

PEAK



2.0

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Notes from PEAK 2.0 Coordinator



“Success is where preparation and opportunity meet.” –Seneca

Evaluations are nearing their end and it is time to begin putting together your action plans for your next PEAK year. Did you know there are lots of resources to help you develop your action plan? We recommend exploring the Action Planning Resources tab on our website: <https://www.he.k-state.edu/aging/outreach/peak20/action-planning/>. You can find sample action plans, planning tools, the action plan template, and even step-by-step action planning worksheets for each core. We are always anxious to help homes navigate and fully use these resources, so do not hesitate to reach out to one of our team members if you have questions or want more assistance.

This newsletter issue features the work of Migette Kaup, who is a designer and member of our team. She looked carefully at the differences in environmental use in upper and lower level homes and found some key trends. The most exciting finding was the ability to change use of space in traditional nursing home structures to support person-centered care without major capital expenditures. Learn key ways in which homes re-conceive spaces and practices to use the environment differently.

Laci Cornelison, PEAK 2.0 Program Coordinator

How Do We Deliver Person-Centered Care in an Old Building?

Environmental Assessment

By: Migette Kaup, PEAK 2.0 Co-PI, PhD, Interior Designer specializing in healthcare interiors

There are numerous examples of successful models of PCC that have been featured in the literature for their radical shifts in the built environment such as the Green House models and other small house design strategies (e.g. Rabig, et al., 2006). But, the majority of nursing home buildings in existence in the US are still physically designed around a large-scale institutional archetype and mimic the dominant pattern for many health care facilities built since 1960 (Koncelik 1976; Schwartz, 1996; Thompson & Goldin, 1975). This creates a reoccurring question for providers, “**how do we deliver PCC in an old building**”? We based this study on the notion that there should be patterns and approaches in the ways that care teams use their buildings and that these strategies could be shared with other providers.

Methods:

We used many different methods to determine how buildings were being used. These included participant observation and open-ended staff interviews; reviews of building layouts; analysis of the floor plans to establish environmental inventories; photo documentation of the composition of the interior features and spaces and equipment integral to strategic practices that support PCC

Sample:

In 2016, there were 339 nursing homes eligible to participate in the PEAK 2.0 program, and 229 homes enrolled in PEAK. A purposeful sample of 10 nursing homes was targeted. Five of these homes were in the early adoption stage of PCC. Five of the homes were at advanced levels of adoption.

Procedures for the Environmental Assessment:

One of the key features of the PEAK 2.0 criteria is the identification of a ‘staff work area’ (SWA). Therefore, the first environmental assessment measure was to identify the boundaries of the SWA on the floor plan, and, to complete an environmental inventory of the spaces. Weekly assignments for staffing schedules, interviews, and tours of the building confirmed operational practices relative to the physical boundaries of SWAs.

Findings:

Staff work areas are an important component of homes in the PEAK Domains and Cores. For example, Domain #2: Staff Empowerment, is defined as “all staff are empowered to support resident choices and make decisions about their own work.” This has an embedded Core attribute of “Relationships” which is defined as “residents enjoy meaningful relationships with a small group of consistently assigned caregivers.” And, this is enacted (and documented) by the Supporting Practice #1 of “get small” – defined as “the team identifies small areas of the home as work areas.” Therefore, the first environmental assessment measure was to confirm the boundaries of the SWA on the floor plan and to complete an environmental inventory of the spaces contained within the designated SWA.

How SWAs are Used:

