

Colorado Culture Change Coalition (CCCC) Technical Assistance Project

Report of Year One 2012

Within a grant to the CCCC from the Colorado Health Foundation, was the carrying out of a two-year technical assistance culture change project: year one (2012) with 5 homes, year two (2013) with 5 additional homes. The northern part of the state was selected for year one. Several northern homes were invited to partake and the following 5 agreed:

- | | |
|--|--------------|
| 1. Golden Peaks Care & Rehabilitation Center | Fort Collins |
| 2. Spring Creek Healthcare Center | Fort Collins |
| 3. Berthoud Living Center | Berthoud |
| 4. Alpine Living Center | Thornton |
| 5. The Peaks Care Center | Longmont |

Each home signed a Memorandum of Understanding and committed to the following:

- Complete the online Artifacts of Culture Change measurement tool at the beginning and at the end of year one.
- Develop a Culture Change Team comprised of the Administrator, Director of Nursing (DON), a direct care nurse, a direct caregiver, a team member from dietary, housekeeping, therapy, social services and activities, and two residents that will meet at least every other week to work on identified goals.
- Develop at least three culture change practices selected from the Artifacts tool.
- Choose three clinical/Quality Measures to improve using culture change ideas and practices.
- Obtain a baseline staff turnover percentage and commit to improving.
- Culture Change Team participates in discussions with Consultant and CCCC Executive Director (ED) during quarterly visits.
- At least three members of the Culture Change Team attend a quarterly regional learning collaborative where education is provided and each home's team shares their progress.
- Complete an evaluation after each quarterly visit and collaborative workshop.
- Submit a quarterly summary of steps taken and steps to be taken on the Artifact measures, clinical/Quality Measures and staff turnover percentage.



- Submit actual data on the culture change practices/Artifacts items, clinical/Quality Measures and staff turnover.
- Complete the Pay for Performance application in 2013 and 2014.
 - Administrator and DON read the book *Meeting the Leadership Challenge in Long-Term Care* and participate in quarterly discussions about it.
 - Administrator completes the Ideal Administrator Web-based self-assessment tool developed by the American College of Health Care Administrators at the beginning and end of 2012 and 2013.
 - Agree to videotape progress on culture change journey with use of video recorder provided and allow video to be used by CCCC.
 - Submit an annual report to CCCC and consultant.
 - Be willing to present at CCCC Educational Forums.

Carmen Bowman as lead consultant under contract with the CCCC and Penny Cook as the Executive Director of the CCCC provided the quarterly visits and quarterly collaborative workshops.

Quarterly Visits

The four hour quarterly visits consisted of discussions with the Culture Change team on progress, discussions on a leadership topic using the book *Meeting the Leadership Challenge in Long-Term Care*, all staff/resident education, assistance with the P4P application, and occasional meetings/trainings with varying teams/departments. A Survey Monkey Internet-based survey was created and a link sent to each team after each visit.

Feedback from the Survey Monkey surveys was the following:

Four of five homes completed the 1st visit survey, somehow the 2nd visit data was either not sent or not received, somehow 6 completed the 3rd visit survey (for five homes) and 2 completed the fourth visit survey (so far Golden Peaks and The Peaks). The remainder will be completed before December 31, 2012.

A scale of 1 to 5 was used:

1 Strongly Disagree, 2 Disagree 3 Neutral, 4 Agree, 5 Strongly Agree

The following simple questions were asked:

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This consultation was inspiring
 This consultation was educational
 This consultation was helpful

	1 st visit	2 nd visit	3 rd visit	4 th visit	
Inspiring	4.75	unavailable	4.67		
Educational	4.75	unavailable	4.5		
Helpful	4.75	unavailable	4.6		

Comments:

- Penny and Carmen did an outstanding job in explaining the purpose of the program and provided excellent training in helping transform a building that embraces culture change.
- I appreciate that you were realistic in the amount of time we'd need to work through the discussion and presentation.
- All sessions were fantastic (3rd)
- I think all were very interested and want to be involved. (3rd)

What could be done differently?

- I wish I would have had access to a larger room for the instruction.
- I can't think of anything that would have improved our first visit. It was great!
- Friday afternoon meetings make it hard to focus. Not because it's Friday, but because so much happens at my building on a typical Friday afternoon. I feel guilty leaving my team! (3rd)
- I wish our team had been able to spend more time preparing for your visit, including coordinating staff and resident attendance at the educational sessions. (3rd)
- I need to find a bigger room. (3rd)

What do you need from us?

- Continued encouragement!
- I think I'm good for now.
- No needs at this time.
- It's been hard to come up with things to do on the onsite consultation days. Perhaps if you came up with a standard menu of options from which we could choose. This is so much newer to us than it is to you, so we don't always know how to make the best use of your time. (3rd)



- I appreciated your input on how to structure the visit. This being a new project for us, we're not always sure how to best utilize your time. (3rd)

Quarterly Collaborative Workshops

A Survey Monkey Internet-based survey was created and a link sent to each team after each workshop. Four of five homes completed the survey after the 1st workshop, two after the 2nd workshop and one after the 3rd workshop.

