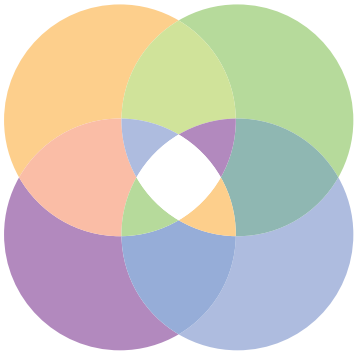

Engaging Staff in Individualizing Care

An Implementation Handbook

Pioneer Network™ | B&F CONSULTING

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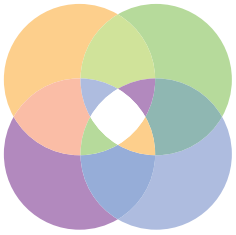

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Acknowledgements

Pioneer Network is extremely grateful to The Retirement Research Foundation for its generous support of Phase One and Phase Two of the Pioneer Network's National Learning Collaborative including the development of this Handbook and web-based resources focused on the "how to's" of Engaging Staff in Individualizing Care. We also wish to acknowledge the tireless and expert work of B & F Consulting (Barbara Frank and Cathie Brady) during both Phase One and Phase Two and especially for the development of this Handbook. Thanks also to Amy Elliot, Ph.D. and Sonya Barsness, MSG for their work during both Phase One and Phase Two and especially for the development of the online Communication Map that can be found at www.pioneernetwork.net/Providers/CommunicationMap. We thank Connie McDonald and the staff at MaineGeneral at Glenridge and Gray Birch in Augusta, ME for sharing their work so generously throughout the National Learning Collaborative. Special thanks to the following colleagues who served on the Phase One and Phase Two National Advisory Board who provided valuable input throughout the project:

Ruta Kadonoff, American Health Care Association (Chair)

Michele Laughman, Division of Nursing Homes, Centers for Medicare & Medicaid Services

Doug Pace and Carol Scott, Advancing Excellence LTC Collaborative

Marilyn Reierson, Stratis Health

Cheryl Phillips, LeadingAge

Sarah Burger, Coalition of Geriatric Nursing Organizations

Sherrie Dornberger, National Association of Directors of Nursing Administration in Long-term Care

David Farrell, The GREEN HOUSE™ Project

Marianna Grachek, American College of Health Care Administrators

Christa Hojlo, U.S. Department of Veterans Affairs

Becky Kurtz, Administration for Community Living, U.S. Department of Health and Human Services

Beverley Laubert, National Association of State Long-term Care Ombudsman Programs

Christine Mueller, University of Minnesota School of Nursing and Pioneer Network Board of Directors

Carol Siem, American Association of Nurse Assessment Coordination

Karyn Leible, American Medical Directors Association

Pioneer Network is also extremely grateful to the individuals from the four corporations and five state culture change coalitions that spent countless hours as conveners for both Phase One and Phase Two of the National Learning Collaborative as follows:

Peggy Brenner and Vicki Dedrick, ACTS Retirement-Life Communities

Mary Tess Crotty, Genesis HealthCare

Julie Ballard, Health Systems, Inc.

Angie McAllister and Ellie Curry, Signature HealthCare

Susan Crane, Florida Pioneer Network (FPN)

Joan Devine, Missouri Coalition Celebrating Continuum Care Change (MC5)

Lynda Crandall, Making Oregon Vital for Elders (MOVE)
Darlene Cray, New Hampshire Culture Change Coalition
Peggy Williams, South Dakota Culture Change Coalition

Our sincere and utmost appreciation goes to the following nursing homes that agreed to serve as the "incubator" homes for Phase One of the National Learning Collaborative and to be visited and interviewed for Phase Two: Harvest and Spread:

ACTS Retirement-Life Communities – Fort Washington Estates (Fort Washington, PA)
ACTS Retirement-Life Communities – Southampton Estates (Southampton, PA)
ACTS Retirement-Life Communities – Normandy Farms Estates (Blue Bell, PA)
Avera Rosebud County Care Center (Gregory, SD)
Bethesda Dilworth (St. Louis, MO)
Coos County (Berlin, NH)
Cornerstone Care Option (Portland, OR)
Friendsview Retirement Community (Newburg, OR)
Genesis County Village (Lancaster, NH)
Genesis Glendale (Naugatuck, CT)
Genesis Kimberly Hall North (Windsor, CT)
Good Samaritan Society Corsica (Corsica, SD)
Health Central Park (Winter Garden, FL)
Health Systems, Inc. – Grandview Healthcare Center (Washington, MO)
Health Systems, Inc. – Dixon Nursing and Rehab (Dixon, MO)
Lutheran Senior Services Hidden Lake (St. Louis, MO)
Lutheran Senior Services at Laclede Groves (St, Louis, MO)
Rosa Villa Health Center (Portland, OR)
Signature Healthcare at the Courtyard (Marianna, FL)
Signature Healthcare North Florida (Graceville, FL)
Signature Healthcare Washington Rehab and Nursing Care (Chipley, FL)
The Morrison (Whitefield, NH)
Westminster Towers (Orlando, FL)

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Sonya Barsness, MSG, Project Evaluation Consultant

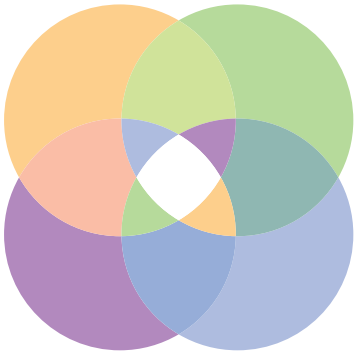
Background

Thanks to support from The Retirement Research Foundation, 52 nursing homes in nine states participating in the Pioneer Network's National Learning Collaborative learned ***how-to*** operationalize individualized care. They successfully "incubated" four key organizational practices — consistent assignment, huddles, CNA involvement in care planning, and QI Closest to the Residents — with results that exceeded even our own high expectations. Our goal in the Incubator Phase was to trial these organizational practices so that residents' customary routines would be the path to better quality of care and quality of life outcomes, and to pilot the methods for teaching the adoption of these practices. The 52 incubator nursing homes participated in Learning Sessions that fostered collaborative ***how-to*** sharing among participants as they implemented the practices and applied them to clinical areas such as reducing avoidable hospitalizations and inappropriate use of antipsychotic medications and of alarms. Our initiative also included a tier of less intensity through which over 200 nursing homes in nine states attended group viewings of a series of practitioner ***how-to*** webinars that accompany the Collaborative. These homes too, reported remarkable progress in improving care through individualized approaches supported by these organizational practices. However, the most tangible progress has occurred among homes that have participated in the learning sessions and used the action periods to implement these organizational practices. These incubator homes reported that implementing these four organizational practices improved their ability to learn about and honor residents' customary daily routines from the day a resident moves into the home resulting in improved clinical outcomes in areas such as mobility/fall prevention, re-hospitalizations, and anti-psychotic medication use. Two resources for nursing homes interested in implementing these practices were created as a result of this project: A Starter Toolkit for Engaging Staff in Individualizing Care available as a free download at https://www.pioneernetwork.net/resource-library/resource-libraryengaging-staff-individualizing-care and a 12 Webinar Set on Engaging Staff in Individualizing Care available for purchase from Pioneer Network's online Store at https://www.pioneernetwork.net/product/engaging-staff-individualizing-care.

Due to the success of the National Learning Collaborative project, The Retirement Research Foundation awarded funding to Pioneer Network for a Phase Two: Harvest and Spread project for the purpose of maximizing the benefits of the incubator phase by harvesting the experience of the participating homes. In partnership with our coalition and corporate conveners, project staff and consultants engaged in the following activities:

- Conducted an in-depth analysis to measure the incubator homes' results and capture their how-to's;
- Developed case studies documenting how use of these organizational culture change practices contribute to better outcomes;
- Created this implementation handbook and an online Communication Map that capture the on-the-ground operational strategies which the incubator homes used to implement the foundational practices.

Pioneer Network welcomes feedback from users of the Engaging Staff in Individualizing Care Implementation Handbook via info@pioneernetwork.net.



Engaging Staff in Individualizing Care

An Implementation Handbook

Information to Get Started – Why and How: Engineering High Performance into Everyday Practice

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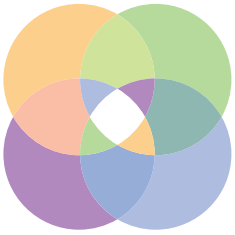


Engaging Staff in Individualizing Care

An Implementation Handbook

INTRODUCTION TO THE HANDBOOK

Why and How: Engineering High Performance Into Everyday Practice

Information to Get Started Video Clips

Clip 1: Four Practices Provide the *Infrastructure* for High Quality Individualized Care

Clip 2: Dedicated and Engaged Staff "Own" the Quality of Care of "Their" Residents

AN INFRASTRUCTURE FOR QUALITY RESULTS

Pioneer Network is pleased to share this Implementation Handbook for ***Engaging Staff in Individualizing Care***, developed by B&F Consulting through our National Learning Collaborative funded by The Retirement Research Foundation. The Handbook supports implementation of a ***communication infrastructure essential for effective care delivery*** to ensure positive resident and staff experiences, and good organizational performance. Fifty-two nursing homes worked with five state culture change coalitions and four corporations to incubate B&F Consulting's method through a layered implementation of ***four foundational organizational practices***.

The four incubated practices together provide the infrastructure for engaging staff in individualizing care to continually improve quality of care and quality of life outcomes. These practices are:

1. Consistent assignment
2. Shift Huddles
3. Quality Improvement (QI) closest to the residents
4. Involving consistently assigned CNAs in care plan meetings

These practices, used together, create a system to accelerate clinical improvement by capturing and applying staff's deep timely knowledge of residents' individualized needs, customary routines, and daily condition. The practices provide daily mechanisms for the staff closest to the residents to work with the rest of the care team to design and use effective interventions that improve resident's quality of care and life, and ultimately result in better organizational outcomes.

Coalition and corporate conveners, using an evaluation protocol designed by Amy Elliot, Ph.D. and Sonya Barsness, MSG, harvested lessons learned and tools used by the incubator nursing homes, which are incorporated into this Handbook. Elliot and Barsness also designed a Communication Map that depicts the impact of these practices on resident outcomes that can be found at https://www.pioneernetwork.net/communication-map.

B&F's method combines quality improvement, staff engagement, and individualized care to maximize resources for the best outcomes.

Quality Improvement: The core tenet of quality improvement is that systems drive outcomes, and if we want to improve outcomes we need to improve our systems. When people depend on each other for successful outcomes, they need systems that make it easy to work together toward those outcomes. Staff working in nursing homes depend on each other all day every day to meet the physical, mental, and psychosocial needs of each resident. So how can nursing home systems help people work well together? The most effective quality improvement approaches make it easy for staff to make the right choices, and the least effective systems make it harder for staff to do what's needed. For example, if staff are routinely rotated to new assignments or floated to cover absences, it is harder for them to get in a rhythm with the residents they are caring for or with each other as co-workers. If staff start work without a quick huddle to hear what they all need to know about residents they are caring for, then co-workers will be hesitant to step in for residents not on their assignment, which impedes teamwork. ***Incubator homes found that when staff consistently work with the same residents and co-workers, and huddle regularly to share knowledge and problem-solve together, these work systems engineer communication and teamwork into daily practice as the default, rather than leaving communication and teamwork to chance.***

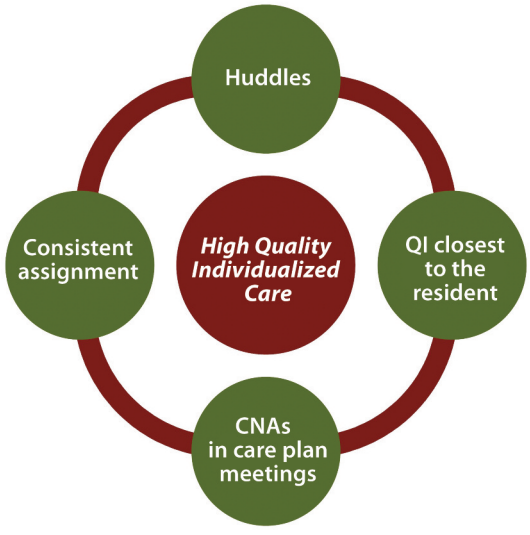
Staff Engagement: Timely, problem-solving communication is crucial given the combination of physical, mental, and/or psychosocial frailties that people living in nursing homes have. Acute conditions come on quickly for frail nursing home residents, and have significant potential impact; therefore they need to be recognized and acted on quickly to prevent irreversible declines. When staff closest to the residents care consistently for the same people, they note immediately the most subtle early warning signs of a change in condition. Staff's timely sharing of this information through a communication pipeline allows the care team to act quickly, in concert, to prevent a decline such as an avoidable hospitalization. This four practice method engineers staff engagement into processes for immediate and longer term assessment, care planning, and quality improvement deliberations to ensure that interventions are timely and have the best chance of success, by combining clinicians' expertise with staff's knowledge of residents' unique customary routines.

Individualized Care = Quality of Care + Quality of Life: Nursing home law, regulations and survey guidance consistently establish as the standard of practice that care is tailored to each individual's unique physical, functional, and psychosocial needs and circumstances. Nursing home residents' quality of life is important for its own sake ***and*** as the key to good care outcomes. Quality of life and customary routines provide the road map for applying clinical protocols

most effectively. *Asking a resident to lie down for a nap after lunch to relieve pressure and prevent a sore from getting worse won't work if the person has a favorite program to watch. When staff at an incubator home heard about the need to relieve pressure for one of their residents, they quickly adjusted the plan to place pillows and pads in the woman's favorite chair so she could watch her program and heal her sore. At another home, when staff learned that a resident wanted to skip a morning therapy appointment because he feared he would have bowel incontinence if he couldn't follow his morning routine, they adjusted the timing accordingly.* Overriding people's customary routines makes residents more vulnerable to both physical and psychosocial decline. Too often, clinicians planning in a conference room do not have the deep knowledge of residents' routines and preferences needed to design effective individualized care. Then the interventions are not always on target or sustainable. ***Incubator homes found that including staff closest to the residents in designing the interventions, through participation in care plan meetings and by moving QI out of the conference room to take place among staff closest to the residents, enabled them to apply successful individualized approaches that took into account residents' customary routines.*** They were able to make significant clinical improvements — reducing falls, hospitalizations, and use of antipsychotic medications. Honoring routines contributes to residents' physical and psychosocial well-being.

B&F's method intentionally emphasizes clinical needs and care delivery in recognition of the fact that people are in nursing homes ***because*** they have clinical needs, and nursing home staff can only meet their care needs by individualizing care. It's easy to honor residents' routines when they are able to communicate and there appears to be no conflict with clinical goals. While supports for fairly independent people can more easily be individualized, care and services for people with more acute needs can be harder to individualize. In fact, ***the more intense care needs are, the more important it is to adapt to residents' customary routines, because, the more frail someone is, the less there is room for error. Following someone's customary routines and supporting their quality of life provides a game plan for successful application of care interventions.***

The experiences of incubator homes demonstrates that these four foundational practices give organizations their best opportunity to know and meet the individual needs of each resident. The first practice provides stability and consistency at the point of care, through ***consistent assignment.*** Then, through the use of ***huddles*** (the second practice), staff check in regularly and frequently with each other to collaboratively care for residents throughout the day and share what they know as the clinical team works to prevent adverse events and maximize well-being. Through involvement in ***QI huddles and care planning*** (the third and fourth practices), staff closest to the residents work with the rest of the organization to meet residents' clinical needs and customary routines.



These four practices are mutually reinforcing. When staff work consistently with the same residents, they get to know them intimately and can notice subtle differences that may be early indicators of acute developments that need attention. When staff have a place to share what they are seeing and talk it through with others who have the clinical expertise and insight, they are able to better care for the person, and the organization is able to better support the staff in providing individualized care.

The graphic on page 11 represents the progression of the internal communication network as homes engineer consistent assignment, huddles, QI closest to the residents, and CNA involvement in care planning into organizational processes and routines. The communication map, practices, insights, and tools gathered from homes are integrated throughout the Handbook to display piece by piece the interrelated components of this progression.

WHY THESE PRACTICES?

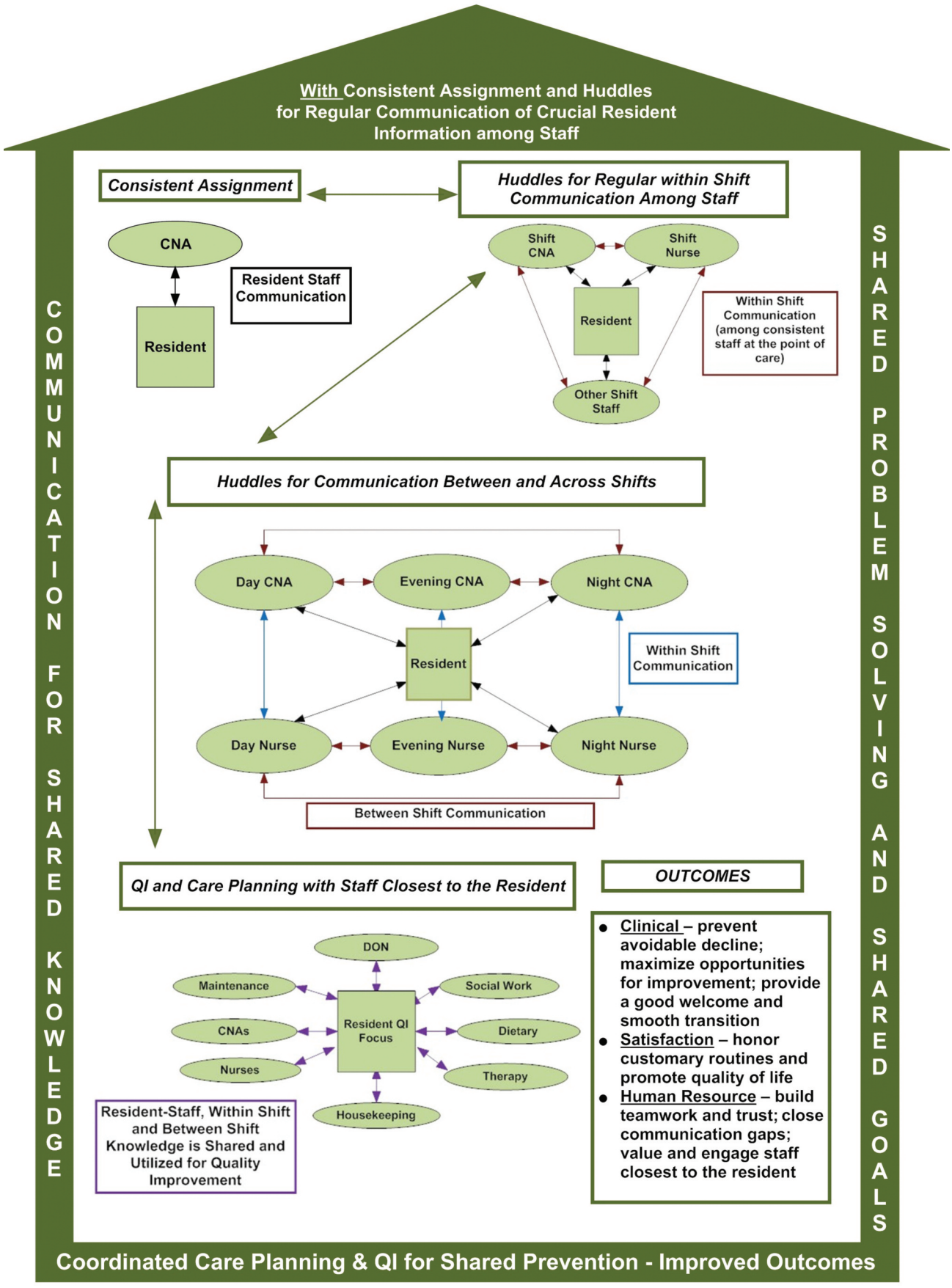
An Infrastructure for Communication

One of the most important responsibilities for leaders is to ensure that staff have what they need to do a good job. The foundational organizational practices described in this handbook give staff a structure that allows them to contribute good ideas and to make good decisions in the daily moments of caregiving. There are many moments throughout the day in caregiving that require on-the-spot judgment and decision making and your staff exercise this judgment every day. When you intentionally and rigorously facilitate communication within and across work groups (see figure on page 11), you ensure that staff have the information, ideas, and action they need from each other to achieve the best outcomes for the people you are all caring for together. When you link daily communication among staff closest to the resident with the formal systems for care planning and quality improvement, these interdisciplinary systems then have the timely, accurate information needed for the entire care team to support the staff at the point of care.

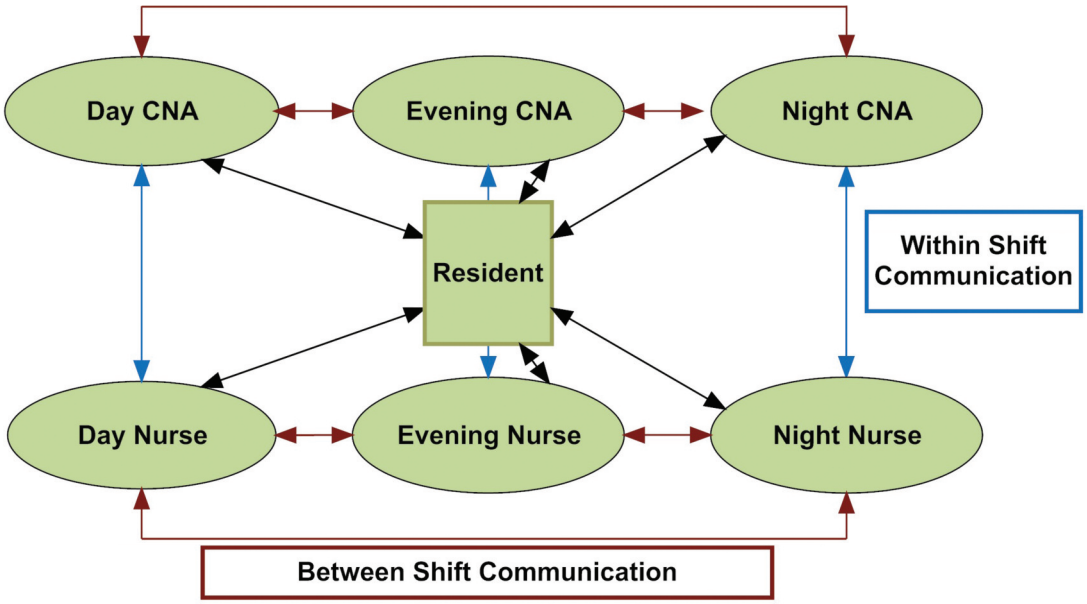
Good reliable, consistent communication doesn't happen without reliable, consistent systems for getting together. When staff have systems for regular communication, and are listened to and supported by leadership, they sharpen their critical thinking and collaborative problem solving skills. They become adept at identifying issues early and quickly developing an effective game plan for action. Their recognition of issues and activation of interventions can happen so quickly that your organization becomes nimble in responding to needs and proactive in continual improvement. This happens when staff closest to the resident are fully supported to act on what they know their residents need.

Good reliable, consistent communication doesn't happen without reliable, consistent systems for getting together.

Staff closest to the resident are dependent on the actions of others to meet their residents' needs and so they need a direct pipeline to other departments and disciplines to share what they know


With Consistent Assignment and Huddles for Regular Communication of Crucial Resident Information among Staff
COMMUNICATION FOR SHARED KNOWLEDGE
SHARED PROBLEM SOLVING AND SHARED GOALS
Consistent Assignment
Huddles for Regular within Shift Communication Among Staff
CNA
Resident
Resident Staff Communication
Shift CNA
Shift Nurse
Resident
Other Shift Staff
Within Shift Communication (among consistent staff at the point of care)
Huddles for Communication Between and Across Shifts
Day CNA
Evening CNA
Night CNA
Resident
Within Shift Communication
Day Nurse
Evening Nurse
Night Nurse
Between Shift Communication
QI and Care Planning with Staff Closest to the Resident
DON
Maintenance
Social Work
CNAs
Resident QI Focus
Dietary
Nurses
Therapy
Housekeeping
Resident-Staff, Within Shift and Between Shift Knowledge is Shared and Utilized for Quality Improvement
OUTCOMES
Clinical – prevent avoidable decline; maximize opportunities for improvement; provide a good welcome and smooth transition
Satisfaction – honor customary routines and promote quality of life
Human Resource – build teamwork and trust; close communication gaps; value and engage staff closest to the resident
Coordinated Care Planning & QI for Shared Prevention - Improved Outcomes

about residents' routines so that these routines can be accommodated. *When the management team rounds daily, staff can let them know critical information that can be responded to immediately, e.g., that the bed doesn't fit for a tall man who came in last night. Maintenance is able to get the right bed immediately, adding to his comfort and likely averting a fall. If staff can tell the management team that a resident needs a midnight snack after he has worked up an appetite from his customary nighttime pacing, food service staff can make his preferred food easily available.* This system for regular communication is an infrastructure that engineers the flow of individualized resident information to those who need to act so that staff closest to the resident can meet residents' needs, as illustrated in the internal communication network in the below graphic representing high engagement huddles.



An Infrastructure for Quality Improvement

These practices lay the foundation to put Quality Assurance and Performance Improvement (QAPI) into action in a meaningful way by providing an ***infrastructure that links organization-wide initiatives and localized needs.*** QAPI requires inclusiveness, high engagement, and critical thinking throughout the organization. It expands the deliberations from exclusively those who traditionally meet in the conference room to actively including the staff closest to the residents, and moves the location of the discussion out to these staff so that they can most easily attend. The practices in this handbook provide the basis for staff closest to the residents to be able to step in and participate fully in determining root causes and designing and trialing strong corrective actions.

A key tenet of quality improvement is that **our systems create our outcomes.** A corollary is that for our systems to work effectively, we need to ensure that the people who work interdependently in these systems have regular, timely ways to share what they know and help each other reach their common goals. The closer you move the locus of communication to the point of care, the more accurate and current your information is. Communication with and among staff closest

to the residents brings the entire organization to the source for a close look at the situation and to engage the staff closest to it in thinking through what will work best. This actualizes staff's responsibility for the well-being of their residents and empowers staff to fulfill that responsibility by shaping the delivery of care to meet the needs of each resident. When staff are working at their best together, they prevent avoidable declines and maximize the potential for good outcomes.

A key tenet of quality improvement is that ***our systems create our outcomes.***

QAPI calls for **staff's critical thinking and problem solving skills** in the analysis of root causes and the implementation of effective interventions. Many QAPI tools depend on effective involvement of staff working directly with situations being improved. Tools such as process mapping, root cause analysis, and pilot tests only work when staff handling the situations everyday share what they know. When staff are thinking critically every day, they more easily apply those skills to a fishbone or flow chart. As staff develop their analytical skills they help the organization identify areas for performance improvement.

Quality improvement is a dynamic set of activities that **link action and outcomes at the point of care with all the efforts of the rest of the organization**. They give your organization the ability to continuously improve so that you are able to truly provide the *highest practicable physical, mental, and psychosocial well-being of each resident*. When staff have to work around inflexible systems they then have to mitigate the negative effects of these inflexible systems on the residents they care for. The man whose bed is too small will have trouble sleeping which will affect his physical and cognitive abilities and may result in a fall on his way out of bed. *The man who needs to maintain his lifelong routine of pacing at night may strike out when staff attempt to redirect him back to bed, and then be sedated with an antipsychotic medication to treat "aggressive behavior" that wouldn't have happened if staff had supported his routines.* These day-by-day interventions add up to quality measures on use of antipsychotics and on falls, and other outcomes.

When staff are connected to performance improvement everyday, they can identify red flags and underlying systems issues that impede their ability to meet residents' needs, and can prevent potential harm from occurring. *One nursing home was concerned that staff weren't using the lift to assist residents. When the management team took their falls meeting out of the conference room to the staff, they learned the reason — the system for keeping the batteries charged was ineffective and staff were left with the poor choices of helping a resident without the lift or telling the person to soil themselves. No amount of in-servicing on falls and lifts would have improved the situation. QI Closest to the Residents resolved it immediately.*

QAPI emphasizes the **integration of quality of life and quality of care**, and it requires a highly inclusive approach to the systemic analysis and action needed to continuously improve outcomes. These foundational organizational practices bring QAPI into play in a way that fully engages the staff in individualizing care. *The man who hungers for oatmeal at midnight after pacing for hours is no longer being told to go back to bed and then treated with antipsychotic medications for his distressed response. Instead staff tune in to each person's routines and organize meals, care, and supports around their customary schedule. Doing so avoids causing residents' distress,*

and the subsequent sedation and deconditioning caused by the antipsychotic medications.
For many years, the hallmark of a well-run organization has been the efficiency and consistency of care practices, such as turning residents every two hours at night, or having each person up, washed, and dressed for breakfast. However, we have always known that **the best care is individualized and the best clinical results come from applying clinical knowledge in the context of each individual**. These organizational systems are foundational for staff to know each resident as an individual and apply individualized approaches to care needs. For example, because cell rejuvenation happens during stage three of sleep and psychosocial rejuvenation during stage four, a good night's sleep is required for healing and well-being. Staff working with the same residents come to know their sleep patterns and by huddling and communicating together can individualize their schedule for repositioning and bathroom assistance to maintain skin integrity and meet continence needs while maximizing sleep time. Having a QI process built around the in depth knowledge staff have of the residents they consistently care for, makes that process more effective in less time, by going right to the source and adapting care interventions to each individual.

This shift from a blanket approach to care, to one which is highly individualized, requires critical thinking on the part of all staff. "We've always done it this way" is the antithesis of a quality improvement approach. Sometimes, what we've always done is the very root cause of the problems we are trying to address. QAPI drives organizations to use Root Cause Analyses to understand why problems are occurring, and to apply systemic action to resolve the root causes. When consistently assigned staff know their residents individually and communicate together through regular huddles, they can routinely note potential concerns and develop individual strategies to prevent or address these concerns. Staff develop the critical thinking skills individually and collectively to identify root causes and effective interventions.

Organizations that have all these practices fully operational as the infrastructure for their daily work are then able to adapt their systems to changing conditions fluidly, cohesively, and expediently — they do not have to make exceptions for midnight snacking, because supporting each individual's customary eating routines is the norm. Staff who work closest to the resident can bring the information gleaned in their day-to-day huddles to get to true root cause analysis and then help shape and test the interventions until they are working at their best to meet residents' needs. **These foundational practices provide the forum to activate staff engagement in improving quality every day**.

An Infrastructure for Preventing Avoidable Declines

Having systems to ensure that staff have regular, timely ways to share what they are seeing and discuss what to do about it, enables staff to act at the earliest signs of a concern, in ways that can often nip it in the bud, and prevent or mitigate a decline. What seem like subtle changes are often indicators of an acute situation that is rapidly unfolding. Timely action is necessary to prevent the situation from having severe consequences. The CMS Survey Guidelines explain that to be in compliance with the requirement to provide the *highest practicable physical, mental, and psychosocial well-being of each resident,* homes must prevent avoidable declines.

Avoidable declines can be "iatrogenic," a medical term meaning declines caused by the care provided rather than as a natural progression of one's disease or condition. Off-label use of antipsychotic medications, and use of alarms when a resident is at risk of falling, are examples of iatrogenic practices because in both cases, they lead to avoidable deconditioning and decline in physical, mental, and psychosocial well-being. Instead, using these four practices to bring information from staff closest to the residents about residents' customary routines and individualized needs, incubator homes initiated individualized interventions that prevented falls and prevented resident distress instead of using deconditioning interventions like alarms and antipsychotic medications.

Avoidable declines also occur when there is a delay in care, often caused by a gap in communication. *When a group of nursing homes working on a project to prevent avoidable hospitalizations studied the previous month's hospitalizations, they learned that for many of the hospitalizations, some among the caregiving staff knew that something was not as it usually was for the resident. But along the communication trail, the information didn't get passed along or acted upon.* Homes that have implemented regular ways for staff to communicate have a ready-made infrastructure for this information to be passed along and shared, and thus for avoidable declines to be prevented.

These are systems that, when practiced routinely and regularly, give you the ability to catch and treat developments in their early stages and prevent them from becoming full-blown issues for a resident. From care for individual residents to overall organizational performance, staff can identify adaptations they need to make to meet their residents' needs. *After midnight snacks are made available for the first person, staff quickly identify others with similar, or different, food and schedule related needs.* When management routinely huddles with staff closest to the residents, together they are able to earmark areas for systematic improvement, such as midnight snacking, and keep the key performance metrics, such as residents with distress and agitation or receiving antipsychotics, in the forefront of their common efforts. **These practices help organizations move from a constant reactive response of putting out fires to a proactive approach of preventing them.**

HOW TO IMPLEMENT THESE PRACTICES

Your process for initiating these practices is key to their success. In taking on any new practice, it's not just ***what*** you do but ***how*** you do it. Use a high engagement process in which staff are involved every step of the way in shaping the new practice. This will give the staff experience in problem solving together and build staff's trust in the process so that they believe they can work through concerns as the process unfolds. This also gives staff experience with the analytical thinking required for Quality Assurance and Performance Improvement. Since the purpose of these systems is to provide forums for staff's critical thinking and problem solving, make the process for

*In taking on any new practice, it's not just **what** you do but **how** you do it.*

implementing these practices a beginning for staff to figure out how to make it work. In this way, staff will learn critical thinking and collaborative problem solving by doing it AND will have trust in the new process because they have helped shape it.

As in any practice, as you start to take it on, the first step for success is to talk with your staff about <u>why</u> you are making the change. Talk about the benefits for residents, for the staff themselves, and for the organization. Use adult learning methods such as giving people an experiential exercise (for example, helping each other to drink to understand how receiving care feels), or an opportunity to reflect on their own experience (for example when they've worked together to solve a problem for resident care). Staff have a strong intrinsic motivation to work together to provide the best care for the residents. They will welcome the benefits of these practices as long as they experience the follow-up on what is discussed, so that they are better able to care for residents.

Pioneer Network's Starter Toolkit for Engaging Staff in Individualizing Care, available for free at https://www.pioneernetwork.net/resource-library/resource-libraryengaging-staff-individualizing-care, has sample exercises and video clips to help organizations introduce these practices and begin discussion with staff for their implementation.

These practices are mutually reinforcing, work best together, and are hampered when done in isolation. For example, consistent assignment works best when staff who are consistently working with the same residents are routinely able to share what they know about "their" residents — through daily shift and QI huddles as well as through care planning. Huddles in turn work best when staff know residents deeply because they care for them daily. Conversely, the practices can fail in isolation. If staff are consistently assigned, but don't have a way to share what they know and are forced to provide care in a way that they know is opposite of what their resident needs, they may prefer the emotional distance of rotating assignments. ***While it is hard to start up several new practices at once, by doing so you help sustain all of them because the staff, residents, and organization feel the immediate benefits of tapping into staff's deep knowledge of residents.***

Leadership support is essential to the success of these practices. These practices work best when the Administrator and the Director of Nursing are personally committed to their success and understand that the systems are vital to their organization's ability to deliver high quality care. Leadership support needs to be consistent and fair or the practices will fall by the wayside. A recent study by Canadian researchers found that consistent assignment and huddles backfire when what staff report in their huddles about residents they care for and care about is not listened to and acted upon by their supervisors and the organization (Caspar, 2014).

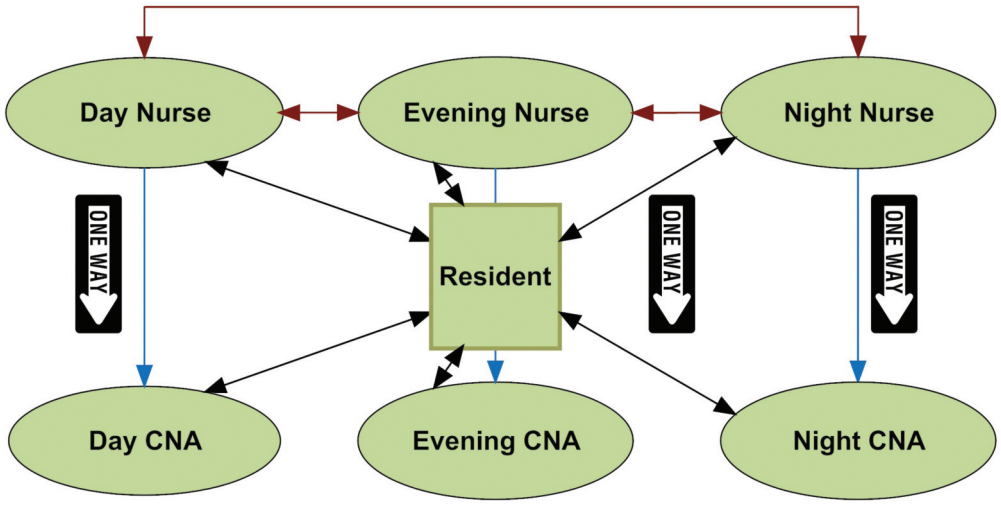
Leaders need to develop skills and systems. Building a *positive chain of leadership* involves strengthening your own leadership and communication skills, as well as those of charge nurses upon whose abilities these systems depend. Simultaneously, make sure that there are direct ways to bring information from staff closest to the residents into care planning and quality oversight.

Use It or Lose It

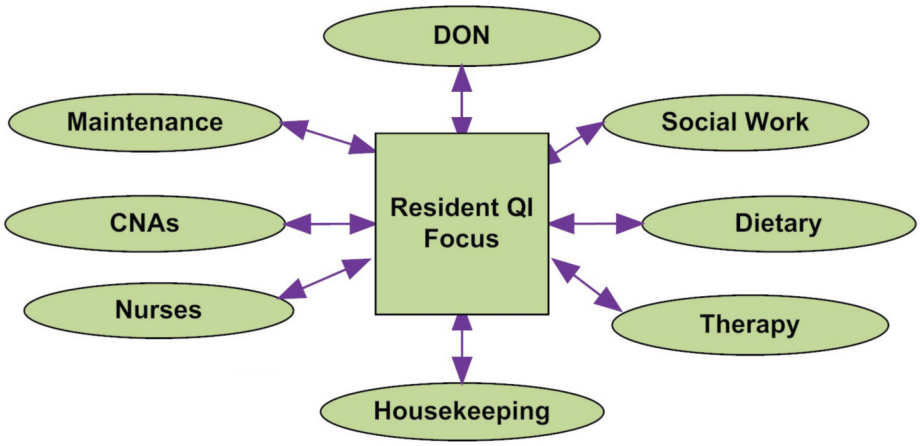
The key to the success of these practices is management's consistent support. *If staff tell management that the bed doesn't fit, and then have to make many more requests before it is fixed, the huddle with management has no credibility.* The effectiveness of the huddle is directly related to how well management uses the process to respond to the information they get. By responding quickly they support the staff most directly responsible for residents' well-being, and increase the residents' belief and experience of being in good hands.

Caspar (2014), in her study of consistent assignment and huddles, made an analogy to a backyard with a fence down the middle, the formal systems of care plan meetings, quality assurance meetings, management stand-up, wounds, weights, etc., on one side of the fence, and the actual daily life of care on the other side. She said that systems like consistent assignment and huddles are gates opening between the two sides. She found that where the communication was two-way, staff involved in daily care found the systems valuable. But where the communication was one-way, staff felt negatively about the systems.

In one-way communication, the gates are merely a means for management to give instructions to staff without asking for or listening to their related information and ideas, or they provide a forum for staff to tell management of their residents' needs but then the information is not acted on by management. Casper found that when staff were not listened to, being consistently assigned and participating in huddles was distressing. To know their residents so well and not be able to come through to meet their needs, hurt more than to keep emotional distance by rotating regularly. To participate in a huddle with no hope that anything would come of it felt like, at best, a waste of time, while having a huddle to be given instructions without the opportunity to share pertinent information left staff disengaged and frustrated. The graphic below illustrates a huddle with top-down communication where CNAs may learn more clinical details about residents to support care, but are not able to share their intimate knowledge of residents' routines, needs, and current condition.



Two-way communication was the norm in the incubator homes. Staff related how much it meant to them to be able to voice their residents' needs and be part of figuring out how to meet their needs. The graphic below from the internal communication map highlights this process. Staff closest to the residents described how through huddles and care plan meetings, they became more astute in their observations and their ability to portray what they were seeing. They shared the gratification of being able to work together to intervene successfully and see their residents improve because of it. They attested to how the practices were pivotal in achieving better outcomes — that by knowing their residents so well and being able to game plan together through daily huddles and through QI and care planning, they found individualized ways of taking care of their residents that prevented the falls, prevented the distress and subsequent antipsychotics.



Resident-Staff, Within Shift and Between Shift Knowledge is Shared and Utilized for Quality Improvement

Involve staff from the start and regularly to make practices work better. Staff may well sour on the process if problems they experience go unaddressed by leadership.

Pilot test *with the team most likely to succeed and provide the supports and make the adjustments you need to along the way.* Have those who piloted help their peers take it on.

Learn by doing. In every way, as you implement this, build your staff's capacity to work together. These practices will blossom as staff get better at working together, and the staff will blossom with increasing ability to take challenges on.

Give staff what they need to succeed. Use the practices as soon as you implement them. As soon as staff are working consistently with the same residents, give staff the information they need about their residents and count on their knowledge in QI and care planning. Take a developmental approach using just-in-time teaching to help staff know what to look for within the context of their residents' physical and psychosocial information, and to be part of daily decisions for the best outcomes.

Share medical records with CNAs. They are part of the care team. As such, make sure your HIPAA policies reflect that they have access to all information pertinent to their care and have responsibility for that information's confidentiality. Help CNAs learn where to find information in the medical records and how to read and understand medical terminology.

Make mid-course adjustments. The key to sustainability is adjusting to continually improve the processes as you go along. The work doesn't end at the beginning of implementation. Management needs to work with staff to address barriers. Very few new processes work perfectly when they are first implemented. With all of these practices, as they are put in place, they need to be revisited regularly to talk about how they are working. For instance the schedule that you have worked so hard to put in place one month may be significantly changed within a few months by a change in census or in residents' status.

Be open to staff's ideas about how to make adjustments that are different from how management thinks it should happen. At one home, staff were so dedicated to their residents that they didn't want to redistribute the assignments. Instead they worked among themselves to support each other while each maintaining their primary responsibilities to their residents.

HOW TO USE THIS HANDBOOK

The effectiveness of these practices is directly dependent upon the consistency of support provided by leadership. We caution against attempting to implement any of these practices unless your organization feels compelled to do so by the conviction that these practices are necessary to do a good job and therefore commits to provide the support needed for the practices to flourish and uses the information shared by staff closest to the residents in determining the best care interventions for residents. Without this sincere belief, these practices will wither on the vine, and staff will be frustrated by their unfulfilled promise.

This is an Implementation Handbook, designed to help you put the organizational practices into operation. This Handbook describes, for each practice, preconditions for success, ways to get started and how to fully develop and improve them as you go along. Each section includes important considerations and tools as you strengthen your processes, and linkages to your quality improvement and care planning systems.

The heart of the Handbook is the how-to's. The how-to's provide proven, practical guidance for putting each process in place. The Handbook has written guidance, and tools, tips, and video clips from incubator homes.

These practices work best if they are used to add value to daily organizational performance. While they can certainly help staff closest to the resident work better together within their immediate sphere, staff will be frustrated if their knowledge of residents is ignored by the rest of the organization. Incubator homes used these practices to engage with staff closest to the residents in organization-wide decision making about how to serve individual residents best, and how to accelerate overall improvement in key quality areas.

As you think about how to take full advantage of these practices, consider moving any meeting about residents that you now have in a conference room out to staff closest to the residents. You'll get better solutions in less time than a typical conference room meeting because you'll be going right to the source for information and ideas, and designing interventions directly with the people responsible for implementing them. Moving the meeting out of the vacuum of the conference room to where the actual experience is occurring, allows the situation to be seen as it is in real life. Consider the difference in information and insights available when meeting in the conference room about a resident's fall compared to meeting right where it happened, and talking directly with the resident and staff involved. *When one home moved its falls meeting out to where the fall occurred, the clinical team quickly saw that the fall was because the rack in the closet was too high for the resident to hang clothes safely. Once seen, it was easily corrected. It would not have been so easily evident if the team had remained in the conference room. Instead, a one-size-fits-all response (such as an observation protocol) would likely have been decided upon, and inconsistently followed.*

The material presented in this Handbook is meant to be adapted to your unique needs and circumstances. There is no blueprint for one way to implement these practices and no need to apologize for adapting it to make it your own. Incubator homes varied in how they structured huddles, and how they incorporated staff participation into their QI efforts. Some homes will want to huddle at the beginning of a shift while others will find that timing works better later. In some homes, CNAs lead the huddle and in others nurses do. Every nursing home is different and therefore will design different structures for communication. In fact, it's best that you make it your own, both because it will work better for you, and because by going through the process of staff engagement in creating and honing it, staff will start stepping into the skills and problem-solving processes that these practices are a forum for. So, if you try to follow a cookie-cutter approach to put this place without engaging staff in figuring out how to make it work, you actually undercut the very purpose of the processes, which is to engage staff in critical thinking and problem-solving.

We are all works in progress, and our systems are too. While there is naturally wide variation in the way these practices are implemented, there are specific attributes of each practice that lead to greater effectiveness and steps in a progression that homes can take, starting from scratch to continually refining. Putting these practices in place is never a "one and done." They require continual revisiting and refining because they can easily get off track, or dynamics can change with a change in staff or in census. ***One of the significant lessons from the incubator homes was that for these practices to remain effective, leaders had to routinely check back in with staff and support tweaks and modifications as they went along.***

These tools should be considered by your organization as your infrastructure for good care. As you make these systems your own, the bottom line is to use systems that stabilize staff relationships with residents and with each other, so that they become deeply knowledgeable about the details of each resident's physical, mental, and psychosocial well-being and fulfill their piece in supporting that well-being. ***Your organization's performance is judged by residents' experience at the point of care and so your organization's success depends on your ability to provide consistently good service closest to the residents.*** Consistent assignment, shift huddles, and involving CNAs in care plan meetings and QI are four practices that enable your organization to keep your finger on the pulse of your residents' needs and keep you nimble in responding to those needs. They will not work if the practices are routinely upended when they are inconvenient. For example, floating a CNA away from her consistent assignment to cover for an unscheduled absence should be the last option, because it doubles the disruption in continuity of care. When you believe in their importance and act accordingly, the practices will flourish and deliver positive outcomes for residents, staff, and your organization.

This handbook is the third tool produced by B&F Consulting through Pioneer Network's National Learning Collaborative. It provides provides in-depth information on how to operationalize these foundational practices and maximize their effectiveness. The other two resources are available at www.Pioneernetwork.net:

1. Pioneer Network's **Starter Toolkit for Engaging Staff in Individualizing Care** is available at no charge. It includes tip sheets, starter exercises and video clips for each of the four practices, and for their application to three clinical areas (Promoting mobility, reducing falls and alarms; A good welcome in the first 24-hours; and Reducing off-label use of antipsychotic medications by engaging staff in individualizing care to alleviate resident distress) and for individualizing dining, mornings, and night time care. (https://www.pioneernetwork.net/resource-library/resource-libraryengaging-staff-individualizing-care)

2. Pioneer Network's **Engaging Staff in Individualizing Care Five Part Webinar Series** is available for purchase. It includes 60 minute webinars, teaching instructions and handouts used by the incubator homes to support their implementation of these practices. The webinars feature teams of staff and clinical experts providing detailed discussions of how they put these practices in place and how they used the practices to achieve clinical improvements. (https://www.pioneernetwork.net/product/engaging-staff-individualizing-care)

In addition to these resources, Elliot and Barsness developed an internal ***communication map***, based on the experiences of the incubator homes, to illustrate how these practices provide a conduit for residents' voices to flow throughout the organization. The map is available on the Pioneer Network website (https://www.pioneernetwork.net/communication-map) and portions of the map are included in this Implementation Handbook.

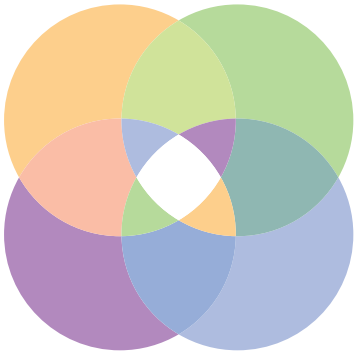
REFERENCES

Caspar, S. (2014). The influence of information exchange processes on the provision of person-centered care in residential care facilities. Unpublished dissertation. University of British Columbia, Vancouver, BC, Canada.

Information to Get Started Video Clips

Clip 1: Four Practices Provide the *Infrastructure* for High Quality Individualized Care

Clip 2: Dedicated and Engaged Staff "Own" the Quality of Care of "Their" Residents



Engaging Staff in Individualizing Care

An Implementation Handbook

STEP 1

Consistent Assignment

Pioneer Network™

B&F CONSULTING

Funded by

THE RETIREMENT RESEARCH FOUNDATION

Engaging Staff in Individualizing Care

An Implementation Handbook

STEP ONE
Consistent Assignment: Engineering Trust and Individualized Care

STEP ONE Consistent Assignment Video Clips

Clip 1: From Consistent Assignment to Dedicated Assignment
Clip 2: Consistent Care is Better Care
Clip 3: Work With Staff to Figure It Out
Clip 4: Make the Math Work for Consistent Schedules and Back-ups
Clip 5: When You Make Everything Consistent Staff Can Plan Their Day

WHAT IT IS:

Consistent assignment is a system that stabilizes the relationship between residents and the staff closest to them. It is accomplished by arranging for the same CNAs and nurses to provide care for the same residents every day these staff are working throughout the resident's stay. Homes using consistent assignment seek to minimize the number of different staff who care for each resident to the fewest possible within the regular schedule of days working and days off and to organize the schedule around resident assignments to ensure consistency of the caregiving relationship. **Note:** If CNAs and nurses rotate to different groups of residents after a period of time, whether daily, weekly, monthly, or even after several months **this is rotating assignments, not consistent assignments**.

The operating principle is ***consistency***. Stability at the point of service is the key to good quality. Consistency fosters deep familiarity between residents and the staff most directly involved in their day-to-day life and care and solid working relationships among these staff. Therefore, while consistent assignment usually refers to nursing staff, it follows logically that best practice is to consistently assign housekeeping, activities, social services, food service and other staff as well.

WHY IT IS IMPORTANT:

In performance improvement, the ***strongest corrective actions are ones that make a practice part of every day standard operating procedure***. Consistent assignment is a system that engineers stability and teamwork into day-to-day routines. This stability and teamwork at the point of care creates the foundation for nursing homes to honor individualized routines and prevent avoidable declines. Although this may appear to be an easy practice to implement, it is in fact, quite complex and its effectiveness varies a great deal depending on both management and staff's understanding and dedication to both the initial implementation and sustaining the practice over time. Treat it as a ***work in progress*** that is continually revisited. Pay attention to ***how*** you implement it so that you are continually trouble-shooting. And ***use it*** — when management uses staff's intimate knowledge of residents to provide the best individualized care and services, everyone strives to ensure that the consistent assignment works well because everyone appreciates its value.

Creates champions. In this very personal business of caregiving, staff ***caring about*** the people they ***care for*** makes them champions for their residents' well-being. The relationship between the resident and those providing care on a daily basis is the closest relationship to the resident, and the one that matters most on a day to day basis. When residents were asked what matters most for their quality of care in a 1985 study by the National Citizens' Coalition for Nursing Home Reform, their universal response was *kind and caring staff who know and help me as a person*. This finding influenced the development of the national quality of life law and regulations and has since been validated in multiple research studies (Custers, et al., 2012; White et al., 2012).

Yields quality. Focusing on "the point of care" is a quality improvement principle as well. In quality improvement, supporting performance at the point of service, where the rubber hits the road, is central to quality results. Consistent assignment is an organizational system that solidifies the caregiving relationship, providing the foundation for good outcomes, as long as leaders listen to what staff tell them about residents' needs and support staff in fulfilling these needs.

