Nursing Home Best Practices Evaluation

Final Report

Prepared for the Centers for Medicare & Medicaid Services (CMS)
National Nursing Home Quality Care Collaborative

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Abstract

Nearly 1.7 million people live or receive short term care in the nation’s 15,000+ skilled nursing facilities. An evaluation of high performing nursing homes was undertaken in 2012 to provide insight into how to measure and improve overall quality in nursing homes. The purpose of the evaluation was to identify practices that appear to contribute to the high overall quality offered by a select group of nursing homes, as a foundation to rapidly spreading these practices to nursing homes across the country.

The evaluation was conducted by the Oklahoma Foundation for Medical Quality (OFMQ) and Stratis Health, under contract with the Centers for Medicare & Medicaid Services (CMS), as the Quality Improvement Organizations’ (QIOs) National Coordinating Center for the Improving Individual Patient Care (IIPC-NCC) aim of the QIO 10th Statement of Work. The IIPC-NCC selected ten nursing homes to include in the evaluation. Using an appreciative inquiry approach, site visit teams conducted interviews with staff and board members at each nursing home. A change package, or menu of strategies, change concepts, and actionable items that any nursing home can adopt, was developed based on site visit findings and shared with nursing homes nationwide. Much of the success of the ten nursing homes can be attributed to the learning culture within the facilities, the commitment and passion of leadership and direct care staff, the focus on relationships at all levels, and the recognition that every person, whether resident, family, or staff, brings unique gifts that contribute to the community.

*Keywords:* High performing nursing homes, Oklahoma Foundation for Medical Quality, Stratis Health, CMS Five-Star Rating System, change package
Table of Contents

Abstract ................................................................................................................................. 2

Table of Contents .................................................................................................................. 3

Executive Summary .............................................................................................................. 5

Background Information ........................................................................................................ 13
  Background Information: CMS and QIO Emphasis on Overall Quality ......................... 13
  Background Information: Measuring Nursing Home Quality ........................................ 14

Study Questions ...................................................................................................................... 15

Methodology .......................................................................................................................... 16
  Site Identification Criteria and Process .............................................................................. 16
  Approach ............................................................................................................................... 18
  Figure 1: Processes of Appreciative Inquiry ...................................................................... 19
  Data Collection Site Visits .................................................................................................... 19
  Data/Study Limitations ......................................................................................................... 21

Nursing Home Characteristics .............................................................................................. 23
  Table 1: Facility Characteristics Table ............................................................................... 24
  Bethany Health Care Center, Framingham, MA ................................................................. 25
  Foulkeways at Gwynedd – Gwynedd, PA ......................................................................... 26
  Franciscan Convalescent Hospital, Merced, CA ............................................................ 27
  Jewish HealthCare Center, Worcester, MA ............................................................... 28
  Landis Homes, Lititz, PA ................................................................................................. 29
  Mercy Retirement and Care Center, Oakland, CA ................................................................ 30
  NHC HealthCare, Anderson – Anderson, SC ................................................................. 31
  NHC HealthCare, Parklane – Columbia, SC .................................................................... 32
  Pleasant View Home, Albert City, IA ............................................................................... 33
  Westview Care Center, Britt, IA ..................................................................................... 34

Findings: Strategies of High Performing Nursing Homes ..................................................... 36
  Table 2: Summary of Strategies and Change Concepts ..................................................... 36
  Figure 2: Fueling PDSA cycle for rapid adaptation ......................................................... 37
Strategy 1: Lead with a sense of purpose. 38
Strategy 2: Recruit and retain quality staff. 41
Strategy 3: Connect with residents in a celebration of their life. 43
Strategy 4: Nourish teamwork and communication. 46
Strategy 5: Be a continuous learning organization. 48
Strategy 6: Provide exceptional compassionate clinical care that treats the whole person. 51
Strategy 7: Construct solid business practices that support your purpose. 56

Implications, Summary, and Conclusions 59
Cross-Cutting Themes 59
Implications 59
Implementation Considerations 60
Policy and Regulatory Considerations 61
Figure 3: Health Reform: Actions to Build Capacity for the Triple Aim and Succeed in Multiple Payment Models 62
Summary 63
Conclusions 64

Appendices and Supporting Information 66
Appendix A: National Nursing Home Quality Care Collaborative (The Collaborative) and Quality Composite Measure Score 67
Appendix B: Best Practices Evaluation On-Site Visit Team Members 70
Appendix C: Articles Reviewed to Assist in Defining Nursing Home Quality 73
Appendix D: Site Selection 78
Appendix E: Materials Provided to Participating Nursing Homes 82
Appendix F: Site Visit Conversation Opening Talking Points 87
Appendix G: People Interviewed at Nursing Homes Visited 89
Appendix H: Discussion Guide Prompt 96
Appendix I: Documents Shared During Site Visits 99
Appendix J: List of Expert Panelists 177
Appendix K: Change Package 178

Back Cover 219
Executive Summary

I. Background Information

Nearly 1.7 million people live or receive short term care in the nation’s 15,000+ skilled nursing facilities. This number multiplies exponentially to the number of people whose lives are touched by the experience of having a family member or friend in a skilled nursing facility. As a result, working to improve the quality of care and quality of life in the skilled nursing facility setting, and clearly defining, measuring, and assessing quality are of great importance to millions of people; however, they are complex and challenging tasks. Since there is neither a single or ideal way to measure overall quality in nursing homes nor a universally accepted formula for achieving high quality, an evaluation of high performing nursing homes was undertaken in 2012 to provide greater insight into those questions.

This report describes the study referred to above and its findings, including an assessment of key characteristics and practices of a select group of high performing nursing homes. The purpose of this study was to identify best practices and characteristics that appear to contribute to the high overall quality offered by this select group of nursing homes, as a foundation to rapidly spread these practices to nursing homes across the country, with the aim of ensuring that every nursing home resident receives the highest quality of care.

The Oklahoma Foundation for Medical Quality (OFMQ) and Stratis Health, under contract with the Centers for Medicare & Medicaid Services (CMS), as the Quality Improvement Organizations’ (QIOs) National Coordinating Center (NCC) for the Improving Individual Patient Care (IIPC) aim of the QIO 10th Statement of Work, identified and studied ten high performing nursing homes and summarized and synthesized the findings.

Note that throughout this report, the terms “skilled nursing facility” and “nursing home” are used interchangeably.

II. Methodology

Site Selection

The IIPC-NCC utilized data and feedback from multiple sources to help identify nursing homes to visit and study. In addition to available data sources on nursing home quality, state survey findings, and staffing, the IIPC-NCC also considered size, geographic location, rural/urban status, ownership type, and profit status to obtain a pool of facilities representative of nursing homes across the country. Starting with 15,207 nursing homes, and following the selection criteria summarized below, 117 nursing homes (0.74% of all homes) were identified for possible inclusion in the evaluation.
Site Identification Criteria and Process
To identify nursing homes to include in the evaluation, the IIPC-NCC employed a multi-step screening process. Initially, the IIPC-NCC identified nursing homes that had consistently rated high in the CMS Five-Star Quality Rating System from 2009 through 2011. They revisited those ratings in July 2012, eliminating from the pool those facilities that had not maintained an overall rating of five stars. Further review of individual outcome metrics excluded homes that were above established national benchmarks for measures relating to pressure ulcers, physical restraints, and urinary tract infections.

To maximize the diversity of the nursing homes across several criteria including geography, nursing home size, rural/urban location, ownership type, and profit status, while also ensuring efficient use of resources available to conduct the study, the list of nursing homes was then limited to those in the following states: California, Connecticut, Florida, Iowa, Kansas, Maryland, Massachusetts, New York, Pennsylvania, and South Carolina. The IIPC-NCC then applied an additional set of quality and performance-related screens, including state-level data obtained from QIOs and state survey agencies, and further narrowed the list to nursing homes in California, Florida, Pennsylvania, Massachusetts, Iowa, and South Carolina. Conversations with administrators and further pre-screening yielded a list of ten nursing homes in five states. The participating nursing homes are listed below.

- Bethany Health Care Center, Framingham, MA
- Foulkeways at Gwynedd, Gwynedd, PA
- Franciscan Convalescent Hospital, Merced, CA
- Jewish HealthCare Center, Worcester, MA
- Landis Homes, Lititz, PA
- Mercy Retirement and Care Center, Oakland, CA
- NHC HealthCare, Anderson, Anderson, SC
- NHC HealthCare, Parklane, Columbia, SC
- Pleasant View Home, Albert City, IA
- Westview Care Center, Britt, IA

Approach
Using an appreciative inquiry approach, the site visit teams talked with as many people as possible at each nursing home, including administrators, CEOs, board members, directors, managers, supervisors, direct care staff, providers, and contracted vendors. Interviewers asked participants to share what was working well in their organization. Interviewers used a discussion guide prompt but, consistent with appreciative inquiry methodology, did not use a standard question set.

Interviewers looked for systems and processes, actionable items, interesting and effective practices, activities, or conditions that produce excellent results. They probed for stories or examples to illustrate the strategies that appeared to have the greatest impact. The site visit
teams looked for knowledge, information, and life giving forces that could potentially be used and applied by nursing homes across the country.

When all visits were complete, the site visit team compiled qualitative data from site visit interviews and developed lists of findings across all homes; engaged expert panels in meetings to validate, clarify, and solidify practices and refine language reflecting the findings; and developed a Change Package of effective practices to be used as the foundational document and vision for the National Nursing Home Quality Care Collaborative. The 2013-2014 Collaborative was led by CMS, the IIPC-NCC, and QIOs and open to all nursing homes across the country.

Data/Study Limitations

The purpose of this study was to gain a holistic understanding of the practices and characteristics of a group of high performing nursing homes in order to inform the framework and potential quality improvement strategies for nursing homes in the Collaborative and to share what was learned with all interested nursing homes. The results of the study should be considered with several limitations in mind, including limited geographic reach, small sample size, lack of a control group, the general subjectivity of rating systems, and limited perspectives of interviewees due to the evaluation’s focus on nursing homes’ internal systems.

III. Nursing Home Characteristics

Ten nursing homes were visited for this evaluation, two each in California, Iowa, Massachusetts, Pennsylvania, and South Carolina. All ten homes had 5-star overall ratings at the time of the site visits and eight of the ten maintained 5-star overall ratings through the end of 2013. Five of the homes are non-profits; five are for-profit corporations or partnerships. The sample includes small, medium and large nursing homes, with bed counts ranging from 41 to 290. Two of the facilities are part of a continuing care retirement community (CCRC). Eight are located in urban areas, two in rural.

IV. Findings: Strategies of High Performing Nursing Homes

As a culmination of this project, a change package was developed as a way to summarize and solidify the foundational practices of high performing nursing homes. The Change Package is a menu of strategies, change concepts, and specific actionable items that any nursing home can begin testing for purposes of improving residents’ quality of life and care.

Strategy 1: Lead with a sense of purpose.

Strategy one sets the expectation for excellence in leadership, one of the basic building blocks forming the foundation of a learning organization. Site visit teams observed that the actions of leaders, multiplied by the actions of many, shaped the culture of these ten organizations. Senior leaders at the nursing homes clearly articulated their purpose – to provide exceptional,
individualized care and compassion for their residents – treated staff with respect, focused on keeping their skills up-to-date, and encouraged their leadership team and staff to continually look for ways to improve themselves, the organization, and the long term care field.

**Strategy 2: Recruit and retain quality staff.**

Without high quality staff, no nursing home can achieve its goal of providing high quality care and a high quality of life for its residents. Site visit teams observed that the participating nursing homes identified and developed great talent in all interdisciplinary team members, by setting high expectations and fostering an affirming culture. They recruited and hired qualified, caring staff that fit their mission, values, and culture, and then cultivated longevity through a supportive work environment.

**Strategy 3: Connect with residents in a celebration of their life.**

Everyone has a life story. In creating an environment where the resident always comes first, the ten participating nursing homes have found ways to treat the resident as a whole person, with a family, a history, and connections in the community. Site visit teams observed that the focus in these homes was on helping to keep residents active in their families’ lives and in the community while always respecting resident preferences. At the end of life, a celebration of life honored the resident and embraced family, other residents, and staff.

**Strategy 4: Nourish teamwork and communication.**

Effective teamwork is widely recognized as critical to providing high quality, safe health care. In the long term care setting, it is essential for every member of the staff to bring, through the mechanism of the team, their unique perspective and skills to the common goal of providing high quality care to residents. Site visit teams observed that at the ten participating nursing homes, disseminating information in a complete, consistent, and timely manner nourished teamwork and communication among staff and between staff and residents. Strong communication linked people and built relationships. Members of high-functioning teams respected one another and worked interdependently towards common goals.

**Strategy 5: Be a continuous learning organization.**

A learning organization is built on a foundation of exceptional executive leadership; a strong mission and values that drive decisions and actions; a culture of nurturing professional growth and innovation; a focus on systems for change; and a fair and open culture. Site visit teams observed that the participating nursing homes were continuous learning organizations: they know where they stand and when and how to change; they use data to drive performance; and they have a clear understanding of their organization as an interdependent system.

**Strategy 6: Provide exceptional compassionate clinical care that treats the whole person.**

Clinicians have come to recognize that in order for health care to be effective, it must acknowledge that mind, body, and spirit are interwoven to create a whole person. Site visit
teams noted that the participating nursing homes observe this important principle. The homes recognize that a focus on the whole person requires staff that know the residents well and can anticipate their needs. It also requires an engaged and competent medical and care team that effectively manages residents’ changing health conditions and avoids healthcare acquired conditions (HACs).

**Strategy 7: Construct solid business practices that support your purpose.**

A well-run nursing home excels as a business yet feels like home. It seeks ways to effectively manage the bottom line with integrity and with the resident as the focus. It runs efficient operations; invests in equipment and supplies to provide the highest quality care; and ensures that its physical and outdoor environments are comfortable and inviting. Site visit teams observed that the facilities in this study paid close attention to these foundational practices.

**V. Implications, Summary, and Conclusions**

**Cross-Cutting Themes**

Cutting across the seven strategies and across the nursing homes was a strong focus on relationships, leadership, communication, creativity, flexibility, teamwork, mentorship, training, and working across disciplines. These homes seem to see regulatory compliance and solid business and financial practices as a starting point. They put in place the procedures, practices, and processes that will ensure they are high performers in those areas, using that competence as a springboard to go above and beyond. These nursing homes define “interdisciplinary team” as including not only clinical staff, but also, for example, housekeeping, dietary, activities, and maintenance staff, as all of these disciplines have contact with the resident.

**Implications**

Several of the strategies that surfaced in this evaluation have unique implications or considerations that are important to highlight. Specific to staff recruitment and retention:

- **Strategy 2: Recruit and Retain Quality Staff** is built on an assumption that homes have access to an adequate supply of skilled workers and can therefore be selective in hiring. However, the ten homes have also built reputations for being excellent employers and as a result, available workers compete to work for them. The homes tend to attract well-rounded workers who stay longer because of the homes’ positive culture and working environment.

- The nursing homes make it a priority to treat not only the resident, but also the employee, as a whole person – a complex individual with a unique set of interests, skills, and needs.

- Not all of these nursing homes offer pay or benefits above the industry standard. Their staff see monetary compensation as only part of what makes it attractive to work there.
Strategy 3: Connect With Residents in a Celebration of Life and Strategy 6: Provide Exceptional Compassionate Clinical Care are both about treating the resident as a whole person. Traditionally, it has been common for nursing homes to focus primarily on meeting the resident’s clinical needs. The nursing homes in this evaluation started there and were observed to go to the next level by expanding services and support to also meet residents’ psychosocial and spiritual needs.

**Implementation Considerations**

Nursing homes seeking to implement some or all of the strategies outlined above will need to consider several aspects of their facility and its employees. First, several of the strategies discuss the culture of the facility and its staff. As with any organization, making changes to the culture of a nursing home – no matter how slight – requires full buy-in from the staff. Clear and frequent communication and incremental change are critical. Many of the strategies require little to no financial investment; finances should not present a significant barrier to nursing homes hoping to incorporate the majority of the strategies. While some strategies may require a small time-investment up front, many should actually begin saving the staff time almost immediately. Time constraints should not hinder the implementation of these strategies.

As so many of the strategies and change concepts identified in this study are grounded in the actions, attitudes and skills of people – as individuals and in groups – it is critical that nursing homes look closely at their recruitment, hiring, orientation, and human resources systems and processes and make adjustments as needed. As nursing homes make changes in response to this evaluation and the resulting change package, the value of building relationships and collaborations and learning from peers cannot be over-stated. It will be critical to their success.

**Policy and Regulatory Considerations**

Based on this evaluation, the nursing homes that perform at the highest level are those whose leaders are proactive in using the policy and regulatory environment as a tool rather than an obstacle. These leaders tend to see policy and regulatory changes as learning opportunities and regulatory standards not as a set of goals to reach for, but rather as a floor. They set their expectations far above that floor.

Building on work by Porter, Lee, and Wagner, Stratis Health has developed a model, “Health Reform: Actions to Build Capacity for the Triple Aim and Succeed in Multiple Payment Models,” (the model can be viewed at [http://www.stratishealth.org/expertise/health-reform/](http://www.stratishealth.org/expertise/health-reform/)) intended to inform and clarify actions that will help providers, payers, policy makers, and society move forward in a productive way in the new health care environment. In many ways, the homes in this evaluation already behave consistently with the model, demonstrating a deep-seated understanding of what it takes to lead effectively in the current health care environment.
Summary

In this evaluation, much of the nursing homes’ success can be attributed to the learning culture within the facility, the commitment and passion of leadership and direct care staff, the focus on relationships at all levels, and the recognition that every person, whether resident or staff, brings unique gifts that contribute to the community. This culture is reflected in each of the seven strategies discussed in this report, each of which in turn appeared in some form in every facility included in this evaluation.

The first two strategies are focused on those who lead, manage and run the facility, as well as those who care for the residents; and it is clear that quality care starts with quality staff. The next several strategies highlight the importance of good relationships, whether that means staff-to-staff or staff-to-resident. The final strategy involving solid business practices represents the support and foundation for all of the other strategies. Having the resources to be able to recruit and retain staff, provide staff with the tools they need to provide high quality care, and being able to meet resident needs for the physical environment combine to allow the staff to focus on their relationships with the residents and with each other. In summary, teamwork, communication, and a high commitment to quality contribute to a culture of family and community, which in turn fosters deep relationships and high quality, resident-centered care.

Conclusions

Site visits to ten nursing homes in five different states revealed seven strategies associated with high performing nursing homes. These strategies allow these nursing homes to experience a high level of resident and staff satisfaction, a high level of resident quality of life, and high quality care delivered in a timely manner.

It is the combination of all of the strategies together which appears to propel facilities to the top of the list of nursing home quality. When implemented thoughtfully and with integrity, the individual strategies mesh to create an overall culture whose main purpose is to provide excellent care and improve the quality of life for the residents as well as the staff. The result is a place where staff loves to come to work to see and interact with fellow staff and the residents and a place where residents are respected, have autonomy and choice, and receive excellent care.
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Background Information

Nearly 1.7 million people live or receive short term care in the nation’s 15,000+ skilled nursing facilities. This number multiplies exponentially to the number of people whose lives are touched by the experience of having a family member or friend in a skilled nursing facility. As a result, working to improve the quality of care and quality of life in the skilled nursing facility setting, and clearly defining, measuring, and assessing quality are of great importance to millions of people; however, they are complex and challenging tasks. Since there is neither a single or ideal way to measure overall quality in nursing homes nor a universally accepted formula for achieving high quality, an evaluation of high performing nursing homes was undertaken in 2012 to provide greater insight into those questions.

This report describes the study referred to above and its findings, including an assessment of key characteristics and practices of a select group of high performing nursing homes. The purpose of this study was to identify best practices and characteristics that appear to contribute to the high overall quality offered by this select group of nursing homes, as a foundation to rapidly spread these practices to nursing homes across the country, with the aim of ensuring that every nursing home resident receives the highest quality of care.

The Oklahoma Foundation for Medical Quality (OFMQ) and Stratis Health, under contract with the Centers for Medicare & Medicaid Services (CMS), as the Quality Improvement Organizations’ (QIOs) National Coordinating Center (NCC) for the Improving Individual Patient Care (IIPC) aim of the QIO 10th Statement of Work, identified and studied ten high performing nursing homes and summarized and synthesized the findings.

Note that throughout this report, the terms “skilled nursing facility” and “nursing home” are used interchangeably.

Background Information: CMS and QIO Emphasis on Overall Quality

As part of the Quality Improvement Organization (QIO) 10th Statement of Work, QIOs expanded their efforts beyond a focus on individual quality measures such as physical restraints and pressure ulcers in nursing homes, to focus on overall quality of care and quality of life with a special emphasis on healthcare acquired conditions (HACs) for which an evidence base is established, prevalence is high, or the condition is particularly burdensome to the population. The overall goal of this change was to measurably improve the quality of care and life experienced by the nation’s long term care residents and support nursing homes in establishing effective and efficient operational systems that allow them to achieve extraordinary results.

To support this change, the National Nursing Home Quality Care Collaborative (the Collaborative) was launched by CMS, the IIPC-NCC and QIOs in January 2013. The Collaborative seeks to:

- Ensure every nursing home resident receives the highest quality care,
- Instill quality and performance improvement practices,
- Eliminate healthcare acquired conditions,
• Improve resident satisfaction,
• Achieve a rate of composite score of 6 or better by July 31, 2014. (Further description of the Collaborative model and the composite measure is included in Appendix A.)

In preparation for this national learning collaborative, the IIPC-NCC and CMS team members (see biographical sketches in Appendix B) identified, visited and interviewed staff at ten high performing nursing homes. The intent of the visits was to gain a holistic understanding of the practices and characteristics of these homes, in order to inform the framework and potential quality improvement strategies for nursing homes in the Collaborative.

Findings were summarized in the form of a Change Package and shared with Collaborative participants across the country, to support their efforts to improve the quality of care and quality of life in nursing homes.

Background Information: Measuring Nursing Home Quality

For purposes of this study, it was useful to review the current thinking around what comprises quality in nursing home care. Constructing a standardized method of measuring nursing home quality is difficult due to the multidimensional nature of nursing homes and their residents. However, there exist several commonly cited sources of information relevant to the discussion, including federal datasets such as the Minimum Data Set (MDS); the Online Survey, Certification and Reporting (OSCAR) data; and data from the Nursing Home Compare/Five Star rating system. The MDS is part of a federally mandated clinical assessment of nursing homes that are certified and house Medicare and/or Medicaid patients. It contains information on cognitive ability, communication and hearing, physical functioning, nutritional status, skin conditions, and other aspects of care. OSCAR, a network maintained by CMS, contains data collected during the process a nursing home goes through to become Medicare/Medicaid certified. The Five Star quality rating system incorporates information regarding health inspections, staffing, and quality measures, and is updated on an on-going basis. In addition to these datasets, often resident and staff interviews and satisfaction surveys are cited when attempting to create an overall picture of nursing home quality.

Although there is a plethora of data and much work has been done over the last ten years by leaders in the field of nursing home quality and measurement, a method for obtaining a comprehensive view of a high performing facility was not supported in the literature. A literature review (see Appendix C) showed that efforts have been made to define the characteristics of a high quality nursing home and develop methods to measure those qualities. Primary existing measures of quality fall into three broad categories: structural measures (facility size, occupancy, ownership type, staffing, and percentage of Medicaid and Medicare residents); process measures, which describe the process of care provided; and outcome measures, which measure the results of nursing care processes. According to the literature, nursing home care quality is most accurately represented through a mix of these types of measures (Castle and Ferguson, 2010; Goodson et al, 2008; Shiverick, 2008). However, these three types of measures do not include quality of life, resident autonomy, or resident satisfaction and this is frequently called out as a weakness of nursing home quality measurement systems (Konetzka

Mor’s research (2006) cautioned that creating a single metric to represent quality can be problematic from a statistical perspective as well. For example, two facilities that differed on one measure in one direction and on another measure in the other direction ended up scoring similarly on the composite, demonstrating one danger of combining uncorrelated measures. Domains interrelated and predictive of one another would be needed in order for this method to have statistical integrity. Shiverick (2008) described a composite score index which combined the domains of customer and employee satisfaction, workforce stability, clinical outcomes, and regulatory performance since these domains are interrelated and predictive of one another.

Work continues to refine and improve the Five Star system, and some states, as well, have brought additional measures into their composite score.

**Study Questions**

After reviewing the current thinking around nursing home quality, the IIPC-NCC confirmed that there exists neither a single or ideal way to measure overall quality in nursing homes nor a universally accepted formula for achieving high quality. This evaluation was designed as a way to begin to answer those questions.

The purpose of this study was to gain a holistic understanding of the practices and characteristics of a group of high performing nursing homes in order to inform the framework and potential quality improvement strategies for nursing homes in the Collaborative and to share what was learned with all interested nursing homes.

The primary focus of the evaluation was to examine the systems and practices that high performing nursing homes have in place that allow them to achieve extraordinary results. The goals of the site visits were to learn about the dimension and nature of these homes’ systems and practices, how they were put in place and how the staff overcame barriers, in order to glean what these organizations are doing to achieve excellent performance and results. The promising practices from the selected homes were used to develop a Change Package which has been shared broadly through the QIOs. The sole purpose of identifying high performers and collecting information about their promising practices was to encourage collaboration and dissemination of creative and promising quality improvement strategies.
Methodology

As discussed earlier, due to the multidimensional nature of nursing homes and their residents, no single satisfactory, standardized method of measuring nursing home quality exists. For this evaluation, several quality criteria were used to identify a number of nursing homes as high performers. These criteria, described below, combine to create a detailed yet incomplete picture of any individual nursing home’s quality of care and life. Teams of representatives of the IIPC-NCC visited the identified facilities to interview staff and learn what factors and practices seem to contribute to their high performance. The IIPC-NCC team hypothesized that there would be similarities across several of the nursing homes, and that actionable items could be identified which could then be shared with other nursing homes interested in improving their performance.

Site Identification Criteria and Process

The IIPC-NCC utilized data and feedback from multiple sources to help identify nursing homes to visit and study. In addition to available data sources on nursing home quality, state survey findings, and staffing, the IIPC-NCC also considered size, geographic location, rural/urban status, ownership type, and profit status to obtain a pool of facilities representative of nursing homes across the country. Starting with 15,600 nursing homes, and following the selection criteria listed below, 117 nursing homes (0.74% of all homes) were identified for possible inclusion in the evaluation. Ten homes were ultimately selected for site visits.

The process of site identification was as follows:

The IIPC-NCC identified nursing homes that had consistently rated high in the CMS Five-Star Quality Rating System. The Five-Star system takes into account state health inspections, staffing levels, and MDS quality measure results. During the initial screening, eligible nursing homes were those with an overall rating of 5 stars consistently for three years, from 2009 (when the ratings were first available) through 2011.

The IIPC-NCC revisited the CMS Five-Star ratings in July of 2012. At that time, nursing homes on the initial list that had not maintained an overall rating of five stars were removed from the pool. Additionally, nursing homes on the initial list that had fewer than 3.5 stars for quality, health inspection, or staffing were also excluded from the pool of eligible nursing homes.

Further review of individual outcome metrics excluded homes that were worse than established national benchmarks for measures relating to pressure ulcers, physical restraints, and urinary tract infections.

The geographic locations of the 117 nursing homes remaining in the pool at this point were considered in an attempt to construct a diverse representative sample, as well as to identify facilities clustered closely together thereby creating opportunities to visit multiple sites within the same city or area. The locations of the 117 homes are plotted on the map below.
In order to maximize the diversity of the study homes across several criteria including geography, nursing home size, rural/urban location, ownership type, and profit status, while also ensuring efficient use of resources available to conduct the study, the list of nursing homes was then limited to those within the following states: California, Connecticut, Florida, Iowa, Kansas, Maryland, Massachusetts, New York, Pennsylvania, and South Carolina.

The IIPC-NCC then applied a series of screens involving quality improvement measures related to falls and medications, information obtained from the relevant QIOs, state survey agencies and long term care ombudsmen, and other relevant state-level factors including state report cards and participation in special state initiatives. Participation in the Advancing Excellence in America’s Nursing Homes campaign was also considered.

Finally, geographic location was considered again, and a preliminary list of nursing homes consisting of two nursing homes in each selected city/area was identified. This list was provided to CMS for discussion and approval, and included nursing homes in California, Florida, Pennsylvania, Massachusetts, Iowa, and South Carolina.

The administrator at each nursing home on the list was called to assess their interest in participating, and each nursing home was pre-screened for a potential site visit. After this step, ten nursing homes remained on the list. All ten agreed to voluntarily share information with the
IIPC-NCC about what they are doing to get excellent results and provide their residents with the highest quality of care; to make their staff available for interviews during site visits by an IIPC-NCC team; and to have the fact that they would be participating in the study, as well as study-relevant information learned during site visits, made public.

The facilities that participated in the site visit process were:

- Bethany Health Care Center, Framingham, MA
- Foulkeways at Gwynedd, Gwynedd, PA
- Franciscan Convalescent Hospital, Merced, CA
- Jewish HealthCare Center, Worcester, MA
- Landis Homes, Lititz, PA
- Mercy Retirement and Care Center, Oakland, CA
- NHC HealthCare, Anderson, Anderson, SC
- NHC HealthCare, Parklane, Columbia, SC
- Pleasant View Home, Albert City, IA
- Westview Care Center, Britt, IA

Section III provides additional information on the characteristics of the ten participating homes. Appendix D provides a more detailed description of the site selection process.

**Approach**

The team selected a qualitative research method, appreciative inquiry, as the foundation for conducting interviews during site visits and for processing and making meaning of the results.

In an appreciative inquiry approach, researchers intentionally choose the positive as the focus of inquiry. According to the Center for Appreciative Inquiry, when individuals, teams, or organizations want to make changes, a “fix-it” model is often employed. Data are collected, obstacles are identified, and diagnoses are made. In appreciative inquiry, those conducting the study make an intentional choice to seek out what is already good and right about the individual, team, or organization, and design their questions accordingly.

The appreciative inquiry approach can be described through five foundational principles, sometimes called the 5 D’s. The first three principles are most relevant to the work accomplished through this study. The last two apply to the work of individual nursing homes working to improve the quality of care and life for their residents.

It was the intent of the team conducting this study that the Change Package growing out of this project, published in March 2013, would capture the stories, strengths, and life giving forces of the ten participating nursing homes. The team wanted to do this in such a way as to inspire nursing homes across the country to create shared images of their own preferred future, and then innovate and improvise ways to create that future.
Below is a graphic illustrating the five core processes of appreciative inquiry.

Figure 1: Processes of Appreciative Inquiry

(From “Generic Processes of Appreciative Inquiry,” Center for Appreciative Inquiry, at centerforappreciativeinquiry.net, accessed 3/19/14)

Data Collection Site Visits

Prior to each visit, the IIPC-NCC sent several documents to prepare the nursing homes for the visit (Appendix E). These included a summary of the evaluation and its goals, information release forms, and an agenda for the visit.

The site visits took place between September and December of 2012. Members of the site visit teams had the opportunity to meet with staff and engage in frank and open conversations. Across all ten selected facilities, the site visit teams interviewed a total of 302 nursing home staff, between 17 and 45 at each home. Each visit typically encompassed 1.5 to 2 days.

The site visit teams included members possessing deep and varied experience and expertise across a range of disciplines relevant to long term care, including program and executive leadership at the national, state and facility level, diverse nursing expertise, medical expertise, human resources, training and change management. Team members included Jade Perdue-Puli, Kelly O’Neill, Marilyn Reierson, Cathy Maffry, Jane Pederson, Marilyn Oelfke, and Tom Kelly. (See Appendix B for team members’ credentials and biographies.)

The beginning of each site visit included team introductions and sharing of general information regarding the project and objectives (See Appendix F). The remaining time involved individual
interviews with staff, with a final meeting with the administrator near the end of the second day. A debriefing meeting was held the day following the site visit.

Using the appreciative inquiry methods discussed above, the site visit teams talked with as many people as possible at each nursing home, including: administrators, CEOs, board members, directors, managers, supervisors, direct care staff, providers, and contracted vendors. A list of people interviewed at each site can be found in Appendix G. Interviewers asked participants to share what was working well in their organization; interviewers used a discussion guide prompt (See Appendix H) but, consistent with appreciative inquiry methodology, did not use a standard question set. The discussion guide prompt outlined operational and relational areas common to long term care organizations, including leadership, workforce, resident and family involvement, organizational culture, quality improvement and others.

To get started, site visit teams posed questions such as the following:

- What do you think is contributing to your good results?
- What are the best things about working here?
- What do you like most about your job?

When interviewees became engaged and comfortable with the conversation, interviewers then asked additional questions to better understand the activities or conditions that produced excellent results. Additional questions included:

- What is working?
- What is causing it to work?
- What strategies had the greatest impact?
- What do you do to get results? Who does it and how?

Interviewers looked for systems and processes, actionable items, interesting and effective practices, activities or conditions that produce excellent results. They probed for stories or examples -- who is doing what and how -- to illustrate the strategies that appeared to have the greatest impact. The site visit teams looked for knowledge, information, and life giving forces that could potentially be used and applied by nursing homes across the country. The participating nursing homes shared examples of documents, tools, or other resources that help them achieve results (See Appendix I).

Detailed notes were taken by each site visit team member. After each visit, the site visit team summarized key findings for review and discussion at the debriefing meeting. Key findings were organized by emerging themes. As the site visits progressed, the themes were continuously reviewed and refined.

In most cases, visits to both nursing homes in each of the five states were conducted in the same week. The debriefing meeting concluded the visit. This meeting was open to staff from nursing homes as well as interested partners and stakeholders, such as the QIO, State Nursing Home Survey and Certification Agency, long term care ombudsman, long term care trade
associations. Many CMS staff participated in the debriefing meetings as well. Participants offered helpful insights and suggestions.

Following each visit, the site visit team developed a list of people from the nursing home to be considered to serve on an expert panel (described below) to be assembled to support development of the Change Package. Nursing home personnel who were passionate and who the site visit teams felt had a good understanding of how what the home was doing led to their excellent outcomes were selected as expert panel members.

When all visits were complete, the site visit team:

1. Compiled qualitative data from site visit interviews and developed lists of findings across all homes.
2. Organized the lists into seven major themes or strategies, with sub-categories within each strategy describing specific actions taken by the high performing homes.
3. Established an expert panel for each strategy consisting of staff from the nursing homes who were able to clearly articulate the effective practices used in their nursing home.
4. Engaged the expert panelists in a series of meetings to validate, clarify, and solidify practices and refine language reflecting the findings.
5. Developed a Change Package of effective practices to be used as the foundational document and vision for the National Nursing Home Quality Care Collaborative. The 2013-2014 Collaborative was led by CMS, the IIPC-NCC, and QIOs, and open to all nursing homes across the country.

Data/Study Limitations

The purpose of this study was to gain a holistic understanding of the practices and characteristics of a group of high performing nursing homes in order to inform the framework and potential quality improvement strategies for nursing homes in the Collaborative and to share what was learned with all interested nursing homes. The results of the study should be considered with the following limitations in mind:

Geographic limitations. While every effort was made to include a variety of types of nursing homes that were representative of several different geographic regions, it cannot be claimed that the participating nursing homes are representative of all nursing homes in the country.

The sample size was small. Due to time and resource constraints, only a limited number of site visits could be conducted. Accordingly, the results may not be generalizable to other facilities.

No control group was utilized. Consistent with appreciative inquiry methods, the study did not utilize a control group or investigate a change in performance in response to a defined intervention.

Ratings systems are inherently subjective and imperfect. The selection of higher performers was based largely on data from the CMS Five Star Quality Rating System, which is widely recognized as a robust tool for assessing nursing home performance. However, the
website CMS.gov cautions that no rating system can address all of the important considerations that go into a decision about which nursing home may be best for a particular person, and that consumers should use the website only in combination with other sources of information. As a result, it cannot be claimed that the ten nursing homes involved in this study were the highest performers in the country, even at the time the site visits were conducted.

**Limited perspectives of interviewees.** Although a wide range of staff were interviewed at each nursing home, it was not feasible to interview every staff person; therefore it is possible that some perspectives or best practices in use at one or more of the participating nursing homes is not included in this report. While it is also possible that some best practices were overlooked by not involving other stakeholder groups, for example, residents and family members, the focus of this report was intended to be on nursing homes’ internal systems. That focus, combined with time and resource limitations, made it infeasible to include a broader cross-section of interviewees.
Nursing Home Characteristics

This section presents an overview of the organizational characteristics of each of the ten nursing homes included in the evaluation. Ten nursing homes were visited for this evaluation, two each in California, Iowa, Massachusetts, Pennsylvania, and South Carolina. All ten homes had 5-star overall ratings at the time of the site visits and eight of the ten maintained 5-star overall ratings through the end of 2013. The remaining two homes had average overall star ratings for 2009-2013 of 4.98 and 4.95. Five of the homes are non-profits; five are for-profit corporations or partnerships. The sample includes small, medium, and large nursing homes, with bed counts ranging from 41 to 290. Two of the facilities are part of a continuing care retirement community (CCRC). Eight are located in urban areas, two in rural. See Table 1 on the next page.
## Facility Characteristics

<table>
<thead>
<tr>
<th>Facility</th>
<th>Bethany SNF</th>
<th>Pouikeways At Gwynedd</th>
<th>Franciscan Convalescent Hospital</th>
<th>Jewish HealthCare Ctr</th>
<th>Landis Homes</th>
<th>Mercy Retirement &amp; Care Ctr</th>
<th>NHC Healthcare, Parklane</th>
<th>NHC Healthcare, Home</th>
<th>Pleasant View</th>
<th>Westview Care Ctr</th>
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<tbody>
<tr>
<td>Location</td>
<td>(Framingham, MA)</td>
<td>(Gwynedd, PA)</td>
<td>(Merced, CA)</td>
<td>(Worcester, MA)</td>
<td>(Libby, PA)</td>
<td>(Oakland, CA)</td>
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*Refers to CMS’s quality rating system, which gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have quality that is much above average and nursing homes with 1 star are considered to have quality much below average. Each nursing home receives an overall Five Star rating and a separate rating for the three additional areas listed here. Eight of the ten homes have maintained a 5-star overall rating for every month from 2009 through 2013. Pouikeways at Gwynedd had a 5-star rating for every month except December 2013 when they received a 4-star overall rating, bringing their average overall star rating for 2009-2013 to 4.98. Landis Homes had a 5-star rating for every month except the last 3 months of 2013 when they received 4-star overall ratings, bringing their average overall star rating for 2009-2013 to 4.95.

**Facility size: Small (275 beds), Medium (76–150 beds), Large (>150 beds)**

***As reported in CMS database***
The following section presents profiles of the ten nursing homes visited.

**Bethany Health Care Center, Framingham, MA**

The mission of Bethany Health Care Center is to provide quality care for residents in a manner which helps them to be connected with God, with other people, and with the world in which they live. The board of directors attributes Bethany’s success to several key factors, including creative, compassionate and effective leadership; commitment to staffing to need, even if it means higher than average staffing levels; and on-site involvement of a physician and nurse practitioner, which helps keep residents out of the hospital. Bethany Health Care Center is a 169-bed, not-for-profit corporation.

Bethany’s Model of Care Program (BMCP) “treat in place” modality of care has been adopted by Bethany residents, families, and staff. The role of the administrator, medical director and nurse practitioners, director of nurses, and assistant directors of nursing are all central to the program. BMCP emphasizes quality of life, taking into account the circumstances of any illness and the presentation and preferences of the resident and tailoring the treatment plan accordingly.

Each day at Bethany begins with a morning meeting to discuss high-risk issues with administration, nursing leadership, and social services. An interdisciplinary group meeting focusing on resident health changes, conditions, and activities of the day follows. The BMCP is supported by Bethany’s in-service education department, with educational sessions tailored to meet the needs of the skilled nursing floors. An institution-wide performance improvement plan is in place to guide facility staff in meeting the individual needs of residents while supporting the goals of the community and overall organization.

Bethany’s emphasis on creating quality community life for its residents is evident in the atmosphere in the nursing home neighborhoods – residents, families, and staff are connected in a strong network of relationships, and there is a way to invite others into that network. The board and administrator promote opportunities for residents to be together, at meals, during activities and throughout the day, and consistent assignment for staff is the norm.

According to one board member, Bethany staff members adhere to the highest standards of excellence. “Bethany has been blessed by their staff that is dedicated and compassionate in their approach to caring for others. Over the years, above-average tenure rates of our employees have resulted in the development of relationships between residents and caregivers, promoting a strong sense of community. The longevity of nursing and support staff contributes to Bethany’s ability to deliver extraordinary and unsurpassed healthcare.”

