Person Centered Care rises to the Level of Regulation Part 2

Carmen Bowman, Regulator turned Educator

EDU-CATERING: Catering Education for Compliance and Culture Change in LTC
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Physician services §483.30 (all Phase 1)

- Physician recommendation that an individual be admitted.
- Each resident must remain under the care of a physician.
- A **physician, physician assistant, nurse practitioner, or clinical nurse specialist** must provide orders for the resident's immediate care and needs.
- **New**: Physicians can delegate dietary orders to dietitians and therapy orders to therapists.

§483.*35* Nursing Services

- The facility must have sufficient nursing staff *with the appropriate competencies and skills sets* to provide nursing and related services *to assure resident safety and* attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care *and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).* (Phase 2)

PROCEDURES AND PROBES

Refer to ***the Critical Element Pathway on Sufficient and Competent Staffing*** *for additional information.*

- *When interviewing staff, residents and others, are concerns raised with the amount of time staff are available to provide care and services, such that there is not sufficient time allowed to provide the necessary care and services to a resident. If so, verify these concerns through observations and record review if necessary.*
- *Does the facility assessment describe the type and level of staff required to meet each resident's needs as required under 483.70(e). Does the type and level of the staff onsite reflect the expectations described in the facility assessment?*
- *Does the workload or assignments of the nursing staff allow them time to participate in team meetings, care planning meetings, attend training, spend time caring for residents and take time for breaks including meal breaks?*

- *Are there enough licensed staff to provide services to residents, and assist and monitor aides?*
- *Do residents and families report that* nursing staff *are* responsive to residents' *request for* assistance, *such as* call bells *typically* answered *promptly? Do they feel that they can have a conversation with a direct caregiver and not feel rushed?*
- *Are there any indications of delays in responsiveness for staff such as pungent odors, residents calling out, or residents wandering with inadequate supervision?*
- *Are there any indications of the use of devices or practices to manage residents' behaviors or activities such as the use of position-change alarms, positioning residents in chairs that limit their movement, or residents who are subdued or sedated?*

- *Are* residents who are unable to *use* call *bells or otherwise communicate their needs* checked frequently (e.g., each half hour) for safety, comfort, *bathroom needs* positioning, and offered fluids and *other* provisions of care? *Have* care problems associated with a specific unit, *day or* tour of duty *been identified by the facility? For example, does documentation show that skin integrity issues are identified more on days following a long weekend?*

❖**P**ersonal needs (bathroom)
❖**P**ositioning
❖**P**ain
❖**P**lacement of personal items
❖**E**ngagement

- *Has the use of overtime hours increased? (If overtime hours have increased substantially, it can indicate that there is not sufficient staff or a back-up plan when staff call-out).*
- *When there are staff call-outs, did the facility fill those positions in a timely manner (e.g. within 1 hour after the start of the shift)?*
- *Concerns such as falls, weight loss, dehydration, pressure ulcers, as well as the incidence of elopement and resident altercations can also offer insight into the sufficiency of the numbers of staff. Surveyors must investigate if these adverse outcomes related to sufficient staffing.*

***"Competency"** is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.*

Examples for evaluating competencies may include:

- *Lecture with return demonstration for physical activities;*
- *A pre- and post-test for documentation issues;*
- *Demonstrated ability to use tools, devices, or equipment that were the subject of training and used to care for residents;*
- *Reviewing adverse events that occurred as an indication of gaps in competency; or*
- *Demonstrated ability to perform activities that is in the scope of practice an individual is licensed or certified to perform.*

Nursing leadership with input from the Medical Director should delineate the competencies required for all nursing staff to deliver, individualize, and provide safe care for the facility's residents. There should also be a process to evaluate staff skill levels, and to develop individualized competency-based training, that ensure resident safety and quality of care and service being delivered.

