

CHAPTER 2. VA NURSING HOME CARE UNIT

2.01 ESTABLISHMENT

NHCU (Nursing Home Care Unit) will be established at VA medical centers only after approval by the Chief Medical Director.

2.02 AUTHORITY

Title 38 U.S.C. 610 authorizes the VA to provide nursing home care.

2.03 RESPONSIBILITY

[a. The medical center Director has overall responsibility for the NHCU. Organizationally aligned under the Chief of Staff, or Associate Chief of Staff for Extended care, overall NHCU administration will be the responsibility of the Chief, Nursing Home Care Unit. The Chief may be a registered nurse or a physician, as described in paragraph 2.03 c through e.

b. Under all models, a registered professional nurse designated "Associate Chief, Nursing Service for Nursing Home Care," or "Supervisor, Nursing Home Care Unit," is responsible for the nursing care delivered to patients, while a physician, designated as the Medical Director is responsible for the delivery of medical care. Under a matrix management system, each is responsible to the Chief of the NHCU for programmatic issues, and to his or her clinical service chief for the quality of the professional services provided.

c. **Nurse Administered Unit.** Under this model, the Associate Chief Nursing Service for Nursing Home Care or Supervisor, NHCU has administrative, programmatic and operational responsibility for the NHCU. This model is the one most commonly utilized. Under this model, the nurse would carry the title of Chief, Nursing Home Care Unit, as well as the Nursing Service title.

d. **Physician Administered Unit.** Under this model, a physician has administrative, programmatic and operational responsibility for the NHCU. This model would be useful in heavily academically affiliated tertiary care hospitals where patient care is medically complex and where teaching and research are important components of the NHCU program. Under this model, the physician would carry the dual title of Chief, Nursing Home Care Unit, and Medical Director, Nursing Home Care Unit unless another physician is designated as Medical Director.

e. **Combined Physician/Nurse Administered Unit.** Under this model, the administrative, programmatic, and operational responsibility for the unit are shared or divided by the ACNS and the physician. Division of responsibility will vary from site to site since leadership depends on demonstrated expertise in particular areas of management. This nurse/physician model would, like model d. be appropriate for heavily academically affiliated, tertiary care hospitals or for very large NHCU where division of responsibility may achieve a more efficient and effective use of staff.

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(1) Where responsibilities in the broad management functions are shared, that is, where both nurse and physician participate in programmatic, administrative and operational management of the nursing home, it would be appropriate to designate both a Chief and an Associate Chief, Nursing Home Care Unit. If this is done, it must be decided locally, whether the nurse or the physician is designated as Chief or Associate Chief.

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(2) Where management responsibilities are divided between physician and nurse, it would be appropriate to designate a Chief, Nursing Home Care Unit and a Director of the particular management function assigned to the nurse or physician. For example, if the nurse were responsible for administrative and operational functions, and the physician for programmatic functions, the nurse would be designated as Chief, Nursing Home Care Unit and Associate Chief Nurse for Nursing Home Care, while the physician would be designated Program Director and Medical Director, NHCU, or vice versa.

f. Other models for management of the Nursing Home Care Unit must be submitted to the Office of Geriatrics and Extended Care, VA Central Office for approval.

2.04 FUNCTION OF NURSING HOME CARE UNIT

The threefold function of the NHCU is to provide:

(1) Compassionate care to those patients needing rehabilitation to restore them to their optimum level of functioning;

(2) Care that will prevent or delay deterioration of those patients having profound physical disabilities and/or behavior management deficiencies, and

(3) Supportive care to patients and families through the dying process.

