Coaching Guide Bonus Material

PRACTICE & LEADERSHIP IN NURSING HOMES

Building on Academic-Practice Partnerships

Andrea Yevchak Sillner, PhD, RN, GCNS-BC
JoAnne Reifsnyder, PhD, MSN, MBA, RN, FAAN
Ann Kolanowski, PhD, RN, FGSA, FAAN
Jacqueline Dunbar-Jacob, PhD, RN, FAAN

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GLOBAL NURSING EXCELLENCE

INTRODUCTION

This downloadable extra material from the *Coaching Guide for Practice and Leadership in Nursing Homes* consists of material cut from the *Coaching Guide* for the sake of space. It provides additional in-class activities, assignments, and case studies by chapter.

CHAPTER 1

Debate Activity or Assignment: Person-Centered Care in Advanced Dementia

Background

As the aging population continues to grow, nursing homes face increasing challenges in providing quality care for residents with advanced dementia. PCC is a holistic approach that emphasizes the individual needs, preferences, and values of residents, aiming to enhance their quality of life. However, critics argue that it may not be feasible or cost-effective for individuals with significant cognitive impairments due to the complexity of their needs and the resources required.

Debate Proposition

1. **Position A:** "It is not possible or cost-effective to provide PCC to people with advanced dementia."
2. **Position B:** "Nurses can still provide PCC to nursing home residents with significant cognitive impairment."

Discussion Points:

These discussion points can be used to center the in-class discussion based on the two positions above or they can be asked as questions in a discussion forum or assignment format.

1. **Understanding PCC:** What does PCC entail, and how does it apply to residents with advanced dementia?
2. **Resource allocation:** What are the costs associated with implementing PCC, and do these outweigh the potential benefits?
3. **Quality of life vs. cost:** How do we measure the value of improved quality of life against financial constraints?
4. **Role of nursing staff:** What combination of nursing staff (RNs, LPNs, CNAs) is most effective in delivering PCC to residents with significant cognitive impairment?
5. **Training and education:** How can staff be trained to effectively implement PCC in a cost-effective manner?

Suggested Answers

Position A: "It is not possible or cost-effective to provide PCC to people with advanced dementia."

1. **Complexity of care needs:** Advanced dementia often results in complex medical and emotional needs that require significant time and resources. It may be impractical to meet these needs while maintaining a person-centered approach for every resident.

2. **Cost implications:** Implementing PCC typically involves extensive staff training and potentially hiring more skilled professionals, which can increase operational costs for nursing homes that are already facing budget constraints.
3. **Staffing limitations:** With high staff turnover rates and shortages in skilled nursing professionals, it may be unrealistic to expect nursing homes to consistently deliver PCC to all residents, especially those with advanced cognitive impairments.
4. **Prioritization of tasks:** In facilities with limited staff, urgent medical tasks may take precedence over individual care preferences, thereby reducing the effectiveness of PCC.

Position B: "Nurses can still provide PCC to nursing home residents with significant cognitive impairment."

1. **Individualized care plans:** Even residents with advanced dementia can benefit from individualized care plans that focus on their unique preferences and histories. Care can be tailored to enhance their comfort and dignity.
2. **Staff training:** With proper training, LPNs and CNAs can effectively implement PCC strategies under the guidance of RNs. This teamwork can optimize care delivery while making efficient use of available resources.
3. **Quality of life improvement:** Research shows that PCC can significantly improve the quality of life for residents with dementia, reducing behavioral issues and improving overall satisfaction with care. This can lead to cost savings in the long run through decreased hospitalizations and better resident outcomes.
4. **Creative approaches:** Innovative methods, such as using life stories or sensory stimulation, can be employed by nursing staff to engage residents meaningfully, demonstrating that PCC can be integrated even in challenging circumstances.
5. **Advocacy for resources:** Advocating for funding and resources to support PCC initiatives can be a viable way to address the cost concerns, emphasizing the long-term benefits of improved resident well-being.

The debate surrounding the provision of PCC for individuals with advanced dementia raises critical questions about the quality of care, resource allocation, and the role of nursing staff in nursing homes. As nursing students or professionals engage in this debate, it is essential to consider the complexities of dementia care while advocating for approaches that enhance residents' quality of life. The right combination of staff, training, and commitment to PCC can lead to significant improvements in care, even in challenging environments.

CHAPTER 2

Brain Drain Activity: Rapid-Fire Concepts in Person-Centered Care

The objective of this Brain Drain activity is to engage learners in a rapid-fire brainstorming session where they can generate and share as many relevant concepts or terms as possible related to person-centered approaches to care for nursing home residents. This will encourage quick thinking, collaboration, and a deeper understanding of care practices.

Preparation

1. Briefly explain the purpose of the Brain Drain activity and its focus on person-centered care in nursing homes.
2. Define person-centered care and its significance in enhancing the quality of life for residents.
3. Provide an example to illustrate the concept (e.g., "What are person-centered approaches to care during morning routines?").

Explain the rules of the rapid-fire brainstorming session:

- Participants will have either 30 seconds or 60 seconds (depending on your preference) to shout out or list as many related concepts or terms as possible.
- Encourage all participants to contribute, emphasizing that all ideas are valuable, regardless of their complexity.
- Remind them to listen actively to avoid repetition and to build off each other's ideas where possible.
- Decide whether they will be writing their responses on a piece of paper or sticky notes to post in the room, verbally sharing, or typing them into an online discussion forum.

