The KOllaborator

PERSPECTIVES IN ELDER CARE

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Kendal Outreach launches new *Leading Nurses* initiative

The U.S. Department of Health and Human Services has awarded Kendal Outreach, LLC, a grant of more than $800,000 to mount a nursing education, practice, and retention initiative called *Leading Nurses*.

Kendal Outreach is collaborating with Widener University (based in Chester, Pa.) on the three-year grant program, which will provide leadership training to 60 directors of nursing and registered nurse leaders working in Delaware Valley nursing homes.

Chronic turnover and performance problems in the long-term care field have fueled a quest for more effective and practical ways of developing, managing, and retaining nurse leaders. This follows a growing acknowledgement that the quality of long-term care is largely dependent on the staffing levels, competence, and performance of nursing staff.

The goal of *Leading Nurses* is to improve the care of approximately 3,750 nursing home residents. *Leading Nurses* consists of daylong training sessions each month during the first year followed by two additional years for the nurses to implement specific protocols to improve resident care outcomes.

The program will provide the participating nurses with skill sets in four key areas:

- Emotional intelligence and resilience training to help them understand themselves as leaders;
- Leadership skill development to help them manage others;
- Change management skills to help them and those they supervise embrace new methods in resident care; and
- Evidence-based clinical protocols for them to implement in their workplaces.

Throughout the three years, the participating nurses will receive ongoing support from peer mentors, faculty, and the *Leading Nurses* program staff members.

"Through this project, we have a great opportunity to profoundly impact nurse leaders and the provision of quality care in long term care in Pennsylvania, New Jersey, and Delaware."

Beryl Goldman
Project Director for Leading Nurses
Director for Kendal Outreach

Pennsylvania Restraint Reduction Initiative (PARRI) funding renewed

In August, Kendal Outreach, LLC, received a $619,380 grant from the Pennsylvania Department of Public Welfare to extend the Pennsylvania Restraint Reduction Initiative (PARRI) through June 2010. Begun in 1996 under a two-year pilot project grant to Kendal Outreach, the program has produced impressive results. When Kendal's PARRI team began its work, physical restraint use in Pennsylvania stood at 29%. By the end of 2008, restraint usage had dropped to 2.9% statewide.

Kendal Outreach staff use PARRI funds to provide free onsite consulting, training, and extensive clinical support to Pennsylvania long term care settings. To date, 31,000 individuals—91% of long term care staff in the state—have participated in services offered under PARRI grants.

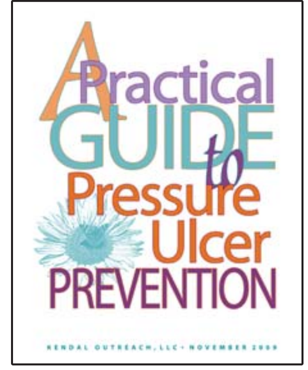
"The results of the Pennsylvania Restraint Reduction Initiative speak for themselves," says Jerome Arzt, a health insurance specialist at the Centers for Medicare and Medicaid Services.

"We are very pleased with the dramatic reduction in the use of physical restraints achieved by facilities in Pennsylvania," Arzt says. "It is exactly the type of effort and achievement that we would like to see duplicated in other states, as well. Kendal Outreach is to be commended for their part in helping to make such an impressive outcome possible and no doubt will continue to help nursing homes learn how to provide better quality of care for years to come."

Besides establishing 20 Physical Restraint Reduction Training Sites throughout the Commonwealth, PARRI has developed four major program initiatives since 1996 including:

- Providing education and clinical support on medication review and reduction leading to the establishment of three Chemical Reduction Training Sites in the state;
- Launching PA FIRST (Fall Interventions, Resources, Systems, and Training), Pennsylvania's first fall management and prevention project leading to the establishment of four PA FIRST Training Sites;
- Developing a pressure ulcer prevention program and establishing seven locations designated as Pressure Ulcer Prevention Training Sites; and
- Developing a dignity in dementia training program called CAPStone. The program incorporates team building, interactive learning, and hands-on coaching.

Kendal Outreach offers *A Practical Guide to Pressure Ulcer Prevention*



Pennsylvania has one of the highest rates of pressure ulcers in long term care facilities in the nation. In response to the high rate, a project aimed at assisting facilities to evaluate and refine their process for pressure ulcer prevention was initiated in the fall of 2007 by the Pennsylvania Restraint Reduction Initiative (PARRI), a program of Kendal Outreach, LLC.

Many long term care providers focus on wound healing, with prevention efforts being limited to common standardized interventions which address only some of the risk factors for pressure ulcer development. In addition, there is a lack of focus on the individuals who are newly admitted, readmitted or who experience a change in condition in order to identify their increased risks for developing a pressure ulcer. A complex cycle frequently occurs, where new ulcers develop, are healed, and then reoccur. The focus of the PARRI educators has been to help facilities recognize that they must put as much emphasis on a systematic assessment of risk factors and an individualized plan of care for the prevention of pressure ulcers as they do the treatment of existing wounds. Fewer facility-acquired pressure ulcers means less time spent on the treatment and documentation of those ulcers, not to mention the high costs associated with that care for supplies.

