Person-Centered Care:
Aging in Place in Assisted Living

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Demographics of Aging

• Since 2011, approximately 10,000 Baby Boomers reach the age of 65 every day
• Over 4,000 Americans turn 85 EVERY DAY!
• By 2030, one out of every five Americans – some 70 million people – will be 65 years or older
• 75+ population will increase 70% BY 2025
• Every 68 seconds, someone in the US develops Alzheimer’s Disease
Difference in Generations

- Greatest Generation: Silent / Stoic
  - Not be a bother to anyone
  - Take care of yourself
  - Not entitled
  - Looked out for each other
  - Did not want to go to a nursing home
Difference in Generations

• Baby Boomers
  o Entitled
  o Me First
  o Demand for person-centered care
  o Desire all the amenities
  o Good food
  o Activities
  o Wellness
  o In charge of their care
Mr. McNally

• Form groups of 4-6 people
• Deal all the cards out
• Working together, organize the information on the cards into a sequence so you can answer two questions:
  o What was Mr. McNally like when he first came in?
  o What caused his decline?
Objectives

• Develop skilled and competent staff to manage the higher acuity of an aging population with chronic medical conditions with a shortage of nurses and primary care givers
• Using evidence based data to implement processes that detect change in condition early
• Person-centered care and advanced care planning are key elements of successful outcomes
• Collecting, tracking and using data
Currently, Assisted Living/LTC is

- Staff Directed
- Staff Centered
Culture Change is Defined as Honoring the voices and choices of residents and staff
What is Person Centered Care?

A comprehensive and on-going process of transforming an entity’s culture and operation into a nurturing, empowering one that promotes purpose and meaning and supports well-being for individuals in a relationship-based, home environment.

(CEAL, June 2010)
How Can We Accomplish PCC?

• Encourage the personal development on an individual basis
• Maximize the resident’s dignity, autonomy, privacy, socialization, independence, and choice every chance you have
• Support lifestyles that promote health and wellness
• Promote family (includes family of choice) involvement (supporting the choice of the resident)
• Develop positive family relationships among residents, staff, families and the community at large
Initial Assessment

• Besides being a regulatory requirement, this is the first glimpse into a resident’s life

• For residents who have a diagnosis of dementia and difficulty communicating, the evaluation is critical

• The assessment tool should enable the staff to initially identify the residents' strengths and to build off of those strengths for meeting the resident’s needs and preferences

• Building off a resident’s strengths increases the likelihood of success
Assessments Should Include

• Medical Information
• Functional status
• Cognition, mood and behavior patterns
• Personal grooming habits and abilities
• Social patterns, recreational preferences, spiritual requirements and physical activity needs
Patienthood to Personhood

Personhood defined by Thomas Kitwood:

A status conferred by one person on another which conveys recognition and respect
Personhood

• Acknowledging another person’s personhood says:
  o I see you
  o I see your uniqueness
  o I see our common humanity
Enhancing Person Centered Care

Let's start with the mantra ~ When in doubt send them out
Hazards of Hospitalization

- Decreased function
- Increased Cognitive decline/ Delirium
- HAI- often leading to severe chronic debility and even death
- Loss of self esteem leading to depression- often severe
- Decreased Resident and Family Satisfaction
Managing Chronic Medical Conditions

• Decline in Clinical Condition
  o Failure to recognize decline, prevent complication, or poor quality of care
  o Poor transitions of care/discharge planning
  o Lack of advance directive
  o Lack of ability to meet the needs of the patient/resident (perceived or real)
Managing Chronic Medical Conditions

• Residents stay with familiar staff who know them and their needs

• Residents remain in a familiar environment with their personal possessions and maintain their routines as much as possible

• Residents avoid an uncomfortable, often traumatic trip to the hospital and long waits in the ED
4 Significant Conflicts

1. Confusion over the role of the licensed nurse
2. Conflict over the transformation of a traditional care model to a resident-centered care model
3. Reconciling individualized care with quality nursing care
4. Nurses fear perceived or real threats to nursing autonomy, regulatory-related issues and the professional nurse’s scope of practice and accountability
Competency of Nursing Staff

• RN vs. LPN
  o Model for delivery of nursing care
  o Team/functional nursing vs. primary care

• Nursing skill/competency evaluation
  o Skills checklists, observation not self reported
  o Routine re-evaluation

• Staffing rotations
  o Avoid the Mon-Fri first string/weekend second string approach
Evaluation of Pre-Admission Process

• Are you taking admissions that you have no business accepting?

