SA19- Pioneer Network: Helping You Find the Processes to Support Your Passion

Saturday, March 24
2:30 PM- 3:30 PM

Session Description

For many providers, passion drives the desire to implement person-centered practices in their community. For others, the driver may not be passion, but the need to comply with the new regulatory requirements imposed by the Centers for Medicare & Medicaid Services (CMS). We know that passion alone will not assure sustainable practices and certainly we have all seen attempts at regulatory compliance which are short lived, more of a band aid than a cure. Pioneer Network has long supported the need to create processes and systems to support passion and provide the foundation needed to sustain person-centered practices. In this session, we will explore some foundational practices that can support your passion and drive the implementation and sustainability of person-centered practices. We will identify resources to help build and develop the processes and systems, discuss how to use quality assurance performance improvement (QAPI) to help in the development and sustainability of the person-centered practices, and discuss the role of the medical director in assuring that person-centered practices are the standard in the community.

Learning Objectives

Identify practices that are based on a medical model and describe ways to replace them with person-centered practices as required by CMS and consumers.

Explain how to develop processes and systems that will support the sustainability of person-centered practices.

Implement strategies within QAPI to implement PCC practices in a systematic way to ensure sustainability.

Find resources to help in the development of processes and systems supporting person-centered practices and recognize how medical practitioners can serve as leaders in this change effort.

Presenter(s): Joan Devine, RN-C, NHA; Jonathan Evans, MD, MPH, CMD

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
Pioneer Network: Helping You Find the Processes to Support Your Passion

Jonathan Evans, MD
Joan Devine, Director of Education, Pioneer Network

Learning Objectives
By the end of the session, participants will be able to:

• Identify practices that are based on a medical model and describe ways to replace them with person-centered practices as required by CMS and consumers.
• Explain how to develop processes and systems that will support the sustainability of person-centered practices.
• Implement strategies within QAPI to implement PCC practices in a systematic way to ensure sustainability.
• Find resources to help in the development of processes and systems supporting person-centered practices and recognize how medical practitioners can serve as leaders in this change effort.

Pioneer Network Vision and Mission

A culture of Aging that's life-affirming, satisfying, humane and meaningful

Pioneer Network advocates and facilitates deep system change and transformation in our culture of aging.

Our Values

- Know each person
- Each person can and does make a difference
- Relationship is the fundamental building block of a transformed culture
- Respond to spirit, as well as mind and body
- Risk taking is a normal part of life
- Put person before task
- All elders are entitled to self-determination whenever they live

CMS Defines Person-Centered Care

To focus on the resident as the locus of control and support the resident in making their own choices and having control of their daily lives.
Barriers
- Time
- Resources
- Knowledge
- Leadership

Leadership
- Support of Key Leadership
- Misused Hierarchy
  - We don’t change, but we expect others to
  - Leadership trying to “sell change” instead of “becoming it”
- Proper use of Hierarchy
  - Ensuring that the right decision is made at the right place at the right time by the right person.
- Silo Thinking
  - Produces silo operations

Risk for Multi-Facility Chain
The view that culture change is a delegated program—and that it belongs only to the CCRCs

“Change at the corporate level is more of a predictor of success than at the self-led team and household level.”
Steve Shields and David Slack
An Editorial and Technical Brief on the Household Model Business Case

CMS & Person-Centered Care

Resident Rights (483.5)
- The facility must protect and promote the rights of the resident and the residents wishes and preferences must be considered in the exercise of rights by the representative.

- The right to identify individuals or roles to be included in the planning process and right to request meetings and the right to request revisions to the person-centered care plan.
• To participate in **establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.**

• The right to be informed, in advance, of changes to the plan of care

• The right to see the care plan, including the right to sign after significant changes to the plan of care.

• …homes must include assessment of resident’s strengths and needs.

• Incorporate the resident’s personal and cultural preferences in developing goals.

• The right to be informed, in advance, of the care to be furnished and the type of care giver of professional that will furnish care.

• The right to be informed in advance, by physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

• The right to request, refuse and/or discontinue treatment.

• Care Plans must be culturally-competent and trauma-informed

• The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being

• **practical** ("sensible") vs **practicable** ("possible")
Care Planning (483.21)

• A baseline plan of care within 48 hours of move in and a summary given to the resident and/or representative.
• Care plan to include resident goals for admission and desired outcomes.

• To the extent possible, the participation of the resident and the resident’s representative(s)
• An explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined not practicable.