A competency-based program might include:

a. Evaluates current staff training programming to ensure nursing competencies (e.g. skills fairs, training topics, return demonstration).

b. Identifies gaps in education that is contributing to poor outcomes (e.g. potentially preventable re-hospitalization) and recommends educational programing to address these gaps.

c. Outlines what education is needed based on the resident population (e.g. geriatric assessment, mental health needs) with delineation of licensed nursing staff verses non-licensed nursing and other staff member of the facility.

d. Delineates what specific training is needed based on the facility assessment (e.g. ventilator, IV's, traches).

e. Details the tracking system or mechanism in place to ensure that the competency-based staffing model is assessing, planning, implementing, and evaluating effectiveness of training.

f. Ensures that competency-based training is not limited to online computer based but should also test for critical thinking skills as well as the ability to manage care in complex environments with multiple interruptions.

Behavioral health services §483.40 **New**

(All Phase 2 but …)

- F740
- *Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.*

behavioral health

Necessary behavioral health care/services:

- *Ensuring necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;*
- *Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being.*

- *Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being;*
- *Providing an environment and atmosphere that is conducive to mental and psychosocial well-being;*
- *Ensuring that pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated.*

F741

- *The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:*

- *§483.40(a)(2) Implementing non-pharmacological interventions.*
- Dr. Al Power pushes the envelope by saying beware of making the next list of "non-pharmacological approaches" another generic list.
- We must INDIVIDUALIZE, INDIVIDUALIZE, INDIVIDUALIZE
- Start with the generic, good list of non-pharmalogical approaches.
- Additionally, add what is personalized/individualized.

Non-pharmacological approaches

Generic List

- Sleep
- Hungry
- Thirsty/dehydrated
- Pain
- Bored
- Lonely
- Agitated/mad/upset

*What can you do to improve upon both generic and individualized approaches?

Individualized List

- **What would yours be?**
- Scrapbook
- Bible
- Phone
- Computer
- Book

What is *health*care?

- What if other important approaches got on the list? What if nurses/all of us, before anything medical, suggested:
  - Sleep
  - Going outside
  - Music
  - Individualized engagement
  - Essential oils
  - Talking with a friend/calling a family member
  - Others?

*What can you do to truly improve health?

Under §483.152 Requirements for approval of a nurse aide training and competency evaluation program, nurse aides are required to complete and provide documentation of training that includes, but is not limited to, competencies in areas such as:

- *Communication and interpersonal skills;*
- *Promoting residents' independence;*
- *Respecting residents' rights;*
- *Caring for the residents' environment;*
- *Mental health and social service needs; and*
- *Care of cognitively impaired residents.*

- *In phases 1 and 2, it is the expectation that all facility staff members, including non-nurse aide staff, assisting residents living with behavioral health needs, be competent in care areas, such as those mentioned previously.*

The 3 plagues of institutionalization identified by Eden:

- *Boredom*
- *Loneliness*
- *Helplessness*

New Tag, New Reg, New Section

- F744
- *§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.*

GUIDANCE §483.40(b)(3)

- *Providing care for residents living with dementia is an integral part of the person-centered environment, which is necessary to support **a high quality of life with meaningful relationships and engagement**. Fundamental principles of care for persons living with dementia involve **an interdisciplinary approach** that focuses **holistically** on the needs of the resident living with dementia, as well as the needs of the other residents in the nursing home. Additionally, it includes qualified staff that demonstrate the competencies and skills to support residents through the implementation of **individualized approaches to care (including direct care and activities)** that are directed toward **understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities**.*

The facility must provide dementia treatment and services which may include, but are not limited to the following:

- *Utilizing **individualized, non-pharmacological approaches** to care (e.g., **purposeful and meaningful activities**). Meaningful activities are those that **address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being**.*

- Rejecting the status quo
- Village Model - dues
- Cohousing
- Cooperatives
- Housesharing
- Affinity Groups (**no bingo at the Artists Colony**)
- Desire real and "age friendly" not "make believe," "sterile, artificial"

Conversations with Carmen May 15, 2015 actionpact.com

LET'S COMPETE WITH BINGO

Meaning and Purpose

Recommend "too many service projects to count" – that will compete with bingo

"They want to be able to engage in meaningful activities that make a difference." (Kane, 2001)

Service/volunteer ideas:

"It is meaningful relationships and purposeful engagement (even at end of life) that defines aging well."

