2011 Indiana Healthcare Leadership Conference on Care Coordination and Transition

October 27, 2011

Indianapolis, Indiana.

A Smooth Hand-off
Getting Residents Off to a Good Start

Faculty:
Cathie Brady & Barbara Frank
B&F Consulting

Transitions in Care

- A Statewide and National Issue
- Transfer trauma avoided by smooth transition
- A good start makes a good stay
- Think from perspective of person making transition
- Use the tools – MDS, QoL, QIS
- Start the conversation
  - Internally
  - with hospitals

Arrangements with Hospital

- Relationships
  - with QI and Clinical, not just between marketing and discharge planning
  - Regular meetings to share information and trouble shoot
- Nurse to nurse report
- Orient hospital to:
  - time factors in your need to know about meds and equipment
  - impact of transition process and arrival time on resident

Your Welcome

- Entry process and surroundings
- Warm initial welcome
- Someone who's available to be an anchor
- Make person and family comfortable, attend to immediate physical and emotional needs

First Things First

In first few hours

- Accommodate physical surroundings to resident's functional abilities
- Accommodate care schedule to resident's daily routines
- Diary patterns
- Share social history, patterns, and ADLs with care team

Staff to reality
while you work to change it

OBRA 87 requires
each nursing home to
provide care and services to:

attain or maintain
the highest practicable
physical, mental, and psychosocial
well-being of each resident

Highest Practicable =
No "avoidable" decline

Unavoidable =

natural progression of a
resident's disease or condition

Individual Assessment of Each Resident's Abilities and Needs

With Participation by:

Resident and Family

Hands-on Caregiving Staff

Interdisciplinary

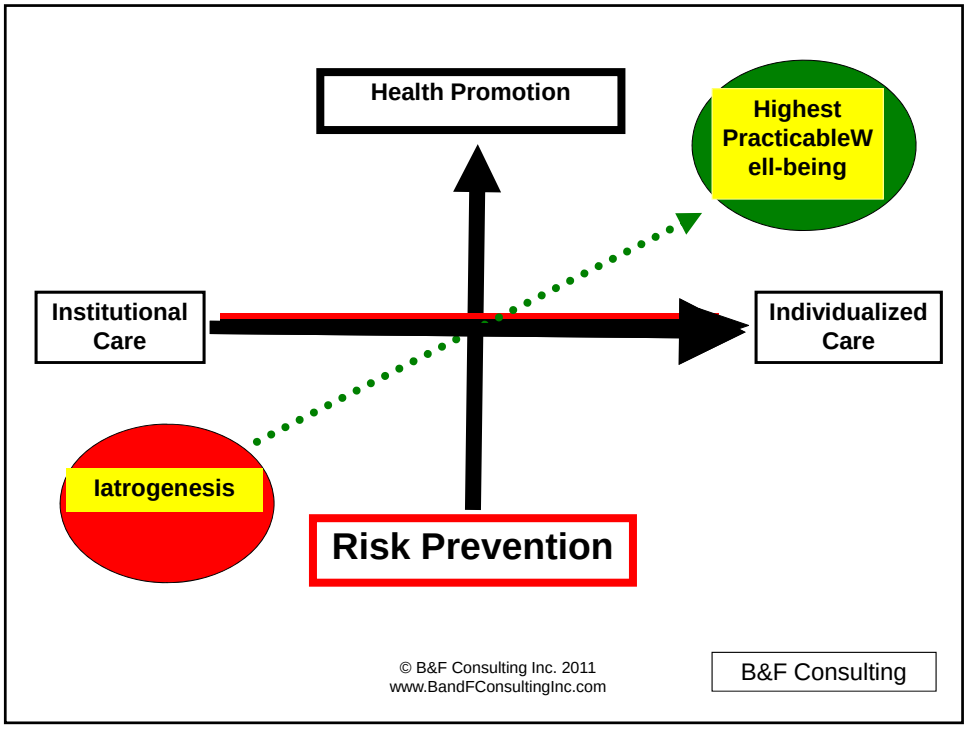
What was Mr. McNally like
when he first came in?