“In the spirit of the Sisters of St. Joseph who sponsor Bethany, we bring to our mission of health care a desire to promote unity and reconciliation wherever there is brokenness, alienation, or separation.” Bethany’s services include long term care, short term care, rehabilitation, outpatient rehabilitation, memory impairment, respite and hospice, and social services.
Foulkeways at Gwynedd – Gwynedd, PA

Established in 1967, Foulkeways was the first Quaker based continuing care retirement community (CCRC) in the country. Located in the highly competitive Philadelphia market, it is one of 60 CCRCs in the area, and is home to over 300 adults age 65 and older. Staff and leaders attribute Foulkeways’ success to the fact that “everyone cares for one another.”

Consistent with Quaker principles, decisions at all levels of the organization are made by consensus, from the board of directors to the neighborhoods in skilled care. Everyone is expected to contribute and to “speak their truth” but once consensus is reached, everyone is expected to support it. This philosophy encourages community thinking with respect of all. A general climate of friendship, cooperation, and action is present throughout the Foulkeways community.

The nursing home at Foulkeways is a 52-bed Medicare-certified, skilled facility. In the 1990s, when leaders and staff realized that seniors didn’t want what they were offering, the search began for a new model of skilled care. After visiting several facilities and meeting with staff, residents, and family members, Foulkeways created their own model of care that encouraged and supported strong interaction within the community. A “culture of caring” was created and supported throughout the CCRC.

One of the first steps was to create a Main Street to connect all residential settings on the campus as a way to bring people together. The Main Street includes a library, pharmacy, gift shop, beauty salon, rehabilitation center, and activities center. Restaurants, mail room, auditorium, and several living room spaces providing multiple options for socialization are also available in the community center. Volunteerism among residents is encouraged, with over 100 active resident-sponsored and managed committees.

The skilled facility was re-built in 2001 with single-loaded corridors (resident rooms on only one side), private rooms with European showers and walk-in closets. All of the resident rooms look out onto gardens and/or green space. The rooms are located in clusters of ten, with services decentralized to the cluster. Two clusters, or 20 residents, make up a neighborhood with some shared services. A nurse and a nursing assistant are permanently assigned to each group of ten residents. Although Foulkeways does not have universal workers, all staff are trained and expected to help wherever they are needed. A traditional department structure is in place, but staff work together as if there are no departmental lines.

A nurse practitioner (NP) is available to residents and staff every day to help address health care needs. Even though this is an added cost to the facility, Medicare reimbursement is available for most NP services. Most important, having an NP available has contributed to a reduction in hospitalizations, fewer acute episodes of illness and better control of chronic conditions.

Food is delivered to the country kitchens located in each neighborhood. Permanently assigned dining staff set up the dining room, prepare and serve the food, and assist as needed. Resident choice is honored. Staff are trained to say, “we can get that,” rather than, “we don’t have that,”
no matter the request. Breakfast is open throughout the morning, cooked in the country kitchen nearest the resident’s room. Family members are always welcome.

At Foulkeways, friendships exist across all levels of care and among residents and staff. For example, residents get involved with helping staff to learn English as a second language; staff say this helps to establish long term relationships. Communication happens naturally as everyone works closely together to ensure that residents’ needs are met. At Foulkeways, “We always welcome students, to learn from them and to help them see how good things can be in long term care. We want to do our part to contribute to a new vision and way of doing things in long term care.”

Franciscan Convalescent Hospital, Merced, CA

Franciscan Convalescent Hospital is a 71-bed skilled facility operated by Avalon Corporation, a private, for-profit organization. The facility serves a culturally diverse population, providing short term rehab, long term care and memory care. The staff at Franciscan attribute the organization’s success to communication and teamwork.

Because it is a small facility, the staff at Franciscan are able to review all documentation daily and identify omissions and/or potential problems quickly. The care center has become a “test site” for Avalon when launching new programs due to their reputation within the company for doing a good job. They were the first Avalon facility in the region to implement an electronic medical record, which has enhanced their ability to communicate internally as staff have access to the information that they need in real time. The staff noted that corporate surveys are conducted by managers to effectively ensure that standards are routinely met. This process also allows corporate best practices to be identified, which are then shared with other facilities. The facility has a strong compliance person in the building who oversees the quality improvement program and encourages team involvement in quality initiatives.

Communication is open and “free flowing” in this facility. Everyone works together. All staff feel comfortable bringing up concerns that they see. They have developed tools to help ensure that details are addressed. Managers are actively involved with staff in providing care and routinely round with staff and residents. Staff have consistent assignments. Nursing assistants round with staff from on-coming shifts to make sure that resident needs are communicated. The small size of the building helps to keep everyone connected.

Teamwork is evident as staff work together to care for the residents. One staff member noted, “we are not just co-workers, we are friends.” Everyone watches out for one another. All have a sense of ownership and feel responsible for outcomes. Managers actively listen to staff concerns and see that they are addressed.

The diverse backgrounds of the residents and staff create unique opportunities for sharing. The dietary department works with the residents and their families to provide ethnic foods of their preference. Family members are encouraged to bring in specialty foods for their loved ones. The facility staff strive to address each resident’s unique background so that they will be comfortable in the setting.
The Franciscan Convalescent Hospital has a respiratory therapist on staff, a rarity among long term care facilities. The goal of the respiratory therapy program is to reduce readmissions to the acute care setting due to respiratory issues. The therapist assesses all new residents who have a respiratory diagnosis – asthma, COPD, pneumonia, or CHF. She addresses all aspects of the disease, including depression, anxiety, oxygen use, medications, and exercise needs, and works with each resident to develop an individualized program to prevent complications. Although the program has been in existence for less than a year, Franciscan Home has already begun to see the benefits in the form of fewer readmissions.

The Franciscan Convalescent Hospital received a National Quality Award from the American Healthcare Association in 2011.

Jewish HealthCare Center, Worcester, MA

Jewish HealthCare Center strives to ensure that the needs of every resident are met with dignity, comfort, and love. They are proud of their repeated Five Star Quality Rating by the Centers for Medicare and Medicaid Services (CMS), along with numerous other certifications and awards. The staff at Jewish HealthCare Center credit their success to high quality staffing; leadership longevity, which has provided a solid foundation on which to build; effective communication; and a commitment to resident-centered care. Jewish HealthCare Center is a 141-bed non-profit corporation established in 1916.

Attracting and retaining quality staff is a top value for Jewish HealthCare Center. They invest in hiring the best candidates – those with passion for the work combined with appropriate experience – and providing them with thorough and continued education. They maintain staffing ratios at a level appropriate to support resident-centered care. An in-house director of health and education provides initial and continuous training. Staff are expected to have a high level of integrity and to hold one another accountable. The average tenure for nursing assistant, nursing, and ancillary staff is seven to nine years of service at Jewish HealthCare Center.

Leadership at Jewish HealthCare Center is progressive and open to innovative programs and approaches to improve care and outcomes. Leaders at Jewish HealthCare Center say, “Quality of care is definitely number one. Whatever the board or we have to do, we make sure we have what the resident needs. And we like to be on the cutting edge.” For Jewish Health Care, being on the cutting edge means, in part, seeking partnership opportunities to improve quality. As a result, they have participated in pilot projects with Centers for Disease Control (CDC), the Massachusetts Department of Health, and higher education institutions like the University of Massachusetts and Quinsigamond Community College, all as part of their quest to improve quality. They strive to have the latest and best technology available to serve their residents and staff. This includes supports like telemedicine, mobile radiography, bladder scanners, and software that helps staff better understand residents’ ability and interest in participating in activities.

At Jewish HealthCare Center, effective communication is emphasized and taught. Expectations of staff are clearly communicated upon hiring. Senior leaders make a practice of being open and available to all staff. Routine daily and weekly meetings facilitate the flow of information,
and staff are empowered to speak up whenever needed, especially regarding resident care and needs. This open communication reaches across all staff levels and disciplines.

Resident-centered care is the priority at Jewish HealthCare Center. They promote a home environment and allow individuals to wake, eat, and sleep at preferred times. Proactive and empowered staff provide extended care whenever possible to avoid hospitalizations for residents who may temporarily need a higher level of care. Multi-disciplinary staff are engaged with the active resident council to ensure needs are heard and met.

Landis Homes, Lititz, PA

Landis, a 103-bed skilled facility, is part of a continuing care retirement community which is home to over 700 residents living in a range of housing options. Landis Homes’ vision statement is simple and straightforward – to be “Leaders in Serving.” As a faith-based retirement community Landis has served the local community and beyond since 1964. The staff at Landis Homes attribute their success to the organization’s five guiding principles: joy, compassion, integrity, stewardship, and community. Their shared focus on these guiding principles is evident throughout Landis Home’s approach to resident care.

Greeting everyone with a smile is the norm at Landis Homes. Days can be busy and it often feels like there is more to do than can fit in the time available, however, the practice of looking residents and colleagues in the eye and greeting them with a smile or hello helps everyone have a better day. Staff members also find joy in listening to the residents. As one said, “I always try to remember not to focus too much on my task and instead focus on the lives of the residents – they have done a lot in their lives.”

Compassion is at the heart of the initiative Landis calls “Honoring Lives.” The leadership at Landis Homes found that using the term culture change as a way to express the principles of person-centered care did not resonate with their staff. Instead they felt the key to putting the needs and wishes of the residents first was to honor them as individuals. One staff member described her approach to care as, “I think of the resident as someone else’s parent or grandparent, and treat them how I would want them to be treated if they were my own parent or grandparent.”

At Landis Homes excellence is the standard. High expectations for performance keep the bar high for everyone in the organization. Senior leaders understand that simply stating the organization has high expectations will not be effective unless it is modeled by everyone in the organization. Excellence and integrity are modeled from the top down, resulting in an organization where staff feel supported and their contribution is valued. An example is Landis’s practice of before saying “no” always trying to figure out a way to say “yes.” This practice applies whether a resident is making a request or a fellow staff member is asking for assistance.

The staff at Landis Homes feel responsible not only for protecting and caring for the residents but also pride themselves on being good stewards of the environment in which they work and their residents live. Keeping the building clean and well maintained makes the physical structure feel less like a facility and more like a home. This is important to both the staff and the
residents as it makes Landis Homes a place where people want to be, rather than a place they have to be.

Encouraging a supportive environment is a key way Landis Homes builds a sense of community within and among the staff and residents. Two phrases from conversations with staff at Landis “I never feel alone” and “I always know someone has my back” characterize this sense of community and support. At Landis Homes building relationships is at the heart of the organization. They recognize that staff and residents come from diverse backgrounds and have diverse interests. An event they have developed to assist in building relationships in their community is the “International House of Personalities.” At this event, staff, residents and others such as missionaries from local churches share about their culture through presentations, foods, and other activities. Staff at Landis Homes say they feel like they are a family.

Mercy Retirement and Care Center, Oakland, CA

Mercy Retirement and Care Center is a 59-bed, multi-level skilled facility located in the inner city of Oakland, CA. Mercy is a non-profit, faith-based organization. Established by the Sisters of Mercy in 1872, the facility has a long history of caring for the community. The philosophy of care is based upon the enduring principles of the founding sisters: “celebrate the individuality of each person and honor the inherent worth of all people.” The Eldercare Alliance was formed between the sisters and the Lutheran Synod creating the corporate structure that exists today. A group of strong, engaged leaders supports the facility at the corporate and board level. Mercy is a certified Eden Facility and has become a place where life revolves around close and continuing relationships. The facility was recognized by US News and World Report as ranking in the top one percent of nursing homes in the country.

Relationships are fostered both inside and outside of the facility. The organization is continually seeking best practices and looking for ways to partner with others. Conscious efforts are made to identify innovative programs and organizations from which the organization and staff can learn. The Eden philosophy provides the basis for their resident-directed care model and staff have researched other models as well, adopting concepts that will support their organization’s vision. As a learning organization, continuous improvement is the goal. Once a program/process is identified as having potential for the facility, it is shared with the residents/family members and staff to gain their feedback and support before any attempt is made to implement it. As a result, the passion and support for the change comes from within. One such program is a new dementia care program that is currently being implemented. Inside the care center, relationships are strengthened through consistent assignment of staff, creating neighborhoods and bringing everyone together. The use of learning circles has been incorporated into routine practice to enhance relationships among all.

At Mercy, care is everyone’s responsibility. Leaders are visible and involved. Departmental barriers have been effectively broken down; all staff and all departments work together to address resident, family, and staff concerns. All staff are empowered to make a difference in the lives of the residents in their care, and given the tools and training needed so that they can do so. Staff are hired for fit first, skills second. This means that during the interviewing and screening process, a match between the organization’s culture and a candidate’s personality is
the key. If a fit is found, then screening for appropriate skills and experience occurs and a hiring decision is made. All employees are then supported through a comprehensive orientation program, ongoing in-service training, workshop attendance, and on-the-job mentoring to give them the confidence needed. Team members hold one another accountable.

Effective communication among the team is evident at Mercy. Technology is used to support staff efforts to continually improve processes and systems to support residents and staff. Staff give verbal reports at change of shift and round together to communicate changes and care needs. Quality data is shared throughout the organization and everyone is involved in addressing concerns that are identified. The governing board created a resident care committee consisting of board members, physicians, family members, residents, and staff to ensure that quality care and life are maintained throughout the facility.

The staff works hard and celebrates often, and strong relationships among residents, family members, and staff are acknowledged. Annually the “Heart of Gold” Award is given to a staff member who has been nominated by residents, family members, and staff.

From Mercy Retirement and Care Center’s website: “When you walk through our doors you enter a home – to join our senior living community is to become part of our family.”

**NHC HealthCare, Anderson – Anderson, SC**

NHC HealthCare, Anderson (Anderson) focuses on quality and is proud to be deficiency-free for more than 18 years. Anderson is one of 69 homes owned by National HealthCare Corporation. Services offered include Chronic Confusion Dementia Illness (CCDI) unit, short term rehabilitation, skilled nursing, and hospice. The staff at Anderson attribute their success to three main factors: effective communication strategies, high quality hiring principles, and data-driven quality improvement goals.

Communication is an integral part of the success at Anderson. Anderson leaders and managers participate in many corporate and regional activities designed to promote the sharing of successful ideas and strategies. The day always begins with a morning multi-disciplinary meeting, which highlights one of the corporate “Twenty Promises.” Each day a promise of the day is selected and staff share one or two stories depicting the promise in action. Making the promises meaningful by sharing stories serves as a daily reminder to help nurture and grow the culture. This process is designed to get the entire team on the same page, and give them grounded focus for the day. The morning meeting includes discussion of any issues of the day and a review of goals and individual resident concerns. As part of its proactive communication strategy, Anderson utilizes meetings designed to encourage effective communication among staff, including shift reports, morning stand-up meetings, rapid cycle huddles, and Five Star review meetings.

Anderson leadership shared that they have high standards for hiring. Potential staff are screened for not only skills and experience, but also what Anderson calls “spirit” qualifications, including motivation, character, and attitude. Staff are hired to become part of the team and are viewed as such from the initial interview. Anderson encourages the growth and success of its
employees through incentives like tuition allowances or bonus rewards for continuing education or certifications. Staff are referred to as “partners in quality” and have ownership in the company through a 401(k) plan. Each member of the staff is viewed as a valuable asset to the team. Anderson attributes its low turnover rates to effective hiring practices and fostering a sense of ownership.

Quality improvement goals are closely monitored at the corporate level using a corporate dashboard as well as a facility specific scoreboard; organizational data are displayed and maintained where they are visible to staff. Staff view the process of tracking and monitoring data and quality outcomes as instrumental to their culture. For example, they are accustomed to using rapid testing cycles to solve problems and support improvement activities. Staff at all levels are aware of goals and share in celebrating when goals are achieved.

**NHC HealthCare, Parklane – Columbia, SC**

NHC HealthCare Parklane (Parklane) proudly displays the Five-Star Quality Rating for all residents, family, staff, and visitors to see. Parklane is one of 69 homes owned by National HealthCare Corporation. Services offered include Chronic Confusion Dementia Illness (CCDI) unit, short term rehabilitation, skilled nursing, and hospice. Customer satisfaction is the driving force for Parklane, along with the quest for excellence that provides a different kind of care – one that ensures that staff and residents are surrounded by people who make a difference in their lives. The staff at Parklane attribute their success to three main factors: strong leadership, clear staff expectations and empowerment, and quality efforts informed by data.

Parklane leaders receive training through the Ritz-Carlton Leadership Center, which is strongly focused on customer service and satisfaction. Although leaders are extensively trained, it is the engagement and leadership they provide at the facility level that makes the difference. Leaders ask questions of staff to encourage staff engagement and team problem solving. Parklane leaders have an open-door policy and are involved with staff at all levels, as well as with residents and families they serve. The personal relationships that leaders have developed with staff, residents, and families foster open and honest two-way communication. In an effort to keep employees productive and committed, staff are supported in trying to balance work and personal priorities. Some examples of support include encouraging employees to ask for help, changes to work schedules, and monetary loans. Frequent leadership rounding allows leaders to support staff whenever and wherever needed, and to foster relationships and connections among staff, residents, and families. The leaders exemplify the actions and embody the culture of service they expect.

Staff expectations are intentionally set high and are communicated clearly. When new employees at all levels within the organization are hired, they are told that this is a Five Star Facility and that they are being hired to help continue that level of performance. Certified nursing assistants and nurses are the “eyes and ears” of the leadership team and are empowered to be active members of the multi-disciplinary care team. Consistent assignment allows nursing assistants to get to know residents and provide compassionate care. Staff are encouraged to participate and share concerns or ideas with the team. Any staff members
interacting with a resident are asked to note resident changes and request physician visits as appropriate.

Parklane utilizes data to help inform the leadership team and others of pressing needs within the organization. In addition to a corporate dashboard, Parklane tracks numerous specific measures, which they have identified, to support the systems within the organization. Parklane uses data to inform priorities, drive quality initiatives, and monitor performance.

**Pleasant View Home, Albert City, IA**

Pleasant View Home is a 41-bed skilled facility located in northwest Iowa. It is privately owned by local stockholders who elect a board of directors; the board hires the administration and oversees the operations of the facility. The goal in establishing the home was to care for the aging population in this rural, farming community. Residents, staff, and family members have grown up together in this small community and as a result, there is a strong sense of community in the facility and the basis for the “family caring for family” philosophy. At Pleasant View, many staff members are caring for their grandparents, other family members, and neighbors. If an employee doesn’t know a resident personally, they almost always know someone who is connected to that person.

Communication happens naturally at Pleasant View as people live and work together. Department managers and administrators meet every day for a “stand up” quality meeting using the 24-hour report to guide the agenda. They have created a no blame culture where all staff feel free to express opinions and concerns. Managers work closely with staff in caring for residents and meeting their needs. Each department keeps a communication book as a tool to help keep staff informed. Monthly in-service training events are planned a year in advance in response to staff interests and concerns.

Though staff are hired and assigned for a specific job, many staff are cross-trained in several areas so that they can help where needed. Cross-training the staff has allowed more staff to meet resident needs in a timely manner. Cross-training also benefits the team, and at Pleasant View a high priority is placed on teamwork.

Residents are encouraged to participate in care planning when possible, and conferences are scheduled at all times of day and week to accommodate family schedules. Residents are also encouraged to share ideas, for example, residents are actively involved in planning the menu. They meet with the dietary manager regularly to make suggestions for new items and to give feedback on things they don’t like any longer.

The home is located next to a large Lutheran church. Because many of the residents can no longer attend church services, Pleasant View staff coordinate with the church to “video stream” the services and residents are able to watch in real time. Community members are invited to the home for coffee on Sunday afternoons, and family members and auxiliary members help out as volunteer servers.

Strong community support and involvement are evident at Pleasant View. Community members have donated items such as flat screen TVs and hand-crafted furniture, and often help with
seasonal decorations. The staff clearly appreciates this support, and residents, in turn, have many opportunities to connect with the community. The home and the local school work together on special programs, and local children are encouraged to visit on holidays. The current board chair comes every month to sing with the residents.

A Pleasant View nursing assistant put it this way: “This is their home – we are here to help make it better for them.”

**Westview Care Center, Britt, IA**

Westview Care Center prides itself on being deficiency-free for more than 17 years and has been named one of Iowa’s top nursing homes in *US News and World Report* multiple times. Westview Care Center is one of 30 homes owned by ABCM Corporation. Services offered include a Chronic Confusion Dementia Illness (CCDI) Unit, short term rehab, skilled nursing and hospice. The staff at Westview Care Center attribute their success to three main factors: high quality staffing, effective communication, and their culture of person directed care. Westview is a 71-bed facility.

At Westview, recruiting and retaining quality staff is a top priority. The interview process is not just about the candidate selling themselves to the home, but also about the home selling the applicant on the position. The process of preparing new employees for what will be expected of them starts in the interview, where information is shared about the organization, its culture, and the high expectations Westview has of its staff. In order to be employed at Westview, it is critical that job candidates express that they want to work there because they want to take care of people.

All new hires start with a full month of orientation regardless of past positions held. During this lengthy period, the main focus is on reinforcing expectations pertaining to resident interaction and co-worker communication, and most important of all, encouraging new employees to get to know the residents and making it clear that all of their work is about the residents.

High performing staff are selected to be trainers for new staff so that they can teach what they are doing that makes them high performers. Cross-training is considered essential and many staff are cross-trained as Certified Nursing Assistants (CNAs). Educational scholarships and loans are available from the corporation to encourage professional growth.

Staff at Westview demonstrate a commitment to effective communication. They utilize documentation such as a communications log book, a nurse-to-nurse report sheet, staff huddles, and neighborhood walk-through rounds. The CNAs are encouraged to voice their opinions, participate in resident care, participate in rounding, and communicate with the team about individual resident needs and preferences. Staff at all levels are encouraged to provide input on procedures and policies that affect the overall community culture.

Westview has embraced the philosophy and practice of person directed care. Staff view the residents as family and because of the nature of being a nursing home in a small town, many staff have known the residents since long before they moved to the nursing home. Residents’ daily routines and habits are encouraged and accommodated. Consistent assignment is used
80-85 percent of the time. Each neighborhood is empowered to make decisions about activities and what to do each day. Results from family satisfaction surveys focused on quality of life, quality of care, and quality of services are used to inform quality improvement efforts.
Findings: Strategies of High Performing Nursing Homes

As a culmination of this project, a Change Package was developed as a way to summarize and solidify the foundational practices of high performing nursing homes.

The Change Package is focused on the successful practices of high performing nursing homes and the themes that emerged regarding how they approached quality and carried out their work. The practices in the Change Package reflect how the leaders and direct care staff at these sites shared and described their efforts. The Change Package is a menu of strategies, change concepts, and specific actionable items that any nursing home can begin testing for purposes of improving residents’ quality of life and care. The Change Package is intended to be complementary to such resources as literature reviews and evidence-based tools and resources.

Through interviews conducted at each facility in the sample, seven strategies common to all ten nursing homes were identified. These strategies convey overarching principles critical for success. Each of these strategies plays a role in creating a community where residents are well cared for and experience a high quality of life, and at the same time an environment that the staff enjoy coming to every day. The result, researchers found, was often a facility that for many staff and residents felt like a home or a family. Caregivers often expressed pride not only in their work, but in the facility itself and the culture contained within. Many saw their role at the facility as “more than just a job,” instead viewing it as a lifestyle – one that was intertwined with their own lives and the neighboring community as a whole. While certain aspects of these strategies varied from facility to facility, they were relatively consistent across all ten nursing homes.

For each strategy, a set of change concepts was also identified. A change concept can be defined as a general idea, with proven merit or logical foundation, which is capable of stimulating specific ideas for changes that lead to improvement. Change concepts are intended to help nursing homes operationalize the strategies. Each change concept describes a type of effective practice that was identified in various forms at a number of sites. The strategies and change concepts are listed in Table 2.

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Change Concepts</th>
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<tbody>
<tr>
<td>1. Lead with a sense of purpose.</td>
<td>1.a Be the leader you would want to follow.</td>
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<td></td>
<td>1.b Let the mission drive your actions.</td>
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<td></td>
<td>1.c Plant now, harvest later: Nurture professional growth and foster innovation in others.</td>
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<td></td>
<td>1.d Focus on systems for change.</td>
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<tr>
<td>2. Recruit and retain quality staff.</td>
<td>2.a Hire only the best fit for your organization.</td>
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<td></td>
<td>2.b Welcome new staff – make them part of the team.</td>
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<td></td>
<td>2.c Set high expectations – support success.</td>
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<td></td>
<td>2.d Give the best staff a reason to stay.</td>
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<tr>
<td>3. Connect with residents in a</td>
<td>3.a Treat residents as they want to be treated, remembering that your facility is their home.</td>
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<tr>
<td>celebration of life.</td>
<td>3.b Foster relationships.</td>
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### Nursing Home Best Practices Evaluation Final Report

### Strategies

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<tr>
<td>3.c</td>
<td>Create connections with the community.</td>
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<td>3.d</td>
<td>Provide compassionate end-of-life care.</td>
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### 4. Nourish Teamwork and Communication |

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<td>4.a</td>
<td>Expect and support effective communication with staff and between staff.</td>
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<td>4.b</td>
<td>Be a collaborator among collaborators.</td>
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### 5. Be a Continuous Learning Organization |

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<tr>
<td>5.a</td>
<td>Make systems thinking the norm.</td>
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<td>5.b</td>
<td>Track your progress.</td>
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<tr>
<td>5.c</td>
<td>Test, test, test!</td>
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### 6. Provide Exceptional Compassionate Clinical Care that Treats the Whole Person |

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<tr>
<td>6.a</td>
<td>Carefully build care teams and keep them together.</td>
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<td>6.b</td>
<td>Choose medical leadership wisely.</td>
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<tr>
<td>6.c</td>
<td>Transition with care (between shifts, departments, and all care settings).</td>
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<tr>
<td>6.d</td>
<td>Strive to prevent problems and treat when necessary.</td>
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### 7. Construct Solid Business Practices that Support Your Purpose |

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<td>7.a</td>
<td>Seek strategic and creative approaches to expand your resource base to meet your mission and serve your residents.</td>
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<tr>
<td>7.b</td>
<td>Maximize your efficiency.</td>
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<tr>
<td>7.c</td>
<td>Ensure you are making the most of your physical assets.</td>
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In addition to the strategies and change concepts, a set of action items was described for each change concept. Action items are specific changes that any nursing home interested in improving quality can test in their organization. Reflecting real practices observed on-site, action items help bring the change concepts and strategies to life. They provide fuel for a Plan-Do-Study-Act (PDSA) approach to rapid adaptation, testing, and adoption as seen in Figure 2.

**Figure 2: Fueling PDSA cycle for rapid adaptation**

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<table>
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<td>Strategies are high level concepts that convey overarching principles critical to success.</td>
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<tr>
<td>Change Concepts are general ideas for effective practice, to stimulate specific ideas for changes.</td>
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<tbody>
<tr>
<td>Action Items are real practices observed on-site, specific changes that can be tested.</td>
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The Change Package is intended to be a resource that can be used by nursing homes around the country looking for ways to improve their systems and level of care. A first draft of this document was circulated to a panel of experts (Appendix J) who participated in a series of conference calls to discuss and refine its contents. The goals of this panel were to validate, clarify, and strengthen the contents; to help identify root causes supporting the best practices and what benefits they deliver; and to add any relevant change concepts or action items. The most recent version of the Change Package is included as Appendix K and can also be downloaded from [http://www.healthcarecommunities.org/](http://www.healthcarecommunities.org/). Site registration (no cost) is required to join the nursing home quality community and access the Change Package.
The strategies, along with narrative illustrations of what those strategies look like in action, are included below.

**Strategy 1: Lead with a sense of purpose.**

Strategy 1 sets the expectation for excellence in leadership, one of the basic building blocks forming the foundation of a learning organization. Site visit teams observed that the actions of leaders, multiplied by the actions of many, shaped the culture of these ten organizations.

Change concepts identified for this strategy are:

- Be the leader you would want to follow.
- Let the mission drive your actions.
- Plant now, harvest later: Nurture professional growth and foster innovation in others.
- Focus on systems for change.

Following is a narrative description of what the site visit teams observed with respect to this strategy in the ten nursing homes that were part of this study, including specific examples of the strategy in action.

Senior leaders at the nursing homes clearly articulated their purpose – to provide exceptional, individualized care and compassion for their residents. They talked about how they wanted their residents to be treated – as they themselves would want to be treated, or as they would want their own parents or grandparents to be treated. They talked about wanting and committing to be the best nursing home, about “being vested and wanting to do the best we can for our residents. It is not just a job; it is about taking personal pride in achieving our goals and objectives.”

As a typical senior leader walked through their building, they would greet residents and families by name, shake a hand or put an arm around a shoulder, ask how a resident was doing or follow up on something they had recently talked about with that resident. They stopped to answer call lights and assist residents. They made note of how the building looked, helped to tidy up, and made note of anything in need of repair or follow-up.

Equally as important as the focus on residents and families was the leaders’ focus on and respect for staff. They talked very positively about their staff, about how they believed in them and what the staff does to provide good quality care. They talked about the trust and pride they had in their staff, and how current employees take new staff under their wing to show them “how things are done here” – how to provide good care. They gave credit to their staff and described them as loyal, wonderful and caring, and taking pride in their work. They talked about treating staff as they themselves would want to be treated.

Senior leaders greeted staff by name, made introductions, thanked staff for what they are doing, asked about their personal well-being and any needs they might have, and involved them in
problem-solving and decision-making. They talked about providing a safe environment for staff to share concerns and ideas, and the importance of following up on those ideas. These leaders tend to work within a frame of “leadership by asking questions” rather than having all the answers. Most do not see themselves as problem solvers, but rather as facilitators working with their team to address problems.

At Bethany HealthCare Center, a board member said, “We know our employees well and we know what is going on in their life. It is that connecting and knowing the people that work here that make the difference. We have such a low turnover rate, people come and want to be a part of this. Something is good and nice here, and because our staff is okay, the residents will be okay.”

Board members and senior leaders spoke of their mutually supportive relationships. Administrators reported taking great care in selecting potential board members and noted how important their board’s support is to the home’s success. Board members spoke of the importance of supporting senior leaders, and how critical it is, if something does go wrong, to continue to work collaboratively with them and let them know they have your support, rather than assuming punitive actions are necessary. Board members and senior leaders alike led by asking questions to better understand the situation, including systems and processes that produced the results.

For those homes that are part of a system or larger corporate entity, the larger body’s support for leadership at the nursing home level was critical as well. Westview Care Center, with the support of its owner ABCM Corporation, offers an extended training and orientation period for new leaders as well as a leadership/peer support program for team leaders. NHC, owner of NHC HealthCare, Parklane, and NHC HealthCare, Anderson, offers networking groups and communities of practice which allow leaders employed by homes the company owns to easily connect with one another to share learning and information.

The leaders focused on keeping their skills and abilities up-to-date, and encouraged their leadership team and staff to continually look for ways to improve themselves, the organization, and the long term care field. For example, employees were encouraged to attend conferences and participate in state or national committees and were empowered to participate in interdisciplinary team problem solving. The administrator of Bethany Health Care Center keeps herself informed by going to conferences and reading journals, and when she comes across something interesting, beginning a dialogue with leadership staff to explore the idea further, finding out if they’re familiar with it or have seen it in action. At Jewish HealthCare Center, senior leaders support one another in a tight-knit leadership group.

Many of the leaders of these nursing homes have an important characteristic in common – they think in terms of systems. They understand that all of the processes that make up their community comprise a larger, interconnected system, and they see the connections and links between all the different processes and actions in that system. Before making a change in one

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“One day I was walking with our administrator, and she said ‘Mary, we are so lucky to have you here. Thanks for all you do.’ Can you believe that? I was so touched. I’ve had administrators who didn’t know my name or ever acknowledge me.”

NHC HealthCare, Parklane
area, they first consider carefully the impacts that change might have in other areas, and they use what they learn to inform their decisions and actions.

Leaders welcomed the opportunity to participate in research and quality improvement initiatives, and also invited students from a variety of disciplines to have learning and caring experiences in their organization. One administrator said, “We have the opportunity to provide a new vision of how to provide long term care for all future caregivers and other long term care professionals.”

Staff in these organizations said they were proud to work there, enjoyed and loved their residents, and respected and admired their leaders. They were grateful for their leaders; many described a specific situation where their administrator or director of nursing had helped them personally in a time of need, or had shared kind and grateful words with them such as “we are so lucky to have you here.” They talked about the value of having leaders and a team to rely on, saying, “We all help each other” and, “Our team will not accept mediocre or sloppy.”

Staff talked about being able to make a difference, knowing they were valued and appreciated by their residents, leaders, and team members. They were very clear about the values of the organization, noting, “We are here for the residents, they deserve only the best,” and, “When our residents’ families cannot be here, we are here for them.” They talked about having the resources and help they need in order to do a good job every day. “You have whatever you need to take care of residents, no short-cutting here, you always feel like you did whatever you could for the residents. When you go home, you go in peace.” “I would come and live here. We take care of the whole person, the spiritual, the physical, the mental, and social, it is the whole thing. We care about every single person who walks through the door.”

Board members talked about leadership as a key to these organizations’ success. One board member referenced the “incredible respect that people have for one another and incredible leadership, passion, and personal commitment from our administrator. This is a solid foundation that crosses right through the facility. The standard is set and everyone sees that and knows the standard of care and teamwork that they must provide. Expectations are set very high.” A staff member shared, “It is truly their leadership that has brought the rest of us to where we are.”

These nursing homes let their mission drive their actions. The mission of Foulkeways at Gwynnedd is to provide comprehensive services for seniors based upon Quaker principles that promote independence, innovative living, respect, security, and choice. Based on customer input, they developed a resident centered residential social model that emphasizes interaction, privacy, and support and limits the separations between skilled care, personal care, and independent living.

Foulkeways leaders and staff make decisions every day that are guided by their mission and unique social model. For example, residents receiving skilled care can move around and use
common areas; they do not have to seek permission. Meal times are flexible and food service offers a variety of options including a tray line and an “always available” menu for residents. The dietician offers resources to help with food choices, but residents are free to choose what they want to eat and the staff honors their wishes. When hiring, Foulkeways looks for people who will mesh and work well together; the result is a home-like atmosphere that is family oriented with a strong sense of relationships. Each year, Foulkeways chooses several organizational values to focus on, including them in employee evaluations for that year. One core value that resonates on a daily basis is that all staff and residents are to be treated with respect and dignity.

The mission of NHC HealthCare, Parklane, is as follows: “At NHC, care is our business. Care that respects the individual. Care that promotes recovery, well-being and independence. Care that seeks to meet all standards of quality.” According to Parklane’s administrator, “Every decision is made by asking what the best thing is for the resident/patient, whether it is related to staffing, capital expenditure, or any topic. If we ever lose sight of that then we have lost our north star. If you focus on what is the most economical and profit-oriented, or what makes staff the happiest, then that can get you off the north star.”


For specific action items related to this strategy, please refer to the Change Package (Appendix K).

**Strategy 2: Recruit and retain quality staff.**

Without high quality staff, no nursing home can achieve its goal of providing high quality care and a high quality of life for its residents. Site visit teams observed that the participating nursing homes identified and developed great talent in all interdisciplinary team members, by setting high expectations and fostering an affirming culture. They recruited and hired qualified, caring staff that fit their mission, values, and culture, and then cultivated longevity through a supportive work environment.

Change concepts identified for this strategy are:

- Hire only the best fit for your organization.
- Welcome new staff – make them part of the team.
- Set high expectations, support success.
- Give the best staff a reason to stay.
Following is a narrative description of what the site visit teams observed with respect to this strategy in the ten nursing homes that were part of this study, including specific examples of the strategy in action.

Leaders of these homes defined what they meant by “quality staff” and the characteristics they looked for when hiring, emphasizing the importance of employing people who are passionate about providing compassionate care. They determined who needed to be involved in the hiring process based upon the position to be hired, and included staff members and residents as appropriate. They used behavioral based questions in interviews; for example, asking how the applicant would respond to a variety of situations involving resident or family requests or concerns. Some asked “What would you consider to be a high quality nursing home?” They began to embed a consistent message of high expectations during the interview – making it clear that they were looking for a good fit, consistent with the organization’s mission, vision, and values.

These organizations focused on welcoming new staff and helping them feel part of the team. They focused on supporting new staff through the potentially challenging first few months on the job and were flexible with orientation timing, length, and focus. They assigned buddies or mentors, and checked in with the new staff regularly to see how they were doing and what they needed. They identified training needs and provided training for new staff. They provided opportunities for staff to shadow other disciplines during orientation so that they could see how their role interacted with others.

They focused on skill-based competencies – identified what competencies were needed, assessed skill levels, and followed up with training and re-testing. Leaders set the expectation that it is the job of all staff to respond to resident needs and requests. They had mechanisms to gather input from staff to gain feedback on the quality of care being provided, and they responded in a timely way to needs that emerged.

Staff shared that their culture of high expectations started at the top. One said, “We know what our leaders expect, and you know that you will be held to that.” One organization defined its high expectations as being a reliable team member that comes to work on time, provides high quality care for residents, implements the care plan, supports team members, and keeps leaders informed and aware of any needs or concerns getting in the way of providing good care.

It was noted that existing teams shared and modeled the expectations for care and teamwork. They would note if a new person needed additional support in order to meet expectations, bringing the issue to the attention of a supervisor or nurse manager if needed. The typical training/mentoring model could be described this way: train, model, coach, and openly discuss any issues that arise. Staff noted that leaders were out and about and checking in with staff and residents. One leader noted “we make rounds, we can tell how things are going by how staff

“Everyone here knows that there are very high expectations. It starts at the top, and extends to everyone that works here. We know our leader has high expectations for herself and for all of us, and we all do our best to meet those. You feel disappointed in yourself if you don’t. We help hold each other accountable.”

Jewish HealthCare Center
reacts to questions and by observations, whether they are on top of things and looking to resident comfort and care first.”

Leaders of these homes give their best staff a reason to stay by having competitive compensation and benefits, by supporting staff in their professional development, by providing opportunities for flexible schedules so that employees are better able to balance work and home/family needs. They listen to staff and work with them to address opportunities for improvement. They provide effective, caring supervision and leadership for employees.

At some of the homes, employees are encouraged to take courses, not only on topics within their field but outside it as well, and find ways at work to apply what they’ve learned. A member of the building maintenance staff at Foulkeways at Gwynedd was interested in landscaping and decided to take a course. When he came back to work, even though it wasn’t required as part of his job, he created a beautiful water garden based on what he had learned.


For specific action items related to this strategy, please refer to the Change Package (Appendix K).

**Strategy 3: Connect with residents in a celebration of their life.**

Everyone -- including every nursing home resident -- has a life story. In creating an environment where “the resident always comes first,” the ten participating nursing homes have found ways to treat the resident as a whole person, with a family, a history, and connections in the community. Site visit teams observed that the focus in these homes was on helping to keep residents active in their families’ lives and in the community while always respecting resident preferences. At the end of life, a celebration of life honored the resident and embraced family, other residents, and staff.

Franciscan Convalescent Hospital helps to create a home-like environment by treating call lights as “stop lights.” Everyone in the building -- including dietary, billing, and maintenance staff and the administrator -- is empowered and encouraged to stop and answer a call light and as a result, it is a common practice for all staff. Staff who respond to a call light determine what the resident needs and then communicate with nursing or other staff as appropriate.
Change concepts identified for this strategy are:

- Treat residents as they want to be treated, remembering that your facility is their home.
- Foster relationships.
- Create connections with the community.
- Provide compassionate end-of-life care.

Following is a narrative description of what the site visit teams observed with respect to this strategy in the ten nursing homes that were part of this study, including specific examples of the strategy in action.

Leaders and staff members at every level described that their primary purpose was to provide quality care to the residents. They articulated that their facility was the residents’ home and they strived to make it a welcoming place for residents and their families. They had systems in place to learn about the residents’ needs and preferences before and during admission and to share that information with all staff involved in caring for the resident. They described how they focused on and provided resident centered care, anticipating and responding to resident needs and preferences. They provided customer service training for their staff.

Leaders and staff paid attention to language, choosing to use words that reflect that this is the residents’ home; for example, a resident would “move in” as opposed to “being admitted,” and “avenue,” “neighborhood,” or “household” took the place of “unit.” They created an environment where greeting everyone with a smile and making eye contact with residents, staff, and visitors was the norm. One staff member shared that if she ever had to leave her current organization and look for a new nursing home to work in, she would start by walking around in the new home and observing how everyone looks at and reacts to one another; that would speak volumes about the culture of the organization.

These homes worked to create opportunities for residents to develop bi-directional relationships with each other and with staff; some homes had a buddy or guardian angel program pairing residents and staff members in long-term relationships. Some homes created opportunities for residents to give to others and to find and make meaning in their own and others’ lives. For example, at some homes, residents helped gather food for a food drive, participated in creating a gift for the community’s New Year’s baby, collected gifts for an individual they selected from a local giving tree, helped staff with English as a second language, and collected or provided monetary donations for individuals and groups in need. Staff are encouraged to bring their families in to develop
relationships with residents. At one home, the children of staff members come after school to socialize and do their homework.

Staff and leaders fostered relationships with families, welcoming family members and encouraging them to communicate with staff and residents. They had processes in place to encourage and remind staff to contact families with updates, questions, and invitations to join activities.

