

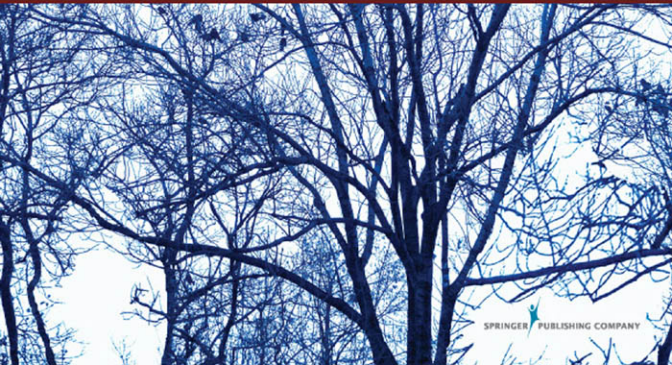


ASSISTED LIVING NURSING

A MANUAL FOR MANAGEMENT AND PRACTICE



BARBARA RESNICK | ETHEL MITTY
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Assisted Living Nursing

A Manual for Management and Practice

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SPRINGER  PUBLISHING COMPANY

New York

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Foreword

Assisted living is a residential long-term care option that provides housing, 24-hour oversight, personal care services, health related services, or a combination of these on an as-needed basis to vulnerable and medically, functionally, and cognitively impaired older adults. Assisted living is the fastest-growing senior housing option in the United States. Key philosophical tenets of assisted living are aging-in-place and maximizing the function and quality of life of the resident. The goal of the physical environment is a home-like atmosphere, pace, and place that specifically avoids the appearance of an institutional or medical facility.

Most assisted living residents are in their early 80s, require some assistance with at least two activities of daily living (ADLs), and demonstrate functional decline over time similar to that of nursing home residents. Assisted living residents have similar medical diagnoses and chronic illnesses and take approximately the same number of prescription medications as nursing home residents. Between 66% and 80% of assisted living residents suffer from dementia, depression, other psychiatric illness, or receive psychotropic medications, and approximately 25% of assisted living communities have a dedicated Alzheimer's or dementia unit. Many states permit and encourage assisted living facilities to admit or retain residents who meet the state's nursing home level of care; all states permit hospice care in the facility. At least 65% of residents need assistance with managing their medications. The older adult living in assisted living seeks a protective but not restrictive environment. The balance between autonomy and safety is constantly renegotiated, sometimes on a daily basis.

Seeking freedom of expression, self-determination, and personal growth, an assisted living resident benefits from nursing practice that maximizes their independence, dignity, and overall continued well-being. Yet, on-site licensed nursing varies substantially across and within states. Nurses may be present 24/7, or only on a periodic or on-call basis. Nursing oversight can include assuring appropriate placement, health promotion, identifying acute clinical problems quickly, and optimally managing physical and behavioral problems. A professional nurse in assisted living may have the responsibility for assessment of potential residents to determine their suitability and safety living in an assisted living environment as well as assessing change in condition to determine if a resident needs a higher level of care. When fully realized, the scope of practice of the nurse in assisted living resembles a combined role of administrator, wellness coordinator, and clinical expert, focused on health promotion and opti-

mizing function. Nurses with special expertise in care of older adults increase the likelihood that assisted living residents will be able to age in place and more importantly do so with meaningful quality of life.

Relatively isolated from nursing and interdisciplinary colleagues, an assisted living nurse is an autonomous decision maker and manager of care, people, and systems. The guiding principles of assisted living nursing practice are a unique blend of gerontological and administrative nursing framed by person-directed care planning. Despite the growing body of knowledge about aging, persistent myths about aging erode optimism, outlook, and quality of life for the older adult. Hence, the assisted living nurse needs to be as informed about prevailing science and evidence-based practice as about the misperceptions about aging that work against the older adult's self-care abilities and independent decision making.

This book precisely fills the need for a text that informs assisted living nurses as to best practices in geriatric nursing care. Expert clinicians and managers share their knowledge, skills, and practices across the key domains of assisted living nursing leadership and care of the older adult. The tools, protocols, and tables that are an inherent part of every chapter provide effective strategies and resources that address what is known as to the science of nursing practice while keeping in mind the practicality needed in a busy residential and clinical environment. Nurses will find this book invaluable as they seek to shape care to assure that people age with dignity and quality of life.

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Preface

Assisted living (AL) nursing is a unique domain of practice. It is holistic because it brings together—as no other domain of nursing practice can—people, health, environment, and psychosocial factors. The goal of assisted living nursing practice is to preserve (if not restore) an older adult’s function, independence, and engagement with the environment and the people in it, and maximize the older adult’s well-being and quality of living. Nursing practice in assisted living is guided by the older adult’s (i.e., resident’s) values and preferences, supporting them in their choices. The nurse or nursing role in the AL community requires nurses to have expertise in both gerontologic and administrative nursing. Nursing activities for residents in assisted living can include a variety of things such as wellness management, counseling, health education, chronic illness management and monitoring, and care at the end of life. Nurses in AL communities have the responsibility of educating, guiding, mentoring, and motivating the direct-care workers in these settings and in some cases the other nursing staff with whom they work. In addition, the nurse has a responsibility to the organization and the community to oversee quality assurance and improvement, cost-effective practices, and marketing. This book was written to provide nurses with the knowledge and skill to provide the level of combined gerontological and administrative expertise that is required of them in the AL community.

