Culture Change Collaborative
Colorado Grant Project 2010-2011 Summary

A Civil Money Penalty Distribution Grant was awarded by the Culture Change Accountability Board to Edu-Catering to work with twenty nursing homes that would volunteer to be a part of an almost one year collaborative implementing at least three culture change practices.

A formal announcement was emailed by the Colorado Culture Change Coalition to its list serve members on 8/17/11 with a deadline of 9/24/01. Only 11 homes applied. A second announcement was sent on 10/4/10 that the deadline was extended until 10/22/10 and two criteria waived that both the administrator and director of nursing be in place at least two years. By the extended deadline, 22 homes applied, were selected and sent Welcome letters.

The Artifacts of Culture Change measurement tool was co-developed by Edu-Catering (C. Bowman) under contract with CMS and CMS (Karen Schoeneman) released by CMS for public use in 2006. This tool was used for two reasons: 1) it reflects 66 culture change practices and homes were asked to chose three of them, and 2) each item and the entire tool itself holds a measurement which could be evaluated later. Each home was asked to complete the Artifacts tool online at www.artifactsofculturechange.org also contributing to the national data bank being created by the Pioneer Network.

Edu-Catering worked in collaboration with the Colorado Culture Change Coalition in announcing the project and hosting both the midway and end-celebratory events together.

One goal was to have homes represent the various counties and geographical locations throughout Colorado. Using the breakdown of the CCCC regional chapters, of the 22 homes, 8 were in the Denver Metro, 1 in the Northern (Greeley), 3 in the Northeastern (Brush, Akron, Wray), 2 in the Western Slope (Grand Junction, Gunnison) and 7 in the Southern (Pueblo, Colorado Springs, La Jara, Homelake, Las Animas).

Criteria for selection included:

- Consistent staffing is established in the home.
- A commitment letter is signed by the administrator and DON agreeing to:
- Complete the online Artifacts of Culture Change measurement tool.
- A Culture Change Collaborative team comprising of at least the administrator, DON, a direct care nurse, a direct care giver, a team member from dining services, housekeeping, therapy, social services and activities, and a resident agreed to meet at least every other week to work on identified items.
- Develop at least three Artifacts items over approximately one year and committed to an internal Action Plan every team meeting.

- Ideally the whole team but at least three members of the Culture Change Collaborative team committed to participating in an initial conference call to learn how to use the Artifacts tool, a first quarter conference call which focused on ideas on overcoming resistance to change per several homes' request, an in-person midway conference which focused on the areas chosen by all homes as well as barriers and solutions, a third quarter conference call and a celebratory event at one of the CCCC chapter meetings where the team shared their journey with others (most over a Power Point venue).
- A brief summary of steps taken/steps to be taken quarterly.
- Completion of the online Artifacts of Culture Change a second time.

The first conference call was almost a two hour call reviewing each of the 79 Artifact items (66 culture change practices and 13 outcome items) and everything known about each. Thankfully, responses were positive: "This was so helpful, gave us fresh eyes and we found this very helpful and the resource list." "I learned so much! Very exciting!" The second call addressed the number one barrier being identified, overcoming resistance to change. Thankfully response was positive: "Great telephone conference! My people gave good feedback."

An in-person midway conference was held 1/28/11 in collaboration with the regularly scheduled CCCC Denver chapter meeting. This grant paid for the cost of renting the Summit Conference center for the CCCC meeting and subsequent grant workshop and for morning refreshments. The CCCC educational offering in the morning was a review of Colorado's unique Medicaid P4P reimbursement program which ended up being perfect timing for the homes in this project as they turned their attention to person-directed, culture change practices. The rest of the day was approximately a four hour event which addressed any barriers identified and covered each of the 28 areas/Artifacts chosen in detail. Three culture change experts from our state were invited and shared their expertise: Maxine Roby, Diane Goode, and Beth Irtz. Although representatives from each home had planned to be there, in the end four homes were unable to attend. Thankfully response was positive: "Thank you for the great education program. Our staff stated they had learned a lot and this was very educational and informative."

Although team conference calls were offered to each of the 22 homes, only 11 arranged for one. Thankfully response was positive: "Our community meetings still continue to evolve- our phone conference with you really helped give light to new ideas for encouraging our direct caregiver's participation." "Thank you for the teleconference, your advice was very beneficial." "Thanks for the call-our team enjoyed it." Interestingly enough, the last team conference call was with Bent County and they were the only team to invite two elders to attend.

The last quarterly call was held 4/15/11. This call covered all the outstanding items committed to in this project. It also explained the end celebratory events and what is

being asked of each home to share. It also was used to answer questions either posed prior or during the call. Homes were also encouraged to think about how to sustain their efforts after the project is over. Thankfully response was positive: "Thank you we got a lot of really good ideas (for resistance to change)."

Each home was invited to share their journey story at the June CCCC Chapter Meetings. Six homes did not share: 3 dropped out officially, 3 never returned calls/emails. Three of the CCCC rural chapters asked for the day to be expanded into more and the topic of the Creating Home II National Symposium on Culture Change and Food and Dining was selected and presented making it a full day event.