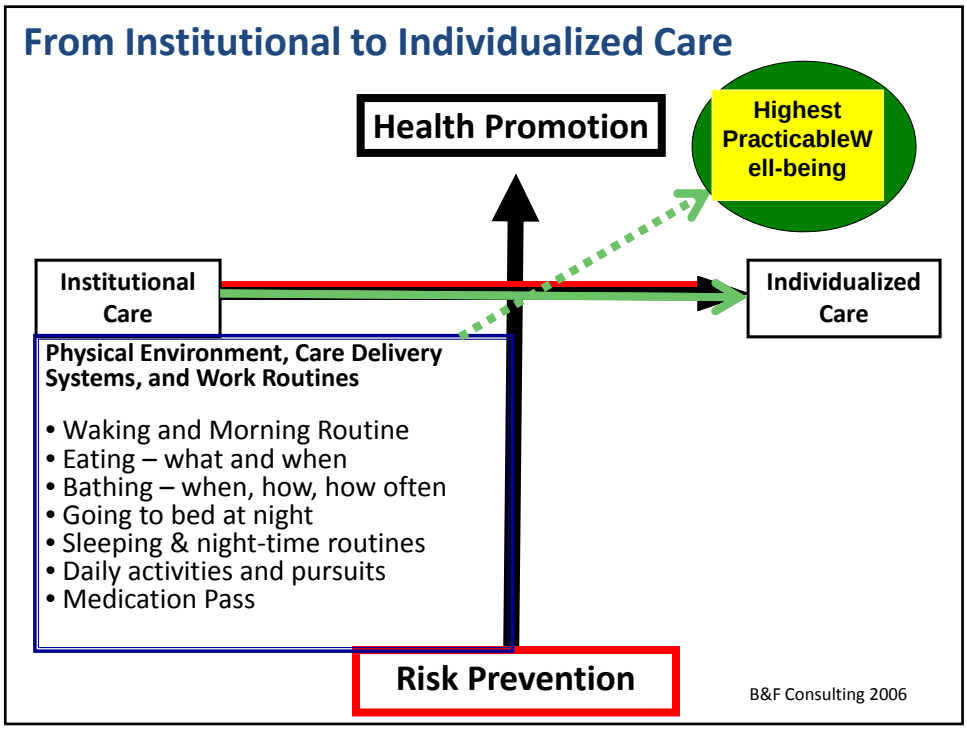
His decline was not a *natural progression of his disease or condition*.

What was the sequence of events that caused his decline?

Iatrogenesis

We caused it


Health Promotion
Highest PracticableWell-being
Institutional Care
Individualized Care
Iatrogenesis
Risk Prevention
© B&F Consulting Inc. 2011
www.BandFConsultingInc.com
B&F Consulting


From Institutional to Individualized Care
Health Promotion
Highest PracticableWell-being
Institutional Care
Individualized Care
Physical Environment, Care Delivery Systems, and Work Routines
• Waking and Morning Routine
• Eating – what and when
• Bathing – when, how, how often
• Going to bed at night
• Sleeping & night-time routines
• Daily activities and pursuits
• Medication Pass
Risk Prevention
B&F Consulting 2006

Section F
Customary Routines

Quality of Life Requirements

QIS resident and staff interviews

Section F - Customary Routines

How important is it to you to:

A. Choose what clothes to wear
B. Take care of your personal belongings
C. Choose between a tub bath, shower, or other
D. Have snacks between meals
E. Choose your own bedtime
F. Do your favorite activities
G. Go outside to get fresh air

Quality of Life Surveyor Guidelines
F242 Self-Determination and Participation

- Right to make choices over:
  - Activities
  - Schedules
  - Health care
  - Interactions with members of the community
  - Aspects of his or her life that are significant to the resident
- Choices over schedules is specified to include schedules of waking, eating, bathing, and going to bed at night, as well as health care schedules

Gathering and Using Information

- Facility must:
  - Actively seek information
  - Be "pro-active" in assisting residents to fulfill their choices
  - Make residents' choices known to caregivers