The same scale of 1 to 5 was used:

1 Strongly Disagree, 2 Disagree 3 Neutral, 2 Agree, 1 Strongly Agree

The same simple questions were asked:

This consultation was inspiring

This consultation was educational

This consultation was helpful

	1 st workshop	2 nd workshop	3 rd workshop		
Inspiring	4.75	4.5	4		
Educational	4.75	4.5	5		
Helpful	4.75	5.0	4		

Comments:

- The workshop generated great conversation for the trip home and with the team the next day.

What could be done differently?

- Start earlier so that we aren't in the middle of traffic at 5:00 returning to Denver.
- Maybe we should start earlier for those who have to travel so that we don't in up in rush hour traffic coming back on I-25.
- Can't think of any improvements. (2nd)

What do you need from us?

- A "Culture Change 101" orientation video for current and future staff. We haven't yet found a video that walks you through the history and philosophy in an introductory tone. (2nd)



How much time out of our four hours together would you like for collaborating with your peers?

- 30 minutes-1 hour
- No - format was good. Liked having up to date information on legislation and regulations.
- I think the current amount is ample.

Would you want more time for collaborating with one another (asked in 2nd survey)

- Not at this point (2X).
- Unfortunately, I don't think we can make more time for it right now. Possibly in the future. (3rd workshop)

The four hour quarterly collaborative workshops consisted of the sharing of progress, discussions of a leadership topic using the *Meeting the Leadership Challenge in LTC* book, education on the 2012 Life Safety Code changes and the New Dining Practice Standards in a series format and always concluded with a learning circle each sharing one thing they learned or would do differently as a result of the workshop.

Other feedback received was that Friday afternoons are not a good day of the week for the collaborative workshops. Thus, other days will be selected for year two.

One home wrote in their quarterly report: "We found the insight of others to be very helpful, and the camaraderie among our peers will only prove helpful to us during our journey."

"Book Club"

The excellent book, *Meeting the Leadership Challenge in Long-Term Care*, was given to the administrator and director of nursing in each home and discussions were held during almost each quarterly visit and collaborative workshop on leadership based on the book.

The Spring Creek team decided to create "mural moments" that would show staff and residents their commitment to change just as David Farrell's painting of his nursing home, painting over graffiti, showed commitment as reported in the book. Spring Creek's "mural moments" became Fun Fridays.

The Peaks chose Longevity and Turnover and utilized some of the ideas in the book such as to better train employees, extend orientation, have all managers meet each new staff team member and develop various rewards.



Recording the Journey

The project provided each home with a flip camera to document changes and their journey. Photos were shared at the end collaborative where each team shared their story.

Culture Change Practices/Artifacts Items

<u>Alpine</u>	Outdoor path/garden	Resident store	Rest. dining/quiet DR
<u>Berthoud</u>	Staff self-scheduling	Consistent staffing	Staff Ambassadors
<u>Golden Peaks</u>	CNAs care conferences	Indiv. Memorials	Staff Ambassadors
<u>Spring Creek</u>	Washer/dryer	Restaurant dining	Consistent staffing
<u>The Peaks</u>	Culture Change Award	Staff longevity	Adaptive assists

Clinical/Quality Measures

<u>Alpine</u>	Falls	Behaviors	Depression
<u>Berthoud</u>	Alarms (& Falls)	Anti-psychotics	Depression
<u>Golden Peaks</u>	Falls	Restorative	Pain
<u>Spring Creek</u>	Falls	Alarms	Weight loss
<u>The Peaks</u>	Falls (& Alarms)	Anti-psychotics	Acquired pressure ulcers

The Peaks

Culture change/Artifacts items: Longevity, Awards and Adaptive Assists.

Longevity and reducing turnover became a focus for 2013 for all departments, even becoming a performance goal for each manager. A fuller orientation program for all new employees was developed which includes having each department manager attend



orientation to meet new employees and training on culture change. Also each new employee is paired with a "buddy" while orienting to their department. Orientation is now based on need per the individual instead of an arbitrary three days. A new Culture Change Award was developed with the criteria being a person who represents the mission and goals of culture change. The new award will be presented at the annual end of the year awards banquet.

The Peaks team chose adaptive door handles, adaptive sink paddles and tilt mirrors. Unfortunately the budget did not allow for the purchase of these items but they have incorporated them into next year's budget. In the meanwhile, mirrors were installed behind the sinks for residents who use wheelchairs so they can see themselves. Lower closet rods are also planned for the end of 2013.

Quality of care/clinical measures: reduction in medications, falls, and facility acquired wounds.

