New Jersey Alliance for Culture Change

A COMPILATION OF PERSON-CENTERED BEST PRACTICES PRESENTED AT NJACC CONNECT FORUMS

November 2019

NJACC

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The History of New Jersey Alliance for Culture Change

NJACC's focus is on providing education and training opportunities to help transform aging service organizations across the state into places where residents and team members are engaged and leading a life of purpose!

As an independent 501(c)(3), we directly reach hundreds of people each year including employees of senior living organizations, residents and family members. Both not-for-profit and for-profit organizations take part in our various programs and we welcome anyone who is interested in learning more about person-centered care, including people living in the community who are interested in supporting elders in our state.

We were founded in 2012 and thrive because of the support of our dedicated Board of Directors, which typically consists of:

- Forward thinking senior living providers.
- Leaders from aging service organizations, including LeadingAge NJ, the Health Care Association of NJ and the NJ Hospital Association.
- Active and retired professionals from the fields of consulting, academia, etc.
- Active and retired professionals from various agencies, including the NJ Long Term Care Ombudsman, the NJ Department of Health, and HQSI.

All the above are volunteers with very different backgrounds that are committed to one purpose: to transform the traditional culture of long-term care practices to one that promotes individualized care and services, supporting dignity and choice for each person! Each of our board and committee members is passionate about serving as a resource and inspiration to those new to the culture change journey, as well as those further along in their transformation.

Our Purpose

The NJACC promotes Culture Change in care settings to improve the lives of individuals and their caregivers by seeking to transform the traditional practices of long-term care to practices that uphold individualized care and services, supporting dignity, choice and autonomy.

- The NJACC will create a presence for Culture Change in New Jersey through mediums such as social media, our website, and an e-newsletter.
- The NJACC will focus on education for the "masses."
- The NJACC will host forums for stakeholders to share with each other, including best practices, success stories, and more.
- The NJACC will connect with direct care workers to support and honor their voices. We will work with established groups, determine their needs, etc.
- The NJACC will promote Culture Change theories and practices to the future leaders of long-term care, utilizing support networks, education, and more.

Person-Centered Best Practices

As part of our focus on educating the masses, NJACC hosts an annual Connect Forum to provide long-term care providers, residents and families information and practices that can drive person-centered care. In 2017, we turned to the focus of the NJACC Connect Forum on showcasing person-centered best practices being implemented by NJ long-term care providers.

By sharing this compilation of best practices from the annual NJACC Connect Forum, we hope to inspire other NJ long-term care providers an opportunity to implement small steps into the Culture Change journey!

NJACC Connect Forum Person-Centered Best Practices

- November 3, 2017: "Shake it up w/Person Centered-Care Best Practices" Presentations
  - "Caring Conversations: Humanities at the Heart of Elder Care"
    Presenters: Helen Blank, PhD & Nancy Gross, MS, MMH
  - "Person-Centered Care & Parkinson's Disease"
    Presenters: Lori Morell, Natalie Macaro, Tanvi Desai & Katelyn Ciarelli, Parker Health Group, Inc.
  - "Volunteers in Action"
    Presenters: Dawn Neglia, Justine Dmuchowsk & Meadow Lake Residents
  - "Using IT to Create a True Community Dedicated to Improving Quality of Life"
    Presenter: Chip Rowe
- November 1, 2018: "Building Community with Person-Centered Care Best Practices" Presentations
  - "Building Community by Walking a Mile in Their Shoes"
    Presenters: Toni Lynn Davis, MHA, CNHA, FACHCA, Helena Berardinelli, MA, ADC, R-DMT, CAN, The Manor Healthcare & Rehabilitation
  - "A Positive Approach to Care"
    Presenters: Maureen Braen, CDP, CPXP & Elisabeth M. Micich Otero, MSN, RN-BCCC, QCP, Christian Health Care Center
- November 7, 2019: Person-Centered Best Practices
  - "Driving Excellence in Everything We Do"
    Presenter: Jesse S. Rosenblatt, LNHA, MPH
  - "Team Collaboration on Resident-Centered Care"
    Presenters: Alicia Fereno, RN, MSN, Ranjana Hallur, MSOTR/L & Jennifer DeBellis, LPN, Rose Garden Nursing Home & Rehabilitation
  - "Living With a Purpose"
    Presented By: Erica Rattray-St. Jean, MSW, Belen Raymundo, Kelly Johnson & Parker at Somerset Residents & Family Member, Parker at Somerset

Shake it Up with Person-Centered Care Best Practices
November 3, 2017

"Caring Conversations: Humanities at the Heart of Elder Care"
Presenters: Helen Blank, PhD & Nancy Gross, MS, MMH

Summarize your best practice in 100 words or less.
Our unique project, based on a national hospital model focused on the joint use of the humanities and bioethics, demonstrates that increases in quality of life and enhanced satisfaction for long-term care residents may be achieved by promoting a sense of wellness, meaning and purpose among staff members. In caring for the carers, we increase their feelings of purpose, and validate their contributions by respecting who they are and what they bring to their work. This effort builds community, heightens cultural understandings, and promotes workplace satisfaction. The goal is to integrate compassion and empathy into the culture to maximize person-centered care for residents, many of whom face advancing illness and disability.

What issue does your Person-Centered Care Best Practice address, and what are the primary achievements and/or goals?
Our Person-Centered Best Practices promote increase in quality of life for long-term care residents by fostering a sense of wellness, meaning and purpose among staff members. In attracting interdisciplinary staff, from nursing assistants to Medical Directors, and promoting dialogues and shared written reflections, Caring Conversations has demonstrated an ability to strengthen the identity and collegiality of the team, allowing them to empathetically "walk in the resident's shoes". By use of film, poetry, literature and art, and the integration of ethical concepts such as autonomy, respect for persons and preferences, written evaluations confirm significant increases in staff members' sensitivity levels, communication, interpersonal and listening skills. Attendees gain a sense of respect for who they are and the high value they bring to their work in caring for the elderly. Incorporation of the humanities as well as ethical principles (e.g. promise-keeping, truth-telling confidentiality, etc.), enables those caring for seniors on a daily basis to appreciate their situation and develop perspectives that nurture a healing culture in the facility. The on-the-spot readings and film clips illuminate topics of aging, caregiving, death and dying, bereavement, professionalism, psychosocial issues, prejudices and stereotypes, and conflict resolution. Most importantly, program participants gain in an expanded comprehension of suffering, illness, loss, and love: the shared experience of all human beings.

