

Pioneering Change

**Returning Control
to Residents
Education Module**



to

Promote **E**xcellent **A**lternatives in **K**ansas
Nursing Homes

ABOUT THIS MODULE

This educational module is intended for use by nursing homes who wish to promote more social, non-traditional models of long-term care. The intent of this module is to assist organizations in implementing progressive, innovative approaches to care that should make a significant difference in the quality of care and the quality of life for those living and working in long-term care environments.

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Center on Aging
Kansas State University
103 Leisure Hall
Manhattan, KS 66506-3501
785-532-5945
gerontology@ksu.edu

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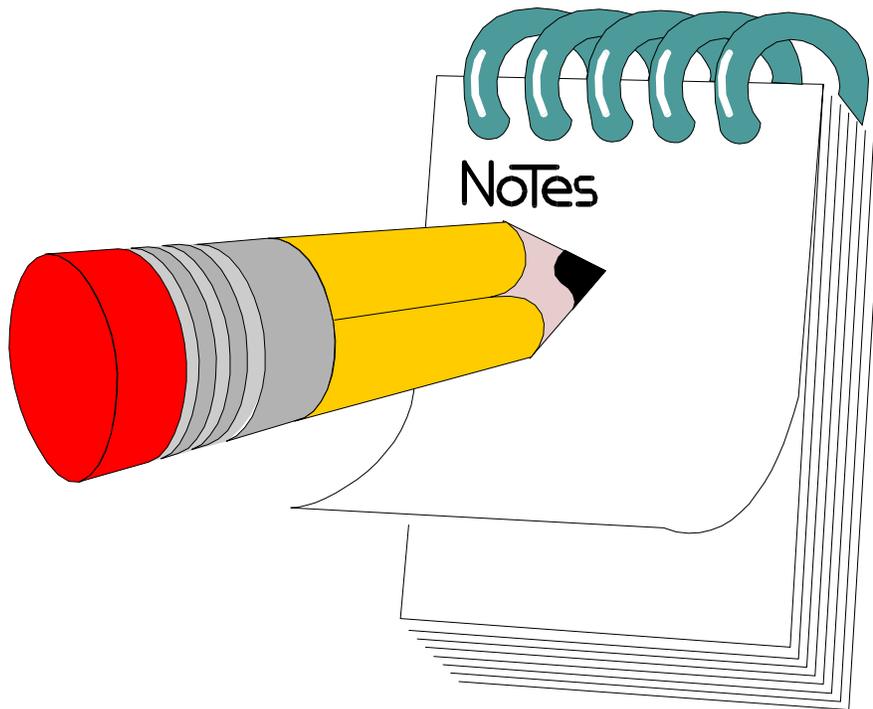
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Course Objectives:

1. To understand general concepts of resident control and autonomy.
2. To develop strategies for enhancing resident control and autonomy
3. To understand the ability to work with regulations for resident autonomy and control.
4. To raise awareness of desired outcomes from resident-centered care.





Pretest

The pre- and post-tests included with this module are optional. The questions provide information about the materials to be covered and can be used for learning self-evaluation. At some future date, these tests may be used as a part of a continuing education requirement.

1. Which of the following would be considered a resident-centered approach in providing care for a non-responsive resident?
 - A. Contact the family about past behaviors and habits.
 - B. Implement trial and error (for example, trying different wake and sleep times) to find the care treatment that seems most desirable to the resident.
 - C. Use empathy, or imagine what you would want in similar circumstances.
 - D. All of the above.

2. Which of the following supports the “regenerative” model of care, or the “we can all grow until we die” philosophy of Barry Barkan?
 - A. Moving to a nursing home indicates that the resident cannot function on his/her own.
 - B. Activities are offered for individual needs and are developed to promote learning.
 - C. Only group activities are offered and residents may choose to attend them or not.
 - D. Most older adults only like to watch television.

3. Some nursing homes “allow” residents to determine when to get up. The use of the word “allow” in this example implies
 - A. That the resident is able to control all aspects of their lives.
 - B. That the resident feels the control in their lives is internal.
 - C. That the control is external to the resident or extended because the organization is kind, not because the resident is competent.
 - D. That the resident feels the control over this aspect is stable.

4. The staff at ABC nursing home had been studying the SOC theory. They were wanting to improve resident satisfaction with the nursing home within the first few weeks of moving in and had decided to work on the “selection component” of the theory. Which of the following might be an example of selection?
 - A. The ABC staff would assign an aide for the first few weeks to help the resident integrate into the home.
 - B. The home planned to purchase a dog.
 - C. The staff decided to spend a lot of time educating the community on what ABC had to offer so that more older people would be likely to choose it as an option for long-term care.
 - D. The room would be painted before the resident moved in.

5. Nursing homes help residents to function at their highest ability by providing “compensation” for individual losses. An example of this is:
 - A. Providing seating arrangements in strategic places so residents can rest on their way to meals and activities.
 - B. Designing neighborhoods with dining and living spaces closer to the residents so they don’t have to walk so far.



- C. Providing eating utensils with thicker handles.
D. All of the above.
6. Mrs. Gray believed that she was able to control many things in her life while living at ABC nursing home because:
- A. the staff expected her to make her own decisions about her daily schedule, what to wear, when and what to eat.
 - B. she paid a lot of money to live there.
 - C. her daughter had said she could expect to make her own decisions once she moved in.
 - D. none of the aides treated her with respect.
7. Continuity theory means that people basically stay the same throughout their lives. Which of the following statements best expresses that?
- A. What goes around, comes around.
 - B. Just a chip off the old block.
 - C. What will be, will be.
 - D. You haven't changed a bit!
8. Two aides at ABC home were visiting about how quickly Mrs. Jones had become "institutionalized." Which of the following behaviors in Mrs. Jones might indicate that the aides were correct?
- A. Mrs. Jones continued to maintain contacts with her close friends in the community.
 - B. While she had stated on admission that she was a late riser, Mrs. Jones began getting up for breakfast at 6:00 a.m.
 - C. Mrs. Jones lost interest in selecting her wardrobe for the day and asked her helpers to do it for her.
 - D. Both B and C.
9. Nurses aides at ABC nursing home are seen moving residents in wheelchairs without asking or telling residents where they are going. This type of care reflects:
- A. Care based on regulations
 - B. An example of the continuity theory: people stay the same throughout their lives.
 - C. A "we know what is best for the resident" attitude.
 - D. Resident-centered care.
10. Which of the following could be considered activities appropriate for nursing home residents?
- A. Music: sing-a-longs
 - B. Bingo
 - C. Daily devotions
 - D. Preparing a cup of tea
 - E. Listening to a travel-log
 - F. Watching television
 - G. Leaving the nursing home
 - H. Planting flowers
 - I. Coloring Easter eggs
 - J. All of the above!

Answers found on page 38



Returning Control to Residents

Introduction

(Refer to the section on how to use the modules in the original “Culture Change Education Module”)

Maybe I shouldn't have looked back, but the all-purpose room had a big window facing the parking lot and I couldn't help glancing in to see if my mother was watching me leave, waving as she usually did at all our good-byes. Thankfully, this time she wasn't watching so she did not see the tears on my cheeks or the shock I felt at not being able to instantly find her in the little gray-headed wheelchair-bound armada gathered around in a circle, all with lap robes and shawls. We had always laughed over her hospital “nursery room” story about how she couldn't pick



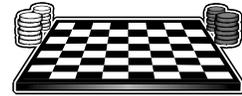
her own babies out from the other newborns, but now the story had turned and was no longer

amusing. In one shattering afternoon her individuality seemed to dissolve right before my eyes.... (excerpted from “A Nursing Home Odyssey” by Mary M. DeShaw, 2002,

<http://garnet.berkeley.edu/~aging/odyssey.html>)

The honoring and sustaining of individuality can be in short supply within the nursing home environment.

