it wasn't effective" or "We're back to where we were." Most staff members can list a number of initiatives and models that have been rolled out with great fanfare but were subsequently abandoned or forgotten about. The "flavor of the month" syndrome can confuse and frustrate staff members who feel they are already doing a good job. Resident-centered care rises above all these initiatives by creating a culture that embraces the many competing demands confronting any organization. Satisfaction scores, survey results, clinical outcomes and financial indicators can all be approached through a resident-centered perspective.

Culture change is not an overnight event, but a long-term shift in who the community is. There is no instruction manual to quickly implement this transformation. The resident-centered care journey is a long-term commitment that is inevitably filled with bumps in the road. Anticipating the certainty of set-backs and accepting that there is no quick fix will distinguish this journey from other previous ventures. A culture of empowerment and engagement will stand the test of time, which positions the community to continue to be responsive as the demands of stakeholders evolve.

MYTH #15: EMPOWERING RESIDENTS AND FAMILIES WILL HEIGHTEN RISK OF LITIGATION.

Fear of litigation by residents and their families may exist among some long-term care professionals. Empowering residents and families to have a voice and broader choices could be perceived as risky since individuals with no power or autonomy are less able to bring legal suit against a long-term care organization. However, long-term care executives and research indicate the opposite is the case: the empowerment of residents, their families, and frontline staff could actually deter litigation.

Historically, litigation against nursing homes is based on claims associated with wrongful deaths, pressure ulcers, dehydration and weight loss, emotional distress, falls, improper restraint use,

medication errors, and sexual assault.[19] Supporting transparency, openness, and close and trusting relationships in long-term care settings could help prevent such occurrences, many of which reflect major safety issues. Indeed, a recently developed nursing home falls management program (FMP) has been characterized as foundational to the development of a "culture of safety:"

> "Culture change, a key aspect of FMP implementation, requires organizational leadership support as well as attitude and behavior change by staff to facilitate emergence of a "culture of safety." Key elements include acknowledgment of high risk in a blame-free environment. Direct caregivers must feel free to report errors or near misses, with the full support of both a team that seeks solutions and an administration that provides resources necessary to address identified concerns. A clear fall definition coupled with consistent staff reporting without shame or fear of punishment support the comprehensive investigation of incidents and accurate data collection. This represents a dramatic shift, from secrecy and the locking away of incident reports to an open reporting system in which data are analyzed and results used for clinical decision making. A "culture of safety" fosters heightened staff awareness."[20]

Ultimately, culture change could deter litigation, especially by making residents and family members comfortable discussing concerns and problems as they arise, before more grave issues transpire. This perspective was espoused by a long-term care executive, someone who would certainly be taking these concerns seriously:

> *"If you're effective at implementing culture change and you develop a better bond in any particular center with the residents and their families, they're much less likely to be litigious if there is a problem or a perception of a complaint of some nature, which also can affect your survey outcomes. If somebody is comfortable coming to the center with a problem, they're less likely to call the state hotline, if you will, that could lead to a survey inspection and citation finding."*
>
> (Long-Term Care Executive)

MYTH #16: THERE IS NOTHING WRONG WITH OUR CULTURE. IT DOESN'T NEED TO BE *CHANGED*.

Many long-term care communities have a wonderful culture and history that deserve to be respected and valued. To dismiss years of service to others undermines staff and demeans the hard work of many. At the same time, for many organizations it would be disingenuous to believe that there are no opportunities for improvement or for enhancing resident, staff and family members' active involvement in the direction of the community.

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[19] California Advocates for Nursing Home Reform (CANHR, Much Ado About Nothing: Debunking the Myth of Frequent and Frivolous Elder Abuse Lawsuits Against California Nursing Homes 5, 14 (Nov. 2003). For the three-year period January 1, 2000 to December 31, 2002, only 501 elder abuse lawsuits were filed against the 577 nursing homes studied, with 58,134 licensed beds.)

[20] Taylor JA, Parmelee P, Brown H, Strothers HS 3rd, Capezuti E, Ouslander JG. (2007) A model quality improvement program for the management of falls in nursing homes. *J Am Med Dir Assoc.* 2007 Mar;8(3 Suppl):S26-36.

As Charles Darwin stated, "It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change." Organizations must constantly evaluate their operations to adapt to ever changing demands. A resident-centered approach is continually informed by various stakeholder perspectives. This allows communities to respond to the stakeholders' actual expectations, rather than what the organizational leaders perceives them to be.

MYTH #17: MY STAFF/RESIDENTS CAN'T/WON'T ACTIVELY PARTICIPATE IN CULTURE CHANGE EFFORTS.

This myth appears not only during the initial discussions that an organization may have regarding resident-centered care, but also periodically throughout the journey. Behind it are the assumptions that 1) residents, who are often older and hail from the "Silent Generation," are not interested or willing to be an integral part of the decision-making that affects their lives and 2) staff, for a variety of reasons ranging from lack of education to poor interpersonal skills, are not capable of making sound decisions and are inherently opposed to change. To base culture change on *assumptions*, however, flies in the face of many of the core concepts of the movement. Culture change is about engaging all stakeholders. It is about focusing on what may be possible instead of being guided by what proved, in the past, to be impossible. It is about questioning assumptions.

When given the proper support, residents, families and staff will want to be part of the transformation occurring in their community. For residents, it goes beyond an announcement at a traditional resident council meeting that a new "program" is being introduced. For example, residents at Middlewoods of Farmington, an assisted living community in Farmington, Connecticut, learned about creativity and looking at situations through different perspectives at a resident retreat. These skills have helped to encourage and increase resident involvement in deciding what happens in their community.

Likewise, obtaining staff's enthusiastic involvement necessitates more than the traditional mandatory inservice. Resident-centered communities focus on raising the awareness of staff about the shortcomings of the traditional model of long-term care delivery. Honest dialogue is held about the benefits as well as concerns of working in a community that supports a resident-centered philosophy. Staff members are provided training and the tools they will need to be successful. At Evergreen Retirement Community in Oshkosh, Wisconsin, one of the originators of the Wellspring philosophy, staff members are educated on using a performance improvement approach to address opportunities that they identify. Through this approach, staff is exposed to team building, problem solving and conflict management skills, all of which can be utilized in their every day work.

Perhaps the most important, as well as the most challenging, element as a community evolves is sustaining this significant change in resident, family and staff involvement. Providing the education, training and tools, while extremely important, is just the beginning. Residents, families and staff need to be consistently encouraged to take on a more active role. They must be supported in the decisions that they make so they will feel confident to take on the next

opportunity they encounter. Just as every supervisor and leader makes a mistake sometimes, so will it be for residents, family members and staff. In resident-centered environments this is seen as an opportunity for learning and growth rather than a chance to prove how the person was not capable of making proper decisions. As vital as it is to have staff step forward to take on a more active role, it is equally as vital to have supervisors and leaders step back from decision-making and provide genuine support. Strategies for engaging staff, residents and families are referenced throughout this Guide.

MYTH #18: CULTURE CHANGE TAKES TOO LONG. IT WILL BE SEVERAL YEARS BEFORE WE REAP THE BENEFITS.

There simply is no such thing as a culture change ~~–m~~magic bullet." Many of the attitudes, behaviors and operational approaches that are the focus of cultural transformation have been ingrained in a community over the course of many, many years. It is important for any community embarking on a change effort to recognize and communicate to all stakeholders that cultivation of a more resident-directed, relationship-centered culture is part of a long-term vision. It is also important to set the expectation that sustainable change on a broad scale will occur gradually as smaller changes steadily take root. These smaller-scale changes become important milestones in a culture change journey, reassuring all in the community that the change effort is underway and very much on track—even if it may feel like there is still a long way to go. The significance of these ~~–e~~early wins" was validated by a 2010 study which found that early successes in the culture change journey (e.g. the adoption of less complex culture change practices that can potentially be introduced at little cost and relatively quickly) effectively position organizations to take on more complex change.[21]

The experience of the homes that participated in the Improving Nursing Home Culture (INHC) pilot further illustrates that real change—with demonstrable outcomes—can occur in a relatively short time period. Guided by the HATCh (Holistic Approach to Transformational Change) model, participating homes focused on shifting care practices, work place practices, and environmental modification toward a person-directed approach. Using the Plan-Do-Study-Act quality improvement methodology, individual homes measured the impact of the changes introduced in a variety of ways. Outcomes realized by individual homes during the *eight-month* pilot included an 8.9% reduction in falls; a 50% decrease in the use of psychotropic medications; increases in both resident and staff satisfaction; a reduction in worker's compensation claims from 44 to 7, an improvement in survey deficiencies from 13 to 3, a decrease in pressure ulcers from 4.9% to .7% and a reduction in suppository use from 9 to 0.[22]

Within every community there are fertile opportunities for change in the short-term, and an early step in the journey may be to identify those short-term wins. Attention to the short-term, though,

[21] Sterns, S. Miller S C., & Allen, S. (2010) The Complexity of Implementing Culture Change Practices in Nursing Homes. *Journal of the American Medical Directors Association*.

[22] Individualized Care Training Curriculum, The Holistic Approach to Transformational Change (HATCh), Quality Partners of Rhode Island - Nursing Home Quality Improvement Support Center (NH QIOSC), Contract #: HHSM-500-2006-RI002C, October 6, 2005

must not come at the expense of a long-term vision steadily focused on amplifying the voice of residents, empowering staff with flexibility in how they meet the needs of residents, encouraging leaders to role model expected behaviors and attitudes, embracing conflict as a driver of positive change and welcoming families as active participants in the community. This "journey approach" will likely distinguish this effort from previous more fleeting initiatives and readies the community to create lasting change. *For more on generating short-term wins, see page 83.*

MYTH # 19: CULTURE CHANGE ONLY APPLIES TO NURSING HOMES.

Given their long-time emphasis on quality of care over quality of life, a pervasive myth is that culture change efforts are exclusive to nursing homes. This is a particularly common line of thinking among assisted living communities which have long been focused on quality of life. As the acuity of residents in these settings, though, continues to increase, assisted living communities are obliged to concurrently focus on quality of care—without compromising quality of life. Given this, assisted living communities can learn much from their culturally transforming nursing home counterparts.

This myth also has the potential to stall change in short-term rehabilitation. In these settings the conclusion is often drawn that the relatively short length-of-stay and supreme importance of organizing one's day around a rehab schedule precludes the introduction of many culture change principles, such as personalizing care, providing patients/residents choice in how their day unfolds and creating a built environment with the comforts of home. Again, this is a shortsighted view of culture change. The success of many hospitals in personalizing care for patients who may only be in the hospital for a matter of days repudiates length of stay as a reason why culture change *won't* work. Patient-centered hospitals have found a number of creative ways to overcome the barrier of a short length of stay to personalize care. They have introduced "My Story" posters as a mechanism to get to know patients on a deeper level than just room number and diagnosis. Displaying the posters in patient rooms provides a quick and easy way for anyone entering the room—be it a nurse, housekeeper, therapist, culinary associate—to make a personal connection with the patient. Introducing flexible times for procedures such as blood draws and taking of vitals has facilitated more patient-direction in care. And while creating a residential environment may not be an appropriate aim for short-term rehab, certainly introducing some of the comforts of home creates a soothing and supportive environment for healing, and could even be helpful for preparing the resident to return to his or her personal home.

MYTH #20: RESIDENT-CENTERED CARE ONLY BENEFITS RESIDENTS.

This mindset fails to capture an important component of resident-centeredness. A resident-centered approach not only enhances residents' quality of life and quality of care, it also enhances caregivers' quality of work life. With an emphasis on policy, protocol, regulations and the bottom-line, the long-term care industry has long burnt out even the most nurturing of caregivers. A shift to a more resident-centered approach does not negate an emphasis on these

important aspects of operations; they are constants. It does, however, elevate the importance of forging relationships and building community. On the whole, these priorities are far more aligned with the reasons many caregivers went into this line of work to begin with. Providing caregivers the flexibility and permission to do the kind of work they entered the field to do—in the way they want to do it—goes a long way toward creating a positive workplace culture. The caregiver experience is further enhanced when processes and mechanisms are in place to ensure that the voice of those working closest with residents are in a position to influence how support and services are provided, both on an individual and organizational level. The development of career ladders, approaches to recognize and reward good works, and employee wellness initiatives are other components of a values-driven culture that support caregivers in achieving both their professional and personal aspirations—and convey the message that resident-centered care is not only about enhancing the lives of residents, but *all* members of the community.

BUILDING COMMUNITY: A PROCESS FOR TRANSFORMATION

—What we are building here is something that will make your life worth living. It is a community. When you are building something, it takes a while, but this will go beyond you and me. It's bigger than all of us." (Nursing Home Resident)

In this section, a transformation process that engages all stakeholders in creating and implementing a change vision is described in depth. Involving stakeholders in such an active and meaningful way in a continual quality improvement process requires a shift in operations *and* attitudes. The first mindset that must be adjusted is emphasizing that changes are made *with* members of a community—not *for* them. This is a profound distinction for leaders to understand, embrace and communicate to all in the organization, and will differentiate the transformation effort from previous quality improvement "projects." Change cannot rest on the shoulders of leadership alone. Residents/patients, family members, volunteers and staff are all vital partners in the change effort. They are integral not only in identifying opportunities for improvement, but also in implementing and evaluating the subsequent changes. Cultivating a shared vision, fostering ownership among all stakeholders and, ultimately, *building community* are what will transform a long-term care community at the deepest of levels—far beyond what implementation of any inventory of practices can accomplish. In the pages that follow, a number of stretch goals challenge readers to expand how they involve residents and families in the change effort. Their characterization as "stretch" goals is not to imply that they are an embellishment to an already established change effort. On the contrary, involvement of residents and family members is an essential component; however, it is an aspect of change that continues to be among the most challenging.

John Kotter's Eight-Stage Change Process

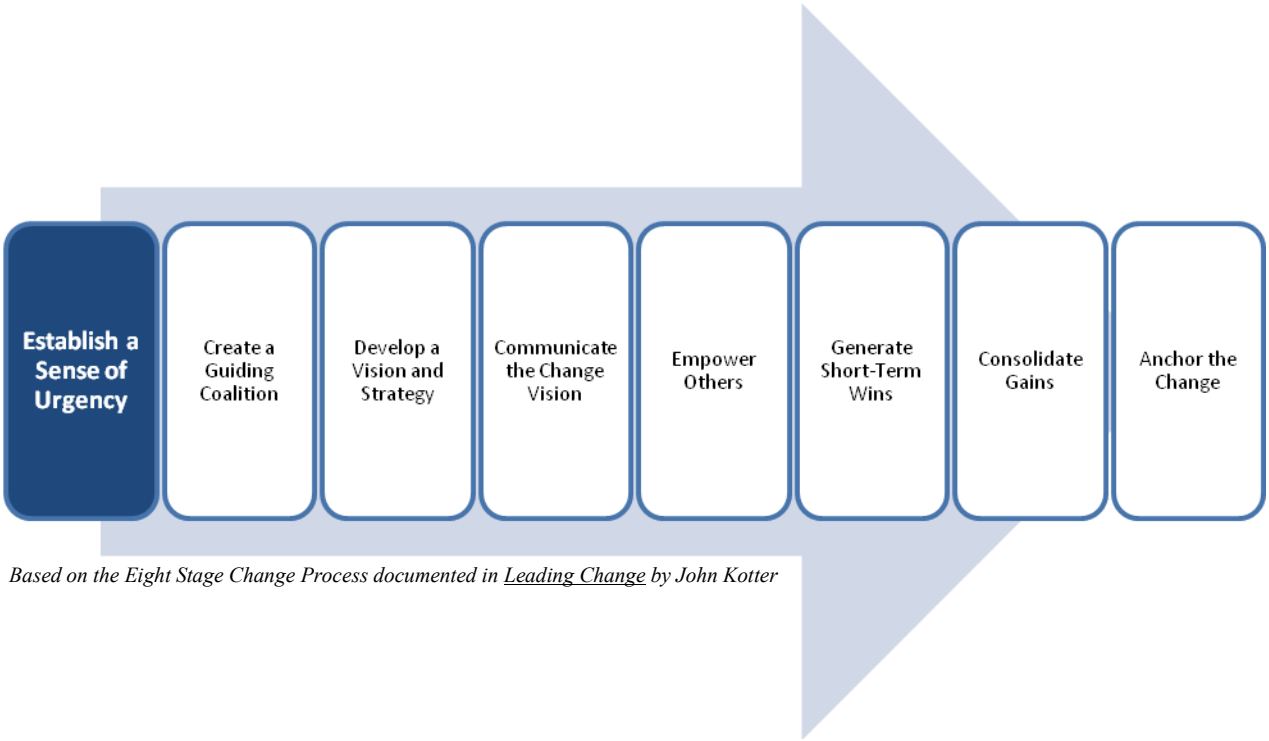
1. **Establishing a Sense of Urgency**
2. **Creating a Guiding Coalition**
3. **Developing a Vision and Strategy**
4. **Communicating the Change Vision**
5. **Empowering Others**
6. **Generating Short-Term Wins**
7. **Consolidating Gains**
8. **Anchoring the Change**

The process outlined here is not specific to any one culture change model; it is applicable to any approach. This defined process will be referenced throughout the Guide to reinforce that the practices featured are but one piece of a comprehensive change equation. The framework for this discussion will be John Kotter's Eight Stage Process of Creating Major Change. A professor at Harvard Business School and world renowned change expert, John Kotter has originated many theories on how to "do" change. He introduced his eight-step change model in the book *Leading Change*.[23]

> *"The difference between an institution and a community is relationships….Communities are built upon and thrive on relationships. That is their energy—just as heat is the energy that fuels warmth, and light is the energy that fuels the light spectrum. This is the shift that formal leaders must make; this understanding of community and relationships as their fuel. Then they begin to put every action to the test of relationship—Is what I am about to do and how I am going to do it going to create and build relationship or destroy it?"*
> (Long-Term Care Executive)

[23] Kotter, J. (1996) Leading Change. Harvard Business Press: Boston.

Step One: Establishing a Sense of Urgency



Based on the Eight Stage Change Process documented in Leading Change by John Kotter

Creating a strong sense of urgency begins with looking beyond *what* needs to change to foster a collective understanding of *why* the change must occur. John Kotter suggests that for change to be successful, 75% of management must be convinced that business as usual is no longer a viable plan.[24] This means that leaders must be awakened to the gap between the way things are and they way they ought to be. This gap can be brought to light through a process that engages the entire long-term care community in an open and honest dialogue about what is "urgent" or most important to improve from a multitude of perspectives. After all, the urgent issues through the eyes of leaders in the organization may be different than those expressed by residents, family members and staff. Pairing this qualitative data with quantitative data further grounds a collective understanding of the current state of the organization. Expanding the repertoire of performance metrics to include resident, family and staff satisfaction, staff turnover, absenteeism, overtime, agency use and quality indicators often uncovers the root causes of poor performance on conventional metrics for evaluating long-term care, creating deeper awareness of why change is imperative. Information gathering alone though is futile; most important is that leaders "muster up the courage to listen carefully" to all perspectives so that the information gathered can be used in a meaningful way. Helping others to see the gap will then create a shared sense of urgency grounded in the need to do better for those who live in, work at and visit the community. While creating urgency around the gap, however, leaders must also recognize the courage and commitment of caregivers who continue in their efforts to support and care for residents despite a broken system.

[24] Kotter, 1996, pg. 48.

Tools for Building a Sense of Urgency

Assessment Tools
A number of assessment tools are available to help organizations identify gaps and areas for opportunity. An inclusive and transparent process of completing such a tool will build consensus and broaden the understanding of the opportunities that exist for change. The self-assessment included on page 10 of this Guide is just one of a number of tools available to help organizations plot a community-specific course for creating a resident-centered environment:

Artifacts of Culture Change	**www.artifactsofculturechange.org/ACCTool**
Culture Change Assessment Mechanism	**www.cfmc.org/files/nh/Culture%20Change%20Assessment%20Mechanism.xls**
Culture Change Indicators Survey	**www.caregivereducation.org/culture/ifce_cc_indicator_survey.htm**
Culture Change Staging Tool	**www.myinnerview.com/_media/doc/general/CultureChange123105.pdf**
Eden Warmth Surveys	**www.edenalt.org**
Individualized Care Organizational Self-Assessment Tool	**www.health.ri.gov/programs/facilityregulation/individualizedcarepilot/IndividualizedCareOrganizationalSelf-Assessment.pdf**
Quality First CQI Climate Survey	**www.ahcancal.org/ncal/quality/Documents/cqi_rai_tool.pdf**

In addition to an organizational self-assessment, a **leadership self-assessment** (*as described on page 62*) could be another important tool for building a sense of urgency.

Focus Groups
Focus groups with residents, family members, and staff provide invaluable qualitative information. Focus group questions are designed to promote candid and in-depth dialogue. Questions are open-ended and targeted (i.e. not asking two things at once). The use of neutral moderators in safe environments encourages comments of all types—positive and negative. It is common to be able to encourage participants to share their ideas and suggestions for enhancements and improvements which most surveys are not able to obtain in any real depth. Responses are then synthesized to identify themes related to strengths and areas of opportunity, and these findings become an important platform for prioritizing organizational goals, planning and awakening a sense of urgency around opportunities for improvement.

Learning Circles
Data collected using any of the tools above can be validated in learning circles. The unique structure of learning circles ensures that everyone—leadership, staff, residents and families— is on equal ground and has equal opportunity to actively participate. Participants sit in a circle; there is no hierarchy in the seating arrangement. The facilitator (who may be someone from within the community or external to it) poses a question or topic for discussion. A volunteer responds with their ideas and insights, and then the person sitting adjacent to them does the same until each person around the circle has had an opportunity respond. This process unfolds without

interruption; there is no cross-talk or disruption, which is managed by the facilitator. Speakers have the option to pass at their turn, and after everyone in the circle has had the opportunity to speak, the facilitator will revisit those who passed to offer another chance to contribute. At this time, the floor is opened for general discussion. The facilitator closes the circle at the appointed time by asking for reflection on the topic or on the material that has been discussed. The facilitator also takes the opportunity to define next steps with the group if certain objectives are to be met. This structure is designed to give voice to those groups or individuals who historically may feel least empowered to speak up. As such, for many long-term care communities, learning circles have become an essential tool for engaging all stakeholders in navigating their change journey, from helping to define early goals and expectations to prioritizing initiatives and decision-making as the improvement efforts unfold.

See Augsburg Lutheran Home and Village's guidelines for learning circles with residents and staff, page 98.

Sample Learning Circle Questions for Creating a Sense of Urgency

Why is change and evolution of what we do important?

What may happen to our organization if we don't change?

These questions, and others, are asked in the learning circle format to uncover what the key stakeholders are thinking and feeling. It is important to have the group explore why change is important, as this will create a sense of urgency that they will be able to own and communicate to others.

First Hand Experience
As a staff member or CEO, spending the night in one's setting can be a powerful exercise for gaining a deeper understanding of the experience and helping to identify priorities for change. Capturing honest feedback from staff or board members who received services for themselves or a loved one during or immediately after their experience can further help to uncover organizational deficiencies and/or inconsistencies.

Environmental Assessment
Creating households and neighborhoods necessitates a new approach to operations. It is not uncommon, therefore, for a sense of urgency for cultural transformation to be driven by changes in the physical environment. A number of Planetree continuing care communities use a **component mapping** process to align plans for the physical environment with the Planetree framework for a resident-centered culture. The component mapping process includes a tour and analysis of existing facility plans. A detailed assessment follows, with the proposed programs and systems for Planetree implementation compared to the existing facility. A series of strategies and tactics is then developed to further enhance the healing environment in the context of the components of the Planetree model.

Community Image Survey
An understanding of the perceptions of the community-at-large becomes a springboard for change and for re-framing expectations. A community image survey is a tool designed to explore those perceptions. Evergreen Retirement Community in Oshkosh, Wisconsin, conducted a perception survey in the local community. What was discovered, despite ongoing public relations work, was that those living in the surrounding area thought of the entire campus, which is comprised of skilled nursing, apartments, independent living, and assisted living, as "one big nursing home."

Competitive Analysis
Conducting an annual competitive analysis not only identifies strengths and weaknesses but also assists in prioritizing key programs and services that may urgently need to be improved or developed to position an organization relative to competitors. Middlewoods of Farmington, an assisted living community in Farmington, Connecticut, used a **mystery shopper** approach to evaluate itself against surrounding competition. Their findings resulted in immediate action with improving promptness in follow-up to inquiries as well as establishing a new tour process. *See page 144 for more on Middlewoods of Farmington's tour process.*

New Interpretive CMS Guidelines
As a result of dialogue created around resident-centered care at the first Creating Home National Symposium on Culture Change and the Environment Requirements, many Interpretive Guidelines were changed. Key to the change was the opportunity to create an environment where all decision makers were present in one place—a model of decision making that can create energy and immediate outcomes in your organization as well. The second National Symposium concluded in 2010 and focused on dining regulations and infection control. One can assume that future interpretive guideline changes will be forthcoming to further stimulate change.

Conference Participation

> *"...and then we started discussing the increasing demands in the baby boomer generation and we heard 'it' for the first time at the Pioneer Network conference. That gave our leadership team a sense of urgency and we knew it was time to finally get the ball rolling."* (Nursing Home Administrator)

Conferences such as The Pioneer Network Conference, Planetree's International Conference, the Eden Alternative International Conference, as well as association conferences and regional meetings provide exposure to what is possible and ideas for how to achieve change. They inspire, motivate and offer access to practical tools. Participation in a state coalition further facilitates networking with other providers and exploring opportunities for state advocacy related to regulation and implementation. Attendance and participation alone, though, do not create a sense of urgency for change. It is essential that information obtained at any conference or meeting be disseminated throughout the organization as a means of communicating the opportunities and urgency more broadly.

Communicating Your Sense of Urgency

A well thought out communication strategy is imperative for driving and sustaining a sense of urgency. All stakeholders should be exposed to a consistent and transparent message. During this stage of change, some organizations ramp up the frequency of community/town hall meetings, resident council meetings, and one-on-one discussion. To combat the threat of complacency, the Regional Director at SnF Management created bulleted communication about the culture change effort to be distributed every three days. In addition, he met with the resident council weekly, and gave the community access to his cell phone and email address.

To maintain momentum, many long-term care communities have regular **town hall** or **community meetings** where all stakeholders review the progress made on issues raised and continue discussion on what matters most. **Daily stand-up meetings** are standard in many organizations. Traditionally, they are used as opportunities for introducing changes in policy, survey preparation and conveying important information team members may need to know about individual residents. Expanding the scope of these meetings to include a dialogue about the change effort will elevate a routine practice into an important tool for engaging staff in culture change. This adaptation of a traditional task further supports the change effort by providing an opportunity for teams to ask questions of leaders and for leaders to enhance their visibility.

Many communities are looking beyond traditional communication books, boards, and meeting minutes as methods for communicating with staff. More ―high-tech" methods are becoming more common, such as providing **a team laptop** where team members can check email or creating an **intranet site** where staff can easily access important information.

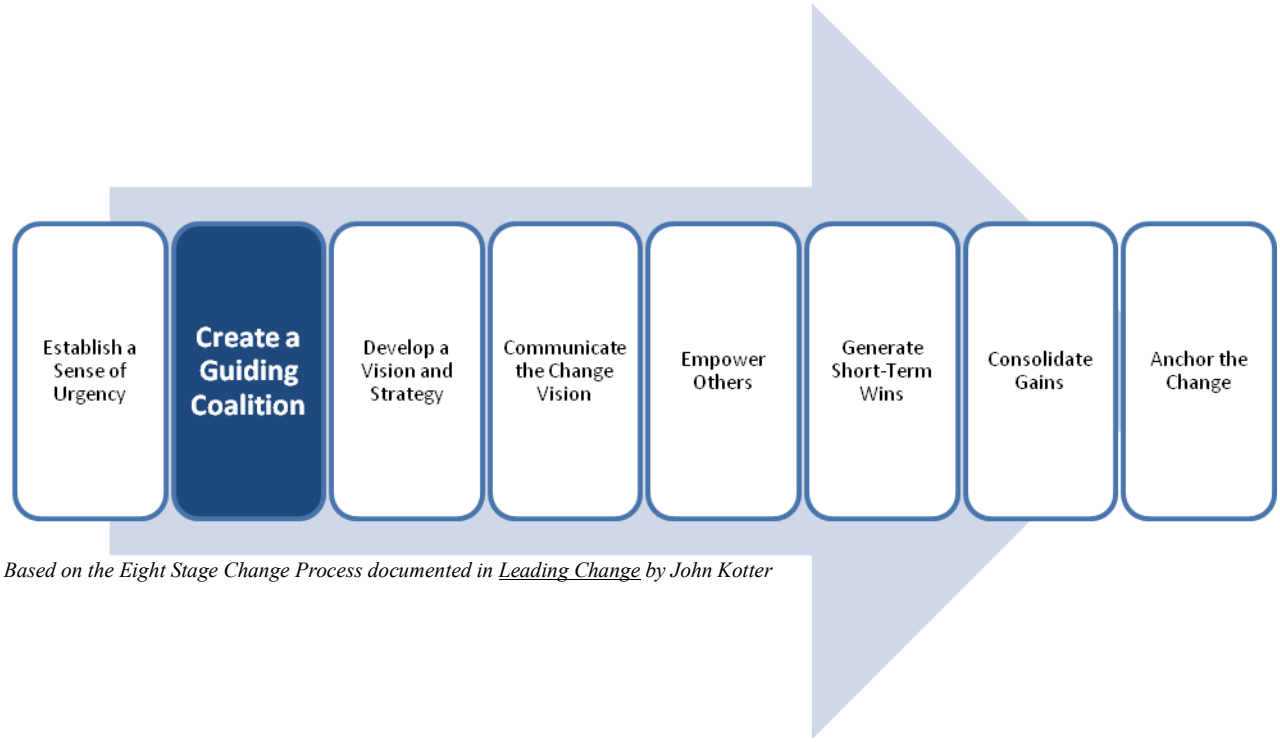
Using Partnerships to Create Urgency

Partnering with external leaders and consultants may be helpful for providing a ―bigger picture" context for the change vision, facilitating honest dialogue, and helping to heighten the visibility and importance of the effort for all stakeholders. External partners offer the credibility of an outsiders' perspective, sometimes referred to as the ―consultant mystique."

Creating partnerships to communicate urgency can be done in very creative ways as well. Evergreen Retirement Community invited a local psychology professor to work with staff on team building skills as they moved through the process of change.

S T R E T C H GOAL	*Of course, not all experts have to be brought in from outside your organization. Consider the wealth of internal wisdom and resources available to you. You may be surprised at the ideas generated when you bring residents, families and staff to the table for dialogues related to business development, census building, marketing, and more.*

Step Two: Forming a Powerful Guiding Coalition



Based on the Eight Stage Change Process documented in Leading Change by John Kotter

Culture change expands the definition of leadership beyond titles, positions and hierarchy. Forming a powerful guiding coalition starts with identifying the true leaders in your organization. This includes both formal and informal leaders from all levels, departments and shifts—those who "get it" and are already attempting to prompt action. The guiding coalition (sometimes called a steering team or culture change committee) includes representation from all key stakeholder groups, including residents, family, and volunteers. It may also include external stakeholders who may be positioned to influence the support of the greater community. A common approach for building this guiding coalition is to start with a strong core of staff believers. At first, this core may be limited to a handful of people leading the effort. It then grows over time as respected, reputable individuals with the capacity to lead from various sectors within the community are identified. Finding the right blend of strengths and interests pays great dividends toward future success.

Coalition members lead by example. They embody the values of the vision for change and actively work to enhance team building organization-wide. Members' involvement on the coalition needs to be supported at all levels. This includes providing frequent recognition for their efforts, ample notice of meetings to allow for optimal participation, and scheduling support that enables them to participate in meetings and implementation.

The coalition does not work in isolation. Coordinating its work with existing committees or councils (such as quality improvement, safety, resident, family, and employee councils) is imperative. One effective approach is to identify a member from each of the existing committees

who will assist in coordinating coalition objectives and activities with already established priorities. This attention to coordination will ensure that the coalition is not creating "more projects" but rather is a vehicle for evaluating and implementing an overall strategy for quality improvement. As the transformation matures it is common to find that the quality improvement committee and the guiding coalition morph into one productive working group.

Recruitment of Coalition Members
Many organizations cite that the most effective way to recruit members of a guiding coalition is to extend a **personal invitation** from the CEO, supervisor or other leader in the organization. Including a personal note as to why the individual was invited to participate reinforces that the invitation is in recognition of their ongoing contributions to the organization. A posting on the wall asking for participants does not convey the same message of importance or exclusivity. The person being invited should be honored and excited at this invitation!

As the coalition matures, it is important to maintain an appropriate balance of those with experience on the coalition and those who will infuse fresh perspectives. Instituting **staggered term limits** is one approach for maintaining this important balance. Those who have served on the coalition are perhaps best qualified to identify others who may be effective members. Recognizing this, Wesley Village in Shelton, Connecticut enlists former members in the recruitment of new members. **Staff members who have fulfilled their term on the steering committee are invited to bring a friend to a meeting** whom they believe will be a strong addition to the coalition.

Creating a Charter
Creating a charter establishes a consistent understanding of the scope of the guiding coalition's work and institutes a formalized structure for the effort. Charters often include information such as roles and responsibilities of members, term lengths, etc. The group should identify a chair person or co-chair structure to provide leadership to the group and a method of ensuring ownership of the work.

See Bethel Health Care's Steering for Tomorrow Charter, page 99.

Building the Coalition Team
Once membership of the guiding coalition or steering team has been established, it is important to support them in becoming a productive group. There are a number of strategies that can be utilized for team building purposes. Planning a **kick-off celebration** for the entire organization is a fun undertaking that will inspire creativity and group cohesion as the team works toward a clear and defined outcome.

At Landis Homes Retirement Community in Lititz, Pennsylvania, the team formation focused on **identifying the coalition's purpose and structure**. Having begun with the name "Culture Change Committee," the team soon concluded that this nomenclature did not effectively communicate its objective. Ultimately, the name *Honoring Lives* was agreed upon. Throughout this re-naming process, team members refined skills related to communication, consensus building, conflict negotiation, and empowered decision making. This process deftly illustrated

how an effective team works and how building consensus may take time, but the experience and the outcome are worth the journey.

Involving All Stakeholders

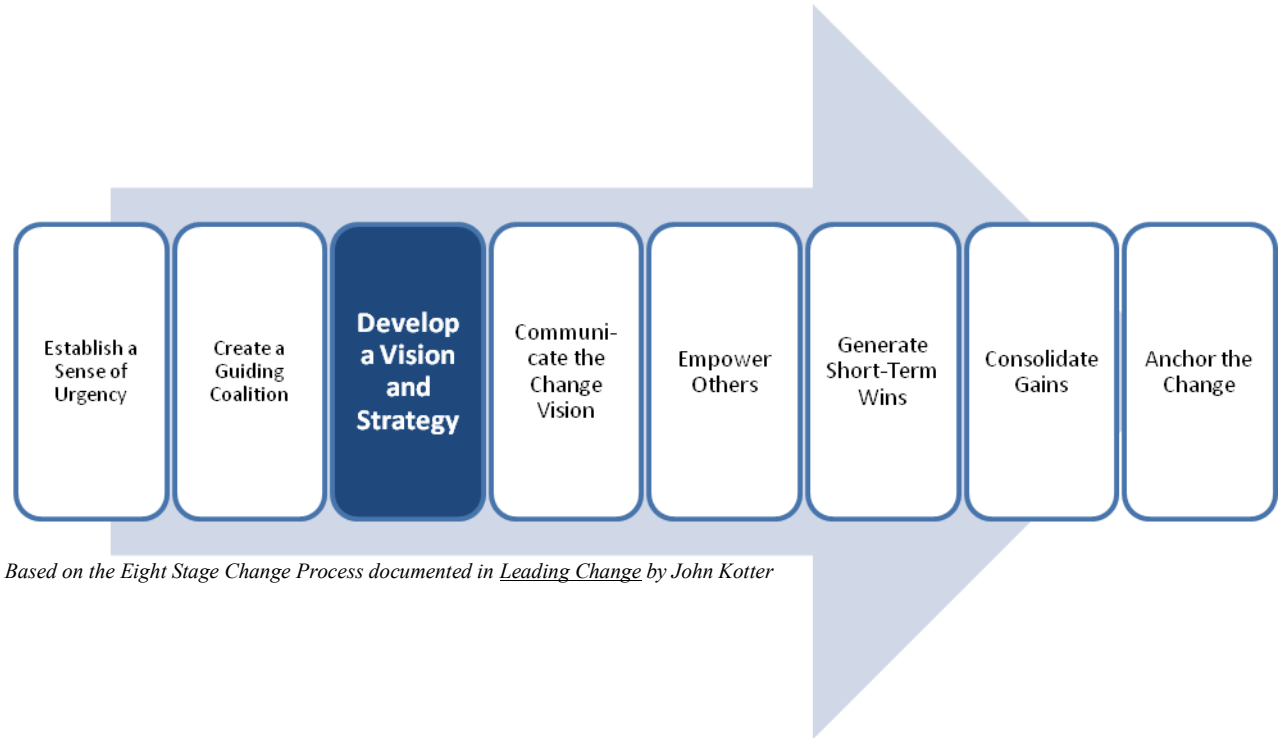
> *"I am a client and this is my home, but I am also the organization. Other residents come to me because they know I am able to address their concerns. We make the decisions that help make this place the best place to be."*
> (Nursing Home Resident)

It is not uncommon for the coalition of staff, residents and family members who will be coordinating the transformation of the organization to feel alone in the beginning of the process, a small group swimming against the tide. Involving other stakeholders in sub-committees and discrete projects and inviting their input on initiatives in progress casts a wider net for engagement and involvement in continuous improvement efforts.

Key groups to engage in this work are **resident and family councils** to ensure that council and coalition efforts are aligned around a common vision. *For more on working with resident and family councils, see page 148.*

Potential opportunities for **engaging the governing body** of the organization include discussion regarding what resident-centered care represents, why the organization should embrace it, and thoughts on implementation. Outside educational programs geared to their role as board members or a corporate office may be helpful in inspiring their engagement in the change. Inviting board members/corporate staff to tour the community on a regular basis and participate in functions are invaluable opportunities for them to experience the changes that are occurring first-hand and to interact with staff and residents.

Step Three: Developing a Vision and Strategy



Based on the Eight Stage Change Process documented in Leading Change by John Kotter

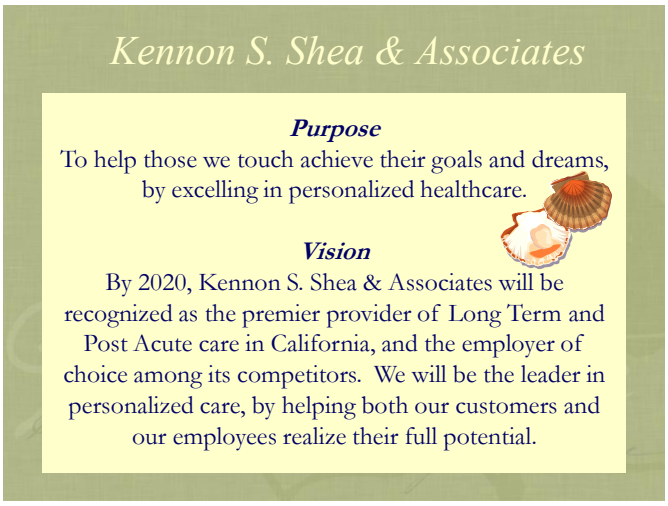
In *Leading Change*, author John Kotter suggests that successful transformation rests on a picture of the future that is relatively easy to communicate. Conceiving this evocative picture of the future, then, is fundamental to developing a strategy for change, for ultimately it becomes the catalyst and connective tissue for all future efforts.

Articulating the Vision

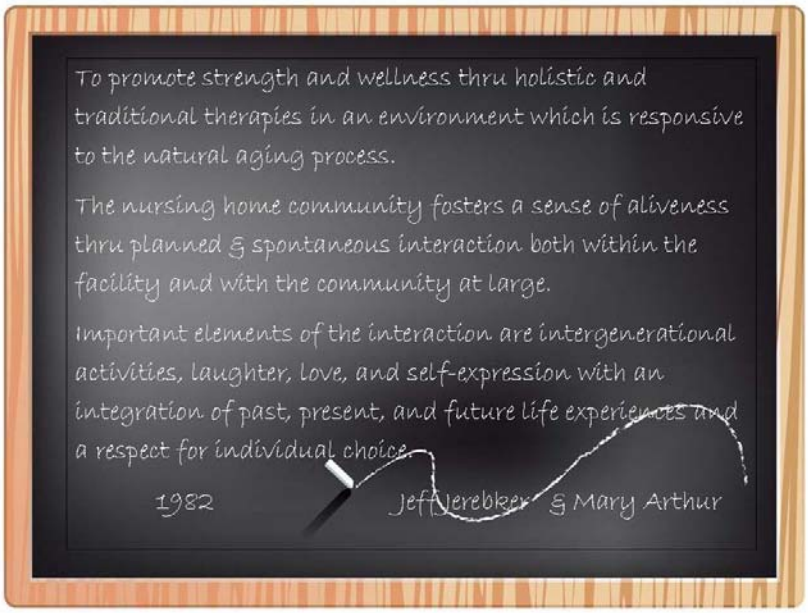
Once the vision is established, attention turns to developing a strategy to execute the vision and a consistent message to articulate it. Crafting a consistent message does not mean writing a script for all to follow. It is important that each coalition member finds their unique voice to express the vision; however this should be done within the context of a consistent message and language. All coalition members should be familiarized with key speaking points that enable them to confidently and effectively communicate the vision.

Developing and practicing an **elevator speech** is a useful exercise for distilling the vision down to its very essence. The name is derived from the goal – being able to express the vision in a way that it is clearly understood by the recipient from the time you get in an elevator to the time you reach the destination. Elevator speeches are concise. They educate, motivate and resonate with a variety of audiences, including staff, residents, families and volunteers.

As illustrated here, a **purpose statement** is often a hybrid of a mission statement and a vision statement that communicates the reason the organization exists, why it does what it does and its vision for the future. At Kennon S. Shea & Associates, the CEO gathered stakeholders from the eight communities that comprise the system to brainstorm a new vision, values, and mission.



The vision and culture change journey for Piñon Management began over 30 years ago on a blackboard that still sits in CEO Jeff Jerebker's office. That vision remains the foundation of Piñon's success and has morphed into a more concise message with the same powerful impact: *"To provide leadership, stakeholder and team involvement as we continue to grow a meaningful, life-enriching and financially sustainable organization."*



Piñon's vision is linked to an annual operational planning vehicle referred to as the **Visioning Tool**, which aligns commitment to action and ultimately outcomes. Each community within Piñon Management uses the same tool to identify and hold itself accountable to its community-specific mission, vision, priorities, values and stakeholders. Defined benchmarks and measures of success are established for cultural, clinical, financial, business development and workforce development objectives, and the community's vision for each area is to be achievable within a one year time frame while still building upon long-term strategies for success. A series of check points help guide communities in developing and managing their vision. These include:

- ✓ *Does the Vision foster a holistic environment?*
- ✓ *Does the Vision promote profitability?*
- ✓ *Is the Vision realistic?*
- ✓ *How will performance be monitored and reviewed?*
- ✓ *Are there benchmarks for success and measures for success?*
- ✓ *Will data collection tools be used?*

After a full year of visioning and strategic planning, the Maimonides Geriatric Centre Board of Directors—which includes residents, community members, volunteers and staff —came up with a powerful three word message: "**More than Care**." The statement goes on:

> *"Over the next five years, we will build on our strengths and move toward a stronger vision to become the resource of choice for the Jewish elderly of Montreal and a model of excellence for long-term care everywhere. Focused on the 'MORE THAN CARE' theme, we will be a leader in providing excellent long-term care and a model for others to follow."*

Alignment of Vision, Values and Principles

A guiding set of principles can be a powerful platform from which an organization can develop its vision. The Pioneer Network's Values and Principles, available for download at **www.pioneernetwork.net/Data/Documents/pioneer-network-values.pdf**, are foundational for many organizations working toward values based change. For many Eden Homes, Eden Alternative's "Ten Principles" **(www.edenalt.org/our-10-principles)** are core to their vision, and Planetree affiliates look to the Planetree components (*see page viii*).

In developing the vision for its nursing homes, the Veterans Administration leadership turned to the HATCh (Holistic Approach to Transformational Change) model. Developed by the Centers for Medicare and Medicaid Services (CMS) in partnership with Quality Partners of Rhode Island, HATCh emphasizes the "means and actions by which we begin to migrate from institutional to individualized care." It includes transformation in six domains: workplace practice, environment, care practices, leadership, family, community and government and regulation.[25] Efforts to align the VA's vision and values around the HATCh principles included a nationwide strategic effort to change the name of their "Nursing Care Units" to "Community Living Centers"—a very concrete way that principles are expressed through practice.

Proclamation for Resident-Centered Care

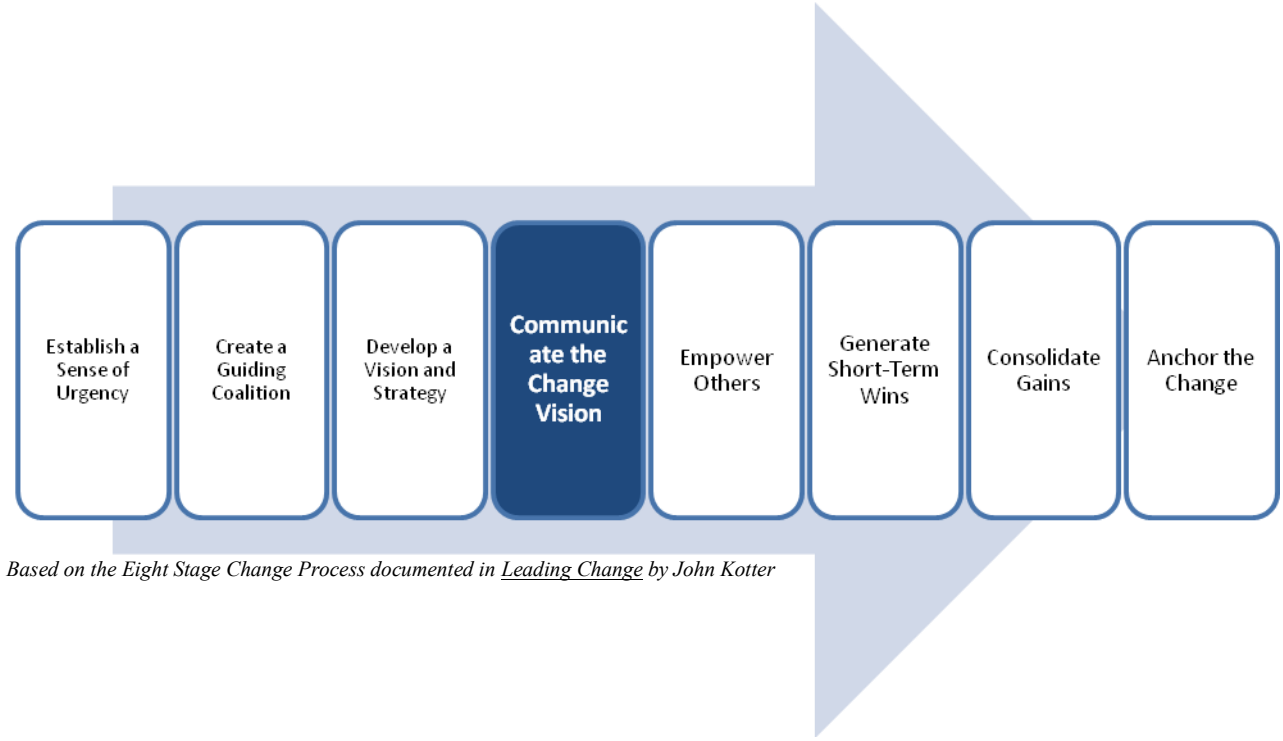
Publicly proclaiming an organization's values is another tangible way to align vision, values and principles. Doing so communicates a community's core beliefs to both internal and external audiences. It also establishes expectations and can help to drive accountability to the values. The Proclamation for Resident-Centered Care is a tool that a number of communities use to articulate the core values of resident-centered care that will drive future changes. Complimentary personalized copies are available from Planetree upon request. *See the Proclamation for Resident-Centered Care, page 101.*

Web Communications

A number of transforming communities have taken to the Internet to communicate their vision for change to a broad audience. At **www.sheahealth.com,** the CEO, CFO and other staff from Kennon S. Shea & Associates express personalized messages about the "Shea Vision" and what "culture change" means to the organization. Piñon's Web site —**www.Pinonmgt.com**—conveys an organizational commitment to the vision and culture change through video and storytelling.

[25] Individualized Care Training Curriculum, The Holistic Approach to Transformational Change (HATCh), Quality Partners of Rhode Island - Nursing Home Quality Improvement Support Center (NH QIOSC), Contract #: HHSM-500-2006-RI002C, October 6, 2005

Step Four: Communicating the Change



Based on the Eight Stage Change Process documented in Leading Change by John Kotter

The opportunity and responsibility to communicate the change vision rests on the shoulders of everyone in the community. It is not merely a matter of internal newsletters, Web sites and community meetings. Communicating the change vision is inclusive of all the ways that messages about the community's culture and future direction are conveyed—verbal and non-verbal, in the terminology that is adopted, through the environment, through formalized systems and policies, organizational charts and in approaches to conflict. For the change vision to have credibility and integrity, all communication must be aligned. Nothing is more undermining than inconsistent practices that undercut the need for change and create a community of inequity. Any disconnect between what is said and what is actually done will seriously compromise any effort toward change.

The Role of Leaders

Change of the magnitude addressed in this Guide does not happen overnight, nor do the changes in leadership style that it may require automatically materialize. It is essential that leaders are supported in acquiring the skills to lead effectively in this new paradigm.

Leadership Self-Assessment
Leaders determine, guide and communicate the vision of an organization, and as such, leadership engagement in any organizational culture change initiative is crucial. To prepare themselves for this task, many leaders within culturally transforming communities place energy into their own

development in conjunction with the development of those they lead. Leaders' self-reflection and internal transformation sets the stage for organizational transformation. Leaders are encouraged to truly examine who they are, why they want to transform their community, and how their style may have to change to propel their teams forward. One tool for doing so is the **Leadership Practices Inventory** (LPI) created by Jim Kouzes and Barry Posner. Organized around a conceptual framework of "Five Practices of Exemplary Leadership®," the LPI can be instrumental in building self awareness and accountability to a new leadership paradigm.

Conducting a **360-degree evaluation** of one's leadership style is an important, though potentially difficult, part of transforming it. It requires leadership teams to be receptive to having their style candidly evaluated and intentional about utilizing the feedback provided by all members of the community. This process is also an important step for modeling communication and transparency with teams. Sharing the results and the plan for improvement will validate that stakeholders' voices have been heard. As the community continues to transform, this step will make the implementation of peer-to-peer evaluations easier for the teams.

Role Modeling

Daily problem solving and decision making provides ample opportunities for leaders throughout the community to model the vision in action. A leadership team that communicates "Do as I say, not as I do," and withholds pertinent information in order to perpetuate a structure of power will fail to engage an empowered organization regardless of intensive education sessions for staff. The vision will only resonate and be credible when all stakeholders can see, hear, and feel the difference. Soliciting input from others, maintaining transparency and embracing conflict are all tangible ways that leaders can align their leadership style with the change message.

Another specific way that the leadership team can model the change vision is by participating in or leading an education or engagement program for the community. This action helps staff envision connecting with residents beyond the boundaries of their job and demonstrates that they have "permission" to do so. At The Cloisters of La Jolla in La Jolla, California, the administrator shared her talent for making jewelry with residents and staff. At Bishop Wicke Health Center in Shelton, Connecticut, the leadership team plans an elaborate act for the annual talent show.

Similarly, SnF Management's **Personally Yours Program** was created in the spirit of modeling the way. In each community, managers are individually assigned a list of residents with whom to build authentic relationships.