Specifically this book will provide AL nurses with evidence and research-based information and knowledge regarding nursing management and clinical practice, descriptions of components of ethical nursing practice explicated in each chapter, and a “refresher” for former long-term care nurses who wish to return to practice (a sorely needed workforce) as well as for nursing students or those new to the nursing workforce. Moreover, the book provides an introduction to this unique domain of nursing practice for nurses unfamiliar with the demands as well as the consummate satisfaction of assisted living nursing. This book can, and should, be used as a resource for the assisted living nurse interested in taking the American Assisted Living Nurses Association (AALNA) Assisted Living Nurse Certification exam.

Each chapter provides a theoretical, scientific, and/or conceptual base for the nursing acts that are recommended, whether clinical or managerial. Recommendations are research-based or borne out of the years of experience of expert clinicians in management or clinical practice. To the extent possible, each chapter suggests guidelines, protocols, and other nursing activities that will facilitate or enhance staff development and resident well-being. The book is divided

into five sections: “Management and Leadership,” “Approach to the Resident,” “Syndromes,” “Psychological Health,” and “Diseases and Disorders.” There is extensive cross-referencing in each chapter to other sections of the book or chapter as well as an Internet reference list for sources of information regarding care of the older adult including state and federal resources. Each chapter in Section I, “Management and Leadership,” begins with a brief introduction that describes the specific content of the chapter. For example, Chapter 4, “Marketing, Quality, Consumer Choice, and Admission Agreements,” discusses nursing’s role in marketing, the preadmission evaluation, assessing nursing’s marketing image, safety goals, satisfaction, and mechanisms of quality accreditation. The clinical chapters (Sections II–V) address age-related changes, disease etiology, symptom management, nursing assessment and intervention, and patient education. Overall this is a comprehensive source of both management and clinical information for every nurse working in the assisted living or long-term care environment.

This book reflects an interdisciplinary team of individuals including physicians, nurses, social workers, and dentists. Specifically, as coauthors of this work, we would like to thank the following: The American Geriatric Society for partnering with us on this endeavor; the individual contributors of the Geriatric Review Syllabus, which served as a basis for the clinical chapters; and the advanced practice nurses who were chapter coauthors. With deepest appreciation we thank Ardis O’Meara who completed the final editing and organization of this book.

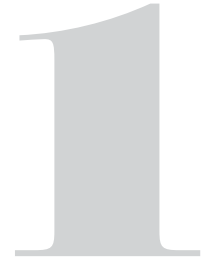
Ethel Mitty
Barbara Resnick

S E C T I O N I

Management and Leadership

An assisted living (AL) nurse is both a manager and a clinician, a combined role that requires management as well as gerontological knowledge and leadership skills. The 13 chapters in this section of the book focus on managing nursing care and nursing staff in the context of AL nursing practice, AL philosophy, and regulations. The first chapter is an overview of the AL community population, their demographics, and the nature of AL nursing, including the scope and standards of AL nursing practice. Subsequent chapters address health care

financing, marketing and service plan construction, theories of nursing, organizational culture, management theory, and leadership styles and responsibilities, such as staffing and assignments (workload), problem solving, change and conflict resolution, job descriptions, staff development and performance evaluation, reimbursement and budget, ethical and legal aspects of practice, and research and quality improvement. The content includes assessment and hands-on how-to guidelines.



The Assisted Living Setting of Nursing Practice

Ethel Mitty

This chapter describes some key demographics of the older adult population in the United States that pertain to assisted living (AL) residents: life expectancy, socioeconomic status, literacy, trends in health and functional status, and elder mistreatment. The second half of the chapter addresses key concepts of AL: the notion of homeyness, resident independence and self-direction, and aging-in-place. It concludes with a description of the American Geriatrics Society position paper on AL, the scope and standards of practice, and principles of AL nursing.

AGING AND LIFE EXPECTANCY

The aging of the baby boomers (i.e., those born between 1946 and 1964), longevity differences within and between population groups, and increases in the old-old age group (i.e., over 85 years old) has created a significant shift in the composition of the older adult population in the United States. In 2007, about one in eight persons living in the United States was age 65 or older—approximately 13% or 37 million people. By 2030, one of every five persons (i.e., 20% or 71.5 million people) will be age 65 or older. The older adult U.S. population is predominantly White, but minority older adults are expected to increase. Life expectancy upon reaching age 65 is an average additional 18.7 years (20.0 years for females, 17.1 years for

males). The number of centenarians in the United States is growing and is expected to be over 800,000 by 2050.

Socioeconomic Status and Education

Overall, older adults are becoming better educated, better off financially (though ethnic minorities lag behind non-Latino White Americans), and are changing their living arrangements, especially with the growth of AL. In the early 1960s, 35% of people age 65 or older had incomes below the federal poverty level, and only 70% received Social Security pensions. Improvements in the Social Security system (e.g., cost-of-living-adjustments), Medicare, asset income, and government employee and private pension systems have significantly improved the economic well-being of older adults in the United States. In 2008, approximately 4.5 million older adults were Medicare and Medicaid beneficiaries (i.e., so-called dual eligibles); 95% of all older adults are Medicare beneficiaries. The effect of the national and worldwide economic downturn in fall 2008 on the economic well-being of current and future AL residents is unknown at the time of this publication. The forecast, however, is that older adults will be economically less well off than heretofore seen as a result of pension wipeouts, inability to sell their home, and so forth.

Older adults with more education are generally in better health and at lower risk of disability than those

with low levels of educational attainment. Between 1970 and 2001, the percentage of older adults who completed high school increased from 28% to 76%; it is projected at 83% by 2030. Those with a bachelor's degree or more will have increased from the 2001 level of 15% to 24% by 2020. It is suggested that better-educated older adults will be more activist and informed health care consumers (i.e., adept at using the Internet to get information) and more demanding of the health care system.