Caregivers generally are well-meaning persons who desire to express their compassion for the residents they serve. Unfortunately, for many of these caregivers the pressures of the job, the tasks that HAVE to be done, outweigh the opportunities to provide resident-centered care. For the best of them, the resident-centered focus sends them home at night feeling like they haven't achieved their goals for the day. One nursing home caregiver has compared her work role to her role as a mom. She never feels like she has enough time. The work is unfinished when time isn't found to read the paper to Charlie or to play checkers with June.



The alternative, however, to resident-centered care is residents who are lost in “the wheelchair-bound armada gathered around in a circle.”

This module is all about recognizing the individuality of residents and the staff who serve and support them. Many nursing homes have become “mindless” cultures where practices are repeated over and over again simply because they always have been, not because they are the most appropriate for the moment. Bathing is a case-in-point. Traditional bathing techniques (tub baths and showers) have frequently been a trigger for problem behavior. Alternative methods for keeping clean have been



demonstrated as safe, effective, and less problem inducing, and yet many caregivers cannot give up their assumptions about how bathing should occur within the nursing home environment. Many other examples can be found that demonstrate notions about how nursing home services must be delivered, such as waking persons in the morning based on the location of their rooms, and assumptions about therapeutic diets. The focus on these tasks has de-emphasized the persons who are the recipients of the tasks.

Defining the Terms

It is important to consider carefully the terminology adopted by your nursing home since it can reflect the way the organization views residents and may impact determinations of individual differences. Each of the following terms has a slightly different meaning and you will want to choose the one that best matches your philosophy of care.

Resident-directed: This philosophy was developed at Mount St. Vincent in Seattle. Leaders in a traditional model nursing home wanted to change the way they provided care so they asked residents what they desired. Resident input, constantly sought by staff, drives the culture changes. **“Resident-controlled”** may be a derivative of this model.

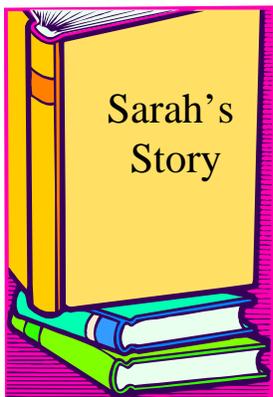
Resident-centered: This term implies providing care that is intended to be based on what the resident desires but may also be based on what staff members “think” they desire. It is important to consider the use of this term and philosophy carefully. Staff feelings should never replace suggestions and ideas from the persons living in the home. The input of residents should be actively sought.

Person-centered: This philosophy was first implemented in the developmental disability movement. As it has been adopted by long-term care environments it may mean extending the focus on the needs and the desires of the residents to all persons in the nursing home community. In other words, staff are viewed as being as important as the residents. It implies that all members of the community work in collaboration to develop plans that are best for all involved.

Regenerative community: This term was coined by Barry Barkin from Live Oaks in California, who believes that we should promote the notion that ALL people, no matter what their needs, can continue to grow until they die. This idea is demonstrated well by the following story. You may want to use it for an opening activity in a small group training session.



This is an often repeated story of a nursing home administrator who was well known for the kind, compassionate, and innovative care that he and his staff provided within his nursing home. He was frequently asked to speak at conferences and in-service trainings. At one of these meetings he told the



following story: Sarah was a difficult person to care for. Her behavior was erratic and she had difficulty making her wishes known. All of her physical needs had to be provided by others. If what she

spoke was a language, it wasn't from this earth. Sometimes she was so delightful and engaging that people begged to take care of her, while other times it seemed impossible to make her happy. Sarah frequently kept people from sleeping at night with her crying and screaming. She had to be fed and many times the food ended up in her hair and all over her clothes. She was constantly drooling and wore a bib to catch the spit upon her chin. She could not change her own clothes and was incontinent.

The administrator asked the small group of staff members what they would do for a person like Sarah.

(You may wish to have members of your staff contribute to the discussion at this point, having them describe similar

situations and what staff members did for this person)

In the story, one staff member replied, "Oh, we have seen many residents like Sarah. There isn't much you can do for them but attend to their physical needs and try to love them." The other staff members nodded in unison.

The administrator listened attentively and then said, "but.....Sarah is my eight-month-old daughter."

(Author unknown)

What does this story mean to you?

Assumptions about frailty: as this story was told, you created a picture of Sarah in your mind. Because you work in a nursing home, it was natural for you to think of a person that may have fit Sarah's description. A person who can do so little for herself or himself can easily appear to have no further value other than perhaps for our own compassion. In fact, many of us create assumptions about ability and worth from the moment a person becomes a resident. Simply moving to a nursing home suggests dependency and the lack of ability to be responsible for oneself.

Societal comparisons of the beginning and end of life: A second point is that we frequently describe Alzheimer's dementia as a reversal of the developmental process. The older person loses in reverse order to what he or she gained in infancy. (For more information about this see Barry Reisberg's work as



listed in the references. His work can be very good in helping families to understand these processes). However, there may be danger in this description. If we believe this to be true we may begin to believe that older persons at the end stages of life have the same needs as children at the beginning and can be treated like them. This could hardly be true.

Renee Rose Shield (2003), in an essay about dependency, writes about the tendency that Western civilizations have to judge very old and dependent adults as being similar to children. However, dependency in children is applauded while it is scorned in older people, and sets up an imbalance between the caregiver and the dependent person. “The payment for the dependency is acquiescence and gratitude” (p.127). Lack of control, she further states, may be the basis for the shame that accompanies dependency.

Assumptions about the inability to grow at the end of life: It is easy to care for the dependent child because one assumes that the child will grow into independence. Indeed, caregivers do everything they can to foster autonomy within children so that they can develop into unique individuals. If we make assumptions about the inability to grow at the end of life it supports our inclination to focus on the tasks rather than the persons involved.

Rosalie Kane writes, in Everyday Ethics:

Resolving Dilemmas in Nursing Home Life:

...In childhood, people are typically expected to become unique individuals even as they learn to assume defined social roles. In old age in the nursing home, however, people are expected.... to homogenize their individual traits and eccentricities to a remarkable extent in order to fit into a bureaucratically defined behavioral norm... This cultural expectation makes it possible... to exhort residents toward conformity with the institution and to rationalize many kinds of intrusions as necessary for the residents' own good (p. 23).

What is our role with frail elders?

Recently several administrators worked together to try to develop a theory of long-term care. They were stalled,



perhaps because we as a society lack a theory of what role frail elders are meant to play in society. Lacking this theory, perhaps long-term care theory needs to be couched in terms of what we as caregivers need to be able to feel in working with frail elders. This appears to be the impetus for true culture change. The leaders of change have been enlightened to the “need” to provide care for elders in a way that was more aligned to their beliefs about humanity. They didn’t feel satisfaction working in the current culture.



Let's return to Sarah.....

Let's return to the example of Sarah and ask the question "if the staff who answered how they would care for Sarah were a culture changed home, how would they have answered differently?"

A culture change organization may have answered in a manner that was observed in a Kansas nursing home. A visitor was touring the facility one day with an administrator when he asked why a particular resident was out of bed. She appeared to have no communication skills and had been a resident of the home for years and he'd never seen her up before. The staff member pushing the resident in a wheelchair explained that there had been no clear reason stated for why she needed to be in bed. The staff as a group decided to try dressing her and getting her up to see how she reacted. They felt that she was more responsive and seemed to enjoy the activity.