What stakeholders (family, residents/ clients, employees, departments/ disciplines, and shifts) participated in developing and implementing this best practice?
The designers of Caring Conversations have spent many years facilitating Literature and Medicine programs in hospitals for interdisciplinary staff members. In adapting this national successful program to the long-term care facility have sought input from administrators, clinicians, chaplains, social workers and individuals from other disciplines. In addition, we have led seminars for staff and family members of residents on topics such as, Advance Care Planning, End-of-Life Decisions, and the Role of Palliative Care as well as professional programs focused on leadership, team building and meditation. Helen is a member of the Board of Trustees of a long-term care facility and has great familiarity with the daily issues confronting staff and residents. The national Literature and Medicine program, which is the model for the Caring Conversations program, has confirmed that the use of the humanities, literature and other expressions of creative arts, helps those who care for patients/ residents to appreciate their circumstances and develop the understanding and outlook that promotes a supportive

environment. The program has been specifically-tailored for the nursing home environment, taking into account the psychosocial and medical status of residents during this part of their life's journey, the impact of end-of-life issues on residents/ caregivers, the emotional issues for family members, and the burnout and stress often experienced by staff who are asked to cope with these challenges on a daily basis. In implementing the program at various long-term care facilities over the last five years, we always engaged an individual in the organization to act as the liaison and provide internal support. During the recruitment process, the facilitators reached out to all disciplines (including clinicians, social workers, chaplains, maintenance staff, food services, admissions, human resources, etc.) to ensure that a broad spectrum of experiences and concerns are illuminated during the sessions.

How does it work? What methods or procedures/ protocols are used to get results?
The Caring Conversations project in collaboration with the New Jersey Council for the Humanities creates a meaningful experience for participating employees in long-term care facilities. At each site, we have standardized the procedures that have led to success. A positive incentive is that the Council provides funds for the facilitator honorariums and the gift book distributed at the concluding session. The facilitators usually hold a brief demonstration session at each interested site prior to program implementation, to provide the experience, sample materials and syllabi.

The attendees are drawn from all disciplines in order to provide a variety of personal and professional perspectives. The workshops are conducted in the facility on a once-a-month basis from January to June (6 sessions) for approximately sixty minutes. The organization provides the room and light refreshments for attendees. Since each facility has a different culture, resources and needs, the sessions are scheduled at a time that is convenient for the facility to accommodate what works best and will allow staff members to attend on a regular basis.

The discussions are facilitated by humanities scholars and the syllabi for the workshops are developed and submitted prior to the start of the program. Promotional materials developed for participant recruitment are provided to a liaison person in the organization. All resources (e.g., films, short stories, poems, etc.) used during the workshops are provided by the facilitators at no cost to the organization. At the concluding session, participants will complete a brief evaluation survey developed by the Council to assess their workshop experience and provide feedback to the facilitators and program funders. All attendees receive a certificate, which is placed in their permanent file, to demonstrate their participation in the Caring Conversations program.

What has your best practice accomplished, and how have you been able to measure this?
Program participants are asked to complete a survey prepared by the NJ Council for the Humanities. Past date collected by the Council (which includes out program results) indicate that participants had great or moderate increases in the following areas: (1) Empathy for residents, 79%, (2) Interpersonal Skills, 64%, (3) Communication Skills, 58%, (4) Job Satisfaction, 62%, and (5) Cultural Awareness, 67%. As further evidence of the project's positive impact, please read Attachment 1, a letter written by Dr. Joshua Schor, the Medical Director at Daughters of Israel, who captures many of the program's influences among staff members at that facility. Participants have indicated in their evaluations that the Conversations program provides a "safe space" to explore and share their feelings and listen to the experience of others. Over the years, many have expressed that it has helped them to evolve as professionals, and better respond to the residents with increased patience and heightened understanding. Evaluations and facilitator observation confirm a continuous improvement of resident care through reflective practice.

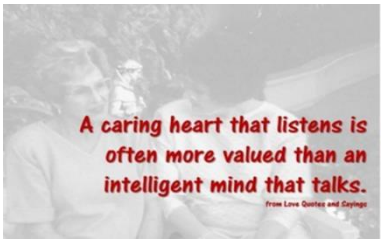
What problems, obstacles or challenges might other nursing home/ communities face in replicating your innovation? Do you know of any other nursing home/ communities which have tried this or a similar idea? Were there any adverse effects or unexpected outcomes? Identify your lessons learned.
The challenges in making this program successful in a long-term care facility focus on (1) scheduling that allows for the creation of an agreed upon time slot so that staff members from all disciplines are able to participate on a regular basis, (2) having a dedicated and capable internal liaison, and (3) gaining the support of the nursing home administrators for this ongoing initiative by demonstrating its high value to resident care.
The program has been implemented and is currently running at Daughters of Israel (5 years). The unexpected outcomes in several of the ongoing facilities have been the notable increase in camaraderie and caring among participating staff members, resulting in an increased efficiency when they respond to each other's requests regarding resident needs. After Dr. Schor's presentation of this program in Phoenix, Arizona in March 2017, we have received requests from administrators in Missouri and elsewhere who are interested in replicating this program in their facilities.

What was the cost to implement your best practice (includes staffing, supplies, equipment, and any other costs)?
The Caring Conversations Program is funded by the New Jersey Council for the Humanities. The Council provides the monies for the facilitator honorariums and the end-of-year gift for participants. The Humanities Scholars supply all the resources (e.g., short stories, poems, video clips, etc.) utilized during the six-monthly workshops. The responsibility of the facility is to provide a suitable space and most offer light refreshments, (snacks, lunch, etc.) depending on the time of day when the program is held.

What are the reasons you consider this best practice to be successful and innovative?
The Caring Conversations Program is a unique blend of humanities and ethics that most participants would not be able to access in other ways. The American Society of Bioethics and Humanities believed that this program was so unique and innovative, that they invited the facilitators to give a Caring Conversations workshop at their national conference in San Diego in 2014 to highlight our model.

The interdisciplinary nature of the participants, and the sharing of personal and professional experiences, creates a sense of community, that is often not present, and an increased sense of empathy for each other. This transfers over to resident care as staff members gain a new appreciation of the effects of culture, understandings about the aging process, heightened awareness of the sense of loss felt by many residents, and an appreciation of family concerns (their own and others), and a respect for all persons. The participants feel valued, cared for an listened to, and they have the opportunity to sit side by side with individuals in the facility with whom they had not previously had a relationship.

The influence of Caring Conversations is to promote a healing culture and explore the attitudes, beliefs and values that must be present in an empathetic environment. By empowering staff members to explore and articulate their feelings and concerns, they are able in turn to relate in a kinder and more compassionate way to each other, as well as to residents and their family members who may sometimes be challenging.