The following were the advertisements for each:

Wednesday, June 8, 2011 Northern CCCC Chapter
Meeting at Bonell Good Samaritan Village
708 22nd St. Greeley 970-352-6082
9:00 am to 3:00 pm
9:00 am to noon - Stories and Results of the Culture Change Collaborative CMP Grant
One of the grants awarded in the first round of CMP grants was the Culture Change Collaborative project. 22 Colorado nursing homes signed up and committed to choose and then work on, as a team that includes residents and family members, three "artifacts" or culture change practices over the one year time frame. They also agreed to complete the Artifacts of Culture Change measurement tool both in the beginning and at the end of the project. Come hear some of the stories and results while being encouraged in your own culture change journey.
Homes Sharing their Story
Bonell Good Samaritan - Greeley
Woodridge Terrace – Commerce City
Networking Lunch 12:00 to 1:00 pm
1:00 pm to 3:00 pm Workshop
Creating Home II National Symposium on Culture Change and the Food and Dining Requirements – Recap and Results
Carmen Bowman, CMS Contracted Facilitator of Creating Home II
and CCC Grant Project Director
Workshop and lunch are FREE. Please RSVP to Carmen Bowman at **carmen@edu-catering.com** by June 3.

Friday, June 10, 2011 Northeastern CCCC Chapter
Meeting at Eben Ezer Lutheran Care Center
122 Hospital Road, Brush 970-842-1702
9:00 am to 3:00 pm
9:00 am to noon – Stories and Results of the Culture Change Collaborative CMP Grant
One of the grants awarded in the first round of CMP grants was the Culture Change Collaborative project. 22 Colorado nursing homes signed up and committed to choose

and then work on, as a team that includes residents and family members, three "artifacts" or culture change practices over the one year time frame. They also agreed to complete the Artifacts of Culture Change measurement tool both in the beginning and at the end of the project. Come hear some of the stories and results while being encouraged in your own culture change journey.
Homes Sharing their Story

Eben Ezer Lutheran Care Center - Brush
Hillcrest Care Center - Wray
Washington County - Akron

Networking Lunch 12:00 to 1:00 pm
1:00 pm to 3:00 pm Workshop
Creating Home II National Symposium on Culture Change and the Food and Dining Requirements – Recap and Results
Carmen Bowman, CMS Contracted Facilitator of Creating Home II and CCC Grant Project Director. Workshop and lunch FREE. Please RSVP to Carmen Bowman at **carmen@edu-catering.com** by June 3.

Wednesday, June 15 Western Slope CCCC Chapter
Meeting at Gunnison Living Center
10:00 am to 3:00 pm
10:00 am to noon – Stories and Results of the Culture Change Collaborative CMP Grant
One of the grants awarded in the first round of CMP grants was the Culture Change Collaborative project. 22 Colorado nursing homes signed up and committed to choose and then work on, as a team that includes residents and family members, three "artifacts" or culture change practices over the one year time frame. They also agreed to complete the Artifacts of Culture Change measurement tool both in the beginning and at the end of the project. Come hear some of the stories and results while being encouraged in your own culture change journey.
Homes Sharing their Story

Colorado State Veterans Center Homelake
Eagle Ridge of Grand Junction
Gunnison Living Community
Rio Grande – La Jara

Networking Lunch 12:00 to 1:00 pm
1:00 pm to 3:00 pm Workshop
Creating Home II National Symposium on Culture Change and the Food and Dining Requirements – Recap and Results
Carmen Bowman, CMS Contracted Facilitator of Creating Home II and CCC Grant Project Director
Workshop and lunch FREE. Please RSVP to Carmen Bowman at **carmen@edu-catering.com** by June 8th.

Thursday, June 23, 2011 Southern CCCC Chapter

Meeting at Hildebrand Care Center in Canon City
1401 Phay Ave. 719-275-8656
2:00 – 4:00 pm - Stories and Results of the Culture Change Collaborative CMP Grant
One of the grants awarded in the first round of CMP grants was the Culture Change Collaborative project. 22 Colorado nursing homes signed up and committed to choose and then work on, as a team that includes residents and family members, three "artifacts" or culture change practices over the one year time frame. They also agreed to complete the Artifacts of Culture Change measurement tool both in the beginning and at the end of the project. Come hear some of the stories and results while being encouraged in your own culture change journey.
Homes Sharing their Story

- Bent County HealthCare Center – Las Animas
- Horizon Heights Care Center - Pueblo
- Mount St. Francis Nursing Center – Colorado Springs
- Springs Village Care Center – Colorado Springs
- Union Printers Home – Colorado Springs
- Village at Skyline – Colorado Springs

Friday, June 24 Denver CCCC Chapter
Location TBA
9:00 am to 11:00 am - Stories and Results of the Culture Change Collaborative CMP Grant
One of the grants awarded in the first round of CMP grants was the Culture Change Collaborative project. 22 Colorado nursing homes signed up and committed to choose and then work on, as a team that includes residents and family members, three "artifacts" or culture change practices over the one year time frame. They also agreed to complete the Artifacts of Culture Change measurement tool both in the beginning and at the end of the project. Come hear some of the stories and results while being encouraged in your own culture change journey.
Homes Sharing their Story

- Allison Care Center - Lakewood
- Cedars Healthcare – Lakewood
- Covenant Village - Westminster
- Mountain Vista – Wheat Ridge
- Park Forest Care Center - Westminster
- Sandalwood – Wheat Ridge
- Uptown Care Center - Denver

Regarding the presentations, feedback was positive:
"My staff loved going to Canon City for the presentation! I was so proud of them!"

