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RESIDENT ASSESSMENT: THE SPRINGBOARD TO QUALITY OF CARE AND QUALITY OF LIFE FOR NURSING HOME RESIDENTS

WORKSHOP

BEFORE THE

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UNITED STATES SENATE

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RESIDENT ASSESSMENT: THE SPRINGBOARD TO QUALITY OF CARE AND QUALITY OF LIFE FOR NURSING HOME RESIDENTS

MONDAY, OCTOBER 22, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, in the Dirksen Office Building.

Staff present: Portia Porter Mittelman, staff director, Holly Bode, professional staff.

STATEMENT OF PORTIA PORTER MITTELMAN, STAFF DIRECTOR, SENATE SPECIAL COMMITTEE ON AGING

Ms. MITTELMAN. Good morning everyone. I think we're about ready to get started.

My name is Portia Mittelman. I'm Staff Director for the Senate Special Committee on Aging, and I'm here to welcome you to today's event. This is a wonderful turnout. Something good is truly happening and we hope that it will continue to happen as we go forward today.

I also bring greetings today from the Chairman of our Committee, Senator David Pryor, who, as some of you may know, is busy in conference right now trying to get our budget situation settled. Everyone cross your fingers that we can get that done this week. It's been a very difficult weekend for Members and staff, so think good thoughts for all of us.

I want to introduce my very special colleague, Holly Bode, who is on the Senate Special Committee on Aging with me. Holly is our expert on nursing home issues and has been very instrumental in the OBRA legislation and putting together this event that we're going to share today.

So, at this time, Holly Bode.

STATEMENT OF HOLLY BODE, PROFESSIONAL STAFF, SENATE SPECIAL COMMITTEE ON AGING

Ms. BODE. Thank you.

Good morning. My name is Holly Bode and I work for Senator David Pryor, Chairman of the Senate Special Committee on Aging. On behalf of Senator Pryor and Senator Brock Adams, Chairman of the Senate Subcommittee on Aging, I'm really pleased to welcome everyone here today to this presentation, "Nursing Home Reform: Something Good is Happening".

The Campaign For Quality Care and National Citizen's Coalition for Nursing Home Reform have put together a very impressive program. They've brought people together from all over the Country to talk about their experience with resident assessment and other aspects of OBRA 1987 nursing home reform. We're here today about hands-on practical experience; in other words, translating legislation into practice.

I think the message today is on positive outcomes, and that the effort to implement OBRA is worth it. As the Congress struggles to come to terms with our Nation's budget deficit, it's a particularly valuable and very timely message. As a member of the Senate Finance Committee, Senator Pryor has been deeply involved in the budget-making process. As Portia mentioned, he has also been chosen to serve on the Conference Committee which has the responsibility to hammer out the differences between the House and the Senate budgets. To make things even more interesting, Senator Pryor has also taken a lead in the Senate on technical corrections to OBRA 1987 nursing home reform provisions.

As most of you probably know, the nursing home technical issues are a very important—but often contentious—part of the House and Senate budgets. As the conferees and their staffs—myself among them—argue and negotiate over the nitty-gritty details of OBRA, it's vitally important that we all be reminded why we're doing it. On a personal note, I can tell you that after having spent almost every day this month here at my office, I need to hear that the Congress' efforts to make OBRA 1987 work are worthwhile.

Working on nursing home issues has been a great experience for me. It's not always easy, but it's never, never dull. I hope that today's program will inspire us all, and teach us something in the bargain.

It's wonderful to see so many people here today. I want to thank the National Citizen's Coalition for Nursing Home Reform (NCCNHR) and the Campaign For Quality Care for putting this together and to everyone for coming. I look forward to a really productive and very informative day.

I would like to conclude my remarks by thanking you again and introducing Susan Rourke, the President of NCCNHR.

STATEMENT OF SUSAN TITUS-ROURKE, PRESIDENT, NCCNHR

Ms. TITUS-ROURKE. Thank you very much, Holly.

My name is Susan Titus-Rourke and I'm the President of the National Citizen's Coalition for Nursing Home Reform and would like to thank, especially, the Campaign For Quality Care, the national organizations that have joined us over the past years, the Senate Special Committee on Aging, and the Subcommittee on Aging of the Senate Labor and Human Resources Committee for making today possible for us. If something good is really going to happen, we're here to see how it's going to happen today.

This is a very special time for us. The past 15 years—this is our 15th anniversary meeting as a citizen's coalition—and for the past 15 years, citizen's groups, residents, families, and committed professionals have had a dream. We really believed in the fact that a nursing home could be a home; that, in fact, there could be care given with dignity; that being sick or old did not mean that you lost your capacity to choose or to be a person—you were not to be just thrown away. During the past years we worked on this dream and tried to make it real in Michigan, Wyoming, Nebraska, and all the States that people come from here today.

And as we worked on those changes in the States, it became clear to us that State laws were not enough, that we could work a little bit in our corner of the world, but we needed Federal laws and Federal changes. As we began working together, we joined with professionals, with worker's groups, with nurses, with social workers, and with enlightened facility operators who also shared the dream of quality care, and we brought all those words and thoughts to Washington, D.C. where, with the Campaign For Quality Care, we crafted our dreams into words on paper.

Those words are the Nursing Home Reform Amendments of 1987, popularly known—as OBRA. That's really the blueprint for our dream.

That's why we're here today, really, to look at OBRA 1987 as a beginning. It's maybe the ending, in many ways, of our work with words, but it's a lot of beginnings for us. It's a beginning to change the fabric, the very fabric of how care and life in a nursing home occurs. It's, in fact, a beginning of changing what we expect of ourselves as professionals, as consumers, as family members, and as residents. It's beginning, really, to bring the "home" into nursing home, and to bring the choices back into the life of the people who live there in nursing homes.

As we have caught brief glimpses of the potential for change, we know that it can happen. What we're going to do today is to look at the future, to catch a glimpse of what the future of nursing home care can be for those who live in nursing homes, those of us who may want to use nursing homes, and those of us who may live and work in nursing homes in the future.

The way that we're going to work this today is that we're going to be starting where we should be starting, with the people whose bus isn't here yet.

The resident's bus did not arrive, and I want to let people know that when they come, we'll be stopping so that they can come and be settled in the front. We hope that this is certainly the last day that the residents will be last in coming in and not being first. Today, they'll be first, though, because our program this morning will be to begin with the resident, to look at what the resident care needs are, what the resident's desires are, and how she or he would really want to live in the nursing home. We'll have a panel on that.

Then this afternoon, the early afternoon, we'll be looking at how the care in a facility can be organized in order to meet those needs and desires, the hopes, the dreams, and the glimpses of the future.

Then the third part of our program, at the latter part of this afternoon, we, as consumers as residents, and as professionals, will talk about how we can make our law happen. We can't just go away from Washington, D.C., and brush our hands and say, "That's it." It's our law, our words. We need to make it happen. We'll be putting that piece together this afternoon.

What's really exciting to me, and that we'll need to be working on together today, is that this isn't just us looking at what could happen. This is really a report that will go to Congress. Portia and Holly have framed for us the way this is going to be. There is going to be a reporter so if there is a chance for you to ask questions, please state your name. You are a witness in a report that will be going to Congress. So this isn't merely our own dream, it's an opportunity to confirm those glimpses of the future for everyone else.

I'd like to take this opportunity, again, to thank everyone for coming and introduce the first part——

Ms. MITTELMAN. Susan, before we get started with the program, I was remiss in not introducing another person who is very instrumental in this event today, my colleague, Bill Benson, who is the Staff Director of the Subcommittee on Aging.

Bill is in the back there. Bill, wave.

Ms. TITUS-ROURKE. Bill is one of us.

I think the residents are coming in. The bus actually arrived, so if we could take just a quick break.

There will be a little bit of uproar as people get seated in the front, but let me introduce, at this point, Sarah Burger.

We'll take just a moment to get people seated, and then Sarah Burger will be taking over. I'll introduce her in a moment. Thank you very much.

Ms. MITTELMAN. I'd like to call the meeting back to order. Would everyone please be seated?

Ms. TITUS-ROURKE. Thank you very much for taking this break. I'd like to give a special welcome to all the residents of nursing homes who took the energy and time and commitment to join us today so that we could all work together to make OBRA happen. Join me in welcoming them.

The next part of our program will be moderated by Sarah Burger. Sarah Burger is a nurse with a masters degree in public health who is a consultant to the Coalition—the National Citizen's Coalition for Nursing Home Reform—and is a long time advocate for the residents and families of nursing homes.

Sarah.

STATEMENT OF SARAH BURGER, CONSULTANT, NCCNHR

Ms. BURGER. Thank you very much, and it's a pleasure to be here today.

Rita Mae Brown is a humorist who is actually appearing here in Washington, D.C., this week, so it's appropriate that I take one of her charming quips to start the morning. She's been heard to say that if the world were a rational place, men would be riding side saddle.

I can't change those kinds of practices, however, I think, together, we might say that if the world were a rational place, resident assessment would be comprehensive, accurate, standardized, and reproducible, as described in OBRA 1987. Then resident assessment really is the springboard for good care and quality of life for the residents.

There has always been a process for providing care to residents in nursing homes. That process is as follows: The resident comes in and there is an assessment; then there is care planning where the needs are identified and care is planned; then that care plan is implemented by the staff; and finally that care is reevaluated and the process starts all over again. It goes around and around for the entire time that the resident is in the nursing home.

It is a process which will continue, except for the fact that that process had one flaw that was very major. The assessment instruments which have been used heretofore have been flawed. They were very medically oriented and they did not take into account the psychosocial aspects in a person's life, which are so important in any home environment. They were also cursory—leaving out incredible amounts of information which would have been useful to staff and to the resident in providing appropriate care.

Without assessing the physical, the mental, and the psychosocial aspects of an individual, there is no way facilities can meet the challenge of OBRA to provide care and services, as well as to attain and maintain the highest practicable mental, physical, and psychosocial well being of each and every resident.

With us this morning, we have two experts on the new assessment instrument. Catherine Hawes is from the Research Triangle Institute in North Carolina and has been Project Director for the development of the resident assessment instrument. Catherine is sitting beside me here.

Down at the far end, on my right, is Kathryn Murphy, nurse clinical specialist at the Hebrew Rehabilitation Center for the Aged in Boston, MA.

Ms. HAWES. You may think that in order to work on this instrument you have to be named Catherine. That's not entirely true.

Ms. BURGER. But it helps.

Catherine Hawes will tell us how the tool was developed by the Health Care Financing Administration with her help, and the help of many others as well.

Catherine.

STATEMENT OF CATHERINE HAWES, RESEARCH TRIANGLE, NC

Ms. HAWES. Thank you.

As soon as I get it positioned, I'll cough and test everybody's hearing, I'm afraid.

I'd like to thank you very much for inviting us to be here. I'd also like to say, on the 15th anniversary of NCCNHR, that we would not be sitting here today to talk about nursing home reform if it weren't for NCCNHR and the leadership that they've given over the last 15 years toward improving quality of care and quality of life in nursing homes.

In fact, there wouldn't have been an Institute of Medicine study, that sort of started this process. So, I'd like to thank all of you, again, for the incredibly important role that you've played, and continue to play, in nursing home reform.

I'd like to say something that I think is really important about the resident assessment instrument that we have proposed to HCFA and that many of the States are using. While it took a regulation to make it uniform across the Country, the assessment process itself—and the one that we've tried to make standardized across all nursing homes in the Medicare and Medicaid programs—is something that grows out of what good clinical practice is. We didn't try to create an assessment process that sort of grew out of whole cloth. People were already doing and know what good geriatric assessment and care planning is. Our process was simply to bring that to bear on the development of the standardized assessment instrument.

Our goal throughout was to develop an assessment system that would guide care planning. That's the only purpose of the items that are in this assessment instrument. We had the following sort of overall five goals for an assessment system to be used in nursing homes to improve the quality of assessment, of care planning, and of care provision.

The first is that it must be comprehensive. When I say "comprehensive", I mean two things. Clearly, it has to cover the mutliple domains that affect residents—functional status and sense of well being—and OBRA specified fairly clearly what those domains had to be. But the second thing, and I think equally important, is that the assessment process in nursing homes must capture the strengths of residents, the preferences, the customary routines, as well as the needs for assistance and care.

The process that we saw in some facilities was one which gave you a list of nursing care needs, but somehow ignored the whole person that existed with those needs. So we've tried to show that individual person with strengths, with preferences, which will affect what the care planning process ought to be and the outcomes of it.

The second goal is that in addition to being comprehensive, the assessment should be clinically relevant, that is, all of the items in a mandatory assessment system should really be relevant to care planning. We've called this the core assessment items, the minimum data set for care screening and assessment, which led to snorts of amusement and sometimes derision among the nursing home industry, some of whose idea of minimum was five items, whereas ours is five pages of items. But we believe that they are the minimum number of items that are essential to either screen or give determinations of information that should guide a care plan.

The third goal that we had for the assessment system was that it should empower residents and direct care staff in nursing homes. It should empower residents in the sense that it would require discussion with residents.

One of the things that we were struck by in the testing—and we went to 60 nursing homes across the country to test various stages of the assessment instrument—one of the things that we were struck by is that the nurses told us that for the first time they had discussions with residents about customary routines, about preferences, about their lives before they entered the nursing home, about the things that they wanted to do rather than yes or no questions about "Do you need assistance with" x, y, or z. We thought that was an important aspect of assessment that was—it's time for that to be standard across the country.

We also believe that the system ought to foster interdisciplinary cooperation—and we've seen that it does—and that it force nursing staff to talk—or the nurses, social workers, and other staff in the facility responsible for the assessment—to talk with the aides who are the direct caregivers. Nursing assistants provided the most accurate information about the needs of residents, about how they were doing on a given day or over a particular period of time, and we felt that that was important to make uniform across the country.

The fourth goal that we have is that it must be administratively feasible for the average nursing home. This was a tension that we felt. We wanted to improve what the minimum standard that was acceptable would be. We wanted to move that up, but we also felt that it had to be feasible for most nursing homes in the Country. It had to be feasible in terms of time; it had to be feasible in terms of the kinds of staff that would be used for the most common aspects of the assessment process; and it had to fit a range of effective models that nursing homes may use for assessment and care planning.

Let me just add right here that whatever you may have heard, this assessment process does not dramatically change the amount of time most nursing homes spend on assessment, although it will probably change the mix of time. Nursing homes tend to spend more time talking with residents and more time talking with nursing assistants in this assessment process, but we're looking at a process that's an hour to an hour and a half in length. We don't think that's unreasonable in terms of administrative feasibility for something that will guide a year's worth of care planning.

It's not an administrative add-on. In facilities where the standard of practice and assessment in care planning has not been up to snuff, this will replace the cursory process. Where there's already a good process in place, what the resident assessment instrument does is to bring all that information together in one place. It's accessible to all disciplines so that if somebody in activities wants to see how somebody is doing in terms of psychosocial well-being because they may have something to say about that, or if nursing staff wants to see how people are doing across a variety of other dimensions, that document, that summary, that whole picture of a whole resident will exist there for that.

And then last but not least we wanted an instrument that was reliable, which had items and definitions that were sufficiently clear that two social workers looking at the same resident, or two nurses looking at the same resident, would reach the same conclusions about that resident's care needs. Otherwise, the system—the kind of care plan a resident gets would be dependent on who did the assessment. If you got somebody good, that's terrific. If you got somebody on a bad day, that's not so terrific.

We tested the instrument. We went through—I've lost count actually. Kathy may have a count. I stopped counting at the 40th version. We've gone through 40 revisions of the core instrument; it's been tested in six States by us and in five States by another part of HCFA; we personally have been into 60 nursing homes using facility staff to do the assessments; and we've had assessments performed on more than 800 residents to find out if the item is clinically relevant. If the definition is clear, it will lead to care planning.

Now, just two other things that I want to tell you—I've told you how we developed it, but what is it? There are two parts to the resident assessment instrument that will be mandated by HCFA. The first is called the minimum data set for care screening and assessment. That's the basic assessment instrument that facilities will use. States may add items, but they cannot use fewer items or different definitions. What you'll hear discussed today is that assessment instrument.

The second part of it are what we call resident assessment protocols. They are in the 18 areas that are the 18 long-term care quality of care requirements. The purpose of these is to link that assessment information to decisions about care planning. One of the things that we found in going out into facilities is that a lot of facilities have great looking care plans, but they are documents that sit in the records of the surveyors. They are not living documents that reflect the needs, the preferences, and the strengths of living residents.

So what we've tried to do is to help facilities see how to link the assessment information about a resident's status with care plan decisions.

Sarah.

Ms. BURGER. Thank you, Catherine.

One of the exciting things about the development of the instrument is that Catherine, with her cohorts and colleagues, has used a true interdisciplinary process to form it. I think practically everybody in this room has had something to do with it. That speaks well, I think, for the product that we have because we all have part ownership in it.

Thank you very much.

Kathryn Murphy has taken time out from her about eight lives that she's leading at the moment—being a full-time student and a full-time worker, and heaven only knows what else—and juggling her time between exams, she has come to tell us how this wonderful instrument works.

STATEMENT OF KATHRYN MURPHY

Ms. MURPHY. Thank you, Sarah, and thank you for giving me the opportunity to talk about the minimum data set. What I'd like to talk about this morning is to give you some practical how-to information for completing a resident assessment and some pointers to keep in mind throughout the assessment process.

Number one, the caregiver's primary objective in using the resident assessment instrument, which includes the minimum data set and the resident assessment protocols, is as a vehicle for getting to know the strengths, needs, perceptions, preferences, goals, and the unique story of another human being who is dependent on the provider for planning, delivering, and monitoring his or her care in the nursing home.

Once the primary objective is met, the secondary objectives of quality care and quality outcomes naturally evolve. If the assessment process is treated by caregivers as an exercise in paper compliance, the objective will be lost and both residents and staff are at risk of becoming demoralized.

Two, the resident assessment, using this system, provides an excellent opportunity for caregivers to develop trusting working relationships with the resident and his family or significant others. Involving the resident and family as partners in care promotes the concept of individualized care that is tailored to the strengths, needs, and preferences of the individual.

This concept is crucial to the clinical decisionmaking process, especially when it involves choices regarding the use of physical restraints, psychotropic drugs, and life-sustaining technology. The more emphasis is placed on resident family participation in assessment and care planning, the less time and effort must be spent on defensive work in nursing homes, which has also consumed about 20 percent of health care dollars.

Next, the minimum data set is not a questionnaire that must be completed from front to back. It is a set of common definitions. I recommend that each caregiver involved in assessment develop his or her own unique style of interviewing and chatting with residents' families and colleagues. Let the resident guide the assessment process. By that, I mean to let the resident establish how the caregiver brings up topics that are crucial for assessment.

It is not necessary to complete the evaluation in the order the sections appear on the form. For example, if during the course of learning about a resident's customary routine, he or she becomes tearful and agitated, it would be in the resident's best interest to pursue feelings about psychosocial well-being, or sad or anxious mood versus jumping into the next section on the form which is cognitive patterns. You will have lost in the process.

Next, continuity of care is extremely important in the assessment process. Persons with chronic physical, mental, or neurological illnesses have changes in function which are variable throughout the course of the day or week. Be sure to include the insights of colleagues who work on other shifts and weekends, for example. A resident who may be alert, oriented, and fairly independent during the daytime may decompensate as he grows tired and be more confused and dependent later in the day.

Next, interdisciplinary collaboration is the hallmark of comprehensive geriatric assessment. The manner with which this is carried out in each nursing home will naturally depend on resources available. Make good use of clinical consultants in this process.

Involvement of the people who provide the bulk of hands-on care to elders in nursing homes—namely nurse assistants—is imperative in this process. In our field trials, we commonly heard from licensed staff, when we asked them questions about resident functioning, "I really don't know that about Mrs. S. You'll have to ask the nurse assistant caring for her." Not only will you be able to gain useful insights about the residents, but also insights about the quality of care being provided at the bedside, the stress level of the caregiver, and the educational needs and concerns of staff.

Be objective when coding the minimum data set. Code each item according to the guidelines which will be provided in the training material, and not according to your judgment of whether the answer will be perceived as good or bad. If you're not objective, you'll be unable to effectively use the resident assessment protocols to both the resident's and staff's benefit.

As an example, in some States, where we were training nurses how to use the minimum data set, there was a fear of coding problem behavior for fear of labeling a person. Or sometimes staff would not want to code a behavior because the behavior really wasn't perceived as a problem. For example, the staff might have become used to a resident wandering or scratching, or striking out during care. The problem is that it is a problem for other residents and their families and they may not be so understanding.

If you don't code items objectively and appropriately, caregivers may be depriving a resident of the opportunity to have someone evaluate the behavior and begin to understand why he hits, scratches, or wanders. Once that is understood and addressed, the resident may not feel the need to strike out.

Next, share ideas among your colleagues, challenge one another in the assessment process, and challenge conventional wisdom about the resident. Be supportive of one another in the learning process, and also be flexible in your implementation process and change or modify as the need presents itself.

And last, but not least, have fun. One of the things that we've found that the nurses liked the most was having the chance to get to talk with the residents. The residents love the opportunity to participate in the assessment process. That was one of the most rewarding aspects for the nurses and the social workers in the process.

Ms. BURGER. Thank you, Kathryn.

The two Catherines have set the stage for us very, very nicely.

What we thought might be of interest to you this morning was to actually see this process working. So we have gathered together a panel who will demonstrate the assessment and care planning process.

The information we're using was actually gathered in one of the trials that Kathryn spoke of. So we're using actual data, although names have been changed. You don't know who this person is, or where she lives. However, we're going to call this resident Mrs. Lula Rogers. Lydia Borkin, who I'll introduce in a minute, is going to be Mrs. Rogers today and she will tell you a little bit about herself when the time comes.

You're going to enter the process when the initial minimum data set, which we've been talking about, has been done, before triggers and RAPs come in to complicate the issue. So at this point people know some basic information, but just that. The part that you're going to sort of eavesdrop on is the part that would be done quite informally between colleagues, between the resident, between the advocates, between all the staff. They went around and decided what to do, what the problems were, and what they needed more information on. So this would not be as formal a process as you're seeing. It would be informal.

Then each of the panel members will tell, from their perspective, how they view the information on the MDS, and also what triggers and resident assessment protocols they would want to use and how they would view the information from that.

Then finally they will tell you—or give you a few clues—as to the kinds of things that they would want to bring to Mrs. Rogers' care planning conference which will occur later this week.

Now let me introduce my care planning team, Mrs. Rogers, and our advocate. We're going to start with Maggie Donius. She is the registered nurse, and she will be the leader of this conference this morning. She joins us today from the Benedictine Nursing Center in Mount Angel, OR, and is also at the Oregon Geriatric Education Center. She has worked 11 of her 15 years in long-term care because she's excited and challenged by it. She's a clinical nurse specialist and conference coordinator this morning.

Maggie, will you stand? Then you can get an idea of who each of these people are.

Sara Hunt, will you stand?

Sara is a social worker and gerontological specialist. She was the Louisiana State Long-Term Care Ombudsman, so she's playing both sides of the aisle. Sara has been the NCCNHR representative on the Advisory Committee in the development of MDS, and she's been a social worker on interdisciplinary functional assessment teams.

Next, we have Tom Snader, who is a consultant pharmacist. He currently works for Manorcare Corporation and provides care at 13 of their Allentown, PA facilities. He's the past president of the American Society of Consultant Pharmacists, recipient of the George F. Archambauld Award, and author of the chapter on Long-Term Care Pharmacy in the Remington Practice of Pharmacy. He comes well qualified.

Next, we have Caryl Gurski. Stand on that side. She joins us from the Hillhaven Corporation. She is an occupational therapist and an area coordinator for rehabilitation in the mid-west region. She consults directly to 12 skilled nursing facilities in Wisconsin, and is director of occupational therapy at the Woodstock Health Care Center. She is the public information chairman for the Wisconsin Occupational Therapy Association.

Next, we have Robert Joyce, the physical therapist and Director of Rehabilitation Support Systems, College Park, MD, which provides physical, occupational, and speech therapy to clients on the East Coast. He is also the associate editor of Geriatric Rehabilitation and on the Board of Directors of the American Physical Therapy Association, and Secretary for the Geriatric section of that organization.

Lydia Borkin, on my left, has been a resident of a New York nursing home for 10 years. She has been President of the Resident's Council for 7 years. She is also an active participant with the Coalition for Institutionalized and Disabled. Finally, she has been a trainer for surveyors in the New York NYQUAS system.

Next, we have Steven Levenson. He has been the Medical Director of the Levindale Hebrew Geriatric Center and Hospital in Baltimore, MD for 8 years and has been in long-term care for 13 years. He's on the Board of Directors of the American Medical Directors Association and his special interests include implementation of the new law and regulations, information systems, and ethical issues—an important point.

Next, we have Ruth Perschbacher, a music and activities therapist from North Carolina. She has served as Vice President and Government Relations Chair for the National Association of Activities Professionals. She has conducted numerous workshops on resident assessment and has 8 years of full-time experience directing activity programs in nursing homes.

Ann Gallagher is a registered dietitian who represents the American Dietetics Association. She is President of Gallagher Associates, Fort Wayne, IN, which serves long-term institutions. The best news is that she has just been awarded the American Dietetic Association's Medallion Award for her contribution to the profession, and especially for her work with HCFA and long-term care.

I hope a lot of other professional organizations take note of our award winners down there who seem to be sitting together. Maybe we ought to move up closer to you.

Next, we have Julie Oulette, who joins us from South Yarmouth, MA. Julie is a certified nursing assistant and has worked at the Windsor Nursing Home for 9 years. She is Chairperson of the Hospital Worker's Union, and Secretary of the Executive Board of that organization.

Kathy Gannoe has been a Long-Term Care Ombudsman from Central Kentucky for 6 years; she's worked for 12 years with mentally retarded; and she is Secretary for the National Citizen's Coalition for Nursing Home Reform. That sounds like "Old Boys Clubs" to me.

Let me now turn this over to Maggie Donius, who will handle the care conference.

Ms. DONIUS. Good morning. I think, Lydia, in the role of Mrs. Rogers, was going to tell a little bit about herself. So, Lydia, if you would take the microphone and——

STATEMENT OF LYDIA BORKIN, NURSING HOME RESIDENT, BRONX, NY

Ms. BORKIN. You'll have to excuse my voice. It's almost gone.

I'm Mrs. Rogers, and I came to live at the nursing home 7 years ago from another nursing home. Before that, I lived alone after my husband died. I spent my time reading papers, favorite books, keeping house, shopping, cooking, cleaning, and visiting with my family and friends. I went to the local church and I joined in their activities.

I was able to take care of myself until about 10 years ago. I shopped, cooked, and cleaned, and always enjoyed a leisurely shower after the end of a busy day. I'm still lucky to be able to have my wits about me. Life has not been easy, but I still have all my marbles.

But physically I've really slowed down, especially recently. I need help getting dressed, showering, opening cartons, and getting out of bed. The worst is my bladder, which is completely out of control. It's very embarrassing. In fact, I'm feeling quite blue and find myself really short-tempered with the staff. I don't even know why I last shouted at them. I've even been mean to the residents. I don't know why I do that either. Maybe it's just worrying about what's going to happen to me.

I have high blood pressure, arthritis, and then I've had a bout with cancer. I am taking so much medicine that I don't even know what they are. I wonder if I should stop taking some of them. No one comes to talk to me about it. They told me when they added a new one about a week ago that it would make me feel better, but I don't think so.

I feel so badly I admit I even don't want to eat. I've always been a person who liked to eat, but even now I don't enjoy food. I've had some mood ups and downs before, but—I don't know—maybe it's just old age.

Thank you.

STATEMENT OF MAGGIE DONIUS, BENEDICTINE NURSING CENTER, MOUNT ANGEL, OR

Ms. DONIUS. The scenario that Lydia has just so nicely gone over for us summarizes the information that was collected on the minimum data set from the tool. From that information—and those of you who are here with the NCCNHR group and have that nice large blue plastic bag full of materials.

The largest packet in that plastic bag is the information that pertains to the minimum data set tool. The tool is in there along with the RAPs that Catherine talked about and that I will now list off.

So, the minimum data set identified these following problem areas, or potential problem areas, that indeed now the team will discuss.

Delirium was triggered, meaning that there were specific items that pertained to mental status on the tool that then triggered a RAP. The trigger legend is also in that packet. In other words, automatically, if you use this legend, it signalled that you needed to look at that particular area. You could read through the RAP, it would give you some summary information, and indeed give you some guidelines by way to proceed.

So I'm now going to read down the list of those concepts that were triggered from that assessment and data tool. So delirium was the first one, activity of daily living function and rehab potential, urinary incontinence and indwelling catheter—that's the same RAP—mood state, behavior problem, activities, nutritional, dehydration, fluid maintenance—the same RAP—pressure ulcers, and psychotropic drug use.

One of the items that was not automatically triggered was falls, but indeed there was concern on the telephone conversation that we all had with one another that indeed falls is another area that we may need to address.

Because there is quite a bit of overlap in terms of the disciplines that are gathered around the table here, there will be some repetition. In the interest of time, I'll select specifically the area of incontinence for nursing to address, and then we'll go around the table and have each of the persons representing their disciplines give their perceptions and how they might proceed.

In terms of the incontinence which Mrs. Rogers told us about is totally out of control and very embarrassing for her, there is some additional information that we would need to seek from her that was not collected on the tool by virtue of an omission, the timing of the onset of the problem. Indeed, we do not know how long this has been a problem, only that it is a problem. So, in terms of the discipline of nursing, what we would want to do is eliminate any causes of the incontinence that we could eliminate, just within our own realm, before we needed to seek physician's orders or other information.

So the first thing that we would need to do—other than getting the information from Mrs. Rogers in terms of how long it has been a problem, when she noticed that it was a problem, and her feelings and symptoms around that—would be to make sure that everything is okay in the bowel department, to make sure that that's not contributing to her problem, because indeed it could be that if we correct that problem, her incontinence would resolve.

Another thing that comes to mind—and indeed is triggered on the RAP, and it lists these things—is that we would want to call the physician to seek an order for a urinalysis to make sure that she doesn't have a urinary tract infection. Indeed, if that's the problem, it could be that if the infection is treated that her problem would be resolved. At the same time that we collected a specimen for urinalysis to make sure that there were no abnormalities, we could also make sure that she's not retaining urine, in other words, that when she urinates, indeed her bladder is empty.