"Person-Centered Care & Parkinson's Disease"
Presenters: Lori Morell, Natalie Macaro, Tanvi Desai & Katelyn Ciarelli

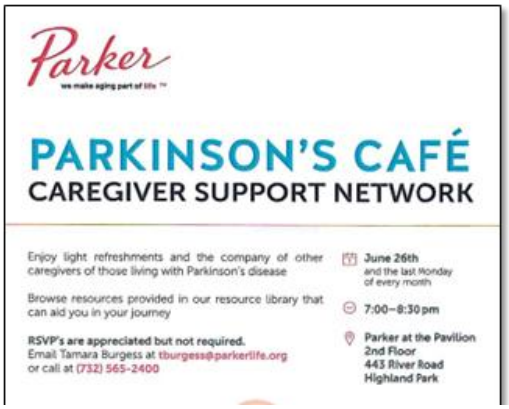
Summarize your best practice in 100 words or less.
After experiencing an increase in the number of individuals living with Parkinson's Disease (PD) utilizing Parker's services, we identified a need for additional education and training regarding the disease process, models of care, and how best to serve those living with PD and their caregivers. The I.M.P.A.C.T.S. Program was developed to enhance the lives of those living with PD. The I.M.P.A.C.T.S. Program believes that there are three components to living well with Parkinson's disease: exercise, therapy, and education/ support services. The I.M.P.A.C.T.S. Program utilizes an interdisciplinary and person-centered approach to develop plans of care that include these three components.

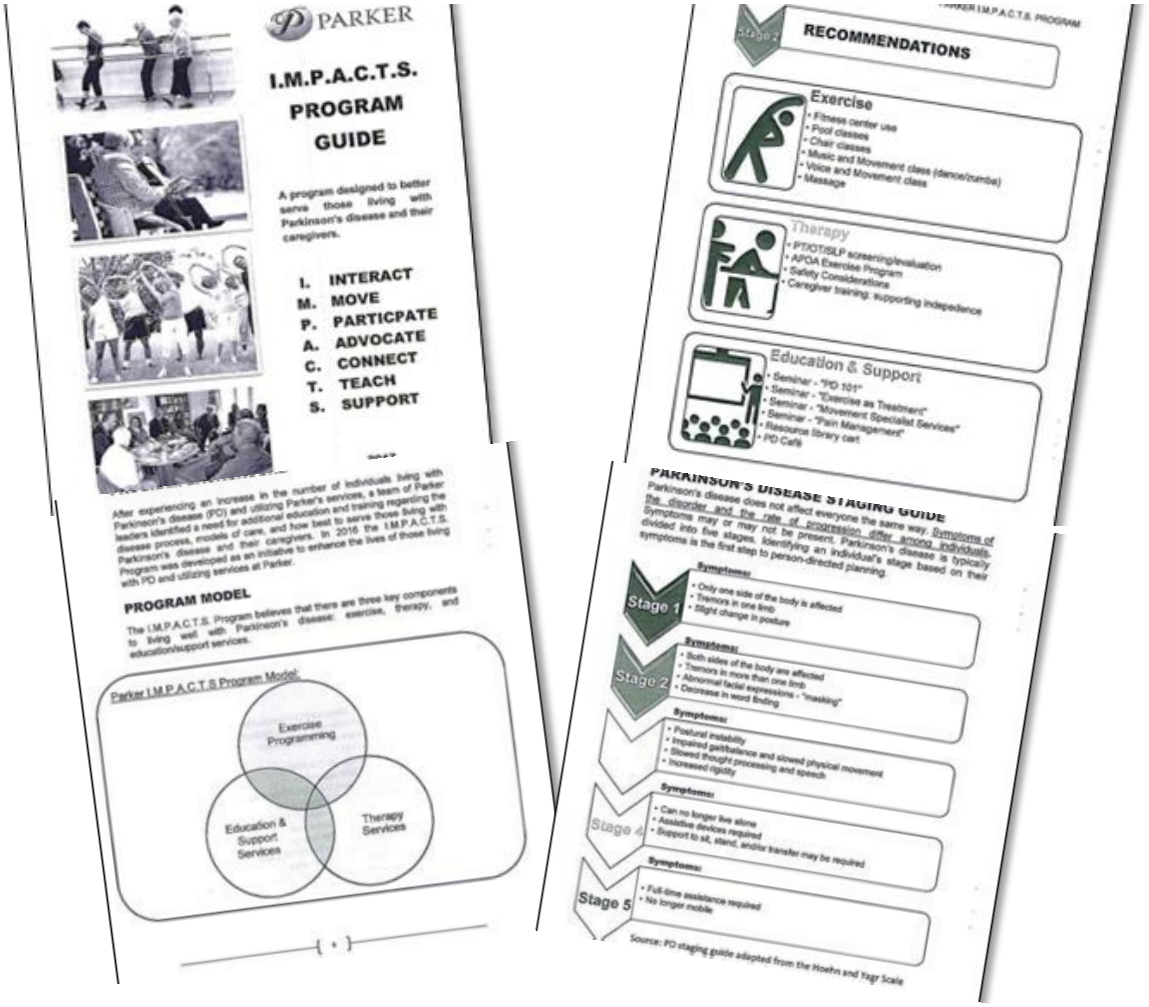
What issue does your Person-Centered Care Best Practice address, and what are the primary achievements and/or goals?
Prior to the I.M.P.A.C.T.S. Program, individuals living with PD were grouped with and cared for in the same way as those living with dementia. Although individuals living with PD can experience cognitive changes, their overall needs differ from those living with dementia. The I.M.P.A.C.T.S. Program acknowledges that individuals living with PD and their caregivers can benefit from an interdisciplinary, person-centered approach that addresses their specific needs based on their disease stage and personal preferences.

What does I.M.P.A.C.T.S. stand for?
Interact Move Participate Awareness Connect Teach Support

The primary goals of the I.M.P.A.C.T.S. Program are to:
1. Identify and appropriately stage individuals diagnosed with PD;
2. Create and/or identify a person-directed plan:
   - Residential Services- create and implement a person-directed plan of care based upon the individual's PD stage, capabilities, and personal preferences.
   - Home and Community Based Services- identify and provide resources and tools based upon an individual's PD stage, capabilities, and personal preferences.
3. Provide education to support a person-directed plan:
   - Targeted Populations include- individuals living with PD, caregivers, Parker employees, and other key stakeholders (physicians, home care providers, etc.).

To achieve these goals, the I.M.P.A.C.T.S. Program supports the development of the following services: training, education, tools, and resources; recommendations and referrals; PD- specific exercise programming; PD- specific therapy services; and PD-specific support groups and networks.





What stakeholders (family, residents/clients, employees, departments/ disciplines, and shifts) participated in developing and implementing this best practice?
The I.M.P.A.C.T.S. Program was developed by leaders and the Rehabilitation Services Program. caregivers, participants and clinical leaders were engaged by these leaders to discuss how they could better care for those living with PD. Caregivers were surveyed and participated in focus groups to identify what services would be beneficial to them now, and based on their experiences, what resources had been lacking in the past.