The medication reduction goal was a decrease in unnecessary medication by 10%. Baseline tabulation was 350 unnecessary medications. By the end of the project, there was a 12% reduction of psychotropic medications. Steps taken were a weekly psychotropic review, CNAs tracking identified "behaviors" for medications in place and non-pharmacological approaches.

The falls goal was a decline in falls for residents within 72 hours of admission. Outcomes varied here: there were 5 falls in the first quarter, 3 in the second quarter and 6 the third quarter. Steps taken were moving those at high risk for falls closer to the nurses' station, high/low beds, floor mats beside the beds and alarms. However, the alarm usage idea changed during the project. See below.

The goal for facility acquired wounds was a decrease by 50% which was met and maintained for at least the third quarter and by the end of the project. Steps taken were pressure mattress overlays, skin and weight reviews weekly, weekly wound care nurse rounds and skin protocol added to orientation packets as well as discussed with nurses and CNAs during orientation.

Something unique the Peaks team did was to choose the same clinical goals as they chose for their Advancing Excellence goals.

Census Data is below:

Quarter	Occupancy	Medicare	Medicaid	Respite	Private	Man care	Hospice
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1	88%	2	35	0	15	15	15
2	83.91% M,J,J	5.2	49.2	.03	15.5	14.06	15.2
3							
4	97%	10	45	0	12	15	9

Turnover Data:

Quarter	Overall turnover	Turnover CNAs	Turnover RNs	Turnover LPNs
1		68%	45%	53%
2		17%	2 %	21%
3		41%	13%	0%
4		24%	18%	13%

Lessons Learned

In the final report from The Peaks, a nice description of a "lesson learned" through this project was share:

What we learned is that, while showing success in each goal, each goal needs to be constantly updated and re-evaluated. For example we choose to have a reduction in falls for all new admissions, within the first 72 hours. This number began to decline and our action plan was to evaluate each new admission and if they were already a high fall risk or if they were being admitted because of a fall, we automatically placed sensor alarms on the bed and in the wheelchair if they used a wheelchair. Basically this was successful, yet we began to notice that some became agitated with the alarms, and others it startled them and there was a fall from that. Also alarms were not going to stop the fall just notify us sooner. Thus the goal was good, the goal was achieved, but the action needed to be different (The Peaks final 2012 report).

The Peaks team also reports that they were able to remove alarms completely from 5 residents who live at the Peaks and have removed some alarms for those residents using more than one.

Artifacts scores

Start: 195

End: 224

Point increase: **29**



Ideal Administrator Self-assessment scores

Start: 186

End: 209

Point increase: **23**

The Culture Change Indicator Survey scores

Start: 116

End: 125

Point increase: **9**

Alpine Living Center

Culture change practices/items: garden with walking/wheeling path, gift store, and restaurant-style dining.

Residents decided on what to plant in the vegetable garden, tilled the soil, planted and harvested zucchini, tomatoes, lettuce, corn, English cucumber, dozens of pumpkins and eggplant. Residents made a variety of dishes out of their produce and shared them amongst themselves and staff. A concrete walkway and patio were poured. The goal is for next spring is to have the pathway decorated with flowering plants and patio furniture to create a nice additional sitting place for the residents to watch their garden closely.

The dietary manager gave up her office for space for a store run by the residents that provides items they are interested in purchasing. The residents chose the colors for the walls in the store and the staff painted the room. Shelving was purchased and the residents decided on what they wanted to sell in the store: puzzle books, snack items, toiletries, stationary, games, and specialty coffee. The residents have developed a schedule and will run the store themselves.

Increasing choices in dining was the third Artifact item although the team worked first on adding a 3rd dining room, a "quiet dining" area for residents requiring assistance. The new dining room started in the middle of July. Unfortunately a small group of staff did not like the new dining room. The culture change team thinks this is primarily because it has altered their daily schedule. This even resulted in a complaint called in to the state survey agency which resulted in an investigation but no deficiencies. The residents who eat in that dining room are doing very well. Multiple residents have increased their food intake and some residents who were not feeding themselves are



now doing so. The main dining room is much quieter and service in all 3 dining rooms moves much faster. The team then turned their attention to improving the entire dining process especially the esthetics and additional choices.

Clinical/Quality Measures: (There was no baseline collection of this data as homes took the first quarter to decide on which clinical/quality measures to select and address.)

Q/M	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Fall	60.7%	56.5%	56.4%	n/a
Behavior	33.3%	44.7%	38.9%	n/a
Depression	17.3%	7.3%	12.2%	n/a

Falls have remained about the same, flagging high. The team reviews each fall daily for cause and possible prevention. The Inter-Disciplinary Team (IDT) discusses interventions each day and provides staff/family/resident education directly related to issues surrounding each fall. The Alpine team also works with the pharmacy consultant to try and reduce the number of medication for each resident to assist in reducing falls. The team also started a program called Happy Feet whereby each day staff members stop what they are doing and get residents up and walking. All qualified staff is involved in this process. The DON now invites residents who fall frequently and who are able to discuss concerns related to the falls to the falls committee meeting to help reduce repeats falls.