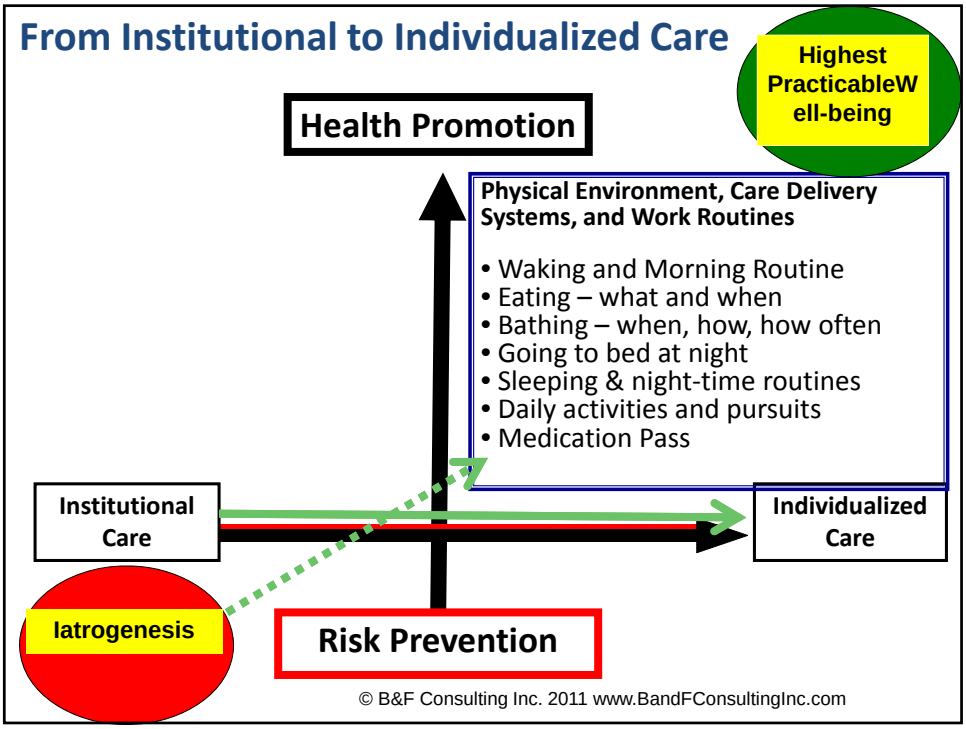
You have the information in hand, but do you have it in the hands of those who need it?
Relational Coordination

"Just-in-time" communication

Who needs Customary Routines information by when?

- Consistent caregiver on each shift
- Coordination by SW/Activities and CNA/Nurses
- Start-of-shift stand-up
- Shift-to-shift hand-offs
- Hand-offs to Weekend Staff

From Institutional to Individualized Care



Functional Ability

Assess and Accommodate
From Day One

The Up and Go Test (TUG)

Joanne Rader 2011

- Sit and rise from chair
- Walk to and from toilet
- Use toilet (including clothing management)
- Get in and out of bed
- Turn around (180-360º)

Accommodate physical surroundings and seating to resident's functional abilities

F246 Accommodation of Needs

Karen Schoeneman, CMS
Pioneer Network Webinars June 2009

- Guidelines stress that this tag's focus should be on the physical environment
  - Bedroom, bathroom plus some degree of individualization in common areas
- Language added that facility should be accommodating NEEDS and preferences
  - Facility needs to assess both needs and preferences of each resident and accommodate to extent reasonable, so long as others are not endangered

F246 Accom. of Needs (Cont.)

Karen Schoeneman, CMS
Pioneer Network Webinars June 2009

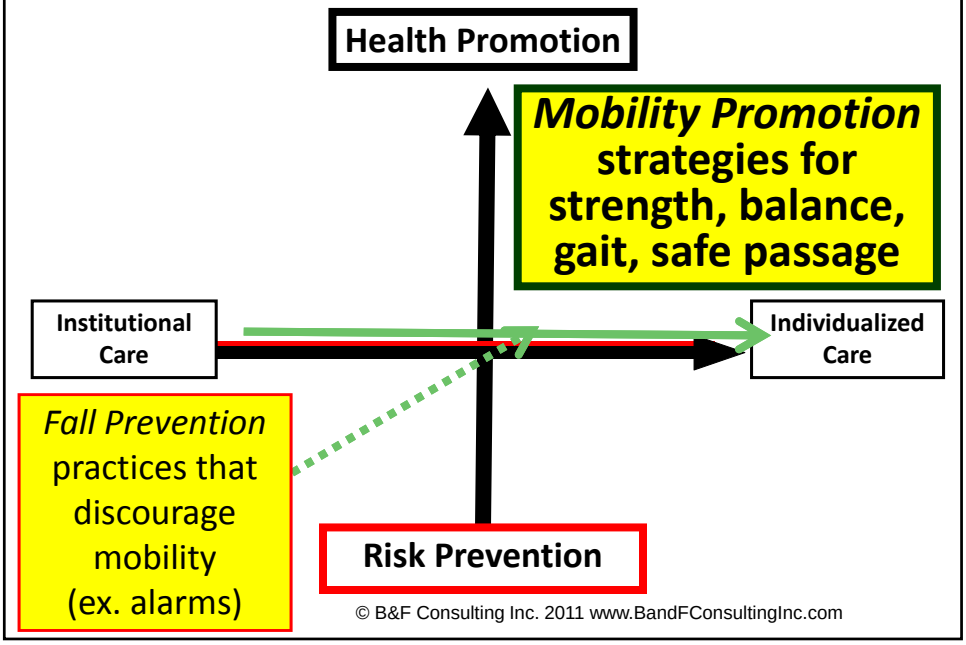
- Specifics provided about individualizing the bedroom and bathroom to assist resident to:
  - Open/close drawers, turn faucets on/off
  - See self in bathroom mirror, have toiletries at hand
  - Open/close doors, operate room lighting
  - Use bathroom facilities (access grab bars, etc.)
  - Other – use call bell, turn table light on/off
  - Sufficient electrical outlets, comfortable seating, task lighting, furniture arrangement