As the PARRI educators worked with long term care providers, several points became apparent. First, facilities that already had a solid process in place for the identification and treatment of wounds were able to incorporate pressure ulcer prevention strategies easier than facilities without a strong process. Second, high staff turnover wreaks havoc with pressure ulcer prevention efforts as does the lack of consistent care assignments. Third, the use of pressure ulcer risk assessments and having pressure ulcer prevention policies do not by themselves reduce the risk of pressure ulcer development. Finally, front line caregivers were often at a loss to develop new interventions on the plan of care.

To address these issues, *A Practical Guide to Pressure Ulcer Prevention* was developed by PARRI staff. The purpose of the guide is to help facilities develop a strong process for pressure ulcer prevention. It contains information that includes:

- Developing a strong team and meeting process;
- The importance of gathering relevant data;
- How to focus on basic care issues and evaluate organizational systems that drive care practices;
- Expanding the assessment focus of risk factors beyond standardized assessments to determine root cause; and
- Providing individualized interventions to reduce, modify, or eliminate risk factors.

Each risk factor discussed in the guide has quality assurance questions specific to that risk, along with

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Urinary Incontinence in Older Adults

Options for Realistic, Effective Treatment

By Diane A. Smith, MSN, CRNP

With all of the new trends in person-centered care, providing dignity is a critical foundation to care approaches, and therefore, absolute reason to treat urinary incontinence. This condition increases depression and causes residents to lose social supports. They wonder whether they "smell," and they avoid social excursions where bathrooms are not readily available. As a result of urinary urgency, frequency and leakage, residents in long-term care settings commonly refuse physical therapy, ambulation and social events.

Staff members who are not in tune to the medical condition may inaccurately label residents with incontinence as "lazy, demented, depressed or socially inappropriate." They typically order a psychiatric consult, which leads, in turn, to inappropriate treatment with use of unnecessary [anticholinergics] medication, which can cause somnolence, lethargy or increased falls. So the treatment of this problem for both resident and staff remains at the center of how we develop assessment criteria leading to appropriate and effective care.

Among residents who live in long-term care settings, urinary incontinence is and has been a common and undertreated problem. Symptoms are often ignored because staff members believe that incontinence management is time consuming or that affected patients are too frail for proper assessment and treatment. Neither of these misperceptions is true, and it's time to correct them. The scope of this issue is large: More than $3 billion are spent annually on the management of incontinence for residents in long-term care settings.[1]

Not a Benign Problem

Incontinence is more common in older adults than osteoporosis, cancer or heart disease.[2] Due to its high prevalence, the medical community often views incontinence as a benign problem that does not require evaluation or treatment. In reality, incontinence is not benign at all.

Most falls by older adults occur en route to the bathroom as they rush to relieve an urge to void, especially at night. If they urinate on themselves on the way to the bathroom, they may slip on the urine and fracture a hip. Falls often result in hip fractures and increased pain; the sequelae from the fall may even lead to death.

Eighty-five percent of women who undergo hip replacements subsequent to a fall experience chronic incontinence. But if urgency, nocturia and incontinence are treated before a fall occurs, pain, suffering, nursing home placement and significant expenditure can be avoided.

Older adults with incontinence tend to experience more urinary tract infections (UTIs) than those without the condition, especially when the incontinence is also fecal or the resident has frequent loose stools (usually secondary to constipation management).[3] UTI rates improve when incontinence is treated. Vaginal atrophy is known to cause urgency, frequency and urge incontinence, yet how many women with incontinence receive a simple vaginal exam and treatment for atrophy?

Examination is Key

Many urologic symptoms may appear straightforward, but the source of the problem is not always the urologic system. Most older adults in long-term care facilities do not receive the examination or evaluation that would identify the true cause of urologic symptoms.

First look at the history of the resident. Has s/he had uterine prolapse, benign prostatic hyperplasia (BPH), bladder surgery, falls, fracture, bladder or prostate cancer? Does the resident have urgency, frequency or nocturia? Does he or she have dementia, depression, or unexplained behaviors (e.g., crying that it hurts to urinate but no infection is apparent)? Does the resident call out to be toileted, even after he or she has just been to the bathroom? Is the person incontinent despite toileting?

All residents with incontinence require a physical examination. In women, pelvic exams should be conducted to look for a prolapsed vagina and or atrophy. Symptoms of vaginal atrophy are frequency, urgency and incontinence. In men, a prostate exam might reveal enlargement, asymmetry or pain on palpation.

The abdominal exam may identify pain, tenderness, hernia, masses, or abnormal peristalsis. If constipation is a problem, the abdominal pressure from a large retained stool can cause symptoms of urgency, frequency, or even urinary incontinence or retention. Treatment of constipation is an

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Diane A. Smith, a women's health nurse practitioner, is senior vice president and clinical director for Silvercare Solutions [www.silvercaresolutions.com]. Silvercare provides on-site continence care services in long term care settings.

(*Urinary Incontinence in Older Adults*, *continued from page 3*)

important first step to resolve the patient's incontinence.

Diagnostic Testing

Three simple tests are the hallmarks of evaluating geriatric incontinence: post-void residual, urine specimen examination, and a cystometrogram (CMG).

The post-void residual should be less than 100 cc. If it is higher, check for medications that can cause retention. Consider incomplete bladder emptying secondary to neurologic causes such as diabetic neuropathy, stroke, Parkinson's disease, vertebral fracture or damage from disease, injury, or osteoporosis. If it is occurring as a result of medication or a reversible cause such as chronic constipation, modify the medication regimen or reduce or eliminate the constipation.