A wide variety of stakeholders supported program implementation including medical directors, administrators, directors of nursing, recreation managers, and social workers. In the future we hope to gain support from the MDS Coordinators, to integrate I.M.P.A.C.T.S. Program approaches and interventions into the formal care planning process.

How does it work? (What methods or procedures/ protocols are used to get results?)
The I.M.P.A.C.T.S Program works by providing support and maintenance for the following services:

1. Training and education resources/ tools: a resources side was developed to help those living with PD. The guide identifies a number of interventions that an individual can select from based upon their PD-stage and personal preferences. The guide can also be used by caregivers to assist them in managing and preparing for an individual's disease

progression and their own self-care. Educational seminars are scheduled quarterly. The topics of the seminars change each quarter.

2. Recommendations and referrals: a resources cart was created. The cart includes materials regarding treatment and care management services that area available in the local area.

3. PD specific exercise programs: exercise programs are adapted to meet the specific needs of individuals with PD- focusing on movement and speech. Two new exercise programs were implemented: Voice and Motion and Music and Movement. Recreation therapists and wellness staff attended Dance for PD trainings.

4. PD specific therapy services: rehabilitation therapists provide training (e.g. safe transfers, mobility and cognition tips) to caregivers enabling them to better care for individuals living with PD. Physical and Speech therapists were scheduled to attend LSVT Big and LSVT Loud Trainings to introduce PD-specific therapy techniques into treatment sessions.

What has your best practice accomplished, and how have you been able to measure this (you my give numbers and/or specific "before and after" examples)?

The I.M.P.A.C.T.S. Program has enhanced the quality of life and care for those living with PD and receiving services at Parker. This had been accomplished through:

- Improved caregiver awareness of the specific care needs of individuals living with PD;
- Availability of a variety of PD-services (therapy, exercise, education) to support and enhance the wellbeing of individuals living with PD, based upon their PD stage and personal preferences.

Measurements of the program's success include:

1. Positive qualitative feedback from those living with PD and their caregivers;
2. High ratings on seminar evaluations- provided at the end of each quarterly education seminar;
3. Increase in the number of participants attending PD-specific exercise classes on a weekly basis;
4. Regular attendance at the PD Café Support Network

What problems, obstacles or challenges might other nursing homes/ communities face in replicating your innovation? Do you know of any other nursing home/ communities which have tried this or a similar idea? Were there any adverse effects of unexpected outcomes? Identify your lessons learned.

We are not aware of any nursing homes/ communities which have tried a similar idea. There were no adverse effects or unexpected outcomes associated with the program.

Obstacles and challenges to implementing the I.M.P.A.C.T.S program may include:

1. Lack of support from leadership. Lessons learned: it helps to educate leadership on the number of individuals you are serving with a diagnosis with PD. We counted the number of individuals living with PD for each of our locations/ programs. your PD population may be larger than what you would expect. Are those you serve with a diagnosis of PD satisfied? Are their caregivers satisfied? A survey may help you to identify gaps and make a case for the program.
2. Completing education priorities/ poor attendance. Lesson learned: PD education is not a regulatory requirement. Employees may not see PD education as a priority. It is important to engage supervisors/ managers early in the program development. Having

leadership understand the goals and benefits of the program, along with the population you're trying to serve, will make program implementation easier. It is critical that leadership encourage and support their staff to attend education sessions on a PD as individuals living with PD require very different care and services.

3. Providing stage appropriate programs. Lessons learned: We quickly learned that programming must reflect an individual's PD stage, or it will not be successful. We originally launched Voice and Motion in our using homes, however, found it was too difficult for individuals living with later stage PD to be successful. Music and Movement (modified) replaced this program and was much better received.
4. Caregiver support attendance. Lesson learned: Caregivers are already under a great deal of stress and it may be difficult for them to attend support networks or educational programs. Scheduling support groups and educational programs at the same time that a program for their loved one is being offered may be helpful to improve attendance. Reaching out to each caregiver to explain the benefits of the support network/ education, may also provide an opportunity for 1:1 counseling/ support and understanding their specific their needs/ concerns.

What was the cost to implement your best practice (include staffing, supplies, equipment, and any other costs)?
As the I.M.P.A.C.T.S. Program continues to expand and enhance existing services, we anticipate the need for additional staffing to assist with program coordination. At this time, we have been able to manage the development of this program with existing staff.

Start-up costs associated with the program included the training and education of current staff that facilitate the PD specific programs. Staff visited the Parkinson's World Congress in Oregon, the Muhammad Ali Center in Arizona, and Parkinson's Place in Florida. The start-up costs to implement the I.M.P.A.C.T.S. Program by other providers is expected to be less, as Parker is open to sharing the best practices that we have learned, reducing the need for significant travel.

Costs:

- Staffing: $0
- Travel (conference fees and tours of premier providers): $7,000
- LSVT BIG & LOUD Certification Training (therapy): $545/pp
- Dance for PD Training (Exercise): $400/pp
- Resources cart: $100
- Seminar/ education refreshments: $50/quarter

What are the reasons you consider this best practice to be successful and innovative?
The I.M.P.A.C.T.S. Program has been largely successful due to the support of Parker's Executive Leadership Team. The Executive Leadership Team embraces innovation and supports the idea of their employees which create a culture of continuous improvement. The I.M.P.A.C.T.S. Program is an example of continuous improvement and best practice. It was created to improve services for those we care for and reminds us that those living with PD require both specialized and personalized support. The I.M.P.A.C.T.S. Program is innovative as we are currently unaware of any long-term care communities caring for individuals with PD differently than the rest of their population.

"Volunteers in Action"
Presenters: *Dawn Neglia, Justine Dmuchowsk & Meadow Lake Residents*

Summarize your best practices in 100 words.
Together with our residents we have started a volunteer program in our continuum of care community. Residents who reside in the independent living apartments, assist the residents in the regulated healthcare areas of assisted living and long-term care. The residents feel that their efforts have increased their scene of worth and purpose through volunteering and while doing com increased the quality of life of residents we serve. We would like to share our volunteer opportunities that include "Pushovers" (who assist with transport), library service, mail service, one to one room visits, knitting of lap blankets and our grounds/ gardening club. It promotes the feeling of a community within.

What issue does your Person-Centered Care Best Practice address, and what are the primary achievements and/ or goals?
Our best practice addresses the quality of life and sense of worth and purpose of our residents. Though our volunteer program with their peers' group, the residents thought out our entire continuum community are connected, active and involved. The residents who are receiving the assistance appreciate the continued relationship with the residents they possibly once lived near. The residents who are providing the volunteer services are also working alongside the employees of our community and this lends more to a team and family style approach vs. a caregiver only relationship.