F246 Accom. of Needs (Cont.)

Karen Schoeneman, CMS
Pioneer Network Webinars June 2009

- Facility should furnish common areas with furniture that enhances residents' abilities to maintain their independence in sitting down and arising, and should strive to accommodate residents of different heights through different sizes and types of seating choices
- Staff helping residents who have trouble seeing and hearing

From Fall Prevention to Mobility Promotion



MDS 3.0 Interdisciplinary Approach

- Section C – Cognitive Patterns
- Section D – Mood
- Section E – Behaviors
- Section G – Functional Status
- Section H – Bowel and Bladder
- Section J 800 – Pain
- Section K – Nutritional Status
- Section M – Skin Conditions/esp. 1200
- Section O – Therapy – section C
- Section Q – 500 – Return to Community

Before or as soon as the person comes in, get to know and make sure to share:

- Social history for cues and clues
- Individualized routines
  - Use a diary to get to know the person (not alarms)
- Use MDS process just-in-time to:
  - assess functional ability
  - get to know routines
  - understand meaning behind behaviors
- Share the information with everyone who needs it in time

Pioneer Network Integrating the MDS 3.0 Into Daily Practice

Preventing Avoidable Decline The Ultimate Quality Improvement Plan

Connie McDonald, NHA, Administrative Director
Gray Birch and Glenridge
Augusta, Maine
Connie.mcdonald@mainegeneral.org

Pioneer Network Integrating the MDS 3.0 Into Daily Practice

Preventing Mr. McNally's Decline Is Mandated By OBRA and It is Quality Care

Identifying risks for decline must begin before the person arrives

What's the MDS Got to Do With It? **Lots!**

- Provides a guide for avoiding decline
  - CAAs (Care Area Assessments) Summary is a list of potential risks for decline
- Trends the quality of care
  - Captures the baseline data
  - Shows improvement or decline from last MDS

Pioneer Network Integrating the MDS 3.0 Into Daily Practice

Paradigm Shift: *Prevention is Easier than Repair* for Both Resident and Caregiver

- Examples:
  - ✓ Pressure Ulcers
  - ✓ Pain
  - ✓ Depression (Mood State)
  - ✓ Falls
  - ✓ Psychosocial Well-Being
  - ✓ Contractures

Be Prepared

- Alert Dedicated CNAs and Primary nurses to potential risks
- Communicate this information at huddles and change of shift prior to and for 3 days following admission
- Build an interim Plan of Care based on the risks
- Make a diary of patterns
- Create documentation tools that capture everything that answers all the MDS questions

Pioneer Network Integrating the MDS 3.0 Into Daily Practice

Put It Into Practice: Day One

❖Each discipline gathers the information that identifies the person and his needs

- Admission Nurse or Case Manager
  - ✓Identifies from recent medical history what risks exist for medical decline: immobility, falls, skin, pain, constipation, medications
- Direct Care Nurse
  - ✓ Identifies what preventative protocols will be necessary
  - ✓ Includes risks on the Dedicated CNA's assignment sheet as visual reminder

Pioneer Network

Integrating the MDS 3.0 Into Daily Practice

- Social Worker
  - ✓ Gathers psychosocial history and lifestyle preferences prior to/immediately on moving in day from elder/family. Creates a "*Life Story*".
  - ✓ At 1st Huddle/Change of Shift SW shares what is known with direct care staff and connects info to potential for depression (decline in mood):
    - independent, enjoys big breakfasts esp. bacon,
    - loves outdoors, birds, roses,
    - Red Sox fan ,
    - was a Fire fighter working the evening shift,
    - close with grandchildren

Pioneer Network

Integrating the MDS 3.0 Into Daily Practice

- Dedicated CNA
  - ✓ Uses the psychosocial information to begin to build a relationship with Mr. McNally
  - ✓ Partners with him by telling him what we are monitoring so that he will participate in his own plan of care
  - ✓ Reports back to Primary Nurse
  - ✓ Provides all information to the on-coming shift