Power, Eheart, Racine, Karnik -- Aging Well in an Intentional Intergenerational Community: Meaningful relationships and purposeful engagement *Journal of Intergenerational Relationships, 2007*

New Program Brings That Warm And Fuzzy Feeling

Fostering two baby kittens draws out residents to reminisce about their pasts, engaging with others.

Joanne Kaldy

At Catalina Springs Memory Care, Health Service Director Rebecca Hamilton and her team are thinking outside of the box, and that box has kittens in it. The Arizona-based facility has introduced a program that brings in orphaned kittens for residents to care for, and it has succeeded "beyond our wildest dreams," Hamilton says.

The program evolved from a staff meeting where the team was looking for innovative ideas. "I have a relationship with the Pima Animal Care Center here and have fostered kittens myself, so I thought it would be a good fit. Everyone was enchanted with the idea and very supportive," says Hamilton. She contacted the animal care center, and the response was immediate. "The partnership was formed, and in 12 hours, they said, 'We have the perfect two kittens for the pilot project.'"

From the start, the residents took the project seriously. "They realize that this is important work—that they are saving these kittens' lives," says Hamilton. "They would feed them, burp them, rock them, and hold them," she says. Until the kittens were old enough to use a litter box (they were two weeks old when they came to the facility), the residents "understood the need to pat their bottoms to get them to void."

PETS AND PEOPLE: A PERFECT PARTNERSHIP

The presence of the kittens has had an almost magical effect on people at the facility. "People talk more, and they're happier," Hamilton says. Residents are more engaged.

For example, she observes, "We have one older woman with memory impairments who, after caring for the kittens, has started to talk about growing up on a farm and having 19 cats in the barn. The more she cared for the kittens, the more memories came back."

Provider providermagazine.com

Joan Vendilito with Turtle

Hamilton notes that the act of caring seems to have unlocked memories for many of the residents. "They started talking about their children or about pets they had as kids. It's really been astonishing."

The kittens also have enhanced caregiver-resident relations. Hamilton recalls, "I overheard a caregiver talking with some residents. They were chatting about the kittens—which one was their favorite, what would be good names for them, and so on. They are working together on

Marion Jane Nelson feeding Peaches

Kitten playtime at Catalina Springs

Meaning and Purpose for Men

*What offers the men in your community meaning and purpose?

Meaning and purpose with dementia

- Think INDIVIDUAL, don't worry about the stage of dementia
- What makes sense for this person to have? To have, to hold, even to "fidget" with?
- "A Delores Box"

- Engage the family
- We need their help, they need ours
- Encourage/ask to take resident outside
- Bring in photos, see what happens, memories

- Help one to engage with their surroundings: clock, calendar, art, photos identified, windows, bird feeders
- And music

*What can you do to promote **individual engagement**?

Pharmacy services §483.45 (Phase 1 but…)

- Drug Regimen Review.
- Policies/procedures for **monthly drug regimen review**.
- **New**: review of medical record (Phase 2).
- Requires pharmacist to **document any irregularities and inform attending physician, medical director, DON**.
- Requires **attending physician** document review of irregularities and what, if any, action taken including no change and why.

- *The pharmacist performing the monthly MRR must also review the resident's medical record to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. Certain circumstances which may include residents who have multiple medical conditions, concurrent administration of certain medications, administration of medications which require close monitoring through lab work, and transitions of care may also increase the risk of adverse consequences. Review of the medical record as part of the MRR may prevent errors due to drug-drug interactions, omissions, duplication of therapy, or miscommunication during the transition from one team of care providers to another.*

New definition

- F758
- §483.45(c)*(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:*
- *(i) Anti-psychotic;*
- *(ii) Anti-depressant;*
- *(iii) Anti-anxiety; and*
- *(iv) Hypnotic*

§483.*45(e) Psychotropic* Drugs (Phase 2)

Based on a comprehensive assessment of a resident, the facility must ensure that--

- §483.*45(e)(1)* Residents who have not used *psychotropic* drugs are not given these drugs unless *the medication* is necessary to treat a specific condition as diagnosed and documented in the clinical record;
- §483.*45(e)(2)* Residents who use *psychotropic* drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
- §483.*45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and*

PRN

- §483.*45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.*
- §483.*45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.*

Laboratory, radiology, other diagnostic services §483.50 **New** (Phase 1)

- New section, was under Administration.
- **Clarifies** that a physician assistant, nurse practitioner or clinical nurse specialist may order laboratory, radiology, and other diagnostic services in accordance with state law and be notified of abnormal results.