She's on several medications, one of which is new, and that also could be causing problems in terms of her incontinence. It could be that her medication is doing things to the bladder that were unintended causing her problem.

The other thing would be to discuss with Mrs. Rogers some sort of toileting program so that indeed, until we get this situation hopefully rectified, that she would be taken to the toilet, or reminded to go to the toilet at some prescribed time, so that indeed we could try to increase her continence while we're working on the problem.

Another thing would be to seek information or seek a consult from the physician in terms of any portion of a physical exam that would need to be done to rule out medical causes for her incontinence.

Also, we're told from the MDS that indeed there are some abnormal lab values. Some of those abnormal lab values could indeed be contributing to her incontinence. So that would be the other area for investigation.

Incontinence can also be associated with depression, which it seems certainly may be an issue in Mrs. Rogers' case. Indeed, she's on medication for such. Is she on enough? Is it on the wrong medication, and could it be contributing to her bladder problem?

So that would be additional information that we would need to seek and areas that we would want to consider. Indeed, those things are on the RAP, the resident assessment protocol.

Another role that I would take on in coordinating our care conference is during the time that we would all be meeting that the resident would be present. I would take it on as my responsibility—and certainly it doesn't have to be nursing, but I think it's helpful to have someone in the group that indeed is looking after the comfort of the person who is sitting in on the meeting and just every now and then asking, validating, "Are you comfortable with how things are going? Do you need to say something here? Have we said something that's incorrect?" to make sure that the person feels comfortable in being included in the process.

Again, in terms of time limitations and trying to eliminate some overlap, that's all that I will say right now from the realm of nursing, and I'll turn it over to Tom Snader who is representing pharmacy.

STATEMENT OF TOM SNADER, PHARMACIST, MANORCARE CORP., SELLERSVILLE, PA

Mr. SNADER. Thank you very much.

It's really a pleasure to be invited, not only to here, but to this conference for the pharmacist is not routinely considered to be a member of this assessment process, and that's an important factor that I want to address.

Pharmacy in long-term care really has two parts: one as a provider of the pharmaceutical item, the drug; and it has to be provided in the way that the resident can take the product. So here is a minimum data set that I've seen for the first time as a pharmacist. As a provider of the medication, it tells me things about the client that are very important. The resident can swallow their medication; the resident has no catheter in place; and the resident has multiple drugs that have supportive diagnosis in some cases but potential interactions and complications.

My computer, as a providing pharmacist, can help me maybe predict some of these issues and intervene before the medication is set so that the right dosage can be sent over and labeled correctly.

This particular resident can see well. She wears glasses, but she can read, so she was a candidate for serving herself with the medications in her room, I don't see any physical handicap, other than maybe her arthritis, that might interfere with that.

So, as a pharmacy provider, I have some information from the minimum data set that I've never had before. I just hope that I'm able to get that information, because normally I'm not a part of that process. I'm isolated from the facility in some other location.

But there is another pharmacist, the consultant pharmacist, who, since the early 1970's, has been coming to the facility and reviewing the charts of the residents and has been making comments about what has been called apparent irregularities. Actually, it's a peer review of the therapeutic modalities that are being employed. What I'm trying to do as a consultant is to make sure that the therapy is reaching the goal that the staff has set and is causing no adverse effects to the resident, that it's cost effective, that it's being monitored right—blood pressures are being taken, laboratory tests are being done, et cetera.

So, now I have a minimum data set which is also extremely useful to me. Usually, as a consultant pharmacist, when I come in I work also in isolation in that I see a chart, I see a record, I talk to people in one period of time, one moment. I don't have the overall picture. Now I do.

So as I looked at this minimum data set, I came away with aspects that I want to bring to this meeting. I'm certainly happy that I've been asked to participate in the patient conference. Again, I want to remind you, I'm not necessarily asked to participate.

In this particular resident, I see a change that's occurred in the last 90 days, and I also see a new medication. Now before I've come to this meeting, I've prepared an analysis of the medications that have been ordered for Lula, and hopefully I've talked to her about some of her concerns.

Now I know that there are medications for arthritis that can cause change in mentation, behavior. That's something that I have to rule out. I also know that this particular resident is receiving a sedative hypnotic, is receiving a minor tranquilizer, is receiving an anti-depressant, is receiving a drug for psychosis, if you will, or behavior.

Now under OBRA I've also worked up a plan for dosage reduction that I want to present to the physician because I want to get the dosage down to the lowest possible dose for this particular resident. So I have that plan to present to this meeting—or I would have if I had all the information here.

I've also looked at the possibility of dosage reduction of those other medications. The minimum data set says that Mrs. Rogers sleeps well all night. That may mean that her medication for sleep is only PRN and she's not using it, or that it could be used all the time. I know that sedative hypnotics can cause confusion and agitation. I know that.

Anti-depressants—I have an abnormal laboratory test reported in this particular minimum data set. Some of the medications used for depression—lithium, for example—are critically assayed by laboratory tests. Alterations in their levels can be influenced by sodium, and I know she's being treated for hypertension, so possibly she's on diuretics which affect sodium, which then influences lithium, which then influences the behavior or the mentation of the resident.

It sounds rather clinical, but without the minimum data set, I would have just seen this particular resident at one moment of time. I now have a picture of something that's dynamic, that in 90 days there has been a change. There's also been a change in therapy. There may be cause and effect. I will have analyzed that and presented the possibility of the pharmaceutical drugs that are being used having a role in that particular change in behavior.

I've also now had an opportunity to listen to Mrs. Rogers, and what did I hear? Nobody talks to her about her medications. I've been remiss in my job as a pharmacist. Like the medical model, I oftentimes fall back into the typical medical model process. I talk to the other professionals—physicians and nurses—and have probably passed on information, but not to the residents, not to the guarantors, not to the family members.

If you look at OBRA, you can see that a lot of those regulations reflect my lack of ability in the past to pass on information to those residents. I'm going to change that now, so I'm going to be with Mrs. Rogers to talk about her medications. If she's thinking about not taking them and not being compliant, I have a problem as a pharmacist. If my medications are appropriate for her care, I have to have her cooperation. If that anxiety is leading to her behavior and her aggressiveness, then I have something that I can do positive at the resident level. She has a right to know. She certainly is with it, so she ought to know about her medications.

So that is something new that I have learned from this meeting that I'm going to have to follow-up on that I didn't realize before.

Her incontinence—maybe everything isn't caused by drugs, but certainly incontinence can be the result of certain pharmaceutical agents that we use to treat depression, or to induce sleep. So this is an issue that we have to look at. Anti-hypertensive drugs, water pills, can certainly induce incontinence. And this is something that's changing. I'm not a diagnostician, but I can look at the medications that have been ordered.

So I would have gone down the list of the medications, matched them up to appropriate diagnosis, made sure that the goals that were to be achieved are being achieved without any adverse side effects. If there are any side effects or suggestions, if there is a correlation between the new drug and the symptoms, then I would present that to this Committee. If the abnormal laboratory tests are as a result of my medications, or a possible result of the medications, I'll throw that on the table for the Committee to consider.

So right now, I'm presenting the reduction of the dosage plan of the anti-psychotic, which would be considered then, hopefully, by this Committee, plus any other information that I've gleaned.

Ms. DONIUS. Thank you.

We'll now hear from Sara Hunt, representing social work.

STATEMENT OF SARA HUNT, SOCIAL WORKER AND GERONTOLOGIST, MIDLAND, MI

Ms. HUNT. You said that you had been remiss in your duties as a pharmacist. I feel that in this process we're part of a new management team—the home is under new ownership. Hopefully we would not have let Mrs. Rogers become so depressed and have some of these symptoms and problems that showed up for so long without beginning to see what we could do.

As I looked over the minimum data set and listened to Mrs. Rogers speak, I started thinking about numerous questions and I wanted more information.

Like Maggie said, there are a lot of areas of overlap, and that's part of the real value in this kind of process. There are pieces of information that I want to find out from Mrs. Rogers, but I want to hear it because I'm going to use that information a little differently than would Maggie, or Ruth, or some of my other colleagues. After we gather it individually and put it together, than we begin to see what we really can do. Then we can bring Mrs. Rogers in, find out what she thinks and what she's willing to try.

So what would I do in terms of beginning to conduct the more in-depth assessment after the initial screening? I would go to Mrs. Rogers and say, "There are some items from the assessment that don't seem like they fit together. Tell me a little bit more about how you were so involved in the community. You've transferred into this facility, what precipitated your coming here? What has been your experience since admission?" I would try to discover what has been the course of her depression. Is it recent, or has it been a historical problem? Has she received treatment in the past? What kinds of things seem to work, and what doesn't work? Does anyone ever come to talk to her about her condition or her drugs? How does she feel about that?

I'd want more information about Mrs. Rogers' knowledge of her current condition and her past patterns. Has she ever had anything that has even come close to continuity of her previous life style in the facility?

She mentioned that she had a problem with cancer, a diagnosis. I'd want to know more about when, how she responded, what's happening, and if something is really bothering her now about that diagnosis. Is it current or something that she had at one point in time?

She mentioned that she talks to staff and to residents sometimes a little mean and she doesn't really know why. I'd want to talk to her more about her feelings and give her some sort of outlet and opportunity to express them.

I'd also want to do a little probing about her lack of activities and what goes on when the staff comes in to provide care routines. Not only would I want to interview her in these areas, but I would want to observe. I would want to come back by her room at different times of the day to see for myself how she's interacting with staff—and maybe just as importantly, how direct care giving staff are interacting with Mrs. Rogers—and being to find out more about the specifics of the behavior problem that seems to exist as recorded on the minimum data set.

I'd also want to talk to her family. There is an indication that family has some responsibility for Mrs. Rogers in this facility. I'd want to ask them some questions about her continuity of life, her patterns, her history, and what kind of treatment has worked or not worked.

Also, I'd want to talk to other staff. I would particularly go to nursing assistants and find out what they knew about the behavior, her being sometimes mean. What she says, what she does, how it occurs. What do they know about what precipitates the behavior(s) and what works as a successful intervention. Is there any pattern? How can we get to the bottom of the behavior?

I would certainly want to go to people around this table to find out about the side effects of medication, what they've tried in their professional disciplines in terms of intervention, and find out more about the incontinence problem: what might be done, what might be causing it. As a social worker I'm concerned about these factors feeding into the depression and Mrs. Rogers's feelings of self-esteem, perhaps even her lack of involvement in activities.

So there are a lot of questions that I have about the interactions of drugs and other things that might happen with this resident, as well as Mrs. Rogers's perspective and course over time. I'd want to bring this kind of information to the care planning conference so that we could begin to sort through exactly what's happening and talk with the resident about what she wants. I do think there's a good potentional for positive interventions to help Mrs. Rogers feel better about being in the facility and to improve her functioning.

Ms. DONIUS. Thank you.

Representing occupational therapy, we'll now hear from Caryl Gurski.

STATEMENT OF CARYL GORMLY GURSKI, OCCUPATIONAL THERAPIST, HILLHAVEN CORP., KENOSHA, WI

Ms. **Gurski**. Thank you.

It's a privilege to be here and to be part of this distinguished panel.

Occupational therapy has historically viewed patients holistically. For initial assessment of a patient's needs, we would look at mental, emotional, physical, and psychological needs, or the whole personhood involved in our attempt to provide what she may need to enhance her independence.

It has been my experience in working with gerontic practice that elderly patients lose ability to adapt to their environment as control of the environment and of themselves is lost. I lovingly refer to it as Nursing Home Syndrome, if my employer will indulge me.

In my discussions with Mrs. Rogers—and I would have that discussion before the care planning conference—she has told me that she is especially depressed because she has lost the ability to take of her basic needs. Occupational therapy's focus for treatment always is enhancing functional independence and activities of daily living, or what you do from the time you open your eyes in the morning until you close your eyes at night. This would include rolling over in bed, getting out of bed, eating, getting dressed, washing—all of those things that most of us take for granted. Those things have become more difficult for Mrs. Rogers.

I would be concerned, as an occupational therapist, and in my evaluation would assess her need, for addressing the anxiety that she's feeling. I would look at her lack of diversional activity, maybe an interest inventory, only in terms of what physical limitations she may have, and certainly would work in concert with the activities director of the facility to implement activities that would fit within those limitations and perhaps provide some new challenges.

I would certainly want to consult with Social Services and with Nursing in terms of their impressions of this individual and in the past interests that she may have had. I would hope to work in concert with the physical therapist and the activities director in providing big muscle kinds of activities because I know professionally that anxiety actually causes tightening of the muscles, and unfortunately, the muscles which make us less receptive to our environment, the muscles that make our bodies pull into ourselves rather than relaxing the muscles that open us to activity and life.

I would certainly look upon Mrs. Rogers as a wonderful candidate for activities of daily living therapy because I know from the minimum data set that she has some ability to make some decisions, and she certainly has the potential to return to independence, my nursing colleagues tell me. So I would be looking at therapy which would help her to find a comfortable routine again.

I might look at giving her some assistance in sequencing that routine, maybe in a little different way than she has before. I certainly would want to provide a setting that would give her a success experience, an opportunity to reexperience the dignity of self-care independence.

I might want to design a program for carry-over in nursing that would provide some input in terms of the verbal cues that she needs, or maybe a particular set-up of the activity that would guarantee her success experience. I would certainly want to encourage all of the staff to provide her positive feedback for her increased ability.

I might want to provide some adaptive equipment. Perhaps one piece of equipment might change or enhance her ability to do a task for herself again. She certainly has the cognitive, or the thinking and problem solving skills to be able to handle new training, doesn't she? The minimum data set has told us that, as she says, she's "able to continue to think." She hasn't "lost her marbles" she told us earlier. Often patients find it actually challenging to use a new piece of equipment.

I would want to look at her nutritional level with my colleague, the dietitian, only in terms of why she isn't eating all of her meal because the minimum data set told me that she's eating 25 percent less than the total meal on a regular basis. I guess, as an occupational therapist, I wonder what is it about Mrs. Rogers that might be interfering with that? She has arthritis. Maybe she's having more chewing difficulty. Maybe she's having less ability in making those joints do the things that they used to do. Perhaps, again, I could provide her with a special piece of equipment that might help her eat independently again.

And maybe another factor—and we don't think of this often enough in the nursing home sitting—that is the environment where we do this dining or eating. Is she sitting in a dining room with patients who are disoriented, who are crying out? She's told us that she has all of her marbles. Maybe that's distracting to her and may be contributing to more depression and reducing the amount of time that she wants to spend in the dining room eating that meal. So I would want to look at the environment to see what adaptations we might want to make in the area.

In terms of the incontinence, I guess I would want to look at how able she is to transfer to the toilet. I know from the minimum data set that she's relatively independent, but, again, she may be having some joint limitations that are making those transfers more difficult. Perhaps a built-up toilet seat might make getting on and off the toilet easier, and make getting to the toilet a little faster procedure while she's having these difficulties.

I would certainly want to look with my physical therapy colleague and with my activities therapy colleague in terms of mobility. I would want to look at, has she lost strength? Has she lost, again, the ability to move these joints? Maybe she has lost some coordination. Maybe she is experiencing more pain. I would certainly need to look at those things if I'm going to facilitate her independence in activities of daily living.

I would look to working with Mrs. Rogers on a one-on-one kind of basis with a therapist. I might even consider—with her blessing, of course—incorporation into a small group type of activity. Sometimes when patients are involved with others like themselves they are more motivated by one another than they are by the therapist or the professionals on the team.

Oftentimes the activities that we could be involved in in a small group situation focus the attention on the object or on the activity and not on the skill that's required. With someone who is experiencing some depression, we want to provide them with the best opportunity to have success and pleasure and fun while accomplishing the therapeutic goal.

And finally, I would certainly want to be concerned with her sense of self-esteem, with her sense of self-concept, with the social worker, the activities director, with nursing, and the whole team. We all need to be concerned. We want to give her as much success as possible. We want to encourage family and friends to continue to participate in the outings, as they have in the past, as she is able to be more physically independent.

Thank you.

Ms. DONIUS. Thank you.

We'll now hear from Robert Joyce representing physical therapy.

STATEMENT OF ROBERT JOYCE, PHYSICAL THERAPIST AND DIRECTOR, REHABILITATION SUPPORT SYSTEMS, COLLEGE PARK, MD

Mr. JOYCE. Good morning.

The thing about the minimum data set and the RAP triggers that most impressed me, was, as Tom said, that they provide a dynamic picture of the patient over time. Traditionally, all of the tools that we have very often used provide a momentary snapshot of the resident at that moment. However, as we grow older, change is inevitable. Change occurs to all of us and very often we don't recognize that. The thing about the minimum data set is that it gives us the information that we need to plan a program of intervention, certainly from the standpoint of physical functioning.

In looking at the minimum data set and the RAPs that are triggered, there are several areas, from my professional background, that I see that immediately make a closer look at this resident more important. First, her direct caregivers feel that there is a chance for improved function. They have known her for quite a while. They must know what her capabilities are and that sometimes she can do this and sometimes she can't. What's the reason?

Furthermore, an interview with Mrs. Rogers, herself—why have things changed now? What are her goals? What are the things that are bothering her? Very often, a decline in physical function can result in depression. There are a lot of other things that I would want to know from her.

As far as her physical systems, immediately looking at this, we had a trigger on ADL function under the area of bed mobility, so the first thing that I would want to do is to go and look at her to find out what may be the problem. Could it be a neuromuscular skeletal problem? Could it be the arthritis that makes it more difficult? Spinal arthritis makes it very difficult to get in and out of bed, yet you can walk just fine.

The other thing we would want to look at is the assistance she needs in bathing. Why does she need that? Is there something that we can do to intervene to change that? It may be as simple as just adapting the environment.

The other area that I would want to look at is falls. Now, in this particular area, she didn't trigger immediately for falls, however, there is the danger there, based on this assessment, that she could fall. There's just a little something there that says this resident might possibly fall.

To me, that's a wonderful tool because traditionally I don't very often find out about the patient until after they've fallen, or very possibly after they have fallen and then fractured a hip. In this case, I can go and look at the patient and determine, what's their balance status? What sort of vascular problems might they have that leads to this? So that gives me a better idea. I can then intervene rather than having to play the one who tries to put them back together again.

The other thing, in looking at the minimum data set—although it didn't immediately trigger as per the triggers on the resident assessment protocols—but just looking at it, she does need some minor assistance in transfers and locomotion. Again, that gives me something further that I can look at. Can we make a change in that?

So, from that perspective, that gives me a lot of information that heretofore I would never have had, so now, from a physical therapy standpoint, and a rehabilitation standpoint, we can begin to become involved in prevention whereas in previous times what we would do is restoration. Certainly, economically it's a lot better for our health care system. And certainly from the standpoint of the resident—like most of us would want—we want to solve the problem before it becomes a problem.

So from that perspective, I think the MDS provides a lot of information as to what dynamic changes are occurring with the resident over time versus where they are right now at this moment.

Ms. DONIUS. Thank you.

Now Steven Levenson will address concerns from the physicians' point of view. I need to point out here that in this particular scenario, Doctor Levenson is the new physician of record—and has come into this situation sort of after the fact.

Doctor Levenson.

STATEMENT OF STEVEN LEVENSON, M.D., MEDICAL DIRECTOR, LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, BALTIMORE, MD

Dr. LEVENSON. We decided that I would represent the physician taking over the case because I wouldn't necessarily want to claim to have been the one taking care of her before.

The attending physician in the nursing home has really four major roles. Unfortunately, often, for whatever reasons, he doesn't get—is unable or unwilling to play those roles. The nursing home setting is really a unique practice site for medicine because it's not just a matter of dealing with illness, but taking a look at several other issues and factors that relate to the management of medical problems.

So the four attending physician responsibilities in the nursing home would include practicing good geriatric medicine and basic internal medicine, including the management of actual illness.

Second would be to consider function and quality of life to be end points of the medical treatment, so therefore deciding not only which problems or conditions are amendable to medical treatment, but also whether they ought to be treated or to what extent depending on such things as the wishes and needs of the resident.

Third would be to facilitate the care plan, in other words, to enable the rest of the staff to carry out some of the issues and items that they have concerns or questions even though, as a physician, I may not be physicially present.

Fourth would be to advise and guide both the other staff and the resident in terms of offering suggestions, recommendations, and giving information and advice about what to look for when there is concern about the complications or side effects of medications.

So I see the minimum data set as an important foundation for providing the information that can better link the medical and other professional plans of care.

And as a physician I would typically go through—or hopefully go through—a six step process. For example, in this case of Mrs. Rogers, the first thing would be to take a look at the medical diagnoses and assessments and ensure that they are accurate and complete. For example, she's listed as having hypertension. The question would be, is this hypertension an ongoing problem? When and how was it diagnosed, or was it just episodic? If episodic, then does she necessarily need to have medication still for hypertension, which could be causing more side effects than it is doing good?

Second—a diagnosis of depression. Again, is this a major clinical syndrome of depression requiring medical intervention and medications, or is it an episodic problem that might be better managed in some other nonmedical fashion?

Then there is a diagnosis which merely says cancer. So, of course, I would want to know, when was this diagnosed? What kind of cancer? What kinds of treatments were instituted, and what might have been the residual effects? For example, if there was radiation therapy to the pelvis, then that might have affected the bladder and thereby contributed to the current problem of incontinence.

Also, concerning the diagnosis of osteoarthritis, I would want to know how and when this was diagnosed and how severe it is. So in the physical examination I would see the extent of the deformity and the dysfunction caused by this problem.

Second, as the physician, I would want to review Mrs. Rogers' functional status and problems. I see from the minimum data set that she is cognitively intact; has good memory and recall; has substantial decisonmaking capacity; that her sensory and communication functions are adequate; that she needs substantial assistance in ADL in four areas; and in addition to that that the staff taking care of her believes that she has some potential for improvement; that she has frequent bladder incontinence; that she's been verbally abusive and has socially inappropriate behavior, and that that has been worse in the past 90 days; that there's been a general deterioration in her activities of daily living; and that she's been leaving 25 percent or more of her food uneaten at most meals.

The third thing that I would want to do is to review, then, medications, laboratory tests, special treatments, and procedures. I see that she is on six medications, which is sort of the minimum, fairly typical amount, that nursing home residents tend to be on. Among those medications, she is on anti-psychotics, anti-anxiety, and antidepressant medications—a dynamic triad—and has been on them fairly consistently during the past 7 days.

In addition, there is some indication of abnormal laboratory values during the past 90 days. I would want to know what those were because there are lots of abnormal lab values among nursing home residents and many of them don't necessarily mean anything or require treatment, but the trick is to figure out which ones do mean something and which ones indicate that additional work-up or treatment is indicated.

The fourth step in this process is to talk to the resident and the staff who has talked to the resident to find out about any special desires, wishes, or needs such as advanced directives, living wills, durable powers of attorney, something that might influence the extent of treatment, work-up, or evaluation.

The fifth step is then to come up with a medical plan of care. This centers around the medications. After reviewing the current regimen, I would want to think about, are these medications helping, or might they be the source of the problem as opposed to the possible solution? For example, the anti-hypertensive might be affecting behavior or continence. As mentioned before, the medication that she might be on for osteoarthritis might be affecting behavior or mental status.

Then I would want to consider either changing, discontinuing, or renewing the medications. For example, if osteoarthritis is a problem contributing to her dysfunction in activities of daily living, then I would want to see if she's on the right kind of anti-arthritic, or if the dosage is adequate. I would want to focus on the anti-psychotics, as I said before, making sure that the diagnosis is correct, considering whether the medications are necessary, and whether there are alternatives.

I would want to think about, if she does need the medications, whether those medications have undesirable side effects and whether others might be better with fewer side effects. I would also want to think about the problem of paradoxical side effects, that is, the higher you raise the dose of some psychotropic medications, the worse the condition gets as opposed to the better it gets.

I would want to take a look at the abnormal lab values and see whether they need additional follow-up or additional testing. For example, as mentioned before, I would want to get a urinalysis and possibly a urine culture to see whether there was a simple and potentially reversible cause of the incontinence.

I would want to consider—where I could, depending on the community and the location of the facility—think about consultants, such as a urologist, who might be able to help by doing a cystoscopy, or a psychiatrist, who could help in recommending dosage adjustments or changes in medication.

Then, finally, and perhaps most importantly, I would want to provide information and advice to the resident and to the staff because even though I, as the physician, am sort of in absentia, I hold the key to a lot of the successful implementation of the plan of care in the sense of providing the information that other disciplines need in order to carry out their parts of the plan of care. So I would want to offer a realistic prognosis. As I said before, I would want to make suggestions or write orders to assist in the nonmedical management, especially of behavioral dysfunction, in an attempt to move away from the simple application of restraints and psychotropic medications wherever possible.

And I would want to help the staff coordinate my medical orders with the care plan so that there is consistency. For example, if they say that they think the resident has rehabilitation potential, then I would want to make sure that there were some orders to at least have a consult from a physiatrist, or from physical and occupational therapy.

So then, my role as the physician is sort of a complex and a tricky one, in terms of managing medical conditions and assisting the staff in managing all the other personal and health care issues that they have to deal with in the facility.

Ms. DONIUS. Thank you.

We'll now hear from Ruth Perschbacher, representing activity.

STATEMENT OF RUTH PERSCHBACHER, MUSIC AND ACTIVITIES THERAPIST, ASHEVILLE, NC

Ms. PERSCHBACHER. Good morning.

Again, as everyone else has said, the minimum data set certainly raised a lot of questions for me. The beauty of it is that Mrs. Rogers, in her introduction, answered some of those questions that I did not have from the paper.

One of the things that I was very concerned about, looking at the MDS, is that she is awake a lot though she has no involvement in activities. It's hard for me to imagine someone who is awake a good deal of the day who is not involved in some type of activity.

So I would want to look and find out if that's true, and find out how people are defining activity pursuits. Activity pursuits really is a very broad area where people are involved in activity that's important to us. It might be cooking; it might be activity with another resident; it could be any number of things.

One of the things that she did say was that she liked cooking. That was not on the minimum data set. I also like to cook, so I would go to Mrs. Rogers and appeal to her a little bit as one cook to another and see what kind of cooking she likes to do. I know that when I'm kind of down and out, one of the things that I love to do is to get into the kitchen. This might be something that Mrs. Rogers also might find of interest.

The other thing is that she shows some signs of verbal abuse, so also on the minimum data set, it does not say that she has any problems with relationships. I see that—I think if someone were verbally abusing me, I might not feel as kindly toward them. So, again, I might wonder if she wasn't having some problems with relationships—and she really did say that she was.

There is not a better way to resolve any kind of work through relationships than through food.

So we might talk to Mrs. Rogers about making some food and inviting some of her friends, some of the residents, and some of the staff members and really get involved in a type of food activity. This would have a lot of other implications if she isn't eating a lot and perhaps if she were cooking some of her own food, she might be eating more, she might enjoy her food better in a social situation. Also, if she could be involved in the actual preparation, that might give her some motivation, even so, if she is having trouble with her arthritis, she might use some of her fine and gross motor skills a little bit more because she would be doing something that she really enjoys.

So I would really try to bring in these other areas. The incontinency—maybe I just need to be sure that she knows there is a bathroom in the activity room so that she can go to the bathroom when she wants to, so we can look at what those barriers are that are keeping her from participating in some of the things that she really enjoys. Obviously, she has a lot of interests, and I want to really tap into those things.

Ms. DONIUS. Thank you.

Representing nutrition, we'll now hear from Ann Gallagher.

STATEMENT OF ANN GALLAGHER, REGISTERED DIETICIAN, GALLAGHER ASSOCIATES, FORT WAYNE, IN, REPRESENTING THE AMERICAN DIETETICS ASSOCIATION

Ms. GALLAGHER. Thank you.

Having served on the Advisory Committee for the MDS, this instrument, of course, is very close to my heart and it's exciting to see how much more we now know about the resident compared to what we know before. I've been working in long-term care for 20 years, so it is indeed quite different today.

In looking at the MDS, it triggered three areas that took us into the nutritional status RAP. Those areas are the weight loss that Mrs. Rogers has had in the last 30 to 180 days; the fact that she is leaving 25 percent or more of the food that's being served to her; and she's on a therapeutic diet.

First of all, before going to see Mrs. Rogers, I would want to know how many calories she's going to need a day to maintain her present weight, which ends up being approximately 1,700, and she's going to need about 2,000 ccs of fluids to keep her hydrated.

I would want to identify the reasons for the weight loss and for her decrease in appetite. I would want to look at whether it was secondary to her depression, or is it food intolerance due to the diagnosis of cancer? What kind of cancer does she have? Are her food choices and her food preferences being honored? Are her meals appropriately spaced, or does she have breakfast and lunch too close together? Does she need between meal feedings so that she'll eat better? What kind of environment is she eating in? Just as Carol, my OT colleague stated, the environment at meal time is very important. Is she eating in a dining area that has a nice environment for her? She is an alert resident.

I would want to look at what kind of a diet she's on. She's probably on a sodium restricted diet since she has hypertension and since she has some edema. Does she really need to be on that sodium restricted diet is something else we would look at. Maybe she's on a 1 or 2 gram sodium diet and it could possibly be changed to a 3 or 4 gram sodium diet.

We'd also look at her medications as many anti-psychotic drugs will decrease appetite. Is this a drug-induced anorexia that we're looking at? All of these problems, left untreated, can result in refusal to eat and cause significant weight loss and lead to malnutrition for Mrs. Rogers.

We would also want to look at her arthritis. This does not seem to be a dietary problem at this time. The reviewer thought that the resident is capable of increased independence with ADLs, but she does need some type of supervision or assistance with eating, at least she did in the last 7 days.

So, in the future, if her arthritis progresses, she may need a self-help feeding device to enable her to keep feeding herself. This is where we would work in conjunction with OT.

She has the potential for being dehydrated in that she has the decrease in her ADLs and she needed some assistance or supervision. We would want to monitor her fluid intake. Because she is leaving 24 percent or more of her food, it is possible that she will not be taking all of her fluids.

We would also want to check to see if she's on a diuretic. We would look to see what the abnormal lab values are, as many abnormal lab values, especially electrolyte imbalances, can easily be reversed. We want to take a look at her depression and sadness because that can be a factor that also leads to dehydration.