Activity Steps

Part 1: First Round of Brain Drain

1. Start the timer and ask participants to shout out or write down as many person-centered approaches to care as they can think of, specifically related to a designated task or time of day (e.g., morning routines, mealtime, activities).
2. As responses come in, write them down on the whiteboard or digital platform in real time, categorizing them if patterns emerge (e.g., emotional support, physical care, social interaction).
3. Group reflection: After the first round, review the listed concepts together. Ask participants:
    - Which ideas resonate most with them?
    - Are there any that surprise them or that they hadn't considered before?
    - How do these concepts align with their understanding of person-centered care?
    - Encourage discussion about specific examples or experiences related to the ideas shared.

Part 2: Second Round of Brain Drain

1. Repeat the rapid-fire activity, but this time focus on a different aspect of person-centered care (e.g., evening routines, resident interactions, or care during specific health events).

2. Again, document responses on the whiteboard or digital platform.
3. Group discussion: Discuss the responses gathered in the second round. Use guiding questions such as:
    - What similarities and differences did you notice between the two rounds?
    - How can these approaches be implemented in daily care routines?
    - What barriers might exist to integrating these concepts into practice?
    - Encourage participants to share how they can advocate for more person-centered care practices in their nursing homes.

Conclusion

1. Summarize the key concepts identified during the activity and reinforce the importance of person-centered approaches in improving resident care.
2. Encourage participants to take one or two ideas from the discussion and think about how they might apply them in their own practice.

Optional Follow-Up Activity or Assignment

After the activity in a written assignment or discussion forum format, participants could be asked to select one person-centered approach identified during the Brain Drain and write a brief reflection (one to two pages) answering the following questions:

1. How might you implement this approach in your own practice?
2. What challenges do you anticipate and what are some potential solutions?
3. What is the expected impact on resident quality of life of your approach?

This detailed structure for the Brain Drain activity ensures an engaging, fast-paced environment that fosters collaboration and critical thinking about person-centered care in nursing homes.

CHAPTER 3

ADDITIONAL RELATED ASSIGNMENT: Creating a Resident Care Plan Incorporating DEIB and Cultural Preferences

Objective

To apply DEIB principles to design a culturally appropriate, person-centered care plan for a nursing resident. This additional assignment can be done by both nursing students and practicing nursing home staff.

Instructions

1. Resident profile: Instructors can create a fictitious resident or choose a resident in the nursing home from a culturally, linguistically, or socially diverse background. Alternatively, the learners can create a profile of their own. The profile should include:
    a. Name, age, gender identity
    b. Cultural/ethnic background
    c. Language preferences
    d. Religious/spiritual practices
    e. Dietary needs
    f. Health conditions and current treatments
    g. Family/social dynamics or barriers
2. Assessment of needs: Based on the profile, learners should assess:
    a. Cultural values and health beliefs that may impact care
    b. Barriers to equitable care (e.g., language, systemic bias, isolation)
    c. Preferences related to privacy, gender of caregivers, rituals, etc.
3. Develop a care plan that includes:
    a. Physical care needs and how they are delivered in a culturally sensitive way
    b. Communication strategies (e.g., interpreter use, preferred language)
    c. Cultural and spiritual considerations (e.g., prayer times, religious holidays, cultural food practices)
    d. Staff training or education needed to support the resident
    e. Inclusion of family or community in the care process if appropriate
4. Reflection: Write a brief reflection on what you learned about integrating DEIB in care planning, challenges with implementing this type of care plan into nursing home practice, and how this process impacts the quality and equity of care of care that you provide.

CHAPTER 5

Watch & Reflect: Hospice, Palliative, and End-of-Life Care

This assignment can be done in-class as a screening and then discussion or assigned as homework.

Direct learners to watch the PBS Emmy-nominated documentary *Being Mortal* (2015), which examines the relationship between doctors and patients nearing end of life and

how the medical professional can help them as they face death: https://www.youtube.com/watch?v=lQhI3Jb7vMg.

Assign a reflective activity as thoughtful in-class or discussion board dialogue or as a short written response about the content.

Reflective Questions

1. After watching the documentary, how do you think patients perceive their journey through terminal illness? What aspects of their care seemed most important to them as they approached the end of life?
2. How is the role of the healthcare provider portrayed in the documentary when discussing terminal illness with patients? What can be learned from their approaches to communication and care planning?
3. What are some of the challenges that healthcare professionals face when communicating about end-of-life issues? How can these challenges be addressed to improve patient care and satisfaction?
4. In what ways do family dynamics influence decisions about end-of-life care? Discuss how a nurse can facilitate family discussions that honor both the patient's and the family's wishes.
5. How did the documentary change or reinforce your views on end-of-life care? Are there any practices or ideas presented that you would like to adopt or advocate for in your nursing practice?

Debate Activity or Assignment: Ethical and Clinical Decision-Making in End-of-Life Care

The purpose of this activity is to engage students in a thoughtful, structured debate about two complex and controversial issues in nursing home care: managing residents with swallowing difficulties who request a regular diet and navigating family decisions that may conflict with a resident's end-of-life care preferences. The goal is to promote critical thinking, improve communication skills, and enhance students' ability to respond to sensitive ethical dilemmas in clinical practice.

Preparation

1. Introduction to the topics: Begin the activity by introducing two key ethical dilemmas that commonly arise in nursing home settings:
    - **Topic 1:** Managing a Resident's Request for a Regular Diet Despite Difficulty Swallowing at the End of Life

      This topic addresses the dilemma of a resident who, due to difficulty swallowing (dysphagia) or a progressive illness, requests to continue eating a regular diet at the end of life, even though doing so may increase the risk of aspiration, choking, and potential discomfort.

- **Topic 2:** Addressing a Family's Decision to Pursue Medical Treatments That May Not Align With the Resident's Values and Goals

  This scenario involves a situation where family members insist on pursuing aggressive medical treatments (e.g., invasive procedures, chemotherapy, or mechanical ventilation) for a resident who, based on their previous conversations or advanced directives, might prefer comfort-focused care at the end of life.