Evaluation is an important component to any grant and of course was to the CCAB. The following are the tools and attempts used to capture any measurements possible.

The Artifacts of Culture Change (ACC) measurement tool

The ACC tool is a widely used culture change assessment tool used by nursing homes that will be a focal point of this collaborative. Under contract with CMS, the Artifacts of Culture Change tool was co-developed by this author under contract with CMS and Karen Schoeneman of CMS in 2006. It is a tool designed to capture the concrete changes homes make that reflect a changed culture, changes in attitude, policies and practices to be more resident-directed. A full report called Development of the Artifacts of Culture Change Tool explains the rationale for developing the tool, the point scale and has a large Source Information table. The Source Information gives backup for each item, where it exists around the country, as well as any research found which supports it. The Development report, the Artifacts tool itself and the first Artifacts Benchmark Report 3/10-4/11 are available at the Artifacts' own website www.artifactsofculturechange.org hosted by the Pioneer Network. The tool is comprised of the following six domains with a point structure that gives the following potential totals for each: Care Practices 70, Environment 320, Family and Community 30, Leadership 25, Workplace Practice 70, Outcomes 65, Total points 580.

The ACC was used to capture a baseline point total for each of the 22 homes and to capture progress in approximately one year's time, actually 10 months, with a second Artifacts score. It was hypothesized that point totals would be increased. The same analysis can be made of each subsection/domain point totals. The tool also becomes a goal setting tool and indirectly serves to educate staff and residents of nursing homes of what can be.

Each of the original 22 homes did complete the Artifacts tool upon application.
In the end, 13 homes submitted a second Artifacts score. In every case, the scores were improved: +14, +26, +32, +36, +39, +42, +52, +53, +59, +73, and +77 with an average of 47 points more.

One of the most incredible outcomes of this project is that in every case except one, points were much higher than the expected 15 points more (three areas, 5 points usually for each area). Here are responses as to why:

"We did more than the three areas required because it is the right thing to do. I think it has to do with changing the mindset of everyone. By doing so, we begin to look for other ways to improve the culture. The reason for a higher score is that we worked on a number of other items as well without including it in our regular discussions, i.e. removal of nurses station, beginning to use I in the care plans and I have been here longer so we got more points under the turnover of administrator sections to name a few."

"We added extra programs in massage therapy, aroma therapy, etc. This all helped with the State Survey concerns as well, we got tagged for pain management."

"The mindset changes so the Artifacts went up."

"The Artifacts of Culture Change was a good tool to get the ideas from and to think outside the box. I have given the tool to each neighborhood coordinator now for idea generating and encourage each neighborhood to think outside the box. Our Artifacts Tool score at the onset of the project was 212. When we completed another tool at the end of the project our score was 251! How satisfying it was to see concrete evidence that our efforts were worth it. As it turns out, we ended up working on more culture change items than just what we did for the project."

"Completing the Artifacts was quite a process, an eye opener, helps to zero in, drill down and creates a much more personalized life than residents are accustomed to. Even the MDS 3.0 is not as specific to life as the Artifacts tool."

Medicaid P4P

An attempt was made to evaluate each home's Colorado Medicaid P4P points at the start and end of the project. Only 3 had applied for P4P scores before and after the project and all improved: from 44 to 66; from 73 to 90; and from 78 to 100 out of a 100 possible total. Most of the project's homes have now indicated they will apply for Medicaid P4P reimbursement. One home said they were going to roll their team's work for this project into working on Colorado's P4P requirements.

Speaking of Medicaid money, because of a focus on open and restaurant dining Union Printer's Home was reminded of, and brought out, the china dishes that were paid for by ResQUIP Medicaid monies years ago and were not being used.

Clinical Measurement – QI/QMs

Although each home's Quality Indicator/Quality Measures were collected at the start of the project, due to the advent of the MDS 3.0 and not yet being updated by CMS, they could not be collected at the end of the project.

Administrator Self Assessment

There are not that many measurement tools available but one found seemed applicable to this project. The Ideal Administrator Self Assessment was developed by the American College of Health Care Administrators based on its Principles of Excellence for Leaders in Long-Term Care Administration. The assessment focuses on the following areas of leadership: focusing on the mission of the long-term care facility; creating a culture of quality; ensuring residents' well-being; being solicitous of caregivers; creating a home; and practicing sound financial management. For each of these areas, administrators respond to a series of questions about how often over the past 12 months they have exhibited a certain behavior. For example, on a scale of one to five, they say how often they have encouraged residents to participate in care planning, have a choice in bathing or eating, access to snacks, use of permanent staff assignments and many other

person-directed/culture change practices. All 22 homes completed the assessment upon admission. In the end, 7 administrators completed it again (3 homes had a change in administrators, 3 dropped out, 3 never returned emails or calls, the remaining just never submitted the second assessment by the end of the project). In each of the seven, total scores improved: +3, +15, +24, +26, +33, +57, +69 with an average of 32 more points. These improvements were especially exciting and impressive as none of the areas of this assessment were specifically focused on but as a result of being exposed to person-directed/culture change ideas, many administrators became aware and made changes for residents increasing choice, including them in decision making and more. This is a very exciting "side effect" with regards to measure in this project.