Oftentimes, knowing how to take care of residents as they would desire is a trial-and-error process. It may also help to ask family members to assist staff members to understand the things that their parents appreciated in their life before the nursing home. If these strategies have been tried and were unproductive, staff members may wish to implement "substituted judgement." What would they want done for them in a similar situation?

Another statement about language:

Terms for the type of care offered are not the only words that need to be examined when adopting new philosophies. A good way to start changing is to examine the written materials produced by your organization. Do mission statements and newsletters accurately describe the work that you do? Do job descriptions and job titles reflect new models of care? For example, the terminology "charge nurse" may not fit within a design where staff members share responsibilities for care decisions.



Many nursing homes are adopting smaller units of residents and staff. These units have been called neighborhoods, households, courts, clusters, and communities. Each of these terms implies a different type of philosophy. For example, households may imply for some hearing the term a more intimate environment and more isolation than would the terms neighborhood or community.



Returning Control Activities

Group Activity: (This activity may work well as a group activity where participants brainstorm and share options from group members and then select the words that “best” suit the organization)

Following is a list of terms commonly used in traditional model nursing homes. For each provide an alternative option:

facility: _____
patient: _____
charge nurse: _____
nurse aide: _____
diaper: _____
feeders: _____
wing or unit: _____
admit or place: _____
discharge: _____
lobby or common area: _____
nurse’s station: _____
housekeeping: _____
agitated: _____
food service: _____
ambulation: _____
elopement: _____

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Autonomy and Control: What Is It That Each Resident Wants?

Ultimately, long-term care residents, regardless of disability want what we all want: to be treated with kindness and respect; to engage in pleasant, meaningful activities; to have good relationships with our families and other people; and to make our own choices about things that are important to us on a daily basis. (Logsdon, 2002, p. 155).

Two older research studies show the effects of resident control on their lives. In one (Langer, & Rodin, 1974), residents in a nursing homes were given live plants. Half of the residents were told that their plants would be cared for by the staff. They were also told that they should not worry about anything because the staff would take care of all of their needs. The residents in the other half were asked to be entirely responsible for the care of the plant.



They were to choose where to position the plant and when to water and fertilize it. This group was also told about the choices that they had at the home. They could choose when to go to activities, what they wanted to do with their day, what they wanted to eat and so on. They

could also make suggestions about improving care at any time. At the end of the study duration, staff members judged the persons who had full control of plant care and had heard the message about choice to be happier, healthier and more engaged in life in the home. Furthermore, when the residents were revisited eighteen months later, these residents were much more likely to be still living than were the residents whose plants were cared for by staff.

In a second study, Schulz (1978), wanted to extend this idea of control by residents so he arranged for college students to visit residents of a nursing home. Some residents were allowed to choose when they wanted the students to visit, other residents were visited but had no control over when the visits would occur. As expected, the residents with control had similar results to the residents providing plant care in the study above. However, there was a very different situation when residents were revisited eighteen months later. The residents who had control over student visits were now worse-off than were the residents who had lacked control.





What was the difference in the two studies? Why did one study benefit residents for a long-duration and not the other? When Schulz examined the differences he found three things:

1. Stable vs. unstable: The plants and the suggestion boxes stayed with the residents while student visits ended at semester. In order for resident control to have positive benefits, it must be long-term or stable. Residents who perceive that they have some control over events in their life and then have that control taken away may experience negative outcomes.

2. Global vs. specific: Residents in the plant study felt that they controlled more than one specific aspect of their lives. The residents responsible for plant care were also told that their input in other aspects of their daily care was valued while in the Schulz study only the student visits were offered as an opportunity to exert control.

3. Internal vs. external: Residents in the plant study felt that they could control important outcomes because they were responsible and competent not because someone was “allowing” them to do it. In other words, the control came from within, not from external sources like a benevolent management.

These are important qualities to consider when implementing philosophies of care

that are meant to engage residents in controlling their own lives. We can go back to language here, how often do we say “residents are **ALLOWED** to choose when to get up in the morning?” This example implies that the control is external to the resident. They don’t determine when to get up because they are believed to be competent to do so but because someone else is kind enough to let them do it.

Autonomy and Control Activities

Case study:

“Mrs. S., an 87-year-old cognitively intact woman residing in a nursing home, needs assistance getting dressed in the morning. At first the nursing assistant assists Mrs. S. in choosing what she wants to put on each morning, but in the rush to get through her heavy workload, the assistant finds it easier and quicker simply to pull some items from Mrs. S.’s closet and put them on her. Although a seemingly small matter, in Mrs. S.’s severely constrained world she has lost control over an important dimension of choice that allows her to define and communicate who she is (Hofland, 1995, p. 16).”





Questions for personal reflection:

Return to the Schulz discussion about the factors necessary for residents to gain positive outcomes from a perceived sense of control: stable, global, and internal. How must this scenario be changed so that these factors might be enhanced?

How might Mrs. S continue to choose her own clothing without it becoming too much trouble for staff members?: _____

What other ways might Mrs. S. choose to demonstrate her individuality? _____

You may wish to discuss your answers in a small group. Look at the end of this module on page 38 for possible solutions to these questions.

Group activity:

Consider the following examples.

Which situations would be stable, global and internal in nature and enhance control and well-being? How might the other examples be changed so that they might provide these benefits?

- Residents in nursing home A live in one of three neighborhoods. The staff in neighborhood 1 have given residents a choice of activities to select from throughout the day. In neighborhood 2 they are given one activity option and the choice of attending or not attending. In the third household residents are given the opportunity to develop the list of activities that will be available as well as the choice of which they prefer to use or participate in.
- Residents in nursing home B are told that they will be allowed to sleep as long as they like in the mornings. A staff member enters the room periodically to wake the resident and ask them if they are ready to get up.
- Residents in nursing home C are visited frequently by sorority women from a local university. Students arrive to hang decorations, earn service points, and then leave. One sorority decides to have students adopt residents for a semester. The



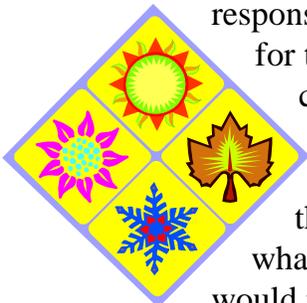
young women meet with their selected resident and arrange a time for a weekly visit.

- Residents in nursing home D also live in three neighborhoods. In one unit they are invited to sit in and participate in the hiring of the leaders for each of their neighborhoods. In the second group the residents are involved in all hiring decisions for the people that will be associated with their care. In the third group all staff members are interviewed and hired by administration.

Examples of Resident-Centered Care from the Field

Most of the examples of the process and outcomes of resident-centered care tend to be anecdotal in nature. This section could involve numerous examples of stories of how returning control to residents can improve their quality of life. Here are a few that have been witnessed.

- Ralph's behavior improved when he was given the responsibility of caring for the nursing home cat and reporting the daily weather. Staff had taken the time to find out what types of things would make Ralph feel better about himself.



- The staff at ABC nursing home always asks new residents how they would like their room decorated and encourage them to bring personal items from home such as beds, dressers, and night stands. This way the room becomes what the resident wants, not what the staff thinks the resident wants.

- Georgia had worked the night shift all of her life. When she was moved to a nursing home because she was no longer able to care for herself she was unable to adapt to the sleep schedule there.



The staff decided that they could accommodate her habits, and they would keep her company at night and let her sleep during the day.