2. Assign roles: Divide the students into pairs or small groups and assign each group a position on the topic:
   - One group will argue in favor of the resident's wishes (even when they conflict with medical advice or best practices), while the other group will argue for prioritizing patient safety, comfort, and quality of life (even if that means limiting the resident's choices).
   - Similarly, for Topic 2, one group will argue in favor of respecting the family's wishes for aggressive treatment, while the other group will argue for honoring the resident's values and goals for care.

3. Research: Students should spend a few minutes researching the relevant ethical principles (e.g., autonomy, beneficence, non-maleficence) and clinical guidelines related to dysphagia management, advanced directives, and end-of-life care.

   Encourage students to reference credible resources such as clinical practice guidelines, research articles on palliative care, and ethical frameworks for decision-making in healthcare.

Debate Outline

I. Introduction (two to three minutes per group):

Each group will begin by presenting their stance on the topic. They should start with a brief overview of the issue, followed by a clear argument for their position:

A. **Example for Topic 1:** If advocating for the resident's right to request a regular diet, the argument might focus on autonomy (the resident's right to make decisions about their own care) and quality of life (the resident's desire to continue eating something familiar and enjoyable). If arguing against it, the focus might be on non-maleficence (avoiding harm by preventing aspiration and choking) and beneficence (promoting the resident's comfort by prioritizing safer food options).

B. **Example for Topic 2:** If supporting the family's decision for aggressive treatments, the argument might focus on family involvement and hope, suggesting that families may see continued treatment as their loved one's best chance for recovery. If arguing against it, the focus would be on the resident's values and the importance of palliative care to ensure comfort at the end of life, especially if treatments are not aligned with the patient's wishes.

II. Supporting Arguments (five to seven minutes per group):

Each group will have the opportunity to present three or four key arguments to support their position, drawing on evidence and ethical principles:

A. **For Topic 1:**

1. Argument 1: Respect for patient autonomy and the resident's right to make informed decisions about their care.
2. Argument 2: The importance of honoring the patient's desires for normalcy and comfort, even at the end of life.
3. Argument 3: Ethical principles such as beneficence and non-maleficence, evaluating whether the potential harm from aspiration outweighs the benefits of offering the resident a familiar diet.
4. Argument 4: Impact on quality of life and dignity at the end of life—should comfort take precedence over medical safety in such cases?

B. **For Topic 2:**

1. Argument 1: The family's right to be involved in decision-making and their emotional desire to provide their loved one with every possible chance for recovery.
2. Argument 2: The potential for hope in the face of terminal illness and the emotional and psychological benefits of continuing aggressive treatments.
3. Argument 3: The ethical conflict between honoring family wishes and respecting the patient's autonomy, especially if the resident's advanced directives or verbalized preferences suggest comfort-focused care.
4. Argument 4: The risks and burden of unnecessary treatments on the resident's physical and emotional well-being, and the role of palliative care in supporting a more humane death.

III. Rebuttals (three to four minutes per group):

After the initial presentations, each group will have a chance to respond to the opposing side's arguments.

Encourage students to focus on:

A. Countering ethical principles: For example, how the family's wishes might infringe upon the resident's right to a dignified death.

B. Offering practical solutions: For example, suggesting that if the resident insists on a regular diet, they can be given options like pureed foods or thickened liquids, which could offer a safer alternative while respecting the resident's wishes.

IV. Conclusion (two to three minutes per group):

Each group will summarize their key points and restate their stance on the issue.

In the conclusion, groups should reinforce the ethical principles that justify their position and offer a balanced perspective on how the decision-making process can prioritize both the resident's rights and well-being.

Post-Debate Reflection and Debrief

After the debate concludes, facilitate a class discussion to reflect on the key issues raised during the debate. Discuss the following questions:

1. What were the ethical principles that guided the arguments for both sides?
2. Were there any points of agreement between the two sides?
3. How do we balance patient autonomy with the need for safety and comfort at the end of life?
4. In what ways do family members' desires impact clinical decision-making? How should a nurse or clinician navigate conflicts between family wishes and resident preferences?
5. How can we ensure that the care we provide aligns with the resident's goals, even when there are disagreements with family members or the resident's condition changes?

Reflection on Communication and Professionalism

Encourage students to reflect on the importance of communication skills in navigating these difficult conversations. How can nurses and clinicians communicate effectively with residents and families, especially when the decisions are emotionally charged?

Emphasize the need for professionalism, empathy, and cultural sensitivity when addressing these complex issues.

Mix & Match Group Activity: Dementia Care

Description

This small group activity facilitates identification of potential intervention strategies in response to dementia-related behavioral symptom presentation. The goal of this activity is to support students in exploring and generating logically informed interventional responses to behavioral symptoms and to support their articulation of the rationale for various strategies. Simultaneously, students will generate clues about underlying causes/contributors to symptoms to facilitate critical thinking about symptom presentation and reflection about the experience of symptoms.

Each group will work with a set of note cards for potential symptoms and interventions, outlined in Table 5.1. This is a list of common symptoms that may be discussed, but instructors can adapt symptom descriptions and develop more cards based on learning objectives. For example, tearfulness could be described to facilitate an exploration of loneliness or depressive symptoms and interventional responses. Encourage use of wild cards, which can

be used in the activity as frequently as students would like to identify potential intervention strategies.

Number of participants and roles: Two to four participants fulfill two roles during this activity: a) symptom "clue" generators and b) intervention generators.

Materials required: Each group will need "symptom" and "intervention strategy" notecards (examples in Table 5.1). Each group will need a description of the rules of play.

