THE FIRST 24 HOURS

AN UNFOLDING CASE STUDY IN PERSON-DIRECTED CARE

Pioneer Network

The First 24 Hours: An Unfolding Case Study in Person-Directed Care

Welcome to ***The First 24 Hours: An Unfolding Case Study in Person-Directed Care***. The first day that a resident spends in a nursing home is a complex time. Although most homes have systems in place to gather information and to orient the resident to a new environment, homes that emphasize person-directed care also use this time to begin integrating the new resident's choices into daily life and a plan of care. The goal of this unfolding case is to illustrate systems to support person-directed care for a resident's first 24 hours in a nursing home. In particular, the case study highlights recently developed person-directed competencies in the following areas:

- The Role of the Medical Director in Person-Directed Care (source AMDA). Online resource here: http://www.amda.com/governance/whitepapers/G10.cfm

- Nurse Competencies for Nursing Home Culture Change (Hartford Institute for Geriatric Nursing, in collaboration with the Coalition of Geriatric Nursing Organizations and Pioneer Network). Online resource here: http://www.pioneernetwork.net/Providers/ForNurses/

- Nursing Home Administrators from the Nursing Home Administrators Examination Study Guide, 5th Ed. Pages 274-291, National Association of Long Term Care Administrator Boards, 5th Ed. Washington DC: 2010

Uses: This case study is a beginning framework and resource that can be modified for various uses such as the following examples:

- **Classroom or Distance Learning:** The case study could be modified for classroom applications. The current case could be employed in classrooms with less experienced students to encourage critical-thinking and innovative problem-solving. It could also be modified to include more clinical applications for clinicians or graduate students.

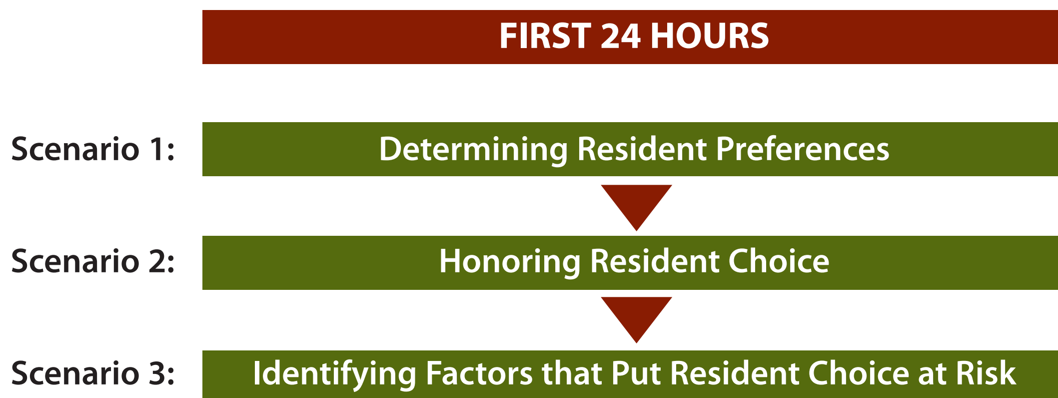
- **Provider Training or Discussion:** An interdisciplinary team in a nursing home could use the case to examine systems and person-directed practices. Although this case focuses on the competencies of Medical Directors, Nurses, and

Administrators, the case is broad enough that all other members of the team such as social workers, dieticians, therapists or others could participate.

- **Workshops or Presentations:** The case could also be used for presentations, small groups or workshops to help participants visualize the components, systems and supporting competencies of person-directed care.

Methods: The case could be utilized for independent study, for group discussion or in a role play methodology. We've included a few suggestions, but we encourage any method that best suits particular learning objectives.

Time to Complete: Depending on learning objectives and time available for this activity, we believe that participants can complete the case in an hour. Of course, fruitful discussion could be a goal that might extend the timeframe. It is our hope that the unfolding case is one component in a lengthier overall process such as broader learning activities in a classroom/workshop or to support a change process in a nursing home.
The case study map and suggested activities are listed below.