These homes created connections with the community, asking for suggestions from residents and families about activities they would like to attend in the community, and about community members or groups they would like to invite to the nursing home. Examples include universities, churches, community colleges, day care centers, and schools. They made use of available technology; in one case they used streaming video to broadcast religious services at the nursing home, allowing residents to participate in real time.

The nursing homes provided compassionate end-of-life care. They trained and supported staff in caring for residents and families during this emotional time, with a focus on respectful and comforting care, honoring resident and family preferences. Many talked about systems they had in place to ensure that a dying resident was not left alone.

When a resident died, these nursing homes provided opportunities for fellow residents and staff to mourn the loss and celebrate the person’s life. They made sure that staff and residents knew when a resident passed away. One home changed its process after a resident learned about the death of another resident much later, and shared, “My best friend died and no one told me. I wish I had gotten to say goodbye!”

Residents’ wishes are always honored, but at some of the homes, rather than having the dying process be secret, a bouquet of white flowers or a white ribbon on the resident’s door indicates that the person is in the dying process. A tray of refreshments might be kept in the dying resident’s room for family and visitors. After the person has passed away, staff set up a memorial table and invite residents and staff to write a note about their favorite thing about the resident; the notes are then passed along to the family. Most of the homes offer to hold an on-site service to remember the resident, for family members, residents, staff, community members, and friends. At least one home sees this as so important that they always have a
service for any resident who dies, even if another service is being held elsewhere. In all of these examples, the homes treat the resident as a whole person, in life and through and beyond the dying process.

“One of our residents was talking one winter day about how she loved the snow, and hadn’t been out in it for ages, and would love to experience that again. The next day a staff member brought a coat, gloves, hat, and bundled the resident up and took her outside in the snow. The resident appeared so happy, and with her permission, they took a picture of her, capturing her joy. The very next day, the resident passed away, and the staff were so glad that they listened to the resident and found a way to make her happy.” Landis Homes


For specific action items related to this strategy, please refer to the Change Package (Appendix K).

**Strategy 4: Nourish teamwork and communication.**

Effective teamwork is widely recognized as critical to providing high quality, safe health care. In the long term care setting, it is essential for every member of the staff to bring, through the mechanism of the team, their unique perspective and skills to the common goal of providing high quality care to residents. Site visit teams observed that at the ten participating nursing homes, disseminating information in a complete, consistent, and timely manner nourished teamwork and communication among staff and between staff and residents. Strong communication linked people and built relationships. Members of high-functioning teams respected one another and worked interdependently towards common goals.

Change concepts identified for this strategy are:

- Expect and support effective communication with staff and between staff.
- Be a collaborator among collaborators.

Following is a narrative description of what the site visit teams observed with respect to this strategy in the ten nursing homes that were part of this study, including specific examples of the strategy in action.

These high performing nursing homes had formal methods in place for communicating between shifts and during shifts, recognizing that the free flow of information is essential to providing the
best care possible. They used face-to-face meetings or huddles, shift-to-shift bedside reports, and communication journals placed in resident rooms. One leader said, “Our nursing assistants round together at change of shift. We find this promotes relationships between the staff and shifts. It promotes accountability and prompt follow-up on resident needs. Things don’t fall through the cracks.”

The homes had processes in place for updating care plans. They created processes for all voices to be heard – all disciplines and roles, all shifts, and including families and residents whenever possible. Leaders then listened, interacted and followed up in a timely and respectful way.

Staff described that they worked well together across departments. Job shadowing across disciplines helped to remove boundaries and increased understanding of what each person needs and contributes to make the household run smoothly. The homes used cross training (for example nursing assistants and housekeepers) to foster communication and understanding between roles, and interdisciplinary teams for problem solving. Some held neighborhood meetings that all disciplines, including senior leaders, would attend. A staff member said, “We will always pull each other aside and ask what happened in a situation that didn’t seem to go quite right. We want to help each other. People do that for me and I want to do that for them. We’ll share with each other how to do better.”

To increase staff’s sense of ownership and accountability while also promoting engagement and job satisfaction, the homes involved all staff in changes and improvement efforts. When one home tackled the problem of removing all audible alarms, they started by surveying staff to gather information on their needs and recommendations. Leaders looked for opportunities to model and coach to help strengthen team relationships. For example, they anticipated staff’s possible need to address a situation or concern with a co-worker, role-playing the situation in advance. They encouraged and modeled the value that every staff member is responsible for helping out wherever needed. For example, they expected any and all staff to assist a resident that is requesting help and to report equipment in need of repair. Staff are expected and encouraged to help and support each other, to offer and accept help.

A nurse manager at Jewish HealthCare Center shared the following: “Nourishing teamwork and collaboration begins in the interview. Give the candidate an impression of the kind of teamwork they can expect from your staff. Let them know you are aware that they will have busy days that can only be complete and successful with teamwork, supporting and helping one another. I tell the candidate the team will continue to teach even after orientation is complete because there is a lot to learn about all the residents and routines. So a CNA may say to a new team member, ‘Oh, you forgot the footrests,’ or ‘She will want ice in her drink,’ or ‘He will need to get

“My mom passed away recently. My staff was wonderful, they sent cards, they left me messages. At the funeral, a van pulled up—full of my staff members. I couldn’t believe it; I can’t tell you how much that meant to me.”

Pleasant View Home
out of bed first.’ They are not being bossy. The entire team is working together to try to continue
to teach and offer support. A sense of collaboration and teamwork grows from the start. The
new team member is learning by example that we are all here for the same thing.

“Never interrupt orientation by putting the new candidate on a full assignment because you are
short staffed. During the orientation process or within the first couple of weeks after, meet with
the new staff member. They almost always need reassurance and/or re-direction and input
regarding areas to work on. Emphasize that your expectation is growth and improvement, not
that a person is instantly flawless. Reinforce that they can depend on the team to answer
questions and be helpful. We routinely see this turn into a kind of pay-it-forward type of
reaction. When this new CNA is now on the other side and working with an orientee they also
become a mentor. And the team grows.

“Lastly, when you have developed a strong team they will keep the manager informed when
they are unable to teach with positive results or are getting a lot of resistance. Addressing these
cconcerns reinforces accountability. In most all cases growth is seen and the CNA is successful
and stays with us. Always encourage education and continued growth. Become their
cheerleader for success. Always keep the lines of communication open. Involve the CNAs in
finding resolutions if they bring you problems, reinforcing that we are a team.”

Related evidence supporting the importance of nourishing teamwork and communication in
creating high performing long term care organizations includes Baker, Day and Salas,
“Teamwork as an essential component of high-reliability organizations” [Health Services
resource management and patient care quality in nursing homes” [International Journal of
Human Resource Management 3(June 11, 2000): 591-616]; and Temkin-Greener et al, “Nursing
home work environment and the risk of pressure ulcers and incontinence” [Health Services
Research 2012 June; (3Pt1), 1179-1200].

For specific action items related to this strategy, please refer to the Change Package (Appendix K).

**Strategy 5: Be a continuous learning organization.**

A learning organization is built on a foundation of exceptional executive leadership; a strong
mission and values that drive decisions and actions; a culture of nurturing professional growth
and innovation; a focus on systems for change; and a fair and open culture.

Site visit teams observed that the participating nursing homes were continuous learning
organizations: they know where they stand and when and how to change; they use data to drive
performance; and they have a clear understanding of their organization as an interdependent
system. An interdependent system is described as the combination of the people, structures,
supplies, and resources that come together within an organization to make it function.
Change concepts identified for this strategy are:

- Make systems thinking the norm.
- Track your progress.
- Test, test, test!

Following is a narrative description of what the site visit teams observed with respect to this strategy in the ten nursing homes that were part of this study, including specific examples of the strategy in action.

At these facilities, staff, residents, and families were encouraged to identify areas for improvement in care processes. Senior leaders discussed processes and systems to identify areas for improvement – in meetings as well as during everyday interactions. They talked about how different processes and activities are inter-related and parts of systems, and identified implications and potential consequences of changes to show inter-connectedness and relationships.

The administrator of NHC HealthCare, Anderson, said their focus is to achieve quality in all that they do. They are an achievement based company with benchmarks set by the corporation. The company established a “five star quality rating program” several years before the formal CMS Five Star Quality Rating System was publicly reported. The company identifies priority measures and tracks those closely. Measures include clinical outcomes, state survey results, patient/resident satisfaction, financial indicators, and a set of items intended to capture the consumer view, which corporate and regional staff use to rate the facility when they visit. This list includes 40-50 items such as building and grounds attractiveness and cleanliness, responsiveness to call lights, and receptionist greeting. The center displays its corporate five star ratings where they are visible to all staff. If benchmarks are met, the center benefits from financial rewards.

The center has an interdisciplinary weekly Five Star focus meeting where they review a number of priority measures and any concerns. Any problems that have occurred such as falls, pressure ulcers, or weight loss are discussed and ideas for how to address and prevent issues in the future are explored. The center uses a rapid cycle quality improvement approach, including all staff involved with the issue in exploring and resolving the problem and determining measures to prevent reoccurrence. If an issue requires a team response, the issue is discussed at this weekly meeting until resolution is reached. The administrator and other department leaders are in attendance and facilitate sharing of information, data and resources to support staff as they implement and test changes intended to fix problems and prevent reoccurrence.

The homes tracked their progress by measuring indicators that are relevant and meaningful to their residents, for example, resident satisfaction, pressure ulcer rates, falls, infections, emergency department visits, and hospital admissions/readmissions. They set goals, choosing
benchmarks they wanted to exceed. They were transparent about sharing performance data with staff, board members, residents, and families. They identified and prioritized opportunities for improvement. They implemented performance improvement projects and utilized change agents to keep momentum going. They used quality improvement tools and methods, for example, flow-charting and root cause analysis. They used a multi and interdisciplinary approach to improvement.

They created daily opportunities for learning, for example, rounds with physicians or nurses, and short vignettes to encourage discussion and active learning.

These homes make use of prompts and reminders to reduce the possibility of human error. They build systems to account for the fact that staff are humans that can potentially make errors, rather than creating an environment where staff are punished or fired for mistakes.

Westview Care Center establishes organizational goals, identifies changes to meet the goals, and tracks their progress closely. For example, about eight years ago the organization decided to move towards care that is more person directed, to better anticipate and meet resident needs and to do things as closely as possible to how residents would do them at home. The organization set out to meet 100 benchmarks of person directed care, and has involved all staff in making systematic changes to meet the benchmarks. Action plans are developed to plan and implement changes. Leadership notes that if a system isn’t working, we always go back to the team to learn how we can change it so it works better, and we pilot changes before making large scale changes. One staff member noted, “I feel like I have a lot of input on what changes are made – just today I tested an inquiry tracking form and provided suggestions.” Examples of goals the organization has worked on include implementation of consistent assignment for all staff, decreasing noise, eliminating restraints and alarms, and continuing to have no in-house developed pressure ulcers.

Westview Care Center also has numerous checks built into their system to prevent errors and lapses. For example, they use huddles, meetings, checklists, logs, communication sheets, flow-charts, and software flags on a daily or even per-shift basis. These checks and balances are used to ensure that basic QA items are met and to ensure follow-up on any changes of condition, provider notifications or orders, resident requests, tests and consultations, medication and treatment administration records, care plans, and other documentation updates and needs. Shift-to-shift reports include nursing assistants doing rounds together. The nursing assistant from the previous shift and the oncoming shift go room to room, review changes, check on the residents, and make sure residents’ rooms are clean.

QA meeting schedules are posted in advance so that staff members and family members that want to participate may do so. Team members welcome staff and family that attend, including them in the conversation and providing opportunities for involvement.

The administrator at Landis Homes shared that their team’s approach to improvement changed dramatically about fifteen years ago when a new leader joined the team and brought a focus on
systems. Rather than doing quick fixes with inconsistent follow-up to assess if the changes were effective, they began to look at the system to see where gaps and breakdowns occurred, and they used data and tracked changes. This approach got traction when they created tools that were made visible and available for all staff. For example, they used tracking tools that explained what was being tracked and why. They included a standard that the organization compared itself against, sometimes referred to as a benchmark. They developed tools for teams to draft action plans that assigned a time frame and responsible party - that indicated who was going to do what, when, and track if it occurred. They provided education on change, on root cause analysis, on the cause and effect (fishbone) diagram, and the five why’s exercise. Leaders used the tools with staff as the need for them arose. “Staff saw the new leader looking at systems, saw her support to improve the systems, and knew that they could be honest with her.”


For specific action items related to this strategy, please refer to the Change Package (Appendix K).

**Strategy 6: Provide exceptional compassionate clinical care that treats the whole person.**

Clinicians have come to recognize that in order for health care to be effective, it must acknowledge that mind, body and spirit are interwoven to create a whole person. Site visit teams noted that the participating nursing homes observe this important principle. The homes recognize that a focus on the whole person requires staff that know the residents well and can anticipate their needs. It also requires an engaged and competent medical and care team that effectively manages residents’ changing health conditions and avoids healthcare acquired conditions (HACs).

Change concepts identified for this strategy are:

- Carefully build care teams and keep them together.
- Choose medical leadership wisely.
- Transition with care (between shifts, departments, and all care settings).
- Strive to prevent problems and treat when necessary.

Following is a narrative description of what the site visit teams observed with respect to this strategy in the ten nursing homes that were part of this study, including specific examples of the strategy in action.

The nursing homes used consistent or permanent assignment of staff, that is, they had the same staff members providing care to the same resident consistently. This applied to nursing assistants, nurses, and other disciplines.
They include the medical director as part of the leadership team, and as part of the team that establishes and updates clinical care guidelines as well as forms and tools to use in medical records and for communication.

They choose their medical leadership wisely, clearly articulating their expectations of medical leadership, including active involvement in the organization. They expect that the medical director and other providers will listen to nurses, nursing assistants, and other staff by actively seeking their suggestions, assessments and recommendations.

These homes ensure adequate specialties are available to address the complex needs of residents and to bring services to the nursing home to minimize the need for residents to leave the facility for care.

They focus on providing quality care during transitions between shifts, across departments and between care settings. They set times for the medical director and primary physicians to be available for consultations on non-urgent issues. They train all staff to look for changes in resident conditions, and provide evidence-based or expert-endorsed tools and resources to assist in managing resident conditions, for example, congestive heart failure, pneumonia, aspirations, and urinary tract infections. The homes have systems in place for staff to contact physicians about urgent issues. They create structures and processes to ensure key information is consistently transferred among staff and to and from other provider settings. For example, they use transfer forms and checklists when transferring to other care settings. They strive to prevent problems and treat when necessary.

Bethany Health Care Center has a philosophy to “treat in place,” which has been adopted by Bethany residents, families, and staff. When a resident moves in, staff talk with the resident and their family about what can be done and treated in the nursing home. Treatment plans concentrate on the resident’s quality of life, looking at the circumstance of illness and the presentation and preferences of the resident. Providers and staff are well educated and trained on early identification and treatment of symptoms. They have excellent communication systems set up to discuss and manage concerns in a timely manner, and they have access to diagnostic and treatment resources that might otherwise only be available at the hospital. Residents go to the hospital for surgery or blood transfusions, but other medical needs are met on-site by the interdisciplinary staff. Bethany staff begin each day with a morning meeting which gives administration, nursing leadership, and social services an opportunity to discuss high-risk concerns and issues. Following is an interdisciplinary group meeting with representation from each department, where issues such as changes in resident health and conditions and activities planned for the day are reviewed. Bethany’s “treat in place” model reduces numbers of hospitalizations, decreases residents’ hospital days, reduces numbers of infections, allows timely intervention and diagnosis, and contributes to lower staff turnover.
The staff of Pleasant View Home work hard to help residents keep their skin healthy and free of pressure ulcers or skin tears. Staff education about pressure ulcer prevention is routinely provided. Pleasant View staff assess residents’ risk of developing skin breakdown and implement interventions to prevent problems, including pressure reducing support surfaces on beds and wheelchairs and helping residents to keep pressure off bony prominences such as heels. Consistent with evidence-based guidelines, they encourage nutrition and hydration to promote skin, muscle, and connective tissue health and healing. They offer fluids regularly, provide a general diet for most residents, and monitor how residents are eating. They help residents to be as mobile as possible, assessing and addressing pain that might be affecting mobility, and implement individualized turning and repositioning schedules. They involve a wound nurse from a local community hospital in the care of any resident with a pressure ulcer to ensure they are using up-to-date evidence-based care.

The nursing assistants are diligent about helping the residents keep their skin clean and dry, using appropriate incontinence care and products when needed, and inspecting residents’ skin on a weekly and even daily basis. Because they know their residents so well, they can readily identify any changes. Pleasant View staff use a communication book as part of their staff communication system. Skin issues are entered in this book, which the director of nursing reviews daily.

Franciscan Convalescent Hospital has an employee, the nurse liaison, who is based at the local hospital. When a hospital patient is to be transferred to Franciscan, the nurse liaison first completes a physical exam and evaluation and necessary paperwork. Taking care of all of this prior to discharge helps the transition to the nursing home go more smoothly for the resident and their family.
The staff at Bethany Health Care Center avoid using feeding tubes as they are not shown to prolong life or prevent aspirations. Rather, residents are fed. Bethany has only one resident with a Foley catheter; it has been in place for ten years with no infections. They have very little Clostridium difficile (C. diff) or Methicillin-resistant Staphylococcus aureus (MRSA). They use antibiotics very carefully, avoid broad spectrum unless absolutely necessary, follow guidelines about when to do a urinalysis and urine culture, and when and how to treat urinary tract infections (UTIs). When a resident has been on an antibiotic, staff follows up with a home-made yogurt for ten days. They have special levels of care for people living with dementia, including a Namaste program. They use antipsychotics very sparingly. They focus on identifying what the resident’s need is and trying to meet that, making sure nursing assistants and all staff caring for the resident are knowledgeable about the resident and about dementia care, and that all are aware they have access to tools other than medications. The home’s overall number of medicines given to residents is low; they look carefully at what people are taking when they come and re-evaluate what medications are needed.

**On consistent assignment:**

“We assign nursing assistants, nurses, and other disciplines as well to consistently care for the same residents. This enables the residents to be more comfortable, to not be afraid, and to develop relationships with their caregivers. Staff can find any potential problems much earlier and prevent them from getting any worse when they are consistently assigned to the same residents.” Westview Care Center

“You can tell when something is wrong when you work with a resident on a daily basis. When you work with someone for a long time you can tell by the way they look at you that something is wrong. I look for it in their eyes or their skin and I let the nurse know so she can follow up.” CNA, Mercy Care Center

**On effective medical direction:**

“As the medical director, I keep a running list of opportunities for improvement, and I bring these to my regular meetings with the administrator and Director of Nursing or to the quality meetings. They welcome and ask for my input.” Landis Homes

“As the medical director and primary physician for our residents, I work closely with the NPs and our covering docs. I want everyone updated on our residents and on the same page with the plan of care. We focus on being able to treat in place and not have residents going in and out of the hospital. It starts with getting everyone (meaning staff, providers, residents, and family) on the same page with regard to the care plan, and then being able to recognize early changes in condition and provide any care needed in the nursing home. We work hard to establish and promote good relationships and communication between providers and staff, and residents and families.” Bethany Health Care Center
“As a provider, I make myself available 24/7 to nursing home staff. I give them my cell phone number. It is much easier for me to help resolve issues quickly because I know the residents so well. I really don’t get that many calls so it is manageable. I also do it out of respect for my colleagues – I know what it is like to get a cold call and not know the resident at all and sometimes you feel the only option is to send the resident to the ER.” Westview Care Center

“We are eliminating medical care by fax. I ask the staff to call me directly with needs; I want to be able to have conversations to ensure we are making the best decision for the residents. I am available at set times each day, and I am also available by cell phone for issues that cannot wait.” Landis Homes

“This facility’s commitment to quality attracts physicians who have that same concept. Each of our units has a designated medical director. We provide excellent medical care and have a team concept; for example, we have specialists to support the patients/residents in internal medicine, critical care, geriatrics, pulmonology, and orthopedics. Our excellent nursing staff enhances our ability to do what we need to do. We have a utilization review committee that meets monthly; focus topics include transitions of care and antipsychotic medication use. We utilize evidence-based CHF guidelines to assess for and treat any signs of heart failure early as appropriate for each patient. We work with partner hospitals to prevent avoidable readmissions.” Medical Director, NHC HealthCare, Anderson

Mercy Care Center uses the power of music as an intervention to reduce pain and anxiety, and to enhance the quality of life of all residents, especially those with dementia. Music therapy has helped a number of individual residents. One resident was constantly agitated and trying to get up and go somewhere but did not know where she was going. She also had a history of falls, and was considered a high fall risk. The certified music therapist suggested a musical intervention. When engaged in singing, the resident relaxed and hummed along to the music and loved to sing songs. Mercy also purchased several iPods to experiment with using music with residents. One resident’s favorite music was loaded onto an iPod and as she listened, she would have reduced anxiety, settle down in the activity room and sit comfortably on the couch, listening to her music and humming along. The iPod intervention reduced the need for staff concern for the resident’s fall risk while engaging her in something she enjoyed. Music therapy has been effective in shifting mood, managing stress-induced agitation, and supporting cognitive function.


For specific action items related to this strategy, please refer to the Change Package (Appendix K).
Strategy 7: Construct solid business practices that support your purpose.

A well-run nursing home excels as a business yet feels like home. It seeks ways to effectively manage the bottom line with integrity and with the resident as the focus. It runs efficient operations; invests in equipment and supplies to provide the highest quality care; and ensures that its physical and outdoor environments are comfortable and inviting. Site visit teams observed that the facilities in this study paid close attention to these foundational practices.

Change concepts identified for this strategy are:

- Seek strategic and creative approaches to expand your resource base to meet your mission and serve your residents.
- Maximize your efficiency.
- Ensure you are making the most of your physical assets.

Following is a narrative description of what the site visit teams observed with respect to this strategy, including specific examples of the strategy in action.

To expand resource bases, staff members at the homes were encouraged and empowered to help identify opportunities for additional revenue, consistent with their organizations’ values and mission. Staff regularly reviewed the needs of the resident community to determine whether opportunities to address potential service gaps exist.

Grants and research opportunities were explored, fundraising was conducted and partnerships were developed to assist with fundraising, for example with community members and family members. Communicating specific needs that fundraising could support and making events fun are helpful ways, commonly used by these homes, to make the case and generate enthusiasm and support from staff and potential donors.

Referral programs, involving staff, community members and various provider settings (including hospitals, hospice agencies, assisted living communities and home health agencies) were used to attract residents. The nursing homes routinely used resident satisfaction surveys and resident community meetings to hear directly from residents about what they liked and didn’t like. Leaders consistently followed up on issues and concerns, and as a result would have helpful data to share with prospective residents and the community.

To maximize efficiency, the nursing homes made investments in items and services to reduce costs over time, for example more efficient heating/cooling, lighting, solar panels, water-saving plumbing fixtures and equipment, recycling, and medical waste disposal. They had audits done by utility providers to look for cost savings and rebate opportunities. They closely monitored scheduling and hours worked to avoid overtime and use of agency staff. Prior to implementing any cost saving ideas, they assessed how the change would affect staff and residents; they thought about unintended consequences. They negotiated prices for products and services, buying in bulk as appropriate or taking advantage of group consortia volume discounts. They focused on accurate and ethical financial management and accounting practices by analyzing receivables balances and ensuring accurate billing and documentation.
These homes made the most of their physical assets; they created meaningful spaces, such as gardens and kitchens, which residents and families actually use in their daily lives. They critically analyzed noise and lighting to promote resident comfort and safety. They sought feedback from residents, families, and staff on the physical environment and explored opportunities for improvement. They invested in building upgrades to keep the physical plant modern and efficient. They had processes and audits in place to ensure the buildings were clean and well maintained, expecting all staff to report any maintenance issues immediately. Scheduled rounding occurred to check that all areas were clean and to assess whether needed equipment was available, current, and in good working order. They did not skimp on supplies, wanting to ensure that staff and residents had supplies available when and where they were needed.

Change concepts and action items associated with this strategy assume a creative, entrepreneurial orientation in successful leaders, a set of personal characteristics these leaders bring to the job. In addition, it is clear that other actors – especially the board of directors and the larger system or corporation of which the home is a part – play an important role in creating a culture that supports leaders in their entrepreneurial pursuits. For example, at Mercy Care Center, the board actively encourages innovation. When someone brings a new idea to the board, they discuss it and then, if it appears to have potential, create a team (of staff or staff plus board members) to go out and explore it, even if that means taking the team on the road. This process has led to Mercy Care’s adoption of culture change, consistent assignment, and an electronic health record system.

At Jewish HealthCare Center, the board expects the staff to be on the cutting edge with respect to technology and actively supports innovation. Their support is evident in the way technology is incorporated into the life of the community.

Several years ago, Foulkeways at Gwynedd was in the process of shaping their vision for what kind of community they wanted to be and what they wanted the care they offer to look like. The board and staff worked together to hold focus groups within the community, and traveled nationally to inform their learning.

When a cell phone company wishing to expand its service area approached Mercy Care Center, the senior leadership team explored the opportunity and took action, allowing the company to lease their building’s roof to install a new cell tower. This alternative revenue stream seemed unconventional, but it was an opportunity to give back to the local community and this is consistent with the facility’s values and mission, so the team decided to move ahead.

When Franciscan Convalescent Hospital identified that their residents were frequently being hospitalized for respiratory issues, they decided to make respiratory therapy services available on-site. While there are costs associated with having the specialized respiratory care staff, equipment and procedures available in the facility, those costs have been offset by revenues the facility receives for days that patients and residents spend at Franciscan rather than in the hospital. The financial impact of adding respiratory care services has been positive, but the real benefit has been to the patients in post-acute care and the residents in long term care that have
avoided a potentially stressful hospital readmission because they could receive needed care at Franciscan instead of having to be transferred to the hospital.

Franciscan’s focus on efficiency is also evident in their Minimum Data Set (MDS) processes. “We consistently do double checks on our MDS assessments, charting, and care planning, looking for consistency, accuracy, and completeness. We review any discrepancies and follow through on updates. This is to ensure that all resident needs are identified and addressed. All disciplines review the documentation. Every department is involved and is in close communication with the MDS coordinator.” MDS Case Manager, Franciscan

Foulkeways at Gwynedd pays great attention to its physical assets. They have a long history of involving residents and families in building and grounds design and renovation, gathering information on their needs and expectations and focusing on creating a resident centered environment. They create comfortable, inviting, and accessible spaces for individuals, and for gathering small and large groups together across the different settings in the CCRC. They invest in their buildings, keeping them modern and efficient. They understand the value of green space and create gardens and landscapes for residents and staff to enjoy. All resident rooms have a window that is low to the floor with a large windowsill so that even when a resident is in a chair they can see the outdoors. They have a number of committees for residents to participate in, including a gardening committee and an art committee.

Foulkeways also ensures that staff and residents have adequate supplies that are conveniently located, including supplies and chemicals for standard infection control processes. For example, the organization has a supply of "red buckets" that any staff member can easily find and use to clean up spills. The bucket contains all the supplies and chemicals needed to safely and thoroughly clean blood, for example, but staff are not limited to using these just for blood spills. Foulkeways has decentralized a number of services, including housekeeping, to provide for supplies and decision making where the work is actually occurring.

Bethany Health Care Center has worked to implement various “green” initiatives to save water, gas, and waste costs. The organization carefully weighs the costs and benefits of each potential green initiative. They've tackled and seen a quick return on investment on numerous projects, such as energy-efficient light bulbs and electrical ballasts, rain sensors on outdoor sprinkler systems, HVAC, and faucet aerators. In 2009, Bethany installed a cogeneration system which enables the capture of heat produced by the generator, which can then be used to heat water for use throughout the buildings. The system paid for itself in two years, with subsequent significant annual savings in energy expenses. The cogeneration system produces 60 percent of Bethany’s electricity, heats the buildings during winter and keeps hot water flowing in the summer.

Related evidence supporting the importance of constructing solid business practices that support your purpose includes Weech-Maldonado, Neff and Mor, “The relationship between quality of care and financial performance in nursing homes” [Journal of Health Care Finance, 2003 Spring, 29(3), 48-60].

For specific action items related to this strategy, please refer to the Change Package (Appendix K).
Implications, Summary, and Conclusions

Cross-Cutting Themes

Cutting across the seven strategies identified in this study and across the nursing homes was a strong focus on relationships, leadership, communication, creativity, flexibility, teamwork, mentorship, training, and working across disciplines – skills and attributes that can be difficult to quantify or measure and are sometimes called interpersonal or soft skills. This is not to say that these homes did not place importance on the more technical and measurable elements involved in operating a nursing home; none of them would have been identified as high performing and therefore candidates for this evaluation if they didn’t work hard on their performance in those areas. Rather, these homes seem to see regulatory compliance and solid business and financial practices as a starting point. They put in place the procedures, practices and processes that will ensure they are high performers in those areas, using that competence as a springboard to go above and beyond. And they are intentional about what that means. They have processes in place for identifying what they want to achieve and plans for how to get there, and they consistently follow through.

In addition, these nursing homes encourage and emphasize the importance of working across disciplines, defining the term “interdisciplinary team” quite broadly. Traditionally, nursing homes have most often thought of an interdisciplinary team as one made up of different types of clinical staff. These homes, however, go well beyond that definition. Their interdisciplinary teams include not only clinical staff, but also, for example, housekeeping, dietary, activities, and maintenance staff, as all of these disciplines have contact with the resident. Leaders of these homes make a point of asking staff what they observe among the residents, and empowering them to take action to address resident needs when it makes sense for them to do so (for example, getting a resident a pillow). In some of the homes, staff in different roles – most often housekeeping and dietary – are cross-trained to be CNAs to facilitate this kind of interaction.

Maintenance staff, in particular, seem to play a unique role in supporting residents and helping them feel like they’re part of the community. By hanging pictures and doing other tasks for residents as they move in, they get to know the residents early on. At more than one of these homes, the maintenance staff builds this in as part of their job routine. When new residents move in, maintenance staff are prepared to spend a lot of time with them; the residents are often lonely and appreciate the human contact. Because it is clear at these homes that residents are the priority for everyone working there, maintenance staff expect calls from residents and take as much time with the residents as the residents need.

Implications

Several of the strategies that surfaced in this study have unique implications or considerations that are important to highlight. Those are discussed in this section.
**Implications Specific to Staff Recruitment and Retention**

While issues related to labor supply and compensation are not addressed extensively in this report, it is important to note that the change package section related to Strategy 2: Recruit and Retain Quality Staff is built on an assumption that homes have access to an adequate supply of skilled workers and can therefore be selective in hiring. However, it is also true that the ten homes involved in this study have built reputations not only for providing quality care, but also for being excellent employers. As a result, available workers compete to work for these homes. Because their hiring practices emphasize interpersonal or soft skills in addition to technical skills, they tend to attract well-rounded workers who in turn stay longer because of the positive culture and working environment at the homes.

These homes make it a priority to treat the resident as a whole person, but they also make it a priority to treat the employee as a whole person — someone who is not defined only by the job they do at the home but is a complex individual with a unique set of interests, skills, and needs. The leaders of these homes understand that if they make the investment in supporting their employees as whole people, supporting their development and their dreams and helping to meet their needs, they are more likely to be better at their jobs and more satisfied with their work, which in turn will mean the residents will receive better care and feel more like they are part of a community.

Finally, it is important to note that not all of these homes offer pay or benefits above the industry standard. It is clear that staff at the homes see monetary compensation as only part of the package of what makes it attractive to work for these homes.

**Implications Specific to Treating the Resident as a Whole Person**

Strategies 3 and 6 (Connect with Residents in a Celebration of Life, and Provide Exceptional Compassionate Clinical Care) are both about treating the resident as a whole person. It is useful to consider what it takes to create a culture that supports this, and what causes staff and medical directors to want to behave in the ways described in the change package.

The site visit teams’ observations point to the importance of beginning with an explicit definition of “whole person,” a definition that includes the person’s clinical needs and goes beyond them to also include their psychosocial, spiritual and physical needs, as well as their personal goals and preferences. From a clinical perspective, the homes understand how harmful it can be to a resident to have to move frequently between different care settings, and they make a point to develop practices and systems to minimize that. At the same time, staff feel it is critical to understand what makes residents “tick” and how they define meaning in life. Traditionally, it has been common for nursing homes to focus primarily on meeting the resident’s clinical needs. Homes in this study were observed to go to the next level by expanding services and support to also meet residents’ psychosocial and spiritual needs.

**Implementation Considerations**

Nursing homes seeking to implement some or all of the strategies outlined above will need to consider several aspects of their facility and its employees.
First, several of the strategies discuss the culture of the facility and its staff. As with any organization, making changes to the culture of a nursing home—no matter how slight—requires full buy-in from the staff. Some may resist change unless they can see and understand the benefit it will bring to their daily routine and the quality of life for the residents for whom they care. Clearly communicating the purpose behind any changes can help smooth the transition and allow staff to take ownership of those changes. Also, using a methodology like PDSA (Plan, Do, Study, Act) to test and implement small, incremental adjustments is a more effective way to bring about lasting change than attempting to shift the whole organization at once.

Many of the strategies require little to no financial investment. They represent changes to daily routines, attitudes, and overall culture. For this reason, finances should not present a significant barrier to nursing homes hoping to incorporate the majority of the strategies.

Additionally, while some strategies may require a small time-investment up front, many should actually begin saving the staff time almost immediately. It may require some staff to “work differently” than they do currently, but none of the strategies should add strain to the staff’s already busy schedule. The strategies would not have taken hold in the high performing nursing homes if they had required a significant time investment. Therefore, time constraints should not hinder the implementation of these strategies.

As so many of the strategies and change concepts identified in this study are grounded in the actions, attitudes and skills of people—as individuals and in groups—it is critical that nursing homes look closely at their recruitment, hiring, orientation and human resources systems and processes and make adjustments as needed. Nursing homes should take care to employ people, in all types of positions including maintenance and housekeeping, with strong interpersonal skills and the character traits that will allow them to be comfortable in a setting that places a premium on teamwork and flexibility. Nursing homes should also take care to communicate clearly and openly, early and often, with job candidates about the range of skills and competencies that are expected of all workers, placing special emphasis on interpersonal skills.

As nursing homes make changes in response to this study and the resulting change package, the value of building relationships and collaborations and learning from peers cannot be overstated. It will be critical to their success.

**Policy and Regulatory Considerations**

The primary focus of this study was to examine the systems and practices that high performing nursing homes have in place that allow them to achieve extraordinary results, and then to facilitate widespread sharing of those strategies and encourage their adoption and adaptation by other nursing homes across the country. Regarding the policy and regulatory environment within which nursing homes operate, what became evident through this study is that the nursing homes that perform at the highest level are those whose leaders are proactive in using that environment as a helpful tool rather than as an obstacle. These leaders tend to see policy and regulatory changes as learning opportunities. And importantly, they see regulatory standards
not as a set of goals to reach for, but rather as a floor. They set their expectations far above that floor.

Building on work by Michael Porter, Thomas Lee, and Edward Wagner, Stratis Health has developed a model called “Health Reform: Actions to Build Capacity for the Triple Aim and Succeed in Multiple Payment Models. As its name implies, this model is intended to inform and clarify actions that will help providers, payers, policy makers, and society as a whole move forward in a productive way in the new health care environment created by the Affordable Care Act and other recent reforms, illustrated in Figure 3.

**Figure 3:** Health Reform: Actions to Build Capacity for the Triple Aim and Succeed in Multiple Payment Models

The systems and practices that the high performing nursing homes involved in this study have in place reflect a deep understanding of the actions that are necessary to achieve the three outcomes described in the model – improving care and improving the health of residents, while reducing costs. In many ways, these homes already behave consistently with the model. At the foundational level, the homes provide visionary leadership, promote a learning culture, embed strong organizational change skills, use evidence-based or best practices when available and, in most cases, have implemented or plan to implement electronic health records. They also engage residents and families, use robust data and measurement systems, reach into the community to better coordinate care, develop and nurture meaningful partnerships, and focus on the health and well-being of their residents. It is evident that these leaders, as individuals
and as groups, have a deep-seated understanding of what it takes to lead effectively in the current health care environment. Policy makers would be well served to use them as resources in the ongoing process of reforming and improving our health care system and ultimately, the health of our population.

**Summary**

In this qualitative study of high performing nursing homes, much of the nursing home success can be attributed to the learning culture within the facility, the commitment and passion of leadership and direct care staff, the focus on relationships at all levels, and the recognition that every person, whether resident, family, or staff, brings unique gifts that contribute to the community. This culture is reflected in each of the seven strategies discussed in this report, each of which in turn appeared in some form in every high performing facility included in this evaluation.

The first two strategies are focused on those who lead, manage and run the facility, as well as those who care for the residents; and it is clear that quality care starts with quality staff. The first strategy reflects the importance of management within the facility, and how quality care starts with those at the top. In almost all of the facilities, staff talked about the leadership of their facility with respect and appreciation for how they conduct themselves and foster a positive environment for staff and residents. The board of directors or members of the corporate entity at these facilities take an active interest in more than just the business side of the facility; many engage staff and residents personally and frequently, extending the scope of open communication to all levels. Staff members are provided with the tools necessary, and are often given additional training and support for their own education. In addition to good leaders, recruiting and retaining quality staff at all levels adds to the feeling of community and an attitude of success and high expectations. At each facility, staff members held themselves to high standards, and expected the same from their peers. At each location, data were used to measure progress and drive quality improvement. Decisions about the facility, the staff and the residents were rooted in a clear mission that had been communicated to everyone involved. In every case, this mission reflected a commitment to providing the best possible care and service to the residents.

The next several strategies highlight the importance of good relationships, whether that means staff-to-staff or staff-to-resident. Connecting with residents and celebrating their life puts the focus on the needs of the resident in such a way that provides a continuous reminder of the true purpose of the facility: to create a place where the residents feel at home and cared for. Quality of life is a primary focus at these facilities, and life is celebrated through daily activities. Residents and staff feel a sense of community and family at their facility, and many staff members feel that their work is more than just a job. Members of residents’ families as well as the surrounding community are frequently involved in many aspects of care. Teamwork and communication between staff strengthen the sense of community within the facility. Open communication at all levels allows opportunities and problems to be addressed in a timely manner. Continuous learning keeps things fresh, reduces mistakes, and provides staff with a sense of self-improvement and betterment. Providing compassionate clinical care that treats
the whole person is again in line with the sense of family and community that many of these strategies attempt to foster.

The final strategy involving solid business practices represents the support and foundation for all of the other strategies. Having the resources to be able to recruit and retain staff, provide staff with the tools they need to provide high quality care, and being able to meet resident needs for the physical environment combine to allow the staff to focus on their relationships with the residents and with each other.

In summary, teamwork, communication, and a high commitment to quality contribute to a culture of family and community, which in turn fosters deep relationships and high quality, resident-centered care.

Conclusions

Site visits to ten nursing homes in five different states revealed seven strategies associated with high performing nursing homes. These strategies allow these nursing homes to experience a high level of resident and staff satisfaction, a high level of resident quality of life, and high quality care delivered in a timely manner.

At these facilities, performance is closely linked to the culture within the facility. While different in structure, they all produce a sense of family and community among staff and residents alike. A strong mission of resident-centered care encourages staff to get to know each resident as a person and to make the facility feel like their home. Respect for each other and for the residents, along with good communication and high expectations induce staff to help each other in all facets of resident care. The governing body takes an active interest in the day-to-day operations of the facilities and the residents who live there. Resources are provided that allow the staff to do what they need, and staff are recognized for quality work and performance.

It is clear that while each of the strategies impacts the performance of the facility, it is the combination of all of the strategies together which appears to propel facilities to the top of the list of nursing home quality. When implemented thoughtfully and with integrity, the individual strategies mesh together to create an overall culture and attitude whose main purpose is to provide excellent care and improve the quality of life for the residents as well as the staff. The result is a place where staff love to come to work to see and interact with fellow staff and the residents; and a place where residents are respected, have autonomy and choice, and receive excellent care.
# Appendices and Supporting Information

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>National Nursing Home Quality Care Collaborative (The Collaborative) and Quality Composite Measure Score</td>
<td>67</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Best Practices Evaluation On-Site Visit Team Members</td>
<td>70</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Articles Reviewed to Assist in Defining Nursing Home Quality</td>
<td>73</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Site Selection</td>
<td>78</td>
</tr>
<tr>
<td>Appendix E</td>
<td>Materials Provided to Participating Nursing Homes</td>
<td>82</td>
</tr>
<tr>
<td>Appendix F</td>
<td>Site Visit Conversation Opening Talking Points</td>
<td>87</td>
</tr>
<tr>
<td>Appendix G</td>
<td>People Interviewed at Nursing Homes Visited</td>
<td>89</td>
</tr>
<tr>
<td>Appendix H</td>
<td>Discussion Guide Prompt</td>
<td>96</td>
</tr>
<tr>
<td>Appendix I</td>
<td>Documents Shared During Site Visits</td>
<td>99</td>
</tr>
<tr>
<td>Appendix J</td>
<td>List of Expert Panelists</td>
<td>177</td>
</tr>
<tr>
<td>Appendix K</td>
<td>Change Package</td>
<td>178</td>
</tr>
<tr>
<td>Back Cover</td>
<td></td>
<td>219</td>
</tr>
</tbody>
</table>
Appendix A: National Nursing Home Quality Care Collaborative (The Collaborative) and Quality Composite Measure Score

National Nursing Home Quality Care Collaborative (the Collaborative)

The Collaborative is a fast paced, all teach all learn initiative, modeled after the Institute for Healthcare Improvement breakthrough collaborative model, and is being led by the Centers for Medicare & Medicaid Services (CMS) and Quality Improvement Organizations (QIOs). The Collaborative runs from February 2013 through July 2014, and has approximately 5,000 nursing homes participating across the country. The Collaborative seeks to rapidly spread the practices of high performing nursing homes with the aim of ensuring that every nursing home resident receives the highest quality of care. Specifically, the Collaborative will strive to instill quality and performance improvement practices, eliminate healthcare acquired conditions, and dramatically improve resident satisfaction through the achievement of a rate of 6 or better using the Collaborative quality composite measure by July 31, 2014. Prior to the launch, nearly 10% of the nation’s nursing homes had achieved a composite score of 6 or better.