And we would want to talk to Mrs. Rogers herself and to the nursing assistants who take care of her on both the day shift and the evening shift for all three meals. Many times we find that residents will eat better for breakfast or at their noon meal and they're not eating very well at their evening meal. So we would want to know which meals she takes better.

We would look at food and fluid intake records that are kept by the nursing staff. In talking to Mrs. Rogers, we would definitely be sure that her food preferences were taken back to the dietary department, that they were listed on her diet card, and also in her dietary cardex in case the diet card got lost, the food preferences wouldn't be totally lost and we would be able to pick them up from the dietary cardex.

Those are the items that we would take to care planning for this particular resident.

Ms. Donius. Thank you.

We'll now hear from Julie Oulette who is a certified nursing assistant.

STATEMENT OF JULIE OULETTE, NURSING ASSISTANT, WINDSOR NURSING HOME, SOUTH YARMOUTH, MA

Ms. Oulette. Hi.

First of all, I would like to say that as a nursing assistant I really like the MDS. We're just starting to use it at our nursing home, but I could see where I could read this MDS and figure out how to take care of this patient in the best possible way that I could.

Right now, as things stand, nursing assistants aren't very involved with the care plan of the resident. They never have been. They've only been told what to do. I think that with the MDS in place, and the nursing assistants helping to fill this out and give credibility to it, instead of a nurse trying to do it all herself and getting the whole group all together, I think this is going to be a really good thing for our patients, for the nurses, and for everybody who works in the nursing home.

Thank you.

Ms. DONIUS. Thank you.

Representing family, we'll now hear from Kathy Gannoe.

STATEMENT OF KATHY GANNOE, BLUEGRASS LONG-TERM CARE OMBUDSMAN PROGRAM, LEXINGTON, KY

Ms. GANNOE. I'm here in the role of the ombudsman. I'll tell you, if I had teams like this in my nursing homes in Kentucky, I'd quit and sell real estate.

This is just extraordinary.

Normally I get called in on situations when the resident has all these presenting situations and I'm hearing from the family and they're saying, "They've given me 2 days to find Mother a new nursing home. Will you please help?" So I'm excited with this new management team that has taken over at this facility.

The role of the ombudsman, in the assessment process—listening to this and trying to key into this particular process—there are a couple of things that I, as the advocate for Mrs. Rogers, would do. These are some of them.

I would start by just listening. I would go in and listen to this lady, then I would listen to her some more. Then I would listen to her again and try to get direction from her as to what her concerns were.

When I was talking with her earlier about this scenario that we're working on, Mrs. Rogers pointed out to me that in reality some very simple things can trigger depression in a facility. Certainly, if she has had this major change in the management team—she has a new doctor, new nurses, all these sorts of things—these could all lead to her problems. She might be willing to share that with someone who didn't represent the facility staff.

I would ask her what would make her stay at the nursing home facility better, and I would ask her if there was something I could do for her. In the process of doing that I might locate a volunteer friendly visitor who might come in and help reconnect her with the community.

If she's been 7 years in this facility, and if she were active before, it might be that over the course of 7 years her friends have dropped away or become frail themselves, and it might be that I can go out and reconnect her with more able members. For instance, from her church community I might be able to find folks who didn't know her back when she was active, but who might be willing to get involved with her again.

One of the things I would do is to explain to her what this whole thing is all about. I would explain about the minimum data set is, and I would explain why, for the first time, she's having a number of people take a look at her, talk about her, and talk to her about what's wrong with her.

I would hear her when she voiced her concerns about her medication. Perhaps, with her permission, I would go to the director of nursing, or maybe to the pharmacist directly and tell them that she is concerned and would like to have some more information.

One of the things about the incontinence problem—and this is something that I would check just by observing as well as talking with Mrs. Rogers, but probably by observing—I would check and see that they are handling this condition and this problem with dignity so that her dignity is not being violated and that they are not saying in the halls to her—which I'm certain that this CNA would never do—saying out loud in front of everybody, "Did you mess all over yourself again?" or something like that. I would be really alert as an advocate to that kind of atmosphere and attitude in the facility.

One of the things that I would do is to explain my role to her, as an advocate, and tell her I'm available to respond to her concerns and that I'm willing to advocate for her on her behalf at whatever level, from just sitting beside her supportively, like we were doing this morning, all the way to representing her in a care conference or calling in family members who might be able to make her more comfortable.

The thing that I'm excited about, as an advocate, with the MDS, is that now there is a tool that I have in my hand and that the resident has in her hand because we're making a lot of assessments of a person, we're making a lot of plans about really providing quality care—which is what it's all about—and there is a blueprint that we can go back to and look at and measure what's happening in her daily life against the proposal. That's what is happening, and I'm very excited that this is going to be a great tool for advocates. I think that with this kind of team Mrs. Rogers is going to feel better real fast.

Thank you.

Ms. DONIUS. Thank you.

I'd like to bring this now full circle. We started out with Lydia Borkin representing Mrs. Rogers, our resident. I'd like to turn it back over to her. Do you have any comments from yourself, as a resident, or do you have any comments in the role of Mrs. Rogers?

Ms. BORKIN. Of course, it would be much easier for me just to speak of myself, since I am a resident and have been a resident for 10 years at a nursing home.

I must tell you that about 2 or 3 weeks before our annual meeting here I received a notice from our office to say that I would be assessed on October 30. So I'm taking all this in because you must understand that in the 10 years that I've been in the nursing home, this is the first time that I have been assessed. I'm sure that the reason that I am probably one of the first residents to be assessed is because I am a very loud-mouthed person who lives in a nursing home.

I'm very pleased, as Kathy is, to see all this. Although this is very clinical, all of you have presented what you find, what you'd be looking for, and what you'd be doing. There is a person behind these papers, a real live person who has lived many years before she came into the nursing home and had a way of life. When she came into the nursing home she gave up possessions, friends, and activities to make all kinds of adjustments.

So when you look at someone living in a nursing home it would be great if you asked her, what happened to you before you came here? What were your interests? What did you care about? What's going on here that we see such changes?

As Kathy said, we were talking about someone who is depressed and is getting three or four medications. Not only does she not know what they are, she doesn't know if they're the right amounts or if she should be taking them. She should be able to ask anytime there's any medicine, what is that for? What is it supposed to do? Since sometimes you start off with the regular medicine and then are given generic medications, which can be an entirely different shape or color, you don't recognize it. That has to be made known to the resident so she's sure that she's getting the same medicine that she started out with. Then they need to find out if, after a week or two of being on the medicine, do you feel better? Speak to her. Ask her.

So these papers are wonderful. They are great. But, please, talk directly to the resident and someone like Kathy, if that resident cannot speak for herself, or is uncomfortable, someone who will advocate for her. All of these papers are great, but there is nothing like speaking directly to the resident who has lived in the nursing home, and will continue to live there.

Ms. DONIUS. Thank you.

It's now my responsibility to do some kind of a conclusion, summarization, and wrap-up, before Sarah has a question that she wants to pose, and then some questions and answers from the group.

In our conversations around this horseshoe, indeed we have touched upon, either directly or indirectly, all of the RAPs that were triggered by the minimum data set. In various disciplines, we talked about each one of those a number of times. We discussed the fact that indeed her medications may be at the root of her problems, or at least be contributing to her problems; that there is an alteration in her mental status abilities; that there is an alteration in her activity of daily living functioning level, and that there is the feeling that that level could be improved; that hopefully she can become continent again, and that in that process we would be able to preserve her skin; that we would be able to alleviate the problem behaviors that have been occurring; that she would become active not only in terms of care for herself, but also in terms of other activities that go on throughout the day; that she be free of falls, that she not fall and injure herself; and that she be adequately nourished and adequately hydrated.

Each one of these things plays on the other and we have a great big giant circle. It all kind of gets back to the same thing, or gets back to the root of the problem.

What we may have is a new medication that she's been prescribed for perhaps one of the problem behaviors, that may have made her incontinent, that may be decreasing her appetite, that—again, if she's not eating, she may not be adequately nourished. She may have skin problems that are aggravated because of her incontinence. Her immunity may become somewhat tired and she may be open to other infections. It would be the ideal situation that after a meeting or a conversation such as this, that a plan would be developed, the resident and/or the family would be conferred with, and the plan developed would go forward and would alleviate these problems, resolve some of these issues, and indeed, in our case scenario today, that Mrs. Rogers would live with a much higher quality of life.

Sarah, I think I'll turn it back over to you.

Ms. BURGER. Thank you very much, Maggie.

You've seen, from this presentation, how complicated it can be to make a care plan for one single individual. When you think of this in relation to a whole facility, you realize how much expertise is needed and how much thought is needed to go into the care planning and making the quality of life of this individual better.

What I would like to do now is to turn this over to you and have you ask questions of anyone here on the panel.

Ms. HOLDER. If any one of you from the audience have any questions, would you please come up to the microphones that are in the front? If you're a resident sitting in the front, I think we can hand some of the microphones to you, but you'll have to come up to the front so that you can be recorded in the record.

Ms. DLOTT. I have a comment and a question.

Ms. TITUS-ROURKE. Could you identify yourself, please?

STATEMENT OF DEBBIE DLOTT, OMBUDSMAN

Ms. DLOTT. My name is Debbie Dlott and I'm an ombudsman in Burlington, VT.

The comment is, when Mrs. Rogers first described herself, she talked about a love of reading and I didn't hear anyone bring that up. As an avid reader myself, it kind of bothered me. I wish that somebody had mentioned that.

My question is, supposing after reviewing Mrs. Rogers medications, the doctor decides that in fact there might be some benefit to an anti-depressant and Mrs. Rogers flatly refuses to take it. Where would you go from there?

Dr. LEVENSON. That's a tricky one. Certainly, I think it's a good example of the challenge of balancing rights and responsibilities in terms of helping somebody. What we try to do, for instance, at our facility is to do everything possible to speak to the resident and explain the potential for the medication to do good and to help improve the situation. If there is a family, then we would speak with the family and ask them to talk with the resident and encourage that individual to take this medication.

We don't force people. I wouldn't force someone to take a medication or trick them, such as crush it up and put it in their food without letting them know that they were getting it. But I think we face a lot of those very tricky and fine line type of situations where you really could help somebody, and yet, because of their very condition, they don't necessarily want help.

So I would do everything possible to have others encourage and assist her in accepting the treatment.

Ms. DLOTT. And if she still refused?

Dr. LEVENSON. Well, I think that we would have like a trial period, a nonmedical therapeutic trial period of other measures and interventions in an attempt to improve the situation.

If that was at least partially successful, then we would go back and try again if it looked like an anti-depressant may be helpful. Perhaps it wouldn't even be necessary after that trial period.

Ms. DLOTT. Thank you.

Ms. GANNOE. I just wanted to comment about the—I'm glad the other ombudsman brought that up. I had made a note wondering about her personal needs allowance. Newspapers and books cost money, but maybe we could make some arrangements with a library to get them for her.

STATEMENT OF BENTE COONEY

Ms. COONEY. My name is Bente Cooney from the Senior Policy Committee with the National Committee to Preserve Social Security and Medicare, and I'm also Co-President of the Washingtonians for the Improvement of Nursing Homes. I want to congratulate you. I think it was a beautiful, beautiful session.

But one thing I thought was not metioned that may have some impact on the way that the resident might feel, that is the financial aspect. Nobody mentioned that perhaps the resident has a concern about how her stay is being paid for and her spend-down situation. I think maybe that would be the social worker that might want to talk to the resident about that. Could that have an impact on her state of mind and how she feels?

Ms. HUNT. I agree. That's a good point. There are a lot of other questions that I would like to ask her. Many of the purposes of assessment are illustrated by the line of questioning each of you addressed, but also, we are concerned about finding out what her sources of pride were. We talked about continuity of life, from community to nursing home. Assessing this depends on discovering her strengths. What can we bring into the care planning process—in addition to this list of deficits? What is there to build on, no matter how minute those strengths may look at this point in time?

Ms. BURGER. Julie Oulette, this morning, mentioned something else that happens in her facility that certainly might have affected a person such as Mrs. Rogers.

Would you like to tell about the movement of rooms. Julie?

Ms. OULETTE. In our nursing home, a patient will be moved and you come to work the next day and the patient is not in the room anymore, she's down the hall somewhere. You ask, where is Mrs. so-and-so, and they inform you that she's down the hall. When you ask why she was moved, they don't know.

I've seen a lot of patients get very upset over this, and they have really no control. No matter what they say, they move them anyway to make room for somebody else, or to make somebody else more comfortable. I don't know exactly why they do it.

But right now, in our union, we've filed grievences on this. Hopefully, we'll start making people more aware that this stuff really does go on. Sometimes if the patient doesn't have any family members or anybody to advocate for them, then we have to do it. So we've trying to really do something with this room change business.

STATEMENT OF LINDSEY TORRELLI, NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS

Ms. **Torrelli**. I'm Lindsey Torrelli from the National Association of Protection and Advocacy Systems.

I did hear mentioned, earlier, with one of the panelists, the involvement of the resident sitting in. My first priority would be that that would be a requirement. In reviewing the RAP, the resident assessment protocol, or in any discussion, that should be a requirement, as opposed to something that seemed to come across as secondary that the person is sitting in and if they have a question—well, I think it should be a priority that they be there and be personally involved in all of the questioning and not just as a secondary piece.

I'd like to know how the residents feel about that. If someone were discussing me, I would like to be there as opposed to sitting behind someone, or without an ombudsman.

Dr. **Levenson**. I think there are times when a staff needs to be able to have a discussion that is somewhat speculative—for example, what could be or might be wrong—that could raise issues that might cause undue alarm, for example, in discussing a person's behavior or cognitive function. There may be speculation about possible diagnoses.

So I think the resident certainly needs to be involved with that. It's not necessarily appropriate that they would be present at all such discussions or that it be required in all situations. I think there are two aspects of it. First, you would discuss the conclusions and recommendations with the resident, but there also has to be preliminary discussions amongst the staff to sort of iron out differing points of view. If the resident is always in at that point, there could be more confusion than help in terms of all the speculation and reviewing possibilities.

Ms. **Gurski**. I would like to respond to your question also. From my experience, in our facilities residents are always asked to be involved in staffing or care planning sessions—whatever you happen to call them—and there are regulations about that and everything else in the State of Wisconsin.

The interesting thing about that is that in 70 percent of the requests in our Wisconsin facilities, residents refuse. I go back to what I said initially about Nursing Home Syndrome. I think as we empower residents and as residents take the power to be involved in their care—perhaps it will take the next generation, I don't know—but I do think there is some reluctance because, after all, "I am a resident and I don't know what's good for me." Isn't that sad?

I would hope that all of us would be active in that.

Ms. **Gannoe**. I think sometimes there's a tacit agreement that the resident will be encouraged not to participate because it takes time to explain to Mrs. Rogers the technical terms and the flow of the meeting, these sorts of things. I think a role for advocates is to encourage people like Mrs. Rogers. I hear folks in my area say, "It doesn't do any good. If I go, what difference does it make? They don't want me there."

They sense that exclusion that is underlying. I think a role for advocates, as you say, is it empower residents and say, "It's your life and your decision," and offer to accompany them or do whatever they can to make them comfortable. I was glad that one of you all said something about making them comfortable throughout. That means not just physically comfortable, but also emotionally comfortable as well.

Ms. MURPHY. I would also like to add to that that I think that we have a lot to do in terms of educating families about empowering their family members to participate in care planning. Oftentimes what we encounter is family members trying to protect their loved ones by not wanting them to be burdened with decisions that must be made regarding their own care.

We find that alot, especially when it comes to being involved in a research project whereby family members will say, "I really would rather not have my mother involved because she's too old. Just let her be, let her be comfortable." So I think we have a long way to go in terms of educating people.

Ms. PERSCHBACHER. I also think that we don't want to get into a situation where we're requiring residents to attend care planning any more than we're requiring them to wear restraints or take medications or other things. There are lots of ways to participate in care planning. Maybe some of us would not want to sit in a meeting with all of these people. I would not come to this care planning conference myself if all of these experts were sitting there. I'm sorry.

But maybe if Sarah came to my room and talked to me, or maybe if two or three people I had a good rapport with came and discussed this with me—I think we have to be flexible and remember the individual in this process. Yes, include them, but include them as they can be included and want to be.

Ms. BURGER. Freda?

STATEMENT OF FREDA GORRECHT, CBC AND NCCNHR

Ms. GORRECHT. My name is Freda Gorrecht. I'm from CBC and NCCNHR.

I am not in a nursing home—God forbid—but I have been in intensive care in a few hospitals. I've been thinking a great deal about what we're talking about. We're talking about adults, adults standing in line to take care of me. I'm an adult. I have been somebody. I have done something. How much consideration has been given to know who I am? Who I am will very largely depend on what I do when I become a resident, a new person.

Adversary and Adversary—oftentimes those are the caregivers and the care getters lined up. It is normal, in my opinion, for an adult whose life style has to change, to resent it. The symbols of that resentment are you, the care givers. This is a very important psychological change that occurs and I do not know, but I suspect that this doesn't take very much consideration in these so-called conferences in the care giving place.

The people who help a lot in this are the other care getters. Some ways must be thought through to get them to start from point one and level with each other and to plan some ways to handle all of you.

They are not self-motivated to do this because we, as people, are not living that way in our individual families and homes. By the way, that's what is wrong with the families and homes, in my opinion.

But I think that if all the people who are caregivers could sit down regularly and not assess the patients but say, "Let's talk about who they were and what they have become and what might be a way that we could help them help each other."

I know all the fancy titles, by the way, of the Resident Council, and how a very determined resident gets hold of it and God help the rest of them because as a caregiver has the charge to see that the climate is there, that the knowledge is there—this is a very interpersonal relationship. I think that the presentation that you have given today has named the team. It's like I'm waiting for the Pistons to announce who's going to be on their team, because I want to know how that's going to affect the rest of my favorite Pistons, because it will affect them. It will affect them because they are somebody unique and we all are, too.

I hope that we can succeed in getting some of this under the light of day before I die, which I'm planning to be quite a while. It's been quite a while that we all have worked. But thank you very much and never forget that we are all a unique person and have your conference about how unique I am and why I am. If I'm an old tartar, handle me.

Ms. BURGER. Just a minute.

Do you have a comment?

Ms. HAWES. Yes. I would like to actually respond to that. I'm glad to hear that and I hope that everyone takes it to heart.

One of the sections that we have in the assessment instrument is called customary routines in the year prior to admission to the nursing home. We have lifetime occupation and other issues that are designed to get at what people—Carter Williams, who was another social worker that was on our panel, kept pointing out that the day before someone entered a nursing home they had a life in which they decided when they got up, when they went to bed, what they had for breakfast, whether they had breakfast, what they wore—what they did with their entire day—and that somehow, when people enter a nursing home, the social worker that does intake has a sense of that person because they usually ask these questions, but it never gets communicated to the other staff. It's this gold mine of information that sits in the intake document.

So we put it as part of the normal assessment. At first there were people who said, "Oh, this is such a social workey thing to do."

We thought that there was going to be all this resistance to it. In the very first field test it was the nurses who used it. We had this terrific geriatric nurse practitioner from a really good home. She said that she found out more about the residents that she assessed from her own facility, talking to them about their customary routine, than she had known in the 3 years that they had been in the facility because she started to see that person who lived a full life, who didn't just suddenly emerge as a nursing home patient.

So I hope that advocates and residents and those others who care about their well-being will continue to focus and to help facilities recognize that they can adjust to the customary routines of the people who live there, rather than having the people who live there adjust to the customary routines of the nursing home.

So often it's just like making people think. She prefers baths to showers, or showers to baths. All her life she has bathed at night instead of at 7 a.m.—things that are so normal that we all take for granted and that we would like to continue for the rest of our lives.

So we believe that's an important part of the assessment that has to be sort of the first piece. It's usually the first thing that people start discussing with residents in the assessment.

STATEMENT OF MOLLY WEINSTEIN

Ms. WEINSTEIN. My name is Molly Weinstein from Oregon.

Doctor, I would like to go back to something that you suggested, that the staff should resolve their differences before they give their advice to the nursing home resident.

I'd like to submit to you that perhaps asking the resident what their preference is, whether they would like to hear all the options and all the views of the professional people, is perhaps a question that should go before your decision to make decisions behind the scenes, if you will. Some people would prefer it, I submit to you, and some people would not.

As a recipient of medical care in another country, and therefore another system where the doctors and the nurses did discuss your medical situation in front of you, I can tell you that at first I found it daunting, and then in the end it was by far better.

Dr. LEVENSON. I don't disagree with what you're saying. I think that the previous question or discussion was posed as, should there be a requirement that the resident be present at all of these conferences? I was merely saying that there may be some circumstances when first the staff has to get its act together. You're bringing together people from many different disciplines, perspectives, and approaches, to an individual using different terminology and possibly—quite probably actually, at least in my experience—having reached varying conclusions.

I think it can be very confusing to a resident—or anybody for that matter, not just a nursing home resident—when all these terms are thrown at them and there is a lot of speculation as to what might be or could be. Sometimes it's certainly in order to present partial hypothesis or speculations as to what might be wrong because you have to ask the resident, for example, do you want to undergo these tests? Do you want to take these medications as a therapeutic trial?

But I was merely saying that there are times when all of these people from many different disciplines have to get on the same wave length and agree about a common or a conjoint message that they're going to deliver in order to prevent a possible confusion or misunderstanding. The resident certainly needs to be involved, but not necessarily mandatorily present at all such conferences.

Ms. BURGER. Did you want to make another comment?

Ms. WEINSTEIN. My point was that it is the resident's decision, in my mind, if they're going to be included in the front end or the back end of those discussions.

Dr. LEVENSON. Well, I certainly agree with you. They have a say, but I just don't think that it should always be required.

Ms. WEINSTEIN. I agree with you.

Dr. LEVENSON. That was the gist of the previous discussion. I was merely responding to that.

Ms. WEINSTEIN. Thank you.

STATEMENT OF JUDITH GRIFFIN, OMBUDSMAN

Ms. GRIFFIN. I think we can all agree that we have a panel before us here that is on the leading edge.

Ms. BURGER. Excuse me, could you tell me who you are? I beg your pardon.

Ms. GRIFFIN. I'm Judith Griffin, ombudsman, the State of New Hampshire.

There was a question asked earlier, the response to which caused me some concern, even though we do have folks who are on the leading edge before us. The question had to do with perhaps the psychotropic drug would appear to be appropriate, yet the resident would refuse to take it.

Doctor Levenson, one of your approaches in trying to handle this, if she still refused after trying to explain and win her agreement for a trial period, was that you might consult with the family and discuss this with them and see if they would talk with her and exert some influence on her.

I think perhaps that we have forgotten that your business with the resident is confidential and of no business to the family unless she gives you her express permission to discuss her condition with them. We would need to obtain that first that she would allow you to do that.

There is the potential, in that plan of approach, that you're going to be bringing emotional duress to bear in order to gain her acceptance of what you feel she needs. Of course, I know that you know that's not appropriate.

Dr. LEVENSON. Even though I know that's not appropriate, I might have a slight difference of opinion with you. In this sense, at least in my experience, we're often caught between a rock and a hard place. We want to respect individual rights, especially the right to accept or refuse treatment, yet I think it's very important that we take somewhat of a modern approach to individual behavior and thinking.

It is not necessarily possible to separate mind and body in that there are physical problems or conditions that can cause thinking or behavior that is not necessarily under a person's volitional control and that if one is indeed interested in helping a person to have the best quality of life, sometimes there has to be a little pressure put on, or something done that a person might not agree with 100 percent.

That's not the same thing, I don't think, as forcing them to undergo treatment, but there is often anxiety, fear, or physical conditions that cause people to respond in ways without necessarily understanding, realizing, or being able to deal with the potential good to be gained later on. We've certainly had to deal with this on many occasions in our facility. Sometimes we don't institute a treatment and watch the person deteriorate and die as a result.

So I think that in each case one has to try to strike this balance and there is no clear-cut individual rights versus the caregivers paternalistic approach. Sometimes, the individual's rights can be enhanced, to a certain extent, by being a little bit pushy. For example, the residents who will come in having fractured their hip, and say, "I don't want to go to therapy; I don't want to get up; I don't want to do this; and I don't want to do that."

After a period of a little bit of gentle pressure, they do much better, their attitude and condition changed, they were not depressed, and they can come off the medications. So the ultimate good warrants perhaps doing, encouraging, or pushing them to do something that they may not have wanted to do in the first place.

Ms. **Griffin**. Your response is well taken.

I think, though, that we all have seen at one time or another the incredible therapeutic value that often can be derived from a resident being respected when they just say no and that that can very often be very therapeutic as well as chemical and medical interventions.

Dr. **Levenson**. I agree with you absolutely, I just don't think necessarily that we can take an either/or approach, but that each case has to be individually balanced.

Ms. **Griffin**. Absolutely. That's what this is all about, the individual.

Thank you.

Ms. **Burger**. Jackie.

STATEMENT OF JACKIE COOMBS, WASHINGTON STATE NURSING HOME RESIDENT COUNCILS

Ms. **Coombs**. My name is Jackie Coombs. I am President of the Washington State Nursing Home Resident Councils, I am a board member of NCCNHR, and I have been a nursing home resident for over 22 years. I have arthritis. It was very interesting with your comparison this morning.

I have attended care conferences. I have never had a doctor attend my care conference. I would love to have one do it sometime. One of the things that my doctor says is, "Hi. How are you?"—no, never "How are you?"—"Hi. Your T.V. is out of adjustment," but never "How are you?"

He would never attend a care conference. I have asked to attend care conferences. I have never been denied a care conference. I've also been told that I could come but that I couldn't say anything.

Well, if anybody knows me, I went and I said something.

The first care conference I had, except for the doctor I had the complete disciplinary team that is up here. It can be intimidating to a resident. I did not know what I was getting into. They said that I had a care conference coming up, so I asked what it was. I went. I went into this room and the office was completely filled with people. It can be intimidating. I don't intimidate very easily, but I can see where a lot of people—this is one reason why they have trouble when they are asked to attend a care conference.

How do you explain a care conference to a resident? Do you tell them what's going on? Why it would be necessary for them to be there?

I heard you say that residents are invited to care conferences. Sure, you can invite me to a care conference. I don't know what it is. I'm not going to go. I don't know how I'm involved in it. Is it explained as to why it is important?

Ms. HUNT. I think Jackie raised a very, very good point. I think it's important to go over as much of this information during the pre-admission process as possible. When you start talking about what to expect from the facility, what information the facility needs from the resident/family, you also need to talk about the team of professionals who will be involved with care. You say something like, "We'll be asking you questions. It's called an assessment process." You can do this from the very first contact with the resident and with that person's family. You can start talking about what is going to happen in the assessment and care planning process. "We want your participation involvement. Here's what we're going to be asking you."

As each one of the staff begin to do parts of the assessment, they start talking with the resident not only about what is going on and their problems, and asking them to demonstrate this or that, but also about care planning. Asking questions such as "Gee, have you thought about"—"Have you tried"—"Might you be interested in"—et cetera.

Then before the care planning time someone needs to go in and sit down with the resident to discuss: who is going to be at the care conference, what it's going to be like, and how the resident can have input, preparing the resident. That person can use the resident's comments to assist the team in thinking through how they really need to be involved with this resident. There are lots of techniques to use and things that you do to help the resident not feel intimidated, to meet the comfort needs that Maggie mentioned, to lend support to the resident, and to make sure that the resident is there as an equal participant, not as somebody who's being railroaded. The resident shouldn't feel that the team is saying "Go ahead and agree to what we've already decided you should have."

Ms. COOMBS. I also had a care conference where the ombudsman was called in by the nursing home, not by me.

She participated in the care conference.

Yes, she came, but the interesting thing is that the ombudsman that they called in at that time was Hilka Faber. At the time the Washington Nursing Home Resident Councils was working with Hilka Faber, they said that I couldn't have Hilka. So she sent one of her associates, who I also knew, who they did not know that I knew. I had already decided. I wrote a paper and said, "Here. This is it. I'm only as good as the nursing assistant I'm working with. I can't do any better." I went on and listed—unfortunately that was listed in 1981, and it's still true today. I hope, with this new system, that it will not be true next year.

Thank you.

Ms. DONIUS. Could I also respond to that comment?

It's very well taken. I would also like to submit to you, and encourage each and every one of you to do what you can to make people feel comfortable about this. In facilities where the resident has not been historically a part of the care conference, believe me, the staff are just as uncomfortable, and just as intimidated as the residents. So, for many facilities, this is new. It's going to take some time for everybody to get used to that and to feel comfortable with the idea.

Again, I would just encourage you to do anything that you can on both sides to try to enhance that comfort.

Ms. BORKIN. I received what was a written invitation, the date, place, and time that the care conference would be held, and would it be agreeable to me—then down at the bottom it said, "Do you care to attend this by yourself, or do you wish to have somebody accompany you? Are there family members or anyone else that you would like to have with you?"

Of course, that's the very end of it. We should be starting before that. Because I'm so accustomed to dealing with staff, because of my own jobs in the nursing home itself, this doesn't overwhelm me, but I can see that there would be many residents who would find it quite intimidating and would like to have someone with them. I think it's up to you ombudsmen to get in touch with families, and to speak to residents; those residents who live in nursing homes who have been more active, to go around through your Resident Council and explain what these new care conferences are all about so that the residents can at least have some idea as to what they're stepping into when the door opens; and also to explain to family members that they can be present, or the ombudsman can be called upon to sit next to someone at one of the these care conferences.

As I said, there is a lot of education involved here, but the end of this will be that residents will have a better quality of life and a better quality of care.

Ms. BURGER. Thank you, Lydia.

Let's take just one more question. I hate to cut off the questions, but we're very shortly going to have lunch.

Go ahead, sir, and identify yourself if you will please?

STATEMENT OF ANTHONY STARK, OMBUDSMAN

Mr. STARK. My name is Anthony Stark. I have been a volunteer ombudsman for the State of Tennessee for 6 years. I'm also Chairman of the East Tennessee Coalition on Advocacy.

My question is, you have here a complete interdisciplinary group, and all of the them experts. We don't have that out in small communities. What about the 30 to 40 percent of the residents of the nursing homes, some that have been there for 3 or 4 years, and unlike Mrs. Rogers, some of their marbles are gone. Some because of the fact that they didn't have them, some are progressive stages of Alzheimer's, and some because they have been zonked for the past 3 or 4 years every time the nurse didn't like what they were doing.