- Valley View Professional Care Center in Junction City and Lyons Good Samaritan Care Center are both incorporating Make a Wish Programs for the residents. Residents can ask for special activities and the staff and community try to make them happen. One of their successes occurred at Lyons when an older gentleman got to take his first airplane ride.





In each of these examples, staff recognized the residents in their care as individuals rather than care tasks that needed to be completed. This personal identification is essential if the resident's needs are to be honored. This understanding is much more likely in nursing homes where staff have been consistently assigned to the same residents at all times. This type of assignment insures that staff will learn the residents' pleasures, what upsets them, and what they value.

Recently, an administrator working in a nursing home that had radically changed their culture through major structural renovations as well as changes in the organizational and social environments, reported that he felt the physical changes were the least significant in the equation related to improved quality of life for residents. For him, adopting a resident-centered philosophy led to major changes



in his personal commitment to caregiving and felt it was the personal changes in him and his staff that were responsible for the improvements for residents. They began to see their jobs differently.

These internal revelations can occur in any kind of physical environment.

Resident-centered care is NOT dependent on neighborhoods or removing a nurses' station or adding spas instead of shower rooms.

On the other hand, it is frequently seen that nursing staff will hear about resident-centered philosophy and report that they are happy with the notion because it "justifies what they have been doing all along." This may be a misinterpretation of the philosophy. It is possible that in some smaller homes with very consistent staffing and little turnover, resident desires are more readily identified. However, frequently this interpretation takes on a paternalistic or maternalistic nature rather than an empowerment for residents. "We know what's best for the residents" is a common theme.

Linda Bump, a culture change leader from Big Forks, Minnesota, believes that she can identify a home that is resident-centered by observing whether activities are occurring spontaneously. In our own personal lives we may frequently do things on a whim. We may crave ice cream in the middle of the night or decide to play a game of cards at noon. The ability of staff to be able to accommodate spontaneity should be central to resident-centered care.





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Photo by Gayle Doll



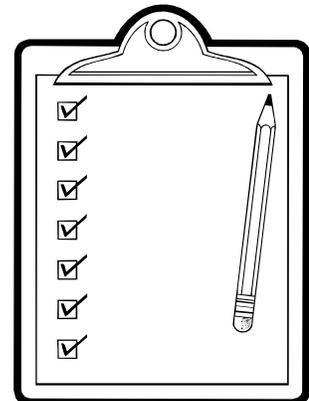
Resident-Centered Environments: No Place for Pain

Kim Lawton, Project Manager, Nursing Home Quality Initiative, Kansas Foundation for Medical Care

Studies show that of the 1.5 million elders residing in nursing homes, as many as 83% experience pain to the point of mobility impairment, depression, and/or decline in their quality of life. Residents that are recognized as having moderate pain on a daily basis or severe pain at any time on the MDS assessment fall into the calculations for the chronic pain measure that is reported on the Nursing Home Compare website (www.medicare.gov).

The Cedars Nursing Home in McPherson, Kansas is one of many homes working with the Kansas Foundation for Medical Care, Inc.(KFMC) to reduce the incidence of pain. Twelve months ago, when baseline measures were taken, one in five residents at the Cedars was experiencing at least moderate pain on a daily basis. The Quality Improvement team made up of the administrator, the director of nursing, the risk manager and neighborhood leaders found this measurement to be unacceptable.

The team knew that they needed to do a better job of screening and identifying those residents who were experiencing pain. Policies were updated to trigger pain assessments conducted at routine times. All nursing staff received training to assist them in pain identification and management. CNAs now carry pocket tools for screening residents. Training re-enforced the need for staff to question and observe the residents during the course of their day for signs of pain. This screening is now monitored on the CNA flow sheets. If the resident reports to the CNA that his/her pain is a 3 or above on the 0-5 point pain scale, the CNA then notifies the nurse for follow-up assessment. The nurse implements a comprehensive pain assessment, in which the resident is questioned as to what makes the pain worse or reduces it. Tools are in place to allow the nurse to assess residents with dementia as well.



Residents are prompted to make informed decisions regarding their own pain management. Staff is supportive both of the residents electing to utilize aggressive pain management, as well as of those residents who decide not to initiate treatment. Education is provided to the family about pain management, and it is added to the resident's care plan.

The program has now been in place for 12 months, and The Cedars score, as reported on Nursing Home Compare, is now a low 2.39% or only three residents out of 95 are experiencing moderate or severe pain on a daily basis. This percentage places them well below the national average of 7.22% and the Kansas average of 9.23%. An additional benefit to developing strategies to decrease residents' pain at The Cedars is that reported resident declines in activities of daily living have been reduced by 50% since the first quarter of 2003.

This example demonstrates extremely well the importance of clinical issues in the promotion of resident-centered care. In nursing homes promoting quality of life for residents and staff, there should be no tolerance for pain.



Frameworks for Autonomy in Long Term Care:

It may be helpful to consider theories from older adult development as they relate to autonomy in long-term care. Hill and Gregg (2002) have written a chapter that proposes using two frameworks, SOC and continuity theory, to develop practices and policies that promote resident control. SOC stands for selection, optimization and compensation and recognizes that with increased age the need for the environment and culture to offset age-related losses increases. Long-term care has historically been a cultural effort to offset the loss of independent functioning in very old age. Hill and Gregg define (p. 10) the goal of residential care as a “culture-initiated compensatory force to promote functioning in the presence of degenerative physiological processes and death”.

SOC is also about how the individual or resident, takes advantage of culture. Specifically, “*selection* involves reducing the number of options available so as to focus one’s skills and abilities on obtainable outcomes” (Hill & Gregg, 2002, p. 10). *Optimization* refers to the ability to respond to functional losses by focusing on the strengths still available to the individual while *compensation* involves developing new strategies to compensate for loss.

SOC can be described as a “coping” strategy for aging. Older adults naturally select, optimize and compensate to make up for losses associated with aging. A good example would be an older athlete.

He would select a venue for competition, such as a Master’s event for persons over the age of 50, that would allow him to successfully race against people of his own age or older rather than younger, quicker athletes. He would optimize his remaining abilities



by practicing those skills he does best, for example if he had been a decathlete, he may determine that he needs now to focus on only one event rather than many. In addition he will compensate for loss by developing new strategies. For an older athlete this may mean that he needs more rest prior to and after events.

Frameworks for Autonomy Activities

Case Study:

The following case illustrates the SOC framework as it relates to long-term care residency:

Charlotte came to the nursing home when she began to have severe problems



with her memory. In addition to memory loss she suffered from paranoia, believing that her caregivers were trying to poison her and take her money. She was moved into the general population and had a roommate whose physical disabilities confined her to the bed.

Charlotte immediately became classified as a behavior problem, frequently getting into her roommate's belongings and ranting about staff. The staff determined that Charlotte was being overstimulated in her environment and moved her to the dementia care unit where she had her own room and had to interact with fewer unfamiliar persons (selection). Activities which Charlotte was comfortable and competent with were developed (optimization). She had worked in a laundry for years and appeared to derive satisfaction from folding clothing. Staff members recognized that Charlotte's attention span was very short, so activity periods were shortened to meet her attentional needs (compensation).

Discussion:

Using SOC theory, think of an example of a new resident to your community who is trying to adjust to the changes in her life with you. How could you help her to be comfortable by using selection, optimization, and compensation? What does she enjoy doing and what challenges do she and staff face in accomplishing that actuality? _____

The second framework of older adulthood that relates well to long-term care is the continuity theory, the premise being that in making adaptive choices, older people try to maintain and preserve existing internal and external psychological structures. In other words, older people will draw on their own sense of identity to solve problems of living. Internal continuity refers to the persistence of temperament, affect, experiences, preferences, disposition, and skills. We say sometimes to old friends, "You haven't changed a bit." People are meant to stay the same psychologically as they have always been and yet in the nursing home we try to shape residents to conform to uniformity.