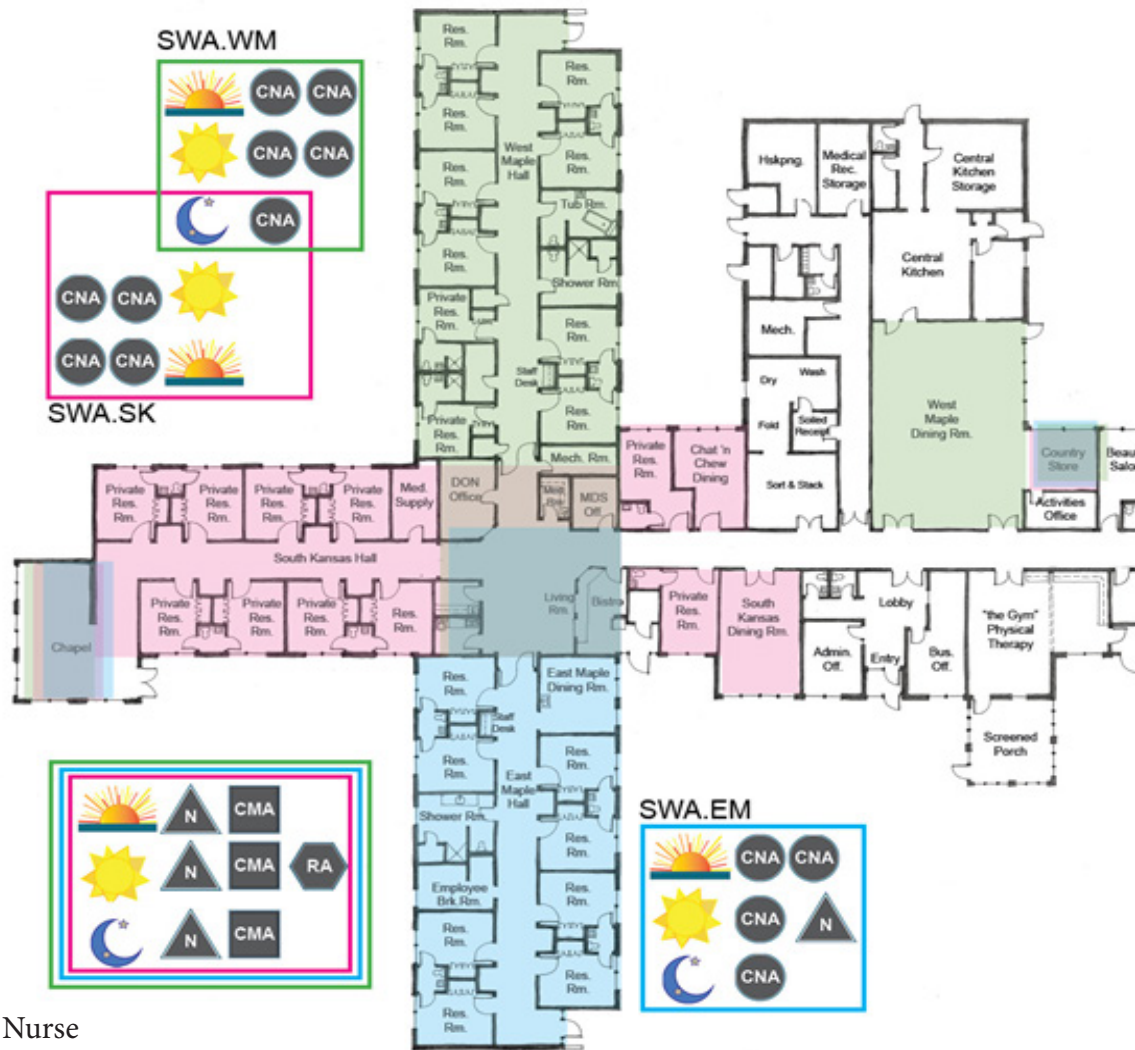
SWAs were confirmed by reviewing the weekly assignments for staffing. Typically, homes schedule their clinical staff in eight-hour blocks of time (only one home in this study used 12 hour blocks for shifts). Staff who are assigned to a dedicated group of residents would be identified as such on the weekly schedules. This allowed for easy identification of homes that still viewed their entire building as a single SWA, and it also provided identification of those staff who covered multiple areas (or floated) during a shift.

Results of the Environmental Assessment:

Staff Patterns and SWAs:

Typically, homes schedule their care employees (Certified Nurse Aides (CNAs); Certified Medication Aides (CMAs); Nurses (Registered Nurses (RNs), Licensed Professional Nurses, (LPNs)) by shifts. The common shift pattern found in 9 out of 10 case studies was to run three, eight-hour shifts (an AM shift, a PM Shift, and a Night Shift). Only one case study reported running two, twelve hour shifts.

Level 1 and 2 homes were more likely to not designate staff to a single SWA unless it was a dementia care unit (See Table 2). More staff were expected to cover (or “float”) across multiple SWAs and on each shift. The one Level 2 home (Participating Home 2.a) that did have clearly identifiable SWAs and designated staff for these areas was also quickly advancing to Level 3 of the PEAK program.



N = Nurse
 CMA = Certified Med Aide
 CNA = Certified Nurse Aide
 RA = Restorative Aide

Upper Level PEAK Home: Floor Plan and Use of Space. Each color represents a staff work area. The boxes are framed in the corresponding color of SWA distinguishing consistent staff vs. shared staff between SWAs.