How are you going to carry this out with a person who can't speak for themselves, and in many cases their families have put them in there and walked off and left them?

Ms. PERSCHBACHER. One of the things that I think it's important to realize is that unless the person is comatose, there is a lot of communication that they can do. If an Alzheimer's resident doesn't like an activity, they usually leave. That's a real clue that they don't like that activity. I think it's the same way. If they don't want to take their shower, they will definitely let you know it. Those are things that we definitely have to pick up on and not use it as an excuse. We need to listen to what they are communicating to us about.

Ms. HAWES. To follow-up on what Ruth said, one of the things that we have in the section on behaviors is a way for staff to look at behaviors, particularly for individuals with communications deficits, and understand what's going on. Somebody who screams may be trying to communicate a very concrete opinion or request, but they don't have the words to do it, so they do it with behaviors.

So we talk a lot about the need to observe, not simply to interact verbally, but to use observation skills and to look at behaviors to understand what's going on with the resident when the resident cannot articulate his or her own needs or preferences.

The other thing that I would like to say about Tennessee is that it is one of the States that we tested the assessment process in. When I listened to this group, it was pretty exciting. This was the first time that I ever heard anyone talk about how they would use the information that hadn't been in the field test, and it was the first time that we had this many different disciplines represented. There are States that don't have, in a normal facility, this level of expertise.

That is one of the things that the resident assessment protocols are designed to address, to help staff make the connections that these professionals made on their own, to say, "Here are some guidelines that you can follow." Here are other pieces of information in the assessment instrument that will help you make a decision about behavior or mood, whether or not you have a psychiatrist who comes to visit, or a pharmacist who is actively involved in the review of drugs, or a physician who is actively involved in the discussion.

So we tried, in some sense, to make a system that is responsive to facilities that may not be staffed as expertly as this panel would staff a facility. I think the continuing problem that we have to face is that there are some State Medicaid Programs—Tennessee struck me. We had all these people who were on mechanically altered diets and had "chewing problems," but no neurological problems like swallowing. It's because the Medicaid Program in Tennessee doesn't pay for dentures.

So anyone who was missing teeth was getting mechanically altered diets and not teeth. So while an assessment system and a care planning conference and this whole process can do a lot to improve care, we still have the underlying reality that it may well point out things that aren't done, and aren't being done, and there are still important reforms that need to occur. This is the ammunition that can be used to do this.

Mr. STARK. I want to thank the panel for their discussion of this, because I am particularly interested in that section of Tennessee.

Thank you.

Ms. DONIUS. Sarah, could I respond to him, also?

I realize that we're out of time, so I'll make my comment brief, but I feel compelled to respond to his comments. Although many of our cognitively impaired residents cannot communicate to us in the way that we conventionally think of communication, what I would say is that the tool facilitates communication of all the disciplines communicating with the certified nursing assistants.

I'll tell you what, the certified nursing assistants who are there day in and day out, providing the hands-on care, know what the quivering of the right side of the upper lip means. That is communication. The tool will facilitate that.

So I think there are good things to be had.

Ms. BURGER. Thank you.

I have a couple of things to say and some directions for lunch, so sit tight and we'll get through that very quickly.

We've certainly seen how important the nursing assistant is. I don't think there was anyone who spoke here today who didn't mention how important and vital it is that we talk with nursing assistants and that they play a very major role in everything that's done.

We've also seen how important it is to let the resident take a lead and decide what it is that he or she wants to become involved in, how much she wants to become involved, and support her, and enable her or him to become thoroughly involved.

And, finally, I think we've learned how very complicated taking care of people who are institutionalized is. In order to preserve that person, and as much of that person as possible, and work with those strengths, and help to build up those things that are not as strong as they once were is a terribly complicated process. We can't forget that.

I think I would close by saying, let's leave the resident and the staff, especially the nursing assistant, in the proper saddle.

Now, let's go back to the luncheon arrangements. For people who are not part of the NCCNHR annual meeting at the 4-H center, please pay $15 at the registration fee table outside this room and get a lunch ticket. Boxes of lunch will be served from the front of the room, the speaker's table. Bathrooms and telephones are located to the left of this room at the end of the hall. If some of you want some exercise, I happen to know that there are some at the other end of the hall, too.

So, enjoy it. Thank you, panel. Thank you all. It's been a wonderful morning.

[Whereupon, at 12:50 p.m., the forum recessed, to reconvene at 2:07 the same day.]

AFTERNOON SESSION—2:07 P.M.

STATEMENT OF SCOTT SEVERNS, ATTORNEY, INDIANAPOLIS, IN

Mr. SEVERNS. If you've ever watched those Senate hearings on television and thought that the participants looked a little ragged around the edges and strained, I can tell you that it's not necessarily the workload, it's the structure of these seats.

But despite our strained appearances up here, we will do our best to convey to you a sense of excitement and accomplishment and warmth that can come out of the resident assessment process, of dropping restraints, and a variety of techniques that have arisen out of this whole movement toward resident centered care.

The panel this afternoon is going to take us the next step. This morning, we heard resident assessment described by some of the foremost experts in each of their disciplines in the country. This afternoon's presentation is going to focus us on what ordinary nursing homes out in the community can do with their staffs who don't necessarily have the credentials of national recognition, but have been able to take this process and make it into one that is a positive process.

Building upon that experience, then, we're going to ask, what is the cost of doing that? What are the resources, and how do resources have to be allocated, both on a systems level, and on an individual home level? And then, most importantly for us as advocates, how can we feel comfortable that the costs that are being asked for and given are used to the ends that we seek?

With those points in mind, what I would like to do is to start this panel with Jamie Pipher, who is from Peterborough, NH, and has been working in long-term care implementation of OBRA requirements and has a very interesting story to tell.

Jamie?

STATEMENT OF JAMIE PIPHER, SOWERBY ADMINISTRATIVE SERVICES, PETERBOROUGH, NH

Ms. PIPHER. Thank you.

Because the expectations of OBRA are so great, and because we know that there will be those who will want us to water down OBRA, and because this is not what we want to do, the allocation of facility resources are even more valuable to us than they ever have been. It is a challenge that many of us have accepted with enthusiasm and commitment.

As a nursing home provider, it became very obvious to us very soon that we had to reevaluate our whole total operation of how we did business if we were going to make OBRA work without it being paperwork compliance, and with it definitely being resident outcome oriented. We wanted to make it work.

We knew that we had to direct our resources in areas that would lead to residents having a meaningful life. That's easy to say, but I want to put it into more simple terms. What I want is to never see on a patient care plan, ever again, the resident will adjust to the facility.

The facility will adjust to the resident, and that is what OBRA is all about, and that is what I want and am very thankful to be a part of.

Sitting on my desk at work, and has had a lot of meaning both in my professional and personal life, is a poem that I think many of you will recognize.

> Why should we be in such desperate haste to succeed in such desperate enterprises? If a man does not keep pace with his companions, perhaps it's because he hears a different drummer. Let him step to the music that he hears, however measured or far away.

To me, this is what OBRA is about. It is knowing what our residents' choices are and building programs around those choices. It is an opportunity for all of us to learn, to teach, and to be creative. OBRA says to us, "It's okay to hear a different drummer." As nursing home providers, we had better listen and we had better respond. Thankfully, those you see up here today want to respond, and I believe have been creative in developing many of the programs.

Now that I have said that, the reality, too, is, how do you do it? These are not outcomes that any of us have ever opposed. These are not outcomes that we would jump up and down and say, "I don't want to do it," but how do we do it? I'm not sure that we're going to have the answers today or tomorrow, but I'm convinced that we will have answers in the years to come because of what you and nursing home providers are beginning to do now.

We know that we have to change. We know that there has to be a change in attitude. We know that there has to be change in what is being taught in our schools. We know that there has to be many things. But in our company, we said, "We're going to start, and we're going to start some place." We're fortunate enough to have administrators who wanted to be a part of the change, even if it meant making mistakes.

I think that was the first thing that was said. Let's try something even if it is not absolutely perfect, and let's not worry about making mistakes, but rather learn from those mistakes and move ahead.

What I want to briefly go over with you today are three of the programs that three of our homes did start as trial programs. I am not going to pretend to you that they are perfect. Some of them have been underway 2 or 3 months. We are still learning from them. One of those is a primary nursing trial program that was started at Northwood Nursing Home in Manchester where Cindy DuBois is the administrator. Cindy is with us today and I'm sure she would be able to answer a lot more questions about her program.

It's an exciting concept. It moves from the team nursing concept to primary nursing where a licensed nurse and a nursing assistant was put in charge of 12 residents. That's how we established it. This co-work primary nursing unit would be responsible for those 12 residents for all of their activities and making sure that family members knew that they were the ones that were responsible and that doctors knew that they were the ones to contact.

We had a lot of questions about whether it would work. Could we find the licensed personnel to fill the slots? Obviously, that has been difficult for those of us in the Northeast to obtain enough licensed personnel. When Cindy put the ad in the paper, people came almost out of the woodwork because they wanted to be a part of this project. They wanted to be a part of long-term care and helping to take it into the 21st century.

She met and did a lot of planning, but it was truly the enthusiasm of her staff that made primary care work at her facility. She had at least two nurses that were on staff at the time that were in what we would call burn-out. They would come to work, do their job, and go home. Within 1 month, those nurses were the most enthusiastic individuals I have ever seen. They were even enthusiastic about doing patient care plans. Their motivation was extremely high.

With working alongside with a nursing assistant, two things happened. The professionalism of the certified nursing assistant went up because she was learning every day, but also the licensed personnel was learning from the nursing assistant about the every day routines of the residents, hands-on was what it was about. The results of the program were an increase in rehab nursing, enthusiasm by the staff, increased participation by family members, but most of all there was an overall awareness of resident individual needs as a result of that particular program.

They are still learning. They are still making changes. The home is a 50-bed home. I'm sure that if we were to try it in a larger home, maybe we would have had some difficulties that you might not have in a smaller home. But it worked. Resident care has improved, enthusiasm is there, and resident's families are happier.

In another one of the homes, we tried something called a 7:30 to 7:30, 6 day a week structured activity program. The idea there was to improve independence of residents through a structured program by recognizing individual needs and focusing in on those throughout the day. Fortunately, we heard Mary and met with her before we put the program totally into effect because after listening to Mary we completely changed our whole concept, and learned that we were going in many different directions. So there is new knowledge that we need to know about in order to make our programs work.

Listening to Mary—I've attended two or three of her workshops in New Hampshire—truly we have based one of our programs on the concepts that we learned. The first thing that she told us, however, is that you can't do everything by tomorrow morning, rather you have to start in little smaller increments. In our 7:30 and 7:30 program, we had to look at what our priorities were and take one concept at a time. We knew that we couldn't change the world overnight.

In that particular program, they took a look at what they call the dining room experience. The activities director said,

> Let's get together and let's make the dining room a nice experience for everybody. Also, let's increase functional ability by putting residents together who want to be together, who socially are happy together, but who also can help each other.

So you didn't necessarily have the nursing assistants doing everything for a little group of people over here while another group sat over someplace else. You had residents helping residents with the help and guidance and orchestrating of the nursing assistants and, in this case, activities directors.

The result of that program, along with the total more advanced activities throughout the day, on weekends, and nights, one quick result was that nursing and activities began truly working hand in hand. A ripple effect was—as it should have been—that the activities programs that were planned were focused around the time of day that best benefited the residents. So it wasn't just having a party when we felt that there should be a party, it was when residents really truly felt that they had the most energy and wanted to be in group activities.

Then other activities were centered around when there were other maybe behavior problems that needed to be looked at, because that could be dealt with through the activities program.

Again, we saw, in effect, that nursing and activities started interacting more and we had better patient care results. One of the quickest results was residents coming up and saying, "When is the next activity? When can I do this? Before, they had an activities calendar put on the wall, and someone would walk in and say, "It's now Bingo." The whole attitude toward activities changed because residents wanted to go, they were part of the planning, and they felt like going.

The last one was more of a change in job description. That was at Applewood Nursing Home in Winchester, again, a 170-bed nursing home. There was a housekeeper position where that administrator took a look at it and said,

> Housekeepers are very important people. They are involved in the lives of our residents. More importantly, they want to be involved in the lives of our residents. How can we provide them more opportunities to be involved in nondirect care duties?

That job description became into something called a personal needs assistant. That personal needs assistant was a housekeeper with expanded job duties but decreased number of rooms to take care of. She, in turn, became one of the team people that met the resident when they were first admitted to the nursing home. It was a face that the resident would begin to know very quickly. The personal needs attendant would check in the clothes because she also was going to be the one to take care of personal clothing throughout the time that she was there. She would make sure that the plants were watered, and that personal items were located and found if they were to be lost, and making sure that the room was set up the way that the resident wanted it to be done.

OBRA is working. It is working through cooperation; it is working through confrontation and creativity; but most of all it is working because of a lot of the caring human beings that care about the older Americans in America. I'm very thankful that we've had the opportunity to share our experiences with you today.

Thank you.

Mr. SEVERNS. Thank you, Jamie.

The next speaker is Joyce Steier from Florida, Oak Manor Nursing Home.

Joyce, would you tell us—even though a lot of us know about you from previous NCCNHR appearances—about your particular home, your particular role in it, and your experience?

STATEMENT OF JOYCE STEIER, ADMINISTRATOR, OAK MANOR NURSING HOME, LARGO, FL

Ms. STEIER. I'll be happy to tell you my experiences.

I'm the administrator of a 180-bed facility in Largo, FL. We are a for-profit organization and my boss makes it very clear to me that when we go into any of these programs that I must keep that in mind.

I'm here to tell you today that OBRA has been a very good thing for Oak Manor Nursing Center and it has become a very cost-effective thing. You don't hear that a lot from the industry and I sometimes think that they have a hit man out after me when I'm going around the country saying this. But I want to tell you that we became more efficient with the new regulations.

I am a new administrator to this facility. I took the position at the end of March. This facility had a census of 110. I told you that it is a 180-bed facility, so we had 70 empty beds that were generating no revenue at all. The facility had been there for 17 years, so you need to know that I'm not one of the fanciest, nicest looking places in town. If there were beauty contests, we would probably come in last.

I think that one of the major problems that we were facing in that facility was the agency personnel. I went to work the first week and looked around and thought I was kind of losing my memory because I couldn't remember any of the employees. That was because two-thirds of them were working for the agency and were replaced on a regular basis. The agency bill for the month of June for that facility was $70,000. That's a phenomenal amount of money if you think of what the nursing home could have done with that kind of money. Had they put that into patient care, it would have made a great deal of difference there.

My goal was to certainly improve patient care and to comply with the OBRA regulation. The first thing that you need to do on any new job is to make an assessment of where you're at. That's what we did, the nursing director and myself. We put the people to work in assessing the residents, finding out how long they had been there, what their physical conditions were, and what we had to deal with. You can tell that this is another reason why assessments are very good.

The main thing that we wanted to do was to take the restraints off of these residents. I have to tell you that after these assessments, Oak Manor, with their 110 residents, had 73 people in restraints, and 32 of them had folie catheters. So they were not any numbers that we could be proud of at all.

Approximately 75 percent of those 110 patients were in wheelchairs. I wasn't sure why they were in wheelchairs, and I have to tell you that many of the nursing personnel were not sure why they were in wheelchairs either. So this is another reason why the assessment was very important. One of the things that I did do was to ask that every nurse cite the reasons why the patient was in a wheelchair and in restraints and to put this in the form of a diagnosis rather than just that Mrs. Jones has always been in a wheelchair. They've been in there for 17 years and I would hate to think that anyone had to sit in those awful wheelchairs for 17 years.

We began the program very slowly and certainly got the rehab nursing program going. That was finding out if there were limbs that could be moved that hadn't been moved in a long time. Our physical therapy department and our occupational therapy offered a lot of assistance to us and to the staff. They did a lot of training. But the majority of the work was done by the nursing department and by the regular staff.

We first began by taking off the restraints during the activities and during mealtime when there was supervision for the residents because I honestly felt that—they had been in restraints, we didn't know what would happen if we took them all off. Guess what happened? Absolutely nothing. They all just sat there just like they had the restraints on because they were so conditioned to do that.

What I did then was to call all the department heads together and have them work with the nursing department because I know the staffing at every nursing home—I always hear this—we need more staff. I don't necessarily think that you need more staff, but you have to learn to use the staff that you have there in your building. I have housekeepers that walk down corridors every day on their way to lunch, and now they take a resident or two along with them. We have utilized the maintenance department, the activities, the social service, and everyone else in the facility to help us get this program going. They are not used as often as they were before because a lot of our residents have learned to walk, so it's not necessary to use them.

But in the beginning I urge you to get all the people in your facility involved in this. I think that the more people you have the less overwhelming it seems.

In the last 3 months things have really changed since we have put these programs in. First of all—the thing that makes any corporation very happy—is that we now have 160 residents. That means that we only have 20 empty beds. We really could have filled those beds, but it would be too strenuous for the staff to have that many admissions. We've had no agency for the months of August and September, none whatsoever. I repeat to you that I don't have the fanciest nursing home in town, and I'm not paying the highest wages.

I think the morale of the staff has drastically changed. They feel a part of the program. I think that from the housekeepers and the laundry people to the nursing assistants and the nurses—they feel like we're all committed to achieve a common goal. I think that's the part that makes things seem better to them. That's why we have less turnover.

We have certainly eliminated buying restraints, wheelchairs, geri-chairs, and all those things that you always buy in nursing homes that are very expensive. Another benefit is that the residents are eating so much better. I think moving them around and giving them a chance to sit at a dining room table in a chair rather than in their wheelchair or having difficulty reaching their food has made a significant difference.

Nourishments are a very expensive thing in any facility. I personally know that in my facility, these little shake-ups that you see people get between meals cost 37 cents a piece. If you multiply that by many, many residents, you'll find out that that is very expensive. That's another item where you can take that money and spend it more effectively for something else.

So the residents are eating a whole lot better at Oak Manor. We have very few people on supplemental feedings. We probably have six or seven of them.

One of the other benefits for the company, and certainly for the residents, has been that we buy less incontinence supplies. We have decreased the amount of diapers and under-pads, which are also very costly, by about 30 percent.

We have certainly decreased and reduced the potential for developing decubitus ulcers. I think if any of you are nurses in the audience, you know how time consuming and how costly treating them is in any facility.

As a result of this program, one of the other good things that happened is that we had to take a long look at chemical restraints because you can't untie people and ambulate them around if you're going to sedate them at medicine time. So we've had to decrease that tremendously. I heard someone say yesterday that they only had three or four medications given in their entire facility. I know that I have many more than that, but I'm hoping to decrease and work on this problem even more, and decrease what we are using.

I believe that you can change the duties of what any of your employees do, reduce your agency bill, increase morale, and still operate within the restrictions of a budget. As you increase profit and the census goes up, a wonderful thing happens. When you start giving good care, it seems like the whole world hears about it, and particularly that world that surrounds your nursing home. We've been there for 17 years, and I've had people coming in. We now have a waiting list because we can only take two or three every day. They've heard about the good things that are happening at Oak Manor.

So I think it would be wise for all facilities to spend their efforts and to use their employees in a more constructive way. I think it's time—and I go to meetings very often—I think it's time that nursing homes stop complaining about budgets and reimbursement. They are very important, but I think they need to start concentrating on using the money that they have in a more effective manner so that they will have more positive outcomes. Good care doesn't always cost more money.

I think that whoever is in charge of the corporation or the administrator needs to instill dedication and enthusiasm into the staff and this, along with all the programs, will certainly make the nursing home more cost effective.

Thank you very much.

Mr. SEVERNS. Thank you, Joyce.

Jenean Erickson is also, like Joyce, an RN and an administrator. She comes to us from Minneapolis. She's been here before and we're familiar with her good work, but we particularly want to hear your work under implementation of OBRA.

STATEMENT OF JENEAN ERICKSON, ADMINISTRATOR, YORKSHIRE MANOR, MINNEAPOLIS, MN

Ms. ERICKSON. Thank you.

I'm really pleased to be with you today. I remember the first time I spent with the coalition in Clearwater, FL, in 1985 when you were putting together the Quality of Life Study and residents themselves identified the definition and the meaning. I was thrilled to be there and came away more determined to make quality of life better in my nursing home.

If you remember Joanie Knowlton at all—I'm sure that if you didn't know her, you will have heard of her—that was a really special trip for her. A group of us helped get her wheelchair over the canal to the ocean. She loved putting her feet in the ocean again. I'll never forget that special time or that day with Joanie.

From that experience with you in 1985, I went back to my facility in Minneapolis, Yorkshire Manor. It's an 84 bed inner-city, typical, actually older nursing home, like the one we just heard about. I renewed my determination to make quality of life even better. From then until now I think that we have made some important strides. I certainly have learned a great deal.

In the American Health Care Association, I serve on the OBRA task force. Through that effort I have been closely involved in the language of OBRA as it's been developed and interpreted. I was fortunate to be selected to help train with HCFA staff last November as they trained surveyors for the first time. My assignment was to teach resident rights. I studied and learned and my understanding of what resident rights meant under OBRA grew. I came away from that effort determined to make it something meaningful and important at my facility.

I wasn't exactly sure how to do that, but I suggested to the Resident Council that we develop a Blue Ribbon Task Force. We let the residents appoint members to it, had the Employee Council appoint members, and finally the Family Council added members. We used a Blue Ribbon Task Force approach to understanding, defining, and interpreting OBRA for our facility as we went forward.

It was a major effort. It's been well worth it, and it's ongoing. Let me just share a little bit about how that has worked with you because it's a little bit different from others you've heard about today.

That task force was appointed last May and June. To begin to communicate what was happening, I put into big print in "English", the best I could, what I thought OBRA was saying. We began to talk about what the words meant and how we could communicate together so that we understood the same sense of meaning from the words. I want to be really honest. We did not understand "highest practicable physical and mental psychosocial sense of well being" at all.

So we discussed it a lot. We used dictionaries and references, and we came up with what it means at Yorkshire Manor. The residents decided it means the "highest possible physical and mental goal that they wish to achieve." That is their definition and that is the one that we're using.

It occurred to me that never before had I paid attention to word choice and what words mean. But as we're going to be defining policy and procedure—and the residents are writing the OBRA implementation policies—it's important that we communicate clearly.

We spent a lot of time on what "choice" means because we thought that it was important. We now know that it doesn't mean, "Do we wear a blue or a brown sweater?" That's preference. Residents have choices much more than that, and that can make a difference. So let me commend to you the process of going to the law itself, understanding words, and picking the words that communicate effectively in your own homes.

We determined that we needed some guidelines so that when we had an idea that there was a way that we could accommodate space to improve the quality of life for anybody, we could easily bring the idea forward. Instead of not mentioning it, or overlooking it, we developed a way to reward whoever brought forward an idea that could be evaluated and implemented. It became a contest for best suggestions to improve environment.

The final decision on those matters about facility rights in balance with the individual rights are made by the Resident Council. That's been very exciting, very empowering, very effective, and it has taken a big load off of my shoulders. So far, they have made the decisions, good decisions and we are very pleased with the process.

In the care planning process, it's important for you to know that probably around the Country, this is done differently in many, many States. In Minnesota we were required to do integrated care planning beginning 1976. It's routine for my residents to be involved in their care planning process. What is interesting for me to share with you is the fact that with their rights now, they can say they don't want to attend any more if they wish. And they said, "Let us choose how we want to be involved in our care planning process." That's autonomy!

One of the things that we decided we would do at care conference time, as we implement MDS—which, of course, we hadn't been doing extensively historically—was to begin to agree on negotiated goals. We are using those words to make it clear that we're not going to forget that there is more than one person setting the goal. Negotiated means the team together with the resident selecting the goal. Not always are staff goals what the resident wants.

I was interested in an earlier presentation to hear OBRA must be working. My residents, too, said that the facility had to adapt to the new resident. That's not in OBRA anyplace, it just kind of comes out of the law. So that's good to know. I thought we made it up, and here it is across the country.

One of the findings we strongly supported in the 1985 Quality of Life Study that you did was, "A trusting relationship with a consistent aide is the most important thing for quality of life." So for more than a year and a half now we have attempted to have the same aide responsible for the same family-like unit for 10 out of 14 days on the daytime shift and again in the evening shift, thus developing a sense of community within a unit. Treating the process as a family-like unit has changed our care delivery system and the quality of life at Yorkshire a great deal.

It has to do with housekeeping, activities—and in our case when we say "primary unit," we're talking about a CNA who has primary responsibility. Of course this all would be under a licensed nurse, but it's a little bit different relationship, and it does make a sense of family that we all like.

Another thing that residents like about a family unit is that they have input into the evaluations of their key staff that work in their unit. Through that process, they are able to fine-tune the kinds of care giving that they really like, and they're able to make changes that make a difference in the quality of their life. Merit rewards are based on family compliments.

From the family units, again, we have determined that there was the need for meaningful adult education for the residents. It's no secret that as we have gone through the last 5 years, physical fitness, nutrition, smoking cessation, etc., not everything that we thought was good has been a success. We had to take a look at how we learn how to make good choices. In the area of nutrition, for example, it was most helpful when the dietitian was able to actually show a plastic glass with nine tablespoons of sugar in it for people to understand that was the sugar amount in a glass of pop. Resident education has taken on an important focus. It has made a difference in choices and is a program the residents are pleased with.

The residents and the staff "team teach" new residents about resident rights. They team teach new employees how resident rights are delivered. On an on-going basis we spend a lot of time teaching residents about their rights in the survey process, teaching them what the regulations are, how they are surveyed, and how they can in fact do anything that they wanted to do throughout the survey process.

It was with no small amount of pride that I read my survey report recently at the Health Department. The surveyor had noted on the form where they were interviewing the residents that, "The residents in this facility take a great deal of pride in the fact that they wrote the policies for resident rights." In fact, it even said that we have a policy against serving rutabagas because they asked for that.

I appreciate your laughter and agree that's funny, but they really wanted that.

I always get a laugh when I share that, but I think it's so important for you to know that this gentleman came to me almost outraged because rutabagas were in the vegetable soup one day. He had been forced to eat it by his mother when he was young and he didn't want it. I told him to do something about it. He did—a petition! They made it so clear that we don't serve rutabagas anymore at Yorkshire.

In the area of roommate choice, we are struggling. It is one of the most difficult things in OBRA to make effective and realistic. We have studied the regulations over and over, and we know what we're trying to do, but we're not sure how we're going to get there yet. I think it's fair to say that even when you select your roommate, it's not always easy to live with them, is it?

If you had a choice of more than just where the open bed was and if the gender was right as a guideline, what would you want for that guideline? We started to say that to residents and they began to think of the variables that were important to them in terms of a roommate. I was confident that every lady who liked to knit would like to live with a roommate who liked to knit, but that's not true. We've learned some important things.

On the list of 10, that are important for us to consider—and we do it together every time—the one that rises to the surface most often is that the alert resident does not wish to room with someone who snores. That's not too tough to implement, is it? So OBRA is going to be doable, if we continue to be realistic and use common-sense approach. We're not done. I'm sure more challenges will surface.

A policy that we did put into place right away, though, was to try to ensure roommate satisfaction. You will be admitted to the spot where the empty bed is, but know for sure that if it doesn't work out, we're going to work with you to try to make improvements. We can't guarantee perfection tomorrow, but we'll continue to work until you're relatively satisfied, and then you be the judge. That feeling seems to have made a difference in how people feel about roommate choice.

As I tell you that some of those fun things are beginning to fine-tune the quality of life, I also think it's important for you to know that we're coming up against some hard, tough areas that we don't have answers for. Some of the people are saying that maybe it's not okay to mix alert and cognitively impaired. In my State, that's maybe discrimination. I'm not real sure how some of this is going to be resolved. As these issues are raised, we'll have an opportunity to make some meaningful answers and seek solutions.

That's an important point, I think. Some of my residents are saying that they don't want to admit so many people in wheelchairs. They would rather have mobile people eat at a certain meal and wheelchairs at another mealtime. We have to talk about this. We can't be short-sighted and think only of ourselves when we're balancing real quality of life issues can we?

One of the totally unexpected findings is one I'm proud of. One of the ladies said to me one day that she sure would like it if she didn't have to ride around in a van with the name of the company on the side of the door. Think about that please. We took it off and they are pleased. They're not labeled and on display for the public. I had no idea—it didn't occur to me and together we learned.

I'm grateful to the people involved in helping me to implement OBRA. I think it would be wrong for me to try to do it myself. It would be much easier because I could simply write policy and tell people what to do. I've done that for 15 to 20 years. But I think this is a lot more effective, and I feel much better about the process. I'm finding that the care outcomes are more focused when we talk about things together. I'm finding that "negotiated goals" are much more effective and they are much more likely to be reached.

The increased pride, the increased autonomy, and the increased independence of the residents, of course, makes the staff feel good. Staff has been performing care giving practices that they thought were good all this time. They did not know that it was not the "highest best" practice to tie or restrain for safety.

I think that's the most critical aspect to change successfully. New skills and new educational tasks are not too difficult—you can go to school, pass a test, and acquire them—but when you have had 10 or 20 years of being a nursing staff member, feeling proud about your care, and thinking you were doing good. Being told that was not good and that you have to do it differently becomes an emotional personal change that's troubling. It's very challenging to try to find the right ways to change those beliefs, those values, and those personal pride issues.

I think we're going to find, when we get all the easy-to-teach items done, the difficult-to-teach behavior is going to take longer and probably take some special education. I believe there will be some hidden costs in that area that we ought to allow for through some flexible kind of planning so that we don't fail to push when we get to that barrier. When your pride is challenged and your ego is on the line, you have to go beyond to implement OBRA fully.

I'm excited about the regulation. I'm excited about where we're going with the care in our nursing homes. And I'm really pleased to be here today.

Thank you.

Mr. SEVERNS. It's really rewarding for me to hear that tie between the resident's definition of quality project that culminated in the 1985 Saint Petersburg Symposium and where we are today with OBRA. That project was really an eye-opener for me. Your distinction there between choice and preference and the depth at which choice is felt, and the way in which you've been able to implement that, giving residents a say-so over the way things function in your facility is really inspiring.

