An Education-Practice Partnership Model for Professional Development in LTC

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Partners Investing in Nursing's Future

Robert Wood Johnson Foundation & Northwest Health Foundation Grant “PIN Grant”

Local Collaborative:

- Local Funding Partner: Daisy Marquis Jones Foundation
- Education Partner: Wegmans School of Nursing, St. John Fisher College
- Practice Partner: Senior Health Alliance of Greater Rochester (SHAGR) Episcopal SeniorLife Communities, Friendly Senior Services, Jewish Senior Life, St. Ann’s Community, St. John’s Senior Communities

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2008-2011 PIN 3 Project:
RN Leadership Program

Phase 1: Needs Assessment
• Comprehensive review of the literature
• 12 Focus groups at Homes for CNAs, LPNs & RN Managers
• On-line survey of SHAGR Nurse Managers
• Meetings with Directors of Nursing

Phase 2: Program Development
• Seven 1-day training sessions done monthly
• Monthly coaching contact between training sessions
• Follow-up networking events

Phase 3: Evaluation & Plan for Sustainability

2012-2014 PIN 6:
Establishment of the Academy

Academy for Leadership in LTC
• An educational collaboration of the Daisy Marquis Jones Foundation, Senior Health Alliance of Greater Rochester, & the Wegmans School of Nursing at St. John Fisher College.
Goals

Establish an Academy of Leadership in Long Term Care responsive to life-long learning needs of nurses in long term care (LTC)

• Provide educational training that encompasses the range of competencies nurses need for management and leadership roles in diverse LTC settings.
• Assess the needs of nurses in LTC for specific continuing education needs and then develop, implement, and evaluate programs to meet these needs.
• Develop networking opportunities to share leadership best practices.
• Support programs for clinical experiences and summer internships for undergraduate nursing students in geriatrics and LTC.

Outcomes

• Create a center for best practices and program innovation to improve care for elders by meeting the professional development needs of nurses.
• Educate future members of the nursing workforce about geriatrics as an important and rewarding specialty to improve recruitment of RNs into LTC.
• Develop infrastructure in Academy for
  – New program development, implementation, and evaluation.
  – Broaden community partnerships and outreach.
Stakeholders

• Leaders in LTC
  – Support, value, & fund ongoing RN professional development → motivate with data re: cost-effective & positive outcomes for resident care.

• RNs in LTC
  – Incentives for ongoing education → seamless progression and support from employers.

• Nurse Educators
  – Facilitate integration of gerontology learning experiences through collaborative clinical planning.

Stakeholders

• Community Partners
  – SAGE Commission (FLHSA) call to action and best practices to improve care for elder services and care
  – Lifespan: Community source for elder care services

• Students in nursing programs
  – Access to programs to understand, value, and learn skills specific to geriatric specialization

• Federal & State Funders
  – Support for specialization of nurses at graduate and doctoral levels to provide leadership in LTC and all health care settings
  – Policy advocacy at all levels
Steps in the Collaboration

- Formation of the “Academy”
- Development of agreement between St. John Fisher College (501-C3) & Rochester Senior Care Alliance (501-C3) approved by counsel at both.
- Creation of Advisory Board → 7 members
  - PIN 6 Project co-directors: one each from SJFC & RSCA
  - Dean St. John Fisher College
  - CEO Rochester Senior Care Alliance
  - Development Director from RSCA facility
  - Development Director from SJFC
  - DMJ Foundation Chair

Infrastructure

- Website http://www.academyltc.org/#!home/mainPage
- Business Plan
- Program Development
  - Updated needs assessment
- Office Space
- Part-time Executive Director
- Part-time Marketing Assistant
- Marketing plan & materials
New Program Development

- Results of needs assessment or requests for programs from stakeholders
- Review of literature & best practices.
- Work groups of education partners, practice partners, & academy staff to develop curriculum and teaching materials.
  - Input for program outcomes, target groups, format, length, cost.
- Pilot new program with practice partners
  - Implement, evaluate, & revise program
  - Review & approval by education partner’s curriculum committee (NYSED authority to offer educational programs)
- Market to all stakeholders
- Ongoing evaluation and updates