Activity	Method	Time
Review Competencies/Resources	Independent review by participants	10-15 minutes
Reflect/Answer Preliminary Questions	Record responses independently or via group discussion	10-20 minutes
Review the Unfolding Case	Participants can read independently or role play as a group	15 minutes
Answer/Discuss Reflective Questions	Answer responses independently or via group discussion	30-45 minutes

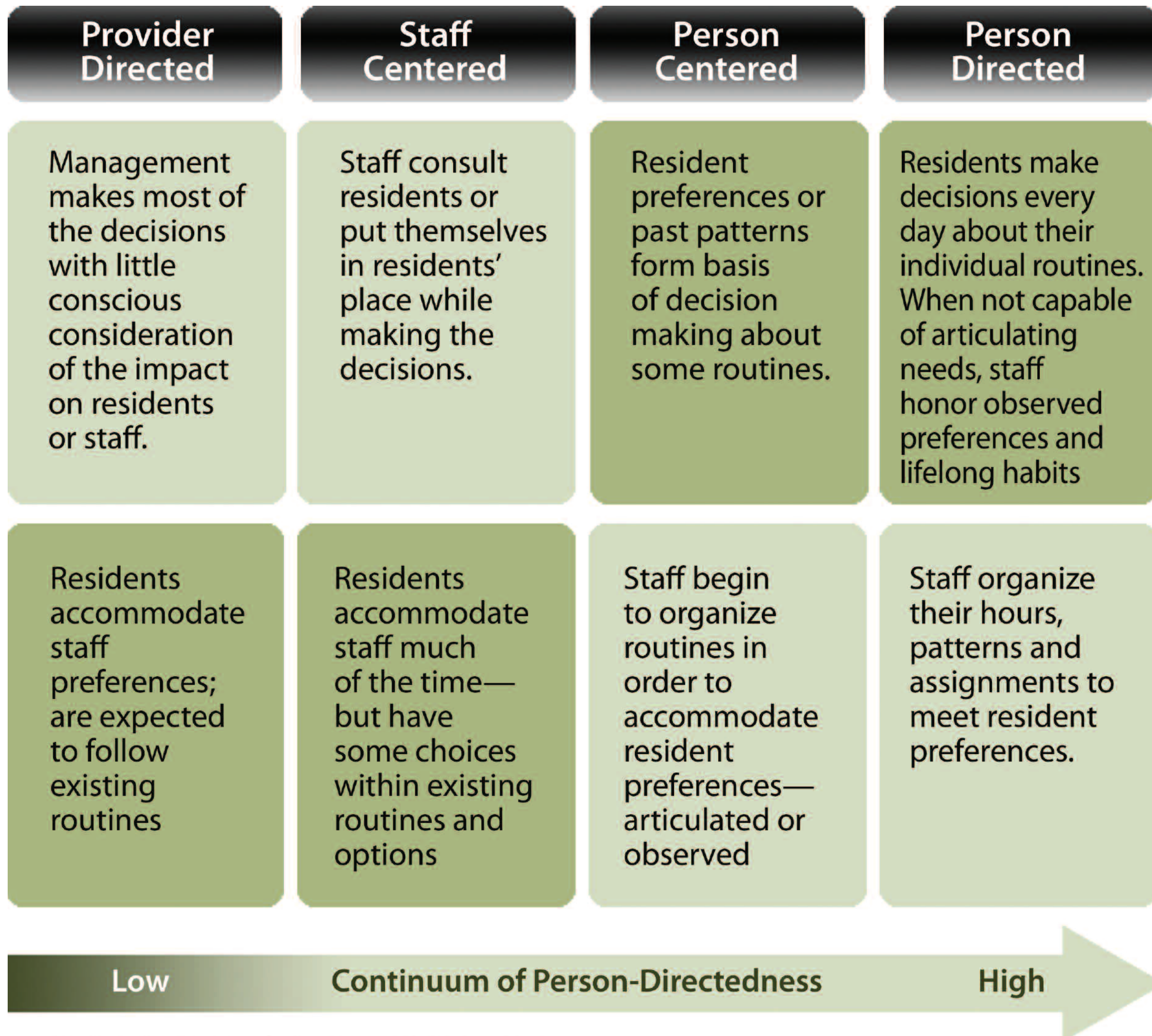
Step 1: Participants can review the introductory materials provided below.