TABLE 5.1 Dementia Mix & Match

SYMPTOM	INTERVENTION STRATEGY
Aggression	One-on-one engagement
Agitation	Distraction/redirection
Anxiety	Address and rule out physical needs Describe these interventions—e.g., toileting, temperature, hunger, pain
Apathy	Sensory stimulation Describe specific interventions—e.g., sensory blanket, music therapy, hand massage
Care resistance	Meaningful activity Describe activity—e.g., puzzle, coloring, folding towels
Appetite changes	Modify care approach Describe how specifically you would try modifying a care approach—e.g., approach from side, fewer people
Sleep changes	One-on-one walk with supervision
Delusions	Reminiscence activity
Hallucinations	Modify environment Describe modifications—e.g., light, noise, temperature
Repetitive questions	Use or trial sensory aids
Wandering	Involve resident in care task differently
Irritability	Take a break
Repetitive vocalizations	Wild card Describe your intervention strategy!

Student Handout: Rules of Play

In this activity, you will identify intervention strategies for approximately 13 distinct behavioral symptoms that you may see in practice. For each symptom, one person in the group will generate additional "context clues" about the symptom and their potential causes. Be creative.

Key tip: Intervention strategies should be proposed that address potential causes of the symptom being described. Participants who play the role of context clue generators are responsible for giving descriptions that help to inform what might be causing a particular symptom.

As you begin, work with one symptom at a time. To make the activity more challenging, you can present more than one symptom with more than one cause to your teammates. For an example, see Figure 5.1.

Context Clue Generators

1. Present a symptom and describe where and how the symptom presents and what it specifically looks like.
2. Provide context clues which include additional information about the findings of different assessment strategies intervention generators propose. Clues can provide further detail about emotional state/affect, content of speech, specific behaviors, or what happens before a behavior to help provide insight into why the symptom might be happening.
3. Provide information about symptom resolution when an intervention strategy has responded appropriately to causes of the symptom; and/or help intervention generator teammates understand why a symptom did not resolve.

Intervention Generators

1. Propose assessment strategies to get clues about potential causes or contributing factors to the presenting symptom. The strategy can involve asking for more information about the symptom.
2. Generate intervention strategies you would trial in response to the described symptom (see Figure 5.1).

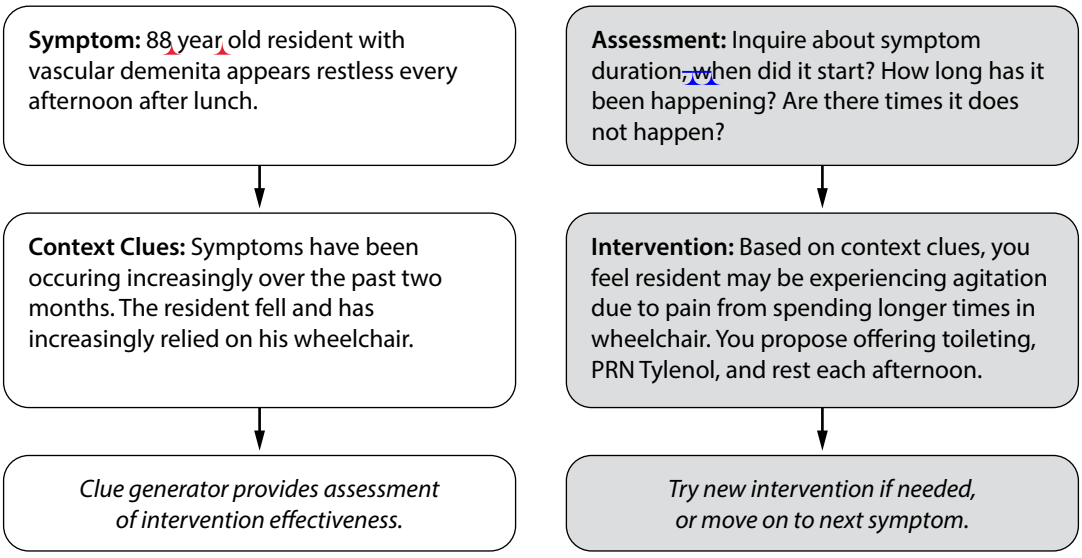

FIGURE 5.1 Dementia mix & match activity example.

Role-Playing Activity: Transitional Care from Hospital to Nursing Home

This role-play activity simulates the transition of a patient from a hospital setting to a skilled nursing facility (SNF). The goal is for students to practice completing the Hospital to SNF Transfer Form (part of the INTERACT toolkit), review and discuss critical information for a smooth transition, and engage in communication between the hospital discharging nurse, nursing home admissions nurse, resident, and family member.

Scenario: Transitional care case study (from Chapter 5, pp. 111–112)

Number of participants and roles: Two to four participants (depending on group size)

- Hospital discharging nurse
- Nursing home admissions nurse
- Resident (if there are three group members)
- Family member (optional, if there are four group members)

Materials:

- INTERACT Hospital to SNF Transfer Form: This form is used to gather and communicate critical information when transferring a patient from the hospital to a nursing home. The form can be found in the INTERACT toolkit: https://pathway-interact.com/wp-content/uploads/2021/08/19-INTERACT-SNF_NF-Hospital-Transfer-Form-06-17-2021.pdf.
- Transitional Care Case Study from Chapter 5 (pp. 111–112): This provides the case details and background information on the patient and their care needs.

Activity Steps

Students will work in small groups, assuming different roles in a hospital-to-nursing home transfer. They will use the INTERACT Hospital to SNF Transfer Form to complete the necessary documentation and practice effective communication.