Prevents avoidable declines. As the long-term care regulatory and payment systems focus increasingly on outcomes, providing stability at the point of care is even more important. With consistent assignment, the CNAs and nurses who work closest to the residents get to know and anticipate residents' individualized needs and routines, and recognize changes from baseline that may be early warning signs of possible negative developments that could become acute episodes. Consistently assigned CNAs are so in sync with their residents that they have a finely tuned awareness of residents' changes in condition. They catch changes at the earliest warning signs and know when something is even slightly different, and they know what to report to licensed nurses. They know what has been tried, what worked and what didn't, and what is normal for each of the residents they care for. CNAs know how to approach daily care in a way that helps prevent or resolve situations that might otherwise cause distress for the resident. The incubator homes that participated in Pioneer Network's National Learning Collaborative found that these individualized solutions contributed to reducing the use of anti-psychotic

medications, preventing hospitalizations, promoting mobility and reducing falls while eliminating alarms.

> ***I know the elder's comfort level. If I notice that they are showing weakness, I will let the nurse know or let therapy know.***
>
> **— CNA, Signature Healthcare at the Courtyard, Marianne, FL**

Builds trust. When staff consistently care for the same residents they develop relationships that end up transforming caregiving from "task-oriented" care to "relationship-based" care. Residents know who is taking care of them and feel secure in the consistency of the relationship. They trust that "their CNA" knows just how to take care of them. Families share that trust and feel they are in a partnership with "their" caregiver. Consistent assignment creates a trust and familiarity that allows residents and their families to feel a level of comfort and ease in partnership with their caregivers. This contributes to residents' overall well-being and supports reciprocal caring relationships between residents and staff. See Appendix for examples of tools used by incubator homes to build and sustain resident-CNA relationships.

> ***I can figure it out. I can see in their eyes what is going on, and I ask them. We can communicate.***
>
> **— CNA when asked how the consistent assignment impacts residents living with dementia, Cornerstone Care Option, Portland, OR**

Reduces residents' distressed behaviors. Most residents will appreciate consistency, and relax, rather than rejecting care, as they come to trust that their caregiver knows when they like to have things happen, and follows their preferences. Incubator homes reported decreases in distressed behaviors and in use of antipsychotic medications as consistent assignments were more fully implemented.

Increases satisfaction. Consistent assignment reduces grievances and complaints as staff are better able to meet residents' and families' needs through day-to-day conversation and problem solving. The familiarity and comfort of the relationship opens the door for more open questions, requests, and sharing by residents and families. Staff become dedicated to their residents. Most CNAs come into this field because they care about people and want to make a difference in the residents' lives. Having consistent assignments allows relationships to grow so that CNAs feel more satisfaction from their caregiving role. Multiple incubator homes in the National Learning Collaborative reported that having consistent assignment has contributed to their retaining staff. Even CNAs who by self report were resistant to making the change to consistent assignment later described the benefits and their own appreciation of having moved to this practice.

Engineers teamwork. Putting consistent assignment in place engineers teamwork into the daily caregiving dynamic. Consistent assignment provides the opportunity for staff to build relationships not only with the residents they care for, but also with their co-workers. Staff learn

to turn to each other and to rely on the wealth of information about a resident that only consistently assigned staff can have. CNAs know how to plan their workday more efficiently because they know their residents' routines and can even have consistent break schedules. They establish a regular rhythm for their work and function better as a team throughout the shift. Housekeepers, food service staff, and all the clinical disciplines also benefit from working with a consistent team. *Conversely, teamwork is impeded when staff don't know the people they are working with.* Of course even with consistent assignment, teamwork doesn't happen automatically. Charge nurses need to foster teamwork in the way they structure interactions, for example by having regular huddles, and staff need to be committed to the goal of growing the team. But without consistent assignment, teamwork is much harder because staff don't have the regularity of knowing their own assignments and knowing their co-workers that allows them to establish rhythms of work and of cooperation.

> ***We no longer hear "that's not my job."***
> ***We are working as a team.***
>
> **— Supervisor, Washington Rehabilitation and Nursing Center, Chipley, FL**

Improves Nurse-CNA dynamics. Consistent assignment also facilitates teamwork in the daily dynamic between CNAs and nurses. Over time CNAs and nurses working with consistent assignments come to know one another well and work in a deeper, more effective manner than when staff rotate. Effective trusting relationships are built on strong, consistent communication. Because CNAs come to know their residents so well and thereby possess a wealth of information, when they spot subtle changes, the nurse, who has developed a solid relationship with CNAs, appreciates and trusts their observations and contributions.

Simplifies scheduling. Scheduling actually becomes simpler when it is built to support consistent assignments. By building the schedule around resident assignments instead of focusing on getting enough hours for each staff person, one incubator home identified that it had enough part-time and per diem hours to consolidate into two new full-time staff positions. Because they work with the same people every day, staff establish a regular rhythm for their work and tend to negotiate with each other about time off needs. As staff become dedicated to the residents they care for regularly, they tend to call out less frequently. They know how much their presence matters.

Speaks to staff concerns. Concerns frequently expressed about implementing consistent assignment include: fear of unfair assignments with some staff bearing too heavy of a burden, staff burn-out, staff not knowing residents not on their assignment, how to cover unscheduled absences, and how to care for residents whom staff find challenging. *However, these circumstances already exist when staff rotate and can actually be handled better with consistent assignments, if these issues are handled by management.*

> ***We now bathe our own consistently assigned residents; we used to take turns with the other aide. It's better now because you know what the resident likes, temperature of the water, how full they like the tub, and if they want the jets on. It's no longer traumatizing for the resident.***
>
> **— CNA, Avera Rosebud County Care Center, Gregory, SD**

Is supported by research. Staff in the incubator homes found that by strengthening the consistency of assignments, they were able to improve working relationships with each other and thereby to improve residents' outcomes. Their experience corresponds with a substantial body of research (see appendix for Provider magazine articles) finding that consistent assignment of CNAs and nurses improves clinical, human resource, and organizational outcomes when it is fully implemented and supported. Benefits include:

- enhanced relationships;
- improved staff attendance;
- lower staff turnover;
- improved clinical outcomes;
- improved quality of life;
- improved staff, resident, and family satisfaction;
- improved accuracy and timeliness of assessments.

> ***We no longer spend money to orient staff to other shifts. They orient only to the shift and area they will be working.***
>
> **— Administrator, Cornerstone Care Option, Portland, OR**

HOW TO DO IT:

A Caution Before You Start

Consistent assignment should only be put in place when it is fully supported by leadership so that CNAs can act on what they learn about residents' preferences. Consistently assigned CNAs have a wealth of information to share about residents' needs and changes in condition and want to participate in designing the interventions they will primarily be responsible for implementing. If assignments are not coupled with some decision-making encouragement and authority, as well as responsive leadership, a large part of the purpose is lost.

In fact, implementing consistent assignment without full support of management can cause staff distress and undermine the benefits your organization is seeking. A Canadian researcher identified differences in CNAs' experience of consistent assignment depending on how well their input was used by the organization. CNAs' concerns about consistent assignments stemmed

from experiences of not being listened to about what their residents' needed and their preferences. CNAs' stress was heightened when these needs and preferences were not addressed because they care so much about the people they are caring for and want to be able to fully meet their needs (Caspar, 2014).

If consistent assignment is put in place in a vacuum, where CNAs have information and no place to share it, or have it acted on, they are being put in an untenable position. If CNAs are not able to use and share what they know about residents in ways that allow them to respond to their consistently assigned residents' needs and preferences, they will find consistent assignments painful. They will become frustrated and may push for rotation, feeling that they are unable to honor the preferences of the residents they are assigned to care for.

For example, if a resident does not want to get up early or have a shower on a particular day, but the CNA has to push through the residents' discomfort because she is required to provide care within a rigid schedule, it makes it hard to have a deep relationship with the resident and yet disregard what they know the resident needs. Don't put consistent assignment in place and then force CNAs to be unresponsive to what residents are saying. This breaks the trust between the resident and the CNA, as well as between the CNA and management.

The other foundational organizational practices — huddles, involving CNAs in care planning, and QI — provide routine ways that CNAs can share what they know about residents' needs and changes in condition and can participate in designing the interventions they will implement. Consistent assignment needs the support of leadership to trouble-shoot problems across departments and foster teamwork within/across shifts. Leadership should maximize the opportunity to foster collaboration among clinical and operations staff to identify and implement effective interventions. For example, leaders can support consistently assigned CNAs who share their knowledge that a resident wants to sleep in and have breakfast at 10:00, by supporting individualized timing of food service to accommodate the later breakfast.

Thus, to have full effect, consistent assignment needs full organizational support for planning, implementing and monitoring/problem solving over time.

Thus, to have full effect, consistent assignment needs full organizational support for planning, implementing and *monitoring/problem solving over time.*

What About Homes with Staff Instability?

Homes with a high rate of unscheduled absences and/or unfilled positions, who often have staff spread thin can move toward more consistency in assignments, and in doing so, start to improve attendance and daily stability.

Start by grouping staff into the work areas to which they are most suited. Some staff work better with people living with dementia while others work better with people in short term rehab. Assign by strengths and preferences.

Now you have smaller groupings of staff to work on scheduling and assignments with, and these staff can now more easily trade off among themselves to avoid a last minute unscheduled absence from leaving co-workers short-staffed.

Now look at your staff composition. Do you have a lot of part time and per diem staff? They can make your schedule a challenge as you try to fit them in and give them enough hours. Instead, ask your top performing part time and per diem staff to move to full time positions with guaranteed hours. Use part time and per diem staff as a consistent back-up pool for the particular work area they work best in.

If you have unscheduled absences or new employees still learning their job, the key to stabilizing is for the management team to pitch in consistently to assist with the work at high stress times of day, and to use human resource practices for long term stability, including taking time to hire right and provide a stable process for new staff to settle in, and working with staff to support good attendance. Through such a progression, building greater consistency into assignments will help tip the balance toward stability.

1. Start by Assessing Your Current Situation

Once you have decided to put consistent assignment in place you must appreciate that it is an ongoing process rather than a task to implement, check off the list and forget. Consistent assignment needs to be tended to with regularity.

Start by finding out the current state of daily assignments, not on paper, but in reality. Many homes have tried to adopt consistent assignment in the past but let it erode over time. You may have fragments of consistency in place. Sometimes managers are not fully aware of how much erosion has occurred. If this sounds familiar then you will need first to do some pre-work.

Once you have decided to put consistent assignment in place you must appreciate that it is an ongoing process rather than a task to implement, check off the list and forget.

It may be that you already have fragments of consistency in place, either from earlier attempts that have eroded, or because there are residents with special needs for whom a consistent caregiver schedule is already in place. Or you may have a dedicated area for residents with dementia that uses consistent assignment. These pockets of practice can be informative as you move forward.

Measure

To understand how much consistency is still in place you will need to collect some data. This calls for measuring the extent to which you currently have consistent assignments. Work directly with your scheduler or with a small group who are identified as wanting to work on this practice. Involving CNAs in the planning of new or revisited practices can make a tremendous difference in how smoothly the implementation goes.

Use a sample of residents. The first step to measure your current level of consistent assignment is to identify a group of residents to use as a sample. If you are a small home, you may want to look at the entire organization. But if you are in a larger home it would be more realistic to start small with one neighborhood or group of residents. Start in the area that will be the most likely to succeed. You know your staff and residents. Choose an area where staff are open and willing to try this approach to care. This will give you a blueprint for rolling it out to other areas.

Measure the number of CNAs giving care. Once you have chosen your sample, look at the staffing sheets and count the number of CNAs formally assigned for all shifts to care for/support each resident in your sample. Additionally you could review the number of CNAs that have signed off on care for a specific shift. Compare that with how many CNAs would be involved in a resident's care if you were at 100% consistency. Consider all three shifts and weekends. This 100% consistency number will probably be somewhere between 9–12 CNAs, depending on your way of scheduling.

Measure the number of times CNAs are moved. Another measurement to look at is how often CNAs are given a different assignment to accommodate another staff member who is absent. Again, separate out a sample of CNAs, and count how many times they are moved from their assignment to cover another assignment due to employee unscheduled absences. If you think you have consistent assignment, but this number is large it means that you have it in theory, but not in true practice. Although you may be surprised and dismayed at the high number you find, you now have a true picture and it will give you baseline information and help you set goals for improvement. Consider using the Consistent Assignment Tracking Tool available at https://qioprogram.org/2019-tracking-tools.

Whenever you start a new practice, it is a good rule of thumb to start with where you will be most likely to succeed — with your strongest nurse leaders and best teamwork.

2. Talk it Through Thoroughly

Talk implementation of consistent assignment through with staff, continually. Your success hinges on *how* you do it, and if you do it well, you are not only putting consistent assignment in place but you are also getting it off to a good start by doing it in a way that builds the group's teamwork and problem-solving.

Bring together small groups and explain why consistent assignment is important to residents, staff, and the organization. It is essential that everyone knows why you are implementing consistent assignment and that you are serious both about doing it and doing it well. Start by sharing with staff what you know about stability at the point of care as the foundational practice for the best care for residents. People learn best by reflecting on their own understanding, and imagining the care experience from the residents' point of view.

Exercise: Personalize the experience of receiving care by having staff help each other drink a glass of water. It's eye-opening to receive help with a basic activity of daily living that people are used to doing for themselves. Ask what it feels like to be helped and then remind staff that having a drink is one of the less intimate ways that residents receive help every day.

Another way to explore the point is to ask staff to imagine needing care themselves for an extended period of time. Consider using a flip chart to capture their comments as they brainstorm the benefits of having the same person care for and support them through this period. What are the similarities between that experience and the work they do now?

After the personalization or brainstorming, ask staff to think about the days after they start a new assignment — what is it like for them and for residents as they have to get to know each other? Compare how it is at the beginning of a new assignment compared with how it is after they've been working with the same person for a period of time. Do they get into a rhythm where they can anticipate needs and organize their approach?

You can state at this time that the decision has been made to go forward with this but that you want it to be done in a way that is fair for everyone so you want to discuss how best to do it. Create an atmosphere where staff feel supported and that they can ask questions and bring up issues such as fair workload. Be transparent. As concerns are brought up be sure to address them. You can explain that once the initial assignments have been made there will be regular meetings set up to see if what was originally thought to be fair actually works. These are mid-course adjustments and should be anticipated. You should be prepared to meet regularly to check in with people once the assignments have been made.

3. Build a Good Process

The success of consistent assignments depends on the effectiveness of the implementation process, which needs to be seen as a continual work in progress with sustained attention and support from leadership. It needs to be put in place through a process that ensures staff involvement, fairness of workload, compatibility of assignments, and supervisory practices that foster teamwork and problem solving, particularly in regard to care for residents that staff find challenging. It needs to be accompanied by regular shift meetings where information about residents is shared among staff so that anyone can be a back-up in caring for a resident.

> ***Consistent assignments have made a big difference … The CNAs will let the nurses know if the work load may be too much. They try to make sure that the work load is evenly distributed … they look at who needs Total Assist; some Assist and who are more independent. CNAs work together well. They also work as teams. Elders choose who they want. If a resident moves to another room or other hall, the CNAs and sometimes the nurse, will request to stay with that elder and they get to do that.***
>
> **— DON, Washington Rehabilitation and Nursing Center, Chipley, FL**

4. Involve Everyone

Assignments must be fair for staff and a good match for residents and for staff, playing to staff's strengths as well as resident preferences. For fairness and compatibility, staff members need to be involved in determining assignments, and supervisors need to facilitate adjustments when assignments do not work or the resident population changes. Meet with staff so they have input into making the assignments. Use this time of developing the assignments as a time to help your staff talk through their own concerns. The more of this up-front conversation that happens the stronger your initial assignments will be.

You should be prepared to meet regularly to check in with people once the assignments have been made.

5. Play to Strengths

If CNAs and nurses currently work in all areas rather than one area, discuss work area preferences with each individual. As you constitute the groupings for each area, this gives the leadership team time to think about individuals' strengths and good matches among the staff. It also is a chance to talk together about the types of skills and strengths needed for each area.

Once you've grouped the staff by area, begin meeting as a group to figure out the best assignments. There are residents that some staff already have closer relationships with, and there are residents that some staff find difficult to care for while others have an easier time with them. Consider personalities and other interpersonal factors.

Proactively seek residents' and families' preferences and defer to their preferences. Their response will give you a lot of useful information about their experience with your staff.

> ***We try to match the CNA with the elder. Even if the elder is difficult to work with, the CNAs will find ways to work with them. They take their time with the elders. We have compassionate CNAs. They are family. Our CNAs are less likely to call out. They take their responsibility seriously and they know the elders are depending on them.***
>
> **— Social Services Director, Washington Rehabilitation and Nursing Center, Chipley, FL**

6. Be Fair

Look together at how groupings in each assignment are balanced. Consider physical and emotional factors.

To get a numerical ranking **based on how much assistance residents need**, you can list each resident and ask each member of the team to rate the level of effort for each resident on a 1–5 scale considering both physical and non-physical factors. Create an atmosphere where everyone can speak their mind.

RESIDENT ASSISTANCE

Resident	Physical	Non-Physical	Total

Use these numerical rankings to make sure that the workload is fair. You may have an uneven number of residents on an assignment if one assignment has more difficult residents. CNAs can split a double room (i.e. each work with one of the residents that live in the room) if that provides a better match and balance. The rooms do not have to be all in a row, although physical proximity is a consideration for work efficiency.

When the team finalizes the assignments, there will likely be residents that staff partner together to care for, because extra help is needed or to provide consistent back-up on breaks or days off. One way this might naturally happen is when staff share a room, each having primary responsibility for one of the residents.

> ***CNAs decide what level of care number to assign to residents. When I tried to decide, it didn't work for them. Actually they do a better job than I do.***
>
> **— DoN, Avera Rosebud County Care Center, Gregory, SD**

7. Team Up and Trouble-Shoot

Many homes use team assignments where one CNA is primary for a resident, and a second CNA is the primary back-up on the same shift. This is helpful for residents who require two people to care for them, either because of physical or non-physical difficulty. It provides consistent back-up at break times or when one CNA is engaged in caregiving with one resident and can't respond to another resident's needs at that moment.

Regularly talk through any situations that staff find challenging and what support is needed from care partners and other clinicians to develop effective strategies. Involve all departments in creating strategies to address these challenges. For example, a resident who exhibits distressed behaviors at meal times might need a different meal schedule, a different type of food preparation, or a quieter environment. Food services, social work, activities staff and others are a resource to support CNAs. Residents who are difficult to care for should never be the sole responsibility of the consistently assigned CNA.

8. Make Everything Consistent

Extend consistency in all aspects of the resident's experience and staff tasks. Have consistent staff breaks, meal assistance, and bathing. Staff will be able to plan their day, based on residents' customary routines and preferences, and having set break times will help them with this planning.

9. Adjust for Changes in Residents and Staff

Residents come and go, and their needs change. Staff also change. Assignments will periodically need to be rebalanced. Use a team process to monitor workload and make adjustments as

residents move out, move in, or experience changes in condition. At one home, the staff were so dedicated to their residents, that even as the assignments became less balanced, they didn't want to switch, so they just helped each other out when a second person was needed and kept their primary assignments. If you regularly check in with staff and create an environment where they problem-solve together, they will make the tweaks that keep consistent assignment working.

10. Hire and Schedule for Consistency, even Back-ups

Make sure your scheduling and hiring practices provide a structure for consistent assignments. Refocus the schedule from a staff schedule to a resident assignment schedule. Instead of working to get enough hours for each employee, work to get maximum consistency for each resident. This is not to dismiss the needs of the staff for working hours, but rather to look from a different vantage point in the planning. Arrange schedules by resident assignments so the same CNAs always back each other up. Encourage them to work together to work out schedule substitutions for each other so that residents have consistency. Develop a pool of consistent back-ups who know the residents they will care for. Have per diem staff work in the same area so they are familiar with the residents and co-workers. Fully orient staff serving as back-up and introduce the back-up staff to the resident.

Here are two examples of how administrators "work the math" so that hiring and scheduling supports consistency of assignments. In both examples, administrators schedule in a way that pairs up CNAs to provide a consistent assignment and a consistent back-up, and then hires into those resident assignments. We include these examples to help you consider how to make your own math work.

A 4-on 2-off Schedule

David Farrell, LNHA, has used a 4 days on, 2 days off schedule in which 3 CNAs cover two resident assignments (A resident assignment is a given set of residents.) with the third CNA having a split assignment:

CNA	M	T	W	TH	F	SAT	SUN	M	T	W	TH	F	SAT	SUN
Mary	1	1	1	1	Off	Off	1	1	1	1	Off	Off	1	1
Jane	2	2	Off	Off	2	2	2	2	Off	Off	2	2	2	2
Beth	Off	Off	2	2	1	1	Off	Off	2	2	1	2	Off	Off

Mary has resident assignment 1, Jane has resident assignment 2, and Beth has two days with assignment 1 and two days with assignment 2.

David suggests you invite staff to try this approach for three months. They'll likely love it and not want to go back because the work is hard and after four days many CNAs are tired and having two days off is refreshing. They also like that they can predict their schedule so they can make appointments, and many find that days off during the week are good for getting things

done. They also like that there is consistency in care and among co-workers. While they have fewer weekends off than in a traditional alternate weekend schedule, they get real rest with two consecutive days off. Everyone works weekends, but the advantage to this is that there is not a separate, disconnected, weekend staff.

Full-time/Part-time Paired Assignments
Connie McDonald at Glenridge Living Community in Augusta, Maine, uses 32-hour full-time and 24-hour part-time positions to establish continuity in assignments, and then hires for open positions by resident assignments. Here's how:

- Each 8 hour shift x 7 days = 56 hours. These 56 hours are shared by 2 CNAs, one at 32 hours and one at 24 hours; They alternate weekends.
- Note that 32 hours is full-time with benefits at this home.
- Hire into 32-hour or 24-hour positions by assignment.
- Two CNAs who share a group of residents can switch days if they need to.
- CNAs who want to pick up extra hours become the back-up pool for any co-workers working on the same neighborhood/household/unit.
- 24-hour CNAs are eligible to apply for 32-hour positions when they become available.

Resident Assignments	32 hours Days	24 hours Days	32 hours PMs	24 hours PMs	32 hours nights	24 hours nights
Group One	CNA 1	CNA 2	CNA 3	CNA 4	CNA 5	CNA 6
Group Two	CNA 7	CNA 8	CNA 9	CNA 10	CNA 11	CNA 12
Group Three	CNA 13	CNA 14	CNA 15	CNA 16	CNA 17	CNA 18

Scheduling for consistency is really all about the math. Make the math work for your community. These are two different solutions — you may find that one of these works for you, or a variation of these. Or you may find a new configuration altogether. You may also discover that your staff composition needs to be adjusted — you may need to move to more full time staff. At Rose Villa, the Director of Nursing worked with staff to match up schedules for consistency, and realized that she had enough hours of per diem staff to convert into two full time positions. Staff found matches that worked individually and for the group and have appreciated having consistency in who they hand off to.

11. Use "All Hands on Deck" to Deal with Absences

This piece of the process may arguably be the most important to success. Unscheduled absences are the reason that consistency fails in many homes. To really support this practice you must maintain consistency even when there are staff absences. This is the time to take bold action. *Consider this: when homes that had used restraints knew that they needed to eliminate this practice they often had to physically remove the restraints from the building to guard against staff reverting to the familiar practices. Their use was no longer an option* when they were taken out. If you want consistent assignments to really work, and understand that this caregiving bond that you are

nurturing is pivotal to excellent care, then you have to be prepared to find ways to protect and support the consistency even when there are unscheduled absences.

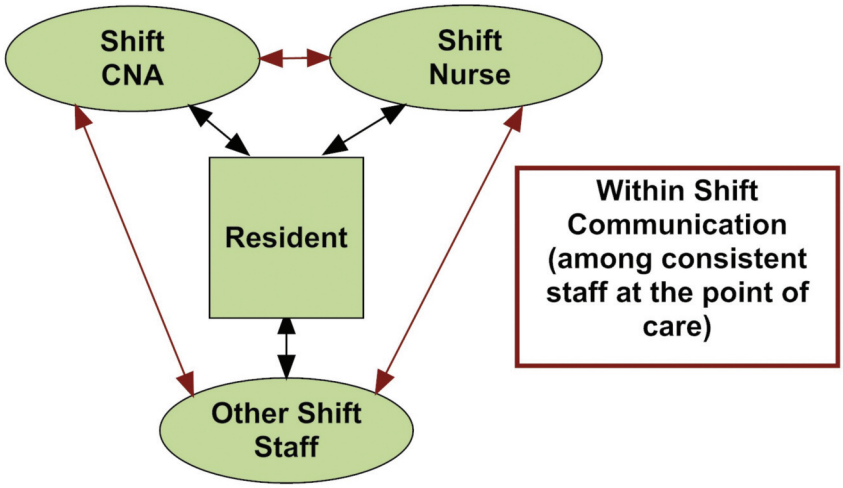
If you want consistent assignments to really work, and understand that this caregiving bond that you are nurturing is pivotal to excellent care, then you have to be prepared to find ways to protect and support the consistency even when there are unscheduled absences.

If one group of assignments is affected by an absence, do not compound it by taking another CNA away from her assignment to fill the gap. This will create two groups of residents without their consistent caregiver. Instead, utilize an "All Hands on Deck" approach where department heads and nurse managers help out at the busiest times, and other team members divide the assignment and pitch in to help with personal care. Ask food service and housekeeping staff to assist at meal times. Your actions show your dedication to consistent assignments.

Homes that have used this approach report that unscheduled absences decrease. There is a lot of peer pressure to do everything you can to come to work if you know that there are residents who will miss you and that you are leaving your co-workers in a bind. It is easier to call in if you believe your absence does not make much difference to anyone.

12. Use It or Lose It

Now that staff are working with the same residents and know them well, tap into what they know and give them the information and support they need. Use daily shift huddles to have consistently assigned CNAs and nurses share about the residents on their assignments so that everyone is able to back-up for each other as needed. Use as-needed huddles if there is a specific concern or need to problem-solve during their shift. Involve CNAs in care planning. Residents will really appreciate having *their* CNA there.



Use the information that staff share with you. Support them to honor residents' routines and preferences and acknowledge the importance of what is reported by the CNA. Honoring resident preferences means building more flexibility into the schedule for meals, medications, personal care and other daily activities AND encouraging CNAs to make independent decisions to meet resident needs and preferences using those system flexibilities. Incubator homes used what they learned about residents' routines to achieve their clinical goals, with great success. If you don't support staff to individualize care, you risk increasing the stress and frustration of staff and residents and undermining your goal of creating stability at the point of care.

Dedicated Assignments

Once consistent assignment is put in place, expect the relationship between resident and caregiving staff to deepen. Connie McDonald, Administrator, no longer refers to this as consistent assignment. Instead she uses the term "dedicated assignment" as she feels it better reflects and honors the relationships that develop.

When you have consistently assigned staff, you are creating the environment for life to be shared for both the resident and the staff member. When we walk through life in an intimate way we share emotions and caring, and deep bonds develop. This is a very human experience. For many residents their stay in a nursing home is the last chapter of their life. Be aware that you will need to provide an opportunity for staff to have closure when a resident dies. When staff develop deep caring relationships, it is normal for them to experience grief when residents they have grown close to die. Make sure to acknowledge and honor their loss, and build in ways to help them have closure. Memorial services held in the home can be very comforting for staff and other residents.

CLOSING

Creating stability at the point of care improves outcomes for residents, staff, and your organization. With the proper support, consistent assignment enables residents to feel secure and trusting in the intimate circumstances of daily caregiving and staff to feel dedicated to the people they care for. Use the process of implementing consistent assignment to build staff's problem-solving and critical thinking skills. Involve staff in making fair assignments and helping trouble-shoot challenging situations. Have daily shift huddles so staff can work together and share what they know about their residents' needs. Tap into the deep knowledge staff will have about their residents by involving consistently assigned staff in care planning and taking your QI meetings out to the staff. With full support and continual attention, consistent assignment will be the foundation for your organization's good care to those you serve.

STEPS TO PUTTING CONSISTENT ASSIGNMENT IN PLACE:

1. **Start** where you have the best chance of success, with your best charge nurse and CNAs, so you can learn from the experience before you take it out to the rest of the organization.

2. **Meet:** Hold regular meetings with staff who will be working consistently together.

3. **Play to Staff's Strengths:** Some staff are naturally better suited to caring for people with dementia while others will gravitate to short-term rehab residents.

4. **Rate:** Ask the team to rate residents considering physical and non-physical factors.

5. **Select:** Have staff select final assignments that are fair and a good match.

6. **Trouble-Shoot and Team Up:** Create team assignments with primary and back-up staff on the same shift. Talk through challenging situations with help from all departments.

7. **Have consistent staff breaks, meal assistance:** Staff will appreciate being able to plan their day around their residents' needs and preferences.

8. **Build a schedule for consistent back-ups:** Make staff schedules by resident assignments. Encourage staff to work out schedules and back-ups so residents have consistency.

9. **Adjust as Resident Acuity and Population Changes:** Use a team process to monitor workload and make needed adjustments to keep assignments fair.

10. **Support Dedicated Relationships:** Honor staff's grief when their residents die.

RESOURCES

www.pioneernetwork.net
Pioneer Network's website provides links to many organizations with resources for implementing consistent assignment, including a free Starter Toolkit for Engaging Staff in Individualizing Care (https://www.pioneernetwork.net/resource-library/resource-libraryengaging-staff-individualizing-care), and, for purchase, a set of the Pioneer Network National Learning Collaborative Webinars used by the incubator homes entitled Engaging Staff in Individualizing Care Five Part Webinar Series (https://www.pioneernetwork.net/product/engaging-staff-individualizing-care)

https://qioprogram.org/consistent-assignment
For a comprehensive set of resources on consistent assignment, go to the resource section under the process goal for consistent assignments.

www.BandFConsultingInc.com.
This website includes "how to's" (publications and videos) on implementing consistent assignment and other quality improvement resources.

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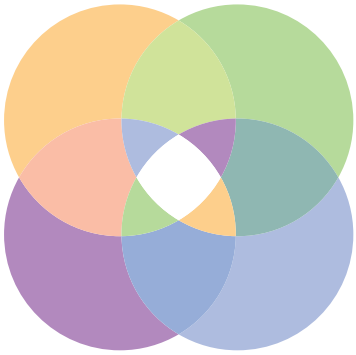
STEP ONE Consistent Assignment Video Clips
Clip 1: From Consistent Assignment to Dedicated Assignment
Clip 2: Consistent Care is Better Care
Clip 3: Work With Staff to Figure It Out
Clip 4: Make the Math Work for Consistent Schedules and Back-ups
Clip 5: When You Make Everything Consistent Staff Can Plan Their Day



Engaging Staff in Individualizing Care

An Implementation Handbook

Shift Huddles

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Engaging Staff in Individualizing Care

An Implementation Handbook

STEP TWO
Shift Huddles: Engineering Teamwork and Communication

STEP TWO Shift Huddles Video Clips

Clip 1: One Team's Story of Starting to Huddle Together and the Benefits They Found in Huddling Together
Clip 2: The How of Inter-Shift Huddles
Clip 3: Report by Exception Saves Time and Focuses where Staff's Critical Thinking is Needed
Clip 4: Interdisciplinary Team Participation in Huddle
Clip 5: Huddle for New Residents
Clip 6: Daily Management Stand Up with Staff
Clip 7: Hall Partners – Continuous Communication
Clip 8: Facilitation Tips for Promoting Constructive Engagement
Clip 9: How to Have Everyone Be There On Time
Clip 10: Mentors Teach New Employees about Shift Huddles
Clip 11: Shift Huddle Engages and Empowers Staff

WHAT IT IS:

Huddles are quick meetings for staff to share and discuss important information, and plan and coordinate action. Huddles occur at regularly scheduled times, such as start or end of shift, and on an as needed basis for quick information sharing and/or problem solving. Huddles make communication and teamwork the routine way of working together among staff closest to the residents and across the organization and create a work environment in which staff come to be in continuous communication, passing along information and quickly problem solving among themselves and across shifts and departments.

> ***The communication is really ongoing throughout the shift. It's really just continual, constant communication.***
>
> **— DNS, Rose Villa Health Center, Portland, OR**

Regularly scheduled huddles provide a consistent time everyone can count on to share timely information and make a game plan for shared action. They need to take place in an area where the privacy of residents' information is protected. There are many types of huddles:

- **Shift Huddle** is an everyday scheduled gathering of the nurses and CNAs working together in an area to share information about each resident and coordinate action. It can occur near the start and end of each shift, mid-shift, or during paid overlap time among off-going and on-coming staff. Shift huddles vary in format. They can be done in a stand-up and/or as walking rounds. Shift huddles also vary in content and dynamics; for example, at the start of a shift, staff are learning what they need to know for the work ahead. At the end of a shift, they are sharing what has occurred. Many homes include non-nursing staff, (such as social services, activities, dining staff, and housekeeping staff) who can benefit from and/or contribute needed information and ideas. Shift huddles occur at least daily on each shift and normally take about 15 minutes, depending on how many residents are living in an area/neighborhood and on staff's ability to focus on pertinent information. The huddle generates information that supports continuity of care by passing along residents' needs and conditions that require attention. When needed, this information is also shared across departments to generate timely support from the rest of the organization.

- **Everyone Stands Up Together** is a shift huddle with the management team. It takes the management team's morning stand-up or daily clinical 24-hour report out of the conference room or administrator's office and moves it to where the staff closest to the residents are, so that CNAs, nurses, and managers share and discuss information, and determine action to be taken. Management "**stand-up**" with staff works best when it is done early enough in the day to be able to act on items identified. A management "**stand-down**" with staff in the afternoon closes the loop on action items. **Everyone stands up together** takes 10-15 minutes in each area of the home. It can occur daily or weekly, on a regular schedule.

- **As-needed huddles** provide a quick exchange of information and ideas to support coordinated action related to a specific timely need. These quick check-in huddles can occur before staff go on break, when a new resident arrives, to let everyone know about a change in a resident's condition, or as any issue arises that needs the team to come together. They can take just a minute or as long as 15 minutes.

- **Quick Check-in Huddles** are used by staff who continually communicate with each other. It can be a check-in before going on break, to hand-off, and upon return, to be handed-back. Anyone can call a quick huddle to pass along a key piece of information. It's much quicker and more efficient than tracking each person down, and everyone gets the same information, at the same time, as well as the benefit of hearing each other's thoughts about it.

- **New Resident Huddles** let staff know about new residents before they arrive and then check in with staff about how new residents are doing during their first few days. Transitions are times of heightened fragility for residents and greatest risk for communication lapses among staff. By ensuring information sharing about new residents, all staff know which risk areas to focus on so they can prevent avoidable declines and can work together to maximize progress for residents from their arrival throughout their stay.

The incubator homes used the following types of huddles in their homes:

- Shift change
- Morning report on the unit/neighborhood
- Clinical updates
- Change of plan
- Routine check-ins
- QI huddles — understanding behaviors, investigating falls, identifying preferences (see Handbook Step 3 on QI closest to the residents)

Their huddles improved relationships between CNAs and nurses because they:

- Strengthened shared knowledge
- Built trust
- Created a level of comfort and certainty about working together

WHY IT IS IMPORTANT:

The quality of residents' experiences depends on the quality of staff communication and teamwork. When staff work well together and share what they know, they are better able to provide good individualized care, catch problems early and act on them effectively to prevent avoidable declines. Preventable declines happen when there is a lapse in communication between staff closest to the resident who notice that something isn't right and those with the clinical expertise and authority to act on these early warning signs. Staff together are better able to prevent a decline and promote an improvement when they pass information from shift to shift and work well together within their team to stay on top of residents' individual needs. Within the busy day to day care demands even the best of intentions to share information with others can easily be lost without a routine structured system for this communication.

Communication and teamwork are often identified as areas needing improvement among nursing home staff. The strongest corrective action to address the root cause of a problem is to engineer a system into standard operating procedures so that the default position is that the correct action is the action most easily taken. Huddles make communication and teamwork easy to do and set the tone for working well together to be the norm.

> ***The CNAs hold each other accountable. The nurses attend. The huddles are slightly different on each hall. Some are more formal than others, but take on the personality of the CNAs. After the huddles, they break out to do rounds together, where more detailed information is shared. The department heads will go to the huddles to discuss elders who are at risk and any other concerns. They also use the huddles for in-services. Admissions will attend huddles to share about customary preferences of a new admission. We also share during huddles information regarding behaviors and interventions. We talk about what to do.***
>
> **— DON, Washington Rehabilitation and Nursing Center, Chipley, FL**

How does information about a resident's clinical risks and goals, changes in condition, new treatments, and customary routines, get to the CNAs and other staff who spend the most time with residents? How are they able to share what they see happening, their ideas for action, and what they need from other departments? Huddles provide a standard way for all staff to share information and work together to provide the best care to residents. They provide a forum for information to be shared and acted on at its earliest stages and followed-up on to completion.

Huddle sheets, communication books, and white boards can supplement the information exchange by providing a place to keep current and pending news in front of everyone and a means to have the information available for people who miss the huddle or need to double-check on it. At Cornerstone Care Option they use a white board in the report room that has cuing questions so they can remember to report more comprehensively, e.g., when was the last time a fall risk resident walked? When were they last helped to the bathroom?

> ***As a resident who was dying was at risk of developing a pressure sore, the CNAs and nurses worked together around the clock to keep comfortably repositioning her. They made a worksheet so that anyone checking in would be able to see if a new repositioning was needed. They had quick huddles regularly to pass updates to each other.***
>
> **— CNA, MaineGeneral at Glenridge Living Community, Augusta, ME**

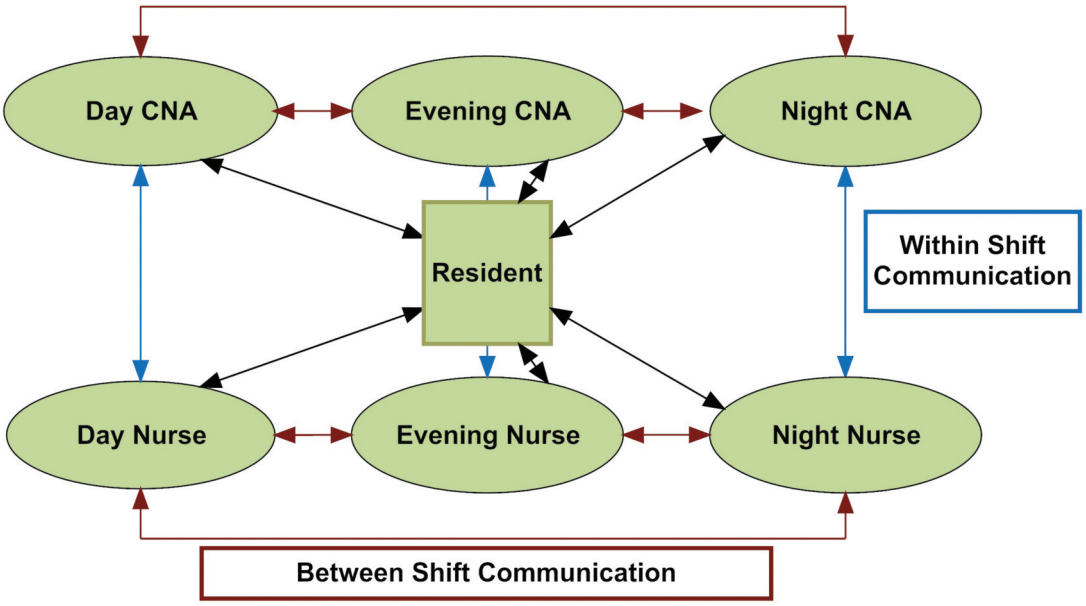
When huddles are used as a two-way communication, they save time, by providing a quick mechanism for everyone involved directly in a resident's care to share information with each other and with the rest of the organization. For the resident who was dying, close communication among the staff allowed them to share in making sure the person died without the added pain

of a pressure sore. Huddling facilitated teamwork. Managers huddled with the team closest to the residents to exchange information and identify any supports needed.

> ***The CNAs do seem to be finding more time to spend with the elders. The huddles and the preferences being shared allows them to not spend so much time trying to figure things out.***
>
> — DON, Washington Rehabilitation and Nursing Center, Chipley, FL

Communication of essential information cannot be left to chance. Huddles are a venue for quick information sharing and action planning so that everyone is able to work together toward the same goal. Of the many possible forms of communication, the huddle allows everyone to hear and discuss the same information at the same time, and promotes people working together to act on the information. A shift huddle reinforces teamwork and allows everyone to hear about residents so staff can help residents even if they are not on their assignment.

When management huddles with staff closest to the residents and acts on what staff tell them by making the necessary accommodations, staff can much more easily meet residents' needs. When the organization then incorporates this information into the assessment, care plan, daily assignment sheets, and QI, everyone is on the same page. These huddles then feed the organization's formal oversight and strategic planning systems and embed continuous improvement into daily operations.



Huddles enable organizations to adjust quickly and effectively to changing circumstances or needs. They make organizations more nimble because over time, when staff are empowered to call a huddle, problem solve together and assist one another, their skills grow. They facilitate individual staff and teams to catch problems early and act on them immediately, preventing and mitigating avoidable declines.

When staff understand the problem and participate in shaping the solution together with the care team, interventions have the best chance of success. When staff problem solve together every day, they have the structures and skills in place to problem solve for on-going QI activities such as clinical rounds, and for formal QAPI Performance Improvement Projects (see Step 3).

HOW TO DO IT:

1. Assess Your Current Situation

Assess your organization's current communication — what works and what doesn't. Determine where the gaps are. One administrator asked staff to rate communication and teamwork each on a scale of 1-5, and then asked again after huddles were underway, and periodically thereafter. She saw staff ratings improve, and when she saw dips she checked in to find out why and made adjustments.

One way to identify gaps in communication is to look at recent complaints to see if the root cause is a lapse in communication. If residents or families expressed a preference, was that preference communicated among staff working with that resident and to other departments whose help was needed to make it happen? Another indicator is hospitalizations. Review your hospitalizations over the last month and talk with staff closest to the residents. Did they see any subtle changes that could have served as early warning signs? Did that information get shared within the shift and with the clinical management team? Your 24-hour report may also provide examples of preventable declines where early information fell through the cracks.

> ***Before the huddles, we didn't know what was happening. We were at a loss. We would find out that the resident was going on a doctor's appointment at the last minute … then we were stressed because we had to rush to get the resident ready. Now we communicate. We share about the resident … if they are declining; who may need help … we talk about every resident … who had a bad day and any interventions that may have worked.***
>
> **— CNA, Washington Rehabilitation and Nursing Center, Chipley, FL**

When staff are consistently assigned and know their residents well, they can quickly share information about changes from the residents' baseline or concerns staff need to keep their eye on. However, if the organization does not yet have consistent assignment, huddles are even more essential so staff have the information they need to care for residents, and to work together as a team to do so.

2. Pilot

When staff are consistently assigned and know their residents well, they can quickly share information about changes from the residents' baseline or concerns staff need to keep their eye on. However, if the organization does not yet have consistent assignment, huddles are even more essential so staff have the information they need to care for residents, and to work together as a team to do so.

If you are just starting huddles, or would like to strengthen your existing huddles, it's always best to try it out with your strongest charge nurse and CNA team. Observe how the shift currently starts and ends, and ask staff what works and doesn't work for them now about how they share information. Tell them you have asked them to pilot test a stronger communication system and that you will work with them to help them get it going. Explain that as they learn what works, you will be able to use their experience and lessons in bringing this practice to the other units/neighborhoods and other shifts. ***The steps listed below are useful both for piloting and for organization-wide adoption.***

Explain why. Explain how they can use the huddle to hear and share pertinent information and how you will use the information to support them. Discuss why their good communication is so essential to the whole organization's ability to support their good care. Give examples of how their catching changes early and sharing them with the whole team can prevent a resident's decline or help a resident be more comfortable. Listen to their ideas and concerns about the huddles and help them figure out how to use their ideas to problem-solve their concerns.

Review what to cover. Explain what it means to report by exception, sharing information that is different from how a resident usually is. "By exception" means reporting only on situations that are different from the norm or that relate to an area of concern. For example, how someone ate today needs to be noted if they had less appetite than usual or if they were on a medication that affected their appetite and so how they are eating needs to be monitored. If they eat today as they normally eat and there are no areas of risk to be watched for related to their eating, then how well they eat would not need to be mentioned. You can use the *Stop and Watch* Early Warning Tool from www.Interact2.net to give examples of the type of information to share about residents who are "not themselves," such as not eating as they usually do, or less able to function without assistance. Use specific conditions to highlight *Stop and Watch* items. For example, if a resident has Congestive Heart Failure, knowing that they are sluggish, swelling, or experience shortness of breath can be an early warning sign that their condition is worsening. Talk about your desire to learn about residents' customary routines, so that for example, a resident who is up late at night and has a preferred night-time snack can get it.

Figure out the best times. Talk with the team about the best times during the shift to come together. Some teams prefer to get the information at the start of the shift so they are up-to-date right away. Others need to get some early care done in time for a meal before they can come

together. Some have the huddle mid-morning, before the first staff breaks. Closing out the shift with a huddle allows staff to report on any new developments. Many of the incubator homes had more than one huddle during the shift — starting and ending their work together, as well as having a brief check-in huddle mid shift. Emphasize the importance of timeliness, so that no one is waiting around for others.

Provide coverage. A frequent staff concern is that they don't have time to huddle or they don't feel comfortable leaving residents unstaffed. As they are getting used to the huddle, management offering to cover the call lights will assure staff that their residents are in good hands, and confirm that management fully supports their participation in the huddle. As huddling becomes their norm and they get good at it, they will also get better about getting work done to free up for the huddle. However, they might always need the assurance of coverage because they will not want to leave their residents' needs unmet.

Develop skills. Have a steady presence to support staff; they may need guidance as they strengthen their skills in running a huddle. Effective huddles involve skills that can improve over time. The key to good huddles is good facilitation by the huddle leader. In good facilitation, a leader keeps the discussion on point, makes sure to hear from everyone with something to contribute, and ensures that action steps are set in motion. If staff discuss something off topic, effective huddle leaders acknowledge the concern being raised and postpone its further discussion to preserve the huddle time for the huddle purpose. Huddle leaders work with participants outside of huddles to help them be better participants by developing their understanding of what information is useful and how to problem-solve constructively. You can interject during a huddle to point out why something being said is important, and to put it in the context of the resident's condition. Model this "just-in-time" teaching and problem-solving.

Debrief. After the huddle, review with the charge nurse what went well and talk about how to help the huddle improve over time. Affirm good skills and useful information. A good huddle is a reflection of good communication outside the huddle — if a charge nurse is not a good listener at a huddle, she may also not be a good listener the rest of the shift. Working with a charge nurse on her interpersonal and leadership skills will have an impact far beyond the huddle itself.

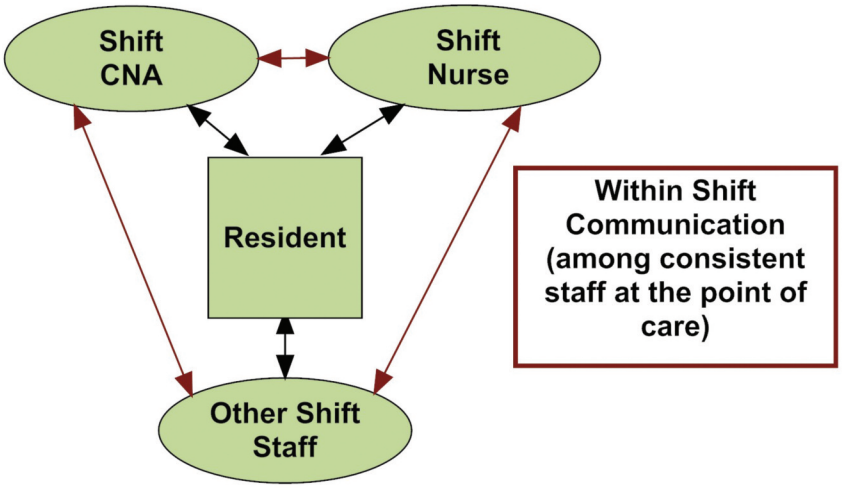
Spread. As huddles get solid in your pilot area, bring the charge nurses together to discuss implementing the huddles organization-wide. Emphasize the importance of continuity of care, and their vital role in passing information from shift-to-shift. Explore mechanisms for getting the information from huddles to the rest of the organization. Have other staff observe the huddle in the pilot area, and have staff who have piloted the huddle talk with their peers about its value and the how-to. Other departments such as food services and housekeeping can benefit from having their own huddles, and from attending the shift huddle. *See Appendix for an example of Signature HealthCare's tracking tool to monitor the spread of CNA participation in huddles in a home over time.*

Change is hard … it was difficult at first to get everyone together and on time … some looked at the huddles as extra work. Now the CNAs will say, "It's time to huddle." They really want to share what they know.

— Social Services Director, Washington Rehabilitation and Nursing Center, Chipley, FL

3. Make Sure Huddles are a Two-way Exchange

Huddle effectiveness is directly linked to how they are done: the greater the **exchange of critical thinking for coordinated action, and the greater the support by leadership**, the more effective huddles are. For nurses who are used to doing a report to each other, it will be new for them to share the report responsibilities with their CNAs. They are used to an informal shorthand in which they highlight clinical issues in an abbreviated way. It will take more time initially to explain what they are talking about to the CNAs. Remind them that, without the huddle, they take even more time because they have to find each CNA one by one and share pertinent information. At first, nurses may be most comfortable leading the report. Help them learn how to have an exchange of information with the CNAs they work with. When they share clinical issues, they can let CNAs know what to look for, and find out from CNAs what they are seeing. As nurses and CNAs get more familiar with this type of exchange, they may transition into CNAs starting the exchange. ***Who leads is not as important as the quality of the exchange.***



The incubator homes from Genesis HealthCare described the difference between report and huddles in their homes. "In a report, someone tells you something. In a huddle, someone listens." They advise that homes make a deliberate effort to ensure that shift report huddles are truly a conversation with all team members having an equal voice, and not just another name for a "traditional shift report" with the nurse as the only or primary speaker.

A huddle:

- Implies equal importance between the person sending and the person receiving the information
- Expects two-way communication
- Is more frequent than traditional shift report
- Can be called by anyone
- Happens close to the bedside
- Addresses urgent or emerging situations

4. Listen well

The key to good huddles is good listening by leaders. The more huddles are relied upon by leaders as the means for working well together for the best care to residents, the more staff closest to the residents will to live up to this responsibility. Staff at Grandview reported that they volunteer ideas now, and trust that what they have to offer will be used.

> ***When you take what the aides say and initiate it, they feel empowered. They feel more comfortable because you listened and included them in making decisions. The staff see us listening to them more, and that helps a lot.***
>
> **— Dietary Manager, Grandview Healthcare Center, St. Louis, MO**

CAUTION: For staff to engage in huddles, they must see that what they bring up is valued by being followed up on. If they bring up ideas or concerns and don't see them taken seriously, they will stop participating.

5. Teach

Recognize that critical thinking and collaborative problem-solving are skills that get better with practice and mentoring. Attend huddles run by people you supervise. Use the very situations you just observed to highlight strengths and talk through how to maximize critical thinking and constructive participation.

Teach critical thinking. To be successful, huddles have to be valuable to the participants. These are not rote reports. They are opportunities for thinking things through and problem-solving together to ensure the best care for each resident. Problem-solving together can involve any or all of these steps as staff work together to understand why something is happening, what to do about it, and whether the original plan needs any adjustment:

- identifying the concern
- exploring possible causes
- determining possible interventions

- trying the interventions/course of action
- evaluating the action taken

This is critical thinking, and quality improvement, in action.

The exchange also presents an opportunity for ***"just-in-time" teachable moments***. For example, if a CNA describes ways that a resident is not eating as she normally would, or needs more assistance than usual, have a dialogue in which the nurse asks probing questions that link to the resident's condition and areas of risk. It may be that a new medication is affecting the resident's appetite or that the lack of energy is an early sign of congestive heart failure. The nurse can explain the medical concerns and what to look for in monitoring the situation.