Behaviors decreased over the last quarter. The new Activity Director restructured activity programming to better support residents with cognitive loss. Monthly the IDT looks at behavioral symptoms more closely to drill down to the root causes. The team is trying to identify what unmet need someone might have that is causing the behavioral symptoms in order to better identify ways to prevent them. The team is involving families more in the care plan for the resident as well.

The percentage for depression went up slightly over the last quarter. The IDT ensures that all residents with depression are offered some type of treatment to assist in relieving or reducing their depression. The activity director and the social worker started a depression group for residents and staff in November in order to provide an opportunity for them to visit with each other related to depression/grief/loss.



Staff Turnover:

Quarter	Total Staff	Turnover CNAs	Turnover RNs	Turnover LPNs
Baseline for 2011		%	%	%
1	84%	26%	12%	9%
2	74%	28%	10%	9%
3	74%	21%	5.3%	10%
4				

Census Information:

Quarter	Occupancy	Medicare	Medicaid	Respite	Private	Man care	Hospice
1	87%	4.40	40.79		11.22	10.22	
2	88%						
3	88%						
4							

Artifacts of Culture Change Scores

Start: 188

End: 218

Point increase: **30**

(Other scores unavailable with change in administrator)

Berthoud Living Center

At the Berthoud Living Center, there was a change in administrators during the summer. With this change the culture change team decided to review the Artifacts tool again to regroup and decide on their three culture change practices/Artifacts items and three clinical/Quality Measures.

Three culture change practices/Artifacts items: staff self-scheduling, consistent/dedicated staffing, Ambassadors (each resident has a staff buddy) were chosen.

Staff self-scheduling

Berthoud started with CNAs only self-scheduling. When presented with the idea initially, "some were excited about it while others had their reservations." However, the team still decided to "go all out" and have day and evening shifts schedule themselves. Guidelines were set up and drivers to ensure the schedule got completed. The goal was

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to rotate the drivers so that "everyone will have a chance to experience it and will help to keep things fair." After this initial meeting, "several of the CNAs were diligently working at it."

The CNAs who served as the drivers for the first two months commented, "it is going fine." And that "it has been somewhat of a team building experience because they need to work together to make the schedule work." One hurdle is staffing shortages lead to "piecing" the schedule together at times. By the end of the project, staff self-scheduling was fully implemented for CNAs of all shifts and has been started with the nurses. According to Berthoud's last report: "CNA's self-scheduling has helped the CNAs to work together better as a team and has slightly decreased call-offs. We plan to continue to use this model."

Consistent/dedicated staffing

The culture change team at Berthoud selected this practice to start by September. However, due to staff shortages and call offs it was not implemented until November in one area (half) of the home. It has worked well in that staff and residents report "it has helped to build trust and knowledge between them." The team is trying to implement this in the other half of the home where CNAs have mentioned residents have more complex physical and behavioral needs making it harder to consistently work with that group. The team desires to work toward this though, pointing out that "consistent staffing may make it easier to consistently work with the group as they build relationships and a routine."

Ambassadors

The Ambassador system got a late start due to it taking longer to hire a Customer Service Coordinator than was expected who has the responsibility to lead it. The team entered the expansion of this already-in-place-but-floundering program by inviting a select small group of other staff to become Ambassadors, namely two restorative aides. The team felt they were great additions. Due to a shortage of CNAs though CNAs have not yet been invited to join up as an Ambassador in order to not "ask anything additional of the existing CNAs at this time." The new Customer Service Coordinator has trained all staff on the concern form process to let them know that anyone can take down a concern or complaint of a resident and get it back to the coordinator.

The Berthoud team would like to see a decrease in the number of residents one staff person is an ambassador for. They plan to continue to promote the program and get other staff involved as they show interest also working to pair people who are naturally drawn to one another.

Decreasing alarms: (with the hope of decreasing falls)

The Berthoud team started slow with one alarm/one person at a time. Alarms were discontinued for two people by August. By October their practice became not to



automatically start an alarm after a fall and to continue working with one person at a time. The team now has a new mindset to explore what else can be done to intervene instead of automatically implementing an alarm after a fall.

The team is working on a way to track whether or not this has had an impact on these residents' falls. An action plan for this item is to come up with a way to track the correlation between removing alarms and decreasing falls.

Decreasing anti-psychotic medications:

Berthoud's social worker, pharmacist and nurse managers have set goals to continue to evaluate where they can to reduce medication. Berthoud's consultant pharmacist is a major proponent of reducing anti-psychotic medications. The team has realized the need to track and measure the reduction of these medications more effectively. The team has implemented a three day rule whereby psychotropic medications are not begun unless three days of charting clearly demonstrates that other approaches have been attempted and failed.