Thank you.

Mary Lucero is President of Geriatric Resources in Orlando, FL.

Mary, would you tell us about your role with facilities and then how you've been able to work with them in implementing some of OBRA's principles?

STATEMENT OF MARY LUCERO, PRESIDENT, GERIATRIC RESOURCES, ORLANDO FL

Ms. LUCERO. Thank you.

I'm glad to be here today. I am by education a gerontologist, by profession a nursing home administrator, and currently the founder and president of a company that specializes in products for Alzheimer's patients and in providing educational services to caregivers of those people. I'm also very excited to be the first recipient of the National Institute on Aging Small Business Innovative Research Grant to study the wandering behaviors of Alzheimer patients.

I'm talking to you today because in 1983 I opened a 120-bed nursing home in the State of Florida. It was the first no restraint facility opened there. In that capacity, I think I did—I'll borrow from Barbara Mandrell's song—she was country before country was cool, and I was OBRA before OBRA was rule.

What we found out in this process was that it did not cost us any more money to do what we were going to do and did. It was primarily a commitment and it was a philosophy that we had to educate staff to, and that we, in the leadership capacity, had to have an unwavering commitment to accomplishing.

So I'm going to share with you a little bit about the historical perspective as to why we did what we did back in 1983. I worked for a corporation that had 800 apartments for independent elderly. They also had a program that provided 700 hot meals to elderly in the community who were homebound. They also had the first program in the United States that was directed toward protective services and guardianship diversion.

When they started the 800 apartments it was in 1965, and by 1982 they had identified that the majority of their residents had obviously aged and that they were now needing a continuum of care. The end result was that we needed a nursing home so that these people were not having to leave the campus where they had spent the last 15 or 20 years of their life and leave their friends.

However, when they shared with the people who were living in the independent living apartments that they were going to provide a nursing home for them, they were not delighted. They did not want a nursing home on the campus because they didn't want to look at it.

So what happened was that they asked me to come in and work with the residents to plan a nursing home that they wanted. So I spent a year meeting with 100 of those high-rise residents who were willing to plan a nursing home that met their needs. It ended up that we opened up a nonrestraining nursing home because that was the primary fear. "You're going to put me in a nursing home, drug me, and physically tie me up." So we guaranteed them, among many other things, that we would approach their care from their perspective, with their input.

We also were very careful in looking at what kind of risks we were assuming. At that point I was told that I was putting myself in a legal situation where I would be at risk to be sued. So what we did was to approach an attorney and shared with him what we wanted to do. He told us that instead of being worried about being sued for not restraining people, and to ask people to release us from liability if they fell because they weren't restrained, that we approach it from a very positive way, that we share with all our new admissions that we had a no restraint policy and to educate them on what that meant and what kind of alternative approaches we were going to be using.

So that was our admission policy. This is our philosophy; this is how we're going to accomplish it; and we ask that you agree to this before you become a resident in our facility.

The next thing we did was to look at what kind of interventions we could use to keep these people safe. So we got with an OT, an occupational therapist, and a physical therapist and identified what we thought were going to be the safety issues and what kind of interventions we were going to need.

We then looked at developing a resident safety assessment tool so that when people came in on admission we were able to identify what kind of safety problems we were going to be dealing with and then we could do an individualized care plan to meet those needs.

We also shared with our physicians that this would be our approach and that we would not honor PRN restraint orders, that we would not allow chemical restraints, and that if they were not willing to participate they were not welcome to have admitting privileges in our facility.

We then shared our philosophy with the staff that we were hiring. We told them, "This is not optional. This is our philosophy. So we will never talk restraint. When we can't find a solution, we will be brainstorming. There will be times when we will do the best that we can, and then pull back later and look at what we can do the next time it occurs, if we were unprepared." It was a wonderful experience.

After 6 months, we found that we had an unexpected problem. We had 50 percent of our residents that were cognitively impaired. The safety issues that we were dealing with when we first opened our facility, and that we spent a year planning with our residents of the high-rises, did not meet the needs of the 50 percent of our residents who were demented and who were not a part of that planning process.

We identified that we had two significantly different populations who had very different needs. The primary safety concern with our alert residents was that they would fall. We had identified interventions to help us keep them safe from falling. We also identified that when we did not restrain dementia residents that they were wandering around. Wandering was very different from falling, so we needed a very different approach.

We also identified that what we had done was to look at—the first intervention is untying people, whether they're going to fall or whether they're going to wander. We had taken our perspective of untying alert people and then the next step was to get them stronger and get them on restorative programs to enable them to continue ambulating, or to transfer independently.

We had not taken a second step with wandering dementia residents. Our first step was to let them go. What the consequences of that was—although, yes, they benefited by not being restrained—they were wandering about our facility, getting into unsafe situations, and going into the rooms of our alert residents, going through their personal possessions, and sometimes getting in bed with them. What was happening was that we had set up a very confrontational posture where our alert residents were, in fact, on some occasions, slapping or smacking our cognitively impaired residents because they were frustrated.

The other thing that we identified was that if we chose to continue to try to commingle these populations, that we had to pull back and realize that we were asking a lot of our alert and oriented people to be patient and to be understanding with our dementia who could not control their wandering behavior in that setting. But when we looked at what we were asking our alert residents, people who were there because they were sick, we were asking an awful lot. When you are sick your coping mechanisms are lowered. When you don't feel good, the last thing that you want is somebody in bed with you that you don't know.

So what we decided was that we would approach the care of our dementia residents just as uniquely as we approached the care of our alert residents. We separated our populations and we decided that we needed to look at what our wandering dementia residents were telling us, even though they could not communicate verbally. We needed to look at body language.

So instead of looking at wandering as a behavioral problems, we also started looking at wandering as a strength, as a capability, something that we wanted to maintain because wandering with a dementia resident is simply ambulation. Anytime someone who is disoriented to time and place moves about without supervision in their environment, they are wandering. That is not necessarily bad.

So we chose to look at is very positively. Instead of looking at it as just untying people, we wanted to look at why they were wandering and getting into trouble. Were they, in fact, sending us a message? Was what we perceived as aimless pacing, or wandering, really a search for something to eat, or drink, or a bathroom? Were they trying to tell us that the activities that we were trying to involve them in did not meet their needs because they couldn't understand what it is that they are doing?

So we also decided that because we had no extra dollars and we had no extra staff to care give any differently, we would change our approach. So we looked at every interaction that we had with a dementia resident was to be positive. And we saw that the primary thing that we needed to give our dementia residents, in addition to freedom, was structure. We needed to structure their day, and they needed constant caregivers.

So we changed our nursing philosophy and we went away from the medical model because the majority of dementia residents in your facilities are physically healthy. They are not bed-bound and they are not in their bedrooms. So we looked at what nursing could do. Instead of looking to activities as the department that was going to spend the balance of the day "entertaining" people, we looked at how nursing can guide and direct the interaction all day and be supported by other departments.

So we also looked at what kinds of things we needed to give up. That meant bedside water pitchers because dementia residents—if they are thirsty, the last place they are going to go to get a drink is the side of the bed. We also identified that they weren't hydrating themselves with water fountains because they are unable to get the water out of the water fountains. We have water fountains that have been developed for physically impaired people which now have a push bar on them. Dementia residents are not familiar with this new-fangled contraption. If it doesn't have a turn handle, they can't get to the water. So we started passing water every 2 hours.

We also identified that they weren't getting anything to eat, except when we fed them three times a day, because there was no food available. So we started offering snacks mid-morning and mid-afternoon.

We also took a look at, when we had a resident who had a fall problem, what we could do. Dementia residents do not take physical restraint willingly, had we even wanted to chose that. So we put—and I'll give you a situation. We had a dementia resident who was a double amputee. She didn't realize that she had lost her legs, so she would try to walk and fall on her head. It was a big problem.

So what we did was to put her bed on a platform on the floor. I have to share with you that the State of Florida came in and cited me for doing that, for not restraining this woman in her bed. We appealed it, we contested it, and said that there was nothing in the regulations that said that we could not put a bed on the floor if the resident needed that.

They countered with that it said in the regulations that every resident in my facility had to have a hospital bed.

I countered, "I have a hospital bed for her, but she can't use it. So if the situation ever changes and she needs that bed and can use it, it is available to me. But the intent of that legislation was for me to maintain appropriate equipment in my facility."

We won.

The next time that I was cited was because I had a dementia resident, a new admission, coming to me who had had a hip fracture. She would not stay in bed the first 3 days after surgery, which was imperative, unless someone stayed in the room with her. She had no family. I had no staff who could stay with her for 72 hours. So what we did was pulled her bed out to the nursing station where she could see someone and she stayed in her bed.

They cited me for obstructing a fire exit. So what we did was to put the bed behind the nursing station so that it wasn't in the corridor. Then they cited me for invasion of resident rights because of privacy. At that point I said, "We have to look at what my priorities are. I have an emergency situation that is going to end in 3 days. It is more important that she be seen and not get out of bed than it is for her, during these 3 days, to have a private bedroom. So if you want to go ahead and cite me, fine, but I think that we will win on humanitarian grounds."

And we did.

I also looked at nursing assistants and what kinds of responsibilities we were charging them with and identified that if we wanted our nursing assistants to be involved in interacting, guiding, and structuring the day for our dementia residents, we needed to take a look at what we were tasking them with that had nothing to do with resident care. The first thing that we gave up was nursing assistants making beds of our ambulatory dementia residents because dementia residents are not in bed.

The reason that nursing assistants are making beds is because of the medical model. Sick people are in bed. But that takes up a lot of time if nursing assistants are doing that and the patients are not in the room.

We have the same thing in looking at bedside water pitchers. We were also cited for not having bedside water pitchers. When you get creative, and you look OBRA over—and I think that's the exciting thing about what OBRA is telling us—it doesn't tell us *how* we have to do things, it tells us *what* we need to do. We were excited because some licensure inspector or nursing inspector interpreted that the way that you hydrate people is to put water at the bedside. It doesn't say that in the regulations. It says that your residents must be hydrated.

We are confusing a manner in which we can accomplish something with the law and with the rule. If you look at how much time nursing assistants spend in filling those water pitchers, cleaning them, picking them up, and on a dementia unit, trying to find where they are because they're used for everything except hydration—we wanted to invest that time more appropriately.

We also looked at what housekeeping could do and asked them—because we identified that in the structuring of the day of the dementia resident, we needed rest periods, so we could cue them that it's time to rest. That way we wouldn't have sleep disturbances at night. That meant that housekeeping had to have periods in the day when they were not on the unit doing loud housekeeping chores, where they didn't have vacuums and shampooers going and that sort of thing. So we arranged with housekeeping periods of the day when it was appropriate to have that kind of equipment on the unit, if it had to be, and when we could not have it.

We also looked at housekeeping adapting the clothing of dementia residents because as they become more impaired cognitively, they also become physically impaired and their clothing didn't fit. So we asked housekeeping to assume that responsibility.

Maintenance disconnected the intercom system, and my staff almost had a heart attack. What we identified—because we did a study—was that over 90 percent of all of the paging that went on in our facility had nothing to do with nursing home work. It was employees getting phone calls from families or business contacts, or my employees talking to each other about everything but resident care. So we discontinued the paging, and only allowed it for fire and disaster drills.

We also charged maintenance that when they came on the unit with their cart filled with wonderful screws and tools, their carts had to be covered so that our dementia residents were not going through all those wonderful things that they could then eat or walk away with and so that we were never having to tell them no. We never place things in front of them if it was going to be a problem if they touched it.

We also looked at dietary and asked them to set trays up according to a person's level of function and identified that we had three primary levels of people with early, middle, and late dementia, and that the trays that were coming on the unit had to be adjusted to those skills. A person in late dementia is not able to use utensils. They don't understand what condiments are. And we were putting all kinds of things on the tray that they were eating inappropriately. And I'm sure that you have all seen dementia residents with a pack of sugar on their tongue. Those are the kinds of things that we decided we needed to eliminate.

We also looked at what social services could do and identified that social services and activities needed to support nursing but not take over nursing. So we had activities and nursing look at the time of the day when nursing needed the most support. It turned out to be during those rest periods, that were at 10 in the morning and 1:30 in the afternoon when late dementia people were resting, that activities and social services were involved in programs with our higher functioning dementia residents.

We also identified that change of shift from 3 to 4 was a cue—a really good cue—to our early dementia people that it was time to go home because the staff were going home. So we had activities involved with our early dementia people at that point of the day so that they did not see that interaction going on.

And, lastly, what we identified was that we didn't have the appropriate tools for activities to use, not only to interact with a resident, but we wanted, when families came in, for them to be able to do something with the resident that was positive so that the families weren't sitting around staring at the resident and looking at us and timing when the last time was that we came up and interacted with the resident, but we couldn't find any appropriate sensory stimulation products. That's how I got where I am today, because I asked my staff to identify the resident's problems and prioritize them, and that I would find a way to stimulate them and use what was remaining.

So I started making products in my garage that met the needs of someone who needed to touch something repetitively, or someone who needed to be involved with something that would soothe them and that was calming. Because I was so successful, I had a lot of other nursing homes calling wanting me to make products for them. So in 1987 I left my position as administrator and opened my company, Geriatric Resources.

We are, at this point, offering a new catalog this month. We have 157 products that are targeted specifically to the three levels of dementia severity enabling all caregivers to interact with dementia residents and not to do things with them that they don't benefit from, but to look at things that are functionally appropriate and present them in an age appropriate manner.

One of the things that I—it has been a tremendously exciting experience to watch my facility learn to adapt, but I think probably one of the most frustrating things in having received the National Institute on Aging grant to study behaviors—it is very frustrating when all of the research dollars are going toward finding a cure, and none of the dollars—or very few, only 3 percent of research dollars are being spent to help us care give to people who have the disease right now.

Last Saturday, we received the news that our Phase Two application, which was to implement all the wonderful things that we identified in our Phase One project, which had been previously approved for scientific merit, would not be funded as there was no money left to bring those products to bear and to you.

So I suggest, when we're looking at legislation, that's one of the things that we need to be concerned about. Certainly we need to find a cure for dementing illnesses, but we also need support for those of us who are care giving, either in our homes or in institutional settings, for these people. We need resources *now* to help us.

I also want to share with you that when we implemented OBRA back in 1983, that we did not and it was never considered a problem of how much more money it was going to take. When I was criticized by the other nursing home administrators in my community—and I certainly was—there was never a question of how much more it was going to cost me. They were more concerned with what kind of liability I was exposing myself to.

I think that's the same thing that is happening to people who are questioning whether or not they can implement OBRA now. The first myth was that we couldn't do it because we're going to get sued. We've dispelled that myth and now we're dealing with, that we can't do it because it's going to cost more money. It doesn't cost any more money to give good care than it costs to give bad care. It's simply your perception.

So let me leave you with this, in conclusion, because I think this is something that has a lot of application for all of us. The only difference between a possible and an impossible task is the person doing it.

Thank you.

Mr. SEVERNS. Thank you, Mary. That was really inspiring to hear that development, from the resident-created nursing home on up.

John Hogan is from the Benedictine Nursing Center in Mount Angel, OR.

John, tell us about your facility and how your experience has been with OBRA implementation.

STATEMENT OF JOHN HOGAN, ADMINISTRATOR, BENEDICTINE NURSING CENTER, MOUNT ANGEL, OR

Mr. HOGAN. Thank you, Scott.

Benedictine Nursing Center is a 130-bed teaching facility that is located in a rural setting in Oregon, to give you an idea of what we deal with. We have unique problems because of that setting. I think one of the critical things about the center, though, is that we have a strong sense of mission in terms of what we, as an organization, are all about. That really comes down to caring for the elderly, the chronically ill, the sick, and the disabled.

I think, though, that that sense of mission carries one point further, and that is making change happen. That sense of mission has really been important to us in terms of implementation, not only related to OBRA, but a number of programs over the last few years.

I think, though, to flip it over and look at OBRA that way, there is really a philosophy related to OBRA. That philosophy, to me, comes in the nut shell of choice. So when we're making change happen, we have choices around how we do that. When we hear everybody here talk about—I think there is a real commitment to making that choice and making that change in a really positive way.

One interesting thing about the center is that we have been using a patient-centered model of nursing, which we refer to as primary nursing, for almost 10 years now. I think that as one of the leaders in that particular model, it's really been critical to us to work towards the element of choice related to resident care.

In using a framework of helping choice happen—because we all can say that we allow choice to happen, but it doesn't take place—but helping choice happen, we have really instituted a number of new programs that have helped us care for those with special needs.

I think it's really an exciting time when you hear nurses, instead of in the old framework of how we worked, saying, "I think Mrs. Jones needs to do this," now saying, "I wonder what Mrs. Jones would like to do?" That is a major philosophical change in long-term care. I think that OBRA has directly caused that.

Some unique programs that we do at our center that I think—there are cost implications to some of these, but some of these are minimal costs, but certainly with a dramatic impact in our setting. One is known as Code 10, which is a special staff awareness relative to residents with wandering behavior. That has allowed us, with virtually minimal cost, to impact how we allow freedom of choice in terms of movement for residents with some safeguards related to that program.

We now have a flex unit, which is a unit designed to meet the needs of residents in an environment that's more suitable to their unique needs. You notice that we refer to it as a flex unit, not as a special unit or a segregated unit, because we do mix populations in that unit. The unit is designed environmentally to help people with unique needs.

We have an employer-sponsored child care program, which means that we actually subsidize the cost of child care for our employees. This has not only helped us recruit and retain staff, but has provided a beautiful addition, really, to our activities effort through an intergenerational program. The blending of those two populations—when those things are happening in our center, you can feel the enthusiasm and excitement when you walk through the door.

We recently—and by recently I mean within the last 2 years—underwent an activities program review. We knew that our program was lacking, but we really didn't want to just do it—as Nike says—we didn't want to just do it, we wanted to do it right. Basically, we spent 6 months reviewing our program. Seven different disciplines participated in that review. At this point, we now have five additional departments participating actively in the activities program and numerous volunteers helping with programing and really providing meaningful and productive efforts.

We no longer do it just because we have to. We do it because it's the right thing to do. That's a difference in philosophy. We're not meeting the letter of the law, we're meeting the needs of the patient.

As part of this effort, I personally participate in a reading group once a month. There are 12 residents in that reading group. I have to say, from a personal standpoint, it's my most enjoyable hour of what I do in this field.

When we looked at the restorative emphasis related to OBRA, we found that we certainly had some things that we could improve on. We moved in a little bit different way than a lot of long-term care. What we did was decide that all of our aides needed to be trained as restorative aides. We have implemented a program that allows additional training to all of our nursing assistants. The reason for this is that really it's everybody's responsibility to improve the quality of life for our residents. We did not want to select a few individuals to put that restorative emphasis on. Therefore, we've elected to put that restorative emphasis to everybody.

In the area of restraints—and you've heard a number of speakers today talk about the issue of restraints—we've moved certainly to better needs assessments and support programs. We have two support programs related to people with dementia, primarily an exercise program and a sitters program which is a program of trained volunteers that sit with individuals that are dying so that the family can have breaks related to that process and also so that the individual is not alone, though sitters are also trained to work with agitated residents so that, again, we have people that are helping us at those different stages.

We recently compared a 3-month period from 1988 to that same 3-month period in 1990 relative to restraints. We found that falls were way up in this quarter of 1990, but that injuries related to those falls were exactly the same. I think that what we found certainly validates everything that we have read relative to the issue of falls and the use of restraints.

We have made some commitments as an organization. Certainly our commitment to the use of clinical specialists, primary nursing models, child care, restorative issues related to nursing assistants—all of those things have costs, but they have resulted in more appropriate interventions. In addition, it's my hope that staff issues, such as burn-out and morale, will see a more positive picture in long-term care, something that I think we all feel we could use.

I think there are a couple of things, though, that is up to all of us to see take place related to OBRA, making sure that what OBRA mandates actually gets put into practice. It was interesting today that someone mentioned to me that if there is a weak link related to OBRA, it's possibly in implementation. I know the last piece of today's talk is around the implementation issues.

But I think it's fair to say that a couple of concerns—and I think it's amazing through this whole process and the time that it has taken to bring us to this point, that we're really down to just a few issues that still need to be resolved in terms of providers, advocates, and the elderly. One of those issues, certainly, is related to reimbursement. That's not a provider issue alone. I think good quality care and a positive quality of life do impact cost and I'll give you an example of what has happened in our State.

As of October 1, we went to five levels of care with reimbursement related to each one of those levels. We have a resident in our facility who has been with us over 20 years in the facility. In effect, as of October 1, this resident fell into the MR/DD gray area out here, and we were notified that that individual would have to move from the facility, but of course, because that individual has been there over 30 months, would have a choice related to that move.

Well, obviously, as we sit down with the family, we'll get that choice exercised. But in the meantime, we have received a letter from the State related to that individual that says that the reimbursement for that individual—even though that individual can stay there if that's her choice—will be dropped to $21 a day.

I think it's important for all of us not to look in terms of reimbursement. I don't look in terms of reimbursement as dollars. I look at it in terms of ethical issues. To me, one of the implementation issues is the ethical side of reimbursement. I ask everybody to really take that to heart and go back and look at, from your standpoint, if ethical things are being done related to reimbursement.

We all need to be concerned about the implementation issues. Certainly the tie to nursing assistant training, the surveyor—however that works out—is critical to all of us. In our setting right now, if the way that the nursing assistant training issue is left standing, our nursing assistant program, which teaches two classes continuously, would be stopped. That's an issue that I think is critical to everyone, certainly in terms of long-term care.

On the whole, what OBRA is starting—and I say starting because I think all of us have a long way to go—is extremely important and needed. Some areas still require looks and revisions, but they are really few and far between at this point. But in a nutshell, OBRA frees not only the resident to make choices, but from my standpoint it frees the health care provider to let that choice take place. I think that's what is really critical for us.

Thank you.

Mr. SEVERNS. Before we get the reaction from our reactors on the reimbursement issues, I'd just like to ask Jamie and Joyce, what kinds of things were you putting more energy into and more resources—both your own energies and your staff resources—and where, on the other hand, did you see declining use?

Jamie, you have three different models going there, or three different trials. What have you seen there?

Ms. PIPHER. I think the first question that we asked ourselves was how we were going to bring about change, which meant change of attitudes in staff. That meant that it had to be their own idea. People who ran the facilities knew their greatest needs. That's how we came up with three different programs, to be very honest. They reflected things that they identified. Out of the six facilities we came up with actually six different ideas. They identified the need; it was their idea; and their enthusiasm. That's how the priorities were established.

Mr. SEVERNS. So did you end up adding staff and conducting special training, or was it more just a question of conducting some sessions with staff to find out what their ideas were and how to implement them?

Ms. PIPHER. A lot of the information gathering of what needed to be done was done, I would say, informally. It was like we had some OBRA training sessions where—starting many months ago—where we talked about what the requirements were going to be. They went back to their homes and said, "How are we going to do this?" Over cups of coffee, ideas came out. Then as the ideas developed on what their needs were, there were training sessions, on that specific project, on what they identified as their priority.

But it was truly—not even frustration—it was scary. How are we really going to do it? We do not want to end up with paperwork compliance like we have in the past. We want patient care plans that are going to work. We want things that are going to work. How are we going to do it with what we have?

We did end up adding some staff in some of the programs. In some of the other programs, we looked at the total resources and did some shifting around. It depended on the facility and its needs.

Mr. SEVERNS. Have you seen any areas where resources used were less because of the changes that have come about?

Ms. PIPHER. Less? No, I cannot say that. I can say that in some cases it was the same. It was just a reallocation of the same resources given in a different direction.

Mr. SEVERNS. Joyce, you talked about the decline of use of various supplies and so forth. How did it affect staffing overall? Did you have to add staff? Where are you at, staff wise?

Ms. STEIER. I didn't have to add any staff. I had to change the staff to permanent employees versus agency. That was a big change. Secondly, I had to work with them, motivate them, and let them work with me in setting up programs. I don't have any less staff—if you want me to give you numbers, for nursing assistants on the day shift I have 1 to 10, on 3 to 11 I have 1 to 15, and 1 to 20 on the 11 to 7 shift. That's the Florida skilled staffing standards. I have remained at that.

Prior to the time that I was there, when we had all the agency, I don't honestly know what the numbers were. There were no records. It's impossible for me to tell. I just know that it was very expensive.

Mr. SEVERNS. Thank you.

Let's turn to our responders, Charles Phillips from Research Triangle, and Bill Scanlon, an old friend from—you're still in Georgetown, Bill?

Charles, why don't you start? Tell us what you're hearing and what it means to us as advocates listening to the debate over reimbursement and funding OBRA.

STATEMENT OF CHARLES PHILLIPS, RESEARCH TRIANGLE INSTITUTE, NC

Mr. PHILLIPS. Very much in line with the title of this entire hearing, the things that you have heard this morning and this afternoon are evidence that good things are happening as a result of OBRA 1987. However, when you return to your home State, you may also discover that OBRA 1987 has created a troublesome new disorder. This new disorder is called "OBRAphobia".

"OBRAphobia" is known to affect both nursing home administrators and operators. Its most common both symptoms include wild-eyed looks, agitated behavior, and profuse perspiration.

There is, however, a proven therapy for "OBRAphobia."

That therapy is found among the strategies and innovations that the panel members have brought to you this afternoon. These speakers are not advocates, like yourselves, who are talking about what should be; they are not residents talking about what they need; these panelists are providers talking to you about what they have done in their facilities. They have shown you, by their example, that the OBRAphobia that you will face is like many phobic disorders. It's not a completely irrational response. But it is a response to the OBRA reforms that is far out of line with the reality of these reforms and the costs that they will entail.

There are irreducible cost increases inherent in OBRA. For those States operating with the bulk of their facilities certified as ICFs, new staffing levels will apply. That will be expensive. The staff development costs associated with nurse aide training and with the training of licensed staff will increase. Such increases will occur.

But there are also a variety of other provisions in OBRA that are relatively costless—notification of resident rights, notification of room changes—and that should have a negligible cost impact.

However, a number of OBRA requirements—for example, the regulations on physical restraint use—may cause problems for advocates. State associations may try to undermine support for OBRA by implying that these requirements will financially devastate State government. One major State association has already estimated that reducing restraint use in that State alone will cost approximately $136 million.

But what you have heard this afternoon is a very different tale. The practitioners and the providers to whom you have just listened indicate that one can reduce restraints and create a livable environment where people are able to move to their highest practicable level of functioning without immense cost. However, one can't be stupid and expect this change to occur miraculously.

You can't. The counterbalancing of new costs and new savings is not going to magically happen. Nursing home operators cannot continue to operate their facilities exactly as they have operated them for years, implement the OBRA regulations, and then say, "Oh my God, OBRA costs a lot." It may have cost more because the operators didn't do exactly the types of things that the providers on this panel have talked about this afternoon. One must recognize the opportunities for savings inherent in OBRA as well as the potential costs.

For example, when one reduces restraints, what happens? The cost of incontinence supplies and the cost of the restraints themselves are dramatically reduced. What does reducing restraints do to nurse aide and licensed personnel morale? Staff don't like to tie people down. Staff don't like to deal with the results of tying people down. As we all know, they are often more dire than those occurring when one leaves residents unrestrained. With a reduction in restraint use, a facility should have an increase in staff morale and a decrease in staff turnover. That, in turn, decrease training costs.

Facilities should also see a decrease in "call-in" days, a day in which someone calls in sick because he or she just cannot face that facility that day. When this happens a facility must pay $20 to $30 an hour for an agency nurse to take the staff member's place while it pays the employee their original salary.

There are a variety of other potential offsets. I think a wonderful example was one of the things suggested by Mary Lucero—providing different trays to people with different levels of cognitive impairment. What's the other possible response? The facility could hire enough staff (who are much more expensive) to feed everybody. You don't have to do that.

Operators must be sensible. Administrators have to think about those reforms. We spend an immense amount of time and energy in schools of business management talking about management science and the science and technology of profit-making. Well, it is time to develop a science of caring and a technology of quality. This is what OBRA demands.

Remember Ms. Lucero's discussing of the in-depth analysis that they did of how one deals with cognitively impaired residents functioning at three different levels. What one is beginning to see there is an inkling of that technology of quality and that science of caring. The focus must not be on an immediate reaction that says, "You can't do this." Instead, the question must become, "How can I understand this problem better so that I can better deal with it?"

Facilities can take this approach; they can provide good care; they can make the necessary changes; and they can do it without incurring the horrendous cost that some are estimating for much of OBRA.

There will be additional costs, however one of the tasks that faces you, as advocates, is to recognize and to deal with a new reality noted earlier. There can be a natural coalition between nursing home residents, advocates and the nursing home industry.

I am sure that you see it every day in your walk don't you?

In reality, this coalition can exist. Because of OBRA the industry is going to ask for increased reimbursement. What advocates would like to see is increased reimbursement that goes to provide better care. In this instance, advocates maybe able to work with the industry. The industry usually has a great deal of political power, as you well know. This maybe one instance in which you can work with that power and utilize it. The only thing that advocates must take care about in this process is that the industry is not simply allowed to "pocket" the increased reimbursement that you helped them obtain.

Advocates must recognize that not all the demands that the providers make, and not all the things that operators say about what OBRA costs are going to be, are simply self-serving. Some of their estimates of OBRA costs will be grossly—shamelessly—inflated. In other instances, the estimates may be realistic. It's very difficult, but what advocates must do is determine which estimates are reasonable and support the industry in helping them get the funds that they truly need to provide good care. In return for your support, you must demand that the industry use in fact go through this process of using these funds for the increases in the quality of care.

One thing that you should do when you think about OBRA as a process associated with reimbursement is to look very carefully at those examples in your States of facilities currently providing care similar to that demanded by OBRA. Use those facilities as resources in the battles concerning how much various reforms will cost. Use them as information sources who can tell you what their experience has been. If you trust their judgment and you trust their motivation, then you will accept the idea that, "Yes, I have to spend a lot more on staff development."

You can accept that statement but you must then say, "Okay, and what kind of staff development are we going to get that will help my coalition, my constituency, receive better care?"

That natural coalition is not something that you should automatically eschew. You may be able to take advantage of it. But some industry associations have taken a stance that's not terribly cooperative. With those, you'll simply have to do battle. You can do battle with the examples the panelists this afternoon have given you, and you can do battle with the industry by making certain that state government knows that what they're trying to do is destroy "the something good that is happening" because of OBRA on the basis of unrealistic and inflated estimates of what OBRA's costs will be.

