Person-Centered Care: Aging in Place in Assisted Living

Loretta Kaes BSN, RN BC (Gerontology), C-AL, LNHA, CALA

Health Care Association of New Jersey

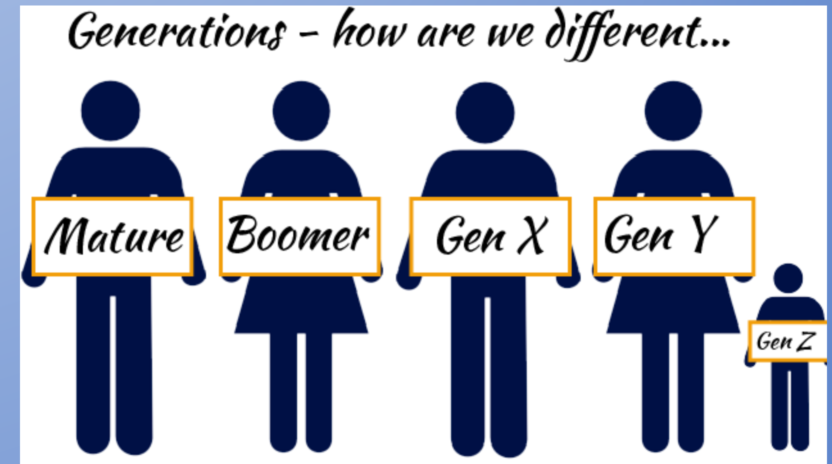
Director of Clinical, Quality and Regulatory Services

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
  - Entitled
  - Me First
  - Demand for person-centered care
  - Desire all the amenities
  - Good food
  - Activities
  - Wellness
  - 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:
  - What was Mr. McNally like when he first came in?
  - 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:
  - I see you
  - I see your uniqueness
  - I see our common humanity

Enhancing Person Centered Care

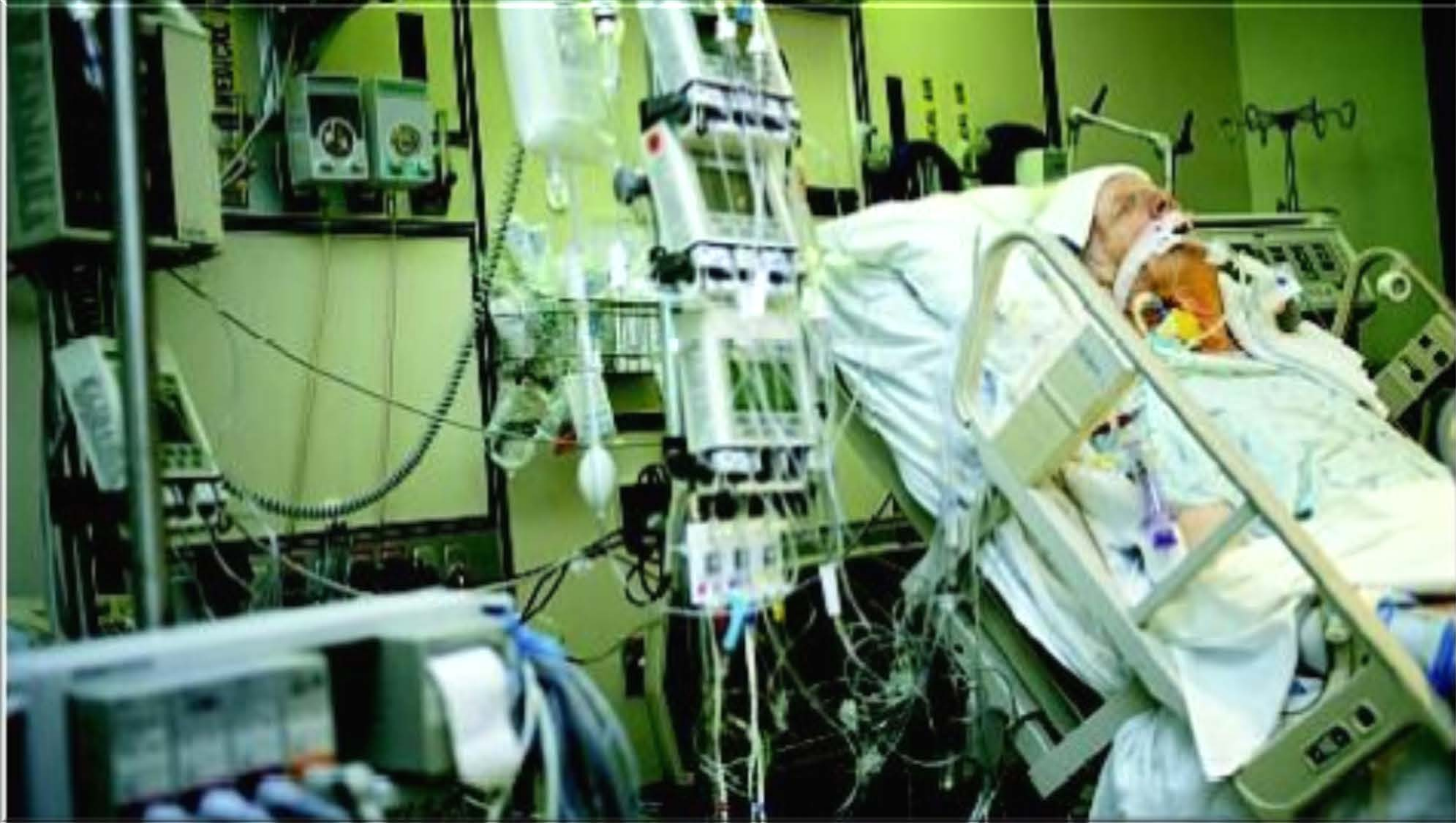
Lets start with the mantra ~ When in doubt send them out

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
  - Failure to recognize decline, prevent complication, or poor quality of care
  - Poor transitions of care/discharge planning
  - Lack of advance directive
  - 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
  - Model for delivery of nursing care
  - Team/functional nursing vs. primary care
- Nursing skill/competency evaluation
  - Skills checklists, observation not self reported
  - Routine re-evaluation
- Staffing rotations
  - 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?
  - On-site assessment vs. telephone review
  - Confirm you can meet the patient's needs
  - Empower DON to control acuity
  - 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:
  - Chronic Pain
  - Chronic Illness
  - Eating Difficulty
  - Frequent emergency room visits
  - Three or more hospital visits within 6 months
  - 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:
  - What the issue is
  - What education is given
  - Resident and Family understanding of what is said
  - What is the outcome
  - Physician input or notification
  - 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
  - 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
  - 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
  - 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