Note: Depending on the learning objectives of the case study, participants might also find it useful to review the New Dining Practice Standards also included in the Appendix.

INSTITUTION VERSUS PERSON-DIRECTED CULTURE

Institution Directed Culture	Resident Centered Culture
Staff provide standardized “treatments” based upon medical diagnosis	Staff enters into a caregiving relationship based upon individualized care needs and personal desires
Schedules and routines are designed by the institution and staff, and elders must comply	Elders and staff design schedules that reflect their personal needs and desires
Work is task-oriented and staff rotates assignments	Work is relationship centered, and staff have consistent assignments
As long as staff know how to perform a task, they can perform it “on any patient” in the home	Staff bring their personal knowledge of elders into the caregiving process
Decision making is centralized	Decision making is as close to the elder as possible
There is a hospital environment	The environment reflects the comforts of home
Structured activities are available when the activity director is on duty	Spontaneous activities are available around the clock
There is a sense of isolation and loneliness	There is a sense of community and belonging

CONTINUUM OF PERSON-DIRECTED CULTURE



Developed by Mary Tess Crotty, Genesis HealthCare Corp,
based on the model by Susan Misiorski and Joanne Rader, distributed at the Pioneer Institutes, 2005.

THE ROLE OF THE MEDICAL DIRECTOR IN PERSON-DIRECTED CARE

The following was added to AMDA's *Medical Director: Role and Responsibilities as Leader and Manager-Functions and Associated Tasks* in 2010. (Note: the full paper detailing this process is in Appendix A).

Function 9: Person-Directed Care—the medical director will support and promote person-directed care.

Task Statements (supporting Function 9)

1. Provides oversight to clinical and administrative staff to help maintain and continuously improve the quality of care (e.g., help develop metrics and periodically analyze processes and results to monitor the success of person-directed approaches).

2. Encourage active resident participation in, and promote the incorporation of resident preferences and goals into development of an individualized plan of care.

3. Helps develop, implement, and review policies and procedures that ensure residents are offered choices that promote comfort and dignity (e.g., choices regarding awakening, sleep, and medication administration times, discussions of risk/benefits regarding medicalized diets, medications and treatments).

4. Collaborates with the interdisciplinary team (IDT), the family, and allied services within and outside of the organization to encourage planning, implementing, and evaluating clinical services to maximize resident choice, quality of life, and quality of care.

5. Educates physicians and other medical professionals on maintaining clinical standards in the context of individualized care.

6. Collaborates with nursing home leadership to create a person-directed care environment while maintaining standards of care.

THE ROLE OF THE NURSE IN PERSON-DIRECTED CARE

Developed by the Hartford Institute for Geriatric Nursing, in collaboration with the Coalition of Geriatric Nursing Organizations and Pioneer Network. (Note: the brief detailing this process in Appendix B).

NURSE COMPETENCIES FOR NURSING HOME CULTURE CHANGE	
1	Models, teaches and utilizes effective communication skills such as active listening, giving meaningful feedback, communicating ideas clearly, addressing emotional behaviors, resolving conflict and understanding the role of diversity in communication
2	Creates systems and adapts daily routines and "person-directed" care practices to accommodate resident preferences
3	Views self as part of team, not always as the leader
4	Evaluates the degree to which person-directed care practices exist in the care team and identify and addresses barriers to person directed care
5	Views the care setting as the residents' home and works to create attributes of home
6	Creates a system to maintain consistency of caregivers for residents
7	Exhibits leadership characteristics/ abilities to promote person-directed care
8	Role models person-directed care
9	Problem solves complex medical/psychosocial situations related to resident choice and risk
10	Facilitates team members including residents and families, in shared problem-solving, decision-making, and planning

THE ROLE OF THE ADMINISTRATOR IN PERSON-DIRECTED CARE

Although not listed as competencies, the National Association of Long Term Care Administrator Boards has transitioned to "resident centered" language in the tasks performed within five core domains of practice, as well as, the addition of resident centered knowledge and skills to support task performance.