Programs

LPN/RN Clinical Skills Training

- Unique LPN/RN Clinical Skills Update Training program addressing the needs of higher acuity levels of residents in long-term care.
- Includes classroom and skills lab training focusing on CHF, COPD, MI, Pneumonia, and UTI that often lead to hospital re-admissions.
- Case studies presented and discussed to further develop clinical reporting skills and practice communicating reports to providers using the SBAR tool.
- Nurses practice updated clinical skills in the Wegmans School of Nursing state-of-the-art Simulation Center.
Programs

TeamSTEPPS® (AHRQ)

• Long-Term Care training program for all members of the healthcare team (nurses, physicians, CNAs, social workers, food service, housekeeping, etc.) to help them adapt a collaborative and cohesive culture within the organization.

• Evidenced-based, one-day training tailored to the LTC environment presenting teamwork skills essential for providing quality care to residents in skilled nursing, assisted living, and continuing care retirement communities.

Programs

TeamSTEPPS® continued

• Classes include teambuilding exercises/interaction, communication strategies, and mutual support development.

• Participants learn decision-making, conflict resolution, and problem-solving skills to help respond quickly and effectively to whatever situations may arise in the facility.

• Case studies illustrate teamwork examples, opportunities, and successes.
Programs

LPN Professional Development Training
• The LPN Professional Development Training supports the LPN management role in long-term care settings.
• Training focuses on communication with residents, families, staff and providers, collaborative work teams, role modeling for staff empowerment, decision-making, team building, listening skills, conflict resolution, and strategies for a positive work environment.
• 3 training days: Case studies, work experience discussions, and faculty guest speakers to provide well-rounded support for LPN’s in this dynamic role.

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Programs

RN Leader Training Program
• Provide leaders in LTC settings with a defined set of management and leadership competencies necessary to build and maintain a skilled, diverse, and committed nursing workforce responsive to the needs and changes in LTC, supported by best practices.
• 5 modules: Leadership theories, transformational/authentic leadership, management responsibilities, communication styles, team building, conflict resolution, employee engagement, diversity, and evidence-based resources.
• 1 day/month for 5 months, on-site individual mentoring to support the specific needs of each leader.
• Classroom training focused on individual development of a personal leadership philosophy and style, which strengthens the ability to lead a diverse team and focus on resident quality of care.
• Opportunities to share clinical and leadership best practices.

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Programs

RN Leader 1:1 Mentoring

• Opportunity for nurses or leaders new to their leader/management/supervisory role or new to LTC environment.
• Training includes individual on-site mentoring sessions as requested by the organization. Mentoring sessions support the specific needs of each individual.
• Upon completion, individuals are prepared to enroll in the recommended five month leader training program.

Factors that Promote Success

• Practice Partners
  — With a history of successful collaboration in a competitive environment.
  — Commitment to ongoing professional development.
  — Focus on quality, safety & resident satisfaction.
• Education Partners
  — With a commitment to community outreach, professional development, & life long learning.
  — Expertise in program development & evaluation.
  — Provide access to simulation facilities.
  — Faculty expertise in gerontology, nursing practice, and national quality & safety best practices.
  — Network of educators and nurses in practice to do training and mentoring
• Funding Partners
  — to provide ongoing funds for health care workforce development.
Advantages

• Access to high quality professional development programs
  – Programs developed and offered by experts in clinical practice & education.
  – Expertise & resources beyond the reach of many agencies.
  – Value of networking for individuals during training for those who often have limited access to this.

Challenges

• Fiscal restraints in LTC
  – Highly regulated with cuts in reimbursements
  – Many competing priorities with LTC professional development for agency funding: “important to achieve safe, high quality care with resident satisfaction but…”
• LTC short staffing and high turnover can deter attendance for completion of programs.
• Incremental training of workforce takes a long time to reach a critical mass → difficult to get reliable & valid data to measure success & impact of programs other than self-report/self assessment of participants.
Challenges

• Challenge of reaching sustainable business model→ ongoing grant funding important.
• Online options can be cost effective and efficient but also can be a challenge for some members of care team.
• Ongoing availability of trainers to offer programs offered at varying intervals during the work week (conflicts with practice and teaching schedules).