Next, a urine specimen examination should be performed. A catheterized urine specimen that is positive for leukocytes or nitrates is not the only indication of a possible urinary tract infection (UTI). Antibiotics have many side effects, so treatment of bacteriuria should not be routine. If the positive urine is accompanied by a change in gait, mental status, heart rate, body temperature or a recent sharp increase in urgency or incontinence, send the specimen for culture and treat appropriately.[4] The significance of a urine sample that is positive for nitrates or leukocytes is not simply the presence of bacteriuria; it is an indication of dehydration, which is common in this population.

The CMG is a low-risk procedure, much like a simple catheterization and filling of the bladder. It can greatly enhance the diagnostic process.[5] After determining the capacity and stability of the bladder, medication therapy can be safely recommended for a resident who complains of urgency and frequency and the possible etiology of vaginal atrophy or overactive bladder can be identified.

Repeat the CMG if the resident has a change in symptoms or stops responding to the treatment plan. Many things can change the geriatric bladder over time (particularly stroke or vertebral fracture), and re-evaluation is suggested to complete the reassessment.

The following sections outline common diagnoses and treatment plans in the older adult population.

Atrophic Vaginitis

Vaginal atrophy is known to directly affect the vaginal health of postmenopausal women. This condition reflects decreases in systemic estrogen. It affects half of menopausal women and even more during postmenopause.[6] Symptoms of vaginal atrophy include vaginal dryness, increased vaginal itching, frequent urinary tract infections and dyspareunia. Decreased estrogen also directly affects urinary continence. In this situation, urinary flow rate is reduced, residual volume is increased, bladder capacity is reduced, and urethral closing pressure decreases.[7] The development of these urogenital symptoms is directly linked to chronic discomfort and negatively affects quality of life, even extending to social isolation.[8]

For decades, estrogen replacement has been the recommended treatment for vaginal atrophy.[7] Numerous studies have examined the safety and efficacy of the various forms of estrogen delivery, but significant confusion continues about which method, if any, is safe.[8] To ascertain the safety and efficacy of treating vaginal atrophy with a low-dose estrogen ring, we conducted a review of recent literature.

Examining Resident Risks

Studies have demonstrated that estrogen delivered in vaginal rings (Estring) does not cause excessive proliferation of the uterine endometrium.[9] These findings are likely related to the low estrogen dose necessary for adequate outcomes.[9]

In the past, the use of unopposed estrogen was believed to increase breast cancer incidence. More recent research suggests that this is not the case. This thinking may be related to older studies that did not include mammography follow-up as a control. New research suggests that estrogen alone has either no effect on breast cancer risk or decreases it.[10] As previously stated, the Women's Health Initiative documented a decrease in the number of breast cancer diagnoses when patients were treated with low-dose, estrogen-only preparations.[8]

Furthermore, a large study of more than 10,000 postmenopausal women concluded that treatment with conjugated equine estrogen (CEE) alone for 7.1 years did not increase breast cancer rates, and despite this, researchers recommended more frequent mammography screening.[10] Lastly, estrogen use was associated with an 8% decrease in breast cancer incidence in postmenopausal women in a large screened population.[11] The control group received no hormonal treatment.

Studies of the relationship between venous thrombosis risk and estrogen replacement therapy have produced mixed data. A study published in 2006 closely examined venous thrombosis risk in patients who took CEE. The results were similar to that of the Women's Health Initiative: A 3.49% risk for venous thrombosis was reported in the first 2 years of CEE use. This rate decreased to 1.91% after 2 years of use.[12] The Women's Health Initiative also concluded that venous thrombosis risk increases with age and obesity. In the 2006 study, the CEE group had a higher BMI and older average age.[13] Therefore, a limitation to this study may be the lack of differentiation among these factors in the control group. Of note, the majority of patients in the control group or the CEE group were not taking aspirin or statins at the time the study was conducted.

A 2005 study documented 75% improvement in vaginal atrophy in 126 women who used a vaginal estrogen ring. Quality of life and the burden of urogenital symptoms were closely monitored in this 12-month study, and women showed a significant preference for the vaginal ring as a delivery vehicle for estrogen replacement.[13]

Overactive Bladder

Symptoms of urge urinary incontinence, or overactive bladder (OAB), include leakage, urgency, frequency and nocturia. CMG testing often shows that the bladder exhibits

early sensation (before 100 cc of water) and bladder contraction or contractions with or without leakage before 200 cc. Therefore, OAB is often associated with detrusor or bladder instability. Because these symptoms often benefit from anticholinergic medication, they can be treated easily.

OAB symptoms are similar to overflow urinary incontinence. In the geriatric population, failure to evaluate with at least a post-void residual can result in worsening OAB and lack of bladder emptying. When suggesting a medication for OAB, efficacy and side effect profile are necessary considerations. The true efficacy of many of these drugs may not be apparent for 12 weeks.

BPH and OAB

In most men, the prostate enlarges with age. The symptoms of BPH in older men are largely ignored by healthcare providers, especially when dementia is present. Symptoms of BPH include urinary hesitancy, but this may not be apparent if the resident cannot adequately describe his symptoms. When symptoms of urgency, frequency, nocturia and leakage are present, a prostate exam is indicated, as well as a post void residual for proper assessment. When the post-void residual is below 100 cc and symptoms are present, a simple CMG can often confirm the diagnosis of OAB.