The following is adapted from "Culture Change and Resident Centered Care." Nursing Home Administrators Examination Study Guide, 5th Ed. Pages 274-291, National Association of Long Term Care Administrator Boards, 5th Ed. Washington DC: 2010

EXAMPLES OF LEADERSHIP AND MANAGEMENT STRATEGIES TO SUPPORT RESIDENT CENTERED CARE	
1	Make priority the creation of meaningful and lasting relationships (staff, residents, family);
2	Administration is visible and knows people;
3	Focus on soft skills –communication, mediation;
4	Create committee and team driven change processes;
5	Promote an environment where individuals are empowered to make decisions;
6	Explore and share best practices;
7	Teach and lead others within the nursing home community;
8	Provide training, learning skill building opportunities;
9	Utilize and implement effective feedback loops.

Step 2: Independently or as a group, participants can reflect on the following topics prior to reading the study.

REFLECTIVE QUESTIONS FOR LEARNERS/PARTICIPANTS

Think about the first 24 hours in a nursing home [providers can visualize the first 24 hours in “our” nursing home]. Reflect on the following key areas and jot down a few notes with your initial thoughts.

What are the……..

1. systems typically in place to determine resident preferences/choices?
2. systems in place to help staff honor resident choices?
3. adaptations that staff make to accommodate resident choices in the course of the day?
4. problem-solving and communication techniques that staff use to identify obstacles/barriers that put resident choice at risk?

Step 3: Review the case. Participants can read independently or role play as a group.

Method suggestion: As participants review the case, they can refer to competencies and make notes of areas where competencies support actions through abbreviations (e.g. MD for Medical Directors, NC for Nurse Competencies, and AC for Administrator Competencies) and the number of the relevant competency. For example, a participant might note NC#6 for the use of consistent assignment in Scenario 1.

INTRODUCTION

This is the experience of Hilda Reed. Hilda is an 87 year old, African-American female who has spent the past 10 years living alone following the death of her husband. She has two children, a son and a daughter. Her daughter, Janet, has been her primary caregiver for the past year after her diagnosis of colon cancer. Following surgery for her colon cancer, Hilda and her family have decided that she should move to a nursing home. Her current medical issues include colon cancer, congestive heart failure and early stage dementia.

SCENARIO 1

Hilda has just arrived at a nursing home after a stay at the hospital for colon cancer surgery. She arrives via ambulance on a stretcher and is wearing a hospital gown. It is 10AM on a Friday morning.

Goal of the scenario: The team welcomes Hilda and gathers information about her preferences to help develop an individualized plan of care.

Hilda: I arrived by ambulance to the nursing home this morning. I was in the hospital for seven days after my colon cancer surgery. Many of my friends have been at this nursing home—I guess it was inevitable that I would go here too. I know I will miss my apartment, but it was hard for me to do my laundry, clean my house, and even cook. I would get so short of breath; my doctor told me that was because I have congestive heart failure. When I got here, a very nice young man greeted me. He said he was going to help me get settled in my room. I have a nice room—my bed is by the window. I have a roommate and she seems very pleasant. My daughter brought some clothes and a portable TV. I wonder how my roommate and I will work out having two TVs in the room?

My aide's name is Anne and she helped me find my cane and got me to the bathroom. It still feels strange to be here, but she seems nice. She helped me change out of the hospital gown to my clothes.

Hilda's Daughter Janet: I just went into mom's room and she has a roommate. At least the room is set up with a partition in between the two spaces, but my mom is a very private person. I really want her to have a private room. I wonder what I can do to get her one?

An aide came into the room and introduced herself as Anne. She told mom the names of everyone on the team who would be caring for her. It's nice to already have that type of information as she gets settled in. She helped my mom get to the bathroom, showed us around and explained to my mom how to call someone to help her.