2.05 PROCESS OF CARE

a. Delivery of care typically occurs over an extended period of time, 3 months and longer, and is directed toward those patients who demonstrate a potential for improvement or toward patients whose rehabilitative goal is the maintenance of existing functions.

b. Ongoing evaluation of the self-help status of the patient should provide the basis for decisions about the amount of support services which are required now as well as those that should ultimately result in the development of maximal independence for the patient and the enhancement of the individual's self-esteem and feeling of usefulness. All staff should be constantly aware of the goals and plan of care for each patient. If the patient's rehabilitative goal allows a return to a more independent living status, alternatives such as Hospital Based Home Care, Adult Day Health Care, Domiciliary, Community Residential Care, or another appropriate setting should be arranged. If hospital care is indicated, arrangements for referral to the medical center are required. The services to be provided in support of these goals are listed in subparagraphs 2.05c through 2.05g.

c. Medical services include direct medical intervention and supervision of medical care by a physician who is appointed full-time or part-time as Medical Director. The Medical Director supervises the physician assistants and nurse practitioners and monitors the quality and appropriateness of medical services.

d. Nursing services include the assessment, planning, intervention, and evaluation of nursing care to patients. These functions are performed by a registered professional nurse who also supervises the activities of the non-

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professional staff; i.e., licensed practical nurse and nursing assistant. A rehabilitative/restorative nursing program is an integral part of nursing services and is directed toward achieving and/or maintaining optimum levels of functioning and independence in patients.

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e. Dietetic services include the provision of appetizing and nutritionally adequate meals, as well as the full range of clinical nutritional services. Supplemental feedings are provided when medically and nutritionally indicated. The clinical dietitian specializing in geriatric nutrition will assure that the goal of achieving adequate nutritional status is the primary focus of dietary regimes. Meals and meal service will be provided in a socially stimulating atmosphere with a rehabilitative focus. All patients are screened to determine nutritional status and nutrient deficits.

f. Social work services include a comprehensive psychosocial assessment of the patient, the patient support network including the family, and the community health and social resources needed to facilitate discharge planning, as appropriate. The social worker promotes coordination and integration of the treatment and discharge planning process; provides consultation and assistance to the treatment team concerning social factors affecting health care outcomes; and facilitates the full involvement of the patient and family in the resolution of problems affecting the plan of care during and following NHCU placement.

g. Dental services are designed to meet the dental needs of patients and include oral examination, diagnosis, treatment planning, and treatment provided by a dentist, assigned full-time or part-time to the program, or by an appropriate member of the dental staff.

h. Personal services include training patients in the performance of activities of daily living; e.g., personal hygiene, grooming, dressing, transfer, ambulation, and other related types of activities. When the patient is limited in performing the activities of daily living, the provision of personal services constitutes therapy in support of the overall treatment plan. The objective of providing personal services is to decrease dependence and maximize independence by encouraging patients to assume as much responsibility for their care as possible. The assessment of these needs is performed by the interdisciplinary team planning process and identified services are provided by the appropriate member of the team.

i. Socialization, recreation, and other motivational programs specially geared to the limitations of the patient should be provided. All staff must constantly seek ways and means of providing patients with opportunities to participate in individual and group activities that are meaningful and purposeful. Special care must be taken to include planning for those patients who are bedfast, severely cognitively impaired, or who exhibit disruptive behavior as these are the ones who are apt to become socially isolated. In addition to the interdisciplinary team, family members, volunteers, and community based organizations, such as recreational, educational, spiritual, and other service groups, should be encouraged to participate in these activities.

2.06 PHILOSOPHY

a. Patients admitted to VA NHCUs have the right to expect care that is specifically planned to meet their physical, psychological, social, and spiritual needs. This can best be accomplished by utilizing an interdisciplinary team planning process to assess needs and to plan, implement, and evaluate treatment goals. Both the patient and the family are encouraged to play significant roles in

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the process. Treatment goals are directed to rehabilitation where possible, maintenance of the current level of function, or supportive care through the dying process.

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b. Although the NHCUC is institutional in nature, every effort is expended to provide as home-like an atmosphere as possible. Quality of life, as defined by the patient, is an important consideration in the planning for the daily operation of the NHCUC. The NHCUC program should:

(1) Assist patients to achieve and maintain optimal levels of functional independence.

(2) Assure that administrative policies and procedures enhance rather than constrain freedom of choice in the establishment of appropriate life styles/behavior patterns.

(3) Preserve the individuality and dignity of patients in all staff-patient interactions.

(4) Enhance the quality of life through the patient's involvement in the development of individualized treatment plans.

(5) Facilitate the patient's return to a community setting whenever possible.

