Summary of Administrator Interviews and Direct Care Staff Focus Group Feedback

Relevant to Facilities in ECP Replication Grant from Original ECP Grant

Each nursing home not only tested the ECP concept but also provided opportunities for focus groups and administrator interviews.

At each nursing home, the process for changing the care plan included:

1. developing Standards of Care (SOCs) for a series of common resident conditions;
2. training staff in the intervention units on the ECP process;
3. implementation of the new care plan process; and then spreading the process to additional units.

Two of the major implementation successes (detailed solidly in the focus group reports) are
(1) the emphasis on interdisciplinary (in which the different disciplines develop a plan for each resident together) rather than multi-disciplinary care planning (in which each discipline develops its own care plan with minimal thought to coordinating the plans) and
(2) the individualization of care plans, so that each resident's care plan is unique and special to each resident.

The implementation and focus group reports contain a more in-depth discussion on the process:

ADMINISTRATOR INSIGHTS ON IMPLEMENTATION

Advice to Other Nursing Homes

What recommendations would you have for others who are just starting a project such as this? What would you do the same and what would you do differently?

- Involve all disciplines from the very beginning. One facility started first with Nursing because it is responsible for the bulk of the care plan. This led to possible resentment and resistance from some of the disciplines as the process rolled out.

- One administrator offered a career-long perspective on attitudes toward change, how at first people find excuses why something cannot or should not be done, and then when the process is finally underway, they admit they would never want to turn back. For example, some years ago staff had resisted doing away with bed rails and restraints as too dangerous for the resident. They were even worried that such action would put their licenses at risk. Now, no one would choose to return to restraints. Drawing the parallel, she added that no one on the units that converted to ECP would choose to go back to the old way of care planning.

- Involve CNA's directly from the beginning. The CNA's have resident-centered information that no one else possesses. CNA's can also give valuable input as to whether an intervention is realistic or "doable" for the resident.

- "Keep it simple." Be sure that the direct care givers can read and understand the SOC's and care plan.

- Be careful about keeping SOC's separate even though they are often inter-related. You can combine them later in the care plan.

- Where the care plans are kept is important. Everyone, especially direct care staff, need easy access to the care plan and SOC's. Different solutions included: having SOC binders at CNA stations, printing the SOC at the front of each exception, or universal computer access.

- The CNA "Kardex" "resident profile" changed significantly in many facilities. In at least two facilities, the CNA card ***is*** the exceptional care plan. This eliminates the need to update changes in more than one place and puts the pertinent information in the hands of the direct care giver.

- Pilot test it on one to two units first.

- Select people with positive attitudes for your pilot.

- There is a danger of getting complacent with the standards. It is important to read, monitor, and update them regularly or as needed.

- Several administrators pointed to the need for continuing education around ECP to ensure that it is done correctly by veteran and newly hired staff and to keep them current and accountable.

Barriers overcome: Writing the SOC's, converting care plans, and supporting/maintaining the new system: There appear to be three phases in which ECP implementation can get bogged down: writing the SOCs, converting care plans, and supporting/maintaining the new system. Each phase requires persistent and skillful leadership to keep advancing. For example:

- In one home, the process of writing SOC's got bogged down in a large committee trying to wordsmith. They sped up the process by having two people prepare a draft for committee input.

- One Director of Nursing advised having a "critical path" or timeline to guide staff and administrators through the process and to avoid getting stuck on the SOC's.

- Sometimes teams started falling back into old patterns. In several homes, the assistant administrator or assistant DON intervened when new care plans seemed to maintain too many of the old repetitive details. In a home where the MDS Coordinator entered all the care plans in the computer, she helped edit out repetitious entries. (Facilitators' note: We felt that some of the other facilities' care plans would have benefitted from this final edit to eliminate unnecessary repetition.)

- Most administrators mentioned the importance of ongoing education, quality audits, and annual review of SOC's to assure that the process stayed on track.

- "Follow up. Follow up. Follow up." – Senior Associate Director

- "Care plans are living and breathing documents." There are always ways to improve them. – Community Director

On a scale of 1 – 5, to what extent would you recommend that other nursing homes undertake this project? (5 = highly recommend)

Seven of the eight administrators responded five and enthusiastically recommended that other nursing homes consider adopting ECP. Only one gave a lukewarm endorsement of three-and-a-half out of five, reporting a moderate waning of interest by the second wave of units implementing the project in the home. This home is planning to convene a focus group to read the pulse of staff reaction before moving to facility-wide implementation.

All agreed the process was time and labor-intensive on the front end, more so than initially expected, but agreed that the dividends were already, or would, pay off manifold. Though in some homes these were only applicable to some disciplines, administrators cited these themes:

- time saved
- reduction in stress
- improved staff cohesiveness and mutual support
- more resident-centered care
- better communication with families
- better synchronization with other changes the nursing home was having to address

FOCUS GROUP FINDINGS

Time Saved

Every team (if not every individual discipline) agreed that the new care planning process saved time in writing care plans. Six of the eight focus groups cited time savings as the largest benefit of ECP. (Interdisciplinary communication and support for the well-being of the resident were also highly rated benefits of ECP.). Before ECP, complicated care plans could reach beyond 30 pages in length. By using standards of care, plans no longer have to repeat large amounts of information about resident conditions and treatment that are consistent facility-wide. The amount of time saved varied widely by facility depending on their processes. It also varied by discipline. Nurses consistently reported saving time. In some facilities, other disciplines did not always agree that the new care planning saved significant time.