If a patient's BPH is assessed adequately, and the post-void residual is normal but symptoms persist, OAB is a probable diagnosis. In such a case, simple CMG can identify detrusor instability, which can be treated by an OAB medication.

Dementia, stroke history and neurologic disease do not preclude proper assessment or treatment of urologic pathology.

Stress Incontinence

Stress incontinence occurs when pressure on the bladder exceeds the closure pressure of the urethra and produces urine leakage. This pressure is exerted by movement, coughing, sneezing or laughing. Women often experience stress incontinence when they have pelvic muscle weakness and estrogen depletion.

Pelvic muscle exercises can improve pelvic strength and reduce urine leakage, but the exercises do not improve pelvic muscle tone if they are not performed correctly. Incorrect performance of exercises (e.g., Kegels) is common.

Several studies have identified the benefits of biofeedback for the management of stress urinary incontinence.[14] A reduction in incontinence episodes can be achieved if the resident practices pelvic floor exercises with the assistance of biofeedback in as little as two weeks.

Overflow Incontinence

Symptoms of overflow urinary incontinence are urine dribbling, frequency and leakage. The diagnosis is apparent when the post-void residual is greater than normal, usually exceeding 400 cc. This can be secondary to neurologic or transient causes as well as vaginal prolapse or BPH. Management consists of identifying the cause and either eliminating it or treating the medical condition.

When the cause is truly neurologic and the bladder has no tone, intermittent catheterization is preferable to chronic indwelling catheterization. This is because the bladder is usually a sterile place. Once a catheter is in place for more than 48 hours, chronic bacterial invasion is guaranteed. This exposes the resident to urosepsis, stone formation and pyelonephritis. A catheter is not a benign treatment and should not be used to manage incontinence or any urologic symptom. For the resident with an indwelling catheter, treat the reasons for retention, and discontinue the catheters soon as possible.

A suprapubic catheter is preferable to a urethral catheter because it prevents urethral erosion. Urethral erosion and bladder spasms are the primary reasons for chronic catheter leakage. A suprapubic catheter does not eliminate or diminish the risk of infection, bladder or kidney stones, or pyelonephritis.

Functional Incontinence

When someone experiences incontinence because he or she cannot get to the bathroom on time but the bladder is functioning normally, he or she is experiencing functional incontinence. If a toileting program, with proper assistance each time the resident requires help, does not decrease the resident's incontinence, functional incontinence is unlikely and a thorough assessment should be performed. Careful assessment of: the resident's ability to ambulate and transfer, with appropriate therapy to maximize function; examining their environment for safe ambulation to the toilet; identifying the transient causes such as constipation, delirium, UTI; under- or un-treated pain; and depression are all imperative in addressing effective treatment of functional incontinence.

Putting it into Practice

The diagnosis and treatment of urinary incontinence in the older adult population is a natural fit for nurse practitioners. NPs can formally establish practices focused on this clinical area—or add it to services they already provide. The Society of Urologic Nurses and Associates recently adopted an official scope and standards of practice for a role called "advanced practice continence nurse in long-term care." Details are available on the society's Web site at www.suna.org.

References

1. Klausner A, Vapnek J. Urinary incontinence in the geriatric population. Mt. Sinai J Med. 2003;70(1):54–61.

2. Schiller JS, et al. Summary Health Statistics for the U.S. Population. National Health Interview Survey, 2003. Vital Health Stat. 2005;224:1–104.

3. Bjornsdottir L, et al. Urinary incontinence and urinary tract infections in octogenarian women. Acta Obstet Gynecol Scand. 1998;77(1):105–109.

4. Nicolle L, et al. Infectious Disease Society of America guidelines for the diagnosis and treatment of asymptomatic bacteriuria in adults. Clin Infect Dis. 2005;40(5):643–654.

5. Ouslander J, et al. Simple versus multichannel cystometry in the evaluation of bladder function in an

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(*Guide to Pressure Ulcer Prevention*, continued from page 2)

co-morbidities which may affect that risk factor, and specific suggestions for interventions, both at a facility and resident-specific level. A CD accompanies the guide, which includes sample assessments, tools, and educational posters. The series of posters were developed to help reinforce important points of pressure ulcer prevention. These can be printed by facility staff from the CD for their use. *A Practical Guide to Pressure Ulcer Prevention* can be used on the nursing unit or taken to pressure ulcer prevention meetings to assist staff with ideas for care plan interventions.

PARRI staff would like to thank the Pennsylvania long term care facilities who participated in the pressure ulcer prevention program and were the inspiration for the guide. They include:

- The Vincentian Home, Pittsburgh
- Redstone Highlands Health Care Center, Greensburg
- Rolling Fields, Inc., Conneautville
- Riverwoods, Lewisburg
- Guardian Elder Care Center, Nanticoke
- Landis Homes, Lititz
- Thornwald Home, Carlisle

A Practical Guide to Pressure Ulcer Prevention will be available for purchase after January 2010. To order e-mail Kashmira Narinesingh-Smith at knsmith@kendaloutreach.org.

PARRI welcomes new training site

Congratulations to the staff at the Thornwald Home, Carlisle, Pa., as PARRI's seventh official Prevention of Pressure Ulcers Training Site. As a training site, Thornwald Home staff will be offering training programs to long term care staff in their geographic area. Thornwald Home presented its first training day workshop on September 21.