What stakeholders (family, residents/clients, employees, departments/disciplines, and shifts) participated in developing and implementing this best practice?
This practice has been developed and implemented by both the residents and the staff. The residents sign up as volunteers thru their Forum (resident) run committees and are assigned duties as appropriate. The Activities Director on the healthcare units make contact with the resident representatives when special events are planned, and they make arrangements to attend. Family members and community volunteers also continue to be volunteers with the independent living residents, allowing the practice to be community wide, extending both in and outside.

How does it work? (What methods or procedures/ protocols are used to get results?)
This process works quite simply. The residents sign up directly to be volunteers (as do our community volunteers, local schools and family members). The alternative option would be for independent living residents to joining one of the Forum Committees who have volunteers who come to the healthcare areas for specific purposes. This includes the Library Committee, the Healthcare Committee and the Grounds Committees. The Activities Director works with the representatives of these committees to recruit for specific events as needed. The volunteers also advise the staff when they are hosting an event in independent living that may be of interest to one of the residents in the Assisted Living or Healthcare units.

What has your best practice accomplished, and how have you been able to measure this (you may give numbers and/ or specific "before and after" examples)?
Our practice is measured by the happiness and satisfaction of our healthcare residents and the sense of community overall. Surveys are sent out regularly for the community and there is opportunity to rate how pleased residents are with our programming. This programming is largely supported by our volunteers. The practice connects the residents to the world of which

they previously lived. It allows them to continue to participate in what they enjoy as part of our larger community.

What problems, obstacles or challenges might other nursing home/ communities face in replicating your innovation? Do you know of any other nursing home/ communities which have tried this or a similar idea? Were there any adverse effects or unexpected outcomes? Identify your lessons learned.
Communities without the connected independent living unit may have more difficulty implementing this practice. Whereas most long-term care centers have volunteers, continuum communities have the added value of the Indenting Living section on site. Possibly working with a local senior housing complex would allow for some replication of this process. There have been no adverse effects of this practice. At times it is necessary to help volunteers to realize their limitations for the safety of all involved.

What was the cost to implement your best practice (include staffing, supplies, equipment, and any other costs)?
There is no direct cost with the best practice. Some larger events where volunteers are served food have a slight increase to cost. Training in done with staff who are already working in the community.

What are the reasons you consider this best practice to be successful and innovative?
The most important reason we find our best practice to be successful is because it involves all of our residents and helps promote self-worth, purpose and a better quality of life for all of those in our community. This is all done thought the implementation of this practices of volunteerism in within our community.

"Using IT to Create a True Community Dedicated to Improving Quality of Life"
Presenter: *Chip Rowe*

Summarize your best practice in 100 words.
The changing face of information on technology, in an age of the Internet, helps all facilities take charge of tracking and measuring the success of their person-centered care initiatives while reducing liability and increasing resident satisfaction. IT provides greater transparency by maximizing family involvement in care planning and execution. Technology can help you overcome the challenge of involving family members at a greater level by providing each family member with 24/7/2365 access to current information, observations, and communication about their loved ones while increasing staff and volunteer productivity and effectiveness which result in a reduction of complaints and negative tags.

What issue does your Person-Centered Care Best Practice address, and what are the primary achievements and/or goals?
What happens to the many observations made daily about your residents and patients? Are they written down and placed in a chart and do they become meaningful information in the development of care plan? Who has access to observations? Can the housekeepers or maintenance personnel make observations about your residents too? After all, they communicate with your residents and patients on a regular basis and in some cases even more often than your skilled nursing staff. Are your activities meeting the needs and desires of your residents? Can you measure the success of your Person-Centered Care best practice? What isn't measured can't be managed and what isn't managed can't be changed.

What stakeholders (family, residents/clients, employees, departments/disciplines, and shifts) participated in developing and implementing this best practice?
Several stakeholders including family members, residents, volunteers, nonskid staff and other employees and departments participated in the development of this best practice.

How does it work? (What methods or procedures/protocols are used to get results?)
During the intake process, as much information about the new resident is gathered by intake staff. This information might include information about the resident's past, their prior profession, what are their likes and dislikes, and what activities they would find most enjoyable to engage in on a regular basis. This information is compiled in a database built specifically for this purpose and becomes shareable by all staff who interact the resident. Master activity categories are assigned to the resident and any time a specific scheduled activity is set on the calendar, that resident is scheduled as an attendee automatically. During the activities and at various times during the day, observations are tracked and noted and attendance at prescheduled activities is also noted using and intelligent handheld device like an iPhone or iPad. Family members have observations related to their loved one and have the ability to communicate with staff directly about areas of potential concern. Staff has the ability to invite family members to care planning meetings and can track whether family members choose to attend or not.

What has your best practice accomplished, and how have you been able to measure this (you may give numbers and/or specific "before and after" examples)?
The ability to involve family members has reduced unusual turnover among residents by 80%. The volunteer community has increased 22%. Complaints about care have decreased by 90%. All of these metrics are retained by our IT system and reviewed on a regular basis by our staff.

What problems, obstacles or challenges might other nursing home/ communities face in replicating your innovation? Do you know of any other using home/ communities which have tried this or a similar idea? Were there any adverse effects or unexpected outcomes? Identify your lessons learned.

Other nursing homes and communities who are not currently engaged in the use of robust IT technology to track observations and behaviors will experience a learning curve. The move away from paper driven observations and filing of those observations will be new to many facilities. Some discipline must be initiated to determine what information should be shared with family members and what information should not be shared but experience is a great teacher. Some facilitates have a policy against use of mobile phones and mobiles tablets and therefore this policy needs to be reviewed to allow for real-time observations to be tracked. The most difficult challenge will be to understand how to measure and then track the results that are experienced with Person-Centered Care initiatives.

What was the cost to implement you best practice (includes staffing, supplies, equipment, and any other costs)?

- Cost of the system- $.33 per bed per day
- Training and Implementation- $3000-$6000 (one-time cost)
- System Support- included in the cost of the system for five hours per month
- Interfacing to your existing EMR system- variable depending on what information desires to be shared between the two systems and which company provides your EMR

What are the reasons you consider this best practice to be successful and innovative?

The tracking of observations about behaviors and interpersonal relationships has never been able to be a significant part of the care continuum. With the ability to not only track the clinical side of someone's quality of life, the ability to track real-time observations, using a handheld intelligent device, about the behavioral and interpersonal quality of life becomes vital in providing a 360-degree view of each resident/ client. The system must be easy to use and with the ability to verbally transcribe notes into an intelligent device makes each staff member including housekeeping and maintenance important contributors to the quality of life of your residents/clients. Finally, and of great significance is the ability for family members, no matter their geographic limitation, to gain access to current information about their loved one any time of the day or night which affords each family member the ability to be as deeply involved as they choose to be.

