PEAK 2.0 Times

This newsletter is brought to you by the Kansas State University Center on Aging through a grant from the Kansas Department of Aging and Disability Services

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July 2014

Resident Choice: Isn't it too risky?

Residents direct their lives. Not us.

When residents direct their own lives, there is inherent risk involved. Think about it. We each make decisions every day that carry with them potential negative outcomes. It is a part of living. What makes dealing with risk so hard to swallow in long-term care environments?

When a person is in our care, we are ultimately responsible for their wellbeing. This is a huge responsibility and it can drive FEAR within us to want to protect people from bad choices. How do we overcome this FEAR and support elders in living the life they wish to lead?

Elders have the same right to be free from abuse and neglect in long-term care as they do to make their own decisions, good or bad. Being free from abuse and neglect & the freedom of self-determination are sometimes at odds with one another. It is our responsibility to develop organizational practices that minimize elders' risk of abuse and neglect and at the same time support resident decisions. These practices can be essential in negotiating the terrain of supporting resident decision-making.

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"Nursing homes can feel stuck between the desire to honor individual wishes with the regulatory requirements to implement interventions to mitigate residents' risk factors. These goals however, are not mutually exclusive or exhaustive. Market competition, consumer demand, and state and federal regulatory policy are aligning in a manner that places great pressure on nursing homes to address both areas of concern. We are encouraged by the work so many homes are undergoing within the PEAK program and look forward to those efforts resulting in superior options for Kansans needing long term care."
-Joe Ewert, Comissioner on Aging

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Let's Explore Some Examples.

Example #1-Elaine:

A resident in your home, Elaine, likes to sleep in until 10:00 a.m. and stay up late at night. As a supervisor, one morning, you walk down the hall and notice that at 9:15 a.m. Elaine is not out of bed. You are not familiar with Elaine's preferred schedule. How do you know it is Elaine's choice to stay in bed or if there has been a staffing break down and Elaine has been left in bed? What system is in place to help you investigate?

Questions to ask:

- Is Elaine's sleeping preference documented anywhere?
- What does Elaine's plan of care say?

As a supervisor/leader, you want to be sure that staff are aware of the resident's preference, the resident's act is purposeful and not a result of staffing breakdown, and the plan of care and documentation reflect the resident's wish to sleep in.

Other things to consider to support resident's preferred sleep cycle:

- Have strong practices in place for skin risk and bowel and bladder assessments. These should be individualized for each resident rather than a standardized every 2 hour check. Individualized care needs may include the timing of checks and repositioning, specialized mattresses to help prevent skin breakdown, and high absorbency incontinence products.

- As homes begin to support individual resident sleeping patterns, homes should consider the availability of substantial bedtime snacks as well as food availability in the morning hours.

- Also, consider evaluating medication pass times to be sure that they are adjusted to match resident's schedules.

PEAK 2.0 Note: *If you are working on the core area sleep, these best practices are items that you can begin to sort out and add to your action plan as action items. This will help you think out how you will tackle them in your organization.*
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Example #2-Manny:

Manny, a resident in your home is a brittle diabetic and receives insulin injections. His physician has recommended that he be on a low concentrated sweet diet and eat meals at regular times with substantial snacks between meals. Manny is mentally competent (BIMS score is adequate) and understood the physician's orders. However, Manny sneaks food, detrimental to his diabetic diet to his room daily and gorges himself on the snacks. When approached by his nurse, Manny explains that he does not care about the diet the physician prescribed. He wants to eat what he likes. The nursing team meets with Manny and discusses the potential negative outcomes that may occur when he chooses to disregard the physician's advice. Manny continues to wish to eat what he chooses. How might you proceed as an organization?

What are some person-centered nursing best practices in this case?

- Recognize that this is Manny's health and he is making the choices that drive the care you, as a nursing team, implement.
- Communicate with the physician Manny's desire to continue with a non-diabetic diet.
- Work with the physician on a schedule to monitor blood sugar and to develop an insulin administration schedule.
- Educate staff on monitoring Manny for adverse diabetic symptoms.
- Educate staff to communicate with the nurse on duty when Manny has chosen to eat lots of sugary treats.
- Provide daily skin assessments and implement practices for pressure ulcer prevention.
- Meet with Manny quarterly or more often if there is a significant change in Manny's condition to discuss the potential negative outcomes and document in the resident's record.
- Revise the plan of care quarterly and as needed to reflect Manny's preferences and care needs.