For more information, contact Diann Snyder, Director of Nursing, at dsnyder@th.ucc-homes.org or 717-249-4118.

PARRI can be reached at parri.kendaloutreach.org.

Thornwald Home staff receive a Certificate of Recognition honoring their commitment to becoming a Prevention of Pressure Ulcer Training Site. From left are: Linda Bartholic, RN, ADON; Kathy Lebo, RN, Nurse Supervisor; and Diann Snyder, RN, DON.

New Kendal Outreach staff member

Since the last issue of *The KOllaborator*, the Kendal Outreach, LLC, consulting team has had the opportunity to welcome and work with Kashmira Narinesingh-Smith, the new executive assistant.

For those of you who have already "met" Kashmira, either face to face, by e-mail or phone, I'm sure you found her to be just the right person to calmly assist you with requests for programs and resources, and provide you with general answers to questions related to care and services for older people. For those of you who haven't interacted with Kashmira yet, you will find that she is detail-oriented and will competently focus on your particular situation, being certain that you receive the answers you seek. Please do not hesitate to contact her at knsmith@kendaloutreach.org or 610-335-1280.

—Beryl Goldman, Director for Kendal Outreach

(*Urinary Incontinence in Older Adults*, continued from page 5)

incontinent geriatric population. J Urol. 1988;140(6):1482–1486.

6. Pastore LM, et al. Vaginal symptoms and urinary incontinence in elderly women. Geriatrics. 2007;62(7):12–18.

7. Kelley C. Estrogen and its effect on vaginal atrophy in postmenopausal women. Urol Nurs. 2007;27(1):40–45.

8. Women's Health Initiative Steering Committee. Effects of conjugated equine estrogen in postmenopausal women with hysterectomy. JAMA. 2004;291(14):1701–1712.

9. Sarkar N. Low-dose intravaginal estradiol delivery using a Silastic vaginal ring for estrogen replacement therapy in postmenopausal women: a review. Eur J Contracept Reprod Health Care. 2003;8(4):217–224.

10. Stefanick M, et al. Effects of conjugated equine estrogens on breast cancer and mammography screening in postmenopausal women with hysterectomy. JAMA. 2006;295(14):1647–1657.

11. Kerlikowske K, et al. Prognostic characteristics of breast cancer among postmenopausal hormone users in a screened population. J Clin Oncol. 2003;21(23):4314–4321.

12. Curb J, et al. Venous thrombosis and conjugated equine estrogen in women without a uterus. Arch Intern Med. 2006;166(7):772–780.

13. Weisberg E, et al. Endometrial and vaginal effects of low-dose estradiol delivered by vaginal ring or vaginal tablet. Climacteric. 2005;8(1):83–92.

14. Holroyd-Leduc JN, Straus SE. Management of urinary incontinence in women: clinical applications. JAMA. 2004;291(8):986–995.

"Would it be helpful to know...that you're using good information to develop support programs and resources that will help your residents live healthier, more satisfying lives?"

Would it be helpful to know:

- The most common disease diagnoses? Medications? Healthy living challenges on your campus or ministry site with your independent residents?
- Whether there is a need to address depression (improved resilience), fall prevention, and/or incontinence with your independent residents? (Yes, it's quite common for independent residents to be challenged by incontinence.)
- Which independent residents need the most assistance and in which particular area(s)?
- That residents are developing healthy aging goals and plans to address them based on a thorough assessment conversation?
- That you're using good information to develop support programs and resources that will help your residents live healthier, more satisfying lives?
- Whether you're providing resources and assistance that target areas of greatest need?

Of course it would!

What is COLLAGE?

COLLAGE, The Art & Science of Healthy Aging, was created in 2005 as a joint venture between Kendal Outreach, LLC, a not-for-profit subsidiary of The Kendal Corporation, and the Institute for Aging Research at Hebrew SeniorLife, a not-for-profit organization affiliated with Harvard Medical School. COLLAGE is a customized suite of standardized and systematic assessment instruments that evaluate health and wellness in areas such as memory loss, nutrition, balance, and mental well-being. The information is collected in a national repository and disseminated to a consortium network consisting of continuing care retirement communities (CCRCs), congregate senior housing sites (both market rate and subsidized), and senior service agencies. COLLAGE reports are provided to members on two platforms: individual resident assessment and organizational performance assessment of individual housing sites or service centers that seek effective interventions, preventive programs and focused services.

The collected and analyzed data provide a framework to incorporate ongoing, systematic, and integrated assessment practices combined with evidence-based interventions in order to improve:

- The ability of older adults to remain independent;
- The overall quality, consistency, and continuity of health services across all levels of care;
- The effectiveness of programs and services; and
- The organization's ability to plan for the changing needs of older adults.

Comments about COLLAGE

"COLLAGE actually embraces all of the principles of quality first that AAHSA has put out there over the past five years. It focuses on an evidence-base, collecting good information, using good data to make better decisions, and gathering data and sharing data across organizations so that people really understand where they are improving and where they still need to do the work. There is no way to get to quality without engaging in the kind of work that COLLAGE allows organizations to do."

—Robyn Stone, Executive Director, Institute for the Future of Aging Services (IFAS) and Senior Vice President of Research, AAHSA, Washington, D.C.