Critical thinking involves two central activities:
- identifying and challenging our assumptions
- exploring and imagining options and acting on them

Promote constructive engagement. Keep this a positive exchange of information needed to care for each resident. Develop staff's competency in constructive problem solving through interventions in the midst of the huddle to help people work well together. If staff slip into blame or negativity, refocus the discussion on constructive action that addresses the concerns raised. Keep on topic and redirect staff who digress by letting them know their point can be addressed later so that the group can return to the focus at hand. At the same time, create an open atmosphere for staff to interject information that you wouldn't have known to ask about but that is entirely pertinent to the discussion. Probe to generate critical thinking about the root causes of a situation and the most effective responses. Thank people for their contributions. Follow-up on issues raised so people know what happened, and to check in and see how interventions are working. Follow-up individually with staff who can benefit from some pointers about how to contribute to the huddle.

6. Support Staff by Using their Information

Huddles require consistent support and participation from leadership to be sustained. The most effective support leadership can provide is to act on information staff share in huddles and follow-up with staff so they know just how valuable their information is. When leaders rely on information from staff, and use huddles for "just-in-time" teaching in response to clinical and psychosocial issues raised, staff become increasingly motivated to share good information and increasingly skilled at the critical thinking that makes huddles so valuable. At Friendsview, CNAs report appreciating when management comes to meetings to inform them of what is going on in the home and what changes are coming, AND asking for their input. One example was a request for input on how and what to include for new CNA orientation.

7. Connect the Dots

Huddles are most effective when they do not occur in a vacuum — when they are linked to the formal systems of care planning and QI that guide daily care. Information shared in the huddle is valuable information to be shared with the rest of the organization so that the clinical management team knows about it quickly and can act on it.

> ***Information from the huddle is placed on the 24-hour report — then shared during "Stand Up" meeting, if applicable; and then the Clinical Meeting follows the Stand Up meeting and the 24-hour report is read and information is processed. There is follow-up to the CNAs during the huddle and they will continue to share throughout the shifts during huddles.***
>
> — DON, Washington Rehabilitation and Nursing Center, Chipley, FL

Daily shift huddles help staff incorporate critical thinking and collaborative problem solving into their daily practice, which will give them a road map for how to participate in care plan meetings and QI huddles. Continually connect the dots among these functions by making sure that information shared in huddles is brought to and used by QI committees and that care plans are updated accordingly.

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8. Evaluate

Huddles are a work in progress. If you currently use huddles, you can evaluate them by considering the degree to which they currently have two-way engagement versus a one-way transfer of information. Do staff problem-solve together? Do they add information that makes a difference in the approach to care?

KEYS TO SUCCESS

Any new practice needs consistent support and application to take hold. When practices add more benefit than burden, staff appreciate the benefits and become invested in continuing the practice. To maximize success so that staff experience huddles as "worth the effort," consider these four keys: Be Prompt, Prepared, Productive, and Provide coverage.

Be prompt. Staff are busy and have limited time. If they can count on huddles starting on time and being brief, they will get there on time so as not to miss the information sharing. If huddles routinely start late, staff will try to get one last responsibility completed before they come to the

huddle so that they are not the ones left waiting around for others, and then winding up behind in their work. Timeliness becomes a self-fulfilling dynamic because staff will come promptly for something they know will start and end on time. For as-needed, unscheduled huddles, give staff a short alert that a huddle will be occurring in a few minutes so they can finish up whatever they are involved in and join the group.

Be prepared. Huddles work best when staff come prepared, so that the time together is spent problem-solving and making a game plan. Expect staff to show up prepared with up-to-date individualized information about the residents on their assignment. It helps to include key up-to-date information on staff assignment sheets about residents' risks, functional abilities, changes in condition, and preferences. The more routinely information is shared with staff, the better they are able to catch key developments at the earliest stages and act on them promptly and effectively.

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Be productive: Huddles work best with a combination of rigor to cover key information efficiently and the flexibility to interject emerging crucial information. Keep discussions on point.

- Share information "**by exception**" — when someone is not their usual self. For example, if someone who usually has no trouble shaving himself one day is not able to do this, or just seems to need more help than usual or someone who usually eats well and on this day has less of an appetite.
- Share information on new residents as it is learned. The whole team needs to have information as quickly as possible to ensure that residents' needs are met.
- Focus on areas relevant to **current risks and opportunities**. For example, if a resident is at risk for congestive heart failure, remind each other of the signs such as shortness of breath or swelling. If someone is improving, reinforce the interventions necessary to support the progress.
- Use "**just-in-time**" teaching to explain what to look for and why. When staff bring up something they see, provide the context for why it is or isn't medically significant. For example, explain why shortness of breath is a danger sign and what it sounds like.
- **Close the loop** on timely issues, with follow-up information for concerns raised in previous huddles, and action to be taken as a result of any current concerns. For example, tell staff when they've had a good catch on the shortness of breath, and explain what's being done medically to treat the person.

Provide coverage: When staff can count on the huddles to be prompt and brief, they can usually get things in shape with their residents to break free for the few minutes a huddle takes. However, having someone not involved in the huddle available to respond to urgent needs from residents, allows staff to focus on the huddle discussion.

HOW-TO BY HUDDLE TYPE

Additional information about the why and how-to specific to the type of huddle is provided for the following:

- New Resident Huddles
- Shift Huddles
- Everyone Stands-Up Together Huddles

QI Closest to the Resident is discussed in Step 3 and covers

- Clinical Rounds
- 24-hour Report/Adverse Events Huddles for one resident or in response to one incident
- QAPI Performance Improvement Project Huddles

1. New Resident Huddle: A Good Place to Start

Why

If your organization doesn't have huddles in place, a good starting point is new resident huddles, for several reasons. One of the areas of greatest discomfort for staff is when they don't know anything about new residents and feel unprepared to provide a good caring welcome. Staff also struggle when they know that something needs to happen in order for them to provide this good care, but it's not something they can accomplish alone — for example that the bed doesn't fit, or the person needs a later schedule for therapy because their customary routine is to sleep late. Because of staff's urgency to know about and share about new residents, they will be very receptive to a huddle in order to take good care of new residents.

If your organization doesn't have huddles in place, a good starting point is new resident huddles, for several reasons.

Mistakes early in a resident's stay can have serious implications. You only get one chance to make a good first impression with a new resident and their family, and the earlier comprehensive information is shared with the whole team, the better the chance for good outcomes. When new residents and their families trust you, they will be more likely to forgive honest mistakes; when they have a rough disjointed start to their stay, they will be heightened in their vigilance and less able to take any new mistakes in stride.

Furthermore, getting things off to a bad start can set someone down a path of avoidable decline. After a few days in the hospital, many residents arrive in fragile condition. They may not have slept or eaten well. They need extra monitoring and quick response time. A newly arrived

resident without the proper equipment, medications, and treatments in place can take a bad turn quickly and end up back in the hospital, or too deconditioned to return home. When you have a short turnaround time for a short stay resident, you have only a minimal amount of time to get things right and keep to the timetable for expected recovery and return home. With greater emphasis on preventing avoidable declines, sharing and hearing key information early and often will help staff get new residents off to a good start. One home began huddling three times per shift for the first 48 hours for new residents coming in from the hospital and found that their re-hospitalizations decreased dramatically, as they were able to act quickly at the first signs of problems.

Ensuring good communication during a time of transition makes that transition go more smoothly. If you've ever had a resident or family member ask, "Don't you all talk with each other?" that's a good indication that they are experiencing your lack of communication. Transitions in care are a vulnerable time for residents and their families, as they face so much that is unfamiliar to them just as they are experiencing challenging medical and psycho-social circumstances. They need the added reassurance that they are in good hands, that staff are competent, working well together and sharing the information they need to provide good care.

New resident huddles allow staff who will be spending the most time with new residents, and having the greatest impact on their initial experience, to have as much information in advance of and upon arrival as possible. Through post-arrival huddles, staff are then able to share what they learn in those first hours with the rest of the team.

> ***Admissions gathers social and customary routines. She shares information with the ADON and then to the huddles. Everyone may learn something new to share … everyone just talks with each other.***
>
> **— DON, Washington Rehabilitation and Nursing Center, Chipley, FL**

How-to

When your admissions coordinator knows that someone has decided to come to your nursing home, have that individual, the administrator, director of nursing or nurse manager bring this information to the staff who work where the new resident's room will be. In addition to the CNAs and nurses, a new resident huddle can include housekeeping, social work, activities, clinical nurses, and therapy.

> ***We find out about their preferences. We have a book at the nurses' station. The information is in the book. That book is taken into the huddles and information about the new elder is shared.***
>
> **— DON, Signature Healthcare at the Courtyard, Marianna, FL**

Share any available information about the person's medical condition, including any areas of risk and what to watch out for; goals including progress or impediments; functional abilities;

equipment needs; the person's social history, including occupation, family situation, and customary routines and coordination with other departments to honor them.

Remember that HIPAA allows information to be shared with those who need it to provide care.

Update the staff through quick huddles as more information becomes available, including expected arrival time. It's actually better to call a few quick meetings to share new information rather than to wait until all the information is in hand, because it often isn't all available until after arrival and by then, staff haven't had any time to prepare. There's an understandable tendency to wait until everything is definite, but it's better to share what you know as you know it. Staff will appreciate being updated and would rather have a little information than none at all.

Highlight key areas of risk given the person's medical condition, and what to do if they see any indicators of a worsening condition. Given that **30% of re-hospitalizations occur for residents who have been in the nursing home for less than a week**, and that residents are in such a fragile state when they arrive from the hospital, it is crucial to catch the earliest signs of danger and intervene quickly. What impact could informed staff have on this rate of re-hospitalization? Use the Interact Care Path tools for specific symptoms of the resident's condition. Share the information as it is needed-for example, if a resident has Congestive Heart Failure, alert staff to watch for shortness of breath and swelling.

Encourage staff to have a quick huddle when a new person arrives, so that they can cover the responsibilities for the CNA who will be caring for the new person. Then this CNA can provide a warm welcome and spend some time assisting as the person arriving settles into the room.

Develop a short welcome process that allows the CNA to settle the person in and gather pertinent information for immediate care. Make sure that information is passed along to others, including the next shifts, and the other departments. Two key areas for information sharing are customary routines and functional abilities.

Customary Routines.

At Park Avenue Extended Care in Long Beach, New York, CNAs developed five questions they ask new residents while consistently assigned staff are helping them settle in during their first couple of hours:

1. How would you like to be addressed?
2. What time do you want to shower?
3. What time do you want to go to bed?
4. What time would you like to wake up?
5. What would make you comfortable?[1]

1. Park Avenue Extended Care, Long Beach, NY

They share this information in a quick huddle with co-workers, and in a communication book at their nursing station. **The nurse manager passes along any information needed by other disciplines** so that dietary, therapy, and other departments can ensure that residents' routines are honored. The activities staff coordinate with CNAs so that the information they get from residents during this welcome process is reflected in MDS Section F on Customary Routines.

Functional Abilities.
The first night is a time when residents are at increased risk for falling because they are in unfamiliar surroundings and in a weakened state from their acute condition and lack of good sleep. At Glenridge Living Communities in Augusta, Maine, CNAs observe residents' functional abilities during the course of their welcoming care. CNAs share their observations with nurses and other CNAs during the first evening and night. They make accommodations for safe mobility such as making sure the bed is at a good height, arranging furniture and lighting for a good path to the bathroom or putting in place a bedside commode. **They communicate what they learn and coordinate their efforts with therapy.**

Post-Arrival Check-in. As crucial as it is to share information with staff before a new person arrives, ***it is equally important to check in with staff afterwards***. Have a follow-up huddle the day after a resident's arrival to find out about anything needed for the resident's care. Discuss the resident's clinical condition including risks and warning signs, functional abilities and goals, customary routines and how to honor them, and any adjustments needed in equipment, supplies, and environment. Are grab bars needed? A late breakfast? A bigger bed? Learning this within the first 24 hours from staff closest to the residents gives your whole organization the opportunity to make needed adjustments immediately rather than have a problem fester and potentially cause bigger problems. ***Remember that staff will only share relevant information with you if they see that you follow-up on the issues they bring to you.***

2. Shift Huddle: Every Shift ~ Every Day

Why
Meeting together reinforces teamwork and allows everyone to hear about every resident. Staff routinely provide in-the-moment help to residents who are not on their assignment and therefore need to know up-to-date information about each resident. This level of communication, in which everyone is on the same page, allows all staff to know what they need to about each resident, so that residents are receiving cohesive, coordinated care.

How-to
The charge nurse or unit manager generally leads the huddle. Everyone needs to be prompt and ready to share and take notes. Gather where you can talk without being heard by non-staff. Consider using a white board or huddle sheet to capture what is shared and action needed.

Areas to Cover

Go resident-by-resident by exception, i.e., talk about each resident but only report information that is a change from base line. Focus on risks and goals. Review functional status, mood, and customary routines. For example for residents at risk for pressure ulcers, discuss anything unusual about how well they ate and drank, and any positioning needs. Discussing someone who has been depressed includes their interactions and participation in activities. When residents do not seem to be their usual selves that day, this is noted and discussed. **INTERACT's *Stop and Watch*** is an excellent tool for clinical areas to be covered (see Appendix page A-139).

Include: (consider putting a laminated index card with these categories on it in the report room as a "cheat sheet" to ensure inclusion)

- **New and "at risk" residents**, including people in the 24-hour report, residents being watched for issues such as wounds, falls, antipsychotic medications and distressed behaviors, weight, mood, any residents in the midst of a change in condition. For new residents, share any available information including social history, family information, medical needs, goals, areas of risk, customary routines and special needs.
- **Change in Condition** assessments or information about residents due for their annual or quarterly assessment and care plan meeting (in their **A**ssessment **R**eference **D**ate - ARD)
- **Transitions.** In a short-term unit, sharing timely information about people readying for discharge helps that transition go more smoothly. In all areas, when a resident dies, huddle is a time to mark the loss.
- **Reportable events, incidents, accidents.**
- **Family concerns and/or compliments.**
- **Follow-ups on any issues** raised for which the loop needs to be closed.
- **Any clinical area** that is being worked on or is the focus of a QAPI Performance Improvement Project (e.g., elimination of off-label antipsychotic use).
- **News from any department** requiring staff knowledge or coordination. Social Services can share transportation arrangements to doctor visits, recreation can prepare a list of items to purchase for the shopping trip, etc.
- **New employee** introduction and check-ins.

3. Everyone Stands Up Together: Closing the Communications Gap

Why

"**Everyone Stands Up Together,**" i.e., a huddle in which management meets with staff closest to the residents, **closes the communication gap that many homes experience**. The management team goes right to the staff working most closely with residents for the express purposes of inquiring what staff need so they can take care of and support residents and sharing information which will assist staff to do their work well. It supports teamwork throughout the organization by bringing those responsible for coordinating all aspects of service delivery right to the point of care.

It saves time. Many items typically covered in the management team's morning stand-up meeting — such as the 24-hour report, unusual occurrences/adverse events, and care areas such as falls and pressure ulcers — require conversation with CNAs and nurses to learn more about what happened, share information, and problem-solve. By having the discussion with the staff who work most directly with the residents and their situations, issues are able to be resolved in that one conversation, instead of the multi-step process of having the morning stand up meeting, then having the management team track down the CNAs and charge nurses involved, and then having to close the loop by communicating back to the others.

Everyone solves problems together. By having everyone meet together, the information shared is heard by those in a position to implement needed changes first hand. When all departments are included, interdepartmental solutions can be arranged on the spot. This way of meeting together routinely gives everyone a way to problem solve together. In this process, communication between departments and with the staff working most closely with residents becomes seamless.

Huddles build trust. By meeting together, the staff have a different relationship with those in management. CNAs and nurses can count on the regular communication and know that the issues they need help with will be addressed and resolved.

Other benefits include:

- Residents' care needs are better met
- Managers can hear about needed changes quickly and can act immediately
- Managers get first hand knowledge of the workload and workplace dynamics
- Teamwork is lived
- Different and better relationships with staff and between staff and management are built
- Care-planning can be done on the spot as needed

How-to:

Consider having the meetings at least two or three times a week, and traveling to each unit/neighborhood. Figure out with your staff what timing works for your home. Meetings on each unit/neighborhood should be completed in 10–15 minutes. (Initially your meetings will be a little longer because people will be a bit unfamiliar with the concept. Managers are not used to giving report in this manner, and those who are working directly with residents may not be sure what to bring up.) Bring it to all shifts by having the shift supervisor on off-shifts and on weekends do a similar check-in with each unit/neighborhood.

Find a **private space** on the unit/neighborhood where you can share resident information without concern about HIPAA. You may have a quiet space available or you may have to look for an empty resident room, space around the nurses' work area, or even the shower room!

Areas to Cover

Areas to include are also discussed in shift and as needed huddles and in management clinical meetings. Both management and staff closest to the resident have vital information to share

and have parts to play in preventing and resolving problems. Combining discussions saves time by ensuring that who has information can share it with everyone who needs it. By having the full picture, management and staff can anticipate and trouble-shoot to prevent problems, and can be nimble in addressing them when they do come up.

- **Check-in with staff.** This should always be the first item on the agenda. Find out how their day is going and if there is anything they need. Update them on things you're working on for them. Help them trouble-shoot. For example, if everyone is waiting for a sit to stand machine to be fixed, let staff know the status. Figure out together the high labor times of day when management can lend a hand with residents who require two people to assist them if the lift is unavailable. 15 minutes of management time could well prevent a fall or injury. The check-in keeps management's finger on the pulse and helps staff when they need it most.

- **Residents at risk.** Discuss the 24-hour report, residents in fragile situations who need a close eye for any indicators of an acute onset, and any residents with clinical concerns such as wounds, nutrition, weights, falls, medications, and pressure ulcers. Develop a watch list that is added to by staff closest to the resident. They will see the early indicators of arising acute conditions. A resident who shows slight signs of confusion is likely having an acute episode. As it unfolds more signs will appear — loss of appetite, strength and focus. By having the clinical team and the staff closest to the resident meet together, the clinical team gets an early alert and is able to get vitals and order labs stat. Early action prevents a situation from escalating into a hospitalization.

- **New Residents coming in.** Let staff know about new residents, including their social history, care needs, functional abilities, family, and customary routines. Staff will be able to share their thoughts about the best room arrangements, help prepare residents for in-coming roommates, and prepare for a good welcome. While the clinical team may not complete their assessment until the next day, staff closest to the new resident will be interacting as they help the resident and family settle in. They will be observing as they provide care and support, learning the person's routines, mood, and functional abilities. Management and staff can discuss how the first night went, routines and preferences, care needs and abilities, how well the transition went, and any information about or from the family.

- **Residents hospitalized or going home.** Management and staff will need to share information about how residents who expect to return home are progressing, and what needs to be accomplished for a successful transition. Staff providing daily care and support will have the most up-to-date information on their needs and abilities, and the management team can share up to date information on planning for the transition. Management can also let staff know how residents who have been hospitalized are faring and what to expect upon return. On return, management and staff then discuss what to keep an eye on and what is needed. Everyone is then kept informed and can trouble-shoot any issues that are barriers to a discharge home or a return to the nursing home.

- **Residents in their ARD Window.** Let staff know whose care plan meetings are coming up and when, so they can have input and/or attend. Management can check in on residents who are coming up for their quarterly assessment and care plan meeting and share about any areas that have been or should be focused on.

- **Quality Assurance & Performance Improvement.** Have a quick review of dashboard data for the whole organization and for the residents in the area where you are meeting. Note and celebrate improvements and talk through any areas of concern. Discuss any relevant performance improvement projects to see how they are going and what help is needed. In areas of focus share big picture updates with staff and check in on how it's going from their perspective.

- **Just in time teaching.** Use this for a quick in-service on a pertinent topic, either being worked on building wide or as an area of focus in this unit/neighborhood. Focus on the watch list and talk through for any residents with concerns some of the key indicators for staff. For example, if a resident is at-risk of congestive heart failure, remind staff that a slight fluid retention is a sign of heart failure so they will need to look for any swelling and watch for weight gains.

Here are some factors to use in evaluating huddles:

Outcomes:

1. Do leaders turn to huddles to share information and problem-solve together?
2. Are huddles helpful in improving outcomes for residents?
3. Is timely information shared about early warning signs of changes in condition?
4. Are interventions identified that are successfully implemented?
5. Is information integrated into care plan and QI activities?
6. Do CNAs know areas of risk to watch out for?
7. Do CNAs know residents' customary routines?
8. Are CNAs supported by other departments so they are able to honor these routines?

Process:

1. Do huddles start on time?
2. Are they brief?
3. Do CNAs and nurses attend? Do other staff attend?
4. Is there a two-way exchange of information and ideas?
5. Do they include just-in-time teaching?
6. Do they include action steps?
7. Does the organization use information about residents gleaned from the huddles to shape daily care and to accommodate residents' customary routines?
8. Is information from the huddles integrated into the care plan, CNA's assignment sheets, and other key documentation?

Value:

1. Do CNAs find them valuable, and why or why not?
2. Do nurses find them valuable, and why or why not?
3. Does management find them valuable, and why or why not?
4. Do other departments find them valuable, and why or why not?

Value:

1. *Do CNAs find them valuable, and why or why not?*
2. *Do nurses find them valuable, and why or why not?*
3. *Does management find them valuable, and why or why not?*
4. *Do other departments find them valuable, and why or why not?*

CLOSING

The most important work of a nursing home occurs at the point of care. When staff closest to the resident work well together, residents experience the best your nursing home has to offer. Huddles are a system that gives these staff regular times to check in, share information, and problem solve together. These huddles are then a source of the essential information your entire organization needs to support the staff who provide care. When staff can share what they know and be supported by the organization to act on it, your nursing home can catch problems early, intervene effectively, and provide round-the-clock continuous high quality individualized care.

RESOURCES

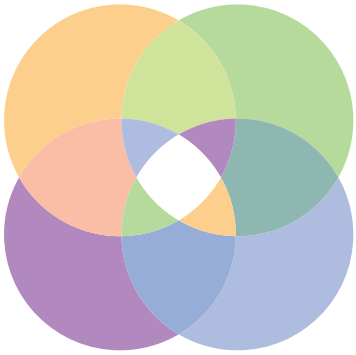
www.pioneernetwork.net
Pioneer Network's website provides links to many organizations with resources for implementing consistent assignment, including a free Starter Toolkit for Engaging Staff in Individualizing Care (https://www.pioneernetwork.net/resource-library/resource-libraryengaging-staff-individualizing-care), and, for purchase, a set of the Pioneer Network National Learning Collaborative Webinars used by the incubator homes entitled Engaging Staff in Individualizing Care Five Part Webinar Series (https://www.pioneernetwork.net/product/engaging-staff-individualizing-care)

www.pathway-interact.com
INTERACT *Stop and Watch*, a nursing home communication tool, can be a guide to staff on information to share in huddles. (https://pathway-interact.com/wp-content/uploads/2018/09/INTERACT-Stop-and-Watch-v4_0-June2018_June-2018.pdf)

www.BandFConsultingInc.com
This website includes a video on QI Huddles Closest to the Resident and other resources for quality improvement.

STEP TWO Shift Huddles Video Clips

Clip 1: One Team's Story of Starting to Huddle Together and the Benefits They Found in Huddling Together
Clip 2: The How of Inter-Shift Huddles
Clip 3: Report by Exception Saves Time and Focuses where Staff's Critical Thinking is Needed
Clip 4: Interdisciplinary Team Participation in Huddle
Clip 5: Huddle for New Residents
Clip 6: Daily Management Stand Up with Staff
Clip 7: Hall Partners – Continuous Communication
Clip 8: Facilitation Tips for Promoting Constructive Engagement
Clip 9: How to Have Everyone Be There On Time
Clip 10: Mentors Teach New Employees about Shift Huddles
Clip 11: Shift Huddle Engages and Empowers Staff



Engaging Staff in Individualizing Care

An Implementation Handbook

STEP 3

QI Closest to the Residents

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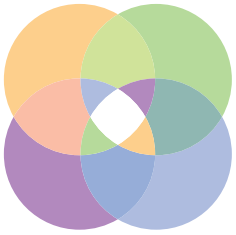


Engaging Staff in Individualizing Care

An Implementation Handbook

STEP THREE
QI Closest to the Residents:
Engineering Staff Engagement in Performance Improvement

STEP THREE QI Closest to the Residents Video Clips

Clip 1: CNAs Identify Problems and Join in Finding Solutions
Clip 2: Take QA for Adverse Events Out of the Conference Room to the Staff Closest to the Residents
Clip 3: Huddle to Promote Well-Being with Staff Closest to the Residents
Clip 4: QAPI with Staff Closest to the Residents
Clip 5: Working Together When A Resident Needs Everyone's Help
Clip 6: Make Decisions With Staff

WHAT IT IS:

QI closest to the residents makes the point of care delivery the hub for prevention and improvement efforts. It is a recognition that there are vital information and ideas that can only be obtained by direct communication with those involved and by locating the discussion at the scene of the action. QI closest to the residents means moving meetings traditionally held in the conference room out to where residents live in order to involve the staff who know residents best, and whenever possible, the residents themselves, to visually observe the situation and environment in question. It engages the staff who will be implementing interventions in finding workable solutions to prevent avoidable adverse events and promote good outcomes. These are "as needed" huddles that focus deeply on one person or situation or area of concern, more so than in routine daily shift huddles. They can be used to investigate a fall, prevent distressed behaviors, or work on a performance improvement project.

QI closest to the resident includes:

- **Adverse Events Investigations** in response to an incident or series of incidents, or for a resident who is at high risk

- **Progress Reports** to attain or maintain positive outcomes and improvements
- **24-hour Report Huddles to closely monitor residents who are on a "watch" list**
- **Clinical Rounds** of committees such as weights, wounds, antipsychotics
- **QAPI** (Quality Assurance & Performance Improvement) huddles that bring the team guiding a Performance Improvement Project (PIP) together with the staff caring for the residents whose situations are being addressed

WHY IT IS IMPORTANT:

In every interaction staff have with residents, their decisions and actions shape the quality of residents' experiences and the quality of their care. ***The further away organizational oversight and support is from this point of service, the less able it is to positively influence these daily dynamics.*** Caring staff work hard to do the best they can for their residents, and often they have to work around systems that unintentionally make it harder for them to do so, or they are asked to implement interventions that miss the mark, and then have to try to lessen the negative impact on residents.

The process for bathing is a good example — if residents are distressed during their shower, it is far more likely that the distress is caused by the system for bathing than by poorly performing staff. A bathing system that residents are distressed by takes a physical and emotional toll on both residents and staff. Staff are likely doing everything they can to lessen the distress residents are experiencing. When factors beyond the staff's control contribute to residents' distress during bathing, the rest of the clinical and operational team can help by retooling the systems that make it such a difficult experience. QI closest to the residents brings the team of clinical and operational leads to the bedside to support the staff to bring about the best results for residents.

Quality improvement's purpose is to identify the ***true systemic root causes*** of problems and then to implement interventions that improve these systems so staff ***can*** deliver the best care. In quality improvement work, it is expected that faulty systems, rather than faulty performance by people, are usually at the root of poor outcomes. The people who know best how the systems work are the people who work with them every day. A good idea on paper may not work out so well in daily practice. It may create more problems than it fixes. It takes far more work to try to implement interventions that are off the mark and burdensome than to implement interventions that have an immediate benefit and are easy to do. ***Everyone benefits from on-point interventions, and it takes everyone's contribution to figure them out and put them into action.***

Quality assurance and performance improvement look both back and forward, looking back to understand why something happened, the systemic causes, and looking forward to see what can be done to redesign these systems so they support better outcomes. The staff most involved

in the bathing experience will have details and insights that are needed to create a better bathing system. By being part of identifying problems and solutions, they will have trust that the interventions will, for the most part, work, and that they will be able to make continual improvements to the process as they go along. Best practice is to involve staff closest to the resident in root cause analysis and development of interventions in daily review of adverse events, focused oversight on key clinical areas, and performance improvement initiatives.

Involve staff closest to the resident in root cause analysis and development of interventions in daily review of adverse events, focused oversight on key clinical areas, and performance improvement initiatives.

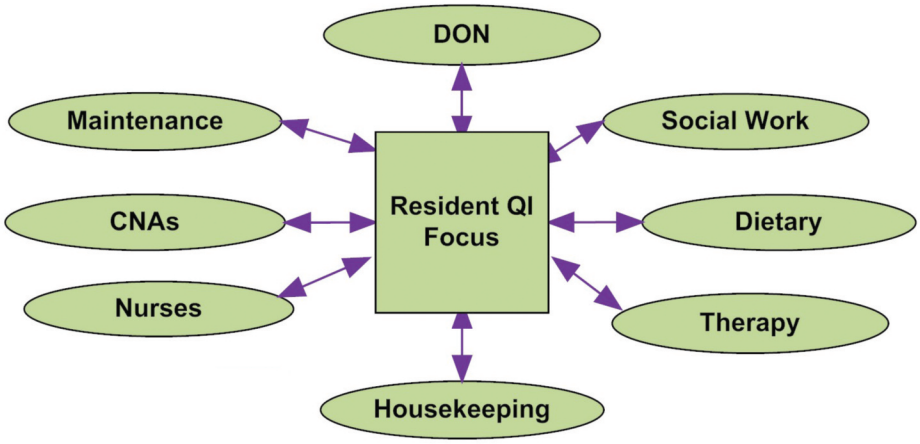
Encourages critical thinking. Engaging staff closest to the residents in QI grounds the deliberations of clinical and operations departments' heads in the reality of day-to-day dynamics. It activates critical thinking throughout the chain of care delivery. Critical thinking can be snuffed out as soon as it isn't listened to; for example, if the CNA is directed to get the bath done after reporting the resident's distress. It thrives when the organization's deliberative processes are anchored in staff's analytical examination, insightful determinations of root causes, and precisely honed interventions. In the case of bathing, staff would likely know exactly what makes a resident uncomfortable, and could, through trial and error, quickly identify a number of small changes to the bathing system that would alleviate the resident's distress. If other departments support CNAs in making these adaptations, they will likely continue to come forward with more good ideas. This is a change from "we have a policy and a procedure for everything." By working together and exploring options, starting with finding out the resident's customary routines, staff can provide a bathing experience that alleviates a resident's distress instead of causing it.

Decreases cycle time. Most preventable adverse events occur because of delays in necessary care. The delay in care usually occurs because early indicators were not recognized or communicated or acted on soon enough. In frail elders, very slight changes in mood, appetite, stamina, or focus are often indicators of an acute event unfolding. Their frail constitution means that they are highly vulnerable as an acute situation ensues. Acting quickly saves lives. A resident who is more confused than usual may be experiencing an infection, or congestive heart failure, or pneumonia, that, left untreated for even a day, can have severe consequences. ***Cycle time is the time it takes for information about subtle indicators of an acute development to get from the point of care to being acted on.*** When it takes too long for timely information about residents' conditions and needs to be shared and acted on, declines that could have been avoided if the information had been acted on sooner are considered preventable. If the 24-hour report is filled with adverse events, your cycle time isn't getting you information quickly enough to prevent these occurrences. A direct pipeline to the point of service quickens cycle time. QI huddles with staff activate their awareness of what to look for and what to report to prevent adverse events.

CNAs identify when 'something's different,' such as someone is leaning in their wheelchair.

— Nurse Practitioner, Health Central Park, Winter Garden, FL

Saves time. When a clinical team meets in the conference room to review an adverse event or oversee an area of clinical concern, a good deal of time is spent beforehand and afterwards going to the staff involved to gather information and then getting it to everyone else who needs it. Bringing QI discussions to the point of care gets more done in less time than conference room meetings. Staff who consistently care for residents have the information about their current circumstances, progress, and responses to prior interventions for which the clinical team needs to determine the root cause and design effective interventions. Clinical management of residents' care depends on the quality of care delivered by staff working with residents every day. Staff see the subtle changes in the day-to-day that might not even be on the radar screen of clinicians.



Resident-Staff, Within Shift and Between Shift Knowledge is Shared and Utilized for Quality Improvement

Improves solutions. Nursing homes have many oversight committees related to key quality measures (i.e. weights/nutrition, wounds/skin care, "behaviors"/antipsychotics). These weekly or monthly conference room meetings also require time beforehand and afterwards that can easily be saved by having the team of clinicians round and discuss residents of concern directly with the staff caring for them. The "behaviors" committee might review concerns related to residents who reject showers. When clinicians combine their expertise with the deep knowledge that staff closest to the resident have, together they can arrive at interventions that have the best chance of success. Taking that meeting on rounds and asking staff who give the shower what happens and why, and what can make it better, will produce a far more workable solution than can ever be devised in the vacuum of the conference room.

At one incubator home's shift huddle with the evening staff, the charge nurse shared information from nursing management about one resident who had a pressure ulcer. The instructions were to get the

resident off her backside to relieve the pressure, by having her lie down after lunch. The CNAs shared that she wouldn't want to lie down after lunch because her favorite program was on TV. In a quick problem-solving among CNAs and the nurse, they figured out a way to cushion her favorite chair to relieve the pressure. Achieving quality outcomes requires knowing each resident as an individual.

Speeds implementation. Prevention requires nimbleness, an ability to make quick little adjustments to do what's needed, based on what staff know about each resident's unique customary routines and preferences. QI in the conference room is cumbersome because it lacks the timely, accurate information that staff closest to the resident have. When QI meetings occur at the point of care, solutions can be determined on the spot, incorporated into the care plan and assignment sheets, and put into action, all in one meeting.

> ***I observe the CNAs exchanging lots of information … things that they "pick up" on an elder … changes, potential concerns, early detection … we get that kind of information quicker. The communication goes full circle from the huddles to the nurses to the 24-hour report to the clinical meeting and then it returns to the huddle. The CNAs are empowered. They feel that what they have to say is valued.***
>
> **— Quality of Life Director, Washington Rehabilitation and Nursing Center, Chipley, FL**

Huddles for specific adverse events or areas of risk, clinical rounds, and QAPI/PIP huddles during pilot tests provide a mechanism for the clinical team and the staff that know individual residents best to partner in piecing together the best approach so that interventions are tailor-made to each individual resident. When the people who will implement the intervention are thinking it through directly with clinicians, the staff will have faith in and commitment to the intervention.

HOW TO DO IT:

1. Start with consistent assignment and shift huddles

Staff will have more to contribute if they are consistently assigned and therefore know their residents very well. They will be better at contributing if they are used to huddling daily. They will have the whole picture in mind if they are also participants in the care plan process and have the information about risks and goals on their assignment cards. These practices are mutually reinforcing, so in turn, staff will be increasingly better contributors in daily huddles and care plan meetings as they partner in on-going and event specific quality improvement huddles.

> ***Now we communicate. We share about the resident … if they are declining; who may need help … we talk about every resident … who had a bad day and any interventions that may have worked.***
>
> **— CNA, Washington Rehabilitation and Nursing Center, Chipley, FL**

2. Assess your current cycle time

How long does it currently take for essential information to get from the point of care to those empowered to act on the information? For a clinical area such as hospitalizations or falls, look back over all the adverse events of the previous month to find out how many days before an adverse event staff saw early warning signs and how long it took for that information to be acted on. Look at other areas, such as how long it takes to learn about equipment that isn't working or is needed. Consider the flow of information to the staff closest to the resident, too — How often are appointments, doctors' orders, labs, or therapeutic interventions missed or found out about at the last minute causing staff to scramble?

3. Map your current process

Use the quality improvement practice of mapping the current process. Map the process for how timely information is shared with staff closest to the resident, and how their information is shared with the rest of the team. How many people does the information need to go through over what period of time? What's your cycle time for getting information from the point of care to acting on it? For example, when a consistently assigned CNA (at the point of care) notices that a resident does well eating certain finger foods, what are the mechanisms for sharing this information so that it gets to the people who can ensure that those foods are available? Is it something that would only get passed along if the CNA went out of her way to seek out the food services director to share the information? If that's the case, how often will that information not be passed along? Identify the most direct path for the information that's currently missed to be shared reliably. Consider how quickly it could be acted on if the dietary department had a regular presence in routine huddles. Even if the dietary representative was not in the huddle on the day that this information was gleaned, the relationships that develop over time when there is a regular presence allow for a quick catch up of this good information.

> ***The team process resulted in significant improved relationships between dietary staff and nursing. We went from an "us and them" to a "we" team description.***
>
> **— Dietary Manager, Friendsview Retirement Community, Newburg, OR**

4. Reconsider every meeting

For every discussion you have in a conference room, consider whether it would be more productive to have the discussion directly with those involved. Typically, when a problem is noted, the intervention is to in-service the staff, create a new form, and audit regularly. This rote approach assumes that the problem is that staff do not know what to do or need to be monitored to do it correctly. Bringing QI closest to the resident isn't just moving the location of a meeting. It's changing the nature of the deliberations. It asks staff what is happening, inquires about systemic factors contributing to the problem, and involves staff in identifying real time solutions. If you change the venue, you will also have to change the way the meeting is conducted. You may need to use "just-in-time" teaching to explain some of the factors that staff need to know to contribute effectively. You'll want to hear detailed information from staff and it may take practice for them to be able to provide it.

For every discussion you have in a conference room, consider whether it would be more productive to have the discussion directly with those involved.

At one nursing home the QA nurse was frustrated by her lack of success in improving the use of assistive devices. When she audited, she repeatedly found a high percentage of assistive devices unused, sometimes even in the wrong resident's room. She had in-serviced the staff, created forms, and conducted audits, all without changing outcomes. Finally she took her efforts out of the conference room and met with CNAs and nurses to ask for their ideas. She led staff through mapping the current process and discovered that CNAs and nurses weren't notified that the device had been ordered or delivered, and weren't told by therapy who and what the device was for. No wonder the devices sat unopened, unused, or in the wrong rooms. Together they mapped out a new process through which therapy copied them on orders, and purchasing kept both therapy and unit/neighborhood staff informed about a device's arrival. When it did arrive, therapy met with the consistently assigned CNAs as they trialed the new device with the resident, so that everyone could learn how to use it and see if it worked.

To promote staff participation, prompt people and ask probing questions. Stay with it and keep enhancing staff's problem-solving competence. Use questions such as:

- What are possible causes?
- What causes can you do something about?
- What's the easiest to change that will have a big impact?
- What help do you need?
- How will you know it worked?
- Who do you need to be involved?

5. Teach QI skills

Root cause analysis, process mapping, and pilot testing are skills that get better with practice. Formal QI tools, such as a fishbone diagram (see Appendix), are meant to help expand thinking to consider causes that may not be obvious. They help people step back and look at what is

happening with new eyes. Staff can get so used to work-arounds that they need the opportunity to step back and analyze a situation in order to be able to identify barriers and interventions.

At one home, the Falls Committee saw that a large number of falls were occurring for residents who were supposed to be assisted with a lift but the lifts weren't being used. They held a root cause huddle with staff and learned that the staff would go to use the machines and find they weren't working. Asking why and drilling down, they learned that the batteries were often used up or not even in the machines. They process mapped the charging experience and learned that the place set up to charge the batteries was far away from where the lifts were used. The staff also identified that they couldn't tell which battery went with which machine. When staff went for a lift and it didn't work or the battery wasn't in, they couldn't take the time to track down the battery because they had a resident waiting for assistance. Once they were done helping one resident, they were on to the next, with no time to try to sort out which battery to use or get it charged. The staff piloted tested numbering the batteries with the machines and worked with maintenance to find a more convenient spot for charging. This helped somewhat. In their next pilot test, staff worked out timing for charging batteries so that lifts were always available, even as some were being charged. They created a log sheet to keep track and found the right place to keep the log sheet by the new charging station. Sure enough, falls for residents requiring the lifts were eliminated.

Involve staff in identifying both root causes and effective interventions. They will happily pilot test solutions that help them take better care of residents. See *Appendix for a Lutheran Senior Services example of a Team Member In-Service Sheet where all team members and recommended interventions in QI huddles are recorded.*

6. Anticipate and prevent

Often adverse events seem random until staff know what to look for. With distressed behaviors, for example, teach the ABCs — Antecedent, Behavior, Consequence — so that staff start to see patterns such as the impact of loud noises or commotions, and start to see early indicators of a resident's distress before it becomes full blown. Staff at incubator homes became better at anticipating residents' needs and then preventing negative occurrences.

7. Create a safe environment for true sharing

Remember that most problems are caused by systems, not people. Be welcoming of new ideas. Use what people suggest. Appreciate divergent viewpoints and make it safe for staff to question an existing process and to let you know how that process doesn't work. Routinely seek participation when making decisions so that when you call a quick huddle to discuss a care issue, staff are very comfortable jumping in. Thank people for their contributions. Follow-up on issues raised so people know what happened, and to check in and see how interventions are working.

Jim Collins, in his book *Good to Great*, cites four practices in companies that made the leap to great, for creating a climate where the staff's truths can be heard:

- Lead with questions, not answers
- Engage in dialogue and debate, not coercion
- Conduct autopsies without blame
- Build in "red flag" mechanisms

> ***It wasn't easy for me to talk in that meeting at first but it's getting easier and I hear lots of personal things about residents that helps me to know them better.***
>
> **— Dietary Manager, Cornerstone Care Option, Portland, OR**

8. Ask and deliver

Always ask what staff need from you **and always follow-through**. When you have followed through, close the loop by directly saying to staff exactly what you have done. Often leaders hold back from telling staff what they've done, and instead quietly go about following up. This is not "bragging" about what you have done, it is information sharing that "closes the loop." It is important to let staff know that they were heard, and that action was taken directly as a result of their identifying a need. Closing the loop in this way encourages staff to continue to offer their ideas, because they know they will be heard and that sharing what they know will make a difference.

9. Cover call lights

During these quick huddles, enlist help from others not involved in the discussion to meet residents' needs and free up the staff.

10. Continually improve

Staff's engagement in the QI process gets better with practice. Some staff will immediately feel more comfortable jumping in while others will need more encouragement. At the end of each QI discussion, do a quick debrief on what was helpful and thank people for their participation. Continually talk with staff about the connections between their interventions and residents' outcomes. Share data on results, and celebrate "wins" where adverse events are caught early or prevented altogether. Draw on staff's experience as they face the next challenge.

1. How-To: Adverse Events Huddle
Go to the Scene

Adverse Events Huddles need to happen as quickly after an event as possible, so that as soon as staff take care of the resident, they can reconstruct what happened while it is still fresh. Often it is very useful to include the resident in the discussion, so that, for example, if a resident fell, she can say what she was trying to do when she fell. Knowing directly from a resident what she was trying to do can point staff to easy solutions. A resident who fell reaching for clothing in her closet could be helped by lowering the rod so that clothes are more easily within reach. A resident who fell on his way to the bathroom may need more assistive equipment such as lighting, bars, and color differentiation. Going to the scene provides vital information that cannot be found in the conference room or in the adverse event write-up.

Give staff lead-time to finish what they are doing so they can join in a huddle. Include staff from all departments who were present.

Provide an overview of the reason for the gathering and an update on how the resident is doing and any new clinical information. Ask staff who were involved or have pertinent information to share what they know.

There are many ways to discover root causes and contributing factors. Consider creating a time-line with contributing factors to piece together what occurred and identify potential root causes. Use the Five Whys (see Appendix) approach in which you keep probing with staff about why something happened until you get to the root cause. You do not have to use formal QI tools — adapt the processes to the situation. If you are creating a time-line, keep asking for details about what happened until the sequence of events is clear. Then help the staff look for any factors that contributed to the occurrence as well as any early indicators, such as seeing a resident's increasing agitation. Avoid blaming — remember that the root cause of most errors is a systems failure. Generate ideas about preventive strategies. Use a white board or some other visual means for capturing the discussion and ideas. Conclude with action steps, assigned responsibilities, and time frames. See Appendix for ACTS Retirement-Life Communities' example of a Fall Huddle Investigation Worksheet.

> ***Mostly they seem to have given the CNAs permission to posit various ideas for addressing the behaviors based on that resident's background and routines, given those ideas a try, and tried again if they didn't work.***
>
> **— Development Coordinator, Good Samaritan Society, Corsica, SD**

As information is shared and action determined, get it into the care plan and update assignment sheets.

2. How-To: Progress Report Huddle
Go to the Source

Progress Report Huddles are very quick check-ins at a convenient or pertinent time. They can be used when staff are focused on one resident or on an area of improvement. If staff are trialing an intervention they can have a quick huddle during or right after its use to make any adjustments. For example, if staff are introducing an iPod to a resident they will want to keep a close eye on how the person is responding. If staff are exploring finger foods for a resident with dementia who is distressed by sitting at the table to eat and more comfortable walking around with food, they can debrief quickly after a meal to compare notes.

Often as staff explore the benefits for one person, they see others who might also benefit and can trial with them as well. This naturally leads to process changes as staff get better at operationalizing their intervention. For example, if a number of residents use iPods, they'll need to be labeled, charged, updated, stored, sanitized, etc. Progress Report Huddles can also pass along operational tips so that they are consistently practiced.

Checking in with each other allows staff working across departments to identify and make needed adjustments quickly so that any roadblocks or barriers are quickly addressed without staff having to have the extra burden of workarounds. If finger foods are to be part of the routine for some residents, nursing and food service staff will work together to make this happen.

These meetings work best when they are quick and timely. They don't need to be more than a minute or two, and are best done right on-the-spot when it's fresh on everyone's minds.

Use a quick format. Consider a go-round so that each person can offer any concerns or ideas or confirm that everything was fine. Then take a quick look at any issues identified to see if there is a quick fix or need for a longer discussion. For example, if it's time to change up the music on someone's iPod, figure out who'll do it. This keeps everyone up to date and shares the load.

Some items that need longer discussion may need to be addressed quickly. They may be able to be included in the shift huddle, or they may need a time of their own. For example, noticing increased distress for a resident during meals may require everyone observing and a little trial and error. Knowing the flow of work, find the next best time to get together before the end of the day, or by early in the following day to compare notes and figure out a game plan.

Others may be bigger still. Trialing an open breakfast time could require a regular check in with enough time to think about the best ways to take it forward. A time can be set aside weekly for a deeper review while the quick check-ins are happening every day.

Include others whose help and ideas may be needed. If other departments have a role, this allows you to get them to the meeting as well.

3. How-To: 24-hour Report Huddle Who's at Risk?

The 24-hour Report Huddle is a two-way exchange in which clinical leadership brings issues to the staff closest to the residents and they in turn bring issues forward that need clinical management. Use these huddles to discuss "at risk" residents to prevent adverse events as well as adverse events that have already occurred. These huddles can shorten the cycle time for quicker recognition of and response to early indicators of acute conditions.

Make these action-oriented meetings. Focus on areas of active concern where timely, up-to-date information and problem solving is necessary. Clinical and operations leads and staff closest to the resident share perspectives about what is happening, why, and what can be done about it.

For residents who've experienced a concern in the last 24 hours, learn more from staff about what happened and why. For adverse events that were huddled on very soon after they occurred, update staff on any progress and get their feedback on how residents are doing and whether proposed interventions seem workable. For adverse events not requiring an immediate huddle, review them during this 24-hour report huddle. Problem-solve. A resident who has a pressure ulcer may need more protein and more pressure-relieving padding or more frequent repositioning. Talk through how staff will do this, what barriers they see, and what they need. A resident with a fever may need more frequent hydration. Staff will need to know what is being done by nursing and other clinicians as well as what they can do to help.

For at-risk residents on your watch list, review with staff what their conditions are and what indicators to keep watch for (i.e. watch for shortness of breath, swelling, or lethargy in residents at risk for Congestive Heart Failure). Explain what these indicators mean. The more staff understand about why, the more attentive they will be. Use the *Stop and Watch* tool by Interact (see Appendix) to highlight key areas to be watchful for. Make a game plan for how to be notified if any indicators are present, and share tips on immediate steps staff can take.

For residents newly admitted from the hospital, this meeting will be a time to gather more information from staff who have been settling them in, as well as to highlight any new information gathered from the clinical team during the admission and assessment process. Compare notes between what is on paper and what residents' actual situation is. Often, for example, residents' real abilities to transfer, stand, walk, or provide self-care are different from what the written record says. While the interdisciplinary team will be conducting its assessment during the initial days, the staff closest to the resident will already have had many hours providing initial care. This is also a time to share any information about the resident's social history and network, and customary routines. Work with the staff caring for the resident to make any needed adjustments to daily routines or care plans. ***Ask staff what they are seeing.*** Staff will have real-time information about residents' conditions, and since the time of transition especially right after a hospitalization is one of heightened vulnerability, any indicators of concern need to be acted on quickly.

4. How-To: Clinical Rounds Huddle Accelerating Improvement

Rounds accomplish what regular clinical meetings are tasked to do — focus in on residents at risk in specific clinical areas. Be consistent about rounds so staff can prepare their questions and arrange their time to be able to participate. If staff are discussing areas of risk in their daily huddles, it will be easy for them to participate in clinical rounds. They'll have the information from the other shifts to share in the rounds, and then pass along any new information or approaches to the next shift.

Find a private place to huddle and arrange for someone to cover the call lights so staff are free to focus.

Start by asking for an update from the staff caring for each resident under review. Provide specific guidance on what type of information is helpful and why, in the context of the person's current clinical situation, overall prognosis, and goals. Brainstorm to understand any underlying causes contributing to risks or declines and potential approaches to trial to address them. Come up with an action plan, including who will do what by when, with what goals, and when the group will reconvene to follow-up.

Frequent, timely check-ins makes a big difference. Often interventions provide new information and require mid-course adjustments. Very rarely does reality match exactly what is planned. Staff need to improvise and learn a lot from doing so.

At Genesis HealthCare incubator homes, staff have Clinical Rounds to talk about situations in which residents have had distressed behaviors. The purpose of their clinical rounds on residents' distressed behaviors is to promote non-pharmacologic approaches by understanding the meaning behind the resident's actions. At the huddles, staff talk about the circumstances, using these questions as a guide:

At time of occurrence:

- *Why is this happening?*
- *What is the meaning behind the behavior?*
- *What is the unmet need?*
- *What is this person trying to tell me?*

5. How-To: QAPI PIP Huddle Improving Performance

QAPI (Quality Assurance & Performance Improvement) Huddles are quick check-in huddles during pilot tests of interventions in a Performance Improvement Project (PIP). Staff closest to the residents whose care is being addressed meet with those guiding the pilot of interventions to share observations and determine next steps. **PIP Huddles** can occur as often as daily or on each shift during an active pilot test, for 5–15 minutes, depending on the number of residents and complexity of the intervention. These huddles need to be held at a time and in a way that is easiest for staff to participate.

Meet with the staff in the area where the pilot test will occur to discuss the reasons why and the how-to of the intervention. When staff see the benefits for residents, they will want to do whatever they can for residents to have a good experience. They will likely have concerns that will need to be kept front and center as the trial process goes forward.

Whatever area you decide to work on, the key to success is to start small. Work on only one or two residents at a time so that staff can learn about new practices and make adjustments. Talk over which residents would be best to start with, where there is the greatest chance of success with the least potential for problems. Thoroughly discuss the resident(s) in the trial to learn as much as possible about areas of risk, potential for success, and factors to keep an eye on. Make an individualized approach based on the person's customary routines and preferences. Decide together how staff will know they have succeeded. Be sure to identify any needs staff have in order to be successful.

At one home, staff caring for people living with dementia used trial and error to figure out who needed finger foods, or smaller bowls, or other adaptations to make their eating more comfortable. They huddled quickly anytime they saw something that worked, or didn't work, to share information with the whole team. Then everyone else knew to keep an eye out and help it along. As staff who helped residents eat saw which foods worked for which residents, they shared this information with the dietitian and food service staff who made sure the preferred foods were in steady supply.

While conducting the trial, have frequent check-ins about how things are going and what adjustments and supports are needed. Continually link pilot findings back to organizational practices that may need to be adjusted to achieve the best outcomes for residents. As the PIP team tracks data from baseline to see if interventions are working, share this information with staff so they can see their progress. When finger foods result in less distress at meal times and better enjoyment of meals, staff will know day-to-day that the situation is better. When they see the data, they will know just how much better. Having information about progress is a natural motivator.