1. Review the case scenario: Start by reading through the Transitional Care Case Study from Chapter 5. This will give you context about the resident's medical history, the reason for the hospitalization, and the care needs during the transition to an SNF.
2. Assume your role: Each participant should take on a role. The roles are:
    - Hospital discharging nurse: Responsible for providing all relevant medical information to the nursing home admissions nurse. You will give a summary of the resident's hospital stay, treatment plan, and discharge instructions.
    - Nursing home admissions nurse: Responsible for receiving the transfer information from the hospital nurse and ensuring it is appropriately documented and understood for continued care at the SNF. Ask questions as necessary.

- Resident: Simulate the resident's perspective by providing details about their current condition, preferences for care, and any questions or concerns they may have about the transition.
- Family member (optional): If there is a fourth participant, they will represent the family member of the resident. The family member may have concerns or additional information regarding the resident's care and preferences.

3. Role-play the handoff communication:
    - The hospital discharging nurse and the nursing home admissions nurse will perform a handoff communication—transferring key information about the resident's condition, treatment, and care needs.
    - Use the INTERACT Hospital to SNF Transfer Form to document the necessary details. Ensure that the following information is communicated:
        - The resident's medical history, current diagnoses, and treatments
        - Medications the resident is taking
        - Nursing needs (e.g., wound care, mobility, etc.)
        - Dietary requirements and any special instructions
        - The resident's functional status, including any limitations in activities of daily living (ADLs)
        - Any advance directives or end-of-life care preferences, if relevant
4. Ask questions:
    - As the nursing home admissions nurse, ask questions to ensure all critical information is understood, such as, "Can you clarify the resident's current level of mobility?" or, "Does the resident have any specific dietary restrictions we need to be aware of?"
    - The resident can also ask questions about what to expect upon arriving at the nursing home (e.g., "Will I be able to see my family frequently?").
    - The family member might ask about the resident's safety, comfort, and the availability of any special services, such as palliative care.
5. Complete the INTERACT Transfer Form: After the handoff, fill out the INTERACT Hospital to SNF Transfer Form together.
    - Be sure to accurately transfer all relevant information provided during the role-play.
    - The nursing home admissions nurse may ask additional questions to complete the form, such as confirming medications or clarifying any unclear aspects of the patient's medical history.

6. Brainstorm and discuss: After completing the form, engage in a group discussion with the following prompts:
    a. What additional questions do you have for the hospital discharge nurse, resident, or family member?

       Suggested answer: Identify any gaps in the transfer information that need clarification.

    b. Is there anything you think could improve the transition experience for this resident?

       Suggested answer: Discuss possible improvements to communication, care coordination, or patient/family involvement in the process.

    c. What actions would you recommend the nursing home team take next?

       Suggested answer: Consider next steps for ensuring smooth integration into the nursing home, such as arranging follow-up care, informing the nursing staff about the resident's condition, or making any necessary adjustments to care plans.

Debrief and Reflection Questions

After the role-play is completed, debrief the activity as a group. Discuss the following questions:

1. How well did the handoff communication go? What went well, and what could have been improved?
2. How did you ensure all relevant information was conveyed? Was there any critical information that was overlooked or misunderstood?
3. What are some challenges that might arise during the actual transfer process, and how can they be mitigated?
4. How can you apply the lessons from this role-play to real-life situations in transitional care?

CHAPTER 7

Assignment: Licensed Nurses in Nursing Homes

This is an in-class or online assignment that can be done in small groups.

Objectives

- Differentiate the responsibilities of RNs and LPN/LVNs in nursing homes that are aligned with the RN and LPN/LVN scopes of practice outlined in the state's nurse practice act and any associated regulations.
- Apply the responsibilities to determine potential RN and LPN/LVN staffing for nursing homes.

Assignment Instructions

Both RNs and LPNs/LVNs are employed in nursing homes. Review the following about RNs and LPN/LVNs:

1. Look up the Nurse Practice Act for the state and compare and contrast the scope of practice and any associated regulations pertaining to RNs and LPN/LVNs.
2. Look up the staffing requirements for RNs and LPN/LVNs in nursing homes—both state and federal.
3. Compare and contrast the education program requirements for RNs and LPNs.

Given the federal/state nurse staffing requirements, education requirements, and the state's Nurse Practice Act, determine the responsibilities of staff RNs and LPN/LVNs in nursing homes. What responsibilities are the same? What responsibilities are unique to RNs? What responsibilities require collaboration between RNs and LPN/LVNs?

Based on this analysis, propose recommendations for licensed nurse staffing in nursing homes.

Assignment: Quality of Nursing Home Care

This is an in-class or online assignment that can be done in small groups or individually.

In this research and reflection activity, learners will use the Nursing Home Compare website to find data about the quality of a nursing home. They will then reflect on the usefulness of the Nursing Home Compare website for helping families to select a nursing home for their loved ones.

Assignment Instructions

There is publicly available information about the nursing homes, including information about the quality of care and staffing. This information is available at the CMS Nursing Home Compare website. For this assignment, you will review the quality data for one nursing home available on the Nursing Home Compare website.

1. Go to the CMS Nursing Home Compare website (https://www.medicare.gov/care-compare/?redirect=true&providerType=NursingHome). Put in a zip code to find nursing homes in that zip code area. Select one nursing home and click on the hyperlinked name of the nursing home and view the:
    a. **Inspection results:** Click on the hyperlink at the bottom of the page titled "View all health inspection, infection control inspection, complaint, and facility-reported issue details."
    b. **Staffing information:** Determine how the nursing home's staffing compares to the average staffing at the state and federal levels.

c. **Quality measures:** Click on short stay quality measures and long-stay quality measures. Determine how the nursing home's quality measures compare to the quality measures for the state and U.S.