A Place to Begin: Four Foundational Practices

(1) Consistent assignment
(2) Huddles
(3) Involving CNAs in care planning
(4) QI closest to the resident

Engaging Staff in Individualizing Care – Starter Toolkit

Trust

Choice

Authentic Decision-Making
Documentation for Honoring Resident Choice and Mitigating Risk

I. Identify and Clarify the Resident's Choice
II. Discuss the Choice and Options with the Resident
III. Determine How to Honor the Choice
IV. Care Planning the Choice
V. Monitoring and Making Revisions to the Plan

Let's Look at Some Practices

Alarms
Why do we use them?

- A fall prevention strategy
- A wandering prevention strategy
- Part of the standard set of interventions we have used over the years
- Families ask for the... “it's what the hospital used”
- Alarms work. We have reduced falls by ........
- We know someone is moving, falling, walking unassisted because the alarm sounds
- May not stop the fall but will tell us someone "is on the move"

Negative Potential or Actual Outcomes

- Loss of dignity
- Decreased mobility
- Bowel and bladder incontinence
- Sleep disturbances
- Confusion, fear, agitation, anxiety, or irritation in response to the sound

CMS State Operations Manual

What are the real effects of Alarms?

- Decreases / hinders resident movement
- Negatively impacts resident dignity and choice
- Increases agitation for resident wearing the alarm and others
- Provides a false sense of security to staff and family
- Mal-functioning alarms are a liability for the provider
- "Once [the facility] opted to utilize an alarm to protect the resident, it assumed the responsibility of making sure that the alarm worked properly."
- Birmingham Nursing & Rehabilitation Center – Esat v. CMS
CMS Interpretative Guidance

- While position change alarms are not prohibited from being included as part of a (fall prevention) plan, they should not be the primary or sole intervention to prevent falls.
- F604 Respect & dignity
  - Guidance 483.12(a)
    - "there is no evidence that the use of physical restraints, including, but not limited to, bed rails and position change alarms, will prevent or reduce falls.
- F689
  - "For example, a facility implements a position change alarm for a newly admitted resident with a history of falls. After completing a comprehensive assessment of the resident, facility staff identify the resident's routines and patterns, remove the alarm, implementing more individualized interventions that address the actual cause of why a resident may be changing position (e.g. has been in one position too long or is trying to reach for a personal item) which could lead to a fall."

What the Guidance Says

- Guidance 483.10(i)
- Some practices that can be eliminated to decrease the institutional character of the environment include, but are not limited to, the following:
  - The widespread and long-term use of audible chair and bed alarms, instead of their limited use for selected residents for diagnostic purposes or according to their care planned needs. These devices can startle the resident and constrain the resident from normal repositioning movements, which can be problematic.
  - Devices such as position change alarms may help to monitor a resident’s movement temporarily, but do not eliminate the need for adequate supervision.

What the Data Says

"Results failed to demonstrate a statistical difference in bed falls between the experimental group (with alarms) and control group (without alarms)."

Tideiksaar, R. Feiner CF, Maby J. "Falls Prevention: the efficacy of a bed alarm system in an elderly hospital setting." Department of Medicine and

"After discontinuing their [alarm] use, we found a decrease in the rate of falls, and a decrease in the percentage of our residents who fell. Staff has easily adapted and reports a calmer, more pleasant environment."

Bressler K, Redfern R and Brown M, "Elimination of Position-Change Alarms in an Alzheimer’s Dementia Long-Term Care Facility.”

Individualized Medication Administration

Excellence in Practice

Natural Awakening
Harnessing the Power Within

- Staff have many answers – engage them
- So do residents & families – engage them, too
- The leaders’ job:
  - Focus everyone on clear vision & goals
  - Define the parameters
  - Encourage & support team formation
  - Support implementation of team-driven solutions
  - Address barriers
  - Celebrate success
  - Understand that not everything will work the first time – learn from mistakes & try again

Important Questions to Explore

- What is it about our systems that allow (or encourage) these problems to continue?
- Can we create systems to support the new initiatives that do not rely on individuals to remember and that integrate the changes into work routines at all levels?
- Can we create a system where ongoing learning is built into the daily routine, and good practice is automatically reinforced, rather than relying solely on sending workers to training programs and hoping they will learn, absorb, remember, and follow through?

Resources

- Engaging Staff in Individualized Care
- A Process for Care Planning for Resident Choice
- Dining Practice Standards
- Promising Practices in Dining
- Just in Time Toolkits
- Tools for Change

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Are you a Butterfly?

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Or just a caterpillar with wings?

Thank you!