"As for the self-assessment, I think it was because I was such a new administrator-only 5 months in this job-when I did the first one. It really raised my awareness for where I needed to go and what I needed to work on. Now, a year into this position, I have a better handle on it. I will be very interested to see how the managers evaluate me and compare it to what I did." (This administrator gave the Ideal Administrator Self Assessment to all her managers to rank her anonymously – wow.)

Anecdotal Feedback from Participating Homes:

"Was a good experience to go through all this." Bonell

"Thank you so much for a wonderful meeting last week and for all your support and positive encouragement as we implement culture change in our home! The project was an amazing success and we are so grateful for your positive energy and attitude!" Gunnison

"Thanks to our efforts to change the culture, falls are less, behaviors are less, and staff members are less stressed. Over all the feeling in the building is better." Woodridge

"This has been an incredible experience. We are mostly excited about our residents having increased decision making. Thank you for the opportunity to participate in this project." Eagle Ridge

"We had families at our first meeting. Their response was very good, very enthused. It was rewarding talking to them." Union Printers

"Residents have told us, 'we really appreciate you listening to us.'" Uptown

"We have enjoyed being a part of this wonderful change. Thank you. Thank you for everything. This truly has been a very beneficial program. It has brought life to our facility and our residents. It has had ups and downs but we continue to work through it

and continue to move forward for what is in the best interest of our residents and staff. Thank you again." Colorado Veterans Home Homelake

"We appreciate being a part of the culture change coalition grant project. We feel it helps to make change happen and improves the quality of life not only for the neighbors who live at Eben Ezer but the staff who provide care to the neighbors who live here."

"The Union Printer's Home (UPH) culture change journey started with the involvement in the Culture Change Collaborative CMP Grant (CCCG). Although it was realized some culture change directives were already in place, the CCCG was instrumental in exposing the staff to what culture change means and entails. Discussion had taken place among administration about culture change but the decision to start was frequently postponed; a better time to start would come along later. The CCCG project provided UPH administration with the 'jump start' needed to 'just do it'. We are sustaining our momentum with Culture Change by focusing on applying for Pay for Performance. We also have become involved in the Southern Colorado Culture Change Coalition to keep us inspired and involved! Committing to this project with the summaries, calls, and meetings kept the core committee focused and held us accountable to complete the goals set. Once started, the response from the residents and staff was encouraging, convincing the committee to stay on the journey. There is no turning back!"

Observations/Lessons Learned
I have observed that it is pretty amazing what a commitment can result in, how it can bring change, that part is simple. The hardest part is that a grant project manager is not anyone's boss or parent and has no authority to make any home do anything, i.e. submit reports, etc.

One "good problem" was encountered. One home chose open dining and in their discussions with residents turned their attention on the ambiance of dining. This is of course wonderful. The only dilemma it caused is that dining ambiance is not reflected on the Artifacts tool potentially reflecting zero points. When trying to explain this to staff on a phone call, because they are less familiar with the Artifacts tool, it probably looked as what the residents want doesn't which is of course not true. Just an interesting dilemma noticed in this project.

Additionally, I observed at our in-person midway meeting that as the homes heard the other practices chosen by other homes, they want to do them too, beyond the three areas they chose. Then the final increased Artifacts scores revealed that most homes did also adopt other culture change practices during the course of less than a year.

Suggestions and Feedback
Homes were asked for any feedback as well as suggestions they would make regarding this project idea:

Sandalwood Question Responses:

1. Was this collaborative project valuable to you as a team, to your staff, to your residents? If so, how? Sandalwood did find the project valuable it really helped us to focus on smaller changes that also trickled into other opportunities for improving the culture. It was also the first time we had been introduced to the Artifacts tool- We plan on working towards all artifact points.

2. Would you do it again? If so, why or why not? Sandalwood would participate again. It was a great way to organize our excitement and fuel our energy to improve our culture for the residents and staff.

3. Would you encourage other teams to join such a collaborative project? Yes!

4. What would you suggest be done differently if such a project happened again? Another in person meeting- we really enjoyed sharing and learning about what other communities are doing.

5. Has this project encouraged you to sustain your efforts? Will you? How? Yes- our goal is to chip away at each artifact we fill will help improve the culture of our community.

Eben Ezer Lutheran Care Center Question Responses:

1. Was this collaborative project valuable to you as a team, to your staff, to your residents? If so, how?

Yes, this project was valuable to our team. It helped by giving us resources and encouragement to do things that we might not have done without the project.

2. Would you do it again? If so, why or why not?

Yes, we need to keep moving forward with culture change and this would be a help to use.

3. Would you encourage other teams to join such a collaborative project?

Yes we would encourage others to join because of the benefits of working and sharing thoughts and ideas with peers.

4. What would you suggest be done differently if such a project happened again?

Perhaps a visit in person or via telephone mid way in the project for additional support. We would also want to have greater accountability at our community. When our NHA did not follow through on some items we lost momentum.

5. Has this project encouraged you to sustain your efforts? Will you? How?

We have a long way to grow. The Artifacts tool is a good roadmap to continue the culture change journey.