Almost everybody thinks that OBRA will be implemented. The only thing that might stop it is if certain political forces can convince officials that its costs are unconscionable. It is part of your responsibility to help these officials recognize that implementation should not be stopped.

STATEMENT OF WILLIAM SCANLON, HEALTH POLICY CENTER, GEORGETOWN UNIVERSITY, WASHINGTON, D.C.

Mr. SCANLON. I have to say to begin with that it's incredibly heartening to be here and to hear this panel where one positive experience after another can be reported. It's not often that one is able to deal with such clearly identifiable better outcomes, and on top of that some of them are actually very cost effective.

It seems almost crass to talk about money, but since money is an important element within the world that we all live in, it becomes a grim necessity.

I agree with Charles that the estimates that are being cited about OBRA's costs are both greatly exaggerated and wildly incorrect. I think, though, that what we have done today, in some sense, is to add to the uncertainty, because I'm not sure that we can use the experience of this panel as the guide to what OBRA should cost and how much we should be seeking in the way of additional reimbursement.

One of the things that struck me as I heard the panelists was not so much just what they did, but what they did after they did the first thing that they attempted. In each instance, what they were doing or attempting was what might be considered as compliance with the letter of OBRA. Then they attempted to implement the spirit of OBRA, finding a series of innovations and creative ways to truly improve the outcome that was involved. While creativity may be a way of reducing the costs of implementing OBRA in different areas, I don't think we can expect that there will be enough creativity to go around for the 14,000 nursing homes in the United States. That's an unfortunate fact.

We often talk about efficiency as if it was something that everyone can attain. The reality is that there is a lot of difference in talent among people and that we can't expect everybody to achieve the same result. What this leads me to believe, with respect to reimbursement and OBRA, is that we need to adopt a very flexible and open approach regarding how we're going to pay for OBRA.

There needs to be a lot of cooperation and communication between those responsible for regulation and enforcement and those responsible for reimbursement. When regulators visit nursing homes, they must find out, "Are they complying? Are they complying with both the spirit and the letter? If not, why not? Is it an issue of management, or is it an issue of resources?"

When it is an issue of resources, we should be willing to provide the additional resources through the reimbursement system. For the present, we may be unable to fully specify a set reimbursement rules to pay appropriately for OBRA. Instead we may need to have some flexibility within reimbursement systems to provide special funds when they're needed to allow a facility to become compliant with the spirit of OBRA.

The alternative approach—providing enough funds for even the most inefficient to be compliant—is totally impractical, given the fiscal situation that States are in today. One cannot advocate it.

The economy, as you all know, is under a great deal of stress. You talk about OBRAphobia. If you talk to State people about the requirements for adequate reimbursement, you get a real sense of

OBRAphobia. Some of the well have dealt, meaning States dealt over the years with the Boren requirements for adequate reimbursement with a sense of great frustration. It seems there is no reimbursement system, regardless of how well-intentioned, that is Boren-proof, in the sense that no one is going to challenge it in court at some point. Defending a reimbursement system, even when successful, can absorb considerable State resources and impact negatively on the morale of State staff.

OBRA has a requirement similiar to Boren that the resources must be adequate to meet the conditions of OBRA. It is a requirement that is relatively undefined and hard to define. It is likely to be a source of anxiety and anguish even for States attempting to fully comply.

Since we're running late, I would end with a comment on an idea expressed earlier about how hard it is to change a lifetime of conditioning. While this was discussed with respect to appropriate care practices I believe the same applies to reimbursement. We are conditioned about how much a nursing home should cost, and we are only willing to tolerate increases in resources to nursing homes that fit our idea of what they should cost.

We have to recognize the implementation of OBRA, being faithful to its full intent, involves changing the quality of life in nursing homes. If it does cost more, that it is for a different product and that the difference in cost may be totally justified. We need to make the case for improved quality of life and to start anew as to what our concept of the cost of nursing home care ought to be.

Thank you very much.

Mr. SEVERNS. I would like to thank our panelists. I think it gives us a sense of the degree to which we can view OBRA as starting over, really paring away at some of the assumptions, and therefore the reimbursement assumptions also have to be pared away because OBRA is not just taking all that is and adding more to it, rather it is starting over. It is starting over from the point of view of residents who are not yet nursing home residents telling someone who is developing a nursing home what it should look like. It's starting from those kinds of basis, and a new way of looking at things, that we need to call on providers to look at this implementation with a new way of thinking.

We certainly need to call upon the regulators and those who fund long-term care to look upon this with a new sense of what this system can be. We have come a long way. We now know that OBRA is in fact revolutionary. We can bring something new out of this whole process.

I certainly thank all of you for the contributions that you have made and for all of the inspiration that you've given us. I think it really will give us something to go back with.

Thank you.

We're going to reconvene here at 4 p.m. Is that correct?

[Recess.]

Ms. TITUS-ROURKE. I'd like to reconvene this meeting. If you'd join us back in the meeting room we can get started.

The first thing that I'd like to do is to thank all of you for your patience. Those of us who don't sit in wheelchairs regularly discovered a little bit of what it must be like to sit in one place in one chair for a very long time in today's experience.

The other thing that I wanted to say was that as I talked to people in between, for those of us that go to national coalition meetings regularly, this may seem like, "So why did we get all dressed up and go to Capitol Hill just to hear some more educational sessions, great though they must be?" I wanted to remind us what we are doing here. We are really creating a report for Congress on the fact that OBRA implementation is possible. The testimony that we heard here today and the questions that are asked will all be a part of a record that will be the record to Congress that what we dreamt and what we worked on is in fact possible.

The session that we are doing—we talked from the assessment of the resident; we've talked about from the provider's potential and ways of implementing OBRA; and now we really need to look at ourselves as community people, as ombudsmen, as residents, and as family members. What is it that we can do in assuring the effective implementation and enforcement of OBRA? All of this is in the context of remembering that it's really our law, our words.

I guess I'd like to start off with the speakers that are listed on the panel before you. The first speaker to tell us a little bit, to give us our charge, will be Lydia Borkin.

Ms. BORKIN. I'm sure you've heard enough to take back with you and think about for weeks to come. What we're doing, and trying to do, is to change a whole system. That isn't easy to do no matter where you live, where you work, or anywhere in the Government. But we have been working very hard to get OBRA implemented.

It will mean, if we are successful, that all of the residents who live in nursing homes will really have a wonderful place to live. The nursing homes will be run for the care and concern of the resident instead of fitting the resident into the institution of a nursing home. It will take a great deal of education and a great deal of advocacy.

Everybody who knows anything about this will really have to charge themselves with the task of helping others understand this, educate themselves and others, and help them in every way they can, so that when we come to the conclusion, we will find ourselves at the end knowing that our nursing homes are much better places for those people who have been living in them and will continue to live in them for the years to come.

But it's up to us, even those of us who are residents and are limited in what we can do. We must speak out, too, and we must make everyone understand that if we work together we will all end up getting those things that will make life better for all of us.

Ms. TITUS-ROURKE. Thank you, Lydia.

Next will be Carol Benner who is the Acting Director of the Office of Licensure and Certification in the Department of Health and Mental Hygiene in Maryland.

STATEMENT OF CAROL BENNER, DEPARTMENT OF HEALTH AND MENTAL HYGIENE IN MARYLAND, BALTIMORE, MD

Ms. BENNER. Thank you.

Can you hear me? I'm so short that it's tough sometimes when I get behind these things. Sometimes I have to say, "Can you see me?" rather than "Can you hear me?"

I am the Acting Director of the Licensure and Certification Programs in the State of Maryland. What that means is that I am responsible—and hopefully have the clout behind me—to make sure that all of the new regulations, particularly those of OBRA, get implemented. So I am responsible, as is Mr. Flood, for getting all of this implemented and making sure that the nursing homes do.

It's interesting. I heard the last panel talk about what it takes for the providers to make OBRA work. It takes an awfully lot from our end to make it work, too. We've been running around looking for tag numbers for regulations and making sure that surveyors have books, making sure that the surveyors are trained, and that we're doing what we need to do to get OBRA implemented.

Lots of times you hear of an adversarial relationship between the providers and the regulators. I like to think that we're all in this together. The bottom line is quality. Sometimes we go about it in a different way, but my job as a regulator is the same as that of the provider, to make sure that the people living in nursing homes are safe, happy, and healthy.

I believe, certainly in my own State, and certainly across the Country, that the majority of nursing homes do provide good care. But there are a few nursing homes that do not. I think that those few nursing homes reflect poorly on the regulatory process, and certainly on the industry as a whole. What we're trying very much to do is to get rid of those bad actors. I think they are bad actors.

I can share with you that the reason I was late today is because we're doing our first adverse action under OBRA. It's tough. It's the first time. We want to make sure the paperwork is correct and we want to make sure the process is correct. I sat in on an exit conference and heard bad outcome after bad outcome after bad outcome, and the physician who was responsible for this nuring home said, "Well, that person came here to die." After the second bad outcome, the doctor said "That person came here to die, too."

The seventh time after I heard it, I said, "Hey, you don't understand", and by God he didn't.

So, again, for all of you who are out there doing the same thing that we are doing, I thank you very much. We need your help. Education is critical. Talking and working together as well as cooperation is critical because the bottom line is the same for all of us.

Thank you.

Ms. Titus-Rourke. Thank you.

Next we have Patrick Flood, Director of Licensing and Protection in Willistown, VT.

STATEMENT OF PATRICK FLOOD, DIRECTOR OF LICENSING AND PROTECTION, VERMONT DEPARTMENT OF HEALTH, WILLISTON, VT

Mr. Flood. Having sat in the back, I know that a lot of you can't see me, but I hope you can hear me.

I want to keep my message brief and to the point, but I'm here to tell you that I not only think and believe that OBRA can be done, I know it can be done. I know that we're doing it. I also know that it's going to take time. But I do know that it can be done and we should not retreat a step, quite frankly, for any of you that are having doubts.

It does represent a very fundamental change in the way that we do things and the way that all of us behave. It's high time, quite frankly. But I don't think it's that complicated. I think we spend a lot of time splitting hairs around these issues when it's really not that complicated. It's not that complicated if you read the interpretative guidelines about what quality of care is. Frankly, folks, that's just good nursing and should have been going on all the time.

When you read about resident's rights, there is nothing complicated about having residents involved in their own care and making their own decisions. There is nothing complicated about that at all. The rest of the world does it every day. It's not that hard. It just requires a commitment and it requires that all of us adopt the idea and the principle.

Let me tell you a few things that I think we need to do to get there, from my point of view as a licensing director. I think we need to cooperate and I think we need to lead. All of our behaviors need to change, by the way. It's not just the nursing homes that need to change their behavior. In fact, what I find is that many nursing homes want to provide this kind of care. They tell us that they are happy that this has come along and that they have for years disliked restraint use intensely. They are so happy. All they want to know is how to do it. I think we can help them do that. You can help them and we can help them.

I think that nursing homes have an opportunity to become leaders, for a change. For so long they have been thought of as the bottom rung of the health system. I think they're driving some of the hospitals crazy because they're demanding good assessments; they're demanding that people come to them not loaded up with Heldol and on restraints, and the hospitals don't know how to behave. I salute every nursing home that's putting those hospitals on the spot.

I think the licensing agencies—you should go home and ask them to do this, because I think it can be done and it is our responsibility to do this. People, like nursing homes, will respond if they know what is expected of them. It is our job to explain what those expectations are in such a way that they can respond. We have done in-services for all the nursing homes on the regulations; we've done in-services for all the nursing homes on restraint reduction; we've done in-services for all the nursing homes on assessments; and we write to nursing homes regularly, to all of them, answering the questions that they have brought up because we send out a letter every week or every other week. They have a lot of questions.

We have written letters to every physician in the State who has patients in nursing homes explaining the major provisions of OBRA that affect them. It really has to be done. We also have advisory committees every step of the way where we involve the providers, the advocates, the residents, and ourselves.

I think we have to be flexible. It is true that a lot of what you will hear about the survey process doesn't always make sense. We need to be flexible at the licensing level to focus ourselves on what is important. I do not want my staff nitpicking when we're looking at outcomes. If they are nitpicking, then they are not doing what they ought to be doing. When they are nitpicking, they are not paying attention to the resident outcomes.

We are not perfect. We are open to criticism. I can tell you that things are not always being done on time. There are things that we still have to do that should have been done a long time ago, and we have a lot of changes to make. But we're going to work on it.

The other message that I would give you is that, as far as I'm concerned, OBRA is not a set of regulations, rather OBRA is an idea. OBRA is an idea whose time has come. I think it changes the way we all act, and we're not going to be able to go backwards. I don't believe that. I think that we can never return to mass restraints. We can never return to a system where residents are left out of the survey process. Once you plant those seeds, you can never go back. We need to push on it. We can never go back to a structural survey process once we have tried outcomes. We're on a path here, we're on a roll, and I think we need to keep it up.

I also think that you need to understand—I believe firmly that this is a historical moment, and I don't think you should make any mistake about that. If you don't think so, just sit and think about the opposition to the regulations and to some of the changes. It is so major that we must be doing something right.

But I think that you need to go back honestly—we've heard it time and time again today—you need to go back home and link arms with those providers who want do to right, and you need to link arms with those people in the State agencies who want to do right. My fond hope is that when my grandchildren ask me what I used to do for a living that I would be able to tell them that I participated in the great movement of the 1990's to make every nursing home a caring and respectable place for every older and disabled American. I do not consider myself a militant, actually. I consider myself a fairly flexible and reasonable person.

That's part of my message. I think we need to be flexible and I think we need to be reasonable. We need to work very hard. It's too great an opportunity to be lost. I say to you, go home and find the friends in your community and beat the drum. We must not retreat and we must continue until the job is done.

Ms. TITUS-ROURKE. Hollis Turnham, State Ombudsman for the State of Michigan, and Treasurer of the National Association of State Long-Term Care Ombudsman Programs.

STATEMENT OF HOLLIS TURNHAM, MICHIGAN STATE OMBUDSMAN, DETROIT, MI

Ms. TURNHAM. Thank you.

I've been asked to speak about enforcement, one of those pieces that we're all waiting with baited breaths to see where it's going to go. Like Pat said, enforcement is not complicated. It is simple: protect and serve the residents.

There are two major things that I think, when I talk to my colleagues and State ombudsmen, that we still need to push when we go back to the States. First, the State Medicaid Agency's sole responsibility is not check writing. They have a responsibility and a duty to ensure that not only the reimbursement is fair to the providers but that it serves the needs of residents.

It was an embarrassment to sit in the last Medical Care Advisory Council meeting in the State of Michigan and see a consumer advocate ask the staff of our State Medicaid Agency, "So what do you all do about these nursing homes that don't meet standards?" and to see the staff members sit and stare at each other and not know—number one—that they had a responsibility to do something and that—number two—on occasion they have in fact actually done something.

For those of you who are not familiar with what a Medical Care Advisory Council is, that's one more task force, one more monthly meeting you can go home to. It's the one place where consumers, where residents, have direct voice in setting Medicaid policy. In fact, by Federal regulations, recipients, consumer groups, are guaranteed a majority on that Committee. Go back, route it out in your State Medicaid Agency and use it as a vehicle for effective enforcement.

The second issue that we have to take back to the States is that we have to keep saying the words. Remember that old mantra? If you say it long enough, loud enough, and often enough it becomes real. Intermediate sanctions work.

Effective enforcement is not a code word for evacuating a facility. We have to return to our roots, understand, and respect what our clients, our residents, our friends, and our family members are saying. We have to protect the vital community resource that nursing homes can and should play to their communities. If the building is sound, save that resource, save that home. Develop an enforcement system that does not wait until you are automatically down the chute to fast track decertification.

You're going to have to talk about—over and over and over again—"Let's prevent this from happening. Let's prevent this from getting so bad." Sometimes it's startling to go to a department of public health to talk about prevention. Their mantra is, "Health promotion, disease prevention." It's like that word never seeps over into a bureau which regulates health facilities.

Make sure that the regulatory system stops the hemorrhaging. When you do find those hideous situations, there must be the resources, through receiverships in particular, to deal with the issue to protect the residents' rights then and there. Make sure that the enforcement system includes a component that once you have stopped the hemorrhaging, once you've done the prevention, that the Government develops the capacity to evaluate the ability of the provider to give care.

If the decision is that that provider is either unwilling or unable to run a facility that meets minimum standards, that meets basic nursing, physical therapy, occupational therapy, and medical direction, and if the building is sound, you evacuate the owners. You do not evacuate the residents.

You evacuate the owners by ensuring their due process rights to getting a court ordered sale of that facility to someone who is capable of running it as a nursing home.

Finally—I'm going to meet 3 minutes—finally, remember what my mama told me for many years, "Can't never could do nothing."

Don't say, "We can't do that." Don't accept it for yourselves as advocates, and don't accept it from the bureaucracy. Find a way to just do it.

Ms. TITUS-ROURKE. Thank you, Hollis.

Next we'll hear from Kathy Gannoe, Bluegrass Long-Term Care Ombudsman Program, Lexington, KY.

STATEMENT OF KATHY GANNOE, BLUEGRASS LONG-TERM CARE OMBUDSMAN PROGRAM

Ms. GANNOE. Well, I know when to just say, "Amen," and sit down.

I just have to concur. The challenge for me as a local ombudsman is to take the whole idea of, "Let's treat people the way we've known all along that we should be treating them." Let's take it back and remind the providers that that's all OBRA is about, treating folks like we've known in our hearts they should be treated, even though we have individuals in institutions working on a daily basis through Family Councils, Resident Councils, and through individual resident empowerment to make those institutions responsive to the individuals so that they live in the kind of place that Lydia talked about, that it's the kind of place that you can go to and really live.

I just think that's going to be a challenge on a day-by-day basis for those of us who are local ombudsmen.

Ms. TITUS-ROURKE. Thank you, Kathy.

Now we'll hear from Fran Sutcliffe, the Nursing Home Hotline Patrol, an apt name.

STATEMENT OF FRAN SUTCLIFFE, NURSING HOME HOTLINE PATROL, ST. PETERSBURG, FL

Ms. SUTCLIFFE. The seven worst words in the English language are, "This is the way we always did it."

These are the people that never heard about the power of positive thinking.

As we work our way through this system—and there is plenty of work to do—I want to make every effort to identify the people, the residents, in these facilities who are not benefiting fully from OBRA.

Furthermore, I think we need to identify from coast-to-coast attorneys who are interested in class action suits. It may well be that these are the ones that will finally see that OBRA is fully enforced. It will be implemented because we will not give up. We are at the point of no return. We can only go forward. And we will go forward with great determination from this meeting because we have made up our minds that we will just do it.

Thank you very much.

Ms. TITUS-ROURKE. I think we need to remember that we are the initiators of a revolution. It's a simple revolution. It simply says that the residents of nursing homes should set their own agenda for care. It's really clear.

OBRA is the blueprint for that revolution. In fact, as in any revolution, we need to find friends to our revolution, to reach out to committed professionals and enlightened providers of care. We need to convert others, to the vision that we have. We need to watch for those of us that fall back into old patterns of behavior when we forget and only remember Fran's seven words. And we need to remember to help committed professionals learn that their need to care is less important than a resident's right to choose.

In fact, the charge to us is to do what's right and what we know is right. It's not that something good is beginning to happen. I think the message is that we can make something great happen as we go forward from here.

Thank you very much.

I'd like to ask Elma Holder to send us on our way and I believe to thank Bill Benson and Holly Bode if they're here—hiding in the back—coming up.

STATEMENT OF ELMA HOLDER, EXECUTIVE DIRECTOR, NATIONAL CITIZENS COALITION FOR NURSING HOME REFORM

Ms. HOLDER. I would just say to you that it's been a good, long, hard day. We will go back to the 4-H Center very inspired. It has been a tremendous opportunity to be here in these chambers and to express the voice of people throughout the Country. The people who have been up here at the podium have had an opportunity to use the microphones and go on the public record, but I think the exciting thing for us is that we are, as Susan said, producing a document that will be available to use as a tool for advocacy and we can say—and perhaps we can persuade the committees that have so aptly sponsored this day—maybe we can persuade them to put in a participant's list. Then some day, 20 years from now, we'll be able to point proudly to this document and remember how we went through this long day together.

I think the challenges before us are many, and I love Fran's comments relative to positive thinking. I love the State of New York and some of the things that they can come up with, so I want to tell you one thing that New York has been doing.

I was very fortunate to participate in one of the meetings of the committee that's working on the New York State Code to get the State of New York in line with OBRA, a very fascinating process that they have been through this year. Cynthia Rudder has been providing leadership in that State. But what was exciting was that the residents and the advocates in the State decided to try to put their most positive thinking forward and they offered many recommendations to the State of New York to include.

One of the things that they challenged New York, the providers, and the Government with was, "What does resident participation and governance mean?" One of the provisions in OBRA is that residents will participate. They decided to make the recommendation that every governing body of a nursing home would, in fact, have residents participating.

I was in the audience when this was presented to the State Code Committee. You can imagine some of the shock and horror that was expressed at such an impossible task. No way was this ever going to be achieved in a State law that we would allow residents to participate in the governance.

Well, they didn't make it all the way in New York, but by putting that great dream on the table, as they did, they were able to achieve miraculously where at least, in the Code of the State of New York—my understanding is that the governing body of a nursing home has to meet at least once—maybe it's twice, but I think once a year—is it twice, Nellie?

Three times—great. Three times a year the governing body must meet with representatives of the residents and their representatives in nursing homes. So that's one of those impossible dreams.

So we have a lot of challenges and excitment before us as we join in that kind of creativity.

I want to personally thank Bill Benson for the work that he has done in the Committee, Holly Bode, and certainly the Senators involved, and let Bill talk to you about his hopes and dreams for OBRA as well.

STATEMENT OF WILLIAM BENSON, STAFF DIRECTOR, U.S. SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES SUBCOMMITTEE ON AGING

Mr. BENSON. Thank you, Elma.

Good afternoon all of you. I'm supposed to help make the closing remarks, but this is, of course, my opportunity to also welcome you.

I can't think of any other audience that I know that would come to a forum and spend 7 consecutive hours debating, discussing, and listening to presentations as intensely as you have today, and I'm certain that continued all the way through your lunch hour. In fact, only with nursing home advocates would you find, at the end of a long day, more in the room than when the event began early in the morning.

Having attended many events on Capitol Hill, I think that is very true. It's evidence of your ongoing, unbelievable commitment to what you do.

When we first planned this event, we didn't expect—we didn't dream—that Congress would still be in session.

Of course, they are, and perhaps they'll continue to be while you're having your annual meeting next year, too. Who knows?

We hope not. We hope not.

But, anyway, I think for myself and many other staff members, we had hoped to be here for the entire presentation all day, but because we're still in session, this has meant that we could only pop in here and there. That's too bad because there was an awful lot presented, and I would have learned a great deal. But what I saw was most impressive.

Something good is happening. Something good has been happening for a long time now that I would like to comment upon. That something is you—all of you in the audience—the audience members who at the State and local levels are on the front lines in your communities in striving to improve the lives of residents of long-term care facilities. As we look at this landmark event, the beginning of the full scale implementation of OBRA 1987, and the good things that that will lead to—and, in fact, is already bringing about—it is important for us to remember that this is a milestone in what has been, and will continue to be, a long process.

Nearly a decade ago, there was a very serious effort to deregulate and otherwise undermine and frustrate oversight of quality care and Federal requirements for nursing homes. This effort led to congressional intervention; it led to the Institute of Medicine Study; it led to the OBRA 1987 law; and it led to, as of October 1, 1990, implementation of that law.

But the single most outstanding feature of that 10-year period, in my judgment, has been the remarkable role that all of you have played. Citizen groups committed to better nursing home quality—State and local ombudsmen, and various kinds of citizen organizations committed to better care—along with a lot of other concerned citizens, led the charge against this effort under the direction and leadership of the National Citizens Coalition—NCCNHR.

You not only beat back that onerous development of 10 years ago, but you created the reasons that we're here today. Your efforts were much more than defensive in nature. Although you had to be defensive in beating that back, you were positive and creative. You said that with a strong and thoughtful Federal role, the quality of care and life in nursing homes can be much better. Fortunately, many State regulators, providers, and others agreed with you in that view. Because of that—because you were right in that viewpoint—we are here today. You have amply demonstrated how right you were.

Something very good happened a decade ago with your emergence as a powerful voice speaking for nursing home residents. Your collective voice has grown even more powerful over the past 10 years, and make no mistake about it, your voice will likely need to be even more powerful in the years to come.

I would like to conclude with just a few thoughts on that point.

This wonderful new law is on the books and officially underway—fully underway, we hope. By all rights, it should rapidly gain steam toward truly redefining how we view and measure quality of care and life for residents. But as difficult as the path has been thus far, it promises to remain consistently challenging in the years ahead.

The next several years will be quite demanding from a budgetary standpoint. I used the word "demanding" but not "taxing."

I think that we all recognize that and will cope with that in one way or another. What we must be vigilant against, however, is the line of thinking that in effect goes like this, "OBRA 1987 was a great idea, full of wonderful notions, but we just can't afford it right now." Unfortunately, we have heard that argument made, and I'm sure we will continue to hear it made, as we have heard from California's Executive Branch recently. But we will hear it from others as well. We will need your help to ensure that this doesn't become a euphemism for delaying and otherwise frustrating the implementation of this important law.

It is likely that all of us—consumer advocates, State regulators, providers, and staff members on the Hill—will continue to be frustrated by the rulemaking and administrative processes of HCFA with regard to OBRA 1987. Your active involvement will be necessary in trying to get the administration to do the right thing on a timely basis. Or if they're going to do the wrong thing, to at least do that on a timely basis.

Also, as the last 2 years have shown, there will be many kinks to iron out with regard to the OBRA 1987 provisions and the implementing regulations. So-called technical amendments and various corrections will be raised to deal with obvious problems as well as subtleties and nuances in the law. Your help is essential to be certain that these technical corrections do not become a device for nibbling away at the substance and the spirit of the law.

In sum we must remain clear that the real test of good law is the commitment to actually carry it out. This will require the continuing cooperation of the diverse interests—providers, advocates, regulators, and others—who have worked so well together to this point, despite real differences. The remarkable degree of cooperation has been very important here.

NCCNHR, ombudsmen, and other nursing home reform advocates have truly established a presence here on nursing home policy. You have developed the respect of more Hill staff than you probably know. This will be important in the future.

Nevertheless, the bottom line is that your vigilence, your commitment, your energy, your creativity, and most of all your persistence will need to continue to be as strong as it has been for the past decade to ensure that something good, and even better, continues to happen for a long time to come.

Thank you very much.

Ms. TITUS-ROURKE. Thank you, Bill. As an old-time friend of NCCNHR, ombudsmen, and advocates throughout the Country, we're very proud to have you here and have you working on the Hill for us, as we're proud of Holly Bode and the work that she's doing. We'll hear from her next.

Ms. BODE. I want to thank everybody so much for coming. I, unfortunately, have not been able to be in on very much of this today, as I have been involved in some budget conference meetings. But I do want to thank everyone for coming and hope that you have had a very productive and informative day.

I want to thank, again, NCCNHR, for putting all this together.

Ms. HOLDER. I'm glad that Portia Mittelman joined us, who is the Director of the Special Committee on Aging.

You don't have to say anything, but it is a great honor for us, as advocates for people who live in nursing homes throughout the Country, and as residents who are here with us today, to be able to call upon the Senate Special Committee on Aging and to rely on you to be our advocate, as always. We want you to know that we appreciate the work that your Committee has done, and the other Committee that sponsored this day. We're looking forward to the Committee report, that I said earlier we are going to use as an advocacy tool for implementing OBRA.

So thank you very much.

Now we're just going to have a few housekeeping details concerning what we're going to do to get to our buses. The major thing is that we came on the yellow school buses, and most of us are going back. You have the obligation, please, if you will, if you decided to go back by the exciting Metrorail or other means that you go back by your bus and report to the board member on the bus, or report to someone on the bus that you will not be joining on the bus ride back.

So why don't you start following the crowd. I don't think there are any other announcements. We'll see you back at the 4–H Center.

Thank you.

[Whereupon, at 4:43 p.m., the workshop was adjourned.]

APPENDIX

RESIDENT ASSESSMENT

THE SPRINGBOARD TO QUALITY OF CARE AND QUALITY OF LIFE FOR NURSING HOME RESIDENTS

October 22, 1990

Co-Hosted by the
U.S. Senate Special Committee on Aging
Subcommittee on Aging, Senate Committee on Labor and Human Resources
Campaign for Quality Care
National Citizens' Coalition for Nursing Home Reform
in Conjunction with the NCCNHR Annual Meeting

RESOURCE PACKET

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RESIDENT ASSESSMENT
THE SPRINGBOARD TO QUALITY OF CARE AND QUALITY OF LIFE FOR NURSING HOME RESIDENTS

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RESIDENT ASSESSMENT AND CARE PLANNING, THE BASIS FOR QUALITY OF LIFE AND CARE

Prepared by NCCNHR, October, 1990

A NEW PHILOSOPHY

The Nursing Home Reform Amendments of OBRA '87 require a radical turn-about in care practices -- a focus on each individual's highest potential for physical, mental and psychosocial well-being, with reasonable accommodation for individual needs and preferences. The key to achieving this change is the resident assessment and care planning process. The assessment process provides a forum for staff to learn residents' strengths, weaknesses, and customary routines. This information forms the basis of the individualized plan of care which, when carried out, should support resident autonomy and independence -- through restorative nursing practices, individualized activities, appropriate therapies, and facility support for/adjustment to personal routines.

While we are a long way from full implementation of OBRA, it is important for the public to know about OBRA's potential and about the experiences of care-givers who have forged ahead and found these changes not only possible, but preferable to old care approaches.

RELEVANT PARTS OF THE LAW

Quality of life and care

- Nursing facilities must provide care "in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident."

- Residents have the right "to reside and receive services with reasonable accommodations of individual needs and preferences," except where their health or safety or others is endangered.

Resident Assessment

- Nursing homes must "conduct standardized, reproducible assessment of each residents' functional capacity" including their "capability to perform daily life functions and significant impairments..."

- "Each assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered nurse."