External continuity involves stability of physical and social environments. Perceptions of external continuity are high when a person is in a familiar environment, practices familiar skills, and interacts with people they know. Anyone admitted to a long-term care residence, regardless of their personality or rate of decline will experience a significant disruption in external continuity. Continuity theory predicts



that reinstating familiarity into the resident's life will facilitate adaptation.

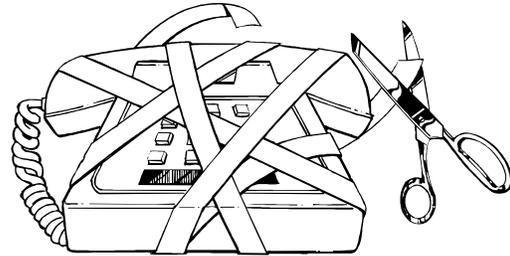
A physical environment that fits individual resident's preferences (room color and own furnishings, room temperature, bathing and eating preferences, time preferences, etc.) and permanent staff for consistent social interactions provide this stability. But this does not mean that homes remain static or that every home in a chain will operate exactly the same way because each community will have different residents with a different mix of personalities and a different variety of preferences. So, too, as new people take up residency and others leave or die a home or neighborhood will evolve.

Case Study:

The following is an example of the continuity theory in practice:

Bob was admitted to a nursing home by his son who complained that changes in Bob's memory and cognitive functioning had become so severe that he was unable to maintain him in his home. One particularly troubling behavior was Bob's frequent calls to his son at work, and this continued after Bob had been placed in the facility. During a care plan meeting it was suggested that the phone be removed from Bob's room so he would no longer be able to make the calls.

Upon the removal of the phone, Bob began to withdraw and appeared to be



depressed. The phone calls had become a part of who Bob was and losing the use of the phone represented a significant discontinuity. The strategy decided on by staff was to reinstate the phone but to rewire it so that when Bob called it rang the nursing staff. The staff assured Bob that his son was doing well and Bob's mood and behavior improved.

Discussion:

Think of an example of the use of continuity theory to meet a challenge in your own nursing facility.

The continuity theory may not be relevant when a neurological change has occurred as illustrated by the following story from a Kansas nursing home:

Mildred was new to the special care unit. The staff had carefully researched her background and had learned from the



family her likes and dislikes, her habits and daily patterns. It was established



that she had been an early riser all of her life so the staff woke Mildred daily at six a.m. to begin her day. Mildred did not seem to be adapting well to her

new environment. She was agitated and upset all day long. One day, the staff wondered what would happen if Mildred were allowed to sleep until she woke up naturally. When they tried it, Mildred did not wake until 10:30, and the benefit for all was that she spent the rest of her day in a calm and peaceful state.

The opportunity presented by the continuity theory and SOC for long-term care is to maximize the degree of selectivity. Older adults, even in the case of profound disability, value the ability to make choices and decisions. At the same time there is a great need for older persons living in long-term care residences to optimize the skill and capabilities that remain intact while compensating for those that have been lost. Using these concepts it may be possible to develop individualized care plans that address maximizing resident functional ability even in the presence of decline.

Group Activity:

Pull a care plan from a file and rewrite the plan from a continuity or SOC theory perspective. Michael Smull, a leader in person-centered care, has designed some

interesting materials for essential lifestyle planning that you may wish to investigate. (See references). Many nursing homes are currently restructuring the care plan process. One of the innovations to come from this process is to write care plans in the first person. In other words, the care plan is written from the resident's perspective: "I have problems sleeping in the night and would like to have a cup of warm milk before bedtime." In nursing homes where this method has been used it has removed the tendency to be task-focused and clinical in the process.

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Daily Rituals

Michael Smull describes the importance of rituals. We use rituals to help us cope. A person may need to get up slowly in the morning, avoiding bright lights, loud music and perky people before he has his coffee. If he is competent he will make arrangements to avoid these things in the morning and will create rituals that help him to prepare for the day. In nursing homes, where residents frequently are not competent in maintaining familiar rituals, staff members may learn from families at admission what these rituals might be. The Minimum Data Set Customary Routine Section will assist staff in exploring previous rituals.

It is important to understand that rituals don't always remain constant. For people living in nursing homes positive rituals need to be identified and established with the residents and then supported by the staff. Once established, however, these rituals will change as desired by the residents not because newly hired staff fail to maintain them. Rituals need to be rooted in who each individual resident is as well as the current circumstances of each. Properly used, rituals will help people through major life changes as well as in daily existence.

Group Activity:

One of the best ways to incorporate rituals into resident's daily lives is to determine what those rituals might be at or before admissions. Use an

interdisciplinary group to develop a set of questions or a form that could be used with family and the resident to determine these important habits.

References:

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The Total Institution

Now that you have some idea of what resident-centered care is, it may be wise to focus on some of the reasons why we have failed to provide it in the past. Sometimes what we want to do with resident-centered care is more apparent when we define what we **don't** want. The following section is meant to contrast the institutional environment of the traditional model nursing home with what we might desire for long-term care.

Goffman (1961) identified five categories of institutions: 1) homes for persons incapable and harmless, as in homes for the blind and aged; 2) homes for persons incapable and socially threatening—mental institutions; 3) institutions that protect the community—prisons; 4) institutions that provide housing for persons in pursuit of technical tasks—army barracks, college dorms; and, 5) retreats—monasteries or convents. Depending on the role it plays in society, each institution develops a specific way of life to which the people who live there are socialized and expected to adjust. For older people this socialization is considerably different than what might be expected for their counterparts living in the community.

In the general community, elders are seen as the least regimented, least integrated, and least organized sector of the population. They do not draw a lot of attention and rarely concern other members of the community or the

regulatory environment. Because of this, prior experience cannot prepare the elder for the role of nursing home resident. Within the nursing home environment, members are expected to comply with rules that encourage conformity. Ruth Bennet (1962) states that most long-term care homes fall on a continuum of total institutionalization with the most extreme having these identifiers:

- designed to be a permanent residence
- all activities occur within the confines of the institution
- all activities are scheduled sequentially for the entire group of residents
- provisions are made for formal “indoctrination” periods in order to teach the rules and standards of good and bad conduct
- provisions are made for continual observation by staff of the resident population
- standardized, objective rewards and punishments are used
- residents are not allowed to make decisions regarding their time or property
- most personal property is removed from the residents
- residents are recruited on an involuntary basis
- congregate living is required as a residential pattern

These statements were made over forty years ago, and yet, many are still prevalent within nursing homes.



Activity: De-institutionalizing Your Home

Mark the place on the continuum lines below for each of the above identifiers of an institution as it relates to your nursing home. This activity may be done individually and then used as a group discussion.

1. _____	_____	_____
Temporary residence	Semi-permanent	Permanent
2. _____	_____	_____
Many activities outside the home	Some community activities	No outside activities
3. _____	_____	_____
Daily individual as well as group activities	Occasional individual and group activities	All activities are planned for groups
4. _____	_____	_____
Residents are encouraged to maintain their identities and lifestyle choices	Indoctrination is not formal but probably occurs on some level	Formal indoctrination to rules and standards of good behavior
5. _____	_____	_____
Staff are careful to ensure that residents get privacy as frequently as is safely possible	Staff try to allow residents some privacy when they are in their rooms	Residents are always watched
6. _____	_____	_____
Resident individualism is honored and behavior is regulated by clearly understanding resident needs	Rewards and punishments may be used but are not standardized	Standardized rewards and punishments
7. _____	_____	_____
Staff members try hard to make sure all residents make many decisions about their own time and property	Those that are capable can make some decisions	Residents are not allowed to make decisions about time or property



8. **Personal property is only limited by space and regulations** **Residents are encouraged to bring some articles from their homes** **Most personal property is taken from the resident**

9. **Residents are recruited on an involuntary basis.** (This one is difficult to change. Hopefully, one day residents will freely choose nursing home residency over other options which may not be appropriate.)