From Union Printers Home:

This project was extremely valuable to our facility, staff and residents as it was the jump start we needed to begin our journey of culture change. We would not be where

we are today if we were not involved in this grant. It gave us a place to start and guidance along the way. It was a perfect way to enter our journey. The intrinsic value of beginning a culture change journey is priceless. I believe I can speak for our staff and residents in that we would do it again in a heartbeat! The positive outcomes alone would be worth doing it again and again. Every facility could benefit from a project like this but especially those who are new to their journey. We gained helpful advice, instruction and direction through the networking with other facilities. The meeting with all of the facilities together was most beneficial for the information we received on how other facilities were implementing their culture change. Having one or two more of these would be helpful. Doing the summaries along the way kept us accountable for what we were doing. This project has also encouraged us to 'stay the course'. We became excited with our successes which lead us to continue our culture change efforts by focusing on applying for Pay for Performance. We also have become involved in the Southern Colorado Culture Change Coalition to keep us inspired and involved! There's no turning back!

Bonell gave the recommendation to require the Culture Change Collaborative teams meet twice a month instead of every other week as that is not always possible.

Sustainability
Homes were asked what they planned to do to create sustainability:
"We are going to continue to work on culture change, to form a new committee with more residents and family members and meet twice a month."

"We are putting in a third dining area in the east end and we are also adding raised garden beds in all resident court yards" (in other words, choosing new practices).

"Overall our initiatives have been received positively and we have had smooth transitions. We will continue to meet as a team monthly to review progress and look at more initiatives to continue our Culture Change journey."

"Even though the project is wrapping up- Sandalwood is not. We have gained momentum and drive to continue conquering/improving each artifact. We are very proud of our accomplishments of opening a general store, encouraging community gatherings and making positive changes to our dining program. Even though the dining was not a complete success of the initial goal (working on our open dining program) it was still successful in making improvements to the ambiance, culinary presentation and choices for our residents. The team has decided to begin looking at memorializing our residents and celebrating their lives. We wish to thank you for the opportunity and look forward to presenting our project successes and learning opportunities."

Replication
An expectation of each home was sharing their story in detail at the ending celebratory events thus encouraging, almost expecting, sustainability for their three chosen areas.

The sharing of their journey hopefully affected and inspired staff of listening homes to implement some of the changes learned about thus spreading sustainability to other Colorado nursing homes.

In addition, this report will be distributed to the CCCC and Pioneer Network for at least posting on their websites. Replication may then take place via Colorado and this project becoming a model for other states to follow. Cathy Lieblich of the Pioneer Network, State Coalitions Coordinator, has asked me to present the summary of this project on a future Coalitions Networking call August 26, 2011.

Impact to Residents
At least three areas of quality of life are being affected for residents of 22 homes, approximately 2200 residents to some degree, even for those residents of the homes that dropped out of the project hopefully. Residents and staff are being included in decision-making regarding at least the three areas chosen and we have evidence now of many more areas. Some teams chose more than three required areas from the beginning (8 homes, approximately 800 residents). As indicated above, many homes ended up incorporating many more culture change practices during the course of the project reflected by huge score increases.

The ending celebrations turned into all-day trainings for three of the five chapter meetings which gave further impact to team members and ultimately residents they represent that were able to attend.

18 other homes represented at meetings = 1800 residents, approximately
22 project homes = 2200 residents, approximately
Approximately 4000+ other residents impacted around the state.

Practices Implemented and Lessons Learned

Various dining styles (Artifact #1) – 13 homes
These 13 homes selected open dining or restaurant style with menus. None selected buffet, family style or 24 hour dining.

Mt. St. Francis decided to offer their continental breakfast in the ice cream parlor to "shake it up" and draw attention to it and to vary the offerings and transform into a coffee shop. One home offered early coffee which was a big happy deal for everyone by having pump pots of coffee/hot water all day, everyone loves it. Adding snacks to the area next. Homes learned that enhancing dining affects all systems.

Sandalwood is creating a "food mood" and staff are "secret shoppers" learning their residents' food desires. Wow.

Bonell realized they had to work in "breaking roles" (silos) in order to serve residents better.

Although Eben Ezer only designated one dining area to have open dining times, this has morphed into more options in each dining room.

Derik Breiner, Culinary Services Manager at Gunnison Living Community says, "The more you have a dialogue with the residents the better the food will be accepted and the better the food will taste."

Springs Village added a doorbell to the kitchen for residents to order anything they want at any time. Administrator says, "get them anything they want, you are the dietary department."

Union Printers started order from the menu. 1st day – 20 orders, 2nd day 40 orders, 3rd day – "I was too busy to count." They also say they are "not wasting near as much food." Although they started with breakfast only, it has morphed into all three meals.

Guardian Angel (#50) – 8 homes
Gunnison Living Center advertised and highlighted that the Guardian Angels would get 30 minutes a week paid time to visit with a resident, put a picture in each resident's room, and sent a letter to family members explaining the exciting new development.

Titles used: Ambassadors, Buddies, Guardian Angels, Birthday Angels, Buddies.