Collaborative Model

The collaborative is adapted from the Institute for Healthcare Improvement (IHI) Breakthrough Series Collaborative Model. The IHI Breakthrough Series is designed to create a structure in which interested organizations can easily learn from each other and from recognized experts in topic areas where they want to make improvements. A Breakthrough Series Collaborative is a short-term (for example, 6- to 15-month) learning system that brings together a large number of teams from participating provider organizations to seek improvement in a focused topic area. Each team typically sends three of its members to attend Learning Sessions over the course of the Collaborative, to learn from colleagues and other experts about the chosen topic and to plan changes), with additional members working on testing changes in the local organization during the action periods in between the learning sessions.

Prior to enrolling participants and conducting learning sessions and action periods, the Collaborative leaders and faculty create the specific content for the Collaborative, including appropriate aims, measurement strategies, and a list of evidence based changes or best practices.

The following image is a diagram of the Collaborative. The efforts depicted on the left side of the diagram, including the study of high performers and development of the framework and changes for the Collaborative are the focus of this report.
The Breakthrough Collaborative: Structured Application of Will, Ideas and Execution

The Collaborative has both a national and local presence. All participants come together for virtual national learning sessions (LS1-6 on the diagram above), and QIOs in each state work with nursing home staff on quality improvement methodology and implementation of tests of change (e.g., plan-do-study-act or PDSA cycles) during the action periods that occur in between the national learning sessions.

Measuring Collaborative Success

Participating nursing homes, focusing on processes that improve their system, measure on individual tests of change. They will look at their Plan-Do-Study-Act (PDSA) improvement cycle results, their clinical outcome measures, and their composite score.

Calculating the NNHQCC Quality Composite Measure Score

The composite is comprised of thirteen NQF-endorsed, long-stay quality measures that represent larger systems within the long term care setting:

1. Percent of residents with one or more falls with major injury
2. Percent of residents with a UTI
3. Percent of residents who self-report moderate to severe pain
4. Percent of high-risk residents with pressure ulcer
5. Percent of low-risk residents with loss of bowels or bladder
6. Percent of residents with catheter inserted or left in bladder
7. Percent of residents physically restrained
8. Percent of residents whose need for help with ADL has increased

9. Percent of residents who lose too much weight

10. Percent of residents who have depressive symptoms

11. Percent of residents who received antipsychotic medications

12. Percent of residents assessed and appropriately given flu vaccine*

13. Percent of residents assessed and appropriately given Pneumococcal vaccine*

*The direction of the two vaccination measures should be reversed because they are directionally opposite of the other measures. This is done by subtracting the numerator from the denominator to obtain a “new” numerator. By keeping all measure directions consistent, the composite score can be interpreted as: the lower, the better.

The composite score is calculated by summing the 13 measure numerators to obtain the composite numerator, summing the 13 measure denominators to obtain the composite denominator, then dividing the composite numerator by the composite denominator and multiplying by 100. This method of calculation is based on the “opportunity model” concept.**

**This measure is intended for the sole purpose of measuring progress in the NNHQCC. It is not intended to replace any existing CMS measures or scores such as the Five Star Rating System. These measures were chosen for the composite because timely data are available for measuring progress in this fast paced Collaborative. QIOs have access to the quality measure data necessary to calculate composite scores for their state.
Appendix B: Best Practices Evaluation On-Site Visit Team Members

The on-site visit team included members possessing deep and varied experience and expertise across a range of disciplines relevant to long term care, including program and executive leadership at the facility, state and national level, medical and diverse nursing expertise, human resources, training and change management. Team members participating in the onsite interviews included:

- Jade Perdue-Puli, CMS project lead
- Kelly O’Neill, NCC project co-lead
- Marilyn Reierson, NCC project co-lead
- Cathy Maffry, interviewer
- Jane Pederson, interviewer
- Marilyn Oelfke, consultant, interviewer
- Tom Kelly, consultant, interviewer

Jade K. Perdue-Puli, MPA

Ms. Perdue-Puli is Health Insurance Specialist, Lead, Learning and Action Networks, for the Division of Program Management, Communications and Evaluation, Center of Clinical Standards and Quality (OCSQ), at the Centers for Medicare and Medicaid Services in Baltimore, Maryland. Ms. Perdue-Puli is responsible for developing Learning & Action Networks (LAN) in every state through the Quality Improvement Organizations (QIO) Program, 10th Statement of Work (SOW), and in that role serves as teacher, facilitator and field agent to the QIO community in expanding their knowledge and improving their practice in the development of LANs. Ms. Perdue-Puli strategically plans the flow and movement of the initiatives in conjunction with Federal and non-federal partners. She serves as expert to 10th SOW themes for LAN development, management, and facilitation based on each aim, and is a developer of the Nursing Home Quality Care Collaborative, an initiative based on the IHI Collaborative Model to improve nursing home systems of care. In this capacity, she developed a change package by reviewing high performing nursing homes. She developed measurement and recruitment strategies resulting in 5,000 homes participating. Ms. Perdue-Puli also assists theme teams with measurement strategy development and effectively collaborates with public and private stakeholders to move 10th SOW aims forward.

Kelly O’Neill, RN, BSN, MPA

Ms. O’Neill, a program manager at Stratis Health, provides leadership on long term care initiatives, both in Minnesota and nationally. She has extensive experience in assessment and improvement of organizational systems and processes in nursing homes. She provides leadership for resident/patient safety activities in nursing homes across the county as part of the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization (QIO) National Coordinating Center contract. She also supports development and implementation of Quality Assurance and Performance Improvement (QAPI). Ms. O’Neill was part of the leadership team that recently completed the national nursing home QAPI demonstration project, under contract with CMS. She develops strategies, resources and educational programs to
support implementation of QAPI at the nursing home level. Her clinical background includes intensive, acute, and rehab nursing. Ms. O’Neill is a Certified Professional in Healthcare Quality and a Master TeamSTEPPS trainer. She has a Bachelor of Science degree in nursing and a Master’s degree in public and nonprofit administration. She serves on AHRQ’s technical expert panel on surveys on patient safety culture and on Abt Associates’ technical expert panel on QAPI: Systems Thinking and Person Centered Care.

**Marilyn Reierson, MS**

Ms. Reierson is a program manager at Stratis Health. She provides leadership on Stratis Health’s long-term care projects, within Minnesota and nationally. She has extensive experience in performance improvement, organizational development, and education in nursing homes. Ms. Reierson provides leadership for resident/patient safety activities in nursing homes across the country as part of the Centers for Medicare & Medicaid Services Quality Improvement Organization National Coordinating Center contract. She supported development and implementation of the Quality Assurance and Performance Improvement (QAPI) National Demonstration project by developing strategies, resources and educational programs to support implementation of QAPI at the nursing home level. She provides technical assistance to nursing homes to successfully integrate the QAPI elements into their organization, utilizing lessons learned from participating nursing homes to help inform national roll-out of QAPI. Ms. Reierson serves on the board of directors and as vice chair for the Advancing Excellence in America’s Nursing Homes Campaign. Ms. Reierson is a Team STEPPS Master Trainer and an Eden Associate. She has a Masters Degree in organizational training and development from the University of Wisconsin, Stout.

**Cathy Maffry, MBA, BSN, RN-BC**

Ms. Maffry has directed national support contracts for the Centers for Medicare and Medicaid Services (CMS) for over nine years. In this capacity, she provides project management and leadership to contracts that are all nationwide in scope. These are related to various hospital and nursing home projects and healthcare settings. Ms. Maffry has an extensive nursing background with a focus in the areas of emergency, intensive care, quality improvement, case management, nursing home and hospice. Prior to her nursing experience, she successfully managed projects for Federal Deposit Insurance Company (FDIC) utilizing a strong financial analysis experience.

**Jane Pederson, MD, MS**

Dr. Pederson, director of medical affairs at Stratis Health, provides leadership and clinical guidance to Stratis Health’s health care quality and safety initiatives. She served on the leadership team for the Centers for Medicare & Medicaid Services (CMS) Quality Assurance and Performance Improvement (QAPI) Demonstration Project and and assisted in the development of QAPI tools and resources. Dr. Pederson is board certified in internal medicine and geriatrics and maintains a clinical practice in the long term care setting. She is an active member of a number of health care societies and committees, including the Minnesota Medical Directors Association and the Minnesota Medical Association. She serves on Minnesota’s Board.
of Examiners for Nursing Home Administrators and participates in state work groups that focus on topics relevant to older individuals. She received an MD and completed an internal medicine residency at the University of Minnesota. In addition, she holds a MS in Health Services Research and Policy from the University of Minnesota.

Marilyn Oelfke, RN, BS

Ms. Oelfke is a registered nurse with more than 40 years of experience, most of which has been in nursing administration. She retired in 2013 from Perham (Minnesota) Living where she had served as senior director of long term care services for 24 years. She now works part-time as a nursing consultant with Action Pact of Milwaukee, Wisconsin, and as a health services specialist consultant for Aging Services of Minnesota.

Ms. Oelfke’s passion to transform the long term care facility into a home for the residents led her and the staff of Perham Living on a 12-year journey into deep culture change. She was directly involved in the conversion of a 96-bed facility from a medical model to the household model of care and in the planning and completion of a multi-million dollar rebuild and remodel of the 1970’s facility. She has presented the Perham Living version of the household model to groups, both large and small, around the country and internationally with visits to Canada and Ireland. She has contributed to articles in *Culture Change Now!* and to resources of the Institute for Patient- and Family-Centered Care.

Tom Kelly, MA, BA

Mr. Kelly retired from Federal Senior Executive Service (SES) with 40 years of leadership experience in managing scientific and federal programs, agency evaluation offices, and national change campaigns. His experience is centered about three strategic actions: establish a national change campaign that rapidly surfaces and spreads best practices to achieve a national goal, produce a rapid evaluation to address urgent issues and program design questions, and develop a manageable program to address a new situation that challenges the traditional role and expertise of the organizations involved.
Appendix C: Articles Reviewed to Assist in Defining Nursing Home Quality


Katz PR, Karuza J, Lima J, Intrator O. (2010). Nursing Home Medical Staff Organization: Correlated with Quality Indicators. JAMDA.


Levenson, SA. (2009). The Basis for Improving and Reforming Long-Term Care. Part 3: Essential Element for Quality Care. JAMDA, 10(9), 597-606


Zingmond DS, Saliba D, Wilber KH, MacLean CH, Wenger NS. (2009). Measuring the Quality of Care Provided to Dually Enrolled Medicare and Medicaid Beneficiaries Living in Nursing Homes. *Medical Care, 47*(5), 536-544.


Appendix D: Site Selection

As discussed earlier in the report, due to the multidimensional nature of nursing homes and their residents, no single satisfactory, standardized method of measuring nursing home quality exists. For this evaluation, several quality criteria were used to identify a number of nursing homes as high performers. These criteria, described below, combine to create a detailed yet incomplete picture of any individual nursing home’s quality of care and life. Teams of representatives of the IIPC-NCC visited the identified facilities to interview staff and learn what factors and practices seem to contribute to their high performance. The IIPC-NCC team hypothesized that there would be similarities across several of the nursing homes and that actionable items could be identified which could then be shared with other nursing homes interested in improving their performance.

The IIPC-NCC utilized data and feedback from multiple sources to help identify nursing homes to visit and study. In addition to available data sources on nursing home quality, state survey findings, and staffing, the IIPC-NCC also considered size, geographic location, rural/urban status, ownership type, and profit status to include facilities representative of nursing homes across the country. An extensive vetting process was used to identify high performing nursing homes. Starting with 15,600 nursing homes, and following the selection criteria 1 through 3 below, 117 nursing homes (0.74% of all homes) were identified for possible inclusion in the evaluation. Ten homes were ultimately selected for site visits.

The process of site identification was as follows:

**Step 1:** The IIPC-NCC identified nursing homes that were consistently rated high on the CMS Five-star quality rating system. The CMS Five-star quality rating system takes into account the following (the Five-star quality rating system user’s guide is available at [https://www.cms.gov/CertificationandComplianc/Downloads/usersguide.pdf](https://www.cms.gov/CertificationandComplianc/Downloads/usersguide.pdf)):

- State health inspections (A health inspection score is calculated based on points assigned to deficiencies identified in each active provider's current health inspection survey and the two prior surveys, as well as deficiency findings from the most recent three years of complaints information and survey revisits), and
- Nursing home staffing levels (total nursing hours per resident day (RN + LPN + nurse aide hours) and RN hours per resident day), and
- MDS quality measure results (the facility rating for the QM domain was, for MDS 2.0 data, based on performance on a subset of 10 (out of 19) of the QMs currently posted on Nursing Home Compare. The rating system may be adapted with MDS 3.0 data).

The Five-star quality rating system provides valuable information to consumers and was utilized as an initial indicator for high performer identification. During the initial screening, eligible nursing homes were those who had an overall rating of 5 stars consistently for three years, from 2009 (when the ratings were first available) through 2011.
Step 2: The IIPC-NCC revisited the CMS 5-star rating system in July of 2012 to remove any nursing homes that were not currently at 5 stars for an overall rating. Additionally, nursing homes that were rated at fewer than 3.5 stars for any of: Quality, Health Inspection, or Staffing were also excluded from the eligible pool of nursing homes.

Step 3: Further review of individual outcome metrics excluded homes that were above established national benchmarks for measures relating to pressure ulcers, physical restraints, and urinary tract infection. Specifically, data from the two most recent quarters (Q4 2011 and Q1 2012) were used to identify any nursing homes whose quality measures in these areas were higher than the national average and/or above a clinically acceptable level. Specifically, nursing homes excluded from consideration if any of the following were true:

- The high-risk pressure ulcer quality measure rate was 6% or greater for both quarters
- The physical restraints quality measure rate was 3% or greater for both quarters
- The urinary tract infection quality measure was over 9% for both quarters

Step 4: The geographic location of the 117 nursing homes identified by the data through this step was considered in an attempt to include a diverse representative sample, as well as to identify facilities clustered together to allow for multiple visits to occur within the same city or area. A national map was created with the location of each potential nursing home plotted (below).
From this map, the list of nursing homes was limited to those within the following states, in an attempt to create a geographically diverse list for consideration, and to include diversity in nursing home size, rural/urban location, ownership type, and profit status:

California
Connecticut
Florida
Iowa
Kansas
Maryland
Massachusetts
New York
Pennsylvania
South Carolina

**Step 5:** The IIPC-NCC then used data from the most recent three quarters available (Q4 2011 – Q2 2012) and investigated specific quality improvement measures involving falls and the use of psychoactive medications in the absence of a psychotic (or related) condition.

**Step 6:** The next step involved contacting the QIO, State Survey Agency, and the long term care ombudsman associated with each nursing home to obtain information that could assist in selecting high performing nursing homes. Information obtained from these organizations included general information regarding the facility, the facility’s reputation, or previous experiences (good or bad) the QIO or State Survey Agency or ombudsman may have had with the facility to help inform the selection process.

**Step 7:** The IIPC-NCC then used additional data available for each nursing home, including state report cards, state requirements, and initiatives such as Pennsylvania’s Healthcare Associated Infections (PA-HAI) reporting. Also considered was whether the nursing home was participating in the Advancing Excellence in America’s Nursing Homes campaign. The information collected in this step was used to try to further differentiate nursing homes and identify those that might be slightly better choices for inclusion in the final evaluation group.

**Step 8:** At this point, geographic location was considered again, and a preliminary list of nursing homes consisting of 2 nursing homes in each city/area was identified. This list was provided to CMS for discussion and approval, and included nursing homes in California, Florida, Pennsylvania, Massachusetts, Iowa, and South Carolina.

**Step 9:** The administrator at each nursing home was called to assess their interest in participating, and each nursing home was pre-screened for a potential site visit. The pre-screening process included a description of the background of this evaluation, as well as the benefits and expectations of participating as a site for this evaluation.

When contacted, both nursing homes in Florida declined to participate, leaving ten nursing homes in a total of five states on the list of potential nursing homes.
Participants agreed to voluntarily share information about what they are doing to get excellent results and provide their residents with the highest quality of care, to make their staff available for interviews during onsite visits, and to have their name made public as a participant.

**Step 10:** The final list of facilities that agreed to participate in the site visit process included the following. The locations of the homes are shown on the map below.

Bethany Skilled Nursing Facility, Framingham MA  
Foulkeways at Gwynedd, Gwynedd PA  
Franciscan Convalescent Hospital, Merced CA  
Jewish Healthcare Center, Worcester MA  
Landis Homes, Lititz PA  
Mercy Retirement & Care Center, Oakland CA  
NHC Healthcare – Anderson, Anderson SC  
NHC Healthcare – Parklane, Columbia SC  
Pleasant View Home, Albert City IA  
Westview Care Center, Britt IA
Appendix E: Materials Provided to Participating Nursing Homes

- Nursing Home Best Practice Evaluation Overview for Participants
- Nursing Home Best Practice Evaluation Information Release
- Example of Site Visit Agenda and Debriefing Visit Agenda

Centers for Medicare & Medicaid Services (CMS)
National Nursing Home Quality Care Collaborative
Nursing Home Best Practice Evaluation Site Visits
Overview for Participants

The Centers for Medicare and Medicaid Services (CMS), Center of Clinical Standards and Quality (CCSQ), is conducting a “Best Practices” evaluation of High Performing Nursing Homes for the purposes of launching a National Quality Improvement Collaborative, led by CMS and the Quality Improvement Organizations (QIOs) across the county. The ultimate goal of the Collaborative is to redefine the quality of care being received by nursing home residents by instituting quality improvement practices, solidifying the foundational practices of nursing homes, such as general business practices, staffing and quality of life indicators. Additionally, we want to improve the overall systems of care with a targeted focus on preventable healthcare acquired conditions such as falls, pressure ulcers, urinary tract infections, and the inappropriate use of antipsychotic medications in the elderly with dementia.

Your nursing home was identified as a high performing nursing home using available data such as the CMS Five-Star Quality Rating System and specific clinical outcomes for the healthcare acquired conditions mentioned previously.

We are visiting you to better understand what your organization is doing to generate your extraordinary results. While we recognize that that there are a variety of factors that contribute to a nursing home’s success, we seek to identify best practices associated with high performing nursing homes. By doing so, we can improve organizational systems and consistently and effectively improve the quality of care delivered to people living in nursing homes.

We will be looking at leadership, cultural, operational, and management techniques of nursing homes as it relates to high performance. We will take what we learn from high performing nursing homes that participate in this evaluation, and share guiding principles and best practices with other nursing homes across the country, with the intent of increasing overall quality. This information will be shared in a change package that will be available to QIOs and nursing homes with which they are working.

We want to have discussions with multiple team members at your nursing home and are interested only in what is working well.

Jade Perdue-Puli, MPA, Nursing Home Best Practices Evaluation Lead, Centers for Medicare & Medicaid Services
We agree to participate in the CMS Nursing Home Best Practice Evaluation and agree to the following:

Our organization has been identified as a high performing nursing home and will share information about what we are doing to get excellent results and provide our residents with the highest quality of care.

We agree to have our name made public as a participant.

The ultimate goal is to learn, share, and spread/replicate what we know to be working with other nursing homes so that they too can become high performing organizations.

We only need to share information about what is working well, and don’t need to share anything that might not be working well.

What is learned from our organization as a whole may be shared with others in this organization, with some partners in this work, like Quality Improvement Organizations or nursing home trade associations, and the hope is that what is learned in this evaluation will be shared and implemented in other nursing homes all around the country.

I understand that participation is voluntary and staff members are able to pass on topics that they don’t have knowledge about or prefer not to talk about.

I understand and agree to the above and wish to participate in the Best Practice Evaluation.

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Nursing Home Best Practice Evaluation Site Visit

Agenda
Nursing Home Name
Administrator: XX
Address
Site Visit Team: XX

We are requesting to speak with the following NH staff or stakeholders; please fill in schedule (time slots) per availability: Administrator, Director of Nursing and RN/LPN nursing leaders, Other Department Directors, Direct Care Staff including CNAs, Board of Director members if applicable, Owners if applicable, Medical Director and/or other physicians, NPs, or PAs

Day 1

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<td>Overview of debrief meeting</td>
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<td>Tour of nursing home</td>
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<td>Review and fill in agenda (if not already filled in)</td>
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<td>Discussions with administrator, DON and with Board of Director(s)</td>
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84
## Nursing Home Best Practices Evaluation Final Report

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<td>Plan for debrief meeting</td>
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<td>Depart nursing home</td>
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Best Practices Evaluation Debriefing Agenda

A. Welcome and introductions
B. Goals for the meeting: Validate, refine and reflect, add and clarify to best practices identified.
C. Review the process to identify and learn from high performing nursing homes.
D. Discuss the goals, structure, and process for the National Nursing Home Quality Care Collaborative
E. Review of emerging, overarching strategies from high performers
F. Discussion of details and stories that describe each of the strategies: after each item the group responded to two questions: 1) what would you add, and 2) what would you change?
G. Discussion of next steps
H. Sharing of quotes from interviewees
Appendix F: Site Visit Conversation Opening Talking Points

Nursing Home Best Practice Talking Points

Beginning of Conversation:

Hi I’m _______ and ___________. We are with ________ and are working under contact with CMS to find out what high Performing Nursing Homes are doing to get excellent results and provide our residents with the highest quality of care. We are a Quality Improvement Organization and have no affiliation with state survey, your local QIO, etc… We are here because your organization has been identified as one of these high performers. The ultimate goal of this work is to Learn, Share, and Spread/Replicate what we know to be working with other nursing homes so that they too can become high performing organizations. So we want to THANK YOU for taking the time out of your busy day to meet with us and share your expertise and experiences. We want to be most respectful of your time so will get right to work!

Before we get started we would like you to be aware of a few things and also make a few requests of you that we hope will get you thinking about your work and how to best explain it to us.

We are ONLY interested in what is working. (This is a first right? 😊) So you don’t need to share with us anything that might not be working well.

There are no specific questions for you to answer we will just talk about your work, your daily activities, the things that you experience, the specific things that you do to help care for your residents. There is not a test at the end of the session and there are no right or wrong responses.

What we learn from you and your organization as a whole may be shared with others in this organization, with some partners in this work, like _ (fill in an organization that this person would be familiar with) and our hope is that what we learn here will be shared and implemented in other nursing homes all around the country. Very exciting!!!

We anticipate that our conversation may take 20-30 minutes but if we finish up before then we will let you get back to your important work. Or if you need to leave before we are finished please just tell us so we can work to get you back.

Once we get started we just ask that you do the following:

Stay focused on what you know to be working – we want to hear the good story ONLY.

Share your direct experience, things that you directly participate in, have seen etc…

If you can think of any stories or examples that might help us better understand your work and why this organization is a great one, we would love to hear them.

Finally, you do not have to participate if you do not want to, or talk about anything/subject that for any reason you find uncomfortable. If you come across a subject that you don’t want to talk
about or have no direct experience with, just say PASS. Would you like to participate? (Must receive a firm YES to move forward)

Before we get started do you have any questions for us?

**After the Conversation:**

*If the conversation is something you feel that needs to be showcased at the debrief, create the possibility at the time of exit:*

We want to make you aware of an opportunity that will occur on ________________ at ________________. We have some vested partners coming in to hear what we have learned from everyone here and just want to check in with you about the possibility of speaking for a few minutes at this meeting either face to face or via conference call? We would work to be flexible with your schedule and would anticipate no more than a 20 minute commitment but would welcome your participation for the entire time.

*Is there a phone number or way that we can easily contact you directly: ____________
Appendix G: People Interviewed at Nursing Homes Visited

Bethany Health Care Center (Framingham, MA) September 19-20, 2012

People Interviewed

Mindy Agran, LCSW, Social Worker, Director, Social Services
Florence Ankomah, CNA
Jim Argir, Director of Plant Operations
Sr. Rosemary Brennan, President, Board of Directors
Katie Brown, Rehab Director
Shannon Burke, Activity Director
Diane Caruso, RN, Clinical Director
Carol Collette, Director of Admissions
Evelyn Cotter, Activities Assistant
Jose Cruz, Housekeeping
Lori Ferrante, Board of Directors
Barbara Galluzzo, RN, ADON
Melissa Galluzzo, Dietary
Susan Gonzales, RN, Director of Nursing
Vicki Graham, LPN
Cheryl Hatch, GNP
Terry Hodge, Human Resource Director
Linda Horrigan, LPN, 3rd Floor Unit Manager
Dr Rohit Jangi, MD, Medical Director
Charlene Johnson, RN
Maria Kehoe, GNP
Holly Lacome, RN, Education Director
Nancy Matterazzo, Dietary
Sr. Jacquelyn McCarthy, CEO/Administrator
John Moran, Laundry
Terry Moran, RN, ADON, infection control
Ginny Moulaison, Operations Manager, Dietary
Rita Mukerjee, RN
Sr Mary Nagle, Mission Effectiveness
Lisa Orme, CNA
Sr Ellen Pumphret, Director, Pastoral Care
Jerry Riley, Controller
Dave Rondeay, Maintenance
Barbara Shockley, Director Mission Advancement
Lyra Sicad, RN, MDS Coordinator
Lou Simon, Operations Manager Housekeeping
Ana Maria Tavares, CNA
Lauren Wilde, RD, Dietary
Zoe Wright, LCSW, Social Worker
Foulkeways at Gwynedd (Gwynedd, PA) August 27-28, 2012

People Interviewed

Bob Barr, Board Member and Chair of the Nominating Committee
Kathy Beck, RN
Kathleen Boyle-Giannini, CRNP
Christine Brady, MSW, LSW
Donna Davis, MDS, Care Coordination
Cynthia T. Evans, Board Member
Ron Foltz, Director of Facilities
Diane Fox, CRNP
Judith Gradel, CDM, Nutrition Care Manager
Marianne Greenway, Minister/Spiritual Needs
Karen Hastings, CNA
Rolland Henderson, Board Member
Diane Kelly, RD LDN, Registered Dietician
Mary Knapp, Administrator
Amy B. Moreno, OTR/L Director of Rehabilitation
Raj Patal, RN
Daniel Pellesrin, Director of Maintenance
Cynthia Prediger, Director of Housekeeping and Laundry
Jean Raiguel, Director of Human Resources
Allyson Schulz, Food Server
Sue Schulz, Director of Rehab
Marie Scutt, CNA
Doug Tweddale, CEO
Patricia Van Buskish, Assistant Director of Housekeeping
Robbie Vetter, Director of Risk Management and Training
Lauren Weigand, RN Supervisor

Franciscan Healthcare Center (Merced, CA) September 24-25, 2012

People Interviewed

Daneka Akens, LVN
Laura Ali, CNA
Irma Basaldana, Business Office
Martina Cadsa, Regional Nurse Consultant
Lisa Chappelow, Administrator
Karla Corbala, Admissions Coordinator
Gregoria Cosio, MDS/Case Manager
Ronnel Cruz, RN, DSD
Bernadette Davis, Dietary Director
Rosie Dennis, Activities/Social Services
Jesse Diaz, CNA & Activities Assistant
Delpar Diolazo, RN Unit Manager
Nellie Mandujaro, LVN Charge Nurse
Lydia Morales, CNA/RNA
Margie Munn, Alzheimer’s Care Director
Alan Prince, Rehab Team Leader
People Interviewed

Ann Albano, Director of Housekeeping and Laundry
Kathy Barron, Charge Nurse
Diane Bolduc, SW
Meg Boyce, Nurse Manager, 4th Floor, LPN
Steve Cammuso, OTR
Carmen Capriole, Director Health and Education
Scott Casey, Rehab Director
Deb Coleman, RN, Asst NM
Bonnie Crouch, MDS Coordinator
Joanna Dzaba, 3rd floor CNA
Cynthia Feal, Asst Dir of Rec Therapy
Cynthia Fitzpatrick, Administrator
Beth Foley, SW
Maggie Gerardi, Secretary
Justin Hall, Cook Supervisor
Jim Hart, Maintenance
Carol Helander, Director of HR
Betty Hope, MDS
Diana Jackson, QA
Ann Jette, Director of Campus Clinical Services
Tina Keifer, CNA, 11-7
Laura King, 3-11 Supervisor
Sue LeBlanc, CNA
Anne Marie LeBoeuff, Hospice Director
Rhea Malloch, LPN, Rx Nurse
Nicole Messier, CNA
Sandy Miller, LPN, Supervisor
Martin Muiruri, RN
James Mwenga, CNA, 5th floor
Ellen Oppong, 5th floor CNA
Christina Pearman, CNA, new LPN
Michelle Peterson, SW
Deb Powers, Director of Food Services
Judy Quinn, Nurse Manager
John Rocheford, LICSW
Kristen Ryder, Dietician
Martina Salek, RN
Moe Saroka, Rehab CNA
Carol Sullivan, RN
Jim Turgeon, Director of Maintenance
Lee Wilkins, Staff Development Coordinator
People Interviewed

Kim Anspack, Social Worker
Eva Bering, VP Operations
Danine Bitting, DON
Ella Burkholder, Director Laundry and Housekeeping
Ethel Caldwell, Administrator
Iris DelRio, CNA
Connie Gockley, Restorative Coordinator
Dori Groff, Life Enrichment Coordinator
JoAnn Hassler, Life Enrichment
Greg Henning, Director of Dining Services
Cindy Hess, Nutrition Care Manager
Stephanie Hoffman, Director of Risk Management and QI
Alma Horning, Dining Services Assistant
Regina Horst, RN, Household Team Leader
Dale K. Hursh, Medical Director
Coleen Kayden, Pharmacist, consultant, Williams Apothecary
Margarita Kosko, Registered Dietician
Megan Kurtz, LPN Household
Charles Longenecker, Board Member
Chuck Maines, Director of Admissions and Social Services
Melanie Martin, RN Household Team Leader
Elaine Muschitiz, RN, Team Leader, Hospice and Community Care
Kristin Nace, Lead RNAC
Emily Oberholtzer, CNA
Chrissy Reedy, CNA
Jenny Rohrer, RN Supervisor
Sandy Smoker, Director of Human Resources
Joyce Spotts, Social Worker Supervisor
Tina Texter, Liaison, Hospice and Community Care
Debbie Urbansky, Rehab Care Manager
Heather Weaver, Dining Services Supervisor
Nancy Worrell, LPN Household Team Leader
Dottie Yoder, Board Member
Judy Zdancewics, RN, Nurse Manager
Larry Zook, President

People Interviewed

Meaza Ayalew, CNA
Lisa Bauer, Volunteer
Alison Cocovich, Activities Coordinator and Music Therapist
Sister Patty Creedon, Administrator
Zaldy Cruz, RNA
Sister Liz Davis, Chaplain
Aileen DeGuzman, CNA
Jessica Flores, Activities Coordinator, Life Enrichment
Reyna Flores, Medical Records Clerk
Robert Fong, Environmental Services
Anna Ganio, CNA
Jana Gesinger, Director of Life Enrichment
Charlie Green, Life Enrichment Coordinator
Jesse Jantzen, CEO
Michelle Laguatan, Physical Therapy Aide
Christine Lozier, CNA
Eleanor Malupa, Social Services Director
Eva Managuelod, DON
Eleanor Mendoza, Staff Development & Infection Control Nurse
Gina Meyer, Rehab Director
Liz Pacis, RN BSN, Charge Nurse
Stella Pena, Dietary
Abbie Robinson, CNA
Gilda Soriano, CNA
Shaye Starkey, Assistant Executive Director
Eva Torres, LVN & MDS Nurse
Susan Virrey, LVN
Cassi Walker, CNA

NHC (National Healthcare Corporation) Anderson October 15-16, 2012

People Interviewed

Denna Brooks, Nursing Station 4/CNA
Brenda Cowans, housekeeping
Marlene Craft, LPN, Station 2
Lee Foote, Floor Care/Maintenance
Carol Grant, Asst bookkeeping director
Mary Gwardiak, Social services assistant for rehab
John Hall, Director of Plant Operations
Edith Henderson, CAN
Katie Hopper, OT
David Johnson, LPN, Nurse Station 5
Mary Ann Johnson, Cook
Sonny Kinney, Regional Vice President
Vicki Land, RHIT Director of Medical Records
Cinnamon Mazzola, Director of Social Services
Dr. Marshall Meadows III, Medical Director
Brad Moorhouse, Administrator
Jennifer Moran, RN, Nursing Supervisor Station 4
Mary Frances Nicholson, Certified Dietary Manager
Kimberly Pearigean, PT/Director of Rehab
Linda Pope, Assistant Administrator
Debbie Reed, Medical records
Janie Reeves, Director of Bookkeeping
Donna Robinson, DON
Kim Taylor, Dietician
Darrah Williamson, Therapy Transporter/CNA
Dianne Williford, Laundry

NHC (National Healthcare Corporation) Parklane October 17-18, 2012

People Interviewed

Kathie Aller, Director of Health Information
Brett Argo, Administrative assistant in rehab
Melissa Argo, Administrator
Sheri Armstrong, Occupational Therapy
Leigh Bebber, NHC SC Regional Nurse
Africana Michelle Bell, RN Nurse Manager
Michael Blank, Supply - IT
Melissa Boyd, Environmental Services Director
Joyce Bozard, PT Director
Patti Coates, RN, ADON & MDS coordinator
Marian Cohn, Benefits Represent
Nakia Daniels, Social Worker
Kimberly Davila, Administrator of Palmettos at Parklane
Randy DeLoach, Maintenance Director
Dorothy Dixon, Unit Manager
Deogracias Elamparo, RN MDS
Jennifer Eldon BSW, Social Services Director
Diane B. Funderburk, Regional Rehab
Arlene C Goyner, Certified Dietary Manager
Dr. David Greenhouse, Medical Director
Carol A Haines, Director of Rehab
Timika Hayes-Williams LPN Unit Manager
Sheila Jenkins, 16 years, Business office manager
Denise Lewis, Nursing Secretary – Staffing
Antonio Lucas, Activities Assistant
Tiffany Michel, RN, DON
Tara Mimmins, Activites Director
Tamiko Outten, Activities Coordinator
Tasha Owens, LPN/Supervisor
LaShawn Pilot, Social Services Coordinator
Dee Prescott, Accounts Payable Bookkeeper
Jose M. Rivera-Bruno COTA/L
Vincent Speaks, CNA
Patra Sullivan, RD
Sharon Trapp, CNA
Jennifer Tucker LPN, Supervisor
Carol Vollmer RD/Director
Renada Weathersbee, Activities Assistant
Cheryl Weldon, CNA
Pleasant View Home (Albert City, IA) September 6, 2012

People Interviewed

Jennifer Bennett, RN/Charge Nurse
Alison Carlsen, Activity Coordinator
Cheryl Christensen, Dietary
Deanne Fales, Dietary Manager
MJ Ferrell, Dietary Aid
Marlowe Foldman (Chairman of the Board)
Misti Garcia, CNA
Connie Hansen, RN, DON
Jessica Johnson, Office Manager
Billie Kunz, Laundry Supervisor, CNA
Dorie Lovin, RN, MDS Coordinator
Barb McCoy, Dietary Aid
Beverly Mericle, Administrator
Kay Pedersen, RN & Charge Nurse
Roberta Scontting, Dietary Aid/Cook
Deb Slinger, CNA
Julie Trenien, CNA, Certified Rehab Aide

Westview Care Center (Britt, IA) September 4-5, 2012

People Interviewed

Dr. John Brady, Medical Director
Holly Brink, Administrator
Sarah Burch, Assistant Administrator
Jamey Cassels, Social Worker
Sara Christians, Neighborhood Care Coordinator
Heather Erickson, Neighborhood Care Coordinator
Sierra Fett, Human Resources & Person Directed Care Coordinator
Michele Garman, DON
Tera Hansen, LPN, Neighborhood Coordinator
Lincoln Harms, Office Manager
Jessica Hobart, MDS Nurse
Linda Holloway, Physician Assistant
Jeanice Kerns, Food Service Supervisor
Jessie Kraft, CNA
Jessica Leerar, LPN Floor Nurse
Mary Marvin, CNA/CMA
Amanda McNeese, CNA
Julie Oehlert, Activity Director
Danika Piper, CNA/Rehab Aide
Jaime Rieck, LPN, Neighborhood Coordinator
Raona West, RN PRN
Angela Wirth, Marketing Coordinator
Kim Young, CMA & Mentor
Appendix H: Discussion Guide Prompt

Interviewers asked the voluntary participants to share what was working well in their organization. Interviewers used these discussion guide prompts but did not use a standard question set.

I. Leadership

II. Workforce

III. Resident and family involvement

IV. Relationships with other key partners and stakeholders

V. Culture of organization

VI. Care practices, including HAC Prevention and reduction efforts

VII. Quality assurance system

VIII. Quality improvement

IX. Other Business Practices not yet discussed, e.g., finance and accounting

X. Knowledge management

Discussion prompts

I. Leadership
   Discussion drivers
   - Organizational structure
   - Governance structure
   - Leadership structure, leadership stability/retention
   - Organizational alignment of priorities

II. Workforce
   Discussion drivers
   - Staff skill mix, experience,
   - Staff certifications and credentials
   - Staff performance objectives/performance evaluations related to NH goals and priorities
   - Staff retention and turnover
   - Length of time key staff members have been with the organization
   - Diversity/culture/language
   - Hiring processes
   - Orientation
   - Ongoing training and education
   - Process for responding to concerns or suggestions for improvement
   - Data used to determine organizations performance as viewed by staff
   - Results
III. Resident and family involvement
Discussion drivers
- Identification of needs and desires
- Involvement in planning care
- Promotion of relationships and community
- Process for welcoming
- Process for responding to concerns or suggestions for improvement
- Data used to determine organizations performance as viewed by residents
- Results

IV. Relationships with other key partners and stakeholders
Discussion drivers
- Primary stakeholder relationships: providers, vendors, suppliers, community, regulators, accrediting organizations,
- Inputs
- Activities
- Outputs
- Outcomes
- Impact

V. Culture of Organization
Discussion drivers
- Teamwork and communication; relationships
- Safety culture
- Inputs
- Activities
- Outputs
- Outcomes
- Impact

VI. Care practices
Discussion drivers
- Assessment and planning for care
- Care delivery
- Consistent assignment, turnover,
- Falls
- Antipsychotic drug use in persons with dementia
- Measurement/outcomes and sustainability of results
- Specific conditions: HACs such as pressure ulcers and UTIs

VII. Quality Assurance System
Discussion drivers
- Inputs
- Activities
- Outputs
- Outcomes
- Impact
VIII. Quality Improvement
   Discussion drivers
   • Comprehensive ongoing program,
   • Identification of problems or issues early on
   • Process to identify root causes of problems
   • Prevention of adverse events
   • Process for selecting improving approaches and intervention strategies
     – by task area (use of evidence-based interventions)
   • Leadership driven
   • Multidisciplinary team involvement
   • All staff involvement
   • Use of data to drive work to improve performance

IX. Other Business Practices not yet discussed
   Discussion drivers
   • Finance/accounting
   • Other operations

X. Knowledge Management
   Discussion drivers
   • The collection and transfer of workforce knowledge
   • The transfer of relevant knowledge from and to customers, suppliers, partners, and collaborators
   • The rapid identification, sharing, and implementation of best practices
   • The assembly and transfer of relevant knowledge for use in your innovation and strategic planning processes
Appendix I: Documents Shared During Site Visits

The documents shared within this appendix following this cover page are grouped by facility.