Pioneer Network — Integrating the MDS 3.0 Into Daily Practice

Day Two and Forward

- Other Disciplines – Rehab, Activities, Clinical Dietary staff - receive the information that explains who Mr. McNally is and what his risks for decline are
- Housekeepers and Maintenance are told his life story so that they also can build friendly relationships
  - These staff members should already know they are expected to report any concerns expressed to them during conversations

Pioneer Network — Integrating the MDS 3.0 Into Daily Practice

www.pioneernetwork.net

- Webinar One: Aligning Daily Documentation and Communication
  - Catch early; Intervene effectively
- Webinar Two: Organizational Systems
  - Consistent/dedicated assignment
  - Communication within and across shifts
  - CNAs actively involved in care planning
- Webinar Three: QI and MDS
  - Focus groups, unit-based QI, rounds

Pioneer Network

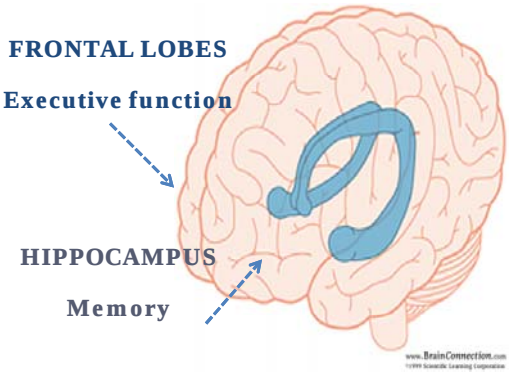
Integrating the MDS 3.0 Into Daily Practice

MDS 3.0 as the Engine for Individualized High Quality Care: **Clinical Applications**

- Dec. 13, 2011 - Webinar Four
  - Promoting Mobility and Reducing Falls by Individualizing Care and Eliminating Alarms
- Jan. 11, 2012 - Webinar Five
  - Individualizing Dining
- TBD - Webinar Six
  - Transitions in Care

www.pioneernetwork.net

If you needed to go into a nursing home, what would have to happen **in the first few hours** for you to feel ***welcomed, safe, and okay*** – as okay as possible?

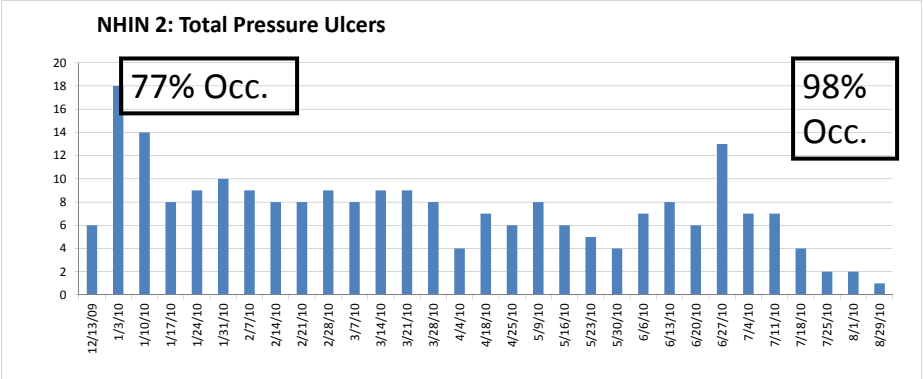


What you do and how you do it effects the release of:

- Cortisol
- Neurotransmitters
  - Endorphins
  - Serotonin

These chemicals can sharpen or flood thinking, memory, and executive function

From NH in Need to NH in the Lead



EMTs: "oh no, you're going there?"	3 residents left AMA Monday morning	Customer Service Committee	Warm Welcome by team

What would we need?

Making a Warm Welcome

- Entrance
  - What does your outside entrance and entryway look like?
  - Are you sitting up?
- Who welcomes at the door? escorts to room?
  - How is staff made available to focus on the welcome?
- What may be needed immediately for care and comfort?
  - Bathroom, shower, meal, rest, unpack, pictures/belongings
- Anchors
  - Orient to room, surroundings, routines, schedule, key staff
  - Opportunity to call family, have them join for meals
- Welcomes:
  - Dedicated CNA or official welcomer, resident, families, basket
- Anticipate and avoid embarrassing moments

For more information:

Cathie Brady & Barbara Frank

cbrady01@snet.net

&

bfrank1020@aol.com

www.BandFConsultingInc.com