Literacy and Health

Literacy is the ability to communicate and function in society. Limited health literacy is associated with increased use of emergency departments, increased rates of hospitalization (associated with medication mismanagement), and failure to take important diagnostic tests (e.g., mammograms). Among older adults in 2003, almost 70% had below basic literacy—lower than any other age group. *Functional illiteracy* is inability to read sufficiently well to function in the everyday; it signifies being at risk. *Health literacy* is the ability to understand and then act on health information; the basic skills are reading, numeracy, and writing (to a lesser extent). Numeracy skills are related to medication management: calculating when the next dose is due or the number of pills needed until it is time to order a refill. An AL resident who wishes to maintain his or her independence needs to be able to read and understand written and verbal information about his or her diagnosis/illness, test preparation, and treatment instructions; ask relevant questions; and manage problems that might arise in his or her care regimen.

An excuse for a missed appointment or medication—"I forgot where I put my glasses"—might be signaling limited literacy. The Test of Health Literacy in Adults (TOHLA; S-TOHLA, short version) includes numeracy items (e.g., figuring out when to take the medication next), when to take a medication on an empty stomach, and is available in Spanish. The TOHLA also tests comprehension of preparation instructions for a diagnostic test, such as what one can eat, the number of hours to be without food, and so forth. Assessment takes 10 minutes.

Using *plain language* does not mean dumbing down. Reading levels for surveys (e.g., satisfaction), interviews, and instructions should be set at sixth-grade but no higher than eighth-grade level. The notion of plain language holds that the information—written or verbal—should be understood on first reading or hearing it. The difficulty with this concept is that emotions, such as fear or anxiety, can block comprehension of even the most simply constructed sentence.

Written material for AL residents should use a 12-point (or greater) font size, sharp characters, and color contrast of print and page. Diagrams and illustrations should be representative of the AL resident. Here are some general guidelines for a document or program to deliver health education or information, such as the evacuation procedure:

- Clearly state the goal of the instructions/education, that is, the desired actions as well as those activities that are not desirable or recommended.
- Make no more than four major points in the document.
- Do not use pictures or diagrams that add little or nothing of importance.
- Avoid fancy script, italics, or use of all capital letters.
- Leave at least one inch between text segments; use headings and bullets when possible to avoid dense text.
- Do not mix positive and negative information (i.e., "go" and "stop") in the same paragraph.

The ability of older adults to access and use Internet information is unknown. Web text is purportedly written at a 10th-grade reading level or higher. Prior to suggesting that a resident go to the Web to get more information, assess their ability to search the Web efficiently—and comfortably.

To ascertain if the resident understood the information/instructions, do not ask: "Do you have any questions?" There is a natural inclination to say "no" to avoid embarrassment; the person has no questions and understood everything. Similarly, there is a natural face-saving inclination to respond "yes" to the question "Did you understand what you were told?" Rather, provide information or instruction in small bits and then use *rephrasing*: ask the resident to tell you in his or her own words (i.e., to rephrase) what you've just said. It is relatively easy to judge if the resident has understood the information and that it has been recalled correctly. A similar process is used in the process of obtaining informed consent for treatment and research participation. To ease the resident's anxiety about having to recall and rephrase, say something like, "I just gave you a lot of information. I am concerned that I didn't leave anything out that you need to know. Tell me in your own words what I said, about what you need to do, and so forth."

Trends in Health, Functional Status, and Disability

In 2006, about 40% of older adults felt that their health status was excellent or good. Minority older adults,

overall, rated their health status as less good than White older adults. In that same year, about 84% of older adults had one or more chronic conditions (virtually unchanged from previous years). Hypertension was the most common medical diagnosis, followed by arthritis, cardiovascular disease, chronic obstructive pulmonary disease, and cancer. Although 80% of those 80 years of age or older report two or more chronic conditions, only 36% say that they are in fair or poor health. Almost two-thirds of community-dwelling older adults received an influenza vaccine in 2006; slightly over half reported that they received a pneumococcal vaccine. The number of AL residents who receive these vaccinations, and whether there are assisted living community (ALC) policies that address this, are unknown and not tracked by most states. As a nursing practice and infection control issues, this warrants examination.

Functional disability is associated with chronic disease and increases with age. Most community-residing older adults under the age of 85 report no difficulty in activities of daily living (ADL) or instrumental activities of daily living (IADL); fewer older adults age 85 and older report little or no difficulty. An admission assessment should ask about the onset and degree of difficulty in ADLs and IADLs.

On average, older adults have more contacts with health care professionals than do younger adults. Those who assess their health as fair or poor have twice as many contacts per year as those who report being in excellent or good health. Information about the resident's pattern of physician (or nurse practitioner) contact should be obtained, recorded, and folded into the service plan. This has import for the resident's feelings of safety and well-being. It bears noting, however, that older adults in 2005 had almost two times greater out-of-pocket medical expenses than younger adults—an increase of almost 60% since 1995. This speaks to the importance of health status monitoring by the AL nurse because some residents might not be refilling their medications in order to save some money.

There is a strong relationship between severe disability and self-report of being in fair or poor health. Data indicate an association between severe disability, low income, and limited educational attainment. Some studies suggest a decline in the proportion of older adults who are unable to do some activities (i.e., one or more ADLs or IADLs); other studies do not support this. Disability increases with age: 57% of the old-old report a significant disability, almost half of whom need assistance. Projection in disability trends are important with regard to increased life expectancy and whether these years will be disability free. For AL, this speaks to service and staffing needs as the residents age in place.