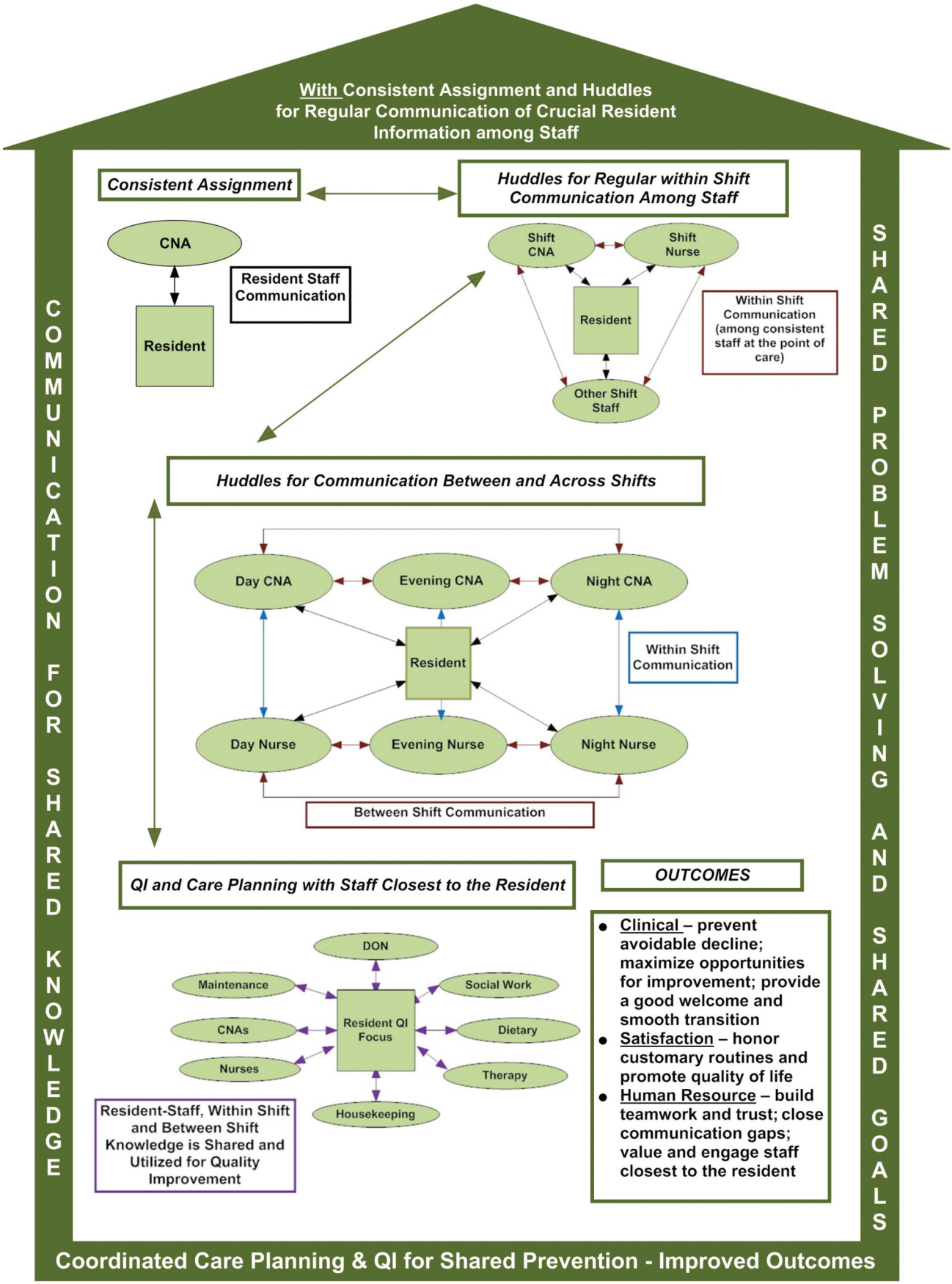
CLOSING

Staff want to take the best care of residents, to be a part of making improvements, and they want help resolving challenging situations. QI closest to the residents brings the problem-solving directly to the staff most involved in the situations under discussion.

QI closest to the residents is the most efficient and effective way to prevent avoidable declines and maximize potential improvement. It is efficient because it saves steps by having the people directly involved in daily care join with the clinical team in analyzing a situation. It is effective because the staff who will implement an intervention join with the other departments whose support is needed to put the intervention into effect.

Bringing your quality improvement activities out of the conference room to the staff closest to the residents shortens the cycle time so that when staff see subtle changes in residents' conditions, they are able to know what they are seeing, bring it to the attention of those who need to assess the situation, and join together in designing and implementing interventions.

QI closest to the resident depends on having consistently assigned staff who know their residents well, and builds on the daily shift huddles in which staff share and problem-solve together. When the whole team is working well together, residents have the best possible outcomes.


With Consistent Assignment and Huddles for Regular Communication of Crucial Resident Information among Staff
COMMUNICATION FOR SHARED KNOWLEDGE
SHARED PROBLEM SOLVING AND SHARED GOALS
Consistent Assignment
Huddles for Regular within Shift Communication Among Staff
CNA
Resident
Resident Staff Communication
Shift CNA
Shift Nurse
Resident
Other Shift Staff
Within Shift Communication (among consistent staff at the point of care)
Huddles for Communication Between and Across Shifts
Day CNA
Evening CNA
Night CNA
Resident
Within Shift Communication
Day Nurse
Evening Nurse
Night Nurse
Between Shift Communication
QI and Care Planning with Staff Closest to the Resident
DON
Maintenance
Social Work
CNAs
Resident QI Focus
Dietary
Nurses
Therapy
Housekeeping
Resident-Staff, Within Shift and Between Shift Knowledge is Shared and Utilized for Quality Improvement
OUTCOMES
Clinical – prevent avoidable decline; maximize opportunities for improvement; provide a good welcome and smooth transition
Satisfaction – honor customary routines and promote quality of life
Human Resource – build teamwork and trust; close communication gaps; value and engage staff closest to the resident
Coordinated Care Planning & QI for Shared Prevention - Improved Outcomes

RESOURCES

www.pioneernetwork.net
Pioneer Network's website provides links to many organizations with resources for implementing consistent assignment, including a free Starter Toolkit for Engaging Staff in Individualizing Care (https://www.pioneernetwork.net/resource-library/resource-libraryengaging-staff-individualizing-care), and, for purchase, a set of the Pioneer Network National Learning Collaborative Webinars used by the incubator homes entitled Engaging Staff in Individualizing Care Five Part Webinar Series (https://www.pioneernetwork.net/product/engaging-staff-individualizing-care)

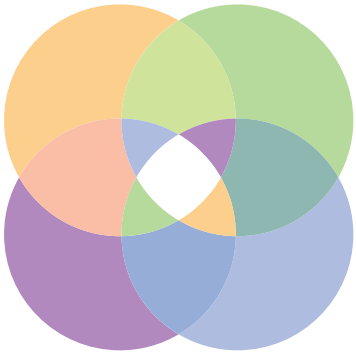
www.pathway-interact.com
INTERACT *Stop and Watch*, a nursing home communication tool, can be a guide to staff on information to share in huddles. (https://pathway-interact.com/wp-content/uploads/2018/09/INTERACT-Stop-and-Watch-v4_0-June2018_June-2018.pdf)

www.BandFConsultingInc.com
This website includes resources for QI Closest to the Resident and other resources for quality improvement.

REFERENCES

Collins, J. (2001). Good to great: Why some companies make the leap… and others don't. Harper Collins Publishers.

STEP THREE QI Closest to the Residents Video Clips
Clip 1: CNAs Identify Problems and Join in Finding Solutions
Clip 2: Take QA for Adverse Events Out of the Conference Room to the Staff Closest to the Residents
Clip 3: Huddle to Promote Well-Being with Staff Closest to the Residents
Clip 4: QAPI with Staff Closest to the Residents
Clip 5: Working Together When A Resident Needs Everyone's Help
Clip 6: Make Decisions With Staff



Engaging Staff in Individualizing Care

An Implementation Handbook

Involving CNAs in Care Planning

Pioneer Network™

B&F CONSULTING

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THE RETIREMENT RESEARCH FOUNDATION

Engaging Staff in Individualizing Care

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STEP FOUR
Involving CNAs in Care Planning: Engineering Better Care

STEP FOUR Involving CNAs in Care Plan Meetings Video Clips

Clip 1: CNAs have the Relationships and Intimate Knowledge of Residents that gives Families Peace of Mind
Clip 2: CNAs Input Makes the Care Plan Accurate
Clip 3: Sharing Information Helps CNAs Care Better for Residents
Clip 4: Families Value CNAs' Involvement
Clip 5: CNAs Work Out Coverage
Clip 6: Helping CNAs Be Comfortable in the Care Plan Meeting
Clip 7: Training to Support Effective Participation
Clip 8: Aligning Daily Documentation with MDS and QIS

WHAT IT IS

Involving CNAs in care planning means that consistently assigned CNAs attend the care plan meeting as contributing members of the care team. With their deep knowledge of residents' daily life, they are turned to for timely, actionable information about residents that helps set the direction for the care provided. They join through all or part of the meeting, usually sitting next to the resident or the family members attending.

In addition, information consistently assigned CNAs share daily in huddles about residents' abilities, needs, and routines is used to update the care plan on an on-going basis, and to guide formation of interventions developed through clinical management meetings.

WHY IT IS IMPORTANT

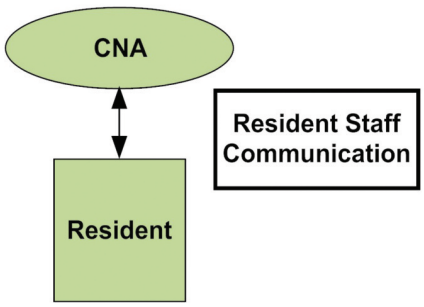
They know residents best. Involvement of consistently assigned CNAs in the care planning process creates more productive meetings because of their first hand knowledge of the resident and their reassuring presence to residents and families who attend. Consistently assigned CNAs know the resident better than any other member of the care team. While clinicians have snapshots in

time, CNAs have the detailed, subtle information that is gleaned from caring for the resident every day. For example, if a resident is experiencing a change in mood or appetite or functional ability, the consistently assigned CNA will likely be the first to notice.

They know subtle changes. Over time, through providing care daily for the same people, a consistently assigned CNA will know residents' likes and dislikes, and customary routines. Their specific up-to-date information about residents is crucial for an accurate assessment and effective care plan. They will know what is calming and soothing for each resident in their care, as well as what will surely upset them. They know the best timing for each care practice, and the individualized way it can best be accomplished. They will note subtle differences that may indicate the very beginning of a change in condition or the onset of a repeated pattern or cycle of decline. By being aware through the care planning process of the context for what they are noting, they will know how to report these changes as well as how to respond to relevant resident needs. Incubator home nurses reported that their CNAs did a much better job of sharing pertinent information once they began participating in the care plan meetings.

Their relationship makes their presence reassuring. Consistently assigned CNAs are a steady presence in the residents' lives. Residents and families develop strong relationships with CNAs and are reassured by CNAs' presence at a care plan meeting. Having someone there that residents and families know and trust because of their day-to-day involvement makes this meeting easier and less intimidating for them. Having the CNA attend the meeting honors this bond the resident and family feel for their dedicated CNA and communicates to the resident and family how much the organization values and trusts their CNA's skills and knowledge. It may also save time in that information that families often ask for is information that the CNA knows and can supply right at the meeting. By having the CNA there contributing, the "I don't know, I'll have to check, and get back to you" replies are lessened.

They know the little things that matter. CNAs know the details of residents' day-to-day life, their activities and their recent experiences that families are most interested to hear about at care conference. They are also ready to let families know about anything the resident needs, such as clothing or toiletries or hobby supplies, etc. Having the entire team together at care conference provides residents and families the opportunity to visually observe and join the process of supporting the life the resident wishes to live.



Their contribution is valued. Involving CNAs in the deliberations of the assessment and care planning process brings that process to life and affirms CNAs' central role as the staff closest to the resident. Having their involvement maximizes their good information by making it central to the planning that shapes care delivery. Inviting the consistently assigned CNA to the care planning meeting also contributes to creating an overall environmental culture where staff are valued for the knowledge they bring and adds to professionalizing the role of CNA.

I can let them know of any changes [in the care plan]. I spend most of the time with them. I pick up on little changes. The Care Plan team asks me lots of questions. Like if someone has weight loss, they will ask me if I have any information … maybe the resident is bored and tired of the same food all the time. I know what they like. I work with the families and when the family is happy, everyone is happy … like if the resident has a certain blanket from home and it's special, I make sure it is on the bed.

— CNA, Washington Rehabilitation and Nursing Center, Chipley, FL

HOW TO DO IT

If CNAs have not been a part of care planning in your home, you will need to make a plan to activate their involvement. With support, CNAs can come to care conference prepared to make suggestions that are true contributions and that support the resident. The information they share can transform assessment and care planning from rote exercises to timely, relevant, effective processes. If you currently do involve CNAs, the following information may increase the benefits of doing so.

Use it with Other Foundational Practices

Do not involve CNAs at care conference until you have consistent assignment in place. CNAs' involvement in care planning will only be of value to the care planning process if the CNA knows the resident and knows how to be an active contributor to the process. Consistent assignments provide CNAs valuable knowledge based on their deep relationship that rotating CNAs don't have. If you do not have consistent assignment in place then asking CNAs to join in the care planning process will be a waste of their time.

Using huddles, another foundational practice, will help the CNA join in this process more easily. On-the-spot sharing of observations and problem-solving through daily and QI huddles contributes to the discussions at a care plan meeting, just as involvement in care planning, with the understanding it provides of the whole picture, improves CNAs' contributions to daily and QI huddles. Huddles and care planning meeting involvement sharpen and hone critical thinking, communication, collaborative problem solving as well as contribute to a sense of ownership related to resident outcomes. Through effective huddles, CNAs learn what to report and how to report it in ways that help them be good contributors to the care plan meetings. When there is a constant communication loop between the point of care and the meetings about care, meetings are more productive because they have timely specific information to work with, and staff at the point of care have the clinical information they need to respond to moment by moment issues as they come up.

Yes, [care plans are being changed more often]… because of what the CNAs are sharing in the huddles. It will go on the 24-hour report or earlier. The care plans are updated and changed based on what the CNAs are telling us.

— DON, Washington Rehabilitation and Nursing Center, Chipley, FL

1. Examine the Current Process

Start by examining closely the care planning process as it currently is. You may find that there are opportunities for improvement in your current process so go into the review with an open mind for potential improvement in your system. In many homes, the care-planning meeting consumes time and energy with little real value other than compliance. ***It does not have to be this way.*** Look at the meeting in terms of how it functions and if it is what you desire it to be. Does the meeting start on time? Do care team members come prepared to work on areas that need decisions or do they come unprepared and so a good deal of time is spent updating everyone on each member's area of concern, or simply completing the documentation needed for paper compliance?

Good care planning meetings start on time with everyone involved already up to speed and ready to talk through areas that need everyone's input. When used as it was intended, the MDS is a potent vehicle for exchanging information and structuring an interdisciplinary approach.

Good care planning meetings start on time with everyone involved already up to speed and ready to talk through areas that need everyone's input. When used as it was intended, the MDS is a potent vehicle for exchanging information and structuring an interdisciplinary approach.

Be on time. As the question about CNA participation is considered, take the opportunity to examine and reset other aspects of the care planning process as well. Many homes have a culture of never starting on time. Some people arrive on time only to find that the team is not all present, so they leave to catch up on a few things and the meeting starts late. This is not a good practice even if you were not inviting CNAs to join. It is a waste of a precious resource — staff time. Have an expectation of promptness so that CNAs and other staff are not losing time waiting. Keep meetings pertinent and on task, supporting a culture of professionalism. One team member should take the lead and mind the time.

Be prepared and productive. Have everyone come prepared and use each other's time well. A good care planning meeting is an action oriented meeting. It is the place where all team members can discuss issues and plan action. Avoid having "dead time." Everyone should come prepared with up to date knowledge of residents so they can share information and talk through the care issues that need the team's attention. This is not the time for catching up on records. This supports respectful professionalism, the culture that you want to invite CNAs into.

2. Prepare the CNAs for Participation

Once your care planning process is working more effectively, you are ready to invite CNAs. This will be new for everyone, but especially for CNAs who haven't been a part of this type of meeting before.

Explain why. Start by spelling out expectations to both the team and CNAs. Explain why — what you expect to gain from it. Remind everyone that while it has always been part of the CNAs' job to share in discussion about care, the organizational steps have not previously been in place to activate this aspect of their role. Now, because of the valuable information and relationships with the residents that the consistently assigned CNAs and nurses have to offer to the care planning process, you want to put in place the organizational supports for their active involvement in care plan meetings.

Support CNAs. Enlist the support of the other care team members in helping make the CNAs comfortable. Some will be shy about attending this meeting, and others will be eager. Let CNAs know that there will be support for them as they take on this new experience.

Provide training. One way to help the CNA get comfortable with this new expectation is to offer staff training that includes information on the purpose of assessment and care planning, the elements of the MDS, what you are trying to accomplish in the care plan meeting, as well as logistical information such as how long it will take, and where it will be held. You may enlist the support of the MDS coordinator for some of this training. You will want to allow time for questions. Explain how the meeting flows, their role in the meeting, and what information they should share. Have an open discussion encouraging their questions and comments. You can cement the concepts by conducting a ***mock care plan meeting***. This will familiarize CNAs with the process in a safe place where they can ask questions and start to develop a comfort with this process before they go into a real care plan meeting. In the training, ask the group if there are any CNAs who have participated in the past with this process, and if there are, ask them to share their experiences.

Guide CNAs on what to share. Explain what to share in the meeting. This requires thinking through what you want from them at this meeting. Your current care planning team can help you come up with a list of questions and information the CNAs should come prepared to talk about. Tell CNAs the types of questions families usually have. The **INTERACT *Stop and Watch*** tool is a good example of the kind of information to share and can be given as a guideline. Help the CNAs sort through all of the information they have so that they understand what information is needed for this meeting. Show CNAs MDS Sections D – Moods; E – Behavior; F – Customary Routines; and G – Functional Status so they can see what type of information must be documented and reviewed. (Ideally their assignment sheets should be aligned with this MDS coding so they are already familiar with the terminology.) Let them know that **they will be expected to contribute**.

Prepare and debrief. Some CNAs may be hesitant about adding in comments as the meeting progresses; help them overcome this by asking for their thoughts and suggestions. Shy CNAs may

need some help in thinking through and even rehearsing in the beginning what information they will present and eager CNAs may need some help in refining what they will share at this meeting. As you start this process you may want to build in a few minutes to meet with the CNA before the meeting to answer any questions they have, and a few minutes afterwards to debrief. When you first start this you will want to debrief afterwards, especially if the meeting is difficult. Provide feedback with specific examples of how CNAs' contributions made a difference and include them in the follow-up loop after the meeting.

Run a good meeting. Use a consistent format. Have a good process together, including ground rules, such as attentive listening and not interrupting each other. Help people stay on point. Identify key issues that need to be addressed so they can be focused on without taking up lots of time on side issues. Everyone appreciates a well-run meeting that makes good use of people's time and will take their own participation up a level when that's the norm.

Over time, as CNAs become more comfortable contributing, you may consider asking the CNA to start the meeting with up to date information on the resident's day-to-day experience and any issues that need attention from the care team or the resident's family. This can get the meeting off to a good start by giving families and residents the time to discuss what is most important to them and that their consistent CNA needs to be part of discussing, then freeing up the CNA from parts of the meeting that they may not need to be involved in.

At Rosa Villa, having CNAs join care conference has required a lot of "cheerleading" from Resident Care Manager and SW in terms of reminding CNAs on the day of their care conference to be sure to plan to be available. To prepare staff, they have incorporated the role expectations into new staff orientation, e.g., what care conference is, what their role is, where to find the meeting schedule and when their days to attend are. All of this has been refined over time as they observed and identified ways to support CNAs. Schedules are posted in the break room each week. They have also added evening shift meetings both to accommodate families that cannot attend during the morning meetings and also so that afternoon CNAs get the opportunity to be involved. *See Appendix for an example of Rosa Villa's care conference notices.*

3. Create a System for Meeting Notices

Build in ways to notify CNAs when meetings will occur. This can be done in several ways:

- At shift huddle, share the names of residents who will be having their meeting that day, as well as the time. Have a short discussion to plan so that CNAs can cover for each other during that time.
- Post the weekly list in the break room, so that CNAs can plan their week. (One home also posts the key information needed at the care plan meeting right next to the weekly list.)
- Note on the CNAs' assignment sheets when one of their residents comes into their **A**ssessment **R**eference **D**ate (ARD) period. (One home made the sheets a different color to call attention to the ARD period.)

Encourage the CNAs who will be attending the meeting to obtain information from evening and night shift CNAs who also consistently care for the same resident, if possible.

4. Link Quarterly Care Planning to Huddles

Connect the dots between quarterly oversight and daily care. Use huddles as brief mini-care plan discussions when a resident is experiencing an emerging or full-blown situation requiring clinical oversight, or when a resident is new and staff are still getting to know the person's routines and abilities. Make this a two-way street where staff closest to the residents share their information and are given the whole picture. Include pertinent information about residents' areas of risk and customary preferences on daily assignment sheets. Update the care plan and the assignment sheets as staff share new knowledge or emerging concerns.

Daily huddles in which CNAs share pertinent information about their residents' risks and opportunities, and areas where action is needed, prepare CNAs for active participation in care planning meetings by giving staff the whole picture of the resident's needs and circumstances and explaining the link with care needed. For example, if a CNA knows that a resident is at risk for congestive heart failure and that key early warning signs of worsening are weight gain, shortness of breath, and less energy, the CNA will understand the need for weighing the resident regularly and will know to share any developments of concern.

One way to ensure inclusion of the CNA's information is to have the care plan coordinator attend huddles periodically, which has the extra benefit of capturing any follow-up information on new residents and also helps with timely action on changes in residents' condition. Homes have found that not only care, but also documentation, improves when CNAs understand the whole picture of a resident's circumstances.

5. Remove Obstacles

Make it an expectation that is non-negotiable that CNAs ***will*** attend the care plan meeting. Encourage staff to have a quick huddle to arrange to cover for each other as they attend care plan meetings. Think through all of the things that could come up to make it hard for CNAs to attend, and make contingency plans. If the staff is working with an unscheduled absence on the day of a care plan meeting, a nurse manager not involved in the care plan meeting can provide coverage so the CNA can still attend. Having contingency plans supports consistent participation of CNAs and indicates that their presence at the meetings is essential.

> ***The other CNAs cover. The elders are very willing to work with the CNAs. It's truly a give and take.***
>
> **— Social Services Director, Washington Rehabilitation and Nursing Center, Chipley, FL**

Carefully consider the time you have your meetings. Does the current timing work for family members or does it prevent them from attending? Are the meetings scheduled at a time that

would make it difficult for CNAs to attend? In many homes, the current schedule was done at a time convenient for the clinical management staff attending; now that you are opening up this process consider timing that is easier for CNAs and families.

To maximize family involvement consider scheduling evening meetings. You may find that the evening schedule is easier for some family members. Train evening shift staff on how to participate in the care conference so you can provide the same personal involvement at meetings in the afternoon/evening. Encourage evening staff to check in with the other shifts in preparation for the meeting.

6. Find the Right Location

Where you hold the meeting is important. Be sure to hold the meeting in a place that is easy for the resident, their family and the CNA to get to. If you are currently holding the meeting in your conference room, ***consider moving it to the resident's room*** or a location right on the neighborhood that is accessible to the resident, family, and CNA. Conference rooms may be convenient for management staff, but may feel intimidating for residents and their families and harder to get to for CNAs. This simple change can mean the difference in how people contribute and in who shows up. It can save everyone from the discomfort of being in a potentially intimidating conference room space, or from having to travel across the building. Then if the meeting is running late, it is easier for the CNA and resident to be flexible in joining in.

7. Align Daily Documentation with MDS Codes

Match the coding on the CNAs' assignment sheet and documentation records with MDS sections on functional status and mood. This will support more consistency between documentation and coding and help CNAs be conversant with the MDS categories. Ensure that the assignment sheet is up-to-date with the current information from CNAs about each resident's functional status, customary routines, and from the clinical team about any clinical areas of risk to be watched for.

8. Highlight CNAs Involvement to Families

Involved family members will want to know that their consistently assigned CNA will be involved in the care conference. In your formal invitation to families to attend care conference, describe the meeting and list who will be there by name and position, including the CNA. Cement this by asking the CNA to accompany the resident to the meeting and have the CNA sit next to the resident or their family member. Encourage residents and families to come with their questions and ideas, and facilitate the process so that CNAs speak directly with them about any issues relevant to daily routines, ADL care and support. Encourage CNAs to come with a list of the resident's needs from the family such as new clothes or personal items.

Families appreciate having CNAs at the care conference. At Rosa Villa care conferences, family members turn to the CNA rather than the social worker or nurse with their questions about resident needs or issues. The consistently assigned CNA has valuable information and can be

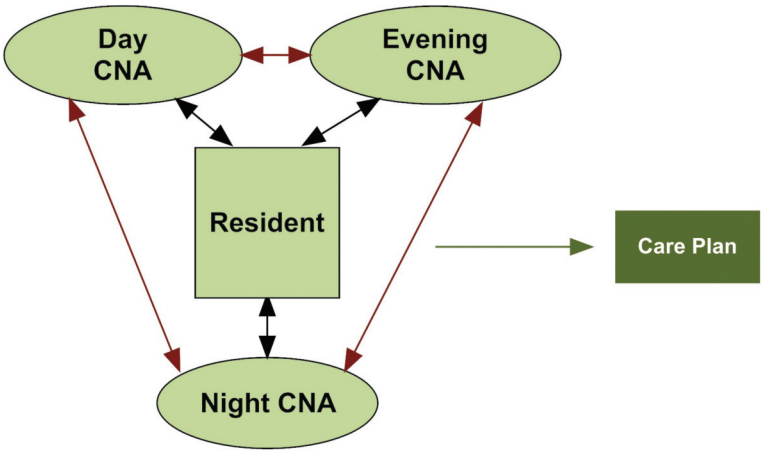
a reassuring presence to family members as they navigate this unfamiliar territory-the care planning conference. At a Friendship View care conference, a resident's son and husband appreciated hearing the specifics from the CNA about their mother/wife's progress from a serious health set back. She could provide very specific information about ambulation and other day-to-day activity.

CLOSING

Involving consistently assigned CNAs in the care plan process makes the process more effective because CNAs know their residents so well and have pertinent up-to-date information about their functional status, mood, customary routines, and needs. Families and residents are reassured by the presence of their consistently assigned CNAs and the information they provide. This practice only works when CNAs are consistently assigned, and works best when it is connected to daily discussions staff have in shift huddles about each resident's daily condition and in QI huddles about areas of clinical concern.

First make sure the care plan meeting functions well, in a way you would want to invite CNAs to join in to, where everyone who attends is prompt, prepared, professional, and productive. Prepare CNAs and the care team for how to maximize CNAs' involvement. Support the process by having a system for notifying CNAs about upcoming meetings and helping them work together to cover each other so they can attend. Consider holding meetings closest to the resident, at a time most convenient to residents, CNAs and families.

Connect the dots between the care plan process and daily care. Involving CNAs will make the care plan meeting far more productive, and improve the daily care that flows from it.



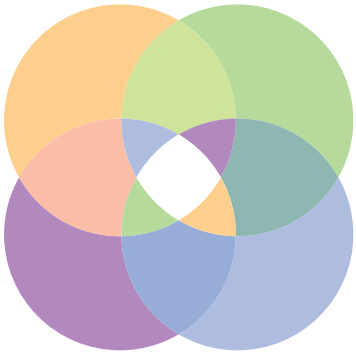
RESOURCES

www.PioneerNetwork.net
Pioneer Network's website provides links to many organizations with resources for implementing consistent assignment, including a free Starter Toolkit for Engaging Staff in Individualizing Care (https://www.pioneernetwork.net/resource-library/resource-libraryengaging-staff-individualizing-care), and, for purchase, a set of the Pioneer Network National Learning Collaborative Webinars used by the incubator homes entitled Engaging Staff in Individualizing Care Five Part Webinar Series (https://www.pioneernetwork.net/product/engaging-staff-individualizing-care)

www.interact2.net
INTERACT *Stop and Watch*, a nursing home communication tool, can be a guide to staff on information to share in care plan meetings. (https://pathway-interact.com/wp-content/uploads/2018/09/INTERACT-Stop-and-Watch-v4_0-June2018_June-2018.pdf)

www.BandFConsultingInc.com
This website includes videos and other resources for involving CNAs in Care Plan Meetings.

STEP FOUR Involving CNAs in Care Plan Meetings Video Clips
Clip 1: CNAs have the Relationships and Intimate Knowledge of Residents that gives Families Peace of Mind
Clip 2: CNAs Input Makes the Care Plan Accurate
Clip 3: Sharing Information Helps CNAs Care Better for Residents
Clip 4: Families Value CNAs' Involvement
Clip 5: CNAs Work Out Coverage
Clip 6: Helping CNAs Be Comfortable in the Care Plan Meeting
Clip 7: Training to Support Effective Participation
Clip 8: Aligning Daily Documentation with MDS and QIS



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APPENDIX

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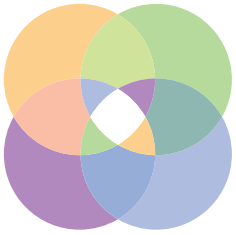

Engaging Staff in Individualizing Care

An Implementation Handbook

APPENDIX

ADDITIONAL RESOURCES

Relational Coordination

Consistent Assignment

Shift Huddles

QI Closest to the Residents

Involving CNAs in Care Planning

Impact of relational coordination on job satisfaction and quality outcomes: a study of nursing homes

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Human Resource Management Journal, Vol 18, no 2, 2008, pages 154–170

This article develops a relational perspective on the coordination of work. Existing theory suggests that relational forms of coordination should improve performance in settings that are highly interdependent, uncertain and time-constrained. Going beyond previous work, we argue that relational coordination should also improve job satisfaction by helping employees to accomplish their work more effectively and by serving as a source of positive connection at work. Using a cross-sectional sample of nursing aides and residents in 15 nursing homes, we investigate the impact of relational coordination on quality outcomes and job satisfaction.
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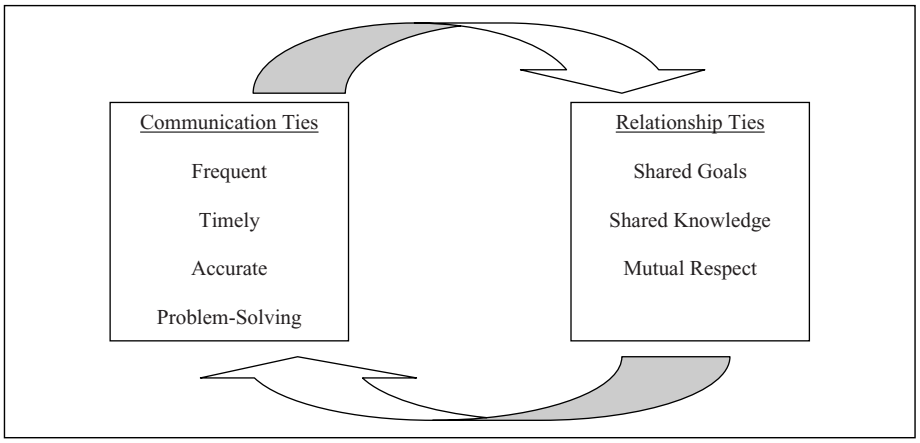
In recent years, advocates for the elderly have called for a renewed focus on quality of life in addition to clinical outcomes, asking nursing homes to deliver care that is more holistic and resident centred (Bowers *et al.*, 2001; Stone *et al.*, 2002) and to become regenerative communities that nurture the capabilities of residents rather than simply attend to their physical decline (Eaton, 2000). The concept of resident-centred care is based on the notion that all activities and information respond to resident needs in a coordinated way, organised around horizontal, cross-cutting work processes rather than around the functions in which employees work. Coordination is therefore potentially of great importance for achieving this vision of eldercare.

But what is meant by coordination? Coordination has traditionally been viewed as an information-processing problem by organisation design and contingency theorists (*e.g.* Lawrence and Lorsch, 1967; Galbraith, 1977; Tushman and Nadler, 1978). Over time, however, coordination has come to be understood to be a relational process as well, involving shared understandings of the work and the context in which it is carried out (*e.g.* Weick and Roberts, 1993; Crowston and Kammerer, 1998; Faraj and Xiao, 2006). The theory of relational coordination argues specifically that

FIGURE 1 *Dimensions of relational coordination*



the effectiveness of coordination is determined by the quality of communication among participants in a work process (for example its frequency, timeliness, accuracy and focus on problem solving rather than on blaming), which depends on the quality of their underlying relationships, particularly the extent to which they have shared goals, shared knowledge and mutual respect (Gittell, 2006). The quality of their relationships, in turn, reinforces the quality of their communication. See Figure 1 for a depiction of this dynamic process. Whereas coordination has been defined as the management of interdependencies between tasks (Malone and Crowston, 1994), relational coordination can be defined as the management of the interdependencies between the people who carry out those tasks (Gittell, 2006).

Impact of relational coordination on performance outcomes

Relational coordination is expected to improve performance in potentially significant ways. Frequent and timely communication can generate rapid responses to new information as it emerges, resulting in minimising delays and maximising responsiveness to customer needs. Accurate communication reduces the potential for errors, and problem-solving communication avoids the negative cycle of blaming and information hiding, keeping the focus instead on continuous improvement and learning. High-quality relationships reinforce high-quality communication, encouraging participants to listen to each other and to take account of the impact of their own actions or inactions on those who are engaged in a different part of the process, therefore helping them to react to new information in a coordinated way, further contributing to performance of the work process.

But when does relational coordination matter? Relational coordination is expected to be particularly important for achieving desired outcomes in settings that are characterised by high levels of task interdependence (Thompson, 1967), uncertainty (Argote, 1982) and time constraints (Adler, 1995). When *task interdependence* is low, participants can carry out their work in a relatively autonomous way with little regard for other participants in the work process, whereas when task interdependence is high, participants must be aware of and responsive to the actions

that are taken by other participants. *Uncertainty* further intensifies the need for relational coordination. When uncertainty is low, responses and handoffs can be pre-planned, requiring little need for coordinated responses to changing conditions. When uncertainty is high, however, participants must be sensitive not only to changes that affect their own tasks but also to changes that affect the tasks of others with whom they are interdependent. *Time constraints* exacerbate the effects of both interdependence and uncertainty, leaving little slack in the system and placing a premium on responsiveness.

Others have argued that these conditions for relational forms of coordination are met in flight departures (Gittell, 2001), acute care (Young *et al.*, 1998; Gittell, 2002), emergency care (Argote, 1982) and on trauma units (Faraj and Xiao, 2006). But are they met in nursing homes? Although nursing aides deliver much of the direct care in nursing homes in one-on-one relationships with residents, they do not deliver all of the care. *Task interdependence* exists between them and other members of the staff who work with the residents, including other nursing aides, nurses, housekeeping staff, dietary staff, activities staff, social workers, physical therapists, and occupational and speech therapists. As in other service settings, these interdependencies are not the simple sequential handoffs found on production lines, but rather are iterative, requiring feedback among staff as new information emerges regarding a given resident. *Uncertainty* exists with regard to the physical and mental conditions of elderly residents, which can vary from day to day in unpredictable ways, therefore requiring staff members to be highly attentive to the resident and to each other in order to respond appropriately and collectively. Finally, *time constraints* exist because of residents' need for assistance to eat, to use the bathroom, to get dressed, to perform basic daily functions, to cope with the emotional distress associated with aging and loss, and, ideally, to experience growth through the final phase of human development. Failure to respond to resident needs in a timely way can be expected to lead to negative clinical outcomes such as urinary tract infections, pressure sores, dehydration, depression, as well as reduced quality of life.

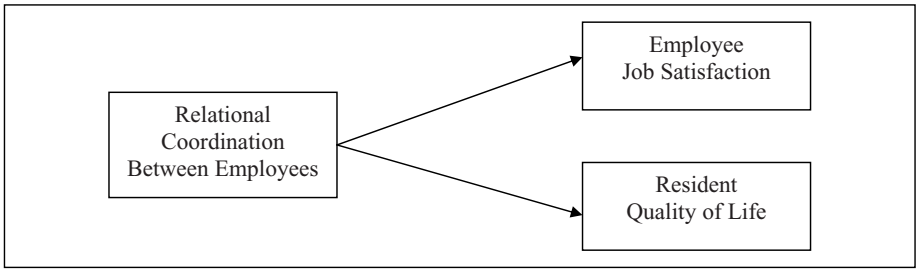
Relational coordination among nursing home staff is therefore expected to improve resident quality outcomes by improving the exchange of information relevant to the care of a given resident under conditions of interdependence, uncertainty and time constraints.

Hypothesis 1: Relational coordination among nursing home employees is positively associated with resident quality outcomes.

Impact of relational coordination on job satisfaction

In addition to improving performance outcomes, relational coordination may also improve job satisfaction for staff, although this proposition has not been previously explored. We know that having the necessary resources to accomplish one's work is an important source of job satisfaction (*e.g.* Hallowell *et al.*, 1996). Relational coordination is a form of organisational social capital, an asset that makes it easier to access resources needed to accomplish one's work (*e.g.* Nahapiet and Ghoshal, 1998; Baker, 2000; Adler and Kwon, 2002). Because of this instrumental benefit of relational coordination, we expect that relational coordination will be positively associated with job satisfaction.

FIGURE 2 *Relational coordintation, job satisfaction and quality of life*



There is a second way in which relational coordination can be expected to increase job satisfaction. We know from organisational psychology that high-quality relationships are a source of well-being for people at work (Kahn, 1998; Williams and Dutton, 1999; Lewin and Regine, 2000; Dutton, 2003; Dutton and Heaphy, 2003; Dutton and Ragins, 2007). Dutton and Heaphy (2003) define a high-quality connection as one that is life giving and a low-quality connection as one that is life depleting. High-quality connections take many forms, but they have in common a keen awareness of and attunement to the needs of the other, and thus are energising to the individuals involved in them. The energising nature of high-quality connections comes from the recognition and validation of one's self by others. These high-quality connections tend to create a positive cycle that is generative of other high-quality connections, just as low-quality connections tend to create a negative cycle that is generative of other low-quality connections. We expect that the positive relationships that underpin relational coordination (shared goals, shared knowledge, mutual respect) will therefore lead to higher levels of job satisfaction. Because of both instrumental and intrinsic benefits of connecting with others, we expect that relational coordination will be positively associated with job satisfaction.

Hypothesis 2: Relational coordination among nursing home employees is positively associated with their job satisfaction.

In sum, relational coordination has been shown to affect performance in airlines (Gittell, 2001, 2003) and in healthcare settings (Gittell *et al.*, 2000, 2007b) but not in nursing homes, and its effects on job satisfaction have not been previously explored in any setting, to our knowledge. Using a cross-sectional sample of nursing aides and residents in 15 nursing homes, we investigate the impact of relational coordination on quality outcomes and on job satisfaction. See Figure 2 for the model to be tested.

METHODS

Participants and data collection procedures

Fifteen facilities, already participating in a larger study of nursing home practices, were invited to participate based on their reputations for being good places to live and good places to work. All agreed to participate. Participating facilities included 5 for-profit and 10 non-profit facilities. Data from each facility included a resident

questionnaire, a nursing aide questionnaire, and publicly available facility-level archival data from the Center for Medicare and Medicaid Services' Nursing Home Compare web site.

The resident questionnaire (38 items) asked primarily about resident quality of life (30 items). We approached five residents from each of two target units in the 15 participating facilities to complete the survey. Based on a brief cognitive screen, we excluded residents unable to give informed consent. Resident surveys were conducted through interviews with a research assistant experienced in issues of dementia and cognitive impairment. Resident interviews were conducted in a space of the resident's choice to allow for maximum privacy and comfort. Residents were offered a non-monetary incentive at the completion of the survey. We received responses from 105 out of 123 eligible residents approached, for a response rate of 85 per cent, with a range of 48–100 per cent in each facility.

The nursing aide questionnaire (82 items) contained questions about relational coordination, job satisfaction and working conditions. We attempted to survey all nursing aides working on the same two target units in each of our 15 facilities on the day the survey was administered. The survey was translated into Spanish and Haitian Creole because of the prevalence of these languages among the nursing home aides in participating facilities and was administered in paper and pencil form, with an optional accompanying audio tape of the survey in each of the three languages. Nursing aides were asked to comment on their satisfaction with their jobs and their relationships with supervisors, and on the day-to-day coordination occurring in their facilities. Aides were given a small monetary incentive for their participation. We received responses from 252 out of 255 nursing aides we attempted to survey, for a response rate of 99 per cent.

Measures

Relational coordination Relational coordination encompasses four communication dimensions: frequent, timely, accurate and problem-solving communication, as well as three relationship dimensions: shared goals, shared knowledge and mutual respect. The relational coordination instrument was originally developed in the airline setting (Gittell, 2001) and applied in the hospital setting (Gittell *et al.*, 2000, 2007b). Based on previous studies, relational coordination was expected to have index reliability scores between 0.80 and 0.90.

We adapted this previously validated instrument to the nursing home setting by changing it in three ways to address the challenges of surveying this population. First, because of the time constraints we negotiated with nursing home administrators for surveying nursing aides, we reduced the number of relational coordination dimensions from seven to five, dropping two of the original communication dimensions – timely and accurate communication. We believed that by keeping two of the four communication dimensions and by keeping all of the relationship dimensions, we would capture much of the theoretical meaning of the relational coordination construct, although ideally all seven dimensions would be included in future studies. Additionally, the questions themselves were simplified to accord with the low educational levels of most respondents in our sample relative to the respondents for whom the instrument was originally defined while retaining the meaning of the original questions to the extent possible. Finally, the items were

TABLE 1 *Relational coordination index*

Gittell RC dimensions	Nursing aide survey items	Factor 1 loadings
Frequent communication	How often do you talk with . . . ?	0.5719
Problem-solving communication	When there are problems, do they try to solve the problem?	0.6859
Shared goals	Do they have the same goals as you do for taking care of the resident?	0.7671
Shared knowledge	Do they know very much about the work you do?	0.8353
Mutual respect	Do they respect the work you do?	0.8070
Eigenvalue		2.73
Cronbach's alpha		0.86

scored on a four-point rather than a five-point scale, again for the purposes of simplification given the low educational levels of our respondents.

Following procedures used in other studies of relational coordination (*e.g.* Gittell *et al.*, 2000), we created a composite index of the nursing aide's relational coordination with each of the other job functions studied (nurses, housekeepers and dietary staff). Factor analysis using the principal factors method in STATA-9 showed that all five items loaded onto a single factor with an eigenvalue of 2.73 and factor loadings between 0.5719 and 0.8353. This simplified relational coordination index that we tailored to the nursing home setting achieved a Cronbach's alpha of 0.86. All of these indicators were consistent with the previous studies that used the original validated instrument (Table 1).

Job satisfaction We used a one-item measure of job satisfaction from the nursing aide questionnaire, asking "Overall, how satisfied are you with your job?" which was scored on a five-point scale from 'very satisfied' to 'very dissatisfied'. In a review of job satisfaction measures, Scarpello and Campbell (1983) concluded that this single item provided the best global rating of job satisfaction. Although there has been a trend towards the use of multi-item scales, a recent study of the efficacy of single-item measures of job satisfaction shows a strong correlation between single-item measures of overall job satisfaction and scales measuring overall job satisfaction (Wanous *et al.*, 1997). Based on our theoretical argument, we expected that relational coordination was likely to affect job satisfaction in a very broad sense, making the measure of overall job satisfaction the most appropriate one for this analysis.

Resident quality of life We used the Kane *et al.* (2002) 14-item measure of resident quality of life based on 14 questions from across 7 domains that were identified theoretically – Privacy, Spiritual Well-Being, Meaningful Activity, Food Enjoyment, Relationships, Individuality and Global Quality of Life – published in Degenholtz *et al.* (2006), and a shorter version of the scale published in Kane *et al.* (2004). We adapted the survey by offering two response categories ('mostly yes' or 'mostly no')

TABLE 2 *Resident quality of life index*

Domains	Resident survey items	Factor loadings
Privacy	Can you make a private phone call?	0.4704
	When you have a visitor, can you find a place to visit in private?	0.3294
Spiritual well-being	Do you participate in religious activities here?	0.6052
	Do the religious activities here have a personal meaning for you?	0.4445
Meaningful activity	Do you enjoy the organised activities here?	0.2887
Food enjoyment	Do you like the food here?	0.6361
	Do you enjoy mealtimes here?	0.7599
Relationships	In the last month, have people who worked here stopped just to have a friendly conversation?	0.6374
	Do you consider any staff members to be your friend?	0.4700
Individuality	Taking all staff together . . . does the staff know about your interests and what you like?	0.4442
	Are the people here interested in your experiences and the things you have done in your life?	0.3000
Global quality of life	Despite your health conditions, do you give help to others, such as other residents or your family?	0.4423
	Do you feel confident you can get help when you need it?	0.2961
Eigenvalue		3.16
Cronbach's alpha		0.69

Note: Fourteen-item quality of life index from Kane *et al.* (2002), with one item dropped because of weak factor loading.

based on testing which suggested greater ease of response by elderly residents. Factor analysis using the principal factors method in STATA-9 showed that 13 of the 14 items loaded onto one factor with an eigenvalue of 3.16 and factor loadings between 0.2887 and 0.7559. We dropped one item – "do you feel your possessions are safe in this nursing home?" – because of a factor loading of less than 0.20. From the remaining 13 items we created a single index called 'resident quality of life' with a Cronbach's alpha of 0.69 (Table 2).

Control variables Control variables for resident quality of life models included resident age, length of stay and gender. Resident age was expected to potentially influence a resident's satisfaction with his or her care, given that some studies have found that older respondents give more favourable satisfaction ratings. Length of stay was also expected to positively influence a resident's satisfaction with his or her care, given that the initial period of adaptation to nursing home life is often the most difficult. Gender was expected to potentially influence a resident's satisfaction with his or her care, given that the majority of nursing home residents are female. All

were determined from the resident questionnaire. In addition to these resident characteristics, we included the percentage of nursing aides on the resident's unit who spoke English as a first language, given that residents may have a preference for nursing aides with English as a first language. We also included two facility-level variables: facility size (number of beds) and ownership status (for profit versus non-profit), both taken from the Centers for Medicare and Medicaid Services Nursing Home Compare web site. Larger facilities are expected to have more resources but also to be more impersonal, so the impact of facility size on resident quality of life could be positive or negative. Non-profits are expected to have fewer resources but to be more focused on the mission of delivering high-quality care as opposed to earning profits, so the impact of ownership status on resident quality of life could be positive or negative.

Control variables for nursing aide job satisfaction models included: nursing aide age, tenure, language, gender and education. We expected age and tenure to be negatively associated with job satisfaction because of the limited growth potential in many nursing aide jobs. Female nursing aides were expected to be more satisfied, given that this occupation is highly dominated by women and given anecdotal evidence that female residents sometimes prefer to be attended by female nursing aides. English as a first language could be either positively or negatively associated with job satisfaction: native English-speaking nursing aides might exhibit higher satisfaction because of better treatment by management, but non-native English-speaking nursing aides might exhibit higher satisfaction because of having fewer alternative job choices. Finally, nursing aides with more than a high school education were expected to be less satisfied, given that the nursing aide job design typically does not make use of higher-level education. All variables were determined from the nursing aide questionnaire. We also included facility size and ownership status, as described earlier, expecting for similar reasons that their effects on nursing aide job satisfaction could be either positive or negative (see Table 3).

Analytical procedure

All models were estimated using random effects linear regression using the STATA-9 xtreg command to account for the multi-level (resident/facility or nursing aide/facility) structure of the data, with facility as the random effect. Random effects models, also known as mixed, hierarchical linear, or multi-level models, are an extension of fixed effects models (Bryk and Raudenbush, 1992). Like other multi-level models, random effects enable us to determine the percentage of variation explained by our models at multiple levels, both within and between facilities. Random effects models also allow us to adjust *p*-values for the fact that our observations are nested within facilities. All variables were entered simultaneously.

The impact of relational coordination on resident quality of life was assessed using random effects linear regression, with the quality of life index as the dependent variable ($n = 93$ residents for whom quality of life and covariates were available) and facility ($n = 15$) as the random effect. We included resident characteristics (age, length of stay and gender) and facility characteristics (facility size and ownership status) as covariates for the reasons given earlier. We present standardised regression coefficients and *p*-values.

TABLE 3 *Descriptive data*

	Obs	Mean	Standard deviation	Min	Max	Difference between sites (*p*-value)
Resident quality of life	105	1.73	0.20	1.25	2.00	0.0046
Resident age (years)	105	82.92	11.56	28	104	0.3260
Resident length of stay (months)	95	26.62	32.19	0	204	0.1145
Resident gender (1 = female)	102	0.80	0.40	0	1	0.1422
Relational coordination	253	1.99	0.57	0.40	3.00	0.0490
Nursing aide job satisfaction	236	4.03	0.98	1	5	0.3848
Nursing aide age (years)	255	39.02	10.53	24	65	0.0000
Nursing aide tenure (months)	253	61.77	69.03	0	360	0.0004
Nursing aide gender (1 = female)	253	0.87	0.34	0	1	0.0569
Nursing aide language (1 = English as first language)	253	0.51	0.50	0	1	0.0000
Nursing aide education (1 = more than high school)	255	0.38	0.49	0	1	0.0255
Facility size (beds)	15	139.87	38.70	92	224	NA
Facility ownership (1 = non-profit)	15	0.67	0.49	0	1	NA

The impact of relational coordination on nursing aide job satisfaction was assessed using random effects linear regression, with job satisfaction as the dependent variable ($n = 231$ nursing aides for whom job satisfaction and covariates were available) and facility ($n = 15$) as the random effect. Again, relational coordination is a facility-aggregate score calculated from individual index scores ($n = 15$). We included nursing aide characteristics (age, tenure, gender, language and education) and facility characteristics (facility size and ownership status) as covariates for the reasons given earlier. We present standardised regression coefficients and *p*-values.

FINDINGS

Descriptive findings

Table 3 shows all variables to be used in our models. The mean overall age of residents was 83, the mean length of stay was 27 months and 80 per cent were female. The mean overall age of nursing aides was 39, the mean tenure was 61 months, 87 per cent were female, 38 per cent had more than a high school education and 51 per cent reported English as their first language. Table 3 also shows descriptive data for facility size and ownership status. The average number of beds in our facilities was 140 and 67 per cent were non-profit. Given that the average facility size in Massachusetts is 110 and that 29 per cent are non-profit, the facilities in our sample are somewhat larger and far more likely to be non-profit relative to the statewide average.

TABLE 4 *Relational coordination and resident quality of life*

	Resident quality of life
Relational coordination	0.37*
	(0.008)
Resident age	–0.13
	(0.198)
Resident length of stay	0.16
	(0.112)
Resident gender (female = 1)	0.19
	(0.052)
Nursing aide first language (English = 1)	0.23
	(0.177)
Facility size	0.12
	(0.461)
Facility ownership	0.21
	(0.256)
Constant	0.01
	(0.970)
R^2 within	0.16
R^2 between	0.24
R^2 overall	0.16

Note: All models are random effects regressions with resident as the unit of analysis ($N = 93$) and nursing home facility as the random effect ($N = 15$). All coefficients are standardised with a mean of 0 and a standard deviation of 1.
*$p < 0.01$ (two-tailed).

The final column of Table 3 reports the significance of between-site variation for each of our measures, which was computed using one-way analysis of variance in STATA-9. One of our important measures does not vary significantly by site – job satisfaction. We address this issue further in the discussion.

Impact of relational coordination on resident quality of life

Table 4 shows models of resident quality of life. Relational coordination was significantly associated with resident quality of life ($r = 0.37$, $p = 0.008$). The model accounts for 16 per cent of within-facility variation and 24 per cent of between-facility variation in resident quality of life. Resident gender was marginally associated with resident quality of life, in the expected direction ($r = 0.19$, $p = 0.052$). Other covariates were not significant. These findings support Hypothesis 1 regarding the impact of relational coordination among employees on quality outcomes.