(6) Assure that programs are founded and developed on a sound knowledge base of geriatrics and long-term care.

2.07 GENERIC NATURE OF NHCUC PROGRAM

a. NHCUC beds have been placed at designated medical centers because of the projected demand for nursing home care. The NHCUC beds are considered generic and should remain available for any patient who has been determined to need nursing care, the services of an interdisciplinary team and the intensity of services which can only be provided in a hospital based nursing home. Therefore, it is inappropriate to dedicate NHCUC beds for patients in certain diagnostic related groups or in specialized programs for those requiring specialized treatments. For this reason the following are examples of the inappropriate use of NHCUC beds:

(1) Ambulatory Care patients admitted to receive renal dialysis, chemotherapy, or radiation therapy because the commuting distance is too great between their home and hospital;

(2) Hospice patients whose care needs exceed the NHCUC program's capacity;

(3) Geriatric Evaluation Units;

(4) Units specializing in Alzheimer's Disease and other dementing disorders;
and

(5) Rehabilitation Units.

b. The establishment of clinical programs, designed to meet the special care needs of patients in the NHCUC, is appropriate, and encouraged.

2.08 ADMISSION GUIDELINES

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a. The need for placement in the NHCU is based on medical and nursing care considerations. Specifically, the patient should require long-term nursing supervision, observation and care by an interdisciplinary team, and/or long-term rehabilitation

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programs and supportive health services. The outcome for the patient will vary depending upon the disease process, presence of permanent or residual disability, response to rehabilitative intervention, and presence or absence of a support system outside of the institution. For example:

(1) Patients with nonreversible pathological conditions, such as Amyotrophic Lateral Sclerosis, Huntington's Chorea, Multiple Sclerosis, Alzheimer's Disease, cancer, etc., should be admitted to the NHCU if the life expectancy is greater than 3 months.

(2) Patients with permanent or residual disabilities should be admitted to the NHCU to determine if a higher level of functioning can be obtained or to provide care that will maintain their current level of functioning.

(3) Patients having the potential for rehabilitation, which will take place over an extended period of time, should be admitted to the NHCU.

b. Those patients for whom admission to the NHCU would be considered inappropriate include:

(1) Those who are not medically stable.

(2) Those who require medical care on a day-to-day basis, need frequent laboratory studies and clinical monitoring (by medicine or nursing), require intensive medical care, or whose behavior cannot be managed in a nursing home setting, or are terminally ill with a life expectancy of less than 3 months.

(3) Those who are receiving parenteral nutrition, except when a Nutritional Support Team is available for care and management.

(4) Those who are able to meet their own self-care needs or do not require the resources available in the NHCU and the medical center.

2.09 SCREENING COMMITTEE

a. An interdisciplinary Screening Committee will be appointed and will consist of the Supervisor, NHCU (or Associate Chief, Nursing Service for Nursing Home Care), the physician directly responsible for the care of patients in the NHCU, a social worker, a rehabilitation therapist, a dietitian, a MAS representative, and other appropriate professional staff. The Chairperson will be designated by the Chief of Staff.

b. Following the eligibility determination by MAS, the Screening Committee will review all applications and make recommendations to the Chief of Staff for admission. The Screening Committee may request whatever information is deemed necessary to arrive at an appropriate recommendation.

c. The Screening Committee will meet as often as necessary to expedite action on all applications. All actions of the Screening Committee will be reflected in minutes, logs, patient records, and MAS recurring reports. These source documents

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should adequately reflect the reasons for a patient being accepted or rejected for nursing home placement.

d. Applicants who are currently hospitalized or domiciled at the same medical center where the NHCU is located will not be given preference over applicants from other VA medical centers.

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e. When considering applications for admission, the Screening Committee must carefully consider the services required by the applicant and determine whether the institution has the resources available to meet those needs.