Bent County Buddies:

- Each elder is assigned one individual and one alternate back-up staff member to act as their Buddy.
- Buddies will talk with elder a minimum of twice per week, may contact family once a month.
- The elder's Buddy will talk to their elder or family, if needed, to see what the elder would like to do for their birthday.
- "In frequent contact" to address potential issues, share stories, write letters, attend special events, shop, give encouragement.
- Attend care conferences if elder/family desires.
- Should elder/family indicate a concern forward to appropriate manager.
- Top Ten Things to Know: Buddy discovers ten things to know about elder.
- Two stories: An elder had a friend in the community who would come and take her, but she became ill and could no longer take her. So the elder's buddy stepped in and comes in on his day off to take her to and from church every Sunday. Another story is an elder who was transported to the hospital and was at the end of her life. The elder had no family or friends to be with her at the hospital during this time. Her buddy went to be with her and became her

advocate while she was living out the last few hours of her life. The employee did this by knowing what her Buddy's preferences were. Such as warm blankets, combing her hair, playing music for her, and holding her hand.

The Colorado Veterans Home at Homelake created Guardian Angels for residents.

- Planned to rotate quarterly but didn't want to switch that soon.
- Names drawn at community gathering.
- Special events: Christmas ornaments, Old Fashion Family Christmas Dinner.
- Meet on a regular, spontaneous basis. Close relationships have formed as a result of the program.

Lessons learned include:

- Pair people more strategically instead of drawing names from a hat, or let staff pick.
- Don't force anyone, respect those who feel they cannot find the time.
- Needs a coordinator to coordinate.
- Some feel do not have supervisor's support, fear getting in trouble.
- B/c started with events, less focused on 1:1.
- Be creative with rewards/competitive nature.

<u>Individualized birthdays (#4) – 6 homes</u>
Caution: beware of doing the same new special thing for everyone.

Bent Co - Elder's Buddy talks to their elder/family to discover birthday wishes.

Eagle Ridge – Administrator and activity director took one resident out to dinner at Red Lobster for his 100th birthday. On the weekend his family had a party for him. "I feel the individual birthdays have been the biggest success. Not only has it enhanced the residents lives, but it has also added to our employees lives. We really enjoy the planning with the resident as well as the party itself."

Mt. St. Frances offers favorite meal at meal time of choice. One resident chose Eggs Benedict for breakfast, "I've never seen that man so happy."

Bowling, square dance, 101 balloons released in honor of a 101 year old birthday, a fiesta for an elder Hispanic heritage and although he is typically only mobile in his wheelchair, he was up and dancing.

Covenant Village developed Birthday Angels. Staff sign up for resident birthdays in the next month. They were already used to inviting staff members to be Christmas Angels so flowed perfectly out of that. For one resident, a tiara was placed on her head, balloons on her walker and although she does not speak, she sang Happy Birthday and other favorite songs all day long.

CNAs attend care conference (#48) – 4 homes
Range of possibilities: Get info from CNAs - come for 5 minutes – 15 min. - stay whole time. "We tried covering only ADLs first with the CNA but something else always came up later." "It makes me feel more involved to be in care conference because I know my residents."

CNAs at Covenant Village have said they can now care for the residents better. They love hearing what the therapists are doing and having a bigger picture.
Covenant Village CNA quotes:
"Care conferences give us an opportunity to interact with families more and to be involved at a higher level."
"I like that we can give input because we are the ones who give the most direct care."
"We know them and spend the most time with them, but now we get to really know who they are, their history and their family. It's a great opportunity."
"It's an excellent idea to have CNAs attend care conferences because we are the ones closest to the residents and know them best…we know what's normal for them and we can quickly identify when something is wrong."
"It's great to be able to hear from others and to hear the plan of care directly. Then we can also help to communicate important information out to other CNA's."

A visitor at a CCCC meeting says he calls CNAs, "Certified Nursing Angels." Very apropos.

"The CNAs are amazing with their input."

Waking/retiring times chosen by residents (#9) - 4 homes

Remember this is not just a good idea but is required:
Tag 242 Self-determination and participation. The resident has the right to:
1) Choose activities, schedules, and health care consistent with his/her interests, assessments and plans of care;
2) Interact with members of the community both inside and outside the facility; and
3) Make choices about aspects of his or her life that are significant to the resident. As of new guidance in 2009, providers are to be *actively seeking preferences,* choice over schedules important to the resident i.e. waking, eating, bathing, retiring. And if resident is unaware of the right to make such choices surveyors are to determine if home has actively sought resident preference info and if shared with caregivers.

Eben Ezer visited with each neighbor, added to questions asked by admission staff
And added answers to CareGuides and CarePlans.
Next phase for any home might be simply not waking people up.
Hillcrest team wisely pointed out "we have always run our SCU without waking residents" and if it can be done there, it can be done anywhere.

Baked goods (#3) – 3 homes
Commonly used were bread machines and convectional ovens. Foods being baked in conventional ovens include: cinnamon rolls, pizza, and cookies. Homes discovered that when you contract to order cookie dough from the Otis Spunkmeyer company, you get the oven for free.

Mountain Vista scheduled times for staff to do baking and also utilizes families and volunteers. They are using the baking as natural aromatherapy: bread before breakfast, and coffee brewing throughout the day. At Hillcrest, they have also gone beyond baked goods only using blenders for smoothies and a soft serve ice cream machine which is a big hit.

Store/gift shop/cart available for residents to purchase gifts, toiletries, snacks, etc. (#31) – 3 homes
"Sandalmart" at Sandalwood and held a Grand Opening.
Hillcrest in Wray invited the owner of the downtown Granma's Treasures gift shop to have a satellite gift shop in the nursing home. What a great way to bring the community into the nursing home. Encouraged every home to do the same or have *the* gift store to go to in their nursing home and to create a coffee shop that rivals those in the area.