Care Planning

- Nursing facilities must provide nursing, medical and psychosocial services to "attain and maintain the highest practicable mental, physical and psychosocial well-being of each resident in accordance with a written plan of care which describes the medical, nursing and psychosocial needs" and how these needs will be met.

- Residents, and family/representative are involved "to the extent practicable" in care planning

- The care planning is to be done by a team, including the physician and nurse "with responsibility for the resident" **(not a nurse hired to do assessment and care planning only)**

THE ASSESSMENT SYSTEM

The Resident Assessment Instrument (RAI) has two parts:

- Minimum Data Set (MDS) contains the federally required core elements and common definitions for comprehensive resident assessment. It also has triggers which identify areas in which the resident needs more in depth assessment

- Resident Assessment Protocols (RAPS) provide additional assessment items and background information about residents, their strengths, preferences and needs which are linked to care plan options. The 18 RAPS cover the following: delirium, cognitive loss/Dementia, Visual function, communication, ADL function/rehabilitation potential, urinary incontinence/indwelling catheter, psychosocial well-being, mood state, behavioral problems, activities, falls, nutritional status, feeding tubes, dehydration/fluid maintenance, dental care, pressure ulcers, psychotropic drug use, physical restraints.

The completed RAP:

- Identifies the resident's unique problems which adversely effect his/her functioning;

- Identifies factors that place the resident's functioning at risk;

- Considers whether identified risk factors can be prevented or reversed, and evaluates how much a resident is able to attain a higher level of well-being and functional independence.

- Evaluates ongoing care practices for the resident by considering alternative therapies and/or consultation with other disciplines or specialties.

INDIVIDUALIZED ASSESSMENT AND CARE PLANNING PROCESS

Interdisciplinary Team: All available professional disciplines should be involved in assessment (and care planning). In addition, the MDS cannot be completed without talking to those who know the resident best: the resident, family, significant others and nursing assistants. A quotation from a nurse who used the MDS in this way illustrates the value of this assessment approach: "Even if I had known these patients for years, I was able to find out things I never knew ... I got a real view of the person."

Individualized Care Planning An individualized plan of care is developed by the interdisciplinary care team and the resident. For example, under current practice a facility might put everyone to bed at a specified hour regardless of the resident's life long habit. Under OBRA the individual resident's normal bedtime is taken into consideration. The process is centered on each resident's unique strengths, needs and patterns. Assessment and care planning are dynamic processes. They require ongoing dialogue between residents and care providers on all shifts. Changes in resident functioning, whether small or significant, shall be noticed.

IMPLEMENTATION OF THE INDIVIDUALIZED CARE PLAN

Facilities which have already implemented individualized care suggest the following:

- Administrative support for flexibility in care - Individual needs should be met before facility needs whenever possible. For example, if a resident has always had a walk at 10 a.m., it is more important for the nurse aide to support the resident's walk than to make her bed at a specified hour.

- Flexible staffing at peak times, changing as the resident population changes. For instance, if many residents like to stay up late, then add staff during those hours rather than during the usual 7 a.m. to 3 p.m. shift. Plan the day around resident needs so staff and residents work together rather than struggle against each other.

- Primary care, assignment of nurse aides to particular residents on a permanent basis, fosters a bonding between residents and staff. The nurse aide can better meet resident needs and identify subtler changes in condition. It is a more efficient use of the aide's time.

- Redefinition of the nursing assistant role to include activities, mobility, occupational therapy, etc., and discussing body care. Although it initially requires more training (by rehabilitation trainers), it allows residents' therapies to be incorporated into the day's activities. For example, walking can be done on the way to the dining room (leaving the wheelchair in the room!). This approach fosters better interaction between therapists and nurse aides.

- Non-direct care staff know ways to become involved with the residents. Often times, less eligible staff such as kitchen staff, groundkeepers, or others, have regular interactions with residents and can help support their needs to walk about or engage in other activities.

- Encourage staff creativity to solve problems involving resident care and use of human resources.

- Keep a good sense of humor

WHAT ADVOCATES CAN DO TO SUPPORT CHANGE IN A FACILITY'S APPROACH TO CARE

- Educate -- make sure resident, families and staff know about the new standards and about this assessment and care planning process.

- Prepare -- many residents are uncomfortable speaking up in a care planning meeting and many care givers are still developing their skills related to resident participation. Advocates can help residents identify what care and daily life issues they want to resolve and what ideas they have about what will work. Communicating this beforehand to the coordinator of the meeting may help improve the process by focusing it more on the resident's agenda.

- Try it -- when issues of concern arise for residents, advocates have a new vehicle for selling their resolution -- the care planning process. Change in facility wide practice occurs individual by individual through assessment and care-planning.

CHANGES CONSUMERS SHOULD SEE AS FACILITIES IMPLEMENT RESIDENT ASSESSMENT/CARE PLANNING

- <u>Increase in quality and quantity of communication between:</u>
  - All facility staff, resident and family
  - Professional and non-professional staff
  - Direct care giving staff and other personnel

- <u>Individualized care plans</u>
  - Activities for individuals and small groups
  - Nurse aides should know what each resident s/he cares for wants and needs
  - Resident should feel through involvement with care planning that her/his needs are met
  - Toileting and other daily routines based on life-long habits and the resident's needs, not on facility schedules

- <u>Environment is adjusted to the individual rather than vice versa</u>
  - Large range of adaptive equipment (extra high toilet seats, large handled eating utensils)
  - Variety of seating for all types of body frames (large, medium, small)
  - Wheelchairs which can be adapted to individualized needs
  - Low beds or padding beside beds

- <u>Evidence of resident choice</u>
  - Nursing assistants encourage residents to make choices
  - Choice on when to arise and retire
  - Choice of seating arrangements in the dining room

- <u>Teamwork</u>
  - Non-care-giving staff interact well with residents
  - Staff help each other
  - All disciplines are involved in care planning

- <u>Better care</u>
  - Lower incontinence
  - Reduced use of restraints
  - Better psychosocial condition
  - Increased mobility
  - Residents are engaged in individualized mobility programs
  - Few chairbound residents
  - Residents walk to meals

For more information, contact the National Citizens' Coalition for Nursing Home Reform:
1424 Sixteenth Street, N.W., Washington, D.C., 20036; (202) 797-0657.

RESIDENT ASSESSMENT

What the MDS Does to Assist in Meeting Residents' Needs:

- Gathers information about an individual's Customary Daily Routine prior to entering the nursing home to help the facility adapt to individual's needs rather than vice versa.

- Identifies problematic signs and symptoms on the admission page so staff are immediately alerted.

- Uses Cognitive Skills For Daily Decision Making to cue the staff to residents' abilities as they effect daily living and to the kind and amount of assistance which may be needed.

- Measures Activities of Daily Living (ADLs) Self-Performance and Continence with five levels ranging from independence to dependence to focus on strengths and needs for assistance.

- Tracks all appliances (not just glasses, teeth and hearing aids) used in all activities of daily living.

- Requires that residents be consulted in parts of the assessment like Potential for Self-Care.

- Facilitates individualized care with an extensive section on Behavior Patterns.

- Gathers detailed information on Activity Pursuit Patterns for individualized activity planning.

Issues for Advocates

- The MDS/Triggers/RAP requires interdisciplinary staff to gather much more detailed information for identification of resident strengths and needs. Facility staff may see the process as simply more paperwork. Advocates can reinforce the fact that individualized information fosters individualized care planning and more appropriate delivery of care to achieve maximum resident functional mental, physical, and psychosocial well-being and functional ability.

- Training is the key to successful assessment and care delivery. States and facilities will bear much of the responsibility for training facility staff and surveyors. Advocates should assist in finding sponsoring agencies for training surveyors and facility personnel together.

- The link between assessment, care planning and implementation must be a strong part of any training program organized by HCFA, state agencies or providers.

- Most of the field trials were done using only nurse assessors. It is strongly recommended that assessment and care planning be an interdisciplinary effort. Training should be targetted to the range of disciplines involved in assessment and set up using an interdisciplinary model.

- Residents and families also need to be informed about the resident assessment and their new oppportunity to participate in decisions about care. They may need assistance to voice their views. It will be important to make the link for residents and families between assessment and the requirements of the law for "highest practicable ... well-being" and quality of life.

- Given the extensive effort and resources expended on this instrument and its value in attaining quality of care and life for residents, urge states to use it rather than develop their own and work diligently to see that it is implemented in a way achieves that goal. It will give us consistency in data from state to state -- better national data for planning, deliverying and reimbursing quality services.

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Editorial

STANDARDIZED ASSESSMENT AS A MEANS RATHER THAN AN END

As part of its response to the Institute of Medicine report on regulating nursing homes (IOM, 1986), Congress passed the 1987 Omnibus Budget Reconciliation Act, which called for the establishment of a minimum data set for all nursing home assessments. Some harbor the hope that nursing home care can be revamped with the right form. Alas, it is hard to find such a panacea these days. The unlikelihood of miracles is not cause for pessimism, however. The work in progress to develop a standardized form for nursing home assessments described by John N. Morris and his colleagues in this issue represents a major step forward in improving care.

In considering minimum data sets, it is important to separate the necessary from the sufficient. Setting out a consistent set of questions to collect on each nursing home admission is a substantial step, but only if the information is both used and useful. Therefore, the investigators are to be congratulated for testing not only whether the assessment tool produces reliable results, but whether it is acceptable to those who must use it.

There is an inevitable battle around any minimum data set between those who view it as an opportunity to find out all they ever wanted to know about the subject but were afraid to ask, and those who recognize that less can often produce more when streamlined approaches reduce respondent burden. Furthermore, one must make an important distinction between data and information. Today, we are literally flooded with data but seem to have very little useful information (Wurman, 1989). A few questions well asked may be more useful than a litany of mindlessly recorded data.

The key to a successful information system goes beyond brevity. Data that are useful to the user is more likely to be collected well. If the major motivation for collecting the information is external regulatory pressure, we can expect paper compliance. If those collecting the data see that they are used by others to take actions that affect them, they will pay more heed to its collection. If they can see that it provides information to them directly, they may actually use it.

The system under development has the potential to succeed on all three fronts. At least part of the response to each goal lies in the use of more sophisticated information approaches, specifically the computer. (One might say that we are seeking electrical rather than paper compliance.) It is high time that long-term care began to aggressively use computer technology to improve itself. The computer can provide both the flexibility and the brevity sought by using branching logic to expand a category when there is reason to explore it more thoroughly. It can avoid duplication by displaying data already collected by others but still permitting the second observer to correct and challenge earlier entries. More important, it can display information to show change over time, thus permitting both the regulators and the caregivers to look at the effects of care.

Once the data are in electronic form, they are easily transmitted and manipulated. It is not hard to envision a large data set derived from these systematic observations that would permit calculations of expected courses for different types of long-term care clients. These could then be compared to individual client's courses to assess the potential impact of care on outcomes of importance.

The ability to compare observed and expected outcomes extends beyond its role as a regulatory device. It could be a major source of assistance to care givers. One of the great frustrations in long-term care, especially in the trenches, is the difficulty to sense when you are making a difference. Because so many clients enter care when they are already declining, the benefits of care are often best expressed as a slowing of that decline curve. Without some measure of expected course in the absence of good care, those who render care daily may not appreciate how much they are accomplishing and thereby may forgo one of the important rewards of their labors.

Simply displaying information about the change in client condition over time, a very simple task for a computer, will encourage those providing long-term care to think more in terms of change over time and less about a series of separate snapshots in time. Given the computer's ability to translate data into graphics, it is a simple procedure to develop pictorial representations of the changes that are occurring for a given client or a group of clients and to contrast those with what might be reasonably expected.

It is difficult not to become excited about the potential for an information revolution in long-term care. A standardized assessment is a big first step. If this program can be introduced as less a regulatory burden and more an opportunity to improve care by offering meaningful information to both the care providers and those responsible for oversight. If the information can be made available in a form that is readily understood and easily interpreted, it may be used for giving care as well as for measuring it. It is thus important to both make the medicine as unbitter as possible and to assure those for whom it is prescribed that it will truly improve their condition.

There is cause for optimism, but don't open the champagne yet. Better information around assessments is not a "just add water and stir" recipe for instant improvement. The full system must be developed to allow those who are charged with the responsibility for assessing clients to obtain meaningful data and to know how to handle that data to generate useful information. To achieve that step in improving nursing home care, we will need ongoing efforts to develop, demonstrate and teach creative use of information management in this setting. We have the chance to make a great leap forward. It would be a shame if we spent our efforts arguing about shoe sizes.

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In response to the Omnibus Reconciliation Act of 1987 mandate for the development of a national resident assessment system for nursing facilities, a consortium of professionals developed the first major component of this system, the Minimum Data Set (MDS) for Resident Assessment and Care Screening. A two-state field trial tested the reliability of individual assessment items, the overall performance of the instrument, and the time involved in its application. The trial demonstrated reasonable reliability for 55% of the items and pinpointed redundancy of items and initial design of scales. On the basis of these analyses and clinical input, 40% of the original items were kept, 20% dropped, and 40% altered. The MDS provides a structure and language in which to understand long-term care, design care plans, evaluate quality, and describe the nursing facility population for planning and policy efforts.

Key Words: Nursing facilities, Quality assurance, Long-term care

Designing the National Resident Assessment Instrument for Nursing Homes[1]

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Introduction

The provision of appropriate care in nursing facilities requires comprehensive knowledge of residents' strengths, weaknesses, and problems. As one feature of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Congress sought to ensure the availability of this information by mandating a national resident assessment system that includes a uniform set of items and definitions for assessing all residents in nursing facilities in this country. Under contract from the Health Care Financing Administration (HCFA), our research consortium, in conjunction with expert consultant and advisory panels, has begun to identify, develop, and test the central element of this system, the mandated Minimum Data Set (MDS) for Resident Assessment and Care Screening. This paper describes progress to date in creating the MDS, drawing on results of a two-state field trial. We describe the history and developmental process of the MDS, present findings for selected data elements, and provide a current draft version of the entire instrument.

Quality Assurance Concerns in Nursing Homes

As early as 1959, a Senate subcommittee identified problems of inadequate and inconsistent nursing home care, and a Health Education and Welfare investigation as well as a series of state studies in the early 1970s confirmed that the extent of compliance with extant regulations for care varied widely. In addition, existing certification regulations (the Conditions of Participation — those conditions that must be met for a nursing facility to participate in and receive reimbursement from Medicare or Medicaid) and the survey process placed more emphasis on a facility's capacity to provide required services than on the quality of services actually delivered (Institute of Medicine, 1986).

A series of legal actions in the late 1970s and early 1980s confirmed the responsibility of the Secretary of Health and Human Services (HHS) to ensure that certified nursing facilities meet regulatory standards (*Smith v. Heckler*, 1984). In addition, attempts by the Reagan Administration to reduce the regulatory burden on the nursing home industry generated considerable opposition among the elderly population and advocates for nursing home residents. Congress blocked the administration's proposed changes and directed HCFA to study how to improve nursing home regulation. In response, HCFA contracted with the Institute of Medicine (IOM) to con-

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[1] The work described here was performed under contract with the Health Care Financing Administration, contract no. 500-88-0055. The conclusions represent the opinions of the authors and do not represent any official opinion or endorsement by the Health Care Financing Administration. Address correspondence to John N. Morris, PhD, Department of Social Gerontological Research, Hebrew Rehabilitation Center for Aged, 1200 Centre Street, Boston, MA 02131.

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duct a study of existing regulations and to recommend changes that would enhance nursing facilities' ability to ensure satisfactory care for their residents. In addition, HCFA financed a number of demonstration projects to evaluate alternative regulatory approaches (Spector & Drugovich, 1989; Zimmerman et al., 1985; Glascock, 1985; Lee, 1984; Kurowski & Shaughnessy, 1983).

Responding to both *Smith v. Heckler* and the IOM findings (Institute of Medicine, 1986) HCFA developed proposed regulations revising both the Conditions of Participation for long-term care facilities and the procedures for their enforcement. These efforts resulted, in part, in a revised system for surveying nursing facilities to determine their compliance with the various Conditions of Participation (Spector & Drugovich, 1989). Congress also took up the IOM's challenge, and OBRA '87 mandated many of the IOM recommendations. The law incorporated new requirements for aide training, minimum registered nurse staffing, and assurance of quality of care, quality of life, and resident rights. One of the major reforms was the national system for assessing residents described here.

Role of Resident Assessment

The need for uniform resident assessment in long-term care had long been recognized (Kane & Kane, 1981; Katz, 1983; Katz & Stroud, 1989). Earlier, in 1980, HCFA published proposed regulations that, among other things, would have consolidated all resident care planning into a single Condition of Participation that also required interdisciplinary assessment teams. Although the Reagan Administration never implemented these proposed regulations, resident assessment reappeared as a major theme in the IOM deliberations.

The IOM appropriately identified uniform resident assessment as a cornerstone for efforts to improve quality and reform the survey process. As it noted:

> Providing high quality of care requires careful assessment of each resident's functional, medical, mental, and psychosocial status upon admission, and reassessment periodically thereafter, with change in status noted. . . . [The] development of individual plans of care clearly depends on resident assessments (Institute of Medicine, 1986, p. 74).

Prior to 1985, the certification survey system focused on a facility's written policies and structural procedures such as staffing levels — its potential to provide care. The proposed revisions redirect this focus to actual, observed care provided to the resident and resident outcomes. The data derived would enable the targeting of facilities and individual residents for more intensive survey, and the development and use of outcome measures to evaluate the quality of care provided to residents. The effectiveness of such an approach, however, depends on the reliability, specificity, and comprehensiveness of baseline and follow-up measures of residents' status.

OBRA '87 clearly acknowledged the importance of uniform resident assessment, requiring that the Secretary of HHS develop such an assessment process and implement it as a Condition of Participation for Medicare and Medicaid by October 1990. Under this legislative mandate, each certified facility must conduct a "comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacities." This comprehensive, multidimensional assessment is to be performed on admission and yearly thereafter, as well as "on significant change" in a resident's status. Although the Secretary may recommend a uniform assessment system, the states are given the option of developing their own assessment systems, provided that the Secretary finds that such alternative instruments conform with a "core" set of items and definitions.

In 1988, HCFA contracted with the Research Triangle Institute, Hebrew Rehabilitation Center for Aged, Brown University, and The University of Michigan to develop and evaluate a uniform resident assessment system. This effort led to the development of a resident assessment instrument to guide individualized resident care planning that consisted of two interrelated components. The first, the Minimum Data Set (MDS), contains the core items necessary for a comprehensive assessment of nursing facility residents. It also provides triggers (individual items or combinations of MDS elements) to identify residents for whom specific Resident Assessment Protocols (RAPs) — the second part of the system — will be completed. Each RAP is a structured framework for organizing MDS elements that can be used to inform the care planning process. The intent in developing these modules is education rather than "prescription." They provide additional assessment items and background information to develop a context in which information about residents, their strengths, preferences, and needs is linked to care plan options. Eighteen of these modules, ranging from communication to nutrition, are being constructed, reviewed, and revised.

The resident assessment system being developed includes the MDS, the care planning modules, training materials for use with the MDS, and surveyor protocols for evaluating assessments and care plans. We describe here principally the work performed in developing the MDS.

Methods and Procedures

Developing the Minimum Data Set

The development of the MDS has involved two major steps: development of the conceptual framework and draft instrument, and a basic reliability test of the instrument and training materials. Future activities will include more extensive field testing, design of data flow and systems, and implementation details.

There are four fundamental goals in the development of the MDS. First, the MDS should replace nonuniform and cursory assessment. Second, it should stimulate learning, change the ways in which many nursing homes use resident-specific information, and facilitate integration of assessment and care planning information. Third, it should lead to improved care planning and care provision, which, in turn, can enhance quality of life. Finally, its development process should serve as a model for the method by which it would continue to be updated in the future.

To accomplish these goals, the MDS not only describes the nursing needs of residents, but also must incorporate measures of their strengths and psychosocial needs in order to consider appropriately the whole person in care planning. Thus the MDS must incorporate measures of physical health, functional status, psychosocial well-being, dietary status, comprehension, vision, hearing, communication skills, activity preferences, potential for self-care improvement, and indicators of quality of life. In practice, the MDS should lead nursing home staff to a holistic view of residents, one in which strengths and needs in one area can be seen to affect, and be affected by, strengths and needs in other areas. The MDS thus highlights resident needs relevant both to current function and to the potential for maximizing functioning. The result is an instrument that is "minimal" in its content — capturing the core elements needed for a comprehensive assessment of an individual nursing home resident — but not small.

In developing the MDS, we addressed (as have other before us, e.g., Kane & Kane, 1981; Katz, 1983; Granger et al., 1975; Lawton & Brody, 1969; Mahoney & Barthel, 1965; Fillenbaum, 1988) a variety of conceptual issues that have potential implications for how the data will be collected and how it will be used. Principles that informed the development process include:

- Assess resident's performance and function, rather than potential function;
- Describe manifested conditions or behaviors (e.g., resident expresses sadness), rather than interpretations (e.g., resident feels sad);
- Provide time frames (e.g., "within last 7 days," "fell in past 30 days") for assessing the behavior or other condition;
- Count services as provided only if specified levels of intensity are met (e.g., physical, occupational, or speech therapies). Some services, such as chemotherapy, did not require such measures, as *any* provision would be significant;
- Include items that support common case-mix measurement systems based on resident characteristics (such as RUG-II [Schneider et al., 1988]).

The iterative process of MDS development began with the 13 domains specified in OBRA '87 as components of a comprehensive assessment: medically defined conditions and prior medical history, medical status, functional status, sensory and physical impairments, nutritional status and requirements, special treatments or procedures, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy (Department of Health and Human Services, 1989).

We reviewed over 60 assessment instruments developed for preadmission screening, state case-mix determination, nursing facility management, and research. Those that met criteria for comprehensiveness for most of the assessment domains mandated by OBRA were reviewed in depth to identify common domains, items, definitions, responses, and scoring patterns (Drugovich & Mor, 1989). Most instruments measured activities of daily living (ADLs), mobility, selected nursing care needs and services. However, few assessed behavioral disorders, mood disturbances, and cognitive functioning, and none addressed residents' preferences and involvement in activities. Consideration of the IOM, OBRA, and HCFA mandates for care planning led to the conclusion that no extant instrument could be recommended "as is" or simply modified to serve as the MDS.

The findings from this analysis informed the second stage of the development process, consisting of clinical deliberations and extensive review and revisions, leading to a draft MDS. In addition to project clinicians and researchers, we involved professionals from a spectrum of clinical disciplines, including nursing, social work, medicine, physical, occupational, and speech therapy, activities, and nutrition. Also represented were consumers, resident advocates, providers, industry representatives, regulators, and measurement specialists. These experts were assembled into a clinical consultant panel and an advisory committee, both of which were involved in each stage of the development process.

An extensive process of developing and reviewing multiple drafts of the MDS was undertaken, a process requiring 18 months to complete. Beginning with those mandated by OBRA '87, we identified domains that would appropriately describe a nursing home resident. Then, existing instruments were reviewed for relevant concepts, questions, response levels, and definitions. Where domains were new, we developed new questions, often assembling special work groups of professionals knowledgeable in the relevant areas. Newly developed individual items were often tested on actual care units. A series of drafts were reviewed by project staff, clinical panel members, advisory committee members, HCFA staff, and identified experts. The process led to additions, deletions, combinations, and revisions of domains and individual assessment items. To date, the MDS instrument has gone through over 20 major draft versions, has been commented on by over a hundred persons, and has been reviewed by literally hundreds more.

Small-Scale Trial

The second major step was to test in nursing facilities the feasibility of the MDS assessment process and the reliability of individual items. This small-scale trial also allowed the research team to evaluate the training materials, instructions, different concations were made in the item's phrasing, directions, or response categories to address the identified reliability problem.

Other analyses considered the length of time to complete the MDS, principally focused on the completion time for later cases, after assessors had performed several reviews.

Measuring Reliability

Three strategies are used to report interrater reliability in the literature: percentage agreement, association or correlation between the judgments of pairs of assessors for the same items, and measures of the degree of congruence between the assessments that adjust for chance errors (Winer, 1962; Fleiss, 1986). All three were employed in the analysis of the small-scale trial data.

Percentage of item agreement is calculated as the number of pairs of assessments of an item on the same resident that were the same, expressed as a percentage of all pairs in the reliability comparison sample.

Measures of association, or *correlation*, provide a more complex statistical description of the matching and mismatching of assessment pairs. In the case of dichotomous indicators of the presence or absence of a property, the Phi associative statistic was applied (Siegel, 1956). For numerical statistics (e.g., a count of the number of different drugs prescribed) it was more appropriate to use the Rho statistic (Siegel, 1956).

Measures of congruence are generally the most conservative indicators of reliability, because they penalize for the "chance" agreement arising from a poorly distributed variable. The Spearman Brown intraclass correlation coefficient was used as the measure of congruence between facility and project nurses. If an MDS item attained a value of .40 or higher, it was considered to be minimally reliable. This .40 criterion is somewhat lower than normally seen in purely research applications. It was considered appropriate for this trial, however, as the study design artificially lowered reliability by contrasting an "internal" and "external" nurses' assessments. An outside nurse, whether a researcher or the representative of a state regulatory agency, will not know as much about the resident nor to whom to turn for information about a resident's condition.

Results

The data collection targeted 400 residents in the 10 nursing facilities. The resulting sample was close to the total projected number (383) and to the designed distribution oversampling strata. The sample contained 70 new admissions, 113 special problem residents, and 200 current residents, compared with targets of 80, 120, and 200, respectively. From the variety of evaluations made possible by this data collection effort, we focus here on the sample of approximately 140 residents on whom we had double assessments — one by a facility nurse and one by a project nurse. These data were principally used to develop reliability estimates for MDS items.

Table 1. Resident Characteristics in Small-Scale Trial Samples, Compared with the 1985 National Nursing Home Survey

	Small-scale trial		
Variable	All[a]	Reliability[b]	NNHS[c]
Demographics			
Gender			
Female	74%	76%	72%
Male	26	24	28
Race ethnicity			
Black	[illegible]	8	[illegible]
White	90	91	92
Other	4	1	1
Nursing home utilization			
Previous stay in a nursing home in last 5 years	51	56	(NA)
Functional status			
Independent in:			
Bathing	9	8	11
Dressing	14	17	25
Grooming	17	21	(NA)
Transferring	31	35	40
Toileting	33	41	39
Locomotion	34	34	29
Eating	50	63	61
Continent of:			
Bladder	39	41	46[d]
Bowel	46	58	
Cognitive status			
Fully independent in decision making	33	44	38

[a]Full sample of small-scale trial (*N* = 383).

[b]Sample of 140 residents for whom two assessments were performed. Repor[illegible] is the average for all 280 observations.

[c]Source: 1985 National Nursing Home Survey (National Center for Health Statistics, 1989). As the MDS and the NNHS use different definition, these figures represent best estimates of item similarities.

[d]Continent of both bowel and bladder.

Comparability of Resident Sample

Table 1 compares the characteristics of our sample with the resident population of all nursing homes in the nation from the 1985 National Nursing Home Survey (NNHS) (National Center for Health Statistics, 1989). On the whole, the demographic characteristics of the residents in the two groups are similar. Although different definitions make precise comparisons difficult, the results generally reflect what one would expect. In comparison to the NNHS, our sample contains fewer residents who are independent in ADLs. Roughly 40% of the NNHS sample were independent in transferring and toileting, compared with about 30% of our sample. The results were similar for independence in eating: 60% for NNHS compared with 50% in our sample. Only 22% of our residents were completely free of cognitive problems, whereas one-third of the larger national sample were equally untroubled by mental disorders. It should be noted, however, that the small-scale trial sample was

Table 2. Reliability and Disposition of Items, by Domain

Domain	No. of items	NC[a]	Reliability range <.40	.40–.69	>.70	Disposition In	Drop	Alter
Background information	42	6	20	11	5	7	8	27
Diagnosis and areas of concern	39	4	11	14	10	23	7	9
Expressive cognitive patterns	19	3	3	8	4	10	4	5
Sensory patterns	13	4	6	1	2	3	3	7
Physical conditions related to ADL	4	0	2	2	0	0	1	3
Mobility	12	0	3	7	2	8	2	2
Dressing and hygiene	12	0	6	2	4	3	4	5
Eating nutrition	28	4	12	8	4	12	7	9
Elimination	23	4	7	6	6	11	6	6
Indicators of rehabilitation potential	7	0	4	3	0	1	2	4
Skin condition	10	0	4	3	3	7	0	3
Psychosocial well-being	19	0	12	7	0	3	5	11
Behavior patterns	20	2	9	8	1	5	3	12
Activity pursuit patterns	24	0	12	10	2	11	2	11
Medication use	4	0	0	2	2	4	0	0
Special treatments and procedures	8	2	3	2	1	5	2	1
Totals	284	29	114	94	47	113	56	115

Note. Domains listed are those in the instrument field tested and are not directly related to the domains of the revised MDS instrument in Appendix.

[a] Item reliability not computed due to low prevalence.

designed to identify particular types of residents in nursing homes and therefore prevalences may contain unexpected biases.

Reliability Tests

Reliability tests were performed on items in the 16 data domains of the original instrument. These domains are displayed in Table 2, together with summary statistics on the reliability results and final disposition of items. (After the field test, domains were rearranged and redefined. Thus the areas discussed follow the groups of questions in the revised rather than the original MDS instrument.) Over 55% of the items on the tested MDS achieved reliabilities of .40 or better. The scope of this article precludes a discussion of all MDS areas. (A copy of the full report on the small-scale trial of the MDS is available from the authors.) We discuss here the results for only three major groups of items as representative of the methodologies, findings, and interpretations of the small-scale trial. The chosen groups represent both an established area of inquiry (ADL) and two others that are more innovative (cognitive patterns and psychosocial well-being).

Activities of daily living. —The tested MDS included two measures of ADL. One indicated whether an ADL activity was performed, such as whether the resident was groomed or toileted. The second measured levels of performance in the ADLs, such as the ability to transfer from bed to chair. The results for these tests appear in Table 3.