Data indicate that a higher educational level and being female (because of their increased life expectancy) are an advantage for disability-free years. The notion of *compression of morbidity* suggests that the period of disability prior to death will gradually shorten (compress) as the number of disability-free years (or active life expectancy) increases. Being less than 85 years old, in good nutritional status, and having good mobility are all associated with increased likelihood of restoration of basic ADL ability that might have been diminished after (possibly associated with) an acute health event. Given that many AL residences provide rehabilitation services or assist the resident in accessing them, the data from these studies is encouraging but clearly indicates the need for cost-effective service plans that recognize the high cost of rehabilitation therapy.

Elder Mistreatment

Elder mistreatment (EM) affects almost 13% of older adults in the United States and includes physical, financial, psychological, and sexual abuse or neglect; it also includes self-neglect. Given that AL residents have family members and friends age 65 and older, it is important to be aware of the red flags of abuse as well as barriers or resistance to disclosure of EM. In AL, self-neglect can be a first sign of clinical depression and/or cognitive dysfunction. Financial abuse can also occur to an AL resident. Women are more likely to report abuse of any kind, especially verbal mistreatment, than are men; both genders report equal rates of financial mistreatment.

Clues regarding exploitation, financial abuse, or misappropriation of property might be apparent if an AL resident describes changes in his or her testamentary will and seems unsure or unclear about it; describes changes in his or her buying or banking practices; describes being forced to sign a document; or describes improper enactment of a guardian, conservator, or power of attorney role, or check-cashing without permission. All states and the District of Columbia have Adult Protective Services (APS) to investigate allegations of EM. Calls about EM protect the identity of anyone making a complaint and can also be made anonymously.

Assessment tools for EM are widely available and are suggested questions or probes when talking with an older adult whom you think might be an EM victim:

- So, tell me, how are things at home?
- Has anyone tried to hurt you in any way?
- Has anyone tried to touch you without your permission?
- Has anyone used degrading or insulting (bad) language to you?

- Have you been made to do things you didn't want to do?
- Have you signed a paper that you didn't understand?
- Have you been missing some meals?
- Are you getting the assistance you need at home?

THE CONTEXT OF ASSISTED LIVING NURSING PRACTICE

The philosophy of AL is based on the industry's declaration that it is a different care model for long-term care than ever known before. AL is not like a skilled nursing facility, nor a retirement hotel, but is rather a unique hybrid. The data indicate that approximately 1 million older adults are living in about 30,000 ALCs. The very diversity of long-term care is one reason that there has yet to be a standardized definition of AL; descriptions, definitions, and licensure vary from state to state, provider-to-provider, and even between ALCs operated by a single provider. Models of AL include independent housing with services (free-standing market rate and low-income); purpose-built free-standing AL facility; nursing home/AL campuses or building(s); and continuing care retirement communities, or CCRCs (see Chapter 17, "The Continuum of Care" for CCRC discussion). The phrase *ALC* denotes various types of housing with services, a specific residence or facility that is licensed (or certified) to provide AL services. Some unique concepts pertain to AL residency.

Home Versus Room

AL is no longer a stopping point before moving in to a nursing home. The vision is that the AL residence is a community; each living unit is the resident's home; the nurse and care staff are invited guests. Residents are encouraged to personalize their units as well as their care. Many communities avoid the use of institutional-looking furnishings. Even the medication carts are sometimes difficult to identify; some look like lovely etageres and often are made of real wood.

The notion of homeyness or "at-homeness" implies the experience of home as much as it does a precise location. It can be construed as one aspect of quality of life, and, as such, it will vary among AL providers, residents, families, and staff. Two major concepts of home are *separation* and *connection*. Separation connotes safety and refuge, privacy, control and ownership, and personal imprinting. Connection means being cared for, reciprocity and relationships, rituals, continuity and meaningfulness, status, identity, and role. The Experi-

ence of Home (EOH) scale (Table 1.1) can be useful for monitoring quality of life in relationship to an AL residence's environment prior to and after making changes in the homelike environment. The simple question, "What makes you feel at home?" could be added to marketing, preadmission and periodic postadmission survey among residents in an ALC.

Resident Independence and Self-Direction

AL residents should be encouraged to continue their usual lifestyle as much as possible. In many ALCs, residents dine when they choose and even prepare meals in their homes, if equipped with kitchens (or a Pullman kitchen). It is not unusual for residents to direct much of their care. Often, the AL nurse has to obtain a physician's order for the resident to manage their own medications, or to change timing on medications to meet the resident's preferred schedule (see Chapter 10, "Medica-



The Experience of Home Scale

Scale: SA = strongly agree; A = agree; N = neutral; D = disagree; SD = strongly disagree.

1. I feel at home here.
2. I can do what I want here.
3. This place feels cold and sterile.
4. I feel safe here.
5. I can be myself here.
6. I have my favorite places/spaces to spend time in here.
7. I have enough privacy to meet my needs here.
8. I feel cared for here.
9. I feel like an outsider here.
10. I am valued as a person here.
11. I feel isolated here.
12. I feel welcome here.
13. When I am away, I look forward to coming back to this place.
14. I feel cut off from my life here.
15. I feel a part of this place.

Note. This instrument is for internal use only; it cannot be published nor can the quality improvement data drawn from use of the instrument. Findings can be described and documented, however, with a view to comparing differences across time or before and after an innovation in the ALC.

tion Management”; Chapter 14, “Resident Assessment and Service Plan Construction,” regarding decisional capacity).

Complexity of Care

AL promotes independence, but the reality is that many residents have complex medical care needs, including oversight. AL is not just for seniors who require occasional assistance with ADLs. Residents are receiving hospice care, have multiple comorbidities and, in some ALCs, have advanced dementia. Some ALCs rely extensively on outside therapies (e.g., occupational therapy, physical therapy) and home health care agencies.