Immersion Leadership

Visible leadership goes beyond the traditional "walk through" or rounds. It is an intentional process of connecting with team members, residents and families in a way that creates new relationships and nurtures existing ones. Immersion leadership places the leader side-by-side with the team to transform a process or procedure together in real time. This is not job shadowing. Rather, it is a process that demonstrates that changes are occurring—and that the way decisions are being made is also evolving. The approach empowers the team to begin the process of accepting ownership and enhanced responsibility. *See page 195 for an example of immersion leadership in action.*

Rounding with Reason
Rounding with reason is a way to connect interpersonally with staff and to ensure that they are staying focused on the vision. Through questions carefully crafted to open the lines of communication, some important opportunities may emerge to further drive culture change efforts. Examples of questions to ask include:

- Do you have everything you need to meet the needs of your residents today?
- How are you assisting residents to become empowered?

Coaching
Traditionally, long-term care communities have taken a reactionary or disciplinary approach to the development of staff. Such a punitive process often fails to provide the change in behavior that is the desired outcome. A shift toward developing staff through coaching is a powerful way for managers and supervisors to model the change vision. In a coaching approach, supervisors are focused on and use employee strengths to empower and guide performance improvements.

Developing a set of behavior and actions that all in the team are expected to follow is an effective way for aligning behavior with the change vision. Managers and supervisors work with their teams to collectively and proactively identify what is acceptable and where the boundaries of empowerment could be crossed. When expectations are clearly stated and agreed upon by all, the process of coaching becomes easier as it focuses on the agreement not being upheld, instead of personalizing the event. In this new paradigm, accountability for these expectations shifts away from managers and to the *team*. Shifting accountability can begin through the process of leadership facilitating the team's discussion and development of its own code of conduct. Often organizations identify standards and expectations early in the process of transformation. It is essential, however, for them to be revisited as the community grows and evolves. Establishing a routine review of the expectations ensures that they remain aligned with the community's vision.

Other Processes for Communicating the Vision to Staff

For staff to embrace and communicate the vision for change, they must feel the vision for themselves in tangible ways. The strategies that follow are just a few of the ways that organizations have made the vision come alive in the life of their community.

All Hands Philosophy
An ~~"a~~ll hands on deck" approach signifies to staff, residents and family members that everyone in the community, including the leadership team, is willing to assist and support in any way necessary. This includes responding to call bells. At Sharon Health Care Center in Sharon, Connecticut, the administrator tracked the reasons a call bell was rung and found that over 65% of the time it was for a request that anyone could meet, such as a tissue or turning the television on. Sharing this information with all the staff helped them to realize that their involvement in responding to call lights was essential. It may be important to remind non-nursing staff periodically that they are able to assist with answering call lights and not to assume that this is clearly understood by all. Including this ~~"a~~ll hands" approach as a responsibility in all job descriptions elevates it from something that you *hope* happens to a formal expectation.

Staff Off-Stage Space

"You can tell how you care for your staff by the room you provide for them for breaks."
(Assisted Living Administrator)

The state of staff space can convey powerful messages that will either reinforce or undermine the change vision. In considering staff off-stage space, it is important to ask oneself whether the break room communicates value, worth, and respect. If it is a space that is hard to access, has fluctuations in temperature, or perhaps is accessible to family members and residents, creating only the illusion of a break, the answer to the above question is no. Providing a useable, comfortable and private break room is one way to convey the importance of supporting and nurturing staff so that they can best support and nurture residents and families.

Alignment of Organizational Processes and Tools with the Vision
Aligning organizational structure and systems with culture change principles establishes a clear set of new expectations that reflect the shifting paradigm of the community. One example is a comprehensive review of communication processes. Is vital information communicated via memorandum and posted on a cluttered bulletin board? Or stapled to a paycheck that only those without direct deposit will likely see? People who are left out of the loop are disempowered. Creating a community of ownership begins with an expectation that communication is a ~~"~~two way street." Everyone must value communication and take personal accountability to ensure that established processes are consistently followed. This alignment of structures and systems addresses a formidable threat to culture change efforts—inconsistency.

Household Audits
Household staff at Brewster Village in Appleton, Wisconsin conducts weekly household audits. The audit tool itself reflects areas identified as priorities, and includes items that may have emerged during surveys, opportunities for improvement identified during observation, and/or culture change principles that the community wants to assure remain in place and active. The audits can change at any time as priorities change. The tool is completed both by CNAs and Rec Aides and another by nurses and social workers. The findings are shared at shift report by the staff member who completed it. If a need for a plan of correction is identified, the team works together to determine how it will be addressed.

See Brewster Village's Household Audit tool, page 102.

Dialogue Days
Dialogue days are an opportunity for the community to come together and discuss feelings and thoughts around a specific issue. Often dialogue days become a way to assess what is on the hearts and minds of stakeholders. In communicating the change vision, the dialogue may be focused on implementation concerns, challenges, or emotional attachments to institutional icons. Whatever the conversation, the follow-up to dialogue days is essential and demonstrates transparency. Consider a debriefing session after the dialogue that includes responding to the following questions:

- *What did we hear related to the topic?*
- *What did we learn about the stakeholders and ourselves?*
- *What is the pulse and morale of the community related to the topic?*
- *What are the action items related to the dialogue day?*

Sample Learning Circle Questions for Communicating the Vision

What are your thoughts and feelings related to the new vision?

What ideas do you have related to the vision?

What are the challenges you are concerned about?

Using Input and Suggestions
Developing effective mechanisms to solicit input and suggestions from all stakeholders engages everyone as problem solvers within the community. For optimal value, any such mechanism not only provides an opportunity for staff to identify opportunities for improvement, but also to present possible solutions. At Wesley Village, the "Village Voice" became a vehicle for staff to provide suggestions and solutions in a way that could be both open and anonymous.

Visual Displays
A visual display in a high-traffic area of the community attracts attention and serves as a visual reinforcement of the vision. At Holbrook Health Center at Piper Shores in Scarborough, Maine, a large Tree of Life traces each resident's life journey from birth to move in. It serves as a continual reminder to all who enter that the community's culture change vision is best met by knowing each person. The impact of the approach is compelling. Whereas 32% of Maine nursing home residents are identified as depressed, only 8% of Piper Shores' residents are diagnosed with depression.

At Bethel Health Care and The Cascades Assisted Living in Bethel, Connecticut, the organization's goals are prominently displayed in the lobbies along with an accounting of the actions being undertaken toward each goal. The committees or persons responsible are listed along with contact information so that a passerby knows who to reach out to if they would like more information or have suggestions to share.

2009 PLANETREE GOALS & ACCOMPLISHMENTS

Focus Areas: Human Interactions, Enhancing Life's Journey & Promoting Well-Being

Importance of Human Interactions

Our Goal: *To foster caring relationships among residents, families, employees and volunteers.*

Our Accomplishments:

- Transition Team
- Ambassador Program
- Language classes
- Planetree Cart

Enhancing Each Individual's Life's Journey

Our Goal: *To offer opportunities for personal growth, self-expression and the fulfillment of individual dreams.*

Our Accomplishments:

- Life Stories
- Resident Interview Team
- Granting Wishes from the Wishing Well (Hot Air Balloon Rides)
- Candles Program
- Artists in Residence Program
- Resident Choir

Promoting Paths to Well-Being

Our Goal: *To provide innovative programs for residents and staff that promote health and fitness.*

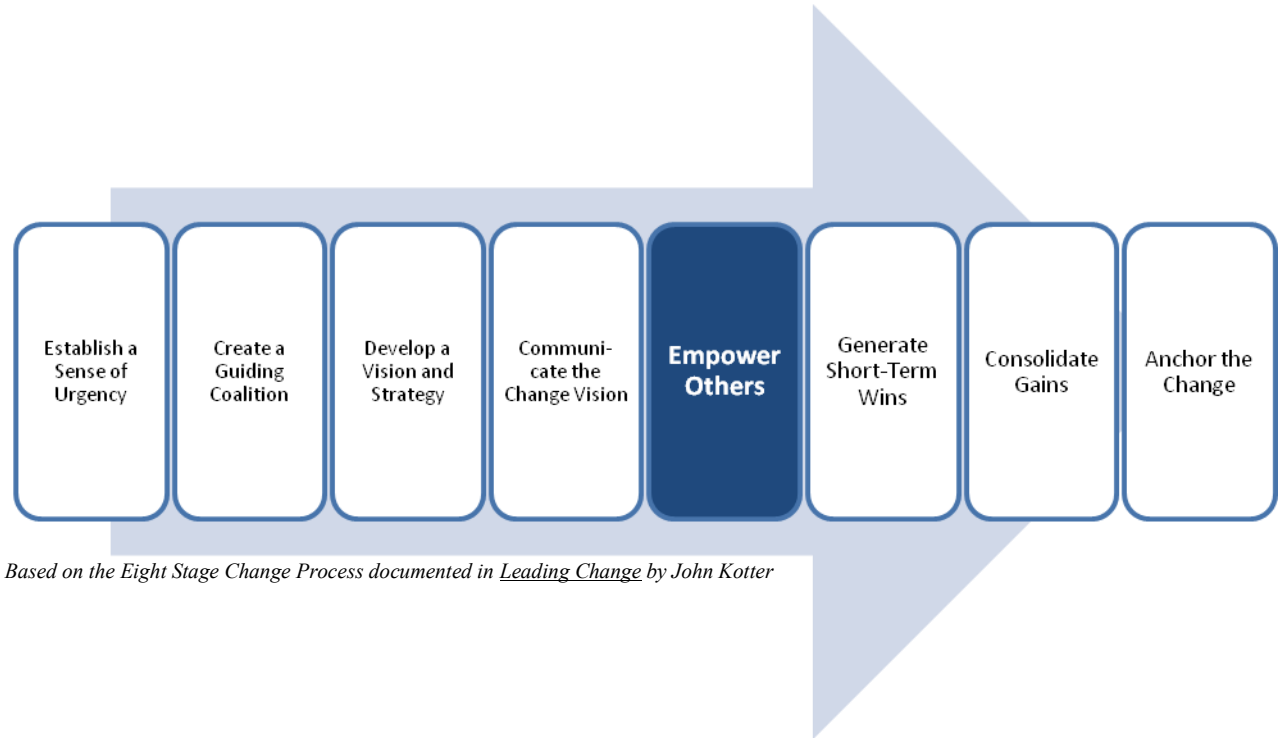
Our Accomplishments:

- Complementary Therapies
- Traveling Spa
- Smoking Cessation Program
- 10 Pound Challenge
- Spontaneous Prayer Circles
- Wellness Center

PLANETREE

Planetree Relationship Centered Continuing Care Environment

Step Five: Empowering Others



Based on the Eight Stage Change Process documented in Leading Change by John Kotter

In general, managers tend to be trained to make decisions, not to empower others. Employees tend to be trained to accomplish tasks, not to solve problems. Residents conform to institutional routines and internalize feelings of powerlessness. Family members are adjusting to a new family dynamic where it is often understood that their loved one's day-to-day decision making and activities have been placed in the hands of others, which may foster unconscious feelings of apathy for a resident's ongoing potential for personal growth. Given these rampant cultural norms of disempowerment, empowering others to realize the vision and overcome obstacles is a critical milestone on the journey toward change. This includes establishing a structure and process that supports the engagement of all stakeholders, deploying team members into action, removing obvious barriers (human or otherwise), and ensuring ample time for staff, residents, and families to plan and act.

Celebration of Mistakes

An integral part of making change is taking risks. This is an underlying truth that needs to be explicitly communicated to all members of a community to accelerate the change process. Communities committed to transformation do not dismiss non-traditional ideas, activities, and actions; on the contrary, they are thoughtfully considered and celebrated. These communities recognize that they will never break out of traditional operational patterns if they are limited only to what is familiar. Team members are encouraged to speak up with their ideas, and all community members share both in successes and failures grounded in a collective understanding of the need for a continuous process of improvement. At Evergreen Retirement Community, the

leadership team focuses on supporting innovation through a receptive approach to risk taking. A "high degree of experimentation" is expected and no one is looking for someone to "hang" if a change doesn't work. This approach is effective because all members of the management team are comfortable questioning each other and having themselves questioned.

Organizational Chart
Organizational charts that are not re-aligned with the culture change vision have the potential to undermine change. Where individuals are positioned is important to consider, as is how positions align with the community's desire to empower individuals.

S T R E T C H GOAL	*Culturally transforming communities stretch their processes to include residents in decision-making. Updating the organizational chart to include the resident provides structure to the resident-directed philosophy. This change alone can communicate to all that the community is unique and not only talks the talk, but walks the path of transformation together. This change to the organizational chart, though, must be coupled with ensuring that residents are truly empowered with decision-making capacity in the organization.*

Supporting Staff Involvement
A common source of resistance to culture change efforts is the assumption by staff that they will be expected to do more work. In fact, as addressed in the myths and facts on page 40, culture change requires workloads to be re-aligned, not augmented. In essence, staff is doing the same work *in a different way*. Nonetheless, staff may be wary of adopting culture change because of concerns of how it will affect their workload. It is incumbent on mangers, therefore, to be attentive to workloads and flexible about shifting responsibilities as appropriate so that staff can concentrate on planning a new effort, working through conflict, and getting to know each other personally. Specific approaches for doing so include:

- Department heads "cover the floor" so that staff can problem solve.
- Ample notice is provided for staff education so that staff can plan their day accordingly.
- Trainings and town hall meetings are scheduled at various times and during all shifts to provide maximum flexibility to staff about when they attend.
- Learning circles and team huddles are a daily expectation.

Empowering through Sensitivity Education and Development

Staff Development
Staff development in culturally transforming communities goes beyond specific job-related tasks to meet a broader range of personal and professional needs. Areas of focus may be conflict management, communication strategies, and building of leadership skills.

S T R E T C H GOAL	*Consider ways to include residents and families in staff development processes.*

Retreats
Retreats differ than traditional staff development efforts in that they are equally focused on both education and inspiration. In this way, they can be a powerful tool for fueling commitment to a collective vision as well as for supporting staff in embracing their role in the change effort. Experiential exercises sensitive staff to the experience of residents, and team building activities support the development of a cohesive team. Staff from all areas of the organization are co-mingled to reinforce that regardless of one's job description or position, everyone is a caregiver in their own right with a responsibility to contribute in a positive way to the life of the community. Retreats can be further set apart from other educational efforts by holding them in a location that inspires well-being, creativity and recognition that this is not ~~–b~~usiness as usual." Some organizations choose to hold retreats off site. When that is not an option, enhancing a space on campus with inspirational quotes, photos and calming music can go a long way toward creating a serene setting. Retreats for all staff can have a profound impact early on in the culture change journey. Not to be overlooked, however, is the potential for retreats to replenish and revitalize staff at times when additional momentum may be needed.

What is important with regard to sensitivity education is that the mere process of re-sensitizing staff will only produce frustration if the systems of care remain unchanged. Many staff members are sensitive to the needs of residents; what is missing for them is the ability to change the systems that hold them to institutional processes and schedules.

S T R E T C H GOAL	*In the spirit of engaging all stakeholders in the change vision, Middlewoods of Farmington, an assisted living community in Connecticut, has initiated resident retreats. Held over a half day, these retreats feature a number of experiential exercises designed to engage residents in identifying with the change vision, to sensitize them to the experience of staff and other residents, to illuminate the importance of positive relationships within the community, and to encourage each resident to get back in touch with who they are outside of their illness or disabilities.*

New Resident/Family Orientation
Another important component to empowerment is ensuring that all new residents and their support network are sufficiently educated through a new resident/family orientation. In resident-centered communities, new resident/family orientation is not a job assigned only to the social work department. It involves a variety of staff—and potentially other residents and family members. A finely tuned orientation that introduces information in a segmented way is essential. *See page 146 for more on new resident/family orientation.*

Identifying Obstacles and Barriers

Setting the Stage for Honest Dialogue about Barriers

> *"We talk about the Eden garden to help us to remember and stay grounded in our work. When you are planting you have to warm the soil… till the soil, plant the seed, and constantly nurture the growth. The garden example is clear and resonates with staff."* (Nursing Home Administrator)

The most important part of "warming the soil" is creating a platform for honest dialogue. The administrator at Fairacres Manor in Greeley, Colorado has frequent one-on-one conversations with staff and group chats over coffee to "plant the seed." These dialogues frequently begin with staff being asked what it would look and feel like if the community were "Oz Manor." They share what they would like to see, and conversely, what they would not want to see. She then explores barriers to staff getting their jobs done in the ways they have described.

Sample Learning Circle Questions for Identifying Obstacles and Barriers to the Vision

What is getting in your way of personalizing care?

What are the "time stealers" in your day? In other words, what steals your time away from residents?

Addressing Human Barriers

Addressing "human barriers" or poor performers who are compromising quality standards, morale, and the vision will hasten the momentum of change. An unwillingness to confront and address inconsistencies in behaviors will result in disempowered staff and will inevitably stall the change effort.

> *"Year after year, we (corporate and regional consultants) write action plan after action plan to address issues, but we fail to focus the leadership team on their low performers and provide them with a comprehensive methodology to make the changes necessary to trigger higher performance."* (Long-Term Care Executive)

Having come to this realization that higher performance would remain out of reach until "low performers" were addressed in a meaningful way, SnF Management developed the following approach for nursing home leadership teams to assess their staff:[26]

1. Make a list of all of the most reliable staff;

[26]From Farrell, D., Brady, C., & Frank, B. (in press). Effective leadership in long-term care management (tent.). Copyright (c) 2011 Health Professions Press, Inc., Baltimore. Used by permission.

2. Meet with the nursing leadership team and, name by name, discuss and then rank each staff member for their clinical skills and their human relation skills. Under both categories (Clinical and Attitude) rank each staff member as – ~~"~~Excellent, Good or Fair." Allow for some healthy discussion among the team as they discuss and rank each staff member.
3. When the list is complete, make a star next to the reliable employees with excellent clinical skills and excellent attitudes. These are the Triple Crown winners. These are the employees you cannot afford to lose. They are the reason why you get thank you cards from grateful family members. And facilities need to employ a comprehensive approach to keep them engaged.
4. Next, make a list of the unreliable staff and rank their clinical and human relation skills the same way. Those that are rated as having fair clinical skills and a fair attitude should be focused on. These are the Triple Crown losers and the employees you cannot afford to keep. They damage the reputation of the facility and put it at risk.
5. Replace these individuals with new hires who are reliable people with great attitudes and who are clinically competent.
6. Then, focus back on the list of reliable staff. Look for those with excellent clinical skills but only a ~~"~~good" or ~~"~~fair" attitude. Meet with them. Let them know their strengths and where you are asking for improvement.
7. Finally, focus back on the list of unreliable staff. If you find someone with ~~"~~excellent" skills and an ~~"~~excellent" attitude, then meet with them and see if you can coach them into being more reliable.

Guided by this process, underperforming employees in one community were replaced with new staff. Using a vastly different methodology than the one in place when the underperforming staff members were hired, the new staff was brought on board based largely on their relational coordination skills. Though it required difficult decisions and challenging conversations, ultimately, the organization not only divested itself of employees who were compromising the change vision but also replaced them with individuals whose skills and attitudes are aligned to it. The outcomes of this process are compelling. Within four months, the organization went from a loss of $95,000 to a profit of $85,000, and in a one year period, it experienced a 70% improvement in deficiencies.

Addressing Regulatory Barriers

Requesting a meeting with the Department of Health provides an opportunity for a candid dialogue about the culture change vision and the regulatory challenges to realizing it. There may also be the potential for requesting a waiver. Building a relationship of reciprocal communication and education on culture change with the Department of Health will build support for change.

Aligning Human Resource Systems with Vision

The Hiring Process

The hiring process introduces a multitude of opportunities to communicate how the change vision is creating a different kind of community experience and how potential employees will be expected to support and model the organization's values. Including a **self-assessment section** is a way to transform a traditional job application into a reflection of the organization's culture. A self-assessment looks beyond work experience and poses questions designed to uncover who the person truly is.

Including all stakeholders in the process of hiring is also important to sustaining the vision. A **peer interview** involves team members who have received training in interview skills. They may focus their questions on communication, team work, conflict resolution and interacting with specific resident populations. The department manager or supervisor then can concentrate on the overall interview process with the applicant and address any subsequent questions. Following the interviews, the different groups gather together to share their thoughts or fill out an evaluation form that will guide the team in their decision making. The inclusive process is as important as the types of questions that are posed to the applicant.

S T R E T C H GOAL	*Consider including residents and family members into the process of hiring and orientation. Many applicants may be pleasantly surprised to be interviewed by a resident or to have segments of the orientation taught by a resident. Inclusion in this process communicates the respect that your community has for its residents and how important it is to have them included in all aspects of their home. At Bethel Health Care, residents are actively engaged in the hiring process for new team members, often asking some of the more challenging questions!* *See Bethel Health Care's Resident Interview Team Policies, page 104.*

Behavioral interviewing is an approach that provides insight into a potential employee's competencies related to the organization's values and vision. Questions are designed around key values and operationalized for consistency. Azura of Lakewood in Lakewood, Colorado uses a behavioral interviewing approach called **Topgrading™** (**smarttopgrading.com**). Topgrading™ has 4 main components: accurately defining ~~–~~A" player performance and behaviors with a Job Scorecard, using a Career History Form to screen candidates, conducting Tandem Topgrading Interviews with finalist candidates, and having candidates set up reference calls with former bosses. The cornerstone of the process is the Tandem Topgrading Interview, a chronological, in-depth, structured interview that results in conclusions about up to 50 competencies.

Many organizations have begun to integrate behavioral or **situational questions** into the interview process. Examples include:

- Tell me about a time that it was challenging to work with a particular resident. Follow Up: How did you maintain the relationship and how did you resolve the challenge?

- You are beginning this new job and you have a number of staff members, family members and residents to get to know. Tell me how you start developing relationships.

- Give me an example of a time where you came up with an innovative solution for a problem at work. Follow up: How did you approach your supervisor and how did your co-workers respond to the idea?

- Tell me about a time when you intervened between two residents having a conflict.

- Have you ever acted as a mentor or a preceptor? Tell me what you feel the purpose of the mentor or preceptor is.

- Tell me about a time that a family member offered complaints to you. How did you handle the situation and what was your resolution to the concern?

- Tell me about a time that you had a conflict with another staff member. Follow up: How did you resolve this conflict and what communication tools did you use?

Job/Role Descriptions
Traditionally, role descriptions have focused on the tasks associated with each role as opposed to *how* the tasks are completed. Many organizations have moved to integrating the importance of team participation, the expectation of blurring roles, the support of the mission/vision through their work, and other key areas of an organization's transformation into the role description. These role descriptions then become the basis for a resident- and relationship-centered performance appraisal for the team member.

See sample job description from Evergreen Retirement Community, page 107.

Performance Appraisals
As with hiring, the appraisal process in resident-centered communities is inclusive. All stakeholders have an opportunity to participate in providing feedback to the team member. Approaches include **anonymous peer feedback**, **learning circle feedback**, and **self-evaluations**. At St. John's Lutheran Ministries in Billings, Montana, peer evaluations are completed via an online survey company. Peers provide feedback to their colleague in the dimensions of mission qualities, leadership, communication, team commitment, and competency. The form ends with open-ended questions on what the employee is encouraged to ~~–s~~top" doing, ~~–s~~tart" doing and ~~–c~~ontinue" doing. At Messiah Village in Mechanicsburg, Pennsylvania, team members participate in an anonymous evaluation of peer members. These evaluations are collated with leadership evaluations to create a cumulative annual evaluation for the team members.

See sample peer evaluation from St. John's Lutheran Ministries, page 111.

S T R E T C H GOAL	*Residents may experience staff members differently than their peers. Accordingly, it is important to involve residents in the performance appraisal process.*

New Employee Orientation
Culturally transforming communities' new employee orientations are dynamic learning experiences that focus on building relationships and community. Strategies for doing so include the addition of experiential elements, incorporation of suggestions from other team members who have previously attended the orientation, and the involvement of residents in the day. The integration of the aforementioned sensitivity and retreat process *(page 70)* is a way of immersing new employees into the culture and philosophy of a community.

The orientation at Saint Elizabeth Community in Rhode Island is a five day program that incorporates the LEAP (Learn, Empower, Achieve, Produce) program (**www.matherlifeways.com/re_leap.asp**), a comprehensive workforce development program designed to empower staff, increase retention, and promote staff-resident relationships through a model of person-centered care. Initially, the revamped orientation was geared to clinical staff only, until it became clear that LEAP was relevant for all staff. Saint Elizabeth Community has further enhanced its orientation process by pairing up each new employee with a **mentor**, and providing the opportunity for the mentor and new employee to get to know each other over an **off-site lunch in the company of the administrator**. Within several weeks of each orientation, the administrator schedules **one-on-one meetings with each new employee to check in** and explore how well aligned the vision communicated at orientation is with the employee's work experience to date at the community.

See a description of Saint Elizabeth Community's Mentor Program, page 114.

Mentoring
Mentoring programs like the one at Saint Elizabeth Community extend the scope of traditional on-boarding processes beyond orientation and skills training to emphasize relationship development. Mentors can familiarize the new employee with the workplace culture and help them to navigate their way through their first few weeks on the job (and potentially beyond). Mentor programs can be mutually beneficial; the new employee is comfortable asking questions and the organization may impact their retention.

S T R E T C H GOAL	*Once a mentor coalition has been formed and is effective for retention and recruitment of employees, communities may wish to expand their mentoring to families and residents. At Crosby Commons in Shelton, Connecticut residents are empowered to welcome one another through visits, gifts, and invitations to events. Having the opportunity for the community members to support one another creates a sense of commitment to the organization and one another. In this process, a coalition can be formed through which the mentors may meet and exchange ideas and support one another's unique perspectives.*

Career Ladders
Many employees seek to grow through advancement in the organization in ways that do not require a license change or an advanced degree. Communities have implemented growth opportunities such as team leaders, advanced nursing assistants, preceptor models, mentor models, dining educators, and others. It is important to ensure that those desiring to grow in the organization have the opportunity and support from the organization to do so.

> *"You have to back the new position up with additional money, responsibility, accountability. All leaders have to be prepared for the change. It does not work if their supervisor treats them the same way they always have. They need mentorship not management."* (Nursing Home Administrator)

A career ladder program enhances the skills and capabilities of frontline staff. Career ladders position staff to take on more self-direction and autonomy and to grow the skills of managers and supervisors to support decentralized decision-making. Fairacres Manor started its career ladder program with the creation of a job description for the team as opposed to for a person. The administrator gathered staff champions who created a list of values and a vision for the position. They subsequently created a commitment statement that everyone had to sign, including the administrator. They all agreed that they were going to try it for 90 days with continual mentorship, education, and communication with administration.

See Fairacres Manor's Lead CNA Values and Commitment Statement, page 116

CAPtains
Wesley Village worked with B&F Consulting to develop its CAPtain program which provides training for a group of selected staff members from the dining, nursing and environmental services departments. The CAPtains are team leaders in their respective departments and come together to brainstorm opportunities and implement changes. Equally as important as their education is the training of the supervisors who work alongside these newly empowered employees.

ADDITIONAL RESOURCES:

Quality Partners of Rhode Island Staff Stability Toolkit
www.qualitypartnersri.org/2/Site/CustomFiles/Qlty_DocMgr/Staff%20Stability%20Toolkit%201.2_122308_smm.pdf

Available as a free download, the Staff Stability Toolkit provides practical "how to" guidance for stabilizing staffing and supporting communities in shifting their emphasis and resources from recruitment to retention of staff. The toolkit includes a series of data gathering and analysis worksheets for drilling into a community's data to assess the current state of stability or instability.

Aligning Work Design with Vision

Many staff members express anxiety about realizing the vision of resident-centered care. You may hear "You want us to do everything we are doing, plus this!?!" or "I don't have time to do what I am supposed to do now!" Underlying the surface message is often the uncertainty that accompanies a change in how things have traditionally been done. Reading between the lines, what staff may actually be saying is "I don't know how to do things differently…I need help." Staff cannot be expected to redesign their work systems without sufficient empowerment, education, and opportunities to take risks. Aligning the work design is an essential piece to the empowerment process. **Most important, though, is that the decisions about redesigning the work come from those actually doing the work and receiving the support and services**.

The following specific approaches for aligning work with a resident-directed philosophy are examined beginning on page 132, in the section Staffing Approaches to Promote Familiarity and Build Relationships:

Consistent Care Giving (or Consistent Assignment)
Universal Worker and Modifications
CNA Education and Training for All Staff
De-Centralizing Departments
Neighborhood Advocate/Team Leaders

Empowering Through Building Teams*

Teamwork is not innate; it must be cultivated, and it begins at the top. Answering call-lights, helping at meals, asking staff what they need and what they think are all practices that nurture teamwork. Leaders must actively guide a teambuilding process to cultivate such markers of teamwork as effective communication, interdependence, and accountability. Teamwork thrives when it is supported by formal systems. Systems that foster consistency in working relationships by stabilizing staffing, schedules, and assignments create the conditions for teamwork. Systems

* We are pleased to acknowledge Barbara Frank of B&F Consulting, Inc. and Nancy Fox of Piñon Management for their contributions to this section.

that facilitate communication—such as start-of-shift stand-up—ensure that everyone has the information to do their job and the opportunity to share what they know. Neighborhood-based interdisciplinary care planning and quality improvement processes ensure inclusion of staff working most closely with residents. Below are five simple tips to get you started:

- **Start investing in the time to cultivate teamwork.** Real change happens when people have a conversation around what they care deeply about. However, staff working within and across departments and shifts often don't know each other, don't have the time to talk to each other, and subsequently struggle to understand one another. Taking the time to build relationships and have conversation around what matters most is the first step. Start with a commitment to a one hour meeting each week.

- **Hear what people are really saying.** There are many benefits to the process of listening. Communication is a reciprocal process, we listen more when we are heard. There are several blocks to listening such as placating, rehearsing and mind reading that can create dysfunction within a team and even impede progress. The Paraprofessional Healthcare Institute has an exercise that underscores ten listening blocks and helps individuals become aware when they are ~~"~~pseudo listening."

- **Lead with your questions.** Jim Collins, in *Good to Great*, says leaders ~~"~~create a climate where the truth can be heard," when they lead with questions, conduct autopsies without blame, and pay attention to red flags. Do not prepare for meetings with answers, prepare with questions. A leaders' ability to recognize that they only have half the picture allows them to gather different insights and perspectives, and model that the answers are within the team.

- **Level the playing field:** All participants must genuinely understand that regardless of role, shift, or department that their success is dependent on one another. Consider leveling the playing field with the learning circle questions:
    - *How do you support your teammates when they need support/help?*
    - *How do you communicate to your teammates that you need support/help?*

- **Develop teams by developing people:** Mentor people. Develop their abilities and judgment. Help teams think through all the factors that need consideration. Give them all the information they need to make a decision. Voice your concerns so they can address them. Support the decision of the team, and expect that others will come up with approaches you might not have even thought of. Create a culture that recognizes risk and can celebrate mistakes as easily as successes.

See Paraprofessional Healthcare Institute's Listening Blocks Exercise, page 117.

Empowering Through Education

Education of team members further supports the goal of empowerment. This education can be on a wide array of topics and can be achieved through a variety of methods, including classroom, experiential, learning circles, and self-learning with discussion. Regardless of what form the education takes, the goal is to have all members of the team come together to learn with *and from* one another, including residents and families members.

Communities like Augsburg Lutheran Home and Village in Baltimore set aside weekly **sacred education time** for team members. Augsburg uses an education process that includes learning circles based on topics generated from a self-created curriculum. During this sacred time the facilitator introduces a topic and provides background information, followed by the participants brainstorming how the topic may be implemented. For example, one of the educational modules focused on environmental noise. What the participants discovered was that while there may be a lot of extraneous or ―bad noise," there was also a lack of ―good noise." These discussions led to the formation of the Sound Team which focuses on the good and bad noise in the community.

ADDITIONAL RESOURCES:

The Career Development Series, developed by The Institute for Caregiver Education: **www.caregivereducation.org**

Paraprofessional Healthcare Institute (PHI): www.phinational.org

Education for Family
Involving families and residents in the educational process is an important part of creating community. Some organizations provide **CPR training** not only for staff, but for family members as well. Another example is a **care partner program** in which loved ones are involved in various aspects of the resident's care. The way in which they are involved is as varied as the resident's needs. Families are educated on topics such as relaxation approaches, pain management alternatives, safe transfer techniques and dietary issues. *For more on care partner programs, go to page 142.*

Education for Residents
Resident-centered communities recognize and support the potential for lifelong learning for all residents. Providing avenues for ongoing resident education is a concrete expression of this philosophical belief. *See Sharing Passions, Expanding Horizons, page 217.*

Other Educational Processes
Education is not just for those traditionally involved in direct care; it turns on the internal switch that makes the need for transformation clear to all stakeholders. Education should be offered to the **Board of Directors and/or corporate office, the Medical Director and physician team, volunteer groups**, and even **local hospital discharge planners** for whom the education can focus on the transitions of care and the culture change initiative.

Conflict Resolution Education
Healthy organizations work toward resolving conflict and encourage team members to move forward after the resolution. In resident-centered communities, conflict resolution education focuses on how members of a community can get to a needs-based solution and communicate with one another to uncover what the needs are under the presenting issue. Some organizations encourage staff to ―bring a problem, bring a solution." At Holbrook Health Center at Piper Shores, staff is urged to have open discussions rather than ―parking lot" conversations.

See Fairacres Manor's Steps to Resolving Conflict, page 121.

Empowering through Recognition: An Appreciative Culture

John Maxwell, leading author of leadership principles and philosophies, once said "I cannot give you what I do not have." On this note, staff cannot be expected to empower residents and enhance choice if they do not have the same provided to them. Communities traveling the path toward resident-directed, relationship-centered care recognize that they need to create an appreciative employee culture to be successful in the journey.

It is important to note that there is to be a balance in creating an appreciative employee culture. Time should be spent creating external motivators; however equal time should be spent identifying internal motivators. This can go a long way in preventing the emergence of an entitled employee culture. Connecting to internal motivators can be promoted through volunteering in the external community as a group, exchanging stories related to resident-centered moments, and sharing personal insights of why individual team members came to work in long-term care. These opportunities to reconnect with internal motivators maintain the balance of the services mentioned below.

Concierge Services
Finding work-life balance is often a challenge for employees. To help address this, some organizations provide concierge services to provide such convenience offerings as oil changes and meals to go. The former may be realized through an agreement with local mechanics to perform oil changes at a reduced rate while the employee works. The garage picks up and delivers the car to the parking lot in the time frame of the employee's shift. Middlewoods of Farmington offers to-go meals for staff. The meals are made in the kitchen and packaged for employees to take home at a reduced cost. On-site banking, dry cleaning services and discounts to local stores and recreation events are other welcomed employee perks that can be incorporated into a concierge program.

Support Services for Employees
In addition to concierge services, many transforming communities offer supportive services to their employees, such as **on-site childcare**. This service is mutually beneficial as it can lead to engaging intergenerational programs (*described in more depth on page 255*). At St. John's Lutheran Ministries, child care goes beyond daycare and encompasses **after school programs** for older children. Saint Elizabeth Community staff has the **ability to bring their children to work if needed**. At Victoria Special Care Center in El Cajon, California the administrator provides a **monetary reward to children who bring in their report card** and show him their good grades. An employee's role in a family may not only be as a caregiver of children. To address this need, some communities offer placement in their **on-site adult day service programs** or use of respite services.

Employee Wellness Initiatives
Other support services focus on employee wellness through **on-site weight management classes**, **smoking cessation programs**, and **fitness centers**. At Brewster Village, staff is invited to use exercise equipment during non-work hours and can do so alongside residents. At

Evergreen Retirement Community, staff has access to **outdoor walking trails** and **therapeutic massage services**. Wesley Village offers staff access to a **naturopathic clinic** that is provided free of charge by a local college of Naturopathic Medicine.

Reward and Recognition
In resident-centered communities, recognition focuses less on rewarding those who complete the tasks of their job, shifting instead to those who are pushing honest dialogue and are confronting problems in a way consistent with the organizational vision.

Recognition can take on many forms, from acknowledgment in the community newsletter to a note of thanks mailed home. St. John's Lutheran Ministries provides a brochure to promote their various recognition programs and invites employees, residents and family members to participate. On-the-spot recognition is a powerful tool that can be utilized in a variety of ways. Saint Elizabeth Community uses **Merit-Grams**, a concept also used at The Hebrew Home in Riverdale, New York. Planetree communities employ a "pay-it-forward" approach to recognition through the use of **Tokens of Kindness**. Inspirational tokens are distributed to staff, residents, volunteers and family members who are making a difference in the orgainzation. The individual receiving the token registers it on a Web site where they also have the opportunity to share their story. The token is then passed on to another individual who is making a difference. This "pay-it-forward" model perpetuates a powerful thread of kindness connected through the token. Maimonides Geriatric Centre in Quebec uses paint cans creatively decorated by volunteers to hold inexpensive "thank you" items and a **hand-crafted journal** sits at the reception desk for all to use for recording special moments.

See St. John's Lutheran Ministries' Recognition Brochure, page 122 and Saint Elizabeth Community's Merit Gram Form, page 124.

Areas of Praise and Areas of Concern
At Wesley Village staff can be "called to the supervisor's office" not for disciplinary action, but to receive "Areas of Praise." Formal recognition of a deed that calls for recognition beyond an informal thank you, an "Area of Praise" is documented in writing and becomes part of the employee's record. When an area for improvement is identified that requires documentation, an "Area of Concern" might be utilized prior to a formal write up.

Recognizing all Stakeholders: Volunteers and Private Caregivers
Volunteers are instrumental to daily operations for many organizations. Inviting them to participate in staff events and celebrations as well as town hall meetings helps convey that they are valuable team members. Recognizing their contributions to the community can be done both formally and informally. *See page 254 for more on approaches for recognizing volunteers.*

A number of communities have extended recognition programs to include private caregivers. At Middlewoods of Farmington, each private caregiver is presented with a corsage during the annual staff celebration. Such a simple gesture of appreciation has led to strengthened relation ships between private caregivers and staff that have benefitted the residents they both serve.

THE CASE FOR ADOPTION: *Staffing Outcomes*

Positive staffing outcomes are a cornerstone of success in a competitive, long-term care economic climate. With labor costs averaging between 50% to 60% of all operating costs (McKnights, 2010), and the cost of turnover estimated at $2500 per occurrence (BJBC, 2008), "happy staff" equate to a healthy organization. Through philosophy and practice, culture change is designed to encourage staff empowerment and generate positive outcomes.

- Turnover & Retention - The Kansas Department of Aging funded a project to estimate the relationship between the elements of culture change as measured by the Kansas Culture Change Instrument (KCCI) and turnover. Findings indicate the turnover was lowest for nursing homes with extensive culture change and highest in the limited culture change group (Bott, et al., 2009). Other research examined culture change adopter homes and found that staff turnover rates were lower and increased more slowly than the group of comparison homes (Stone et al., 2002). Pioneer Network studies report significant decreases to turnover (20% or more) and increases to retention resulting from culture change implementation (Pioneer Network, 2010b).
- Teamwork - The development of formal workforce teams that are multi-disciplinary can result in investment returns from reduced costs. The use of formal workforce teams were shown to decrease costs by up to 13% with approximately $174,000/year due to fewer medical costs incurred (Mukamel, Cai, & Temkin-Greener, 2009).
- Elimination of agency staff - A recent case study found return on investment from the elimination of agency staff of up to $700,000 year (Pioneer Network, 2009).
- Satisfaction - Research of a large nursing home chain found that homes implementing resident-centered care had higher staff satisfaction than comparison homes (Grant, 2008).

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Pioneer Network. (2009). *Case Studies in Person-Directed Care: Teresian House*. Retrieved August 26, 2010, from www.pioneernetwork.net/Providers/CaseStudies/Teresian/

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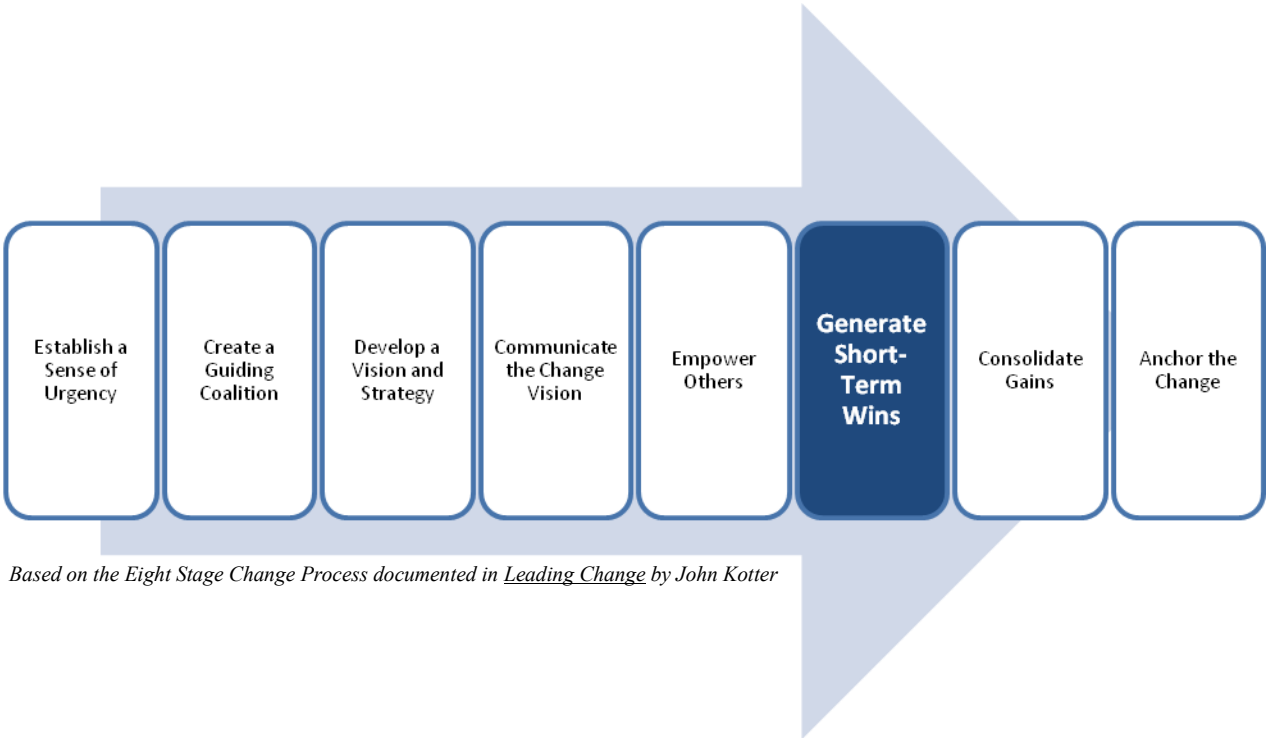
Source: Pioneer Network, 2010

Step Six: Generating Short-Term Wins



Based on the Eight Stage Change Process documented in Leading Change by John Kotter

A common mantra of organizations working toward deep, systemic culture change is "It's a journey, not a destination." Often this mantra is a source of reassurance and encouragement when it feels like change isn't happening quickly enough. Change of this magnitude takes time. That is not to say, however, that a community need wait years for meaningful indications of change to emerge. In every community, there are opportunities directly related to the overall effort that are ripe for change today. These "quick wins" can take on profound importance. They become visible signs of the change processes at work and can be invaluable for convincing individuals within the community that the vision for change is viable and underway.

In addition to the characteristics identified by John Kotter here, short-term win targets should be considered inexpensive. This may help to quell the critics and skeptics who associate culture change with considerable costs.

The plan for short-term wins also needs to be systematic. In other words, the plan needs to be clear, well communicated and organized, and evaluated for results. Lastly, celebrating short-term wins and providing ongoing and positive feedback to those behind the early gains builds morale and demonstrates to the community that transformation is on track.

Characteristics of Short-Term Wins:

- **Visible.** *The stakeholders can see the results*
- **Not Ambiguous**. *There is no argument over the success of the event*
- **Directly related to the overall change effort.**

Source: Leading Change by John Kotter

Piloting to Ensure Success
Piloting new initiatives can help a community to promote risk-taking and reinforce the principles of continuous improvement. A pilot is a work in progress and an opportunity to test out and refine an initiative ~~"~~in the field" (usually on a small scale, perhaps one floor or household) before investing more time and effort in a larger-scale roll-out.

At Fairacres Manor, 90 days is the typical pilot timeframe. For 90 days, a pilot initiative is carried out and monitored, and staff implementing it are mentored and supported in problem solving. At the 90 day mark, the experience of the pilot is considered. Those involved identify what went well and any areas for improvement, and ultimately assess whether the initiative should continue. If the initiative does not continue on after 90 days they simply realize, ~~"~~It was a great idea, and a spectacular failure!"

Just Do It!
A ~~"~~Just Do It" or JDI is a straightforward (usually one step) implementation that yields immediate results. Often organizations identify and implement JDIs after receiving feedback from stakeholders. This process demonstrates to stakeholders in a concrete way that their voices were heard and feedback used. At one assisted living community, residents in focus groups requested more breakfast items for lunch and supper meals while family members requested education and information on MRSA, which had recently been featured on a national news program. Both of these requests were met quickly by the community and served to show that the organization was not only listening to the focus group feedback, but also acting on it. Other examples of JDIs that various organizations have implemented include the introduction of treasure boxes for on-the-spot recognition of staff, more frequent staff meetings during evenings, nights and weekends, and the initiation of resident community meetings.

Sample Learning Circle Questions for Generating Short-Term Wins

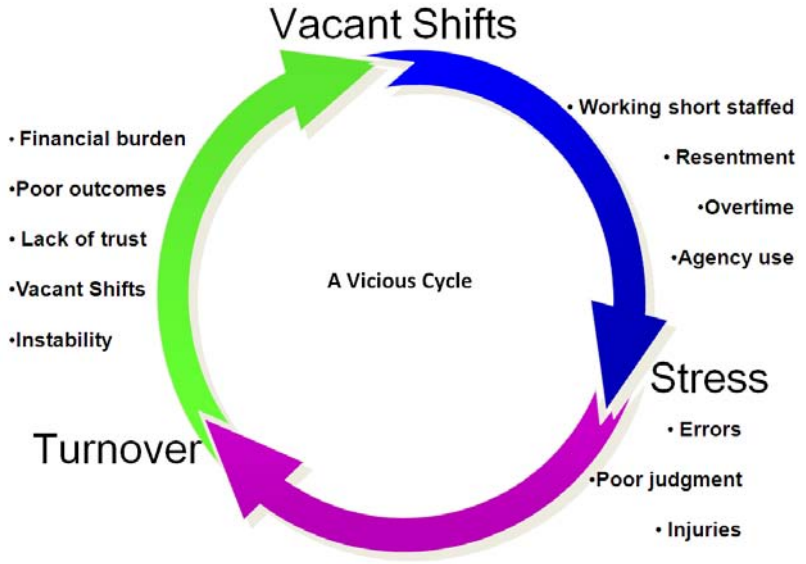
What are the irritants in your day?

What is one change that can be implemented quickly to improve resident and/or staff satisfaction?

"One of our first short-term wins was when we got rid of bonuses for filling staff vacancies and implemented self-scheduling…for the first whole week, in what felt like forever, we were FULLY staffed!"(Nursing Home Administrator)

Cyclical Short-Term Wins: *Reducing Absenteeism, Reducing Stress and Reducing Turnover*

In March 2002, CMS released a Report to Congress that included seminal work by researcher Susan C. Eaton. Her report, entitled "What a Difference Management Makes!"[27] reviews why employees leave some nursing homes and not others. Susan Eaton's untimely and unexpected death did not keep this important work and revelatory research from being continued. Using her research, a Work Force Retention pilot study conducted by Quality Partners of Rhode Island uncovered that 40% of all shifts were understaffed, with an average of 45 call-outs per month. Additionally, staff absenteeism was the found to be the number one reason for termination and what Susan Eaton referred to as "a vicious cycle."



While the issues relative to scheduling and absenteeism are complex, the Improving Nursing Home Culture (INHC) pilot's *Stop Doing* and *Start Doing* lists highlight a number of potential short-term wins with the potential to impact morale, quality, service, safety, and staff retention.

<u>Stop Doing</u>

Many organizations create **incentives to waive benefits** by providing a dollar more per hour to waive healthcare or pension. Yet staff who get sick and can't get antibiotics or medications for their families are absent more frequently and for longer periods of time. The money believed to be being saved is actually a huge loss to the organization in both tangible and intangible ways. **Bonuses for working short** only cause staff to realize that one can earn more by playing into the unpredictability. Why be a steady employee when you can earn more by waiting for the inevitable phone call? Creating stable, full-time slots ensures the stability of your workforce. **Scheduling overtime and double-time** only perpetuates the staffing problems in most organizations. When one calculates the money used in these problem areas (as the pilot organizations did), it is easy to see that it costs much less for steady shifts. **Rotating staff** creates

[27] "*What a difference management makes!"* Chapter 5, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes (Phase II Final Report, December 2001). U.S. Department of Health and Human Services Report to Congress.

little understanding of intimate resident needs and issues. In the INHC pilot, many homes switched to consistent assignment which created a steady workforce and consistent care to residents. Many of the INHC pilot homes also switched from a **sick pay —use it or lose it" system** to an incentive given at Christmas that paid staff half of the unused money. Stop implementing **—no sick pay until second day of absence"** policies. By then, staff has infected residents and other staff. Lastly, the pilot determined that it is important not to **fill vacant shifts with new staff members.** These poor recruits invariably are left on their own to discover where supplies are kept, what the residents need and some of the subtle nuances of care that are necessary for a resident to be happy and satisfied. The frustration, fear and isolation can be overwhelming and prevents a positive transition into a great profession for many.

Start Doing

Some of the pilot sites' top —To Do's" included the creation of a **no-fault attendance policy.** This allowed for no more qualifying absences. If staff members need to take care of their lives, they do so. This removes inequity. Treat people as adults and get rid of the need for physician notes. An effective program starts with collecting good data. To this end, **measure and track attendance**. In the pilot many came to **reinforce positive behaviors** by **rewarding reliability and acknowledging and rewarding improvements** in attendance and stability. To enhance the trust among staff, pilot participants established **proactive replacement plans** and allowed for last minute coverage for each other. Many supervisors **contacted the employee** who called off to show genuine concern and check to see if the staffer might need a replacement for the next shift. Participants also created a **replacement priority list** whose hallmarks were no scheduled overtime shifts, but a voluntary overtime policy with no double time and no agency staff.

Though these changes in the pilot were offered as suggestions and were not mandatory, those organizations that adopted them reported considerable savings and a decrease in staff turnover.

Peaceful Short-Term Wins

Noise reduction is another opportunity for a short-term win. Numerous long-term care communities have implemented effective noise reduction campaigns that demonstrated results within just three months. One Rhode Island home deployed a study group to look into noise reduction. In the course of their work, the group discovered numerous issues, including open telephone lines that were being paid for monthly. When the committee had finished its work, monthly savings of $2,500 were realized.