Dental services §483.55 (Phase 1 but…)

- Must have **policy** identifying instances when the loss or damage of dentures is home's responsibility. (Phase 2)
- Must document **how will ensure resident can eat and drink adequately** while awaiting dental services.
- Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
- Must have a referral for lost or damaged dentures **within 3 business days** unless there is documentation of extenuating circumstances. (Phase 2)

Food and nutrition services §483.60

- "We proposed to re-designate existing §483.35 "Dietary Services" as new §483.60 "Food and Nutrition Services" and revise introductory language to include taking resident preferences into consideration."
- (Phase 1 and …)
- The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the **preferences** of each resident.

Food and nutrition services §483.60

- F802 Staffing
- The facility must employ *sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).* (linked to Fac. Assessment Phase 2)

Support staff

- The facility must provide sufficient support personnel *to safely and effectively* carry out the functions of the *food and nutrition* service.
- "**Sufficient support personnel**" *means having* enough *dietary and food and nutrition* staff to *safely carry out all of the functions of the food and nutrition services. This does not include staff, such as licensed nurses, nurse aides or paid feeding assistants, involved in assisting residents with eating.*
- *If a concern with having sufficient staff is identified, determine if the staffing levels provided were based on the facility assessment. If a concern with the facility assessment is identified, see §483.70(e), F838, Facility Assessment.*

F800 Food and Nutrition services

- ***GUIDANCE §483.60***
- *This requirement expects that there is* ***ongoing communication and coordination among and between staff within all departments*** *to ensure that the resident assessment, care plan and actual food and nutrition services meet each resident's daily nutritional and dietary needs and choices.*
- *While it may be challenging to meet every residents' individual preferences, incorporating a residents' preferences and dietary needs will ensure residents are offered meaningful choices in meals/diets that are nutritionally adequate and satisfying to the individual.* ***Reasonable efforts to accommodate these choices and preferences must be addressed by facility staff****.*

Huddles = real time communication

- Shift huddle
- Morning team huddle
- Leadership comes to neighborhood huddle
- Post incident huddle/post fall huddle
- PIP huddle (increased infections on a certain neighborhood)
- Huddles for anything

*Are you taking advantage of huddles?

Hot Cart System

- ✓Self-directed dining
- ✓All food/drink is mobile
- ✓Lots of choice within menu
- ✓Flexibility
- ✓Saves money, hotter food, better results!

"Resident choice – its not a choice anymore." Suzanne Quiring on *Conversations with Carmen* Oct. 20, 2017 archived Improving the Dining Experience for Residents; Honoring Choice, Exceeding Regulations

www.hotfoodcart.com/USA

just mashed potatoes with lots of gravy" please…

Courtesy SuzyQ Menu Concepts

- If qualified dietitian not full-time, must designate a director of food and nutrition services who--
- For designations prior to November 28, 2016, meets the following requirements no later than **5 years** after November 28, 2016, or no later than **1 year after** November 28, 2016 for designations after November 28, 2016, is:
- A certified dietary manager; or
- A certified food service manager, or
- Has similar national certification from a national certifying body; or
- Has an associate's or higher degree in food service management or in hospitality, from an accredited institution of higher learning; **AND**
- In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, **AND**
- Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

- Provide **sufficient support personnel** to safely and effectively carry out functions of food and nutrition service.
- A member of the Food and Nutrition Services staff **must participate on the interdisciplinary team** as required in §483.21(b)(2)(ii).

Menus and nutritional adequacy. Menus must—

- Reflect, based on a facility's reasonable efforts, the **religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups**;

- **Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices**.

Food and drink.

Each resident receives and the facility provides–

1. Food prepared by methods that conserve nutritive value, flavor, and appearance;
2. Food and drink that is palatable, attractive, and at a safe and appetizing temperature;
3. Food prepared in a form designed to meet individual needs;
4. **Food that accommodates resident allergies, intolerances, and preferences**;
5. **Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice**; and
   Comment: One commenter suggested not referring to 'alternative' or 'substitute' meals, but instead refer to choices and options and "at times of the resident's choosing." Response: We agree and have revised the language at §483.60(d)(5).
6. Drinks, including water and other liquids consistent with resident needs and **preferences** and sufficient to maintain resident hydration.