Aging-in-Place

Aging-in-place and maximizing the function and quality of life of residents in an ALC is a key philosophical tenet of AL. The ALC’s physical environment seeks to avoid the appearance of an institutional or medical-type of facility. Yet ALCs want to provide care to a vulnerable and medically, functionally, and cognitively impaired older adult population—many of whom require some assistance with ADLs and IADLs. Over time, AL residents decline functionally and look similar to nursing home residents.

AL residents are more likely to require assistance with bathing and dressing, are less likely to need help with toileting and locomotion, and are even less likely to need help with eating and transferring in comparison to nursing home residents. Many states permit and encourage ALCs to admit or retain residents who meet a nursing home level of care. On average, residents need assistance with 2.8 ADLs. Approximately 50%–75% of residents require assistance of some kind with their medication. Given the limited data, 66%–81% of residents suffer from dementia, depression, other psychiatric illnesses, or receive psychotropic medications.

Average length of stay is about 2 years; approximately 28% of residents will die in the ALC; 35% will transfer to a nursing home; 15% will be hospitalized and not return to the ALC. All states permit hospice services in ALCs. Almost 25% of ALCs have a dedicated Alzheimer’s or dementia unit.

American Geriatrics Society Position Paper on Assisted Living

The American Geriatrics Society position paper consists of six principles that describe the benefits of AL and

providers’ responsibilities. Developed for the purpose of guiding legislators, health care professionals, and consumers in the achievement of benefits/outcomes that should be expected of ALCs, the principles address:

- Providing complete information about an ALC’s services to assure an appropriate match between a prospective resident and facility (i.e., disclosure);
- A holistic, culturally sensitive admission assessment in order to maintain the older adult’s independent living and maximum function;
- Discussion of the plan of care with the resident, ALC, and family with regard to responsibility for each aspect of the plan;
- Staff knowledge and skills needed to competently provide care for older adults that includes signs of condition change, risk for falls, depression, and so forth; and
- Seamless transition between levels of care (see Chapter 17, “The Continuum of Care”).

Interestingly, the principles address access to AL services or sites for older adults living in rural areas where the absence of such services is seen in the fact that nursing homes are admitting younger and less disabled older adults compared to urban-located ALCs.

SCOPE AND STANDARDS OF ASSISTED LIVING NURSING PRACTICE

The scope and standards of AL nursing practice describes the ethical obligations and duties of the AL nurse; guides the practice and conduct of the AL nurse; articulates the AL nurse’s understanding of the profession’s commitment to health care, nursing, and society; and assures timely identification of acute clinical problems to optimally manage physical and behavioral problems. The nursing role may be a joint role as administrator/wellness coordinator, generally overseeing residents’ well-being, as well as being a clinician. An additional or independent role might be that of a consultant, reviewing health records and guiding unlicensed staff in optimization of residents’ function and quality of life, monitoring residents’ chronic illness status, or conducting assessment during an acute change of condition.

Principles of Assisted Living Nursing

AL nursing practice is holistic in that it seeks to optimize and maintain, if not improve, an older adult’s function,

independence, and engagement in order to maximize well-being and quality of life. AL nurses are guided by the residents' preferences, supporting them in their choices. Role activities include assessment and counseling, health education, clinician, medication management, and helping the older adult access the health care system. Principles of AL nursing embrace and support collaborating with the resident in planning, guiding, and managing his or her care; promoting and assisting the resident to maintain his or her maximum physical, mental, and psychosocial function and to reduce risk of infection and trauma, educating older adults about their options for quality of care and quality of living, maintaining and building practice skills and competencies, and advocacy in the public policy arena.

Scope of Practice

It is important to be aware of the scope of AL nursing practice with regard to the job description, performance evaluation, legal aspects of practice and accountability, and opportunity for career growth. The scope of AL nursing practice includes but is not limited to:

- Assessment: functional and mental status of the resident on admission, during and after acute changes in condition, and annually;
- Service/care planning: communication of the plan to the resident, family member/proxy, and other members of the health care team; oversight of care provided by assistive staff; recognition of deviation from the plan;
- Medication management: assessment of resident's ability for self-administration of meds; oversight of medication storage and administration (by other staff, including those who are not licensed);
- Development and oversight of health promotion and disease prevention programs: immunization, protocols for infectious disease management (e.g., influenza, herpes zoster, *C. difficile*, tuberculosis);
- Care that is focused on optimizing function;
- Determination of resident's decision-making capacity, identification of a surrogate health care decision maker, and establishment of end of life care preferences; and
- Staff development as relevant to the needs of the residents and for professional growth.

Standards of Practice

The standards of AL nursing practice, formulated by the American Assisted Living Nurses Association, are based on the American Nurses Association (ANA, 2001)

Standards of Gerontological Nursing Practice. Each standard contains description, rationale, and measurement criteria.

- Standards 1–4: Assessment, Diagnosis, Outcome Identification, Planning, Implementation, and Evaluation.
- Standards of Professional Performance include the *administrative and wellness coordinator roles* and refer to the expected professional role and behaviors of the AL nurse. These standards are a necessary component of certification of AL nursing as a specialty practice, are part of the scope and standards document, and consist of nine standards: quality of care, performance appraisal, education, collegiality, ethics, collaboration, health care consultant/educator of AL residents, research, and resource utilization.

Licensed Practical/Vocational Nurse Practice Standards

Virtually all states require the licensed practical/vocational nurse (LPN/LVN) to practice under the supervision of a registered nurse, advanced practice nurse, or physician. Given the diverse state regulations and statutes that direct AL programs and services among the states, the LPN/LVN is often the sole, as well as autonomous, decision maker and manager of care in ALCs. The LPN/LVN scope and standards and the LPN/LVN professional performance standards developed by the American Assisted Living Nurses Association use the same headings and address the same domains as the registered nurse document. The complete scope and standards of AL nursing practice for registered nurses and LPNs/LVNs is available on the Web site of the American Association of Assisted Living Nurses (<http://www.alnursing.org>).