2. Based on the information you reviewed:
   a. Provide a brief summary paragraph for each of the nursing home's three quality areas.
   b. Write a short reflection on the use of this data for families to select a nursing home for their loved one.

Discussion Questions

The following questions could be used in class after students have completed this assignment:

1. What are the data sources used to determine the ratings for health inspections, staffing, and quality measures? What, if any, concerns, or issues might there be related to these data sources?
2. What other uses are there for the data on Nursing Home Compare?

CHAPTER 10

CASE STUDY WITH APPLICATION AND ANSWER KEY:
Significant Medication Error

Background

The regulation F760 states the facility must ensure that the residents are free of any significant medication errors.

"Significant medication error" means one which causes the resident discomfort or jeopardizes his or her health and safety. Criteria for judging significant medication errors as well as examples are provided below. Significance may be subjective or relative depending on the individual situation and duration, e.g., constipation that is unrelieved because an ordered laxative is omitted for one day, resulting in a medication error, may cause a resident slight discomfort or perhaps no discomfort at all. However, if this omission leads to constipation that persists for greater than three days, the medication error may be deemed significant since constipation that causes an obstruction or fecal impaction can directly jeopardize the resident's health and safety.

Scenario

A 76-year-old resident with pneumonia, a urinary tract infection, and type 2 diabetes was admitted to a skilled nursing facility. Due to fluctuating blood sugar levels, the resident was on a sliding scale insulin regimen, utilizing a Humulin-R U-500 KwikPen.

When the resident's blood sugar exceeded the ordered coverage, the nurse contacted the provider, who ordered 12 units of Humulin-R. However, the KwikPen only dispensed insulin in increments of 5 units. Instead of contacting the provider to clarify the order, the nurse withdrew insulin from the pen using a separate syringe.

Subsequently, the resident exhibited signs of hypoglycemia and was transported to the hospital. The hospital informed the facility that the resident had experienced an insulin overdose.

Action

The nurse withdrew the insulin from the pen, which is not appropriate clinical practice and gave an incorrect dose of insulin to the resident, this led to a significant medication error and caused the resident to have an episode of hypoglycemia requiring hospitalization.

Interventions

Thorough investigation of the incident to identify the root cause of the error. Implementation of corrective measures, such as:

- Staff education on proper insulin administration, including the risks of drawing insulin from pens with syringes
- Reinforcement of policies regarding medication order clarification and communication with providers
- Evaluation of insulin pen options that allow for more precise dosing
- Implementation of a double-check system for high-risk medications

Questions & Answer Key

1. What factors contributed to the nurse's decision to draw insulin from the pen with a syringe, rather than clarifying the order with the provider?

   Suggested answer:

   Contributing factors may include a lack of understanding of the risks associated with using a syringe to withdraw insulin from a pen device, time pressures during a busy shift, inadequate training on proper insulin administration techniques, and possibly a perceived urgency to administer the medication without delay. The nurse may have assumed the practice was safe.

   Answers may vary here based on experience.

2. How could communication between the nurse and provider be improved to prevent similar incidents in the future?

   Suggested answer:

   Improvement strategies include implementing standardized communication protocols such as SBAR (Situation, Background, Assessment, Recommendation), ensuring clear

documentation of orders and any modifications, and promoting a culture where staff feel that they can ask questions or request clarification without fear of judgment or delay. Using electronic health records with real-time messaging and alerts can help to facilitate quicker provider responses and reduce the risk of misinterpretation or improvisation.

3. What are the potential consequences of medication errors, both for the patient and the facility?

   Suggested answer:

   For the patient, consequences can include hypoglycemia, hospitalization, prolonged recovery, or even death. Medication errors may reduce trust in care provided by nursing home staff. For the facility, consequences can include regulatory citations, legal liability, damage to reputation, decreased family and community trust, and potential loss of reimbursement or certification. It also may result in increased oversight from agencies like CMS or the state department of health.

4. How can a culture of safety be fostered within a healthcare organization to encourage reporting and learning from errors?

   Suggested answer:

   A culture of safety can be promoted by encouraging open, non-punitive reporting of errors and near misses. Regular staff education on medication safety, involving staff in identifying risks and developing solutions, using incident data to improve systems, and not assigning blame can also promote a culture of safety. Leadership should model transparency and accountability and reinforce that the goal of reporting is a process for learning and prevention versus punishment.

Conclusion

This case study highlights the critical importance of adhering to medication administration protocols and the need for clear communication between healthcare providers. By addressing the underlying causes of medication errors and implementing preventive measures, healthcare facilities can improve patient safety and reduce the occurrence of adverse events.

Activity: State Operations Manual "Scavenger Hunt"

Activity Overview

This is an independent in-class activity intended to support student familiarity with various federal regulations in the CMS *State Operations Manual (SOM).* Students will gain experience searching for regulations in the manual and researching the details of various regulations, including resident rights, care planning, medication management, infection control, and abuse.

Time: 45 minutes

Materials needed: CMS *State Operations Manual* (or link); Scavenger Hunt Handout

Assignment Instructions

1. Provide each student with the link to the CMS *State Operations Manual* and "Scavenger Hunt" handout.
2. Direct students to search the SOM for the answers and record the answers on their Scavenger Hunt handouts.
3. When the allotted time is up, the instructor will review the answers for each question, using the Scavenger Hunt Answer Key. Students will self-grade their answers.
4. Conduct a short debrief:
    - "What did you find surprising about this activity?"
    - "What can you take away for next time you need to search and research regulations?"

SOM Scavenger Hunt Questions and Answer Key

Resident Rights:

1. What is the regulation (FTag) and specific regulatory requirement for informing residents of their rights upon admission?