Therapeutic diets.

1. Therapeutic diets must be prescribed by the attending physician.
2. The attending **physician may delegate to a registered or licensed dietitian** the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.

Frequency of meals.

1. Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community **or in accordance with resident needs, preferences, requests, and plan of care**.
2. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, **except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span**.
3. **Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care**.

Assistive devices

- The facility must provide special eating equipment and utensils for residents who need them **and appropriate assistance to ensure that the resident can use the assistive devices** when consuming meals and snacks.
- Highest practicable level of well-being

- **Paid feeding assistants** (FA) —
- (1) State-approved training course. A facility may use a paid FA, if—
- (i) The FA has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law.
- (2) Supervision. (i) An FA must work under supervision of RN or LPN.
- (ii) In an emergency, an FA must call a supervisory nurse for help.
- (3) Resident selection criteria. (i) An FA provides dining assistance only for residents who have no complicated feeding problems.
- (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
- (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan.

Food safety requirements. The facility must—

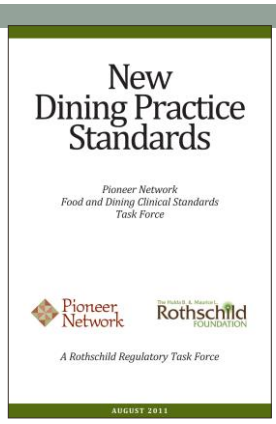
- Procure food from sources approved or considered satisfactory by federal, state, or local authorities;
- Includes food items obtained directly from **local producers**, subject to applicable State and local laws or regulations.
- **This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices**.
- **This provision does not preclude residents from consuming foods not procured by the facility**.
- Store, prepare, distribute, and serve food in accordance with professional standards for food service safety.
- **Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption**, and
- Dispose of garbage and refuse properly.

CMS promotes Dining Practice Standards

- We mentioned in the preamble to the proposed rule an August 2011 report by the Pioneer Network **Dining Practice Standards** but did not provide the location of that resource. We would encourage facilities and practitioners to read the report. It is available at http://www.pioneernetwork.net/Providers/DiningPracticeStandards/.
- Pioneer Network also has a "how to" resource called the **Dining Standards Toolkit** that may assist LTC facilities in their efforts to understand and meet the updated requirements.
- In addition, **CMS produced a video related to these standards**. The video can also assist LTC facilities in their efforts to understand and meet the updated requirements. The video is available at http://surveyortraining.cms.hhs.gov/pubs/VideoInformation.aspx?id=1101&cid=0CMSNEWDINPRSTAN.

Issued by Pioneer Network 2011

pioneernetwork.net

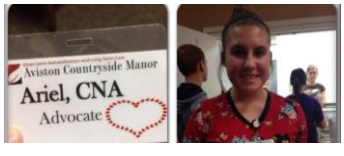


Choices Current Thinking

- There needs to be a new "red flag" or "assumption" for both surveyors and providers that **a tray line** or **set/limited meal times are now viewed as an obvious contradiction of choice** and if this lack of choice leads to failure to thrive it would be considered harm during the survey process.

Recommended Course of Action

- Provide education and support to anyone speaking on behalf of the resident (health care professionals, families, friends, and legal representatives) on their obligation in **advocating for** the resident's/the person's individual life patterns, history, current preferences, opinions and wishes (**not necessarily their own**). Education should be inclusive so that the representatives clearly see their role as **an advocate for** the individual's choice (**not necessarily their own**).



Advocate

What is a legal representative suppose to do? The **resident's wishes and preferences must be considered in the exercise of rights by the representative.**

- Rose had a stroke at 82
- left her immobile, unable to speak clearly or feed herself
- aspirating upon swallowing
- physician strongly recommended a permanent feeding tube
- Despite her losses, Rose was very mentally clear and strongly indicated "no tubes!"
- POA **defended her choices**
- Rose was hand fed pureed food and she did die of aspiration … 7 years later.