10. **Smaller housing units simulate a more “family” living style** **Traditional nursing home with residents in contact with a great many other residents and staff**

Despite our wish to make nursing homes less institutional, some barriers may always remain to removing all of these characteristics. However, this exercise may stimulate some conversation about the areas that your organization might want to improve.

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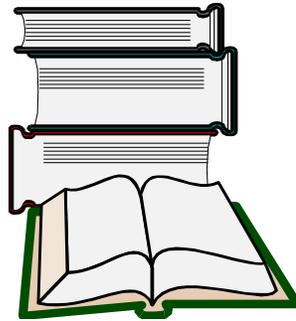
Autonomy and Regulation In Long-Term Care

From Patricia Maben, R.N., M.N.,
Kansas Department on Aging:
Regulations and Resident-Centered Care

“Over the past five years I have had many conversations with nursing facility administrators about the barriers to implementing resident-centered care. These

conversations take on two very different approaches. The first is, “I have some ideas that I believe will improve the care of residents in my facility and I want to know what I need to do to make it happen”. The second approach is the one that occurs most frequently. “I have an idea I want to implement in my facility, but I know the regulations will not allow it.”

My response to the first approach is tell me what you want to do and together we will find a way to make it work. To the administrator with the second approach, I usually respond with, “What regulations will not allow you to do what you want to do?” With few exceptions, we are able to find a way to implement their ideas. Regulations support resident-centered care. Facilities that do



not provide resident-centered care will have much more difficulty with the survey process in most instances than those who work to achieve the goals of resident-centered care.”

Kansas has earned an excellent reputation in national circles for the ability to provide resident-centered nursing home care because of the flexibility of state regulations as well as the proactive efforts of the survey agency in promoting new models of care. However, many providers continue to live with the impression that imposed regulations stand in the way of change. The following section is meant to provide examples of this problem and guidance in working through it.

The standards necessary for licensure are not the only regulations in long-term care but serve as an illustration of the issues. These standards are divided into three different types: 1) structure: the building and the equipment, the organizational structure; 2) process: the care processes related to particular conditions; and, 3) outcomes: a standard that specifies acceptable outcomes for residents. In nursing homes it is possible to control the process to help regulate the outcomes but this probably infringes on the resident’s autonomy. The issue here is whether a residential long-term care setting should be regarded as a total therapeutic environment, like a hospital, or considered more like the type of



environment one would have living at home.

How are regulations perceived as restricting autonomy and control? A certain amount of interpretation is necessary in applying the rules. Many organizations will err on the side of too much control in the belief that they will have better survey outcomes. For instance, there is a belief that no more than 14 hours can elapse between the last substantial meal of the day and the first of the next day. This has dictated resident waking times for many nursing homes. Problems arise because staff members do not understand the regulations fully and make assumptions about their meanings. Many examples of these types of problems can be listed, but most organizations that have adopted extensive culture change have found that the regulations support their efforts. It cannot be emphasized enough that this becomes easier with more knowledge of the regulations and how they can be seen as promoting rather than restricting resident-centered care.

It is important to note that while many long-term care administrators may believe that the regulations seriously restrict resident autonomy and control, they were created to enhance these same qualities. When nursing facility staff wants to change how they deliver care and they believe the regulations may not allow the change, they should contact the licensing agency and discuss their ideas. In most instances, the licensing agency

will help develop a way for the facility to implement their ideas.

As Patricia Maben alluded in her statement above, sometimes regulations become scapegoats for routines, facility developed house rules and cost-saving measures. The measurement stick should always go toward what best benefits the resident.

Autonomy and Regulations Activities:

Case Study:

Mrs. H has objected to the way staff “poke around” in her room. Just before the inspectors came six months ago, a staff member actually looked in the drawers to see if anything was unsafe. Mrs. H’s shoe polish and her bottle of aspirins were taken from her night



table drawer, and the decorative candle she was given for Christmas was removed. When she protested, staff explained that although Mrs. H could handle these things safely, someone who was confused might wander in and harm themselves with these poisonous substances.

(Taken from “Everyday Ethics: Resolving Dilemmas in Nursing Home Life, p. 80 by Rosalee, Kane).

Discussion:

Is there a regulation that could be used to support the staff’s action?



What could the staff do to meet Mrs. H's desires and still protect other residents?

Explain the steps you would take to assure that Mrs. H could retain control over her personal items?

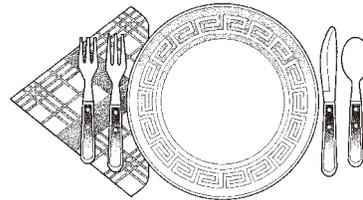
See some possible solutions to these questions on page 38 of the module.

Group Activity: Read through the following examples of common practices in nursing homes. What regulation do you think may have been the basis for the practice? Is it a government regulation or an assumption that has been created within the nursing home itself? Provide alternative interpretations or approaches that may provide autonomy and control for residents.

See the end of this section to learn how Kansas nursing homes have worked

through these issues. Possible solutions to the questions are offered on page 38 of the module.

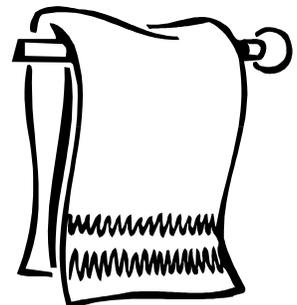
- Mrs. Thomas is awakened at six o'clock in the morning to attend breakfast. In her former life she never ate breakfast. Staff are told that all residents must be in the dining room at 7:30 a.m.



Regulation: _____

Alternative interpretation: (What could staff do to meet Mrs' Thomas's nutritional needs without insisting she go to breakfast?) _____

- Mr. Carter is given his bath every week at ten o'clock on Friday morning whether he's in the mood for it or not. He complains of being cold and doesn't want "those girls to see him naked."

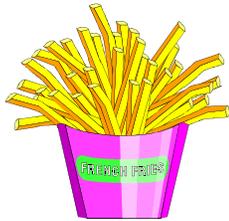




Regulation: _____

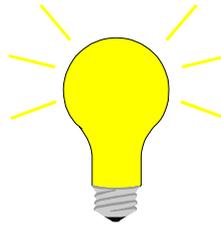
Alternative approach (What alternatives could staff use to make bath time more pleasant for Mr. Carter?) _____

• Mr. Pauls is 89 years old. He requests McDonald french fries. He is on a low-salt diet. Regulation: _____



Alternative interpretation: (How could the staff meet this request?)

• Miss Harriet is awakened several times a night to bright lights and loud voices as staff members check her pad for wetness.



Regulation: _____

Alternative approach:

How Kansas nursing homes have responded:

• Many homes have already made changes in waking times and the way that breakfast is offered. Some, like Larksfeld Place in Wichita offer four meal plans which includes a continental breakfast served in the resident's room upon waking. Many others that have adopted a neighborhood model stock kitchens close to the residents' rooms with snacks and breakfast items. In Meadowlark Hills' Collins House for dementia care residents, a five meal plan is offered which has amounted to



meals being available nearly twenty-four hours a day.