Impact of relational coordination on job satisfaction

Table 5 shows relational coordination as a predictor of nursing aide job satisfaction. Relational coordination was significantly associated with nursing aide job

TABLE 5 *Relational coordination and nursing aide job satisfaction*

	Nursing aide job satisfaction
Relational coordination	0.30*
	(0.000)
Nursing aide age	0.04
	(0.533)
Nursing aide tenure	–0.04
	(0.617)
Nursing aide gender	–0.01
	(0.836)
Nursing aide language	–0.07
	(0.273)
Nursing aide education	–0.12
	(0.066)
Facility size	–0.00
	(0.947)
Facility ownership	–0.02
	(0.835)
Constant	0.00
	(0.750)
R^2 within	0.10
R^2 between	0.31
R^2 overall	0.12

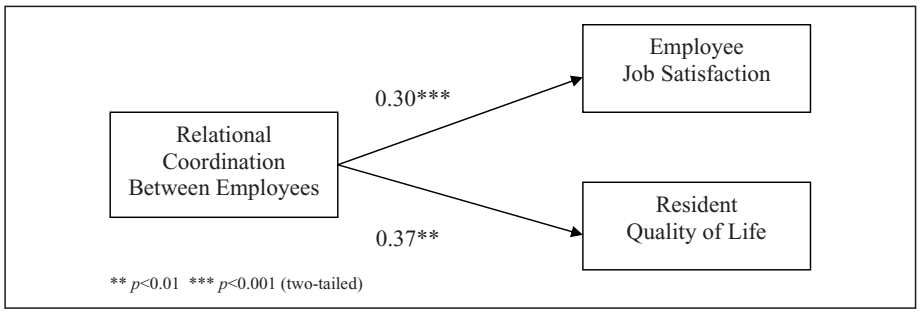
Note: All models are random effects regressions with nursing aide as the unit of analysis ($N = 231$) and nursing home facility as the random effect ($N = 15$). All coefficients are standardised with a mean of 0 and a standard deviation of 1.
*$p < 0.001$ (two-tailed).

satisfaction ($r = 0.30$, $p < 0.001$). The model accounts for 10 per cent of within-facility variation and 31 per cent of between-facility variation in nursing aide job satisfaction. Nursing aide education was marginally associated with job satisfaction in the expected direction ($r = –0.12$, $p = 0.066$). Other covariates were not significant. These findings support Hypothesis 2 regarding the impact of relational coordination among employees on employee job satisfaction. For a summary of findings, see Figure 3.

DISCUSSION

We started by introducing the concept of relational coordination and by arguing that it is most relevant for achieving desired outcomes in work settings characterised by high levels of task interdependence, uncertainty and time constraints. Because these

FIGURE 3 *Relational coordination, job satisfaction and quality of life*



conditions are present in nursing homes, we argued that relational coordination should be expected to influence nursing home outcomes. In a departure from previous theory, we argued that relational coordination should also influence employee job satisfaction because of its instrumental benefits for getting work done and because of its intrinsic benefits for fostering positive connections with others. In a cross-sectional multi-level study of 15 Massachusetts nursing homes, we found support for both of these propositions. Our models account for 24 per cent of the between-site variation in resident satisfaction and 31 per cent of the between-site variation in employee job satisfaction, with relational coordination as the only significant predictor. Our models account for less of the within-site variation however (16 and 10 per cent, respectively), consistent with the theory that relational coordination is an organisation-level phenomenon.

This study makes several contributions to our understanding of relational coordination. Although previous studies have shown the benefits of relational forms of coordination for airline passengers (Gittell, 2001) and for hospital patients (Argote, 1982; Young *et al.*, 1998; Baggs *et al.*, 1999; Gittell *et al.*, 2000; Gittell, 2002), this is the first study to present evidence suggesting the impact of relational coordination on nursing home residents. In addition, this is the first study to present evidence suggestive of the impact of relational coordination on job satisfaction. Studies in other industry settings have established the importance of relational coordination for quality and efficiency outcomes of numerous kinds but have not examined the benefits for workers themselves. Given the central role that front-line workers play in carrying out relational forms of coordination, their reactions to relational coordination are of importance.

The study has several limitations. First, our study is cross-sectional in design and therefore shows associations rather than causality. Second, we examine the impact of relational coordination on resident quality of life, a major focus of resident-centred care efforts, but it would have been desirable to include clinical outcomes as well. Efforts to improve outcome measurement in nursing homes are ongoing (Bowers *et al.*, 2001), and future research may be able to assess the impact of relational coordination on clinical outcomes. Third, the relational coordination instrument had been validated previously in airline and hospital settings (Gittell *et al.*, 2000; Gittell, 2001), but was substantially altered for this study to meet the challenges of surveying nursing aides. Even though numerous functions are engaged in direct care of

residents, we only surveyed one functional group, nursing aides; however, this group is widely believed to have the most direct impact on resident quality of life. Fourth, we used incentives for both nursing aides and residents to encourage their participation in our study, which likely increased participation but which may have also influenced our results in other ways. Finally, one of our variables – job satisfaction – did not vary significantly across sites in this study. This precluded us from testing the extent to which job satisfaction might mediate the relationship between relational coordination and resident quality of life. We anticipate that relational coordination may affect quality outcomes in part through its effect on employee job satisfaction, given that job satisfaction is expected to foster higher levels of client satisfaction because of the mirroring process that occurs during service delivery (Schneider and Bowen, 1985; Hallowell *et al.*, 1996).

Despite these limitations, our study results have important implications for theory and practice. For practitioners, our findings suggest that front-line workers can be partners for achieving desired outcomes. Our findings therefore provide support for efforts to improve the training, pay and status of nursing aides so as to more fully engage them in achieving desired resident outcomes (*e.g.* Eaton *et al.*, 2001). These findings are also consistent with the client-centred approach, which aims to bring together multiple members of the formal care provider team as well as family members and others with significant relationships to the client. In such an approach, the client not only has strong one-on-one connections with each person involved in the delivery of care, but providers themselves are connected in a web of supportive relationships so that the client does not fall through the gaps created by conflict, misunderstanding or fragmented efforts. In previous interventions, some nursing homes have attempted to create holistic care through 'a phased and deliberate effort by the nursing home's leadership to rethink how care is provided and how staff relate to each other' (Stone *et al.*, 2002). To give care in a holistic way that encompasses physical, psychosocial and spiritual dimensions of care (Eaton, 2000; Bowers *et al.*, 2001) arguably requires that coordination among providers be carried out through relationships of shared goals, shared knowledge and mutual respect. These findings thus provide support for models of resident-centred care and suggest that relational coordination may be a component of their effectiveness.

Our study also has important theoretical implications. HR theories have often argued that employees are important for achieving high performance either through their commitment and motivation or through the knowledge and skills that they bring to the job. We suggest an alternative, potentially complementary argument, that employees are important for achieving high performance because of the relationships that exists among them and because of the potential for using those relationships to more effectively coordinate their work with each other. The broader theoretical contribution of this research is therefore to contribute to an emerging relational perspective on high-performance work systems (Leana and Van Buren, 1999; Gant *et al.*, 2002; Collins and Clark, 2003; Lopez *et al.*, 2005; Vogus, 2006), in contrast to a focus on individual human capital (*e.g.* Snell and Dean, 1992) or on motivation and commitment (*e.g.* Tomer, 2001). This emerging perspective focuses on connections between workers, on the design of HR practices to bolster these connections and on the impact these connections have on organisational outcomes of interest. The current study builds on this emerging perspective by demonstrating

that relational forms of coordination contribute to important outcomes for workers themselves as well as for customers.

Our findings suggest the need for further research into HR practices that encourage the development of relational forms of coordination. Given that multiple functions are typically involved in work processes, coordination between those functions is often critical in order to avoid errors, delays and the fragmentation of service delivery. But because of the influence of bureaucratic organisational structures (Heckscher, 1994), distinct occupational communities (Van Maanen and Barley, 1984) and distinct thought worlds (Dougherty, 1992), relational coordination tends to be particularly weak across functional boundaries. Bureaucratic work practices often create divisions between employees whose relationships are critically important for the effective coordination of work (*e.g.* Heckscher, 1994; Piore, 1992). Organisational practices that became widespread through the rise of Taylorism 'have pushed us to restrict communication among the people responsible for the way in which the different parts are performed' (Piore, 1992: 20). Heckscher (1994) envisioned a post-bureaucratic, interactive organisational form in which 'everyone takes responsibility for the success of the whole' and in which 'workers need to understand the key objectives in depth in order to coordinate their actions intelligently "on the fly" ' (pp. 24–25). Gittell *et al.* (2007a) have laid out a particular type of high-performance work system – a relational work system – composed of work practices that are redesigned explicitly to foster the relationships of shared goals, shared knowledge and mutual respect through which work can be effectively coordinated 'on the fly'.

The implications for managers are clear: to foster relational coordination, employees should be selected and trained for relational competence as well as functional competence. Relational competence is not just 'being nice' – it is the ability to see the larger process and to see how each individual's work connects to that of each other individual, in this case around the needs of the residents. It is the ability to see the perspective of others, to empathise with their situation and to respect the work they do even if it requires different skills or is of a lower status than one's own. In addition to selection and training, employee performance should be measured and rewarded with a view towards broader process outcomes like resident well-being, not just the outcomes of their own individual jobs, to keep everyone focused on the larger process and on how their own work connects to that process. Finally, work-related conflicts should be sought out proactively for resolution rather than being allowed to fester, and used as opportunities to build broader understandings of how different pieces of the process connect. We know that front-line supervisors play a critical role in many of these relational work practices, but in many industries, including long-term care, that front-line leadership role is sorely neglected. Future research is needed to refine our understanding of the HR practices that support relational coordination and to better identify and overcome the obstacles to their implementation.

Acknowledgement

We wish to acknowledge Susan Eaton, who was instrumental in the planning stages of this study and in whose memory we dedicate this manuscript. We also thank Barbara Frank for her early input into the study, and our colleagues Lisa

Dodson, Almas Dossa, Walter Leutz and Rebekah Zincavage for their role in study design and data collection. We were supported by funding from the Better Jobs Better Care project of Atlantic Philanthropies and the Robert Wood Johnson Foundation.

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Provider
LONG TERM & POST-ACUTE CARE

Relationships Matter

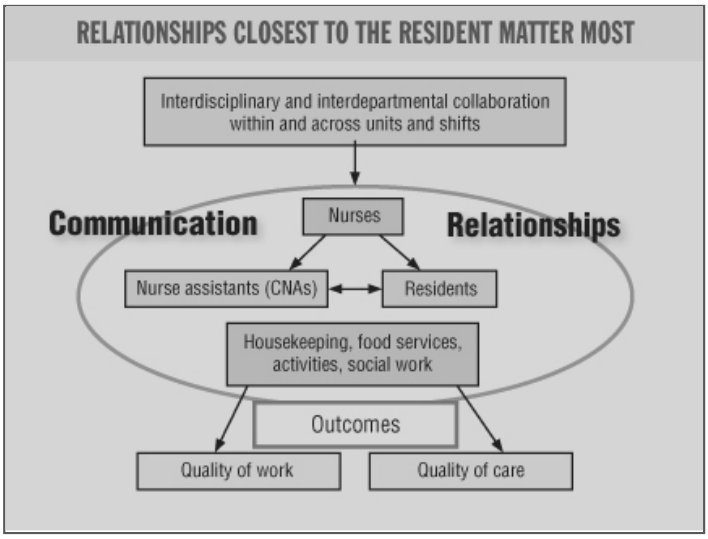
The practice of relational coordination can boost continuous improvement in long term care settings.

FEBRUARY 2013

Barbara Frank, David Farrell, and Cathie Brady

Despite all the advances in equipment and technology to improve care, leaders should remember that staff and their relationships have the greatest influence on performance. Researcher Jody Gittell, PhD, professor of management at Brandeis University's Heller School for Social Policy and Management, documented that high-performing nursing homes have as their foundation high-quality working relationships among the staff.

They found that residents' experiences are powerfully shaped by relationships among staff and that the relationships among the staff that work closest to the residents matter most.



Communication Key In Relational Coordination

The interdependent nature of caregiving work requires what Gittell calls relational coordination (RC). The theory of RC is that the effectiveness of care and service is determined by the quality of communication among staff.

The quality of staff's communication depends on their relationships with each other. This theory is highly applicable to the nursing home environment, where tasks employees perform are closely interrelated.

Their interdependence forces staff to work with one another, but if their relationships and communication are weak, then residents' needs will fall through the cracks and may cause staff conflicts.

Leaders' actions directly shape how well people work together. Effective leaders know the importance of communication and put in place the systems through which people communicate, such as through morning stand-up meetings and shift huddles. Leaders develop people's communication and critical thinking skills so they know what to share and why it's important. And effective leaders look for ways that make the work environment one that supports good communication.

For example, eliminating overhead paging so there is less sensory overload enables staff to communicate directly with each other in a more thoughtful way.

Systems that support RC among staff are the key to their success, whether it's stabilizing operations, generating continuous quality improvement, or implementing culture change.

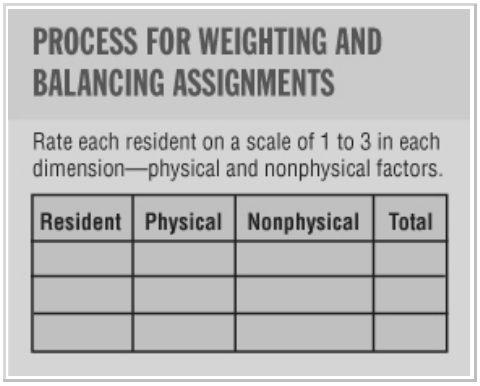
Five Practices That Support RC

Following are five specific RC practices that provide the organizational foundation for success in any improvement effort:

■ **Relationship-Building Rounds.** It starts with communication through rounds. Leadership makes rounds to check in on people, not to check up on people; foster relational coordination; and demonstrate active caring and listening. Maintaining a regular, timely, positive, problem-solving presence fosters quality communication and positive relationships. While it's a good sentiment to say, "my door is always open," requiring staff to come to you with a problem is not as effective as staff knowing they can count on you being present, asking how things are going and what they need.

Rounding several times a day helps leaders mitigate staff concerns while they are still small matters, instead of having unchecked problems mount up into major conflicts and relationship breakers by day's end.

Whether working to stabilize a troubled building or launching a new area of improvement, rounding provides the regular positive presence that allows leaders to keep a finger on the pulse of the organization, catch problems early, and intervene effectively.



PROCESS FOR WEIGHTING AND BALANCING ASSIGNMENTS

Rate each resident on a scale of 1 to 3 in each dimension—physical and nonphysical factors.

Resident	Physical	Nonphysical	Total

■ **Consistent Assignment.** When staff work with the same residents and co-workers day to day, they are able to establish deep relationships. However, if assignments are perceived as "unfair," problems can emerge. Current best practice involves engaging the staff in figuring out the best balance so that assignments are fair and work both for residents and for staff. Ask staff to rank residents by degree of difficulty, in physical and non-physical care. For residents that everyone finds very challenging, consider pairing up and engage all disciplines and departments in problem-solving individualized solutions.

Many organizations that intend to have consistent assignment struggle with what to do when they have an unscheduled absence. It's better to localize the disruption through an all-hands-on-deck approach on the short-handed unit, because pulling a nurse assistant away to cover for the absence actually doubles the disruption by affecting two units. To solidify consistent assignment, monitor how many people now take care of a resident and how many times staff are pulled away from their assignment because of an absence elsewhere.

Maintaining consistent assignment is easier with systems that make the daily staffing math work out. For example, in a “four on, two off” schedule, three staff can share two resident assignments, with one person serving as the consistent back-up for the other two.

AN OPTION FOR SCHEDULING 4-ON 2-OFF SCHEDULE WITH AN EVEN NUMBER OF NURSE ASSISTANT ASSIGNMENTS

	M	T	W	Th	F	S	S	M	T	W	Th	F	S	S
Marie	1	1	1	1	0	0	1	1	1	1	0	0	1	1
Jen	2	2	0	0	2	2	2	2	0	0	2	2	2	2
Elise	0	0	2	2	1	1	0	0	2	2	1	1	0	0

■ **Huddles.** Have the huddles the same time every day so staff can count on them and be on time. Start and end on time, and be brief and on target. When starting with a huddle, consider using the elements of Stop and Watch, the early warning tool developed by INTERACT II as a guide for what to cover.

One way to get started is to use a huddle to let staff know about any new residents expected or to check in on newly arrived residents. It may be best to huddle on an area that needs work, such as which residents are most at risk for re-hospitalization and what can be done to monitor and safely care for them.

At Rosewalk Village of Indianapolis, staff huddle in a small back room and use a white board to note any significant information they need co-workers to know.

Consider involving other members of the care team. In a 10- to 15-minute gathering at change of shift, the nurse assistants at an Augusta, Maine, nursing home discuss each resident’s risks, status, and pertinent events of this shift, including quality-of-life events. Nurses identify any acute medical changes and the follow-up plan and address any changes or additions to the plan of care. Several times a week, social work, activities, rehab, and dietary staff join the huddle to discuss needs, risks, and preferences.

At a nursing home in South Bend, Ind., the management team takes its stand-up out to the units for a huddle to discuss the 24-hour report twice a week. Use the huddles for teachable moments.

When staff share information, it’s crucial to let them know why what they said is important, what they should look for in their care, and to follow up with them as the situation develops. This creates a continuous learning process in which staff get better at catching situations early and knowing how to think them through together.

When first starting a huddle, some staff may not know what to share about a resident.

■ **Involving Dedicated Nurse Assistants in Care Planning.** Once consistent assignment is in place, it will become evident that nurse assistants have a lot to offer. They really know their residents. This knowledge is valuable, but it has to be easy for them to share and comfortable to participate.

Consider relocating the care planning meeting near where the residents and nurse assistants are located. Let them know when residents are in their assessment reference date period, and, during the shift huddle on the day of the meeting, let the nurse assistants know what time the care plan meeting will occur.

Educate them about what information to share in the meeting. Families really appreciate being able to talk directly with their loved one’s primary caregiver.

■ **Unit-based Quality Improvement.** With huddles in place, when faced with a problem, leaders should consider taking the issue to the unit and getting the staff involved in identifying the root causes that may be evident.

Leaders can model effective, respectful group problem solving by setting guidelines such as “no finger pointing.” Then use this approach as a platform for enhancing everyone’s critical thinking and problem-solving competence. Stay with it because some staff members may not be comfortable at first. Recognize that “it takes a village,” and that many problems are not just the domain of the nursing staff.

Systems Drive Outcomes

Wherever improvement efforts are focused, systems shape the outcomes. The better staff work with each other, the better they can care for residents. It sounds so simple, but RC doesn’t happen by itself. It occurs when leaders put the systems in place to generate “timely, accurate, problem-solving” communication; help staff to develop the skills needed to make the most of these systems; and create an environment that supports staff to talk issues through and problem-solve together.

Whether struggling to improve from a one-star rating, reducing antipsychotics, decreasing re-hospitalization rates,or working on culture change, success will come when systems that support and foster RC among staff are used and when those systems are backed up with a leadership approach that brings out and supports what staff have to offer.

For more information: Go to www.BandFConsultingInc.com/WhatYouDoMatters.

David Farrell, Barbara Frank, and Cathie Brady are co-authors of “Meeting the Leadership Challenge in Long-Term Care: What You Do Matters.”

Provider
LONG TERM & POST-ACUTE CARE

Relationships Matter...Part 2

The practice of relational coordination can boost continuous improvement in long term care settings.

MAY 1, 2013

Barbara Frank, David Farrell, and Cathie Brady

Despite all the advances in equipment and technology to improve care, leaders should remember that it's their staff and their relationships that have the greatest influence on organizations' performance.

Researcher Jody Gittell has documented that high-performing nursing homes have, as their foundation, high-quality working relationships among the staff.

Gittell's team found that residents' experiences are powerfully shaped by relationships among staff and that the relationships among the staff who work closest to the residents matter most (see February's 2013 Management column). The interdependent nature of caregiving work requires what Gittell calls relational coordination.

Positive Chain Of Leadership

Systems that generate a dynamic of staff empowerment and engagement will take hold if leaders follow up with staff on what they share and adjust care and operations to meet needs that staff identify.

The leadership abilities of charge nurses become so much more important because several of these systems support day-to-day decision making among staff closer to the problems and closer to the residents, where nurses set the tone through huddles and ongoing interactions.

The more nurse leaders focus on good working relationships, the better everyone works together.

Some nurses come by these skills naturally, but very few have had formal leadership training. Nurses are better able to step into leadership when directors of nursing (DONs) focus on developing their leadership skills by giving them opportunities to take on new responsibilities and then sharpen the nurses' skills by providing timely, accurate, problem-solving-oriented feedback in the context of a supportive relationship.

For example, pilot testing implementation of daily shift huddles with the charge nurse most able to succeed, and helping the nurse step into the new role by providing support along the way, builds skills as the leader builds systems.

Stability Starts With Relationships

If a facility is experiencing daily instability, these relational practices may feel out of reach. However, systems to support good working relationships can actually help to stabilize an environment. In an atmosphere of instability, staff have often lost trust in their leaders. In restoring trust, actions speak louder than words. Action is most effective when it is systematic and consistent so that staff can count on it.

The key is to reduce stress. National Research Corp. has consistently found in its My InnerView staff satisfaction surveys that the factors most affecting employees' decisions to recommend their workplaces to others are that management cares, management listens, and management helps with job stress.

A relational coordination practice to reduce stress is an all-hands-on-deck approach, through which management supports staff at high stress times and staff are able to count both on management's assistance and their accessibility during those times when they are most needed.

All Hands On Deck A Successful Approach

When Susan Hawver became administrator at Bayberry Commons, the staff had had four administrators and four DONs in five years and had a bunker mentality, believing that they were on their own to address problems.

Bayberry was a special-focus facility, with a one-star rating, a low census, and high rates of pressure ulcers and restraints.

When Hawver began making daily rounds to check in on what people needed and to provide support, staff began to sense that they were not alone.

The turning point came when the management team reviewed results from its family satisfaction survey and noted one bright spot among its dismal ratings: Despite not having staff respond in a timely manner to residents' needs, families felt that when staff did come, they were kind and caring.

The management team decided to take an all-hands-on-deck approach to meet residents' needs during the busiest times of the day. Staff identified mealtimes and shift changes for this support. The management team members took assignments to help out and maintained their commitment every day.

They were able to see the inner workings of their staff dynamics, identify simple ways to help work go more smoothly, role-model teamwork, and address staff who needed to step up.

DAVID FARRELL, BARBARA FRANK, CATHIE BRADY, MARGUERITE MCLAUGHLIN, AND ANN GRAY

A Case For Consistent Assignment

When caregivers get to know their patients more intimately, it opens the way for improved quality and a reduction in staff turnover.

CONSISTENT ASSIGNMENT—having the same caregivers consistently caring for the same patients on at least 85 percent of their shifts—sounds like a simple enough concept.

But while it has proven to be a foundational first step in moving facilities from an institutional model of care toward a person-centered model, studies show that it is currently practiced in only about 10 percent of the nation's nursing facilities.

Recently, a group of 254 nursing facilities completed a one-year pilot program as part of a Centers for Medicare & Medicaid Services (CMS)-funded study called "Improving Nursing Home Culture."

Participants presented their results at an outcomes congress held in October 2005, and many identified consistent assignment as an essential element of their successful improvement in both quality of care and staff retention. The results of the CMS study confirm the findings of 11 other in-depth studies that cite evidence for consistent assignment as foundation for quality improvement.

Turnover Affects Quality

While providers, working with quality improvement organizations (QIOs) over the past three years, have made significant progress on the quality measures, it is clear that nursing facility staff turnover and high staff vacancy rates are significant barriers preventing breakthrough levels of sustained improvement.

The American Health Care Association estimates that there are more than 100,000 vacant full-time nursing positions—including registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse assistants (CNAs)—and an average turnover rate of more than 70 percent in the nation's nursing facilities. Turnover leads to staff instability and vacant shifts, which, in turn, result in rushed, depersonalized care. Providers with severe staffing issues are unable to focus on quality improvement until they can stabilize their staffing.

> **People choose to work in long term care because they care about their work and the people they care for.**

To address this concern, Quality Partners of Rhode Island and the Colorado Foundation for Medical Care recently concluded the aforementioned CMS-funded study to explore strategies for improving the nursing facility culture.

Nursing facilities worked with their local QIOs in an effort to shift from institutionally driven care to more person-directed care and found that they needed to establish consistent assignments to structurally hard-wire the relationships needed for caregivers to know patients' individual needs.

Quality First
A Covenant For Affordable And Ethical Long Term Care

A Holistic Approach

Consistent assignment, also known as primary or permanent assignment, means that RNs, LPNs, and CNAs are given the opportunity to get to know their patients intimately.

The more prevalent approach to scheduling is to assign caregivers on a rotating basis, so they move from one group of patients to the next after a certain period of time, usually weekly, monthly, or quarterly. Experts estimate that 90 percent of nursing facilities have policies that require staff to rotate their assignments.

The pilot demonstrated that the one key to transformational improvement in patient care and quality of life involves a holistic approach to quality improvement that embraces the quality of work life of nursing facility staff with a commitment to individualized care. This holistic approach focuses on

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key areas that impact organizations and individuals, including the nature of the environment, care practices, work practices, leadership, family and community, and government.

A key tenet of quality improvement says that "every system is perfectly designed to achieve the results it gets." In order to have different outcomes, it is necessary to examine the root causes of current outcomes and examine the systems that produced them. It turns out that low staff morale and high rates of turnover are often directly related to the longstanding practice of rotating staff assignments. In long term care, the work has inherent meaning for people attracted to caring for others. Yet management systems such as rotating assignment can interfere with, rather than support, the caring connection with patients that often draws individuals to caregiving work in the first place.

Building Relationships

According to research published by the late Susan Eaton, in "What a Difference Management Makes," retention is all about relationships, and relationships are at the heart of a good working environment. This includes relationships with co-workers; across departments; with supervisors; with the organization; and, most importantly, in the case of long term care, with patients and their families.

The National Citizens Coalition for Nursing Home Reform has confirmed that patients and their families value the quality of the relationships they have with the frontline caregivers more highly than the quality of the medical care and the quality of the food. People choose to work in long term care, and stay in the field, because they care about their work, the people they care for, and the people they work with. They want to make a difference in people's lives.

Time and again, studies show that leaders who implement systems that foster and support these caring relationships have an easier time retaining staff. With consistent assignment, it has been found that staff not only develop closer relationships with patients for whom they are caring, but with co-workers as well. Conversely, the system of rotating staff assignment continually severs relationships and inhibits caregivers' ability to recognize patient declines and consistently address care needs.

What The Literature Shows

There are many reasons that long term care managers believe rotating staff assignment is effective. Some of the

most common reasons center on issues such as fairness, preventing staff burnout, and the need for all staff to be somewhat familiar with the needs of all patients.

In other facilities, managers discourage strong relationships between staff and patients to shield staff members from experiencing grief when patients die. Finally, some are opposed to consistent assignment because they do not want individual staff members to be unfairly "stuck" with "hard-to-care-for" patients.

However, these reasons for rotating assignments are not supported by research. In fact, rotating assignments actually exacerbate low staff morale, leading to staff burnout, call-outs, quitting, and overall instability. A thorough review of the literature found 11 research articles that support the practice of consistent assignment over rotating assignment, including:

- Barbara Bowers, in "Turnover Reinterpreted: CNAs Talk About Why They Leave," found that rotating staff made CNAs feel less valued for their skill, experience, and knowledge of the patients. "CNAs defined good caregiving as based on the establishment and maintenance of good relationships with residents," Bowers wrote. "CNAs felt any disruption to these relationships was detrimental to the quality of the care provided and the quality of residents' lives."
- Suzanne Campbell, in "Primary Nursing: It Works in Long Term Care," evaluated the effectiveness of primary nursing, another term for consistent assignment, and found that for patients:

— One year after implementation of primary nursing there was a 75 percent reduction in the incidence of decubitus ulcers.

— After implementation of primary nursing, rates of patient discharge to a lower level of care increased by 11 percent, while in-patient death rates decreased by 18 percent.

— Two years after institution of a primary nursing system there was a 36 percent increase in the number of ambulatory patients.

Campbell also recorded the effects on nursing staff and found that:

— One year after implementation of primary nursing, the turnover rate was reduced by 29 percent.

— One year after implementation, nurses reported feeling more accountable by 26 percent, more able to make and implement nursing decisions by 40 percent, and more able to plan and implement nursing care by 22 percent.

When switching from rotating

assignment to consistent assignment, managers should expect some concern from staff, who have generally been told in the past that the rotating staff model is best. Managers should inform staff that based on a number of studies there is new information and that the facility must make changes to reflect this new knowledge and implement better practices. Addressing staff concerns will be the key to success in making the transition. Following is a process that managers can follow when initiating the transition to consistent assignment:

1.) Call separate meetings on each nursing unit with all of the CNAs from the day shift and with all of the CNAs from the night shift.

2.) Begin the meetings by explaining that nursing facilities that have switched to consistent assignment have improved quality of care and life of the patients and the quality of work life for the staff.

3.) Place each patient's name from the unit on a Post-it note and place all of the Post-it notes on the wall.

4.) Ask the group of CNAs to rank each of the patients by their "degree of challenge," with No.1 being relatively easy to care for and No. 5 being very difficult (time-consuming and emotionally draining, for example). Let the CNAs agree on a number for each patient and write that number on the patient's Post-it note.

5.) Allow the CNAs to select their own assignments. Assignments are considered fair when each CNA in the group has amassed the same degree-of-challenge total. For example, one No. 4 patient is equal to two No. 2 patients. Therefore, the CNAs may not end up with the same number of patients to care for. Relationships with patients are important and also should be part of the decision-making process. The sequence of rooms is less important. However, proximity of the residents is important.

6.) Continue meeting every three months, or more frequently depending on the facility, to reexamine the assignments in order to ensure staff feel that they are fair and relationships with the patients are going well. ■

For More Information

■ For additional material on consistent assignment, see the change idea sheet on consistent assignment at www.riqualitypartners.org/nursing_homes/wfr_train_3.php.

DAVID FARRELL AND BARBARA FRANK

A Keystone For Excellence

Implementing consistent assignment provides a strong foundation for achieving the goals of the Advancing Excellence in America's Nursing Homes program.

IF ONE THINKS OF A NURSING facility as a fragile ecosystem in which each policy, department, staff member, and patient is systematically connected, it is easy to see how a seemingly small change might affect the whole.

Such is the case with consistent assignment, an alternative staffing model that, when put into practice, has been shown to significantly impact such factors as staff retention, resident and family satisfaction, and even clinical outcomes.

Specifically, the term consistent assignment refers to a staffing model in which patients are cared for each and every day by the same staff members, rather than having the clinical staff rotate its assignments from one group of patients to another. The implementation of consistent assignment is the eighth and final goal in the Advancing Excellence in America's Nursing Homes (AE) campaign, and it may well be the linchpin for the entire initiative.

Recent Achievements

By way of example, a large urban nursing facility in California implemented more than 130 changes in its quest to move from an institutional care model to an individualized, or person-centered, model of care.

But of all the changes made, according to the facility's administrator, it was the switch to consistent assignment in the first month of the process that helped pave the way for a host of positive results.

"We built off of relationships that developed and created a sense of community," said the administrator. As a result, he said, over the past year:

- The annualized turnover rate for certified nurse assistants (CNAs) declined from 94 percent to 38 percent;
- The turnover rate for licensed nursing staff declined from 43 percent to 11 percent;
- The nursing staff only worked with less than the optimal number of staff ("short staffed") on 10 occasions in 280 days—less than a 3 percent chance a neighborhood would work understaffed on any given day;
- Nursing department staff call-offs declined by 40 percent;
- Patients at high risk with pressure ulcers dropped from 25 percent to 11 percent;
- Residents at low risk with pressure ulcers declined from 4.5 percent to 0 percent; and
- The overall occupancy rate of the facility increased from 82 percent to 94 percent.

"I am proud of these numbers," said the administrator. "These percentages are people. By creating a better quality of work life for our staff, we enhanced the residents' quality of life, and we gave their families greater peace of mind."

The key is in allowing caring relationships between staff and patients to develop and flourish over time.

This is by no means an isolated case. In fact, facilities that change from rotating staff assignment after a period of time to consistent assignment have reported an impact on key quality indicators that is profoundly positive. Studies have documented a solid evidence base that consistent assignment lowers turnover (AE Goal 7), improves resident and family satisfaction scores (AE Goal 6), and improves the ability of staff to recognize and address clinical issues at their earliest, most preventable stages (AE Goals 1 – 4).

Why It Works

There is nothing particularly complex or magical about consistent assignment. The key is in allowing caring relationships between staff and patients to develop and flourish over time. In

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long term care, the work has an inherent meaning for people attracted to caring for others. Yet, management systems such as rotating assignment can interfere with, rather than support, the caring connection with patients that draws people to caregiving work. Fundamentally, the implementation of consistent staff assignment creates work situations that build on the intrinsic motivation of many staff members—the opportunity to form and sustain close relationships with the patients.

In her article, "Beyond 'unloving Care': Linking Human Resource Management and Patient Care Quality in Nursing Homes" (*International Journal of Human Resource Management*, June 11, 2000), researcher Susan Eaton notes that staff retention is all about relationships. Good relationships are at the heart of good work environments, she says, including relationships with co-workers; across departments; with supervisors; with the organization; and, in the case of long term care facilities, with patients and their families.

Further Confirmation

The National Citizens Coalition for Nursing Home Reform has further confirmed that patients and their families consider the quality of the relationships they have with their frontline caregivers as more valuable than the quality of the medical care and the quality of the food that's served at the facility. Relationships are the cornerstone of individualized, person-directed care.

Researcher Mary Lescoe-Long studied the family members' perspective in six Kansas nursing facilities and found that family members were keenly aware of staff members who displayed personal empathy toward their loved ones. She discovered that family members wanted the CNAs and nurses to "know my mom as a person." And when family members see and feel that personal empathy, it gives them "peace of mind."

When staff care for the same people daily, they become familiar with their needs and desires, and their work is easier because they are not spending extra time getting to know what each patient prefers.

Knowing the patients' routines and preferences, as well as their family members, can only come about through consistent personal exposure over time.

As staff members remember the patients' routines, they are likely to be

When staff care for the same people daily, they become familiar with their needs and desires.

praised by more satisfied patients and families, thus enhancing their own self esteem and, perhaps, lowering their thoughts of leaving a facility. Therefore, consistent assignment fuels success in AE Goal 6 (satisfaction) and Goal 7 (staff turnover).

Better Patient Care

Long term care researcher Lou Burgio compared two nursing facilities with consistent assignments to two nursing facilities that employ rotating assignments. Patients living in consistent assignment facilities received significantly higher ratings on patient grooming and personal appearance than patients in rotating assignment facilities.

In addition, Burgio found that CNAs working in consistent assignment facilities reported higher job satisfaction than those working in rotating assignment facilities.

The Centers for Medicare & Medicaid Services (CMS) recognizes that consistent assignment is key to individualized care.

In a recent CMS surveyor training broadcast, staff members at a facility that uses consistent assignment talked about how they are able to notice and treat small red spots before they become pressure ulcers (AE Goal 1) and how they are able to recognize and address pain in their patients because they know them so well (Goal 3). This is the case even among short-stay patients because the facility is now geared toward establishing solid relationships as soon as a new patient is admitted (Goal 4).

A geriatric psychiatrist in this training broadcast described how, through individualized care, staff know their patients better and can use alternative means of preventing falls and addressing challenging behaviors, thus reducing their use of restraints (AE Goal 2).

Many of the culture change pioneers contend that individualized care depends on having consistent assignment in place.

Leaders who implement systems that foster and support caring relationships between patients and staff have an easier time recognizing and addressing clinical issues while they are still small. Their staffs feel a greater sense of satisfaction and responsibility, as reflected in a higher rate of retention. The system of consistent assignment allows staff to develop close relationships with patients they are caring for and with co-workers they are providing care with.

Clearly, the system of consistent assignment, backed by research-based evidence, is the foundation for individualized care and a first step toward a more stable workforce, improved clinical care, and enhanced quality of life for patients process. ■

For More Information

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Feeding Assistants Deemed Competent

The first evaluative study of federal paid feeding assistant (PFA) regulation demonstrates that the quality of care provided in nursing facilities by staff trained as PFAs is comparable to the quality of care provided by indigenous nurse assistants, according to the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality.

"There were few to no significant differences in the adequacy and quality of assistance provided by regular [certified nurse assistants] versus PFAs," the study's authors concluded. "It is noteworthy that licensed staff in this study reported not only acceptance of the use of PFAs but even enthusiasm for existing programs."

Published in the April 2007 issue of *The Gerontologist*, the study seeks to address the impact of the 2003 PFA regulation that allows a nursing facility to hire single-task workers to provide feeding assistance to its patients.

In order to accomplish this goal, researchers observed PFA care at the facility and individual level and conducted staff interviews at each of seven selected nursing facilities in three states. Data from these observations were used to develop five care process measures relating to the adequacy and quality of staff assistance to encourage both meal intake and patients' independence in eating.

Interviews with multiple upper-level staff members, including administrators, directors of nursing, charge nurses, staff developers/trainers, and other individuals involved in PFA curriculum revealed that, overall, they were satisfied with the PFA program in their facilities. All of the interviewees (100 percent) reported that in addition to making no changes to existing certified nurse assistant (CNA) or licensed nurse staffing levels following PFA program implementation in their facilities, they planned to continue the PFA program and train additional staff.

Nearly all of the CNAs interviewed (96 percent) reported that they considered the PFAs "helpful" for performing one or more mealtime tasks in addition to feeding assistance care provision, while 92 percent reported that they had "no concerns" about the PFA program within their facility.

PFA interviews confirmed that they were "comfortable" with their patient assignments and were able to "get help from licensed staff when needed." Some PFAs reported that they helped with additional mealtime tasks beyond individual feeding assistance, such as transporting patients to and from the dining room; delivering, setting up, and picking up meal trays; and delivering additional foods and fluids between meals.

While the overall assessment of the PFA programs was positive, the authors, nonetheless, suggested that licensed nurse supervision needs to be increased for direct-care staff during mealtime care to aide in the identification of patients in need of assistance and to oversee the feeding of patients with complicated needs.

With regard to the adequacy of staff training, almost all staff providing feeding assistance had received at least eight hours of formal training specifically focused on feeding assistance, which included both written and performance-based competency evaluations. PFAs and CNAs, the authors noted, actually received comparable training relative to this specific care process.

—Meg LaPorte

NUMBER 21 | DECEMBER 2007

fastfacts
Resources for Nursing Home Professionals

CALIFORNIA HEALTHCARE FOUNDATION

Consistent Assignment: A Key Step to Individualized Care

Research has found that providing residents with the same caregiver results in more individualized care, which leads to better clinical outcomes and quality of life. Implementing a consistent assignment system also leads to greater staff satisfaction and lower staff turnover rates. This FastFacts summarizes the evidence supporting consistent assignment and offers a pragmatic method to make the change.

Consistent Assignment vs. Rotating Assignment

Ninety percent of nursing homes require staff to rotate assignments. Consistent assignment (sometimes called primary or permanent assignment) is defined as using the same caregivers (registered nurses, licensed practical nurses, certified nurse's aides) to care for the same residents on every shift. Consistent assignment allows staff to develop closer relationships with residents in their care and with co-workers. Conversely, rotating staff assignment continually interrupts the formation of relationships and inhibits staff's ability to recognize resident decline and optimally address care needs.

There are many reasons why leaders believe that rotating staff assignment is effective. Some of the most common reasons for rotating assignments are centered on fairness, preventing staff burnout, and making all staff familiar with the needs of all residents. Some facilities discourage strong relationships between staff and residents to help shield staff from grief when residents die. Some resist consistent assignments because they do not want staff to be stuck with particularly challenging residents. However, such reasons for rotating staff assignments are not supported by research. In fact, rotating assignment exacerbates low staff morale—leading to staff burnout, call-outs, and turnover.

Benefits of Consistent Assignment

- **Residents receive better care.** Residents feel more comfortable and secure with consistent assignments. One study compared two nursing homes with permanent assignments to two nursing homes with rotating assignments. Residents living in permanent assignment nursing homes rated significantly higher for personal appearance and hygiene than residents in rotating assignment homes. In another study, one facility saw a 75 percent reduction in the incidence of decubitus ulcers after implementing consistent assignments.
- **Improved job satisfaction.** Studies found that nurse's aides working in consistent assignment homes reported higher job satisfaction than those working in rotating assignment homes. Facilities found that after a year of using consistent assignments, staff turnover rates fell by 29 percent.
- **Staff feel valued.** One study found that rotating staff made certified nurse's aides (CNAs) feel less valued for their skill, experience, and knowledge of the residents. CNAs defined good care based on establishing good relationships with residents. Any disruption to these relationships was detrimental to the quality of care and the quality of residents' lives.
- **Staff feel empowered.** With consistent assignments, staff feel more responsible for the care of residents. They feel more accountable for their residents and take pride in helping them improve. Aides also report feeling more accountable and are better able to make and implement nursing decisions.
- **Strong foundation for person-directed care.** With consistent assignments, residents form close bonds with the people who care for them and consider them "family." These relationships are the cornerstone of person-directed care. Relationship bonds form over time—we do not form relationships with people we see infrequently.

Audience: Administrators and Directors of Nursing

fastfacts Resources for Nursing Home Professionals

Consistent Assignment: A Key Step to Individualized Care

- **More familiarity with residents' needs and desires.** When staff care for the same people daily they become familiar with residents' needs and desires and can anticipate their needs. As a result, their work becomes easier because they are not spending extra time getting to know what each resident prefers—they know from experience, which only develops from being in a consistent, caring relationship.
- **Fewer call-outs.** When staff care for the same residents every day they are less likely to "call-out." As one CNA said, "I don't call-out now, because my residents would miss me." Create an in-house pool of staff who can take over when call-outs do occur.

How to Switch to Consistent Assignment

When switching from rotating assignment to consistent assignment, leaders should expect some resistance from staff. Remember, they have been told that the rotating staff model is better for them. Share new research with them and note that new information means better practices. Addressing their concerns will be the key to success. Consider the following example of a process to make the change:

1. Call separate meetings with all of the day shift and night shift CNAs.
2. Begin each meeting by explaining that nursing homes that have switched to consistent assignment have improved resident quality of care and life as well as improved work life for the staff. Suggest that the facility try consistent assignment and see how it works.
3. Write each resident's name on a Post-it note and place the notes on a wall.
4. Ask the CNAs to rate the residents by their degree of "challenge to care for," with number 1 being relatively easy to care for and number 5 being very difficult to care for (time-consuming, emotionally draining, etc.). Let the CNAs discuss each resident and come to an agreement. Write the number on each resident's Post-it note.
5. Allow the CNAs to select their assignments. Make assignments fair by allowing CNAs to care for different numbers of residents depending on their "challenge to care for" number. For example, if one CNA has six residents and another has eight residents but both "degree of challenge" numbers total 27, then the assignments are fair. Also consider existing relationships with residents as part of the decision-making process.
6. Meet every three months (or sooner) and re-examine assignments to ensure that staff feel they are still fair and the relationships with the residents are going well.

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Web Resources

Change Ideas for Consistent Assignment
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More *FastFacts* available at **www.chcf.org/fastfacts.**

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The Ties That Bind

Joanne Kaldy

Imagine this happening: A certified nurse assistant (CNA) accidentally drops a resident during a transfer. The frail, elderly individual is bruised, sore, and has a skin tear. When an investigation is conducted, the resident defends the CNA and refuses to blame her for the accident. She says that the caregiver always is conscientious and responsible and treats her with genuine care and concern. She states emphatically, "I will not help you fire her."

Or consider this story: A very elderly—over age 100—resident passes away. She has no family. She leaves behind a box of belongings, including photos and other personal items. Instead of discarding them and forgetting about a life and what it meant, the resident's assistant asks to keep the items. She says that she wants to keep the woman's memory alive. She says, "We are her family now."

A Family Affair

These are true stories that epitomize the value of consistent assignment. A growing number of long term care facilities have embraced this concept and implemented it with great success, and the investment is reaping tremendous dividends—happier residents and families, fewer behavioral problems, greater staff stability and lower turnover, and more referrals. Staff, residents, and family members alike are so enthusiastic about consistent assignment that facility leaders are wondering, "Why didn't we do this sooner?"

While establishing and maintaining consistent assignment requires some work, many say it's as easy as teamwork, flexibility, and trust. These elements not only help facilities move forward with consistent assignment, they flourish as care becomes a family affair with everyone working together to create a caring, safe, and homelike environment.

Quality First

Keeping the Promise

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Consistent assignment gives residents a sense of security, family.

The benefits of consistent assignment seem obvious. "The CNA gets to know the resident very well and is familiar with the person's habits, routines, and behavior. If the resident's behavior changes—however subtly—the CNA is the first one to notice," says Sister Pauline, administrator, Teresian House Center for the Elderly, a church-affiliated long term care facility in Albany, N.Y.

The CNA's familiarity with the resident also can prevent behavioral changes caused simply because an assistant doesn't know about a resident's routine, pet peeves, or preferences. Sister Pauline gives an example from her own family.

"My mother [who is a resident at Sister Pauline's facility] always wore a scarf, and her CNAs know this, so they make sure she always has a scarf."

She adds, "The aides spend a great deal of time with families and residents, and strong bonds are created. I get beautiful letters from families about care CNAs provided to their loved ones."

Residents, Families, Staff Like It

According to Barbara Baylis, RN, MSN, senior vice president of clinical and residential services for Kindred Healthcare in Louisville, Ky., "The residents and families like having someone they can depend on every day. And they don't have to tell their story over and over again." As a result of consistent assignment, she says, facilities can

Plain Talk From Nursing Staff

Nursing staff from two facilities sat down with *Provider* and shared their thoughts and experiences regarding consistent assignment. Here are some of their insights:

- "I've been on one floor for six years. I like knowing where I'm going when I get to work. We have a routine, and we get it done. Everyone works together."
- "Building a bond with families gives them a sense of security. I take care of a 104-year-old resident, and she doesn't like anyone else to care for her. … Residents get to know when your days off are, and they like knowing who they will see and when."
- "For the most part, each floor is the same here. We all get about the same number of residents. There's a good balance between those people who need more hands-on care and those who are more independent."
- "Team building is an important part of this concept [consistent assignment]. Mrs. Jones might be well on Wednesday, but you don't know what will happen on Thursday. You have to build a strong team so that everyone can help out if there is a problem. We call it global duty. Everyone pitches in."
- "You have to build a relationship with co-workers so that you can say, 'I need a break from Mrs. Smith.' We re-evaluate assignments from time to time to give people breaks as they need them. We try to work among ourselves to figure out assignments."
- "I have one resident who declined when I went on a business trip for a week. She became very upset and would call my name. I have another resident who I take to my home for visits or out to lunch. My job is my home."
- "I have one resident with a very involved family. Her daughter is happy to know that I can spot anything out of the ordinary in her behavior or habits. She's gotten to know me, and she feels much more confident and secure about her mother's care. But you have to be careful not to give families the idea that you're the only person who can care for their mother or father."
- "I can count on the CNAs to detect even minor changes in residents. When residents leave for some reason, they often request to come back."
- "Consistent assignment has helped with efficiency. We can determine what people want before they ask."
- "It's nice to have the same people caring for residents for even simple things like knowing what Mrs. Smith wore yesterday so she isn't dressed in the same outfit today. You don't have to bring in a tray and then take it back because you discover Mr. Jones doesn't like scrambled eggs. You know this in advance."
- "We have one resident with dementia. He would get agitated every time it snowed because he would think he should get out there with his plow. So we learned to close the blinds when it would snow, and he would stay calm."
- "We actually have a long reservation list. People want to come here, and they want to come back when they leave. We get many referrals from families and others, and we're very proud of that."
- "We have a resident now who has been here several times for various reasons. She always tells me how comfortable she is here. There is not a 'getting to know you stage.' We just pick up where we left off, and she gets what she needs from the start."
- "I took care of one resident for a long time. When she passed away, I was working on a different unit, but I requested to do her aftercare. Her family contacted me later and thanked me for what I did."

expect to see a decrease in resident and family complaints and concerns.

The residents and families aren't the only ones who benefit. "Consistent assignment makes it much easier and more pleasant to come to work," Sister Pauline says. "They can plan their schedules according to their residents. They know who gets up early, stays up late, and so on. They know how their residents like their rooms and what they want on their beds. It makes for real harmony among everyone involved."

Consistent assignment also enables staff to detect problems earlier and devise individualized solutions to challenging situations.

For example, Barbara Frank, MPA, co-founder of B&F Consulting, a Warren, R.I.-based company that works with nursing facilities and other organizations on staffing, culture change, and quality improvement, says, "I hear all the time from CNAs that they can anticipate residents' needs all through the day and respond to them promptly and proactively."

She cites a story from long term care physician Al Power, MD, who was trying to prevent pressure ulcer development in a high-risk resident. The nursing facility team kept attempting to turn the woman on her side facing the window, and she kept turning back on her other side toward the door. Her CNA observed that the resident was a bird lover and suggested hanging a bird feeder outside the window. The team did as she suggested, and it worked.

"Consistent assignment lets you intervene in a way that is likely to produce positive outcomes. And staff have a real sense of personal accountability when they work this closely with their residents," Frank says.

Starting on the road to consistent assignment is easier for most facilities than they realize. As Sister Pauline notes, "Many facilities have been doing it for awhile, but they didn't have a name for it." Baylis says, "We initiated this over three years ago when it became an Advancing Excellence Campaign goal [*see box, page 28*]. It is rooted in primary nursing and based on a staffing model that has been around for about 30 years." Currently, about 99 percent of Kindred facilities have consistent assignment.

Assess, Stabilize, Start

A first step to establishing consistent assignment, says Dwight Tew, vice president, talent solutions, for Brookdale Senior Living in Brentwood, Tenn., is determining what staffing additions or changes are needed. Then it is essential to make sure that "you

find the right people for each team and provide them with ongoing education."

Robin Arnicar, RN, CDONA/LTC, director of nursing at the Renaissance Gardens, Silver Spring, Md., adds, "You have to conduct an honest evaluation of your staffing numbers. If you don't have enough staff, you need to do a root cause analysis of why." Then, she says, the facility needs to start recruiting and hiring needed staffers.

Establishing staff stability is key, agrees Frank, to improved performance. "It's hard to maintain consistent assignment if you have to shift people around because you don't have reliability. In addition, you need cohesive teams on each shift," she says.

"You have to establish effective ways for teams to resolve issues as they arise," Frank continues, "otherwise, CNAs can feel stuck and alone in a challenging situation, and that is the kiss of death."

Barriers May Crop Up

While consistent staffing requires leadership support and staff buy-in, the concept needs little selling. Most leaders and staff inherently understand the benefits. However, this doesn't mean that there aren't barriers to implementation. For example, says Frank, "CNAs may worry about being stuck with someone who is hard to care for. However, if you support CNAs, it alleviates people's fears that they will be left alone to deal with a difficult situation."

Knowing that they have support can help give CNAs the patience and time to bond with and understand residents who—at first—may seem difficult. For example, Frank says, "There was a post-stroke resident in one facility whose stroke made it so she could only say 'no' to everyone about everything. When the organization established consistent assignment, the woman's CNA got to know her and could tell from her eyes or other nonverbal cues when she actually meant 'yes.'"

Frank stresses, "It's critical to maintain consistent assignments that staff perceive as fair. Staff have to trust the fairness of the process. You need to constantly trouble-shoot and make sure people get help when they need it."

Another barrier that needs to be overcome up front is the myth that it is better for staff to know all assignments so that they can work anywhere. "This concept seems so anti-relationship," says Frank. She adds that most staff like knowing what to expect when they come to work every day.

Baylis agrees. "CNAs don't want to relearn everything all the time. They want to go to work and get started right away," she says. "They like being efficient and feeling confident about their work."

Setting Up For Success

Of course, preparation requires the resident's involvement. As Sister Pauline

Advancing Excellence: Tools To Build Consistent Assignment

Consistent assignment is one of the eight goals that are part of the Advancing Excellence in America's Nursing Home Campaign, a national initiative designed to help nursing facilities achieve excellence in their residents' quality of care and quality of life.