Decreasing depression:

Within the process of hiring a new activities director, the initiative of decreasing depression through groups was made a part of the interview process. The Geriatric Depression scale is being used before starting and at a two month interval to see if the support group is helping. As of November, two groups have started with the goal to try to help individuals verbalize feelings of depression and express coping mechanisms. A Bible study allows residents to discuss Scripture verses that help them with their struggles. They are also studying how people recorded in the Bible experienced similar challenges and how they coped with them. A musical improvisation group has been implemented where residents are asked specific questions regarding challenges in their lives and their answers are used to create lyrics and write songs. Then the residents sing the songs together.

Staff Turnover:

Quarter	Overall turnover	Turnover CNAs	Turnover RNs	Turnover LPNs
1	45.8%	11%	22%	0%
2	38.4 %	0%	0%	29%
3	51.9%	22%	11%	0%
4	14.6%	4%	0%	0%



Census Information:

Quarter	Occupancy	Medicare /Man care	Medicaid	VA	Private	Man care	Hospice
1	90%	6	42	4	6	3	4
2	91%	7	41	4	7	2	4
3	91%	6	43	3	8	2	2
4	90%	6	42	3	12	2	2

Artifacts scores

Start: 144

End: 182

Point increase: **38**

Ideal Administrator Self-assessment scores

Start: 151

End: 206

Point increase: **55**

Culture Change Indicator scores

Start: 63

End: 83

Point increase: **20**

Spring Creek

Three culture change practices/Artifacts items: 1) restaurant style dining 2) laundry done on the units, and 3) consistent staffing.

Restaurant style dining – Spring Creek has a chef as well as a general manager of the restaurant who focuses on customer satisfaction, delivery of meals, dining experience and ambiance of the dining rooms. Customer Satisfaction scores have continually trended up in the quality of food category from 55% to 78% satisfaction on the discharge surveys. A menu is offered to residents at each meal and the new motto



"fresh is better" is popular at Spring Creek. Residents have told Spring Creek they prefer more of a Village Inn array of foods such as Patty Melts and burgers and grilled cheese. Rueben sandwiches have been very popular. During the 3rd quarter report, the team reports that their "restaurant in a nursing home" is "highly successful" and "residents, staff and family all see this as a main selling point" of the home. The team identified "our biggest hurdle to overcome next is the ambiance and once and for all get rid of the bib!" One exciting outcome is the story of a person who had a short rehab stay at Spring Creek who was disappointed with the food when she first came. The restaurant in a nursing home was implemented during her stay and one morning administrator Mike Oxford found the following note taped to his office door:

Dear Kitchen Staff,

The last two cheeseburgers you have cooked for me have been SUPERB! Thank you so much! And to those of you who serve our meals, thanks for taking care of us with so much love, patience, caring and compassion. You are all Earth Angels!

With much appreciation, Sammara

Laundry done on the Units – The administrator held a contest for the person who could find the best deal for front-loading machines. Although a plumbing issue was encountered that required jack hammering, laundry is now available for residents and families on A hall since August. It has been surprising to the team that not that many residents are interested in using the machines but that those who do utilize the machines "love the option and opportunity. The confidence that they will not lose their items and that they can have control over an everyday chore is something that many of our residents had not had in a long time" (from Spring Creek's 3rd quarter report). One lesson learned is that there is a fair amount of wear and tear on the household size machines. For instance, one washer has had to be fixed for a second time, but Spring Creek is not letting that hold them back from offering this possibility to their residents.

Consistent Staffing – Spring Creek has been able to maintain above 80% consistent staffing on all units and looks to increase this in small amounts by observing for the best match between team members and residents/units. As a result, Spring Creek has seen call offs decrease as well as resident complaints that staff don't know how to care for them.

Clinical/Quality Measures: 1) decrease falls, 2) decrease alarms 3) decrease weight loss.



Falls – The team set a baseline for falls at the beginning of the project at 19, which was 19% of the census for that month. For both Quarter 2 and Quarter 3, the average number of falls was 16 falls per month or 16.32% of census. This was a decrease in the falls measure by 2.68%. After brainstorming during a quarterly visit for this project, the consensus by the team was to get as much information about the residents falling from themselves as well as from the staff that care for them. The team liked the idea to put a poster in the break room creating space for staff to share ideas and as much information they can about the resident with the hope to better schedule care needs and to anticipate their needs before they fall. A new phenomenon seen at the last quarter is that the number of falls experienced by residents who have just moved into the home has decreased although it is not certain why, perhaps it is due to an increased diligence about preventing falls and meeting needs for persons living at Spring Creek.

Decrease Alarms – The baseline measure for alarms was 72 total with 40 bed alarms and 32 chair alarms. By Quarter 2, alarms decreased to 27 total with 17 bed alarms and 10 chair alarms. For Quarter 3, there were 26, 13 bed alarms and 13 chair alarms.