Building Community with Person-Centered Care Best Practices
November 1, 2018

"Building Community by Walking a Mile in Their Shoes"
Presenters: Toni Lynn Davis, MHA, CNHA, FACHCA Helena Berardinelli, MA, ADC, R-DMT, CNA The Manor Healthcare & Rehabilitation

Summarize your best practice in 100 words.
The Administrative Certified Nursing Aide (ACNA) is a program started in February 2018 where five administrative staff and two support staff became CNA's in addition to their regular roles. The ACNA program addresses many things: some intentional, and some came about purely by accident. The original intention of the program was to help staff, especially when we were staffed light. We always had an "all hands on" approach, but now as CNA's, there is so much more we can do to help, especially with toileting and changes. Other goals were to increase the call bell response rate; reduce the number of residents who become incontinent (toileting schedules); and reduce the number of residents whose need for help with ADL's increased.

How does it work? (What methods or procedures/protocols are used to get results?)
Currently we have the following roles helping as ACNA's: administrator, activities director, social work manager, a social worker, staffing coordinator, a housekeeper and a dining aide. We began the CNA classes in December 2017 and with participation in class about 2-3 days a week, we finished classes in January 2018. We took the test in February and had a 100% passing rate.

What was the cost to implement you best practice (includes staffing, supplies, equipment, and any other costs)?
The budget for the program included the fee for certification training. Ten people attended training at a cost of $16,950. Because training was held on our campus, there were no expenses for location, travel or food. All support staff received a $.50 an hour pay increase for completing certification.

During training and when they work on the floors, support staff members receive hourly compensation for their time at the same rate as a CNA. When they assist on the floors during normal work hours, they are compensated at their regular rate of pay. Members of the administrative team are compensated with compensatory time.

What are the reasons you consider this best practice to be successful and innovative?
Since its inception, we have accomplished the following:

- Increased a timely response to call bells by 9.2%, from 72.9% to 89.7%;
- Decreased the number of residents who lose control of bowel and bladder by 4.3%, from 40% to 35.7%;
- Reduced the number of residents who had an increased need for help with ADL's by 8.8%, from 24.4% to 15.6%.

In addition, staff morale has increased and the camaraderie among the teams has also improved. That we are willing to come in, even on weekends, if we are short and support the team has shown the most benefits. Staff are very grateful and know that we truly care, understand and want to be proactive in helping to be a solution for the staffing crisis. As administrative staff working as a CNA, we are able to do so much more by identifying ways that

systems and processes can be improved; identify and replace old and antiquated equipment; and find ways that will benefit the staff using time management to ease their duties. Working side by side with the aides, we see their issues and concerns and can work with them to find solutions.

When residents/family members hear that we as administrative staff are out on the floor working with the CNA's, they feel more at ease knowing we are working as a team to improve their/their family member's quality of life! There were no negative outcomes initiating this program. In fact, the program helped during the survey process!

The program has enabled us to reduce our agency fees.

"A Positive Approach to Care" Presenters: Maureen Braen, CDP, CPXP & Elisabeth M. Micich Otero, MSN, RN-BCCC, QCP Christian Health Care Center

Christian Health Care Center (CHCC) provides a broad continuum of high-quality, compassionate care, offering superior senior-life, short-term rehab, and mental-health services. As a non-profit organization, we deliver Person-and Family-centered Care (PFCC) to our community based upon the Christian principles on which we were founded more than a century ago. In 2015, Person-and Family-centered Care was introduced enhancing our patient-experience movement, transforming our culture, and supporting our existing service -excellence (Studer) and customer -service (patient service) programs. PFCC is foundational to optimize our connections, engagement and interactions with those we care for and to our defined Philosophy of Dementia Care. In 2016, two leading educators on dementia, Teepa Snow, OT/L and Heather McKay, MS, OT/L, educated staff and the community. As a result of the trainings that were a significant component of the presentations by Snow and McKay, Christian Health Care Center adopted the Positive Approach to Care (PAC).

Summarize your best practice in 100 words.
PAC is a highly individualized, non-pharmacological approach to the care of those with Dementia or Dementia related diagnoses. Understanding the value of each person and their unique needs and preferences, we seek to approach individuals in a respectful and dignified manner. PAC philosophy is a combination of PFCC, Positive Physical Approach (PPA), and Dementia Care techniques. The PPA is a structured, supportive approach that engages those we care for from the front with visual connection, while integrating cueing and verbal communications. PPA is the guiding framework and an essential component of our staff education; it is modeled by our leaders and validated through ongoing demonstration of staff competency in these evidence-based interventions. The techniques assist individuals whether they are calm, distressed, crying, angry, frustrated, fearful, or irritable. The approach is person-centered and is effective for our entire population, including those individuals living with dementia. It is a proven and effective intervention to be implemented as we seek exceptional communication that builds nurturing, collaborative relationships and engagement with care partners and those entrusted to our care.

What are the reasons you consider this best practice to be successful and innovative?
The integration of Person- and Family-Centered Care (PFCC) is multi-faceted throughout all CHCC programs but starts with the engagement of our interdisciplinary staff, including, but not limited to, direct care and supporting staff (Nursing, Social Services, Therapeutic Activities, Food and Nutrition Services, Environmental Services, and Plant Operations). We seek to honor personal choice, preference, and goals as identified through individualized care plans and collaborative efforts amongst the care partners that includes the patient, and, their family when clinically Building Community with Person-Centered Care Best Practices Best Practices Summaries indicated. PFCC is a tenant of all CHCC educational opportunities and programs and is continuously measured for effectiveness through rounding and satisfaction surveys. PAC provides staff with a new set of tools that are useful to comfort individuals while providing emotional support and reassurance.

What has your best practice accomplished, and how have you been able to measure this (you may give numbers and/or specific "before and after" examples)?
Data supporting the use of this approach has shown a decrease in the frequency of verbal, physical, and resident assault toward staff, while sustaining efforts to become a restraint-free community. Notably CHCC has achieved zero percent restraint rate for the past two consecutive

years. Additionally, over the past year, there is a noted decrease in the use of Velcro belts and alarms tabs. Another benefit of this approach we have realized is the reduction in the frequency of the use of antipsychotic medications. As with any new initiative, there is some resistance to embracing the culture change. Continual reinforcement, coaching, education, modeling and sharing successes have helped bridge this barrier.

How does it work? (What methods or procedures/ protocols are used to get results?)
Key takeaways for the effectiveness of this initiative include the training of entire interdisciplinary teams in addition to the buy- in, support, and modeling by leaders. Our PFCC Steering Committee and Person and Family Advisory Council, based on their perceptions and personal experience, provide crucial insight and feedback that directly influences the direction and success of PFCC in our culture. Education is ongoing and built upon, not only for the CHCC staff, but for family and community members. CHCC offers learning opportunities such as support groups, small group informational sessions, and large educational trainings to the community. In addition, many resource materials are available and provided to care partners through interdisciplinary meetings and personally established relationships. PAC content is incorporated into other educational opportunities such as General Orientation, Staff Competencies, CNA Update, and small group trainings and in-services. Staff recognition and encouragement is also vital as they shift and grow from novice to expert interveners.