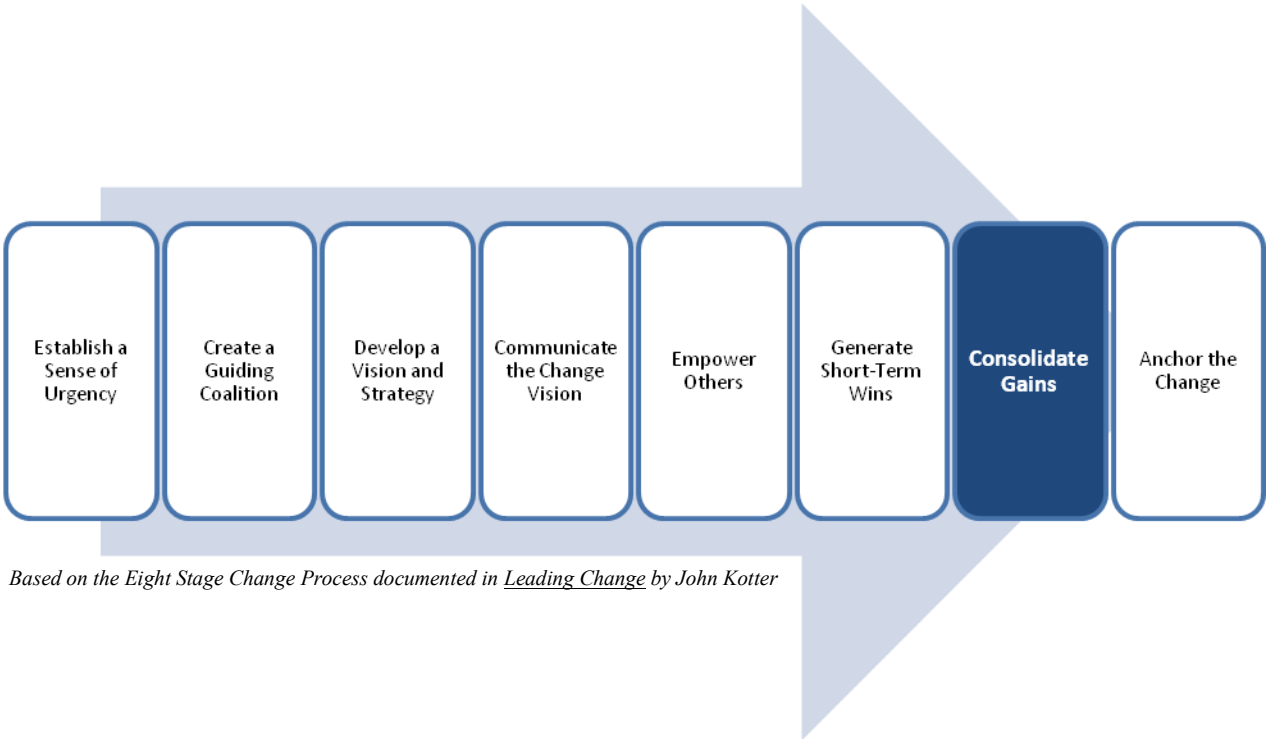
In its Noise Reduction Project Team Workbook, available at **www.qualitypartnersri.org**, Quality Partners of Rhode Island presents a process-oriented approach for addressing noise in long-term care communities. Among the strategies is to hold **Stop, Sit & Listen Breaks**. Individuals are randomly selected to monitor the sounds of a specific area for ten minutes. They are blindfolded to help them better tune into the noises they hear. At the end of the ten minutes, they note their insights onto a card which is provided to the rest of the team.

Magical Short-Term Wins

> *—A fascinating experience I have had is that it is so much easier to hear each other while doing, rather than while planning or in meetings. Being present and in the moment is magical."* (Long-Term Care Executive)

While throughout this Guide we have stressed the importance of planning, short-term wins are all about "doing" and often involve responding ~~–in~~ the moment." Leaders who seek out opportunities to spontaneously respond to the needs and pulse of the community turn neutral parties of the change effort into supporters and reluctant supporters into active helpers. There are numerous examples of magical "quick wins." One administrator took several residents to the Friday Night Fish Fry at the church because he overheard a resident say how nice it would be to go that evening. At another organization, the Director of Nurses sent each staff member a personal note of thanks after a long week of working short. Another administrator gathered staff on each neighborhood for a moment of reflection to relieve stress during state survey. A chef learned that a resident was celebrating her 50th anniversary one afternoon and arranged for the couple's favorite meal and a private dining space that evening. In each of these examples it is evident that when leaders make magical moments a priority, so does the rest of the community!

Step Seven: Consolidating Improvements and Sustaining Momentum for Change

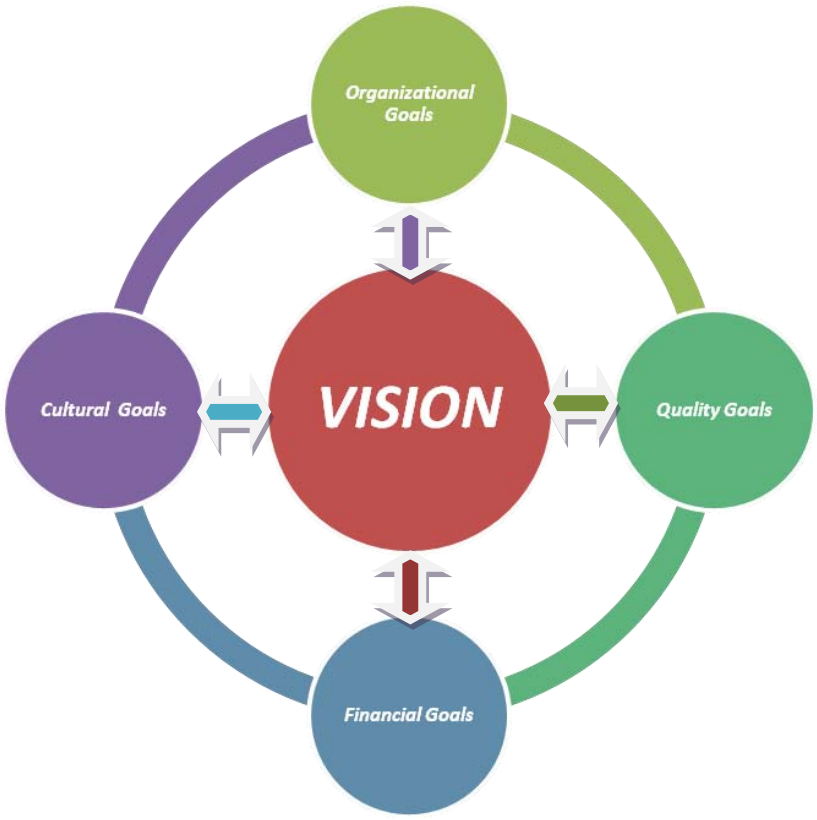


Based on the Eight Stage Change Process documented in Leading Change by John Kotter

Short-term wins are essential, but alone are capable only of only temporary gains. While celebration of short-term gains is appropriate, it is important that celebration and pride in what has been accomplished does not morph into ~~r~~esting on one's laurels." The sense of urgency for change must remain high so that the powerful forces of tradition and resistance do not engulf continued progress. The momentum of short-term gains can be leveraged to address the bigger and more complex opportunities for improvement in the community. Once the most obvious gains have been tackled, it becomes increasingly important to have a process for gathering the perspectives of all stakeholders on opportunities for improvement and for setting and prioritizing annual goals.

Vision as an Anchor for the CQI Process

It is important at this stage to consider how operational, clinical, financial, and culture goals are aligned with the vision. Many communities are challenged to sustain gains because they haven't grounded the vision in a process of goal setting, achievement, and measurement. Many feel as if they are constantly juggling cultural goals with operational goals, all while trying to shore up financial and clinical systems. This feeling and how it is communicated to staff is a sure way of having staff feel that the transformation is something the community is doing versus something the community is becoming. In fact, culture change is a way of life; it is the way clinical and financial goals are accomplished, not a separate process. Having the vision anchor all goals (as illustrated on the next page) is a way of communicating that culture change is not an initiative with a deadline for completion, but an overarching approach that defines the community as a



whole. In resident-centered communities, the vision connects all current and future interdependent goals and changes. Each goal is related to the overarching vision. Goals and their subsequent achievement are more sustainable and have more buy-in from stakeholders when there is an inclusive decision-making process used in the planning and execution of those goals. Once goals are established, it is important to put a system in place to measure and communicate progress. Setting a threshold or benchmark communicates a clear expectation and drives accountability toward reaching desired outcomes. The communication of these goals and ongoing progress is vital to sustaining buy-in, recruiting more help, and creating a community of problem solvers.

Decentralized Priorities

Priorities for change on the short-term rehabilitation area may be different than the priorities on the long-term care floor. Kotter stresses that "change happens much more easily in a system of independent parts."[28] The neighborhood and household models are a good example of creating a system of independent parts that have a low level of interdependency and as a result can readily move change.

At Bishop Wicke Health Center, consistent assignments are implemented in a variety of ways in the different resident areas based on the specific needs of the population. Due to the high turnover of patients, the short-term rehab area meets on a daily basis to discuss each person's assignment while the long-term areas that have much lower turnover have this discussion on an as needed basis. At Evergreen Retirement Community, **unit-based teams** are convened to address an issue specific to one living area. **General teams** address more global concerns,

WORDS OF CAUTION ABOUT GOAL SETTING:

- Keep the number of goals manageable and realistic.
- Avoid the creation of too many committees or work teams.
- Ensure meetings are focused and productive.
- Leaders are needed to guide and deploy work teams, but also must know when to get out of the way.

[28] Kotter (1996), pg. 134.

such as laundry. One lesson learned through this general team approach was to keep equipment standard throughout the community so that staff can assist each other outside of their normally assigned area.

Establishing who will retain ownership of the goals is half of the process equation. The second half —education to assist teams in understanding how goals are set and measured—is just as vital.

S T R E T C H GOAL	*The potential and perspective of any team can be expanded with the inclusion of residents and family members as team members. Identify opportunities to include residents and family members on every improvement committee in your community.*

Processes for Goal Setting
Asking each work area, team, department, and groups of residents and families to complete an **evaluation form** to reflect on the year's accomplishments as well as opportunities provides the groundwork for an inclusive approach to goal-setting. The information is considered by the guiding coalition alongside other metrics such as clinical indicators and financial performance to determine annual goals. In the spirit of transparency, the goals are shared with all community stakeholders and posted around campus for all to see.

Experiential retreats (*described in more depth on page 70*) also provide a setting for staff and residents to learn how to **look for the —next right answer."** This work focuses on the fact that while one solution to an issue may be acceptable, continuing to ask why and how is vitally important to finding the best solution. The value of different perspectives is discussed along with the need for risk-taking.

At Evergreen Retirement Community, staff members attend a seven-week **Learning Wave**, a training focused on team building and identifying and vocalizing areas in need of improvement. Participants utilize the skills they learn on an actual team to address a problem that they have identified. Time is set aside for process improvement and areas that pilot programs are expected to share their success with others. The importance of this work is highlighted through performance reviews that acknowledge the work that is done on teams.

Different approaches to problem solving are often necessary, depending on the scope of a goal or issue. For example, at Evergreen Retirement Community, a task group, team or process improvement event might be utilized to make a process change, depending on the scenario:

- A **task group** meets a few times, focusing on quick areas of improvement.
- A **team** has a direct goal established by a manager, but the team decides how to meet it.
- A **process improvement event** focuses on system changes, follow-up and additional meetings are held as needed.

All of these approaches are expected to deliver results, and exist for a finite period of time. For example, to address a parking issue, one team met three times for a total of six hours and implemented changes which are reviewed every four months.

Deployment of Goals through a CQI Process
At Bethel Health Care and The Cascades Assisted Living, opportunities for improvement are addressed through a process of action teams, leadership initiatives, and Just Do It's. All of these approaches are overseen by the Steering Committee and reinforced with quantitative analysis. **Action teams** have a system-wide impact and involve larger, more in depth changes. **Leadership initiatives** are issues that can be addressed by just one or a few people. **Just Do It's** are the ~~"l~~ow hanging fruit" that can be addressed relatively easily by the organization. A focus on establishing benchmarks and consistently reviewing them aids in ensuring sustainability.

Not all issues or ideas require the work of a committee or team for implementation, which can sometimes slow down or even stop a change from occurring. The team at St. John's Lutheran Ministries speaks of making decisions quickly, and not necessarily through committees. Staff are supported in taking risks and nurtured through their mistakes. A culture of ~~"t~~hinking outside the box" is encouraged at the individual level and benefits the organization.

Focusing on the Process, Not the Person
Instead of focusing on the person when the community experiences an adverse event, the team at Holbrook Health Center at Piper Shores conducts a process meeting. During this process meeting, members of the team focus on how the process and procedure could be adapted to better support individuals. This discussion is framed around identifying solutions to the concern rather than placing blame on persons involved.

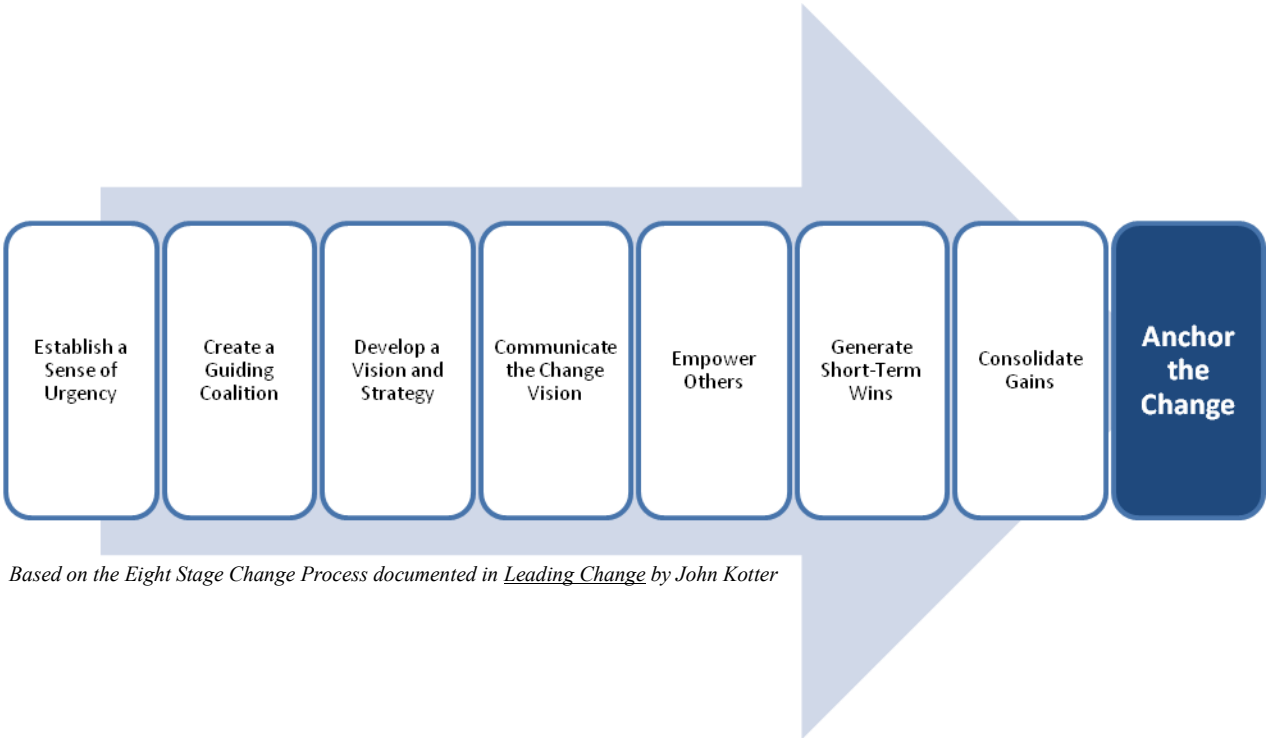
ADDITIONAL RESOURCES:

Getting Better All the Time

A performance improvement manual developed by
the Cobble Hill—Isabella Collaboration Project

www.isabella.org/?newsId=CFF0AB07-D3B1-4645-A81F-953B1D80337F

Step Eight: Anchoring the Change



Based on the Eight Stage Change Process documented in Leading Change by John Kotter

Often long-term sustainability of a new practice is achieved only when it is clear that it has created superior results to old methods. This requires any community on a culture change journey to be vigilant about connecting new operational behaviors to organizational success. Communication of these connections should not be limited only to successes, though. Transparency of both wins and weaknesses can be used to maintain a high sense of urgency and to fuel continuous progress. While solid quantitative results are vital for making these connections, qualitative data and compelling storytelling can also play an important role in articulating the impact of change.

As noted in Section I, *Making the Case for Change*, the long-term care industry is challenged to tie culture change initiatives to outcomes. Unfortunately, there is a pervasive lack of resources and knowledge on how to use data and continuous quality improvement methods to drive and sustain outcomes. Investment in resources and training in quality improvement principles will help to shrink this gap, and adopting a commitment to measurement, evaluation of data, setting thresholds, and benchmarking will equip communities to truly ~~–a~~nchor the change."

The hiring and promotion of staff and succession planning is further scrutinized during this stage of the change process. If promotions or changes in leadership are not compatible with the new practices or vision, the community leaves itself vulnerable to regression. It should also be noted that sometimes the most important step to anchoring the change is to change key people. In this case, a year of high turnover is a pivotal turning point.

Finally, communities at this level of maturity in their transformation should be mindful of recognizing, reinvigorating, and renewing the guiding coalition. This includes creating opportunities for team building, evaluating the strengths and interests of each member, and continuing to align their passion and strengths to the right initiatives. As term limits near completion, ensure that new members are recruited and old members are honored for their work.

Processes for Anchoring the Change

Progress Assessments
A progress assessment is a thorough review of the resident, staff, and family experience with a goal of identifying what changes have truly become a part of the new community fabric. This may include revisiting the **self-assessment tool** in this Guide or the **Artifacts of Culture Change**. It may also involve collecting qualitative information through **focus groups** and **learning circles**.

Measurement
To sustain and create buy-in for more change, a qualitative and quantitative measurement approach is ideal. While focus groups and interviews with all stakeholder groups are instrumental in gathering insights and perceptions of the community, satisfaction surveys and clinical and operational indicators identify tangible results that can be trended over time. With a structure and method in place for collecting and sharing this information (be it weekly, monthly or quarterly), these data can be used to motivate change and thwart complacency.

ADDITIONAL RESOURCES:

In Phase Two of the Advancing Excellence in America's Nursing Homes Campaign, reducing turnover and establishing consistent assignment have been identified as the primary goals. This reflects the findings from Phase One that both must be measured and addressed before organizations can achieve clinical goals or enhance resident or staff satisfaction. To assist organizations in measurement, the campaign has made available two important free tools:

- **A Staff Turnover Calculator**
  www.nhqualitycampaign.org/files/Calculation%20of%20turnover.xls
- **Consistent Assignment Tool**
  www.nhqualitycampaign.org/files/ConsistentAssignment.xls

The Dashboard
A dashboard is a spreadsheet that reports data and compares it to the organization's goals. Posting the dashboard in a public area reinforces that everyone in the community is part of the process of establishing and addressing important goals. Color coding the results can be helpful for communicating the data in a clear and concise manner. For instance, measurement indicators that are color coded in green are targets that have been met; those in red are yet to be met.

See sample dashboard from Southington Care Center, page 125.

Setting Thresholds and Benchmarking

When setting annual goals and performance indicators it is important to set expectations with a targeted performance level that the organization is planning to achieve. A threshold not only communicates expectations but can motivate stakeholders to exceed them. The power of setting thresholds was demonstrated during the first phase of the Advancing Excellence in America's Nursing Homes Campaign when organizations that selected a quality indicator to measure *and* set a threshold for performance achieved greater results than organizations that only selected an indicator to measure. Benchmarking progress both internally and externally is valuable for grounding and evaluating operational success.

Satisfaction Surveys[*]

Satisfaction surveys have emerged as a potent and indispensable tool for effective management of any long-term care operation. Resident and family surveys reveal how well a community's performance measures up in delivering quality of life, quality of care and quality of service. These surveys bring attention to areas where a community's performance achieves excellence and where it fails meet the expectations of its customers. Further, they point to the roots that nourish superior performance and to the causes that result in lackluster performance.

Staff surveys hold a mirror to the effectiveness of managers who are the prime drivers of quality. A good manager responds to the messages these surveys convey, and sets a tone, embraces values and promotes priorities that together create a person-centered work environment, in which workers are supported to be devoted and committed caregivers. Staff surveys reveal whether orientation, training, career ladders, empowerment, appreciation, evaluation, mentoring and other policies and practices dovetail and reinforce each other to create a quality workplace for caregivers who in turn add quality to the life of the residents.

Surveys may also disclose information about the changing customer base and the labor market. Survey findings can help leaders to discern the expectations of short-stay nursing home residents that differ from those of long stay residents, or how a change in the ethnic mix of their staff may have altered the work environment. In addition, they can enhance understanding of what drives census, e.g. is it the community's reputation or merely the advantage of its location?

When conducting surveys, organizations should identify strategies to ensure a high participation rate. These may include assuring respondents that their identity and information will be kept confidential; offering incentives for completing the survey; utilizing short, well-formatted and pleasingly printed survey tools tailored to the needs and disabilities of respondents; personalizing mailings and including a stamped return envelope; giving advance notice of when the survey will be conducted; and following-up with respondents who are tardy or have forgotten to return their survey. In addition, a higher response rate may result when respondents have options of how to participate in the survey: paper and pencil, on-line, via the telephone, mailed surveys, etc. Lastly, it is advisable to avoid conducting surveys when bills are mailed, during vacation times, national holidays, playoffs and other major distractions.

Part of any organization's survey planning process should also be identifying the structure and

[*] We are pleased to acknowledge Vivian Tellis-Nayak, PhD of My InnerView for his contribution to this section.

methods for how the information is shared with all stakeholders.

Evaluating Data
Appropriate evaluation of data is critical to ensuring that an accurate picture of organizational performance is communicated. For example, depending on the percentage of voluntary versus involuntary turnover and the reasons behind the voluntary turnover, an increase in turnover may, actually, be a good thing. As the bar is raised, so too are resident, family and staff expectations. As a result, satisfaction scores may decline even as other metrics improve. No one measure should be used in isolation. Making the effort to dig for the facts and the root cause of changes in data ensures that those issues that truly require attention are addressed in a meaningful way.

Posting of QI Indicators in Lobby
At Bishop Wicke Health Center, four clinical indicators were identified as targets for improvement. Outcomes for these indicators are graphed, compared to local and national benchmarks, and the information is prominently displayed for residents, staff and visitors to see.

Succession Planning

> *"You need a process for succession planning…and a CEO that has a heart, is willful for the future of the organization, and humble enough to know that he/she is not the only answer. One must set aside their own glorification and demonstrate that he/she is not the only one that can lead the organization."*
> (Long-Term Care Executive)

The chief executive officer is the primary determinate of the culture of the organization he/she leads. In the absence of effective processes for identifying candidates whose values are aligned with the organizational culture, even communities with well-established resident-centered cultures could be left vulnerable to regression upon the retirement or resignation of the CEO. Consistent with culture change values, succession planning for the CEO of successful long-term care organizations focuses on developing multiple candidates from within, and is inclusive by providing opportunities for all residents and staff to participate in the selection process.

In anticipation of the retirement of its CEO, at Evergreen Retirement Community, members of the Board of Directors, Residents Council and senior management team had the opportunity to participate in identifying the most valued characteristics of a potential CEO. These characteristics became the foundation for a comprehensive, multi-year succession planning process that not only focused on the goal of identifying internal candidates to replace the retiring CEO but also on developing the leadership skills of all management staff. Components of the succession planning process included a comprehensive leadership and management evaluation; the creation of personal development plans with the assistance of the CEO to address gaps between candidates' abilities and the desired CEO characteristics; mentoring by successful external executives identified by the CEO; and a senior management team development process emphasizing personal and team values formation and leadership skills.

When the time came for the CEO to retire five years after the succession planning process began, the Board had a variety of tools at its disposal to assess the candidates, all of whom were

internal, for leadership capabilities that would perpetuate the organization's well established resident-centered culture. They considered the results of in-depth testing to evaluate managerial and leadership ability, resident and staff evaluations, a professional external assessment, and two interviews with the full board. The board unanimously selected the new CEO who was able to retain the other candidates. David Green, former CEO of Evergreen Retirement Community, has outlined the following underlying principles for succession planning:

1. Succession planning requires a joint commitment of the board, the CEO and the senior management team.
2. Succession planning must be based on organizational core values which are defined by the board and expressed through the organizational culture.
3. The board defines the characteristics of the organizational culture to be preserved and selects a CEO with the ability to create the desired culture.
4. Planning for CEO succession is a board expectation of the CEO at the time he/she is hired.
5. The CEO is expected to develop at least two individuals on the senior management team with the breadth and depth of experience to be CEO.
6. The succession planning process is based on developing shared values among the senior management team members which focus on the well-being of the organization.
7. The board provides funding to support the CEO development process.
8. The CEO is not involved in the final CEO selection process.
9. The full board participates in the entire CEO selection process; only preparatory tasks are delegated to board task groups.
10. No board member lobbies for a particular candidate.[29]

Community Rituals to Celebrate Progress Toward the Vision

Community rituals can be powerful ways to acknowledge and anchor the community's commitment to transformation, to reinforce all members' involvement and to reignite passion and enthusiasm for the vision. The team at Wesley Village planted flower bulbs at the start of its change journey. In reflection, every Spring the community joins together around the blooms to renew its commitment. Maimonides Geriatric Centre plans an annual month-long celebration with a schedule of events that promote and educate the entire community on its change effort. In commemoration of the community's centennial year in 2010, the month-long celebration was extended to a full twelve months of activities. Such celebrations need not be reserved for one-time-a-year acknowledgment of progress toward a grand goal. Equally as important are rituals to celebrate the accomplishment of a specific objective.

External Evaluation and Recognition Opportunities

To recognize and evaluate culture change, some organizations have participated in CARF's Person-Centered Long-Term Care Community Accreditation program. Others have achieved Eden Certification or are striving for Planetree Designation as a Resident-Centered Community. All of these opportunities provide a road map for change along with an opportunity for ongoing evaluation of resident-centered achievement.

[29] King, Karen & Green, David A. (2007) Succession Planning in a Nonprofit Healthcare Organization. *Journal for Nonprofit Management*, 11(1), 6.

Building Community Implementation Tools

Tool A. Augsburg Lutheran Home and Village's Learning Circle Guidelines

Augsburg Lutheran Home and Village
Culture Change
Introduction to Learning Circles
November 12, 2008

Learning Circles: A formal gathering of a group of people utilized to "give a voice" to all participants in order to solve problems, make decisions, keep lines of communication open and/or to simply provide an opportunity for pleasant conversation. Once established on all units and shifts, Learning Circles will be used to the greatest degree possible to determine the unit's policies and daily activities for residents.

Participants can be trained extensively to maximize the benefits of Learning Circles; however, staff can get started with just a few pointers and some self discipline—mostly to keep quiet and listen. The following are the essentials that must be followed:

1. Learning Circles give those who usually don't have much to say or are shy the foremost opportunity. Folks who usually have all the answers need not participant or just listen. These folks will be able to chime in after the fact.

2. In staff-resident Learning Circles (initially) the primary job of the staff is to listen. Residents who always have the most to say may not be the perfect participants, especially if they are not trained or resist training.

3. Eventually and once trained more thoroughly, staff will participate more actively. Depending on the reason for a given Learning Circle, staff and residents will interact freely with each other.

4. Each session of a Learning Circle must have a well defined question or objective.

5. Each Learning Circle will choose a facilitator who ensures everyone is given a chance to speak. It's best to simply go around the circle. Residents may pass, though the facilitator should go back to those residents once everyone has spoken to give them another chance.

6. There is no leader; but the facilitator will ensure each participate generally has equal time.

7. Someone else may take notes.

8. During this initial stage there is no discussion, no back and forth.

9. Participants may not choose to talk the first time through, but should be given another opportunity once everyone has had a chance to speak on the topic at hand.

10. After everyone has had a chance to speak, the group can have open discussion.

11. Staff will encourage residents to speak up and "affirm" their feelings.

12. Staff should resist trying to make excuses when responding to complaints, make decisions on the spot or provide answers they are not sure about. After the meeting staff can discuss issues with each other and bring appropriate matters to administration before eventually getting back to residents.

For these initial Learning Circles staff will say very little and listen. The skills learned will benefit staff not only as participants in Learning Circles, but in resident communications in general. Eventually, the Learning Circle will act as a decision making process in itself with a great deal of give and take between residents and staff. Learning Circles can also be used for various employee meetings as well, whether within a department or among all staff on a given unit.

Tool B. Bethel Health Care's Steering for Tomorrow Charter

BETHEL HEALTH CARE & CASCADES

PLANETREE _STEERING FOR TOMORROW' CHARTER

PURPOSE

The purpose of this charter is to provide a set of guidelines to assist in defining the roles and responsibilities of the Steering for Tomorrow Committee.

MEETINGS

The Steering for Tomorrow Committee will meet monthly. Additional meetings may be scheduled to meet organizational needs.

MEMBERSHIP

The Steering for Tomorrow Committee will be chaired by the Planetree Coordinators or designee. Planetree Coordinators are members of the Steering for Tomorrow Committee but will rotate attendance at the meetings.

Membership may consist of individuals from clinical and non-clinical areas, ancillary support services, residents, family members, volunteers and physicians. There will be representation from both managerial and non-managerial positions within the organization.

Individual membership is voluntary and will be reviewed annually. Members are expected to attend meetings and participate (without compromising employment responsibilities and other obligations) in Planetree-related activities, including annual goal-setting and various work teams. After three unexcused absences, one of the Planetree Coordinators will speak privately to the committee member to determine continued interest and/or issues related to serving on the committee.

Planetree Coordinators or designees will serve as liaisons to the various Work Teams.

The Committee size will range from 8- 20 members based on the needs of the organization.

Work Teams are expected to designate a leader who will coordinate efforts of the work team/project. They will incorporate communication and directives from administration and the Steering for Tomorrow Committee. Work team leaders and participants are not required to be Steering for Tomorrow committee members.

Reviewed and updated by the Steering for Tomorrow Committee, May 2010

Membership Qualifications

• Represents a perspective that is beyond the member's primary role in the organization;
• Displays an understanding and enthusiasm about the Planetree Model and relationship centered care;
• Collaborates with others in identifying and solving problems;
• Embraces change initiatives and is willing to assist with implementation;
• Displays strong communication and organizational skills.

ROLES AND RESPONSIBILITIES

Member Responsibilities

• Committee members will seek to increase their understanding of Planetree principles and promote Planetree
with both employees and the public to foster a relationship centered health care environment;

• Considers the human and financial resources of the organization in the decision making processes;

• Demonstrates respect for other members of the team and values the diversity of the team;

• Demonstrate a willingness to speak with one voice in the process of Planetree integration;

• Assist in plotting the course for educating the entire organization;

• Attend first Retreat sessions.

Member Roles

• Review the Organization Assessment and assist in the development of priorities of focus;
• Focus on outcome measures and ongoing evaluation of implementation of work groups;
• Design methods of communication related to Planetree implementation and work team progress;
• Recruit members to serve on Teams;
• Assist in the review of educational materials, methods and presentations in the promotion of Planetree philosophies;

ORGANIZATIONAL REPORTING

Work Teams will be responsible for reporting Team's activity and outcome measures to the Steering for Tomorrow Committee and a structure is in place for the Planetree Coordinators to act as liaisons, monitor activity and maintain communication.

The Planetree Coordinators will be responsible for reporting the Committee's activity and Work Team outcome measures to the Department Heads and the Total Quality Improvement Committee.

Tool C. Proclamation for Resident-Centered Care

Proclamation for Resident-Centered Care

We proclaim to our residents and community these truths, which we hold to be self-evident:

A resident is an individual to be cared for, not a medical condition to be treated.

Each resident is a unique person, with diverse needs.

Each staff member is a caregiver, whose role is to meet the needs of each resident.

Our residents are our partners and have knowledge and expertise that is essential to their care.

Our residents' family and friends are also our partners and we welcome their involvement.

Access to understandable health information is essential to empower residents to participate in their care and it is our responsibility to provide access to that information.

The opportunity to make decisions is essential to the well-being of our residents. It is our responsibility to maximize residents' opportunities for choices and to respect those choices.

Our residents' well-being can be enhanced by an optimal healing environment, including access to music and the arts, satisfying food, and complementary therapies.

To effectively care for residents, we must also care for our staff members by supporting them in achieving their highest professional aspirations, as well as their personal goals.

exists to serve our residents and our community. We are honored to be here for you.

Tool D. Brewster Village's Household Audit Tool

Household Audit

Completed by:	Date completed:	Household:

Culture change/Resident Rights:	Circle what you observed:		
The villagers routine/choice is followed related to personal cares, sleeping, arising, eating, bathing, appointments (All About Me Form)	Yes	No	NA
The household is free from noise when villagers are sleeping	Yes	No	NA
Villagers are offered continental breakfast as they arise	Yes	No	NA
All household staff promote activities and provide assistance as needed	Yes	No	NA
Staff knock on doors and await permission to enter	Yes	No	NA
Learning circles with villagers and staff are used to plan household activities	Yes	No	NA
Activities are being held as scheduled	Yes	No	NA
Resident Dignity:			
Villagers clothing is appropriate and in good repair for time of day/season	Yes	No	NA
Villagers hair is combed and clean	Yes	No	NA
Villagers are free from odor and wetness	Yes	No	NA
Villagers have all needed equipment (Glasses, dentures, hearing aide, walker, wheelchair, cane)	Yes	No	NA
Gait belts are used with all villagers that need physical assistance unless noted	Yes	No	NA
Dining:			
Leftover foods are covered and dated with date saved and discard date	Yes	No	NA
Staff follow the dining information book for meals and snacks	Yes	No	NA
Staff use gloves, tongs, or napkin when serving a food item	Yes	No	NA
Assistive devices are provided per the dining information book	Yes	No	NA
Staff ask villagers if they prefer a napkin or cover up prior to placing it on them	Yes	No	NA
Staff ask villagers at meals what they prefer to eat and drink	Yes	No	NA
Food is covered when transported to a room	Yes	No	NA
Villagers are offered snacks	Yes	No	NA
Temperatures of foods are being taken prior to food being served	Yes	No	NA
Staff use proper hygiene prior to, during and after handling food (soap/water)	Yes	No	NA
Housekeeping:			
Common items are not found in the bathing room (Lotion/soap)	Yes	No	NA
Bathing room has a nice appearance and is odor free	Yes	No	NA
Laundry room is clean and free of items on the floor	Yes	No	NA
Halls are free of lifts, wheelchairs and clutter	Yes	No	NA
Villagers rooms are free of odor and hazards	Yes	No	NA
Equipment is sanitized between villager use (Lifts, tubs, multiuse items)	Yes	No	NA

Infection Control:			
Hand Hygiene is performed before/after glove use, villager contact and surface contact	Yes	No	NA
Gloves are worn if there is potential exposure to body fluids	Yes	No	NA
Gloves are changed between villager contact and hands are washed	Yes	No	NA
Dirty linens/laundry are carried away from the body	Yes	No	NA
Dirty linens/laundry is bagged at site of use and kept off clean surfaces	Yes	No	NA

What plan of action did you put in place regarding any ~~–~~No" responses above?

Tool E. Bethel Health Care's Resident Interview Team Policies

BETHEL HEALTH CARE
MANUAL: Recreation

REVIEW RESPONSIBILITY: Nursing Director, Staff Education, Resident Interview Team

IMPLEMENTED: September 2008

LAST REVISION:

TITLE: **Resident Interview Team**

POLICY: Residents as chosen for the Resident Interview Team will participate in select interviews to assist in the hiring of staff.

PURPOSE: To encourage participation and resident perspective in the hiring of persons who will have the responsibility of providing personal care within our continuing care community.

SCOPE: Human Resources/Hiring Practices

STANDARDS: Resident s Rights,
Planetree Components: *Human Interactions, Independence, Dignity and Choice, Enhancement of Life's Journey*

GUIDELINES:

1. The Resident Interview Team is established to provide an avenue for resident input into the hiring process for individuals within our continuing care community.
2. Residents are made aware of the Resident Interview Team through newsletters, Resident Council or individual interview processes.
3. All residents with an expressed interest in the hiring of quality individuals within our continuing care community are encouraged to participate.
4. The Director of Nursing, Lead Resident Interview Team member or Staff Development will interview any resident who has expressed an interest or who may be a candidate for participation.
5. Residents have the right to decline participation at any time.
6. The Resident Interview Team will have no less than two members present at any interview.

7. The Director of Nursing or Staff Development will also be present during the interview process to assist in introduction and facilitation.

Note:

Residents who are unable to participate in the interview process but have met a student or trainee that they feel will have success at employment are encouraged to write a note or request a meeting with the Director of Nursing/Staff Development to express their thoughts and rationale for offering an employment opportunity.

PROCESS:

1. Applicants are required to write a brief summary explaining the reasons for applying for the position.

2. The Staff facilitator will read the summary to the interview team and provide a synopsis of employment history and/or any other pertinent information related to the hiring process.

3. The Staff facilitator will meet with the applicant and explain the interview process prior to meeting with the team.

4. The Staff facilitator will introduce the candidate to the team members.

5. The Staff facilitator will turn the meeting over to the residents for questions and discussion.

6. The Staff facilitator will conclude the interview and excuse the candidate.

7. The candidate will be informed of the next steps as performed by the Human Resource Department.

8. A Behavioral Observation Sheet will be completed at the conclusion of the interview process. The Staff facilitator will solicit feedback from the residents related to observations and discussions.

9. Each resident will be canvassed as to employment status or recommendations.

10. Residents have the right to request a second interview, recommend a _Shadow' day, additional educational processes, specific placement within the community or declination for hire.

11. Residents who do not wish to participate on the Resident Interview Team may participate in the "Secret Shopper Program."

12. Resident Interview Team members and Secret Shoppers may request to be part of the training and/or orientation process for new hires.

Secret Shopper Program:

1. Interested residents are identified only to the Director of Nursing.

2. Residents have the right to rate the performance of care givers and make recommendations for continued education and/or other improvement processes to ensure quality care.

3. Identity of the resident remains confidential at all times.

4. Recommendations are made to the Director of Nursing via a method of communication that is most comfortable to the resident.

5. Recommendations are considered and a plan to address them is put into place. The resident is informed of the plan for further feedback if indicated.

6. The Secret Shopper's identity will only be made public per the residents request.

Personnel Responsible: Director of Nursing, Resident Interview Team, Staff Educator

Tool F. Sample Evergreen Retirement Community Job Description

Resident Assistant – Health Center Job Description

Job Title
Resident Assistant – Health Center

Department
Resident Services

Supervision
Supervised by Unit Nurse
Accountable to Unit Manager

Pay Classification
Hourly; Non-exempt; Full-time, Part-time, Casual Call, Overtime as authorized by Manager

Work Hours
Designated by schedule, including weekends and holidays.

Job Summary
Provide physical and psychological care for Health Center residents. Perform clinical procedures commensurate with training. Document all care provided in accordance with policies and procedures, and each resident's individualized plan of care.

Job Dimensions
1. ERC Mission, Values, & Vision; Strategy & Strategic Programs
2. ERC Employee Handbook
3. ERC Safety Plan & Procedures
4. ERC Resident Rights & Responsibilities
5. ERC Operational Policies & Procedures
6. ERC Annual Operating Budget
7. ERC CQI Model
8. Federal, State, & Local regulations

Key Result Areas
1. Planning
2. Resources
3. Customer Satisfaction
4. Regulatory Compliance
5. Reporting/Documentation
6. Departmental Operation
7. Community Image

Essential Job Functions
1. **Planning**
   A. Prioritize and schedule workload to ensure timely completion. **
   B. Plan time off from work in advance, ensuring that essential responsibilities are covered. **
   C. Accept assignment per schedule, read report book, and discuss with unit nurse specific instructions for care.
   D. Accept responsibility for care of the assigned residents, documenting residents care information per department policy.

2. **Resources**
    A. Use and maintain equipment and supplies appropriately. **
    B. Utilize resources from seminars/inservices to enhance service provided to residents, families, and/or staff.**
    C. Work as a team member to meet customer needs. **
    D. Work within scheduled work hours. **
    E. Adjust meal/breaktimes (if applicable) around workload. **
    F. Report to work according to schedule. **
    G. Ensure continuation of adequate supply of individual resident care items, i.e., gloves, soap, utensils, etc.
    H. Assist with orientation of new staff as needed.

3. **Customer Satisfaction**
    A. Respond promptly to communications and follow through on commitments made to residents, families, visitors, and employees in a timely manner without additional requests. **
    B. Show courtesy and respect to all customers in both word and action. **
    C. Listen openly to the ideas of others. **
    D. Take prompt corrective action when areas for improvement are identified by supervisor. **
    E. Respond calmly and tactfully to problem situations. **
    F. Discuss concerns in a constructive manner with persons who need to be involved. **
    G. Actively identify improvement opportunities and offer solutions.**
    H. Encourage residents to be as independent as able in activities of daily living.
    I. Assure resident needs are met in a timely manner (i.e., call lights, personal requests, ADLs, etc.)
    J. Assist with admission, greeting residents and helping them settle in their room.
    K. Assist with discharge, helping residents to pack personal belongings and preparing room for housekeeping.

4. **Regulatory Compliance**
    A. Understands unit safety procedures and responds appropriately. **
    B. Attend mandatory inservices or complete make-up sessions on time. **
    C. Comply with all federal, state, and local regulations. **
    D. Use proper infection control/standard precaution procedures. **
    E. Comply with State Nurse Aide registry guidelines, including completion of required annual continuing education.
    F. Share written and oral information about residents and staff only with persons who ~~"n~~need to know", maintaining confidentiality. **

5. **Reporting/Documentation**
    A. Complete PPR checklist for annual performance evaluation with supervisor in a timely manner. **
    B. Report resident and/or personal injuries per policy. **
    C. Report to supervisor any abuse, neglect, or misappropriation of property per facility policy.**
    D. Report any reasonably suspected or known violation of a legal requirement, ERC standard of conduct or policy/procedure, or violation of privacy and confidentiality of the medical record.**
    E. Promptly inform unit nurse of a change in resident's condition and/or needs which requires licensed intervention.
    F. Share pertinent information with oncoming shift.
    G. Chart pertinent information in the resident's medical record as directed by department policies and procedures, maintaining confidentiality and objectivity at all times.
    H. Clarify with unit nurse any questions related to resident care cards or care plans.

6. **Operations**
    A. Attend 75% of all department/unit meetings. **
    B. Participates as a team member on a project team, standing team, process improvement event, and/or Wellspring team.**
    C. Use telephone systems in a professional and appropriate manner.**
    D. Meet PPR performance objectives.**
    E. Meet PPR education objectives.**
    F. Follow ERC policies, procedures, and protocols.**
    G. Use care cards in completing resident care throughout each shift.
    H. Transfer and ambulate residents using appropriate methods and body mechanics.
    I. Assist residents with personal hygiene, grooming, bathing, dining and any other physical treatment assigned within scope of training and experience.
    J. Perform household tasks as assigned, including but not limited to: completing food service tasks, laundry, etc.
    K. Encourage residents to participate in scheduled activities or take initiative to provide residents with activities and assist with activities and transfers.
    L. Accept responsibility to keep resident rooms and unit neat and clean.
    M. Carry out restorative nursing interventions for residents as outlined by the resident care plan.
    N. Obtain weights and vital signs as assigned.
    O. Compassionately assist with end of life care.
    P. Complete assigned unit duties (i.e., tasks on duty calendars).
    Q. Completes quality audits as assigned. **
    R. Other duties as needed for facility operations. **

7. **Community Image**
    A. Follow ERC dress code/personal hygiene policy. **
    B. Keep work areas neat, clean, and orderly. **
    C. Maintain professionalism in dealing with all customers. **

D. Positively promote Evergreen and its mission in the community. **

** designates a standard item that should be included in all job descriptions.

Marginal Job Functions

Other duties as assigned within scope of training.

Physical Demands

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential job functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is frequently required to stand, walk, stoop, twist, bend, squat, kneel, crouch and reach with hands and arms. The employee is occasionally required to sit, climb or balance, taste and smell. The employee must frequently lift and/or move up to 50 pounds and occasionally lift and/or move more than 50 pounds.

Work Environment

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is frequently exposed to health hazards, uncomfortable temperatures and odors.

Job Standards

1. Valid state nursing assistant certification.
2. High school diploma or equivalency or currently enrolled.

I have received and understand the above job description and will perform the essential job functions.

_____ _____ _____ _____

Employee Signature Date Supervisor Signature Date

Tool G. Sample Peer Evaluation from St. John's Lutheran Ministries

Evaluation Template 2010

Welcome to my peer evaluation. Please take a few moments to complete this survey to help me understand how I can better serve our mission. Help me understand what I do well and how that can be maximized. At the same time...where is it that I need to improve? Your time and effort is appreciated. Comments will be kept confidential as to the source, however all comments will be shared with me. I appreciate your thoughtful responses. Please complete the survey by _____.

Thanks,

MISSION QUALITIES

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unable to Evaluate
Reflects our mission and values in their personal actions	◯	◯	◯	◯	◯	◯
Takes joy in serving others	◯	◯	◯	◯	◯	◯

Comments

LEADERSHIP

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unable to Evaluate
Clearly anticipates or identifies problems and opportunities	◯	◯	◯	◯	◯	◯
Develops solutions through strategic thinking	◯	◯	◯	◯	◯	◯
Leads by setting a positive example	◯	◯	◯	◯	◯	◯
Makes decisions in a timely manner	◯	◯	◯	◯	◯	◯
Is approachable and available	◯	◯	◯	◯	◯	◯
Is honest, truthful and trusted by others	◯	◯	◯	◯	◯	◯

Comments

Evaluation Template 2010

COMMUNICATION

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unable to Evaluate
Communicates needed information clearly	◯	◯	◯	◯	◯	◯
Communicates needed information timely	◯	◯	◯	◯	◯	◯
Empowers and involves staff members in facilitating change	◯	◯	◯	◯	◯	◯
Is sensitive and supportive to other departments	◯	◯	◯	◯	◯	◯
Listens with genuine interest	◯	◯	◯	◯	◯	◯
Encourages the free expression of opinions without being defensive	◯	◯	◯	◯	◯	◯
Can influence others to embrace a position; persuasive	◯	◯	◯	◯	◯	◯
Can respond to challenges raised by others in a tactful positive manner	◯	◯	◯	◯	◯	◯

Comments

TEAM COMMITMENT

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unable to Evaluate
Is a good team member	◯	◯	◯	◯	◯	◯
Embraces diversity in people and ideas	◯	◯	◯	◯	◯	◯
Accepts responsibility and fulfills team commitments	◯	◯	◯	◯	◯	◯

Comments

Evaluation Template 2010

COMPETENCY

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unable to Evaluate
Possesses necessary job knowledge or skills	◯	◯	◯	◯	◯	◯
Is effective and gets results	◯	◯	◯	◯	◯	◯
Functions effectively under pressure	◯	◯	◯	◯	◯	◯
Invests the time and effort	◯	◯	◯	◯	◯	◯
Demonstrates good judgment	◯	◯	◯	◯	◯	◯

Comments

STOP (these things that are hindering my effectiveness and performance)

START (focusing on these expectations that will help improve my effectiveness and performance)

CONTINUE (to exhibit these strengths that are encouraged and appreciated)

Tool H. Saint Elizabeth Community's Mentor Program

The Mentoring Program

New Hire: _____ **Mentor:** _____

A new employee's orientation is greatly enhanced by setting up a mentor for the employee. A mentor is not a substitute for the supervisor, but is someone who can answer the new employee's questions about the work environment and the workplace culture in a positive and encouraging way. Everyone remembers how difficult the first few weeks on a new job can be. The use of a mentor can supplement the team of managers, supervisors, and colleagues who work towards a common goal: ensuring that new employees feel welcome and have the resources to find any answers they need.

Preferred Qualities of a Mentor

A successful mentor will meet many of the following criteria:

- Has volunteered to be a buddy and will be available to the employee
- Can be given the time to be accessible to the employee
- Holds a job similar to that of the new employee
- Possesses a full understanding of the work environment (minimum length of service of six months or a year)
- Has a good performance record
- Enjoys working for the agency/department/work unit
- Is proud of the organization and enjoys his/her job
- Is well regarded by peers
- Has good communication and interpersonal skills
- Has patience and is empathetic
- Is trustworthy
- Exhibits a positive attitude
- Possesses a strong sense of confidentiality

The Role of a Mentor

A mentor's responsibilities include:

- Providing as much clear and concise information as possible to help the new employee feel comfortable in their work environment
- Being a resource on work rules, workplace culture and norms, and unwritten policies and procedures.
- Helping socialize the new employee with peers and joining them for at least one lunch within the first two weeks of the employee's hire date
- Identifying resources in the workplace
- Being available to answer questions
- Reporting any serious issues/concerns to HR or manager/supervisor
- Instilling a sense of belonging

The Role of the EE‘s Supervisor

A Supervisor‘s responsibilities towards the program include:

- Time allowance for mentorship
- Department meal compensation for the first and second employee and buddy meeting
- Support the employee with questions or concerns relating to the buddy program
- Notifying HR with any issues of concern relating to the employee, mentor, or the program/process
- To assign a mentor if there are no volunteers by the date of hire

Tips for Mentor‘s

- *You don't need to be an ―expert.” Your personal work experience is important to new employees.*
- It takes time to develop a relationship. Don‘t try to cover everything right away. Growth occurs over time.
- Don‘t try to force a relationship. Follow the lead of the new employee if he is receptive to being mentored by you.
- Accept that a new employee has his own perspective and work style that may be different than yours.
- Try to be an active listener.
- Keep a good attitude and stay in a teaching spirit.

Mentor Benefits

- Contribute to your team.
- Share accumulated knowledge and experience.
- Gain a better understanding of yourself through helping others.
- Maintain or create a fresh perspective.
- Develop leadership qualities.
- Make new friends in the workplace!

I have read and understand my responsibility pertaining to the mentoring system and will comply with the guidelines set forth through this document.

Mentor‘s Signature: _____ Date: _____

Supervisor‘s signature: _____

Tool I. Fairacres Manor's Lead CNA Values and Commitment Statement

LEAD CNA VALUES

1. RELIABILITY –
2. COMMUNICATION – ABLE TO SPEAK FREELY WITHOUT TAKING OFFENSE.
3. TRUST – CONFIDENTIALITY
4. DEPENDABILITY
5. RESPECT –LISTEN, NOT JUST TALK
6. TEAMWORK
7. PRIDE – IN SELF AND EACH OTHER.
8. ACCOUNTABLE
9. COMMITTED
10. WILLING TO GROW
11. RESPONSIBLE
12. DISCIPLINE WITHIN OURSELVES
13. MANNERS - POLITENESS

VISION STATEMENT

CREATE A HOME WHERE ELDERS CHOOSE TO LIVE.

SIGNATURE_____

Tool J. Paraprofessional Healthcare Institute's Listening Blocks Exercise

Handout 19: Listening Blocks
Module 4: Activity 4.3
MASTER FOR PHOTOCOPYING

19

PAGE 1 OF 4

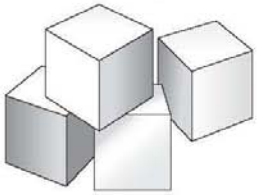
Listening Blocks

This activity is based on a discussion of listening blocks in: McKay, Davis, and Fanning. *Messages: The Communication Skills Book* (2nd edition). Oakland, CA: New Harbinger Publications, 1995.

Listening is the most fundamental communication skill in coaching, but doing it well is very difficult. Listening fully and actively takes an enormous amount of energy and effort, which we do not often have. Because we know it is important for communication and relationships, most of us have developed very effective ways to look like we are listening when we really aren't. This is called *pseudo-listening.*

But what happens, where do our minds go, when we start to pseudo listen? What BLOCKS us from listening with our full attention?

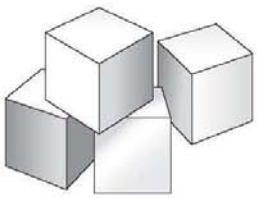
Below you will find the *most common* BLOCKS that prevent us from listening. Everyone has BLOCKS to listening and *pseudo-listens* at times. It becomes a problem when it is important to be listening actively, for example, when we are coaching.



Rehearsing

Rehearsing is practicing (in our heads) what we are going to say while someone else is speaking. We start rehearsing when we have a point to make or something important to share.

Example: You had agreed with a co-worker to come in early today to discuss a problem and she did not show up. She eventually arrives and immediately begins telling you about her hectic morning. While she is talking, you are busy practicing your speech about how disappointed you are that she didn't show up as planned.



Mind Reading

When we mind read we are trying to figure out what the person is really thinking or feeling. Mind readers make assumptions about what people really mean. Usually these assumptions are based on history, body language, and other non-verbal cues.

Example: During your monthly staff meeting you notice that the person giving the report sounds unusually depressed and you assume that she hates her job and is ready to quit.