2.10 ADMISSION PROCEDURES

a. Request for admission to a NHCU will be initiated by the patient's physician and will be supported by sufficient medical findings to show that the applicant meets the requirements of paragraph 2.08. VA Forms 10-10, 10-10m, 10-10f and 10-10i, as appropriate, must accompany applicants from the community. Additional information, as necessary, may be requested by the Screening Committee.

b. The Chief, MAS will be responsible for the initial screening of applicants to establish eligibility, assign a priority, and assure that all required documentation is available for the Screening Committee.

c. The Chief, MAS is responsible for prompt referral of all requests for admission to the NHCU to the Screening Committee and for prompt action and notification to all concerned after a decision is made.

d. The ACNS/NHC or Supervisor, NHCU will notify MAS as vacancies occur in the NHCU and will coordinate admissions with MAS.

2.11 WAITING LIST

a. A waiting list will be maintained by MAS for admission to the NHCU. The waiting list will be established by priorities and date of application.

b. Each applicant on the waiting list shall be provided with an honest appraisal of the time-frame for admission. The applicant will remain on the waiting list until admission, the request is removed, or for any other reason is no longer a candidate for the NHCU.

c. If an applicant is accepted for admission and placed on the waiting list, it is appropriate for the Screening Committee to make referral of this applicant to another program (e.g., Hospital Based Home Care, Adult Day Health Care, Community Nursing Home).

d. Individuals on the waiting list will be contacted no less than annually to determine if interest and need still exist for admission to a VA NHCU.

e. Selection of patients from the waiting list will be made according to priorities and earliest date of application.

2.12 ABSENCES FROM CARE

a. VA nursing home patients who require admission to the hospital will be placed on Absent Sick-in-Hospital status. Those who remain in the hospital for 30 days or less will be assured a bed in the nursing home unit when released from hospitalization (see VHS&RA manual M-1, pt. I, ch. 10).

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b. Weekend passes and trial visits home (see VHS&RA manual M-1, pt. I, ch. 10), when properly utilized with appropriate planning, may be an excellent way to prepare both the patient and the family for eventual discharge home. These visits home should be part of the interdisciplinary planning process.

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2.13 INTERDISCIPLINARY TEAM

a. The care provided the patient should be planned and coordinated by an interdisciplinary team. This team of professionals is representative of a variety of disciplines. Interdisciplinary team members share common team goals, collaborate, and work interdependently in planning, problem solving, decision making, implementing, and evaluating team related tasks, and share the right and responsibility for assuming leadership roles and functions for team progress. Because interdisciplinary team members work interdependently to assure the efficient provision of comprehensive and coordinated, quality care, they give great import to the interactional processes of their team. Communication, role negotiation, and other critical teamwork skills are practiced, and regular evaluations of the team process are undertaken by all members.

b. The interdisciplinary team consists of a core team and adjunct team. The core team should consist of health professionals from the following services: medicine, nursing, social work, dietetics and rehabilitation medicine. If the members of the core team do not possess the expertise required to deal with the patient's needs, then the appropriate adjunct team member should be called upon. The adjunct team complements the services of the core team and may include audiology and speech pathology, dental, optometry, pharmacy, podiatry, psychiatry, psychology and recreation services. The membership of the core team may be expanded and the adjunct team membership may vary from nursing home to nursing home, depending upon local emphasis and available resources.

2.14 TREATMENT PLAN

A written plan of care will be developed and maintained for each patient in accordance with the Accreditation Manual for Long-Term Care Facilities developed by the JCAHO (Joint Commission of Accreditation of Healthcare Organizations). The plan of care should be based on an assessment of each patient and be developed by an interdisciplinary team. All members of the team should sign the patient's plan of care. The plan of care is utilized as a tool for providing care by all staff caring for the patient. Overall coordination and maintenance of the plan of care should be the responsibility of the interdisciplinary team. The treatment plan should be shared with the patient and family who should also sign the plan as active participants in the treatment program.

2.15 QUALITY ASSURANCE

A process of systematic internal review of the NHCU program should be integrated into the medical center's overall Quality Assurance program. Examples include SCEM (Standards, Criteria, Evaluative Algorithms, and Measuring Instruments); Accreditation Manual for Long-Term Care Facilities developed by the JCAHO; program guides developed by the services within the Department of Medicine and Surgery; etc. The evaluations should be scheduled as ongoing periodic reviews with written reports made of the results. Action for followup should be initiated and documented. Deficiencies germane to the NHCU program which are identified during the external review process should be clearly identified and resolved. These reviews are conducted by the Joint Commission and SERP (Systematic External Review Program) teams.

