Long-Term Care Admission Tip Sheet for Staff

A Good Welcome: The First 24 Hours

WHAT IT IS:

A good welcome focuses on making residents immediately comfortable, physically and emotionally. It starts with a staff person, preferably the person's *consistently assigned* social worker or Clinical Nurse Lead (CNL).

It is recommended that one main person charts personal needs, learning the person's routines and comfort wishes. Steps this person would take include offering food, helping settle into the room, introducing roommates (if a shared room), and providing information about services, schedules and people.

Having an "anchor or point person" at this time of high anxiety is comforting.

Use of *assured* communication tools like:

- the electronic health records (EHR),
- SBAR (situation-background-assessment-recommendation) reporting,
- shift huddles,
- electronic whiteboards/digital signage in resident rooms
- messaging apps

…helps other staff and temporary staff to know right away about a person's routines and preferences, so they can do the little things that lessen anxiety and maximize their independence.

When residents first move in, they and their families have heightened stress, both from the problems that led them to need a care home and from their worries about what it will be like and what the future holds. If residents must repeat the same information to several staff members because the information is not shared, their worry increases and their confidence in the home decreases.

Some required parts in the *admission process* can increase this anxiety and have an unintended, unwelcoming effect.

Examples include:

- having the resident undress for a full body skin check,

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- asking about Do Not Resuscitate (DNR) orders and
- about which funeral home a resident wishes to use.

Plan how and when these are done so that they become part of settling in will help take away some of their sting. For example, waiting until bedtime to do the skin check when the resident will be changing clothing anyway is more respectful and energy-saving for the resident as well. Moving into a long-term care home can be a very energy-draining process.

The first 24 hours a resident spends in long-term care is a pivotal time. Systems to support individualized living and care from Day One help residents and families feel that they are in good hands.

WHY IS IT IMPORTANT:

You only get one chance to make a good first impression. Making residents comfortable is key to their well-being.

There is considerable evidence about practices that can alleviate transfer trauma. These practices focus on ways of anticipating and meeting people's psychosocial needs, helping them acclimate to unfamiliar surroundings, and providing immediate comfort and security.

Residents (and their families) need significant support. They may also be very tired from all the preparations relating to coming into long-term care or from having been at the hospital before they came.

When care homes provide a good, warm welcome, they establish trust with residents and families that allows forgiveness and understanding if something does not go according to plan. However, if residents and families get off to a rocky start, their distrust is heightened, and any subsequent errors are magnified.

Thirty percent of rehospitalizations from long-term care occur within a resident's first seven days. These often occur because of communication and care gaps. For example, a resident who arrives in the late afternoon may not get a functional assessment until the next day, yet the staff providing care that evening, night, and the next morning need to know how well the person transfers and walks. Without that information, a resident may fall, or staff may be able to miss important cues.

Factors contributing to a poor night's sleep can impact the resident's mood, appetite, balance, and orientation. In the fragile post-acute state of someone arriving from the hospital, a difficult first night can have a cascading effect, resulting in rehospitalization. Having a process to enable the sharing of resident information will increase the chances that care and support needs will be

met and reduce the risk of negative outcomes.

While long-term care staff have had many residents come and go, for most residents and their families, this is their first experience of being in long-term care. They don't know how it works, and they are afraid and can even be traumatized. When you remember that everything is new and unfamiliar to them, you can make a better welcome.

Residents and families will respond best to their long-term care experience when staff make it a priority to establish their sense of security and "at-home-ness" in a new living environment. Residents have better outcomes if they can maintain their daily rhythms while in long-term care, especially if they are returning to the community.

HOW TO DO IT:

The four foundational practices:

- consistent assignment,
- huddles,
- CNL involvement in care planning and
- (quality improvement) QI huddles among staff closest to the resident

are key to providing a good welcome.

Key areas:

1. Customary routines: CNL's have an immediate need to know bedtime routines, morning routines, showering preference, and dietary choices. Outcomes improve when caregivers immediately begin using knowledge of residents' individual routines in establishing the plan of care. From the outset, have systems in place so that the staff who are caring for a new resident can take the time to get to know the resident and family.
For example, upon admission, the CNLs can ask these five questions:

1. **How would you like to be addressed?**
2. **What time do you want to shower?**
3. **What time do you want to go to bed?**
4. **What time would you like to wake up?**
5. **What would make you comfortable?**

When CNLs ask residents about their routines and preferences, it is essential that they can follow through on any requests that are made. For example, if someone says they are a late riser and want a later breakfast, they must be able to get a late breakfast. Otherwise, asking the question puts the CNL in a very awkward position of having asked and then having ignored the response – the opposite of building trust!