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Public Policies, Assisted Living Models, and Regulations

Ethel Mitty

This chapter begins with an overview of key federal policies that affect assisted living (AL) residents: Supplementary Security Income (SSI); the Older Americans Act (OAA), which established the Administration on Aging (AOA); the Health Insurance Portability and Accountability Act (HIPAA), which established the privacy rule in health care (treatment and research); and the Patient Self-Determination Act (PSDA), which established the right and rules by which individuals could state their treatment wishes in a legal document. Various models of AL are described, as are the components of a mission statement useful to guide practice, orient new staff, and market the AL community (ALC). Nursing's fit with the mission of the AL organization and its role in strategic planning are discussed. The penultimate section, "Regulations and Oversight," discusses the aspects of a standardized admission assessment, disclosure, and the current state of AL survey or monitoring by state governments.

PUBLIC POLICIES

Supplemental Security Income (SSI)

SSI provides an older adult (such as an AL resident) with a monthly check based on the fact that he or she does not qualify for regular Social Security benefits or based on the fact that the Social Security benefits are

inadequate. Individuals age 65 or older or younger persons who are blind and/or disabled are eligible if their income and assets are below a certain level. A means test is the gateway to access, but benefit levels can change yearly. The SSI program is linked to the Medicaid program, thereby entitling the older adult to have access, also, to health care benefits under Medicaid. Many ALC residents used to pay for their room and board costs but not their supportive or health care costs.

Older Americans Act (OAA)

The Older Americans Act (OAA) was enacted in 1965, the same year as Medicare (Title 18 of the Social Security Act [SSA] and Medicaid [Title 19 {SSA}]). The OAA seeks to maintain older adults in the least restricted environment by using home and community-based programs. The OAA established the Administration on Aging (AOA), which is within the Department of Health and Human Services and state-level agencies known as Area Agency on Aging (AAA). The seven different titles in the OAA provide grants for meals-on-wheels and congregate meal settings in order to combat poor nutrition related to poverty among older adults; employment placement; transportation assistance (e.g., dial-a-ride); senior centers and adult day care; in-home services; increased access to health care for rural and minority elders; grants to Native American groups;

protective services regarding elder mistreatment; and legal services. Reauthorized in 2006, the OAA is supporting demonstration programs related to aging-in-place (including aging in naturally occurring retirement communities [NORCs]) and developing mental health screening and treatment services. Access to OAA programs and services by ALCs or their residents varies among states but is worth knowing about!

Health Insurance Portability and Accountability Act (HIPAA)

Among the features of this act is the *privacy rule* that applies to covered entities, of which AL might be one, depending on the state. Because each state has different licensure rules for AL, the privacy rule may be applicable to the AL program based on how the ALC is reimbursed *and* how it transmits patient information. The privacy rule holds that electronically transmitted health information by a health care provider requires special protection of that information. The HIPAA contains 18 identifiers that could identify an individual: for example, medical record number, social security number, or demographic data. This has particular relevance in the conduct of research. For example, date of birth cannot be used in describing research participants 89 years of age or older. In some cases, a fax transmitted by telephone is not an electronic transmission, but if faxed via a computer, it is! Each state has its own interpretation.

It is very important to be aware of the restrictions on transmitting any resident information. The ALC should have specific policies in this regard. If an ALC does not consider itself a health care provider, then HIPAA's privacy rule does not apply. However, if hospice care is permitted in the ALC, it needs to be clarified if the hospice agency or the ALC is the health care provider. It bears noting that patients have to sign consent for their medical information to be shared with insurance companies, other payers, and so forth.

Patient Self-Determination Act (PSDA)

Passed as an amendment to the Omnibus Budget Reconciliation Act (OBRA) of 1990, the PSDA went into effect in December 1991. This act requires that all health care facilities that receive Medicare and/or Medicaid reimbursement (such as, hospitals, nursing homes, home health care, HMOs, and hospice) must inform their adult patients about their right to participate in, or direct, decisions about their health care; accept or refuse medical or surgical interventions; and prepare an advance direc-

tive (AD). An AL resident whose health care costs are covered by Medicaid or who is receiving skilled nursing services from a Medicare-approved provider is entitled to have this information and exert these rights.

ADs allow individuals to state in advance the kind of treatments/interventions that they want or do not want should they become unable to make or communicate their decisions or preferences. As such, ADs guide health care professionals, families, and substitute or surrogate decision makers about the person's wishes. In addition, an AD provides immunity for health care professionals when, in good faith, they follow the person's stated wishes (for example, treatment refusal).

There are two kinds of ADs: durable power of attorney for health care (DPAHC) or health care proxy (HCP) and living will (LW).

- HCP or DPAHC: The individual appoints someone he knows and trusts (i.e., the agent, proxy, or surrogate) to make health care treatment decisions for him if he is unable to do so or is unable to communicate his wishes.
- LW: Specific written instructions to health care providers about the life-sustaining interventions that an individual wants, wants to have used in a limited way, or does not want to prolong her life.

An *instructional* or *medical directive*, legal in virtually all states, identifies the specific intervention that is acceptable to the individual in particular situations (e.g., short-term ventilator support in event of brain trauma; blood transfusion to replace blood loss, etc.).

Oral ADs or a verbal directive consists of *clear and convincing evidence* of a person's wishes. This kind of directive is permitted in some states, but the legal rules vary. *Evidence* means that the person stated his wishes, consistently and unvaryingly over time, with regard to a specific medical situation.