The campaign's website offers a wide range of tools to assist facilities in moving toward successful consistent assignment (www.nhqualitycampaign.org/star_index.aspx?controls=resByGoal#goal2).

Among the tools are key articles on the topic, an implementation guide, a tool for calculating consistent assignment, fact sheets for consumers and staff, and a webinar program.

"I would advise going to the Advancing Excellence website and learning from the information there before they try to reinvent the wheel. This is a good starting place for facilities considering or just beginning consistent assignment," says Barbara Baylis.

The campaign offers several resources, including:

- Consistent Assignment—The Practice and the Experience (www.nhqualitycampaign.org)
- Consistent Assignment: Where Do You Start and How Do You Do It! (Video) (www.nhqualitycampaign.org)
- Implementing Change in Long Term Care (www.nhqualitycampaign.org)
- Campaign Goals and Objectives (www.nhqualitycampaign.org)
- A Keystone for Excellence: Implementing Consistent Assignment Provides a Strong Foundation for Achieving the Goals of the Advancing Excellence in America's Nursing Homes Program (www.providermagazine.com/pdf/2007/caregiving-07-2007.pdf)
- A Case for Consistent Assignment: When Caregivers Get to Know Their Patients More Intimately, it Opens the Way for Improved Quality and a Reduction in Staff Turnover (www.providermagazine.com/pdf/caregiving-06-2006.pdf)
- Change Ideas for Consistent Assignment (www.qsource.org/NHQI/Consistent%20Assignment.pdf)
- Nursing Home Adopts Consistent Caregiver Assignment (www.internetifmc.com/downloads/NHQI/Wyndcrest%20Adopts%20Consistent%20Assignment.pdf)

says, "Before the resident is admitted, we do a pre-admission assessment in which we ask many questions such as what time they get up, what side of the bed they get up on, and what they like to eat for breakfast. We try to mimic their regular schedule so that their admission is seamless."

Later, the CNA and the resident make a care plan just between the two of them that is posted in the bathroom. The nighttime assistant does the same.

"On the first evening, the CNA calls the family and tells them how the resident is doing. Then the daytime aide calls in the morning to tell them how their loved one spent the first night. Immediately, they learn about this relationship with the caregiver; and it puts their minds at ease," Sister Pauline says.

Arnicar suggests seeking out informal facility leaders—people who are influential in their units—and using them to establish a peer team. "These people can move a new program forward or be its demise. You need to recognize that they are influential and ask for their help in explaining the benefits of consistent assignment," she says.

Whatever plans a facility makes to implement consistent assignment, Arnicar suggests starting small and slow.

"Don't do the whole building in one day. Start with one unit or neighborhood, make it work there, and then move on to the next neighborhood," she says, adding, "Empower staff to come up with and share ideas along the way." But don't forget to set rules and structure, she cautions.

"I went to one building, and they had given staffing over to the staff but never gave them rules. They ended up with 55 different schedules, scheduling gaps, and tons of staff burnout and resident complaints." Finally, as the facility implements consistent assignment, it must plan a way to measure results. Arnicar suggests tracking outcomes such as staff, resident, and family satisfaction; number of complaints; number of staff call outs; turnover; and clinical issues such as weight loss, falls, and use of antipsychotics.

Plugging Into Smooth Scheduling

Solid organization and strong processes will enable the consistent assignment program to move forward more smoothly. One option to manage staffing is the use of scheduling software, such as a program that enables users to create an active schedule. It enables facilities to track staffing and account for vacations and call outs.

These systems can be as simple or sophisticated as necessary. For example, they can be designed to send an automatic message to only specific individuals requesting coverage for a call out and enable a sudden absence to be filled by an appropriate substitute in 10 to 15 minutes.

Mark Woodka, chief executive officer of OnShift Software, a Cleveland, Ohio-based scheduling software producer, says, "A facility can't commit to consistent assignment and then implement the program in a disorganized way. People need to know the processes and trust that they will work. Otherwise, you will scramble when you run into conflict."

He notes that his company maintains a template of the master schedule for clients and helps keep it consistent month in and month out.

Scheduling programs can help streamline scheduling and help facilities track staffing over time. They can contribute to cutting down on the use of agency CNAs or nurses, and they can take the burden off of busy managers. However, facilities should consider the costs of these systems and weigh the expenses with their specific needs.

For example, facilities can purchase the license to use scheduling software for a few hundred dollars plus a subscription fee for regular updates. Or they can get the software subscription with a fully hosted service that includes customization, service, and support. Depending on the organization's size, this could cost several hundred dollars annually or more.

Whether or not a facility chooses to use specialized software or outside companies to manage scheduling, managers involved in setting and maintaining schedules need to be involved from the start.

"The people are crucial, and you really need their buy-in. You need to help them understand that consistent assignment ultimately will make their job easier," says Arnicar. She suggests having this person talk to a scheduler at another facility that has implemented consistent assignment successfully.

Maintaining The Momentum

Teamwork among the CNAs is essential for consistent assignment. However, it doesn't always happen quickly and easily, especially when people come from different backgrounds and experiences. Sister Pauline says at her facility, CNAs "meet weekly and do huddles as a shift. As a result, they work together

> They enjoyed an atmosphere where they're caring for residents and having fun doing it. They look at it as something they want to do versus just a job they do for a paycheck.

and support each other." They also make sure that new hires know what to expect and what is expected of them. She says, "When an employee comes in looking for a position, we first have them watch a video about working here."

Hiring the right people in the first place is essential to maintaining consistent assignment. As Tew says, "We stress to interviewees that we focus on health and wellness and making residents as functional as possible for as long as possible." He says that they listen for personal stories or other indications that prospective employees "have a desire to work for the greater good and serve the elderly."

Tew talked to employees at one facility who stressed that they liked their jobs because of the residents, the teamwork, and the leadership. They enjoyed "an atmosphere where they're caring for residents and having fun doing it. They look at it as something they want to do versus just a job they do for a paycheck," he says.

Managers Must Take The Lead

Tew says supervisors and team leaders have a strong role to play in ensuring the success of consistent assignment.

"They need to create an environment where associates feel rewarded, encouraged, and understand their jobs and what is expected of them," he says, adding, "Managers need to be able to motivate staff and make them feel that they are part of the organization. They need to create a safe environment where staff can suggest improvements and changes and where they share the

same level of commitment as managers." Not only do team members need to feel that they can express opinions and share observations, they also need to know that management will act on them. "If you ask for CNAs' input, you have to take it seriously and respond to it," says Frank.

Busting Burnout

Even when facilities hire and keep great people, they need to protect them from burnout. There are many ways to accomplish this.

For example, staff can volunteer to care for residents with whom they have established good relationships.

Elsewhere, full-time relief workers might work strictly for two people—for example, the person consistently handles Mary's three days off and Bob's two.

Facilities also should consider the demands of each resident in making assignments, Baylis says. "I may have nine residents, while you only have six because yours require more care and assistance. Assignments have to be equal not in number but in amount and level of care required. There needs to be equality and teamwork," she says.

Another way to maintain staff satisfaction with consistent assignment is not to force caregivers to work with particular residents. As Baylis says, "Very rarely, we have situations where the caregiver and the resident don't click, and when that happens, we switch them out and someone else cares for the resident. We always try to make accommodations."

However, she notes, "team members usually develop strong bonds with the residents and families, and none of them want to change."

Crowing About Accomplishments

Facilities that have established consistent assignment successfully are wise to promote them as part of their culture. "It's a core business strategy for us," says Tew. "It's a consistent message being delivered from the top down."

He says that his company uses "a lot of people pictures" in recruiting and marketing materials. "It may seem corny," he admits, but he notes that it reinforces the person-centered approach to care emulated by consistent staffing.

Tew also says that staff themselves are the best advertisement. "When you see that people are smiling, friendly, and happy as you walk through the facility, that says a great deal."

Maintaining and promoting the individualized approach to care is key to successful consistent assignment.

"If one resident leaves and that person showered in the morning, you don't just put a new resident in the same routine just because it's convenient. If you do, it can set you up for

problems," says Sister Pauline. "You need to involve the social worker and find the best place, the best routine for each resident."

The facility also needs to prepare residents for staff vacations and absences. As Sister Pauline says, "The resident's personality can change on a day the aide isn't there." She suggests having CNAs tell residents when they're leaving for the day and remind them when they will be out the next day.

The relationships with the resident are so strong that even the family misses the caregiver when he or she is out. "Families will get upset if something happens and their family member has someone different caring for him or her. Often, they will visit more often and stay longer when the regular caregiver is out," she says.

The sense of family that comes from consistent assignment is very real. As Karyn Leible, RN, MD, CMD, chief clinical officer, Pinon Management in Colorado, and president of AMDA—Dedicated to Long Term Care Medicine, says, "Residents love it when staff bring in their kids or grandkids. It becomes an extended nuclear family." Leible, who first practiced consistent assignment as a nurse many years ago, adds, "My son used to round with me when he was two. When I was listening to a resident's heart with the stethoscope, he'd be sitting on the person's lap with a toy stethoscope."

Another time, Leible brought her son into her facility on Christmas Eve. While she worked, he sang carols and baked cookies with the residents. "Many of these people don't have anyone else. They like having someone special to care for them," she says.

"Connecting to others is a human need. These relationships are key, and consistent assignment builds powerful, caring, and important connections that have a real impact on everyone involved." ■

RESIDENT PREFERENCES

Resident: _____ Room: _____

Interviewer: _____ Date: _____

How would you like the staff to address you? _____

What time do you like to wake up? _____

What time do you like to go to bed? _____

Do you prefer:

Shower _____

Bath _____

In the A.M. _____ In the P.M. _____

Before breakfast _____ After breakfast _____ After Dinner _____

What would make your stay in WillowBrooke Court more comfortable?

_____

_____

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Treasured Talks 1: First Conversations

Name of Resident / Guest: _____

Date of Move- In: _____ Date of Birth: _____

Lead in: "I'd like to ask you a few questions so that we can get to know you and serve you better".
Have you observed any changes in your family member's or your own mood, memory in the last month?

What is your name? _____

Is that the name you'd like us to use? It not, what would you prefer? _____

When were you born? (Month): _____ (Date): _____ (Year): _____

Question: What would you like us to know about your family? _____

_____

Sub-questions (to ask in order to get more information – use as needed):

I was married: Yes ☐ No ☐

The name of my husband / wife: _____

Have you been married more than once? Yes ☐ No ☐

Are you currently married? Yes ☐ No ☐

If yes to above, how long have you been or were you married? _____

Do you have children? Yes ☐ No ☐

If yes, how many sons? _____ How many daughters? _____

What are the names of your children? _____

_____

What are some things that make you happy? _____

_____

What could we do for you today to make you feel at home? _____

_____

What did you do for a living? _____

_____

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Treasured Talks 1: First Conversations

How did you come to live / be here? _____

_____

What is your greatest concern about living / being here? _____

_____

Do you have a routine _____

_____

_____

_____

What are the most important things I need to know in order to help you? _____

_____

What could we do for you today to make you feel at home? _____

_____

Additional notes or observations:

Treasured Talk with _____ on (date) _____

Treasured Talk with _____ on (date) _____

Treasured Talk with _____ on (date) _____

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Treasured Talks 3: Ongoing Conversations

Moving is an important life transition. It's vitally important to create a sense of belonging….. and conversation is a great tool for getting there. Knowing more about a person's life story can help you better understand the joys, sorrows, challenges, and triumphs that occur today. Listen attentively and jot down notes others that will benefit others who read what you've learned.

What stresses you out?

What do you do when you get stressed?

Can you give me 5 words that describe you?

Would you describe yourself as a "Neat Nancy " or a " Sloppy Sam"? Why or why not?

Do you have any special talents?

Do you like to use the computer? What do you use it for? Would you like to use the computer here?

What did you do for fun when you were growing up?

Do you like to help others? What kind of things have you done to help?

Would you like to help out while living / staying here? How would you like to help?

Do you have any goals you'd like to accomplish while living here?

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Treasured Talks 3: Ongoing Conversations

Tell me about your parents

Do you have a favorite story you like to tell about them?

What grade in school did you complete?

If she/he went to college: Where did you go to college? What was your major?

This section of questions deals with raising a family. If the resident did not have children, please move to the next section.

What are some of the funny things your children have said or done?

Where do your children live today? Do you see them very often?

Do you have any grandchildren? Do you see them often?

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Treasured Talks 3: Ongoing Conversations

Did you ever serve in the military? If so, what branch of the military?

When and where did you serve? Did you have a spouse that served in the military?

Did you or your spouse ever receive any recognition or awards?

Where were you on these important dates in history? What do you remember?

What traditions were important to you?

Do you have a bucket list? If you do, what's on it?

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Treasured Talks 3: Ongoing Conversations

What was school like? What was your favorite subject?

Tell me about the day you got married. Did you celebrate your anniversaries in any special way?

What would you name as a memorable accomplishment or triumph?

Monthly Ops Review

Period:	Nov-14
Segment:	
Facility:	

CULTURE CHANGE:

	11/1/2014	12/1/2014	1/1/2015	Notes:
C.N.A huddle participation				Count the # of huddles that occur during the month/# of shifts. Create and utilize supportive data to define outcomes from culture change initiatives.
# residents with alarms				
# residents on antipsychotic meds				
% WIG achieved				

Transforming the lives of nursing home residents through continuous attention to quality of care and quality of life

QAPI *at a Glance:*

A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

UNIVERSITY OF MINNESOTA

StratisHealth

Table of Contents

Disclaimer: Use of this guide or its tools is not mandated by CMS for regulatory compliance.

Introduction: Why This Guide?

As you use this guide, please take note of the following:

- The term "Caregiver" refers to individuals who provide care in nursing homes.
- The tool icon:  indicates that there is a QAPI tool associated with that concept in Appendix A of this guide. Click the tool icon to access the corresponding QAPI tool.
- Words underlined in **bold blue** are defined in Appendix B. Click the underlined word icon to be automatically linked to the definitions listed in Appendix B.

Effective Quality Assurance and Performance Improvement (QAPI) is critical to our national goals to improve care for individuals and improve health for populations, while reducing per capita costs in our healthcare delivery system. We have the opportunity to accomplish these goals in each local nursing home with the aid of QAPI tools and the establishment of an effective QAPI foundation. Nursing homes are in the best position to assess, evaluate, and improve their care and services because each home has first-hand knowledge of their own organizational systems, culture, and history. Effective QAPI leverages this knowledge to maximize the return on investments made in care improvement. This *QAPI at a Glance* guide is a resource for nursing homes striving to embed QAPI principles into their day to day work of providing quality care and services.

Nursing homes in the United States will soon be required to develop QAPI plans. QAPI will take many nursing homes into a new realm in quality—a systematic, comprehensive, data-driven, proactive approach to performance management and improvement. This guide provides detailed information about the "nuts and bolts" of QAPI. We hope that *QAPI at a Glance* conveys a true sense of QAPI's exciting possibilities. Once launched, an effective QAPI plan creates a self-sustaining approach to improving safety and quality while involving all nursing home caregivers in practical and creative problem solving. Your QAPI results are generated from your own experiences, priority-setting, and team spirit.

The Affordable Care Act of 2010 requires nursing homes to have an acceptable QAPI plan within a year of the promulgation of a QAPI regulation. However, a more basic reason to build care systems based on a QAPI philosophy is to ensure a systematic, comprehensive, data-driven approach to care. When nursing home leaders promote such an approach, the results may prevent adverse events, promote safety and quality, and reduce risks to residents and caregivers. This effort is not only about meeting minimum standards—it is about continually aiming higher. Many nursing homes are already demonstrating leadership in developing and implementing effective QAPI plans.

We encourage nursing home leaders to use *QAPI at a Glance* as a reference as they examine their own activities in the context of the goals and expectations for QAPI and sustainable improvement. You can also visit the QAPI website at http://go.cms.gov/Nhqapi, which we will update regularly as new materials and resources become available.

WHAT IS QAPI?

QAPI is the merger of two complementary approaches to quality management, Quality Assurance **(QA)** and Performance Improvement **(PI)**. Both involve using information, but differ in key ways:

- QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.
- PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

The chart below was adapted from the Health Resources and Services Administration (HRSA)[1] and shows some key differences between QA and PI efforts.

	QUALITY ASSURANCE	PERFORMANCE IMPROVEMENT
Motivation	Measuring compliance with standards	Continuously improving processes to meet standards
Means	Inspection	Prevention
Attitude	Required, reactive	Chosen, proactive
Focus	Outliers: *"bad apples"* Individuals	Processes or Systems
Scope	Medical provider	Resident care
Responsibility	Few	All

QA + PI = QAPI

QA and PI combine to form QAPI, a comprehensive approach to ensuring high quality care.

QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration. Quality Improvement adapted from http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/QualityImprovement/whatarediffbtwqinqa.html

WHY QAPI IS IMPORTANT

Once QAPI is launched and sustained, many people report that it is a rewarding and even an enjoyable way of working. The rewards of QAPI include:

- Competencies that equip you to solve quality problems and prevent their recurrence;
- Competencies that allow you to seize opportunities to achieve new goals;
- Fulfillment for caregivers, as they become active partners in performance improvement; and
- Above all, better care and better quality of life for your residents.

Being new at QAPI is like being a new driver…

A new driver must coordinate so many actions and pay attention to so many cues that driving feels awkward, confusing, and almost impossible at first. Yet when it suddenly comes together, it becomes automatic and ushers in new horizons for that driver. In the same way, once you get some QAPI experience, it will come together, seem automatic, and will take you to new places in your quality management.

In the following pages, we discuss QAPI and its inter-related components (QA and PI), and emphasize how it can readily fit into your nursing home. Launching QAPI is not necessarily easy or quick, but it has a compelling logic and it is feasible for all nursing homes, beginning wherever your nursing home is right now.

QAPI Builds on QA&A

QAPI is not entirely new. It uses the existing QA&A, or Quality Assessment and Assurance regulation and guidance as a foundation. Maybe you recognize some of the statements below as things you are already doing:

- You create systems to provide care and achieve compliance with nursing home regulations.
- You track, investigate, and try to prevent recurrence of adverse events.
- You compare the quality of your home to that of other homes in your state or company.
- You receive and investigate complaints.
- You seek feedback from residents and front-line caregivers.
- You set targets for quality.
- You strive to achieve improvement in specific goals related to pressure ulcers, falls, restraints, or permanent caregiver assignment; or other areas; (for example by joining the Advancing Excellence Campaign).
- You are committed to balancing a safe environment with resident choice.
- You strive for deficiency-free surveys.
- You assess residents' strengths and needs to design, implement, and modify person-centered, measurable and interdisciplinary care plans.

You are already partly there. All of this is part of QAPI.

QAPI Features

> *"Not all change is improvement, but all improvement is change."*
>
> *Donald Berwick, MD*
> *Former CMS Administrator*

QAPI includes components that may be new for many nursing homes. It emphasizes improvements that can not only elevate the care and experience of all residents, but also improve the work environment for caregivers. With QAPI, your organization will use a systems approach to actively pursue quality, not just respond to external requirements. Look at the following list of QAPI features. How many are you already using?

- Using data to not only identify your quality problems, but to also identify other opportunities for improvement, and then setting priorities for action
- Building on residents' own goals for health, quality of life, and daily activities
- Bringing meaningful resident and family voices into setting goals and evaluating progress
- Incorporating caregivers broadly in a shared QAPI mission
- Developing Performance Improvement Project **(PIP)** teams with specific "charters"
- Performing a **Root Cause Analysis** to get to the heart of the reason for a problem
- Undertaking systemic change to eliminate problems at the source
- Developing a feedback and monitoring system to sustain continuous improvement

Illustrating QAPI in Action

The scenario below illustrates how a QAA committee might develop a plan of correction in response to deficiencies identified during an annual survey. The example shows how facilities often react to regulatory non-compliance with a "band-aid" approach. The activities described are representative of the types of plans of corrections that are often submitted to Survey Agencies and accepted. It addresses the immediate problem, and then takes steps assumed to prevent recurrence of the problem.

Scenario 1

The Issue: Your nursing home, Whistling Pines, received deficiencies during their annual survey because residents had unexplained weight loss, and weights and food intake were not accurately and consistently documented.

What Whistling Pines did: The QA Committee developed a Plan of Correction, which contained the following components: Re-weighing all residents, and updating the weight records for the affected residents; in-servicing the Nursing Department on obtaining and documenting weights and intake. They stated they would conduct 3 monthly audits of weight and intake records, with results reported to the QA committee.

This plan of correction was accepted by the State Survey Agency.

The next case study shows a facility with effective QAPI systems in place to identify issues proactively, before trends become serious problems. A nursing home chooses a limited number of PIP projects in "high-risk, high volume, problem-prone" areas.

Scenario 2

The Issue: During the monthly QAPI meeting at Whistling Pines, staff discovered a trend of unexplained weight loss among several residents over the last two months. During the discussion, a representative from dining services noted that there had been an increase in the amount of food left on plates, as well as an increase in the amount of supplements being ordered. Although other issues and opportunities for improvement were identified at the meeting, the QAPI Steering Committee decided to launch a Performance Improvement Project (PIP) on the weight loss trend because unexplained weight loss posed a high-risk problem for residents.

What Whistling Pines did: The QAPI Steering Committee chartered a PIP team composed of a certified nursing assistant (CNA), charge nurse, social worker, dietary worker, registered dietitian, and a nurse practitioner. The team studied the issue, and then performed a root cause analysis (RCA) to help direct a plan of action. The RCA revealed several underlying factors, which included:

- No process existed for identifying and addressing risks for weight loss such as dental condition, diagnosis, or use of appetite suppressing medications;
- No system existed to ensure resident preferences are honored;
- Staff lacked an understanding of how to document food intake percentages; and
- Residents reported the food was not appetizing.

Based on the identified underlying causes, the PIP team recommended the following interventions:

- Development of a protocol for identifying residents at risk for weight loss to be done on admission and with each care plan. This protocol included a review of medications (appetite suppressants), new diagnoses, and resident assessments, including dental issues;
- Development of standing orders for residents identified as "at risk" for weight loss. These would include bi-weekly weights, referral to attending physician and dietitian for assessment, and documentation of meal percentages;
- Development of a new program for CNAs to be "Food Plan Leads" for at risk residents. The program would include identification of food preferences and accurate documentation of meals - laminated badge cards with pictures of meal percentages were distributed to all CNAs; and
- Revision of the menu to focus on favorite foods, adding finger foods and increasing choices outside of mealtimes.

The interventions were implemented in one area of the building that was home to 25 residents. The PIP team collected data from dietary (food wasted and supplement use), CNAs (observation of resident satisfaction and meal percentages), residents (satisfaction surveys), and weights.

After 3 months, they found that 5 residents gained weight,15 remained stable, and 5 lost weight, but the weight loss was not unexpected and consistent with their clinical condition. Food costs did not increase and supplement costs decreased by 12%.

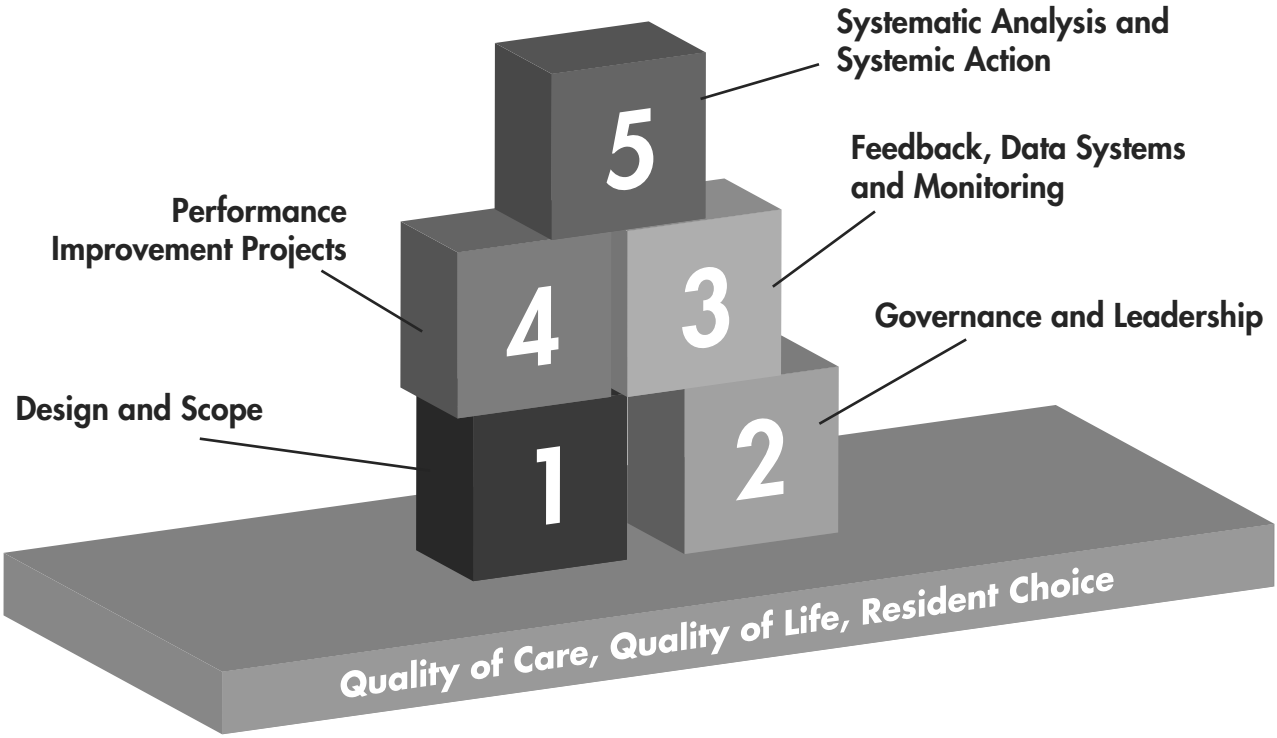
Whistling Pines decided to adopt and expand the changes to other areas of the facility. They received no deficiencies in the areas of nutrition on their annual survey. Using QAPI allowed them to identify and correct developing issues before they escalated to larger problems.

Many of the QAPI action steps discussed in this guide are found in the second scenario. Here are some of the key highlights:

- The facility had a structured Steering Committee for directing the QAPI activities (Step 1).
- The facility established performance measures and was conducting routine monitoring (Step 6).
- The facility used data to identify gaps or opportunities for improvement (Step 8).
- The QAPI Steering Committee used prioritization to decide when to conduct PIPs (Step 9).
- The QAPI Steering Committee created an interdisciplinary team, and as seen in this example, each discipline in the team brought a unique perspective that contributed to a balanced and comprehensive analysis (Step 2).
- The QAPI Steering Committee gave each team member real responsibility to study the issue, analyze the data, and recommend corrective actions (Step 2).
- The PIP team explored the issue, and designed interventions using a Plan-Do-Study-Act (PDSA) model (Steps 9 and 10).
- The PIP team's investigation revealed several underlying systemic issues and made recommendations that addressed those systems, rather than focusing on individual behavior (Step 12).

Five Elements for Framing QAPI in Nursing Homes

CMS has identified five strategic elements that are basic building blocks to effective QAPI. These provide a framework for QAPI development.



The 5 elements are your strategic framework for developing, implementing, and sustaining QAPI. In doing so, keep the following in mind:

- Your QAPI plan should address all five elements.
- The elements are all closely related. You are likely to be working on them all at once—they may all need attention at the same time because they will all apply to the improvement initiatives you choose.
- Your plan is based on your own center's programs and services, the needs of your particular residents, and your assessment of your current quality challenges and opportunities.

THE FIVE ELEMENTS ARE:

■ Element 1: Design and Scope

A QAPI program must be ongoing and comprehensive, dealing with the full range of services offered by the facility, including the full range of departments. When fully implemented, the QAPI program should address all systems of care and management practices, and should always include clinical care, quality of life, and resident choice. It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents). It utilizes the best available evidence to define and measure goals. Nursing homes will have in place a written QAPI plan adhering to these principles.

■ Element 2: Governance and Leadership

The governing body and/or administration of the nursing home develops a culture that involves leadership seeking input from facility staff, residents, and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment, and technical training as needed. The Governing Body should foster a culture where QAPI is a priority by ensuring policies are developed to sustain QAPI despite changes in personnel and turnover. Their responsibilities include, setting expectations around safety, quality, rights, choice, and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff are comfortable identifying and reporting quality problems as well as opportunities for improvement.

■ Element 3: Feedback, Data Systems and Monitoring

The facility puts in place systems to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporate input from staff, residents, families, and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or targets the facility has established for performance. It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

■ Element 4: Performance Improvement Projects (PIPs)

A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention. Areas that need attention will vary depending on the type of facility and the unique scope of services they provide.

■ Element 5: Systematic Analysis and Systemic Action

The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The facility uses a thorough and highly organized/ structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.

Action Steps to QAPI

The next few sections detail action steps that may help you on your road to implementing QAPI. They do not need to be achieved sequentially, but each step builds on other QAPI principles.

The most important aspect of QAPI is effective implementation. Learning and understanding the principles is just the first step.

STEP 1: Leadership Responsibility and Accountability

Creating a culture to support QAPI efforts begins with leadership. Support from the top is essential, and that support should foster the active participation of every caregiver. The administrator and senior leaders must create an environment that promotes QAPI and involves all caregivers.

Executive leadership sets the tone and provides resources. Their challenge is to help leadership flourish in each home.

Put a Personal Face on Quality Issues

Leadership should:

- give residents, family and staff the opportunity to meet board members and executive leaders to generate support for QAPI.
- tour the organization regularly, meeting with residents and caregivers where they live and work.
- choose the person or persons who will be the QAPI lead in conjunction with top management—QAPI needs champions.

Here are some ways leadership can take action:

- Develop a steering committee, a team that will provide QAPI leadership:
  - The steering committee has overall responsibility to develop and modify the plan, review information, and set priorities for PIPs. The steering committee charters teams to work on particular problems. It reviews results and determines the next steps. The steering committee must learn and use systems thinking—a nursing home has many competing interests and needs. Top leadership such as the Administrator and the Director of Nursing must be part of this structure.
  - It is also important to have a medical director who is actively engaged in QAPI. It is possible to adapt your Quality Assurance committee to become your "Steering committee" to oversee QAPI. For this to work, the QA Committee may need to meet more often, include more people, and establish permanent and time-limited workgroups that report to it.
- Provide resources for QAPI—including equipment and training:
  - Caregivers may need time to attend team meetings during working hours, requiring others to cover their clinical duties for a period of time.
  - Equipment might include anything from additional computers, to low-cost supplies like posters to create story boards, or multiple copies of resource books or CDs.
  - Leadership may want to consider sending one or more team members to a specialized training.

- Establish a climate of open communication and respect. Leadership may wish to consider:
  - Having an open-door policy to communicate with staff and caregivers.
  - Emphasizing communication across shifts and between department heads.
  - Creating an environment where caregivers feel free to bring quality concerns forward without fear of punishment.
  - Understand your home's current culture and how it will promote performance improvement:
  - Create the expectation that everyone in your nursing home is working on improving care and services.
  - Establish an environment where caregivers, residents, and families feel free to speak up to identify areas that need improvement.
  - Expect and build effective teamwork among departments and caregivers.

STEP 2: Develop a Deliberate Approach to Teamwork

Teamwork is a core component of QAPI and too often it is taken for granted. You will hear and read that you should discuss a situation with "your team," or that the opinion of "everyone on the team" is valued. The word "teamwork" may have different meanings. Many people work together without being a designated or formal "team."

Characteristics of an effective team include the following:

- Having a clear purpose
- Having defined roles for each team member to play
- Having commitment to active engagement from each member

The roles of team workers may grow out of their original discipline (e.g., nurse, social worker, physical therapist) or their defined job responsibilities.

QAPI relies on teamwork in several ways:

- Task-oriented teams may be specially formed to look into a particular problem and their work may be limited and focused.
- PIP teams are formed for longer-term work on an issue.
- When chartering a PIP, careful consideration must be given to the purpose of the PIP and type of members needed to achieve that purpose. Here are some examples:
  - A PIP team with the goal of helping residents go outside more often decided that grounds personnel needed to be on that team so that procedures for snow removal, sun protection, and outdoor seating could be considered.
  - Another PIP team working at simplifying medication regimens included a pharmacist, even though the time needed to be added to the consultant contract.
  - After a PIP team began working on the problem of anxiety among residents, the members realized that many of the affected residents reported reassurance from the pastor and asked the QA committee to add him to the team that was planning the approach.
  - A PIP team working on reducing falls asked that the housekeeping department be involved as it considered root causes of falls and realized that equipment in the corridors and clutter in the bathrooms contributed.

Note: Generally, each team should be composed of interdisciplinary members. For example, a concern with medication administration should include nursing and pharmacy team members. However, even other disciplines or family members may bring a different perspective to understanding this issue and should be considered for this type of team.

- Family members and residents may be team members, though for confidentiality reasons, they may not review certain data or information that identifies individuals.
- PIP teams need to plan for sufficient communication—including face-to-face meetings to get to know each other and plan the work. The team should also plan for the way each team member will review information that emerges from the PIP.
- Leadership needs to convey that being on a PIP team is an important part of the job—not something to put aside if other things come up. They must also support this idea through action and resources to enable staff to complete daily assignments, provide clinical care and also participate on QAPI teams.

STEP 3: Take your QAPI "Pulse" with a Self-Assessment

In order to establish QAPI in your organization, it is helpful to conduct a self-assessment in your organization. As you continue implementing the action steps outlined in this guide, you should periodically evaluate QAPI in your organization – see how far you've come.

To get you started, we've developed a self-assessment tool to take your QAPI "pulse." It will assist you in evaluating the extent to which components of QAPI are in place within your organization and identifying areas requiring further development. It will help you determine how you really know whether QAPI is taking hold.

You may use the self-assessment tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization's progress. You should complete the tool with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization.

Click here to go to the QAPI Self-Assessment Tool in Appendix A

STEP 4: Identify Your Organization's Guiding Principles

It is important to lay a foundation that will help you think about what principles will guide your decision making and help you set priorities.

Nursing homes are complex organizations, with numerous departments performing different functions that interact with and depend on each other. Establishing a purpose and guiding principles will unify the facility by tying the work being done to a fundamental purpose or philosophy. These principles will help guide your facility in determining programmatic priorities.

Use the Guide for Developing Purpose, Guiding Principles, and Scope for QAPI to establish the principles that will give your organization direction. The team completing this assignment should include senior leadership. Taking time to articulate the purpose, develop guiding principles, and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan.

Click here to go to the Guide for Developing Purpose, Guiding Principles, and Scope for QAPI in Appendix A

STEP 5: Develop Your QAPI Plan

Your plan will assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI. This is a living document that you may revisit as your facility evolves.

A written QAPI plan guides the nursing home's quality efforts and serves as the main document to support implementation of QAPI. The plan describes guiding principles that will be used in QAPI as well as the scope QAPI will have based on the unique characteristics and services of the nursing home. The QAPI plan should be something that is actually used and not viewed as a task that must be completed. You should continually review and refine your QAPI plan.

- Tailor the plan to fit your nursing home including all units, programs, and resident groups (for example, your sub-acute care unit, your dementia care unit, or your palliative care program). Think also of the range of residents. Do you have some younger residents? You may need to consciously develop a distinct plan to create quality of life for those residents.
- Some large organizations or corporations may choose to develop a general plan for all nursing homes in the group—in fact many multi-home organizations already have a corporate quality plan. Flexibility must be built in because individual nursing homes must have a plan that works for them. Leaders at the facility level need flexibility to develop plans for the priorities that fit their needs.

You may use the Guide for Developing a QAPI Plan to help you create a comprehensive plan that addresses the full range and scope of care and services provided by your organization.

Click here to go to the Guide for Developing a QAPI Plan in Appendix A

STEP 6: Conduct a QAPI Awareness Campaign

COMMUNICATE WITH ALL CAREGIVERS

- Let everyone know about your QAPI plan—often and in multiple ways.
- Plan ongoing caregiver education beyond single exposures—the goal is widespread awareness of QAPI initiatives.
- Train through dialogue, examples, and exercises. Transform the material in this guide into smaller pieces and easily understood ideas. Use your home's own experiences with certain caregivers or residents as part of the learning materials.
- Convey the message that QAPI is about systems of care, management practices, and business practices—systems should support quality and/or acceptable business practices, or they must change. Use examples to get the message across, and ask caregivers to think of examples of their own.
- Be sure consultants, contractors, and collaborating agencies are also aware of your QAPI approach. Maybe you have several hospice organizations coming in and out of your home. You may work with a podiatrist who visits regularly. They each have a role in your system.
- Convey the message that any and every caregiver is expected to raise quality concerns, that it is safe to do so, and that everyone is encouraged to think about systems.

- Discuss the hard questions—what is meant by a culture of safety here in our nursing home? How does the nursing home try to balance issues of safety and resident choice/autonomy? These types of questions often do not have easy answers but QAPI opens up these types of issues for discussion and deeper thinking.

Try this:

An exercise where groups that cross disciplines and roles brainstorm the various ways their work influences the work of others. For example, activities personnel may find that their events are cut short because no one is available to help residents to and from activity areas. Also seek examples where resident choice did not prevail. For instance, evening caregivers may say residents cannot be up and out of their rooms after 9:30 pm because no one will be able to help them to bed after 10:00 pm. Brainstorm how to solve problems like these, even if jobs and routines would change.

If systems don't exist, they may need to be developed. If systems impede quality, they must be changed.

COMMUNICATE WITH RESIDENTS AND FAMILIES

- Make sure all residents and families know that their views are sought, valued, and considered in facility decision-making and process improvements by announcing and discussing QAPI in resident and family councils and other venues.
- Ask residents and family members to tell you about their quality concerns. Many facilities today are using some type of customer-satisfaction survey—results should be used to identify opportunities for improvement that will proactively have an impact on all residents and their families.
- Try to view concerns through residents' eyes. For example, getting back to a resident in 10 minutes may seem responsive, but may feel like an eternity to the resident. How would that feel to a resident waiting an answer to a call light or for help to the bathroom?
- Consider including QAPI information in routine communications to families.

Family and resident complaints are often underused, and yet they are a valuable way of identifying more general problems.

STEP 7: Develop a Strategy for Collecting and Using QAPI Data

Your team will decide what data to monitor routinely. Areas to consider may include:

- Clinical care areas, e.g., pressure ulcers, falls, infections
- Medications, e.g., those that require close monitoring, antipsychotics, narcotics
- Complaints from residents and families
- Hospitalizations and other service use
- Resident satisfaction
- Caregiver satisfaction
- Care plans, including ensuring implementation and evaluation of measurable interventions
- State survey results and deficiencies
- Results from MDS resident assessments
- Business and administrative processes—for example, financial information, caregiver turnover, caregiver competencies, and staffing patterns, such as permanent caregiver assignment. Data related to caregivers who call out sick or are unable to report to work on short notice, caregiver injuries, and compensation claims may also be useful.

This data will require systematic organization and interpretation in order to achieve meaningful reporting and action. Otherwise, it would only be a collection of unrelated, diverse data and may not be useful.

Compare this to an individual resident's health—you must connect many pieces of information to reach a diagnosis. You also need to connect many pieces of information to learn your nursing home's quality baseline, goals, and capabilities.

- Your team should set targets for performance in the areas you are monitoring. A target is a goal, usually stated as a percentage. Your goal may be to reduce restraints to zero; if so, even one instance will be too many. In other cases, you may have both short and longer-term goals. For example, your immediate goal may be reducing unplanned rehospitalizations by 15 percent, and then subsequently by an additional 10 percent. Think of your facility or organization as an athlete who keeps beating his or her own record.
- Identifying benchmarks for performance is an essential component of using data effectively with QAPI. A benchmark is a standard of comparison. You may wish to look at your performance compared to nursing homes in your state and nationally using Nursing Home Compare (www.medicare.gov/nhcompare); some states also have state report cards. You may compare your nursing home to other facilities in your corporation, if applicable. But generally, because every facility is unique, the most important benchmarks are often based on your own performance. For example, seeking to improve hand-washing compliance to 90 percent in 3 months based on a finding of 66 percent in the prior quarter. After achieving 90 percent for some period of time, the benchmark can be raised higher as part of ongoing, continuous improvement.
- It may be helpful to monitor what happens when residents leave the nursing home or come back, including discharges to the hospital or home. You may examine discharge rates from your post-acute care area, preventable hospitalizations (i.e., hospitalizations that can be avoided through good clinical care), and what happens after the resident returns from the hospital.

- You'll want to develop a plan for the data you collect. Determine who reviews certain data, and how often. Collecting information is not helpful unless it is actually used. Be purposeful about who should review certain data, and how often—and about the next steps in interpreting the information.

STEP 8: Identify Your Gaps and Opportunities

This step involves reviewing your sources of information to determine if gaps or patterns exist in your systems of care that could result in quality problems. Or, are there opportunities to make improvements?

Potential areas to consider when reviewing your data:

- MDS data for problem patterns.
- Nursing Home Compare (provides quality information about every certified nursing home in the country).
- State survey results and plans of correction.
- Resident care plans for documented progress towards specified goals.
- Trends in complaints.
- Resident and family satisfaction for trends.
- Patterns of caregiver turnover or absences.
- Patterns of ER and/or hospital use.

During this step, you may decide to spend more time discussing the quality themes you have identified with residents and caregivers. They may pick up patterns you have not yet identified, and they may have ideas about what is at the root of the problem. Consider hosting a series of small group meetings with your caregivers, and arrange to meet with your Resident Council. You may wish to provide refreshments and have an informal discussion.

This step should lead to the next steps involving PIPs. Such projects are expected to be chosen to deal with "high risk, high volume, problem-prone areas" related to quality of care or quality of life. Take time to notice the things you are doing well—that's important too, and deserves recognition.

But while you are celebrating accomplishments, you can also begin to set priorities for improvement around issues that the team identifies.

STEP 9: Prioritize Quality Opportunities and Charter PIPs

Prioritizing opportunities for improvement is a key step in the process of translating data into action.

As you continue to implement QAPI, you and your team will:

- Prioritize opportunities for more intensive improvement work. Problems versus opportunities are a matter of perspective and often require discussion.
- Choose problems or issues that you consider important (consider if the issue is high risk, high frequency, and/or problem prone). Remember that problems affecting psychosocial well-being and the ability of residents to exercise choice should also be considered as they may lead to resident suffering.
- Consider which problems will become the focus for a PIP.

- All identified problems need attention—and usually from more than one person, but they do not all require PIPs.
- Begin some PIPs with problems you think you can solve relatively easily. A quick win is worthwhile.

Charter PIP teams:

We use the word "charter" on purpose. A PIP is more than a casual effort - it entails a specific written mission to look into a problem area. The PIP team should include people in a position to explore the problem (usually direct caregivers, such as nursing assistants, are needed). If the problem being addressed involves, for example, dietary choices, then someone from the dietary department should also be on the PIP team.

Chartering implies that the team has been entrusted with a mission, and that it reports back to the Steering Committee at intervals. Being part of a formally chartered PIP team must be interpreted as an important assignment that team members and their supervisors must take seriously. The development of a charter adds strength, importance, and formality to the PIP process. The team typically has a leader—either chosen in the charter or by the team itself. Soon after it begins its work, the PIP should develop a proposed time line, and indicate the budget that is needed.

Use the Goal Setting Worksheet to help your PIP team establish appropriate goals for organizational quality measures, informal improvement initiatives, and PIPs.

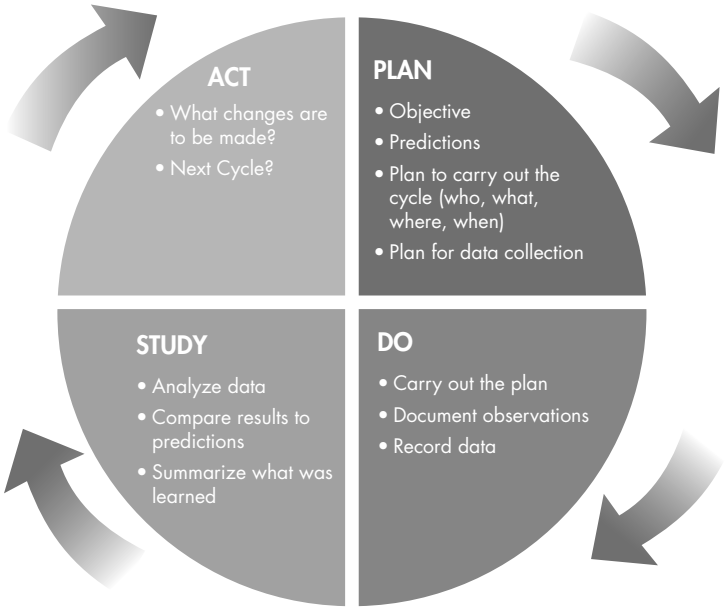
Click here to go to the Goal Setting Worksheet in Appendix A

STEP 10: Plan, Conduct and Document PIPs

Careful planning of PIPs includes identifying areas to work on through your comprehensive data review which are meaningful and important to your residents. It is important to focus your PIPs by defining the scope, so they do not become overwhelming.

You and your team may:

- consider each PIP a learning process.
- determine what information you need for the PIP.
- determine a timeline and communicate it to the Steering Committee.
- identify and request any needed supplies or equipment.
- select or create measurement tools as needed;
- prepare and present results.
- use a problem solving model like PDSA (Plan-Do-Study-Act).
- report results to the Steering Committee.



PDSA MODEL

PLAN-DO-STUDY-ACT (PDSA) CYCLE

During a PIP you will try out some changes and then see whether or not they made a difference in the area you were trying to improve. In the PLAN stage, the team learns more about the problem, plans for how improvement would be measured, and plans for any changes that might be implemented. In the DO stage, the plan is carried out, including the measures that are selected. In the STUDY phase, the team summarizes what was learned. In the ACT phase, the team and leadership determine what should be done next. The change can be adapted (and re-studied), adopted (perhaps expanded to other areas), or abandoned. That decision determines the next steps in the cycle.

STEP 11: Getting to the "Root" of the Problem

A major challenge in process improvement is getting to the heart of the problem or opportunity.

There is danger in starting with a solution without thoroughly exploring the problem. Multiple factors may have contributed, and/or the problem may be a symptom of a larger issue. What seems like a simple issue may involve a number of departments.

Root Cause Analysis (RCA) is a term used to describe a systematic process for identifying contributing causal factors that underlie variations in performance. This structured method of analysis is designed to get to the underlying cause of a problem –which then leads to identification of effective interventions that can be implemented in order to make improvements.

RCA helps teams understand that the most immediate or seemingly obvious reason for the problem or an event may not be the real reason that an event occurred. The RCA process leads to digging deeper and deeper—looking for the reasons behind the reasons. This process will generally lead to the identification of more than one root cause. The root cause(s) and any contributing factors can then be sorted into categories to facilitate the identification of various actions that can be taken to make improvements.

RCA focuses primarily on systems and processes, not individual performance.

The RCA process takes practice, but can be a valuable tool for performance improvement. In order to get familiar with RCA you and your team may consider:

- studying case examples of RCA.
- applying RCA to an adverse event and discussing this technique with the team.
- building RCA examples into training opportunities.

STEP 12: Take Systemic Action

Identifying root causes is only the first step in improving performance. Next you will want to implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring. This is often the most challenging step in the process. Common solutions such as providing more training/education or asking clinicians to "be more careful" do not change the process or system. These proposed solutions are based on two assumptions: lack of knowledge contributed to the event, and if a person is educated or trained, the mistake won't happen again.

Choosing actions that are tightly linked to the root causes and that lead to a system or process change are considered to have a higher likelihood of being effective. Actions that simply support the current process are considered "weaker" and should not be selected as the sole intervention. The goal is to make changes that will result in lasting improvement. Avoiding quick fixes and weak actions is vital to achieving that goal.

To be effective, interventions or corrective actions should target the elimination of root causes, offer long term solutions to the problem, and have a greater positive than negative impact on other processes. In addition, interventions must be achievable, objective, and measurable.

Pilot Test:

Think about testing or "piloting" changes in one area of your facility before launching throughout. Some changes have unintended consequences.

The Department of Veterans Affairs National Center for Patient Safety's Hierarchy of Actions[2] classifies corrective actions as:

Weak: Actions that depend on staff to remember their training or what is written in the policy. Weak actions enhance or enforce existing processes.

Examples of weak actions:

- double checks
- warnings/labels
- new policies/procedures/memoranda
- training/education
- additional study

Intermediate: Actions are somewhat dependent on staff remembering to do the right thing, but they provide tools to help staff to remember or to promote clear communication. Intermediate actions modify existing processes.

Examples of intermediate actions:

- decrease workload
- software enhancements/modifications
- eliminate/reduce distraction
- checklists/cognitive aids/triggers/prompts
- eliminate look alike and sound alike
- read back
- enhanced documentation/communication
- build in redundancy

[2]U.S. Department of Veterans Affairs. National Center for Patient Safety Root Cause Analysis Tools. Retrieved from http://www.patientsafety.gov/CogAids/RCA/index.html#page+page-1.

Strong: Actions that do not depend on staff to remember to do the right thing. The action may not totally eliminate the vulnerability but provides strong controls. Strong actions change or re-design the process. They help detect and warn so there is an opportunity to correct before the error reaches the patient. They may involve hard stops which won't allow the process to continue unless something is corrected or gives the chance to intervene to prevent significant harm.

Examples of strong actions:

- physical changes: grab bars, non slip strips on tubs/showers
- forcing functions or constraints: design of gas lines so that only oxygen can be connected to oxygen lines; electronic medical records – cannot continue charting unless all fields are filled in
- simplifying: unit dose

Prevent future problems by developing and testing strong actions.

QAPI Principles Summarized

- All of QAPI may not be new to your facility. You already have a Quality Assessment and Assurance program—consider beginning by evaluating or re-evaluating that program and then conducting a self evaluation using the QAPI Self Assessment Tool.
- QAPI leadership starts at the top with executive management and the Board of Directors, Owners, or Trustees, and includes top management in each home.
- Three important principles of QAPI are Systems, Systems, and Systems. Start using systems thinking as you assess your own QAPI efforts, and develop a QAPI plan moving forward. Think of your entire center or community as you plan for monitoring, as you conduct PIPs, and particularly as you think about the way problems might be caused and how care is organized.
- Involve the people directly working in a process in order to improve that process. These are the people who really know what happens at any point in the process. It is crucial to focus on organization-wide inclusion, not for the sake of inclusion, but to truly understand what is going on in any given process.
- Communication about QAPI should be continuous throughout the whole organization. QAPI principles and ongoing training should be built into a facility-wide educational effort that involves all caregivers, residents, and families.
- Residents' perspectives need to be considered in setting QAPI priorities. Solicit residents' viewpoints and talk to residents and families about quality as they experience it.
- Two important components of your QAPI plan will be setting priorities and chartering PIP teams. Everyone should have an opportunity to participate in these activities.
- Create a record of QAPI activities. Consider using past experience as a resource as you move ahead. Keeping an ongoing record of QAPI achievements may help to sustain the improvements regardless of crises or changes in leadership. Build it into your plan.
- Celebrate and reward successes.

How to Learn More

Our QAPI website: http://go.cms.gov/Nhqapi

An excellent resource on QAPI in Nursing Homes is CMS' QAPI website. It contains a number of tools and resources including:

- Learning modules complete with videos, QAPI Process Tools and how to use them, case study examples, best practices information, sections to help engage consumers, and much more
- Downloadable QAPI process tools with instructions for their use
- Best practice examples organized by topic
- QAPI tools for specific topics and purposes with links to many related resources
- Special resources for you in your particular practice role in the "Communities of Practice" section
- News Briefs on QAPI implementation

QAPI Tools and Related Resources

QAPI PROCESS TOOLS

These are tools that help make QAPI processes work. They may include:

- checklists
- templates
- flow charts
- reporting forms or outlines
- worksheets

QAPI process tools are important to:

- organize multiple tasks.
- enhance communication within and across teams.
- help generate ideas and reach decisions.
- keep information organized and accessible.
- track successes and challenges using data.

QAPI is largely about well-functioning and tightly coordinated systems that can identify, solve, and prevent problems effectively. Using QAPI can improve diverse aspects of care and services as well as resident, family, caregiver, and staff experience and satisfaction. **TOOLS CAN HELP.**

QAPI TOPIC TOOLS

QAPI Topic Tools are used to study and improve particular topic areas. Many tools are available to assess care processes and outcomes and to allow you to follow progress in areas you want to track and/or improve. Topic tools can take many forms, ranging from simple to complex, and they use multiple sources of information.