"COLLAGE is a gigantic program for us. It gave me a chance to analyze what has happened in my life, what is going on today and will continue to give me hope for the future. COLLAGE gave me an opportunity to rethink my life. I feel lucky—life isn't easy but because I'm here there are opportunities to positively share and plan for the future."

—Resident, Kendal at Ithaca, Ithaca, N.Y.

"We now have access to information about our residents' health risks, and tapping into this offers us a treasure chest of data to guide decision making about the kinds of programs and services we ought to be developing. We are ecstatic about what the new reports will help us achieve."

—Denise Dickinsen, Vice President of Planned Growth and Development, Lutheran Homes of South Carolina, Irmo, S.C.

Aging services organizations have historically relied on intuition, anecdote, and precedent to make critical health and wellness decisions about their residents and clients. The challenge is that quality services can only be developed and delivered when the paradigm shifts—when providers understand the value, power and necessity for good data to drive program development, organizational benchmarking, quality improvement and good decision making.

COLLAGE, The Art & Science of Healthy Aging
An integrated assessment tool and person-centered process to advance healthy aging and improve outcomes. Go to www.collageaging.org to learn more about membership, features, benefits, webcasts and demos. Or, contact COLLAGE at nberesin@collageaging.org or 610-335-1283.

CAPStone: Improving the bathing experience for elders

CAPStone—Creative Approaches, Person-centered Solutions—a program developed by Kendal Outreach, LLC, helps caregivers to provide a person-centered approach to bathing. The goals of the program are to provide resources, tools, and education for long term care staff to develop an ongoing, specialized bathing program. In so doing, the process of bathing moves from being viewed as a "task" to a meaningful, person-centered, and pleasurable experience. The program uses evidence-based knowledge and interventions to address the emotional and physical needs of the person receiving assistance with bathing.

Program Design

CAPStone is an eight week program consisting of education, coaching and mentoring of staff members, and an environmental assessment. It was piloted in a skilled nursing facility where techniques were tested and the components of the program were refined. As a result of the pilot, several key factors were identified including:

- The important role of communication in all levels of the organization;
- The important role of licensed nurses to empower direct care staff to implement changes; and
- The importance of using a person trained in bathing observations to maximize consistency of observations and resultant feedback.

In June 2008, introductory letters and program applications were mailed to all skilled nursing facilities in Pennsylvania, outlining the purpose and goals of the CAPStone bathing program. Thirty-three skilled nursing facilities applied to participate. A total of eight were selected to participate in the project over a one year period.

One nursing unit in each facility was targeted for intensive assistance, with the understanding that the facility would develop a plan to disseminate knowledge throughout the facility after completion of the program. A staff member was chosen by the facility to coordinate implementation of the program and recruit staff to serve on the Bathing Team. The facility coordinator participated in all bathing observations, made suggestions in bathing techniques, assisted in demonstration of alternative bathing techniques (Towel Bath), and was given the authority to make any necessary changes in bath schedules. In turn, the coordinator was responsible for monitoring the resulting changes in resident plans of care. To help the program succeed the coordinator also identified ongoing educational needs of the staff and ensured that any necessary products were available.

The Bathing Team included at a minimum: one nursing assistant from both day and evening shifts; the unit charge nurse; the staff development/education person; and a representative from social services. Other staff members could be added as determined by the facility. In considering who should participate, the coordinator looked for staff having the desired traits which included good interpersonal skills and the ability to work effectively with their peers. The Bathing Team was expected to:

- Attend weekly Bathing Team meetings
- Record, transcribe, and distribute minutes of the weekly meeting to all members
- Disseminate knowledge and information to team members who missed a meeting
- Develop a plan for in-service and training of staff on other units within the facility

The Bathing Team identified residents who became upset and agitated during baths and/or showers. Family members were contacted by facility staff and signed consents were obtained for an observation of the shower or bath by Kendal Outreach staff. Observation of the bathing experience was critical for pinpointing the time the undesired behavior occurred, which allowed staff to determine the probable trigger for the behavior. Once the trigger was identified, interventions could be determined and implemented to modify or eliminate the trigger, thus improving the experience for both the resident and staff. A staff person, usually a licensed nurse, was trained to do the observations so the facility could continue the practice after the formal program ended. The person being trained to do the observation had to be the same person for all observations.

Kendal Outreach educators provided coaching and mentoring of staff following the bathing observation, identifying potential behavioral triggers and offering recommendations for eliminating those triggers. By brainstorming after the bath/shower while it was fresh in participants' minds, creative ideas were suggested for modifying the bath/shower. This was also an opportunity for providing positive reinforcement and feedback, as well as coaching staff members on communication techniques or challenges which were observed during the bath.

During the weekly Bathing Team meetings, staff identified the challenges they faced and were given the opportunity to discuss how to address the issues. In some sites, smaller sub-groups of the Bathing Team formed and tackled areas of concern, researched the challenges, and brought possible solutions to the larger group. The interventions were re-evaluated and revised by these teams as needed.

Education was essential to changing staff attitudes and practices with bathing. Educational programs led by Kendal Outreach educators addressed the importance of person-centered bathing, the bathing environment specific to that facility, and offered alternative bathing approaches and techniques. Team members were able to integrate knowledge from the inservice as they worked to develop individualized bathing plans for the residents. The Bathing Team assessed the bathing environment and made plans for improvements to enhance the environment. Some facilities needed very few environmental changes while others painted and redecorated to create a more esthetically pleasing bathroom.