• Are you receiving adequate information about potential residents’ needs?
  o On-site assessment vs. telephone review
  o Confirm you can meet the patient’s needs
  o Empower DON to control acuity
  o Manage expectations of the family/resident
Palliative Care in the Management of Chronic Medical Illness

• Palliative Care as defined by the World Health Organization, is a crucial part of integrated, people-centered health services

• Nothing is more people-centered than relieving suffering, be it physical, psychological, social or spiritual

• Advanced Care Planning and Palliative Care play an important part in person centered care during an acute exacerbation of chronic illness or at end of life
Palliative Care Continuum

• As part of person-centered care, advanced care planning and palliative care plays an essential function in the individual’s care across the continuum

• The goals of care are focused on the person’s desired comfort and care whether it be during an acute illness or at end of life

• Palliative Care provides pain management, respiratory comfort management, psychological and spiritual support

• Palliative Care can be used to round on high risk residents to intervene early
Palliative Care

• Palliative Care can be initiated early on or can be initiated if any of the following occur:
  o Chronic Pain
  o Chronic Illness
  o Eating Difficulty
  o Frequent emergency room visits
  o Three or more hospital visits within 6 months
  o Difficult side effects from medical treatment
Palliative Care

• Frequent rounding on high risk residents is key to preventing exacerbations of acute symptoms

• If possible, engage services of a physician (physician group) who work with an APN (Advanced Practice Nurse) preferably a Geriatric Nurse Practitioner

• Develop a model of care for chronic medical conditions where high risk patients are rounded on frequently

• Develop protocols with physicians to order prn medications to administer when early signs of trouble occur
What is Trending in Assisted Living to Assist in Aging in Place

- Waivers
- IV for Dehydration, short term ABT
- I-STAT
- Use of PRN Meds to manage exacerbations of chronic diseases
- Cardiac Step Down Rehab Program
- Respite Stay for post surgical residents especially joint replacement
- Respite Stay for hospital stays for medical events
Building Relationships

• Advanced Practice Nurse
• Palliative Care Model
• Resident and Family
Building Relationships

- The key to success is educating the resident and the family
- Be clear and honest in your conversations
- Do not promise what cannot be done
- The more the resident and family understand, the better they will be able to make realistic decisions
- Always ask what the person wants
- All goals of care should be "I centered"
Managed Risk vs. Informed Consent

• Whatever way you document always document the following:
  o What the issue is
  o What education is given
  o Resident and Family understanding of what is said
  o What is the outcome
  o Physician input or notification
  o Who is present / include signature and date

If you didn’t document you didn’t do it.
Person-Centered Care
Medication Administration

• Ask the resident/resident representative how they took their meds at home
• Notify MD how the resident wants to take his medication
• Be specific how the medication label should read
Person-Centered Care Medication Administration

• Once daily - upon rising (5:30am-11:30am) or at bedtime (7:30pm-11pm)

• Twice daily - Upon rising and at bedtime (5:30 am-11:30am) and (7:30pm-11pm)

• Three times daily- upon rising, afternoon, and bedtime (5:30-11:30 am), (12pm-7 pm) and (7:30pm-11pm)
Person-Centered Care
Medication Administration

• Times listed serve as guidance to facilitate individualization for med administration

• Meds to be administered on an empty stomach will be given at resident’s request before breakfast or bedtime

• Medications to be given before meals

• Medication to be given with meals

• Weekly dosing

• Monthly dosing
Person-Centered Care
Medication Administration

• Our care should be “person-centered” whenever possible

• CMS consistently emphasizes person-centered care in regulatory guidance

• Facilities that adhere to rigid lifestyle schedules may be open to Quality of Life citations
Quality Measures

- Resident/Family satisfaction
- Staff retention and satisfaction
- Consistent Assignment
- Staff education and training
- Quality of life in Memory Care Unit
- Hospitalization and ED visit rate
- Reduction of off-label use of psychotropic medications
- Reduction of alarms
Quality Journey

• Best Indicator for a quality community
• Relationship with residents, families, staff and community members
• How are you branded in the community?
• Are your residents interacting with staff?
• Does leadership encourage the “family concept?”
• Do you call the family when good things happen?
• Do you educate the family about dementia and provide support?
The Benefits of Socialization

• Evidence-based research shows that congregate living benefits elders
  o Works best when elders feel comfortable with the people they are living with

• Person-Centered Care means that the staff know all about the elders’ interests
  o Make sure that people of like interests dine with each other and are aware of activities that speak to those interests

• Elders need a purpose
  o Encourage opportunities to help others like collecting food for food banks, etc.
Loneliness, Socialization are Overlooked Social Determinants of Health For Older Adults

• AARP survey “found that we are in the midst of a loneliness epidemic”

• Loneliness may be considered a “social determinant of health” (SDH)

• Loneliness may increase the risk of getting sick

• Research indicates people who are lonely “are more likely to get sick”
Loneliness, Socialization are Overlooked Social Determinants of Health For Older Adults

- Loneliness impacts the body in several ways such as inflammation and neurological changes

- Based on research, the American Psychological Association posited that loneliness is a bigger health risk than obesity
Summary

• Person-Centered Care
• Use of the waivers
• Quality metrics
• Engaged staff
• Satisfied residents
• Resident/Family satisfaction
• Meaningful, purposeful life for elders
• Competent nurses who understand chronic disease management
Conclusion

• Be true to what you are
• Be open to change—change is inevitable
• Educate yourself and elevate your knowledge base—much more is expected of nurses
• Educate and take care of your staff—much more is expected of them
• Take every opportunity to educate the resident, family and your stakeholders—their satisfaction is your most important quality measure
IT'S ALL ABOUT RELATIONSHIPS