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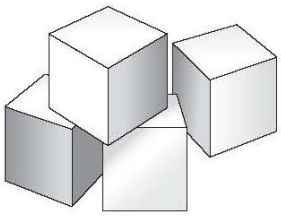
Handout 19: Listening Blocks
Module 4: Activity 4.3
MASTER FOR PHOTOCOPYING

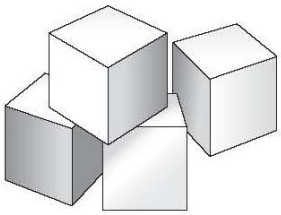
19



Filtering*

Filtering is listening to some things, but not the whole story. We pay enough attention only to hear what we feel we need to hear. Sometimes people filter to avoid hearing certain unpleasant, negative, or critical things, or things that they don't find particularly interesting.

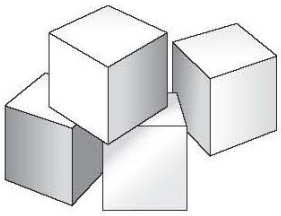
Example: A co-worker, who is known for giving you the upside of everything before telling you what went wrong, approaches you at work. You pseudo listen in the beginning until you hear the words "so the problem is…"



Dreaming*

Dreaming is also commonly referred to as "daydreaming." Usually we are listening and something the person says or does triggers a chain of private thoughts. We are prone to dreaming when we are bored or anxious.

You start thinking about your weekend plans when your colleague starts to bore you by talking about the marathon of TV shows she watched last weekend.



Identifying*

This happens when something a person says reminds us of our own experience and we stop listening and start thinking about what happened to us. Oftentimes we will interrupt the conversation to talk about our own experience. Identifying may also trigger a "too close to the bone" response and listening may become very difficult because the subject matter is too emotionally charged.

Example: Over dinner, when your friend starts sharing how miserable her day was, you immediately begin to think about how miserable yours was as well. You may even interrupt to share what a terrible day you had, totally taking the focus off her.

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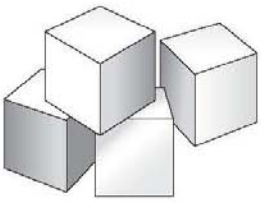
Handout 19: Listening Blocks
Module 4: Activity 4.3
MASTER FOR PHOTOCOPYING

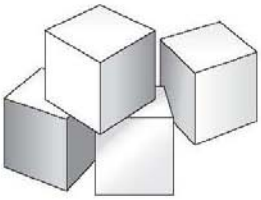
19



Advising

Before the person talking has really gotten to what is troubling them, we jump in with suggestions about how to solve the problem. Instead of listening fully, we are thinking about what to do to fix the problem, what advice to give, or what suggestions to make.

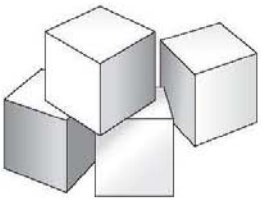
Example: You are in a bad mood and just don't feel like talking. Your sister calls and starts talking incessantly about how her husband won't help with the housekeeping. Instead of listening to the full story, you start advising by suggesting things she can do to get him to help.



Sparring

Sparring means being very quick to interrupt and/or disagree. It often happens when we have strong opinions on a subject. When we stop listening and begin sparring, the situation becomes emotionally charged. One sub-type of sparring is the *put-down*. This happens when we use a sarcastic remark to dismiss another person's point of view. Another sub-type is *discounting*, meaning we quickly dismiss a compliment or positive feedback by running ourselves down.

Example (discounting sub-type): You've just finished knitting a sweater and decide to give it to your niece who says, "This is beautiful, you have a lot of talent!" You spar back and say, "It's nothing; anyone can knit if they just try."



Placating

When we placate, we are nice, pleasant and supportive, but we aren't really listening to what is being shared. Generally, we agree with what is being said without really taking it in. In this mode we may be *patronizing*. It is a block often used with children, people with disabilities, and elders. Often we placate when we don't have the time or energy to listen fully or don't have an "answer" to the person's problem.

—continued, next page

Handout 19: Listening Blocks
Module 4: Activity 4.3
MASTER FOR PHOTOCOPYING

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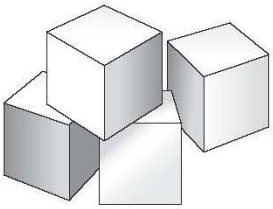
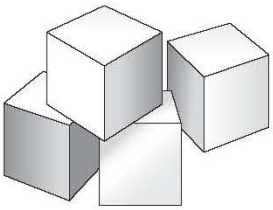
Example: You've just finished your work for the day and are about to leave when you receive a phone call from a family member complaining about the selection of food. You say, "Everything is going to be okay, Mrs. Forrester. We'll see what we can do. Don't worry about it."



Comparing

When we compare, we have a hard time listening because we're trying to see who is smarter, more caring, more competent, etc.—ourselves or the person speaking. We can't let much in because we're trying to see if we measure up.

Example: A co-worker is complaining about how much work she has to do, and you just can't listen and hear her because you're thinking, "I work twice as hard as she does!"



Judging

When we judge, we dismiss someone based on who that person is, what he or she represents or says. At that point, we aren't really listening; we are having a "knee-jerk" reaction.

Example: A new employee comes into your midst and starts finding new and different ways of conducting everyday functions. You dismiss this person's ideas because of their brief tenure and lack of knowledge about the organization's culture.

What three blocks to listening do you most commonly use?

What strategies can you use to: 1) become aware of when your listening is blocked, and 2) return to listening fully?

Tool K. Fairacres Manor's Steps to Resolving Conflict

Active Kindness: Creating a Caring Community

Steps to Resolving Conflict

1. Do some cooling off.
If at all possible, bring your emotions down to manageable proportions before starting. Intense emotion interferes with logical thinking.

2. Decide who will participate.
Besides the people involved, you may want to include a support person for each side or a trained conflict mediator.

3. Agree to the ground rules.
Location and time should feel safe and appropriate for all parties. No yelling, name-calling, interrupting, or physical contact.

4. Listen to the issues.
Each side talks for a set time without interruption.

5. Repeat back what you heard.
Each side repeats back what the other said until each is satisfied that they have been heard.

6. Brainstorm possible solutions.
Brainstorming means no judgment or criticism; list and consider all ideas.

7. Pick a solution(s) to try.
Both sides have to agree to the solution; either side can veto. Each side may have to give up a little of what they want, i.e., compromise. More than one solution can be chosen if that's the best way to resolve the issue.

8. Do it.
Give the solution a fair try. This may take hours, days or weeks.

9. Evaluate.
Get together once more and talk about how things are going. Pick another solution to try if needed.

Tool L. St. John's Lutheran Ministries Recognition Brochure

Safety and Wellness Committee

St. John's Safety and Wellness Committee is dedicated to helping Employees lead healthy lives along with working safe, which the Safety and Wellness Committee agree goes hand in hand. The Committee comes up with different give-a-ways every quarter to help incentivize Safe and Healthy habits. There is also a daily drawing of all active Employees for a $25 gift card every day that St. John's Employees work safe. Names and the number of days worked without injuries are emailed to those who have St. John's email, and posted at Employee Lounges and at Reception Desks around campus. If your name is drawn, you will need to go to the Lillis Center to pick up your gift card, in which there are a variety of gift cards to choose from! Your name is automatically entered into the drawing as of your date of hire. Check to see if your name has been drawn in the Daily Drawing!

DID YOU KNOW?

St. John's has many ways to recognize their Employees!

Employee Recognition Committee

The St. John's Employee Recognition Committee oversees events like the Annual Employee Pancake Breakfast and the Annual Employee Christmas Party.

- The Annual Employee Pancake Breakfast is held on a Saturday at the end of Spring. All Employees are welcome to attend and bring their families. There are always fun things given away at this event including gift bags for any children that have come to enjoy.

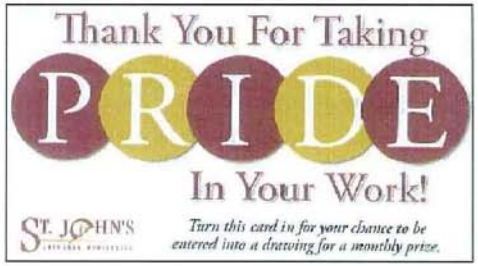
- The Annual Employee Christmas Party is usually held around the middle of December. This is a time that Employees only will gather at the Alberta Bair Conference Room to enjoy a wonderful feast catered by our own Nutrition Services Department. This event is held throughout the day at certain times to ensure that all Employees no matter what shift they work, can enjoy this meal. It is a special time for all staff to celebrate the holidays.

The Employee Recognition Committee has also held events like a Mardi Gras Parade, Beach Day, fun give-a-ways for Employees and much much more! Watch for any special upcoming announcements of fun events happening at St. John's for their Employees!

Hands & Heart of Jesus Award

The Hands & Heart of Jesus Award is awarded to 3 Employees every quarter. The Employees who are awarded this honor have been nominated by a fellow Employee, Supervisor, Resident or family member of a Resident. This is a very special award in which the winner is showered with gifts including a $50.00 gift certificate to the Rex along with their picture and nomination displayed at the East Entrance. The Employees and C.E.O. of St. John's gather to honor these special Employees once every quarter. If you find that you would like to nominate a fellow Employee, who is someone who goes above and beyond each and every day, you will find nomination forms in the East Entrance, the Employee Lounge and in Human Resources. You can fill out the form and return that to Human Resources.

P.R.I.D.E. Cards



St. John's has put together a P.R.I.D.E. Committee. This Committee is designed for staff recognition as well as staff retention. From this Committee came the P.R.I.D.E. Cards. You will see these cards located at every Nurse's station, in the Employee Lounges, and in every Department. The purpose of the P.R.I.D.E. Card is to recognize your fellow Employee on a job well done. Employees can receive P.R.I.D.E. Cards from fellow Employees, Supervisors, Residents and family members of the Residents. If you find that you would like to give a fellow Employee a P.R.I.D.E. Card, feel free to pick one up and fill it out. You can give the card directly to the Employee or to the Employee's Supervisor. If you are the recipient of a P.R.I.D.E. Card, be sure to put your card in the drop box located next to the cards. Every month the P.R.I.D.E. Committee will collect and draw 3 names from all of the boxes located around campus for a $50 gift certificate to some place special. The gift certificates are different every month!

Tool M. Saint Elizabeth Community's Merit Gram Form

Saint Elizabeth Community
Just like family

Celebrating 125 Years (1882-2007) ~ Caring Through the Ages

Merit Gram

***required field**

If you wish to say thank you to a member of our staff we encourage you to fill out this merit-gram and e-mail it to us. The employee will receive a copy of the merit-gram and another will be placed in his or her personal file.

I would like you to know about the good work being done by:

name of staff member:*

residence name:* [Saint Elizabeth \/]

department: [ ]

Who deserves special recognition because:

Sincerely, [ ]

email: [ ]

[Submit Form]

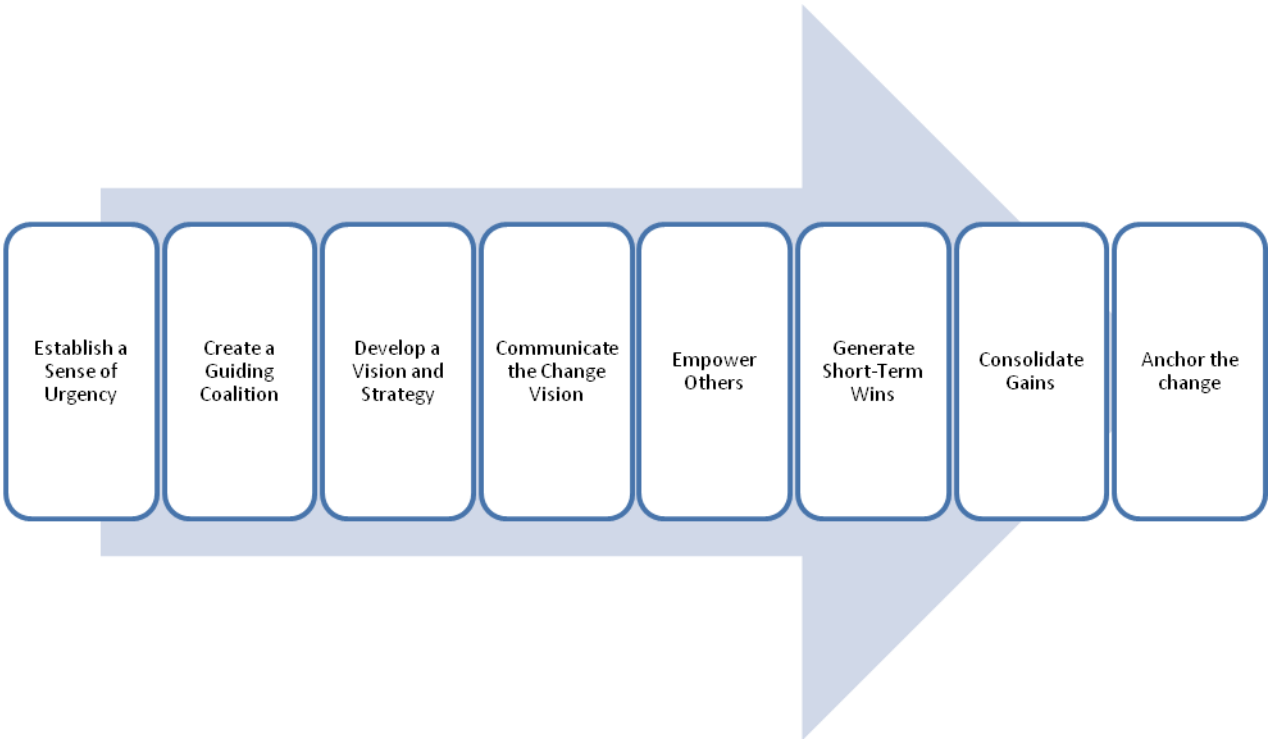
Tool N. Sample Dashboard from Southington Care Center

HUMAN INTERACTIONS	Threshold	Responsible person	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD avg
# retreat attendees															
Employee satisfaction survey/#															
# employees with perfect attendance															
Employee turnover ratio															
Enhancement of Life's journeys	Threshold	Responsible person	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD avg
# life stories completed															
# resident volunteers															
#employee volunteers															
Community rituals															
Independence, Dignity and Choice	Threshold	Responsible person	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD avg
# decline in mob/ADL															
# falls															
# pressure ulcers															
# interdisciplinary participating in RCC															
# residents at RCC															
5 Star rating															
Friends, Family and Social Support	Threshold	Responsible person	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD avg
# participants at Family Council															
# care partners															
# community events at center															
# volunteers for 1:1															
# participants at memorial services															
# volunteers as ambassadors															
Paths to Well-being	Threshold	Responsible person	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD avg
# Music Therapy															
# Massage Therapy															
# Pet Therapy															
# Aromatherapy															
# Therapeutic Touch															
# LTC in GLF															
# Employees at YMCA or GLF															
# Employees in Weight coach															
# Employees in Walking club															
# Employee lost work days due to injury															

Empowerment through information and education	Threshold	Responsible person	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD avg
# communication meetings with employees															
# monthly newsletters distributed															
# suggestions/bright ideas															
# community outreach events & participants															
# occupancy-avg															
# private pay															
# medicaid															
# medicare/managed															
# outpatient referrals															
# GLF starts															
# referrals from outreach															
# referrals from marketing															
# end of life care															
Activities and Entertainment	Threshold	Responsible person	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD avg
# programs with resident and staff involvement															
# residents receiving friendly visits from volunteers															
Themed dinners															
Nutritional and Nurturing Aspects of Food	Threshold	Responsible person	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD avg
Short-term Satisfaction survey for dining															
Long-term satisfaction for dining															
# calls to kitchen for items															
Dining audit/tray accuracy scores															
Weight loss %															
Food supplement cost															
# residents receiving supplements															
# residents on high protein drink															

Environment Conducive to Quality Living	Threshold	Responsible person	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD avg
# activities in outside areas															
$ raised for capital campaign for gardens project															
# noise complaints															
# findings on envt audits															
# resident A/Is due to envt issues															
Spirituality	Threshold	Responsible person	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD avg
# reflections programs															
# spiritual services															
# attending services															
# bible study programs															
# blessing of hands/participants															
# end of life/TP															
# memorialized at service															
# participants at service															
% of people with reflections at mem. service															

A Final Word on Process



In the following section of this Guide, you will find a compendium of resident-directed, relationship-centered practices. The process illustrated here is the adhesive that connects all of these practices together to create the promise of viable change. On their own, none of the practices that follow equate to "doing" culture change. To have any significant and sustained impact, any practice gleaned from these pages must be implemented as part of a long-term, comprehensive vision for change embraced by the entire community. They must be accompanied by transformation of the organizational structure, environment and workforce empowerment. Trusting the common vision and the inclusive strategy for realizing it to guide the community—even during challenging times of staffing shortages, low census and economic difficulties—is a shift in mindset for many. However, for those accustomed to quick fixes and flavor of the month initiatives that invariably fail to make a real impact, this focus on process will clearly differentiate this change effort from all previous endeavors. The process itself is the crux of the change. It has the power to unleash a swell of passion, enthusiasm and activity within your community that will go far beyond the launch of the next promising, but isolated, initiative. Indeed, with time, patience and ongoing attention, it could result in sweeping changes with far-reaching effects that will be felt for years to come by your residents, their families and staff.

INDIVIDUAL AND COMMUNITY LIFE

—We should not separate out residents and staff because it all works out best when it is aligned…A bad experience for residents is a bad experience for staff."
(2.25.10 Long-Term Care Leadership Roundtable)

Long-term care communities are characterized both by the unique individuals who inhabit them and by the relationships and interactions among these individuals. To examine the lives of residents in isolation from the experiences of staff (and vice versa) is a limited view of a community. When residents and staff alike are honored as individuals and given opportunities to contribute in a meaningful way to the life of the long-term care community, the community as a whole is richer. Honoring residents as individuals entails understanding their personal rhythms, routines and preferences and then supporting resident decision-making in all aspects of their lives. This must be accompanied by a system-level approach for engaging all staff in the creative process of individualizing support and services for each resident. This section is also about the long-term care community as a living, evolving entity. People come and go, they experience changes in their physical and psychosocial state, they build relationships that change over time, they fulfill dreams and establish new ones. Here we examine strategies for supporting full, rewarding and productive living on an individual and collective basis in these unique settings.

Shifting to a Resident-Directed Approach

Supporting residents in preserving their personal routines, making decisions about how their day unfolds and maintaining control and autonomy in their lives is fundamental to a less institutional experience across the long-term care continuum. Routines once scheduled around institutional routines are re-visited to first and foremost accommodate the patterns of a resident. Rigid, siloed staffing patterns become more flexible and fluid to maximize opportunities for teamwork, productivity and, ultimately, the ability to serve the resident. Finally, expectations around the primary responsibilities of staff are re-aligned to prioritize relationship-building over a task list.

Systems for Getting to Know Residents

A shift of this magnitude necessitates more than a philosophical commitment and good intentions. It requires a system and team process for evaluating and identifying what is important and meaningful to each resident in their living environment and in daily activities.

The Preference for Everyday Living Inventory (PELI)
This assessment tool, developed by the Polisher Research Institute, is designed to ascertain residents' psychosocial preferences for everyday living related to such aspects of life as the amount and type of social contact, leisure activities and more. Ideally, such a tool is not completed only on move-in, but on occasions throughout the resident's experience to capture and document the evolution of how a resident wants to live his/her life. The tool is available on-line at **www.abramsoncenter.org/pri/documents/PELIQuestionnaire.pdf.**

Care Cards
Collecting information about individual residents' personal routines and preferences is an early step toward shifting to a resident-directed approach. However, mere collection of this information is in vain without effective processes for sharing details with those who work most closely with the resident. At Evergreen Retirement Community in Oshkosh, Wisconsin, Care Cards documenting the residents' preferences related to activities of daily living are completed on admission and distributed to all direct care workers as a readily-available reference.

All About Me Form
At Brewster Village in Appleton, Wisconsin, the collection of this information in its All About Me Form is the foundation for a partnership between a resident and CNA. Completed within 24 hours of a resident moving in, the form is based on a CNA's interview with the resident about their requests and routines. The information collected is entered into the resident care summary, which is kept in the resident's room.

See a sample All About Me Form from Brewster Village, page 157.

Preference Collage
A Preference Collage**,** such as those at Landis Homes Retirement Community in Lititz, Pennsylvania, is a visual representation of a resident's likes and preferences. Creation of the collage is a collaborative activity between the resident, family and staff. Completed shortly after the resident moves in (ideally on move-in day), its creation can be the foundation for building a relationship between the resident, family and staff, as well as providing family members a meaningful way of imparting important information about their loved ones.

Life Stories: Who Are You *Really?*

> *"I think the life stories are a great idea on the wall. I learned things about residents that I didn't know. And they love it. It helps the staff to know them better… It helps to treat them better."*(Nursing Home Staff)

Looking beyond daily routines and preferences, a Life Stories program (sometimes called Life Biographies or Life Histories) is a way to honor the history and life experiences of a resident, deepen others' understanding of the people, places, things and memories that are important to them, and explore their personal aspirations. Residents, staff, and family can be engaged in collecting and compiling this information.

Volunteers can also be a wonderful resource for completing this important work. At Wesley Village in Shelton, Connecticut, specially trained volunteers interview residents, capture their life histories and write them up in the first person.

The Life Biography program at Maimonides Geriatric Centre in Montreal includes a multimedia Power Point presentation about the resident, including pictures, family history and sometimes even music. Created in partnership with family members, the presentation is shown to staff to deepen their understanding of the resident, and is also provided to the family.

Re-printed with permission from Maimonides Geriatric Centre

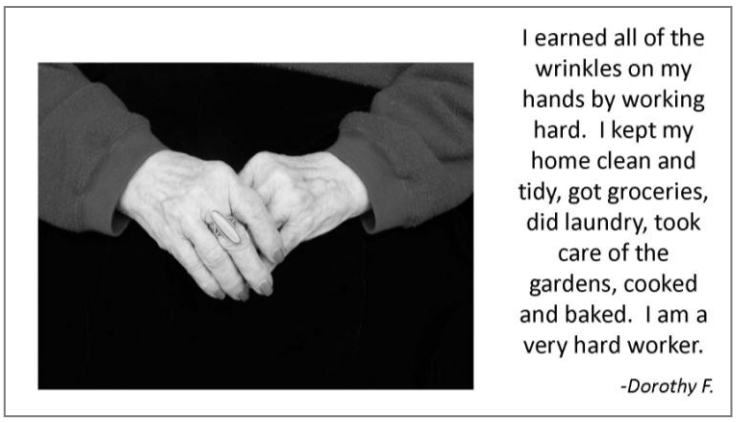
Gathering this information is just the beginning. Most important is that these personal details of each resident's life and history are broadly shared to deepen everyone's understanding of *who they are really*. At Holbrook Health Center at Piper Shores in Scarborough, Maine, residents' Life Stories are gathered into a laminated book that is kept in the resident's room for easy access by staff, family and others (with the resident's permission). In addition, the information is incorporated into the care plan. Other approaches are to read the completed life stories aloud at community meetings or maintain a collection of residents' written up life stories in a book, a copy of which is available in every living and work area.

See Maimonides Geriatric Centre's Life History Questionnaire, page 159.

ADDITIONAL RESOURCES:

LifeBio
www.lifebio.com

Hands Photographs
In a simple yet profound way, photographs of residents' hands gracing the walls of a common area at Evergreen Retirement Community convey the life stories of those who live there. The black and white photographs are captioned with a short sentence on the work of each particular resident's hands to give a glimpse into the person's history.



Re-printed with permission from Evergreen Retirement Community

Resident Videos
At Augsburg Lutheran Home and Village in Baltimore, Maryland, residents are filmed speaking about different aspects of their lives. Mobile kiosks are available on units where residents, staff and others can easily push a button to watch the videos that interest them. Topics covered include residents' careers and the challenges of living in a nursing home or assisted living community.

Staffing Approaches to Promote Familiarity and Build Relationships

"They are fairly consistent and the same people work in the wing. You see them more often and they find out what is going on in your life. They are part of your extended family." (Assisted Living Resident)

"I am now more aware of the patients and I think I am doing more with residents and interacting more than I would have. Now, on my trip to the kitchen or to get a cup of tea, I am interacting with residents, as before I would not have." (Nursing Home staff)

Consistent Care Giving
Consistent staffing assignments (also called personal, primary or permanent assignments) are defined as having the same staff members assigned to the same residents day-to-day (and night-to-night). The approach provides continuity of care and cultivates a relationship of familiarity and trust between caregivers, residents and their family members. Staff becomes more attuned to the patterns, likes, dislikes, and needs of individual residents and is consequently able to be more anticipatory and accommodating. Furthermore, given their level of familiarity, they are better positioned to notice subtle changes in a resident's behaviors and routines, which can result in improved outcomes.

Examples abound of how staff familiarity with residents has improved the resident's quality of care and quality of life. What may appear as chronic loss of appetite for staff who "know" a resident primarily through superficial interactions and progress notes, would likely be addressed with the use of nutritional supplements.

A consistent caregiver's deeper level of knowledge and understanding of the resident, however, may reveal that loss of appetite is not the issue, but rather it is the resident's refusal to eat food on a tray that had been touched. In this real-world example, the solution, then, was not nutritional supplements, but a simple process for ensuring food was placed on her tray in a way such that she was comfortable eating it. Consistent assignment is also often a staff satisfier, creating opportunities for staff to develop richer relationships with residents.

THE CASE FOR ADOPTION:
Consistent Assignment

Consistent assignment has been demonstrated to have a positive impact on resident and family satisfaction and clinical outcomes. In addition, staff attendance improves and turnover is reduced.

Source: Farrell D, Frank B, Brady C, McLaughlin M, Gray A. The case for consistent assignment. *Provider*2006 June; 47-52.

For success, a variety of factors should be considered when making consistent assignments, including existing resident-staff relationships, resident acuity and ~~"d~~degree of challenge." For empowerment, it is essential that caregivers have the opportunity to select and implement their own assignments. Involving staff in making these assignments is an important way to acknowledge the bond between residents and staff and emphasizes that everyone has a voice in the organization.

Holding consistent assignment meetings with staff several times a year allows for re-examination of assignments in light of changes in resident status and staffing. Another important part of the process is the development of communication, conflict resolution and team building skills so that caregivers are better able to support each other, especially on days where staffing may be challenged or a particular resident may be having a bad day.

Suggested Process for Implementation:

(Source: Quality Partners of Rhode Island)

1. Separate meetings are called on each nursing unit with all of the CNAs from all shifts.
2. At the meetings, the importance of consistent care giving is explained as it relates to improved quality for the residents and the quality of work life for the staff
3. Each resident's name from the unit is placed on a Post-it note. All Post-its are placed on a wall.
4. The CNAs are asked to categorize each of the residents by their ~~"d~~egree of care required" with #1 being relatively easy to care for and #5 being very complex (time-consuming and emotionally draining, for example).
5. CNAs are asked to agree on the category for each resident and write that number on the resident's post-it note.
6. CNAs are then asked to select their own assignments based on not only degree of care required, but which residents they feel most able to enhance their quality of living and continue a relationship with.
7. Assignments are evaluated to ensure that each CNA in the group has amassed the same degree-of-challenge total. For example, one #4 resident equals two #2 residents. Distribution of residents is looked at from the perspective of acuity versus number of residents one caregiver is providing care for.
8. As residents transition, assignments are re-evaluated by the team and the process begins anew.

To further assist organizations in implementing consistent assignment, the Advancing Excellence in America's Nursing Homes Campaign has created a free and user-friendly template for tracking the number of CNAs assigned to individual residents on a monthly basis. The tool can be accessed at **www.nhqualitycampaign.org/files/ConsistentAssignment.xls.**

Consistent assignment on its own promotes familiarity. It must be coupled with staff having the autonomy and authority to personalize the care experience for the residents they come to know so well. One specific way this autonomy can be realized is through self-scheduling, which further enhances staff's ability to accommodate the personal rhythms of life of the residents in their living area or household by enabling staff to schedule their work hours around residents' schedules.

Self-Scheduling
Flexible scheduling allows staff to accommodate their often hectic home life while still providing for the needs of the residents. At Brewster Village, staff has the freedom to trade days and shifts with each other. Staff members post their requests for trades and days off directly on their neighborhood or within their department on the posted schedule. In addition, float staff are scheduled to provide an extra set of hands wherever needed.

S T R E T C H GOAL

For long-term care communities that have already implemented consistent assignment of CNAs, consider applying a consistent assignment approach to dietary, housekeeping and activities staff to maximize continuity and opportunities for relationship-building in all aspects of community life.

Focus
Focus

SELF-SCHEDULING

When creating self-scheduling, the first step taken at Fairacres Manor was to discuss the budget with staff. According to Fairacres Manor's administrator, —When the staff understood what it costs to operate…what we pay in labor, utilities, and insurance, they bought in and made this change a success." They also realized that bonuses being paid to replace unreliable staff did not reward staff that consistently showed up. Together they reviewed ground rules for scheduling such as no planned overtime and set boundaries for everyone to —live by." In a very short period of time the results not only were a win for the staff, but ultimately a win for the residents.

Universal Worker and Modifications
A universal worker is cross trained to meet a wide range of a resident's needs, including potentially personal care, housekeeping, cooking and meal assistance, laundry services and activities. Such a staffing model can maximize opportunities for building relationships between residents and staff. Furthermore, it can avert a siloed approach that too often results in inefficiency and frustration on the part of residents and staff. There can be challenges, however, to such a model. When individual staff feel more comfortable in or prioritize some aspects of

their job over others, certain activities may be left at the wayside, ultimately to the detriment of the resident.

A modification to a universal worker model is to use cross-trained CNAs to meet a wide range of residents' needs, but turn to "specialists" for certain roles (for example, housekeeping or activities).

De-Centralizing Departments and Expanding Responsibility

The de-centralization of departments creates an environment where roles are blurred, allowing for the disintegration of the "not my job" and "not my resident" syndromes. Holbrook Health Center at Piper Shores has a philosophy that was first utilized to enhance the dining process and was subsequently moved to other areas as well. Staff members from all areas are expected to join in the dining experience with residents and direct care staff. Three times a week staff who have not traditionally worked directly with residents participate, within current regulatory boundaries. By focusing on possibilities instead of limitations, Piper Shores considered what aspects of the dining experience could be supported by anyone within the organization. Tasks identified included serving, cleaning tables, and assisting residents to their seats. Providing coverage for these more universal tasks allows the direct care staff to complete the tasks that only they can do in a more personal way. St. John's Lutheran Ministries in Billings, Montana conquered a potential barrier to this blurring of roles by having all of their staff ServeSafe certified, allowing them to safely deliver food items to their residents.

The blurring of lines is occurring outside of dining as well. All therapeutic recreation staff members at Brewster Village are certified as nursing assistants, enabling them to assist residents with personal care needs.

S T R E T C H
GOAL

Another method of redesigning work flow is to provide nursing assistant education and training for all staff members. This process eliminates prolonged waits for residents and often assists staff members in not feeling frustrated with having to defer to another member of the team. Fairacres Manor in Greeley, Colorado is one organization that that has offered all staff the opportunity to attend a CNA certification program. Over 80 percent of non-clinical staff, including department heads, dietary, housekeeping, and laundry personnel, are trained certified nursing assistants. While they still perform their department roles, they are cross-functional and are considered "universal workers."

Neighborhood Advocate/Team Leaders

The use of Team Leaders and Neighborhood Advocates is one way of empowering people to redesign work. Often these Team Leaders/Neighborhood Advocates assist in exploring ways to meet the individualized needs and preferences of residents through team work and time management, rather than assignment and task.

See Job Descriptions for Fairacres Manor's Neighborhood Advocates (page 163) and Team Leads (page 165).

First Responsible Nurse
This concept is prevalent in Dutch long-term care communities. As a strategy for optimizing consistency, continuity and relationship-building, the First Responsible Nurse coordinates all care and daily living activities for a resident. He/she is available to respond to family-initiated questions or requests for updates, and also establishes a regularly scheduled in-person meeting or telephone call with family for mutual sharing of information about the resident. Continuity and coordination are further enhanced with the identification of a "first responsible family member," the primary point of contact on the family side.

Life Enhancement Coach
Creating a staff position to promote and integrate improvement efforts ensures a coordinated approach organization-wide. Of course, the transformation is not the "job" of one single staff person; it is a shared responsibility. However, identifying a point person to coordinate resource development, education and training can be an important way to galvanize everyone in the organization toward a shared goal and maintain momentum over the long-run. At Saint Elizabeth Community in Rhode Island, this position is the Life Enhancement Coach. Reporting to the President and CEO and working closely with the administrators of each community, the Life Enhancement Coach provides specialized resident and staff training, implements new programs and coordinates sharing of effective practices.

See Saint Elizabeth Community's Life Enhancement Coach Job Description, page 167.

The Huddle
Staffing approaches in a resident-centered community focus not only on forging relationships between residents and staff, but also on creating a cohesive team among staff that is best able to individualize support and services for each resident. A huddle is a five minute opportunity for team members to "check-in" with one another. The huddle takes place either right before peak activity time or immediately after. The goals of the huddle are to ensure that all team members are accomplishing what they set out to do and to inquire as to any assistance team members may need. As illustrated in the *Focus on Process* box here, huddles can also be a time to address conflict in a constructive way.

Focus on Process

CONFLICT RESOLUTION

The team at Fairacres Manor in Greeley, Colorado identified a number of behaviors considered "fouls." These include name calling, rolling eyes, bringing up the past, speaking in absolutes and making excuses (to name a few.) All staff are familiarized with the unacceptable behaviors and are empowered to "cry foul" during huddles (and on other occasions) to call attention to a colleague's behavior when it is inconsistent with the values of the organization.

Personalizing Care 24/7
As simple an adjustment as **overlapping shifts by 15 minutes** is an efficient way to ensure that personalized care remains a constant, 24 hours a day, seven days a week—even during times of staff transition. Another solution to ensuring this vital communication takes place is through the

creation of a **communication board** or book that the oncoming shift can review prior to their work beginning. It is standard practice to hold brief meetings during every change of shift. Optimally they include nursing, dietary, activities and housekeeping staff. The purpose of the meeting is to quickly convey important information about residents that staff coming on to start their shift will need to know. Having the **lead CNA or team leader attend report** and be responsible for disseminating this information to their team is an effective way to facilitate continuity, coordination and personalization.

All Hands Philosophy
See page 64.

Resident-Directed Care, Support and Services

"When we meet with the team, they ask what can they do for you and no longer say, 'This is what I will do for you.'" (Short-Term Patient)

"A resident would ask, 'Why can't I have coffee in my room?' And we didn't have a good answer. The expectations of our residents changed over the years and will continue to change. We had to change too." (Nursing Home Staff)

Resident-Directed Care Plan and Living Plan
These care plans are developed collaboratively by the resident, family and staff, and reflect the priorities of the resident. The care plan is enriched when it incorporates the information gathered through the processes and tools described earlier in this section for getting to know residents on a deeper level. A resident-directed care plan reflects lifestyle and preferences as they evolve over time, as well as the resident's personal goals and aspirations—which once identified, others in the community can be enlisted to help realize. In some organizations, this change of mindset about the function of the care plan has ushered in a new term: the **Living (or Life) Plan.**

By definition, developing a resident-directed care plan requires **resident and family participation in care (and living) planning meetings**. Accordingly, planning meetings should take place at the convenience of the resident and in an environment where they are most comfortable. At Landis Homes, residents have the option of the care plan team coming to their room/apartment. Additionally, **times of these meetings should be flexible** to include evening and weekend hours for the convenience of family who may wish to participate. **Keeping the care or living plan in the resident's room/apartment**, as opposed to locked in a nursing station, emphasizes the resident as the keeper of the information and enables him/her to share it with all staff—not just clinicians. Providing opportunities for **residents to document information about themselves in the plan** reinforces the resident's authority and influence over the plan. These planning meetings should be interdisciplinary, including professional caregivers from all departments, most importantly CNAs. Given the nature of their work with the resident, their input is essential, and **CNA's active participation (beyond mere attendance) should be prioritized**.

S T R E T C H GOAL	*To further encourage the involvement of family in care and living planning, a number of organizations are evaluating how technology, such as web cams and conference calls, can be used to include family not located in the immediate geographical region.*

Implementing a Resident-Directed Approach

"I said to the aide on the weekend…'When can I get a shower?'…they took care of it right then and there. They didn't hesitate. They just did it with no permission. They are as flexible as can be." (Nursing Home Resident)

"I want a shower every day. I am working out every day and they are accommodating me just fine. I threw a glitch into the system when I came, but they were able to do it." (Short-Term Patient)

"The important part is the part of choices. When you get up in the morning and you are not pushed to do this or this. Every morning is yours to do what you want if you are able to do it." (Assisted Living Resident)

The notion of accommodating the expressed preferences of residents around what time they wake up, shower, eat and go to bed can feel anywhere from overwhelming to impossible. At numerous long-term care communities committed to re-orienting their processes around residents' priorities, however, what some may write off as unfeasible has proven to be both possible and fundamental to their transformation. This shift, however, can only happen when the staff who works most closely with residents are empowered with control over the flow of operations in their area and are supported in prioritizing relationship-building over specific tasks.

Same Work in a Different Way

The process of implementing resident-directed care activities includes the core concepts of team development explored in the Building Community section of this Guide. It also, however, includes a shift to an understanding that caregivers are not being asked to do more work, but rather, they are doing the same work in a different way. This shift of mindset must be coupled with a shift in how care is organized so that staff can be flexible and autonomous by rule rather than by exception. Teams must be guided through the process of redefining their day around the desires of residents. The team's goal at this point should be to overcome former ways of thinking that often led them to answer "no" to requests, to instead work collaboratively to answer how resident preferences and requests can be accommodated. Residents and family can contribute a great deal of value in the process of identifying "how." What is important for leaders to communicate to teams is that initially the choices may be a challenge to manage, however human beings are comfortable in patterns of behavior and over time residents will define new patterns of behavior—the key difference is that they will have chosen the new routine, not staff.

Resident-Directed Bathing
Under the traditional model for long-term care, residents' bathing routines are based on the availability of staff. In a resident-directed model, they are based on the desires of residents. Flexibility reigns, and staff are empowered to organize their day and the tasks that have to be completed around the lifestyle routines of the residents they work with.

When the team at Brewster Village moved to resident-directed bathing, it was with a fair amount of trepidation. Staff feared that by asking residents when and how often they would like to shower, they were setting themselves up to disappoint those whose personal preferences would not be able to be met. As it turned out, their worst fears were unfounded. In actuality, residents did not all want to shower at the same time. In fact, most residents opted to retain their existing shower schedule, and those who preferred a different schedule had their request accommodated. The team at Brewster Village reports that shortly after implementing the change, residents were noticeably more contented with their shower schedules.

ADDITIONAL RESOURCES:

Bathing Without A Battle
www.bathingwithoutabattle.unc.edu

Elimination of Alarms
Few things can make an environment feel (and sound) more institutional than a seemingly constant din of beeps emitted by personal alarms designed to alert caregivers to potential risks to residents. While many long-term care communities have abolished physical restraints, use of audible alarms remains prevalent. Despite their widespread use, however, there is little evidence to suggest that alarms result in fewer falls, and in fact, they can be the cause of agitation, discomfort and sleep disruption. Eliminating alarms is a powerful step toward transformation. While safety is always a paramount concern, the elimination of alarms, along with the implementation of other less intrusive ways to mitigate fall risks, is an example of negotiating "healthy risk" while prioritizing resident dignity, privacy and independence.

Focus on Process

ELIMINATION OF ALARMS

At Brewster Village, the decision to eliminate alarms was made based on current evidence and alignment with the organizational culture. Notification was promptly sent out to all stakeholders, and the elimination of alarms was realized within three months.

During that time, caregivers monitored how often alarms went off over a 72 hours period, trended the reasons for each resident and adjusted their care plans as necessary.

Before eliminating alarms, 49% of Brewster Village's "villagers" had alarms at an annual cost of $1,700 (not including batteries). Even with these alarms, the percentage of falls reached as high as 22%. Once alarms were eliminated, the falls percentage decreased to 18%.

See letter from David Rothmann, Administrator of Brewster Village, announcing elimination of alarms, page 169.

In a culture where staff get to know the natural rhythms and routines of residents and where staff are engaged in cultivating meaningful relationships with residents, the *root causes* of falls are able to be determined and anticipated, virtually eradicating the need for alarms. **Adjustments to the care plan** can be made to address the reason(s) for falls.

ADDITIONAL RESOURCES:
Eliminating Alarms, Reducing Falls
www.bandfconsultinginc.com/Site/Free_Resources/Entries/2009/7/2_Eliminating_Alarms_~_Reducing_Falls.html

In place of alarms, some resident-centered organizations have introduced **small portable motion centers** placed on the floor that emit a quiet signal directly to caregivers' pagers to alert them to motion in the resident's room/apartment. At Magnushof, Schagen, part of the Woonzorggroep Samen system in the Netherlands, **a small tabletop LED light** that can be set to glow in a range of colors is used in its psychogeriatric units. Staff works with residents and family members to identify a specific color that prompts the resident that it is nighttime and that they should stay in bed. The light then is set every night to the identified color.

Resident-Directed Medication Pass
Another opportunity to mirror the patterns, preferences and routines of residents is through a resident-directed approach to the medication pass. In this approach, the timing of medications is guided by the physician order and the resident's lifestyle. Working closely with physicians, the medical director and pharmacists, this can be accomplished by having the physician orders written up to reflect that a med should be administered ~~–u~~pon rising," ~~–w~~ith lunch," or ~~–at~~ bedtime," along with parameters for what that means, e.g. ~~–u~~pon rising"=6 a.m. to 10:00 a.m. Another important feature of the resident-directed medication pass is to work closely with all team members in identifying areas of poly-pharmacy that may be able to be reduced and opportunities for including more complementary alternatives to pain control.

A number of organizations have altered the physical environment to accommodate this philosophical shift. Gone are the oversized medication carts, replaced with locked drawers in resident rooms, medicine cabinets in resident bathrooms, and/or portable baskets that can be carried to the resident and then returned to a central location.

See sample personalized medication administration policy, page 170.

Resident-Directed Dining
See Culinary Engagement Section, page 189.

Resident-Directed Activities
Throughout life people experience pleasures in activities that are meaningful and bring a sense of joy and fulfillment. As we age, it is often more challenging to be able to access those pleasures and incorporate them into everyday life. Caregivers can act as ~~–st~~agehands" to help residents experience those things that they have previously enjoyed and in fact, might be doing if they were living at home. The process begins with knowing what pleasures have been meaningful to

residents in the past. This can be achieved using the approaches described earlier in this section (―Systems for Getting to Know Residents").

For more on resident-centered approaches to activities, see Authentic Experiences that Promote Well-Being, page 216.

Differentiating Between Right of Refusal, Choice and Negotiation

In discussing approaches for maximizing resident-direction in activities of daily living, it is important to consider what is meant by resident choice. Resident-direction means that the residents' desires and lifestyle guide his or her routines for the day. The option to take a shower at 10 a.m. or not take a shower at all is not resident-direction. This ―choice" still reflects the paradigm of supporting residents based on the routines of the organization and the established schedule of staff. In fact, this ―choice" is not a choice at all, but rather the right of refusal.

An organization working toward resident-centeredness may strive to meet individual preferences by providing residents the option between an afternoon shower and a morning shower. While a certain degree of choice has been provided here (unlike the example above), this approach still evokes for residents a sense of coercion and lack of control. Rather than accommodating the wishes of the resident and ensuring space for them to control their daily routines, the expectation set here is that they will conform to the existing rhythms of the community.

The true resident-directed approach is to ask the resident the time they would like a shower and negotiate ways to meet that need. The staff in turn must feel the permission and control to accommodate the request of the resident. Ultimately, resident and staff autonomy, along with a process of negotiation, supports a culture of partnership and co-equals.

Maximizing Independence and Personal Routines

Moving into a long-term care community―be it a skilled nursing home, assisted living community or even short-term rehab―is a significant transition in one's life. For many, the transition stirs one's worst fears about loss of control and increased dependence on others. Resident-centered communities ensure that systems are in place to maximize each resident's independence, dignity and choices in life wherever they are living.

Concierge Services
Offering easily accessible convenience services to residents who otherwise may not be able to utilize them is a meaningful way to support independence. This can be accomplished by working closely with local vendors (hair stylists, barbers, tailors, computer support, eyeglass clinic, jewelry cleaning, watch and clock repair, dry cleaning, etc.) and developing a schedule for each to be on-

site. A ―win-win" scenario, the vendors will likely be eager to expand their client base and residents will be provided with access to a variety of services that enable them to maintain many of their customary habits and routines. Success will be dependent on effective methods for communicating the vendors' visit schedule and the scope of the services they provide.

See Middlewoods of Farmington's Concierge Services Brochure, Page 172.

On-Site Services
When feasible, incorporating these services into the long-term care setting offers optimal flexibility and access for residents to get their needs met. Many organizations offer **on-site hair salons and barber shops**. **Convenience stores** where residents can purchase basic necessities, including toiletries, food items, greeting cards and more can significantly enhance residents' sense of independence. Other possibilities include on-site **health clinics**, **spas** that offer massage therapy, manicures and pedicures, as well as **restaurants, coffee shops** and **cafés** where residents can go out for a special meal. At Tiendwaert (part of Rivas Zorggroep, Gorinchem in the Netherlands), a large community room is transformed into an upscale restaurant once a month. The table settings, centerpieces, and menu are all changed, and residents and family alike look forward to the opportunity for a special meal out.

Transportation
Expanding access to transportation for residents to get their personal needs met off of the campus is also essential for maximizing independence. At Wesley Village and Fairacres Manor, transportation is available to residents seven days a week. To achieve this, staff from a variety of departments have been approved and trained as drivers.

Maximizing Independence and Personal Routines for Short-Term Rehab Patients
For short-term rehab patients, efforts to maintain their daily routines and to facilitate their continued involvement in their pre-rehab lives can be particularly meaningful. Concierge services can be expanded to assist patients in maintaining their lives outside of the rehab setting. At Victoria Special Care Center in El Cajon, California, short-term rehab patients are supported through **concierge services that include lawn cutting, housecleaning** and **pet sitting**. Evergreen Retirement Community offers access to a **business center**, complete with computers, printers, a fax machine and Internet access. The availability of **Skype Kits** and **Wi-Fi** further enhances patients' ability to stay connected for the duration of their rehabilitation.

Care Partners
There is no better way to preserve the familiarity of everyday life than to involve loved ones who have long been the resident's support system. A care partner program offers opportunities for residents' loved ones—those who likely know the resident best and who may have been supporting the resident in a variety of aspects of life before he/she moved into the community— to maintain *their* routines. The goal of a care partner program is to meet residents' personal, emotional, spiritual, physical and psychosocial needs by encouraging his or her support system to be actively involved in his/her care and life, while at all times, respecting the resident's sense of dignity and independence and being mindful of the care partner's comfort-level. The care partner is invited to perform activities and responsibilities mutually agreed upon with the resident and

staff. They may range from serving as the spokesperson to family and friends about the resident's progress and keeping track of personal items to providing personal care, managing comfort, and supporting the patient/resident in mobility and participating in activities. For short-term patients, such a program can be particularly effective for easing the transition from rehab to home.

See Care Partner Guidelines from Bishop Wicke Health Center, page 174.

Can All Risk Be Eliminated?

Living authentically not only involves choice, it also inherently involves occasional risk. For some residents, going out for a walk may result in a fall, but to eliminate the opportunity for a resident to take walks out of fear of what may (or may not) result not only eliminates the risk of a fall, it also eliminates an important, authentic experience in the life of the individual. This concept of redressing the balance of risk and reward must inform improvement efforts. In long-term care communities that prioritize relationships and preserving residents' independence and dignity, residents have greater control in determining the amount of risk they are prepared to assume. When a resident makes a choice that poses a safety or health risk, staff educates him/her about the potential implications of that choice, and works with the resident to negotiate a mutually agreeable approach for meeting the resident's needs or desires.

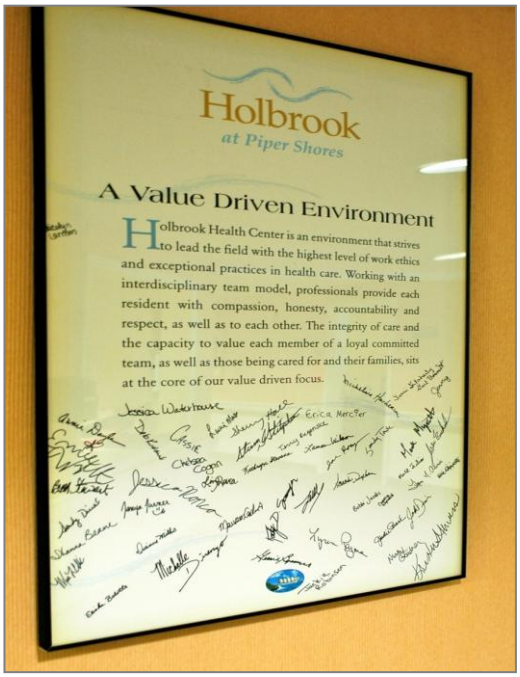
Of equal importance is to view the risk from both perspectives—not only what level of risk the community and resident are willing to accept if the choice is honored, but what are the potential outcomes if the choice is not honored. For example, a resident who is ordered to have a pureed diet is refusing to accept this diet and subsequently refusing intake. Evaluating risk should include an open dialogue with the person to individualize food for them that they would want to eat and would be able to eat.

*Providing residents with **risk agreements** to inform and educate them on choices that may result in risk (particularly when those choices conflict with standards of care) is a way to document residents' informed choices, and can be a way to minimize risk for the organization while maximizing resident independence and choice.*

See Bishop Wicke Health Center's Quality of Life Discussion Policy, Page 176.

Relationships: The Foundation for Community

—They make you feel right at home."
(Nursing Home Resident)



Re-printed with permission from Holbrook Health Center at Piper Shores

Re-Framing Expectations for Long-Term Care

Ideally, the process for acquainting a resident and his/her family to a long-term care setting begins well before their move-in day. Initial meetings and tours for prospective residents provide a valuable opportunity to create a positive impression of community, humanity, and continued growth. At Middlewoods of Farmington in Farmington, Connecticut, a relationship-centered approach to tours was incorporated. To build relationships, prospective customers are now invited to lunch with other residents and staff members and are sent home with warm homemade bread and soup.

Personal touches—an informal lunch in the café, fresh-baked muffins as a gift of appreciation for their time and interest, a handwritten note sent after the tour—can take a prospective resident tour to new heights. Prominently displaying the organization's values in a high-traffic area can prompt dialogue about what is prioritized there. At Holbrook Health Center at Piper Shores, this presentation of the organization's values is signed by all staff, which conveys that these are not just words, but rather the guiding force within the organization. At Landis Homes, its mission and values are imprinted onto a business card which is given to all visitors, board members and staff.

Marketing collaterals that reflect the diversity of the long-term care community— as opposed to exclusively picturing the most high-functioning residents— communicate messages of acceptance, inclusion and an organizational emphasis on possibilities versus limitations.

Offering a host of reasons for members of the external community-at-large to visit the organization can also be an effective strategy for re-shaping expectations about long-term care. (*See Creating a Destination, page 257.*)

The Move-In Experience

—They call me the ambassador and I welcome the person. I make sure they know where they are going and give them a gift."
(Nursing Home Resident)

A personalized approach for welcoming a new resident can ease the transition into their new home and create fertile ground where meaningful relationships can develop. Meeting and greeting new residents at the door when they arrive is a common courtesy that has been lost over the years to a task list of activities to be completed and information to be gathered upon

admission. And yet, when it comes to first impressions, the value of this personal greeting is priceless—and won't cost the organization a cent.