- Checklists or audits completed by caregivers and practitioners. Checklists can be used to review records of various kinds to determine that all steps have been taken. For example, an admission or fall prevention checklist.
- Rating forms completed by caregivers. For example,residents' mood states are rated when residents cannot respond to direct questions.
- Structured observation (e.g., observations of interactions among residents and caregivers or of physical environments). Observations are objective and made at specific times and places; later they may be summarized into a score.
- Direct interviews with residents and family. Such tools, sometimes called resident self-report tools, may be related to single areas of functioning.
- Protocols to guide caregivers' behavior to improve quality in a particular area. Such protocols may include procedures and forms meant to shape caregiver behavior around pressure ulcer prevention, respecting residents' rights, etc. This comprehensive set of tools could be considered a QAPI process toolkit as well.

Nursing homes may wish to select established tools that have been tested and use them consistently.

QAPI RESOURCES FOR PROVIDERS

Each state is served by a Quality Improvement Organization that offers resources and tools for nursing homes. To find your Quality Improvement Organization, visit http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793

RESOURCES AND TOOLS AVAILABLE THROUGH QIOS

Oklahoma Foundation for Medical Quality
Provides tools and resources for nursing homes.
http://www.ofmq.com/nhtoolsandresources Improvement basics for nursing homes, Change management, and Facilitating group agreement.

Stratis Health
The following recorded webinars cover some basic principles of QI and can be used for caregiver education: http://www.stratishealth.org/events/recorded.html

WEBSITES ON SELECTED QUALITY TOPICS

Advancing Excellence in America's Nursing Homes
Supported by CMS, the Commonwealth Fund, and others, The Advancing Excellence Campaign provides tools and resources to improve nursing home care in clinical and organizational areas.
http://www.nhqualitycampaign.org/

Agency for Healthcare Research and Quality
The Department of Defense and the Agency for Healthcare Research and Quality developed the Team STEPPS program to optimize performance among teams of healthcare professionals and improve collaboration and communication. The Long-Term Care version addresses issues specific to nursing homes: http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/ltc/index.html.

Department of Veterans Affairs
National Center for Patient Safety supports and leads the patient safety activities for all VA medical centers and has developed tools including Root Cause Analysis investigations: http://www.patientsafety.gov/CogAids/RCA/.

Getting Better All the Time: Working Together for Continuous Improvement
The Isabella Geriatric Center and Cobble Hill Health Center have developed a web manual on quality improvement approaches as a guide for nursing home caregivers. This is a particularly practical and lively resource that explains and illustrates performance monitoring and improvement approaches in ways that are understandable to most nursing home caregivers. *Getting Better All the Time* was written by Ann Wyatt, a social worker and nursing home administrator; it aims to present a model of quality improvement that integrates quality of care and quality life.
http://www.susanwehrymd.com/files/gettingbetterall-the-time.pdf

Interact II
An example of a more extensive set of tools, INTERACT II is a system of tools to improve how nursing home caregivers communicate around change in resident condition. This comprehensive set of tools could be considered a QAPI process toolkit as well. www.interact2.net

Institute for Health Care Improvement (IHI)
IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement. Learn about the fundamentals of the Model for Improvement and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles.
http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

WEBSITES ON PERSON-CENTERED CARE

Implementing Change in Long-Term Care: A Practical Guide to Transformation
This resource was prepared by Barbara Bowers and others with a grant from the Commonwealth Fund to the Pioneer Network. Although it deals with implementing culture change (not QAPI), it is a good resource on the change process.
http://www.pioneernetwork.net/Data/Documents/Implementation_Manual_ChangeInLongTermCare%5B1%5D.pdf

Picker Institute Publications
These include a *Long-Term Care Improvement Guide*, commissioned in 2010 and a *Patient-Centered Care Improvement Guide*, commissioned in 2008, both by Susan Frampton and others. The website also carries information on current books related to person centered care that Picker Institute recommends.
http://pickerinstitute.org/publications-and-resources/

Appendix A: QAPI Tools

Disclaimer: Use of these tools is not mandated by CMS for regulatory compliance nor does their completion ensure regulatory compliance.

QAPI Self-Assessment Tool

Directions: Use this tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization's progress with QAPI. This tool should be completed with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization. You may find it helpful to add notes under each item as to why you rated yourself a certain way.

Date of Review:_____ Next review scheduled for:_____

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Our organization has developed principles guiding how QAPI will be incorporated into our culture and built into how we do our work. For example, we can say that QAPI is a method for approaching decision making and problem solving rather than considered as a separate program. Notes:					
Our organization has identified how all service lines and departments will utilize and be engaged in QAPI to plan and do their work. For example, we can say that all service lines and departments use data to make decisions and drive improvements, and use measurement to determine if improvement efforts were successful. Notes:					
Our organization has developed a written QAPI plan that contains the steps that the organization takes to identify, implement and sustain continuous improvements in all departments; and is revised on an ongoing basis. For example, a written plan that is done purely for compliance and not referenced would not meet the intent of a QAPI plan. Notes:					
Our board of directors and trustees (if applicable) are engaged in and supportive of the performance improvement work being done in our organization. For example, it would be evident from meeting minutes of the board or other leadership meetings that they are informed of what is being learned from the data, and they provide input on what initiatives should be considered. Other examples would be having leadership (board or executive leadership) representation on performance improvement projects or teams, and providing resources to support QAPI. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
QAPI is considered a priority in our organization. For example, there is a process for covering caregivers who are asked to spend time on improvement teams. Notes:					
QAPI is an integral component of new caregiver orientation and training. For example, new caregivers understand and can describe their role in identifying opportunities for improvement. Another example is that new caregivers expect that they will be active participants on improvement teams. Notes:					
Training is available to all caregivers on performance improvement strategies and tools. Notes:					
When conducting performance improvement projects, we make a small change and measure the effect of that change before implementing more broadly. An example of a small change is pilot testing and measuring with one nurse, one resident, on one day, or one unit, and then expanding the testing based on the results. Notes:					
When addressing performance improvement opportunities, our organization focuses on making changes to systems and processes rather than focusing on addressing individual behaviors. For example, we avoid assuming that education or training of an individual is the problem, instead, we focus on what was going on at the time that allowed a problem to occur and look for opportunities to change the process in order to minimize the chance of the problem recurring. Notes:					
Our organization has established a culture in which caregivers are held accountable for their performance, but not punished for errors and do not fear retaliation for reporting quality concerns. For example, we have a process in place to distinguish between unintentional errors and intentional reckless behavior and only the latter is addressed through disciplinary actions. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Leadership can clearly describe, to someone unfamiliar with the organization, our approach to QAPI and give accurate and up-to-date examples of how the facility is using QAPI to improve quality and safety of resident care. For example, the administrator can clearly describe the current performance improvement initiatives, or projects, and how the work is guided by caregivers involved in the topic as well as input from residents and families. Notes:					
Our organization has identified all of our sources of data and information relevant to our organization to use for QAPI. This includes data that reflects measures of clinical care; input from caregivers, residents, families, and stakeholders, and other data that reflects the services provided by our organization. For example, we have listed all available measures, indicators or sources of data and carefully selected those that are relevant to our organization that we will use for decision making. Likewise, we have excluded measures that are not currently relevant and that we are not actively using in our decision making process. Notes:					
For the relevant sources of data we identify, our organization sets targets or goals for desired performance, as well as thresholds for minimum performance. For example, our goal for resident ratings for recommending our facility to family and friends is 100% and our threshold is 85% (meaning we will revise the strategy we are using to reach our goal if we fall below this level). Notes:					
We have a system to effectively collect, analyze, and display our data to identify opportunities for our organization to make improvements. This includes comparing the results of the data to benchmarks or to our internal performance targets or goals. For example, performance improvement projects or initiatives are selected based on facility performance as compared to national benchmarks, identified best practice, or applicable clinical guidelines. Notes:					
Our organization has, or supports the development of, employees who have skill in analyzing and interpreting data to assess our performance and support our improvement initiatives. For example, our organization provides opportunities for training and education on data collection and measurement methodology to caregivers involved in QAPI. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
From our identified opportunities for improvement, we have a systematic and objective way to prioritize the opportunities in order to determine what we will work on. This process takes into consideration input from multiple disciplines, residents and families. This process identifies problems that pose a high risk to residents or caregivers, is frequent in nature, or otherwise impact the safety and quality of life of the residents. Notes:					
When a performance improvement opportunity is identified as a priority, we have a process in place to charter a project. This charter describes the scope and objectives of the project so the team working on it has a clear understanding of what they are being asked to accomplish. Notes:					
For our Performance Improvement Projects, we have a process in place for documenting what we have done, including highlights, progress, and lessons learned. For example, we have project documentation templates that are consistently used and filed electronically in a standardized fashion for future reference. Notes:					
For every Performance Improvement Project, we use measurement to determine if changes to systems and process have been effective. We utilize both process measures and outcome measures to assess impact on resident care and quality of life. For example, if making a change, we measure whether the change has actually occurred and also whether it has had the desired impact on the residents. Notes:					
Our organization uses a structured process for identifying underlying causes of problems, such as Root Cause Analysis. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
When using Root Cause Analysis to investigate an event or problem, our organization identifies system and process breakdowns and avoids focus on individual performance. For example, if an error occurs, we focus on the process and look for what allowed the error to occur in order to prevent the same situation from happening with another caregiver and another resident. Notes:					
When systems and process breakdowns have been identified, we consistently link corrective actions with the system and process breakdown, rather than having our default action focus on training education, or asking caregivers to be more careful, or remember a step. We look for ways to assure that change can be sustained. For example, if a policy or procedure was not followed due to distraction or lack of caregivers, the corrective action focuses on eliminating distraction or making changes to staffing levels. Notes:					
When corrective actions have been identified, our organization puts both process and outcome measures in place in order to determine if the change is happening as expected and that the change has resulted in the desired impact to resident care. For example, when making a change to care practices around fall prevention there is a measure looking at whether the change is being carried out and a measure looking at the impact on fall rate. Notes:					
When an intervention has been put in place and determined to be successful, our organization measures whether the change has been sustained. For example, if a change is made to the process of medication administration, there is a plan to measure both whether the change is in place, and having the desired impact (this is commonly done at 6 or 12 months). Notes:					

Guide for Developing Purpose, Guiding Principles, and Scope for QAPI

Directions: Use this tool to establish the purpose, guiding principles and scope for QAPI in your organization. The team completing this worksheet should include senior leadership. Taking time to articulate the purpose, develop guiding principles, and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan. Use these step-by-step instructions to create a separate document that may be used as a preamble to your QAPI plan.

STEP 1. LOCATE OR DEVELOP YOUR ORGANIZATION'S VISION STATEMENT

A **vision statement** is sometimes called a picture of your organization in the future; it is your inspiration and the framework for your strategic planning. Consider involving staff in the development of your vision statement. Post it for everyone to view.

For example, the vision of the Good Samaritan Society is to create an environment where people are loved, valued and at peace.

STEP 2. LOCATE OR DEVELOP YOUR ORGANIZATION'S MISSION STATEMENT

A **mission statement** describes the purpose of your organization. The mission statement should guide the actions of the organization, spell out its overall goal, provide a path, and guide decision-making. It provides the framework or context within which the company's strategies are formulated. As above, get caregivers involved in establishing your organizations mission.

For example, Meadowlark Hills is each resident's home. We are committed to enhancing quality of life by nurturing individuality and independence. We are growing a value-driven community while leading the way in honoring inherent senior rights and building strong and meaningful relationships with all whose lives we touch.

STEP 3. DEVELOP A PURPOSE STATEMENT FOR QAPI

A **purpose statement** describes how QAPI will support the overall vision and mission of the organization. If your organization does not have a vision or mission statement, the purpose statement can still be written and would state what your organization intends to accomplish through QAPI.

For example, the purpose of QAPI in our organization is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers and other partners so that we may realize our vision to [reference aspects of vision statement here]. To do this, all employees will participate in ongoing QAPI efforts which support our mission by [reference aspects of mission statement here].

STEP 4. ESTABLISH GUIDING PRINCIPLES

Guiding Principles describe the organization's beliefs and philosophy pertaining to quality assurance and performance improvement. The principles should guide what the organization does, why it does it and how.

For example:

- Guiding Principle #1: QAPI has a prominent role in our management and Board functions, on par with monitoring reimbursement and maximizing revenue.
- Guiding Principle #2: Our organization uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
- Guiding Principle #3: The outcome of QAPI in our organization is the quality of care and the quality of life of our residents.
- Guiding Principle #4: In our organization, QAPI includes all employees, all departments and all services provided.
- Guiding Principle #5: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- Guiding Principle #6: Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, health care practitioners, families, and other stakeholders.
- Guiding Principle #7: Our organization sets goals for performance and measures progress toward those goals.
- Guiding Principle #8: Our organization supports performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice.
- Guiding Principle #9: Our organization has a culture that encourages, rather than punishes, employees who identify errors or system breakdowns.

Add any additional Guiding Principles that may be important to your nursing home. Review the five QAPI elements to ensure you identify and capture guiding principles for your organization.

STEP 5. DEFINE THE SCOPE OF QAPI IN YOUR ORGANIZATION

The **Scope** outlines what types of care and services are provided by the organization that impact clinical care, quality of life, resident choice, and care transitions. Be sure to incorporate the care and services delivered by all departments.

For example:

Post-acute care
Dementia care and services
Dietary
Dining

Once the list of care and service area has been identified, you can determine how each will use QAPI to assess, monitor and improve performance on an ongoing basis.

STEP 6. ASSEMBLE DOCUMENT

Once you've completed steps 1-5, assemble the vision and mission statements, guiding principles, and scope of QAPI into a separate document that may be used as a preamble to your QAPI plan. This document will help you articulate the goals and objectives of your organization; QAPI will help you get there. Consider posting for all to see.

The next step is to develop a written QAPI plan that will meet your purpose, guiding principles and comprehensive scope described above. See *"Guide for Developing a QAPI Plan."*

Guide for Developing a QAPI Plan

DIRECTIONS:

The QAPI plan will guide your organization's performance improvement efforts. Prior to developing your plan, complete the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI.* Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI, therefore this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

I. QAPI Goals

Based on the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI*, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant, and have a time line for completion. (See *Goal Setting Worksheet*).

II. Scope

a. Describe how QAPI is integrated into all care and service areas of your organization.
b. Describe how the QAPI plan will address:
    i. Clinical care
    ii. Quality of life
    iii. Resident choice (i.e., individualized goals for care)
c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents).
d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership

a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).
b. Describe how QAPI will be adequately resourced.
    i. Designate one or more persons to be accountable for QAPI leadership and for coordination.
    ii. Indicate the plan for developing leadership and facility-wide training on QAPI.
    iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.
    iv. Indicate how you will determine if resources are adequate for QAPI.
    v. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

c. QAPI Leadership
    i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current QAA committee.
    ii. Describe how this group of people will work together, communicate, and coordinate QAPI activities. This could include but is not limited to:
        - Establishing a format and frequency for meetings
        - Establishing a method for communication between meetings
        - Establishing a designated way to document and track plans and discussions addressing QAPI.
    iii. Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, owner.

IV. Feedback, Data Systems, and Monitoring

a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.
b. Identify the sources of data that you will monitor through QAPI
    i. Input from caregivers, residents, families, and others
    ii. Adverse events
    iii. Performance indicators
    iv. Survey findings
    v. Complaints
c. Describe the process for collecting the above information.
d. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.
e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects.
f. Identify who will receive this information (i.e., executive leadership, QAPI leadership, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects (PIPs)

a. Describe the overall plan for conducting PIPs to improve care or services.
    i. Indicate how potential topics for PIPs will be identified.
    ii. Describe criteria for prioritizing and selecting PIPs: areas important and meaningful for the specific type and scope of services unique to the facility, requires a concentrated effort on a particular problem in one area of the facility or facility wide.
    iii. Indicate how and when PIP charters will be developed.
    iv. Describe the process for reporting the results of PIPs. Identify who will receive this information (i.e., quality committee, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

b. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific PIPs.

c. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that it include resident representation (as appropriate), and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.

d. Describe your process for documenting PIPs, including highlights, progress, and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference.

VI. Systematic Analysis and Systemic Action

a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize any "unintended" consequences of your actions. Describe how your organization will identify these consequences which may be either positive or negative.

b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.

c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

VII. Communications

Outline the audiences for QAPI communications and the frequency and format of these communications.

VIII. Evaluation

a. Describe the process for assessing QAPI in your organization on an ongoing basis. (See *QAPI Self-Assessment Tool*.)

b. Describe the purpose of this evaluation – to help your organization to expand your skills in QAPI and increase the impact of QAPI in your organization.

IX. Establishment of Plan

a. Date your plan.

b. Determine when you will revisit the plan (i.e., at least annually).

c. Determine how you will track revisions or updates to the plan.

Goal Setting Worksheet

Directions: Goal setting is important for any measurement related to performance improvement. This worksheet is intended to help QAPI teams establish appropriate goals for individual measures and also for performance improvement projects. Goals should be clearly stated and describe what the organization or team intends to accomplish. Use this worksheet to establish a goal by following the SMART formula outlined below. Note that setting a goal does **not** involve describing what steps will be taken to achieve the goal.

Describe the business problem to be solved:

Use the SMART formula to develop a goal:

SPECIFIC

Describe the goal in terms of 3 'W' questions:

What do we want to accomplish?
Who will be involved/affected?
Where will it take place?

MEASURABLE

Describe how you will know if the goal is reached:

What is the measure you will use?
What is the current data figure (i.e., count, percent, rate) for that measure?
What do you want to increase/decrease that number to?

ATTAINABLE

Defend the rationale for setting the goal measure above:

Did you base the measure or figure you want to attain on a particular best practice/average score/ benchmark?
Is the goal measure set too low that it is not challenging enough?
Does the goal measure require a stretch without being too unreasonable?

RELEVANT

Briefly describe how the goal will address the business problem stated above.

TIME-BOUND

Define the timeline for achieving the goal:

What is the target date for achieving this goal?

Write a goal statement, based on the SMART elements above. The goal should be descriptive, yet concise enough that it can be easily communicated and remembered.

[*Example:* Increase the number of long-term residents with a vaccination against both influenza and pneumococcal disease documented in their medical record from 61 percent to 90 percent by December 31, 2011.]

Tip: It's a good idea to post the written goal somewhere visible and regularly communicate the goal during meetings in order to stay focused and remind caregivers that everyone is working toward the same aim.

Appendix B: QAPI Definitions

Performance Improvement (PI)

PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

Performance Improvement Project (PIP)

A PIP project typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. PIPs are selected in areas important and meaningful for the specific type and scope of services unique to each facility.

Quality Assurance and Performance Improvement (QAPI)

QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

Quality Assurance (QA)

QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.

Root Cause Analysis (RCA)

Root cause analysis is a term to describe a systematic process to get to the underlying cause of a problem.

Systems Thinking

Systems thinking is a perspective that considers how things influence one another as a whole, rather than individual elements, or static "snapshots."

Getting Better All the Time

Working Together for Continuous Improvement: A Guide for Nursing Home Staff

This Manual is a product of the Cobble Hill—Isabella Collaboration Project
Cobble Hill Health Center — Isabella Geriatric Center

COBBLE HILL
health center
WE KEEP BROOKLYN HEALTHY...HAPPY...HOME.

isabella
Welcome to our family.

We gratefully acknowledge the financial support of The New York Community Trust, the United Hospital Fund, and 1199 SEIU Training and Employment Funds.

Getting Better All the Time

Working Together for Continuous Improvement: A Guide for Nursing Home Staff

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Introduction

The goal of a nursing home never changes: to provide the best possible care for the people who live here, and to nourish the spirit of residents and staff alike. At the same time, nursing homes are places that change every day: residents and workers come and go, staff learn better ways to deliver care, equipment is modernized, and new regulations are introduced. Thus, to do our work well means adapting to change, and continuously learning new and more effective ways of working — as individuals, as teams, and as an organization.

The need to change can come from many sources, internal and external. For instance, a nurse may report that a high number of residents are falling on a particular unit. A dining service worker may have an idea about how to make meals more enjoyable. The resident council may have suggestions about how to improve the activities program. Nursing Assistants and individual residents frequently have suggestions for improvement. Ideas for change also come from family and staff satisfaction questionnaires, New York State Department of Health surveys, and even from letters of complaint.

Whenever we try to make a change, the most important question we need to ask is: How can we ensure that the change will actually do what is intended? Some changes will undoubtedly be good, such as repairing a broken stairway railing. But even well-intentioned ideas can have bad outcomes. For example, housekeeping might try a new floor wax because it is easier to apply, only to discover that it causes more residents and staff to slip and fall.

So, how can we ensure that changes will actually work? The answer is a process called quality improvement, or QI, an approach that has been successfully adopted by all sorts of organizations, from manufacturers to hotels to hospitals. In short, QI is a scientific approach to evaluating and improving care using teamwork and leadership. Put another way, QI helps us sort out where improvements are needed most, and then helps us determine if we've achieved the changes we were hoping for — and if not, what to do next.

Nursing Home Quality Improvement

You may already have heard about QI. In the past, QI programs in nursing homes tended to focus on clinical issues, such as preventing falls or pressure sores. As nursing homes become more person-centered, we have learned that we will be more successful at improving quality-of-care issues if we also consider quality-of-life issues.

For example, if a resident is not eating well, one might reasonably assume that the cause is related to her diagnosis. However, it might be that she simply doesn't like the taste of the food, that the food is too hot or cold, that she's not getting the assistance she needs, or that she doesn't like her dining companions. If we don't take the time to find out what is really troubling the resident, we cannot solve the problem and get her proper nourishment.

Another lesson from QI is that everyone who might be affected by a proposed change needs to be involved in the QI process. In the QI world, these people are called stakeholders. Stakeholders are not just department heads, they also include those closest to the issue at hand, such as direct care staff, as well as supervisors, residents, and family members. Most of the time, many different departments, and sometimes different shifts, are affected and need to be included as part of the process as well.

Finally, research has shown that there is a direct link between resident satisfaction and staff satisfaction. When residents and families are happy, so too are staff, and vice versa. At our facility, we believe that working together to improve our living and working environment will benefit residents, families, and staff alike. That is why one of our core values is promoting a continuous learning environment for all staff.

Where Do Ideas for Change Come From?

In a nursing home, QI happens many ways. Most ideas for QI grow out of interactions between staff members or among staff members, residents and family members. For instance, when we learn that a resident enjoys listening to Mets games, and we make sure that he gets to hear those games, we are improving quality. When we learn that a resident eats a better breakfast if she has a cup of coffee first, and we make sure they get the coffee, we are improving quality. If we know that a fellow staff member is new on the unit, and we make them feel welcome, we are improving quality.

Often, changes need to be made on the unit or neighborhood level, or across the entire facility. For example, most nursing homes have a committee, or workgroup, to study how to prevent pressure sores. Most nursing homes also have a falls workgroup. Including not only RNs and CNAs from different shifts but also other departments (such as Medicine, to study pressure sores, and Environmental Services, to study falls prevention) can increase the likelihood that effective prevention strategies will be identified and implemented. Such workgroups can bring together staffers from different disciplines

and different roles — that is, all the stakeholders — to address problems that no one person can solve on his or her own.

Since health care facilities have a constant need to solve these kinds of problems, the federal government requires all nursing homes to have an ongoing quality assessment and assurance committee, typically called the Performance Improvement Committee. Whatever its name, the committee usually consists of staff members from different departments and reports regularly to the board of directors.

The Performance Improvement Committee oversees QI projects and establishes workgroups to address specific issues or problems. These workgroups — made up of representatives of the relevant stakeholders — then report their progress back to the overall committee. (Workgroups are discussed in greater detail below.)

Although the Performance Improvement Committee is responsible for overseeing QI projects, that doesn't mean that every QI effort works under the direct supervision of the committee. On some occasions, it's appropriate for staff on a unit or in a specific department to identify a small problem and try out a solution all on their own, without the need to turn it into an actual project.

Your Role in Quality Improvement

A nursing home cannot hope to provide a high level of care, or create a comfortable and rewarding work environment, unless everyone makes the achievement of quality a top priority. The work that each of you do is essential to the functioning of your organization, and how you do your work has an impact on everyone around you, including your colleagues as well as residents and their family and friends.

As you go about your work, and as you engage in problem-solving projects, it is critical that you to listen to the perspectives and needs of others.

Consider these examples:

- A staff member might make beds that look perfect in every way, neat and trim, yet some residents may find them uncomfortable because the sheets press too tightly on their feet. The only way to know whether the bed is comfortable is by asking and observing.
- If a laundry problem arises, the natural inclination would be to think of it as a housekeeping issue. However, many other departments — as well as residents and family members — are involved in the collecting, cleaning, distributing and storing of clothing. Forming a workgroup that includes all these stakeholders is an essential first step in addressing the problem.
- The security department may be considering renewal of a contract for a small piece of equipment worn by residents that notifies the department if a resident with dementia attempts to leave the building. However, the security department's criteria for an effective piece of equipment may be somewhat different than the nursing department's or the finance department's criteria. Including these departments in the decision-making process will help ensure that the best product is selected.

Getting Started

Workgroups are at the heart of the QI process. As mentioned above, they should involve all of the stakeholders in a given issue, especially an issue that has an impact on resident care and daily operations. In forming a workgroup, the Performance Improvement Committee will consider who the stakeholders are — that is, which staff, which disciplines, which shifts, which residents, and which family members are affected by the issue. Then, the committee will identify people who can represent the perspectives of these stakeholders on the workgroup. The committee will also select one or two people to act as workgroup coordinators, or facilitators.

Next, the committee will give the workgroup a set of instructions for carrying out the project, specifically:

(1) What is to be accomplished (what is the problem to be solved?)

(2) What is known about the issue

(3) Suggestions for outcome measures, and

(4) Any boundaries within which the workgroup should work

In addition, if there are stakeholders who are not directly represented in the workgroup, the workgroup must find ways to communicate with them directly. This will ensure that the workgroup gains these stakeholders' perspective on the potential change, and it may help identify ways to measure their response to the change once it is enacted.

For example, a workgroup may have a QI project that will affect housekeeping on all three shifts. Even if there is a housekeeping department representative from the day shift in the workgroup, workgroup members should arrange for meetings to be held with staff on the other shifts as well, ensuring their perspectives are heard and that they are included in the planning and evaluation process. In addition, it is a good idea for the person who is representing the day shift to go back and talk with other day shift housekeeping staff, to hear their perspectives and concerns.

If all the stakeholders in an improvement project are given an opportunity to participate in the QI process, and they understand its goals, they are much more likely to help make the project a success. It is hard to be helpful if you don't understand what is happening.

Working Arrangements

Workgroups typically vary in size from two to ten people. (Larger groups tend to be difficult to manage and can therefore be less productive.) Each workgroup should have a coordinator, or facilitator, who ensures that the group comes together and follows through in its efforts.

When setting up a workgroup meeting, keep these considerations in mind:

- Record minutes of each meeting. Minutes help the group keep track of the discussions and decisions made at each meeting. Minutes should be as simple and brief as possible and include a list of those in attendance (see sample format in Appendix 1).
- Set a beginning time and an ending time, and stick to them as closely as possible.
- Set an agenda for each meeting, with a limited number of items, so that there is enough time for discussion. If the agenda starts to get too long, move some topics to the next meeting.

- Assign tasks to individuals or small sub-groups to complete in-between meetings. Those with assignments should report back at workgroup meetings so that everyone is informed.
- Choose a quiet place to meet that won't have frequent interruptions.
- Quick on-floor meetings, no longer than 15 minutes — can help move the project along in-between regularly scheduled meetings. These can be especially helpful for front-line staff and bedside caregivers, who may find it more difficult to leave the units for lengthier meetings.
- When workgroup members need time for project meetings or activities, they require the support of their co-workers and supervisors.

Communication

At the workgroup's first meeting, it is vital to develop a sense of teamwork. Teamwork stems from good communication. "Icebreaker exercises" can help workgroup members get to know each other better (see Appendix 2).

Once the workgroup has decided what improvement they want to test, the simplest way to get started is to review four key steps: Plan, Do, Study, Act, using the checklists in Appendix 3. (This process is explained in more detail below.) Then, make a list of the tasks ahead, decide who will do what, and establish a timetable for each step.

As the workgroup begins its planning process, encourage everyone's participation, and listen carefully to what each person has to say. While there may be conflicting points of view, disagreements are best handled by trying to understand them as much as possible and by talking through the differences. Problems are much harder to solve if different points of view are not taken into account.

To encourage participation in discussions, "learning circles" can be very helpful. A learning circle (described more fully in Appendix 2) is a method of talking about an issue of concern. Basically, a topic or question is raised, and then each person in the group is asked for his or her thoughts. No one should be allowed to interrupt or comment on what someone else has to say until everyone else has had their turn, and then the topic is opened for discussion.

Stakeholders: Getting Everyone's Perspective

The best way to increase the odds of solving a problem or implementing an improvement is to include the perspectives of people most affected by the issue at hand. True person-centered care can occur only if staff listen to residents and their families, and try to learn more about their needs, preferences, and opinions. Nursing homes can also promote person-centered care by encouraging communication and conversation among all levels of staff, and across all shifts and departments.

When forming a workgroup, the Performance Improvement Committee should answer the following questions:

- Who are most affected by this problem or need for improvement?
- Who can help us gain a better understanding of this problem?

Based on the answers to these questions, the committee will then be able to appoint a workgroup that includes all the relevant perspectives and stakeholders.

The workgroup should always be open to outside advice and opinions. Once the workgroup is formed, it is helpful to seek the opinions of others in the facility. This is a great way to learn more about the problem, to find possible solutions, and to test whether the workgroup's solution is satisfactory. This can be done in many ways, including focus groups, questionnaires, and interviews (see Appendix 4).

Communication, Communication, Communication!

As you tackle a QI project, let others know about your efforts. What you learn may be helpful to other staff members who may be trying to make similar changes. Also, your efforts may inspire your colleagues to address other problems.

In addition, telling other people, including residents, families, and staff, about your project is important because most changes have an impact on everyone in the facility. People are more likely to respond positively to change if they understand exactly what is being changed and why. In addition, proper communication can minimize both confusion and discomfort associated with change, and it can even give people a reason to look forward to change.

There are many ways to share information about upcoming changes. One approach is to hold small group meetings with residents, families, and staff members, while providing ample opportunity for people to ask questions. To reach a wider audience, you might want to hold larger meetings, perhaps incorporating skits showing before-and-after impressions of the changes. This can be an entertaining and humorous way of making the presentation more interesting.

Another way to share information is to make presentations at Performance Improvement Committee meetings, neighborhood or unit meetings, departmental meetings, resident council meetings, and family council meetings. For presentations and large group meetings, it's a good idea for several workgroup members to participate in explaining different aspects of the project.

One way of organizing presentations is by telling the "story" of your project. Storyboards (a series of illustrations or images on large pieces of cardboard) or computer slide-shows (including photographs, charts, or new forms) can be used to communicate the main points of your project. Such presentations should be as simple as possible. Also, they should convey the purpose of the project, how it was tested, what you learned, and any plans for implementation or further investigation. (Tips for presentations appear in Appendix 5.)

Finally, share your experiences through letters or articles in facility newsletters. This will help spread the word about your project to staff members, residents, and family members who cannot attend meetings or presentations.

The Change Process

For every QI project, the process is the same — whether it is small or large, or whether it is undertaken by an individual or by a group.

There are three important questions to answer:

(1) What are we trying to accomplish?

(2) What changes can we make to bring about an improvement?

(3) How will we know whether the change is an improvement?

The four-step ***Plan, Do, Study, Act (PDSA) Cycle*** can help you answer these questions.

Plan

Planning begins with the question, *What are we are trying to improve?* Or, put another way, *What are we trying to accomplish?* Once this is established, you'll need to consider a few more questions: How much do we know about the issue?; What else do we need to know about the issue?, and Whom should we talk with to get additional information? (Appendix 6 lists several methods for clarifying what you are trying to accomplish.)

Once you've answered these questions, it's time to decide what changes need to be made in order to bring about the improvement: *What changes can we make to bring about an improvement?*

In addition, you need to decide how you are going to measure the outcomes: *How will we know whether a change is an improvement?* Not every change results in an improvement, so it is essential to identify specific ways of measuring the effects of a change at the very beginning, before making any actual changes. It is also important to measure change from different perspectives. A specific improvement may work for staff, but not for residents, or vice versa. We are looking for changes that work for all the stakeholders involved. (See Appendix 7 for tips on measuring your progress.)

Do

The next step is to test the change on a small scale. This allows you to learn from experience before trying to implement it more broadly. Before starting, the workgroup needs to decide what criteria (or measures) they are going to use to judge whether their test is successful. Once the trial date(s) has been set, all those affected by the changes — staff, residents, family and friends — need to be informed about the plan. After the trial phase has been completed, data should be collected.

Study

At this point, it's time to evaluate the results. By comparing information collected before and after the test (that is, baseline data and the final outcomes), and by evaluating any input from staff, residents and families, you can determine if the proposed change resulted in the desired improvement. Here, the two basic questions to ask are: Did it work? and, If not, why not? Often, when a change is tested, ideas for further improvements emerge. So, another important question to consider is: What new knowledge did you learn as a result of the test? (See Appendix 8 for tools to help understand and evaluate data.)

Act

The next step, based on studying the test results, is to determine what actions will be taken: If the test is considered successful, how will you spread the change? What preparations and training need to occur for full implementation? What is the plan for ongoing monitoring? Did the test identify other opportunities for improvement?

The results of the test may reveal that the change didn't work, or that adjustments are needed. That requires a new test. Each and every time you alter your improvement, you should repeat the PDSA cycle. This is the best way to ensure that a change is an improvement.

The final step in this phase of the PDSA cycle is to plan for ongoing monitoring. This will make sure that a change that has been instituted continues to work in the long run.

See Appendix 3 for a PDSA checklist, and for an example of how to use the PDSA Cycle for planning a project.

Other Things to Consider in the PDSA Cycle

Even simple projects can benefit from the PDSA process. For example, if a nursing assistant notices that a resident frequently loses the TV remote control in his bedroom, she might talk to the resident and someone in maintenance about attaching it to the resident's bedside. The important steps in this process are (1) observing that something could be improved for the resident, (2) talking with the resident about the improvement, (3) discussing with maintenance about how to achieve the improvement, and (4) checking back later and seeing if the change is working and if the resident is pleased with the arrangement. The change, if successful, might lead to additional benefits. For instance, the resident may be less likely to ring the call bell for assistance or to fall while searching for the remote.

For more complicated change projects, such as those involving many improvements, you may choose to go through the PDSA process for each improvement, rather than trying to test the whole project at once. For example, your goal may be to improve dining services by changing from a tray line to steam tables on the unit, thus allowing for more flexible dining hours and also greater variety of meal choice. This would be a complicated project. It might be better to concentrate first on the move from the tray line to the steam tables. The second step might be experimenting with flexible dining hours, and the third, experimenting with different menu options. Again, each step of the way, be sure to involve staff, residents, and family members in assessing whether the change is an improvement.

So, no matter how complicated or how simple the QI project, ***be sure to follow the PDSA Cycle: Plan, Do, Study, Act.***

Appendix 1

Sample Form for Meeting Minutes

Date:

Present:

Excused:

Topic	Discussion	Action Plan/ Recommendations	Responsible Person:	Follow up Due:
1.				
2.				

Appendix 2

Communicating with Each Other

Effective problem-solving depends upon effective communication. Effective communication means really listening to other people, and being able to appreciate perspectives that differ from one's own. What follows are tools for enhancing communication within workgroups.

Ice Breakers

The purpose of ice breakers is to help people start communicating more comfortably with one another. Ice breakers can be a way of finding common ground and getting to know other people a little better.

Whenever a workgroup meets for the first time, it's a good idea to start with an icebreaker. Even if people in the group already know each other, they may not have worked together directly. Also, in almost any group, group members will know some people in the group better than others. Ice breakers can help everyone feel a little more comfortable.

A simple ice breaker is to ask group members to find someone else in the group whom they don't know well or at all, and have them meet for five minutes or so. When the group comes back together, ask each person to introduce to the group the person they just met with. A variation on this approach is to ask the two people to find something they have in common and report back to the group.

There are dozens of other ice breakers that can be used. The following books have good ideas:

201 Icebreakers, *by Edie West, McGraw-Hill, New York (1996).*

The Big book of Team Building Games, *by J. Newstrom and E. Scannell, McGraw-Hill, New York (1997)*

Learning Circles

This is an approach that helps ensure that everyone in the group is asked for his or her opinion about the issues at hand. Learning circles can be used throughout the workgroup's progress. For example, as a workgroup is getting started, the facilitator might pose the question: "Why do you think this is an important issue for the workgroup?" Members in the workgroup will represent different perspectives, and they may have had different experiences that others in the group are unfamiliar with. The guidelines for learning circles on the next page are from the organization ActionPact (used with permission).

Using Learning Circles when coming to conclusion and consensus: There are times in the workgroup process when the group will need to make a decision. This is an important moment in the group's experience, not just because of the decision itself, but also because it is essential that all group members feel they have had a part in the decision. One way to reinforce the value of everyone's contribution is by using a learning circle to ask everyone: Do you agree with this decision? If so, why? If not, why not? This gives all participants a chance to be clear about their opinion, one way or the other. While it's not always possible to reach a consensus, acknowledging everyone's perspective when making a decision is a critical part of the group process.

Learning Circles

Participants: Participants may include workers, residents, family, and community members or any combination thereof. The ideal number of circle participants is 10-15. If more than 20 are involved, consider suggesting that everyone limit their responses to a sentence or two.

Goal: To develop common ground and mutual respect among the diversity of the nursing home residents, direct care givers, families, management, different departments, and professions.

Rules For the Learning Circle:

Everyone sits in a circle without tables or other obstructions blocking their view of one another.

One person is the facilitator to pose the question or issue. (The question and facilitator may have been determined ahead of time by the team/individual planning the circle. If a universally negative response to a question is predicted, consider shaping the question into two parts. For example: "Share one thing that worries you and one thing that excites you about...")

Be aware that emotional topics can be overwhelmingly in large circles. If the facilitator believes a question will elicit strong feelings of sadness, depression, grief, or anger limit the number of participants to 8-10 and keep them apprised of the time allotted for the circle so they may adjust themselves emotionally. Keep the time per person fairly short (30 seconds is good.) Remember you will be opening it up for discussion immediately after, and it does not take too long to share the feeling. The interpretation or the reasons why would, in this circumstance, be better in general discussion so that people may support, motivate, placate, and cheer as needed.

The facilitator poses the question or issue and asks for a volunteer. A volunteer in the circle responds with his/her thoughts on the chosen topic. The person sitting to the right or left or the first respondent goes next, followed one by one around the circle until everyone has spoken on the subject without interruption.

No cross talk. The facilitator should have made this rule clear at the beginning so that they do not need to interrupt often to enforce the rule of no talking across the circle. (Involuntary laughter and simple words of empathy should not be quelled. But others may not add their thoughts or opinions on an issue until it is their turn to speak.)

One may choose to pass rather than to speak when their time comes. But after everyone else in the circle has had their turn, the facilitator goes back to those who passed and allows each one the opportunity to respond. Of course no one is forced to speak, but there is the expectation that they will. (Usually, they do respond with gentle encouragement

from the facilitator who may need to prompt the talkative to hold their tongue.)

Open general discussion on the topic after everyone has had a chance to speak. While on the surface, the Learning Circle is simply a common sense technique for organizing meetings; there are subtle, underlying forces (of sharing, respect, and broadening one's perspective) at work that yield astounding results.

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Appendix 3

Checklists for Plan, Do, Study, Act (PDSA) Cycle

These checklists can help workgroups make sure they are considering everything they need to carry out a project. Although some questions may be very easy to answer, it is important not to skip steps.

As a workgroup is getting started, the first question is always: What perspectives do we want represented in the workgroup? Be sure to include representatives of the groups that would be the most affected by the change.

Plan Checklist

The plan includes a description of the change being made, predictions of what the change will achieve, and what data is needed to measure the change's success or failure. Don't be discouraged if this part of the process is confusing or takes a long time. This is often the hardest part of a project, because while we know what we want to improve, finding out what is the actual cause of the problem (and therefore, deciding what changes to test) can be complicated. It is very important to learn as much as possible about an issue before you conclude (1) the root of the problem, and (2) what changes to try out.

1. What are we trying to accomplish/what do we want to improve?
2. What do we know about the issue now?
3. Do we need additional information before proceeding? If so, what information, who will get it, and by when?
4. Who do we need to talk with to learn more?
5. Besides the people participating in this workgroup, whose perspective (other shifts, departments, or neighborhoods/communities) would be helpful? How shall we hear from them?
6. What changes do we want to make (i.e., what changes can we make that will result in an improvement)? *At this point, depending on how big or complicated the issue is, the workgroup may want to try out several different improvements, one at a time. The rest of the steps described here can be applied to smaller changes, one at a time, if the workgroup thinks this is the best way to proceed.*
7. What do we think the potential impact(s) will be? What do we think the result(s) will be?
8. How are we going to measure the outcomes? In other words, how will we know a change is an improvement, with regard to:
   a. Staff?
   b. Residents?
   c. Family members?
   d. Costs (if relevant)?
9. What baseline data do we need to collect before testing the change?
10. Who will collect the data, and by what date?
11. Who needs to be informed in advance about the test?
    a. Staff
    b. Shifts
    c. Disciplines/departments
    d. Managers
    e. Residents
    f. Families

12. How will we inform each of these groups, who will do it, and when will they do it?
13. What tasks need to be carried out to test this improvement?
14. Who will do what?
15. What is the timetable for carrying out the test? When will we start, when will we finish?

Do Checklist

During this stage, the change is tested, followed by data collection and preliminary data analysis.

1. What change was tested?
2. What data, if any, do we need to collect following the test?
3. What happened — that is, what are the results?
4. Record observations related to the change.
5. What problems were encountered when implementing the change?

Study Checklist

This phase of the project includes the complete assessment of all data related to the project and a final report of the project results.

1. How do the actual results compare to the predictions?
2. Based on this information, was the change an improvement?
3. What new knowledge did we gain as a result of this test?
4. If the change was not successful, why?
5. Does it need to be re-tested, with adjustments? If so, what adjustments?
6. Did the test produce the results we wanted, or do we need to design a different change?
7. Do we have additional ideas for change we want to try as a result of this test?
8. If the test was successful, shall we make the change permanent?
9. If successful, should the change be expanded to other parts of the facility?

Act Checklist

1. If the change was successful and will be expanded to other parts of the facility, how will we spread the change?
2. What preparations and training need to take place for full implementation?
3. What is the plan for ongoing monitoring , so we can be sure the change continues to work well?
4. Were other opportunities for improvement identified during the test?
5. If the test was not successful, should we make modifications and try again, or should we try a different change?
6. Do we need to start another PDSA for this project?
7. How will we share information about the project with others in the facility?

An Example of How to Use the PDSA Cycle for Planning a Project:

THE PROBLEM: The dining room chairs are old, worn, and uncomfortable.

Whose perspectives should be represented on the workgroup? Residents, nursing assistants, rehabilitation therapists, environmental services, dining services, families, recreation, purchasing, and maintenance.

What are we trying to accomplish? What do we want to improve? Replace the old chairs in the resident dining room with new, more comfortable chairs.

What do we know about the issue now?
Some residents have difficulty getting into and out of the chairs. The chairs are heavy and hard to move. Some residents cannot fit between the arms of the chairs.

Do we need additional information?
How much can we spend to replace the chairs? What materials are easiest for housekeeping to clean? What style of chair will fit best in the dining room? What styles work best for residents? Are certain types of chairs easier for staff to move?

Who do we need to talk with to learn more?

- Maintenance, Environmental Services, Rehabilitation, Recreation and Purchasing Departments, to learn answers to some of the questions above, and to learn about their priorities and concerns regarding the purchase of new equipment.
- Other facilities. Nearby facilities may recently have gone through a chair selection process, or someone in the workgroup may have visited a facility and admired the chairs.
- The Internet. There are many sites (rehabilitation therapy, nursing home design, etc.) that may have suggestions of what needs to be considered in purchasing new furniture, or specific examples.

Besides the people participating in this workgroup whose perspective would be helpful? How shall we hear from them?

- People who live in nursing homes have different needs which need to be considered when purchasing chairs. Residents who are short will want a chair where their feet can touch the floor, residents who are tall will also want to be comfortable. Residents who cannot fit easily between the arms of a chair may need either wider chairs or chairs without arms. Residents who have had recent hip replacements may have special needs. It is important that any chairs brought in to try out, be tried with residents who represent a wide variety of needs.
- Staff from shifts not represented on the workgroup
- Other staff, families, residents. Even if these groups are represented on the workgroups, it is valuable to include the perspectives of others. This can be done through one on one interviews, small group discussions, etc.

What changes can we make that will result in improvement? Using information gathered from the stakeholders listed above, the workgroup identifies possible chair models and manufacturers and requests sample chairs for onsite evaluation.

How will we know a change is an improvement? The workgroup decides what criteria — e.g., cost, comfort, safety and cleanability — will be used to evaluate the chair. Using these criteria, the chairs are evaluated by the workgroup, as well as by representatives of the various stakeholders, including residents, family members, and staff from various departments. Posters are put up around the facility to let everyone know that new dining chairs will be being tested and that everyone's input would be welcome. Staff members on all three shifts are encouraged to participate.

What is the best chair for the dining room? Based on the information that has been gathered, the workgroup decides on a chair with arms they believe will be best for most residents and meets the need of staff and durability and cleanability requirements. (The workgroup also concludes some residents need armless chairs, but decides it needs to gather more information before it can select a model.) The workgroup's recommendation is forwarded to management for a final decision regarding how many chairs will be purchased, based on cost and need.

What happens next? Once a decision by management has been reached regarding how many chairs will be purchased, the workgroup makes plans to notify all the stakeholders that new chairs will be put into dining rooms, and when.

Are any adjustments needed? They also decide to look into the issue of chairs without arms further, beginning a new PDSA cycle looking specifically at armless chairs.

How will we share information about the project with others in the facility? When finishing a project, it is always a good idea to share what you have accomplished with others. In addition to photographs of residents, family members and staff trying out different chairs, it would be a good idea to describe the criteria that were developed for picking the chairs (style, comfort, cleanability, durability, etc.), so that other staff, residents and family members can understand the effort and care that went into the selection process. Most people don't realize that choosing furniture can be complicated, if the needs of all stakeholders are going to be met (residents, staff, cleanability, cost, etc.). An article in the facility newsletter, with a photo or two, is one way to share what was done. Another possibility is a poster, placed in various places around the facility. Presentations at resident and family councils, and at staff meetings, are another way the information can be shared.

Is the change working in the long run? Before disbanding, the workgroup devises a plan for reviewing the effectiveness of the chairs over time. They decide to ask the maintenance department to assess the chairs at various intervals (after the first three months and every six months thereafter), looking at, for example, whether there have been any accidents involving the chairs and how many chairs have needed repair.

Appendix 4

Getting Everyone's Point of View

Whether trying to get to the root of the problem, or when measuring to see if you have solved a problem, it's important to understand the perspective of people directly affected. There are several different ways to reach out to others, including:

Focus groups

Focus groups can be used to explore an issue in depth or to find out what people are thinking or feeling about a change. These are the steps involved, whether you are meeting with residents, family members, staff, or a mixed group, such as residents, staff and family members gathered on a particular community:

- Clarify the purpose of the group. *(What are you hoping to learn more about?)*
- Choose a facilitator *(Select someone to ask the questions and encourage participants to share their thoughts.)*
- Choose a recorder. *(Select someone who will not be involved in the discussion but will be free to take notes. It is important to ask participants for permission to take notes. Also, mention that the information will be kept confidential and will not be connected with the name of any particular participant.)*
- Determine location, date, and time. *(Find a location and time when interruptions will be minimized. Focus groups should be limited to about 45 minutes.)*
- Decide who should participate in the group and invite them. *(Decide how many focus groups you want to have and which perspectives — staff, shifts, residents, family members, disciplines — you want to explore. For each group, try for approximately 8 to 12 participants. If you want staff participation in a group, be sure to obtain the cooperation of their supervisors/department heads in advance.)*
- Develop the questions. *(Make a list of seven to eight questions. Try to finish all the questions, but be prepared for the possibility that you will not get to all your questions by the end of the session.)*
- Lead the discussion. *(When you ask a question and someone answers, probe a little to be sure you understand their answer. For example, if someone answers a question by saying, "sometimes," ask them to elaborate. Learn as much of their thoughts and experience as you can.)*

Interviews

When a workgroup is in the process of learning more about an issue, one-on-one interviews can be extremely helpful. Here are the steps:

1. Decide whom you want to interview.
2. Decide ahead of time what questions you want to ask, but be prepared for the likelihood that things may come up in the interview you had not anticipated. This is fine, because the whole purpose of the interview is to learn more about the issue than you already know.
3. When you request an interview, set a time in advance that works for both of you. In general, the interview shouldn't be longer than a half hour, and perhaps even less.
4. During interviews, do not interject your own point of view. The goal of the interview is to find out other people's perspectives. Even if they offer ideas or opinions you don't agree with, ask them

to describe in detail why they think and feel the way they do. And ask them these questions *as if you really want to know the answer!* Solving problems always involves differing points of view, and finding the right solution can't happen if you don't understand as much as possible about these different perspectives.

Walk-throughs

A walk-through — a step-by-step review of a process or procedure — is another way to gather information. This can be especially helpful for learning more about the experiences of family members and residents. For example, when a new resident is admitted, different staff members meet the resident and family members at various points in the process, starting with whoever is at the reception area when the resident and the family member first arrive. While each staff members knows a lot about their own interactions with new residents, they don't necessarily know what the residents' overall experience is like. The best way to find out is to go through the experience just as the resident would, starting with the moment of arrival in the lobby, on a stretcher or in a wheelchair.

The Institute for Healthcare Improvement (www.IHI.org) suggests the following guidelines for walk-throughs, adapted here for the nursing home setting:

1. Let the staff you are likely to come in contact with know in advance that you will be doing this walk-through. Ask them not to give you special treatment.
2. Go through the experience as the resident would *(arrive in a wheelchair or stretcher, stay on or in it as long as the resident would, wait around in the lobby or hallway as long as a resident is likely to, undress if that is what a resident would be asked to do, go through literally everything that a resident would go through).*
3. As you go through the process, try to put yourself in the resident's position. *Look around as they might. What would a resident be thinking? How would a resident feel at this moment?*
4. At each step, ask the staff to tell you what changes (other than hiring new staff) would make the experience better for the resident and what would make it better for the staff. *Write down their ideas as well as your ideas. Also write down your feelings.*
5. Finally, record a list of what needs you found and what improvements could be made.

After the experience, you can discuss your findings with the rest of your work team and decide what improvements you would like to address.

The "guidelines for walk-throughs", as adapted herein for use in the nursing home setting, are adopted from the "Walk-through tool" of the Institute for Healthcare Improvement (www.IHI.org) and are printed and included herein with the permission of the Institute for Healthcare Improvement (www.IHI.org).

Visiting other facilities

Visits to other facilities can be very helpful for seeing how other people do things. Whether you are going to see a newly renovated space, a particular piece of equipment, or a new program, it's important to carefully observe the interactions between residents and staff, between residents, between residents and family members or friends, and between staff. If you want to make improvements, you need to look at it from all perspectives.

The questions below can help you think about all the factors that can go into an interaction (e.g., Is the environment pleasant? Is it noisy? Too hot? Too cold?). Keep in mind that when you are observing a single resident, a given interaction may seem like a small moment to you, but it may be one of very few interactions the resident has during the day.

How do you feel as you enter the room (and the neighborhood/community)? What do you observe that is:

- welcoming?
- unwelcoming?
- institutional?
- pleasant?
- lacking in spirit?
- objectionable?
- adult?
- childish?