    Answers:

    F572 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

    §483.10(g) Information and Communication. §483.10(g)(1) "The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility."

2. What is the regulation and specific regulatory requirement for a resident's right to refuse treatment?

    Answers:

    F578 (Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22)

    §483.10(c)(6) "The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. The resident has the right to request treatment; however, facility staff are not required to provide medical treatment or services if the requested treatment or services are medically unnecessary or inappropriate. While the resident also has the right to refuse any treatment or services, the resident's refusal does not absolve facility staff from providing other care that allows him/her to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being."

Care Planning:

3. What is the timeframe for completing a comprehensive care plan after a resident's admission?

Answer:

According to F657 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17) §483.21(b) Comprehensive Care Plans §483.21(b)(2) "A comprehensive care plan must be— (i) Developed within 7 days after completion of the comprehensive assessment."

4. How often must care plans be reviewed according to regulations?

Answer:

(iii) "Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments."

5. What are the requirements for interdisciplinary team involvement in care planning?

Answers:

(ii) "Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident."

Medication Management:

6. Which regulation pertains to the storage of medications in a long-term care facility?

Answer:

F761

7. Which regulation defines "Medication Error"?

Answer:

F761

8. Which regulations refer to the use of psychotropic medications?

Answers:

F757, Unnecessary Drugs and 42 CFR §483.45(e), F758, Psychotropic Medications

Infection Control:

9. Which regulation outlines infection control practices in long term care?

Answer:

F880

10. How does the regulation define an outbreak of a communicable disease?

    Answer:

    An outbreak is the occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time.

11. According to the regulation, what are the infection control measures required for residents with multidrug-resistant organisms (MDROs)?

    Answer:

    Contact precautions are used for residents infected or colonized with MDROs in the following situations:

    - When a resident has wounds, secretions, or excretions that are unable to be covered or contained; and
    - On units or in facilities where, despite attempts to control the spread of the MDRO, ongoing transmission is occurring.

Abuse/Neglect:

12. What regulation pertains to abuse in long term care?

    Answer:

    F600 §483.12 Freedom from Abuse, Neglect, and Exploitation

13. How does the regulation define abuse in the context of long-term care?

    Answer:

    "Abuse," is defined at §483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology."

CHAPTER 11

CASE STUDY WITH APPLICATION AND ANSWER KEY:
Discharge Planning in a Nursing Home Setting

This case study uses a scenario similar to the one in the later section "Learning Activity: Care vs. Loss of Reimbursement Scenario and Discussion."

Patient Profile

Name: Mr. John Parker

Age: 78 years

Admission type: Transfer from rehabilitation services in an SNF

Background: Mr. John Parker, a 78-year-old male resident, has been receiving rehabilitation services in an SNF following a hip fracture sustained from a fall at home. He has been hospitalized for three weeks and is now transitioning to the nursing home for additional recovery and rehabilitation. Prior to his accidental fall, Mr. Parker lived alone. His mobility has been limited since his injury, requiring assistance with all self-care tasks. The interdisciplinary team consists of nurses, rehabilitation therapists, social workers, and a physician.

Medical diagnoses:

- Recent hip fracture requiring continuing rehabilitation and recovery
- Hypertension
- Type 2 diabetes: Requires careful monitoring of blood sugar levels and dietary management

Mr. Parker's functional status:

- Mr. Parker requires assistance with bathing, dressing, grooming, and toileting.
- He has expressed anxiety about returning home alone, especially after his fall.
- His mobility is limited; he uses a walker but is unsteady and requires assistance for transfers.

Family involvement:

Mr. Parker's daughter, Ms. Emily Parker, has been visiting regularly. She is concerned about her father's safety and is willing to assist him but is unsure of what support he will need at home.

Interdisciplinary team composition:

- Nurse Sarah: Unit manager responsible for overseeing patient care
- Rehabilitation therapists: Provide physical and occupational therapy focused on improving John's mobility
- Social worker: Assists with discharge planning and connecting Mr. Parker to community resources
- Physician: Responsible for medical oversight and approving discharge orders

Scenario

During a weekly interdisciplinary team meeting, the unit manager, Nurse Sarah, learns that Mr. Parker's payor has notified the facility that he has only two days left of coverage for his short-term stay. The payor has indicated that after this period, the facility will no longer receive reimbursement for Mr. Parker's care, and he must either be discharged or remain without coverage.

The rehabilitation therapists express their willingness to proceed with discharge based on the payor's recommendation, despite Nurse Sarah's observations that Mr. Parker is unable to perform self-care tasks independently and has recently fallen while attempting to walk to the bathroom at night. Sarah questions the therapists about whether they have provided education to Mr. Parker and his spouse regarding functional mobility and self-care tasks at home, to which they respond that this education has not yet occurred.

Despite Sarah's concerns, the interdisciplinary team prepares to sign off on Mr. Parker's discharge. Nurse Sarah must navigate this challenging situation, balancing patient safety with the financial constraints imposed by the payor.

Questions & Answer Key

1. What are the ethical considerations in this case regarding discharge planning and patient safety?

   Suggested answer: The primary ethical consideration is the obligation to prioritize Mr. Parker's safety and wellbeing over financial constraints. Discharging him without adequate preparation could lead to potential harm, such as further falls or health complications.

2. How should Nurse Sarah advocate for Mr. Parker in light of the payor's decision?

   Suggested answer: Nurse Sarah should gather evidence of Mr. Parker's care needs and discuss the situation with the payor to advocate for an extension of his stay based on medical necessity. She can emphasize the risks associated with premature discharge and the fact that education has not been provided to Mr. Parker and his family at this time.