- **Bethany Health Care Center, Framingham, MA (101-115)**
  - Communication to Rehabilitation
  - Consistent CNA Assignment Policy
  - Travelling Inservice: Fire Response
  - Staff Interview Questions
  - Leading Age Annual Awards Call for Nominations: Application for Model of Care Program: Treat in Place
  - Yogurt Nutritional Supplement
  - Satisfaction Survey Results Template
  - Compliance Survey Results Template

- **Foulkeways at Gwynedd, Gwynedd, PA (116)**
  - Be A Star Program

- **Franciscan Convalescent Hospital, Merced, CA (117-119)**
  - OT/PT Evaluation Request Form
  - Influenza Vaccination for Employees
  - Individual Inservice Attendance Record

- **Jewish HealthCare Center, Worcester, MA (120-127)**
  - Personal Facts and Insights

- **Landis Homes, Lititz, PA (128-145)**
  - Action Plan
  - Always Available Menu
  - Analysis of Re/admissions and Emergency Department Visit, Observation Stays
  - Report to Healthcare Quality Improvement Committee on Readmissions to Hospital Within 30 Days
  - Healthcare Mock Survey Checklist
  - Orientation Checklist – Caregivers
  - Orientation Checklist – RN/LPN
  - Facility Acquired Pressure Sore Audit: Root Cause Analysis (resident stay longer than six weeks)
  - Facility Acquired Pressure Sore Audit: Root Cause Analysis (new admission – resident stay less than six weeks)
  - Vision, Mission, Guiding Values, Strategic Focus Areas

- **Mercy Retirement and Care Center, Oakland, CA (146-151)**
  - Compassionate Care of the Dying: Palliative Care Certificate Program
  - Life Enrichment H.E.A.R.T. Program
  - Volunteer Application and Profile

- **NHC HealthCare, Anderson, Anderson, SC (152-155)**
  - Customer Evaluation Form
  - Patient Satisfaction Survey Form

- **NHC HealthCare, Parklane, Columbia, SC (156-163)**
  - Daily Stand-up Talking Points for the Week
  - Quality Improvement Meeting Minute Template
  - PDCA Rapid Cycle Worksheet
  - Rehabilitation Excellence Survey and Instructions

- **Pleasant View Home, Albert City, IA (164)**
  - Algorithm for Treating Behavioral and Psychological Symptoms of Dementia

- **Westview Care Center, Britt, IA (165-177)**
  - Preadmission Move-in Preference Guide
  - Building a Home Person Directed Care Certification Program
  - Iowa Person Directed Care Coalition
Communication to Rehabilitation

Complete for New Admission or Re-admission only:

☐ Admission / ☐ Readmission date: __________________________

Evaluation orders upon admission: OT ___  PT ___  SLP ___

Non- skilled admission: Request a screen: OT ___  PT ___  SLP ___

Complete this section if you are requesting a rehabilitation screen for current residents. Check off all areas of concern. Please do not check off any box above.

☐ Referral   ☐ Annual   ☐ Significant Change
              (Decline/Improvement)

Has an MD evaluation order already been written? If yes, what date? __________________________

Resident is displaying a change in the following area(s):

☐ Ambulating
☐ Attention/Concentration
☐ Balance
☐ Bathing/Showering
☐ Bed Mobility
☐ Behavior/Motivation
☐ Breathing Pattern
☐ Cognition
☐ Comprehension
☐ Contracture: __________________________
☐ Dressing
☐ Eating/Chewing
☐ Expressive Communication
☐ Fall Date: __________________________
☐ Following Directions
☐ Grooming/Hygiene
☐ Incident Type: __________________________
☐ Incident Date: __________________________

Notes to Rehabilitation Department: ______________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Resident’s Name: ______________________________________
Facility Representative Signature: _______________________
Date Reported to Rehabilitation: _________________________
Bethany Health Care Center

Consistent CNA Assignments Policy

Objectives:
- To enhance both resident care and quality of life
- To promote resident dignity and safety
- To enhance interpersonal relationships among residents, care givers and families.
- To enhance individualized care provided by CNAs.
- To increase employee satisfaction and pride in the care they provide.

Policy/Procedure:
- All attempts will be made to minimize the number of different care givers assigned to each resident.
- Assignments will be designed according to each resident’s individual care needs.
- Consistent assignment sheets will be updated on a daily or on an “as needed” basis to reflect short term admissions and other census changes.
- Assignments will be re-evaluated based upon resident care needs and/or changes in resident conditions.
- Assignments will be re-evaluated based upon resident, family or care giver input in an attempt to continue/create positive relationships.
- The resident’s consistent CNA care giver will participate, with resident approval, in the interdisciplinary care plan meetings.
- Residents, family and CNA satisfaction will be assessed quarterly or as needed through the use of information gathered by satisfaction surveys, resident Council meetings and/or individual conversations.
- A consistent assignment committee will include physician or designee, Nurse educator, administrator or designee, three non-licensed direct care givers, licensed nurses and social workers.
- The consistent assignment committee will meet at least quarterly in an effort to review and evaluate the implementation of the program.

February 15, 2012
Revised March 20, 2012
Traveling Inservice – Fire Response

The “Doctor Red” Song by Holly Lacombe

To be sung to the tune of “Take Me Out to the Ballgame”

Shout Dr. Red in a fire

Rescue anyone near

Pull the Alarm and call 911

Confine the fire close windows and doors

Next Extinguish to put out the fire

It’s a RACE when fire occurs

For it’s R-A-C-E in a fire emergency
**Interview Questions:**

A

How did you hear about Bethany/this position?

Why are you currently looking for a job?

What do you think makes a “good” nursing home; or Why would a nursing home be described as “one of the best” by a community?

B

What attracted you to this line of work?

Describe the experience that most inspired you to be part of the “healing ministry”.

What aspects of this work are the most satisfying for you?

What skills do you feel are most critical to this job? What particular skills or experiences make you the best match for this position?

Describe a CNA who is best at their job.

What would your most recent supervisor say are the skills that make you the best candidate for this position?

C

What are some problems you encounter in your work and what do you do about them?

What do residents do that irritate you? How do you respond?

What aspects of your previous position did you find most professionally challenging? Jobs have pluses and minuses. What are some of the minuses of your last/current job?

What are your views on balancing the whole person, values, work, and personal life?

D

What have you found to be the advantages & disadvantages of diversity in the workplace?

Have you ever had to form a working relationship with someone you really disliked to get your job done?

What kinds of people really tax your patience?

Tell me how you handled someone at work who was really angry with you.

E

What kinds of professional development would make you a more-effective worker? or What areas of training would your past supervisor say you would benefit from the most?

Can I call your references?
LeadingAge Annual Awards
2012 Call for Nominations

Honoring Excellence in Aging Services

Please review your entry details below. When satisfied that your entry is complete, please print a copy for your own record, then click the Finish button to send your entry to LeadingAge.

Organization Nomination

I recommend this organization for consideration as a recipient of:
Innovation in Care and Services

If the judges wish to consider your entry in a different category, is this acceptable to you?
Yes

Is the organization a member of LeadingAge? Yes
Has the organization signed the Quality First Covenant? Yes
If chosen, will a representative of the organization be present to accept the award at the LeadingAge Annual Meeting and Exposition this fall? Yes

Nominee Information

Organization: Bethany Health Care Center
Street Address: 97 Bethany Road
City: Framingham
State: MA
Zip: 01702-7237

If selected, accepting the award on the organization's behalf will be:

Name: Jacquelyn McCarthy, R.N., CSJ
Title: CEO/Administrator
Telephone: (508) 872-6750
Fax: (508) 875-5425
E-mail: jacquelyn.mccarthy@csjboston.org

Nominator Information

Name of Nominator: Barbara Shockley
Title: Director of Mission Advancement
Organization: Bethany Health Care Center
Street Address: 97 Bethany Road
City: Framingham
State: MA
Zip: 01702-7237
Telephone: (508) 270-8698
Fax: (508) 875-5425
E-mail: barbara.shockley@csjboston.org

Organizational Questions

For what achievement or scope of services is this organization being nominated and why does it merit the award?

Bethany Health Care Center (a 169-bed short and long-term healthcare center) is nominated for the Innovation in Care and Services Award for its delivery of quality healthcare through the Bethany Model of Care Program (BMCP). Fundamental to the program is a "treat in place" modality of care resulting in significantly reduced numbers of acute hospitalizations from 29 in 2003 to 16 in 2011, a 55% decrease in hospital admissions. Today, Bethany experiences a less than 1% hospital readmission rate due to the BMCP "treat in place modality of care." The program is led by Bethany's Medical Director, who is assisted by two primary nurse practitioners. Central to the program is the role of Bethany’s Director of Nurses, and two Assistant Directors of Nursing with their daily presence on the floors in overseeing the nursing care teams and delivery of care. Integral to the program are: 1) the commitment of the Medical Director and Nurse Practitioners to providing five-day per week visits and 24-hour on-call availability; 2) the healthcare team’s adherence to the institution’s Organizational Performance Plan; 3) a low nursing turnover rate; 4) building on established nursing care practices, ensuring the continuity of care for each resident; 5) the daily collaboration of interdisciplinary nursing and support teams providing for timely intervention and implementation of medical care; 6) a comprehensive array of in-house medical services including a separately licensed medical clinic that gives residents access to a wide range of medical treatments and rehabilitation; 7) In-service education programs tailored to enhance the delivery of quality care that requires a willingness of the staff to change from the traditional medical model of caring for our residents to a resident-oriented approach. With the implementation of the BMCP, residents have experienced an enhanced quality of life and longevity. Resident and family satisfaction are key components in achieving quality healthcare at Bethany. Satisfaction of Bethany’s residents (who range in age from 67 to 105 years old) and their families is demonstrated in the results of Bethany’s consistently scoring 100% in resident/family State conducted satisfaction surveys. Uncompromised in its commitment to quality care, Bethany serves the community regardless of an individual's socioeconomic or religious affiliation. Despite realizing reimbursement rate losses for approximately 82% of its residents, Bethany Health Care Center was named to the 2012 Honor Roll in U.S. News & World Report's annual Best Nursing Homes, ranking in the top 38 long-term care facilities nationwide. The BMCP has been adopted as the preferred model of care by Bethany residents, families and staff. Integrated with the BMCP, Bethany has adopted a "consistency of care" method of delivery of services. Being regularly cared for by the same caregiver is essential to ensuring quality of care, safety and quality of life for Bethany residents. To achieve the desired outcomes, established benchmarks for measuring performance are used. The Bethany "consistency of care" delivery of services includes the monitoring of: data, quality measures, compatibility with Bethany policies and procedures and survey results. Achieving a deficiency-free rating, when reviewed against over 500 standards from the Massachusetts Department of Public Health, division of Health Care Quality, for
2011, demonstrates the continued commitment of Bethany’s healthcare team to the delivery of quality care. The BMCP can be easily replicated with adherence to three key ingredients: 1.) a commitment of the core management team to deliver compassionate and comprehensive “treat in place” care; 2.) a structure to allow interdisciplinary team and staff collaboration on a daily basis; 3.) a willingness to change from traditional modalities of healthcare delivery to a resident-oriented, quality-of-life approach.

**How long has the achievement been in place?**

The Bethany Model of Care Program (BMCP) was first presented to Bethany staff and residents in January of 2003. The program has been operational for 14 years.

**If there is a cost, how is it met?**

A cost savings results from the low turnover rate of registered nurses, licensed practical nurses and certified nursing assistants which in turn reduces recruiting and training costs. The BMCP ”treat in place” modality of care has resulted in cost savings associated with decreased hospitalizations, testing, medication costs and transportation services. Since the program has been incorporated into Bethany Health Care Center’s daily operational plan there is no added cost.

**Has success been measured? If so, how and with what results?**

Measurement of success is credited to adherence to a facility-wide assessment and improvement plan overseen by the governing body and administration of Bethany Health Care Center. The plan is mission based to provide quality care focused on each resident’s needs and family member’s satisfaction. It includes formulating methods to define problem identification, prioritizing as well as monitoring of resident healthcare needs, evaluation and documentation of results. Outcomes of the BMCP “treat in place modality of care” include: 1.) significantly reduced numbers of acute hospitalizations from 29 in 2003 to 16 in 2011; 2.) a 55% decrease in hospital admissions; 3.) a less than 1% hospital readmission rate; 4.) a decline in the number of falls; 5.) lower mortality rates; 6.) enhanced quality of life and longevity; 7.) timely intervention and diagnosis; 8.) lower staff turnover.

**How are the organization’s efforts and accomplishments furthering the principles of LeadingAge Quality First?**

Bethany Health Care Center’s efforts and accomplishment in furthering the principles of Leading Age Quality First are demonstrated threefold: first, in consistently scoring 100% in resident/family State conducted satisfaction surveys. Secondly, for the past three consecutive years, Bethany was ranked among the top long-term care facilities in the country by U.S. News and World Report’s out of approximately 15,000 nursing home nationwide and as one of “America’s Best Nursing Homes,” receiving a five-star rating in the federal government’s measurement of health inspections, nurse staffing, and quality measures of individual care. Lastly, in 2009, Bethany received the American Medical Directors Foundation/Evercare Award for development of its Model of Care Program (BMCP) in improving the quality of life for persons living in nursing homes.

**Executive Summary**

**Provide a brief description of the nominated organization (mission, size, scope of services, persons served, etc.)**

A sponsored ministry of the Sisters of St. Joseph of Boston, Bethany Health Care Center’s mission is to provide quality care for residents and patients. A decade ago, Bethany introduced its Model of Care Program; central to the program is its “treat in place” modality of care which has significantly reduced the number of hospital admissions. Bethany’s goal is to integrate its award-winning delivery of healthcare in addressing the physical needs and living experiences of its residents residing on Skilled Nursing Floors (SNF) 2, 3, 4 and Rest Home floors 5 and 6. Residents on the (SNF) floors (including a 35-bed secured Special Care and memory impairment unit) range in age from 67 to 101
years old with only 27% of these residents either ambulating independently and/or needing some form of supervision; 69% suffer from some form of dementia. Of this population, 74.50% are 85 year olds and above with an average age of 89 years old. Serving an 84.70% Medicaid population on the three skilled nursing floors (SNF) compared to a State Medicaid population of 45.8% (FY 2010 data) for long-term care facilities. There is a 98% Medicaid population on Bethany’s two Rest Home floors. These residents require assistance with daily living and medications. Originally built as a hospital and currently housed on 63 acres of land, the 169-bed short and long-term healthcare center, maintains an on-site outpatient clinic that reduces the need for residents to take disruptive trips to off-site care providers. The separately licensed clinic meets all regulatory standards and gives residents convenient access to a wide range of medical treatments including: dental care, dermatology, ophthalmology, podiatry, optometry, audiology and rehabilitation. Critical to maintaining quality healthcare and services for Bethany’s residents is the delivery of on-site medical, physical, occupational and speech therapy.

Provide a brief executive summary summarizing the key points of the award nomination.

Bethany Health Care Center (a 169-bed short and long-term healthcare center) is nominated for the Innovation in Care and Services Award for its delivery of quality healthcare through the Bethany Model of Care Program (BMCP). Fundamental to the program is a “treat in place” modality of care resulting in significantly reduced numbers of acute hospitalizations from 29 in 2003 to 16 in 2011, a 55% decrease in hospital admissions. Today, Bethany experiences a less than 1% hospital readmission rate due to the (BMCP) “treat in place modality of care.” The (BMCP) has been adopted as the preferred model of care by Bethany residents, families and staff. Integrated with the (BMCP), is a “consistency of care” method of delivery of services. To achieve the desired outcomes, established benchmarks for measuring performance are used. These include: monitoring data, quality measures, compatibility with Bethany policies and procedures and survey results. Critical to maintaining quality healthcare and services for Bethany’s residents is the delivery of on-site medical, physical, occupational and speech therapy. With the implementation of the (BMCP), residents have experienced an enhanced quality of life and longevity. Resident and family satisfaction are key components in achieving quality healthcare at Bethany. Satisfaction of residents (who range in age from 67 to 105 years old) and their families is demonstrated in Bethany’s consistently scoring 100% in resident/family State conducted satisfaction surveys. Uncompromised in its commitment to quality care, Bethany serves the community regardless of an individual’s socioeconomic or religious affiliation. Despite realizing reimbursement rate losses for approximately 82% of its residents, Bethany Health Care Center was named to the 2012 Honor Roll in U.S. News & World Report’s annual Best Nursing Homes, ranking in the top 38 long-term care facilities nationwide.
BETHANY HEALTH CARE CENTER

YOGURT NUTRITIONAL SUPPLEMENT

POLICY
The Dining and Nutrition Services Department will prepare and deliver homemade yogurt with a physician order.

PURPOSE
To provide yogurt with beneficial bacterial cultures in a sanitary environment.

RESPONSIBILITY
General Manager and assigned Nutrition personnel.

PROCEDURE
Yogurt will be provided upon physician’s order.

Nursing will complete and deliver a Diet Requisition and Dietitian Communication Form for the order.

Dietary will prepare the yogurt utilizing the yogurt making machine and according to manufacturer’s instructions and sanitary guidelines. (see attached)

Dietary will be responsible for delivering yogurt in air-tight designated container with date it was prepared and date of expiration. Expiration is 7 days after preparation.

Nursing is responsible for delivery to resident and storage on the nursing unit. Nursing is responsible for returning designated containers.

Yogurt making machine will be sanitized according to unit dish-room procedures (either in dish machine or 3-compartment sink that includes chemical sanitizing step).

Reviewed August 2012
TREATMENT PROTOCOL

A resident who is started on antibiotic therapy will be given 2 oz. of yogurt 3 times a day for one week after the last dose of antibiotic therapy.

A resident with diarrhea for more than 48 hours will be given 2 oz. of yogurt 3 times a day for one week. Other diagnostic tests will be discussed with physician and nurse practitioner as needed.

Facility will monitor residents who have diagnosis of C-Diff on admission. Residents will be given 2 oz. of yogurt 3 times a day for one week. Follow-up test will be done subsequently.

Facility will also monitor residents who have diagnosis of facility-acquired C-Diff and will treat them accordingly.

Reviewed August 2012
### Table A. Item Level Satisfaction Scores and Peer Groups for Bethany Health Care Center

| Overall Satisfaction Scores | Bethany Health Care Ctr | Statewide | Peer Groups
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2007</td>
<td>2005</td>
</tr>
<tr>
<td>Overall Satisfaction Scale</td>
<td></td>
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<tr>
<td>Overall, how satisfied are you with this nursing home?</td>
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<tr>
<td>Overall, how satisfied are you that all of the resident's needs are met?</td>
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<tr>
<td>Would you recommend this nursing home to a friend or family member? (% indicating &quot;Yes&quot;)</td>
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<tr>
<td><strong>DOMAIN1: Satisfaction with the Administrative and Personal Care Staff of the Nursing Home</strong></td>
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<tr>
<td>That the resident gets his or her medication at the appropriate time?</td>
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<tr>
<td>That the quality of physician and specialist services meets the resident's needs?</td>
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<tr>
<td>With the help available for filling out the resident's paperwork?</td>
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<tr>
<td>That the same staff is assigned to care for the resident over time?</td>
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<tr>
<td>That the staff considers cultural and ethnic differences when providing services?</td>
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<tr>
<td>That there is enough staff on during all shifts to provide sufficient help?</td>
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<tr>
<td>With support provided to families from social services and family groups in the home?</td>
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<tr>
<td>That staff attends to the resident's emotional needs?</td>
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<tr>
<td>The staff is friendly when you come to visit?</td>
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<tr>
<td>That the staff treats the resident with kindness and respect?</td>
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<tr>
<td>That the staff is able to communicate effectively with the resident?</td>
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<tr>
<td>That staff get along and work well together?</td>
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<tr>
<td>With the response of the staff to problems and requests?</td>
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<tr>
<td>That there is open communication between the staff and you?</td>
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<tr>
<td>That you receive timely notification of changes in condition?</td>
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<tr>
<td>That staff willingly shares with you how the resident is doing day to day?</td>
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</tbody>
</table>

An up arrow (↑) in the "Diff" column indicates that your facility's score is statistically higher than in 2007 or compared to the statewide or peer group score, a down arrow (↓) indicates that your facility's score is statistically lower (at 95% confidence). Blank cells indicate no difference.

* Denotes a statistical difference between 2007 and 2009.
Table A (Continued). Item Level Satisfaction Scores for Bethany Health Care Center

<table>
<thead>
<tr>
<th>Satisfaction With:</th>
<th>Bethany Health Care Ctr</th>
<th>Statewide</th>
<th>Peer Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2007</td>
<td>2005</td>
</tr>
<tr>
<td><strong>DOMAIN 2: Satisfaction with the Physical Environment  of the Nursing Home</strong></td>
<td></td>
<td></td>
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<tr>
<td>That hallways and public areas are kept odor free?</td>
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<tr>
<td>With the cleanliness of the resident's room?</td>
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<tr>
<td>With the amount of space available to socialize with the resident outside of his or her room?</td>
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<tr>
<td>That the facility is clean and well maintained?</td>
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<tr>
<td>With the physical attractiveness of the nursing home?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>That the resident's room is bright and cheerful?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>With the amount of space for personal possessions within the resident's room?</td>
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<td></td>
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<tr>
<td><strong>DOMAIN 3: Satisfaction with the Activities Available to Residents</strong></td>
<td></td>
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<tr>
<td>That staff encourages the resident to take part in social activities?</td>
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<tr>
<td>That meaningful activities are being offered on all seven days of the week?</td>
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<tr>
<td>With the amount of physical exercise offered?</td>
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<tr>
<td>That there are enough outdoor activities?</td>
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<tr>
<td>With the clergy visits or religious services?</td>
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<tr>
<td>With the variety of stimulating activities offered?</td>
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<tr>
<td><strong>DOMAIN 4: Satisfaction with the Personal Care Services Provided to Residents</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>That dirty clothes are changed as needed?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>That the staff assures that the resident is clean?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>That staff keeps to the resident's planned personal care routine?</td>
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<tr>
<td>When laundry is done by the facility, the laundry system gets the resident's own clothes back to him or her?</td>
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<td></td>
<td></td>
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<tr>
<td>That bed linens are changed as needed?</td>
<td></td>
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</tbody>
</table>

An up arrow (↑) in the “Diff*” column indicates that your facility's score is statistically higher than in 2007 or compared to the statewide or peer group score, a down arrow (↓) indicates that your facility's score is statistically lower (at 95% confidence). Blank cells indicate no difference.

* Denotes a statistical difference between 2007 and 2009.
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<thead>
<tr>
<th>Satisfaction With:</th>
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<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2007</td>
<td>2005</td>
</tr>
<tr>
<td><strong>DOMAIN 5: Satisfaction with Food and Meals</strong></td>
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<tr>
<td>With the food choices provided at each meal?</td>
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<tr>
<td>With the quality of the food, that is, attractive, appetizing, and nutritious?</td>
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<tr>
<td>That there are a variety of menu selections throughout the week?</td>
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<tr>
<td>With the assistance available to help the resident complete his or her meal?</td>
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<tr>
<td><strong>DOMAIN 6: Satisfaction with Residents' Personal Rights</strong></td>
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<tr>
<td>That the resident is encouraged to be as independent as possible?</td>
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<tr>
<td>That staff members respect the resident's privacy?</td>
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<tr>
<td>That the nursing home takes sufficient steps to protect personal items?</td>
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<tr>
<td>That there is enough security for the facility?</td>
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<tr>
<td>With the resident's personal safety?</td>
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</tr>
<tr>
<td><strong>Overall Satisfaction Scale Items</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the care at this nursing home, overall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the management of this nursing home, overall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the staff at this nursing home, overall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the activities at this nursing home, overall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the communication at this nursing home, overall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the meals at this nursing home, overall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the physical environment at this nursing home, overall?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>That the resident's personal rights are respected, overall?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*An up arrow (↑) in the "Diff" column indicates that your facility's score is statistically higher than in 2007 or compared to the statewide or peer group score, a down arrow (↓) indicates that your facility's score is statistically lower (at 95% confidence). Blank cells indicate no difference.

* Denotes a statistical difference between 2007 and 2009.
For the most part, results have

Top rated items are
3). Lowest rated items are ..

Most noted improvement is evident in

The response rate continues on its

**OVERALL SCORE FOR YOUR LOCATION**
(Includes historical and newer items)

<table>
<thead>
<tr>
<th></th>
<th>Least positive</th>
<th>Most positive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2012</td>
</tr>
</tbody>
</table>

**OVERALL SCORE - Newer Items**

<table>
<thead>
<tr>
<th>1. Over the last year I have experienced people living the mission and values of this organization.</th>
<th>Least positive</th>
<th>Most positive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2012</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. I feel I contribute to fulfilling the mission and values of this organization.</th>
<th>Least positive</th>
<th>Most positive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2012</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. This organization provides excellent care, with respect, compassion and kindness.</th>
<th>Least positive</th>
<th>Most positive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2012</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. This organization values spirituality in the workplace.</th>
<th>Least positive</th>
<th>Most positive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2012</td>
</tr>
</tbody>
</table>

Response Rates:

Rating scale used: 1-Strongly Disagree, 2-Disagree, 3-Neutral, 4-Agree, 5-Strongly Agree
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Over the last year I have not observed any serious violations of the policies and procedures or laws/regulations.</td>
<td>2002</td>
<td>2004</td>
<td>2006</td>
<td>2008</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>6. The organization's policies/procedures manuals, and other such documents provide solid guidance as to how the organization conducts its business in an ethical manner.</td>
<td>2002</td>
<td>2004</td>
<td>2006</td>
<td>2008</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>7. If I report someone for non-compliance I would not be retaliated against, even if that person is my supervisor. (while the wording for this survey item changed in 2010, the general meaning remains the same)</td>
<td>2002</td>
<td>2004</td>
<td>2006</td>
<td>2008</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>8. I am proud to tell people about this organization and my work.</td>
<td>2002</td>
<td>2004</td>
<td>2006</td>
<td>2008</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>9. I can rely upon various organization policies and procedures manuals to provide me with useful and ethical guidance as to what is expected of me in the work environment.</td>
<td>2002</td>
<td>2004</td>
<td>2006</td>
<td>2008</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>10. Whenever anyone in the organization finds mistakes in business records, management can be counted upon to take proper corrective action.</td>
<td>2002</td>
<td>2004</td>
<td>2006</td>
<td>2008</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>11. The organization has a reputation for honesty and integrity in dealing with patients, residents, vendors, customers, staff and payers.</td>
<td>2002</td>
<td>2004</td>
<td>2006</td>
<td>2008</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>12. Individuals at all levels are dealt with in the same manner if they fail to follow policies and procedures.</td>
<td>2002</td>
<td>2004</td>
<td>2006</td>
<td>2008</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>14. Regardless of race, gender, age, sexual orientation, religious creed or national origin, employees with similar qualifications are given the same chances for employment, training and promotion within my division.</td>
<td>2002</td>
<td>2004</td>
<td>2006</td>
<td>2008</td>
<td>2010</td>
<td>2012</td>
</tr>
</tbody>
</table>
Be A Star!

You are all invited to take part in the new “Be A Star” program. Help promote better communication and teamwork by becoming “Stars.”

You can “Be A Star” in communication by:

- making sure your co-worker gets the info he/she needs at a shift change
- finding an answer for a co-worker or resident
- making sure you give all info needed to another department so they can do their work
- letting your supervisor know when there is a problem and have a solution to suggest

To “Be A Star” for team work:

- you can take the time to help out a co-worker who is having a busy day
- treating co-workers respectfully in word and actions
- giving a co-worker a break from a stressful situation
- doing something that isn’t your job!

Then help improve the recognition we give each other for the great things we do. Look for those employees whose actions stand out as a communicator or as a team member.

When you see a co-worker who is a “Star” fill out a “Be A Star” card and put it in a collection box. There will be a collection box outside the Meadow Café and in the Gwynedd House Lobby.

Our “Be A Star” program will start August 31st and run until October 31st.

We will be recognizing the outstanding “Stars” at the Employee Recognition Reception in November.
Evaluation Request Form

Patient Name: ________________________________
Referring Nurse: ________________________________
Room #: __________________ Date: __________________

Resident has had the following change:

☐ Improvement  ☐ Decline

In the areas noted as follows:

☐ Falls  ☐ Communication
☐ ADL’s  ☐ Dressing Skills
☐ Gait/Ambulation  ☐ Self Care Skills
☐ ROM  ☐ Bed Mobility
☐ Strength  ☐ Contracture (location) _____________
☐ Balance  ☐ Self Releasing Belt
☐ Functional Transfers  ☐ Wheelchair Positioning
☐ Activity Tolerance  ☐ Low Bed
☐ Diet Change  ☐ MD Request
☐ Swallowing  ☐ Other ____________________________

Nursing has attempted the following:

1. __________________________________________

2. __________________________________________

If applicable, nursing has requested an order for evaluation from the physician for:

☐ PT  ☐ OT  ☐ ST

__________________________________________
Nursing Representative Signature  Date

Copy of Evaluation Request must be kept in rehab files.

Therapy Services Provided by

B 5 9 Evaluation request form
Nursing Home Best Practices Evaluation Final Report, Appendix I: Documents Shared During Site Visits 116
### Influenza Vaccination for Employees 2012-2013

**Screening Questions**

<table>
<thead>
<tr>
<th>Allergy to Eggs?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy to Latex?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

→ If yes, check with physician prior to vaccinating

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you sick with a fever today?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you ever had a serious reaction to the influenza vaccination?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever had Guillain-Barré Syndrome?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

→ If yes to any question in 1-3, check with physician prior to vaccinating

#### Employee Information

<table>
<thead>
<tr>
<th>Employee Information</th>
<th>Consent/Declination</th>
<th>Vaccine Tracking Info.</th>
<th>Administration/Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN/RN</td>
<td>By Signing I am consenting to receive the influenza vaccination</td>
<td>Lot Information:</td>
<td>Name/Initials:</td>
</tr>
<tr>
<td>NAC/LVN/MA/C.N.A.</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>Signature of Consent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have already received the vaccination at a different location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>Where:</td>
<td>Manufacturer:</td>
<td>Date:</td>
</tr>
<tr>
<td>Housekeeping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Services</td>
<td>By Signing I acknowledge that I have been offered this vaccine and have been informed of its benefits and the risks my declination poses to the residents. I have chosen to decline the vaccination.</td>
<td>Route/Site:</td>
<td>Time:</td>
</tr>
<tr>
<td>Other:</td>
<td>Reason:</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>RUA/LUA</td>
<td>Facility Site Name:</td>
</tr>
<tr>
<td>Employee at this Facility</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

→ Signature of Declination
**INDIVIDUAL IN-SERVICE ATTENDANCE RECORD**

**NAME:** ________________________________  **TITLE:** _________

**CERT/LIC NUMBER:** ________________________________

**ALZHEIMER'S TRAINING**

**PRESENTER:** MARGIE MUNN  **ALZHEIMER'S CARE DIRECTOR**

<table>
<thead>
<tr>
<th>SUBJECT/TOPIC</th>
<th>SIGNATURE</th>
<th>DATE</th>
<th>HOURS</th>
<th>DATE</th>
<th>HOUR/S</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HOME-LIKE ENVIRONMENT</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ALZHEIMER'S: DISEASE PROCESS</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. PERSON CENTERED CARE</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. COMMUNICATION IN DEMENTIA - PART 1</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. COMMUNICATION IN DEMENTIA - PART 2</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. PRACTICAL APPROACH TO BEHAVIORS</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. ACTIVITIES OF DAILY LIVING</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. LEADING PROGRAMS</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. PERSONALIZED PROGRAMING/ CULTURAL CHANGE</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. DEATH AND DYING</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. SUPPORTING THE FAMILY</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Personal Facts and Insights

Each of us has a unique personal history. The Personal Facts and Insights form helps you to capture what is most important to share with others in your life.

Name: ____________________________

Preferred name: ____________________

Primary Language: __________________

Family/Friends

Marital status:  □ Single  □ Married  □ Divorced  □ Widowed  □ Partner

Spouse's name: ______________________

Children: (Specify name, age, name of spouse if married, city of residence and if deceased)

Grandchildren: (Specify name, age, name of spouse if married, city of residence and if deceased)

Brothers and Sisters: (Specify name, age, name of spouse if married, city of residence and if deceased)

Significant others and Friends: (Specify name, age, name of spouse if married, city of residence and if deceased)

Of all the family and friends, who visits most often? How often?
**Level of Cognition**

Do you or does the person you are caring for have problems with any of the following? Please check the answer:

1. Repeating or asking the same thing over and over?
   - □ Not at all  □ Sometimes  □ Frequently  □ Does not apply

2. Remembering appointments, family occasions, holidays?
   - □ Not at all  □ Sometimes  □ Frequently  □ Does not apply

3. Writing checks, paying bills, balancing the checkbook?
   - □ Not at all  □ Sometimes  □ Frequently  □ Does not apply

4. Shopping independently (e.g. for clothing or groceries)?
   - □ Not at all  □ Sometimes  □ Frequently  □ Does not apply

5. Taking medications according to the instructions?
   - □ Not at all  □ Sometimes  □ Frequently  □ Does not apply

6. Getting lost while walking or driving in familiar places?
   - □ Not at all  □ Sometimes  □ Frequently  □ Does not apply

*This tool was developed for the Chronic Care Networks for Alzheimer’s Disease (CCN/AD) project and is the joint property of the Alzheimer’s Association and the National Chronic Care Consortium.*

**Communication**

- **Prefers:**
  - □ Being alone  □ Spending time with one or two friends/family  □ Being with a lot of people

What communication styles work best? (short sentences, simple words, touch, gestures) Hard of hearing? Needs extra time to respond?
**Personality and Temperament**

Describe personality and temperament (quiet, moody, anxious, outgoing)

What, if anything, is irritating or upsetting?

What, if anything, is frightening?

What is calming?

What is valued or appreciated?

**Daily Routine**

Describe a typical day:

Any established routines, such as having coffee and newspaper in the morning?
Daily Routine (cont.)

List favorite activities or hobbies:

Likes:

Dislikes:

Religion and Spirituality

Religious or spiritual background or beliefs:

Name of synagogue, church, mosque (if currently a member) include address and phone:

Who, if anyone, should be contacted for religious or spiritual support?

Daily Needs

Bathing

How is the bath taken?  □ Shower  □ Bath  □ Sponge bath  □ Other

How often?  □ Daily  □ Weekly  □ Other

At what time of day?  □ Morning  □ Afternoon  □ Evening

Are there any devices used?  □ Shower chair  □ Hand rails  □ Shower hose  □ Other

Describe the steps involved in bathing (soaps, shampoos used, other supplies, who does the washing, room temp, room set up):
Grooming

Which of the following are used or worn?
☐ Electric shaver  ☐ Razor  ☐ Eyeglasses  ☐ Hearing aid  ☐ Dentures  ☐ Make up  ☐ Wig

Describe the steps for grooming: (shaving, brushing teeth, applying make up, right or left handed, require assistance? How much?)

Toileting

What words or phrases are used for going to the bathroom?

What is the natural schedule for using the bathroom? (time of day, frequency)

Is there control of bowel? Bladder?

Are disposable briefs used? Undergarments? Pads?

Describe the steps in using the bathroom: (reminding, unfastening and fastening clothes, finding bathroom, locating toilet bowl, wiping, amount of help needed)

Dressing and Undressing

Describe the steps for getting dressed and undressed: (order of clothing, laying out clothes, favorite clothing, sleep wear, what is done without help, etc)
Eating

What is used for eating?  ☐ Fork  ☐ Spoon  ☐ Knife  ☐ Hands

Comments:

Are there special dietary needs? (include information such as low fat, low cholesterol, low sodium, diabetic, pureed foods, supplements)

Food allergies:

Favorite foods/snacks:

Strong dislikes:

Is there difficulty swallowing certain foods or liquids? (List and describe)

Describe the steps involved in eating: (special words used to eat, mealtime schedule, possible distractions, where meals are served, table set-up, amount of help needed, etc)
Walking/Mobility

What walking aids are used?  □ Walker  □ Cane  □ Wheelchair  □ None

Describe the type of assistance/supervision needed for walking: (assistance from another person, how far without tiring, difficulty with stairs or changes in flooring, steadiness, etc)

Sleeping Habits

Wake up time____________ Bedtime_________ Naps__________________________

Any difficulty sleeping? What helps? Bedtime routine?

Sleep Partner?

Sexuality

Sexual orientation:

Describe current sexual practice (include if sexually active, type and frequency of sexual activity, sexual partner, assistive devices)
**Personal History**

Date of Birth ___________________ Place of Birth ___________________

Describe childhood including birthplace, parents and grandparents, brothers and sisters, early education, family pets, best friends, favorite activities.

Describe adolescence including your high school, favorite classes, friends and interests, hobbies, sports, your first job.

Describe adult life such as college and work, family life, clubs or community involvement, first home, military service, hobbies, life achievements, accomplishments, travel.