Conversational Assessment
Historically, the admission process for a resident entering a residential care setting has been one of activity and questioning—almost interrogation. Multiple departments descend upon the new resident and ask multiple questions in a hurried fashion to complete mandatory paperwork. While the forms are important, in a resident-centered approach, the development of a relationship and the building of trust is the focus. Team members are educated on the skills of conversational assessing, which simply put, equates to leaving the form outside and engaging in a conversation with the resident and their family. While certainly some questions may be difficult to naturally weave into a conversation, for the most part team members can obtain the necessary information in a more relaxed fashion. In addition, skin assessments can be coordinated with natural care times to preserve the dignity of the individual. Of equal importance is the flow of individuals into the new resident's environment. A mantra for team members to cement their thoughts in is, this may be your hundredth admission, but it is the resident's first and should be treated as such.

At Landis Homes, team members follow a schedule of assessment that allows for rest periods for the resident between visits and has time built in for questions to be responded to. Coordinated forms reduce requests for redundant information. Subsequent forms are pre-populated by other team members with information gathered from previous assessments. The importance of compliance should not overshadow the experience of the person. In other words, the priority is not the form, but the relationship.

Welcome Committee
Modeled after the traditional "welcome wagon," a welcome committee is comprised of residents and staff who volunteer to visit and introduce themselves to all new residents. Doing so with a small plate of cookies or another gift conveys a warmth and kindness that a basic welcome packet and/or handout simply cannot.

Buddy System
Pairing interested residents with new residents is another way to help ease the transition into an unfamiliar place. This can be managed through the Welcome Committee (or another organized group) or through staff to ensure a coordinated approach. Beyond visiting the new resident in their home, the Buddy also personally escorts him/her to the dining room at mealtimes and to other activities to help mitigate natural feelings of anxiety and isolation that may accompany moving into a new community of strangers.

Concierge Book
At Landis Homes Retirement Community, each resident room contains a concierge book. The book offers insight into the organization's history, mission, and vision. Also included are key personnel and their phone numbers, area restaurant and hotel accommodations for family members, recent news, amenities offered and information about the philosophy of care.

Notification to the Community of a New Resident
In the spirit of building a sense of community, communicating the arrival of a new resident is an essential part of the move-in experience. Simple announcements provided to each department and resident are a low-cost, but effective, approach. At Landis Homes, new residents are highlighted on its own closed captioned television station. Such an announcement could be followed by a **newcomer's tea** where those interested have a formalized opportunity to welcome the new resident into their new home. At Fairacres Manor, Neighborhood Advocates **document the resident's history** in a readable life story format.

> *"This helps us to understand the resident as a person first, not just their medical history."* (Neighborhood Advocate)

A Relationship-Focused Orientation to the Community
In resident-centered communities, the orientation of a new resident and his/her family to the organization is not limited to mandatory emergency preparedness information and basic logistics of living there. Instead, the orientation is an opportunity for connections to be forged between the resident and family and the staff as well as to connect the new resident's experience to the vision and philosophy of the organization. At Crosby Commons, an assisted living community in Shelton, Connecticut, the new resident orientation occurs over several days and includes a personal visit to the new resident by a variety of staff, including administration, nursing, maintenance, housekeeping, dietary, activities, the receptionist, chaplain, director of volunteers, and staff from the wellness center. The goal of the orientation is to provide a thorough understanding of the workings and rhythms of Crosby Commons, as well as to familiarize the resident with numerous staff and to a variety of opportunities for discovery, self-expression and fulfillment of personal goals. Each staff member who meets with the new resident uses the occasion to share what the community's relationship-centered philosophy means to them *personally.*

Welcome Rituals
Serving Montreal's Jewish population, Maimonides Geriatric Centre welcomes new residents with a special ritual that honors the profound life transition of moving into the community. Approximately one month after the resident moves in, the rabbi organizes a **Chanukat Habayit** welcoming ritual. This takes place in the resident's room with the resident and family members. Present are the rabbi, a volunteer from the Auxiliary and members of the inter-professional team. A ceremony takes place which includes placing the Mezuzah, a prayer for God to watch over the house and a blessing on wine. Refreshments are served and gifts are offered (plant, coupons for the hairdressing salon, and a gift bag from the Resident's Business Club.

Strengthening Connections Within the Long-Term Care Community
The owner of Bethel Health Care, a skilled nursing community, and The Cascades, an assisted living community, helped to unite these two populations through **Library Lunches**. These two sites experienced communication challenges similar to those often experienced by most continuing care communities with various levels of care. By inviting staff and residents to a lunch where they could get to know one another on a different level, a new understanding of each others' perspectives was realized.

Giving Voice and Ownership to the Community

—We aren't complaining. We just want to be involved in the decisions here." (Assisted Living Resident)

—People are very open to listening and to see how things are done and if it can be done differently. If it cannot be done the way I like, they will tell me why, which I find very satisfying." (Short Term Resident)

Understanding Community Norms

Just as important as understanding the personal rhythms and routines of individual residents is understanding the patterns and priorities of the collective community, be it a household, floor or shift. Creating opportunities for open dialogue among stakeholders cultivates a sense of ownership, builds common ground and ensures that improvement efforts are driven by those most deeply embedded in the organization.

Learning Circles

At Augsburg Lutheran Home and Village, learning circles are convened regularly with residents and staff in each area to determine the area's policies and daily activities in the lives of the residents. Augsburg went so far as to invest in 500 rubber ears that are passed around to participants as a visual reminder that listening is key to a successful learning circle. *See page 52 for more on learning circles.*

Other approaches for amplifying the voices of all members of the community are **focus groups** (*more on page52*) as well as **community meetings** and **dialogue days**. During the latter two examples, all members of a particular area gather together to strengthen community bonds, problem-solve and prioritize around the issues of their area. This structure empowers staff and residents with unit-level decision-making authority. Dialogue days are an important resource for understanding the community culture and assessing stakeholder concerns in a more informal way. *See page 65 for more on dialogue days.*

Systems should also be put into place to collect suggestions from short-term patients/residents, as well as to keep them connected to the organization once they transition out. This can be accomplished by inviting them to participate in **focus groups specifically geared to the short-term rehab experience** and/or creating a **short-term resident advisory council** to provide ongoing guidance into improving the short-term resident experience. A **rehab graduation**—held once or twice a year for all short-term rehab patients discharged over the prior months—re-connects them back to the organization and is an opportunity to celebrate with them their progress.

ADDITIONAL RESOURCES:

Live Oak Institute

www.liveoakinstitute.org

Resident Governance
A resident-directed culture is defined not only by the opportunities residents have to direct their lives and care on an individual level, but also at an organizational-level. By federal and state law, residents have the right to organize, maintain and participate in resident councils. **Resident Councils** are formalized structures to give voice to residents and to represent the concerns and priorities of residents to administration and the Board of Directors. When the scope and activity-level of such councils extend beyond the minimum requirement established by nursing home regulations, these councils can become empowered groups with significant influence and decision-making authority.

S T R E T C H GOAL

In Dutch long-term care communities, the client council represents a group of stakeholders including clients (residents), families, and volunteers. This council is not only a group where concerns are raised or suggestions are made. It is a working team that is fully empowered to make decisions for the organization.

As one example, The Toonladder, a long-term care community in the city of Almere in The Netherlands, was experiencing persistent challenges with trash removal. The administrator, who is obliged to present and discuss solutions with the council, thought she had the nagging problem finally solved with the placement of a dumpster on campus. The proposed solution, though, was vetoed by the client council who would not support the quick fix if it meant compromising the views from a number of residents' rooms and creating an eyesore on the campus. They challenged the administrator to come up with an alternative approach for addressing the trash problem. This simple yet powerful example illustrates the essence of "building community."

Whatever the level of involvement of residents on these and other committees, the input of these important stakeholders should be validated and used to benefit the collective population. Theirs is not token participation that amounts to little more than complaints "entered into the record." Instead, their insights are understood and valued to be essential for problem-solving and decision making.

See Bishop Wicke Health Center's Resident's Council Constitution and By-Laws, page 178.

S T R E T C H GOAL

Resident-centered long-term care communities can take resident governance to even greater heights by ensuring residents have seats at the table during strategic planning sessions and as voting members of the Board of Directors.

Focusing on Possibilities, Not Limitations

"There are so many degrees of humans here." (Nursing Home Resident)

With a growing emphasis on aging in place, long-term care communities are increasingly in the position of negotiating the needs of individuals at varying, and changing, functional levels and health status. A resident-centered approach is not limited only to those residents able to participate on resident councils, on welcome committees, or even just those who are able to verbalize when they prefer to have a shower or wake up in the morning. In concept, the approach is universal. In implementation, refinements may be necessary to meet the individual needs of residents.

Restorative programs are an essential part of creating an organizational culture that focuses on what a person *can* do rather than what they are unable to accomplish. Caregivers at all levels benefit from training in the philosophy of providing every resident every opportunity to do things for themselves and to step in only when invited in by the resident to assist. For some long-term care communities, though, an effective approach for keeping this philosophy top of mind has been appointing team leaders with the responsibility of remaining apprised of each resident's functional abilities with an eye toward maximizing independence.

As with restorative programs, the induction of **fitness and wellness programs** will require education to shift the thought processes of all stakeholders from move-in being the end of one's journey to move-in being the beginning of a new chapter. More and more evidence is showing that the model preferred by the baby boomer generation will include a strong focus on fitness, wellness and complementary medicine. Having these conversations and introducing these programs into a long-term care setting provides an opportunity to explore what works, what is important to residents, and the potential for the program to be expanded to meet residents' evolving needs.

Strategies for Providing Resident-Directed Care and Support for Residents with Dementia

It is often commented that resident-centered care works well, as long as the resident can express their needs and make their choices. To exclude a person with cognitive functional loss from directing their care, though, perpetuates the model of "they can't" rather than "they can."

Life Histories as a Guide

Generally, people will follow similar patterns and choices that they have made all their life, now in late life with cognitive functional loss. It is essential to **include detailed information regarding the resident's past choices, past preferences, and past routines into the plan of care** for the individual. Moving into a long-term care community is stressful enough for residents who don't have dementia, and they still have the cognitive functional abilities to process their transition. Those with dementia are not afforded the ability to process, grieve, or even understand at a basic level their change in environment, change in routine, and change in

the faces they are used to identifying with. The more that can be done to provide a transition that honors these preferences, and to plan approaches and care based on the individual's life history, the more positive an experience the transition will be for the resident and their support network.

Operationalizing life histories is the work of the team. The team should establish a consistent way in which information is collected and disseminated to all who will be caring for the individual. Whatever form the team chooses to use, they should begin with what they need to know first and work from there in **integrating the life history into the plan of care**. For example, it is more essential within the first few days to understand and honor the resident's preferences regarding wake times, sleep times, meal times, and preferences for engagement. As the relationship progresses the team can collect other information that will assist them in truly caring for the person. Life histories are dependent on the individual's and/or family's participation. True, some information can be obtained from the medical record, but this limited information may not be enough to identify preferences that are not routinely included with the medical record. In those cases, team members should be educated on how to interpret the resident's response to care.

Response to Care as a Guide

Caregivers alert to a variety of cues are very able to identify what works and what does not work for individual residents they are caring for. In a resident-centered setting, caregivers are empowered, educated, and encouraged to use this knowledge in planning and delivering resident-directed care to an individual with dementia when the life history may not be immediately known.

Through consistent assignments and education, caregivers can observe and alter the care schedules for an individual, as well as activity and meal times, based on the response to care. For example, a resident may be physically aggressive with care being done in the early morning, however this same resident may be cooperative and participate in their care when it is offered later in the morning. Perhaps a resident refuses breakfast on a routine basis and can even become aggressive when escorted to the dining room. Providing meals at alternate times may be the answer for this resident. Having caregivers who know it is permitted and have the ability to be flexible in the moment is key to resident-directed care being successful in a dementia setting.

Many residents are unable to communicate pain or displeasure except through aggressive responses, either physical or verbal. A team of caregivers trained to feel a person's muscle tone or facial expression change may be able to significantly decrease the number of aggressive responses for the resident and use those moments to allow the resident to direct their care.

Quiet Care

At Mulberry Gardens, residents in the memory care neighborhoods benefit from a system called *Quiet Care*™. This system is a non-invasive way for staff to monitor resident routines, such as movement in and around their room. If an unusual break in the resident's routine occurs, staff is alerted to check on that individual. This can be particularly helpful at night when a resident may be more vulnerable to falling. The system picked up on a number of residents whose bathroom

routines were noted to be outside of their usual practice, alerting staff to the early onset of a urinary tract infection and allowed for an earlier intervention.

Supporting the Community Through Grief and Loss

—This [nursing home] is subject to rules and we are not allowed to know if someone has gone to the hospital. We don't need their prognosis, but at least know where they are. They can feel bad too. I was at [a skilled nursing facility] for a few weeks. It was like I sank into a hole and no one knew where I was."
(Nursing Home Resident)

Focus group feedback demonstrates how disconcerting it is for residents when a peer is suddenly no longer a part of the long-term care community, with no explanation other than rumors and conjecture as to why. Often this lack of communication is a well-intentioned but misguided approach for preserving the resident's privacy in accordance with federal privacy laws. Communities focused on relationships, however, have developed processes that honor the relationships that have developed while still adhering to the wishes of the residents for privacy.

At Middlewoods of Farmington, residents proactively sign a **consent form**, giving written permission that basic information about a hospitalization or a short-term rehab stay may be shared with other residents. When such an instance occurs, an announcement is made to residents who then have the opportunity to sign a get well card for the resident or a condolence card for the family. Residents are also offered the opportunity to visit their fellow residents when they are in short-term rehab. Whenever a Wesley Village resident is hospitalized, a representative from the organization visits them at the local hospital.

See Middlewoods of Farmington's Consent to Share Information Form, page 182.

Rituals Around Death and Dying

Relationship-focused communities support members in honoring the individual who has died and in coming to terms with their own grief. At Saint Elizabeth Community, staff who work closely with a resident are called at home to notify them of a death so that they are not surprised with the news at the beginning of their work shift. For other staff, a notification is placed in a prominent location—at the front desk and/or at the time clock—so that all staff are made aware of the death before their workday begins.

Many organizations have also changed the practice of clandestinely slipping bodies out a back entrance to shield others from learning about the death. An emphasis on resident dignity and honoring relationships has compelled these organizations to now respectfully escort the body out the front door of the building.

End-of-Life Care
With an emphasis on compassion and a holistic approach to care, traditionally end-of-life care is very person- and family-centered. Southington Care Center in Southington, Connecticut offers a specialized end-of-life care program and philosophy named **Tranquill Passages** (spelled with two _ll‘s in honor of Tranquill Chiovoloni, a resident who received end of life care at the Center). Through a multi-disciplinary individualized assessment, personal needs and preferences for end-of-life care are identified. Services and amenities are offered based on the stage that an individual is in as they enter the last stages of life. Family is closely involved. At this point it is understood that the goal is not to cure but rather to provide comfort and the highest quality of life for as long as life remains. The focus is not on death but on compassionate specialized care offered by staff who has received additional training and certification in palliative care.

See Southington Care Center‘s Tranquill Passages End-of-Life Care Assessment Tool, Page 183.

Five Wishes
This tool, created by the not-for-profit Aging with Dignity, has been described as a ~~“~~living will with a heart and soul.” It is used to communicate an individual‘s wishes and preferences around end-of-life, including who they want to make healthcare decisions for them if they are unable, what kinds of medical interventions they want or don‘t want, and what they would want their loved ones to know.

Star Comforter Service
This program was developed by Landis Homes to ensure that no resident died alone. Specially trained Star Comforter Service volunteers are a calming and supportive presence, honoring the wishes of the dying resident. In addition to sitting with the resident, they may provide comfort simply by holding their hand, applying lotion, playing the resident‘s favorite music, placing a cool washcloth on their forehead or reading scripture. The volunteers are trained by the local hospice and then are available on an on-call basis.

See Landis Homes‘ Star Comforter Service Brochure, page 187.

Hospitality Cart
A hospitality cart (sometimes called a compassion cart) is stocked with complimentary snacks and beverages (including baked goods, coffee/tea, juice boxes, microwavable soup, instant oatmeal, etc.) and provides nourishment to family members whose loved one is dying. Often reluctant to leave the bedside, the provision of such a cart stocked with nourishing foods enables loved ones to remain close.

Passage Quilts
Draped over the body, these comfort quilts add dignity to the escort of a body out of the building. They can then be given to the family in remembrance of their loved one.

Reflections
Developed by Wesley Village, this program offers a meaningful way individuals in the community to find closure when a resident in their midst dies. To the extent possible, a

reflection service is scheduled within 24 hours of a resident's death. Staff, residents and family who wish to attend gather together with the chaplain or another designated staff member to share memories and feelings, reflect on scripture or inspirational words, and share a prayer. The service is an open forum, and all in attendance are invited to share their memories of the person who has died.

White Rose Program
This program is a way of honoring the death of a resident. After a death, a white silk rose (or other symbol) is placed on the resident's door or on their bed out of respect and as a means of communicating to others that a death has occurred. The rose is then given to the family as a keepsake.

Prayer Shawls

> *"This shawl is made for you with love. It is offered with prayers for your comfort and peace. May it warm you, even as we continue to hold you in prayer. May it warm you, even as the love of God warms you."*

This is a blessing bestowed on prayer shawls before they are presented to residents nearing end of life. They are often knit or crocheted by volunteers (either from within or outside of the community) who come together as a group, often under the guidance of a volunteer instructor, intentionally thinking about or praying for the eventual recipient. Special ceremonies to bless the shawls are held before they are delivered to the recipients.

Healing Circle
Held quarterly at Maimonides Geriatric Centre, this one-hour service is held to help its professional caregivers cope with the death of residents. All team members are invited to participate. Participants sit in a circle, and a "talking stick" designates one person to share at a time. Everyone has the opportunity to speak, though no one is obliged to do so. Poems and prayers may be read, and songs and music often add to the service. The gathering concludes with the participants expressing their experience during the service, by either writing a statement or drawing a symbol, which is then shared with the rest of the group.

Annual Memorial Service
Coming together to celebrate the lives of those who have died over the previous year can bring a long-term care community closer together and can be a meaningful complement to services or rituals conducted in the days immediately following a resident's death. An annual memorial service can also be a welcome opportunity for family to remember their loved one alongside those who lived with and cared for them. These memorial services often include a reading of the names, as well as sharing of photographs, either framed or as a digital slide show.

Other Transitions

Grief and loss are not emotions reserved for illness and death. Many residents moving into a long-term care community may be grieving the lives they are leaving behind, friends, homes and possessions they treasure, and a perceived loss of independence. It is a natural reaction to a major life transition. Such a natural reaction should be honored and space and time should be allowed for the resident to come to terms with these feelings. It is imperative that those within the organization recognize the difference between natural and expected grief and evidence of depression. Providing emotional support and conversing with the resident will aid in identifying what is natural and what may be an indicator of a more profound concern. Honoring the individual should include supporting them through the stages of grief, regardless of the loss being experienced. Communities can adopt a philosophy of grief that centers on the concept that life doesn't need to be medicated, but experienced. In this model, supportive and evaluative services are provided to the grieving resident, but ultimately how grief is addressed is resident-directed.

Supporting staff members through the stages of grief is also important. Many staff members feel that open grieving for the loss of a resident is not professional or may show weakness on their part. Others may feel the best way to protect themselves is to be disconnected from the process and the resident. Still others may manifest their grief through arguments with other team members, or absenteeism. However the grief manifests, the goal of a relationship-focused community is to create a space in which staff members are included and supported through the grieving process. Additional reading on supporting staff through grief can be found at: **www.almosthomeoutreach.org/node/109**

Spirituality

Spirituality is our own internal ability to find meaning in life. It is what grounds and centers us, and is not limited to religious traditions. It can also be a particularly meaningful source of connection among individuals and the collective population of the long-term care community. Below are practices implemented to support the spiritual dimension of the community.

Blessing of the Hands
This brief ceremony acknowledges the sacred work of caregivers. The ceremony can be done annually or more often if desired.

Pastoral Care Services
The structure of pastoral care and chaplaincy services can vary depending on the community. For sites with limited financial resources, an all volunteer program is a viable option, and can be developed through community networking.

Sacred Spaces
Sacred spaces may include traditional worship areas, but they are not limited to such defined places. Sacred spaces are areas on the campus that foster peace and serenity. They include meditation rooms, reflection rooms, sanctuaries and other such spaces that are welcoming to visitors of any faith tradition, and can be a setting for quiet contemplation or communal worship. Delnor Glen Senior Living, an assisted living community in St. Charles, Illinois, offers a **serenity room** as a quiet place for reflection for residents, family members and staff. Calming music and literature are available for anyone who chooses to use the space.

Healing gardens with benches for sitting or walking paths provide access to the restorative effects of nature. Outdoor **labyrinths** may be used for meditation purposes, and for sites for which outdoor labyrinths are not a viable option, handheld labyrinths are also available.

Focus on Process

CREATING SACRED SPACES

The concept for Delnor Glen Senior Living's Serenity Room was born out of interviews with residents, families, staff and board members. Ultimately, the creation of the space was a collaborative venture overseen by a committee comprised of a representative from each stakeholder group which was convened to ensure that the new space met the needs of all its potential users.

The creation of the serenity room was just one way that Delnor Glen is striving to meet the full range of resident, family and staff needs. Data demonstrates that this approach is making a difference. Satisfaction of staff appears to be increasing, as turnover rates have plummeted from 32.1% in 2007, to 19.5% in 2008, to 16.2% in 2009, to 13.9% in 2010.

Individual and Community Life Implementation Tools

Tool A. Brewster Village's All About Me Form

All About Me

My name is:	Please call me:
Form filled out by:	Date completed:

Preferred Time To Arise	Morning Rituals	Nap Preference
Prior to 6:00 AM	I wake up on my own	I prefer a nap at:
Between 6:00 AM-7:00 AM	Have staff wake me	I don't take naps
Between 7:00 AM-8:00 AM	I use an alarm clock	My nap lasts:
Between 8:00 AM-9:00 AM		
Between 9:00 AM-10:00 AM		
Between 10:00 AM-11:00 AM		
Between 11:00 AM-12:00 AM		
After Noon		
Specific time:		
Sleeping Aids	**Preferred Bedtime**	**Where Do You Prefer To Sleep**
Television on	Specific time:	Bed
Radio on	Between 6:00 PM-7:00 PM	Recliner
Extra pillows	Between 7:00 PM-8:00 PM	Other
Blankets on	Between 8:00 PM-9:00 PM	
Blankets off	Between 9:00 PM-10:00 PM	
No pillows	Between 10:00 PM-11:00 PM	
Snack prior to bed	Between 11:00 PM-12:00 PM	
	Between 12:00 AM-1:00 AM	
	Between 1:00 AM-2:00 AM	
	After 2:00 AM	
Bedtime Rituals	**Bathing Preferences**	**Bathing Assistance Needed**
Outer door open	Shower	I prefer to be independent
Outer door closed	Bath	I need some assistance
Bathroom door open	Wash up/Bag bath	I need help washing my hair
Bathroom door closed	Shower or bath	Limited assistance
Room lights on		Extensive Assistance
Bathroom lights on		Total dependence
Lamp on		
Night light on		
All lights off		
Bathing Day(s) Preferred	**Bathing Time(s) Preferred**	**Bathing Time (s) Preferred Cont.**
Sunday	Prior to 6:00 A.M.	Before bed at:
Monday	Between 6:00 AM-7:00 AM	Specific time:
Tuesday	Between 7:00 AM-8:00 AM	Between 12:00 PM-1:00 PM
Wednesday	Between 8:00 AM-9:00 AM	Between 1:00 PM-2:00 PM
Thursday	Between 9:00 AM-10:00 AM	Between 2:00 PM-3:00 PM
Friday	Between 10:00 AM-11:00 AM	Between 3:00 PM-4:00 PM
Saturday	Between 11:00 AM-12:00 PM	Between 4:00 PM-5:00 PM
Each day	Before breakfast at:	Between 5:00 PM-6:00 PM
	After breakfast at:	Between 6:00 PM-7:00 PM
	Before lunch at:	Between 7:00 PM-8:00 PM
	After lunch at:	Between 8:00 PM-9:00 PM
	Before supper at:	Between 9:00 PM-10:00 PM
	After supper at:	Between 10:00 PM-11:00 PM

Group Size Preference	Please Remember	I Don't Like
Large groups Small groups Individual Independent Outings Other:	I am hard of hearing I use a wheelchair/walker/cane I wear glasses I wear a hearing aide I wear dentures Other:	Noise Being cold Being hot Being touched Being with people Bright lights Dim lights Loud noise/music Meeting people Talking about: These foods: Activities such as: Other:

Things That Comfort Me	Hair Appointments	Hair Appointments Continued
Being in my room Being touched Being with people Calling family/friends Humor Music/Singing Religion Sports Television Reading These foods: Talking about: Hobbies:	I want to go out to do my hair Please do my hair here I prefer a haircut I prefer a perm I prefer a color I prefer a shampoo I prefer my hair set I prefer a shampoo/set I prefer a rinse I prefer my hair conditioned I prefer a comb out I prefer an updo Please schedule me weekly Please schedule me every 6 wks Please schedule me as needed	I prefer before noon I prefer afternoon Specific time: I prefer Monday I prefer Tuesday I prefer Wednesday I prefer Thursday I prefer Friday

4/10

Special Concerns or Additional Information:

Tool B. Maimonides Geriatric Centre's Life History Questionnaire

MAIMONIDES
Going further in geriatric care
À l'avant-garde des soins gériatriques

LIFE BIOGRAPHY PROJECT

In our ongoing effort to personalize the care of our residents, an interdisciplinary committee at Maimonides Geriatric Centre has developed the Life Biography Project. This award-winning project involves a life review of our residents, including unique qualities, strengths, significant events and lifestyle. We count on our future and current residents and their families to provide us with the necessary information. This can be done by completing the attached questionnaire, or requesting an electronic version from our admitting office. Please include any information which you think would help us to provide ~~–m~~ore than care". Photographs enrich the biography, so please share these with us. We will scan the photos and return the originals to you.

You can expect that your efforts will provide the interdisciplinary team with the necessary information to create a Life Biography of the resident.

The information you submit will be used to complete a Power Point presentation about the resident. Once we receive the information from you, a member of our interdisciplinary team will be in contact with you to plan the production. Once completed, and with your consent, this will be shown to staff to help them better understand the individual, and adapt the care plan to best meet his or her needs. This presentation helps the staff to appreciate our residents as individuals, and in turn, to individualize the care. The earlier you provide us with the information, the sooner we can produce the Power Point format and show it to the team working with the resident. Family members will be invited to view the presentation, and a copy of the project will be provided.

Should you have any questions or comments, please feel free to contact at .

MAIMONIDES
Going further in geriatric care
À l'avant-garde des soins gériatriques

Biography Project
Life History Questionnaire

Profile Of Individual Throughout Lifespan

Name: (*meaning of name if known, was resident named after someone and if so, who*)

Nickname: (*reason/source of*)

Birth date, place of birth:

Names of important people: (*Information about and relationships with*)
Mother:
Father:
Siblings:
Spouse/ Partner:
Children:
Grandchildren:
Significant Others:

Education: (*Details, experiences, and accomplishments. Include mother tongue and other languages spoken/written*)

Significant life events (*What changes, sickness, conflicts, experiences i.e. Holocaust, did the individual encounter?)*

Character traits, personality, and values important to the individual:

Reactions to worry, stress and change:

Religion/spiritual practices:

Family Life and relationships:

Work life: (*Occupation, importance of work, details around retirement*)

Leisure, Hobbies and Interests: (*Favourite memories, preference for activities with family/friends, large group or alone*)

Outings/Travel/Entertainment: (*Special memories of vacations, favourite movies,music, theatre productions*)

Community Involvement:

Pets: (T*ypes, names, special memories*)

Special Achievements:

Lifestyle
(*Across the lifespan*)

Personal Hygiene: (*Bath or shower preferred, frequency, time of day, reaction to hot and cold water*)

Diet: (*Number of meals, favourite dishes, snacks, diet preference)*

Dress: (*Gets dressed on waking, after breakfast or other time, favourite colours and clothes,particular clothing preferences, interest in fashion)*

Sleep: (H*abits before going to sleep i.e. reading, snack etc, bedtime,wake up time, nap, work hours and schedule)*

Household management/maintenance/ repairs: (*Responsibilities such as housework, laundry, cooking, financial/budget management, painting, plumbing, gardening, interior decorating etc.)*

What effect, in your opinion, has the individual's health problems had on him/her, you, and others?

Questionnaire completed by:

Name:_____ **Date:**_____

Tool C. Fairacres Manor's Neighborhood Advocate Job Description

JOB DESCRIPTION
NEIGHBORHOOD ADVOCATE

PURPOSE Neighborhood advocate is in charge of a facility neighborhood in regards to the psycho-social well-being of the residents residing on that neighborhood. The advocate is the liaison between departments and is half social services and half activities.

ACCOUNTABLE TO

SOCIAL SERVICES DIRECTOR AND ACTIVITY DIRECTOR

Administrative Functions of the Neighborhood Advocate

1. Ongoing requirements as stated in Social Service job description and Activity job description.
2. Maintain good communication with Nurses, CNA's, and Activity staff
3. Maintain good communication with other facility staff
4. Maintain current CNA license
5. Will demonstrate a sense of ownership and commitment to facility residents

DUTIES AND RESPONSIBLITIES

1. Documents discharge planning
2. Completes social history.
3. Documents care plans and constructs approaches to meet psychosocial needs
4. Documents progress notes
5. Documents quarterly assessments
6. Documents 1:1 services
7. Charts activity attendance
8. Holds neighborhood meetings
9. Conducts neighborhood activities
10. Takes resident to and from facility activities
11. Holds weekly aide meetings
12. Does 1:1 room activities
13. Conducts special resident activities
14. Ensures rooms are homelike
15. Reports to Social Service Director on:
    a. Residents who are aggressive
    b. Residents who are depressed/problems with coping
    c. Residents with increased withdrawal
    d. Legal and financial problems
    e. Difficulties with family situation
    f. Complaints of unrelieved pain
    g. Behavioral disturbances/mood disturbances
16. Meets with psychologist

17. Attends care plan review
18. Holds care conferences with family
19. Writes psychotropic notes one time per month
20. Care conference invitations
21. Gets approval for room changes
22. Ensures residents have clothing

QUALIFICATIONS

1. CNA certified upon hire, or become certified within the first year of employment
2. Previous nursing home or long term care experience is preferred
3. Social work or activities background preferred.

It must be understood that this job description in no way states or implies that these are the only duties you will be required to perform. The omission of specific statements of duties does not exclude them from the position if the work is similar, related or is a logical assignment to the position.

_____ _____

Employee Signature Date

Tool D. Fairacres Manor's Team Lead Job Description

JOB DESCRIPTION
TEAM LEAD

NAME_____ DATE OF HIRE_____

PURPOSE
To provide leadership, serve as a cultural change advocate, and direct the daily plan of care for the residents in accordance with the established nursing and facility procedures.

ACCOUNTABLE TO Director of Nursing and Charge Nurse

Administrative Functions of Team Leader
1. Ongoing requirements as stated in CNA job description
2. Maintain good communication with staff nurses
3. Maintain good communication with other CNA's
4. Maintain good communication with other facility staff
5. Maintain current CNA license
6. Will demonstrate a sense of ownership and commitment to facility elders
7. Will replace themselves for any shift that they are scheduled for but unable to work

TEAM LEAD FUNCTIONS
1. Responsible for mentoring new CNA employees.
2. Responsible for documentation of CNA call-ins and reporting information to Director of Nursing.
3. Responsible for CNA scheduling and daily budgeting of CNA.
4. Serves as a liaison between charge nurse, management, and CNA's.
5. Will prepare and present one topic at in-service every six (6) months.
6. Will have yearly skills checklist evaluated by Staff Development Coordinator.
7. Will work at least one (1) shift per month that is not a normal work shift as needed by facility staffing needs.
8. Will demonstrate interdepartmental teamwork.
9. Will participate regularly in Primary Care Planning Conferences.
10. Will conduct quarterly meetings with CNA's to coordinate elders and improve processes.
11. Will follow all safety rules and procedures.

QUALIFICATIONS, EDUCATION, LICENSE, CERTIFCATION REQUIREMENTS
1. Must be certified as a Nursing Assistant by the State of Colorado and be in good standing with the Board,
2. Must be employed by the facility for six (6) continuous months.
3. No memorandums for job performance in the last six (6) months.

4. An application and required documentation must be completed.
5. Team leaders will be evaluated yearly.
6. Any person not meeting the on going requirements will relinquish the designation and a subsequent pay decrease will become effective the next pay period following the demotion.

It must be understood that this job description in no way states or implies that these are the only duties you will be required to perform. The omission of specific statements of duties does not exclude them from the position if the work is similar, related or is a logical assignment to the position.

I CERTIFY THAT THIS JOB DESCRIPTION WAS REVIEWED WITH ME AND THAT I FULLY UNDERSTAND AND CAN PERFORM THE ESSENTIAL FUNCTIONS OF THIS POSITION.

_____ _____

Employee signature Date

Tool E. Saint Elizabeth Community's Life Enhancement Coach Job Description

Specialized Trainer/Quality Improvement
Life Enhancement Coach :Job Description

General Scope:
Coordinate and conduct specialized resident and staff training such as LEAP, Culture Change Initiatives, and Customer Service. Training must be conducted for staff on all three shifts and in small groups. This requires the position to be flexible with schedule. Training will include initial training and refresher training as needed.

Reports to: President & CEO and Administrators and works with Administration of the residences.

Specific areas of responsibility include:

- Participates in new employee orientation by introducing LEAP and other culture change concepts being done at each facility.
- Work with staff to develop and implement system- wide programs and best practices.
- Responsible for looking for opportunities for reps from each facility to work together on an issue, instead of working separately and then sharing
- Responsible for assessing progress & sharing best practices in regards to the 8 goals of the Advancing Excellence in Nursing Home Campaign & the AAHSA Quality First
- Coordinates each facilities participation with RIQP Culture Change Coalition submitting all required reports in a timely fashion, conducting staff satisfaction surveys, setting QI targets on the STAR website, NHIFT reports etc.
- Monitors and evaluates each facilities performance with Quality Indicators. Develops and implements programs/training to improve the facilities performance on QI's.
- Periodically assesses each facilities progress towards Culture Change by using such tools as –Artifacts of Culture Change", Household Toolkit, etc.
- Develops and implements new programs/initiatives
- Writes articles on successful initiatives. Submits applications for conference presentations.
- Completes grant applications with the assistance of Fund Development department for initiatives.
- Attends monthly leadership meeting to update leadership on the progress that is being made.

Qualifications

Individual must possess:

- 5 years of experience in the long term care field

Individual must:

- Be self-directed.
- Promote quality improvement and team building among staff.
- Demonstrate excellent leadership, communication and organizational skills.
- Be computer literate.
- Possess the ability to read, write and speak the English language.

Essential Physical Requirements and Work Environment

Individual must be able to:

- Push / Pull / Lift / Carry objects less than 50 pounds.
- Sit for prolonged periods of time.
- Perform tasks requiring moderate manipulation such as keyboarding.
- Concentrate on moderate detail with frequent interruptions.
- Remember multiple tasks / assignments given to self and others over long periods of time.
- Reach above, at and below shoulder height.

Receipt of job description:

Signature_____

Date_____

Tool F. Brewster Village's Notification Letter about Elimination of Alarm Use

May 15, 2008

«Title» «First_Name» «Last_Name»
«Address_Line_1»
«City», «State» «ZIP_Code»

REG: «REG»

Dear Villager/ Decision Maker,

As part of our mission and vision, it is our goal to maintain the health, independence, self-esteem and intrinsic worth of each individual living at Brewster Village. We recognize that this approach is not without risk, however, the benefits to this approach far exceed the risk. In recent years, we have systematically reduced the number of restraints used at Brewster Village. We are proud of the fact that we have eliminated their use.

It is now time for us to look at the use of alarm devices to "prevent" falls. We believe that alarms are inconsistent with our philosophy of maximizing the autonomy and dignity of our residents. It has been proven that these devices do not prevent falls and may actually increase falls due to their unexpected sounds and attempts by residents to remove them from their clothing. Because of the staff presence within our households and in our common areas throughout the building, we are alert to the safety needs of our residents. For these reasons, it is our intent to eliminate the use of alarm devices by August 1, 2008.

Fall prevention and minimizing the risks of injury from falls continues to be a priority of our staff. Protocols are in place to identify residents that are at risk and care plans have been developed to minimize that risk. Staff have been educated on different preventive measures that can be implemented to reduce the risk of falls and injury from falls without the use of an alarmed device.

We appreciate your patience and understanding with this change and assure you that we continue to be committed to providing person-directed care in an environment that encourages the dignity and independence of each individual. Should you have any questions regarding this change, please contact your social worker or neighborhood manager.

Sincerely,

David Rothmann
Administrator

Tool G. Sample Personalized Medication Administration Policy

Personalized Medication Administration

Policy: It is the policy of _____ to maximize independence and choice through a variety of methods, one of which is to personalize resident medication administration to align with their choice in awake times, sleep times, and meal times.

Procedure/Protocol:

1. Upon move-in, at least quarterly, and with each MDS Assessment, each resident or their family member will be asked how they managed their medications at home or how the current medication administration is meeting their needs, in other care settings, and what their choices are for wake times, sleep times, and meal times.

2. Careful review of the resident's medication orders will be conducted by an interdisciplinary team to include, the resident, the caregiver, the nurse, physician and a pharmacy consultant and/or representative. This review will take place, at move-in, at least quarterly, with a change in diagnosis, acute illness event, admission to hospital, and routinely by physician and pharmacy consultant.

3. Review will include, but not limited to, the following:

    a. Clinical need for continuation of medication

    b. Potential areas of poly-pharmacy concern

    c. Clinical contraindications for flexible scheduling of medications

    d. Review of resident goals and health management history (how the resident has managed his/her medications and health in the past)

4. Whenever possible residents are encouraged to self-medicate within the guidelines of the organizational self-medication assessment. When self-administration is not possible, flexible medication scheduling will be the norm. As needed medications that are reviewed and are given consistently will have orders converted to reflect a routine medication.

5. Notations to be used in the medication administration record and care plan are listed below:

    a. Once Daily Dosing = Upon Rising **or** Bedtime as defined by the resident

    b. Twice Daily Dosing = Upon Rising **and** Bedtime as defined by the resident

c. Three Times Daily = upon rising, afternoon, and bedtime as defined by the resident

d. With Meals = with meals as defined by resident

6. Resident preferences, related to wake times, sleep times, and mealtimes will be noted in their care plan and updated with each assessment.

Policy supported by and developed from research/information of:
G. Allen Power, MD, Eden Mentor – St. John's Home Rochester, NY, USA
From Institutional to Individualized Care Part III - CMS webinar series

Tool H. Middlewoods of Farmington's Concierge Services Brochure

Featuring our Gift from the Heart Program

An opportunity for personalized service and attention.

For your beloved family members, we make it easy to order the following items:

- Birthday Surprise Cards
- Get Well Soon Soups
- Seasonal Cookie Monday
- Marie's Famous Brownies
- Fresh Fruit Trays
- Fresh Baked Pies
- Relaxation Baskets
- Internet Shopping Assistance

Available by email :

Agiftfromtheheart@gmail.com

At the Heart of our Concierge Program is our desire to address the following Planetree components!

- *Enhancement of Life's Journey*
- *Independence, Dignity and Choice*
- *Empowerment through Information and Education.*
- *Paths to Well-Being*

Middlewoods of Farmington
509 Middle Road
Farmington, CT 06032
Phone: 860-284-5700
Fax:860-284-5710

Middlewoods of Farmington
AN ASSISTED LIVING COMMUNITY

Concierge Services

Providing the best service and care for our

Residents

Residents Family

and Staff.

860.284.5700

Resident Services

- On-Site Physician
- On-Site Foot Care Clinics
- On-Site Ear Care
- Maintenance of Medical Equipment.
- Laboratory Services
- Wellness Lecture Series
- Transportation Services
- Pharmacy Deliveries
- In-house Clothes Shopping

"MAKING LIFE EASIER"

Resident and Staff Services

- Full Service Beauty Salon
- Gourmet Coffee Bar
- Dry Cleaning Service
- Postal Service
- Free Museum Passes
- Notary Public Service
- On-Site Pet Grooming
- Local Resource Book
- Bargains in the Woods Thrift Shop
- Massage Therapy Service

Planetree Pledge
We are dedicated to resident-centered compassionate care... embracing the mind, body, and spirit.

Staff Services

- Holiday Parties and Celebrations
- Free Staff Meals
- Access to Social Worker
- Employee Recognition Programs
- "Friday's To Go" Meal Service

"MAKING LIFE EASIER"

Tool I. Bishop Wicke Health Center's Care Partner Guidelines

Care Partner Program Guidelines

The purpose of the Care Partner Program at Bishop Wicke Health and Rehabilitation Center is to enhance the quality of resident care and the rehabilitation experience. The care partner is regarded as a vital and responsible member of the healthcare team. Involvement in the care partner program improves quality care by participation in communication, education, physical, emotional and spiritual support of your loved one.

This program is a three-way partnership. The care partner is invited to perform activities and responsibilities agreed upon by the resident, staff and the care partner. The level of care partner involvement is specific to the particular resident's needs, but flexible enough to accommodate the interest and ability of the care partner. The care partner's responsibilities may change daily as the resident changes. Also, the care partner agreement may be ended by any of the participants.

Activities and responsibilities of the care partner may include, but are not limited to the following:

Communication

Spokesperson to family and friends regarding the resident's progress
Document questions for the physician
Ask questions of the healthcare team members
Participate in the discharge planning process
Keep track of personal items

Education

Learning about options for continued care
Medication choices
Dressing changes and skin care
Activity and mobility
Restrictions and precautions
Equipment
Resource Center materials

Physical Needs

Meal selection, snacks and dining assistance
Food from home
Dietary restrictions
Monitoring fluid intake
Personal care such as nail care, massage, bathing, hair care

Comfort measures such as neck wraps, cooling cloths and extra blankets/pillows and aromatherapy
Manage comfort (pain medication, positioning assistance)
Activity and mobility
Wheelchair excursions

Emotional Support

Visits, encouragement, positive coaching
Provide reading material
Write letters
Assist with phone calls
Coordinate rest and visitors
Active listening to enhance coping skills and process feelings

Spiritual Needs

Prayer
Quiet time
Request visit from the Director of Spiritual Life
Offer support as needed

The resident initiates the care partner program by designating a care partner (family member or friend). The care partner must be willing and able to participate. Together, the care partner questionnaire/ agreement is completed and signed by the resident, the care partner and a member of the nursing staff. The questionnaire/agreement is the initial communication to the healthcare team members of the care partnership and the specific activities and responsibilities that will apply during the resident‘s stay at Bishop Wicke Health and Rehabilitation Center. The healthcare team members will be available to answer questions, provide information, teach, give support and act as a resource to both the resident and the care partner. The care partner is encouraged to attend the facility‘s Family Support Group meeting, which is held on the third Wednesday of every month from 6:00 – 7:00 p.m. in the Solarium. Near the end of the rehabilitation stay, the resident and the care partner are asked to complete an evaluation. Feedback is an essential component of our program and will help us to improve it.

Tool J. Bishop Wicke Health Center's Quality of Life Discussion Policy

BISHOP WICKE HEALTH CENTER
DEPARTMENT OF NURSING SERVICE
POLICY AND PROCEDURE

QUALITY OF LIFE DISCUSSION

POLICY:

It is the policy of Bishop Wicke Health Center to educate residents on the risk/benefit of choosing not to follow MD orders based on therapeutic recommendations. These recommendations may be perceived by the resident as being incompatible to their personal choice, dignity and/or quality of life.

PROCEDURE:

- Issues based on questions/concerns from a resident and/or family (POA) are brought to the interdisciplinary team meeting for review.
- The appropriate discipline should then be responsible to educate the resident and/or family (POA) regarding the risk/benefit of not following recommendations.
- A quality of life note is written with input from all persons involved.
- The attending MD is notified of the above meeting and discussion.
- The resident and/or family (POA) signs a waiver, if deemed appropriate (i.e. dysphasia waiver)
- The MD order should be changed to reflect the resident/family (POA) wishes.

Note: Quality of Life discussions may pertain to levels of assistance needed with Transfer/ambulation, dysphasia recommendation, restraint usage, etc.

revised 1/07

BISHOP WICKE HEALTH CENTER

QUALITY OF LIFE DISCUSSION

RESIDENT:_____ ID#:_____

DATE:_____

TOPIC:_____

_____

INTERDISCIPLINARY REVIEW: (Nursing, Recreation, Rehabilitation, Social Service, Administrator, Dietary, Infection Control Nurse, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

QUALITY OF LIFE NOTES:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Instituted 12-04)

Tool K. Bishop Wicke Health Center's Resident's Council Constitution and By-Laws

BISHOP WICKE HEALTH CENTER
RESIDENT'S COUNCIL CONSTITUTION AND BY-LAWS
Effective July 2009

ARTICLE I: NAME

Bishop Wicke Health Center Resident's Council

ARTICLE II: PURPOSE

1. The Resident's Council will assemble to meet the needs and wants of all residents living at Bishop Wicke Health Center and to benefit the good of the Bishop Wicke community (residents, staff, families, friends, volunteers)
2. The membership will work with administration and the therapeutic recreation department to schedule meaningful activities for the Bishop Wicke community.
3. The Resident's Council will work to promote and maintain avenues of communication within the internal community of Bishop Wicke, which is defined as residents and staff.

ARTICLE III: MEMBERSHIP/ATTENDANCE

1. All residents residing in the Bishop Wicke community are members of the Resident's Council and are encouraged to be active participants.
2. All members have the right to vote
3. Meetings will be closed sessions. Guests may be invited by the members through the Resident's Council representative or may ask to be present at a

specific time frame. The representative will be responsible for managing guest visits.

4. Non-emergency interruptions are not permitted while the meeting is in session.
5. The Resident‘s Council meeting will be scheduled on the first Friday of every month. If there is a conflict of date, (holiday day) the meeting will be held the day before the regularly scheduled date or rescheduled for another time during the month.
6. The membership of the Resident‘s Council will be responsible to determine the need for calling and scheduling special meetings.
7. Residents needing escort or transport assistance to attend the meeting should make his/her need known to his/her assigned CNA who will transport/escort him/her to the meeting.

ARTICLE IV: GOVERNMENT

1. The administrator of Bishop Wicke will provide support for the Resident‘s Council as and when needed.
2. At the request of the council, the administrator of Bishop Wicke will appoint a qualified staff person to be the representative for the council and will provide a substitute representative in the event the regular representative cannot attend the scheduled meeting.
3. Duties of the representative are as follows:

    - He/She will be responsible for taking accurate minutes of each meeting.

- He/She will ensure that each member who wants a copy receives a copy of the minutes.
- He/She will be responsible to maintain a binder of the council meeting minutes in a pre-determined location.
- The administrator will also receive a copy of the meeting minutes and will distribute copies as he/she feels necessary
- He/She will provide the Council with pertinent information for the meetings such as deaths, anniversaries and the recreation calendar, etc.
- If special meetings are necessary, the representative will be responsible for announcing the date, time, location, as well as ensuring that members are made aware of the meeting.

4. If a resident wishes to file a formal grievance, he/she will be referred to the Director of Social Services.

Article V: Meeting Agenda

The following is the suggested agenda format for the meeting.

Resident Council Meeting Format

1. Call to order
2. Attendance

3. Introduction of new members
4. Reading of the previous month‘s meeting minutes, (approved or amended and approved).

5. Old business
6. New business
7. Deaths, anniversaries, and milestones.
8. Open forum for comments and/or suggestions.
9. Guest speakers
10. Adjournment

Tool L. Middlewoods of Farmington's Resident Consent to Share Information Form

MIDDLEWOODS OF FARMINGTON

Many Residents have expressed that they would like to know when one of their dear friends is in the hospital. Residents often want to know where someone is so they can send wishes for a speedy recovery. Due to HIPPA (a privacy law), Middlewoods of Farmington is unable to disclose this information without your permission.

If you would like others to know when you are out of the building and where you are, please fill out the form below.
We will never share any medical information.

If you do not want your information shared, please disregard this letter. We will be keeping a book at the front desk with this information enclosed.

I, _____, give Middlewoods of Farmington permission to disclose my location if I am to need hospitalization or rehabilitation.

_____ _____
Signature Date

Tool M. Southington Care Center's Tranquill Passages Assessment Tool

TRANQUILL PASSAGES ASSESSMENT

Name: _____ Room Number _____

Passage 1	**Passage 2**	**Passage 3 (Final)**	**Death**
Assessment initiated Date: _____	Signs that EOL is imminent Date: _____	Actively Dying Date: _____	Date: _____

Referral to Tranquill Passages	**By Whom**	**Date**
From inside SCC Staff		
From outside source		

Aware of Referral ☐ Resident ☐ Representative

Advanced Directives	**Date**
☐ CPR	
☐ DNR	
☐ Terminal Care	
☐ No Artificial Feeding	
☐ No Artificial Hydration	
☐ Do Not Transport to Hospital	
☐ Living Will (or similar)	
☐ Copy of Living Will in Chart	
☐ Durable POA	

Tranquill Passages Alert	**Date**
☐ Weight loss 5%/mos. or 10%/6 mos.	
☐ Hydration Update Not meeting fluid goal 72/hr	
☐ Frequent falls 2 or more in one week	
☐ Moderate to severe pain	
☐ Expression of dying	
☐ Change in functional status	
☐ ↓ in activities usually enjoyed	
☐ Agitation/ Δ in mental status	
☐ Wound--Stage 1 or more	

Assessment Completed	**Date**
☐ Nursing	
☐ Cultural	
☐ Social Service	
☐ Spiritual	

	Date
☐ Terminal Care Orders Obtained	
☐ Hospice Referral	
☐ Hospice called (Name)	

Printed Materials	**Given To**	**Date**
Tranquill Passages Brochure		
Hard Choices for Loving People		
Care Notes		
Complimentary Therapy Brochures: ☐ Massage Therapy ☐ Therapeutic Touch ☐ Aromatherapy ☐ Pet Therapy		

TRANQUILL PASSAGES ASSESSMENT

NURSING: Tranquill Passages Data Collection

Name: _____ Room Number: _____

Interview with	☐ Resident	☐ Family	(Name/Relationship)

Passage:	**1**				**2**				**3**			
Symptoms	**None**	**Mild**	**Mod**	**Severe**	**None**	**Mild**	**Mod**	**Severe**	**None**	**Mild**	**Mod**	**Severe**
Pain												
Anorexia												
Nausea												
Vomiting												
Constipation												
Diarrhea												
Dyspnea												
Difficult sleeping												
Fatigue												
Anxiety												
Agitation												
Delirium												
Depression												
INITIALS/DATE												

Passage	**1**	**2**	**3**
Date Pain Eval. Done			

Would You Like?	**Yes**	**No**	**Comments**	**Date of Referral**
Aromatherapy				
Massage Therapy				
Music			☐ CD player in room ☐ Family to provide CD player	
Pet Therapy				
Therapeutic Touch				
Volunteer Visits				
Tranquill Passage Cart			❑ Outside room ❑ Inside room	
Flag for Veteran			❑ Outside room ❑ Inside room	
Sacrament of the Sick			❑ Prefer now ❑ At time of death	
Preferred Church			❑ Church called	
			❑ Sacrament of the Sick given	

Additional Information:

Signature: _____ Date: _____

CULTURAL & SOCIAL SERVICES: Tranquill Passages Data Collection Update

Name: _____ Room #: _____

(Refer to Social Services, Cultural and Spiritual initial assessments.)

Interview with	☐ Resident	☐ Family	(Name/Relationship)

CULTURAL	**During the dying process, what. . . .**
	cultural practices/customs are important to you?
	religious practices are important to you?
	prohibitions do you have?
	food preferences or prohibitions do you have?
	do you fear most?
	is most important about your care?

Signature: _____ Date: _____

Interview with	☐ Resident	☐ Family	(Name/Relationship)

	During the dying process . . .
SOCIAL SERVICES	how can Social Services support you?
	how can Social Services support your family?