To facilitate continuity of the program, another function of the team was to develop a training plan to

The Bathing Team at Kendal Crosslands, Kennett Square, Pa., includes (from left): Mark Austin, Pat Wood, Barbara Erb, and Danielle Martin. (Not shown are Lisa Sweeney and Michelle Blevins.)

educate staff on other nursing units after the eight week program was completed. As each facility had different needs and resources, it was important to have the facilities individualize their respective programs to ensure the successful dissemination of the program and reflect the unique characteristics of their facility.

Lessons Learned

Throughout the CAPStone project, the facility outcomes have supported the evidence-based information present in the literature—specifically, identifying those common behavioral triggers that create difficult bathing experiences for the resident and staff. These triggers include:

- The approach/communication between resident and staff member;
- The resident's experience of being cold;
- The resident's experience of pain or discomfort;
- The lack of privacy; and
- The unexpected spray of water on the body.

Approach/communication between resident and staff

This trigger included both the approach of the caregiver and the manner in which the caregiver communicated with the resident. Examples of this trigger would include such things as "telling" a resident he had to take a bath, talking to the resident in a condescending manner, or disregarding a resident's complaints. It is interesting to note that during bathing observations, the behavior that had been identified by staff as being problematic was rarely seen. The infrequency with which this occurred suggested that the approach and communication between the staff person and the resident was different when the staff person was aware that they were being observed.

The resident's experience of being cold

This trigger was evidenced by resident complaints of being cold or visible signs of feeling cold, such as shivering or holding oneself. This occurred at any point of the bathing experience, and could be attributed to the temperature in the bathroom, the water temperature, or the feeling of air on a wet body.

The resident's experience of pain

Pain or discomfort can be demonstrated through either verbal complaints or non-verbal indicators such as behaviors. Observation for non-verbal signs of discomfort was especially important, as many residents with dementia are unable to articulate feelings of pain or discomfort. Behaviors noted during movement, striking out during care, or rubbing or bracing a joint are all potential triggers indicating pain.

The lack of privacy

Residents in skilled nursing facilities are often afforded little privacy during bathing. Issues related to privacy included: being undressed by another person when the resident did not understand what was happening; being naked in front of strangers; staff members who were not participating in the bath walking into the bathroom for another purpose; or having more than one bath/shower going on at the same time in the same bathing room.

The unexpected spray of water on the body

Staff members spraying water on the resident without warning them would almost always elicit undesirable behavior. Particularly sensitive areas were the genitals and the head/face.

Conclusions

The success of the CAPStone bathing program illustrates the need for changes in current bathing practices in long term care. Through education, a team approach, coaching and mentoring of direct caregivers, a person-centered approach to bathing can be accomplished. The end result is a more meaningful and pleasurable bathing experience for both the residents and caregivers.

ABOUT KENDAL OUTREACH: Kendal, the pioneer of restraint-free care, has 35 years of management and operational experience in the development and execution of comprehensive approaches to safe, individualized care practices that have led to successful outcomes for many organizations. Whether exploring programs to improve existing practices or addressing challenges, our consultants offer guidance and processes specific to organizational needs across the continuum. Kendal consultants have over 100 years combined LTC experience; they currently serve as educators with the Pennsylvania Restraint Reduction Initiative and formerly served as educators with the Pennsylvania Nursing Care Facilities Best Practices project. The long-standing value of maintaining the autonomy and dignity of the frail, elderly person through resident-centered care underlies Kendal's dedication to promoting the well-being and quality of life of those served.

Kendal in Chicagoland

Artist's rendering of The New Admiral at the Lake—a 31-story continuing care retirement community to be built on the shore of Lake Michigan just 10 minutes north of downtown Chicago.

In July, The Kendal Corporation and The Admiral at the Lake, in Chicago, entered into an agreement under which Kendal and The Admiral are continuing a process of collaboration that began in April 2009. Kendal will provide development and marketing support to The New Admiral at the Lake, which will become one of Chicago's newest Life Care/Continuing Care Retirement Communities.

The Admiral, a not-for-profit provider of senior living and health care services, has the longest history of serving older adults in Chicago—150 years. The Admiral approached Kendal, asking for assistance in re-positioning its historic mission on the same site it has occupied since the 1960s, at the corner of Foster Avenue and Marine Drive, which sits on the border of the Uptown and Edgewater neighborhoods at Chicago's lake front.

Drawing its name from the historic hotel that it once occupied at that site, The New Admiral at the Lake will emerge as a 31-story community offering even more dramatic views over Lake Michigan. The new community will continue its service to one of the most interesting and diverse neighborhoods in the U.S.

This collaboration works due to the fact that Kendal's values resonate deeply with those held by The Admiral and its board, staff, and residents. The mission, history, and multi-dimensional attractiveness of this opportunity are compelling, and Kendal is moving swiftly to help The Admiral successfully complete its development plans with the ultimate goal of welcoming The New Admiral at the Lake as an affiliate in the Kendal System.