Describe any significant life event – good or bad:

Completed by: ____________________________ Date completed: ____________
**ACTIONS PLAN**

**Date:** ______________  **Event:** __________________

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action items or initiatives</th>
<th>Responsible Individuals</th>
<th>Time line</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Individual submitting:** ____________________  **Date:** ____________________

---

Nursing Home Best Practices Evaluation Final Report, Appendix I: Documents Shared During Site Visits 127
“Always Available” Menu

- Egg Omelet
- Turkey Breast Sandwich
- Cheese Sandwich
- Peanut Butter & Jelly Sandwich
- Chicken Breast
- Plain Baked Fish
- Mashed Potatoes
- Cooked Vegetable (noon meal)
- Soup (choice may vary)
- Cottage Cheese (w/ Apple Butter)
- Tossed Salad
- Yogurt
- Applesauce
- Peaches
- Pudding
- Jello
- Ice Cream
- Juice (variety)
- Milk
This form is to be used for the following:
1. Analysis of Readmission
2. Admission from Skilled care or Personal Care/
3. Emergency dept and return
4. Observation stay in lieu of admission to the Hospital

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Attending MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of original Admission</td>
<td>Diagnosis: Primary</td>
</tr>
</tbody>
</table>

Reason for completing the form (use one of the reasons above)

<table>
<thead>
<tr>
<th>Date of readmission</th>
<th>Diagnosis of readmission:</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOS of readmission:</td>
<td>Date of analysis:</td>
</tr>
<tr>
<td>Date, time of readmission</td>
<td>Completed by:</td>
</tr>
<tr>
<td>Day of week of readmission</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis Steps</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEP 1: Identify appropriate team to evaluate the admission/readmission. This is a team who knows the Resident.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STEP 2: Establish the objectives and timeline for the analysis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STEP 3: Define the issues: What are the chart findings, any variances, etc.? What happened that resulted in the readmission?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analysis Steps</td>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Be specific with times of any communication.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 4:</strong> List Medications the resident was on.</td>
<td>Prior to first admission:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In hospital:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>While in Health Care:</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 5:</strong> What were the resident’s clinical symptoms that resulted in readmission?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When were the symptoms first noticed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 6:</strong> What interventions occurred? (communication, lab test, etc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 7:</strong> What could have been done to prevent this readmission?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 8:</strong> Gap analysis:</td>
<td>Were there gaps between standard procedures and the actual process that occurred? If so, what were they?</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 9:</strong> Systematically explore for root causes.</td>
<td>What root causes were or could have contributed to the event?</td>
<td></td>
</tr>
<tr>
<td>Analysis Steps</td>
<td>Response</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>STEP 10</strong> Collect and analyze data about causes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What process variations occur and how frequently?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is staff properly qualified and currently competent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is orientation adequate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are policies existent that could have been a help?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 11: Select and implement best fit improvements and measures:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What actions must be taken?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What measures/indicators will be put in place?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 12: Evaluate measurements from # 11 above and effects on the process:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When will these steps be reevaluated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who will be responsible for this evaluation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 13: Continue to monitor to assure sustained improvement:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who will monitor and review performance?</td>
<td></td>
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</tbody>
</table>
Report to HC QI committee 4-26-2012

Readmission to Hospital with 30 days

Since November 2011, there were 8 residents readmitted to the hospital, 2 of them were readmitted 2 x, resulting in 10 readmits to the hospital

Primary diagnosis varied, several residents had 2 diagnosis for the readmits

1. UTI (4 residents)
2. GI bleed
3. MI
4. Cellulites, staph infection
5. Anorexia, hyponatremia (2 x for same resident)
6. CVA/seizures
7. Fecal impaction, renal failure

Primary attending MD were (3) (5) and (2)

3 of the residents did not return to LH

1. One transferred from the hosp to Hospice and subsequently expired there,
2. One expired in the hospital
3. One d/c from hospital to home and subsequently expired there

Gaps identified:

1. Lack of timely assessment of symptoms by nursing staff
2. Inadequate documentation of rationale by both MD and nurse staff
3. Lack of timely notification to MD of change in symptoms
4. Lack of MD response
5. Lack of emergency med box containing the requested medication
6. Requirement to either clarify or change policy regarding act 52 and bladder scanning protocol
7. Delay in response to obtain a lab report
8. Lack of clear understanding of implications of secondary diagnosis as it affects the care, assessment
9. Use of medical director when a protocol is not followed by either the staff or the MD based on family request

Next steps

1. Quantify the percent of readmits
2. Develop action plan to provide follow through
3. Revise policies as necessary
4. Educate nursing staff on assessment skills
**HEALTHCARE MOCK SURVEY CHECKLIST**

Y - Yes;  N - No (If No, record location);  N/A - Not applicable

Name of staff participant ________________________________  Date ______________

<table>
<thead>
<tr>
<th>Environmental Safety</th>
<th>Oregon House</th>
<th>Manheim House</th>
<th>Ephrata House</th>
<th>Lancaster House</th>
<th>Conestoga House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are Maintenance carts attended to at all times?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are janitor’s rooms’ doors locked?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Are Housekeeping carts locked?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are medication carts/medication rooms locked?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Are soaps/ solutions/chemicals kept in locked cupboards?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Are cleaning solutions properly labeled and stored behind locked doors?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are linen room doors closed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are linens and hampers covered when in the hallway?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Are all equipment/carts kept to one side of the hall?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are handrails secure?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are stairwells kept free and unobstructed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are stairwells free of storage?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are exits unobstructed?</td>
<td></td>
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</tr>
<tr>
<td>Are exit lights lit?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Are electrical plugs and cords in good condition?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are resident areas free of multi plug, power strips, or extension cords?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are cords off the floor?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are storage closets free of clutter? Is everything stored 18” or more from ceiling/sprinkler heads? Are all items off the floor?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry area – Is the sprinkler system/pipe free of attachments and without any Ecolab plastic tubing being supported by the sprinkler pipe?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are ceiling tiles in good condition? (If no, give the location of any stained or cracked tiles that need to be replaced.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are all painted surfaces in good condition? (If no, give the location of any places where chipped paint needs to be repaired.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any unscaled openings at areas of wire penetration into walls?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Conestoga House only:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the doors to the terrace locked?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are residents always attended when they are on the terrace?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### HEALTHCARE MOCK SURVEY CHECKLIST

**Y** – Yes; **N** – No (If No, record location); **N/A** – Not applicable

Name of staff participant ___________________________ Date __________

<table>
<thead>
<tr>
<th>Fire Safety</th>
<th>Oregon House</th>
<th>Manheim House</th>
<th>Ephrata House</th>
<th>Lancaster House</th>
<th>Conestoga House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are “SEARCHED” cards on doorframes?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are fire extinguishers inspected regularly?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can staff correctly state what PASS and RACE mean?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the clothes dryers in the houses, are the lint filters cleaned?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are alcohol based hand sanitizers at least 6&quot; from electrical outlets/equipment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are beds against the wall in resident rooms? Is the outlet on the wall in use? Is a safety brace located around the outlet?</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oxygen Safety</th>
<th>Oregon House</th>
<th>Manheim House</th>
<th>Ephrata House</th>
<th>Lancaster House</th>
<th>Conestoga House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are O₂ concentrators clean, and tubing dated and bagged when not in use?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are stored O₂ cylinders separated into full &amp; empty racks?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are O₂ cylinders in holders to prevent tipping?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Are warning signs posted where oxygen is in use or stored?</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infection Control</th>
<th>Oregon House</th>
<th>Manheim House</th>
<th>Ephrata House</th>
<th>Lancaster House</th>
<th>Conestoga House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are areas clean and free of odor?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are all linen carts covered?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are med carts, housekeeping carts, and maintenance carts clear of food and drinks?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Is staff using hand dispensers? Is staff practicing good hand hygiene?</td>
<td></td>
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<tr>
<td>Are pumps (IV and feeding) clean?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Are personal care items labeled and dirty linens removed in shared bathrooms and spas?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Are linens off the floor in residents’ rooms?</td>
<td></td>
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</tr>
</tbody>
</table>
### Dining Services

<table>
<thead>
<tr>
<th>Dining Services</th>
<th>Oregon House</th>
<th>Manheim House</th>
<th>Ephrata House</th>
<th>Lancaster House</th>
<th>Conestoga House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is all refrigerated food and juice covered, labeled and dated?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there thermometers in all refrigerators? Are temperature readings between 34° - 41° F? (Med rooms, activity areas, staff, kitchens)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Is the refrigerator clean and defrosted?</td>
<td></td>
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</tbody>
</table>

### Staff Observations / Questions

<table>
<thead>
<tr>
<th>Staff Observations / Questions</th>
<th>Oregon House</th>
<th>Manheim House</th>
<th>Ephrata House</th>
<th>Lancaster House</th>
<th>Conestoga House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is everyone on staff wearing a name badge?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Do all staff know where the DOH survey is located?</td>
<td></td>
<td></td>
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<tr>
<td>Do the nurses know where the hospice care plans are located?</td>
<td></td>
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</tr>
<tr>
<td>Do staff interactions with residents demonstrate respect, dignity, privacy/choice?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is all resident information concealed? (Including MAR, assignment sheets, medicals records, etc.)</td>
<td></td>
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</tr>
<tr>
<td>Are staff able to give an appropriate answer as to what they would do if a resident was missing?</td>
<td></td>
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<tr>
<td>Would staff know what to do if they felt there was a problem/concern with a resident or with how another staff member was treating a resident?</td>
<td></td>
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<tr>
<td>Do staff know where the MSDS manuals are located?</td>
<td></td>
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<tr>
<td>Do staff know where the Red Emergency Manual is located?</td>
<td></td>
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</tr>
<tr>
<td>Do staff know what to do if they discovered a fire?</td>
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</tbody>
</table>

### Life Enrichment

<table>
<thead>
<tr>
<th>Life Enrichment</th>
<th>Oregon House</th>
<th>Manheim House</th>
<th>Ephrata House</th>
<th>Lancaster House</th>
<th>Conestoga House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there opportunities for resident socialization?</td>
<td></td>
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</tr>
<tr>
<td>Are residents actively engaged in activities?</td>
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<tr>
<td>Is a variety of activities offered?</td>
<td></td>
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<tr>
<td>Are residents encouraged to participate in Life Enrichment activities?</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Do activities take place on evenings and weekends?</td>
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</tr>
</tbody>
</table>
Orientation Checklist

Caregivers

1. Meet with DON

- Obtain registration paper
- Verify PPD cleared
- Review location of emergency/infection control book
- Review location of MSDS book
- Review organizational chart
- Review dress code policy
- Review abuse and neglect reporting
- Review meetings (RN/LPN, house meetings, learning circles, REC day, Institute for caregiver education, Dementia education)
- Review the survey process
- Review medication reduction policy

2. Meet with Betty

- Review schedule location
- Review schedule policy
- Review vacation requests
- Review exchange slip process

3. Meet with Connie Gockley

- Review lift safety
- Review caretracker documentation
- Review gait belt use

4. Meet with Margarita Kosko

- Nutritional needs

5. Meet with Ethel Caldwell

- Review Honoring Lives principles
- Review households
- Teamwork

6. Meet with IT

- Review phone usage
- Review computer "rights"
- Review e-mail access
- Team leaders should not log into the computer for caretracker

7. Meet with manager to review equipment

- Ambu bag and emergency board
- BP cuffs, thermometer, stethoscopes
- Pyxis machine
- Phone sign-in process

8. Meet with Chuck Maines

- Abuse, neglect and behaviors

Shadowing:

1. Housekeeper

2. Dining assistant

3. Life Enrichment Aide

4. Resident Associate

5. Social Service

6. Household team leader

Videos:

1. Pain video

2. Copper Ridge video on SharePoint

3. A Way Back Home

4. Falls video

5. Survey video

6. Caretracker video

7. ADL video
Caregiver Orientation Checklist
(to be completed with orientor)

Name: ________________________________
Position: ________________________________
Start date: ________________________________

___/___ tour of the house
___/___ break room
___/___ locker area
___/___ introductions to team members
___/___ Fire evacuation (alarm panel)
___/___ watchmate panel

___/___ alert charting
___/___ antidepressant charting (awareness)
___/___ Act 52 flow sheets
___/___ bladder assessments
___/___ admission assessment checklist
___/___ NA skin assessment sheets

Resources:

___/___ house calendar
___/___ assignment book
___/___ PT/OT/ST schedules
___/___ NA flowsheets
___/___ 24 hour report sheets
___/___ care plans (room and desk)

Protocols:

___/___ Pressure ulcer
___/___ Elopement
___/___ Falls
___/___ routine vital signs
___/___ WTS/HTS/reweights

Miscellaneous:

___/___ DNR orders (an understanding)
___/___ End of life care
___/___ POLST

Orientee signature and date when checklist is complete: ________________________________
Orientation Checklist

RN-LPN

_____/______ 1. Meet with DON

- Obtain license and CPR card
- Verify PPD cleared
- Review hard copy and intranet access of policies and procedures
- Review location of emergency/infection control book
- Review location of MSDS book
- Review organizational chart
- Review dress code policy
- Review abuse and neglect reporting
- Review meetings (RN/LPN, house meetings, learning circles, REC day, Institute for caregiver education, Dementia education)
- Review the survey process
- Review medication reduction policy
- Lab consents x 3

_____/______ 2. Meet with Steph/Jennine

- RL Solutions

_____/______ 3. Meet with a manager

- Review an admission packet
- Review Medicare A certifications

_____/______ 4. Meet with Betty

- Review schedule location
- Review schedule policy
- Review vacation requests
- Review exchange slip process

_____/______ 5. Meet with Connie Gockley

- Review lift safety
- Review caretracker documentation
- Review gait belt use

_____/______ 6. Meet with Kristin Nace

- Review MDS 3.0
- Review MDS checklists
- Review care plan process
- Review Medicare charting
- Review Alert charting

_____/______ 7. Meet with Margarita Kosko

- Nutritional needs

_____/______ 8. Meet with Ethel Caldwell

- Review Honoring Lives principles
- Review households
- Teamwork

_____/______ 9. Daverci review

_____/______ 10. Meet with Jeannine Perry

- Dressing Changes/Infection Control

_____/______ 11. Meet with IT

- Review phone usage
- Review computer "rights"
- Review e-mail access

_____/______ 12. Meet with manager to review equipment

- Pulse oximetry
- Glucometer
- Ambu bag and emergency board
- Bladder scanner
- BP cuffs, thermometer, stethoscopes
- Pyxis machine
- Daverci finger printing
- Phone sign-in process

_____/______ 13. Meet with Chuck Maines

- Abuse, neglect and behaviors

Shadowing:

_____/______ 1. Housekeeper

_____/______ 2. Caregiver

_____/______ 3. Dining assistant

_____/______ 4. Life Enrichment Aide

_____/______ 5. Resident Associate

_____/______ 6. Social Service

_____/______ 7. Household team leader

Videos:

_____/______ 1. Pain video

_____/______ 2. Copper Ridge video on SharePoint

_____/______ 3. A Way Back Home

_____/______ 4. Falls video

_____/______ 5. Survey video

_____/______ 6. Caretracker video

_____/______ 7. ADL video
### RN/LPN Orientation Checklist

*(to be completed with orientor)*

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
<th>Start date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

|      | Tour of the house |          |
|      | Break room        |          |
|      | Locker area       |          |
|      | Introductions to team members |          |
|      | Fire evacuation (alarm panel) |          |
|      | Watchmate panel   |          |

**Resources:**

|      | House calendar |          |
|      | Assignment book |          |
|      | PT/OT/ST schedules |          |
|      | NA flowsheets   |          |
|      | Report sheets for team leaders |          |
|      | Care plans (room and desk) |          |
|      | Lab ordering process |          |
|      | Portable x-ray/ultrasound ordering |          |

**Documentation:**

|      | Behavioral monitoring record |          |
|      | Pain graphs                  |          |
|      | Alert charting               |          |
|      | Medicare charting (clipboard and rotation schedule) |          |

**Protocols:**

|      | Pressure ulcer |          |
|      | Elopement      |          |
|      | Falls          |          |
|      | Routine vital signs |          |

**Miscellaneous:**

|      | DNR orders |          |
|      | Advanced Directives |          |
|      | Death certificates |          |
|      | End of life care |          |
|      | POLST       |          |

Orienteer signature and date when checklist is complete: ________________________

---

*Nursing Home Best Practices Evaluation Final Report, Appendix I: Documents Shared During Site Visits* 139
## FACILITY ACQUIRED PRESSURE SORE AUDIT

**Resident resides in Healthcare more than 6 weeks**

**ROOT CAUSE ANALYSIS AUDIT**

<table>
<thead>
<tr>
<th>Resident’s Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>House</td>
<td></td>
</tr>
<tr>
<td>Date of Admission</td>
<td></td>
</tr>
<tr>
<td>Date and time pressure sore found</td>
<td></td>
</tr>
<tr>
<td>Location of pressure sore</td>
<td></td>
</tr>
<tr>
<td>Stage of pressure sore</td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>1. Was the Braden scale and skin inspection form completed quarterly and if there was a change in condition, then on every shift?</td>
<td></td>
</tr>
<tr>
<td>If no, explain</td>
<td></td>
</tr>
<tr>
<td>2. Were daily skin checks completed by NAs and documented in Caretracker?</td>
<td></td>
</tr>
<tr>
<td>If no, explain</td>
<td></td>
</tr>
<tr>
<td>3. Was the Co-morbidity Risk factor tool completed quarterly if Braden scale is 18 or less? Was information from the Co-morbidity Risk tool used in care planning?</td>
<td></td>
</tr>
</tbody>
</table>

### If the resident was assessed at high risk for pressure sores:

| 1. Was the turning and repositioning schedule initiated and being documented in Caretracker? |  |
| If no, explain |  |
| 2. Were pressure reducing devices implemented on the bed? |  |
| Date and time |  |
| Device being used |  |
| 3. Were pressure reducing devices implemented on the chair? |  |
| Date and time |  |
| Device being used |  |
| 4. Does the resident have a toileting program established and documented? |  |
| 5. Was the resident care planned for high risk for impaired skin integrity? |  |
| 6. Was Therapy notified for positioning and pressure relief? Devices, recommendations: |  |
| 7. Was the resident’s pain assessed and being managed? |  |
| 8. What average percentage of food and liquids is the resident taking? |  |
| If low, was the dietician consulted and are interventions in place and care planned? |  |
**Questions**

1. What are the contributing factors for development of these pressure sores?

2. Were all the answers to the above questions yes? If there were no's, was there a good reason?

3. Is the resident resistive to care? If so, what interventions are in place to address it?

4. Is friction and shearing a concern? If so, are special turning devices being used?

5. Are the heels off loaded?  
   Are “bunny” boots and heel protectors being used?  
   Yes | No

6. Was footwear evaluated?  
   Yes | No

7. Was resident educated (if appropriate)?  
   Date and documented:  
   Yes | No

8. Was staff re-educated?  
   Date and documented:  
   Yes | No

**Comments**
### FACILITY ACQUIRED PRESSURE SORE AUDIT

#### New Admission (up to 6 weeks).

#### ROOT CAUSE ANALYSIS AUDIT

<table>
<thead>
<tr>
<th>Resident’s Name</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>House</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date and time pressure sore found</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of pressure sore</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage of pressure sore</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Was skin assessment located on buff admission sheet completed within 6 hours of admission?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no, why not?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How many hours?</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Was the Braden Scale assessment and skin inspection form completed on admission?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no, explain</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Was the Braden scale and skin inspection form completed subsequently every 5 weeks on every shift?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no, explain</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Were daily skin checks completed by NAs and documented in Caretracker?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no, explain</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Was the Co-morbidity Risk factor tool completed on admission?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Was information from the Co-morbidity Risk tool used in care planning?</td>
<td></td>
</tr>
</tbody>
</table>

**If the resident was assessed at high risk for pressure sores:**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Was the turning and repositioning schedule initiated and being documented in Caretracker?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no, explain</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Were pressure reducing devices implemented on the bed?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date and time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Device being used</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Were pressure reducing devices implemented on the chair?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date and time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Device being used</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Were the resident’s voiding and elimination patterns monitored?</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Was a toileting program established and documented?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>7</td>
<td>Was the resident care planned for high risk for impaired skin integrity?</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Was Therapy notified for positioning and pressure relief?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Device being used:</td>
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<tr>
<td>9</td>
<td>Was the resident's pain assessed and being managed?</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>What is the average percentage of foods and liquids being taken?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If low, was the dietician consulted and are interventions in place and care planned?</td>
<td></td>
</tr>
</tbody>
</table>

**Questions**

1. Why did the pressure sore develop? What are contributing factors?

2. Were all the answers to the above questions yes? If there were no's, was there a good reason?

3. Is the resident resistive to care? If so, what interventions are in place to address it?

4. Is friction and shearing a concern? If so, are special turning devices being used?

5. Are the heels off loaded? Are "bunny" boots and heel protectors being used?

6. Was footwear evaluated?

7. Was resident educated (if appropriate)? Date and documented:

8. Was staff re-educated? Date:

**Comments**
Vision
Leaders in Serving

Mission
The ministry of Landis Homes is to serve aging adults and their families by honoring and enriching their lives in a community of Christ-like love.

Guiding Values
We commit to these values as we honor God in serving others.

♦ Joy
Nurturing an atmosphere which is positive, hopeful and thankful, while delighting in serving others, fulfilling responsibilities and celebrating life.

♦ Compassion
Demonstrating Christ-like love and concern in our relationships, serving one another with grace, humility, gentleness and sensitivity in a manner which respects diversity and honors the dignity and worth of everyone.

♦ Integrity
Committing ourselves to be honest, sincere, trustworthy and accountable in relationships, communication and decision-making, with a respect for confidentiality.

♦ Stewardship
Devoting ourselves to faithful and responsible use of resources entrusted to our care, upholding high standards of performance and quality, striving for excellence and serving beyond expectations.

♦ Community
Relating with a spirit which is characterized by cooperation, teamwork, encouragement and mutual respect, valuing each person, affirming gifts and abilities, and seeking improvement through learning, creativity and openness to change.

Strategic Focus Areas
From May to November 2008, the Landis Homes Board made contact with 150 stakeholders in Appreciative Inquiry, and then in a strategic planning process facilitated by Rick Stiffney and Lee Schmucker of MHS Alliance, identified the following four Strategic Focus Areas:

♦ Retirement Community – keeping it strong and vital
♦ Affordable Living
♦ Services at Home
♦ Creative Partnerships – in support of the above
We provide compassionate care that offers comfort and support to those experiencing loss or dying.

Mercy Retirement & Care Center

Compassionate Care of the Dying

Palliative Care Certificate Program

Elder Care Alliance is a nonprofit organization committed to serving and enriching the physical, emotional, and spiritual well-being of older adults through a network of professional, faith-centered care communities and services.

Spiritual Care Services and Staff Development
Palliative Care Certificate

Mercy Retirement & Care Center has a history of providing compassionate care for all residents.

To improve our skills in caring for residents who are dying, we have initiated a program which offers participants a Palliative Care Certificate.

The Palliative Care Certificate is available to anyone who attends ten inservices that focus on palliative care and assisting dying residents and their families.

Participants will have eighteen months to complete the program, however a certificate can be earned in as little as twelve months for those who wish.

Each person completing the program will receive a certificate and special pin.

Inservices

To earn your certificate, choose from the following inservices. Inservices marked with an asterisk (*) are required for completion of the program.

- Palliative Care, Comfort Care – What is it?*
- Nutrition and Hydration*
- Pain Management, Part I: Understanding and Assessing Pain*
- Pain Management, Part II: Non-Drug Interventions for Managing Pain*
- Pain Management, Part III: Using meds to Manage Pain for the Dying*
- The Dying Experience* (includes care of the dying, the death process, and post mortem care)
- Spirituality of the Elderly
- Grief and Loss
- Death and Dying – How to Be With the Dying (includes honoring cultural and spiritual diversity)
- Taking Care of Self
- Hospice Care
- Advance Directives – Durable Power of Attorney

The Director of Staff Development will maintain a record of attendees. Inservice hours will be credited for CNA recertification.
The H.E.A.R.T. Program, implemented by Life Enrichment staff and our many volunteers, complements the vital work of Physical Therapy and Spiritual Care Services.

As a community we are focused on person-centered care and seek to promote:

- **H**: health
- **E**: education
- **A**: arts
- **R**: reminiscing
- **T**: technology

Volunteers are a vital part of our H.E.A.R.T. Program.

Last year, volunteers donated over 2600 hours to Mercy residents. Volunteers lead art classes, perform at musical events, assist with outings, lead laughter yoga sessions, and provided hundreds of hours of companionship to our residents.

Elder Care Alliance, a non-profit organization, is cosponsored by the Sisters of Mercy of the Americas West Midwest Community and the Sierra Pacific Synod of the Evangelical Lutheran Church in America. RCFE#015600255 SNF#CA20000237

Residents are the H.E.A.R.T. of our community.
Mercy Retirement & Care Center
Life Enrichment
H.E.A.R.T. Program

H: health
- Community Drum Circle
- Deep Breathing Relaxation
- Arthritis Foundation Exercise Class
- Tai-Chi Class
- Daily Walking Group
- Laughter Yoga
- Meditation
- Healing Chair Yoga
- Indoor Golf

E: education
- Health and Wellness Lectures
- Crossword Puzzles
- Cooking Class
- Trivia Groups
- Daily News
- Farmer’s Market Trips
- Museum and Cultural Trips
- Courtyard Gardening Group

A: arts
- Art Class
- Dance Class
- Music Therapy
- Poetry Group
- Musical Performances
- TimeSlips Storytelling Project

R: reminiscing
- Happy Hour
- Life Story Book Project
- Intergenerational Projects
- Trivia and Reminiscence Groups
- Resident Led Enrichment Programs
- Holiday and Family Events
- Never2Late Touch Screen System
- iPods with personalized music
- iPads for Google search
- Posit Science - Brain Fitness

T: technology
Mercy Retirement & Care Center
Volunteer Application and Profile

Name of Applicant: ________________________________ Date: _____________

Address:
____________________________________________________________________
(Street and Apt. Number)   (City)   (Zip)

Telephone: (___) ___________ Cell: (___) ____________

Email: ____________________________

Date of Birth: ______________________

In Case of Emergency, Contact: ___________________ Phone: (___) ____________

1. How did you hear about Mercy? ______________________________
_______________________________________________________________________

2. Why are you interested in volunteering at Mercy? __________________________
_______________________________________________________________________

3. What type of residents would you be comfortable working with?
   ____ Independent (Assisted Living)
   ____ Elders with memory impairment (Oasis)
   ____ Elders with physical disabilities and dementia (Care Center)

4. Please check the activities you can see yourself doing with the residents here at
   Mercy.
   ____ interviewing people, life stories     ____ card games/ word games/ jokes
   ____ letter writing                       ____ helping with parties
   ____ performing music                     ____ reading to one or more persons
   ____ singing                             ____ visiting
   ____ sewing/ crochet/ knitting           ____ hairstyling, manicures, make- up
   ____ short walks                          ____ conversation
   ____ cooking                             ____ drama, plays
   ____ puzzles, table games                ____ decorating for the holidays
   ____ computer fun                        ____ gardening
   ____ arts & crafts                        ____ dancing
   ____ BINGO                               ____ tea parties, ice cream socials
   ____ exercise, bowling, ball toss        ____ pet care
   ____ Other activities that you might be interested in doing, please
   specify:______________________________________________________________
5. Do you speak other languages? If yes, which one(s):
________________________________________________________________________

5. Have you spent time with elders or older family members? If so, how was that experience for you?
________________________________________________________________________
________________________________________________________________________

6. Is your volunteering required by a specific program or school related? If so, how many hours are you expecting to complete?
________________________________________________________________________

7. What times would you be willing and able to volunteer? How many hours a week or month? Special occasions only?

   ___ Monday, from ___ to ___  Tuesday, from ___ to ___
   ___ Wednesday, from ___ to ___  Thursday, from ___ to ___
   ___ Friday, from ___ to ___  Saturday, from ___ to ___
   ___ Sunday, from ___ to ___

8. Do you have any special needs or limitations? If so, please specify:
________________________________________________________________________
________________________________________________________________________

9. Can you affirm that you are in good health to the best of your knowledge?
________________________________________________________________________

10. Comments, questions, concerns, anything else you’d like us to know about you, etc.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

11. Signature ______________________________ Date __________

    Thank for your interest in
    Mercy Retirement & Care Center!
SC - NHC Healthcare, Anderson

Nursing Home Best Practices Evaluation Final Report, Appendix I: Documents Shared During Site Visits

**Admissions / Social Services**
- Accessible to families
- Courtesy shown during interviews
- Helpfulness of information provided
- Shows support for individual needs

**Nursing Services**
- Attitude of helpfulness and concern
- Attention to needs of individual
- Promptness in service
- Demonstration of professional knowledge and skill

**Food Service**
- Taste of food served
- Food attractive on plate
- Meals served on time
- Menu is varied
- Food preferences / needs honored

**Environment**
- Cleanliness of buildings
- Attractive furnishings
- Maintenance staff courtesy
- Laundry services

**Recreation / Activities / Leisure**
- Patients spend free time as they prefer
  (Conditions of patients and preferences taken into consideration)
- Interesting programs offered
  (Room visits, large / small groups, volunteers, outings, entertainment, spiritual events, etc.)
- Recreation / Activities staff is helpful
  (Provides supplies for individuals, makes plans based on preferences, offers encouragement)

**Therapy Programs**
- (Physical, Occupational, Speech)
  Professional skill of staff
  Helpful attitude of staff
  Achievement of expected outcomes

**Business Office**
- Helpful and courteous staff
- Efficient handling of business matters
- Information provided promptly

**NATIONAL HEALTHCARE CORPORATION** asks your assistance in assessing the quality of care received. Your comments will be used in our continuing efforts to improve the quality of service to all patients. Please rate the following areas of care according to the scale indicated. Choose either the higher or lower number for each rating. We appreciate the opportunity to serve your long term health care needs in a health care center owned or managed by NHC.

In addition to your talking with the staff in the center, it is very important to us as the management company that we know the kinds of services you expect and whether you are satisfied. Recognition is also provided to the partners who receive a high rating from you. All you need to do is place the survey in the enclosed self-addressed envelope and drop it in the mail.

Over the years we have learned a great deal from patients and families who share with us the experience they have had. This is the most valuable information we can get.

Thank you,
Patient Services
615-690-2020
<table>
<thead>
<tr>
<th>Atmosphere produces feeling of confidence in care provided:</th>
<th>10 9 8 7 6 5 4 3 2 1 0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients are respected as individuals:</td>
<td>10 9 8 7 6 5 4 3 2 1 0</td>
</tr>
<tr>
<td>Staff is alert to patient problems and is helpful in finding solutions:</td>
<td>10 9 8 7 6 5 4 3 2 1 0</td>
</tr>
<tr>
<td>Patients are informed of care planned and care provided:</td>
<td>10 9 8 7 6 5 4 3 2 1 0</td>
</tr>
<tr>
<td>Family is satisfied with communication with center:</td>
<td>10 9 8 7 6 5 4 3 2 1 0</td>
</tr>
</tbody>
</table>

**CENTER RATING**

Overall, how do you rate the total service of the center:  

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you recommend the center?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# PATIENT SATISFACTION SURVEY

Center: **NHC Anderson**

Please circle one number that corresponds with your satisfaction level, 10 meaning you are highly satisfied and 1 meaning you are not satisfied.

<table>
<thead>
<tr>
<th>OVERALL, how are we doing...</th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Fair</th>
<th>Poor</th>
<th>Very Poor</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ...involving you and your family in center events? and keeping you informed of community happenings?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>2 ...in helping you be as independent as your health will allow?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>3 ...in making interesting &amp; useful leisure activities available to you on a daily basis?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>4 ...in providing you with a nice, clean room that meets your expectations?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>5 ...providing good meals?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>6 ...are you getting the assistance you need when requested?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>7 ...in providing you with quality medical care from your doctor/nurse practitioner when needed?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>8 ...in providing you with high quality staff who know your needs and make every attempt to fulfill those needs?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>9 ...in helping you feel that you and your belongings are safe and secure here?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>10 ...at providing you with answers to your questions and helping you with any concerns you may have?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>11 ...Overall, how would you rate this center?</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

**Please write any additional comments on the back of the survey.**

---

**Nursing Home Best Practices Evaluation Final Report, Appendix I: Documents Shared During Site Visits**

1/2007
**Monday, October 15, 2012**

**Promise # 2 - Use your name always.**

I will tell you my name and the purpose of my visit.

**Talking Points**

- For a patient with Alzheimer’s disease, telling them your name and the purpose of your visit is not only a courtesy, it is vital in helping them cope with the many things in their lives which they can no longer remember. When you make it a habit to tell them, they don’t have to be embarrassed by asking and admitting they don’t remember you.

- Jenny Maltais is a partner at Villa Crest. On her “WALK to end Alzheimer’s” web page, she shared about her mother and her mother-in-law, who both have Alzheimer’s. She says, “These two women have a lot in common. They have led long and happy lives, each raising six children and each celebrating over 50 years of marriage. They are both now living in Nursing Home Alzheimer units very near their long time residences, but not understanding where they are and why they are there. My mother-in-law still has language skills, my mother does not. Their lives have been stolen from them; all their cherished memories gone, maybe only coming back to them for a few moments. Their children, grandchildren and great grandchildren have been robbed of their love and attention. If I could wish for anything, it would be to stop this terrible disease.”

- Many of you have recently walked in your local WALK to end Alzheimer’s events, and NHC thanks you for giving your time to help raise money and awareness for this very important cause.

---

**Tuesday, October 16, 2012**

**Promise # 3 - Address your needs with a sense of urgency.**

All partners answer call lights within one minute.

**Talking Points**

- We apologize for not mentioning our NHC Bookkeepers last Friday, as it was their special day to be recognized. Many of you may have already celebrated their special day, but if not….it’s never too late!!

- Our Bookkeepers know how to address needs with urgency, and are challenged to do just that on many occasions. Customers come to them with urgent needs, wanting quick answers to questions about their bill or their accounts, and other things. Our Bookkeepers know how to be courteous, give attention to details, and get what is needed in a timely manner. NHC appreciates this talented group of partners!!

- Today is National Boss’s Day! Don’t forget to say a special “thanks” to your Supervisor!

---

**Wednesday, October 17, 2012**

**Promise # 4 - “Put my heart” into everything I do.**

Empathize with you. Care for you the way you want.

**Talking Points**

- This email that came to home office and is a great example for Patient Centered Care Awareness Month:

  "I just wanted to send a pat on the back to employees at your Springfield, TN location. Shasta works in housekeeping - but she took the time to love my Grandmother. She would come in on her day off and take my Grandmother to play Bingo! That meant the world to me. Grandma always spoke so highly of her. Laura and Shasta were two employees that she would always tell me how much she liked them! My Grandmother passed away on Sunday and we are going to miss all the staff at NHC. I wanted to be sure that Shasta and Laura received a little extra pat on the back!"

- We know NHC partners do many things on a daily basis which “mean the world” to our customers, and we thank you for putting your heart into everything you do!!
DAILY STAND UP TALKING POINTS FOR THE WEEK OF OCTOBER 15, 2012

Thursday, October 18, 2012

Promise # 5 - Respect your privacy, dignity, and confidentiality.

Talking Points
- October is Residents’ Rights month. The organization sponsoring this special month says, “It’s a time for celebration and recognition, and offers an opportunity for every facility to focus on and celebrate awareness of dignity, respect and the value of each individual resident. The theme for Residents’ Rights Month 2012 is, ‘My Voice, My Vote, My Right’, with the goal of encouraging all Residents the right to vote and participation in the political process.”
- NHC Recreation partners have done an excellent job at making sure that all patients/residents who would like to vote are registered and can vote either at the polls or with absentee ballot.
- Today is “Get to Know Your Customer” Day. We thank you for recognizing this important day. But more importantly, we thank you for striving to make every day “Get to Know Your Customer” Day!!

Friday, October 19, 2012

Promise # 6 - Answer the telephone within 3 rings and with a “smile”.
Transfer the call if needed. Do not leave a caller on hold.

Talking Points
- You can improve your customer service skills by using your own experiences as training. Think back to good experiences and try to copy them. Think back to bad experiences and try to keep from doing those same things to your customers.
- Have you ever had a bad phone experience? The way you were spoken to, the lack of attention towards your requests, the lack of common courtesies.....all these are important to remember. And if they make you mad, use that frustration and anger to create something good. Think about what angered you, and promise never to treat your customers that way. Make a plan for a Better Way of service, and WOW your customers!!

Saturday, October 20, 2012

Promise # 7 - Give you as many choices as I can.

Talking Points
- October is National pizza month. What if you went to your favorite pizza place and the only thing on the menu was plain pizza? No meat, no veggies, no cheese.....just sauce. It probably would not be your favorite pizza place any longer.
- We all like choices!!

Sunday, October 21, 2012

Promise # 8 - Maintain a safe and secure environment for you.
Be aware of all emergency procedures.

Talking Points
- It’s time to review the proper way to operate a fire extinguisher:
  - Pull the pin
  - Aim the hose
  - Squeeze the handle
  - Sweep the fire
Remember the word PASS!!

Caring in a Better Way Day by Day
I. OUTCOME REPORTS:

A. **CSI**: Current score, Trend: Current, Overall

DISCUSSION:

RECOMMENDATIONS:

B. **FALLS**: Current number, Trend: Current, Overall

DISCUSSION:

RECOMMENDATIONS:

C. **PRESSURE ULCERS**: Current number, Trend: Current, Overall

DISCUSSION:

RECOMMENDATIONS:

D. **WEIGHT LOSS**: Current number, Trend: Current, Overall

DISCUSSION:

RECOMMENDATIONS:

E. **MDS QI/QMs**: (Areas of concern, discussion, recommendations)
RAPID CYCLE SUBJECT: NHC Healthcare, Parklane

PLAN/DO/CHECK/ACT

DATE BEGAN: ___________      DATE AIM ACHIEVED: ___________

AIM =

MEASURE =

QUANTIFIED OUTCOME IMPROVEMENT:

Increased/Decreased ___________

from ______% to ______% 

LIST ATTACHMENTS: [Graphs/charts for measures; Brainstorming (Form B) if applicable; Cycle documentation (Form C)]

CYCLE LEADER

Date Submitted to Committee

CONFIDENTIAL:
Prepared for the Ongoing Analysis of QUALITY IMPROVEMENT
Work Product/Attorney/Client Privilege

FORM A
Nursing Home Best Practices Evaluation Final Report, Appendix I: Documents Shared During Site Visits  158
RAPID CYCLE SUBJECT: SC- NHC Healthcare, Parklane

RECORD OF BRAINSTORMING

PLAN/DO/CHECK/ACT

SESSION DATE: _______ TIME BEGAN: _______ TIME ENDED: _______

STAKEHOLDERS PRESENT:


BRAINSTORMING IDEAS:

1. __________________________________________________________________________

2. __________________________________________________________________________

3. __________________________________________________________________________

4. __________________________________________________________________________

5. __________________________________________________________________________

6. __________________________________________________________________________

7. __________________________________________________________________________

8. __________________________________________________________________________

9. __________________________________________________________________________

10. __________________________________________________________________________

11. __________________________________________________________________________

12. __________________________________________________________________________

13. __________________________________________________________________________

14. __________________________________________________________________________

15. __________________________________________________________________________

PLACE AN ASTERISK (*) BESIDE THE IDEA(S) CHOSEN TO BE IMPLEMENTED.

SESSION RECORDER

CONFIDENTIAL:
Prepared for the Ongoing Analysis of
QUALITY IMPROVEMENT
Work Product/Attorney/Client Privilege

FORM B
Nursing Home Best Practices Evaluation Final Report, Appendix I: Documents Shared During Site Visits 159
Rapid Cycle Subject: ________________________________

Plan/Do/Check/Act

Date Change Implemented: __________________________

Change =

<table>
<thead>
<tr>
<th>Checks</th>
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Results of Check:

1. **Adapt**: Change partially effective, tweak change, repeat cycle. (This form is now complete. Start new form for the adapted/tweaked change.)

2. **Adopt**: Change effective, implement center wide. (Complete the rest of the form.)

3. **Abandon**: Change not effective, try next idea on brainstorming list, start new cycle. (This form is now complete.)

Act: (Plan for implementation center wide): ______________________

____________________
Signature Cycle Leader
____________________
Date Effectiveness Evaluated

Confidential:
Prepared for the Ongoing Analysis of
Quality Improvement
Work Product/Attorney/Client Privilege.

Form C
### NHC

**Rehabilitation Excellence Survey and Instructions**

**Center:** ___________________________ **Date:** ___________________________

**A +/- will be given on the following standards.**

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
</table>
| 1. | YTD patient satisfaction score of 9.5 or higher.  
*This pertains to the NHC Quality Control card scores for therapy.* |
| 2. | YTD monthly efficiency of 75% or higher.  
*This will come from the efficiency report from each center (Billable minutes/Manpower hours)* |
| 3. | YTD department revenue vs expense is proportionate to the budgeted revenue/expense.  
*As evidenced by the comparative income statement and YTD budgeted expense.*  
*Check with your administrator or regional coordinator.* |
| 4. | Rehab Partners to be professional in appearance, wearing clean uniform or lab jacket,  
clean shoes, and visible name badges.  
*If any partner is lacking any of the items described, the score for the department is a (-).* |
| 5. | Department clean and orderly.  
*Check for cleanliness and organization of the office and gym area during the unannounced visit.* |
| 6. | Consumer View average score for therapy areas at least 9.0  
*Use average of scores for the past six months (or 1 yr if none available in the past six months)* |
| 7. | Rehab provided clinical inservice to rehab staff at least quarterly.  
*Inservice must be clinically relevant to rehab (example: practice techniques, article reviews,  
overviews of continuing education courses - mandatory annual inservices do not pertain to this criteria)* |
| 8. | Screenings completed at least annually by at least 1 discipline.  
*100% of charts audited have a screening by all therapy disciplines completed at least annually.* |
| 9. | Quality Screenings completed by at least one discipline when:  
- fall w/in 72hrs  
- decline in mobility  
- decline in ROM  
- behavior  
- pain  
- decline in ADL  
- wt loss  
- decline in cognition  
- little activity |
*Number of present inpatients during the last quarter on Part B caseload (as indicated by CPCs  
Therapy Audit Report) equals at least 5% of the current census of the center for that quarter.  
The purpose of this item is to insure all patient needs are met.* |
| 11. | 100% charts of patients d/c'd from therapy show recommendations for continuing  
care/interventions  
including home programs, follow up therapy (i.e., homecare patients, outpt), restorative programs,  
recreation programs & objective d/c data |
| 12. | Pt transitioning to LTC - 100% charts have:  
Pt Care Plan updated  
Orders updated  
Caregiver Education Documented  
75% charts show planned transition to LTC through  
restorative programming (joint therapy/restorative) |
| 13. | SMART 95% Clinical Documentation & 100% Technical documentation Audit. |
| 14. | Involvement of ST and/or OT with Dementia Program.  
*As evidenced by at least 3 of the following:*  
- Staging in Speech/OT documentation  
- Development of functional/restorative program.  
- Evidence of active participation in related committee mtgs w/in the yr (view mtg minutes)  
- At least 1 interdisciplinary Rapid Cycle w/nursing w/in the year on a related issue  
- At least 1 formal in-service on related issue |
| 15. | Pressure Ulcer prevention and intervention as evidenced by center pressure ulcer score  
.50% or less.  
*YTD score as calculated by the regional nurse.* |
| 16. | Falls prevention and intervention as evidenced by center fall ratio of 4.82 per 1000 pt days.  
|     | YTD score as calculated by the regional nurse. |
| 17. | Weight loss/dehydration prevention and intervention as evidenced by center score of 3.75% or less.  
|     | YTD score as calculated by the regional nurse/dietician. |
| 18. | Center provides at least 6 days per week of at least 1 discipline. |
| 19. | Evidence of program growth.  
|     | Compare YTD billed minutes. Current year to last year Efficiency Report, if equal or higher.  
|     | (This is scored as a +) |
| 20. | Presence of outpatients on current caseload. (True outpatient, not in-house Part B)  
|     | An average of at least 2 outpatients per month over the past quarter. |
| 21. | 100% accuracy of SOC & EOC dates entered and SOT, EOT & COT OMRA's. (10 randomly selected patients w/in the last quarter) |
| 22. | Communication system regarding patient goals established with patient/family/responsible party  
|     | As evidenced by: chart documentation Other, list: |
| 23. | MDS minutes accuracy.  
|     | 0% error rate of MDS minutes to Rehab minutes over the past quarter. |
| 24. | Center has all 3 disciplines all year & all credentials of staff are current  
|     | 100% accuracy on verification of credentials from on all rehab partners based at the center. |
| 25. | Partners providing coverage w/contract accts &/or NHC Homecare/Hospice (1-5 rating) |
| 26. | Center is a clinical affiliation site (1 or more students in last year.) (1 - 5 rating) |
| 27. | External Marketing of Center Rehab Programs as evidence in the community (i.e. article in local news media, professional or community speaking, TV exposure, etc.) (1-5 rating) |
| 28. | Staff have specialty certifications (ie GCS, McKenzie, Modalities, Vital Stim, NDT, etc) (up to 20%=1, up to 40%=2, up to 60%=3, up to 80%=4 & up to 100%=5) |
| 29. | Staff are members of National &/or State Therapy Associations (up to 20%=1, up to 40%=2, up to 60%=3, up to 80%=4 & up to 100%=5 |

**Total**

Scoring items: 1 - 24: (+) is = 5 points (120 points possible). Each item is an all or nothing.  
26-29: scored as listed.  
Total/145 = Final Score  
If final score is less than 60%, a plan of action is expected with Regional follow-up.