- When caring for frail elders there is often no clear right answer. Possible interventions often have the potential to both help and harm the elder. This is why the physician must explain the risks and benefits to both the resident and interdisciplinary team. The information should be **discussed amongst the team and resident/family**.

- The resident then has the right to make his/her informed choice **even if it is not to follow recommended medical advice** and the team **supports the person and his/her decision, mitigating risks** by offering support, i.e. offering foods of natural pureed consistency when one refuses recommended tube feeding.

- It is when the team **makes decisions for the person** without acknowledgement by all that problems arise. The agreed upon plan of care should then be monitored to make sure the community is best meeting the resident's needs.
- *What we've learned: have all the right people involved to hear the resident's choice and the team's support of it and to also mitigate risk.*

New DINING STANDARDS TOOLKIT

Rothschild Foundation | Pioneer Network

- Model policies
- Garden policy
- Brochures for residents, families
- Tip sheets for professionals
- Model letter to physician
- Preferences profile
- Individual biography of nutrition
- Much more

www.pioneernetwork.net

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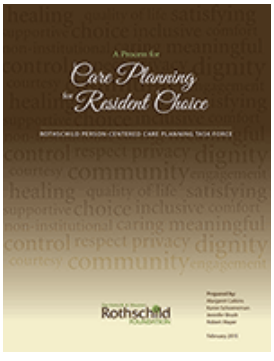
A Process for Care Planning for Resident Choice

pioneernetwork.net



THE 3 D'S

"We must get better at documenting the dialogue of discussion."

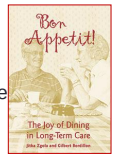
Paula Leslie, PhD, CCC-SLP, Fellow of the Royal College of Speech and Language Therapists (UK), Professor in Communication Science and Disorders, University of Pittsburgh

*What can you do to improve documenting the dialogue of discussion?

alzheimersresourcecenter.org

- place cards
- introductions at each meal
- use of conversation cards and conversation starters
- find common interest among dining companions

- Staff may have to *initiate conversations* among residents
- The person with cognitive impairment may lack social judgment. His or her faux pas should neve be the source of embarrassment or reprimand. Help residents *save face* in such situations.



The Art of Conversation

Discussion Starters:

1. Favorites
2. Facts
3. Deeper questions

People – WE - run out of things to talk about when we sit with the same people everyday - 3 times a day.

From *Vibrant Living*

www.actionpact.com

Pioneer Network

Relationship is the fundamental building block of a transformed culture

Is it okay to be in relationship with residents? YES!

F550 Resident rights: Dignity

Promoting resident independence and dignity while dining, such as avoiding:

- Staff standing over residents while assisting them to eat;
- Staff interacting/conversing only with each other rather than with residents while assisting with meals (simply include residents)
- Bibs or clothing protectors instead of napkins (except by resident choice) (SINCE 1987)

Is this normal?

Who are bibs for? Residents: "Bibs are for babies"

Oversized napkins or dining scarves instead of bibs

Dialogue with residents about what is normal, invite them to get back to normal with you.

Staff Dining with Residents

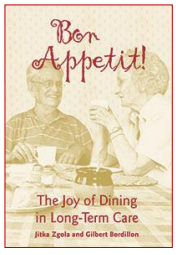
Clear Creek Care Center
Wed. Buffet/Staff
Dine with Residents

Can you hear the buzz of conversation?

Fighting over staff, not eating…
Start small, a cup of coffee

Could you create joy in dining?

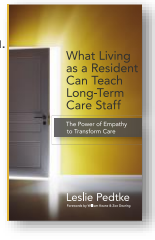
- Every meal should be the best experience it can be
- **Focus on making the experience the best**
- Switch to being a server from your role



If you were a resident what would you appreciate?

- **Nothing about her without her. Nothing about me without me.**
- Excellent communication = ***selfless understanding of the other person.***
- Show the respect you expect. (Adults, not children.)
- When you are hired to work in long-term care, you are making a commitment to be there for people who need you. You are committing to *being there*.
  So be there. They need you.