Behind the scenes systems to support the scenario goals:

- *It's a policy in this home that residents are welcomed and acclimated to their environment on move-in day. Practices to support that policy include a member of the team welcoming the resident and their family, assisting in unpacking and arranging belongings and orienting the resident and the family to the environment and call system (if not done prior to move-in).*

- *Consistent Assignment is part of the team process, so team members will greet and interact with Hilda in the first 24 hours with a critical eye on adapting their existing routines to her schedule.*

[One hour later]: *Hilda is experiencing some confusion in conjunction with her new setting and from side-effects from her pain medication. The nurse comes to meet Hilda and assess her care needs.*

Day Shift Nurse: [Goes to see Hilda]. "Hi Hilda, my name is Kate and I am the nurse you will see most days. You must be Janet. It is really nice to meet you both." **[Kate sits down next to Janet. Kate asks how they are both doing and talks for a few minutes. She assesses Hilda's pain. They also discuss Hilda's preferences for her diet and other aspects of her care. She sees that Hilda is tired, and after asking to look at Hilda's abdomen to assess her surgical site, tells her she will return later after she has a chance to rest. Kate tells Hilda and Janet that she is looking forward to getting to know them both better.]**

Hilda: The nurse came and spent some time with me—asking me lots of questions about whether I had pain, when I wanted to take a bath and other things like that. I got a little mixed up about some of the things she asked me. I had some trouble remembering how many grandchildren I had and even how many days I was in the hospital. Sometimes things get really confusing for me and I think I am at my home with my husband. He died sometime ago—I can't remember when.

I am hungry. I'd really like an egg salad sandwich and a dill pickle that I canned. The nurse told me that the doctor wants me to be on a low salt diet. She asked what I thought and I said that doesn't sound very good to me. I really need salt and pepper to make my food taste good. She said that they would work with my doctor and the dietician to figure out a solution. She asked if I needed anything and I wondered if I will be able to have a glass of milk and a cookie before I go to bed—I have that every night. She said absolutely and made a note of it.

Administrator: A CNA just came to my office to notify me that Hilda's daughter is not happy that she doesn't have a private room. I really don't want to have a family upset, so I got up and went to the resident's room with hopes the daughter is still there. Sure enough, I found the resident and her daughter. I listened to Hilda and Janet's concerns and offered to put Hilda on the list for a private room. At the end of the conversation, both the resident and the daughter thanked me for coming by to see them and to address their concerns. Though I do not enjoy conflict, it does feel good when you can help someone that is upset become more satisfied.

Daughter Janet: The nurse came and asked mom a lot of things about her preferences for getting up, bathing, eating, daily routines and her favorite things to do. Since the pain medication that mom had to take after her surgery is making mom groggy, she also talked with me to learn more about mom and our family. I told her that she sleeps late and likes a cup of coffee and crosswords in the morning. Before I left the Administrator came in to discuss the private room. He promised to put her on the list which makes may feel better. It's nice to know that the whole team is concerned and wants mom to be herself.

Behind the scenes systems to support the scenario goals:

- *The team is expected to adapt to the resident's preferences, traditions and choices and communicate those choices to other members of the team. The nurse begins this process with initial questions. The CNA is also gathering information in this first 24-hours such as Hilda's needs for her cane as she helps her to the restroom.*
- *It is the homes' policy that when a family member or visitor makes a request, team members try to the best of their ability to comply with the request. If the team member cannot provide the service or ensure the request happens, they seek out another team member who may be able to assist. In this case, the CNA communicated the concern for the private room to the Administrator.*
- *It's a policy in this home that staff remain aware of a resident's anxiety about moving into their new home. In this case, Hilda's nurse noticed that she was tired and decided to complete her assessment after Hilda had time to rest.*

- *The home involves family in the orientation process, but the resident remains the focus. In this case, the nurse remained focused on Hilda but also engaged her daughter for information since Hilda was groggy from the pain medication.*

SCENARIO 2

[Minutes later]: *The Nurse calls the nursing assistants, Anne and Sue, to the desk for a quick team huddle.*

Goal of the scenario: The team reviews information to begin to develop the individualized plan of care.

Day Shift Nurse: Hi Anne, I just want to thank you for making Hilda feel so welcomed already. I saw that you have begun introducing her to the team and that you helped her to the bathroom. I think that helped Hilda and her daughter feel calmer during what must be a very stressful day for them both.

I want to share a little more about Hilda's health needs. She just had surgery for colon cancer so she has an incision covered by a bandage on her abdomen—please let me know right away if you see any blood or other drainage on the bandage. We will need to watch her pain, so please let me know right away if you observe any symptoms of pain like groaning, grimacing, or if she tells you straight out she is in pain. Hilda also has congestive heart failure so she gets a bit short of breath. Let's put her on intake and output for three days, and let me know right away if you think she is having trouble breathing.