Signature: _____ Date: _____

SPIRITUAL: Tranquill Passages Data Collection Update

Name: _____ Room#: _____

Interview with: ☐ Resident ☐ Representative (Name/Relationship) _____

1. Are you part of a religious/spiritual congregation? _____

   Name of your congregation _____

   Location of your congregation _____

   Name of pastor _____

2. Would you like us to contact your church or congregation and let them know that you are here at SCC?

   ☐ Yes ☐ No Date contacted: _____

3. Would you like someone from our Pastoral Care department to visit with you?

   ☐ Yes ☐ No Comments _____

4. Is there a person or group of people who are very important to you and who you really love?

   _____

5. Is prayer or meditation important to you? _____

   Are there things that you would like to help you pray or meditate? (i.e. rosary, bible, prayer book, devotionals, music) _____

6. What gives your life meaning? (i.e. beliefs, places, physical items) _____

   _____

7. We have many religious activities here at SCC, would you like to participate in any of the following?

☐ Catholic Communion	☐ Daily Devotions
☐ Rosary	☐ Bible Study
☐ Weekly Christian church service (all faiths)	☐ Hymn Sing-Alongs

8. Are there any other Spiritual activities you enjoy? _____

9. How would you describe yourself?

☐ Very religious	☐ Not religious
☐ Fairly religious	☐ Against religion
☐ Slightly religious	☐ Spiritual

10. What spiritual resources do you have?

☐ Faith	☐ Prayer
☐ Hope	☐ Scripture
☐ Meaning / Purpose	☐ Other

Comments:

Signature: _____ Date: _____

Tool N. Landis Homes Retirement Community's Star Comforter Service Brochure

In addition to the nursing staff, social services staff and our campus chaplains, Landis Homes offers the ***"Star Comforter Service."*** The program offers the services of a core group of trained volunteers available to support terminally ill residents at any location within Landis Homes. The service offers someone to be with you during the last days or hours of life.

Any questions regarding this service can be directed to

- **Ethel Caldwell, NHA Administrator of Health Care ext. 3572**
- **Social Services, ext. 3591**

Landis Homes

1001 East Oregon Road
Lititz, PA 17543
(717) 569-3271

jes designs
10/2009

Star Comforter Service

Support in your Time of Terminal Illness

What does the Star Comforter Program offer?

A group of volunteers has been specially trained to be sensitive to your physical, psychological and spiritual needs while honoring and respecting your wishes.
A volunteer will be with you for whatever amount of a time requested, providing he/she is available. The service is offered during the day, evening or through the night, including holidays and weekends.

Some things found to be most comforting are

- playing soft music
- reading
- gentle touching (holding hands, light massage)
- being a quiet presence

There are other comfort measures that can also be suggested or used, depending on your desires. Volunteers and staff will work with you to accommodate your desires whenever possible.

How do I use this service?

Please request the service of a volunteer through social services, nursing or pastoral care and explain that you are interested in the service. They will contact the volunteer.

When your request is made, it is helpful to have an idea of how many hours you would like to have the support of a ***Star Comforter*** volunteer.

CULINARY ENGAGEMENT

—Down here you sit at the table with other people and you become like a mini family."
(Nursing Home Resident)

Dining has garnered much attention from those working to improving the experience of residents and staff in their long-term care communities. It is the one thing that all of us can relate to. Food frames our memories. It reflects our culture and history, and is an important aspect of many of our most cherished traditions and rituals.

An important discovery for many organizations is the amount of change that can be implemented in a community through dining transformation. For example, if one chooses to have open dining times, this may lead to more expansive choice related to wake and sleep times. Those that implement liberalized dining may expand the care planning process to include additional input and education of individuals and their families. Many communities that start with dining are pleasantly surprised to discover how other processes shifted as a result.

Liberalizing Diets

Liberalized diets are defined by efforts to relax dietary prescriptions often established initially to help manage or treat a disease like diabetes, high blood pressure, congestive heart failure or heart disease. Beyond supporting improved quality of life where a resident enjoys food and beverages that are familiar and satisfying, a move toward liberalized diets also has been shown to result in improved intake and a decrease in the malnutrition and unintended weight loss that often occurs when residents are served food they don't want—and consequently won't eat.

Balancing food enjoyment and satisfaction with nourishment and safety concerns takes the entire healthcare team, including dietary, nursing, therapy, and physicians. It also takes creativity, resourcefulness and teamwork. For the diabetic resident, though, whose dessert options are expanded beyond sugar free pudding with an aftertaste to include the same desserts served to everyone else in the dining room (through a carb controlled approach in a smaller portion), the results of a liberalized diet can be profound, enhancing not only intake, but also a sense of inclusion, pleasure and satisfaction.

Another benefit of liberalization is the impact on staff. The more restrictions and details, the more room there is for error. When liberalized diets are introduced, production for the culinary team becomes more efficient and mistakes in providing detailed diet orders often decrease.

At Parkside Special Care Center, an exclusive Alzheimer's/dementia home in El Cajon, California, the dietary manager and dietitian made recommendations to liberalize thirty-six out of the fifty-two residents' diets. Doctors, upon careful review, agreed to all the recommendations over time, recognizing that mid to late stage dementia residents should have fewer restrictions and more flexibility in food offerings.

ADDITIONAL RESOURCES:

Creating Home in the Nursing Home II: A National Online Symposium on Culture Change and the Food and Dining Requirements

www.pioneernetwork.net/Events/CreatingHomeOnline/Symposium/

All the webinars and accompanying papers from the Creating Home in the Nursing Home II symposium can be downloaded at no cost, including:

Bowman, Carmen S., MHS (January 28, 2010) The Food and Dining Side of the Culture Change Movement: Identifying Barriers and Potential Solutions to Furthering Innovation in Nursing Homes. Pre-symposium paper.

Wayne, Matthew S. MD, CMD and Leible, Karyn P. RN, CMD. (2010) The Role of the Physician Order. White Paper.

Dining Interview Sheets

Liberalization is a very careful, intentional and individualized process. At Brewster Village in Appleton, Wisconsin, a dining interview sheet is used to re-evaluate each resident's needs and requirements. Though primarily completed by the dietary staff, CNAs and rec aides are also involved in gathering information about residents' food likes and dislikes, snacking patterns and meal routines. The findings are input into an electronic charting system which generates a user-friendly overview of each resident's needs and preferences. These are incorporated into dietary binders located on each household as a reference for staff to consult about specific residents.

See Brewster Village's Interview Sheet, page 204.

The Involvement of Speech/Language Therapists in Liberalizing Diets

Many therapists are moving toward only providing mechanically-altered food when absolutely necessary. For instance, rather than downgrading someone to puree from mechanically-soft chopped, mechanically-chopped ground is being offered as an interim option. Another approach is to only offer mechanically-altered items as necessary, such as a resident who can tolerate mechanically-chopped vegetables and starches, but may need pureed meat. Individualizing items still provides food recognition and a sense of dignity for those who struggle with altered food presentation and tolerance. Having a creative and aggressive therapy department is a key component in liberalization, including upgrading altered diets. As residents improve, it is vital

that, when appropriate and safe, upgrades are made to return residents to food that is tolerable and more conducive to their satisfaction and intake.

Finger Foods
Providing finger foods enables residents to maintain the freedom to feed themselves for as long as possible. This can be particularly important for residents with dementia who may begin to lose their ability to properly use utensils.

THE CASE FOR ADOPTION:
Nutrition Education

Educational offerings on diet, nutrition and the risks of significant changes in weight can be particularly important for short-term residents preparing for a return home. As hospitals are beginning to be penalized for readmissions, they too will be looking for long-term care settings that take the added steps to ensure residents are educated, informed, and successful when pertaining to their nutritional status.

Supporting Residents in Making Wise Nutritional Choices Through Education
As diets are liberalized, opportunities are created for experienced dietitians, dietary managers, and chefs to educate long- and short-term residents on making wise nutritional choices, and helping them to understand how their decisions, good or bad, may affect their overall health. Setting up consistent seminars in a community, with invitations to residents, families, and staff, will allow for continued education and personalization of care. Healthy snacks and beverages may be provided to promote positive nutrition and topics could include diabetes, gluten-free diets, heart disease, and dysphasia. Additional hand-outs may include names of grocery stores providing items that encourage certain diets, support groups for specific diseases or ailments, or health and nutrition association contacts numbers and Web sites.

A corollary to a resident-directed approach to food and dining is that residents (or family members if assisting with their choices) may make health and nutritional decisions contrary to professional recommendations conferred by well-meaning staff. In these cases, it becomes incumbent upon the entire team to make all efforts to provide thorough education on why certain recommendations were made, as well as the risks and potential hazards of contrary choices. At Victoria Special Care Center in El Cajon, California, when a resident makes nutritional choices that diverge from the professional advice, the resident or decision-maker is asked to sign a **Resident Nutritional Consent Waiver** consenting to the choice in spite of the education and recommendations that were made. The waiver documents steps taken and parties included in the educational process, such as the doctor, DON, and dietitian. The choice is then routinely reviewed with the resident and family during care planning sessions, with education on the potential implications of the choice ongoing. Documentation of the choice and the continual education provided demonstrates that the choice was resident-directed and that any personal risk assumed was done so with a thorough understanding of that risk.

See Victoria Special Care Center's Resident Nutritional Consent Waiver, page 205.

Risk Management

There can at times be a fine line between accommodating the choices and preferences of those we serve and safeguarding them through adherence to regulations designed to preserve their wellness and safety. This can be particularly difficult when dealing with universal guidelines or restrictions. Ensuring compliance may have to include some creative measures, including warnings posted in the dining room, residents' rooms, or directly on menus. Some examples can be taken from the restaurant approach to these measures, such as the service of undercooked (dippy) eggs or rare, red meats. Such approaches provide appropriate warnings to all who enjoy these food preparations, but also allow them the freedom of choice to satisfy their preference.

Meeting Individual Preferences

"I am a fussy eater and I tell them that. But if I don't like it, they will get you something else." (Nursing Home Resident)

Individualizing meal and snack preferences for residents may seem like a daunting task, but numerous communities are demonstrating that accommodating resident requests and preferences is possible. At Holbrook Health Center at Piper Shores in Scarborough, Maine, the dietary staff meets with residents and families to review choices, preferences and alternate menus. Personalization not only allows residents to choose what they would like to eat but also where they would like to dine.

Full Service Menu
At Evergreen Retirement Community in Oshkosh, Wisconsin, residents in some assisted living accommodations select their meals from a full service menu provided during meal times, similar to a restaurant experience. An order is placed by the residents to a server and the meal of their choosing is then cooked to order.

Soup and Salad Bar
At St. John's Lutheran Ministries in Billings, Montana, a soup and salad bar is set up in the dining room for residents to pass through and build their own salads and choose food items to their liking.

Late Breakfast Policy
Meeting individual preferences refers not only to what one prefers to eat, but also *when* one prefers to eat. Providing flexibility in meal times facilitates residents in maintaining their own personal routines. At Victoria Special Care Center, residents who prefer to sleep in have the option of a later breakfast.

See Victoria Special Care Center's Late Breakfast Service Policy, Page 207.

Varied Dining Venus
Offering choices for where a resident may enjoy a meal creates additional opportunities for individualization. A number of organizations have looked beyond the dining room, offering residents the option to eat in their own room, in a café or bistro environment or on an outdoor patio.

S T R E T C H GOAL	*Whereas in many communities a food council is an advisory group, Brewster Village's Food Council and Evergreen Retirement Community's Dining Team are resident-run and directed groups with significant authority over the culinary experience of the community. Some staff may attend, but it is the residents who make the agendas and decisions. Topics include menu items they would like added or removed, complaints or suggestions about service or delivery, and planning menus for holidays and special events. Informed by this resident input, the culinary team uses its skills and resources to provide these resident-directed choices.*

Resident-Centered Menus
At Victoria Special Care Center, residents (and families) are encouraged to create individualized menus to reflect either preferences or diet restrictions, such as vegetarian, gluten-free, or religious diets. The culinary team is then provided the necessary education and flexibility to accommodate requests for specialized diets, and all altered menus are reviewed and approved by the registered dietitian to meet nutritional needs and requirements.

The freedom and permission to not only meet needs, but also requests, has created an environment conducive to individual choice and satisfaction. The foundational philosophy at Victoria Special Care Center states that "The answer is always yes." Administration instructs staff to say "yes" first and then figure out a way, with appropriate support, to make it happen. Whether a resident prefers a made-to-order omelet for dinner, fresh catfish, homemade tortillas or falafel, the culinary team ensures these requests are accommodated. Even if a resident is just having a bad day or is struggling with a recent transition to Victoria, a staff member will be sent to the resident's favorite restaurant to bring food back for them or the chef will make a steak dinner to their liking.

Stocking Foods Based on Residents' Preferences
Choices and preferences in food are critical components to resident satisfaction, overall health, and nutrition, including intake levels. In individual neighborhoods at Brewster Village and St. John's Lutheran Ministries, hamburgers, bagels, and other items are always stocked for residents to eat either as an alternative to a prepared meal or whenever they choose. In some homes, **24-hour menus** are created and distributed to resident rooms for the hours the kitchen is closed. **Stocking pre-made** or **grab and go items**, such as fresh fruit, yogurts, salads, sandwiches, and individual soups in an accessible kitchen refrigerator or at nurses' stations ensures that whether a resident wants a midnight snack or a new resident arrives after the kitchen is closed, nourishing and satisfying food is always available and accessible. Food intake charts may also be kept to track a resident's intake of these items for charting purposes and the dietitian's review.

Incorporating Resident and Family Recipes
Introducing resident and family recipes into the menu is a way to bring a resident's previous home into their present one, and can be an exciting process for the entire community, even if every residents' recipes aren't incorporated. Just knowing these types of recipes are used, rather than corporate or institutional menus, brings the warmth and comfort of home into menus. Some communities may choose to recognize residents through naming the items, such as Mary's brownies or Grandma Lucy's meatloaf. Offering newly admitted residents and families the opportunity to bring recipes can also be a source of new ideas. No two recipes are exactly the same, so even a different rendition of a similar item can add flair and slight variation to food items. This type of system embraces the history and traditions of individual residents and can also be a way to spotlight and celebrate the diversity of the community as a whole.

De-institutionalizing the Dining Experience

Considering residents can spend up to six hours a day engaged in dining and food-related activities, a commitment to resident-centeredness obliges an organization to ensure these periods of time are dignified, comfortable, and put residents at ease. De-institutionalizing the approach to dining service may be one of the most difficult, yet necessary, areas of focus. Balancing time constraints, varying needs and multiple seatings naturally drives a task orientation during meal periods. The way in which service is provided, though, is just as valuable as the food itself.

Trayless Dining
An important step toward creating a more residential dining experience is eliminating the use of trays. Serving all food and drinks directly at the table, rather than on individual service trays, provides a familiar and non-institutional atmosphere for enjoying meals. At Victoria Special Care Center, a member of the culinary team circles the dining room with a beverage cart prior to meal service, providing residents with their choice of beverages. Use of a **portable steam table** in the dining room adds both visual and aromatic appeal to meal times. While one member of the culinary team plates food items, the rest of the team serves the residents table by table. Staff and residents

Focus on Process

PILOTS

At Bishop Wicke Health Center, the need to overhaul the dietary process was clear but the way in which to do so was not. As a result, it was decided that changes should be piloted in one living area. Breakfast on the short-term rehab area was identified as being the meal most in need of change and various program changes were piloted there. As a —work in progress," feedback from all stakeholders was welcomed. The leadership team conveyed through their actions that it was important to identify problems with the changes but not point fingers. A quick, daily meeting of all the nursing and dietary assistants involved was held for the first few weeks, and bi-weekly thereafter. Ten minutes was all it took to ask, —What went well today?" and "What could make it better tomorrow?" After a successful pilot in this one area, the other previously tentative areas were asking when they could implement the changes as well.

know each other by name and the culinary team immediately provides the residents with any nutritional needs or requests they may have. This approach also allows the caregivers to focus on feeding, medications, and monitoring meal intakes.

Open Dining Seating

The elimination, or at least flexibility, in seating charts can provide residents with the opportunity to either sit in the same place or mingle with different friends at their own discretion. For some, seating preferences are very habitual and they could continue to have the option to "claim" their seat when entering the dining area. For others, as friends depart or decease, they may not desire to sit with the people that they are assigned with. At Victoria Special Care Center, those residents who "must" sit in the same spot are encouraged to arrive slightly early to ensure their seating preference is available and others are left with the choice to sit anywhere they would like. The only "reserved" tables are for those residents needing assistance during meals. Nursing recognized that the efficiency of supporting these residents was much more effective by having them together at several assigned tables. Of course, though, consideration should also be given to the relationships and interactions among these residents when making decisions about table assignments.

Dining Scarf™

These handmade scarves crafted out of colorful fabric are a more dignified alternative to a traditional bib. Patterns and a video resource can be obtained from the Alzheimer's Resource Center of Connecticut, Inc. through its Dining with Friends™ initiative at **www.alzheimersresourcecenter.org.**

Service Techniques to Break Down Barriers and Departmental Silos

Bringing the culinary team into the dining room is just one way to add more personalized service to the dining experience. At Saint Elizabeth Community in East Greenwich, Rhode Island the **nursing staff cooks and serves residents in the dementia area at a breakfast bar/kitchenette**, allowing nursing staff to provide and serve in a different capacity. This service technique allows residents to have their breakfasts prepared for them by the nursing staff while they sit at the counter and watch as it is being prepared. The timing of breakfast occurs when the resident wakes up and is ready to eat (up until 10:00 a.m.). While this did necessitate Saint Elizabeth Community to obtain a variance from the state for staff to prepare meals, it was well worth it for the pleasure it has provided to their residents.

Focus on Process

IMMERSION LEADERSHIP

At Messiah Village in Mechanicsburg, Pennsylvania, leadership immersed themselves into the dining process in both the skilled nursing and assisted living areas. In the assisted living setting, they immersed themselves with the team to identify the concerns and issues that were preventing a higher satisfaction rate from the residents. In skilled nursing, the leadership immersed themselves into the process of eliminating tray style dining. What was learned by leadership is that through immersion they are there to provide empowerment, feedback, and generate ideas in real time—implementing real sustainable change through being there.

For more on immersion leadership, see page 63.

Another approach for breaking down the anonymity of those who prepare the food for the community is to provide periodic **brunch-style service** with a made-to-order omelet or waffle station in the dining room. This allows culinary staff to cook and serve in the presence of residents.

See Saint Elizabeth Community's Policy on Preparing and Serving Breakfast, Lunch Supper and Snacks, page 209.

Consistent Assignment of Culinary Staff

See consistent caregiving, page 132.

THE CASE FOR ADOPTION: *Culinary Engagement*

An enhanced dining experience and culinary engagement have measureable impact on quality of life as well as clinical and organizational outcomes for the implementing organization.

- The use of real food that residents enjoy improves clinical outcomes in areas such as weight loss (69% reduction in the first three months and no "unavoidable" loss in six months for the cited study) and a decline in medication usage for laxatives and appetite stimulants (Bump, 2010).
- Organizations save money by reducing the use of supplements (a savings of $1,164 per month in the cited evaluation) and plate waste as residents eat foods of their choice (Bowman, 2010).
- A recent study found that enhanced dining options resulted in a 52% increase in resident satisfaction (Remsburg, 2010).
- In an analysis of the effects of an enhanced dining environment in nursing homes, particular focus on areas such as table dressings (tablecloths, napkins, flowers), family-style meals, and staff presence at the table resulted in significantly increased caloric intake for residents over a six-month period (Nijs et al., 2006).
- Research shows that independence with eating improves the quality of life of residents with dementia (Carrier, West & Ouellet, 2009).

Bowman, C. (2010). *The Food and Dining Side of the Culture Change Movement: Identifying Barriers and Potential Solutions to Furthering Innovation in Nursing Homes*. Pre-symposium Paper: Creating Home in the Nursing Home II: A National Symposium on Culture Change and the Food and Dining Requirements. Retrieved August 30, 2010, from www.pioneernetwork.net/Data/ Documents/dining%20symposium%20background%20paper%201-28-_10.pdf.

Bump, L. (2010). *The Deep Seated Issue of Choice*. Symposium Paper: Creating Home in the Nursing Home II: A National Symposium on Culture Change and the Food and Dining Requirements. Retrieved August 30, 2010, from www.pioneernetwork.net/Data/ Documents/CreatingHomeOnline/Paper-Bump.pdf.

Carrier, N., West, G.E., & Ouellet, D. (2009). Dining experience, foodservices, and staffing are associated with quality of life in elderly nursing home residents. *Journal of Nutrition,Health, and Aging*, 13(6), 565-570.

Nijs, K.A.N.D., de Graaf, C., Siebelink, E., Blauw, Y.H., Vanneste, V., Kok, F.J., & Van Staveren, W.A. (2006). Effect of family-style meals on energy intake and risk of malnutrition in Dutch nursing home residents: A randomized controlled trial. *Journals of Gerontology, Series A: Biological Sciences and Medical Sciences*, 61(9), 935-942.

Remsburg, R. (2010). *Home-style Dining Interventions in Nursing Homes: Implications for Practice*. Symposium Paper: Creating Home in the Nursing Home II: A National Symposium on Culture Change and the Food and Dining Requirements. Retrieved August 26, 2010, from www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-Remsburg.pdf.

Source: Pioneer Network, 2010

The Dining Environment
The dining culture may arguably be one of the most difficult barriers to overcome. Whether it's providing meals to fifty people in the same crowded room, rushing residents to eat to ensure scheduled service time for a second seating, providing temperature appropriate meals during room service, or dismantling the institutional feel during meal times, tasks tend to override an atmosphere of hospitality. There are some basic approaches that can be taken in all communities to enhance an environment of hospitality, including:

- Using **two- and four-top table setups** rather than large table seating not conducive to personal conversation (though family-style group dining does work well in small neighborhood settings)
- Enhancing tablescapes with **appealing linen**, **cloth napkins**, **flameless candles, fresh (non-poisonous) flowers**, and **holiday-appropriate items** (in collaboration with activities)
- Piping in **music** chosen by residents
- Investing in enhanced dining ware, such as **porcelain plate ware** and **"glass-like" drink ware**
- Utilizing **outdoor areas and patios** including built-in or portable grills, weather and space permitting.

Certainly, some of these items may come at an initial expense, but these approaches can immediately begin to de-institutionalize the feel of the dining environment.

There may even be opportunities for **local musicians** to come to the community over meal times, such as at St. John's Lutheran Ministries. During meals in their independent dining room, local volunteers from the community set up at the entrance of the dining room and play acoustic guitar, adding ambiance and serenity during meal service.

Residential Style Dining
A natural place to start in creating a home atmosphere for dining is to ponder the question "*How does it feel when I enter my dining room and sit down for dinner?*" Responses may include: eating with familiar faces, choosing to sit outside if the weather is pleasant, enjoying a meal with family, and dining family-style (food served out of larger bowls placed in the center of the table). In examining the experience of dining in a residential community, it is important to consider whether the tasks and side conversations of staff outweigh the dialogue and communication with residents, including staff pulling up chairs to converse with them during meals. Are carts and dirty dishes in constant visible sight or does it feel like mom is quietly moving around, cleaning dishes and making everyone feel at home? Is service ware matching and in good order or are random dishes and cups used, suggesting that we serve with whatever we can find? There are so many low to no cost changes that can be made to the dining experience; creating atmosphere does not have to cost much monetarily, but rather is an intentional process of time, thought, and walking in the shoes of those we serve.

Restaurant Style Dining
At Parkside Special Care Center, there were concerns about residents with varying levels of dementia dining together. Those who needed minimal assistance would become highly agitated by the noises, interruptions, and eating processes of those around them. In deciding it would be

conducive to provide separate dining areas for the different levels of care, restaurant-style dining was created for a select group of residents. Tables and chairs are set up in the living room by housekeeping and maintenance with contrasting colors of linen tablecloths and napkins, flameless candles, era-appropriate music, porcelain plate ware, and fresh-cut flowers. Residents are seated and provided with fresh-baked bread and water upon their arrival. One caregiver then serves each resident in courses, removing a course and providing them with another one as they finish individually. It can be particularly overwhelming and even detrimental for residents diagnosed with dementia to have several drinks and courses placed in front of them at once. The feelings of being overwhelmed and unable to choose can lead to minimal intake. Alternatively, serving one item at a time allows for residents to solely focus on what is in front of them. Removing used dishes and drink ware also provides a greater sense of dignity and normalcy. Parkside also invites the caregiver to sit and eat with the residents they are serving during meal times, blurring staff roles and adding a personal touch to the dining experience.

See Parkside Special Care Center's "Lunch Bunch" Policies and Procedures, Page 211.

Engaging Everyone in the Food Culture

It takes the voices, opinions, and experiences of all to provide diversity, cultural sensitivity, freedom of choice, and individuality—all components of providing food in a resident-centered manner. Consider the culinary team the mirepoix of the culinary experience. The mirepoix is the foundational ingredients of soups and stock. Those ingredients, though, cannot stand alone and can never create a finished product; they are only a base to build on. On a similar note, in settings committed to continuous improvement, culinary engagement is hardly relegated only to the staff working in the kitchen and dining rooms. It is a community-wide focus, with residents and family having input into the menus and contributing family recipes, and all members of the community coming together to support the optimal enjoyment of food and mealtimes.

Resident Involvement in Table Setting and Preparation

Oftentimes the rituals associated with meal preparation are among the activities that are most meaningful to residents as extensions of their lives in their prior homes. Recognizing this, a number of communities have moved toward providing opportunities for residents to be engaged in table setting and preparation of the dining room. At Parkside Special Care Center, members of the culinary team sit at a table with a few residents prior to meal time and roll silverware into cloth napkins. Proper preparation is followed, such as hand washing and the use of gloves. Residents are then able to sit down, relax, converse with staff, and enjoy this preparation for meals. Other residents enjoy helping caregivers with the table settings, such as preparing tables with tablecloths, silverware and flowers.

See Parkside Special Care Center's Silverware Rolling Policy, page 212.

Food Preparation and Certification

Any move toward the inclusion of those outside the culinary team in food preparation and service starts with providing the necessary education and information on proper food handling techniques. When St. John's Lutheran Ministries recognized that families and residents desired

to prepare food in household kitchens, the community offered **training classes in basic food preparation techniques** taught by qualified culinarians.

Caregivers of the neighborhoods at St. John‘s cook directly on each unit. To support them in this role, ongoing culinary education is provided by the on-site chef and culinary staff. In addition, they are all ServeSafe certified.

At Victoria Special Care Center where employees from multiple disciplines serve food from snack carts, **food handler‘s card classes and certifications** are given to ensure proper procedures and education in food handling. These extra steps also provide added assurance to surveyors when they see staff serving food. Records back up added education for those handing out and preparing food.

Community Herb and Vegetable Gardens
Limitations in long-term care used to include foods being brought in from the outside or grown in gardens within communities. Being under the blanket of an ―approved source,” such as a certified vendor, organizations have historically been very hesitant to provide any other food options. With resident choice now a principal factor and focus, however, many settings have opened their collective minds to a number of additional possibilities, including food brought in from families or fresh produce from a community garden. When considering implementation of a community garden, it is important to be informed about and adherent with compliance issues, such as all organic, raised beds (for wheel chair accessibility and rodent control).

The herb and vegetable garden at Parkside Special Care Center is a community-wide project, with residents and staff from human resources, housekeeping, culinary, maintenance, activities and the business office all actively involved. Garden boxes were built by maintenance staff and moved into a large, gated park next to the community to accommodate multiple residents. Residents are led to the garden in small groups to participate. One box was set aside for herbs and vegetables and another box was planted with flower bulbs to eventually, when bloomed, be placed on resident dining tables. This program became healing for all involved, allowing staff the opportunity to become engaged in unique ways in residents‘ lives and, at the same time, providing residents with a feeling of home.

See Parkside Special Care Center‘s Garden Policy, page 213.

―Celebrity Chef”
Food and cooking television programming have become a popular form of entertainment that make viewers feel like ―foodies” and chefs in their own right. Parkside Special Care Center, convinced that cooking demonstrations for those with dementia would not only bring enjoyment, but also recollection of times past, began a program under the direction of the administrator coined ―Celebrity Chef.” The administrator—an excellent cook with a passion for food—provided the first few presentations for the residents, creating items from scratch and explaining ingredients and the process. The creation was then served for all residents and staff to enjoy. Other staff members began to join in, sharing and preparing their recipes with the residents while wearing an official chef‘s hat and coat.

Cooking Classes for Dietary Managers and Staff
Though many dietary managers have excellent clinical and basic food preparation skills and the culinary team is well-equipped to follow standardized recipes, when the goal is to elevate the dining experience, the culinary team may benefit from the expertise of those with a culinary or hospitality background, such as food vendors, local chefs and/or an employed certified chef. Possible topics for educational sessions include made-from-scratch soups and baked goods, garnishing techniques, knife skills education, and serving appealing pureed foods. Regardless of the approach or who provides the education, a strong statement of support is made to the culinary team when they recognize the investment in their professional development.

Professionalizing the Culinary Experience

Language
A recurring theme of this Guide is the extent to which language influences attitudes and behavior. A dignified and carefully thought out approach to language should also be incorporated into the culinary sector. Altering and upgrading the verbiage used to describe the culinary team and their positions can automatically add a sense of professionalism to the environment and a feeling of dignity to hard-working staff. Replacing outdated and hospital-like terminology with creative language brings originality, innovation, and a unique sense of identity to culinary professionals and the entire community. This chart includes a few examples to consider:

From…	*To…*
Dietary Department	**Culinary or Hospitality Team**
Lead Cook	**Sous Chef**
Dishwasher	**DMO (dish machine operator)**
Dietary Aide	**Food or Beverage Server**
Director of Dietary Services	**Culinary Director or Executive Chef** (if applicable)
Menu	**Offerings**
Bib	**Clothing Protector**

Hiring Certified Chefs
A number of long-term care communities are moving toward hiring qualified, certified chefs to create their menus and to accommodate personal requests and preferences. While this is no doubt a significant financial investment, it has been an important strategy for expanding resident choice, enhancing the dining experience, and creating a bridge between quality of care and quality of life. Furthermore, the case can certainly be made that it is more feasible to teach a chef the clinical side of healthcare through the dietary certification process and oversight of a dietitian than it is to teach a clinical dietary manager with minimal food background what it takes to meet the daily food demands and requests of our residents, families, and staff.

Though chefs entering long-term care may be unaware of the term ~~–e~~ulture change," their professional training has undoubtedly imbued in them a commitment to innovation, personalized service and a deep vision for progress through their passion for food. With a certified chef on staff, herb and vegetable gardens on the premises become a focus of recipe development,

culinary classes and food presentations educate and entertain the entire community, nutrition and education seminars are taught, menus are changed more often and fresh ingredients and made-from-scratch recipes are instituted.

Promoting Hospitality
Activities such as **Gourmet Night** or **An Evening with the Chef** can be hosted to spotlight the in-house culinary talent. Featuring a special, "higher end" menu, personal invitations are sent to residents, family members, doctors, potential discharge connections, and the local community-at-large. Having department heads and other staff present for a meet-and-greet elevates the potential of the event as a marketing opportunity.

Employee Attire
De-institutionalizing dining requires examination of all aspects of the experience, including the attire of culinary staff. Institutional, all-white uniforms can be replaced with a more up-to-date bistro look that appears professional and offers recognition to residents and guests as to the identity of the culinary team.

With many settings embracing casual dress for all employees, it can be difficult at times to determine who the dining services staff may be. Ensuring all members of the community are able to recognize the culinary team builds personal relationships and provides a comfort zone for those in the community. In this case, providing identifiable aprons stitched with the name and insignia of the community offers easy recognition of culinary staff for residents and guests.

Nurturing Through Food

Engaging and nurturing people through food is not merely the provision of three meals, nourishments between meals, and an occasional activity with a few snacks. In our personal lives, food availability is a constant and stable resource, and any event preparation with family and friends begins with the phrase, "What food can I bring?" Providing ample opportunities for people to connect around food creates a more dynamic community and should inherently be the responsibility and passion of more individuals than just the culinary staff.

First Impressions
Regardless of who walks through the front door of a long-term care community—a new resident, visiting family or friends, guests taking tours, doctors, or applicants interested in employment—the importance of first impressions cannot be underestimated. When entering the lobby at Victoria Special Care Center, everyone is welcomed by the receptionist or a staff member with an offer of a beverage or something to eat. A beverage station in the lobby is stocked with assorted hot and cold drinks and appetizer menus are offered for guests to peruse. Meals are offered to families as well, with reassurance that the food they are eating is the same menu item with the same quality served to their loved ones.

Beyond the Kitchen and Dining Room
Other forms of nurturing through food may include **baking bread in resident areas**, having **baking and cooking activities** in which residents prepare the items and then enjoy the fruits of

their labor, or having **community barbeques** not attached to a specific holiday. Victoria Special Care Center also provides **daily afternoon snack carts** for everyone to enjoy. A wooden, canopied cart, hand-built by the maintenance department, is wheeled up and down the hallway each afternoon. Items offered include fresh fruit, cheese and crackers, fruit smoothies and ice cream floats. Several times throughout the week, a carnival-style **popcorn cart** moves through the hallways as a culinary team member offers all staff, residents and guests freshly-popped popcorn. Removing the anonymity of those who prepare food and bringing it into the community creates a culture of familiarity and also provides the aromas associated with home.

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Chef Soup Class for Residents and Staff
At Victoria Special Care Center, residents and staff gather in the dining room and the chef creates a made-from-scratch soup for the entire community to enjoy. The chef explains the origin of the soup, any history related to it, and the ingredients used in preparation. The response of the residents after a taste test becomes a barometer to gauge whether or not that specific soup will make its way onto the menu. After each class, the chef takes requests for what the residents would like to have in the following months. Requests have included family favorites, cultural recipes, and chilled summer soups. Regardless of the creation, the residents always enjoy this time of education, interaction, and best of all… home-made soups to enjoy.

Celebrating Diversity through Food
Considering many long-term care settings are melting pots of cultures from around the country and world, it is important that the food provided reflects this diversity. At Landis Homes in Lititz, Pennsylvania, food is used to help cross cultural divides and celebrate the rich diversity within its community. Finding its workforce becoming increasingly more diverse, the organization introduced **Diversity Meals**. These meals are prepared by staff or residents of different ethnic and cultural backgrounds to reflect their food traditions. Meals are shared with residents and staff, and are accompanied by a brief presentation about the culture and origins of the selected food items.

Food for Staff

Any effective resident-centered approach, though centered on the experience of residents, is also attentive and responsive to the specific needs of staff. One way to support and care for staff is through an **employee meal program**. Several avenues can be taken, but the end result has multiple benefits. Employees eating the same food as residents encourages staff to promote intake and familiarity to the residents during meals. The opportunity to receive a quick and timely meal on-site allows staff to enjoy a more leisurely and restorative thirty minute break,

rather than having to the leave the site for food. The provision of a complete and nutritious meal means that staff won't be relegated to eating fast food or skipping meals altogether, resulting in more energy and better productivity throughout the day. Employees also realize a financial benefit, considering typical to-go food can cost anywhere from $8-$12, considerably more than the standard cost of an employee meal provided on-site. Finally, it saves staff some precious time at home, freeing them up from having to pack a meal prior to coming to work.

Whether it's a barbeque, major holiday, or indulging in a treat from a snack cart, including staff as part of resident celebrations and events can also boost morale and be another benefit to employees.

See Victoria Special Care's Center's Employee Meal Program Policy, page 215.

S T R E T C H GOAL	*Middlewoods of Farmington in Farmington, Connecticut provides **to-go meals** for employees at a nominal cost. Employees place a food order, which is then boxed up by the culinary team for them to pick up at their convenience before they leave for the day.*

Culinary Engagement Implementation Tools

Tool A. Brewster Village Interview Sheet

Interview Sheet

Preferred Name:
_____

Where did you live before coming here?_____

Where you living alone/with someone:_____

Diet:_____

Any restrictions:_____

Diet History:_____

Meal pattern:_____

What did your meals consist of?_____

Snacking Pattern
What type of snacks do you prefer?_____
_____

Food Preference
Chewing problems:_____

Swallowing problems_____

How is your appetite?_____

Medical Information:
Height_____
Weight_____
Usually weight_____
Weight gain or loss in the past month_____ 6 months_____
Allergies to any food?_____

Any problems with nausea/diarrhea/constipation/congestion?_____

Teeth_____ Dentures upper lower good repair

Tool B. Victoria Special Care Center's Resident Nutritional Consent Waiver

Risk and Consequence Form

I, _____ am aware that I am at risk for

_____

_____

due to _____.

I wish to _____

_____

despite recommendations by my physician and speech- language pathologist.

_____ Date_____

Patient

_____ Date_____

Responsible Party

_____ Date_____

Speech Language Pathologist

Refusal to Follow Prescribed Diet Release Form

I _____ understand that my physician Dr. _____ for reasons of my health and medical treatment, has ordered a _____ diet due to a medical diagnosis of _____. I _____ understand that not following the prescribed diet will be detrimental to my health and well being and could cause medical complications such as _____ _____. I do not wish to follow the diet that has been prescribed for me by my physician, my family members, and my other advisors. I have been advised of the benefits and risks of not following my prescribed diet. I therefore declare that it is not my intention to follow my prescribed diet and request that I be provided with substitute food.

_____ _____

Signature of Resident Date

_____ _____

Witness Date

Tool C. Victoria Special Care Center's Late Breakfast Service Policy

LATE BREAKFAST SERVICE POLICIES & PROCEDURES

Victoria Special Care Center
654 S. Anza Street, El Cajon, CA 92020
Ryan Krebs, Executive Chef

CNA's Responsibilities:

- Night shift CNA's are to ask every resident in their section, before putting them to bed, if they would like their breakfast at the regular service time (6:30am) or at the later time (8:45am).
- CNA's will then fill out breakfast slips according to resident's choice for breakfast time.
- For those residents who chose late breakfast, the CNA should simply write **LBC** (Late Breakfast Cart) on the slip.
- Late breakfast residents will be indicated by the night CNA placing the appropriate sign outside the resident's room, with the corresponding room number (A or B). This will ensure the morning CNA's, rehab, etc. do not wake the resident before their chosen meal time.
- CNA should turn in all breakfast slips to the appropriate nurses' station.
- Morning CNA's are responsible to take all breakfast slips to Dietary Department for morning meal service.
- Once late breakfast carts are delivered in the morning at 8:45am, it is the CNA's responsibility to distribute breakfast to the appropriate residents.

Dietary Responsibilities:

- Each morning, when nursing delivers breakfast slips, Dietary must separate regular meal service slips from late breakfast slips (which will be marked LBC).
- LBC trays will be produced after final meal in dining room is served.
- LBC trays should be ready by 8:45am. Trays should be produced in the kitchen and taken to appropriate stations in insulated room service carts for CNA's to distribute.

Tool D. Brewster Village Food Council Committee Description

Villager Food Council Committee

I. Purpose of Village Food Council:

A. Villagers will have an avenue to provide input into menu items offered.

B. Villagers will participate in the planning of menus for special events and/or holidays.

II. Village Food Council Members:

A. Villagers from Brewster Village Neighborhoods.

B. Employees from activities, dietary and social services.

III. Meetings:

A. The committee meets 5 times a year (January, March, May, September and November).

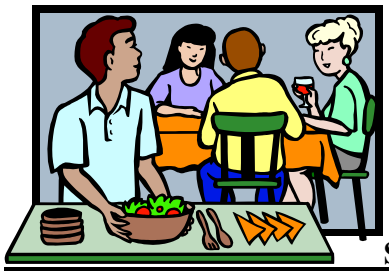
B. The meetings will be held on the 4th Tuesday of the aforementioned months at 3:30 PM.

C. Team members will be notified by appointment cards, and the activity calendar will list date and time of meeting.

IV. Role of Food Council Members:

A. To represent peers from their neighborhood in relation to food ideas, questions, or concerns.

Tool E. Saint Elizabeth Community's Policy on Preparing and Serving Breakfast, Lunch, Supper and Snacks



SAINT ELIZABETH COMMUNITY

PREPARING AND SERVING BREAKFAST,LUNCH,SUPPER AND SNACKS IN ADDITION TO FACILITY PREPARED MEALS/SNACKS.

EMPLOYEE RESPONSIBLE: ALL EMPLOYEES

Anyone who prepares food will follow the safety precautions to protect themselves and residents. All staff is trained on infection control policies and procedures in orientation and yearly with mandatory inservice training.
Dietician will provide mandatory additional training in food prep and food handling to all staff involved in cooking initially and then annually.

POLICY: STAFF WILL PREPARE FOOD IF THE RESIDENT REQUESTS IT.
FOOD WILL BE PREPARED IN KITCHENETTE AREAS/HOUSEHOLD KITCHENS ON UNITS/DINING ROOMS and/or COFFEE SHOP
MAY USE STOVE,MICROWAVE,GRIDDLE,FRYER ETC.
SPECIAL EVENT MEALS MAY ALSO BE PREPARED
FOOD WILL BE AVAILABLE 24 HOURS A DAY.
ITEMS SUCH AS(but not limited to):
Cookies, breads, sandwiches, eggs ,toast, bagels ,soups, canned foods, dessert
Replicate special foods residents enjoyed in the past

PROCEDURE:

- Hair will be restrained if required.
- Wash hands-employees practice acceptable personal hygiene habits. Gloves are used only for handling ~~"r~~eady to eat" foods.
- Put on clean apron:

Change apron when:
-It becomes soiled
-When leaving the kitchen to go to the rest room
-Upon returning to the kitchen from another area
-After performing cleaning tasks

- Wipe down counters and work area with sanitizer solution.

-Employees are aware that the environment is conducive to protecting the health and wellness of the residents and employees through high levels of sanitation standards.

- Review residents‘ diet orders
- Prepare residents‘ food items as requested.
- Employees have an understanding of food temperature/time controls. Foods will be served at the appropriate temperature to ensure good flavor and to prevent food borne illnesses.
- All food is properly wrapped, dated and labeled. All store food in a safe and sanitary matter.
- All warewashing principles are practiced. Send all ware to central dishwasher for cleaning.
- Mandatory ―clean as you go” policy
- Employees all have a firm understanding of infection control precautions and food prep regulations.
- Sanitary garbage storage and disposal is practiced.

Tool F. Parkside Special Care Center's Lunch Bunch Policies and Procedures

"LUNCH BUNCH" POLICIES & PROCEDURES

Written on: September 25, 2007
Ryan Krebs, Director of Dietary Services
Parkside Special Care Center

- Lunch will be served for up to twelve (12) selected residents at 11:30 am in the Parkside Living Room; list of residents may change according to level of appropriateness
- Living Room must begin to be cleared of residents from morning activities beginning at 11:10 am, or as soon as morning activity is finished
- Three (3) tables must be set up in the living room **(Maintenance & Act. Assist.)** with twelve (12) chairs at the table by 11:20 am, or as soon as residents are cleared from the living room
- Tables are to be kept outside the sliding glass door inside the employee break area
- Tablecloths, linen napkins, candles, cd's, etc. will be kept in the locked, glass cabinet located in the Resident Living Room
- Keys to the cabinet will be issued to Activities Supervisor and Assistant, Maintenance Supervisor, Dietary Supervisor, and Laundry
- Table set-up **(Act. Dept.)** will include tablecloths, matching linen napkins at each chair, three (3) battery operated candles, and fresh-cut flowers, which will be provided on a rotating weekly basis by the **Parkside staff**
- **CNA on duty** will provide warm wash cloths for resident hand washing prior to and after meal being served
- Service and supervision of dining will include, but is not limited to, **one (1) CNA and one (1) Activities Department employee**.
- Bus tubs will be provided to remove dirty dishes when dining is finished; cart, dishes and soiled linens must be returned to the appropriately department immediately after lunch is finished **(CNA on duty)**
- Spot removal cleaner must be applied by **CNA and Act. Assist.** to tablecloths and placemats prior to placing in bags to be laundered
- Tables must be returned to area outside sliding glass door **(Housekeeping & Maintenance**), and chairs in living room must be re-set for afternoon activity
- After breakdown is complete, carpet must be vacuumed prior to residents re-entering living room **(Housekeeping)**
- If desired, **CNA on duty** may request one (1) lunch from the kitchen prior to service, to be eaten in the living room with residents after all residents are served; meal satisfaction forms will be provided by the Dietary Department for staff to evaluate meal

Tool G. Parkside Special Care Center's Silverware Rolling Policy

"SILVERWARE ROLLING" POLICIES & PROCEDURES

Written on: February 20, 2008
Ryan Krebs, Director of Dietary Services
Rene Jones, Activities/Social Services Director
Parkside Special Care Center

- Silverware activity should be done in an appropriate area for residents to be free of distractions, such as the empty dining room or the living room, if other activities are not being conducted at the time.
- Rotating departments will be chosen by Activities Director. A schedule for the departments' days will be consistent. It is the responsibility of the individual Department Supervisors to decide who will be most appropriate to perform the activity at the allotted time. This should be done at the beginning of the shift, so the responsible staff member is aware of the time and activity.
- Two residents will be chosen by the Activity Director to participate in the activity. If these residents are not able, or are uninterested in participating, communicate with the Activities Director who might participate instead.
- Times for the activity must be a priority to ensure readiness for mealtimes. Scheduled times are as follows:

    - 10:30am (for lunch)
    - 3:30pm (for dinner)
    - 7:00pm (for breakfast)

- Staff member must have 14 matching napkins (from Laundry or cabinet in living room) and 14 sets of spoons and forks (from Dietary Department).
- Staff member must wash hands, and assist residents in cleaning/sanitizing hands prior to activity. Process may include one of the following: Full hand washing procedures, cleaning hands with scented, soaped hand towels, or using sanitizer solution. If dirt or soil is visible on hands, full hand washing procedures must be followed.
- Gloves must be worn for entire activity. If resident touches hair, face, or any part of body, gloves must be changed.
- Seat residents at a clean, sanitized, clutter-free table (refer to Helping Programs Policy for complete details)
- Once activity is completed, take rolled silverware on a service tray to Living Room for next meal period. Place in locked cabinet.
- If resident shows or has contracted any form of illness, such as sneezing, cold, flu, etc., they may not participate in activity.
- Staff member must fill out Activities Evaluation Form by the end of their shift and return it to Ryan Krebs, Director of Dietary Services.

Tool H. Parkside Special Care Center's Garden Policy

Program: Helping Programs, Volunteer, and Work Related Programs

Alternate Titles: Garden Club, Gardening Club, Park Planting, Watch it Grow, Seeds of Change, Flower Arranging, Table Toppers

Policy and Purpose:

- To enhance a sense of well-being and to promote or enhance physical, cognitive, and emotional health.
- To promote feelings of self-esteem, pleasure, reminiscence, comfort, success, and independence.
- Promote the involvement in an activity "that amounts to something," such as those which produce something; activities using skills from residents' former work and life, and activities that contribute to the nursing home.
- NOTE: (from the F248 Interpretive Guidelines) Surveyors need to be aware that some facilities may take a non-traditional approach to activities…Residents, staff, and families may interact in ways that reflect daily life, instead of formal activities programs. Residents may be more involved in the ongoing activities in their living area, such as care-planned approaches including chores, preparing foods, meeting with other residents to choose spontaneous activities, and leading an activity."

Objectives/Outcomes:

- To enhance participants' feelings of self-esteem and self-worth through successful participation in tasks or programs that have purpose or connection with the work of the world.
- To utilize long-term memory skills and create the pleasures associated with a productive work environment.
- To exercise fine motor, large motor, and hand/eye coordination skills.
- To empower participants to select ways in which to enhance the appearance of their environment.
- To promote personal responsibility, creative expression and choice.
- To create the positive feelings associated with working toward a goal with team effort.

Equipment and Materials:
For flower arranging: A clean work surface, unbreakable vases, clean water, safe scissors or clippers, lists of edible and non-edible plants
http://homecooking.about.com/library/weekly/blflowers.htm
http://homecooking.about.com/library/weekly/blflowersnot.htm

For gardening: Planting beds (chicken wire over the top soil surface has effectively reduced planting soil being disrupted by cats or pests.) Purchased potting soil, purchased seeds or seedlings from commercial sources, above lists of edible and non-edible plants, washable garden gloves, trowels, watering cans or hose, sunhats or sunglasses, sunscreen according to participant needs

Program: Helping Programs, Volunteer, and Work Related Programs, continued

Program in Detail:
Consider the equipment, atmosphere and conversations normally associated with gardening or flower arranging activities. Consider a hand washing area, large print printed directions, pictures of flowers or gardens, or samples of finished arrangements. Include participants fully into the planning, preparation, and picking or harvesting step-by-step procedures.

Program in Detail:
Preparation and Procedures

- Consider obtaining a physician‘s order to approve resident‘s participation as a resident volunteer in work-related programs.
- Include program involvement into the Resident plan of care.
- Determine project to be prepared
- Obtain all required materials to complete the program. Have all materials in easily accessible containers, bags, or areas.
- Assist all participants to wash their hands before and after program.
- Wear gloves, sun hats, or sunglasses for comfort or as desired.
- Wash gloves and hats for visible soil and between different resident wearers.
- Consider storing gloves in zip lock bags to avoid having insects make home inside gloves between uses.
- Introduce participants to each other as desired or needed. Couple participants in compatible groups to foster dual assistance. Consider strengths and abilities.
- Explain desired outcome and show examples or samples.
- Direct participants through program.

Closure

- Show off the fruits of their labor.
- Praise and thank participants for their specific contributions.
- Inform participants of time, day, and place of next program. Solicit project ideas for next time.

Notes

- Program staff or trained volunteer can offer projects to individual participants with one-on-one assistance or for participant‘s independent enjoyment.
- Assist as needed with hand washing and re-washing.
- Monitor safety around any sharp or hot equipment
- Observe safety and dietary precautions for participants.

Tool I. Victoria Special Center Center's Employee Meal Program Policy

To: All Victoria Staff
From:
Re: Employee Meal Program

Beginning this Wednesday, May 12, 2010, free meals will no longer be offered to staff. We do encourage you to participate in our affordable $2 meal program, which will be offered for all three meals, seven days a week. Some adjustments have been made to the program so please read the following information carefully.

- Employees will be offered the same menu item as the resident's menu at a minimal cost of **$2.00 per meal.**
- Employees may eat breakfast, lunch, or dinner **during the regular meal periods.** Meals requested outside of the meal periods will not be available. If you are busy and cannot eat during the meal periods, simply request a meal during the meal period and we will hold it for you.
- You may purchase ~~"m~~eal cards" from in Human Resources. The cards will be available in increments of 5 meals ($10), 10 meals ($20), or 20 meals ($40). Depending on the card you choose, that amount will be deducted from your next paycheck.
- Once the card is issued, it will be your responsibility to hold on to it. **NOTE: The cards will no longer be kept in the kitchen. If you are presently have a card in the kitchen, please pick it up and carry it with you.** When you order a meal, it will be punched on your card and returned to you. Once that card is full, return to for another card.
- **NO CARD = NO MEAL; if you lose your card, you lose your meal purchases. Sorry…**
- You can use the card for whatever meals you like and the card never expires.
- If the kitchen runs out of the main entrée for a meal period, we will provide an alternative meal for you, such as a soup, sandwich, fruit, etc.
- **There will be no substitutions.** You may only receive the meal that is provided on the menu.
- **If you do not request the full lunch, your card will still be punched for receiving a meal. Please DO NOT ask the dietary staff for free food.**
- You may request (1) drink with your meal, consisting of iced tea or the juice of your choice. No sodas, Gatorade, or bottled water will be available.

Please keep in mind that it will take some time for the kitchen staff to adjust to this new program as well. We ask for your flexibility and understanding as we do our best to provide you with quality meals at a minimal cost.

If you have any further questions, do not hesitate to contact in Human Resources.
Enjoy!!!

AUTHENTIC EXPERIENCES THAT PROMOTE WELL-BEING

—I plan to _unplan.' Things don't always go as planned. Be more like a family and let things flow." (Recreation Therapist)

An important function of a resident-centered community is to facilitate residents experiencing those things that they have previously enjoyed, as well as supporting them in exploring new interests, talents and dreams. The self-satisfaction, belief in the inherent worth of oneself and the ability to experience happiness and joy that come as a result all contribute to a person's overall sense of well-being. The experience of gaining pleasure from daily activities is something that is vitally important not only to an individual, but to the overall health and climate of any long-term care community as a whole. After all, it is these pleasures of life that will provide the magic, the excitement and the glue to transform a disparate group of people into a vibrant, alive and joyful community committed to a journey of life that is the best it can be for each and every individual.