Leslie Pedtke, Author
What Living as a Resident Can Teach Long-Term Care Staff



The Power of Home
The Power of the Institution

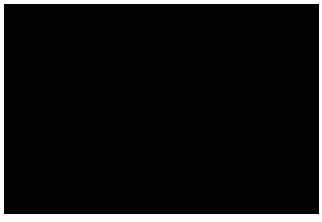
*Which do you have?

"You mean … I can go into the kitchen?"
Elder moving into a Green House home in Colorado

Mirasol
Green House
Loveland, CO

Getting to Normal

*What could you do to get to normal?



Video clip from Action Pact's
Nourish the Body and Soul DVD

Specialized rehabilitative services §483.65

- Adds respiratory services
- (Phase 1)

Administration §483.70 (Phase 1 but …)

- Relationship to other HHS regulations: nondiscrimination, protection of human subjects of research, fraud and abuse, protection of identifiable health information.
- **New: Facility Assessment**. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. (*Phase 2)
- The facility must review and update that assessment, as necessary, and **at least annually**. The facility must also **review and update** this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.

- The facility assessment must address or include:
- (1) The facility's resident population, including, but not limited to,
- (i) Both the number of residents and the facility's resident capacity;
- (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;

- (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
- (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
- (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

- (2) The facility's resources, including but not limited to,
- (i) All buildings and/or other physical structures and vehicles;
- (ii) Equipment (medical and non-medical);
- (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
- (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;

- (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
- (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.
- (3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

- "We believe the added specificity of this approach precludes facilities from making staffing decisions based solely on fiscal considerations without taking resident specific factors and needs into account. Further, the facility assessment is **conducted at the facility level** and it must be used in making staffing decisions, precluding staffing decisions from being made solely at a corporate level based on fiscal considerations and without taking facility- and resident specific factors into consideration. We believe this approach provides facilities adequate flexibility while still requiring that there be sufficient staff to care for residents."
- **Free Facility Assessment tool by CMS and QIOs** **http://qioprogram.org/facility-assessment-tool**

GUIDANCE

- *Strategic planning is an organization's process of defining its strategy, or direction, and making decisions on allocating its resources to pursue this strategy.*

  However, while a facility may include input from its corporate organization, the facility assessment must be conducted at the facility level.

- *The facility assessment will enable each nursing home to thoroughly assess the needs of its resident population and the required resources to provide the care and services the residents need.*

  It should serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources, and may include the operating budget necessary to carry out facility functions.

- *An assessment of the resident population is the foundation of the facility assessment. It must include an evaluation of diseases, conditions, physical, functional or cognitive status, acuity of the resident population, and any other pertinent information about the residents that may affect and plan for the services the facility must provide (e.g., MDS data, Facility Characteristics report form CMS 672). The assessment of the resident population will also contribute to identifying the physical space, equipment, assisted technology, individual communication devices, or other material resources that are needed to provide the required care and services to residents.*

- *The facility must review and update this assessment annually or whenever there is, or the facility plans for, any change that would require a modification to any part of this assessment. For example, if the facility decides to admit residents with care needs who were previously not admitted, such as residents on ventilators or dialysis, the facility assessment must be reviewed and updated to address how the facility staff, resources, physical environment, etc., meet the needs of those residents and any areas requiring attention, such as any training or supplies required to provide care.*

- Medical records.
- Social worker. For homes with 120 residents. Adds **gerontology** as a field in which a bachelor's degree is required.

Quality assurance and performance improvement §483.75 **New** (Phase 3 plus)

- Maintain documentation and demonstrate evidence of its ongoing QAPI: systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

- *§483.75(e)(2) Performance improvement activities must **track medical errors and adverse resident events**, **analyze their causes**, and **implement preventive actions and mechanisms** that **include feedback and learning** throughout the facility.* "unlearning"
-
- *§483.75(f)(6) **Clear expectations are set around safety, quality, rights, choice, and respect**.*

→ our future

- Initial QAPI plan must be provided to State agency surveyor at annual survey (Phase 2)
- QAA committee: All requirements in Phase 1 except addition of infection control preventionist in Phase 3
- Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS **upon request**.
- Disclosure of information (Phase 1)
- Sanctions: Good faith attempts by committee to identify and correct deficiencies will not be used as a basis for sanctions (Phase 1)

Our Future

- Proactive - What is LTC known for?
- Preventative/Preventive OTHER WORDS?