We discussed her diet and Hilda would prefer to have choice and salt in her diet. ***[They discuss options and which members of the team need to be involved including the Medical Director and dietician. They suggest educating Hilda about the possible implications of salty food but to leave the ultimate decision of food choice to Hilda. They discuss diagnostic tests to monitor her CHF given the salt intake. They also review Hilda's preferences for bedtime and wake-up. The nurse shares Hilda's bedtime and wake-up rituals and her desire to sleep in. They discuss communicating this information to the next shift.]***

I am hoping both of you can spend a few minutes today visiting with Hilda and her daughter Janet—just getting to know them and offering your kindness and support. I know this will make our day a little more challenging today since we have two new elders moving in. I'd like to ask each of you to share your ideas about how we can help each other today.

Anne (nurse aide 1): Miss Hilda is really nice. I was assigned to clean out the refrigerator this afternoon but can move that to tomorrow. That will give me a little extra time.

Sue (nurse aide 2): I was supposed to go on an out trip this afternoon with the residents. Do you think we could ask team 3 to replace me on that trip? I don't think they have anyone moving in or going home today. I think all will go well if that could work out.

Day Shift Nurse: Those are both great suggestions. I will go talk with Team 3 right now to see if that could work out Sue. Thank you both!

Behind the scenes systems to support the scenario goals:

- *At move in, the team completes a Resident Preference form. The following information is recorded to ensure that Hilda's usual routine and preferences are available to team members:*
  - *Usual time to arise in the morning [Hilda likes to sleep in]*
  - *Nap pattern including time, length and preferred location [She likes a quick nap on the afternoon on her reclined after reading a book].*
  - *Usual bedtime [around 10PM].*
  - *Bedtime rituals [She likes cookies and milk and to watch TV]*
  - *Prefers bedroom door closed or open. [Closed]*
  - *Use of night light [She prefers a night light]*
  - *Toileting pattern during the night*
- *The care plan will also reflect Hilda's preferences related to sleeping and arising. In the evening, team members will assist Hilda to perform her "nightly rituals" that she traditionally does at home before bed.*

SCENARIO 3

Later that night — Hilda falls

Goal of the scenario: The team troubleshoots Hilda's fall risk with a goal of maintaining her independence and mobility.

Hilda: I got out of bed and before I knew it, I was on the floor. I thought I heard a baby crying and that's why I got up. A young woman found me and yelled out for help. I was OK—she just needed to help me get on my feet. Before long there was a bunch of people checking me, taking my blood pressure and looking to see if I had hurt myself. They asked

if I wanted to go back to bed, but I'm not tired. I told them that I want to sit in a chair. They helped me into the chair to sit and think a little while. I must have fallen asleep.

Evening shift Nurse: Hi Hilda, I am so glad to see that you aren't hurt! Can you tell me what caused you to fall? ***[The nurse can see that Hilda seems to be confused at the moment and realizes that she had just received her pain medication an hour before the fall. The nurse calls a quick huddle with the nursing assistants to discuss the fall and brainstorm interventions to prevent additional falls. Together with the nursing assistants, they agree to very quietly check Hilda every half hour when she is in bed for the next three days to observe more of her natural patterns. They also noted that she fell asleep with her TV on and the show that was on the TV at the time of the fall had a baby in it—perhaps that is how Hilda heard a baby crying. They decided they would be sure to turn off the TV as soon as she falls asleep.]***

Next day

Hilda: I woke up in my bed this morning groggy. I think that I fell last night, and I'm a little sore this morning. It is 10AM when I usually wake up and I feel like I slept well. ***[Anne comes in with a morning cup of coffee with cream and sugar and helps find Hilda's crossword puzzles. She helps Hilda get ready for the day and asks what she would like to wear].***

Anne: What would you like to do today, Miss Hilda?

Hilda's Daughter: Last night, the nurse called to let me know that my mom had fallen but was ok. I told her that I would want to check on her in the morning. The nurse said that Anne would be here again to give me a report. When I got here this morning, I peaked in my mom's room. She was still sleeping and wearing her favorite nightgown. She seemed to be resting peacefully and Anne said that they would let her sleep. I'm still upset about the fall and I want her to have a private room. I don't expect this to be perfect, but I want to know that everyone is doing their best for mom. I feel like they are so far.