3. What alternative options could the interdisciplinary team consider to ensure Mr. Parker's safe transition home?

   Suggested answer: The team could consider arranging for home health services to support Mr. Parker after discharge. They might explore a temporary stay in a personal care facility that provides the necessary therapy and support. Additionally, Sarah could advocate for a reassessment of Mr. Parker's condition by the payor.

4. How can the team effectively communicate with Mr. Parker and his family about the discharge plan?

Suggested answer: The team should meet with Mr. Parker and his family to explain the situation clearly, discussing the implications of the discharge and the support he will need. Providing written materials and scheduling follow-up appointments with home health services can help ensure they feel prepared.

5. What resources are available to assist Mr. Parker post-discharge, and how can the team facilitate these connections?

   Suggested answer: Available resources might include home health aide services, physical therapy at home, meal delivery programs, and community support groups for seniors. The social worker can help facilitate these connections and ensure Mr. Parker has access to necessary services.

Conclusion

This case study illustrates the complexities of discharge planning in a nursing home setting, particularly when faced with financial constraints from payors. It emphasizes the importance of interdisciplinary collaboration, patient advocacy, and effective communication with residents and their families to ensure safe transitions in care.

CHAPTER 12

CASE STUDY WITH APPLICATION AND ANSWER KEY:
Using Medicare.gov's Care Compare Website to Select a Nursing Home for Short-Term Rehabilitation

Scenario

Ms. Chiomi Adamu's father, Mr. Joseph Adamu, was recently hospitalized after a hip fracture and needs short-term rehabilitation in a nursing home with memory care support for his early-stage dementia. Ms. Adamu is worried about finding a place that will provide high-quality, specialized care during his recovery. Mr. Adamu needs a nursing home where he'll receive therapy to regain mobility, with staff who understand dementia care.

Ms. Adamu consults with Emma, a nurse at the hospital, who introduces her to Medicare.gov's Care Compare website, a tool designed to help families evaluate nursing homes based on quality measures and ratings.

Action

Emma sits down with Ms. Adamu to show her how to use Care Compare and explains some of the key quality measures that will be especially helpful in choosing the right facility for her father:

1. **Finding nursing homes with memory care units:** Emma guides Ms. Adamu to start by entering her preferred geographic area on the Care Compare homepage, selecting the nursing home option, and filtering for facilities that have memory care units. Together,

they identify three local nursing homes that provide both short-term rehabilitation and memory care.

2. **Understanding key quality measures:** Emma explains that Care Compare displays various quality measures for each facility, including rehospitalization rates, functional improvement outcomes, and safety measures.
3. **Short-stay quality measures:** For Mr. Adamu's recovery, these include the percentage of residents who successfully return home and those who avoid hospital readmissions, which can indicate effective therapy and resident care.
4. **Staff training and qualifications:** Emma highlights that facilities with higher ratings for nursing staff typically have more trained personnel who understand dementia-related behaviors, making it a safer and more supportive environment for Mr. Adamu.
5. **Comparing the three facilities:** Using Care Compare, Ms. Adamu reviews each of the three facilities. She compares their overall ratings and specific short-stay rehabilitation outcomes. One facility has higher rehospitalization rates, while another has a strong record of functional improvement and personalized dementia care training for staff.

   Emma points out that health inspection results and staffing ratios are also available on Care Compare, which can help Ms. Adamu determine if a facility has adequate resources to provide consistent care.
6. **Reviewing resident and family experience ratings:** Emma advises Ms. Adamu to look at resident and family satisfaction ratings, which indicate the quality of life and overall experience at each facility. This information can provide insight into whether the facility prioritizes person-centered care, a vital aspect for residents with dementia who may need a familiar and comforting environment.
7. **Using Care Compare as a starting point:** Emma reminds Ms. Adamu that while Care Compare is an excellent tool, visiting the facilities in person can provide additional insight. She encourages her to print one copy of the *Nursing Home Quality Checklist* to take with her for each visit to keep track of answers; and to specifically ask the nursing home staff about dementia-specific training during her visits and observe how staff interact with residents.

Outcome

After reviewing the facilities on Care Compare and visiting two of them, Ms. Adamu decides on a nursing home with a strong functional improvement record, positive resident feedback, and dedicated dementia care practices. The facility's attention to both short-term rehabilitation and memory care gives her confidence that her father will have a safe and supportive environment as he recovers.

Questions & Answer Key

1. How did using Care Compare help Ms. Adamu make an informed decision?

   Suggested answer: Care Compare provided data on quality measures, staffing, and resident satisfaction, allowing her to compare facilities objectively and choose one that met her father's rehabilitation and dementia care needs.

2. Why are short-stay quality measures important for Ms. Adamu to review?

   Suggested answer: Short-stay quality measures, like rehospitalization rates and functional improvement outcomes, directly reflect the facility's effectiveness in rehabilitation, ensuring Mr. Adamu has the best chance of recovery without complications.

3. What additional steps did Emma suggest Ms. Adamu take beyond using Care Compare?

   Suggested answer: Emma suggested she visit each facility, observe staff interactions, and ask specific questions about dementia care practices, helping her gain a fuller understanding of the facility environment.

4. How can staffing levels on Care Compare influence a family's choice in nursing home placement?

   Suggested answer: Higher staffing levels often mean more attentive care and quicker response times, especially important for residents with dementia who may need more frequent assistance and oversight.

5. What information on Care Compare might indicate a facility is well-suited for residents with dementia?

   Suggested answer: Family satisfaction ratings, staff training in dementia care, safety measures, and low rehospitalization rates can indicate that a facility prioritizes both quality care and a supportive environment for dementia residents.