The Value of Authenticity

—I think this is the greatest thing that has happened to me. To do what I want…I have three paintings started in my room and no one bothers me. I have had a good life. I am content in what the future holds. At least I am not alone. I come out in the morning and it's good to say, _Good morning.' I'm up and start singing." (Assisted Living Resident)

Lives are being lived within long-term care communities, not simulations of lives. Accordingly, efforts to *approximate* "real life" as part of culture change efforts simply do not suffice. For normalcy to be maximized, authenticity is integral. Most of us do not celebrate group birthdays one time a month, nor are holidays celebrated the day before or the day after. These are institutional practices based on maximizing cost and time efficiency. Changing these practices can be a powerful way to support the change vision. At Brewster Village in Appleton, Wisconsin, **residents direct their birthday celebration** (which happens on the actual day of their birthday) by choosing the kind of cake they want, indicating whether they prefer to be sung to and making known other aspects about how they choose to commemorate the day. This practice honors the individual and their personal milestone in a way that a group "one-size-fits-all" birthday celebration does not. In this same spirit of authenticity, at Landis Homes in Lititz, Pennsylvania, **Christmas is celebrated on Christmas morning** (not on an afternoon a couple of days before), with residents who choose to participate gathering with staff to open stockings in a festive atmosphere.

At Brewster Village, it doesn't take a major holiday to bring the community together in an authentic way. All it takes is **Green Bay Packers football**. Truly, what could be more authentic than a group of fans converging around the television for a football game? Every game is wired into the community, and all interested staff, residents and family members watch together.

Sharing Passions, Expanding Horizons

> *—I am so proud…this is the first time I ever graduated from any school as I needed to go to work when I was 12 years old."* (Nursing Home Resident)

> *—They have taken us on trips. We picked apples and went to the beach. These are things I've never done before."* (Nursing Home Resident)

> *—I participated in the fashion show and then the drama club. I was too busy but it was good because I got to see the residents. And they got to see me as a person."* (Nursing Home Staff)

Creating opportunities for people to pursue interests and connect around shared passions add to the vibrancy of a community. Music, dance, education, the arts, fitness and games all have a place in long-term care environments. In resident-centered settings, these opportunities for social engagement, education and entertainment are identified, planned and carried out with resident involvement and direction, and ultimately they may be enjoyed by any member of the community. Staff and family involvement is encouraged. The role of activity professionals, then, is to orchestrate the passions of the community. The schedule and scope of programs changes as the population itself changes to reflect the interests and passions of those who reside, work and visit. Lastly, the most important measure of the success of an activity or program is not the number of residents in the room while it was carried out, but rather the quality of the activity itself and the engagement of those present (even if just a small group).

Skill Building and Educational Programs
Tapping into the specialized talents and expertise of those in the community (residents, family, volunteers or staff) to provide lessons in art, music, drama, poetry, knitting, flower arranging or gardening can be a wonderful way to celebrate the talent of an individual while simultaneously encouraging others to venture outside their comfort zone to try something new.

Adult Education Program
The Adult Education Program at Maimonides Geriatric Centre in Quebec is an interdisciplinary approach to providing intellectual and social stimulation through self-directed lifelong learning. A resident steering committee generates a list of potential education topics based on the interests of residents. This group also plans the program schedule, including the start date, number of courses, speakers and the graduation ceremony. A variety of courses are offered, each featuring a number of related lectures. Courses have included Current Issues and World Affairs; Music and Dance; Jewish Culture; and the Highlights of Montreal. At the conclusion of each session, a graduation is held to recognize the accomplishment of those who have completed their courses.

Families are sent personal invitations to attend and the graduates don caps and gowns and receive a diploma.

See Maimonides Geriatric Centre's Adult Education Program Session Plan, Page 226.

Fitness

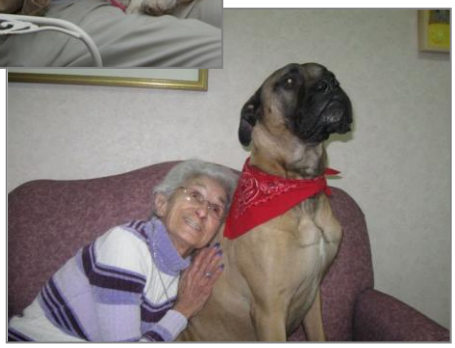
Fitness centers where staff and residents can work out side by side, resident and staff **walking clubs**, and friendly competitions such as the **Olympics** held at Bethel Health Care in Bethel, Connecticut which "pitted" residents from different areas against each other are examples of meaningful activities that benefit the mind and bodies of individuals—and the soul of the community as a whole. The Orchards, an independent and assisted living community in Southington, Connecticut, has purchased a **Wii Game Console** for residents, visitors and staff to use in the community room. The game has created opportunities for members of the community to engage in unique ways.

Cognitive Fitness

Mulberry Gardens, an assisted living community in Southington, Connecticut, offers a specialty in memory care. Through a grant offered by the Community Foundation of Greater New Britain the community purchased the *It's Never Too Late*™ (IN2L) system that offers a cognitive fitness (or brain fitness) module along with several other modules such as movie trivia; television shows from the 1950s through present day; games and entertainment; life stories blueprint; and physical fitness. One of the programs allows the user to operate a pedal device similar to a bicycle pedal while following a bicyclist along a biking path on a large screen television that accompanies the system. Another allows viewers to access a live camera at the Washington Zoo to see baby pandas in their habitat. Systems like IN2L provide a platform for socialization, reminiscence and mental and physical fitness, not to mention pure entertainment.

ADDITIONAL RESOURCES:

***It's Never Too Late*™: www.in2l.com**



Re-printed with permission from Southington Care Center

Pet Therapy Programs

Visits with trained pet volunteers are a wonderful option for those who love animals. The benefits of a pet visit may include decreased pain, decreased blood pressure, diminished depression and a sense of well-being. At Southington Care Center in Southington, Connecticut, over 70 dogs have been certified as therapy animals by the Delta Society Pet Therapy Program and are now in active volunteer work with residents and staff. *See a sample of Southington Care Center's Pet Therapy Program Materials, page 228.*

The Arts
For many, the arts are food for the soul. Glee Clubs, choral groups and drama clubs provide opportunities for members of the community to connect around a mutual love of music and performance. The creation of visual art can be another powerful form of self-expression. In Oshkosh, Wisconsin, Evergreen Retirement Community's **ageless art studio** is a space with an instructor where residents from all living environments, staff and individuals from the larger community draw and paint. Dedicating public space for the display of resident and staff artwork adds a new dimension to art activities. At St. John's Lutheran Ministries in Billings, Montana, many residents who partake in art classes have their works on display in a gallery near the dining room. Similarly, some communities take their musical shows on the road and entertain at various senior centers or other organizations. A shared passion among the members becomes an even richer experience when taken outside of the setting for others to enjoy.

Community Service
See Community Connections, page 252.

Intergenerational Programming
See Community Connections, page 255.

Work Life
For many residents, going to work has been a defining aspect of their lives. Residents at Brewster Village have the option of continuing to go to work. In the **workshop**, residents do a variety of tasks including recycling, shredding paper, making and packaging dog bones and making firestarters for campfires. Hours worked are tracked, with residents clocking in and out. Compensation comes in the form of chips that can be cashed in. The experience of working in the workshop has enhanced residents' sense of pride, self-esteem and achievement.

There may also be opportunities to leverage residents' professional experiences to the benefit of others in the community. At Middlewoods of Farmington in Farmington, Connecticut, a retired CPA assists other residents in completing their taxes.

Journey of Dreams
A number of communities have adopted programs that create opportunities for residents to continue to achieve hopes and dreams in spite of restrictions or advanced age. At Wesley Village in Shelton, Connecticut, residents are invited to write down their personal wishes or dreams. The wishes are collected by staff members who then enlist others in the community to make them come true. Since the start of the program, wishes have included everything from spending a day at the beach, being on television and going up in a hot air balloon to the practical (and yet undeniably gratifying) wish of two residents to have their closets re-organized.

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S T R E T C H GOAL

Travel

—It wasn't all about going to Cape Cod; it was about the group. We were like a family. If you didn't want to make your bed, you didn't make it…just like home".
(Nursing Home Resident)

—With this trip we were able to just be people at the Cape house, no titles, no patients or residents, or caregivers; we were just people on vacation."
(Life Enhancement Coach, Saint Elizabeth Community)

Re-printed with permission from Saint Elizabeth Community

It is commonly believed that once a person has entered a long-term care setting that taking overnight vacations is a thing of the past. The logistics of managing medications, meals, caregiving and routines outside of the normal environment of care can be daunting. A number of communities, though, are finding ways to make memorable vacations a part of residents' current lives. Planning any family vacation requires preparation, coordination and budgeting. Planning a vacation for staff and residents requires an additional layer of planning, including securing permissions from the state health department and CMS and devising a comprehensive disaster plan. The additional work, though, reaps profound rewards, as residents and staff get to know each other on a deeper level, free from the inherent structure and regimens of the nursing home. Such was the case at Saint Elizabeth Home in East Greenwich, Rhode Island when a group of residents and staff enjoyed an unforgettable Cape Cod vacation.

Similarly, Fairacres Manor in Greeley, Colorado decided to take on this challenge in 2009 when they took five skilled nursing residents for a five-day trip to the Black Hills of South Dakota. The residents were accompanied by a nurse, CNAs, activities staff and a neighborhood advocate. The trip was wonderfully successful until one resident became ill enough to require a trip to the hospital. The other residents were offered the opportunity to leave their friend and return home. They refused and insisted on staying with the gentleman until he was able to return home with the group.

Of course, trips need not be so ambitious to create lasting memories. A day trip to a local attraction or a day out on a boat fishing can be profoundly meaningful and pleasurable in their own right.

Support for Solitude

> *"I've never been a joiner and always lived raising a family and by myself. I stay in my room and do what I want to do and can come and do things with others."* (Assisted Living Resident)

> *"They wanted me to come out and mingle and when I started to do that I got to go home. Normally I read six books a week and I didn't get to read one book here, not one book."* (Short-Term Patient)

While involvement in the community is hopefully a pleasure for residents, it is also important to respect individuals' need for solitude. For many, time on one's own is fundamental to their health and wellness. For these residents, including those quoted above, the answer to the query, "How would you be spending your day in your previous home?" includes a number of solitary activities—by choice. In an environment where support and services are individualized, residents are not coerced into participating in group activities that feel neither natural nor personally rewarding. Instead, the community respects and accommodates the choices they make about how their day will unfold, including the time they choose to spend on their own. Part of accommodating these choices is providing physical spaces supportive of solitude, including meditation spaces, gardens, and/or screened in porches and gazebos.

Family Involvement

Families (however "family" is defined by the resident) are sometimes the only common thread that carries through a resident's life as they transition from one level of care to another. For this reason, it is imperative that families are fully integrated as part of the long-term care community. Inviting family members to share their unique gifts and talents by teaching residents, families and staff builds a unique community that demonstrates in both word and deed that family is welcomed and viewed as part of the team, not adversaries of it.

Sometimes, however, family and other visitors may struggle with how to make best use of their time visiting with their loved one. To address this, Wesley Village developed a list of **100 meaningful visit ideas**, ranging from interviewing and recording a loved one as he/she recounts a story from their life or packing a picnic basket to enjoy outside to reading the newspaper together or going on a virtual museum tour.

An excerpt of Wesley Village's 100 Meaningful Visits is on page 230.

Wi-Fi, Social Networking and Skype

Lending **laptops** and **wireless Internet access** are increasingly being made available in long-term care communities to facilitate communication, connections and lifelong learning through **e-learning**.

Recently the University of Alabama Department of Sociology and Social Work was awarded a five-year $1.9 million National Institute on Aging (NIA) grant to study the ability of computer use and social media networking to enhance the quality of life of elderly adults through online

social connections and easier access to health information.[25] **Social networking** offers a contemporary solution to the disconnectedness that often is associated with old age and limited mobility. Residents are learning to use technology to open up new worlds of information and connection with others. The advent of Skype, computer software that enables individuals to make free video and voice calls, brings the potential for a host of beneficial applications in long-term care environments. Evergreen Retirement Community offers short-term rehab patients use of **Skype kits** to stay connected with family, friends and associates.

E-Mail Communication
Developing a system that encourages friends and family to email residents helps them to maintain connections with those outside the community. One dedicated email address can be established for the program. Family is encouraged to email the resident at that address (with guidelines for how to format the subject line for ease of delivery, e.g. resident's first and last name, room number/living location). Volunteers can then be recruited to check the email on a daily basis, print out the messages and hand deliver them to the residents.

Embracing Spontaneity

Rich and rewarding lives are not scheduled down to each fraction of every day. To do so would be to shortchange ourselves of the unexpected joys of life. Informal opportunities to share experiences occur spontaneously throughout the day—picking herbs from an herb garden, peeling potatoes, taking a walk on a beautiful day, dancing to a song that comes on the radio. When staff feels empowered and encouraged to facilitate these experiences, residents and staff members become emotionally engaged in sharing these simple pleasures. Life is not "staged;" many of the most endearing experiences in life happen spontaneously.

"Sometimes just knowing that a resident has a preference for tea can set the stage for conversation and connection. Anticipating that preference by pouring her favorite tea before she asks makes both of us feel special."
(Food Services Manager, Bethel Health Care)

Simple Pleasures
Disease and disability can restrict the ability to make connections that once were a natural part of life. Dementia robs people of their memories of things that brought great pleasure and meaning throughout life. Physical restrictions may make people dependent on others to help them access the pleasures they once were able to access on their own. Yet there are things in life that are universally understood and appreciated by most. They are not dependent upon memory or language or even status or background to be enjoyed and appreciated. Pleasures in life evoke feelings. Caregivers have a wonderful opportunity to facilitate positive feelings by paying attention to universal pleasures in life that might include:

[25] University of Alabama Media Relations September 2009

- Freshly baked breads, cakes and pies
- Coffee percolating in the morning and the smell of breakfast cooking
- An herb garden
- The sound of music
- The purr of a kitten
- The feeling of sunshine on your face
- The touch of a friend‘s hand
- A kiss on the cheek
- The sound of the ocean
- Freshly-mowed grass
- A baby‘s giggle
- New fallen snow
- Appreciation for art and dance.

Sensory stimulation may be particularly useful for people with late stage dementia. **Sensory kits**, portable kits that include objects that stimulate all the senses, can be used to bring some of these simple pleasures to bedbound residents. For example, a box with beach-related items may include beach smells, a vial of sand, shells, bird feathers and smooth rocks.

Holistic and Alternative Therapies

Many holistic and alternative therapies are now being offered in long-term care environments. These natural, safe, and supportive methods are often used to support the alleviation of physical and emotional aspects of pain. They are designed to promote the mind/body/spirit connection and improve quality of life. Many can also be helpful for reducing anxiety and stress.

—[Residents‘] needs are being met more with the aromatherapy or the pet therapy. They will order the aromatherapy for someone having a bad day and I have heard that it has worked on the majority of [residents].”
(Nursing Home Staff*)*

Aromatherapy
Aromatherapy is the art and science of using essential oils to relax, balance and stimulate the body, mind, and spirit. Essential oils can treat mental and physical imbalances through inhalation or by hand massage. Aromatherapy is used in a wide variety of ways for many different purposes including appetite stimulation, restlessness, insomnia, pain and anxiety.

Massage Therapy
Therapeutic massage is a hands-on treatment that provides physical relief of muscle tension and soreness while increasing circulation and eliciting the relaxation response. In end-of-life care, as well as in all levels of care, gentle massage can reduce stress and help release anxiety and fear.

Music Therapy
Music plays an important role in many peoples' lives. It communicates, motivates, soothes, calms or enlivens, alleviates pain and anxiety and lifts the spirit. Music is holistic and basic to our existence; our own bodies are made up of rhythmic systems. Music works its wonders as a universal language when other treatments are not enough.

Therapeutic Touch (TT)
This is a holistic intervention used to treat a variety of conditions. The purpose of TT is to restore the balance and flow of vital energy within the body while stimulating the person's own healing response. It is used to decrease pain, increase relaxation, lessen anxiety and provide comfort.

See Southington Care Center's Holistic Nurse Job Description and Therapeutic Touch Policy, pages 231-236.

Activities for Staff

While staff should be encouraged to participate in meaningful activities with residents, attention should also be given to activities for staff to build camaraderie and provide a harmonious workplace. Many communities recognize the importance of laughter and having fun together in nurturing a strong sense of teamwork. The **FUN Club** at Wesley Village is comprised of staff from various work areas and departments. As a team, they arrange events such as fishing derbies, day trips, and talent shows. The **Dinner Club** at The Orchards at Southington picks a local restaurant and invites all staff who is able to attend to enjoy a meal together. Having fun and connecting at the most basic human levels is an integral part of creating community. All stakeholders should be encouraged to plan, participate, and contribute to community events.

Focus on Process

COMPLEMENTARY THERAPIES

The process of introducing complementary therapies at Southington Care Center in Southington, Connecticut began eleven years ago with a readiness assessment that helped both in determining what modalities to introduce first and illuminated staff's attitudes about complementary therapies. Spearheaded by the community's holistic nurse, the readiness assessment was followed by extensive staff education, including in-services and mentoring at the bedside. Caregivers were taught how to provide gentle massage and intentional touch. A —Nurture the Caregiver Day" provided an opportunity for all employees to experience the benefits of a number of complementary therapy modalities for themselves. Over the years, a continuous flow of holistic care education has been offered for staff, residents, volunteers and community members.
Furthermore, numerous staff—including RNs, LPNs, CNAs and therapists—have sought out continuing education to become credentialed as aromatherapy and therapeutic touch practitioners.

Authentic Experiences that Promote Well-Being Tools

Tool A. Maimonides Geriatric Centre's Adult Education Program Session Plan

COURSES TAKE PLACE
ON
Thursdays at 10:30 a.m.
5th Floor Dining Room

Spring Break (NO CLASS)
April 1st

Graduation Photos
May 5th

Graduation Rehearsal
May 6th

Graduation Ceremony
May 13th
3:00 p.m.
Synagogue

For more information
Tel.: (514) 483-2121, Ext. 2219 or 2341
Email: therapeutic.recreation@ssss.gouv.qc.ca
or
rehabilitation@ssss.gouv.qc.ca

MAIMONIDES
Going further in geriatric care
À l'avant-garde des soins gériatriques

Adult Education 2010 Course Outline

Lifelong Learning Opens the Mind

"An integral part of lifelong learning is the free exchange of ideas and viewpoints among older learners. There's nothing like listening to or taking part in stimulating discussions to help us see the other side of an issue. That give-and-take opens our minds and brings us to a whole new level of enlightenment."
-N. Nordstrom

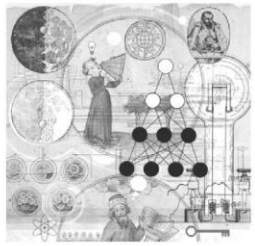
"May there never develop in me the notion that my education is complete, but give me the strength, leisure and the zeal to continually enlarge my knowledge."
-Maimonides

Course 1:

Jewish Themes:

Learn more about the Judaic traditions, rituals and the richness this culture has to offer. This course will look at diverse interpretations and the impact it has on our culture, now and in the future.

Feb. 4 Ethics of our Fathers
Feb. 11 Jewish Liturgy
Feb. 18 Spirituality
Feb. 25 Anti-Semitism



Course 2:

History:

From the beginning of time, the inquires and the investigation of human behaviors have been very fascinated. This allows us to connect the past with the present while paying special attention to the written records provided by the scholars.

March 4 Africa
March 11 Meditation and Stress management
March 18 Art and Drama
March 25 Concordia Student Presentation

Course 3:

Well-being:

Take charge of your life and learn how to practice a healthy lifestyle that fulfills your mental, physical, emotional and spiritual well-being.

April 1 SPRING BREAK (NO CLASS)

April 8 Holistic Medicine
April 15 Stress and Pain Management
April 22 Family Notary
April 29 Dr. Joe Schwartz

Tool B. Southington Care Center's Pet Therapy Program Materials

Pet Therapy Dogs Needed:

The Jane Haze Pet Therapy Committee is looking for volunteers with dogs interested getting their pet registered with the Delta Society. A new class is forming at Southington Care Center for handlers and their dogs, in November. If you think your dog has the right temperament to be a visitor to our residents, please see Deb Brown, Director of Resident Programming at Southington Care Center or call 860-378-1286 for details and for application.

If your dog passes the evaluation at the end of the classes, The Jane Haze Memorial Pet Therapy Fund may reimburse the expenses if you and your dog commit to volunteer for SCC, Mulberry Gardens, Jerome Home, the Orchards or VNA of Central Connecticut.
Please see application for details.

All dogs must be at least 1 year of age. Dogs must have good temperament and current on shots. Proof of rabies required.

Deadline for applications is Friday, October 24.

Therapy Dog 1 class (5 weeks) **Basic Obedience skills, positive reinforcement techniques, behavioral issues addressed directly related to Pet Assisted Therapy, exposure to health care equipment**

Held on the following dates (all Thursday, all from 6 – 7 pm): Cost: $90

- Nov 6th
- Nov 13th
- Dec 4th
- Dec 11th
- Dec 18th

Therapy Dog 2 Class (5 weeks) Preparation to become registered Delta Pet Partners
Role Playing-how to approach clients in wheelchairs and hospital bed
How to recognize stress in an animal
Additional commands taught: leave it, back up, look, take it, touch
Cost: $90 plus Manual $40
class dates:

- Jan 8th
- Jan 15th
- Jan 22nd
- Feb 5th
- Feb 12th
- **Delta Test: Sunday, Feb 15th at your facility. Starting from approx 9:00 – 4:00. Each test will take approx 20 minutes (or more) per team.**

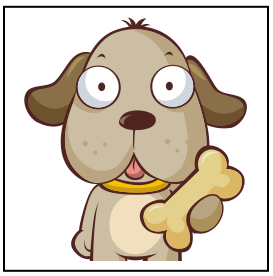
There is a limited number of spaces available. Applicants will be notified if chosen for the class.

Contacts:
Deb Brown
860-378-1286

Southington Care Center

45 Meriden Avenue
Southington, CT 06489
(860) 621-9559

Delta Society Pet Therapy Class Application



Please print or type clearly Date: _____

HANDLER'S INFORMATION

Name: _____ Phone: _____
Last First

Address: _____
Street Town Zip Code

Birthdate: _____ (**required)* E-mail _____
Mo/day/year

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____
Name Relationship

Family Physician: _____ Phone: _____

Have you been convicted of a felony or imprisoned for any reason? Yes No
If yes, please explain on a separate piece of paper. Include all pertinent information.

PET INFORMATION

Dog's Name: _____ Breed: _____

Age: _____

Has your dog had obedience training? _____

Is your dog currently registered by Therapy Dog, Inc._____ or Delta Society_____

*****REQUIRED**
Please attach veterinary paperwork attesting to the health of your dog, including Immunization Schedule and Proof of Rabies Vaccination.

_____ _____

Applicant Signature **Date**

Tool C. Wesley Village's 100 Meaningful Visits (excerpt)

40. ***Reading***.... Find a book and read it aloud with your loved one from beginning to end. If both parties are able to read, take turns reading and listening.

41. ***Dance at the prom***...*Look* for flyers posted to see when the next prom or semi-formal dance is scheduled and participate in the occasion with your loved one.

42. ***Laugh out loud....*** There are many ways to bring humor into your visit with your family member. Watch a funny video, DVD or TV show or share a fun joke that you may have heard.

43. ***Sports and fitness***... Exercise together. There are several videotapes available for exercises for elderly in wheelchairs. It could be simple arm lifts, walk or hand exercises.

44. ***Show off your accomplishments***.... Bring in report cards, awards, or any other achievement you are proud of to show to your loved one. Parents, grandparents, relatives, and friends are often as gratified of a child's successes as the child himself.

45. ***Ask for help on homework or school project***.... Since previous generations may have utilized different strategies and practices regarding studies and education, passing on these traditional methods can possibly strengthen a child's academic success.

46. ***Study leaves….*** Work together with your loved one to find various types of leaves and try to determine what type of tree they came from.

47. ***Familiarize your loved one with your daily activities….*** Bring in pamphlets, pictures, etc. from your career, vacations, and extracurricular activities to help keep your loved one connected to your life in the community.

48. ***Attend a lecture or educational program…***Attend a presentation offered by (name of organization) that is of interest to you and your loved one and learn new facts together.

49. ***Review old news and learn about local history….*** Together with your loved one, read newspaper or magazine articles from the 1940's to encourage old memories and interesting storytelling.

50. ***Remain in touch with current world news….*** Read the newspaper and/or magazines together and discuss the articles. Also, share your opinion about world politics and have a "light" debate (avoid heated discussions) if your views differ.

51. ***E-mail***.... Help your loved one re-connect with lost relationships through e-mail.

52. ***Chocolate filled wisdom….*** Buy a box of chocolates and under each chocolate place a short note with words of wisdom, inspirational quotes, love/friendship messages, or anything sentimental or meaningful to you; and present it to your loved one

Tool D. Southington Care Center's Holistic Nurse Job Description

NURSING DEPARTMENT
HOLISTIC CARE COORDINATOR
JOB DESCRIPTION

TASKS ASSIGNED TO THIS POSITION MAY INVOLVE POTENTIAL AND/OR DIRECT EXPOSURE TO BLOOD/BODY FLUIDS.

Name: _____ Date of Hire: _____

Purpose of Your Job Position

The primary purpose of your job position is to plan, organize, develop and direct the overall operation of the Holistic Care Program in accordance with current federal, state and local standards, guidelines and regulations that govern our facility and as may be directed by the Administrator, the Medical Director, and/or Director of Nursing Services, to ensure that the highest degree of quality care is maintained at all times.

Delegation of Authority

As the Holistic Care Coordinator you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties. Your immediate supervisor is the Director of Nursing Services.

Job Functions

Every effort has been made to make your job description as complete as possible. However, it in no way states or implies that these are the only duties you will be required to perform. The omission of specific statements of duties does not exclude them from the position if the work is similar, related, or is a logical assignment to the position.

Major Duties and Responsibilities	***RC= Risk Category***
Administrative Functions	
Plan, develop, organize, implement, evaluate and direct the Holistic Care Program in accordance with current federal, state and local standards, guidelines and regulations that govern the long-term care facility.	3
Explore, anticipate, and influence new directions and dimensions of health care especially within the practice of Holistic Nursing.	3
Encourage and report the research of holistic concepts and practice.	3
Develop and implement a Holistic Care Program organizational structure.	3
Participate in developing, maintaining, and updating written policies regarding the Holistic Care Program.	3
Develop, maintain and periodically update the Holistic Care Program Procedures Manual and the Holistic Care Program objectives and statements of philosophy.	3
Make written and oral reports/recommendations to the Director of Nursing Services, as necessary/required, concerning the operation of the Holistic Care Program.	3
Participate in surveys (inspections) made by authorized government agencies as requested by the Administrator or the Director of Nursing Services.	3
Perform administrative duties such as completing nursing forms, reports, evaluations, studies, charting, etc., as necessary.	3
Participate in the development, maintenance, and implementation of a Holistic Nursing Access tool.	3

Assist the Director of Staff Development in developing and implementing appropriate plans of action for Holistic Care educational training.	3
Develop and maintain a reference library of written material that will assist the facility in establishing, and maintaining, a Holistic Care Program that support the concepts and practice of health of the whole person.	3
Committee Functions	
Act as chairperson of the Holistic Care Committee.	3
Serve on, participate in, and attend various committees of the facility (i.e., Performance Improvement Committee, Medical Staff, Quality of Care)	3
Evaluate and implement recommendations from established committees as they may pertain to the Holistic Care Program.	3
Personnel Functions	
Required to give a four week notice upon termination of employment.	3
Maintain an excellent working relationship with the medical profession, facility employees/staff, and other health related facilities and organizations.	3
Create and maintain an atmosphere of warmth, personal interest and positive emphasis, as well as a calm environment throughout the facility.	3
Serve as a role model for residents, resident‘s families, staff, and members of the community by practicing self care and actualizing optimal health.	3
Function as an empowering network for persons interested in Holistic Health, Complementary modalities and Integrative Medicine.	3
Nursing Care and Consultation Functions	
Provide direct nursing care as necessary.	1
Utilize the Holistic Nursing Access Tool (when appropriate).	2
Provide Holistic Nursing care for staff and residents according to the Holistic Care Program policies and procedures.	3
Staff Development	
Develop, implement, and maintain a Holistic Care Program orientation for all new employees.	3
Participate in developing, and implementing, Holistic Care educational programs and training for all Southington Care Center employees and staff.	3
Develop Holistic Care educational programs for residents, resident‘s family members, and the community.	

	3
Develop a Holistic Care program for volunteers.	
Attend and participate in continuing educational programs designed to keep you abreast of changes in Holistic Nursing and your profession as well as to maintain your license on a current status.	3
Safety and Sanitation	
Ensure that all nursing staff, personnel, family and volunteers that perform Holistic Care interventions (i.e., Caring Touch, Massage Therapy, Therapeutic Touch, etc.) that involve potential exposure to blood/body fluids participate in an in-service training prior to performing such tasks.	3
Ensure that all nursing staff, personnel, family and volunteers, that perform Holistic Care interventions follow established hand washing techniques.	3
Resident‘s Rights	
Maintain the confidentiality of all resident care information.	3
Ensure that all residents are treated fairly, and with kindness, dignity, and respect.	3
Ensure that all resident interviews (Holistic Nursing Access) are conducted in private.	3
Ensure that all Holistic Care interventions/care is provided in privacy (when appropriate) and that all nursing staff, personnel, family, and volunteers knock before entering the resident‘s rooms.	3
Ensure that nursing staff, personnel, family, and volunteers are knowledgeable of the resident‘s right to refuse Holistic Care interventions. Ensure that such requests are in accordance with the facility‘s policies governing advance directives.	3
Report all any complaints and allegations of resident abuse and/or misappropriation of resident property.	3

Working Conditions

- Works in an office area(s) as well as throughout the nursing service area (i.e.., drug rooms, nurses‘ stations, resident rooms, etc.).
- Sits, stands, bends, lifts and moves intermittently during working hours.
- Is subject to frequent interruptions.
- Is involved with residents, personnel, visitors, volunteers, government agencies/personnel, etc., under all conditions and circumstances.
- Is subject to hostile and emotionally upset residents, family members, personnel, etc., under all conditions and circumstances.
- Communicates with the medical staff, nursing personnel and department supervisors.
- Works beyond normal working hours and on weekends and holidays when necessary.
- Is involved in community/civic health matters/projects as appropriate.
- Attends and participates in continuing educational programs.
- Is subject to falls, burns from equipment, odors, etc., throughout the work day.
- Is subject to exposure to infectious waste, diseases, conditions, etc., including TB and the AIDS and Hepatitis B viruses.
- Maintains a liaison with the residents, their families, support departments, etc., to adequately plan for the residents‘ needs.

Educational Requirements

- Must be a graduate of an approved RN program.
- Must be Board Certified in Holistic Nursing (HN-BC).

Experience

- Must have, as a minimum, 2 years of clinical experience in a hospital, long term care facility, or other related healthcare facility, one year of which must be in a supervisory capacity.
- Must have, as a minimum, 2 years of experience in Holistic Nursing.

Specific Requirements

- Must possess a current, unencumbered, active license to practice as a RN in this state.
- Must be able to read, write, speak, and understand the English language.
- Must possess leadership and supervisory ability and the willingness to work harmoniously with professional and non-professional personnel.
- Must be detailed oriented and possess organizational skills.
- Must possess public speaking skills.
- Must possess group facilitator and teacher/educator skills.
- Must possess the ability to utilize the Holistic Nurse Caring Process (HNCP).
- Must demonstrate the art of self-care and be a role model of self-care for residents, resident‘s families, co-workers, and the community.
- Must possess the ability to make independent decisions when circumstances warrant such action.
- Must possess the ability to deal tactfully with personnel, residents, family members, visitors, government agencies/personnel, and the general public.
- Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long-term care and to Holistic Care.
- Must possess leadership ability and the willingness to work harmoniously with professional and non-professional personnel.
- Must possess the ability to plan, organize, develop, implement, and interpret the programs, goals, objectives, policies and procedures, etc., that are necessary for coordinating and providing a quality Holistic Care Program.
- Must have patience, tact, a cheerful disposition and enthusiasm, as well as the willingness to handle difficult residents.
- Must be willing to seek out new methods and principles and be willing to incorporate them into existing nursing practice.

- Must be able to relate information concerning a resident's condition.
- Must not pose a direct threat to the health or safety of other individuals in the workplace.

Physical and Sensory Requirements
(With or Without the Aid of Mechanical Devices)

- Must be able to move intermittently throughout the workday.
- Must be able to speak and write the English language in an understandable manner.
- Must be able to cope with the mental and emotional stress of the position.
- Must be able to see and hear or use prosthetics that will enable these senses to function adequately to ensure that the requirements of this position can be fully met.
- Must function independently, and have flexibility, personal integrity, and the ability to work effectively with residents, personnel, and support agencies.
- Must be in good general health and demonstrate emotional stability.
- Must be able to relate to and work with the ill, disabled, elderly, emotionally upset, and, at times, hostile people within the facility.
- Must be able to lift, push, pull, and move a minimum of 50 pounds.
- Must be able to perform tasks that may involve exposure to the resident's blood/body fluids.
- Must be able to assist in the evacuation of residents during emergency situations.
- Must be able to perform CPR and emergency medical treatment.

Tool E. Southington Care Center's Therapeutic Touch Policy

PURPOSE

Therapeutic Touch (TT), a contemporary interpretation of several ancient healing practices, is a consciously directed process of energy exchange during which the practitioner uses the hands as a focus to facilitate the healing process. The intervention is administered with the intent of enabling people to re-pattern their energy in the direction of health. Indications for use include, but are not limited to:

(1.) reduction of pain and anxiety
(2.) promotion of relaxation
(3.) facilitation of the body's natural restorative processes

POLICY

Therapeutic Touch may be practiced by a practitioner who has successfully completed a minimum of a 12-hr Basic Level workshop addressing the cognitive and experiential aspects of Therapeutic Touch. In addition, Therapeutic Touch practitioners need to have practiced TT on a consistent basis for at least 1 year with the guidance of a mentor. During the mentorship year, at the discretion and under the supervision of a mentor, the practitioner can begin utilizing TT at Southington Care Center. A further requirement of practitioners is the completion of a 14-hr Intermediate Level course of instruction. All TT classes must be taught by a NH-PAI Qualified Therapeutic Touch Teacher.

Therapeutic Touch may be offered to any individual / family whom the practitioner judges may benefit. Therapeutic Touch is an autonomous health care procedure performed within professional practice guidelines. Therapeutic Touch does not require a physician's order.

CONSIDERATIONS

Therapeutic Touch is a process that is always individualized and usually does not exceed 30 minutes. In general, residents with psychiatric disorders, the elderly, and/or debilitated are more sensitive to the interaction.

PROCEDURE

(1.) *Explain the procedure and obtain verbal permission from the resident or family member whenever possible.*
Rationale: *TT can be explained as a relaxation intervention that may relieve pain, decrease anxiety, and/or promote a sense of well being.*

(2.) The practitioner centers by bringing their body, mind, and emotions to a quiet, focused state of consciousness.
Rationale: Centering is the essential aspect of TT and should be maintained throughout the procedure. Maintaining the centered state prevents the use of personal energy and emotional attachment to the outcome.

(3.) Make a conscious intention to therapeutically assist the resident.
Rationale: TT is a purposefully directed process.

(4.) Assess the condition of the energy field by becoming aware of differences in sensory cues in the palmer surfaces of the hands as well as other intuitive and sensory cues in the field. Hands are usually held about 2-4 inches away from the resident's body and are moved in a head to feet direction.
Rationale: Baseline assessment of the energy field is necessary in order to intervene effectively during the TT intervention.

(5.) Use calm and rhythmic hand movements to clear areas of energy imbalance in the field.
Rationale: Repatterning and mobilizing the field facilitates symmetrical and rhythmical energy flow.

(6.) The hands are used as a focal point for modulating energy as determined by the assessment.
Rationale: Assessment of the field provides a knowledgeable base for intervention.

(7.) Repeat prior phases as necessary.
Rationale: Phases are dynamic and integrated.

(8.) Give the resident an opportunity to rest. Evaluate response.
Rationale: Rest is useful for integrating the TT process.

(9.) Document the outcomes(s).
Rationale: TT is an interaction that can effect a change in the person's condition.

09/18/01

REFERENCES:

Krieger-Kunz Model of Therapeutic Touch, Nurse Healers Professional Associates, Int., 3760 South Highland Drive, Suite 429, Salt Lake City, Utah 84106

AN ENVIRONMENT OF LIVING

—When you walk in the entrance it should be like walking into someone's living room." (Nursing Home Staff)

Taking steps—big, small or anywhere in-between—to de-institutionalize a long-term care environment is often among the most high-profile and visible signs of culture change. For some organizations, it is the changes to the physical environment that ultimately drive changes in process and attitudes; but for others, re-design, renovation or construction reflect internal transformations that have already taken root. Regardless of the sequencing, both need to occur for true, sustainable change to be achieved. When creating a residential environment, common areas of focus include personalization of living spaces; inclusion of spaces that foster camaraderie, community and socialization as well as those that support choices for solitude; abundant natural light; access to nature and the outdoors; and a domestic aesthetic in furnishings and finishes. While many of these have long been the standard in assisted living communities, there is a growing movement to apply the same principles in skilled nursing communities.

It is important to recognize though that a home aesthetic may not resonate for all residents of the community. For short-term patients anticipating discharge, creating welcoming and comfortable spaces that support them in maintaining normal routines and activities may be a more meaningful goal than creating a place that evokes the comforts of home.

A number of tools to guide organizations in transforming their physical environment already exist and would be helpful complements to the strategies contained within this Guide. They include:

- **Pioneer Network's *Design on a Dollar Roadmaps*** featuring a number of low-cost environmental modifications to create home in long-term care settings

- **SAGE P.L.A.C.E.**, developed by the Society for the Advancement of Gerontological Environments

Scale and Relationship-Building

—It's our home, and when employees cross the threshold, they are part of our family." (Nursing Home Resident)

—Scale is probably the number one barrier to developing relationships. The bigger the space, the more people that are around, and the easier it is to pull into yourself and not want to have relationships. When it's a small scale, these are people you know you are going to be seeing on a regular basis."
(Long-Term Care Leadership Roundtable, 2.25.10)

Issues of scale within the environment contribute significantly to building community and, more specifically, to developing close relationships. The intimacy of small-scale living creates opportunities for camaraderie and familiarity. For organizations planning construction or major renovation, restructuring a large community into smaller scale living environments can be achieved through the development of **households**, each designed as a distinct cluster. Resident rooms/apartments are arranged around decentralized gathering spaces and staff work areas. Within the household, residents have both private and communal spaces. A common front door creates a physical delineation between the household and community space and anyone who does not live in the household is expected to knock before entering. Residents' personal doors open not into public corridors, but to the common areas shared with household-mates. Residents of the household often eat and enjoy "down-time" together. With recognizable spaces—residential-scale living rooms, kitchens, dining rooms and parlors—making up the household, the space doesn't merely evoke home, it *is* home.

Adjacent households create a **neighborhood**, cultivating relationship-building within the larger community. The central community space connecting households can be transformed into a **town square—**a destination for residents, staff, visitors and volunteers. A variety of convenience services and amenities that benefit the community-at-large, e.g. a hair salon, fitness center, café, library, and a worship or meditation space, might be located in the town square.

The small scale created by the physical surroundings can be perpetuated through introduction of a staffing model characterized by self-directed teams of consistent caregivers. *See Staffing Approaches to Promote Familiarity and Build Relationships, page 132.*

No Need to Wait
Low Cost Changes That Can Be Made Today

For many communities, new construction or significant renovation to create households is not an option, at least not in the short-term. This need not be a reason to put off creating small scale living environments. At Magnushof, Schagen, part of the Woonzorggroep Samen system in the Netherlands, small scale living environments have been fostered by carving its traditional 40-bed unit into two smaller areas of 20 residents each. Residents are grouped by cultural affinity or background (arts lovers, farmers, professionals) into a geographically close-knit cluster of rooms. Residents in these lifestyle-based clusters share common areas and staff, and the area's activities and meals are personalized to reflect the common cultural thread of those in the area.

Re-naming small clusters of rooms with residential-sounding names, such as street names or some iconography that references local geography, history or culture, can be a low or no-cost way to create neighborhood appeal.

Personalization of Space

"They let us do what we want. I move my bed around. They don't tell me I can't!" (Nursing Home Resident)

"I love [this place] …I was able to bring my own furniture…I brought things that meant a lot to me." (Assisted Living Resident)

Personalizing Resident Rooms and Apartments
In so many ways, home is a reflection of who we are. Ensuring opportunities for residents to personalize the space in which they live creates ownership and pride in their home. **Choices in paint color** for resident rooms/apartments, flexibility in **selection of artwork** and **linens,** and the ability to move in **furniture from home** all transform a space into a home.

Another opportunity for personalizing space is offering a **flexible approach to the room arrangement.** While traditionally the placement of call bells has dictated bed placement, a move toward **wireless call systems** significantly opens up possibilities for orienting furniture within a room. When closets are replaced with **moveable armoires**, flexibility in room arrangement can be further maximized. **Built in niches** for artwork, picture frames, books and treasures also contribute to the personalization of space.

Personalizing Community Spaces
Personalization of space need not be limited to residents' personal spaces. Plentiful opportunities exist for households to reflect inhabitants' interests, memories, and family members.

Mulberry Gardens of Southington's Wall of Memories; Reprinted with permission from Mulberry Gardens of Southington

At Mulberry Gardens in Southington, Connecticut, a **Wall of Memories** is a community treasure. The gallery of photos is located along a prominent wall in the Connecticut assisted living and memory care community's lower level. Forty uniformly framed 8 x 10 portraits of residents living in the community are displayed. The display includes wedding portraits, photos of residents in their military uniforms or with a famous person or political figure, and family portraits. The photos speak volumes about the rich history and unique life stories that each resident brings to the community. They form the basis for conversation, connection and community for residents, their families, staff members and volunteers.

At Landis Homes in Lititz, Pennsylvania, residents' **personal collections** (woodworking, trains, tea cups and tea pots, etc.) displayed in common areas are a source of enjoyment for everyone in the household, and a window into the passions of fellow community members.

Eliminating Hallmarks of the Institutional Model

Removal of the Nurses Station
Consider the not-so-subtle messages conveyed by large central nursing stations. Half walls or glass partitions literally block individuals from connecting—not to mention the degree to which efforts to create home are undermined by the presence of such institutional relics. Removal of the nurses' station opens up space that can re-purposed for the daily activities of life, and reinforces that staff belong interacting with residents, not behind a desk. This atmosphere of home is further supported by moving electronic documentation systems into common areas, and keeping resident care and living plans *(see page 137)* in resident rooms/apartments.

A Spa versus a Shower Room
The terminology "spa" rather than "shower room" indicates a commitment to creating a dignified bathing and personal care experience for residents. The inclusion of appropriate lighting, non-slip surfaces, comfortable chairs and amenities such as towels, robes and personal care products lend themselves to an improved bathing experience. Special attention to providing safety items such as handrails/grab bars and other regulatory requirements contributes to a positive, safe experience in this space.

A bleak, uninviting and institutional shower room can be re-designed with a more relaxing residential style. Decorative tiles, aromatherapy, heated towel racks, plush towels and tranquil music can create a spa environment, calling to mind a place residents associate with pleasure, rather than discomfort and embarrassment. Comfortable seating, mirrors for make-up and hair and other amenities all contribute to transforming this space into a spa.

As important as the environment is to the bathing experience, altering and re-designing the process is of equal importance. *See page 139 for more on resident-directed bathing.*

Elimination of Med Carts
When residents' medications are kept in a secure cabinet in their room/apartment, the need for traditional med pass rounds is eliminated. Caregivers no longer have to navigate the corridors with cumbersome, and at times noisy, carts which are often left in the corridor, compromising the home atmosphere and causing clutter. *See page 140 for more on a resident-directed approach to medication pass.*

Creative Storage Solutions
Decentralizing storage into smaller cabinets located in each household mitigates the need for large, institutional storage solutions. This can be a timesaver for staff, providing easy access to items where they are most often used in the household. When making plans for new construction, consider incorporating alcoves along corridors where carts, wheelchairs and walkers can be set aside without causing clutter.

No Need to Wait Low Cost Changes That Can Be Made Today

A number of resourceful communities, including Holbrook Health Center at Piper Shores in Scarborough, Maine have used paint and/or fabric to "camouflage" linen carts and trash bins to maintain the domestic aesthetic of the household. **Any community endeavoring to do so, however, should be sure to confirm it is permissible by all applicable codes and regulations.**

Re-printed with permission from Holbrook Health Center at Piper Shores

Lighting and Day Light

Good lighting is perhaps the *most important* and least understood element in designing healthcare environments. It is essential that lighting is designed to provide ample illumination for staff and resident tasks while accommodating the needs of older eyes and the desired residential aesthetic. The design requires extensive skill and expertise. Consultation with a lighting designer with specific expertise in the design of senior living facilities can provide the community with lighting that meets a variety of needs.

Lighting is a powerful design tool to support individuals of any age to engage in the activities of their daily lives. Higher quality and quantities of appropriate lighting can help to maximize abilities and minimize challenges for those with compromised vision. The challenge becomes adjusting the environment to support the users' needs and to help compensate for vision changes, no matter the cause.

Incorporating good lighting design and energy efficient indirect lighting will improve the quality of lighting and help to provide appropriate and safe pathways for residents in long-term care communities. Although the first intent may be to replace harsh overhead lighting with residential-style table and floor lamps that enhance a domestic aesthetic, special consideration must be given to the safety considerations in corridors, bathing areas, dining areas and treatment areas. Thoughtfully selected **table and floor lamps** can help to provide appropriate task lighting as well as the preferred ambiance. Using **light controls (dimming switches)** provides residents with a greater degree of control over lighting conditions.

The Olfactory Environment

In resident-centered communities, the aromas of fresh coffee brewing or a meal being prepared in the family kitchen replace the unpleasant odors often expected in long-term care settings. **Aromatherapy** offered via atomizers offers a subtle and pleasant fragrance that can have a relaxing effect for all. In addition, moving toward a more **"green" approach to cleaning**

significantly enhances the olfactory environment by replacing noxious cleaning products with less offensive products and odors.

See the list of chemicals and products used for Wesley Village's "Earth Friendly" cleaning program on page 251.

Wayfinding
Use of **iconic symbols** to support wayfinding throughout the setting diminishes the need for institutional signage. Use of objects (a piece of furniture, artwork, etc.) provides residents with a more meaningful cue to their location. Larger objects provide a practical way of differentiating one household from another and serve as distinctive landmarks for common destinations. Replacing institutional signs with **classic street sign type signage** directing community members to households/units is a familiar way to enhance wayfinding.

The use of **memory boxes** at the entrance of each resident's room/apartment allows the opportunity to further personalize their space and provides a cue for finding their front door.

Noise Reduction
Optimally, the sounds of a long-term care community are the sounds of living—conversation, laughter, music, nature. In reality, however, these sounds are often obscured by the sounds of institutional life—overhead pages, vacuuming, carts clanging down corridors and beeping alarms. Overhead pages can be eliminated with the use of **quiet pagers or beepers** that staff carries with them. Changing the setting on pagers to **vibrate** further reduces noise levels.

An organizational culture in which **all staff members are empowered to respond to a call bell** means residents do not need to repeatedly use the call bell, a common source of noise, and that their needs are responded to more quickly.

Being alert to squeaky cabinet doors, cart wheels and door hinges, doors that slam and noisy equipment is key to maintaining a quiet environment. Engineering and maintenance staff can be enlisted to provide quick fixes in the form of lubricating squeaky wheels, adjusting loose hinges, and installing silencers on doors and cabinets to cushion them when closing.

Maintaining a quiet environment is indeed a community-wide pursuit. At Brewster Village in Appleton, Wisconsin, housekeepers **re-structured their routine vacuuming schedule** to vacuum between 11:00 a.m. and 12:00 p.m., a time selected for being the least disruptive to residents, most of whom were eating lunch. In addition, if necessary a **silent sweeper** is used when residents (called villagers at Brewster Village) are sleeping. The availability of the silent sweeper has mitigated the need for staff to pull out full size (and noisy) equipment for minor floor maintenance.

Eliminating the use of alarms preserves the dignity and independence of residents and reduces noise levels. *For more on eliminating alarms, see page 139.*

An Environment that Supports Lifestyles

Fundamental to culture change is supporting residents in maintaining their long-established routines while serving their new needs. Consistent staffing, liberalized diets and flexible schedules are examples of important components that help to realize this aim, but they must be supported by the physical environment. A multi-purpose room, for instance, may be a practical space for any number of planned group activities, but with its institutional orientation and nomenclature, it is unlikely to be a space where impromptu, spontaneous activities tend to unfold. Creating fun and interesting spaces such as an on-campus **café, restaurant,** a **meeting hall** where residents can convene with their existing social networks (civic organizations, book clubs, family parties), or a **convenience store** all support residents in maintaining routines and living their lives fully.

Outdoor Spaces

> *"Our grounds are magnificent. Not all facilities are as fortunate to have woods and trees and groundhogs. Patients (sic) love it and there are so many wonderful places for patients (sic) to sit and walk and bring families. And as a staff person, I enjoy it too when I can get out."* (Nursing Home Staff)

Screened porch at Delnor Glen Senior Living, St. Charles, Illinois. Re-printed with permission from Delnor Glen Senior Living

Research has demonstrated the salutary effects of nature, and consistent with healing healthcare design standards, it is imperative that **every resident's living space has a view to the outdoors**. When more significant renovation and landscaping is feasible, **screened in porches** and **gazebos** can become welcoming spaces for residents and staff alike to enjoy nature. Creating **outdoor patios connected to community spaces** such as a café creates opportunities for outdoor dining when the weather cooperates. **Waterfalls** and **ponds** help to create a picturesque campus and enhance views. **Outdoor labyrinths** combine the positive influence of nature with the restorative effects of meditation. Today, it is even possible to install wheelchair-accessible labyrinths.

At Southington Care Center in Southington, Connecticut, a new **healing garden** features a variety of plantings in themed gardens with paving stone pathways that meander around the garden. Two wheelchair and standing height raised garden beds are home to a variety of herbs. Residents and short-term rehab patients have ready access to this space that has become a

destination for herb and garden lovers. Physical and occupational therapists have worked a walk through the garden into their therapy routines for those who enjoy this pleasure of life.

Wesley Village in Shelton, Connecticut has created opportunities for residents on its Alzheimer's floor to also enjoy the outdoors by utilizing a **wireless pendant system** that enables staff to remotely determine the location of the resident.

No Need to Wait
Low Cost Changes That Can Be Made Today

Bringing **animals and plants** in reinforces the community as a place of life. Incorporating **outdoor flower and herb gardens**, **window boxes, fish tanks** and **aquariums** are all relatively low cost ways of connecting residents, staff and others in the community with the serene, restorative aspects of nature.

Of course, not all communities have the benefit of extensive grounds. **Rooftop gardens, solariums,** and **indoor healing gardens** are additional ways that communities with outdoor space constraints can provide access to nature.

VA San Diego Medical Center's indoor garden
Re-printed with permission from VA San Diego Medical Center

Spaces to Support Continuing Education

Providing robust **on-site libraries**, **computer labs with Internet access** and **classrooms** ensures physical space to support a community's philosophical commitment to supporting residents and others in the community in pursuing lifelong learning opportunities.

Consumer health resource centers are a hallmark of Planetree communities. Staffed by knowledgeable health professionals and/or volunteers, a consumer health resource center serves as a community resource and offers a variety of health information, including lay books, medical journals, newsletters, materials for adult and new readers, audiovisual media and computer services.