- Joanne Rader, author of *Bathing Without the Battle*, has presented at conferences in Kansas a number of times. Staff members have learned from her that showers are not the only method for keeping residents clean. They can honor resident desires for dignity as well as ensure cleanliness through other methods. For example, Rader promotes a “towel bath” similar to a massage where most of the body remains covered at all times during the bath.
- Many nursing homes, like St. Joseph Senior Care Community, are instituting liberalized diets. With a doctor’s written permission it is possible to be flexible with dietary intake while maintaining healthy nutrition. These issues should be discussed in care planning sessions.
- Friendly Acres at Newton has had a new night care plan in place for two years. They invested in extra-absorbent night briefs and don’t wake residents to change them unless the brief is soaked. Residents who turn themselves in bed are not disturbed. There have been no increases in skin problems associated with these changes and residents are happier when they sleep undisturbed.

Conclusion:

As we learned from the continuity theory, we all have a desire to remain as

we have always been. The fear that older people have of being placed in a nursing home may derive from a fear of losing oneself and becoming little more than a “task” that needs to be completed. Focusing on person or resident-centered care allows the resident to continue living life in a manner that is consistent with their past lives.

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Projects

In the previous module we have presented information about measuring change and have encouraged all nursing homes to do so. One of the problems with this population is the difficulty in showing the effectiveness of a strategy for impaired persons who are in developmentally declining stages of life. Sometimes it is best to only hope for maintained well-being for an extended period of time rather than to seek improvements. It is perhaps best to consider two major intervention target areas: functional ability and quality of life.

One of the first points to make is that these measurements should come from multiple viewpoints, including those of the staff, residents and their families. The projects that follow should provide ideas for implementation within your own nursing home. Some projects are more appropriate for organizations in the beginning stages of culture change while others may be activities that will help those who have already started change to reassess their progress. Each will be followed by suggestions for assessment and evaluation that will provide information about successful or unsuccessful implementation. (For a more in-depth review of assessment and

evaluation refer to the “Measuring Change” module.)

- 1. Care Planning:** Care plans are derived from the Minimum Data Set assessment. This assessment is completed on each resident at least four times a year. Most nursing homes use an MDS coordinator to manage this process and typically completion of the assessment is seen as a clinical process. The results from these assessments are then used to develop care plans for the residents. For this project you will want to have an interdisciplinary team examine the current process for care plans. Answer the following questions:
 - Who contributes to the MDS documentation and how?
 - Who attends care plan meetings?
 - What efforts are taken to motivate and accommodate residents and their families to attend care plan meetings?¹

¹Families may attend care plan meetings. However, if the family members are not the resident’s guardian or DPOA for health care, they cannot be privy to clinical information about the resident. If the resident gives them permission to attend, it is of course OK. There are many ways facility staff can involve families in the process including talking with families during visits about their concerns and what they are happy about. Staff can call family members for input.



- How are care plans written? Are they understandable by all parties?
- How are care plans implemented?

Once the current process has been thoroughly examined the group should begin to brainstorm ways to make the care planning process more resident-centered. How can care plans be written to enhance autonomy and control? Many nursing homes have begun to write care plans in the first person. In other words they may say, in effect, “I, Mary Smith, choose to sleep in every morning until nine o’clock and to have a simple breakfast of juice and toast.” The change to first person from “the resident behavior may be improved if permitted to sleep in until nine o’clock” motivates the staff to see the resident and his or her needs from a personal perspective and facilitates including the resident in the planning.

In addition, changes may be made in the way that the MDS is completed. Rather than doing all of the assessments in one or two sessions by a single coordinator, sections may be completed by persons most connected to the resident at times that make the activity seem like a normal part of the daily life of the resident.

Care plan meetings themselves should be examined to determine effectiveness in enhancing resident autonomy and control. Making it a formal process probably means that residents and family members will not choose to attend. Goal setting over tea or coffee as a social

group may make a positive difference for all involved.



Assessment and evaluation: One of the most obvious changes may be in the involvement in residents and family members in the care planning process. Attendance at meetings may be one way to assess this involvement. Increased involvement at care plan meetings may also mean decreases in family complaints about care or increases in family satisfaction both of which are normally accounted for in most nursing homes.

Additional improvements may be seen in resident outcomes. Health and psychological indicators may hold steady or improve when residents feel that they are more in control of their lives.

2. Admission Process Changes: Regulations require that a number of official forms be completed at admission. These forms outline resident rights and responsibilities as well as the functions that the nursing home promises to provide for the resident. Physical



assessments may be completed and many questions are asked. None of this process is even remotely close to what it might be like if an older person were to relocate to a new neighborhood across town.



As we've learned from the SOC theory, residents who select their own living options are much happier. Ideally, residents would be living in your nursing home because they "chose" to do so. Nursing homes must see themselves as recruitment specialists. How can they enhance their reputation in the community so that when the time was appropriate an older person in need of assistance in daily life would choose to live there?

Typically, many residents come to nursing homes because of an acute situation or crisis which removed the option to choose from the resident. In this situation, it is critical that the nursing home do everything possible to provide meaningful choices and create a community for the new resident. For this project you will want to consider what some of these options might be.



Suggestions include: providing mentors for new residents, establishing resident

welcoming committees, holding "getting to know you" teas and matching new residents with a nursing home employee. Many nursing homes provide scrapbooks with a page for each resident. Consider providing the supplies and a special time for family and new residents to come in and create an entire memory scrapbook either before or shortly after admission.

Assessment and Evaluation: Many residents experience depression upon admission to a nursing home. It might be helpful to monitor depression screenings before and after implementation of new admission procedures. Family and resident satisfaction can also be measured.

3. Birthdays: Nearly every nursing home counts the monthly birthday party as one of the activity rituals. Celebrations are always welcome but birthdays should also be recognized individually. If your home is organized into neighborhoods or households you may want to ask for donations of cake mixes and pans for the kitchen. Preparing a birthday cake and celebration can become an activity. Better still, you may want to ask the resident if he/she would prefer another dessert to celebrate the occasion.





Assessment and evaluation: For this change you may only need to assess and evaluate anecdotally. What are residents, families, and staff saying about the adoption of this change?

4. Activity Planning: “You’ll never get me to do any of that craft stuff,” a nursing home staff member said during an interview. Many staff members recognize that the activities offered in nursing homes are not consistent with the lifestyle of residents prior to living in the facility but seem unable to think of creative options to traditional activities. Because residents have come to believe that traditional activities are the only possibilities available to them, they may not be helpful in developing a list of nontraditional options. These options may come from the daily rituals of the residents and ideas of family members as they are uncovered upon admissions.

Nontraditional activities may be individual in nature. For instance, an active day for one resident may be having the local newspaper read to her first thing in the morning, devotions with her resident assistant at noon, a walk through the park with a volunteer in the afternoon sun, and a songfest in the evening for a social activity. A resident with moderate dementia, who was a secretary for many years, might enjoy an activity such as typing. Whenever possible the resident



should be involved in planning and determining activities, not just deciding whether or not to attend preplanned events.

For this project, an interdisciplinary team (not just activity staff) will examine current activity plans and calendars and brainstorm methods for increasing variety and control for residents. Because resident assistants will necessarily be involved in many of these activities they should play an integral role in the development of new ideas for changes in activity programming. And, of course, you’ll want to ask for residents to be part of this process.

Assessment and evaluation: As one nursing home has discovered, when residents are happily engaged in activities they require less assistance from nurse aides. Many times call lights are lit out of boredom and loneliness rather than physical needs. As well as counting call lights, it may be possible to determine satisfaction outcomes for residents and staff as related to activities on surveys.