Notice the environment and, the ambience. What are your reactions to the:

- lighting?
- floor covering?
- temperature?
- entrances and exits?
- furniture?
- decorations?
- activities setup?
- cues for residents (e.g., signs, clocks, calendars)?
- extraneous noise?
- interruptions?

Overall, does the environment seem to belong to the residents, or to the staff, or both?

After 10 to 15 minutes have passed, choose one resident and observe for 10 minutes her or his level of participation in activities.

- Is it passive or active participation?
- Is there interaction between resident and other residents?
- Is there interaction between resident and staff?
- Is the interaction facilitated by staff or is it spontaneous?
- What do you think the resident is feeling?
- What facial expressions and body postures do you observe?
- What behaviors do you observe?
- What needs of the resident are being met?

Observe the staff's communication to residents, noting the:

- tone of voice
- vocabulary
- style of communication (repetition, simplification, gesturing, etc.)
- emotional connection with the resident
- the differing staff skill levels

What are you feeling at the end of your observation?

"The facility visit guideline appearing on pages 18 and 19 of this manual are reprinted with the permission of the Alzheimer's Disease and Related Disorders Association a/k/a Alzheimer's Association, New York City Chapter."

Short Survey/Questionnaire

A very simple way to get prompt feedback is to put together a short survey or questionnaire with the following guidelines:

- As a rule, use only one-to-five simple questions.
- Once you've decided on the questions, test them first on 5 to 10 people (staff members, residents, and/or family members) ensuring the questions are easily understood and that they provide helpful information.
- Rewrite the questions, if needed.
- Be sure to explain the purpose of the survey when you ask people to fill it out.
- You are more likely to get a response if the survey is filled out on the spot.
- Decide how many responses, and/or over how long a period you want to distribute the surveys.
- Collect the surveys at least weekly.
- Put the data on a chart and analyze.
- Be prepared to respond quickly to complaints or other feedback that need immediate follow-up.

The "short survey/questionnaire guidelines" are adopted from the Institute for Healthcare Improvement (www.IHI.org) and are printed and included herein with the permission of the Institute for Healthcare Improvement (www.IHI.org).

As an example, here are some questions that might be asked if you are trying to enhance activity options after dinner:

- What time do you usually finish dinner?
- What time do you go to bed?
- Is there a different time that you would prefer to go to bed?
- How do you spend the time between dinner and bedtime now?
- Is there something you would like to be able to do during this time period that you can't do now? *Give examples.*

Other information sources

Information that is regularly collected (perhaps for another purpose) is often the easiest to use. When starting a project, compile a list of existing sources of information that are relevant to your project, e.g., from the MDS (Minimum Data Set) log books, resident or staff satisfaction surveys, etc.

However, it may be necessary to gather data that is not usually collected (say, the average number of visitors to a particular unit on Sunday afternoons, which you might want to know to help determine the best kind of activities to schedule for that period). The important thing is that whatever information you collect, it needs to be as accurate as possible.

Checklists

A checklist is a simple way to collect data. This tool can be used to show how often an event or condition occurs. For instance, a checklist could be used by environmental services to track calls for assistance from the neighborhoods between 5 p.m. and 9 p.m.

Here's a demonstration of how to use a checklist, going back to the example about collecting information on Sunday visitors:

1. Agree on the data to be collected and where it will be found *(e.g., the visitor's sign-in log in the lobby).*
2. Decide who will collect data and when (remember to speak with the staff in reception/security to gain their cooperation and to find a time that works for them).
3. Select a sample size *(e.g., all visitors on your neighborhood/community, four Sundays in a row).*
4. Make sure the questions are clear *(e.g., instead of saying "Sunday afternoon," indicate specific times, such as, "Sunday, between noon and 3 p.m.")*
5. Try out the form first, and make changes as needed.
6. Make up a check sheet for the data collectors, including places for the date, time, name of data collector, and any comments
7. Collect the data.
8. Tally all individual data sheets.
9. Evaluate the data, and decide which activity to try.

Appendix 5

Sharing What We Learn

The most effective presentations are made by members of the workgroup. Presentations may be made to other neighborhoods, to the performance improvement committee, to visitors, or at conferences. Presentations can be strengthened by visual images accompanying the presentations, such as photographs, PowerPoint presentations, or storyboards (illustrations or diagrams on large cardboard mats).

An effective presentation would include:

1. What you were trying to improve
2. The members of the workgroup and the perspectives they represent
3. Who else — departments, staff, residents, families — was consulted
4. What changes were made, and what steps were taken
5. What measures were used
6. What results were obtained
7. What improvement were achieved (if none, why not)
8. What else was learned
9. What other changes are planned
10. Whether the change should be expanded to other neighborhoods, throughout the facility, and if so,
11. What preparations and training will be needed for full implementation

The workgroup might also consider putting together a skit that illustrates the point it is trying to make. For example, a workgroup that wanted to improve the way that new staff are received on a neighborhood and in the facility, might perform a skit showing the wrong way and the right way to make someone feel welcome. The skit would be advertised throughout the facility ahead of time, inviting everyone to attend.

Appendix 6

Getting Started: Tools to Define an Issue and Get to the Root of a Problem

Usually when we are trying to solve a problem, it's tempting to try to come up with a solution before we really understand what is causing the problem. This can get in the way of actually solving the problem. While each of us may have a significant amount of experience with a given problem, the reality is that most of the time there is more to the issue than we are aware of. That is why before a potential solution is offered, it is so important to include other perspectives.

For example, lost personal laundry is a common problem in nursing homes. In one nursing home that studied this issue, the assumption was that staff was being careless in how they returned clothing to residents, by not paying attention to the labeling on the clothing. However, the home eventually discovered this was not the source of the problem. The actual causes were that: some residents had so few clothes that staff regularly "borrowed" from other residents in order to be able to dress those without enough clothing; and that the wardrobes in resident rooms were small, so if a resident had too much clothing for the space, staff would place them in nearby wardrobes where there was room.

Another common concern in nursing homes is "hoarding" of linens. A frequent solution offered for this is to limit the amount of linen available to staff, to minimize excessive use of linens. This, however, is not a solution that gets to the root of the problem. In this case, getting to the root of the problem involves understanding why staff "hoard" linen in the first place. A home which studied this concluded that one of the linen issues in their facility was that staff used linens for other purposes, such as wiping up spills, and lap covers for residents in wheel chairs. In addition, they found that some staff did multiple layering of draw sheets on beds, and some staff changed beds excessively. Their first step in addressing the problem was to find alternates for wiping up spills and for lap covers for residents. Ultimately, staff "hoard" linen because they are worried they will not have enough. "Solving" the linen problem means addressing the reasons staff "hoard" to begin with.

Here are two common tools that can be used to think through an issue and get to the root cause of a problem:

Brainstorming

Brainstorming is often used as a starting point for addressing an issue (although it can be helpful at many different points in a problem-solving process). Someone in the group agrees to act as the facilitator, with everyone else in the group participating. A question about the issue is put to the group (for example: What can we do to make early evenings more interesting for residents?), and then people in the group are asked to make suggestions. The group should be given a few minutes to think about the question, and then about 15 or 20 minutes to do the brainstorming.

The rules for brainstorming are simple and should be explained to everyone up front:

1. All ideas are valuable as long as they are related to the subject (people shouldn't try to figure out if it is a "good" idea or not);
2. No one, including the facilitator, should comment on or criticize anyone else's idea;

3. People should not analyze or try to do problem-solving during this time, and;
4. The facilitator should write ideas on a flip chart so everyone can see every idea as it is stated by the person making the suggestion.

Brainstorming can be done by having participants call out ideas as they have them (the most common method), by writing ideas down on post-its and then adding them to everyone else's on a large sheet of paper on the wall, or through a learning circle (see Appendix 1).

Once the brainstorming is finished, the facilitator and the participants will group similar ideas together. (For example, let's say the challenge is to come up with suggestions for early evening activities for residents. One idea might be to show a weekly movie musical. Another might be to show travelogues about different parts of the world. Since both ideas involve videos, they could be grouped together. However, a suggestion to have a weekly cookie bake would be in a different category.) For this to work, the facilitator needs to ask the person who made a specific suggestion if it is okay to group his or her idea with the others. Usually, no more than four or five groups of suggestions will emerge after this process is finished.

Since it isn't feasible to explore every idea right away, the next step is for the group to set priorities for further exploration of the proposed ideas. The simplest way to set priorities is for the group to vote on the groups of suggestions. However, sometimes it will be easy to decide by consensus and a formal vote won't be necessary.

It is extremely important, when doing this exercise, not to cut off the flow of ideas from participants. While the number of suggestions may seem overwhelming at first, the whole purpose of the exercise is to open up the minds of group members to problems, and potential solutions, which may have been overlooked in the past. After the actual brainstorming, when the group moves on to grouping ideas together, and finally, to setting priorities, the group will become much more focused.

Flow Chart

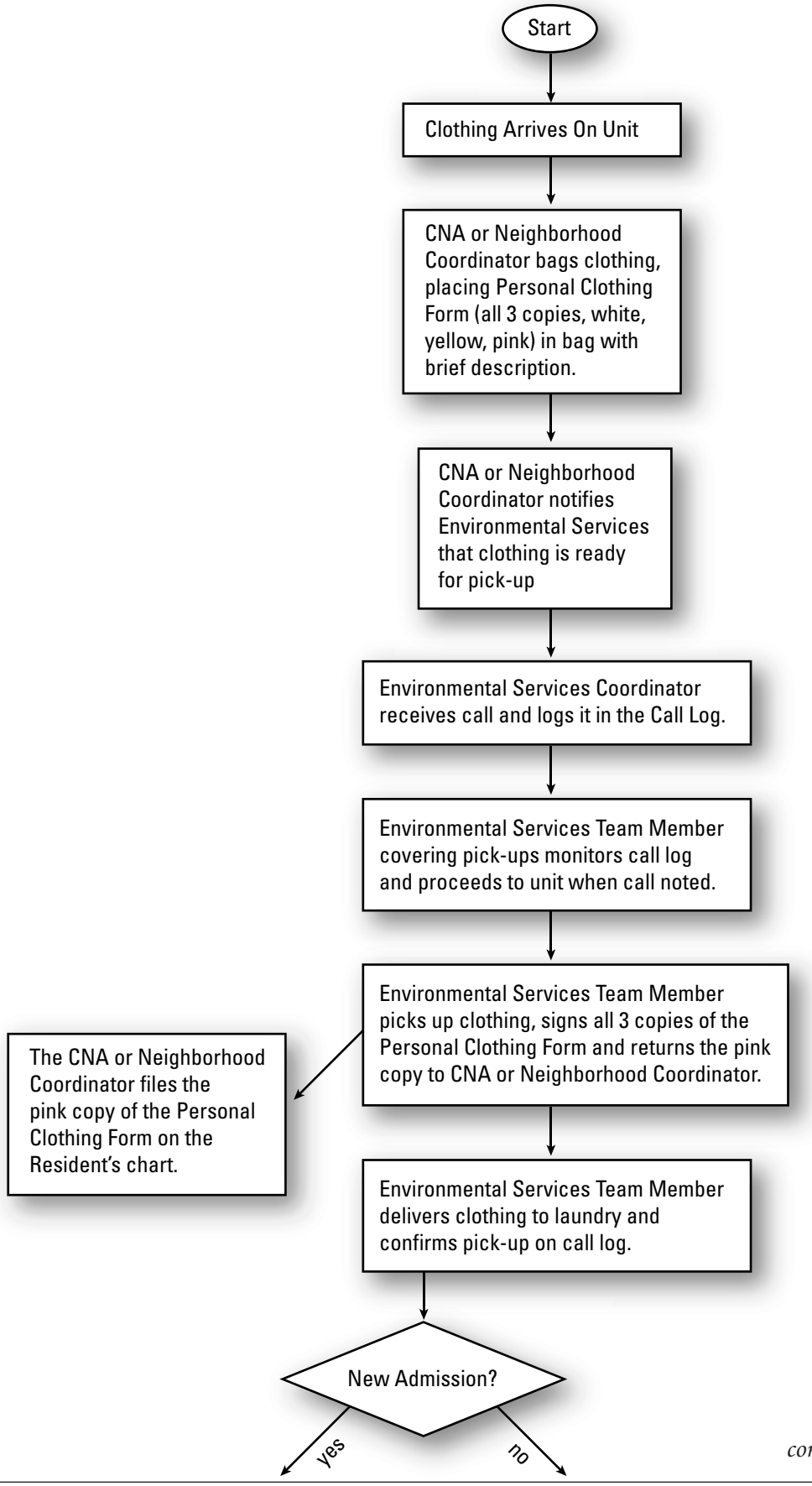
Almost any service provided in a long term care facility is the result of a series of tasks performed by several different departments. Think of how dietitians, dining services, purchasing, nursing, housekeeping, social services, and recreation all have a role in delivering meals. Often, problems in accomplishing complex tasks happen when work is handed off between departments or between people. One way to identify where a problem may be occurring is to put together a flow chart, showing every step in a process, from beginning to end.

It is important to show every step in the process, the specific departments/positions, the specific actions, the decisions, and the notifications that are part of the process. A home that recently reviewed its intra-facility transfer process discovered, by comparing their policies and procedures with what actually happens when they put the flow chart together, that the reason resident trays usually kept going to the "old" floor for a couple of days following the transfer, was that they had forgotten to make notifying the dietary department part of their transfer policy.

The following diagram shows the steps and decisions involved in labeling resident clothing:

Flowchart

Labeling of Resident Clothing



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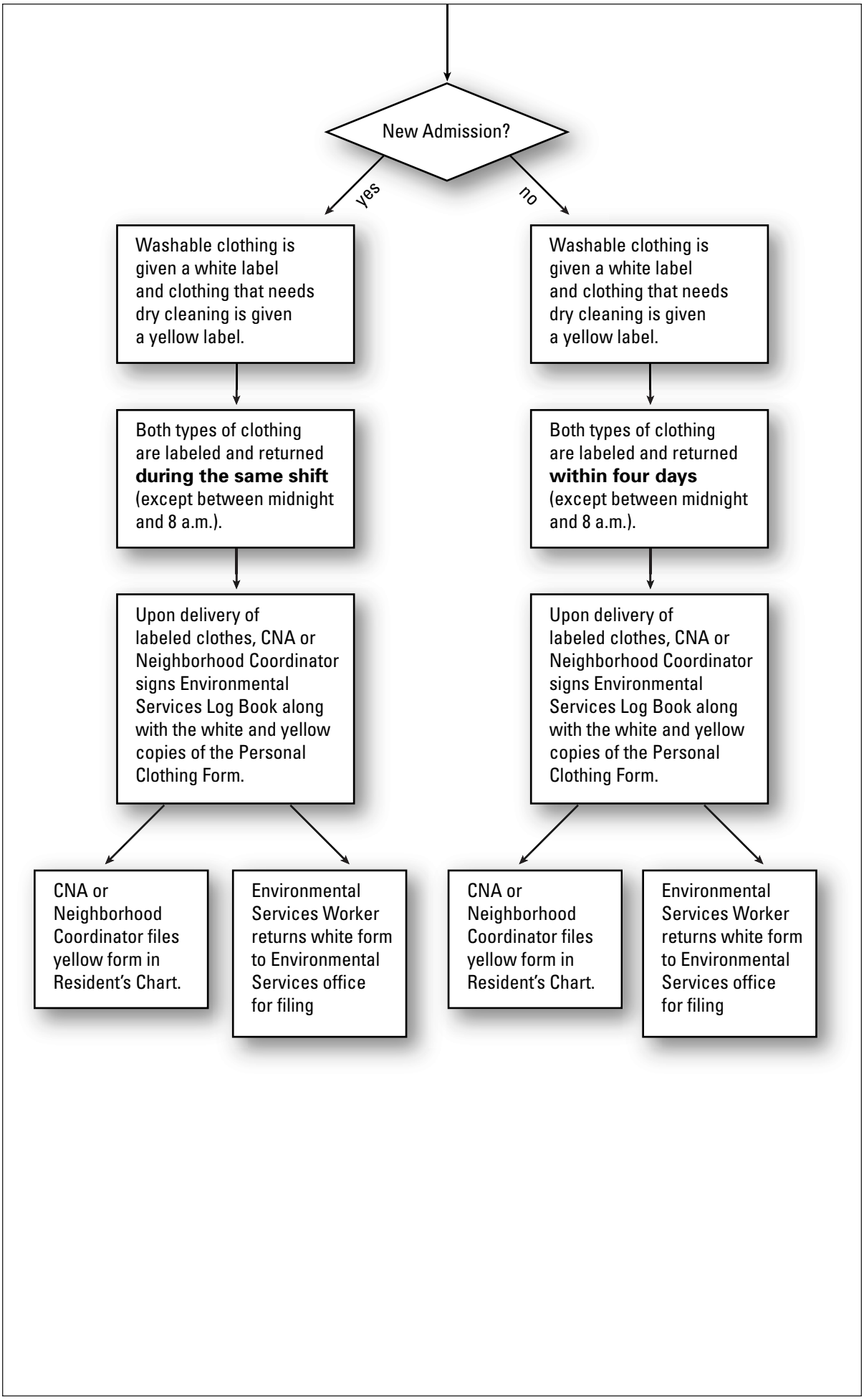

New Admission?
yes
no
Washable clothing is given a white label and clothing that needs dry cleaning is given a yellow label.
Both types of clothing are labeled and returned **during the same shift** (except between midnight and 8 a.m.).
Upon delivery of labeled clothes, CNA or Neighborhood Coordinator signs Environmental Services Log Book along with the white and yellow copies of the Personal Clothing Form.
CNA or Neighborhood Coordinator files yellow form in Resident's Chart.
Environmental Services Worker returns white form to Environmental Services office for filing
Washable clothing is given a white label and clothing that needs dry cleaning is given a yellow label.
Both types of clothing are labeled and returned **within four days** (except between midnight and 8 a.m.).
Upon delivery of labeled clothes, CNA or Neighborhood Coordinator signs Environmental Services Log Book along with the white and yellow copies of the Personal Clothing Form.
CNA or Neighborhood Coordinator files yellow form in Resident's Chart.
Environmental Services Worker returns white form to Environmental Services office for filing

Appendix 7

Measuring Our Progress

Why do we measure?

Measures are used to help us understand how well we are doing. If we measure, by counting, the number of falls that happen on a unit in a given three-month period, it gives us information that we can evaluate and use to make an improvement plan to reduce future falls. However, the only way to know our plan is successful is to also count the number of falls *after* we make our changes.

When deciding how to measure whether a change is an improvement, make sure that different perspectives are represented. For example, if we plan a change that we believe will benefit staff on both day and night shifts, we need to remember to include staff from both shifts in evaluating the change. If we are planning a change that is expected to benefit both residents and staff, we need to find a way to measure how residents and staff are experiencing the change. *Do not assume that a measure from one perspective gives us the whole story.*

What do we measure?

To measure something, we need to decide what measures to use. In other words, what questions will give us information that can tell us what we want to know. For example, CMS (Centers for Medicare and Medicaid Services) gathers data from the individual MDS (Minimum Data Set) forms that gives us the following information: (1) How many falls have occurred in the facility in the last 30 days? (2) How many residents have been observed with indicators of depression in the last 30 days, and (3) How many high and low risk residents have pressure ulcers? Because CMS collects information from facilities all across the country, we can compare the number (or percentage) of falls at our facility in a given period with the average number (or percentage) of falls in facilities in our state, or across the country.

When deciding what to measure for an improvement project, be as specific as possible. For example, if you want to know how many residents are injured as the result of a fall, it is important to count the number of falls *that result in injuries.* If you ask only about the number of falls, you will get misleading information, because many falls occur without injury. On the other hand, if you want to know the number of residents who are injured in a fall, but only ask about the number of residents who had injuries (without specifying whether they were from a fall or not), you will also get misleading information, because there are other ways besides falls that residents can be injured.

While some improvement projects may require only one measure, other projects may need several. For example, let's say a facility is changing from a tray to an on-unit steam table system of providing meals to residents. There would be many different things to measure in order to determine whether the change is an improvement. In this case, the QI team should ask residents and family members how the residents are enjoying the food and the mealtime experience. The QI team might also measure whether the overall use of food supplements changes once the dining system has changed (since one of the assumptions about making this change is that residents will enjoy eating more, leading to less of a need for dietary supplements). But we will know this only if we measure the use of supplements both before and after the changes. Another measure we can use for assessing the dining program is to look at the number of residents who have unexpected weight loss. Some measures cannot be anticipated. For example, early in this change process, one of the dining services workers may report that more residents seem to be coming out of their rooms to eat their meals in the main dining room on the community. This change might not have been anticipated, but it could be added to the list of measures (e.g., Where does this resident prefer to eat his or her breakfast/lunch/dinner, in the main community dining area, or in his or her room?).

Different Types of Measures

There are two general types of measures. One type is a *sentinel-event indicator,* which means that each time it occurs (even if it's only once), it is serious enough to investigate. For example, an outbreak of salmonella in a nursing home requires a full investigation to see where corrections may be made so that it doesn't happen again.

The most frequently used type of indicator, however, is called an *aggregate-data indicator.* To aggregate data simply means to gather information together. For example, regularly collecting information about the number of falls is called aggregating, or gathering, data.

Information we gather can be used in many different ways to help us understand how to approach a question or problem. One way is take the data that is collected and place it on a chart (see next appendix). This helps us see patterns.

Appendix 8

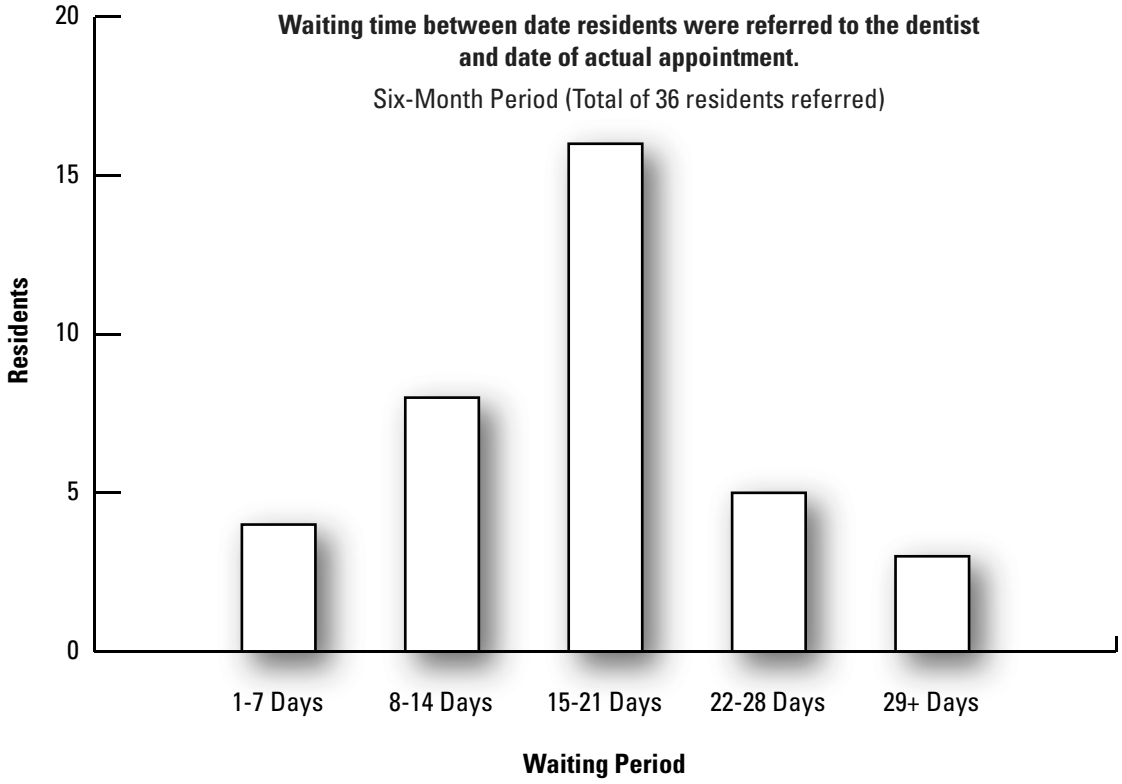
Tools to Help Understand and Evaluate Data

Once information has been gathered, we need to organize it in a way that helps us better understand what is happening, and then plan our next steps. Diagrams and charts are tools that can help us organize the information we have collected.

Histograms

Histograms are a type of chart to show us variations in data over time. For example, if we want to have an idea about the length of time between when residents were being referred to the dentist and when the residents actually saw a dentist, the chart might look like the one below.

To make this histogram, you need to decide: (1) how many residents you are going to collect information about (e.g., everyone in one unit referred during the first six months of the year, or everyone in the facility referred during the first two months of the year); and (2) how are you going to count (days, weeks, or months?) the time between the referral and the visit.



Once you have made this chart, then you want to try and understand why it looks the way it does. For example, why is there a gap between one group of residents who saw the dentist within a week of their referral, and another group where the gap was several weeks? What explains this difference? Was the group of residents who saw the dentist within a week having emergency dental visits? Is the second group just going for routine check-ups? Or was the dentist on vacation for a month, and there was no alternate dentist available, so no residents saw a dentist for any reason during that month? Basically, the histogram is a tool for helping us understand more clearly what the information we gathered actually means.

Scatter diagram

A scatter diagram can help us identify and understand possible connections or relationships between two different factors. For example, if a specific neighborhood or community is exploring the best way to organize staffing in order to help residents rise in the morning when they would prefer to, we could start by listing the number of residents, and then the time when these residents prefer to rise:

9:30 +																			
9-9:30						x													
8:30-9											x								
8-8:30									x										
7:30-8		x		x	x			x		x			x						
7-7:30	x						x					x		x		x			x
6:30-7			x														x	x	
6-6:30															x				
5-6 am				x															
Resident #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19

This diagram tells us several things:

- that only two people want to be up by 6:30 a.m.
- that no one wants to sleep past 9:30 a.m.
- that 2/3 of the residents prefer to get up between 7 a.m. and 8 a.m.

However, there are several things the diagram does not tell us. For example:

- which residents are able to dress themselves and which need assistance
- which residents are able to have breakfast on their own and which need assistance
- whether the residents who get up early want to have breakfast immediately or prefer to wait
- what time breakfast can be served from the kitchen
- what kind of food is available on the unit outside of normal breakfast hours, and whether we can provide breakfast outside regular hours that is satisfactory to residents

Once we have the answers to these and perhaps other questions, we would have a better idea of how many staff are needed at which times, and of the best times to provide breakfast, in order to respond to resident preferences.

Appendix 9

The Performance Improvement Committee at This Nursing Home

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Appendix 10

Resources for Performance Improvement and Person-Centered Care

For more information about the Cobble Hill—Isabella Collaboration Project, and the work that is produced in this Manual, you can contact:

- Cobble Hill Health Center
  380 Henry Street
  Brooklyn, NY 11201
  Contact: Louise Dueno
  718-855-6789, x138

- Isabella Geriatric Center
  515 Audubon Avenue
  New York, NY 10040
  Contact: Ellen Parish
  212-342-9360

In addition, the following organizations have information on their websites to help you learn more about quality imporvement, and about person-centered care:

- Culture Change Now!
  www.actionpact.com

- Institute for Healthcare Improvement
  www.ihi.org

- Pioneer Network: Culture Change in Long Term Care
  www.pioneernetwork.net

- Quality Partners of Rhode Island
  www.riqualitypartners.org

The following book is also a useful resource:

- *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance Improvement* [2nd Edition) by Langley, Gerald J.; Moen, Ronald; Nolan, Kevin M.; Nolan, Thomas W.; Norman, Clifford L.; and Provost, Lloyd P. © 2009, Jossey-Bass (John Wiley & sons, Inc.).

Appendix 11

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How to Use the Fishbone Tool for Root Cause Analysis

Overview: Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an adverse event or near-miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain the correction.

A cause and effect diagram, often called a "fishbone" diagram, can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories. A fishbone diagram is a visual way to look at cause and effect. It is a more structured approach than some other tools available for brainstorming causes of a problem (e.g., the Five Whys tool). The problem or effect is displayed at the head or mouth of the fish. Possible contributing causes are listed on the smaller "bones" under various cause categories. A fishbone diagram can be helpful in identifying possible causes for a problem that might not otherwise be considered by directing the team to look at the categories and think of alternative causes. Include team members who have personal knowledge of the processes and systems involved in the problem or event to be investigated.

Directions:
The team using the fishbone diagram tool should carry out the steps listed below.

- Agree on the problem statement (also referred to as the effect). This is written at the mouth of the "fish." Be as clear and specific as you can about the problem. Beware of defining the problem in terms of a solution (e.g., we need more of something).
- Agree on the major categories of causes of the problem (written as branches from the main arrow). Major categories often include: equipment or supply factors, environmental factors, rules/policy/procedure factors, and people/staff factors.
- Brainstorm all the possible causes of the problem. Ask "Why does this happen?" As each idea is given, the facilitator writes the causal factor as a branch from the appropriate category (places it on the fishbone diagram). Causes can be written in several places if they relate to several categories.
- Again asks "Why does this happen?" about each cause. Write sub-causes branching off the cause branches.
- Continues to ask "Why?" and generate deeper levels of causes and continue organizing them under related causes or categories. This will help you to identify and then address root causes to prevent future problems.

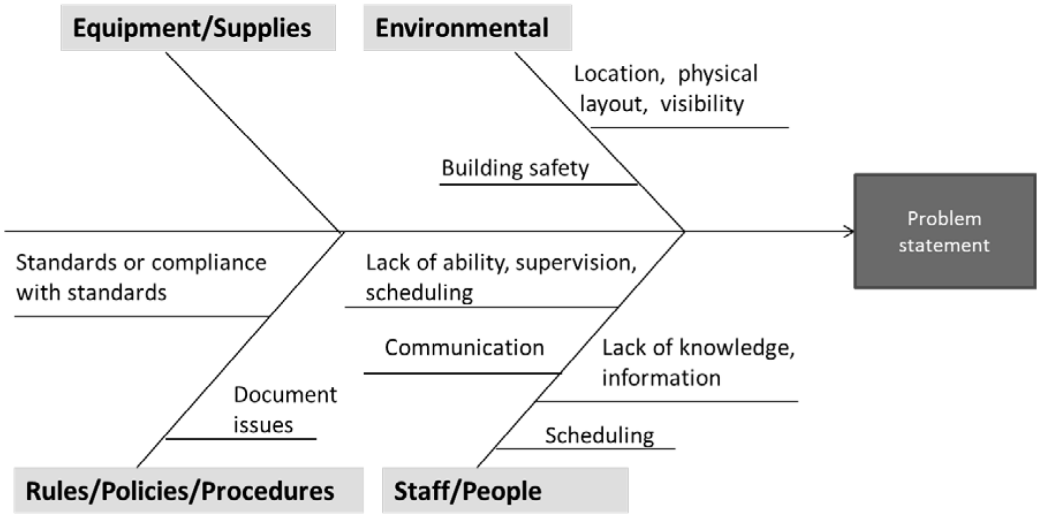
Tips:

- Use the fishbone diagram tool to keep the team focused on the causes of the problem, rather than the symptoms.
- Consider drawing your fish on a flip chart or large dry erase board.
- Make sure to leave enough space between the major categories on the diagram so that you can add minor detailed causes later.
- When you are brainstorming causes, consider having team members write each cause on sticky notes, going around the group asking each person for one cause. Continue going through the rounds, getting more causes, until all ideas are exhausted.

- Encourage each person to participate in the brainstorming activity and to voice their own opinions.
- Note that the "five-whys" technique is often used in conjunction with the fishbone diagram – keep asking why until you get to the root cause.
- To help identify the root causes from all the ideas generated, consider a multi-voting technique such as having each team member identify the top three root causes. Ask each team member to place three tally marks or colored sticky dots on the fishbone next to what they believe are the root causes that could potentially be addressed.

Examples:

Here is an example of the start of a fishbone diagram that shows sample categories to consider, along with some sample causes.

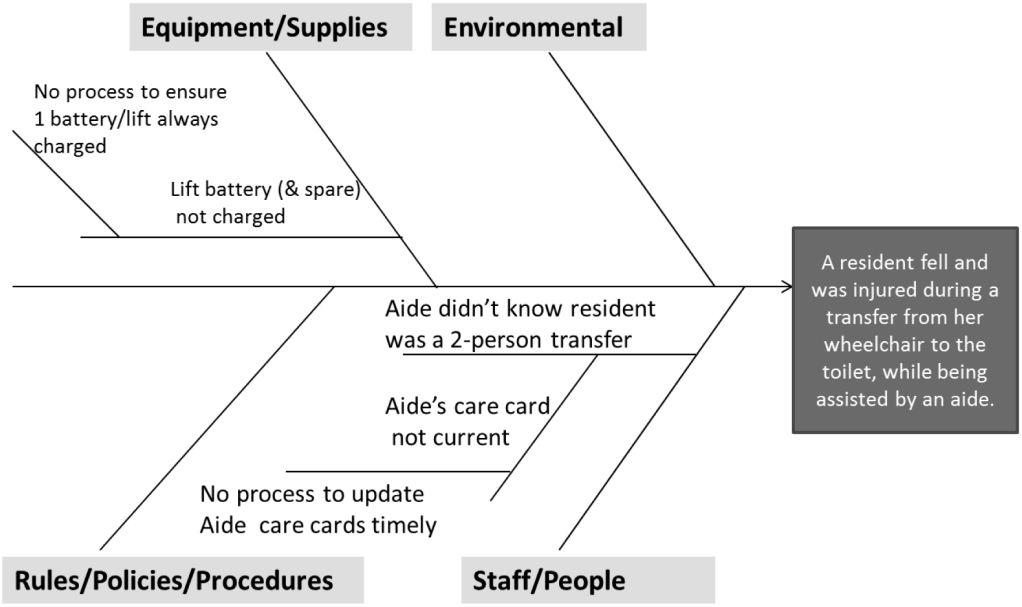


Here is an example of a completed fishbone diagram, showing information entered for each of the four categories agreed upon by this team. Note, as each category is explored, teams may not always identify problems in each of the categories.

Facts gathered during preliminary investigation:

- Time of fall: change of shift from days to evenings
- Location of fall: resident's bathroom
- Witnesses: resident and aide
- Background: the plan of care stipulated that the resident was to be transferred with two staff members, or with one staff member using a sit-to-stand lift.
- Information from interviews: the resident was anxious and needing to use the bathroom urgently. The aide was helping the resident transfer from her wheelchair to the toilet, without using a lift, and the resident fell, sustaining an injury. The aide stated she did not use the lift because the battery was being recharged, and there was no extra battery available. The aide stated she understood that the resident could be transferred with assist of one.
-

With this information, the team proceeded to use the fishbone diagram to better understand the causes of the event.



The value of using the fishbone diagram is to dig deeper, to go beyond the initial incident report, to better understand what in the organization's systems and processes are causing the problem, so they can be addressed.

In this example, the root causes of the fall are:

- There is no process in place to ensure that every lift in the building always has a working battery. (One battery for the lift on this unit is no longer working, and the other battery was being recharged.)
- There is no process in place to ensure timely communication of new care information to the aides. (New transfer information had not yet been conveyed to the aide. The aide's "care card" still indicated transfer with assist of one for this resident.)

The root causes of the event are the underlying process and system problems that allowed the contributing factors to culminate in a harmful event. As this example illustrates, there can be more than one root cause. Once you have identified root causes and contributing factors, you will then need to address each root cause and contributing factor as appropriate. For additional guidance on following up on your fishbone diagram findings, see the Guidance for Performing RCA with Performance Improvement Projects tool.

Five Whys Tool for Root Cause Analysis

Overview: Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an event, such as an adverse event or near –miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain corrections.

The Five Whys is a simple problem-solving technique that helps to get to the root of a problem quickly. The Five Whys strategy involves looking at any problem and drilling down by asking: "Why?" or "What caused this problem?" While you want clear and concise answers, you want to avoid answers that are too simple and overlook important details. Typically, the answer to the first "why" should prompt another "why" and the answer to the second "why" will prompt another and so on; hence the name Five Whys. This technique can help you to quickly determine the root cause of a problem. It's simple, and easy to learn and apply.

Directions: The team conducting this root cause analysis does the following:

- Develops the problem statement. (See Step 1 of Guidance for RCA for additional information on problem statements.) Be clear and specific.
- The team facilitator asks why the problem happened and records the team response. To determine if the response is the root cause of the problem, the facilitator asks the team to consider “If the most recent response were corrected, is it likely the problem would recur?” If the answer is yes, it is likely this is a contributing factor, not a root cause.
- If the answer provided is a contributing factor to the problem, the team keeps asking “Why?” until there is agreement from the team that the root cause has been identified.
- It often takes three to five whys, but it can take more than five! So keep going until the team agrees the root cause has been identified.

Tips:

- Include people with personal knowledge of the processes and systems involved in the problem being discussed.
- Note that the Five Whys technique may not always help you to identify the root cause. Another technique you might consider is the fishbone diagram. The fishbone diagram forces you to think broadly across various categories that could be causing or contributing to the problem (See How to Use the Fishbone Tool for Root Cause Analysis tool).

Problem statement	One sentence description of event or problem
Why? ⇨	
Why? ⇨	
Why? ⇨	
Why? ⇨	
Why? ⇨	
Root Cause(s)	1. 2. 3. To validate root causes, ask the following: If you removed this root cause, would this event or problem have been prevented?

Example:
Here is an everyday example of using the Five Whys to determine a root cause:
Problem statement – your car gets a flat tire on your way to work.

1. Why did you get a flat tire?
    - You ran over nails in your garage
2. Why were there nails on the garage floor?
    - The box of nails on the shelf was wet; the box fell apart and nails fell from the box onto the floor.*
3. Why was the box of nails wet?
    - There was a leak in the roof and it rained hard last night. (Root cause=leak in the roof)

*IF YOU STOPPED HERE AND "SOLVED" THE PROBLEM BY SWEEPING UP THE NAILS, YOU WOULD HAVE MISSED THE ROOT CAUSE OF THE PROBLEM.

Stop and Watch
Early Warning Tool

INTERACT
Version 3.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S	Seems different than usual
T	Talks or communicates less
O	Overall needs more help
P	Pain – new or worsening; Participated less in activities
a	Ate less
n	No bowel movement in 3 days; or diarrhea
d	Drank less
W	Weight change
A	Agitated or nervous more than usual
T	Tired, weak, confused, or drowsy
C	Change in skin color or condition
H	Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

ACTS
Retirement-Life
Communities®

FALL HUDDLE INVESTIGATION WORKSHEET

Please complete as soon as possible after a resident fall. Those individuals included in this investigation include the primary caregiver, director of nursing or designee, administrator and other neighborhood staff involved with the resident.

Resident Name: _____ Date of Fall: _____ Time of Fall: _____

1. Ask the resident what he/she was trying to do just before the fall occurred.

   _____Ambulating
   _____Attempting to self-transfer
   _____Transfer assisted by staff
   _____Reaching for something
   _____Slid out or fell from wheelchair
   _____Rolling/sliding out of bed
   _____Attempting to go to the bathroom
   _____Sitting on shower/toilet chair
   _____Other (specify):

2. What was the position of the resident following the fall?
   (Please draw a picture of the area and position of the resident if unable to describe the position when found.)

3. When was the resident last toileted (includes change of incontinent products) prior to the fall? Approximate time: _____

4. Has the resident been within the community less than 24 hours? Yes_____ No_____

5. Were alarms in use at the time of the fall? Yes_____ No_____

6. If alarms were used, were they working? Yes_____ No_____

7. What was the surrounding area like at the time of the fall?
   Cluttered_____ Noisy_____ Busy_____ Equipment_____

8. What was the condition of the floor at the time of the fall?
   Wet_____ Dry_____ Carpeted_____ Uneven_____ Other_____

9. If the resident has hearing aids, were they worn? Yes_____ No_____
10. If the resident wears glasses, were they worn? Yes_____ No_____
11. If worn, were the glasses clean? Yes_____ No_____
12. Was the resident receiving psychotropic medications? Yes_____ No_____
13. Was the resident receiving antihypertensive medications? Yes_____ No_____
14. Were there any medication changes in the last 7 days? Yes_____ No_____
15. Was the resident using as assistive device? Yes_____ No_____ What type_____
16. If the resident fell during a staff transfer, what was the amount of assistance provided during the transfer? One person_____ Two person_____ Three or more persons_____
17. Was the resident wearing shoes or non-skid slippers? Yes_____ No_____
18. Did the resident have any unusual activities or behaviors observed within 4 hours prior to the fall? Yes_____ No_____ If yes, please explain: _____
19. Were any immediate interventions implemented as a result of unusual behaviors? Yes_____ No_____ If yes, please explain: _____
20. Any other relevant information that could have contributed to the fall? _____
    _____
21. If further information is necessary to determine the root cause analysis, re-enact the fall event: _____
    _____

Signature of staff member completing the form: _____

Names of Fall Huddle participants: _____

Date: _____ Time: _____

Root Cause of Fall
(To be completed by the licensed nurse)

_____Alarm

_____Environmental noise

_____Environmental factors/items out of reach

_____Toileting status

_____Vision or hearing

_____Amount of assistance provided

_____Assistive/protective device

_____Health status/physical condition

_____Footwear

_____Medication

_____Mood and/or mental status

_____Other

HIDDEN LAKE CARE CENTER
TEAM MEMBER HUDDLE
IN-SERVICE SHEET

DATE: _____

RESIDENT NAME: _____

TEAM MEMBERS:	INTERVENTIONS:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
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_____	_____
_____	_____
_____	_____
_____	_____

National Learning Collaborative on Maximizing MDS 3.0 to Catalyze High Quality Individualized Care

Three Part Webinar Series: Integrating the MDS 3.0 Into Daily Practice

Pioneer Network

Sharing Successful Strategies from Maine's LANE/Culture Change Coalition

From Direct Care Worker to Bottom Line

By Connie McDonald, Administrative Director for Glenridge and Gray Birch Rehabilitation and Nursing Care Centers, Augusta, Maine

The most prominent definition of culture change in nursing homes focuses on "resident-centered care" and all the things that includes such as choices and lifestyle preferences. And it is pretty much universally accepted that in order to have resident-centered care, there must be consistent assignments of direct care staff. The value of consistent assignments is that a relationship develops between the caregiver and the resident and through this the residents' preferences and choices are known and met.

This article is to share one strategy that takes advantage of the well informed dedicated CNA 24-hour team to improve the documentation that eventually supports a higher RUG and reimbursement.

1. **Reorganize the shift hand-off process**

   A. Dedicate a minimum of 15 minutes for the whole going-off team to communicate with the whole coming-on team. Never record the report and leave for the next shift to listen to. So much important information sharing is lost when a dialogue can't take place. For example, one person on one shift may be successful in getting a person to take a bath or eat well and can share what their technique is.

   B. Let the dedicated CNA report on their shift plus pertinent info from the last shift for all their dedicated residents. The nurse can add any pertinent medical changes and reminders.

      - Reports should focus on only what is out of the norm such as lethargic today, refused lunch or struck another resident. Do not report on things that are routine or unremarkable such as normal bowel movements or "slept well". On the other hand if the person did not sleep well that should be reported as it may explain behaviors or alert the team to monitor for pain.

- Make sure each dedicated CNA has the strengths and risks noted on their assignment sheet for each resident. For example likes to socialize, enjoys music, risk for falls, pressure ulcers, hydration, mood or behavior concerns. Informed CNAs have a much more comprehensive approach to care.

2. **"Spotlight" all the residents that are in the ARD window each week. By having more emphasis on these residents it will make sure that there is less "copy cat" documentation and higher accuracy during the time when it will be captured for the MDS.**

   A. Post the care plan and have staff identify what the progress on goals is and what isn't working or has changed. For example Mrs. Smith now requires limited assist with transferring and Mr. Jones now requires 2 assist to get out of bed or chair.

   B. Make sure that the Social Worker joins the shift hand-off discussion at least once per week to share her/his insight and to ask questions about the indicators of depression and mood. The Dietitian and Activities Coordinator should also contribute to the discussion each week on the "Spot light" residents for the quality of life discussions. It's a wonderful teaching moment and creates a cohesive team. The MDS interview questions and the QIS survey focus can be used for guidance.

Engaging the whole care team in the flow of pertinent resident information will ensure a higher RUG score. Missing documentation about the occasional 2 assist can cost a facility from $34.00 - $150.00 a day and depression indicators can yield another $15 per day according to Post Acute Consulting, LLC. The result of this transformation of the shift hand-off will be better care and better reimbursement. A win-win!

For more information, contact Connie McDonald at:
Connie.mcdonald@mainegeneral.org

New & Qtrly Resident interview questions*

*Complete prior to initial care plan meeting & 1st qtrly ARD note. Continue if resident has expressed issues.

Address any concern/issue in your chart notes and/or care plan

Resident Name: **Date:** **SW initials:**

Depending on how well you know the resident, ask all the questions that apply and add others if there were previously noted concerns. Modify the language as appropriate for individual residents so that they understand the question and you are getting the correct information..

Choices:

1) Do you know that you can have food choices at meals? No Yes
   If answer is no: Is this acceptable to you? No Yes
2) Do choose your bedtime? No Yes
   If answer is no: Is this acceptable to you? No Yes
3) Do you choose when to get up? No Yes
   If answer is no: Is this acceptable to you? No Yes
4) Do you choose your clothing? No Yes
   If answer is no: Is this acceptable to you? No Yes
5) Do you choose bath times? No Yes
   If answer is no: Is this acceptable to you? No Yes
6) Do you attend the activities here? No Yes
   Do you like what is offered? No Yes

Comments:

Treatment, Privacy, Dignity & Safety (Abuse)

1) Do you feel the staff likes you and treats you well? No Yes
2) Does staff respect your privacy when they work with you, like when changing your clothes, or in the bathroom? No Yes
3) Do you feel safe here? No Yes
   (If any answers are "no", follow up)

Comments:

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Keep folder in NBHD file for reference if challenged during survey
Revised 6/10

Gray Birch Annual Activity Assessment

Name: DOB: From Where:
Nickname: Recognize B-Day Diabetic: Yes or NO
Yes or No Food Allergy:

Activity Preferences: C=Current, P=Past, N=No Interest

_____ Cards/Games:_____ _____ Arts/Crafts:_____
_____ Exercise/Sports:_____ _____ Music:_____
_____ Reading:_____ _____ Spiritual:_____
_____ Community_____ _____ Outdoors:_____
_____ TV:_____ _____ Gardening:_____
_____ Talk/Converse:_____ _____ Computer:_____
_____ Bingo:_____ _____ Hobbies:_____
_____ Baking/Cooking:_____ _____ Pets:_____
_____ Other:_____

_____ Registered Voter Wants to Vote?_ _____ Veteran (Years Served and Branch)

Martial Status:_____ Children:_____

Preferred activity preferences: (Check all that apply)
___In Room ___Dayroom/Family Room ___Off Unit ___Outside ___Community ___1:1 Visits

Past Occupation:

MDS 3.0

Interview Conducted with:

1. **Resident**
2. **Family/Significant other**
3. **Interview could not be completed**

QIS Survey

How important is it to you to:

____ Have books, newspapers, and magazines to read?
____ Listen to the music you like?
____ Be around animals such as pets?
____ Keeps Up With the news?
____ Do things with Groups of people?
____ Do your favorite activities?
____ Go outside to get fresh Air when weather is nice?
____ Participate in religious services or practices?

1. **Very Important**
2. **Somewhat important**
3. **Not Very Important**
4. **Not very Important at all**
5. **Important, but can't do or no choice**
6. **No Response or non-responsive**

1) Do you participate in any of the activity programs here?	[] No []Yes [] Do not wish to participate
2) Do the organized activities meet your interests?	[] No [] Yes
3) Do you receive assistance for things you like to do, such as supplies, batteries, books? (Facility should have items available for residents to use.)	[] No [] Yes
4) Are there activities offered on the weekends, including religious events?	[] No [] Yes
5) Are there activities available in the evenings?	[] No [] Yes
Comments:	

Activity Assessment Completed by:_____

DEPRESSION SCORES 01/16/2015

RESIDENTS	Little Interest or pleasure	Down/Depressed/Hopeless	Trouble falling/staying asleep	Tired/Little Energy	Poor appetite or overeating	Feeling bad about self or failure	Trouble concentrating	Moving/speaking slow or opposite	Thoughts better dead/hurting self	Being short-tempered, easily annoyed	FREQUENCY SCORE

Morningside House
Aging in America® – Continuing Care

Name: _____
MR#: _____ RM#_____

To be completed for:_____ (mm/dd/yy)

SHIFT	*7-3*					*3-11*					*11-7*				
TYPE OF ASSISTANCE	**Self**	**1HH**	**2 HH or more**	**Does not do this**		**Self**	**1HH**	**2 HH or more**	**Does not do this**		**Self**	**1HH**	**2 HH or more**	**Does not do this**	
Activities (Mark off each item with a ✓)															
My Resident:															
1. Gets into or out of bed															
2. Positions him/herself correctly in bed															
3. Rolls from side to side in the bed															
4. Sits up from lying down															
5. Moves to or from the bed, chair, wheelchair, or standing position (don't count the bath and toilet here)															
6. Is able to eat															
7. Manages his/her food (open, cuts up, butter bread etc)															
8. Manages lifting a fork, knife and/or spoon or a cup or glass															
9. Needs reminding to finish the meal															
10. Uses the bathroom or uses a commode or urinal or bedpan.															
11. Transfers on and off the toilet, commode and/or bedpan.															
12. Manages taking clothes or brief off and/or pulling them up and adjusting them after going to the bathroom, or using the commode or bedpan															
13. Manages wiping him/herself and/or washing hands after going to the bathroom															
14. Manages his/her own ostomy or catheter															

Day C.N.A Signature	Evening C.N.A. Signature	Night C.N.A. Signature

ADL Assessment revised Oct, 2010

Morningside House
Aging in America ~ Continuing Care

Name: _____

MR#: _____ RM#_____

To be completed for:_____ (mm/dd/yy)

SHIFT	*7-3*	*3-11*	*11-7*
MOOD (Mark each item as appropriate with a check ✓)			
My Resident:			
1. Is easily distracted-can't concentrate			
2. Moves very slowly			
3. Is really fidgety or can't sit still or lie still			
4. Doesn't want to do things			
5. Doesn't like to do what he/she used to do			
6. Feels sad or down or hopeless or cries all the time			
7. Sleeps all the time			
8. Can't fall asleep			
9. Doesn't have energy that he/she used to have			
10. Doesn't eats as well as he/she used to			
11. Eats all the time and didn't used to			
12. Says he/she feels bad and/or has let his/her family down			
13. Says he/she would be better off DEAD			
14. Says he/she would like to hurt him/herself			

SHIFT	*7-3*	*3-11*	*11-7*
BEHAVIOR (Mark each item as appropriate check ✓)			
My Resident:			
1. Pushes, hits, kicks, scratches other			
2. Threatens, curses /screams at at others			
3. Hits or scratches self, rummaging, pacing			
4. Takes off clothes in public, smears feces, engages in public sexual acts			
5. Makes disruptive sounds, screams			
6. Rejects taking medication, lab work, x-rays, Rehab, participating in activities			
7. Needs help with ADL BUT REJECTS IT.			
8. Wanders and bothers others			
9. Wanders and does not bother others			
10. Believes things that aren't true (ex; "picking up their child from school today, looking for a deceased loved one", etc)			

Day C.N.A Signature	Evening C.N.A. Signature	Nights C.N.A. Signature

Mood & Behaviors revised Oct 2010

Communicating the schedule to the C.N.A.s each week

Schedule of care conferences is placed in break room each week. Also includes list of suggested topics for C.N.A. to discuss at care conference.

Care conference schedule is also noted on the C.N.A. daily assignment sheet.

Each C.N.A. works with their hall partner to communicate what time they will be away at the care conference.

Care Conferences for this week:

Thursday, January 31st :
10:00am Mrs. A
10:20am Mrs. B
3:30pm Mr. C

- If you are the caregiver for any of these residents, please meet us in #41 Friendship Room at the designated time.
- In the last 3 months, have you noticed:
- Activities of daily living—any change in the person's ability to participate in care?
- Mood & Cognition—does the resident seem content? Agitated? More or less confused?
- Dining—change in appetite? Change in the amount of assistance needed for dining