As an organization, we continuously strive to provide a healthcare environment that is grounded in exceptional care, where the individuals entrusted to us are central and trusting relationships are formed and strengthened through collaborative partnerships with our patients, families and the community-at-large.

Person-Centered Best Practices
November 7, 2019

"Driving Excellence in Everything We do, even in a Nursing Home"
Presenter: Jesse Rosenblatt, LNHA, MPH

Summarize your best practice in 100 words or less.
We take the small things for granted. In this presentation we will talk about our people-based organization and how to get the most out of them. The secret is it does not cost any additional money to start this momentum to excellence. We need to focus on our employees and ensure that they know that they are essential to us. What does that mean and how will that translate to better care for our residents? If we take good care of our employees our residents will be in much better hands. Everyone is focused on that we are here for our residents and our residents are not here for us. How do we live our values and produce excellence in everything we do on a daily basis including and most importantly which is outstanding quality outcomes? The presentation will walk through best practices that were applied to a skilled nursing facility and the results were superior and drove excellence outcomes. The excellence outcomes included 5 Star status based on CMS standards, a deficiently free survey and outstanding customer service.

What problem does your best practice address, and what is its primary purpose?
Our employees are neglected. The employees need the training and the leadership to ensure that they are doing what they are supposed to be doing. We are delivering 24/7 care in most cases and all shifts need the proper attention. We need to give our staff the tools to provide outstanding care to our residents and families. The care provided is simply in our staff hands 24/7. As leaders, we need to empower our supervisors and listen to them. We focus on putting the pride back into their work and let our employees deliver outstanding outcomes as a team, and celebrate those successes is what will be discussed.

What stakeholders (family, residents/clients, employees, departments/disciplines, shifts) participated in developing and implementing your best practice?
Everyone is encouraged to participate.

How does it work? (What methods or procedures/protocols are used to get results?)

- Leadership Meetings: We met as a leadership team daily until we were comfortable with what needs to be delivered to our employees. We then shift to a monthly meeting format that invite all supervisors and above to learn about all of the great initiatives that are happening and how the team came up with these ideas. We brainstorm on their issues and create the proper teams to ensure that all issues are properly worked out.
- Individual Employee Mentorships: The key is we don't allow our employees to complain unless they have suggestion to solve the issue. We then use their ideas to improve our operations and give them the credit. We have signed job descriptions and evaluations annually. We involve our employees on multiple levels, so they see what is going on and understand the meaning behind what we are doing. We have an open-door policy and we ensure that we are sending emails and have open discussions on what is being

discussed and how can we improve quality, safety, and satisfaction of the organization. Then most important is that we celebrate the successes together.

- Overall philosophy: We treat our residents and families like our family. We try to put ourselves in their shoes and we are the experts to steer and assist them in their challenging NH journey. We always let them tell us how they are feeling, and we empathize about their situation. We always have the time!

What has your best practice accomplished, and how have you been able to measure this?

We have maintained a 5 Star CMS Rated Building for 4 years. We have become the facility of choice in the community where our neighboring physicians recognize our outcomes and we are running close to a 100 percent census.

What problems, obstacles or challenges might other nursing home/communities face in replicating your innovation? Were there any adverse effects or any ways that things turned out differently than you had planned? Do you know of any other nursing home/communities which have tried this or a similar best practice idea?

The problem/obstacle/challenge is having management not buy in to what we are trying to accomplish. The saying 'we did that, and it didn't work' or 'it will never work' was immediately taken out of the equation. We will not allow extreme negativity of our staff towards our organization. We want to be uplifting and inspire. Another problem/obstacle and challenge is the trust of our employees. They have to trust their leaders and it is always a two-way street. These ideas were best practices from other industries and were applied towards the post-acute world.

What was the cost to implement you best practice (include staffing, supplies, equipment, and any other costs)?

There was relatively no additional costs. We were able to maximize our time better and be able to get rid of the waste.

What are the reasons you consider this best practice to be excellent and innovative?

It makes our jobs easier by making it more fulfilling, it creates essential teams within the workplace and delivers outstanding outcomes to residents and to their fellow co-workers that essentially needs patient centered care. Ultimately it increases revenues because it drives excellence in places that you would never expect it and will be recognized by the community as the place to receive excellent care.

"Team Collaboration on Resident-Centered Care"
Presenters: Alicia Fereno, RN, MSN, Ranjana Hallur, MSOTR/L & Jennifer DeBellis, LPN, Rose Garden Nursing Home & Rehabilitation

Summarize your best practice in 100 words or less.

Nursing and Therapy collaborate and daily re-evaluate to provide best practice care with the use of daily huddles. Our Rose Garden team believes, "It Takes A Team to Provide Quality Care." This includes the communication between families and all disciplines. Our Administrator and Director of Nursing found our previous practice was lacking in overall communication. With their guidance the team met and created the daily huddle approach to provide individualized needs and customized care. In the clinical meetings the team reviews the progress. The huddle between Therapy and the unit manager discuss updates that ensures maximal improvement of the resident. The culture change is to provide individualized care for each client through collaboration. The huddle has had a positive outcome on the Quality of Care for our residents!

What problem does your best practice address, and what is its primary purpose?

The problem that the Daily Huddle addresses is the lack of communication between nursing and rehabilitation service thereby affecting resident- centered care. The primary purpose is to provide a better communication method between the nursing and rehabilitation team and include the resident for resident engagement and resident reflection which is going to provide a best care practice!

What stakeholders (family, residents/clients, employees, departments/disciplines, shifts) participated in developing and implementing your best practice?

It takes a team approach for quality of care that focuses on and addresses any small concerns immediately. This includes residents, families, all employees, department heads, administration, doctors, and consultants.

How does it work? (What methods or procedures/protocols are used to get results?)

Daily huddles are done in the morning and again in the afternoon. It is a stand- up meeting between the nursing manager and therapy director, with the resident included for any concerns. In the morning huddle, identified issues are addressed, and the impact of interventions are discussed in the afternoon huddle. During the progress of the day any emergent issues are immediately addressed with the primary. Any issues that had been resolved are shared with the team during daily morning meetings.

What has your best practice accomplished, and how have you been able to measure this?

It has improved satisfaction of residents; they understand the cohesive team approach. It has lowered the rate of hospitalizations. The length of stay has decreased. Families are happy to return and refer their friends and family.