Spaces to Support Spirituality and Wellness

Sacred spaces are areas on the campus that foster peace and serenity. They include **meditation rooms**, **reflection rooms**, **sanctuaries** and other spaces that are welcoming to visitors of any faith tradition. Such spaces are settings for quiet contemplation or communal worship.

Fitness centers or **workout rooms** equipped with a range of equipment enable residents of varying levels of health and wellness to derive the physical and psychological benefits of exercise. A number of sites have created **scenic walking paths** on level surfaces that are used by residents, family members, staff and members of the community-at-large. **Pools** provide a setting for aquatic-based exercise and a **wellness center** can become a destination for massage therapy, acupuncture, Reiki treatment, yoga, tai chi classes and other activities that promote a holistic approach to wellness.

Maimonides Geriatric Centre in Quebec created a **spa room** as a venue where residents and staff alike can rejuvenate the body and soul. The room is equipped with vibroacoustic chairs, essential oils, aromatherapy hand lotions and a tranquility fountain.

Delnor Glen Senior Living's Serenity Room
Re-printed with permission from Delnor Glen Senior Living

To meet the needs of the community as described in each of these examples, the physical space must be compatible with the appropriate programming to support optimal use. For example, when Evergreen Retirement Community was developing plans to open a pool, a survey was distributed to members of the community to determine potential barriers to its use. The findings were used to proactively address the barriers. Proven sound investments included installation of a swim suit extractor (to ensure residents wouldn't have to return home in a wet bathing suit), private changing rooms to maintain residents' privacy and a heated floor to maximize comfort.

Family Spaces

It is one thing to welcome family *in spirit*, and quite another to back up the commitment in practical ways, such as providing comfortable, inviting spaces where families can visit and engage in meaningful activities.

In most cultures, family life centers around the hearth or in and around the kitchen. Green Houses are known for their design which includes a centrally located hearth and adjacent open kitchen. This open plan provides dining space for all members of the household. The kitchens are open to residents and families and include lower height counters for wheelchair accessibility. The open style of this plan provides both an invitation and ―permission" to use the kitchen for socializing, family dining and even cooking favorite family recipes. The kitchen is stocked as a way to encourage the presence of families and their active involvement in the community.

Middlewoods of Farmington's Country Kitchen
Re-printed with permission
from Middlewoods of Farmington

Numerous organizations have successfully navigated state codes and regulations to create kitchens that support independence and authenticity while still maintaining safety. At Middlewoods of Farmington in Farmington, Connecticut, the **Country Kitchen** is open 24 hours a day. It is fully stocked with beverages, snacks and a wide array of baking supplies and mixes for impromptu moments and as a place where residents can prepare some of their own signature recipes.

Overnight accommodations for family to remain close through the night range from **sofa beds, cots** and **recliners** to hotel-style **guest rooms.** Such spaces are particularly meaningful when a loved one is dying and family wants to remain in close proximity.

It is important to consider all the generations who comprise a family when planning spaces for families. Inviting **spaces for children** may be either outdoor or indoor play areas, equipped with toys and books for a wide age range.

Other Spaces

Snoezelen Room
Snoezlen rooms, also called ―comfort rooms," provide sensory stimulation through the use of lights, sounds, music, images, textures and aromatherapy. This multi-sensory approach has been found to reduce agitation and improve mood. Potential items to include in snoezelen rooms include aromatherapy atomizers, dimmed lighting, music, fountains, textured panels, massage pillows and videos.

Spaces for Men
With the predominance of women in today's long-term care communities, it is not uncommon for communal spaces to have a distinctly feminine appeal. To increase the sense of inclusion and create spaces that resonate with all members of the community, men in the community should be included in discussions about what home means for them. Possibilities include a **workshop**, **pool room, game room**, a **bar** for socializing, or even a **putting green**.

Short-Term Rehab Patient Rooms
A residential environment may not be an appropriate aim for short-term rehab patients anticipating a return home. With an understanding of the unique needs and expectations of this population, efforts should be made to maximize privacy, comfort, choice and family involvement. Views of nature, appropriate lighting, comfortable seating and overnight accommodations (sofa beds or recliners) for family, and artwork consistent with evidence-based findings for the selection of healthcare art[30] minimize an institutional feel and create a supportive place for healing to begin. Equipping the room with a DVD player and Wi-Fi can be effective ways to connect short-term patients with their lives outside of the community. Coffee machines, mini refrigerators and microwaves offer convenience and support autonomy.

Transitional Care Suite
As short-term rehab patients anticipate an imminent return home, they are transitioned into a transitional care suite. This space replicates an apartment, providing an opportunity for patients to practice navigating independently through the trials of everyday life in a safe environment with assistance readily available if need be.

Space for Staff
Off-stage space for staff to refresh and rejuvenate is an important component of the built environment. It should provide the necessary amenities and comfort staff needs during their shifts, and should not be an afterthought. Soliciting staff input can be a meaningful and effective way of engaging staff in the creation of a positive work environment.

Focus on Process

STAFF INPUT INTO OFF-STAGE SPACE

At Southington Care Center in Connecticut, staff was actively involved in creating a space that was relaxing and restful for them. A committee of non-supervisory and supervisory staff was formed to lead the renovation and staff chose the color of the room, the types of tables and even decided to rename the room. Options and minutes for the meetings were posted to include everyone in the process.

Involving the Community in Environmental Improvements

Consistent with the values of culture change, any change to the physical environment should reflect the needs and preferences of the community. Opportunities should be provided for residents and staff to have meaningful input into these changes, whether major renovation or a low-cost "makeover" of a space. This can be accomplished by **inviting residents and staff to participate on design teams**, by **sharing architectural and design plans, finishes and color boards** with the resident council and/or during community meetings, and offering opportunities for members of the community to weigh in on **furniture selection for common areas**. Token approval of plans already underway is not meaningful input. Timing is everything! This

[30] Ulrich, R.S. "Effects of Viewing Art on Health Outcomes." In S.B. Frampton, P. A. Charmel (eds.), *Putting Patients First: Best Practices in Patient-Centered Care*. San Francisco: Jossey-Bass, 2008.

dialogue should take place in a timely manner to allow staff and resident feedback to be thoughtfully considered and incorporated to the extent feasible.

For smaller make-over projects in existing space, **enlist members of the community (residents, staff, architects, designers) to travel the corridors by foot, in a wheelchair and using a walker** to get a better understanding of how residents experience the space, e.g. where do they experience glare, where is the clutter, what are the best locations for artwork for maximum enjoyment, and other considerations.

THE CASE FOR ADOPTION: *Environmental Outcomes*

A home environment is an investment for the organization, but with planning and "smart thinking", transformations need not be costly or without significant returns.

- Return on investment - One study found that construction and debt costs are more for private rooms, but this difference could be recouped in less than two years if the NH charges $23 more a day for a private room, and in less than three months if one of the two beds in the shared room were empty (Calkins & Cassella, 2007).
- Cost effective transformations - Research that evaluated 1,988 resident rooms and baths developed hundreds of cost effective environmental transformations to support culture change and resident-directed care (Cutler & Kane, 2004).
- Smart-thinking - Exposure to daylight is essential for the physical and emotional health of older adults, yet research shows that artificial lighting represents 40 to 50 percent of the energy costs of commercial buildings (Brawley, 2008). Thus, by incorporating daylight into the environment, long-term care organizations increase benefits to residents and decrease costs. Best of all, daylight is free!

Brawley, E. (2008). *Lighting: Partner in Quality Care Environments*. Symposium Paper Creating Home in the Nursing Home: A National Symposium on Culture Change and the Environment. Retrieved August 29, 2010 from www.pioneernetwork.net/Data/Documents/BrawleyNoell-WagonerLightingPaper.pdf.

Calkins, M. & Cassella, C. (2007). Exploring the cost and value of private versus shared bedrooms in nursing homes. *The Gerontologist*, 47(2), 169-183.

Cutler, L. & Kane. R. (2004). Practical Strategies to Transform Nursing Home Environments. Retrieved August 27, 2010, from www.pioneernetwork.net/Data/Documents/Practical_Strategies_to_Transform_Nursing_Home_Environments_manual.pdf.

Source: Pioneer Network, 2010

Other Considerations for Master Facility Planning

"If you don't have to share a room, that is the way to live." (Nursing Home Resident)

Flow of Traffic to Maximize Patient Privacy

In any congregate living environment, privacy is paramount to preserving residents' control of their environment. Privacy should be prioritized during planning processes, and attention to detail with regard to resident preferences should be considered. A resident focus group and

resident council can provide invaluable feedback in this regard. Beyond private rooms/ apartments, thoughtful consideration should be given to the flow of traffic throughout the community to maintain resident dignity and modesty.

Private Rooms
Privacy is a basic human need, and though circumstances may have us concede certain degrees of privacy, our need and desire for it hardly diminishes as we age. When the opportunity presents itself, research demonstrates conclusively that residents and their families, as a rule, strongly prefer private rooms over shared rooms and private bathrooms over communal ones.

Making a Statement with Architecture
With a growing emphasis on aging in place, architecture and design can encourage interactions among members along the full continuum of a community, which more and more includes residents in independent living, assisted living, and skilled environments. An increasingly obsolete but still quite prevalent standard isolates nursing homes from the rest of the community as a way of ―shielding" others from the residents requiring the highest level of care. A compelling statement can be made about acceptance, inclusion and possibilities in all phases of life by reorienting the design of a community. Expansive community gathering spaces, fitness rooms, and dining spaces placed within the nursing home all draw individuals in, transforming the nursing home into a destination for activity and life, rather than a place of isolation.

The architecture should support a variety of uses. Careful design choices can provide for resident interaction, socialization, privacy and companionship in their daily living:

- *Public spaces*: Those spaces that are accessed by the community-at-large, visitors, volunteers, etc. This may be the ―town squares" or common atria spaces.
- *Semi-public spaces*: Areas that include family rooms, living rooms and spaces where residents may visit with each other, visiting volunteers or larger groups.
- *Semi-private spaces*: This includes private family dining areas, neighborhood or cluster family rooms and areas that are generally not open or adjacent to the main entrance to the facility. This may also include treatment rooms, such as rehab gyms, or group therapy rooms, etc.
- *Private spaces*: the resident's room, bathing space and consultation or office areas are included in this group. Staff areas for respite are also included in this category.

Connections to the External Community
Fostering connections to the community-at-large is an important consideration when planning significant construction or renovation. Many of today's long-term care communities in the U.S. are nestled into spacious campuses set back from the external community. A model prevalent in the Netherlands sets the small households more centrally within the larger community. Common spaces, including outdoor patios, look out onto the life of those who live nearby―children walking to school, mothers pushing baby strollers, mailmen delivering the mail, etc.

Low-Cost Environmental Changes That Can Be Made Today

- Conduct a clutter audit. Over time, laundry carts, medication carts, abandoned wheelchairs, trash cans (and more) can contribute to cluttered corridors that reinforce an institutional aesthetic.
- Encourage residents and staff to display photos and personal items in common areas, just as they would in their prior home.
- Re-name units with more residential names that call to mind nature, the local history, etc.
- Bring in potted plants and/or a window herb garden.
- Change routine floor maintenance schedules to reduce noise levels.
- When paint, finishes and furnishings need to be replaced, enlist residents and staff and make selecting replacements a community project or activity.

ADDITIONAL RESOURCES:

Creating Home in the Nursing Home II: A National Symposium on Culture Change and the Environment Requirements

http://www.pioneernetwork.net/Policy/CreatingHome/

Papers and presentations from the Creating Home in the Nursing Home I symposium can be downloaded at no cost.

Environment of Living Implementation Tools

Tool. A. List of Chemicals and Products Used in Wesley Village's "Earth Friendly" Cleaning Program

Product	**Use**	**Manufacturer**
Liquid sunshine	Glass and general purpose cleaner	United Laboratories
Liqui-zyme	Deodorizer	United Laboratories
Duo-zyme	Heavy duty degreaser/ drain maint.	United Laboratories
Bowl Control	Bathroom cleaner (only used in the bowl at Wesley Village)	Clean control corporation (Odoban commercial)
Shower X-tra power	Shower and tile cleaner	United Laboratories
Suncide	Insecticide	United Laboratories
Shine-up	Furniture polish	JohnsonDiversey
Top notch	Black marks on walls	Starco Chemical
Basic D	Automatic Dishwashing concetrate	Shaklee
Stretch n dust	Dusting clothes	chicopee
Satin Sheen	Dishwashing detergent	Shaklee
Omni-air	Wall mounted Air freshner	Triple S
Hydro Clean	Cleaner and stain remover	American Industrial Supply (AIS)
Zyme-Screen	Non toxic urinal block and screen	United Laboratories
Weather-zyme	Outdoor cleaning agent	United Laboratories
Gp forward	Scrub and recoat cleaner	JohnsonDiversey
HOST	Dry carpet cleaning and spotting	Racine Industries Inc

* Note that not all these products are necessary for a cleaning department. Most of these products have multiple uses and therefore, not all are needed. Some of these products are used on a project basis, and not daily.

COMMUNITY CONNECTIONS

—This service brings out the best of everyone [here.]…
It exemplifies the very best of our staff and residents in meeting the needs of our community and the outside community."
(Assisted Living Resident)

Resident-centered long-term care communities focus not only on the relationships that flourish within the organization, but also on supporting connections to individuals, organizations and causes in the outside world. Beyond the microcosm of the long-term care community are countless opportunities for residents, family members and staff alike to be of service to others, maintain their established interests and personal ties, meet new people who share similar passions, and expand their horizons.

The reverse is also true. Educational, social, civic, volunteer and entertainment opportunities held within the home and open to the public-at-large can provide exposure the richness of the life in the community, and can radically transform attitudes about long-term care communities on a broader scale.

Service to Others

Providing service to others can add a rich dimension to anyone's life. Particularly for those who may feel they are growing increasingly dependent on others, involvement in civic, humanitarian and/or service activities can enhance feelings of accomplishment, personal fulfillment and self-esteem. A shared sense of achievement and dedication to a common goal can be cultivated when such activities are enjoyed as a group of residents, staff, and family. Furthermore, getting involved in the outside community can broaden individuals' horizons at a time when it may seem as though their world is getting smaller and smaller.

The possibilities for service activities are endless:

- Recruiting a team to participate in a local fundraising walk-a-thon (either as walkers, fundraisers or day-of volunteers). Coming up with a team name, creating t-shirts and walking in memory or in honor of a family member or resident can elevate the event to a true community-building occasion

- Volunteering at a local soup kitchen or food pantry

- Reading aloud to local school children
- Collecting and packaging items to send to military personnel
- –Adopting" a family around the holidays to provide gifts and trimmings
- Stuffing envelopes for a local not-for-profit organization
- Knitting baby caps and/or prayer shawls.

Relay for Life
Re-printed with permission from Middlewoods of Farmington

Social Action Club
At Maimonides Geriatric Centre in Quebec, a social action club built on the Jewish tradition of doing *mitzvoth*—or good deeds for others—offers a multitude of opportunities for residents to engage in meaningful service to others. Coordinated by an art therapist and therapeutic recreation specialist, the club's programs are adapted to the needs and abilities of residents to maximize opportunities for participation.

Individual Service
While some staff and residents may be motivated to get involved in service activities sponsored by the organization, others may take matters into their own hands. Ensuring support for self-directed service activities on an individualized basis is also important.

Volunteer Programs

Welcoming in volunteers from the external community can further enhance the overall environment and atmosphere of a long-term care setting. In resident-centered settings, volunteers are caregivers in their own right and are fully embraced as members of the team.

Recruitment
There are a variety of avenues for volunteer recruitment. Local schools are often an abundant source of volunteers, with schools increasingly requiring students to earn community service credit hours. Other outreach opportunities include local civic organizations and volunteer fairs. Utilizing volunteers who are also family members has true value in that it represents to the residents that their families are willing to give time to all residents. Saint Elizabeth Community in Rhode Island boasts that both current families and family members of former residents make up a large part of their volunteer network.

Maimonides Geriatric Centre developed the **para-professional volunteer program** as a vehicle for recruiting baby boomers who may be recently retired from professional careers and/or are

experiencing ~~–e~~mpty nest syndrome." The paraprofessionals commit to volunteering approximately six hours per week for three ~~–s~~emesters" (one semester equals eight weeks.) This arrangement accommodates the desire of many in this age group to travel or spend time at second homes. Included in their weekly time commitment is regular education through lectures and workshops. Paraprofessionals work alongside professional staff. Placements over the years have included one-on-one work with residents, speech therapy, fitness, rehab, art therapy, sensory stimulation, pet therapy and more.

On-Boarding

Given the important roles that volunteers play, the process to recruit, orient and train them should be thorough and intentional, not an afterthought. **Scheduling an interview with a prospective volunteer** is an opportunity to explore what kind of volunteer work would be most meaningful and appropriate for him/her based on qualifications and interests so that a mutually satisfying assignment can be made. A **written volunteer job description** outlining their responsibilities and expectations emphasizes the professionalism of the role, even if it is unpaid.

Formal **orientations** to the organization will ensure that volunteers understand their roles, expectations, and have a general understanding of how the community operates. Any behavioral standards in place for staff apply to volunteers as well, and **retreats** or other educational opportunities to sensitize staff to the interconnectivity of the community should be inclusive of volunteers.

The work of supporting volunteers can not lie solely on the Director of Volunteers; it is a collective imperative. This includes being prepared for the arrival of a volunteer, remaining attuned to their needs, keeping them abreast of news and changes within the organization, providing ongoing education, and regularly acknowledging and celebrating their contributions to the community.

Volunteers give generously of their time, energy and talents. Ongoing formal and informal **recognition** of these contributions is an important component of any volunteer program. A **Volunteer Recognition Dinner or Luncheon** is an occasion for publicly celebrating volunteers. Acknowledging volunteers' years or hours of service—with a plaque, certificate, pin, etc.—reinforces how much the community values its volunteers. **National Volunteer Week** is another natural opportunity to spotlight volunteers. Including their names in a newsletter or a photo collage of volunteers in a public corridor can be an occasion to reflect on all the ways volunteers enrich the life of the long-term care community.

A **handwritten thank you note** or **birthday card** sent to a volunteer's home can be just the kind of positive recognition needed to sustain them through some of the more challenging aspects of their volunteer work. For some, **credit hours** (for school, church, court) are an important benefit of their volunteered time.

Perhaps, though, the most meaningful recognition for volunteers—or anyone in the community, for that matter—is a simple, heartfelt and spontaneous *thank you*. All staff and residents should be encouraged to express their gratitude to volunteers regularly.

Intergenerational Programs

Programs that support the joining of generations benefit young and old. Some long-term care communities sponsor **after school** or **daycare programs** for their staff members and include residents as part of the caregiving team. The infusion of childhood wonder and energy can be infectious, bringing countless bright moments to each day. For residents accustomed to being around children, the opportunity to continue doing so is immensely meaningful. And, of course, the children and childcare providers benefit as well from the loving interactions with residents.

Providing opportunities for residents to interact with children of all ages need not be as resource-heavy as offering on-site child care. Holbrook Health Center at Piper Shores in Scarborough, Maine hosts a **Halloween party** for residents and local children.

St. John's Lutheran Ministries in Billings, Montana takes advantage of its proximity to a local school by providing opportunities for residents to participate in **school reading** and **—talking about history" programs** where they share with students their first-hand accounts of living through historical events. In addition, interested residents are invited to participate in **art classes** held in conjunction with the children at the daycare on campus.

Community Education and Outreach

Community education opportunities leverage the expertise within the long-term care organization to educate the larger community on issues related to aging.

Lunch and Learn Programs
Open to the public at large, these programs are simple in concept, focusing on a variety of educational topics, such as health and wellness seminars or legal advice related to living wills and healthcare agents. Offering a simple lunch is often an effective way to attract participation. Beyond the benefit of the important information conveyed to attendees, they may also leave the site having absorbed other information about the quality of life in the long-term care setting that they never expected, making the sessions powerful marketing opportunities as well.

Maimonides Intensive Summer Session for Individual Volunteer Experience (MISSIVE)
This unique and mutually beneficial volunteer program in place at Maimonides Geriatric Centre is geared toward youth (ages 16 to 26) interested in a career in healthcare. In addition to daily educational lectures by healthcare professionals from a variety of disciplines, the students receive hands-on practical experience volunteering in their department of choice. In addition, each MISSIVE participant is paired with a resident who has been identified as someone who could benefit from more social stimulation. Students are recruited through university volunteer fairs, high school guidance counselors, career centers and ads in local newspapers. The program runs for eight weeks during the summer months when staffing can be challenged by vacation schedules. At the conclusion of the eight weeks, the students present a final project that has been worked on for the duration of the session. Work on this final project rounds out the experience

by providing opportunities to explore leadership and creativity skills while strengthening the cohesion of the group.

Government Affairs
Inviting government officials and state regulators into a long-term care community to educate them on the aims and approaches for culture change can be a particularly constructive form of targeted outreach. At Fairacres Manor in Greeley, Colorado, visits by governmental leaders have been valuable opportunities for the community to tell its story to those in a position to influence regulations. The visits are coordinated through the marketing department which diligently contacts every sitting legislator and candidate for city, county and state office.

Community Partnerships

Saint Elizabeth Haven
A safe place for frail or handicapped victims of elder abuse, Saint Elizabeth Haven is an extension of the services of Saint Elizabeth Community in Rhode Island. A partnership with private and state agencies, Saint Elizabeth now offers a haven within its current residences for elderly (60+ years of age) victims of abuse in need of a place to stay for up to 30 days. Referrals come from a network of partner agencies. Saint Elizabeth Haven was modeled after the Harry and Jeanette Weinberg Center, the first safe haven for elderly victims of abuse in the United States. Education and outreach have been essential for bringing attention to this important issue and awareness of the Saint Elizabeth Haven.

THE CASE FOR ADOPTION:
The Consumer Perspective

In 2010, the Picker Institute funded a consumer education pilot to build awareness and advocacy for culture change. Of the 502 consumers participating in the study, 97% "strongly agreed" or "agreed" that they would rather live in a culture change community than one that practices a traditional model of nursing care. This finding is certainly intuitive given that culture change offers consumers a more individualized, consumer-oriented practice and environment. Recent studies corroborate this expectation through improved levels of resident and family satisfaction.

- The increased levels of engagement in Green House homes led to more positive family outcomes than comparison homes. Outcomes include greater satisfaction with the experience and with the family member's care (Lum, Kane, Cutler & Yu, 2009).
- Similar studies of Green House homes also found greater perceptions of quality of life by residents (Kane, Lum, Cutler et al., 2007; Rabig et al., 2006).
- It is a consistent finding of Pioneer Network case studies that residents rate satisfaction at the highest levels (98% excellent or good rating in the cited study) (AHRQ, 2009).

AHRQ Health Care Innovations Exchange. (2009). *Nursing Home "Neighborhoods" Emphasize Dignity and Independence, Leading to Improvements in Resident Health and Quality of Life and Lower Employee Turnover*. Retrieved August 30, 2010 from **www.innovations.ahrq.gov/content.aspx?id=1906.**

Kane, R. A., Lum, T. Y., Cutler, L. J., Degenholtz, H. B., & Yu, T. C. (2007). Resident outcomes in small-house nursing homes: A longitudinal evaluation of the initial Green House program. *Journal of the American Geriatrics Society, 55*, 832-839.

Lum, T.Y., Kane, R.A., Cutler, L.J., & Yu, T.C. (Winter, 2008-2009). Effects of Green House® nursing homes on residents' families. *Health Care Financing Review*, 30(2), 35-51.

Rabig, J., Thomas, W., Kane, R. A., Cutler, L. J., & McAlilly, S. (2006). Radical redesign of nursing homes: Applying the Green House concept in Tupelo, Mississippi. *The Gerontologist, 46*, 533-539.

Source: Pioneer Network, 2010

YMCA Partnerships
Some organizations have joined their local YMCA in order to participate in health and wellness programs outside the scope of what is available internally.

Public Relations: Celebrating Residents

Feature stories about residents in local newspapers shine a light on individuals for their accomplishments, expose the public-at-large to what is going on right in their own neighborhood and challenge common assumptions about aging and long-term care.

United Methodist Homes created the **Senior Wisdom Awards** as a formalized vehicle for recognizing seniors who are models of graceful aging and who contribute in significant ways to their communities. Churches and other community organizations are invited to submit individuals for consideration, and an awards ceremony is held to honor those whose lives are inspirations to others.

See United Methodist Homes' Senior Wisdom Award Nomination Form and Letter, page 259.

Creating a Destination

Offering reasons for members of the public-at-large to visit the long-term care community can be an effective strategy for re-shaping expectations about aging and long-term care. Inviting the public into the community can be as simple as **welcoming young trick-or-treaters on Halloween**, creating a **walking path on the campus** that anyone may utilize, hosting a **community barbecue** or putting on outdoor **summer concerts** for the enjoyment of all.

Library Book Drop
A simple partnership between the local library and Delnor Glen Senior Living in St. Charles, Illinois benefits residents of the assisted living community and library patrons in the surrounding area. Delnor Glen has been established as a library book drop location where anyone can return a borrowed library book. Twice monthly, someone from the library picks up the returned books and restocks the book shelves at Delnor Glen, providing a rotating selection of books for residents to borrow. Residents are also able to make special requests for books.

Art Walks
The **Exhibits at Evergreen** program at Evergreen Retirement Community in Oshkosh, Wisconsin draws art lovers from the surrounding area to the retirement community to see a rotating collection of works from Wisconsin artists installed in a dedicated gallery space. Held in conjunction with Oshkosh's popular monthly gallery walk, the exhibit space has transformed Evergreen Retirement Community into a destination for the public-at-large. Catered by Evergreen's chef, artists' receptions are not only an opportunity for residents, staff and the public to connect over a shared passion for local art, but also to be exposed to the quality of life—and quality of food—within the community.

Activities such as these can re-define expectations about aging and long-term care. They leave lasting impressions that in these unique environments residents are active contributors to the community life, that they voice their opinions, ideas, concerns and dreams, that family members too are part of the community, and that far from the conventional wisdom about long-term care communities, these organizations are places of life, growth, and vitality.

Community Connections Implementation Tools

Tool A. United Methodist Homes' Senior Wisdom Award Nomination Form and Letter

March 16, 2004

«Addressee»
«Organization_Name»
«Address_Line_1»
«Address_Line_2»
«City», «State» «ZIP_Code»

Dear «Salutation»:

United Methodist Homes invites you to recognize one special senior member of your congregation with an award at the third Senior Wisdom Awards ceremony to be held at Wesley Village in Shelton, CT at 2 PM on Wednesday June 16. All United Methodist Churches that have recently contributed to United Methodist Homes have been invited to select an awardee.

The Awards are intended to honor older adults who are models of graceful aging and who continue to contribute in a significant way to their community. Jerry Franklin, President and CEO of CT Public Broadcasting, will present the awards. If you attended a previous ceremony, you know what a positive celebration it was of the lives and contributions of the honorees.

A brief biography of each honoree will be included in the program booklet. In order to be included in the program, the enclosed form for the Senior Wisdom Award recipient from your church must be **received by April 30, 2004.** The form may be submitted by mail, fax 203-944-8290, or email to jnorko@umh.org.

The event is being planned by the Office of Development and Public Relations. If you have any questions about the Senior Wisdom Award program, please call Julie Norko at .

Sincerely,

Jim Stinson
Director of Spiritual Life

cc: Chair, Administrative Council

Enclosure

United Methodist Homes

Senior Wisdom Award Recipient

Name: _____Phone:_____

Address:_____

_____

Date of birth and age:_____

Describe the reasons why this person was selected. (This section will be printed in the Award Program booklet. It may include highlights from the sections that follow):

_____

_____

_____

_____

_____

Major work experiences, if any:

_____

_____

Volunteer activities:

_____

_____

_____

Education (Institutions and degrees if applicable):

_____

Name of person submitting application: _____

Church name: _____ Date:_____

Please use envelope provided or return to: Office of Development and Public Relations, United Methodist Homes, 580 Long Hill Ave, Shelton, CT 06484. You may also fax this information to: 203-944-8290, or e-mail to jnorko@umh.org.

TRANSITIONS OF CARE

Contributing Author: Cheri Lattimer, National Transitions of Care Coalition

—If I had not been at the hospital, I am not sure that my parents would have completely understood the transition process... You are missing little details if you are trying to get well. I can picture my parents, if I wasn't there, saying everything is fine, no questions. But then if you ask them, they are not really sure." (Family Member)

With its emphasis on the individual as the locus of care, a person-centered approach transcends the fragmentation of the current healthcare system. The specific setting of care becomes less relevant than the experiences of the individual. When efforts along the healthcare continuum are aligned around the fundamental concepts of personalizing, humanizing and demystifying the healthcare experience for the care recipient, person-centered care is taken to new heights. Work to apply person-centered concepts to the transitions of care, therefore, is an important extension of any long-term care community's work to become more resident-directed and relationship-centered. The term "transitions of care" refers to a patient leaving one care setting (i.e. hospital, nursing home, assisted living, skilled nursing facility, primary care physician, home health or specialist) and moving to another as their condition or healthcare needs change. The care transition often involves multiple persons including the patient, family or other caregiver, nurses, socials workers, case managers, pharmacists, physicians and allied health providers. An optimal transition should be well planned with the involvement of the patient and family, and adequately timed. More often, however, the communication between settings and the coordination among caregivers, patients and healthcare professionals fail to provide all the information needed for optimum quality of care.[31]

ADDITIONAL RESOURCES: **Care Transitions Theme**

The Care Transitions Theme is a CMS-funded initiative for Medicare Quality Improvement Organizations (QIOs) to measurably improve the quality of care for Medicare Beneficiaries who transition among care settings through a comprehensive community effort. Fourteen QIOs began working with target communities within their respective States on August 1st, 2008, and the project will be completed by August 2011. Each QIO is working in one community and they are implementing a variety of evidence-based interventions. More information on the Care Transitions Theme, including the participating communities and early findings can be found at **www.cfmc.org/caretransitions** and a report on the various interventions which are being tested for community-based implementation can be found at:

www.cfmc.org/caretransitions/files/Care_Transition_Article_Remington_Report_Jan_2010.pdf.

[31] Improving on Transitions of Care: How to Implement and Evaluate a Plan, The National Transitions of Care Coalition April 30th 2008.

—It is poor communication between well-intentioned professionals and an expectation that patients themselves will remember and relate critical information that can lead to dangerous and even life-threatening situations."
(National Transitions of Care Coalition)

The Need for Person-Centered Transitions
The lack of connectivity between providers in the health system has risen to the national consciousness, as evidenced by the provisions highlighted in the Patient Protection and 7Affordable Care Act 2010. Poor transitions have been identified to increase unplanned readmissions, compromise patient safety through poor communication and place a significant burden on patients and their family caregivers. The Institute of Medicine (IOM) emphasizes that healthcare quality suffers —due not to a lack of effective treatments, but to inadequate healthcare delivery systems that fail to implement these treatments." (IOM, Priority Areas for National Action: Transforming Health Care Quality 2003).

Improving the coordination of care among the various care settings within the long-term care continuum can improve patient safety, quality of care, and health outcomes while avoiding significant costs and reducing inappropriate readmissions. Another important consideration in improving transitions is the reduction of patient and family caregiver frustration, emotional distress and dissatisfaction when poor transitions cause adverse outcomes and complications.

National Priorities Partnership 2008

The National Quality Forum (NQF) in its role as a convener and partner of the National Priorities Partnership has a focus on care coordination. NQF has endorsed a definition and a framework for measuring care coordination with five key domains: Healthcare Home; Proactive Plan of Care and Follow-up; Communication; Information Systems; and Transitions or Hand-off.

The NPP has identified care coordination as one of its six National Priorities and has emphasized national action on the following goals to:

- Improve care and achieve quality by facilitating and carefully considering feedback from all patients regarding coordination of their care;
- Improve communication around medication information
- Reduce 30 day readmission rates; and
- Reduce preventable Emergency Department (ED) visits by 50 percent.

The National Transitions of Care Coalition (NTOCC) has been working to address the gaps and barriers to safe transitions and provide significant resources and tools for patients and providers to improve communication and patient safety. NTOCC brought forth seven key considerations for improving transitions:

1) Improve communications during transitions between providers, patients and caregivers
2) Implement electronic medical records that include standardized medication reconciliation elements
3) Establish points of accountability for sending and receiving care, particularly for hospitalists and nursing home providers
4) Increase the use of case management and professional care coordination
5) Expand the role of the pharmacist in transitions of care

6) Implement payment systems that align incentives
7) Bring forth performance measures to encourage better transitions of care

Improving Care Transitions through Communication and Patient/Family Engagement
NTOCC developed a conceptual model for Transitions of Care which highlights the need for bi-directional communication between providers and engagement of the patient and family caregivers. The sender and receiver must make every effort to transfer information in a timely manner and share accountability across care settings.[32] The care transition-based interaction(s) between accountable providers of care (both the sender and receiver of information) occurs in a "hub of coordination" context with a primary aim of ensuring effective and safe transition between care settings and/or providers. Consistent with a person-centered approach, integral to this "hub of coordination" is active involvement by the patient and family caregiver. The sender especially is expected to educate the patient and family about the necessary care transitions activities, answer their questions and seek their active participation in the decisions about transitions.

Case Managers
Improving transitions involves all healthcare professionals, but establishing accountability for the various transition steps such as medication reconciliation, patient and caregiver coaching, supporting patients to obtain self management skills, and ensuring that a care plan and follow up visits with primary care providers occur after a transition, is key to improving and ensuring a safe transition. Many of the models supporting care transitions are utilizing a case manager (nurse or social worker) to provide the health coaching and care coordination support to the patient and family. The case manager is an integral part of the clinical team and often can be seen as a connector of information to other health care providers as patients move from one level of care to another.

> *"When the surgeon comes in to tell you what he's done, and the ramifications of it, you are under anesthesia. And my daughter was talking to the doctor every day and keeping me updated. Why would they tell you about the surgery when you are only hearing a word here and there?"* (Patient)

Focusing on the One Constant of Care: The Patient
A constant in all episodes of care is the patient. Recognition of this simple fact illuminates the vast opportunities for enhancing care coordination and transitions when patients are equipped with sufficient support, education and tools to be active partners in their healthcare. Patients and/or their caregivers can assist in facilitating communication and interaction between their providers during transitions and actively participate in decision-making regarding treatment options. This, though, is dependent on their receiving the support and collaboration of the healthcare providers that manage and coordinate their care options.

Assessing and Supporting Health Confidence[*]
One patient-reported measure that indicates effective preparation for healthcare transitions is called "health confidence." While the importance of health confidence has long been recognized

[32] Transitions of Care Performances Measures, Paper by the NTOCC Measures Work Group 2008, www.ntocc.org

[*] We are pleased to acknowledge John Wasson, MD for his contributions to this section.

among many health professionals, it has been under-emphasized or misinterpreted as being the same as ―compliance.‖ Though it can be assessed in several ways, ―health confidence‖ essentially reflects how well the patient/caregiver agrees that s/he is confident to control and manage most health problems or health concerns. Information quality and clinician knowledge of patients‘ functional limits are the two most important predictors of health confidence. Recent syntheses of research—most notably in the form of the chronic care model—have brought the concept of confidence to the center of clinical care. When confidence is made a CARE Vital Sign, outcomes can be improved quickly. The ―C‖ in CARE refers to **checking** on what is important to the patient – for example, the patient‘s confidence. The ―A‖ refers to planned **action** based on the patient response. The ―R‖ refers to **reinforcement** of the action over time, and the ―E‖ refers to **engineering** the previous processes into clinical practice so that they become part of everyday work.

While it is easy to ask ―How confident are you that you can manage and control most of your health problems?‖ it often takes a lot of insight for very sick patients or caregivers to understand their problems and a lot of clinician time to understand what really matters to the patient or caregiver. When patient, caregivers, and clinicians are not on ―the same page‖ the mis-communication can lead to unnecessary tests and procedures, medical errors, and poor outcomes. **HowsYourHealth.org** offers a family of tools that patients and caregivers can use to better understand their problems. At the same time a summary of the patient insights can be given to the clinician. This information serves as a very strong foundation for effective communication.

Transitions of Care Models

Various models of care have emerged over the last few years focusing on enhancing communication and engagement of the patient and family caregiver with their healthcare providers. Specific information on several of the models and additional resources on transitions of care can be found at the following Web sites:

Care Transitions Program℠	**www.caretransitions.org**
Transitional Care Model	**www.nursing.upenn.edu/media/transitionalcare/Pages/default.aspx**
Guided Care™ Nurse Model	**www.guidedcare.org**
Project RED – Re-engineered Discharges	**www.bu.edu/fammed/projectred/**
BOOSTing (Better Outcomes for Older Adults through Safe Transitions) Care Transitions	**www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm**
NFCA - National Family Caregivers Association - Family Caregiver Tool Box	**www.thefamilycaregiver.org/**
Consumers Advancing Patient Safety Tool Kits	**www.patientsafety.org**
Case Management Society of America – CM Medication Adherence Guidelines & Disease Specific Adherence Guidelines	**www.cmsa.org**

Common Approaches Across Models
A number of common elements for improving transitions are recognized across these various models, including:

- Medication list / reconciliation and adherence assessment
- Transitions summary at discharge
- Follow-up visit with PCP/Specialist
- Care Plan
- Coaching with patent and family caregivers
- Post transition call and/or visit
- Accountability for sending and receiving communication.

ADDITIONAL RESOURCES:

National Transitions of Care Coalition
www.ntocc.org

NTOCC has provided patient tools and resources for consumers to utilize to assist in coordinating communication, including:

- **My Medicine List** (listing of medications a patient is taking)
- **Taking Care of My Health** (questions to share with healthcare providers)
- **Patient Hospital Guide** (what to expect during a hospitalization)

Tools are also available from NTOCC specifically for providers.

Measurement of Transitions
The development of performance measures is essential to implementing and sustaining transitions of care innovations. The Care Transitions Measure (CTM-3), a National Quality Forum (NQF) endorsed tool, represents a self-report measure of the quality of care transitions. Developed by Eric Coleman and colleagues with funding from The Commonwealth Fund, The Robert Wood Johnson Foundation, and the Paul Beeson Faculty Scholars in Aging, the objective of the CTM-3 is to capture the patient's perspective in a manner that drives quality improvement.[33] With possible responses being ~~–s~~trongly disagree," ~~–d~~isagree," ~~–a~~gree," ~~–s~~trongly agree" and ~~–d~~on't know / don't remember / not applicable," the aspects of the transition experience patients are asked to assess are:

1. The nursing facility staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.
2. When I left the nursing facility, I had a good understanding of the things I was responsible for in managing my health.
3. When I left the nursing facility, I clearly understood the purpose for taking each of my medications.

The tool can be downloaded at **www.caretransitions.org.**

[33] Coleman EA, Mahoney E, Parry C. (2005 March) Assessing the quality of preparation for posthospital care from the patient's perspective: the care transitions measure. *Med Care*. 2005 Mar;43(3):246-55.

Transforming Transitions through the Eight Step Change Process

Changing the way we manage transitions of care is more than just the implementation of tools and resources. It requires changes to workflows, processes and culture. Consider integrating John Kotter's Eight Step Change Process as a roadmap for improving care transitions.

Create a Sense of Urgency

- Identify and track your community's readmission rate to area hospitals per patient diagnosis
- Meet with hospital administration to understand how your readmission rate compares with other local providers and how readmission rates vary per diagnosis. Identify and review clinical data available and the relevant financial impact of improved transitions
- Conduct focus groups with all stakeholders to gain perspective on the facilitators and barriers to effective care transitions
- Review a readmission case and illustrate what went wrong, what could have worked better and where the breakdowns in communication occurred; present this as a de-identified case study

Form a Powerful Coalition

- Work with the hospital and local healthcare providers to form a coalition to improve transitions; include non-traditional providers such as area agencies on aging, senior centers, consumers, etc.
- Identify relationship building strategies as a coalition and for caregivers across the continuum
- Establish regular meetings to identify goals and track progress
- Identify a way to measure the coalition's progress, e.g. administering surveys prior to forming and periodically thereafter throughout the coalition process
- For organizations with more than one level of care, set up an internal transitions work team

Develop a Vision and Strategy

- Develop a concise message that conveys WHY effective transitions of care are important and calls your community to action, e.g. —Every element of a patient's transition will be assessed, based on whether it enhances or detracts from personalizing, demystifying, and humanizing the healthcare experience."

Communicate the Vision

- Hold town hall meetings that include members from the external community and across the healthcare continuum to learn about and discuss the issues of transitions.
- Ask hospital executives and physicians to provide education to your community on prevention of hospitalization and the importance of improving care transitions.
- Use the media to communicate your vision

Empower Others to Act

- Bring front-line staff across the continuum together to discuss opportunities and challenges and to, most of all, *build relationships*.
- Coordinate site exchange visits (inviting a hospital discharge planner to spend a day with nursing home intake managers and vice versa)
- Include all stakeholders on the work team to improve transitions of care
- Communicate progress and recognize individual contributions

Generate Short-Term Wins

- Identify language barriers that exist between settings
- Consolidate patient/family educational materials and coaching strategies
- Collaborate on systems for medication reconciliation
- Ensure follow-up physician appointments are scheduled
- Conduct follow-up calls with patients after discharge using the Care Transitions Measure Tool

- Collaborate on patient-centered documentation systems, clinical protocols, care planning process, and transition plans

Sustain Momentum

- Review readmissions case studies as a way to consolidate improvements needed
- Review opportunities for using technology to improve transitions
- Create joint educational tools for patients and staff
- Integrate staff development and training opportunities across the continuum
- Continue relationship building
- Celebrate successes

Anchor the Change

- Evaluate progress through annual focus groups
- Exchange targeted quality data routinely
- Measure stakeholder satisfaction, readmission rates and associated clinical and financial outcomes
- Communicate outcomes to all stakeholders

ELDERTOPIA: THE RISE OF A NEW OLD AGE

By Dr. Bill Thomas

—It is in the act of confronting long-term care's shadow that we find the strength, courage and endurance we need to persevere in the work of change."

This commentary will draw on the line of thinking advanced in this Guide and challenge the reader to explore concepts that go beyond the scope of this work.

Even though everyone talks about it as if they know what it means, the term —culture change" lacks a single, authoritative, definition. This fuzziness is due, in part, to the grassroots nature of the movement that has led providers to approach change from many different starting points. Because it arose as a reaction against the most restrictive and conformity-enforcing aspects of institutionalization, the movement has resisted the creation of its own conformity-enforcing standards. This history helps explain the current lack of clarity but does little to answer the long-term care professional who asks, —What is culture change?"

Culture change's blessing, and its weakness, is that it requires us all to confront settled assumptions and examine new ways of thinking. Frank discussions of the weaknesses of contemporary long-term care often engender fierce and emotional responses from people who take such criticisms personally. Explicitly stating that the critique is directed against a system and is not an attack on any individual or group does nothing to lessen the anger. Nevertheless, culture change must maintain a critical perspective on conventional practice if it is going to move the field toward a person-centered future.

Though some might be uncomfortable with the notion, we will begin with the idea that the culture change movement is dedicated to ending the reign of the total institution[34] and replacing it with a wide range of person-centered cultures that are dedicated to growth and genuine human caring. America's struggle to improve the institutional care offered in a variety of settings is an effort which spans generations and has engaged the energies of a wide range of talented advocates. Many trace the current culture change movement back to Barry Barkan's Live Oak Definition of an Elder. In 1976, he foresaw how the people of his generation might, in the decades to come, form the largest and most influential group of elders the world has ever seen. Barkan made an imaginative leap from demography to the act of creating —regenerative

[34] Goffman, Erving. Asylums: Essays in the Social Situations of Mental Patients and Other Inmates.

community" on a vast scale. Such a community would serve all people, regardless of their age. His words remain fresh and insightful more than a quarter century after they were first written.

An elder is a person
Who is still growing,
Still a learner
Still with potential and
Whose life continues to have within it
Promise for and connection to the future

Barkan begins by restoring elderhood to its rightful place. Longevity, far from diminishing the person, possesses a unique promise and potential. Elderhood contains a capacity for growth that must be declared and then protected. In honor of healthy beginnings, Barkan deploys the word ~~–s~~till" in a powerfully affirmative sense. All that was, remains, still there is more to be experienced, more to be known, more to be felt.

An elder is still in pursuit of happiness,
Joy and pleasure
And her or his birthright to these
Remains intact.

The definition moves on to the political realm, echoing the Declaration of Independence. Barkan proclaims that the elder retains, in full measure, all of these rights. The mocking stereotypes of older people commonly found in the media make it clear that the bias against older people now stands as the last form of bigotry that can be spoken of openly in polite company. The body, in old age, will be transformed. The force of time will batter and break the capacities of youth. The inalienable rights of the elder, however, remain undiminished. Happiness, joy, and pleasure, Barkan astutely observes, can be made available to all of us regardless of how tired or worn body and mind might become. The importance of this claim is underlined in a time when science provides the means to extend life despite advanced age and physical infirmity.

Moreover, an elder is a person
Who deserves respect
And honor
And whose work it is
To synthesize wisdom from long life experience and
Formulate this into a legacy
For future generations

The definition closes with a summary of the ancient transaction that lies at the root of elderhood. He advocates a respect for elders that is active rather than passive. These are not good manners or, heaven forbid, good customer service. Instead, he offers a vibrant, living exchange that has been part of the human experience for millennia. Elders have a role to play, one that is centered on the legacy they will leave for future generations. The experience of a life lived provides the raw material for a legacy of wisdom that can benefit future generations. Although we rarely think of old age as an invention, it is a uniquely human creation. Barkan deftly rescues

elderhood from the realm of charity and forbearance and restores it to its rightful place as the greatest of all human inventions.

Seeing with New Eyes

> *—While many culture change initiatives begin with efforts to improve the physical environment in which nursing home residents live, it is now clear that the social environment has much more of an impact on the well-being of staff and residents."*

Barry Barkan has devoted his life to bringing this definition to life in the context of "Regenerative Community." As the elder among a group of culture change "pioneers" Barkan's words continue to resonate and inspire. Among his most important contributions to the field is his understanding that sustained change demands a close relationship between content and process. This guide offers an unparalleled exploration of the process of change. How could specific content, such as the redefinition of elderhood inform and enrich the process of change?

Imagine for example a change process that is driven by insight into the difficulties that loneliness, helplessness and boredom cause for our elders. While some find it difficult to acknowledge the existence of these afflictions, doing so can lead us to powerful new insights. To begin with, the explicit use of this language demands, from us, greater clarity of thinking. What, in the context of long-term care, do these words mean?

- A lonely man needs companionship the way a thirsty man needs water. The organizational ethic of efficiency interferes with the provision of companionship by demanding that staff members remain busy at all times. It is this relentless emphasis on duties, routines and procedures that leads organizations to place tasks ahead of people.

- The enormous scale of the buildings, ostensibly designed to foster "long-term care," actually disable the people who live in them. Control over the most ordinary elements of self-care, eating, bathing, and dressing are taken out of the resident's hands and given over to paid staff members. The gradual descent into a life stricken by helplessness is an unintended and too often unnoticed consequence of life in an institution.

- Boredom is a great crushing weight that can squeeze the life out of any human being. It is the pain we suffer when we seek but cannot find variety and spontaneity in daily life. Because they are operated as therapeutic institutions, nursing homes frequently embrace the virtues associated with machine like efficiency. The best facilities are thought to be those that deviate least from predetermined schedules and routines.

Acknowledging the reality of loneliness, helplessness and boredom helps us fuse content and process in ways that create exciting new possibilities. Culture change requires that we make these kinds of leaps, no matter how difficult, because it is in the act of confronting long-term

care's shadow that we find the strength, courage and endurance we need to persevere in the work of change.

The conventional approach to management in long-term care does not serve us well primarily because it moves decision-making authority so far away from the elders. Residents are too often denied the opportunity to become the elders they are meant to be. The task of creating a better long-term care system for elders requires us to also remake the relationship between management and staff. One well known model of culture change teaches that, "As managers do unto staff, so shall the staff do unto the elders." An organization that learns to give love, respect, dignity, tenderness, and tolerance to employees creates the potential for these same virtues to be awarded, in abundance, to the elders. This form of caring reciprocity lies at the heart of all justice.

While many culture change initiatives begin with efforts to improve the physical environment in which nursing home residents live, it is now clear that the social environment has much more of an impact on the well-being of staff and residents. How we see our world, what we think about and how we treat one another do more than anything else to define the quality of life for people who live in and work in long-term care. Changing these attributes is both difficult and imperative and sustained progress is possible only when a creative, courageous leadership commits itself fully to this difficult work.

Going Beyond Long-Term Care

While we have every reason to be proud of the progress that has been and is being made in the field of aging services, we also have an obligation to widen our perspective. For most of human history, life's third age, elderhood, provided a noble station within which a person could experience old age. Today, few Americans even recognize the word "elderhood." In place of insight into the true nature of aging, many people hold a lazy range of nostalgia soaked opinions. They declare, for example, that "Old people used to be respected!" Few, however, can even guess what the true sources of such respect might have been. Beneath the rich diversity of experience found within the history of aging around the world and through history lies a simple truth: Old age works and has worked for the benefit of all, for thousands of years.

Even as those of us who value and care for elders ask: "How can aging help us make a better world for people of all ages?" A much larger and vastly more powerful contingent bemoans the burden aging places on the public purse. Our society rarely grants older people a suitable role within the social order. We are snatching defeat from the jaws of victory. The culture change movement arose within the context of long-term care but its influence cannot and should not be limited to that sphere. Working together, we can use culture change to support the development of the most elder-rich culture in all of human history. Since the dawn of humanity, elderhood has been protected, sustained, and nurtured because it is able to bind families, communities, tribes and nations together.

It is not easy to sustain an appreciation for the intrinsic value of aging while living in a society that conceives of older people as broken down adults whose ongoing value is questionable, at best. We have to understand, we are told, that there are limits to what a compassionate society

can *do for them*. We are in need of a radical interpretation of longevity which values elders (and their needs) as being essential to our collective pursuit of happiness and well-being. It should not come as a surprise that our language lacks a word that describes the interdependence that joins young and old. The wisdom of living in a multi-generational social structure and making use of social structures and rituals designed to protect and celebrate older people is ancient, undeniable and deserving of a word of its own. For this reason, I have coined the term:

Eldertopia / ell-der-TOE-pee-uh / noun *A community that improves the quality of life for people of all ages by strengthening and improving the means by which (1) the community protects, sustains, and nurtures its elders, and (2) the elders contribute to the well-being and foresight of the community. An Eldertopia that is blessed with a large number of older people is acknowledged to be —elder-rich" and uses this wealth to advance the good of all.*

Our nation's elders are a vast storehouse of lived experience, wisdom and understanding. We need elders because we need families, congregations, neighborhoods and communities. We must work toward the construction of a new Eldertopia because old age connects us to a rich array of human virtues and experiences. Elders can show us news ways of experiencing time, money, faith, childhood and relationships. They can connect us with our past, and our future. We should be proud that culture change is improving the lives of elders and changing the face of long-term care but that is just the beginning. Just as Barry Barkan foresaw, we now stand on the cusp of a new era. We have the potential to bring forward the most influential and effective generation of elders the world has ever known.

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PICKER/PLANETREE FELLOWS

Funded by the Picker Institute, the Picker/Planetree Fellowship was created as an opportunity to engage long-term care professionals with first-hand experience implementing resident-centered care in the development of this Improvement Guide. The 2010 Picker/Planetree Fellows are:

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Annie Levy is a creative director and photographer who conceives and creates exhibits, projects, and experiences that transform the way we see things. Her projects bring to life the stories of "ordinary" people through the art of portraiture in its variety of forms — image/text, exhibition/installation, presentation/workshop. With a special focus on the lives of older people and the world of medicine, she creates works for both innovative and traditional venues that inspire, educate and influence public opinion and perception. Her work has been featured at the United Nations, commissioned by, among others, The Frick Collection for their Art of Observation program, the Hebrew Home (Riverdale, New York), the Alzheimer's Association (New York, NY) and is permanently installed in Roosevelt Hospital (New York, NY).Annie has also recently formed Photo ID, a non-profit organization whose mission is to design, develop and create exhibits, projects and experiences that change the way we see and are seen. For more about Annie Levy, please visit: www.annielevy.com.