The DON championed this effort by questioning and challenging staff members whenever alarms were suggested. The team created their own goal to not initiate alarms automatically when one moved in with a risk for falls. The team also implemented the precedent to analyze each fall to see if an alarm would have prevented it and then discontinuing the alarm if it would not have.

Weight Loss – The baseline for this measure was six residents, or 6% of residents with significant weight loss. Each month brought a decrease in the number of residents being reviewed for weight loss and an increase in weight gain was started to be observed. The next quarter showed 3.75 residents with weight loss or 3.8% of all residents and 10.33 residents who have had weight gain representing 10.55% of all residents.

Here is an exciting link between Spring Creek's culture change practice of restaurant dining and the clinical measure of weight loss (as reported in their 3rd quarterly report):

The facility's dining program continues to be a bright spot for us even from a Quality of Care perspective. We are currently under 1% for weight loss for the quarter, only following one resident with a significant weight loss!

Another exciting outcome of Spring Creek's endeavor is a new philosophy:



Our weight loss continues to be extremely low now that we have **championed choice over physician orders.**

Artifacts of Culture Change Assessment

Start: 193

End: 256

Point increase: **63**

Ideal Administrator

Start: 181

End: 187

Point Increase: **6**

Culture Change Indicators Survey

Start: 81

End: 95

Point Increase: **14**

Census Data:

Quarter	Occupancy	Medicare	Medicaid	Respite	Private	Man care	Hospice
1	87%	10	73		7	4.5	5.5
2	85%	8	72		7	7	4
3	86%	9	70		9	7	4
4	90%	9	70		9	10	4

Turnover Information:

Quarter	Overall	Turnover CNAs	Turnover RNs	Turnover LPNs
1	26.4%	20.78%	2.56%	0
2	54.48%	38.53%	11.11%	11.11%
3	35.23%	66.21%	3.70%	0%
4	58.01%	48.72%	6.67%	0%

Lessons Applied from the Book

The Spring Creek team ran with the Mural Moments concept instituting "Fun Fridays:"

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A barbeque for all residents and staff has occurred every Friday, along with themed days with competitions that give the staff and residents the opportunity to have a good time. Since this idea came up we've had sports jersey day, crazy hair day, mustache day, western wear day, flash and clash day, 50's day, and Red White and Blue day. These have proven to shift the morale and create facility pride once again, for both residents and staff.

The committee also took a great deal of pride and effort in planning the annual Certified Nurse Aide Week. The committee decided that we would take on a "servant" approach for the Nurse Aides (called Resident Care Specialists). A department sponsored each day and that department was to spearhead the efforts. We had Housekeepers washing cars and cooking out, Therapy providing massages from certified masseuses, Department Managers providing meals and delivering gifts to all shifts, Dietary cooking and serving breakfast in restaurant style dining, and Activities hosting an outdoor games event where residents and staff alike had opportunities throw pies at the administrator and nurse managers! This move in attitude took very little effort and has quickly become a staple of Spring Creek for years to come (Spring Creek 2nd quarter report).

Golden Peaks

Culture change/Artifacts practices: individual memorials, CNAs attend care conferences, every resident has a staff who acts as a buddy.

Memorials/remembrances for residents who pass:

Residents agreed that memorials and other gestures should be individual and occur immediately following a resident's death. Neither staff nor residents want to be "protected" from the news. The team decided that flowers and a photo, if available, would be placed on the mantle in the dining room to both announce and honor the resident's passing. The team decided that any obituary should also be posted where everyone could see it, preferably in the lobby. The team decided that residents who are closest to the individual who passed should be notified personally. The team decided that each resident should be asked when they move in about their wishes for an end of life memorial or remembrance. With input from the residents, a questionnaire was drafted to be used by the social services director after one moves in and is ready. It was decided the social services director should work with each resident's family member and the activity director to coordinate an onsite remembrance. Families may be as involved in the planning as they would like, and families decide whether they will participate or whether the event will be limited to



facility staff and residents. Individual memorials/remembrances have occurred consistently since June. They are now a part of Golden Peak's culture.

CNAs attend care conferences:

Surprisingly some residents were hesitant to speak freely in the presence of CNAs. Residents agreed, however, that CNAs' participation at the outset could be beneficial to both residents and staff. At the residents' request, all agreed that CNAs would attend only the first five minutes of each care conference. The team also agreed that each resident's consistently assigned CNA should participate in the meeting, vs. a Lead CNA or other CNA assigned to attend all care conferences in a given day. The team decided to seek CNAs' input prior to the meetings. With input from CNAs and residents, a tool was created by which CNAs share their observations regarding residents' increasing or decreasing needs for assistance with activities of daily living as well as their observations regarding residents' acceptance of care and other needs.