2. Functional status: While physical therapy might not do a complete evaluation until the next day, **CNLs and nurses need to know immediately how well someone is able to transfer**, balance, etc. While CNLs can't "assess," they can observe and share what they see with the nurse and with the PT and the nurse doing the assessment the next day. Passing this information to co-workers and oncoming staff helps everyone support safe mobility.

3. The Welcome: Include the necessary people who have a role in the new resident's first 24 hours, not a parade of the entire staff. Note how welcoming the entryway used by the ambulance or family member support is. Take pictures. Are there more "no smoking" signs than "welcome" signs?

Follow the path the newcomer takes.

Are the staff in that area aware that a new resident is coming in and where the resident needs to go?

Take the gurney ride or wheelchair stroll to see what it looks, sounds, and feels like to be flat on one's back staring at ceiling lights while conversation happens around you. See if you can spot ways to make improvements that make these first moments more welcoming.

4. **Personalized Welcome: Make sure that the new resident has an anchor person** - someone available to answer questions and to be there for them as they settle in. Build a system that allows the staff who will be caring for the new resident to be freed up to focus exclusively on providing a good welcome.

For example, have the receptionist call the nurses' station to let staff know that the resident has arrived. For late-day arrivals, have the staff nearest the entry point know that the resident is coming so they can make the call to the assigned staff. With a quick huddle, staff can share the workload so that the CNL providing the welcome has time to help the new resident and family settle in, get to know the new resident, and meet their immediate needs. **This is especially helpful for late afternoon, evening, and weekend arrivals.**

5. Get information ahead of time: Gather as much information as possible about new residents before they arrive. Use nurse-to-nurse report with the discharging hospital or other care provider. Establish some common elements to be shared in these reports. Gather the

resident's social history, customary routines, skin condition, functional status, equipment needs, medications, and orders.

6. **Share information with staff and get information from staff:** Share information about pending arrivals with staff through huddles. Have a quick huddle with the admissions coordinator and/or social worker and the staff who will be caring for a new resident, to let them know the person's social history, family, and any other useful information for the care and well-being of the resident. Having this information known by the direct caregivers is vital to the new resident's well-being.

7. **Do what you say you will do: Be sure that the room assigned to the new resident is the room that was promised**. If a room is required to have a bathroom or a ceiling lift, make sure the new resident isn't moved into a multi-person room. This will feel like a bait and switch to the new resident.

8. **Comfort, comfort, comfort:** Check with the resident upon arrival to see if they need food, to go to the bathroom, help washing up, or anything that will make this transition easier. Have information about what's available to eat, how to make a phone call, how to personalize the room and if possible, how to adjust the temperature to their liking. Invite family members to stay for meals. If a resident is going to be joining a table in the dining room, smooth the way with introductions that help people get comfortable with each other. Help establish ease among roommates by helping them get to know each other. Ask what they need for a good night's sleep and what their normal morning routine is.

9. **Encourage personalizing the room**: If someone loves to read, listen to music, or look at pictures of loved ones, having these personal items set up alleviates the tensions of unfamiliarity and provides environmental comfort. A welcome basket (maybe from family council) and/or a personalized welcome card or table tent on the dresser or bedside table creates a warm welcome.

10. **Provide information in chewable chunks:** The stress of a move makes it hard to absorb too much information. Rather than having a parade of people introduce themselves or bombarding a resident and family with packets of information, have a welcome packet that serves as an easy reference, such as a directory of key staff's names, positions, pictures, and phone numbers, and a written schedule of meals and other services.

11. **Have a checklist:** Note everything that has to be completed before the new resident arrives. Make this into a process in which every department knows its responsibilities and checks off

duties completed. Be sure that all equipment and prescriptions are in place. Don't allow for any gaps in care caused by lack of orders, prescriptions, or knowledge of the resident's needs and abilities.

12. **Evaluate orders initiated in the hospital or community:** Watch for orders for antipsychotics, alarms, sleeping pills, restraints, dietary restrictions, and medications with contraindications. Hospitals have far less time to get to know residents, are not generally focused on the care needs specific to the geriatric population and often pay less attention to customary routines and the communication inherent in a resident's distressed behavior. Many of these orders might, with proper evaluation, be discontinued.

13. **Work on improving transitions:** While your admissions coordinator and the hospital's discharge planner or family member in the community play the primary communication roles in navigating an individual resident's transition from a hospital or community to long-term care, the staff's work with the clinical leadership of the hospital will be key in establishing protocols for a better transition process.

14. **Part of this collaboration in building working relationships might include agreement on universal communication tools**,
Example: Point Click Care. Greater familiarity with the information to be collected and where to find it on the collection tool will result in more positive outcomes for residents with fewer omissions or gaps.

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