Community meetings (#52) – 2 homes
Sandalwood now has a Joke Master who has a "Joke Off" every community meeting. Concerns at Resident Council are less. They also sing "On the Sandalwood (Sunny) Side of the Street" each meeting.

Bathing without a Battle techniques used (#10) – 2 homes
Focusing on the Bathing without a Battle techniques resulted in other ideas such as personalized bathing care plans, resident driven décor, redecorating and new bath tubs purchased for residents. One home shared that some staff/families doubt the value of the bed bath thus indicating the need to educate and educate some more. Throughout the project I encouraged homes to expose all staff to the Bathing without a Battle video in order to encourage ideas for individualizing care in general. One final report indicated, "We've gotten some ideas for person centered care outside of bathing."

I care plans (#14) – 2 homes
Uptown converted to I care plans by doing 3 a month and experienced amazing support from the IDT. The administrator admitted, "I never thought this would be such a huge thing and when I discovered the detail, the dialogue and the prompts for personal accountability, I realized it was huge." Administrator also tells staff if they take the time to read the care plans that are now so good, she will give them a lotto ticket.

Staff is not required to wear uniforms or "scrubs" (#58) – 2 homes

Residents know staff by relationship. "No one needs to be made to feel sicker than they are." One home's corporate office would not allow them to stop wearing uniforms/scrubs. The other home did change the policy and practice that uniforms are not required but some staff members still choose to wear them, it was not forced upon staff to not wear them.

Home warms towels for bathing (#35) – 2 homes
Eben Ezer turned towel warming into blanket warming as well and has been well received. One resident has said, "Is that blanket warm? If not, don't give it to me." Staff team has now changed their approach to offer a warm blanket to everyone and if don't want, won't give instead of asking if they want one since they have been so well received.

At Bonell, when CNAs were asked what is needed re: bathing they said, "More time with residents," "don't rush them." Residents said, "bathing is not my favorite thing in this building," "It's cold here. You have your clothes on (to staff)." Now take more time, more focus on resident, as well as warming towels.

Awards given to staff to recognize commitment to person-directed care, e.g. Culture Change award (#61) – 2 homes
At Mountain Vista awards are given at monthly culture change meeting, also using a suggestion box.

Activities, informal or formal, led by staff in other departments (#60) – 2 homes
Bonell had terrific success with this. Staff members are found playing cards or Dominoes with residents. The home transformed old nurses' stations into low islands where residents, families and staff can and are found visiting, sharing a cup of coffee or playing a game. The activity director shared that one day she told staff of one neighborhood she was going to go get flowers for their flower beds and the staff member replied, "we already did."

One neighborhood has gotten very focused on checker games and has deemed it men only. Games may go on for hours. One resident plays as strategically as in Chess. One staff member did many things on her own time in other words "off the clock" such as makeovers and dancing. Now she does all these things "on the clock." Without being asked, the dining staff team pitched in and made decorations for a Big Daddy's Diner event. A new CNA was "caught" playing Dominoes only three weeks into her new job. The activity director acknowledged that staff, during orientation, are doing their job to indicate to new staff team members it is okay. It was profound that a "newbie" felt this comfortable even during probation. Bonell's motto is "Take the time because these people might not be here tomorrow." Four non-English speaking team members are taking ESL so they can interact with residents as much as possible.

Regularly scheduled intergenerational program at least 1/wk (#42) – 2 homes
Colorado State Veterans Home implemented:

- Baby socials, every other month with theme. "The ladies, especially, really like to hold the babies and talk with them."
- Middle school Book/Pen Pal Club
- Weekly children's reading hour
- Monte Vista Kids connection. 4th and 5th grade, every other week
- As a change in culture, we are experimenting with more involvement of staff's children in our home. There has become an understanding and respect of the evolving needs of children, parents, schedules and the need for our neighborhood family to have consistent intergenerational relationships. During work hours, staff occasionally brings their children to visit and interact with their neighborhood family.
- We continue to encourage staff to integrate their own children into our intergenerational lifestyle by bringing their kids to work with them when possible.
- One of the evening shift aides brings her middle-school aged son to work with her twice a week. He helps call the Bingo numbers, he reads to residents, visits with them and watches TV with them, to mention a few of the activities that he participates in.
- Many other staff bring their children when it works into their schedule and workload, regardless of the age of the child. We have all the way from little babies to teenagers coming.
- Relaxing rigid ways. As long as it is not abused, and not bad for the kids or bad for the residents, staff member gets permission and we make a plan as to what the child will do.
- "Grand Friends"
- "There seems to be a general feeling of greater comfort in our home when the children are here, and like something missing when they are not here. Our staff feels comfortably bringing their kids to work with them. The kids are comfortably around the residents and the residents look forward to the kids being here. We hope to have a playground someday on our campus so that kids from the community can come at any time to enjoy our wonderful home. We are working on putting a junior volunteer program into place and are going to continue with the highly successful programs that we already have going. We have lots of interest and enthusiasm in our intergenerational programs and feel like the sky is the limit in this area."