Administrator: I just read my daily report and realize we had a few incidents last night including a fall by our newest resident Hilda. I am going out to check on the status of the resident and to ensure we have an intervention in place to prevent further falls.

2 hours later

Hilda: Anne helped me to the dining room for breakfast. I was able to use my cane which makes me feel better. My daughter came with us, and that was so nice. They asked me what I would like for breakfast and I asked if I could have scrambled eggs and bacon. They said "of course" and I ate a lot. I didn't think that I was very hungry at first, but it really hit the spot!

Administrator: I stopped by Hilda's room to discuss the fall last night with Hilda and her daughter. I explained our quality assurance process to prevent further falls. I assured her there is an adjustment period, but we will work hard to minimize any further incidents. In the conversation, I did mention we cannot prevent all falls, but we sure can work hard to minimize them. At the end of the conversation, both the resident and the daughter thanked me for coming by to see them and to address their concerns.

[The Day Nurse calls a group huddle]

Day Nurse: I completed my assessment with Hilda this morning and we talked about her shoes. Hilda's slippers do not have rubber soles and fit her feet very loosely. We need to speak with Hilda's daughter about footwear that may help Hilda walk more steadily.

Anne: (Talks to Nurse). I just spent some time with Hilda and got some more information that might help her from falling. Her daughter Janet told me that her Mom wears glasses, and she did not bring them with her to the hospital. Janet was so anxious over the entire situation of the surgery and coming to the nursing home that she forgot to bring them in. Janet promised she would bring them later today.

[The team continues to problem-solve ways to maintain Hilda's independence while minimizing her risk for falls]

Behind the scenes systems to support the scenario goals:

- *When problem-solving issues such as Hilda's risk for the falls, the team considers methods that maintain Hilda's preference for independence (in this case her choice to walk with her cane).*
- *Hilda's choices about her daily life and information about her background are recorded in a Communication Book. In addition, there is information provided by the nurse leader on assisting Hilda with activities of daily living and other care issues. It is the responsibility of each team member to be familiar with the information contained in Hilda's Communication book prior to providing her care.*
- *Hilda will not be awakened at night for vital signs, medications or other procedures unless clinically necessary. She will be allowed to sleep as long as she wishes in the morning.*
- *To support Hilda's choices in schedule, medication pass times are more flexible and natural (as Hilda would take her medications at home). They are given upon rising, after dinner, and at bedtime.*

Step 4: Independently or as a group, participants can reflect on the following topics after reading the study.

REFLECTIVE QUESTIONS FOR LEARNERS/PARTICIPANTS

1. Review your notes from Step 2. What are some examples of the similarities/ differences in the areas below from your initial notes in Step 2 and the practices/systems that you read about in the Unfolding Case scenarios?
   - systems typically in place to determine resident preferences/choice
   - systems in place to help staff honor resident choice in caregiving
   - adaptations that staff make to accommodate resident choices in the course of the day
   - problem-solving and communication techniques that staff use to identify obstacles/barriers that put resident choice at risk
2. Where did you note areas that competencies supported the systems and practices in the home?
3. Why would these competencies be important to assure that these systems are in place and effective?
4. What are examples of outcomes that might be associated with honoring Hilda's choices (e.g. choice in mobility, diet, sleep patterns, engagement) in her daily life?

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ACKNOWLEDGEMENTS

Pioneer Network would like to acknowledge the following organizations for participation in this project:

AMDA

Hartford Institute for Geriatric Nursing

PHI

National Association of Long Term Care Administrator Boards

The following resources were instructive to this final product:

Nursing Professor Case Study Bank. Online resource available here:
http://www.nursingprofessor.com/home/casestudybank.html

Kaiser Permanente Nursing Pathways Using Case Studies in New Ways.
Online resource available here:
http://nursingpathways.kp.org/national/learning/webvideo/programs/usingcasestudies1/index.html

Household Matters: A Good Life ‘Round the Clock. More information available here:
http://www.pioneernetwork.net/Store/HouseholdMatters/

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