RN/LPN Clinical Update Training
Objectives of RN/LPN Training

• Participants will be able to:
  – Briefly describe the significance of the problem regarding hospital readmissions from the nursing home setting
  – Identify the most common medical diagnoses which result in hospital readmissions from the nursing home setting
  – Describe the causes, pre-disposing factors, pathophysiology, clinical manifestations, as well as the nursing & pharmacologic management of the common medical diagnoses
  – Name two INTERACT tools that can be used by nursing staff to communicate changes in residents’ status

Format of Training Program

• Day 1
  – Reducing hospital readmissions
  – Nurse-Physician communication
  – Respiratory and cardiac skills lab review with simulation mannequins
  – Pathophysiology and assessment for key medical diagnoses
  – Group case studies

• Day 2
  – Evidence-based practice lecture in computer lab
  – Pathophysiology and assessment for key medical diagnoses
  – Simulation Center tour
  – Group case studies
Format of Training Program

• **Day 3**

  Simulation Experience
  - 2 different patient scenarios
  - LPN evaluation of patient’s **APPEARANCE**
  - LPN communication to RN via SBAR tool
  - RN evaluation via **ASSESSMENT** of patient
  - RN communication to Provider via SBAR tool
  - Collaborative management and treatment of the patient with one of the six discussed medical diagnoses

Why is this training important?

• About 20% of Medicare beneficiaries are discharged from the hospital to a nursing home (NH).
• Nearly 1/4 of Medicare beneficiaries discharged from the hospital to a NH are readmitted within 30 days. – This cost Medicare $4.34 billion in 2006
• As many as 45% of NH resident readmissions to acute hospitals may be avoidable.

(Mor et al., 2011; Walsh et al., 2010)
Readmission Rankings for Discharges to Skilled Nursing Facilities by State

Source: National Coordinating Center for Integrating Care for Populations and Communities, CY 2012
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Common Causes of Hospital Readmissions

- Not recognizing change in resident’s status soon enough
- Lack of adequate RN staffing
- Lack of readily available lab, x-ray, and/or pharmacy services
- Lack of availability of on-site medical providers
- Ineffective nursing staff communication with medical providers (MDs, NPs, PA’s)
- Lack of advance care planning or advance directives
- Resident and/or family preferences
- Concern about potential legal liability
- Concern about possible Department of Health (DOH) citations

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Issues with Readmissions

- Transfers to hospitals often result in complications for older adults
  - Delirium
  - Falls
  - Incontinence
  - Immobility
  - Hospital-acquired infections and pressure ulcers
  - Under-nutrition and weight loss
  - Overall distress and discomfort to resident and family

(MedlineUniversity.com, 2013)

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Why This is Important

- Minimizing avoidable, preventable, and unnecessary hospital readmissions can result in increased resident satisfaction, fewer complications, and reduced costs.
- In future health care reform, Medicare may financially reward LTC facilities with lower hospitalization rates for certain conditions.
- Reduced costs and financial rewards can improve the financial viability of LTC. These savings can subsequently benefit employees.

( MedlineUniversity.com, 2013 )

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Top Diagnoses for Readmissions

• Five conditions account for 78% of all avoidable 30-day NH readmissions:
  – Heart failure
  – Respiratory infection
  – Urinary tract infection
  – Sepsis
  – Electrolyte imbalance

(Mor et al., 2011)

• Training focused on:
  – Pneumonia
  – Chronic Obstructive Pulmonary Disease
  – Myocardial Infarction
  – Heart Failure
  – Urinary Tract Infections
  – Sepsis
For each medical Dx
- Discussion of common causes/etiology
- Discussion of risk factors/pre-disposing factors
- Discussion of pathophysiology of disease
- Discussion of clinical manifestations
  * Early detection is KEY
- Discussion of nursing management of disease
  * Early Intervention is KEY
- Discussion of pharmacologic interventions
- Discussion of patient education and prevention