**Comments:**
Algorithm for Treating Behavioral and Psychological Symptoms of Dementia (aka Problem Behaviors)

**STEP 1: IDENTIFY, ASSESS, AND TREAT CONTRIBUTING FACTORS**
- Determine and document frequency, duration, intensity, and characteristics of each problem behavior
- Identify, assess, treat or eliminate ANTecedents and TRIGGers

- Unmet physical needs?
  - Pain
  - Infection/illness
  - Dehydration/nutrition
  - Sleep disturbance
  - Medication side effects
  - Sensory deficits
  - Constipation
  - Incontinence/retention

- Unmet psychological needs?
  - Loneliness
  - Boredom
  - Apprehension, worry, fear
  - Emotional discomfort
  - Lack of enjoyable activities
  - Lack of socialization
  - Loss of intimacy

- Environmental causes?
  - Level/Type of stimulation: noise, confusion, lighting
  - Caregiver approaches
  - Institutional routines, expectations
  - Lack of cues, prompts to function & way-find

- Psychiatric causes?
  - Depression
  - Anxiety
  - Delirium
  - Psychosis
  - Other mental illness

Monitor outcomes to assure full treatment response
- If problem behavior persists after antecedents are adequately treated, use NON-DRUG INTERVENTIONS

**STEP 2: SELECT AND APPLY NON-DRUG INTERVENTIONS**
- Select interventions based on the TYPE of problem and ASSESSMENT of retained abilities, preferences, and resources
  - Cognitive level
  - Physical function level
  - Long-standing personality, life history, interests/abilities
  - Preferred routines and daily schedule
  - Personal/family/facility resources
- Train staff to use selected interventions appropriately/following best practice and evidence-based guidelines
- Tailor intervention to individualized needs, combining approaches and interventions to promote comfort & function
- Monitor outcomes using rating scales to quantify behaviors

- Adjust caregiver approaches
  - Personal approach: cue, prompt, remind, distract (treats, activities); focus on person’s wishes, interests, concerns; use/avoid touch as indicated; avoid trying to reason, teach new routines, or ask to “try harder”
  - Daily routines: simplify, sequence tasks; offer limited choices; use long-standing history & preferences to guide
  - Communication style: simple words and phrases; speak clearly; wait for answers; make eye contact; monitor tone of voice/other nonverbal messages
  - Unconditional positive regard: do not confront, challenge or “explain” misbeliefs (hallucinations, delusions, illusions); accept belief as “real” to the person; reassure, comfort, and distract
  - Involvement/Engagement: tailor activities to increase involvement/reduce boredom; individualize social and leisure activities

- Change the environment
  - Eliminate misleading stimuli: clutter, TV, radio, noise, people talking; reflections in mirrors/dark windows; misunderstood pictures/decors
  - Reduce environmental stress: caffeine; extra people; holiday decorations; public TV
  - Adjust stimulation: reduce noise, activity, confusion if over-stimulated; increase activity/involvement if under-stimulated (bored)
  - Enhance function: signs, cues, pictures to promote way-finding; increase lighting to reduce misinterpretation
  - Involve in meaningful activities: personalized program of 1:1 and small group vs. large group
  - Adapt the physical setting: secure outdoor areas; decorative tactile objects; home-like features; smaller, segmented recreational and dining areas; natural and bright light; spa-like bathing facilities; signage to promote way-finding

- Use evidence-based interventions
  - Agitated/Irritable: Calm, soothing, distraction
  - Individualized music
  - Aromatherapy (e.g., lavender oil)
  - Simple Pleasures
  - Pet therapy
  - Physical exercise/outdoor activities
  - Resistant to care: Identify source of threat; change routines and approaches
  - Wandering/Restless/Bored: Engage, distract
  - “Rest station” in pacing path
  - Adapt environment to reduce exit-seeking
  - Physical exercise/outdoor activities
  - Simple Pleasures
  - Disruptive vocalization: Distract, engage
  - Individualized music; Nature sounds
  - Presence therapy: taps of family
  - Apathetic/Withdrawn: Stimulate, engage
  - Individualized music
  - Simple Pleasures
  - Repetitive questions/ramblings: Reassure, address underlying issue, distract
  - Validation therapeutic lying
  - Simple Pleasures
  - Depression/Anxiety: Reassure, engage
  - Physical exercise
  - Pleasant activities
  - Cognitive stimulation therapy
  - Wheelchair biking

**STEP 3: MONITOR OUTCOMES AND ADJUST COURSE AS NEEDED**
- Quantify behavioral symptoms using rating scale(s)
- Assist accurate “dose” (intensity, duration, frequency) of interventions
- Provide/reinforce staff training and development activities to assure full understanding and cooperation in daily care
- Adapt/add interventions as needed to promote optimal outcomes
- Consider antipsychotics for persistent and severe cases that meet criteria for use. See Antipsychotic Prescribing Guide.
Resident: ____________________

Where is your bathroom in relation to where you sleep?

__________________________________________________________

What side of the bed do you sleep/get up on? __________________

Do you want to be awakened to receive medication if needed? Y N

Bathing Preferences:

☐Shower/How often____________

☐Whirlpool bath/How often________

☐Wash up/How often____________

☐Other ___________/How often________

Please indicate first, second and third bathing choice:

____Before breakfast

____After breakfast

____Afternoon

____Before bedtime

Do you have a fear of water (describe)?

__________________________________________________________

Eating Preferences:

Breakfast: Time: _______

Preferred Drink(s):________________________

Favorite foods: __________________________

Lunch: Time: _______

Preferred Drink(s):________________________

Favorite foods: __________________________

Dinner/Supper: Time: _______

Preferred Drink(s):________________________

Favorite foods: __________________________

Snacks:

Do you eat between meals? Y N

Any particular times? ________________________________

Preferred Drink(s):________________________

Favorite foods: __________________________

Any other food or beverages that you particularly like and haven't mentioned?

Page 1 of 5

[Pre-]Admission Move In Preference Guide, Rev. 4/2012
Resident: __________________________

Who do you most often speak to or see in your family?

__________________________________________

Do you currently have any pets?

__________________________________________

Do you have a fear of pets or animals?  
If yes, please describe:

__________________________________________

Anything else you feel we should know to make you comfortable?

__________________________________________

My Favorite Things:

What name do you prefer to be called?

__________________________________________

Favorite things you like to have by you:

__________________________________________

What things make you happy?

__________________________________________

What things make you feel sad?

__________________________________________

What holidays or events are special to you?

__________________________________________

What are your hobbies?

__________________________________________

I like to wear certain items on a daily basis:  
(describe)  
☐Make up  ☐Cologne  Perfume  ☐Jewelry  
☐Hat  ☐Wig

__________________________________________

My Room/Activities:

Do you like a ☐warmer or ☐cooler room?
Do you like a ☐brighter or ☐darker room?
Do you like a ☐busy room or ☐quiet room?
Will you bring a favorite chair?  ☐Y  ☐N

Will you have your own phone?  ☐Y  ☐N
☐Cellular  ☐land line

Will you have your own computer?  ☐Y  ☐N

Will you have your own TV?  ☐Y  ☐N
Do you watch TV?  ☐YES  ☐NO
How often?  

How late in the evening?  

What are your favorite shows:

__________________________________________

Do you have any other items you would like to bring?

__________________________________________

What is your expectation for activity involvement?

__________________________________________
Resident: __________________________

**Paperwork/Moving In:**

Who plans to complete admission paperwork (name)?

When? ____________________________

Who will you have helping you move in and how are they best contacted?

______________________________

What is your overall impression of our home? What MOST impressed you?

______________________________

On a scale of 1-10, with 10 being the highest, how would you rate yourself on how prepared you feel to make the move to our community? ______

What can we do to make it a 10?

______________________________

*NOTE: Give attached Pages 4/5 to the Resident*
What you might like to bring with you:

Clothing- at least 4 changes of machine washable daywear, your own pajamas and robe, socks, underwear, sweater, jacket, and non-skid footwear (slippers and shoes).
  • Please do not bring large sums of cash or valuable or irreplaceable items including jewelry.

Toiletries and other personal use items:
  hearing aids, eyeglasses, makeup, favorite hair products, brush/comb, dentures/toothbrush/toothpaste, deodorant, lotion, electric shaver.
  • Please no aerosols or straight razors.

Furnishings- (if you’d like) favorite chair, your own bed, dresser, lamp, pictures, computer, tv, radio, phone, clock, fan, small refrigerator
  • Extension cords/multi-plug adapters and throw rugs are prohibited by the Fire Marshal.

Medical Equipment- (if you currently use or plan to use) walker, cane, wheelchair, bipap/cpap machine

Favorite Things- books, tapes/DVDs, pillows, blanket, photo albums, writing materials, craft or hobby materials, a joke or story

Please be aware that there will be “paperwork” that needs to be completed either prior to or on the day you move in. This may take about an hour.

Important documents that you will need to bring (please do not keep these in resident’s room—if you need assistance with this, please let us know):
  • Social Security card
  • Medicare card
  • Other insurance cards
  • Prescription drug (Medicare D) card
  • Medicaid card
  • Power of Attorney or legal representative documents
  • Living Will
  • Form of payment if private pay

This is the address and phone number of the home:

Facility Contact Person(s):
Your Care Liaison is: __________________________ Phone Number: __________________________

Our facility is certified to provide both Nursing Facility (custodial) and Skilled Nursing Facility (SNF) services.
  • An advance payment of $________ is required at the time of admission if you will be paying privately. This amount is an estimate of your cost for a month, based on our daily rates. The exact cost will be determined after the facility’s assessment of your level of care, which can take up to 14 days. This assessment period is under the SNF level of care.
  • If you are admitted under Medicare Part A coverage (requires a minimum of 3 consecutive days in acute care within the last 30 days), the advance payment will be required at the time Medicare Part A coverage ends unless:
    1. you are discharged from the facility, or
    2. the home has verification of your Medicaid NF eligibility.

Page 4 of 5
[Pre-)Admission Move In Preference Guide, Rev. 4/2012
The home will give you at least 2-days advance notice before Medicare Part A coverage ends.

- If you qualify for Medicare Part A coverage, it pays 100% of routine care charges for the first 20 days in a benefit period, and all but the daily co-insurance for days 21 – 100 in the benefit period.
  
  > If you do not have Medicare supplemental insurance that pays the daily co-insurance after day 20, you will be required to pay $________ per day while under Medicare Part A coverage.

For Medicare Advantage plan members, please contact your insurer as their coinsurance amounts and the days they apply to vary.

If Medicaid NF coverage is approved at the time of admission, or any time after, DHS will determine the client participation that you must pay to the facility each month for your care.

If you have any questions or concerns, please do not hesitate to contact the care center directly or your Care Liaison. Thank you!
# Building a Home PDC Certification Program

## R U Ready Checklist

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Met</th>
<th>Not Met</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 Vision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Commitment Statement is posted in a prominent place, easily accessible for staff, residents &amp; visitors to view.</td>
<td>✔️</td>
<td></td>
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</tr>
<tr>
<td>2. Staff are able to recite the Commitment Statement or the principles it expounds.</td>
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<td></td>
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<tr>
<td>3. Residents are aware of the Commitment Statement and/or where it can be found.</td>
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<tr>
<td>4. Contracts address commitment to PDC and respect for the principles in care/services provided by outside agencies and practitioners.</td>
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<tr>
<td>#2 Individuality &amp; Self-Determination</td>
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<tr>
<td>5. There is a system eliciting preferences from current &amp; new residents.</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>6. Staff are familiar with residents' preferences.</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>7. Residents' preferences are honored.</td>
<td></td>
<td>✔️</td>
<td></td>
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<tr>
<td>8. Each resident is recognized on the day of their birthday.</td>
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<td></td>
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<tr>
<td>9. Residents' deaths are recognized individually and within 5 days of death.</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>10. Residents have the opportunity for spiritual expression of their choice.</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>11. Residents feel privacy and respect is afforded in care and communication.</td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>12. Customs, holidays and traditions of residents’ cultures are recognized, accommodated and celebrated.</td>
<td></td>
<td>✔️</td>
<td></td>
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<tr>
<td>#3 Individualized Care</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>13. The MDS assessments are reflected in resident care plans.</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>14. Care plans approaches are individualized, not standardized.</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>15. Residents are made aware of specialized therapies available.</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>16. System in place for assessing need and preferences of environmental accommodations.</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>17. Residents are made aware of environmental accommodations.</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
</tr>
</tbody>
</table>

Page 1 of 6
Person Directed Care Benchmarks, 2012, ABCM Corporation
### Building a Home PDC Certification Program

#### R U Ready Checklist

| 18. There is a designated place of privacy for a dying resident and family/friends. | ✓ |
| 19. There is a system in place for staff to be with a dying resident when others (i.e. family, friends and volunteers) are not present. | ✓ |
| 20. Residents are made aware of privacy accommodations and staff availability (for dying resident). | |
| 21. Staff have specialized education on death & dying education. | |
| 22. No less than annual education for all staff in working with residents with dementia. | |
| 23. There is a system in place for assessing and writing needs/preferences for other specialized education needs (such as Parkinson's, diabetes...). | |

#### Benchmark

<table>
<thead>
<tr>
<th>#4 Relationships</th>
<th>Met</th>
<th>Not Met</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. 65% of residents have a maximum of 9 CNA caregivers over a one month period of time.</td>
<td>✓</td>
<td></td>
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</tr>
<tr>
<td>25. Residents have the same nurse assigned for them each shift 85% of the time.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Managerial professional nursing roles are engaged.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Residents can name or identify their primary caregiver.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Neighborhoods are identified and named.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Residents are assigned to a neighborhood and are able to recognize it.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Staff are assigned to a neighborhood and identify with it.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Residents have an employee as a &quot;buddy&quot; or &quot;guardian angel&quot;.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Formal volunteer program (designated coordinator, annual recruitment &amp; recognition, orientation).</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Volunteers (individuals or groups) are utilized an average of no less than two times weekly.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Space is made available and promoted for community groups.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Planned activities involve children an average of no less than 1 time a week.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Programs are offered to families no less than quarterly, to include support, education and/or opportunities for socialization.</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Page 2 of 6

Person Directed Care Benchmarks.2012.ABCM Corporation
Building a Home PDC Certification Program

R U Ready Checklist

<table>
<thead>
<tr>
<th></th>
<th>Met</th>
<th>Not Met</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. There is a system in place to offer peer support to residents and families as assessed or requested (i.e. new residents, families in need of extra attention or support...)</td>
<td></td>
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</tr>
<tr>
<td>38. New staff are assigned a mentor for the first 3 months.</td>
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<tr>
<td>39. Residents state satisfaction with trusting staff.</td>
<td></td>
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<tr>
<td>40. All residents are assessed for their interests and ability to participate in the community.</td>
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<tr>
<td>41. Residents who have expressed an interest to participate and involvement, are afforded the opportunities to their satisfaction.</td>
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</tbody>
</table>

**Benchmark # 5: Empowerment**

42. Representation of all departments and at least 50% of all full-time staff participate providing input at meetings.

43. Representation of residents & families in care and other teams whose outcomes could impact residents' lives and confidentiality would not prohibit their involvement.

44. All staff will have the responsibility for developing and updating of resident care plans.

45. Residents and/or families are actively involved in the development of their care plan needs/wishes, goals and interventions.

46. Neighborhood meetings are held no less than one time a month.

47. Learning circles are held in each neighborhood no less than one time a month.

48. Employees have involvement in team efforts to develop work schedules and in scheduling to meet neighborhood needs.

49. Resident Advisory Board meets with the Administrator no less than 12 times a year.

50. Residents and families report satisfaction with opportunities to make their own choices and decisions and feel that the environment is conducive to asserting themselves.

51. Staff report satisfaction with opportunities for significant input into residents' quality of life and employee workplace practices and feel that the environment is conducive to asserting themselves.
### Building a Home PDC Certification Program

**R U Ready Checklist**

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Met</th>
<th>Not Met</th>
<th>Next Steps</th>
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<tbody>
<tr>
<td>#6 Homelike Environment</td>
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</tr>
<tr>
<td>52. There are no restrictions on decoration, with consideration of available space and life safety code. Encouragement to decorate individually is in resident handbook or admission material.</td>
<td>✔</td>
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<tr>
<td>53. Residents have access, 24/7 to equipment (other than TV) for communication, information and entertainment including computer, internet, cable/satellite, and video games.</td>
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<tr>
<td>54. There is appropriate space and equipment available for independent exercising.</td>
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<tr>
<td>55. Residents &amp; families have access to preferred food and beverages in the resident's room and/or common area refrigerator.</td>
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<tr>
<td>56. There is availability of hot and cold drinks at 24/7.</td>
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<tr>
<td>57. Space is available to families for private visits.</td>
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<tr>
<td>58. Residents and families state satisfaction with sound levels in the home.</td>
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<tr>
<td>59. No overhead paging except in emergencies.</td>
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<tr>
<td>60. Outdoor space may include an outdoor walk way, benches, chairs, gazebo, covered porches,ervenues etc.</td>
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<tr>
<td>61. Furniture accommodates socialization and activity where all residents gather; residents are not routinely lined up in a linear format.</td>
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<tr>
<td>62. There is a nontraditional nurses’ station (lowed disguised, table, absent); carts, barrels &amp; wheelchairs are not stored in hall or common spaces.</td>
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<tr>
<td>63. There are no medication carts in dining areas during meals.</td>
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<tr>
<td>64. Medication administration at mealtimes only for those residents who have requested it or when the medication requires it.</td>
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<tr>
<td>#7 Learning Organization</td>
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<tr>
<td>65. In-services have stated learning objectives; offer alternatives for those not in attendance at live workshops, require full participation for credit and prohibit children being present.</td>
<td>✔</td>
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<tr>
<td>66. Employees will be offered no less than 1 non-traditional educational opportunity per year.</td>
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Page 4 of 6

Person Directed Care Benchmarks.2012.ABCM Corporation

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### Building a Home PDC Certification Program

#### R U Ready Checklist

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>67.</td>
<td>There is assistance in securing education or training for staff who request it.</td>
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<tr>
<td>68.</td>
<td>Employees are offered the opportunity to set a personal goal in their annual performance review.</td>
<td>✓</td>
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<tr>
<td>69.</td>
<td>Residents have learning opportunities offered to them no less than quarterly.</td>
<td></td>
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<tr>
<td>70.</td>
<td>Family and community members are invited to participate in learning opportunities no less than 2 times a year.</td>
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<table>
<thead>
<tr>
<th>Benchmark</th>
<th></th>
<th>Met</th>
<th>Not Met</th>
<th>Next Steps</th>
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<tbody>
<tr>
<td>#8 Customer Service</td>
<td></td>
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<tr>
<td>71.</td>
<td>The three main meals are available for no less than 50 minutes each.</td>
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<tr>
<td>72.</td>
<td>Meal choices go beyond the main &amp; alternative menu at breakfast, lunch &amp; dinner.</td>
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<tr>
<td>73.</td>
<td>Room service and table reservations are available.</td>
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<tr>
<td>74.</td>
<td>Accommodations are made for meals requested outside of the three main meals.</td>
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<tr>
<td>75.</td>
<td>A system/program is in place to honor requests that are not typically part of the normal offerings (e.g., Whatever it Takes, Make a Wish).</td>
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<tr>
<td>76.</td>
<td>Residents state satisfaction with requests that are being honored.</td>
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<tr>
<td>77.</td>
<td>Education is provided for all staff on how to meet residents' needs and wishes, ordinary and extraordinary.</td>
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<tr>
<td>78.</td>
<td>No less than 50% of all staff are cross-trained in at least one other department/position.</td>
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<tr>
<td>79.</td>
<td>All staff have been educated in the responsibility of answering call lights.</td>
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<tr>
<td>80.</td>
<td>No employee, unless otherwise engaged in resident care, will walk by a lit call light.</td>
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<tr>
<td>81.</td>
<td>All staff are educated in residents' activities programming.</td>
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<tr>
<td>82.</td>
<td>Staff report knowledge, promotion of and involvement in residents' activities.</td>
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<tr>
<td>83.</td>
<td>Bathing is in a non-institutional setting which may include, but is not limited to the use of potpourri, non-flame candles, heat lamps, and towel warmers.</td>
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<tr>
<td>84.</td>
<td>Residents report satisfaction with their bathing experiences (not</td>
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</tbody>
</table>
# Building a Home PDC Certification Program

## R U Ready Checklist

<table>
<thead>
<tr>
<th>85. Residents have a scheduled shopping cart/store or shopping trips available.</th>
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<tbody>
<tr>
<td>86. Visitors are greeted as they enter by staff.</td>
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<tr>
<td>87. Phones are answered courteously and within 2 rings.</td>
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<tr>
<td><strong>Benchmark</strong></td>
<td><strong>#9 Recognition &amp; Celebration</strong></td>
<td>Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>88. The Employee Feedback Questionnaire average score for Appreciation is a 3 or above.</td>
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<tr>
<td>89. There is no less than one program available for staff, residents, and families to recognize employees for their achievements and efforts.</td>
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<tr>
<td>90. There is no less than annual recognition to teams and/or individuals who championing PDC.</td>
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<tr>
<td><strong>Benchmark</strong></td>
<td><strong>#10 Maintenance</strong></td>
<td>Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>91. Ads for staff include recognition of PDC philosophy.</td>
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<tr>
<td>92. Key components of PDC are included in employee selection interview questions.</td>
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<tr>
<td>93. No less than 50% of non-managerial staff are trained and involved in interviewing prospective employees.</td>
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<tr>
<td>94. PDC material is included in orientation for all new employees.</td>
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<tr>
<td>95. 50% of employees score “Outstanding” in their performance evaluation related to “Relationship with Residents” and “Teamwork”.</td>
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<tr>
<td>96. 50% of employees have set a personal goal.</td>
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</table>
Person Directed Care

Choose Your Day Your Way
Even in the Nursing Home/Care Center

Many nursing homes are adopting a philosophy of Person Directed Care so that residents can enjoy their day their way.

Person Directed Care is a movement in long term care facilities that offers increased choices in many aspects of daily life. Each nursing home will be at a different stage in their ability to offer customized services. It is important for anyone considering a nursing home for themselves or a loved one to think about what is important to them and ask.

IPDCC

The IPDCC brings together individuals and organizations committed to improving care through person directed care activities.

If you have questions, would like more information or would like to join our efforts call Julie at:

1-866-236-1430

IPDCC Steering Committee

- ABCM Corporation
- Briggs Corporation
- Continuum Health Care Services
- Des Moines Area Community College
- IFMC
- Iowa Association of Homes & Services for the Aging
- Iowa CareGivers Association
- Iowa Department of Inspections & Appeals
- Iowa Health Care Association
- Iowa Veterans Home
- Office of the State Long-Term Care Ombudsman

www.iowapersondirectedcare.org
**Dining: Can I eat what I want, when I want?**
A Person Directed Care home will offer a wide variety of food choices and availability to accommodate your preferences and usual eating habits. Meals are often available for expanded hours with a variety of choices for all appetites. If you are hungry for a sandwich at 10:00 at night or are used to corn flakes for your supper these would be graciously accommodated in a Person Directed Care home.

**Pets: Can I bring Fido?**
A Person Directed Care home recognizes the importance of pet companionship. Many may have a facility dog or cat and some may be able to accommodate your personal pet.

**Bathing: Can I choose how and when I bathe?**
Traditional nursing homes will schedule bathing two times a week. In a Person Directed Care Home bathing preferences including frequency and type are accommodated. For example if you prefer a quick shower before breakfast, or leisurely whirlpool before bed, or maybe just a daily sponge bath, this can be done in a Person Directed Care home.

**Waking/Sleeping: Can I get up and go to bed when I want?**
Rather than require you to follow the schedule at the staff’s convenience, the Person Directed Care Home will accommodate your waking and sleeping schedule. For example, if you prefer to sleep in until 9:00 or even 10:00am, breakfast will be awaiting you when you arise. Staying up to watch the late, late movie? The Person Directed Care home will provide the popcorn!

**Activities: Can I continue to do the things I enjoy?**
A Person Directed Care home will encourage opportunities for your individual interests while also offering a variety of new experiences for intellectual growth, socialization and fun. So you can choose to host your bridge club (the Person Directed Care home will provide the room and refreshments) or go to community events with your new friends or both!

**Relationships: Can I have the same people taking care of me everyday?**
A Person Directed Care home will have consistent assignment where you build a relationship with the same caregivers who get to know you and your schedule and special wants and needs.

**IPDCC: Moving Iowa toward person directed care.**

- Individual's input is sought and some preferences are applied. Environment in common areas is more inviting.
- Individual is offered more choices, often including when to wake, eat and bathe. Surroundings are more like home.
- Individual determines own schedules, activities, meals and caregivers.
Appendix J: List of Expert Panelists

Following is a list of individuals who participated in the expert panel meeting to inform development of the National Nursing Home Quality Care Collaborative Change Package.

- Jim Argir, Director of Plant Operations, Bethany Health Care Center
- Christy Beard, NHC Care
- Eva Bering, Vice President of Operations, Landis Homes
- Kathleen Boyle-Giannini, Geriatric Nurse Practitioner, Foulkeways at Gwynedd
- Brigitte Burke, Corporate Registered Dietician, NHC Care
- Ethel Caldwell, Administrator, Landis Homes
- Lisa Chappelow, Administrator, Avalon Healthcare
- Sister Patty Creedon, Administrator, Mercy Retirement & Care
- Joelenne Galie, Director of Nursing Services, Foulkeways at Gwynedd
- Barbara Galluzzo, Assistant Director of Nursing, Bethany Health Care Center
- Michelle Garmin, Director of Nursing, Westview Care Center
- Susan Gonzales, Director of Nursing, Bethany Health Care Center
- Terry Hodge, Human Resource, Director, Bethany Health Care Center
- Jesse Jantzen, Chief Executive Officer, Mercy Retirement & Care
- Leslie Joyner, NHC Care
- Mary Knapp, Administrator, Foulkeways at Gwynedd
- Jacquelyn McCarthy, CEO, Administrator, Bethany Health Care Center
- Mary Nagle, Director of Mission Effectiveness, Bethany Health Care Center
- Marilyn Oelfke, Nursing Home Consultant, Perham Living Center
- Kelly O’Neill, Program Manager, Stratis Health
- Jane Pederson, Director of Medical Affairs, Stratis Health
- Jade Perdue Puli, Centers for Medicare & Medicaid Services
- Kate Peterson, Vice President of Operations, Stratis Health
- Judy Powell, Senior Vice President in Charge of Patient Services, NHC Care
- Allison Rainey, Assistant Vice President of Nursing, NHC Care
- Marilyn Reierson, Program Manager, Stratis Health
- Sandy Smoker, Director of Human Resources, Landis Homes
- Jackie Spangler, NHC Care
- Shaye Starkey, Assistant Executive Director, Mercy Retirement & Care
- Celia Taylor, NHC Care
Appendix K: Change Package

The document within this appendix follows this cover page on pages 213-252.

The document is also available online: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/NNHQCC-Package.pdf.
Welcome to the Nursing Home Quality Care Collaborative!!

We are excited that more than 4,200 Nursing Homes and their partners have committed to ensuring that:

Every nursing home resident receives the highest quality of care. Specifically, instilling quality and performance improvement practices, eliminating healthcare acquired conditions, and dramatically improving resident satisfaction.

In order for real change to occur the foundational practices and culture for change must be fertile, flexible and fast! This change package is a living document that seeks to provide a menu of strategies, change concepts and actionable items from which your collaborative team will choose from and begin testing. The intent is not that any nursing home would try to attempt every change concept at the same time but prioritize your efforts based on those areas where you feel change is needed (think about collecting a few “wins” first). We suggest that you be inclusive of your executive leadership, staff, residents and families in the prioritization of your efforts as everyone has something valuable to contribute! Subsequent versions of the change package will build upon what we learn as a collaborative community and grow to support your internal goals and the national measurement strategy.

While getting started can sometimes seem overwhelming, the key to success is simply testing small tests of change often! What can you test by next Tuesday? To get started, one nursing home may want to select a few of the actionable items for which they believe they have already implemented and collect information on the effectiveness of the effort while another may want to identify numerous areas where they feel improvement can be made and begin by testing in each of those areas. However it looks for your nursing home, there are many quality improvement practices, tools and supports available.

Lastly, the great thing about a collaborative is that you are never in it alone. You have the support of a national network of nursing homes, quality improvement organizations, Advancing Excellence, the state survey agencies, ombudsmen, residents and families, health care providers and advocacy groups all working towards the same goal of improving the system of nursing home care. Use the resources available to you and share your data, knowledge and successes so that the network can all learn from you.

Thanks for all the incredible work you do!

Your partner,

Jean Moody-Williams
Director, Quality Improvement Group
Center for clinical Standards and Quality
Centers for Medicare and Medicaid Services
National Nursing Home Quality Care Collaborative

Change Package

March 2013 v 1.2

This material was prepared by the Oklahoma Foundation for Medical Quality and Stratis Health, the National Coordinating Center (NCC) for Improving Individual Patient Care (IIPC) Aim, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-IIPC NCC-C7-139 030513
Introduction

This change package is intended for nursing homes participating in the National Nursing Home Quality Care Collaborative led by the Centers for Medicare & Medicaid Services (CMS) and the Medicare Quality Improvement Organizations (QIOs), to improve care for the millions of nursing home residents across the country. The Collaborative will strive to instill quality and performance improvement practices, eliminate Healthcare-Acquired Conditions (HACs), and dramatically improve resident satisfaction by focusing on the systems that impact quality such as: staffing, operations, communication, leadership, compliance, clinical models, quality of life indicators and specific, clinical outcomes (targeted focus on inappropriate antipsychotics in persons living with dementia, falls, pressure ulcers, physical restraints, urinary tract infections, and healthcare-acquired infections).

This change package is focused on the successful practices of high performing nursing homes. It was developed from a series of ten site visits to nursing homes across the country, and the themes that emerged regarding how they approached quality and carried out their work. The practices in the change package reflect how the nursing homes leaders and direct care staff at these sites shared and described their efforts. The change package is a menu of strategies, change concepts, and specific actionable items that any nursing home can choose from to begin testing for purposes of improving residents’ quality of life and care. The change package is intended to be complementary to such resources as literature reviews and evidence-based tools and resources.

Acknowledgments

We gratefully acknowledge the contributions of the following organizations that so generously shared their time, effective practices, and their experiences which informed the content of this change package.

- Bethany Health Care Center, Framingham MA
- Foulkeways at Gwynedd, Gwynedd PA
- Franciscan Convalescent Hospital, Merced CA
- Jewish Healthcare Center, Worcester MA
- Landis Homes, Lititz PA
- Mercy Retirement & Care Center, Oakland CA
- NHC Healthcare – Anderson, Anderson SC
- NHC Healthcare – Parklane, Columbia SC
- Pleasant View Home, Albert City IA
- Westview Care Center, Britt IA
Strategies

1. **Lead with a sense of purpose:** The actions of leaders, multiplied by the actions of many, shape a culture and an organization. Strategy 1 sets the expectation for excellence in leadership. The foundation of a learning organization rests upon: exceptional executive leadership; a strong mission and values; and an accepting non-punitive culture.

2. **Recruit and retain quality staff:** A quality-driven nursing home identifies and develops great talent, in whatever discipline they serve, by setting high expectations and fostering an affirming culture. It recruits and hires qualified caring staff that fits its mission, values, and culture, and then cultivates longevity through a supportive work environment. Staff members at every level feel that their primary purpose is to provide quality care to the residents.

3. **Connect with residents in a celebration of their lives:** Distinctive nursing homes create an environment where the “resident always comes first.” The focus is on keeping residents active in their families’ lives and the community, according to resident preferences. At the end of life, a celebration of life honors the resident and embraces family, other residents, and staff.

4. **Nourish teamwork and communication:** Teamwork and communication among staff and between staff and residents is nourished by disseminating information in a complete, consistent and timely manner. Strong communication links people and build relationships between staff and residents. High-functioning teams respect one another and work interdependently towards common goals.

5. **Be a continuous learning organization:** A continuous learning organization: knows where it stands; knows when and how to change; uses data to drive performance; and views the organization as an interdependent system. The interdependent system is described as the combination of the people, structures, supplies, and resources that come together within an organization to make it function.

6. **Provide exceptional compassionate clinical care that treats the whole person:** A focus on the whole person requires staff that knows the residents well and can anticipate their needs. It also requires an engaged and competent medical and care team that effectively manages residents’ changing health conditions and avoids Healthcare-Acquired Conditions (HACs).

7. **Construct solid business practices that support your purpose:** A well-run nursing home excels as a business yet feels like home. It seeks ways to effectively manage the bottom line with integrity and with the resident as the focus. It runs efficient operations; invests in equipment and supplies to provide the highest quality care; and ensures that its physical and outdoor environments are comfortable and inviting.
# Table of Contents

1. **Strategy: Lead with a sense of purpose.**
   - 1.a Change Concept: Be the leader you would want to follow.  
   - 1.b Change Concept: Let the mission drive your actions.
   - 1.c Change Concept: Plant now – harvest later: Nurture professional growth and foster innovation in others.
   - 1.d Change Concept: Focus on systems for change.

2. **Strategy: Recruit and retain quality staff.**
   - 2.a Change Concept: Hire only the best fit for your organization.
   - 2.b Change Concept: Welcome new staff – make them part of the team.
   - 2.c Change Concept: Set high expectations - support success.
   - 2.d Change Concept: Give the best staff a reason to stay.

3. **Strategy: Connect with residents in a celebration of their life.**
   - 3.a Change Concept: Treat residents as they want to be treated, remembering that your facility is their home.
   - 3.b Change Concept: Foster relationships.
   - 3.c Change Concept: Create connections with the community.

4. **Strategy: Nourish teamwork and communication.**
   - 4.a Change Concept: Expect and support effective communication with staff and between staff.
   - 4.b Change Concept: Be a collaborator among collaborators.

5. **Strategy: Be a continuous learning organization.**
   - 5.a Change Concept: Make systems thinking the norm.
   - 5.b Change Concept: Track your progress.
   - 5.c Change Concept: Test, test, test!

6. **Strategy: Provide exceptional compassionate clinical care that treats the whole person.**
   - 6.a Change Concept: Carefully build care teams and keep them together.
   - 6.b Change Concept: Choose medical leadership wisely.
6.c  Change Concept: Transition with care (between shifts, departments, and all care settings).
6.d  Change Concept: Strive to prevent problems and treat when necessary.

7.  **Strategy: Construct solid business practices that support your purpose.**
    7.a  Change Concept: Seek strategic and creative approaches to expand your resource base to meet your mission and serve your residents.
    7.b  Change Concept: Maximize your efficiency.
    7.c  Change Concept: Ensure you are making the most of your physical assets.
1. **Strategy: Lead with a sense of purpose.**

**Change Concepts**

1.a  Be the leader you would want to follow.
1.b  Let the mission drive your actions.
1.c  Plant now – harvest later: Nurture professional growth and foster innovation in others.
1.d  Focus on systems for change.

1.a **Change Concept: Be the leader you would want to follow.**

**Action Items**

1.a.1 Institute an “open door” policy for all levels of leadership to establish presence and consistent availability for staff.
1.a.2 Routinely spend time in all neighborhoods and during all shifts (spend less time behind office doors where your view, and perceptions are obscured).
1.a.3 Hold and attend neighborhood/household meetings on all shifts.
1.a.4 Talk directly to staff and residents. Establish a practice to ask:
   - How they are doing.
   - What they need in order to do their best work and provide excellent care.
   - How you can help reduce frustrations that prevent them from doing their best work.
1.a.5 Demonstrate interest in staff by addressing them by name.
1.a.6 Commit to following through on issues brought to you—keep that commitment.
1.a.7 Quickly address staff issues and requests, providing feedback to the person making the request, even if you cannot accommodate the request (explaining why and expressing genuine appreciation).
1.a.8 Ask for help when needed, showing respect for the perspective and expertise of others.
1.a.9 Provide help both when asked and when not asked. Set the example and pitch in!
1.a.10 Make policies and procedures helpful and meaningful. If a policy or procedure is not effective, change it. Do not inadvertently support work-a-rounds.

1.a.11 Align your actions with your organization’s shared values. For example, if one of your organization’s values is honoring resident choices, make sure you and your staff honor resident choices.

1.a.12 Recognize and honor staff and resident opinions. Use their name; say that you value them; and acknowledge what you saw them do or know what they did. Demonstrate your sincere appreciation.

1.a.13 Empower all staff, residents and family members to look for improvements and suggest changes. Follow up on their feedback (your responsiveness will bring more suggestions).

1.a.14 Change your mind if someone has a better idea. Then give them credit.

1.a.15 Remove negative language. Talk positively about others.

1.a.16 Establish customer service expectations, for example, expected times for turn-around on issues raised by staff and residents. Then meet or beat that time.

1.a.17 Seek out feedback on your individual performance and mentoring from peers.

1.a.18 Credit others for contributions that positively affect your performance.

1.a.19 Say "thank you" to staff because these simple words are highly valued. Find and thank at least one staff member each day for something they have done that you are truly grateful for.

1.a.20 Ensure necessary equipment is readily available, well maintained and in good working order. Do this by creating a system where all staff members are responsible for notifying maintenance staff of problems. For example, if a certified nursing assistant (CNA) notices there is little hot water, this should be reported to maintenance for immediate repair.

1.a.21 Track staff incidents and accidents. Conduct root cause analyses to understand what happened and take action to prevent future occurrences.

1.a.22 Acknowledge and celebrate milestones such as six months or one year with no accidents.
1.b Change Concept: Let the mission drive your actions.

Action Items

1.b.1 Use an inclusive process to establish, review, and reaffirm your mission that involve staff, residents, and families.

1.b.2 Ensure values are considered core to the facility and those who live and work there, for example, respect, resident-centered care, honoring wishes, service, family, enriching lives, building relationships, care, dignity, quality.

1.b.3 Translate the mission into action. For example; create a, “caught in the act of practicing the mission and values” practice, as a way to show or point out what it means to put the mission into action.

1.b.4 Share the mission and values with people as they are applying for work in your organization. Screen applicants based on mission and vision “fit.”

1.b.5 Include the mission and values in the orientation of new staff. For example, if “build relationships” is a core value, encourage new staff to get to know residents and establish a relationship.

1.b.6 Share the mission and values with all staff.

1.b.7 Ensure that there is alignment of mission and values with what is happening in the facility every day. Ensure all processes honor the values.

1.b.8 Discuss values daily. Tell stories about how the values are carried out.

1.b.9 Use values in carrying out decisions on a daily basis. Ask “does this decision match with our values?”

1.b.10 Conduct regular surveys of staff and residents regarding whether the values and mission are evident in the day-to-day work and the operations of the organization.

1.b.11 Make strategic decisions based upon mission. Ensure that mission and values are core factors in strategic decisions.

1.b.12 Establish and focus on clear expectations for all staff that is centered on mission and values; in turn, staff will create high expectations (linked to culture and initiated at orientation and reinforced along the way) for themselves and each other. Expect the best.

1.b.13 Build relationships with board or corporate members who may have unique connections to your community or organization that advance the mission and values.

1.b.14 Encourage frequent visits to the facility by the board, and encourage them to speak directly to residents and staff to understand how your mission and values are embodied in your work.
1.c Change Concept: Plant now – harvest later: Nurture professional growth and foster innovation in others.

**Action Items**

1.c.1 Set the expectation for leaders and staff to look for and share ideas for ways to grow and innovate.

1.c.2 Encourage staff to attend conferences and participate in state or national committees. Expect them to bring ideas back to the organization and develop a process for sharing.

1.c.3 Guide and empower staff to solve problems. For example, leaders should respond to problems that are raised not by proposing a solution but instead by asking the team to investigate and determine what they believe would work best. Leaders serve as a resource and coach to the staff.

1.c.4 Supply clinical and non-clinical consultants to staff, when needed, to provide ongoing learning, professional growth and success.

1.c.5 Seek creative ideas from multiple sources within and outside the organization in order to foster innovation. Create a safe environment to test new changes, to try new ways to meet resident needs.

1.c.6 Accept or seek out opportunities to contribute to learning in the long-term care profession. For example, participate in research studies or projects contributing to the advancement of the long-term care field.

1.c.7 Participate in educating student nurses, PTs, social workers, aides, etc. Learn from them and their schools about new emerging practices. Make sure they are on the right path with promoting individualized care in long term care.

1.c.8 If practices are not making sense or are frustrating to staff, residents or family, do not settle for “this is just the way it has to be”—challenge that, sort out what you have control over and look for ways to address improvements.

1.c.9 Build leadership skills through training, support and coaching to help staff be effective.

1.c.10 Help leaders and staff to feel in control of and committed to their neighborhoods or departments – to know that they can influence how their days go and the outcomes they achieve.