The Five Wishes document consists of a HCP and LW but also speaks to a person's comfort interests and needs, how she wants to spend her last days, what she would like her family to know, whom she wants to forgive or whom she seeks forgiveness from, and what she would like said at her funeral. This is an intensive document, not to be completed in one sitting. Consider a small group meeting in the ALC for interested residents (and their families) to begin the discussion, including whom they can contact for the next step, if desired. The document is legally accepted in 40 states and is also available in Spanish.

The physician's order for life-sustaining treatment (POLST) may or may not be an AD; its status varies

with states' health care association positions. Nevertheless, it is considered a legal document and represents a physician's (MD) or nurse practitioner's (NP) orders written after consultation with the patient about the kind of care he wants at the end of his life. POLST originated in Oregon and is spreading across the United States. A nurse or social worker can fill it out, but it must be signed by the MD or NP. It is helpful to have an AD in addition to the POLST, in order to guide clinicians, but it is not required. The POLST addresses desired intensity-of-intervention levels regarding cardiopulmonary resuscitation (CPR), comfort care, antibiotic use, and artificial administration of nutrition. It also indicates the goals of care, signatures of those with whom the orders were discussed, and when it was reviewed.

Location of the ADs, whether in the medical file or some other ALC file, varies by state and by ALC; there are few state mandates in this regard. Some ALCs post a sign on the inside of the resident's room door stating whether or not an AD exists and where it is located. This has been done, as well, with regard to do-not-resuscitate (DNR) orders (even though they are not considered an AD in the legal sense). All individuals are presumed to have the capacity to create an AD unless shown otherwise (see Chapter 14, "Resident Assessment and Service Plan Construction," for discussion of decision-making capacity). ADs should be reviewed annually and if there has been a significant change in condition.

Key Terms Related to Self-Determination

Conservator: appointed when the court finds that an individual is unable to properly and safely attend to her legal and/or financial matters. The conservator is not automatically the individual's HCP or agent.

Guardian: appointed by the court to act on another's behalf—and make decisions—when he is unable to attend to personal matters, such as health care, safety, and treatment decisions. As with conservatorship, guardians are not necessarily the legally designated HCPs/agents, yet they make health care decisions. States vary in this regard, however; there is lack of clarity, as well, on the legality of a guardian authorizing a DNR order.

Power of attorney (POA): similar to conservatorship, the court allows another person to act on behalf of an individual with regard to contracts, bills, access to banking and checking, and so forth. As a rule, the POA does not have the legal right to make health care treatment decisions.

MODELS OF ASSISTED LIVING

The concept of AL, right from the start in the 1970s, had three basic components: (a) a residential environment consisting of private space and community space shared by all residents, including dining, (b) a capacity to deliver personal and health-related services both scheduled and nonscheduled, and (c) an operational *philosophy* that supported resident autonomy, values, independence, and choice with regard to residents' preferred lifestyles. In marketing as well as in state regulations, the AL mission is to have an organization and structure that support these aims. The right to remain in the ALC and age in place tends to vary with regulations and individual provider decisions. Values embedded in the philosophy and mission include the ALC's focus on ability rather than disability (e.g., design features such as roll-in showers and tubs, adjustable closet features, etc.) and an intention to manage chronic illness as well as respond appropriately to acute illness. A key construct of AL—preservation of residents' self-esteem—constitute the ALC's philosophy, mission, and values and is embedded in its organizational style, structures, and processes.

Four different models of AL have emerged over time, each attempting to actualize an AL philosophy, mission, and values. These models can frame descriptions or expectations regarding nursing services and nursing's role in an ALC.

- (1) *Hybrid model*: This model incorporates residential housing (sometimes purpose-built), available services, and a philosophy focused on resident choice. Attempting to move away from the nursing home image of dependent older adults, these hybrid AL operations avoided use of the word "facility" and substituted, instead, "residence," or "community." Phrases associated with health care, such as "admission and discharge" criteria were replaced by "move-in/move-out" language.
- (2) *Hospitality model*: An outgrowth of hoteliers becoming housing providers, this model purveyed concierge-like hotel services and extensive, gracious public and private spaces. Hands-on personal or health care was not part of this model's mission or vision, although, of late, these ALCs are offering some health-related services. This model was likely responsible for suggesting that satisfaction surveys are a legitimate outcome measure of quality (of life).
- (3) *Housing model*: This model originated in already-existing buildings where older adults had need for,

but difficulty accessing, personal and health-related services. In large part stimulated by states' Medicaid waivers to bring services to the domicile, this model set the highest standards regarding a home-like environment and how it could be measured (e.g., privacy and control over one's private space by locking the door, temperature control, personal furniture). In metropolitan areas, AL services are being provided in NORCs for some tenants.

- (4) *Health care model*: An outgrowth of the nursing home sector, this model responded, in part, to the need for (nursing) health care supervision but not at the level provided by a skilled nursing home. Originally, these operations were compared to the pre-Medicaid nursing home older adult—that is, the person living in a board and care home or a so-called home for the aged. This model now has a distinct niche in the long-term care continuum (between independent housing and nursing home), forced the adoption of strict move-in/move-out criteria in virtually every state, and is credited for pushing forward the notion of clinical accountability and quality of care outcome measurement.

Mission and Philosophy

A *mission statement* has a present orientation; it states why a residence/facility/institution such as AL exists. The document is generally brief and should include a description or statement regarding the type of organization (e.g., if religiously affiliated, a teaching institution, for- or not-for-profit); the population that the facility (wishes to) serves; programs and services provided (broadly described); relationship with the external community; accountability and quality improvement responsibilities or initiatives; goals of service; and measurement of success (i.e., how the organization will know it has achieved what it set out to do).