"The home should determine exactly what the resident is refusing and why. To the extent the home is able, it should address the resident's concern. The home is expected to assess the reasons for this resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatments, and continue to provide all other services. If a resident's refusal of treatment brings about a significant change, the home should reassess the resident and institute care planning changes.

Ongoing assessments should be done to determine the resident's wishes have not changed and to reeducate the resident. A onetime refusal or discussion is not an acceptable standard of practice. The home should always strive to honor resident's wishes but also take credit for the discussions they have had with the resident with the necessary documentation."

-Audrey Sunderraj, Kansas Director of Survey and Certification

Resident Choice & Cognitive Impairment

Resident Choice: It's not just for the Mentally Competent

Cognitively impaired residents make decisions everyday. One of the added challenges in working with residents with dementia and supporting choice is the addition of potential poor judgement, altered thinking abilities, and behavioral symptoms related to disease. When navigating these situations interdisciplinary care conferences and ongoing reassessment and discussions are critically important.

When it comes to resident choice and dementia think through these things:

-What is the resident's pattern of behavior currently around daily routine? (Such as waking and sleeping patterns, eating preferences, etc.)
-What was the resident's pattern of behavior around daily routine prior to the disease? At home with the disease?
-In staff and family/loved one observation, what daily routine does the resident respond to best?
-Build the resident's daily routine and care around what the resident responds to best. Be consistent with the routine that works best for the individual resident.
-Be sure to involve the right players in these discussions:
    -The resident (through the presence, observations, etc.)
    -Family, previous caregivers, and/or DPOA-HC
    -Current caregivers: nurses, direct caregivers, house keepers, etc.
-If the resident begins to respond differently to the agreed upon daily routine or the resident begins to change their pattern of behavior, revist the plan of care.

Check out this great resource on interdisciplinary care planning:

https://www.nhqualitycampaign.org/files/Abramson_IDCP-procedure_manual.pdf

The article on resident choice and risk was a collaborative effort between: Laci Cornelison, MS, LBSW, ACHA; Judy Miller, RN; Jackie Sump, LBSW; Rhonda Boose, KDADS PEAK Director; Joe Ewert, Comissioner on Aging; & Audrey Sunderraj, Kansas Director of Survey and Certification

Grants & Foundations

Article Written by: Holly DeNoble from Attica Long-term Care

There are many routes that non-profits can take advantage of when needing financial assistance to accomplish a goal or need. There are Community Service Tax Credit programs, Community Development Block Grants, Federal grants, and various foundations you can receive funding through. Foundations can be nationwide, statewide, or even local.

Don't let your budget and current financial status set the tone for needed improvements that will benefit your elders or your employees. Here at Attica Long Term Care, it took my Board of Trustees telling me, "If you can find the money." Those words made me think. Where could I find these funds? It started with surfing the web, asking colleagues and government officials, even directly speaking to foundations. It is a slow process, and it doesn't happen overnight. After numerous phone calls and networking with different entities, we found our first foundation with a mission that fit our goal. With that, a door opened. When we received the letter of acknowledgment that our submission was accepted, it was like the flood gates had opened. Since we have started to write proposals, we have received many wonderful benefits from numerous foundations and government entities that have made a difference in our elders' and employees' lives.

Some of the organizations and foundations that have helped us achieve our PEAK goals are:

1. The Kansas Department of Commerce has been a great resource. Through them, we were able to renovate an empty wing of our facility and convert it to an Alzheimer's Unit. We have also purchased five apartments here in Attica and have converted them into Independent Living units for our CCRC.

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2. The Harper County Community Foundation, a local foundation, has helped us to purchase a 15 passenger activity bus, a soft-serve ice cream machine, kitchen equipment, computers, CPR training dolls, AED and an AED trainer, and nursing competency mannequins.

3. The Sunflower Foundation has helped us with technology grants (computers and purchase of the Care Tracker system). Our most recent award from them was for assistance with our PEAK goal of staff education and one on one consulting from GERTI for our facility in implementing culture change.

There are many more governmental agencies as well as foundations which have missions to bring better care to our elders. All it takes is a little time and thought, and you too could be helping to make your visions of change a reality. There are even grant writers available who can help assist you with your grant writing needs. When we first started, we sought out assistance for help in applying for our first Tax Credit, and over time we decided who else is better prepared to tell our story than us.

A special thanks to Holly and the Attica team for sharing.

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