What problems, obstacles or challenges might other nursing home/communities face in replicating your innovation? Were there any adverse effects or any ways that things turned out differently than you had planned? Do you know of any other nursing home/communities which have tried this or a similar best practice idea?
Change is always difficult to adapt and was not well received by some team members. Getting the team all working together toward the same goal and not working on their own was the primary challenge. Another difficulty was finding time and consistency between nursing and therapy. University Hospital, Newark New Jersey, is directed by Danilo Bolima, EdD, MSN, RN, NEA-BC, PCCN, CNML, CNE, has been doing a daily huddle with success.

What was the cost to implement you best practice (include staffing, supplies, equipment, and any other costs)?
Time in educating and coaching team commitment.

What are the reasons you consider this best practice to be excellent and innovative?
It builds team communication and builds a positive and encouraging work environment. Residents always give positive feedback and accolades. The appreciation received builds great employee morale and rewards the caregiver. Most importantly, residents are given a resident-centered care, thereby getting them home faster and with a successful outcome.

"Living with a Purpose"
Presenters: Erica Rattray-St. Jean, MSW, Belen Raymundo, Kelly Johnson & Parker at Somerset Residents & Family Member, Parker at Somerset

Summarize your best practice in 100 words.
Our best practice promotes purposeful living in long term care settings. It addresses or reduces boredom, loneliness, and helplessness which may contribute to Depression, and other mental or physical illnesses. Our goal is to enhance the overall quality of life of our elders through person centered programs that support dignity and self-determination. This practice can be implemented with little to no money, anywhere, and with any population. It is especially beneficial to have a program like this for the elderly population, because the experiences are guaranteed to help them realize that they can still contribute and that they have a role to play during this phase of life.

What problem does your best practice address, and what is its primary purpose? As mentioned above this practice addresses loneliness, helplessness and boredom. It also addresses many other problems or concerns such as those frequently raised among elders in a long-term care home like inability to make new friends, loss of role, lack of purpose, loss of control, loss connections with children and the outside world.

What stakeholders (family, residents/clients, employees, departments/disciplines, shifts) participated in developing and implementing your best practice?
This practice was implemented with the residents and the social work department. Regarding implementation, the club from inception receives assist from all stakeholders on every project or fundraising initiatives, from administration to families. Two years ago, we were arranging potted plants for sale the next day, and our evening porter saw some elders struggling so he jumped right in and joined us. He assisted some elders who were having some physical challenges arrange plants in pots. The environmental manager came in on his day off and assisted with a car wash, nursing and recreation are main players and assist with trips to the ballfield, provides donations, participate in fund raising initiatives and talent shows. Families donate their time, and money to many different initiatives. Everyone is genuinely happy to be a part of something that is so beneficial and uplifting for our elders

How does it work? (What methods or procedures/protocols are used to get results?)
The club participates primarily in quarterly charitable initiatives. Initiatives are scheduled months ahead of time. Events have taken the form of promoting awareness, monetary fundraising or the collection of goods for various causes. The members sell hand-crafted products/arrangements, raffles, 50/50, on-line fund raising, talent shows, bake sales, car wash, baseball ticket sales and many more. Members also collaborate with others like our organization's wellness department on their Alzheimer's fund raiser initiative. They collaborate with outside organizations like Somerset Patriots as well. The club members meet monthly, bi-weekly, then weekly when they are working on an initiative. For example, a project like the car washes needed all hands-on deck, we recruited volunteers, created and distributed a flyer out advertising the need for donation of towels, buckets liquid soaps and other supplies. We engaged families and students as much as possible

What has your best practice accomplished, and how have you been able to measure this?

We have accomplished a lot. After coming up with the club principles, mission and format we started out on our first initiative in May 2015. We completed a dedication garden which was a tribute to one of our past elders. We have donated money to the Alzheimer's Association, and money and goods to the Living Water Children's Centre Fund by the end of 2015. We raised a total of $406 that year and we sent an extra-large suitcase to Kenya with sporting goods, school supplies, toiletries, and clothing. To date we have raised approximately $5000-$7000 in goods and monetary donations. We sponsored a child for "Camp no Limits: Limb Loss Foundation" ($500), UNICEF ($220), St. Jude's ($1072), Caribbean Medical Mission ($1011), Center for Great Expectation ($640 in gift cards one year, and 22 children's gifts & toiletries the next), Samaritan's Purse (holiday gifts), Elijah's Promise (food), Alzheimer's Association ($$), and so on.

What problems, obstacles or challenges might other nursing home/communities face in replicating your innovation?

The challenges others might face is assigning responsibilities or taking ownership. In some places social workers or recreation might not feel they have the time to be responsible for a club in addition to their mandatory work. Ownership is necessary and goes to the staff member who is the founder/co-founder or program administrator. That person is there to guide and provide the elders with reminders. Responsibility includes the creation of the program, recruitment, cofacilitating meetings, infusing the club with ideas, researching the charities that are near and dear to elders, and connecting with a point person from various charitable organization, assign roles and responsibilities, promoting the cause, order supplies and recruit addition volunteers. The leader updates and keep elders in the loop, and receive in person or handwritten thank you.

Were there any adverse effects or any ways that things turned out differently than you had planned?

Yes, I asked for some assistance and instead my role as a co-manager/facilitator changed from decision maker to advice giver. Leaders thought having another department like recreation manage the club, will free up my time for more managerial roles. This change just shifted responsibility from one person to another, because a department cannot run a club, but a person/people do. My administrator decided that since we did not meet our targets during that year that maybe the solution is having more than one person co-manage with the elders. Currently I co-manage with a recreation staff member along with the club members. This worked out great because if one of us is not present for a meeting or on vacation things continues as business as usual. Having an additional person who is committed to co-manage infuses the club with ideas and allow for the responsibilities to be shared.

Do you know of any other nursing home/communities which have tried this or a similar best practice idea?

I have heard of a nursing home in California that started to do volunteer work like our Living with a Purpose Club, but other than that I am not well informed of others elsewhere. I received a call from another home seeking information about how to implement something similar but after providing the information on implementation I did not hear back from the representative.

What was the cost to implement you best practice (include staffing, supplies, equipment, and any other costs)?

The cost varies. There will be a one-time fee, or an infrequent cost associated with the purchase of club T-shirts, and a banner and that is if the members want to have something that unifies them and provides a visible identity. There is a one-time cost associated supplies necessary for

the making crafts for sale. After the initial sale one can put aside $50-$100 for seed money for the other initiatives. Some initiatives like a 50/50 requires no cost up front.

What are the reasons you consider this best practice to be excellent and innovative?
The club provides a forum for our elders to get to know each other and form new friendships, receive peer support, open their minds and eyes to new possibilities, give care to others, receive recognition and not feel invisible or useless. It sometimes creates an extension to previous roles they had in the community, i.e. our accountants & bankers fell into the roles of treasurers and our clerks are secretaries.


New Jersey Alliance for
Culture Change