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2.16 DISCHARGE TO HOME OR ALTERNATIVE LEVEL OF CARE

a. Discharge planning is an integral component of the treatment program. The discharge planning process will be initiated as soon as possible following admission to the

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NHCU and will be based upon the interdisciplinary assessment of the patients' needs. Discharge planning will be reevaluated throughout the patient's stay at the NHCU.

b. Discharge from the NHCU will be accomplished when the treatment goals have been reached and appropriate community resources are available to sustain the patient either at home or in an alternative level of care.

c. Discharge to home or a community agency or facility must be accomplished in an orderly fashion with ample time allowed to prepare the patient and family, to make appropriate referrals, and to assure that needed equipment and supplies have been procured and/or structural modifications to the home have been accomplished. Precipitous discharge with inadequate planning should always be avoided.

d. Additional policies on discharge planning are contained in M-1, part I, chapter 5.

2.17 DUE PROCESS

a. If, in the planning process for a community placement, it is discovered that the patient or family, or patient representative objects to outplacement, they should be made aware that they may present medical information relating to the patient's condition which would prevail against the discharge plan.

b. If the patient, family, or patient representative wishes to present new medical information, they will be given up to 1 week from receipt of notice of the discharge plan, to indicate their intent to present such information. The subsequent length of time allowed for the family to present the evidence should be reasonable, based on the nature and source of information to be provided, up to a maximum of 7 calendar days.

c. The medical information presented by the family should be reviewed by the attending physician who will decide whether or not to continue discharge planning to another setting, including a community nursing home. A decision to proceed with planning will be reviewed by the Chief of Staff. This review function may be delegated to another physician or to a medical review panel, if desired.

d. The family should be notified in writing of the decision. Beyond this point, the normal steps for either discharge planning or for continued VA nursing home care should be followed, depending on the decision.

e. Should continued VA nursing home care be planned, the case may be reviewed at any time there is new medical evidence that the veteran has reached maximum benefit of the VA Nursing Home Care Program.

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(4) Assure appropriate, timely followup of veterans placed in CNH.

(5) Develop working relationships with local regulatory and quality assurance agencies, ombudsman and/or complaints offices and assure regular exchange of information with these offices.

(6) Conduct, as needed, surveys of the nursing home market, to ensure that the supply of nursing homes under contract is adequate to meet the needs of patients.

(7) Provide overall guidance in the management of the CNH program.

d. The contracting officer is responsible for negotiating and consummating contracts with community nursing homes.

e. Followup of the veteran will normally be the responsibility of the placing facility and will be conducted primarily by Social Work and Nursing Services. Other services are expected to provide consultation to the nursing home in the followup process as needed. For example, patients with an identified nutritional problem

CNHC PROGRAM: QUALITY OF CARE/QUALITY OF LIFE INDICATORS

The following is a list of areas of observation of nursing home care, defined by VA Community Nursing Home staff over the past 10 years, which, when applied with professional judgment, can be indicators of the quality of care and the quality of life in nursing homes.

1. Physical Environment

- a. Attractiveness of building
- b. Maintenance of building
- c. Maintenance of grounds
- d. Lighting of interior
- e. Adequacy of privacy/personal living space
- f. Privacy for resident/family counseling/visitation
- g. Absence of offensive odors
- h. Absence of excessive noise
- i. Condition of furnishings
- j. Suitability of furnishings
- k. Accessibility of total facility to all residents

will receive followup visits as determined necessary by the dietitian. A written referral will be made to another VA medical center or clinic when the distance to the nursing home or other circumstances make followup by the authorizing facility impractical. The medical district coordinator in consultation with the Social Work Council will determine facilities having followup responsibilities for specific nursing homes in the district.

f. Social Work Service will maintain an up-to-date list of all veterans outplaced under contract to community nursing homes which will be updated periodically and made available immediately in the event of disaster or other incidents. A copy will be provided to the Chief, MAS.

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