CNAs have attended care conferences since July. The Unit Manager is responsible for coordinating CNA participation. There has been much positive feedback from staff and residents. The activity director tells the story that one day family members had questions about something and without the CNA there, the managers would have had to say, "We'll check into it," but because the CNA was present she explained it thoroughly to the satisfaction of the family. A resident who was hesitant at first has since stated, "I think it's great." At a quarterly visit in July, during a staff training with Penny Cook and Carmen Bowman CNAs were asked their opinion of attending care conferences. CNAs replied they thought it was a good idea as they would be able to get to know their residents even better, outside of daily cares.

Every resident has a staff buddy:

A hybrid of SunBridge's existing staff ambassadors with new ideas has been developed. When a person moves to Golden Peaks, the ambassador takes the lead in getting to know them and then introducing the resident to others by way of a "Getting to Know You" questionnaire. The team made many enhancements to a pre-existing questionnaire. The ambassador explains the various staff positions and how each relates to the resident. The ambassador checks in with the resident on an at least a weekly basis to make sure the resident's needs are being met and to ensure the resident's room is safe and comfortable. Ambassadors can also help residents celebrate their birthdays and other special events, and to guide the team through the residents' end-of-life wishes as well. This system involves only department managers at this time with the goal of including more staff at a later point in time.

Clinical/Quality Measures: restorative services, falls and pain.

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Restorative services:

The team has decided to do a fun Walk to Italy event where each step equals a mile and when the number of steps has been accomplished an Italian dinner will be enjoyed by all. A "Jeopardy" style game was created to bring attention to the new way restorative services will be provided to residents. The typical restorative nursing program was discontinued and staff have committed to including and incorporating restorative services into daily cares. Golden Peaks may end up role modeling this new concept and get all residents moving more.

Fall prevention:

The team identified that falls often occur due to unmet needs, typically bathroom needs, and all agreed staff should strive to know the residents' routines and to anticipate and meet needs before a fall occurs. The team is using the Getting to Know You questionnaire and ensuring each resident has an Ambassador to also identify fall prevention strategies. A new tool is being used to identify the root cause of an incident/accident whereby "Why?" is asked at least five times. The team realized that residents are not always directly asked about the cause of their falls, and that it may be valuable to ask their roommate as well therefore "Ask the resident" has been added to the existing post-fall checklist. An All Hands on Deck idea is also being implemented whereby staff besides the CNAs conducts purposeful fall prevention rounds to get more eyes on residents more often who are at high risk for falling.

Pain management:

The team plans to identify and reach out to local massage schools to bring massage and touch to residents who might benefit from it. With the holidays approaching, the idea will be included in the resident/family newsletter that a resident's family/friends could arrange a massage as a gift for their resident family member. The team also plans to pursue Civil Monetary Penalty grant funds that may be available to kick-start a pain relief/massage project. The team also realized the potential tie-in of our Getting to Know You questionnaire and Ambassador for each resident bringing ideas to engage people with meaningful activities that might also aid in pain relief. Golden Peaks is also offering resident-animal companionship through the Human-Animal Bond in Colorado (HABIC) program, based out of Colorado State University and has become a training site for social work students, whereby second-year CSU students are partnered with the residents who are most in need of their support and companionship. Both of these unique offerings to the people living at Golden Peaks may also impact pain.

	Q1	Q2	Q3	Q4
Restorative (percentage of residents on	0%	0%	0%	0%



qualifying programs)				
Falls (percentage of residents with a fall based on their most recent MDS)	19.5%	28.8%	32.9%	20.8%
Pain (percentage of residents with pain based on their most recent MDS)	20.9%	25.4%	29.6%	27.1%

TURNOVER	Q1	Q2	Q3	Q4
Facility Turnover for past 12 months (rolling)	71%	56%	56%	60%
RN Turnover for past 12 months	39%	29%	20%	20%
LPN Turnover for past 12 months	137%	88%	67%	67%
C.N.A. Turnover for past 12 months	95%	67%	81%	79%

OCCUPANCY	Q1	Q2	Q3	Q4
Overall occupancy	86%	89%	91%	91%
Medicaid	65.7%	67.4%	66%	61%
Medicare	6.9%	6.3%	4.5%	7.5%
Insurance	2.5%	2.9%	2.3%	0%
Private Pay	20.5%	16.5%	20.2%	14.1%
Hospice	4.4%	4.8%	6.7%	8.8%

Artifacts of Culture Change Scores

Start: 191

End: 225

Point Increase: **34**

Ideal Administrator Self-assessment

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Start: 57
 End: 176
 Point Increase: **119**

Culture Change Indicator Survey
 Start: 93
 End: 99
 Point Increase: **6**

Artifacts Points

Home	Alpine	Berthoud	Golden Peaks	Spring Creek	The Peaks
Start	188	144	191	193	195
End	218	182	225	256	224
Pt increase	+30	+38	+34	+63	+29

The across-the-board point increases were substantial. With the selection of three Artifacts items/practices as part of this project, a point increase of 15 points was expected. The double and triple point increases are exciting to see. As experienced in a similar project (Culture Change Collaborative with 20 homes in 2010 under a Colorado CMP Grant), typically with a focus on changing culture and exposure to other culture change practice ideas from the Artifacts tool, more practices than the “required for the project” three are implemented as was observed in this first year.