> "It's a timesaver. It prevents a lot of repetitive information – the same thing over and over. …" – Charge Nurse

> "I really liked the idea that it wasn't going to be repetitive documentation. … I feel like we've always documented in 50 million places, and I really liked the idea that it was going to be much more concise." – PT/OT

"… When I had to write a care plan, it was such a looming thing to me … [Since ECP]; I get to be more accurate, more detailed." – RN

Easier for everyone to understand and communicate care plan

- Easier for new people on unit ; easier to train new staff
- Now you can focus on exceptions –important things jump out more
- Easier to update consistently – less room for error

Interdisciplinary care planning and communication enhanced or reinforced

- Promotes better communication between nurses and CNA's People who know the resident give input to the care plan – now direct care staff are heard more than before
- Major change in mindset accomplished to conduct truly interdisciplinary care planning
- ECP further reinforced existing interdisciplinary communication in neighborhoods
- CNA's now have hands-on easy access to SOC's

ECP is more resident-specific and resident-friendly

- Easier to see resident-specific details – "their life"
- CNAs get more information. Other disciplines get more information from CNAs.
- CNA detailed info critical. Changed focus to resident likes/dislikes, challenges.

Better care planning meetings

- ECP allows time for patient and family in the care planning meeting.
- Care conference down to one hour. Preparation shorter.

Documented and affirmed what CNA's already do

Facilitators to implementation

- Have SOC manual on every unit accessible to everyone on care planning team –especially CNA's
- SOC's are an on-going process – have process for developing new ones
- Good team – worked well together
- Interdisciplinary teams, neighborhoods deep in culture
- Lots of educational meetings
- Any level staff can suggest changes to SOCs

Delivery of care is more difficult. Residents are sicker

- Younger, and more aggressive about their care.
- More behavioral issues, more complicated medical issues. Using SOCs and exceptions makes it easier.

Barriers to implementation

- Different care planning systems (ECP and non-ECP) on different units
    - Confusing for floaters
    - Tough on staff serving units in both systems
- Resistance to change
    - Changes over years – is this just another trend?
    - Hard to let go of old habits and care plans
- Current computer system not supportive of ECP
- Not everyone in loop at start
- Difficult at first to determine difference between SOC and exception

Advice to others – "Go for it!"

- It's labor-intensive at the beginning, but worth it in the end
    - Just do it – don't drag out implementation – conversion is the hardest part
    - Develop SOCs with interdisciplinary team using the language and procedures unique to your home – common sense standards you use every day
    - Be prepared for initial angst. Changing mindset is hard.
- Involve staff – important to reducing resistance
    - Have initial overview for all staff
    - Make it interdisciplinary from the beginning
    - Address fear of losing individualization
- Need constant follow-up addressing problems early on
- Look outside the box – it's worth it!
- Be supportive of each other.
- Don't become complacent once it's in place

Facilitators' Note: We perceive, as did some of the interviewees, that there are levels of "interdisciplinary" care planning. At least three of the facilities had brought about a change in mindset. Team members recalled the old way in which each discipline basically wrote separate parallel care plans. "You didn't mess with Social Work's care plan." In these facilities, team members mentioned how they had learned from each other as they developed the SOC's and converted care plans to ECP. These changes required skillful leadership, wrestling with old mindsets, and much good will.

Two of the eight homes had implemented cover sheets for their care plans that listed personal information about the resident's life, family, occupation, education, hobbies, likes and dislikes. These psycho-social cover sheets enable you to understand the resident in a wholly different light than the "medical" care plans.)

The Implementation Process in Practice

The process of implementation varied to reflect the very different cultures and operating procedures of the homes. This demonstrates that there are many ways to implement ECP in many kinds of settings with differing levels of resources.

In a small home, the interdisciplinary team met once a week over brown bag lunches to develop the SOC's. Their DON provided support in tracking down policies and research. The group brainstormed current procedures for a particular standard and then refined them into an SOC. The DON did final tweaking and submitted SOC's to the medical director for final approval. The team found this approach time-consuming but very worthwhile. They felt that they learned more about how their disciplines interacted in addressing resident care. This was a long-standing team that met every morning before and after ECP.

By contrast, a very large home used their on-going model of performance improvement to develop SOC's. An overall Steering Committee represented leaders from each of the disciplines. Then, ten work groups were formed to develop ten SOC's. The work groups were cross-disciplinary and involved staff from different levels of the organization. They were led by an "expert" in that area. The work groups researched policies and current best practices and then drafted SOC's to submit to the Steering Committee. The Steering Committee then reviewed the drafts and made suggestions for further revisions or refinements which the work groups resubmitted for approval. The Steering Committee and work groups included staff members who were not involved with the ECP pilot. "It was a fairly laborious process" and took over two months.

In another home, a cross-disciplinary work group met each week for an hour over six months to work on SOC development. They had "homework" to prepare. At meetings, a draft SOC was projected from the computer to a screen for all to see and suggest edits. The members found this cross disciplinary communication so valuable that they have continued it as a pre-meeting for care planning meetings as they convert care plans from the old system to ECP. Now rather than preparing care plans alone in their offices without input from anyone else (and often unable or unwilling to read other discipline's care plans), they can share insights, find ways to reinforce each other's goals for residents, and focus on resident-centered interventions. The DON expressed her surprise and delight in how invested the team members are in this process. Attendance and preparation remain excellent although the DON cautioned that they were still in the "honeymoon period."

As can be seen from the discussion above, the analyses of the focus group and administrator interviews were remarkably similar, yielding information that is of great use for facilities that plan to replicate the project. This information includes:

- Implementation of ECP is time-consuming, but worth it and the project demands up-front time and commitment of leadership to avoid "resistance to change."
- The project helped to improve individualization of care.

Feared DOH objections did not materialize.