Lower Level PEAK Home: Floor Plan and Use of Space. Each color represents a staff work area. The boxes are framed in the corresponding color of SWA distinguishing consistent staff vs. shared staff between SWAs.

Scale and scope of the SWAs:

In the homes that were at Levels 1 and 2, only one out of the five homes had distinctive SWAs that were not solely related to dementia care. As noted in the previous section, most staff were responsible for attending to the entire resident population at any time throughout the building, even if the organization had “named” the hallways. At Levels 1 and 2, the total area being covered by the majority of staff (in non-dementia specific units) ranged from 12,855 – 22,353 square feet (sf), for an average of 17,550 sf per staff person.

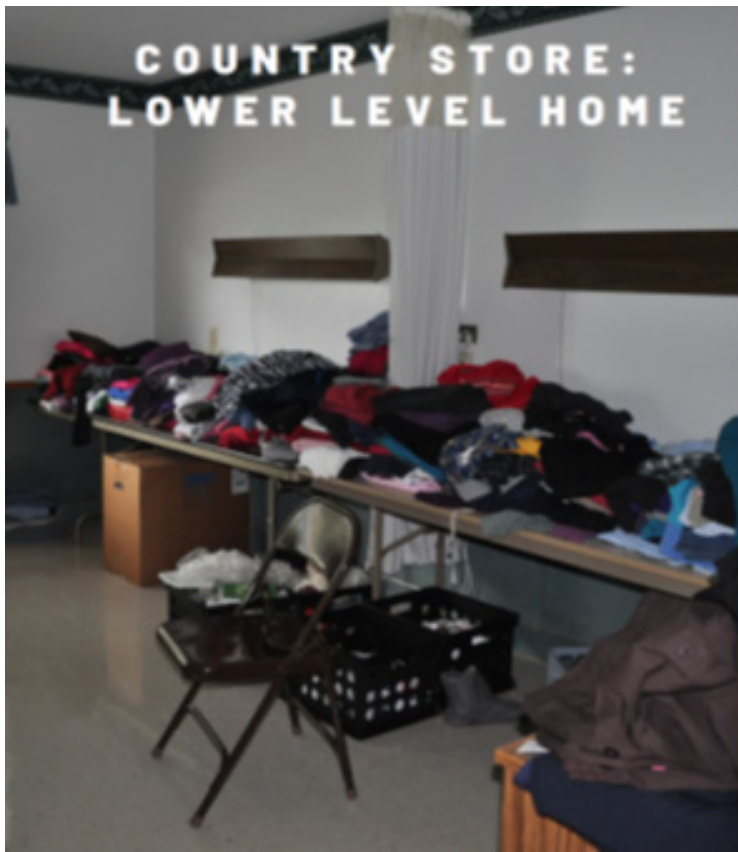
All Level 4 and 5 homes had clearly designated SWAs with dedicated staff for at least two of the three shifts. The amount of area being covered by most staff ranged from

4,587 – 12,240 sf, or an average of 7,152 sf per staff member. Only one of these homes had floating staff, and this was isolated to the night shift. This home was smaller than the others with only three SWAs. Even when staff float between areas, the average area is 10,711 sf. This is nearly 40% smaller than Level 1 and 2 homes.

Patterns of Place and Practice:

Level 1 and 2 homes were more likely to have fewer social areas, amenities, and resident support spaces located “within” a Staff Work Area (SWA) versus Level 4 and 5 homes. As all SWAs in all case studies were combined, the common pattern is a lack of designated resident centered areas that are within close proximity to the residents and a designated team of staff. The presence or absence of a designed SWA dining room is a notable distinction between homes at the early stages of PCC practices and those homes that are more advanced in their practices. Early adopters are more likely to expect residents to access centrally located and shared social areas regardless of their proximity to the resident’s room. The Level 4 and 5 homes also had “shared” areas and amenities, but residents could access many things (including food) in close proximity to their dedicated staff team within the SWA.





COUNTRY STORE:
LOWER LEVEL HOME



COUNTRY STORE:
UPPER LEVEL HOME



LIVING ROOM:
LOWER LEVEL HOME



LIVING ROOM:
UPPER LEVEL HOME

Implications of Findings: Long-term care providers do not have to be constrained by their outdated buildings in order to effectively advance their efforts in delivering PCC. If considered holistically and strategically, impactful changes to institutionally shaped buildings are possible