Pre-emptive

Anticipatory

Protective

What is your culture?

- Proactive?
- Preventative/Preventive?
- Preventionists?
- ***Be your own surveyor***
- Find and fix your own problems
- Does each team member feel comfortable to give ideas, to point out problems?
- ***QAPI is a gift from the government***
- Do you have a QAPI atmosphere/culture?

- Culture Change is QAPI

Infection control §483.80

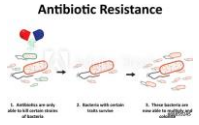
- Infection prevention and control program.
  As linked to Facility Assessment Phase 2
  New: antibiotic stewardship program - antibiotic use protocols and a system to monitor antibiotic use. (Phase 2)
- **Infection preventionist**: primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field and specialized training. (Phase 3)
- ***Who should be an infection preventionist?***

Antibiotic Stewardship Program

As summarized by the CDC, the core elements for antibiotic stewardship in nursing homes include:

- *Facility leadership commitment to safe and appropriate antibiotic use;*
- *Appropriate facility staff accountable for promoting and overseeing antibiotic stewardship;*
- *Accessing pharmacists and others with experience or training in antibiotic stewardship;*
- *Implement policy(ies) or practice to improve antibiotic use;*
- *Track measures of antibiotic use in the facility (i.e., one process and one outcome measure);*
- *Regular reporting on antibiotic use and resistance to relevant staff such as prescribing clinicians and nursing staff; and*
- *Educate staff and residents about antibiotic stewardship.*

- ***The Antibiotic Stewardship Program in Relation to Pharmacy Services***
- *The assessment, monitoring, and communication of antibiotic use shall occur by a licensed pharmacist in accordance with §483.45(c), F756, Drug Regimen Review. A pharmacist must perform a medication regimen review (MRR) at least monthly, including review of the medical record and identify any irregularities, including unnecessary drugs.*



Compliance and ethics program §483.85 **New**
(all Phase 3)

- Written compliance and ethics standards, P/Ps.
- Assignment of specific individuals. ***Who?***
- Sufficient resources
- Due care not to delegate authority to persons with propensity toward criminal violations.
- Effectively communicate the standards, P/Ps.
- Reasonable steps to achieve compliance (monitoring).
- Consistent enforcement.
- Appropriate response to violations and attempts to prevent.
- If 5 homes or more: Annual training, Officer, Liaisons.
- Annual review.

Physical environment §483.90

- Provide sufficient space and equipment.
- Maintain all mechanical, electrical, and patient care equipment in safe operating condition.
- **Conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment**. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.
- **For new construction**:
  No more than 2 residents/room
  Each room has bathroom with shower
- **Smoking policies** (Phase 2)
- Call system from each resident's bedside (Phase 3)

Training requirements §483.95 **New**
(Phase 3 mostly)

- Communication
- Resident Rights and Facility Responsibilities
- Abuse, Neglect & Exploitation (Phase 1)
- QAPI
- Infection Control
- Compliance and Ethics
- In-service Training of Nurse Aides- 12 hours per year to include dementia and abuse prevention.
- Required training of feeding assistants – State approved (Phase 1).
- Behavioral Health – including dementia care (Phase 1)

Big News

- Comment: One commenter requested that we clarify that a new intervention is not required after each fall or incident, but that a root cause analysis should be conducted.
- Response: **We agree that the response to a fall or incident should be episode specific, that a new intervention may not always be necessary, and that frequently a root cause analysis will be necessary**. We defer to sub-regulatory guidance for additional discussion. (p. 246)

New Survey Process

- Began Nov. 28, 2017 (includes Phase 1 & 2 requirements)
- Single Computerized Long-Term Care Survey Process
- Provider/Public Slide Deck available

- Training Website: https://surveyortraining.cms.hhs.gov/index.aspx
  - Click on: *I am a Provider -Course Catalog –LTC Survey Process SME Videos*

- Critical Element Pathways are public, study and know them well

Contact Info

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