Ideal Administrator Self-Assessment Points

Home	Alpine	Berthoud	Golden Peaks	Spring Creek	The Peaks
Beginning	n/a	151	57	181	186
Ending	n/a	206	176	187	209
Pt increase	n/a	+55	+119	+6	+23

Culture Change Indicator Survey Results

Home	Alpine	Berthoud	Golden Peaks	Spring Creek	The Peaks
Beginning	n/a	63	93	81	116
Ending	n/a	83	99	95	125
Pt increase	n/a	+20	+6	+14	+9



It is equally exciting, and not all that surprising, to see point increases from small to very large in these other measurement tools probably for similar reasons as for the Artifacts tool.

End Celebratory Event November 9, 2012

Each of the five homes was asked to present their journey at a Northern Network CCCC event on Nov. 9, 2012. Unfortunately, Alpine Living Center was unable to make it. The administrators and teams of Spring Creek, The Peaks, Berthoud Care Center and Golden Peaks gave inspiring presentations. Team members of these homes said they appreciated hearing about each other's journeys. Approximately 40 people attended which included staff from the project homes. One attendee said it was great for consumers to hear the concrete things homes are doing and that it was "a good program." Another attendee said she got ideas for her assisted living residence even though nursing homes were presenting. Several Ombudsmen attended and said they have more information to share with other homes they visit.

In addition, anyone interested in helping to lead the northern chapter of the CCCC was invited to stay and some enthusiasm was, and commitments were, generated for the support of getting this chapter going again.

Summary of Year One

Progress was really observed via the Artifacts measures. An increase of 15 points was anticipated (three items with an average of 5 points possible). However, a much higher average of 38.8 points was seen for our five homes. It appears that exposure to other practices and ideas leads teams to implement them. The average point increases for the Ideal Administrator Self-assessment, 50.75, and for the Culture Change Indicator Survey, 12.25, bear this out as well. Turnover fluctuated as did the clinical outcomes for each of the homes but perhaps having two years to work on these areas will reflect improvement. Occupancy rates did increase across the board for our five homes (other than one slight 1% dip for one home in one quarter) which is a common outcome of a changed culture and exciting to see, especially for the homes themselves. It is also exciting to see "new" ideas become commonplace. For instance, it is much more normal now in each of our homes to not automatically use alarms when one falls or when one



moves into the home having a risk for falls. We plan to focus on preventing falls and eliminating alarms by engaging residents with life even more so in year two.

Lessons Learned and Successes

Penny Cook, Executive Director of the CCCC shared her insights into the first year of the project:

There is anecdotal evidence that the application of person-centered care principles and practices has a positive impact on clinical measures and financial outcomes. This is the premise of the technical assistance project. Through the past many months, I have realized that it's not as simple as that. There are many challenges in the operations of a home and many barriers to change. However, the five homes participating with us have done an amazing job in creating enthusiasm and in making steady progress towards the goals they have chosen. They are committed to the project and most of all, committed to improving the quality of life and the quality of care for residents living in their homes. Although I have worked in the long-term care industry for many years, I have new appreciation and admiration for the staff members who work in nursing homes each and every day. The results obtained from 2012 show that they are really making a difference!

One "good problem" encountered is that other ideas come from staff and residents meeting regularly together that are not necessarily reflected in the Artifacts tool. We simply need to remind teams of this for purposes of the project, perhaps asking for the Artifacts item number while simultaneously supporting and encouraging whatever additional ideas come from the good habit of asking and listening to residents.

During the course of the project, there were a few ideas that developed that will be incorporated into Year Two. It is important for non-managerial staff to be engaged in the work being done at each home, so in Year Two at least one non-managerial staff member from each home will be encouraged to attend the quarterly collaboratives on a rotating basis. In addition, during every collaborative, there will be a sensitivity experience offered so staff members can have a better understanding of the losses residents experience.



Revvig up for Year Two - 2013

Homes on the eastern plains of Colorado have been contacted and invited to partake in Year Two for the year of 2013. Thus far the following homes have signed the Memorandum of Understanding:

1. Sterling Living Center
2. Devonshire Acres, Sterling
3. Ft. Collins Healthcare Center
4. Bonell Good Samaritan Greeley
5. Kindred Transitional Care and Rehabilitation - Brighton

Project Outcomes

One of the most profound outcomes of this project was shared by Mike Oxford, Administrator of Spring Creek in his 3rd quarterly report:

We are excited to end this year strong and continue to learn from the committee and from Penny and Carmen. **Culture Change daily feels more like our normal business and less like a project** (emphasis added).

Submitted by Carmen Bowman, Project Consultant 12/3/12