Case Studies
- During training, participants are placed in groups and provided a patient scenario with clinical manifestations suggestive of one of the medical diagnoses that we focus on during the lecture portion of the training
- Focus is on early intervention and using the SBAR tool for communication
- As a group, discuss how to manage the patient’s condition
Simulation Experience

- Students receive two different patient scenarios
- Scenarios reflect one of the six medical diagnoses
- Patient setting allows for hands-on nursing and pharmacologic interventions
- Experience encourages use of communication tools to focus on effective communication
INTERACT

• INTERACT: acronym for “Interventions to Reduce Acute Care Transfers.”
• INTERACT is a quality improvement program designed to improve the care of LTC residents with acute changes in condition.
• The overall goal of the INTERACT program is to reduce the frequency of transfers to the acute hospital through early identification and assessment of changes in resident condition.

(Florida Atlantic University, 2013; MedlineUniversity.com, 2013)

INTERACT Tools

• Categories include quality improvement, communication, decision support, and advanced care planning
• Communication
  – Stop and Watch Early Warning Tool
  – SBAR Communication Form
• Decision Support
  – Care Paths: Algorithms that drive nurses’ clinical decision making in regard to specific signs, symptoms, and changes in residents’ status
Significance of Problem – Acute Care

- Joint Commission reviewed over 3,500 sentinel events that occurred in acute hospitals from 1995-2005
  - Inadequate communication was consistently the main root cause of these events.
  - Nearly 70% of sentinel events during this 10-year time period were caused by breakdown in communication process.
Significance of Problem – LTC

• Inadequate communication in the LTC setting contributes to adverse events and unnecessary re-hospitalizations
• It also negatively impacts the quality of care provided to residents and patients
• Communication in LTC relies heavily on telephone communication, especially on off-hours and weekends when covering providers may not know the residents

Barriers to Communication

• A number of barriers to effective communication have been identified by both LTC nurses and medical providers
• Provider-identified Barriers
  – Nurse not prepared (#1 complaint)
  – Nurse not succinct enough
    • Too wordy
    • Too much non-priority information
Barriers to Communication

• Nurse-identified Barriers
  – Provider rushing, not allowing nurse to fully explain situation
  – Provider not calling back in timely manner
  – Provider yelling, being rude
  – Provider does not know the resident

SBAR to the Rescue...
What is SBAR?

- SBAR model is a simple method to help standardize communication
- Allows all parties to have common expectations:
  - What is going to be communicated
  - How the communication is structured
  - Required elements
- Focuses on the problem, not the people

**SBAR** is a tool for LPNs and RNs to evaluate changes in the resident’s condition AND communicate them to the MD/NP/PA AND document them.
Why SBAR?

• Similar to the SOAP model
• Provides answers to physicians’ three main questions:
  – What is the problem?
  – What do you need me to do?
  – When do I have to respond?
• Standardized approach that promotes efficient transfer of key information
• Helps create an environment that allows clinicians to express their concerns

SBAR

• Situation
• Background
• Assessment
• Recommendation
Before Calling MD/NP/PA

- Evaluate the Resident: Complete relevant aspects of the SBAR form
- Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, oximetry, and finger stick glucose, if indicated
- Review Medical Record: Recent progress notes, labs, orders

Situation

- Identify the change in condition, S&S
- When the change in condition started
- Whether or not the change has improved or worsened since that time
- Aggravating and alleviating factors
- Whether or not this change in condition has occurred in the past
  - If yes, what treatments/interventions were used
Background

• Resident description
• Medication alerts
• Vital signs
• Condition-specific information
• Recent lab results
• Advance directives and other resident/family preferences for care

Assessment

• State what you think is going on with the resident
  – **RNs:** I think the problem may be (*e.g.* cardiac, infection, respiratory, dehydration)
  – **LPNs:** The resident appears (*e.g.* short of breath, in pain, more confused)
Request/Recommendation

• State what you request or suggest:
  – Vital sign monitoring
  – Lab work
  – X-ray
  – EKG
  – Provider visit
  – Other orders
  – Transfer to hospital

Questions?
References

- Florida Atlantic University. (2013). About INTERACT. http://interact2.net/about.html
- Renz, S.M., et al. (2013). Examining the feasibility and utility of an SBAR protocol