Dining service options for long term care residents

Residents make the decision to move into a long term care setting for many different reasons. For some it can be a matter of personal choice, but for a vast majority, the main reason for moving is a major health occurrence, which the family does not feel that they can handle at home. Loved ones are critical in helping our residents make the decision of where they will live. For this group an important attribute is "not to feel guilty" about the place into which their loved ones move.

A community has to appeal to both of these generations. The hospitality department plays a very important role in this effort. As residents move into such communities they worry that they are losing much of the control that they had, but the food and the hospitality experience is one area that can allow them to have the same semblance of life that they had before.

Residents and their families want a community that will offer an opportunity to live a full lifestyle in a home-like environment. This paradigm shift is necessary and critical for the growth and continued success of the community.

Implementing such a model of service enhances the dignity and well-being of residents, allows them spaces to socialize and interact with staff and other residents, and gives them some say and control over their environment.

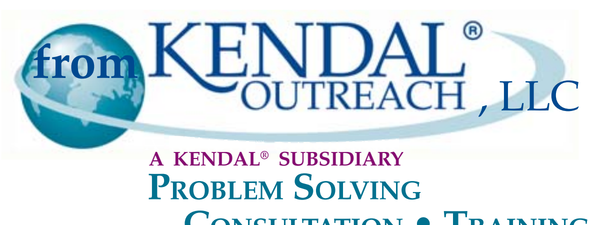
One way to offer residents this kind of service is the "Country Kitchen" concept. This dining concept has been implemented in several communities around the country and has been instrumental in increasing resident satisfaction. In such environments, dining programs play a very important role in community life. Country kitchens are designed to look like residential kitchens, with a few commercial pieces included to facilitate service.

We want the residents to feel like they are in their own kitchens at home. A thermal shelf used to serve the food is inset into a counter that looks just like a residential counter at home. In many cases this area can be set up as an island, which, when not in use, can be used for social activities such as cooking demonstrations, etc.

This arrangement eliminates the need to send out menus beforehand and allows the residents to select their meal based on their immediate preferences. This system also allows the residents to enjoy their meal at their own pace, while ensuring the products are served at the optimum temperature. In addition, meals can be served over a longer period, allowing residents to dine at their convenience or according to their preferred schedule or routines.

An added benefit of the county kitchen concept is that it allows staff to work together in serving the residents' meals. Foodservice staff typically plate the food, clean soiled dishes, and reset the area for the next meal while staff members (including nurse aides, nurses, etc.) help serve and seat the residents. This process fosters an environment rich in harmony and camaraderie.

(continued on page 11)



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Kendal Outreach, a subsidiary of The Kendal Corporation, is a not-for-profit consulting provider specializing in creative solutions for health care clients primarily devoted to long-term care.

The pioneer of restraint-free care, Kendal has over 35 years of management and operational experience in the development and execution of comprehensive approaches to safe, individualized, care practices. Whether exploring programs to improve existing practices or address challenges, our consultants offer guidance and processes that can lead to successful outcomes for your organization, your staff, and the people you serve.

The long-standing value of maintaining autonomy and dignity of the frail, elderly person through resident-centered care underlies our dedication to promote the well-being and quality of life of those served.

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- Single-issue analysis
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Areas of expertise

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- Medication Review
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- Depression
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- Structuring Consistent Care Giver Model

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We tailor programs to meet your unique needs.

For more information, visit **www.kendaloutreach.org** or call Kendal Outreach at **610-335-1280.**

(*Dining Service Options*, *continued from page 10*)

This is a win-win proposition for the residents and the staff. Besides giving residents more dining choices, the country kitchen concept creates an environment similar to what they had at home. Implementing these changes helps assure that the dining experience at communities will never be considered institutional again.

About the Author

Taizoon S. Jhaveri, Director of Strategic Initiatives and Development for Culinary Design Service, is a seasoned hospitality industry professional and a content expert on creating hospitality programs for the senior living market. He is an internationally known speaker and author often invited to present information on dining programs, trends, and the role of hospitality services in senior living. For more information, e-mail mjhaveri@iammorrison.com or call 800-686-6323, extension 5416.

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From the perspective of a physician, researcher and former Chief of the Health of the Elderly Programme for the World Health Organization, Dr. Knight Steel will address the "big picture" health issues of our time and their impact on aging services organizations. How do leaders use healthy aging outcomes to make good decisions that positively impact consumers? How do leaders improve their capacity to develop an effective, dynamic organization in a rapidly changing, and often conflicting landscape of information and interests? This presentation, sponsored by Kendal Outreach LLC, was given during the American Association of Homes and Services for the Aging's (AAHSA) 2009 Annual Meeting in Chicago. To download the podcast, go to www.kendaloutreach.org.

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Pressure Ulcer Prevention:
A Systems Approach
1:30 P.M. EST (60 minutes)
January 12, 2010

Behavioral Challenges in Long Term Care:
A Forum
1:30 P.M. EST (60 minutes)
February 9, 2010
Note: The format of this webinar is a forum—the presentation will be developed from questions solicited from, and submitted by, registered participants prior to the session.

Physical Restraint Use in Long Term Care—
Still Holding Us Back
1:30 P.M. EST (60 minutes)
March 9, 2010

Person-centered Dementia Care:
Life Histories and Memory Books
1:30 P.M. EDT (60 minutes)
April 13, 2010

"So You Say You're Not in Pain…?"
1:30 P.M. EDT (60 minutes)
May 11, 2010

Fees
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