1.c.11 Develop opportunities for leaders to learn from and support each other. For example, establish groups of new leaders and provide mentoring in order to help them understand the organization and provide support. Through this, the new leaders also become support for each other.
1.d Change Concept: Focus on systems for change.

**Action Items**

1.d.1 Use the root cause analysis (RCA) process to look at systems rather than individuals when something breaks down – this is a practice that will be useful not only to create a non-punitive environment but also support Quality Assurance and Performance Improvement (QAPI). Demonstrate that you are willing to take the time to investigate and understand why something happened before determining a response.

1.d.2 Proactively look for opportunities to improve the system and avoid events by asking staff, “Where are we at risk? Where are you most concerned about making an error? Where could we improve our system or process in order to prevent errors?” This supports the expectation and importance of staff sharing information about potential problems and quality concerns.

1.d.3 When a mistake/unintentional error occurs, do not punish staff. Assure so that they feel safe to report the problem immediately. Respond to errors or incidents based on distinguishing whether there was an inadvertent error made, versus at-risk behavior versus reckless behavior. Do not punish for errors or mistakes but instead look for how to improve the system and console the staff involved.

1.d.4 Have leaders confer before deciding how to handle a quality breach by a staff member, rather than having each supervisor act alone. Explore process factors that might have caused the mistake so the appropriate response can be made.

1.d.5 Build trust with and between your staff (do what you say you are going to do – if you make a promise, deliver on it).

1.d.6 Openly admit your unintentional errors so people are less afraid to admit theirs.

1.d.7 Recognize that having a non-punitive culture does not mean not holding people accountable. Make sure that staff members understand that there are reckless and intentional behaviors that will result in punitive actions. For example, taking tips from residents, abuse of any kind, etc.
2. Strategy: Recruit and retain quality staff.

2.a Hire only the best fit for your organization.
2.b Welcome new staff – make them part of the team.
2.c Set high expectations - support success.
2.d Give the best staff a reason to stay.

2.a Change Concept: Hire only the best fit for your organization.

Action Items

2.a.1 Define what quality staff means to you based on the mission, describe the characteristics you are looking for.

2.a.2 Create job ads that highlight high standards that fit your mission, values, and culture. (For example, use phrases such as “we are a skilled nursing facility seeking qualified individuals for our team of caring, dedicated professionals.” OR “at XXX your work is always appreciated and never underestimated. We support our employees with competitive pay and benefits, quality leadership and a positive team environment.”)

2.a.3 List quality achievements or awards on your website recruitment page and in your job ads as a demonstration of your commitment to quality.

2.a.4 Determine who needs to be involved in the hiring process based upon the position to be hired. Include opportunities for neighborhood staff and resident involvement in the selection process.

2.a.5 Before hiring, take candidates to the work site to see how they respond to those who live and work there.

2.a.6 When interviewing staff, ask why they got into profession; why they do this work. Look for candidates who are sincerely passionate about providing compassionate care.

2.a.7 Explore “fit”. “Fit” is equally important to skills.

2.a.8 Use behavioral based questions during interview, for example, ask how they have responded to or would respond to different situations that arise in nursing homes. Have Human Resources staff conduct the first interview to focus on the “fit”.
2.a.9 Ask candidates about their values. Use open-ended questions and ask them to share stories, give examples of how they have demonstrated their values. Include a question like: “What would you like to learn by working with us?” or “Describe to me what you consider to be a high quality nursing home?”

2.a.10 Ask about aspirations for personal and professional growth. This sends the message you want them to grow with your organization.

2.a.11 Embed a consistent high expectation message during the initial interview to align with the mission of service and resident-centered care.

  o Use organization values and performance improvement as part of interview process. Make it clear to the candidate that you are looking for a good fit for the organization but also this is the person’s chance to determine if this is a good fit for them. For example: give candidate a copy of your organization’s Mission Statement and company values and ask: “Which one of these values resonates with you and tell me how you might use it in your work?”

2.a.12 Ensure continuity and consistency of high expectations is carried through all aspects of initial hire. During the hiring process explain that ideas for performance improvement are solicited from residents, family and staff.
2.b Change Concept: Welcome new staff – make them part of the team.

Action Items

2.b.1 Ensure continuity and consistency of high expectations is carried through all aspects of orientation. Review value based expectations during orientation. For example: “Employee works cooperatively and collaboratively with staff from other departments.”

2.b.2 Provide employees with the tools and training they need in order to do their job well. For example, in-services, online and in-person training opportunities.

2.b.3 Assign a “buddy” or “mentor” for new staff to help them learn about the culture and “how we do things here.” Ensure the mentor is someone who represents the mission and values in their attitude and work, and is available to support the new staff member through the challenging first months of a new position.

2.b.4 Make the length of orientation flexible, based upon the individual’s needs, in order to develop strong employee orientation practices.

2.b.5 Have staff shadow other disciplines during orientation so that they see how their role interacts with others.

2.b.6 Encourage new staff to ask questions, and take the time to answer thoroughly and thoughtfully.

2.b.7 Schedule a 30-45-90 day follow-up interview by Human Resources to find out what support, additional training, etc. is needed. Give feedback to the manager.

2.b.8 Create opportunities for staff members to work together as a team on projects in order to foster a sense of family and community. (For example, the staff on each floor/unit decorates a pumpkin for Halloween and the residents vote for the best, or each department creates a “theme gift basket” for the holidays for a raffle, or staff members work together to create activities or decorations for a themed Nursing Home Week.)
2.c Change Concept: Set high expectations - support success.

**Action Items**

2.c.1 Embed a continuous and consistent message of high expectations through all aspects of on-going employment.

2.c.2 Tie and reinforce value-based expectations in performance appraisals. For example, look for or ask about examples where the individual demonstrated flexibility, independence & initiative while fostering a cooperative, caring attitude among staff.

2.c.3 As a leader, uphold the high expectations of the organization. If you see an issue, take action and set the tone for high expectations.

2.c.4 When hiring nurses, give them a sample competency test/checklist to set the expectations that they will be assessed on these skills on the job. Ask them to contribute to improving the test/checklist.

2.c.5 After hire but before orientation, have new employees complete a skill-based competency test.

2.c.6 Conduct annual Skills testing. Make it engaging; expect all staff to participate.

2.c.7 Explore experiential learning opportunities such as being placed in lifts, being fed, cleaning a resident room.

2.c.8 Foster a higher level of understanding and appreciation among staff members of separate departments. For example, encourage staff in non-clinical departments (housekeeping/dietary/laundry etc.) to obtain nursing assistant certification (as appropriate), allowing them to broaden their job.

2.c.9 Develop cross-training among departments to create blended roles; for example, housekeeping/laundry, housekeeping/dietary or dietary/activities. Involving staff in different roles promotes higher levels of cooperation and collaboration among staff members.

2.c.10 Include interdepartmental collaboration in job descriptions.

2.c.11 Set the expectation that all staff responds to resident needs and requests, whether or not they are assigned to work in that specific neighborhood.

2.c.12 Solicit staff feedback on staffing levels to ensure adequate help and respond to needs that emerge.

2.c.13 Use formal (staff satisfaction surveys) and informal (rounding) means to gain feedback on the quality of care and respond to needs that emerge.

2.c.14 Hold short stand-up meeting between manager and staff for each shift to identify concerns, resource needs, etc.

2.c.15 Recognize and reward staff for achieving organizational goals. For example, long periods without accidents.

2.c.16 Provide opportunities for staff to recognize or nominate fellow staff members for recognition or awards.
2.c.17 After survey process is complete, recognize the full team for their contributions. For example, formal leaders come in on all shifts and provide treats while rounding facility.

2.c.18 Celebrate successes - it’s the little things that matter.

2.c.19 Recognize and reward staff for performance and commitment. For example, sponsor an annual banquet to recognize staff for years of service. Invite family members to attend. Send the family a questionnaire prior to the banquet to share stories during the introduction. Invite residents to come if they are able.

2.c.20 Before initiating change in the organization, meet with any staff and residents/families that will be impacted by the change in order to gain their support, buy in, and get their feedback. This sends an important verbal and non-verbal message that the organization believes they have valuable information to contribute.

2.d Change Concept: Give the best staff a reason to stay.

**Action Items**

2.d.1 Ensure your compensation and benefits are competitive in your marketplace.

2.d.2 Establish profit-sharing to make staff “partners” instead of “employees” (for-profit organizations).

2.d.3 Support staff in their professional development. For example, encourage continuing education, provide scholarship programs, reimbursement for time; pay percentage of tuition, provide in-services, or provide training on English as a second language.

2.d.4 Implement weekly paychecks, 401(k) plans, etc.

2.d.5 Provide an Employee Assistance Program (EAP) with no questions asked.

2.d.6 Provide opportunities for flexible schedules and work environment so that individuals are able to better balance work and family/home needs.

2.d.7 Create opportunities for the voices of your staff to be heard.

2.d.8 Coach and support supervisors so they provide effective, caring supervision and leadership for employees.

2.d.9 Implement succession planning; identify internal staff members with the potential to fill key leadership positions and provide them with development experiences. For example, involve them in problem solving and strategic planning.
3. Strategy: Connect with residents in a celebration of their life.

3.a Treat residents as they want to be treated, remembering that your facility is their home.
3.b Foster relationships.
3.c Create connections with the community.
3.d Provide compassionate end of life care.

3.a Change Concept: Treat residents as they want to be treated, remembering that your facility is their home.

**Action Items**

*Admission process*

3.a.1 Welcome new residents by creating opportunities for them and the staff to get to know each other. For example, a learning circle in the neighborhood to introduce the new residents, having information gathered through psycho-social assessments and preferences, conducting interviews with all staff in the neighborhood or having a staff member interview the residents and present a summary for all staff.

3.a.2 Schedule an admission conference when a new resident arrives and gather not only clinical information but also personal history, preferences, etc.

*Know residents as individuals. For example, establish processes and expectations such as:*

3.a.3 List residents’ choices and preferences related to all aspects of their daily lives. For example, wake time, food preferences, activities, bathing and bedtime. Make the list available to all staff to consult with as they are working alongside the resident.

3.a.4 Provide a book or journal about each resident’s care processes and programs so that staff can update for others to read and stay current.

3.a.5 Keep all disciplines/staff informed of residents’ preferences and progress so they can relate to the whole resident using processes such as 24-hour report, daily stand-up, huddles, and interdisciplinary team meetings.

3.a.6 Create a household notebook that provides information about the person’s life (similar information you may see in an obituary but don’t have to wait till they die to learn it).

3.a.7 Publish a monthly birthday list that includes resident and staff birthdays to emphasize that you work together and celebrate together.
3.a.8 Create a game. For example, share pieces of a biography of a resident and ask staff to identify them (or vice versa), or identify a baby picture.

3.a.9 Learn from family members to care for residents as they know them.

**Staff training and expectations**

3.a.10 Use words that reflect that this is the resident’s home. For example:
   - Use avenue, neighborhood, or household instead of unit.
   - Describe the resident as moving in rather than being admitted.
   - Use the word 'encourage' that supports the concept that residents are in control of their own choices.
   - Explain that staff assists with eating rather than feeds the resident.

3.a.11 Create an environment where greeting with a smile and making eye contact is the norm to show that you value residents.

3.a.12 Conduct care conferences in the location most comfortable to the resident and best promotes openness and sharing. For example, in the resident’s room.

3.a.13 Make prompt response to resident's needs as top priority. For example, expecting all staff and all disciplines to respond to call lights and structuring services and staff to allow for maximum response to resident needs.

3.a.14 Train staff that their appropriate response to resident’s requests are positive, for example, “Thank you for asking. Let me see what I can do.”

3.a.15 Keep care plans, journals, or other tools updated. Encourage all staff to update them as they identify changes.

3.a.16 As part of the first day orientation for new staff, tell stories on how residents’ desires have been met. For example, how an opportunity was found to provide a way for a resident to do something special.

**Structures for resident engagement**

3.a.17 Promote bi-directional relationships between residents and staff. For example, a buddy or guardian angel program that matches residents and staff persons in a long-term relationship. Allow staff paid time to nurture these relationships.

3.a.18 Create a “Resident Life Committee” composed of residents and staff who come together to discuss any issues or ideas created by individual neighborhoods or the overall nursing home. Use their suggestions to make changes that contribute to the residents’ quality of life. For example, adding their favorite foods to the menu arranging for a requested music event, etc.

3.a.19 Create opportunities for the residents to “give to others” and promote meaning in life. For example, help gather food for food shelf drive, participate in creating a gift for the new year’s baby, select name from local giving tree at holiday times, help staff with English as a second language needs, collect or provide donations for individuals/groups in need.
3.a.20 Feature a monthly resident at household meetings along with their family present to provide an opportunity to meet everyone and talk about their lives/interests.

3.a.21 Celebrate different staff and resident cultural traditions as a way to better understand differences and similarities. For example, sharing foods, customs, and traditions.

3.a.22 Support residents to become involved and celebrate life events of staff such as weddings, births, etc.
3.b Change Concept: Foster relationships.

**Action Items**

3.b.1 Welcome and encourage family members to communicate with staff and resident. Proactively provide opportunities for families to communicate, including contact information and who to contact when.

3.b.2 Invite family and friends to visit anytime, eliminating visiting hours for resident’s family members. Help them feel welcome. Give family information on how to access the building at times when doors may be locked.

3.b.3 Encourage families to feel “at home” when visiting – access to beverages, comfortable places to visit, etc.

3.b.4 Proactively initiate frequent communication with family members (regular calls or meetings) and discuss all aspects of resident care and life.

3.b.5 Create “two-way” communications – sharing with family and listening to their opinions and concerns.

3.b.6 Provide feedback – if you say you are going to follow-up, do so, and let them know what you found out.

3.b.7 Invite family members to witness and provide care as they desire.

3.b.8 Provide family members with ideas of activities to do with residents when visiting, especially for family members of residents with dementia who may not be able to express their needs. For example, help them decorate their room, bring in the family pet for a visit, share family photo albums, share stories, or join them for coffee in the dining room.

3.b.9 Invite family members to activities that the resident enjoys and would enjoy having family members with them at as well.
3.c Change Concept: Create connections with the community.

Action Items

3.c.1 Ask for suggestions from residents and families about activities they would like to attend in the community and follow up on their suggestions and provide transportation. For example, trips to see the changing colors of the leaves, a shopping trip, attend religious services, attend a community event, or attend a local play.

3.c.2 Make use of available technology. Use video streaming to broadcast the religious services at the nursing home allowing residents to participate in real time.

3.c.3 Be active in your local community to increase awareness and understanding of the services and care you provide and who your residents are. For example, at health fairs, with the Chamber of Commerce, or at the senior center(s).

3.c.4 Ask for suggestions from residents and families about community members or groups they would like to invite to the nursing home and follow-up on their suggestions. For example, invite the local clubs (for example Red Hat Club, Ladies Aide groups, Kiwanis, Masons, card clubs) so residents can participate, and invite local business men and women to have lunch with residents, sharing what’s new in their business.

3.c.5 Establish discussion groups of interest to residents. For example, an ecology club.

Action Items

3.d.1 Provide on-site training for staff on the death and dying topic to aid them in providing compassionate care to the dying resident and supporting family members and each other.

3.d.2 Encourage empathy by training staff to ask themselves what they would want if they were in the resident’s or family’s position.

3.d.3 Support the neighborhood staff members as they provide care for the dying resident and after the resident passes away, acknowledge their care and presence and feelings.

3.d.4 Develop a system for ensuring that the dying resident is not alone (honoring resident’s preference) – include family, staff and volunteers. Have a signup sheet for volunteers/staff to take shifts if the family is not available. Encourage the family to step away from the bedside for their meals, etc. by providing someone to sit with their loved one while they are gone. Be present with the resident and family so that they are not alone.

3.d.5 Provide comfort items for the family/representatives staying with the resident. For example, food, water, and/or blankets.

3.d.6 Involve clergy/pastoral care staff in support of staff as well as resident & family during the dying process. Also, provide access to faith resources 24-hours a day.

3.d.7 With permission of the resident and/or family, encourage other residents and staff to visit the dying resident if they wish.

3.d.8 Let family stay with the body as long as they want after the death occurs.

3.d.9 At the time of death, find ways to honor the deceased resident in line with their and their family’s preferences, that give fellow residents and staff the opportunity to mourn the loss and celebrate their life. For example:

- At the time of death, have a reverent but public ceremony where staff and residents can acknowledge and celebrate the deceased. Make sure that staff on all shifts is aware of the procedure so that it happens whenever someone passes away. Laminate the prayer and/or directions for the bedside service so that any staff member can lead it.
- Escort the resident out the front door to the hearse, draped in a special “dignity” quilt. This is called the Walk of Honor.
- Schedule time for a memorial for each resident to share memories of their life. For example, have a process for saying “good bye” when the body leaves the facility and “welcoming back” when the body is brought back for the wake.
- Encourage staff to write notes to the family members to share thoughts, wishes, and memories. Collect the notes and send to the family members. Provide opportunities for anyone who wishes to share memories of the resident.
- Have a memory book in the main waiting area – as each resident dies, a page is added with reflections from the wake and any comments added by those present.
3.d.10 Provide an option for families to have a funeral service at the nursing home as another way of including them and acknowledging that this is their loved one’s home.

3.d.11 Provide a meal for the family during the wake.

3.d.12 Do a service for all who have died during the year – as the name is read, a candle is lit, after the service, the family is invited to take the candle home with them.

3.d.13 Greet the family as they return to collect personal belongings, let them know how you are feeling and acknowledge their feelings. Show them you care.

3.d.14 Show slides at annual staff training of all residents that died to help staff remember and assist with grieving. Include photos to put a face with the name.
4. **Strategy: Nourish teamwork and communication.**

4.a  Expect and support effective communication with staff and between staff.

4.b  Be a collaborator among collaborators.

### 4.a Change Concept: Expect and support effective communication with staff and between staff.

**Action Items**

4.a.1 Implement a formal method for communication between shifts. For example, face to face meetings or huddles between shifts, Nursing Assistant shift-to-shift bedside report, and a communication journal in residents’ rooms.

4.a.2 Conduct regular staff surveys and share results with staff, including opportunities for staff response and questions.

4.a.3 Establish the use of learning circles and huddles to foster relationships and create an opportunity for all to be heard.

4.a.4 Establish a process of updating care plans that supports effective communication, is sustainable in practice and requires measurement.

4.a.5 Include “all voices” that have a stake in what is being discussed. For example, if you are discussing an issue that pertains to a household you need to include the nursing assistants, dining, housekeeping, nurses, residents, families, etc. Use methods that encourage open and honest communication, especially to get at concerns. For example, staff may be more willing to share concerns in an anonymous survey.

4.a.6 Develop communication plans that use multiple approaches (e-mail, verbal, newsletters, etc.) based on content and audience to ensure a consistent message is disseminated throughout the facility and across all shifts. Do not rely on word-of-mouth.

4.a.7 Include all shifts in communications.

4.a.8 Establish regular neighborhood meetings on each shift for the purpose of identifying what is working well as well as opportunities to improve.

4.a.9 Remove boundaries between departments. For example:

- Shadow other disciplines at the time of hiring so they know what everyone needs to do to make the household run.
- Have housekeepers become CNAs which fosters communication and understanding between roles.
- Use interdisciplinary teams for problem solving.
- Hold neighborhood meetings that all disciplines attend.
4.b Change Concept: Be a collaborator among collaborators.

**Action Items**

4.b.1 Provide training in systematic methods so the team focuses on the project, not on figuring out how to work together as a team.
   - Use templates or methods for consistency and to support shared expectations of process. For example, agenda and minutes.
   - Use organizational resources. For example, having a place to put information on an intranet/SharePoint.
   - Encourage team tools such as brainstorming techniques.
   - Provide training on how to coach and provide feedback.

4.b.2 Celebrate successful collaboration.

4.b.3 Create systems that support teams to function even when they do not have the luxury or meeting to discuss. For example, a list of zip codes available of all staff to quickly organize carpooling during bad weather.

4.b.4 Model executive teamwork in interactions with each other and the rest of the organization. Do not delegate teamwork in crisis situations. For example, in a natural disaster the management stays in the facility along with the other team members - maintaining teamwork even when things go wrong.

4.b.5 Involve all staff in changes and improvement to increase the feeling of ownership and accountability. For example, when tackling a problem such as removing all audible alarms, start by surveying staff and gather their needs and recommendations.

4.b.6 Look for opportunities to coach to help strengthen team relationships. For example, role play a situation with staff prior to when they may need to address a conflict with a co-worker.

4.b.7 Cross-train staff so people can assist each other and collaborate.

4.b.8 Encourage and model for all staff to do whatever is necessary. For example, expect anyone to assist a resident that is requesting help, everyone is responsible to report equipment that is not in good repair, etc.

4.b.9 Encourage staff to help and support each other on and off the job. For example, having a practice in place to make sure staff is able to attend life events of other staff, such as funerals.

4.b.10 Involve managers in work of the neighborhoods. For example, everyone assists periodically in dining room during a meal.

4.b.11 Reward and recognize teamwork. Performance evaluations can include feedback on collaborative practices as much as individual contribution and achievement.
4.b.12 Encourage and reward staff for supporting each other. Create a real-time reward or recognition program to highlight when staff models this behavior.

4.b.13 Teach and model offering and accepting help.

4.b.14 Teach and model giving constructive feedback that is timely and specific and respectful, to help team members improve.

4.b.15 Enable management and administrative staff to be as close to the residents and direct care staff as possible to foster shared focus on resident needs. For example, place offices in neighborhoods rather than by department.

4.b.16 Share thank you notes received with everyone in the facility For example, via e-mail, posted on a bulletin board.
5. Strategy: Be a continuous learning organization.

5.a  Make systems thinking the norm.

5.b  Track your progress.

5.c  Test, test, test!

5.a Change Concept: Make systems thinking the norm.

Action Items

5.a.1 Establish the nursing home as a learning organization whereby staff identifies areas for improvement in themselves and in care processes at the facility.

5.a.2 Create daily opportunities for learning. For example, conduct rounding with MD or nurses or discuss short vignettes for learning.

5.a.3 Discuss processes and systems to identify areas for improvement regularly – in meetings as well as everyday interactions.

5.a.4 Empower residents to get involved by identifying areas of improvement.

5.a.5 Build redundancies into the practices in order to prevent errors and lapses. For example, create checks and balances.

5.a.6 Use prompts and reminders to assist staff in completing critical processes and steps and prevent potential adverse events.

5.a.7 Make visible and talk about how different processes and activities are inter-related and part of systems.

5.a.8 Identify implications and consequences of changes to show inter-connectedness and relationships, intended and unintended.
5. Change Concept: Track your progress.

**Action Items**

5.b.1 Measure important indicators of care that are relevant and meaningful to the residents you serve. For example, pressure ulcer rates, falls, infections, emergency department and hospital admissions/readmissions, satisfaction.

5.b.2 Set stretch goals. Choose national, state, and local performance benchmarks to beat.

5.b.3 Get everyone involved in setting goals including staff, management, and the board.

5.b.4 Openly and transparently share your performance data with staff, board, residents and families.

5.b.5. Be a valued partner to payers and other parts of the health care system by demonstrating the high quality of care you provide, opening the doors to your participation in new care delivery and payment models. For example, Accountable Care Organizations, bundled payment programs, readmissions initiatives.
5.c. Change Concept: Test, test, test!

**Action Items**

5.c.1 Prioritize opportunities for improvement.

5.c.2 Know when to make real changes to processes and when to make enhancements to current processes.

5.c.3 Identify and support a change agent for each improvement project – a cheerleader and/or key facilitator of change in your facility. Choose someone who is expected and able to keep momentum despite setbacks and other factors that come up and distract.

5.c.4 Use a change methodology like PDSA (Plan, Do, Study, Act) to test small incremental changes; track and monitor your progress.

5.c.5 Take advantage of existing performance improvement templates and tools that are easy to use and guide systems thinking to define the problem, test interventions and measure the impact on the problem and on the larger system. Tools may include flowcharting, the PDSA cycle and root cause analysis.

5.c.6 Use an action plan template that defines who and when—to establish time lines and accountability.

5.c.7 Use a multi-department and multi-disciplinary approach to improvement. Involve people who care about the process being improved.

5.c.8 Involve residents and external stakeholders in improvement initiatives.

5.c.9 Set specific numerical performance improvement goals that staff and leadership personally own, believe in and understand their role in achieving.

5.c.10 Track and report progress in meeting performance improvement goals.

5.c.11 Celebrate success and find creative ways to reward and recognize staff who contribute to achievement of goals.

5.c.12 Set up a scoreboard for staff that monitors progress towards important goals. Example of a goal: days at zero pressure ulcers. Post the scoreboard that chart progress in common areas such as halls, staff room, etc.
6. **Strategy: Provide exceptional compassionate clinical care that treats the whole person.**

6.a Carefully build care teams and keep them together.

6.b Choose medical leadership wisely.

6.c Transition with care.

6.d Strive to prevent problems, and treat when necessary.

### 6.a Change Concept: Carefully build care teams and keep them together.

**Action Items**

6.a.1 Assign each staff member consistently to one area/neighborhood of the home so that they can serve one group of residents and care for the same residents almost every time they are on duty.

6.a.2 Train/educate your staff on the benefits of consistent assignment.

6.a.3 Implement consistent and then permanent/life time assignment. Start small – go slow. Meet with staff to enlist support and listen to concerns. For example, try on one neighborhood for 2 weeks, then progress to monthly, and finally permanent as the staff adjusts.

6.a.4 Involve staff in planning for consistent assignment. Enlist their help in making assignments looking for balance and what is doable.

6.a.5 Use feedback from residents and families in making assignments.

6.a.6 Meet regularly with staff and residents to discuss how consistent assignment is working, including reviewing assignments to ensure that relationships are going well.

6.a.7 Monitor the process as a QI project by discussing the status of change efforts at each QI meeting, making sure that all disciplines are informed and involved in process.

6.a.8 Make changes in resident assignment only when it will benefit the resident.

6.a.9 Empower direct care staff to be involved in team decision making by encouraging them to come forward with concerns and ideas.

6.a.10 Include all staff and disciplines in activities that provide opportunities to build relationships with the residents and the other team members.
6.a.11 Introduce new residents and staff to all staff and all departments.
6.a.12 Assign all disciplines permanently to a neighborhood and consider them as part of the team.
6.a.13 Have all disciplines attend neighborhood meetings and encourage full participation such as dining services, maintenance, and housekeeping.
6.a.14 Look for opportunities to blend roles, promoting opportunities for staff to work differently in support of good resident care and life. For example, housekeepers or dietary staff also trained as CNAs.
6.a.15 Involve medical leadership in senior management meetings.
6.a.16 Involve the medical director in the team that establishes and updates clinical care guidelines.
6.a.17 Involve medical leadership in the development of forms/communication tools to use in medical records and for communication.
6.a.18 Involve the medical leadership in providing education programs for staff. For example, have the medical director complete grand rounds regularly where they are educating staff on identification of early symptoms of heart failure, pneumonia, etc.
6.a.19 Bring services to the nursing home to minimize the need for residents to leave the nursing home for care. For example, lab, x-ray, EKGs, modified barium swallows, ultrasound, INR testing, etc.
6.a.20 Ensure adequate specialties are available to address the complex needs of residents – optometrist, podiatrists, psychiatrists, psychologists, orthopedics and geriatric psychiatry.
6.b Change Concept: Choose medical leadership wisely.

**Action Items**

6.b.1 Clearly articulate the expectations of medical leadership to have strong administrative and communication skills through the position description. Look for longevity and active involvement in organizations. Don’t be afraid to be selective.

6.b.2 Choose an ideal model of care for residents and hire your medical director based on that idea. For example, if the ideal situation is to have a medical director round daily, set the expectation and hire based on the idea.

6.b.3 Provide routine feedback on the performance of the medical director and other providers to them.

6.b.4 Expect that the medical director/providers listen to nurses, aides, other staff, and actively seek their suggestions, assessments, and recommendations.

6.b.5 Involve the current medical director in training his/her replacement.

6.b.6 Provide competitive compensation so that the medical director can dedicate appropriate time to the facility.

6.b.7 Encourage the medical director and physicians to keep track of opportunities for improvements and bring those to leadership and QI.

6.b.8 Engage the medical director and physicians in the QAPI committee to review data, look for trends and opportunities for improvement, and make recommendations for addressing them.

6.b.9 Seek the input of primary care physicians/providers in initiatives that impact their residents or the systems of care in the facility.

6.b.10 Engage in QAPI by sharing data and trends, encourage input on opportunities for improvement as well as any recommendations for addressing them.

6.b.11 Include the medical director as a part of the leadership team and structure your team and meetings so they can actively participate.
6.c Change Concept: Transition with care (between shifts, departments, and all care settings).

**Action Items**

6.c.1 Set standard times for medical director/primary physician to be available for consult regarding non-urgent issues. For example, 7-8 am or 5-7 pm.

6.c.2 Reduce or eliminate medical care by fax. Instead, communicate verbally with primary care physicians/providers.

6.c.3 Foster close communication between medical director/primary physician and NPs or PAs, including:
   - Provide regular and timely updates on residents to anticipate needs or changes.
   - Ensure consistency with plan of care.

6.c.4 Use available technology to connect with the medical director when they are not on site. For example, electronic medical records and video chat.

6.c.5 Schedule the medical director/primary physician availability to nurses 24/7.

6.c.6 Arrange communication channels with the medical director. For example, the medical director provides personal cell phone numbers to staff and encourages staff to call.

6.c.7 Create a structure and processes for communication to ensure key information is consistently transferred from staff to staff.

6.c.8 Ensure that all changes in resident status have been communicated by having nursing assistants round together at the change of shift.

6.c.9 Identify clinical cases for use in education to recognize changes in resident conditions early and react to them appropriately. For example, review an a-typical presentation of heart failure.

6.c.10 Provide evidence base or expert endorsed recommended tools and resources to manage conditions that contribute to hospitalizations. For example, congestive heart failure, pneumonia, aspirations, or urinary tract infections.

6.c.11 Teach all staff to look for changes in resident conditions. For example, use “stop and watch” forms (small enough to fit in a pocket) that can be completed and given to the nurse.
6.d Change Concept: Strive to prevent problems and treat when necessary.

**Action Items**

6.d.1 Collect data/information with regard to hospital admissions/re-admissions and emergency department transfers as determined by the nursing home medical and clinical leaders:

- Track and analyze admission and transfer data.
- Identify if the decision to hospitalize was made by the resident’s physician or an on-call provider that is not as familiar with the resident.

6.d.2 Conduct root cause analyses on all residents going to the emergency department or hospital to understand potentially avoidable hospitalizations.

6.d.3 Review hospital re-admissions with staff as a group learning experience and identify any opportunities for improvement. Track the resident outcomes.

6.d.4 Provide standardized communication tools to give nurses options to be better prepared to update the provider and ask for what they need. For example, SBAR (situation/background/assessment/recommendation) communication templates or Care Paths.

6.d.5 Encourage and assist resident/families to complete advanced directives.

6.d.6 Communicate and provide education to the providers, residents and families on what equipment and medications you have available to treat the residents at your facility.

6.d.7 Collaborate with referring hospitals to identify needed information at time of admission to NH and transfer to hospital. Provide and receive feedback on effectiveness of interventions.

6.d.8 Ensure evidence-based policies and procedures are in place and staff are trained and supported to follow them for common conditions. For example, pressure ulcers, infections and other conditions unique to your facility.

**Pressure Ulcers**

6.d.9 Identify before admission if a person is at risk for skin breakdown in order to prevent pressure ulcers.

6.d.10 Inspect skin on admission (within xx hours) in order to prevent pressure ulcers.

6.d.11 Conduct comprehensive skin risk assessment (within xx hours) of admission and review on an ongoing basis using a standardized form.

6.d.12 Inspect skin on a weekly basis as a means to prevent pressure ulcers.
6.d.13 Communicate risk assessment results, skin checks and interventions to the nurses, nursing assistants and interdisciplinary team members.

6.d.14 Implement a plan for skin integrity (within xx hours of admission) to include, per individualized assessment, as appropriate:

- Support surfaces (bed and W/C).
- Offer fluids regularly for hydration.
- Provide resident preferred food choices and help the resident eat if needed. Real food first, fortified foods, and then supplements only when necessary.
- Help the resident to be as mobile and active as possible.
- Keep skin clean and dry.
- Provide incontinence care if needed.
- Individualize turning and repositioning schedules.
- Keep heels elevated off bed.
- Involve dietary and therapy before any issues arise.

6.d.15 Identify all potential causes of decreased mobility, including mood/mental health concerns, pain, etc. Develop a plan to address.

Infections

6.d.16 Practice antibiotic stewardship through monitoring the appropriateness of antibiotic use to prevent overuse of antibiotics.

- Do not use broad spectrum antibiotics without culture results and quickly change to narrow spectrum antibiotics that target the bacteria identified on the culture.
- Avoid antibiotics known to cause *C. difficile* and consider following with probiotics or yogurts containing Lactobacillus or Bifidobacteria.

6.d.17 Implement and follow guidelines for obtaining urinalyses and urine cultures.

6.d.18 Set expectation that all staff will be immunized.

6.d.19 Provide immunizations for residents and staff at no cost to staff. Go to the staff to give immunizations rather than making them come to you.

6.d.20 Ensure hand hygiene processes are being followed to avoid facility and iatrogenic (healthcare-acquired) infections:

- Conduct periodic observations of hand hygiene.
- Make hand sanitizers available.
- Post reminders for staff in restrooms and at sinks.
- Educate staff and residents.
6.d.21 Train and retrain all staff in standard precautions.

6.d.22 Follow proven environmental cleaning techniques to reduce the potential for the spread of infections:
   - Use disinfectants as recommended.
   - Use of disposable laundry bags to reduce handling of soiled linen.

**Physical Restraints and Falls**

6.d.23 Eliminate the use of physical restraints.

6.d.24 Deem audible alarms as restraints and develop plan for reduction and ultimate elimination.

6.d.25 Assess all residents for risk for falls and develop an individualized plan for their safety.

6.d.26 Promote strengthening and balance for all residents as a means to prevent falls.

6.d.27 Review all falls (including times, explore causes, determine whether patterns exist) and implement interventions for prevention based upon findings.

6.d.28 Involve resident and family members, the inter-disciplinary team members, and direct care staff in the investigation of falls and ideas for prevention.

**Behavioral Health, Caring for Persons Living with Dementia**

6.d.29 Educate staff and family on different types of dementia, and approaches to care, including medication use, in order to reduce/eliminate the use of anti-psychotic medications.

6.d.30 View “disruptive” behaviors as attempts to communicate needs. Explore patterns, times, potential causes to help understand the needs that are being communicated.

6.d.31 Involve direct care staff on all shifts in identifying and sharing approaches that work for behavior disorders. For example, meet with nursing assistants to gather creative ideas and ways they have identified and met resident needs without the use of anti-psychotics.

6.d.32 Provide individualized care based upon the resident’s response. Empower the nursing assistants to use their best judgment and knowledge of the resident when caring for them.

6.d.33 When anti-psychotic medications are used, document the specific reason for use. For example, instead of stating paranoia, describe specific symptoms such as not eating because of fear of being poisoned by food.

6.d.34 Encourage staff to meet the resident’s needs rather than accepting behaviors as typical.

6.d.35 Promote an environment that has been proven to be supportive: quiet; normal routine of home, familiar areas, consistent staff, etc.
7. **Strategy: Construct solid business practices that support your purpose.**

7.a  Seek strategic and creative approaches to expand your resource base to meet your mission and serve your residents.

7.b  Maximize your efficiency.

7.c  Ensure you are making the most of your physical assets.

**7.a Change Concept:** Seek strategic and creative approaches to expand your resource base to meet your mission and serve your residents.

**Action Items**

7.a.1 Encourage staff involvement in identifying opportunities for additional revenue (no silly questions; letting them know their thoughts count; safe to speak up and be involved).

7.a.2 Engage senior leadership in exploring opportunities to search for alternative revenue streams that are in line with the facility’s values and mission. Make the case; provide a cost/benefit analysis, use visuals, etc. Make it fun, whoever comes up with the best idea wins a prize.

7.a.3 Regularly review community needs, for example, PT, OT, speech, respiratory. Ask your referral sources about service gaps and unmet community needs.

7.a.4 Attend local events to increase awareness of services to meet the community’s needs.

7.a.5 Seek grants/research opportunities, both private and public, to generate revenue. Maintain relationships with potential funders. Keep funders updated on the status of projects.

7.a.6 Explore innovative ideas to generate revenue. For example, lease unused space, create an office for a dentist, and lease the rooftop for cell phone tower.

7.a.7 Encourage staff involvement in fundraising.

7.a.8 Develop relationships with families for help in fundraising to provide needed equipment and materials.

7.a.9 Include the surrounding community in developing creative ways to fundraise.

7.a.10 Generate a list of equipment and materials for fundraising. For example, walkers, wheelchairs, clothing or art materials for recreational activities, etc.
7.a.11 Include a recreational wish list (for example, games, art supplies, gardening materials, services, areas of expertise) in community accessible places (for example, website, family/community newsletter) with instructions on how to donate.

7.a.12 Create an internal referral program for staff and residents/families to increase the number of residents.

7.a.13 Develop a database contact program (e-mail/phone/in-person) involving the leadership team to increase the total number of residents with minimal increase in expense.

7.a.14 Create an event to draw community financial support. For example, fundraisers, yard sales, or a garden tour.

7.a.15 Focus on fast result channels to increase the number of residents: professional referrals: hospice agencies, assisted living communities, home health agencies.

7.a.16 Develop and execute a master marketing/outreach plan and calendar to create a demand for services offered.

7.a.17 Develop statistics on the average length of stay (ALOS) per diagnosis, re-hospitalization rate, best practices, 5 star rating, etc. and share with hospitals, physician groups, and other referral sources as part of marketing materials.

7.a.18 Develop an anti-attrition program with the goal to have zero dissatisfied ratings (not related to medical, financial, death).

7.a.19 Routinely use resident satisfaction survey and follow up on issues and concerns to have data to share with prospective residents and the community.

7.a.20 Hold routine resident community meetings to involve residents in the life of community (share what residents like and do not like). Inform residents of changes happening in the community.
7.b Change Concept: Maximize your efficiency.

**Action Items**

7.b.1 Make investments in items and services that will reduce costs over time. For example, more efficient heating/cooling, lighting, solar panels, water saving plumbing products, recycling and medical waste disposal.

7.b.2 Engage utility providers to audit the facility for cost savings and rebate opportunities.

7.b.3 Creatively review budget for potential cost savings. For example, off-site storage and vehicles for resident transportation.

7.b.4 Closely monitor scheduling and hours worked. For example, penalty pay, overtime, and use of agency staff to reduce costs and increase efficiency.

7.b.5 Create opportunities for staff to be involved in ideas for cost savings without compromising service.

7.b.6 Assess impact of cost savings ideas on staff (routine, care practices, etc.) prior to making decisions. Think about unintended consequences.

7.b.7 Negotiate prices for products and services. Buy in bulk. Seek opportunities through trade associations or other consortia to achieve group volume discounts.

7.b.8 Meet with resident/family upon admission to discuss finances including insurance, billing, and other financial matters, to identify resources to cover your costs.

7.b.9 Analyze the receivables balance by payer source to identify issues related to a specific revenue stream.

7.b.10 Ensure billing staff have knowledge of the Minimum Data Set (MDS) information to help verify accuracy of clinical data.

7.b.11 Validate (chart audit) processes to ensure accuracy of billing. (Consistent accurate and complete documentation is foundational to reimbursement commensurate to the work performed.)
7.c Change Concept: Ensure you are making the most of your physical assets.

**Action Items**

7.c.1 Solicit resident and family feedback on the physical environment and explore opportunities for improvement.
7.c.2 Offer adequate outdoor spaces to provide opportunities for residents, family and staff. If spaces are not being used, find out why and make improvements.
7.c.3 Create meaningful living spaces that residents actually use in their daily lives, such as gardens and kitchens.
7.c.4 Critically analyze noise and constant light to identify opportunities to reduce resident confusion and promote a strong sense of safety.
7.c.5 Re-Invest in building upgrades to keep them modern and efficient.
7.c.6 Provide a room maintenance checklist to track cleaning and maintenance needs (and procedures) with a record of what was done and when.
7.c.7 Have a ‘room of the day’ for housekeeping. Each day, one room is thoroughly cleaned, rotating through all resident rooms.
7.c.8 Create maintenance request forms so that items are addressed quickly.
7.c.9 Schedule managers to round with staff regularly checking to see that all areas are clean and equipment needs met.
7.c.10 Have supplies (lotions, combs, toothpaste, Kleenex, blue pads, disposable briefs, etc.) available where most efficient (on each unit, or in each room) as opposed to a central location in order to reduce staff time required to obtain supplies.
7.c.11 Do not skimp on supplies with the small things that make the staff feel safe and respected.
7.c.12 Self-check equipment. Everyone takes the responsibility to ensure that equipment is accessible and in good repair.
7.c.13 Evaluate the age of equipment and the potential need for replacement on a regular basis (annual or more frequent as necessary).