Nursing does not need a separate mission statement, but the nursing service or practice—even if not an identified department in the ALC—should have a statement that describes what nursing at the ALC believes *and does* about achieving the ALC's mission. A nursing philosophy statement is more concrete than the ALC's mission statement and is useful in orienting staff to the ALC. It addresses nursing's beliefs about aging (including cultural sensitivity); resident rights; practice values/standards of care; accountability and quality improvement protocols; and education and evidence/research-based guidance of practice.

Strategic Planning

Most organizations have a strategic plan (SP), if only for the opportunity to think about where they have been and the direction in which they are heading. SPs should be reviewed annually, especially after a major shift in organization or ALC ownership and/or mission. The SP is written with a view to the organization's internal and external environment, desired customers (i.e., residents), and how the organization will meet their needs and serve their interests. The SP can also address risk reduction, especially if the ALC admits persons with significant dementia.

The nursing organization/service contributes to the SP in a very specific way by analyzing what nursing does well, what it does poorly; nursing's strengths and weaknesses; and nursing staffing needed to meet the ALC's goals. As a nursing manager contributing to SP development, it is important to be aware of trends in nursing education *and* practice (especially changes in entry-level practice and nurse delegation regulations) and changing demographics of older adults.

REGULATIONS AND OVERSIGHT

The challenge for many AL nurses is that the regulations have not necessarily kept pace with the presenting and emerging needs of older adults in ALCs (for example, insulin administration by nonlicensed staff). To be effective, AL nurses must have a strong working knowledge of regulation, as well as knowledge of how to work with the regulatory agency when residents' care needs are unique.

While some federal laws affect AL operations (see, for example, Chapter 3, "The Economics of Assisted Living"), regulations and oversight are primarily the responsibility of each respective state. Hence, there are differing terms regarding the types and levels of care and various settings in which AL services can be provided. For the provider as well as the consumer, this represents options as well as confusion. Virtually every state is continuing to create and/or revise its AL statutes and regulations. Since 2004, the states have been addressing the fact that frailer and sicker older adults are residing in ALCs—some by preference, others by state policies that encourage AL rather than nursing home residency. Most states have adopted the licensure term "assisted living," but about one-third of states use the term "residential care." Some states use these terms: "board and care," "home for the aged," "adult foster care," "en-

riched housing,” and “personal care home.” Several states have multiple levels of licensure, each serving a specific kind of resident or care need. Most states define AL in their regulations or statutes and identify the state agency responsible for AL monitoring/oversight. In 2008, 44 states had specific requirements for ALCs providing Alzheimer’s/dementia care services.

All states require a pre- or on-admission assessment, but few states have a specific, *standardized admission assessment* form that the ALC is required to use. In those states, the document might be available on the state agency’s Web site. Some states have a separate form to be used for those residents whose AL costs will, in part, be covered by Medicaid. In a few states, ALCs have the option to add their own data-collection instrument—or items—to the state-mandated form. Some states permit the ALC to use its own form, but it has to be approved by the state oversight agency. Virtually all states require physician clearance or approval for the older adult to live in an ALC. Most states require periodic review of the initial assessment data and when there has been a significant change in the resident’s condition.

An increasing number of states require full *disclosure* to prospective residents regarding the ALC’s services and costs, move-in/move-out policies, staffing, and so forth. Most states either identify the types of conditions or care needs that are permitted in the ALC, and/or those that are not permitted, and/or require move-out. Some states provide only very brief descriptions of permitted or prohibited conditions or needs. In many states, the ALC is guided by a brief regulatory statement that says, in effect, that a resident cannot (or should not) remain in the ALC if service needs are greater than what the ALC can provide or if the resident is unable to safely and independently evacuate the premises in event of a fire. Some states permit a medically unstable resident (i.e., one who needs skilled nursing care or monitoring) to remain in the ALC for a finite number of days—with or without getting the additional nursing care needed by paying for it privately.

In greater or lesser detail, states’ AL regulations/statutes address:

- Medication management (i.e., use of unlicensed assistive personnel to administer or assist with medications; see Chapter 10, “Medication Management”)

- Fire safety requirements
- Staffing requirements and training
- Administrator education/training and licensure
- Continuing education requirement for staff and/or administrator
- Bathroom and physical plant requirements
- Alzheimer’s unit requirements, including state approval of the program and the number, type, and education of staff working in this program
- Resident rights and dispute resolution
- Criminal background check requirements
- Emergency preparedness
- Infection control standards (including food, nosocomial infection reporting, etc.)
- Medicaid coverage

Survey Oversight

There is no uniform survey content or process across all states. Some states describe what the survey will examine; other states do not conduct surveys. In many states, survey and oversight is under the aegis of a state office of quality assurance, but specific definitions or criteria might be lacking. Some states offer formal consultation and advisement by state surveyors for AL providers; others are revising their survey process and content. Surveys can be standard, abbreviated (i.e., if there have been no deficiencies or ombudsman reports since the past survey), or conducted by self-report. The content and manner of deficiency citations varies between states. Unlike nursing home citations, the deficiency citations do not speak to severity or resident endangerment, nor do they place a hold on admissions until the quality of care issue has been addressed.

RESOURCES

- National Academy for State Health Policy. (2008). *Assisted living and resident care policies compendium, 2007*. Retrieved September 21, 2008, from www.aspe.hhs.gov/daltcp/reports/2007/07alcom1.pdf
- National Center for Assisted Living. (2008). *Assisted living state regulatory review, 2008*. Washington, DC: Author.
- Wilson, K.B. (2007). Historical evolution of assisted living in the United States, 1979 to the present. *The Gerontologist*, 47(special issue), 8–22.