At Bent County where there is an onsite child day care, different age groups interact with the elders. When it is one age group's day not to visit with the elders, they still beg to. The team agreed they now have created their own built in accountability thanks to the children meeting more regularly with the elders than before the grant project. "Now the kids are so used to it, they want it."

Overhead paging system turned off or used only in case of emergency (#40) – 1 home
Messages get to the right people via: phone speaker systems, walkie talkies, pagers, voice mail, cell phones and wireless call and communication systems such as the Vision Link Wireless Nurse Call System. Staff of homes with overhead paging turned off say it is: quiet, like home, and peaceful.

Home arranges for someone to be with dying resident at all times (unless prefers alone) (#12) – 1 home
Companions for the Dying at Mt St Frances where they are also utilizing Guardian Angels and this has gone well for residents without family. Part of Guardian Angel duties at Mountain Vista.

Memorials, remembrances held for individual residents upon death. (#13) – 1 home
Mt. St. Francis is using 5 Wishes document to explore, reformatted care plan to include end of life discussions wishes and also discussing in care conference.

Aromatherapy offered (#5) – 1 home
Mountain Vista now includes in their activity interest assessment prompts to discover resident preferences.

Performance evaluations include support of resident directed care (#66) – 1 home
Mountain Vista learned that they needed to add culture change to their mission statement and educate staff to goals and department directors in conducting new performance evaluations in order to support this change.

Computer/Internet access, including adaptations such as large keyboard/touch screen (#32) – 1 home
Colorado State Veterans Home at Homelake now has in house wireless internet, a web-cam, Skype and email for residents, a digital stereo headset, a large, touch screen monitor, oversized keyboard residents order movies from Netflix, are having a hoot with the wii, and have asked for help in creating their own Facebook page, and have asked for web surfing and computer 101 classes.

Heat lamps, panels or equivalent in bathing areas (#34) – 1 home
Bonell learned that infrared heat lamps with shielded light bulbs are needed so if water sprays the bulbs will not shatter, ceiling mounted, bring about energy and cost savings also.

Residents or family members serve on QA (#49) – 1 home
At Uptown, they started with one resident only and quickly realized needed one from each neighborhood. The residents come to the first part of the QA meeting where anything is discussed regarding the whole building, not individual residents. "When I talked to residents about what they like most about it, they say that we want their input."

Closet rods accessible (#24) - 1 home
Eagle Ridge team shared, "It was very inexpensive and has made such a difference in our residents' lives. All of the residents that wanted the closet rods are very happy with them. We had a couple of people that didn't want a low rod so we made no changes in their rooms. One resident just 'toodles' in her closet now, happily."

CNAs consistently work with the same residents (#55) – 1 home – dropped out of project

Career ladder positions for CNAs (#62) – 1 home – dropped out of project

Cafe (#45) – 1 home - dropped out of project

Snacks/drinks are available at all times i.e. pantry, refrigerator, snack bar (#2) - 1 home – dropped out of project

Three profound quotes also summarized the value of such a project:

"It has been challenging keeping up momentum in the midst of survey and POC (Plan of Correction) - I whole heartedly agree that this journey does not stop when our regulators enter our home - I need to be better at leading the pace and pushing forward despite deficiencies/POC - as the leader if I can make this happen my team will follow."

"I was going to wait to get on a cc journey 'til after the new year and realized I can't."

"We have struggled with the implementation of a full program committed to culture change and this program **will provide us with the discipline necessary**."

In the end, that was the key that such projects give homes the opportunity to apply *the discipline necessary* to make moves, to make changes that improve lives, to consider new practices they have been meaning to implement. The culture change movement in general and even the Artifacts tool has recently received some criticism from leaders in the movement. It is true that sometimes programs that do yield good results end up being the low hanging fruit some homes stay contented with. However, the ultimate goal of culture change is deep transformational change. A good example is how the residents at Parkview Care Center in Denver, Colorado live. When budget cut decisions need to be made, they are … by the residents who live there. That is an example of deep transformational change from institutional to self-directed just like every person lived before they moved into an institution.

So while it may be true that some changes are only superficial and small is also true, as discovered in this project, that when homes make a commitment to make changes, even just three of them, it does impact the changing of an institutional culture. One form of evidence of this is anecdotal statements such as:

> We did more than the three areas required because it is the right thing to do. I think it has to do with changing the mindset of everyone. By doing so, we begin to look for other ways to improve the culture. Bonell
>
> Sandalwood did find the project valuable it really helped us to focus on smaller changes that also trickled into other opportunities for improving the culture.

The other form of evidence of this is the increased points on the Artifacts of Culture Change tool, many way beyond the anticipated 15 point increase (most of the Artifact items reflect a point total of 5 points X three areas = 15) with, in fact, an average increase of 47 points. Additionally, the increase in the Ideal Administrator Self Assessment scores (average of 32 more points) was another "side effect" piece of evidence reflecting changed thinking, mindset and culture.

It was an honor to get to do this experiment: to get to encourage homes to consider changes and to get to watch them grow, to see improvements to residents' and staff team member's' lives. Hopefully as a result of the CCAB's funding of this project, these homes and other Colorado homes will continue to make changes and perhaps this project will be replicated in other states, perhaps again in our own as well, impacting many more residents' and staff team members' lives for good. Thank you to the CCAB for making this possible.

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