5. Morning Schedules: A morning staff person was heard requesting that night staff dress people in the middle of the night and put them back to bed so morning aides would not be as rushed preparing residents for the 8 a.m. breakfast. Rethinking what residents must have in the morning will allow residents and staff alike to experience a more relaxed existence. Using an



interdisciplinary team, devise a plan for more relaxing morning schedules.

Assessment and evaluation: Satisfaction surveys should register positive changes for both residents and staff alike. There may be less dietary waste when residents are not forced to eat breakfast at times that feel contrary to their normal lifestyles.



Post-test

The pre- and post-tests included with this module are optional. The questions provide information about the materials to be covered and can be used for learning self-evaluation. At some future date, these tests may be used as a part of a continuing education requirement.

1. Which of the following would be considered a resident-centered approach in providing care for a non-responsive resident?
 - A. Contact the family about past behaviors and habits.
 - B. Implement trial and error (for example, trying different wake and sleep times) to find the care treatment that seems most desirable to the resident.
 - C. Use empathy, or imagine what you would want in similar circumstances.
 - D. All of the above.
2. Which of the following supports the “regenerative” model of care, or the “we can all grow until we die” philosophy of Barry Barkan?
 - A. Moving to a nursing home indicates that the resident cannot function on his/her own.
 - B. Activities are offered for individual needs and are developed to promote learning.
 - C. Only group activities are offered and residents may choose to attend them or not.
 - D. Most older adults only like to watch television.
3. Some nursing homes “allow” residents to determine when to get up. The use of the word “allow” in this example implies
 - A. That the resident is able to control all aspects of their lives.
 - B. That the resident feels the control in their lives is internal.
 - C. That the control is external to the resident or extended because the organization is kind, not because the resident is competent.
 - D. That the resident feels the control over this aspect is stable.
4. The staff at ABC nursing home had been studying the SOC theory. They were wanting to improve resident satisfaction with the nursing home within the first few weeks of moving in and had decided to work on the “selection component” of the theory. Which of the following might be an example of selection?
 - A. The ABC staff would assign an aide for the first few weeks to help the resident integrate into the home.
 - B. The home planned to purchase a dog.
 - C. The staff decided to spend a lot of time educating the community on what ABC had to offer so that more older people would be likely to choose it as an option for long-term care.
 - D. The room would be painted before the resident moved in.
5. Nursing homes help residents to function at their highest ability by providing “compensation” for individual losses. An example of this is:
 - A. Providing seating arrangements in strategic places so residents can rest on their way to meals and activities.



- B. Designing neighborhoods with dining and living spaces closer to the residents so they don't have to walk so far.
C. Providing eating utensils with thicker handles.
D. All of the above.
6. Mrs. Gray believed that she was able to control many things in her life while living at ABC nursing home because:
A. the staff expected her to make her own decisions about her daily schedule, what to wear, when and what to eat.
B. she paid a lot of money to live there.
C. her daughter had said she could expect to make her own decisions once she moved in.
D. none of the aides treated her with respect.
7. Continuity theory means that people basically stay the same throughout their lives. Which of the following statements best expresses that?
A. What goes around, comes around.
B. Just a chip off the old block.
C. What will be, will be.
D. You haven't changed a bit!
8. Two aides at ABC home were visiting about how quickly Mrs. Jones had become "institutionalized." Which of the following behaviors in Mrs. Jones might indicate that the aides were correct?
A. Mrs. Jones continued to maintain contacts with her close friends in the community.
B. While she had stated on admission that she was a late riser, Mrs. Jones began getting up for breakfast at 6:00 a.m.
C. Mrs. Jones lost interest in selecting her wardrobe for the day and asked her helpers to do it for her.
D. Both B and C.
9. Nurses aides at ABC nursing home are seen moving residents in wheelchairs without asking or telling residents where they are going. This type of care reflects:
A. Care based on regulations
B. An example of the continuity theory: people stay the same throughout their lives.
C. A "we know what is best for the resident" attitude.
D. Resident-centered care.
10. Which of the following could be considered activities appropriate for nursing home residents?
A. Music: sing-a-longs
B. Bingo
C. Daily devotions
D. Preparing a cup of tea
E. Listening to a travel-log
F. Watching television
G. Leaving the nursing home
H. Planting flowers
I. Coloring Easter eggs
J. All of the above!

Answers found on page 38



Answers to Pretest, Post-test and Other Activities

Answers to Pretest and Post-test:

1: D, 2: B, 3: C, 4: C, 5: D, 6: A, 7: D, 8: D, 9: C, 10: J.

Answers to questions on page 13:

This is a common scenario. Even with the best intentions staff members may be forced to fall back on an efficiency model. There are several possible ways that Mrs. S. may be able to retain her control over certain aspects of her world and yet allow her caregiver to complete her work. Because Mrs. S. is cognitively able to make decisions her caregiver may consider checking with her when she awakens and asking her to think about what she would like to wear for the day as she assists another resident with morning care. When she returns Mrs. S will have independently made a decision about her day. This technique could be used in many situations. Another option may be to have the evening staff ask Mrs. S what she would prefer to wear the next day and have it laid out and ready for the morning.

Answers to Autonomy and regulation questions on pages 27-29:

Case Study:

KAR 28-39-152(i) If Mrs. H could self administer her medications, a nurse could do an assessment to determine that she is competent. The nurse could then contact her physician for an order to let Mrs. H self administer her medications or just her aspirin. If there are residents on Mrs. H's unit that have a history of wandering, she could store her shoe polish in a drawer or on her closet shelf. The candle is a fire code issue. If she uses it for decoration only, there would be no reason to remove it.

Group Activities:

1. KAR 28-39-158(e)(2) There shall be no more than 14 hours' time between a substantial evening meal and breakfast the following day, except when a nourishing snack is provided at bedtime, in which instance 16 hours may elapse. A nourishing snack shall contain items from at least 2 food groups.

If the resident does not want to eat breakfast the staff should care plan for this and offer ways to ensure that she is offered the necessary nutrients during the day. It may be a snack when she gets up or they fix breakfast for her when she wants it.

2. KAR 28-39-152(a) (3)(A) Any resident who is unable to perform activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal



and oral hygiene. The facility shall ensure all of the following: (A) Residents are bathed to ensure skin integrity, cleanliness, and control of body odor.

Nothing in the regulation states that the resident has to be bathed twice a week. The staff must find ways to keep the resident clean. For this gentleman, I would recommend a towel bath as described by Joanne Rader in the video “Bathing Without a Battle.” This video was provided by CMS to every certified facility in the country.

3. KAR 28-39-147(e)(3) The adult care home shall afford each resident the right to refuse treatment.

Staff should talk with dietitian about this issue. If the facility uses the liberalized geriatric diet system, most dieticians will help to plan for one high salt meal a week. If he wants french fries and the ordered diet is low salt, staff could also call his physician and discuss this wish. Most physicians will give an order to allow residents to have french fries occasionally. If the physician says no and the resident demands, inform the resident of the possible risks and if he decides he wants to take the risks, notify the physician and give him the french fries. In real life, when staff discuss the wishes of the resident with the physician and dietitian, a safe way is usually found to meet their wishes.

4. 28-39-152 (b&c). These regulations are for urinary incontinence and pressure ulcers.

There is no requirement that residents be awakened at night. Residents can be checked at night for incontinence without waking them. Many facilities now use adult briefs made especially to be worn at night that wick the urine away from the skin. The regulations at KAR 28-39-152(h) just talk about good care. The facility needs to design this lady’s care to meet her needs.

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