The dichotomous measures of performance (such as whether residents groomed themselves), common in many assessment systems, did not perform well. Reliability coefficients for these items ranging from .32 for bed/chairfast in mobility down to −.15 for bedfast in transfer. It appears that these concepts, which focus on actions not taken, were not easy to translate accurately. In addition, the nurse assessors believed most of these were of little use in care planning. We decided provisionally to retain only bedfast, which achieved the best reliability and was important in care planning, in the next version of the MDS. It was redesigned so as to increase the reliability by providing a more precise behavioral description. No similar adjustments were seen for the other ADL dichotomous performance variables; thus, they were all dropped.

The multicategory performance items assessed resident self-performance of ADL functions over the prior 7-day period. Residents were assigned to one of five categories: independent, supervision (without hands-on care), limited assistance, extensive assistance, and total dependence. These multiple levels contrast with many assessment systems with fewer levels, often only a dichotomy.

All ADL performance measures (transfer, locomotion, grooming, bathing, dressing, and eating) were found to have high reliability levels of at least .75 (Table 3). Item definitions thus appeared to work well, and training materials were well received by field staff. Field staff also agreed that the ADL items were crucial to care planning and that multiple levels provided important descriptors of residents needs and status that were more helpful in identifying resident abilities and staffing needs. For example, the nurse assessors uniformly liked the availability of an ADL level for "supervision," for it permitted recognition of the significant time that can be spent on these activities. Information at this level of specificity was not consistently present in resident records, and interfacility differences occurred in perceptions regarding who were and were not "heavy care" patients.

Table 3. Reliability Statistics and Item Disposition for Activities of Daily Living

Variable	Association[c]	Reliability[d]	Prevalence[a] Reliability cases	All cases	Score agreement[b] Perfect	Within 1	Disposition[e]
Activity not performed							
Bedfast (transfer)	.06	-.15	6.9	12.1	86.2		Alter
Bed chairfast (locomotion)	.19	.32	10.8	19.8	84.3		Drop
Grooming	.00	-.07	7.6	7.6	92.4		Drop
Bathing	.00	-.07	7.6	7.0	92.4		Drop
Dressing (bedclothes)	.17	.23	14.8	21.4	78.0		Drop
No food fluids	.02	-.08	4.1	6.9	91.8		Drop
Self-performance level							
Transfer	.69	.81	65.2	68.7	53.9	83.6	Alter
Locomotion	.62	.76	65.6	65.6	46.3	82.9	Alter
Grooming	.62	.75	79.0	82.8	40.5	73.3	Alter
Bathing	.61	.76	92.1	91.3	38.6	84.1	Alter
Dressing	.63	.78	83.3	85.0	33.3	80.8	Alter[f]
Eating	.88	.80	37.3	50.4	55.2	89.6	Alter

[a] Prevalence is based on positive response, that is, the percentage of residents found to be in receipt of services or to have the appliance or to have the physical problem. For multicategory variables, the prevalence estimate equals the percentage who have the problems (e.g., are not independent in the ADL function).

[b] Percentage of all cases that agree either perfectly and, in cases of multiple categories, within adjacent categories.

[c] For multicategory variables, the associative statistic is Rho; for dichotomies, it is Phi.

[d] The reliability coefficient was Spearman Brown. For multicategory items, the associative statistic employed was Rho; for dichotomies, the associative statistic was Phi.

[e] Indicates whether, on the basis of small-scale trial, item was kept, altered, or dropped from the next MDS version.

[f] The revised MDS that is attached (see Appendix A) includes refined definitions for the five performance levels; it is felt that these refined coding options will lead to even higher levels of reliability.

Table 4. Reliability Statistics and Item Disposition for Cognitive Patterns

Variable	Association	Reliability	Prevalence[a] Reliability cases	All cases	Agreement	Disposition
Comatose	[b]	[b]	0.0	0.5	100.0	Alter
Memory	.55	.71	56.2	67.0	84.0	Alter
Memory recall problems						
Knows current season	.38	.55	42.9	43.1	69.3	In
Knows room location	.38	.55	31.5	36.0	73.2	In
Recognizes staff	.41	.58	22.0	23.5	79.5	In
Gives appropriate response to staff	.06	.10	15.7	19.3	74.8	Drop
Can identify family	.34	.50	6.3	8.5	92.1	Drop[c]
Is oriented to place	.39	.55	29.5	31.7	74.0	In
Recognizes self	.32	.48	10.2	8.8	87.4	Drop[c]
Cognitive skills deficit	.58	.73	54.5	78.4	88.6	In

[a] Prevalence is based on positive response, that is, the percentage of residents found to have the cognitive problem or capability. For multicategory variables, the prevalence estimate equals the percentage who have the problems (e.g., do not have full memory function). See Table 3 for definitions of other columns.

[b] Prevalence too low to calculate association or reliability.

[c] These two dropped items had good reliability statistics but were redundant with other items.

The result of these analyses and the debriefing comments was confirmation of the effectiveness of a five-category ADL scale for the performance of all the ADL functions. These questions constitute Section E of the revised MDS instrument (provided in Appendix).

Cognitive patterns. — These items in the MDS described residents' cognitive functioning, for example, as represented by memory or decision making (Table 4). On the MDS version that we tested, cognitive items were intertwined with expression patterns; these are separated into two sections on the new MDS.

Only 2 of the 383 sample residents were judged to be comatose, but neither was included in the reliability test. This item was retained despite its low prevalence due to its clinical importance in care planning. To ensure reliability, the question was altered to include a full definition.

Table 5. Reliability Statistics and Item Disposition for Psychosocial Well-Being

Variable	Association	Reliability	Prevalence[a]		Agreement	Disposition
			Reliability cases	All cases		
Relationships						
Loves family friend	31	44	80.2	75.1	77.1	Alter
Conflict with family	10	18	5.3	6.2	90.8	Drop
Conflict with staff	18	32	18.1	13.6	75.6	Alter
Conflict with residents	24	38	9.9	8.8	86.3	Alter
Contacts family friends	23	38	9.9	9.3	86.3	Alter
Interacts easily	29	44	55.3	51.6	64.1	Alter
Roommate incompatible	13	23	4.6	4.5	92.4	Alter
Avoids interactions	32	48	17.6	13.2	80.2	In
Attitude toward own life						
Grief apparent	10	.18	11.5	13.9	81.7	Alter
Satisfaction with self	.04	09	41.6	35.1	53.4	Alter
Concern with health	.27	42	22.9	24.1	74.0	Alter[b]
Unresolved feel in past	03	− 08	4.2	6.8	91.6	Drop
Feels cut off from past	.09	11	6.5	8.2	88.5	Alter
Sense of purpose goals						
Establishes own goals	.35	51	23.3	20.7	76.3	In
Involved in facility life	.25	.41	40.1	35.7	64.1	Alter[b]
Expresses need without conflict	.18	.30	51.1	46.5	58.8	Drop
Aggressive about needs	.04	.06	16.4	17.0	73.3	Drop
Resists responsibility	.46	63	13.0	10.2	87.8	In
Goals at odds with staff	.20	.24	10.3	6.8	84.0	Drop

[a] Prevalence is based on positive response, that is, the percentage of residents found with the indicated characteristic. See Table 3 for definitions of other columns

[b] Reliability values for the long form reliability cases were significantly higher — for "loves family friend," .62; for "conflict with staff," .49, for "conflict with residents," .60, for "concern with health," .71, for "involved in facility life," .51.

The four-level item that describes memory, the ability of the resident to recall what was learned or known, was reliable (.71) and was only slightly modified to eliminate confusion in the question between short- and long-term memory. Reasonable reliabilities (at least .48) were exhibited by six of the seven items assessing the areas in which memory problems were seen. Of the remaining six reliable items, two ("identification of family" and "recognizes self in mirror") were dropped as they were redundant to the remaining four (the K.R. alpha reliability values for a four- and six-item scales were almost the same, at .80). The sole unreliable item, "how to respond to staff," was also highly correlated with the remaining items, and was dropped.

Finally, the variable providing four levels describing a resident's ability to make consistent and reliable decisions (see Appendix, Section B) was reliable (.73); it was retained.

Psychosocial well-being. — This domain relates to resident happiness, sense of control over one's life, meaningful social involvement, and satisfaction with self (see Table 5 for individual items tested). In developing this set of items, we sought to capture both resident strengths and problems. A particular goal was to develop measures of well-being, an effort strongly endorsed by resident advocates and central to the project team's philosophy.

A major task in the analyses was to determine whether a useful summary index of resident strengths could be created. Therefore, decisions to retain the draft MDS items in this domain were governed by three factors: 1) individual item reliability for the entire comparison sample; 2) item reliability for the subset of comparison cases scored with a long form of the MDS that included every possible definition as opposed to a shorter version that included only more abbreviated information (there were few differences in reliabilities based on the two forms; this issue is discussed in some detail in the full report of the small-scale trial); and 3) a variety of results from procedures employed to determine how items in this domain combined to form internally consistent summary scales (including results derived from factor analyses, K.R. 20 alpha reliability assessments, scale intercorrelations, and Spearman Brown values for the summary scales).

Of the 19 items designed to assess aspects of psychosocial well-being, seven achieved reliability coefficients of .40 or better, with two more only slightly poorer, at .38 (Table 5). Another item was reliable when presented in less abbreviated format ("conflict with staff," at .49). All of these items were retained, although some have been revised based on conversations with the assessors of the small-scale trial.

These analyses, coupled with the advice of a panel of experts in this particular area, led to a new set of three organizing concepts for this area. These include: resident's initiative and involvement in life; resident's relationship with staff, other residents, and family; and basic attitudes describing satisfaction with the life the resident is experiencing, including measures of grief over losses, satisfaction in role status, and boredom with life. In our modifications, we attempted to identify items to explicate these concepts by choosing those already found to be reliable by modifying others that were appropriate but less reliable, or by creating new items. All will be subjected to future testing for reliability.

Our analyses identified a single, reliable summary scale encompassing six items that characterizes the resident's level of initiative and involvement in the institutional environment:

Initiative Scale Items (count of positive responses)
- Easy interactions with others
- Avoids interactions with others
- Establishes own goals
- Pursues involvement in life of facility
- Resists responsibility
- Accepts invitations into most group activities

In scaling the second and fifth items, scoring is reversed so as to be consistent with the other positively phrased items. The first five items tested well for reliability, although two were altered slightly based on assessors' feedback. To these we added the final item, which is new and experimental, but was often identified in the debriefings as important. The new scale has a Spearman Brown reliability of .64 and K.R. 20 alpha reliability values of .61 for cases assessed by project nurses and .70 for cases assessed by facility nurses. For our reliability sample, using scores of the facility nurse as the standard, 15% of cases are in the two lowest categories of the five-item scale (reflecting those who are least in control of their lives in the facility), 50% are in the two middle categories, and 35% are in the two highest (or best control) categories. The availability of such a scale for psychosocial well-being (and we are hopeful that further research will identify additional scales) avoids the "laundry list" problem of many assessment instruments.

The two other new areas of psychosocial well-being were more complex, as no scale was identified. In describing resident relationships, the item "conflict with family," with reliability coefficient .18, was dropped. The remaining five items (exclusive of the two incorporated into the scale above) were altered in language with the goal of improving future reliability. For example, rather than ask whether the resident had conflict with staff, we now ask more specifically for overt or covert conflict or repeated criticism of staff. In the second group of items describing attitude, all but one item was retained in an altered form, and a new item was also added: loss of significant other within the year. Similarly, substantially altered items now constitute the third section, with the addition of a question indicating identification with past role. The final version of the questions now comprise Section G of the MDS (Appendix).

Overall, the measures of psychosocial well-being, although experimental, were considered some of the most important in the MDS by practitioners. In the debriefing, these assessment items were frequently identified as providing an opportunity for the assessment nurse to talk with the resident and to address an important domain critical to quality care.

Time to Complete an MDS Assessment

We analyzed the time required to complete the MDS, based on the experience of the 20 nurse assessors participating in the small-scale trial. Each nurse completed MDS assessments for approximately 27 randomly assigned cases. The assessments all included review of resident records, interviews of residents and direct care and clinical staff, and extensive referencing of the MDS definitions and coding examples. For the first third of the cases, nurses averaged 129 minutes per assessment. The average time per assessment dropped to 100 minutes for the next third of their cases, and to 90 minutes for the final one-third. For the last few cases, the assessors estimated that an average case would be completed in 1 hour and 20 minutes. The data suggest that after only 18 assessments, assessors had reached the plateau of the "learning curve."

We also asked the nurse assessors how much time the MDS added to the normal assessment process at the facility, and whether they thought the additional assessment time was worthwhile. In general, they reported that the MDS added approximately 30 minutes to the normal assessment time. Although most (58%) thought that this was somewhat longer than the regular assessment, 17% said that it was significantly longer, and 25% said that it was about the same. They noted that in completing the MDS, they talked with both residents and nursing aides, whereas the normal assessment process in these facilities did not necessarily entail such interviews. All the nurses said this was essential, some noting the importance of including aides in the assessment process because only they had some of the firsthand, detailed information required. Nurse assessors also mentioned the psychological boost the aides seemed to get from being asked about the residents for whom they care.

With only minor exceptions, the nurse assessors described the value of the incremental assessment time in very positive terms. Of 15 who responded, 10 said the extra time was definitely worthwhile, four said it was probably worthwhile, and only one considered the extra time not worthwhile. Most nurses also felt that the MDS covered relevant domains more comprehensively than did their existing protocols and felt that these domains were important for developing appropriate care plans. The areas most frequently cited as being more comprehensively covered in the MDS included: cognition (except on Alzheimer's units), customary routines, psychosocial well-being, behavior patterns, advanced directives, indicators of rehabilitation potential, modes of expression, vision, oral status problems, height, weight, and restraints.

Discussion

The criteria and methods described earlier for three domains were applied to the entire original MDS instrument. On this basis, 40% of the items were rated reliable and will be retained in their current form. The remaining items include 20% that were dropped and 40% that were altered (Table 2). These changes have resulted in a significantly modified and greatly strengthened MDS (see Appendix). This final instrument has been subjected to additional reliability testing and has been proposed for designation by the Secretary of HHS.

In terms of the resources necessary to complete the assessment, the results of the small-scale trial support the contention that the MDS is a feasible system for use in nursing facilities. Good progress has been made in defining items that are acceptable to nursing staff and in implementing a process that brings together both residents and all the staff that care for them. Our initial efforts have resulted in items and definitions that have met with wide acceptance and high levels of reliability.

Some of the elements now contained in the MDS represent refinements and better delimitations of existing concepts, such as the ADLs discussed in this paper. We have made significant progress in defining a usable five-category assignment system, one that does not require continual reference to a litany of examples. As a second example, we are providing better delimitation for diagnoses (i.e., that they be relevant to the care the resident receives). Other domains such as cognitive patterns had surprisingly high reliabilities in their current form. These offer exciting possibilities to screen uniformly for cognitive problems. Still other domains represent less well-defined areas: psychosocial behavior, customary routine, rehabilitation potential, and the like. Here, high reliabilities are more difficult to obtain, but the importance of these items was universally supported by our consultants, advisors, and nurse assessors. They indicated that this type of information and the types of operational measures provided in the MDS are crucial to care planning and provide an important stimulus for staff to talk to the individual resident. We expect that these elements as well as the resident assessment protocols currently under development will continue to see modification as we further test the instrument in practical settings.

In the broader view, there is enormous potential for a computer-based implementations of the resident assessment process. Not only can such implementation aid in accurate data collection, for example by providing easily accessed definitions and preliminary data checks, but also it can be designed to identify patterns of deficits or strengths and assist in triggering the need for care planning. Beyond nursing homes, the MDS may see applications in other sectors, such as assessment of less disabled persons at home or as a screening tool for nursing home admission.

Refinement to the MDS will not stop when it is implemented as the national assessment instrument in October 1990. We have recommended that any assessment instrument must continue to incorporate new approaches, be tested, and change. The process, however, will maintain its mandate to bring residents into the decision process and increase their control of their care and treatment. The MDS should simplify the transfer of knowledge concerning strategies for caring for frail residents, the re-education of staff moving between facilities, the establishment of a broad market within which the private sector can generate unique and innovative care planning and computer-based information systems, and the development of a comprehensive picture of the nursing home population on which to make planning and policy decisions.

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PATIENT CARE TECHNIQUES

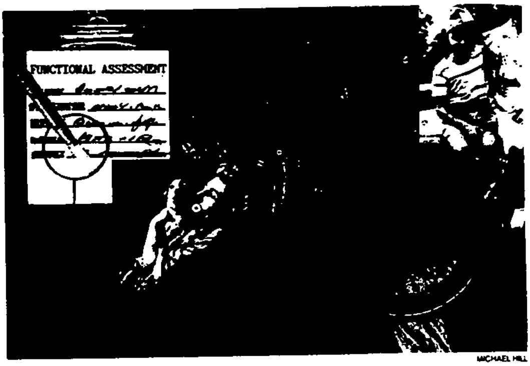
Comprehensive Resident Assessment Holds Promise

Katharine Murphy

A therapeutic milieu that fosters maximization of an individual's potential for self-care, decision-making, interpersonal relationships, and personal growth is the hallmark of long term care. The cornerstone for creating such an environment lies not only in motivated caregivers, the philosophy of care, and availability of resources, but also on the clinical assessment of each resident's functional capacity, health care needs, and personal wishes regarding autonomy, lifestyle, and treatment options.

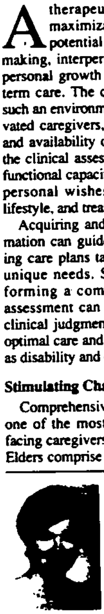
Acquiring and synthesizing this information can guide caregivers in developing care plans tailored to an individual's unique needs. Spending the time performing a comprehensive functional assessment can help diminish errors in clinical judgment that often lead to suboptimal care and negative outcomes, such as disability and dependency.

Stimulating Challenge



MICHAEL HILL

Comprehensive resident assessment is one of the most stimulating challenges facing caregivers in nursing homes today. Elders comprise a widely diverse population with significant variations in their individual responses to the physiologic and psychosocial impacts of aging, morbidity, and therapeutic regimens. Disease manifestations in old age are often different from the classic textbook presentations that clinicians associate with the general adult population.



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Frequently, the existence of one or more underlying chronic diseases complicates evaluations. This can be illustrated by considering the following two examples. An otherwise healthy, 40-year-old woman experiencing symptoms of urinary urgency, frequency, and dysuria is most likely suffering from a urinary tract infection; the symptoms are so characteristic that she probably inferred the diagnosis herself before consulting her physician. However, the presence of a urinary tract infection may not be so apparent in a 95-year-old nursing home resident with Alzheimer's disease, who is unable to discern and articulate the physical changes in her body. This resident may have more general signs and symptoms of disease related to alteration in functional abilities—e.g., increased confusion, restlessness, urinary incontinence, self-care deficits—signs that are likely to be the norm in frail, confused elders. The cause of the functional impairment is not readily identifiable, as these signs and symptoms could be related to any number of physical, emotional, social, or iatrogenic disorders.

The challenge to the caregiver is on early detection of functional impairment and systematic exploration of its underlying cause(s) in order to identify treatable conditions and restore function. In striving to improve the quality of life of older persons, the traditional "disease-oriented" approach to assessment many caregivers learned in school serves them less well than a more holistic approach based on knowledge of the functional impact of aging and disease.

Improving the long term care delivery system's ability to respond to the needs of the elderly was a major objective of the Omnibus Budget Reconciliation Act of 1987 (OBRA). Development of a usable, holistic, clinically relevant system of resident assessment to inform and guide care planning in long term care facilities is but one of a wide range of approaches mandated by OBRA.

OBRA-Mandated MDS

The Minimum Data Set (MDS) is an essential element of this assessment system. Through a contract with the Health Care Financing Administration (HCFA), the MDS is being prepared by Research Triangle Institute, in collaboration with Hebrew Rehabilitation Center for Aged, Brown University Center for Gerontology and Health Care Research, University of Michigan Institute on Gerontology. The conceptual development process of the MDS has been characterized by extensive and intensive review and revision by clinical experts in geriatric nursing, medicine, psychiatry, social work, rehabilitation, Alzheimer's disease, and mental retardation, assisted by an advisory committee of 25 representatives from organizations working to maximize quality in long term care.

Currently, the draft MDS has been field-tested in five nursing homes in Massachusetts and five in North Carolina. This trial is one of the first of many steps in the effort to produce a reliable assessment tool that allows nursing home staff to assess residents accurately, comprehensively, and consistently from a functional perspective.

Conceptually, use of a standardized Minimum Data Set to assess residents periodically should provide caregivers with a longitudinal perspective of a resident's unique strengths, limitations, and needs. Variations in an elder's functional abilities from the initial assessment (usually upon admission to a long term care facility) can be readily identified. In most assessment systems, when problems and needs of an individual resident are noted, it is the responsibility of the caregiver(s) or primary care team to formulate a plan of care to address those needs and to modify the approach if and when needs change.

Not Keeping Pace

This type of approach relies heavily on the premise that all caregivers responsible for decisionmaking and care planning have expertise in gerontology and geriatrics. The fact is, however, that the dramatic demographic shift toward old age and increasing demand for quality services has overtaken the number of trained caregivers available: there are too few health professionals with formal training in geriatrics, particularly with the special skills required for proper evaluation and treatment of frail elders in long term care settings (e.g., dealing with confused residents exhibiting difficult behaviors, determining less restrictive alternatives to use of restraints).

From a nursing education perspective —preparation of the majority of care planners in nursing homes—gerontological components of basic nursing programs have traditionally been weak. This is not surprising when one considers that only 30 percent of nursing faculty have had any formal preparation in care of the elderly. Nationally, programs with specialization in gerontological nursing are offered in only half of the states. It is no wonder that, as of October 1988, less than one percent of the 980,000 practicing nurses nationwide have ANA certification in gerontological nursing.

Although this statistic is disappointing to those concerned with improving the quality of long term care, it does reflect a 50 percent increase since March 1985, giving caregivers hope for further advancement and trends in the field. However, until that future can be realized, creative, viable alternatives to formal geriatric education of caregivers must be explored and implemented.

One approach to augment this need is being developed by the research team responsible for HCFA's MDS project. They are preparing 20 resident assessment care planning modules which may be used in conjunction with the MDS in an attempt to guide comprehensive care planning. The MDS will serve as a screening instrument to ascertain a resident's functional needs. For clinical purposes, however, caregivers may require more information about the problems they identify via this instrument before proceeding to develop a care plan.

Comprehensive resident assessment care planning modules that could be used when functional deficits are found may ease that transition between identification and treatment of conditions requiring attention. In essence, these modules would provide staff with information critical for performing a more in-depth assessment. Focused on functional deficits and relevant resident strengths, they will be geared to offer realistic, flexible treatment options. Using these modules, nursing professionals with little formal education in clinical geriatrics could become more proficient and confident in the care planning decisions they make.

Subjects addressed by these modules were selected from the February 1989 *Federal Register's* list of quality long term care indicators. These subjects present risks and problems common to residents in long term care facilities (e.g., ADL impairments, sensory deficits, alterations in hydration and nutrition, pressure sores, urinary incontinence, use of psychoactive drugs and restraints). The wide variability in the characteristics of residents and the distinct differences in the nature of long term care settings determine how these modules are developed.

No 'Cookbook' Approach

Given this working principle, it would be virtually impossible for creators of the modules to deliver a prescriptive "cookbook" approach to care. Rather, their approach focuses on helping nursing home staff to interpret and integrate information that they have assembled and upon which they must base clinical decisions, and to select from among many alternative treatment interventions. The objectives of this assessment and care planning process would be threefold: to assist staff in approaching their clinical decisions with greater objectivity and clarity; to provide caregivers with some of the nuances specific to clinical geriatrics; and, ultimately, to enhance the quality of care nursing home residents receive.

The development process utilized for the resident assessment modules is similar to that of the MDS. Each module is based on an extensive literature review of the given subject along assessment, current problem, and care planning parameters. This is followed by clinical specification by successive teams of multidisciplinary experts on that particular subject.

Each module is then critically reviewed and revised by clinical and nursing home experts from around the country. All modules will then be reviewed for consistency, flexibility, accuracy, and reasonableness by a panel consisting of representatives from the nursing home industry, the American Nurses' Association, and geriatric medicine. Ultimately, the modules will be field-tested for reliability in 10 states in the fall of 1989. The target date of implementation is October 1990.

The fields of gerontology, geriatrics, and long term care are changing rapidly. The MDS and Resident Assessment Planning modules will serve to enhance the quality of care in nursing homes by providing the means for comprehensive assessment of individual needs and by offering flexible, realistic treatment strategies. In addition, this effort can expand critical and creative thinking by health care professionals, educators, administrators, researchers, and policymakers in seeking innovative solutions to difficult challenges. ■

RESTORING IDENTITY TO SOCIALLY DEPRIVED AND DEPERSONALIZED OLDER PEOPLE

Helen M. Gossett*

It is far from pleasant to realize that the older person who is institutionalized because of handicap or debility endures his final living years in an impoverished environment of social deprivation, suffering serious depersonalization. These are really mild words for the shattering experience imposed, generally without choice, upon this segment of our older population. They deserve more than this from society.

The plight of the aging and the truly aged person (for plight it is) does not start in the nursing home, it only ends there. How does he get there? What is the path to the door? Generally, there is a gradual progression of losses, diminution of strengths, decreasing opportunities for meaningful and restorative personal and social experiences and increased isolation. As self-sufficiency decreases, there is less opportunity for continued living in the community. Society has not yet stepped in to replace and provide those supports and services which once came from the family and the neighborhood. Generally, the family, the supporting agency or a hospital through its physician and social workers, step in and decide that the older person can no longer adequately care for himself or be cared for in the community. When the long-term care institution is chosen as an alternative to continued living alone or with his family, it is often not the best solution, but the only one.

The decision for the initial nursing home placement generally is made for the older person. It is generally his first major loss of autonomy and self-direction -- his destiny is taken out of his own hands. This is also the time he loses an important anchor in life, his home, with all the small (and great) mementos of his past. Sometimes it is the room which he has occupied in a relative's home, which all too soon is put to other use. Frequently deceit is used, misrepresentation or no information at all given to the person to be taken or transferred to the nursing home.

In contrast to the person entering a hospital, who has a socially acceptable physical ailment, the nursing home admittant has no respectable symptom except "failure." Forcibly excluded from the community, he is a reject from society, economically expendable; no longer economically or socially productive.

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* Gossett was Director of Nursing Home Project, United Hospital Fund of New York. Her paper was delivered at the Fall Membership Meeting of the Community Council's Citizens Committee on Aging, October 20, 1966. The preceeding is an excerpt from her paper.

If he is accompanied to the nursing home by a relative, the chances are he sits silently by, while he is discussed as if he were a deaf mute or a nonentity. Although this may be his only residence henceforth, he is escorted to his room without an introduction to the many "strangers" he encounters. Although he has just entered the door, he has already had taken from him much of his self-respect and feelings of worth. There is soon also the dawning realization that he has lost his "home" -- that there can be no future-oriented plan (or dream) of ever returning to familiar surroundings. There is also at this time the growing realization, when the family has made the institutional placement, that the choice has been made between caring for the older person and some other family interest or obligation. In being denied preference, the older person has been, in essence, rejected by his family.

In coming into the institution, confronted suddenly with large numbers of older persons (some of whom may be incontinent, out of contact, visibly depressed), the new resident, for a brief moment, at least, faces this mirror of himself, these "others" who will be his only peers from this point on.

It is easy to see that the person who enters a long-term care institution suffers a severe loss with considerable damage to his self-esteem and feelings of worth.

Actually, we all suffer losses and changes in status throughout life, but use other life experiences to compensate. We thus restore our balance. Because of the nature of the experience of being institutionalized, with its traumatic separation from usual ways of living, the person entering a long-term care facility is in more urgent need of assistance from the institutional community in regaining his personal and social equilibrium than he may need from other types of institutions such as hospitals and homes for the aged. These supports need to be similar to those usually received from family, friends and neighbors; and the environment needs to approximate living at home to the degree this is possible in an institution.

We have found that the most prevailing problem of the resident of long-term care institutions is deterioration: there is apathy, withdrawal, isolation; loss of motivation; confusion and disorientation; depression and regression.

If one attempts to analyze the situation of long-term care residents to seek factors that might have contributed to this deterioration, in addition to the experiences we have already mentioned, one might consider some of the following observations: There are many reminders that one is living in a medical setting -- that one is ill: staff uniforms, nursing stations, bedpans or urinals beside each bed, hospital-type furniture, etc.

There are few homey touches, as plants, homelike furniture, rugs, pictures on the walls, personal belongings.

We observe most residents sitting in chairs, doing nothing. There is nothing to do; no place to go. One gets the impression of individual social isolation. We have been surprised that

residents pay very little attention to one another, whether they are in their own rooms, in the halls, recreation area or in the dining room, although there is good communication with staff.

Lack of privacy is extensive both in rooms and elsewhere. Residents are always in full view of their roommates. Toilet facilities have no locks, and no way to signal occupancy; private conversations with relative or friends are relatively impossible.

We see few books, newspapers or magazines. In the rooms there are no calendars, clocks and very few radios.

It is rare to hear a resident called other than by his first name, by all levels of staff. He is often discussed as if not present, or ignored as if he were not there. The tone and manner of speaking to him are often that which one uses to a child.

Residents are directed in all things, and live by institutional routines. There is little opportunity to exercise choice. Of necessity it is a regimental existence.

To state it baldly, the only role a resident has is the submissive, sick role; the only privacy is in his mind; the only choice may be which side he will sleep on at night, the only certain future is death.

This is a brief overview, but it is easy to see that there is an anonymity to the institutionalized aged with a monotonous marking of time.

Today it is fairly well-accepted that for the body to remain functioning it must be exercised -- there is less recognition that to remain alert, motivated, socially functioning, one needs to exercise personal and social functions to get feedback from others and know that one is a particular individual.

These following social needs are interrelated and form a complex whole -- which is the Self, living and acting in a social context, with integrity, individuality and significance for oneself and others.

The first of these if the need for CONTINUITY OF LIFE EXPERIENCE, which means maintaining a thread to the "past," a "living present" and "a future" to move toward. Where ties to the past have been surgically cut through loss of family, friends, home and possessions, a nurturing channel can be made through familiar cultural rites, revival of skills and interests, and by recognition and acknowledgement of past achievements.

A future to move toward may at first seem difficult to attain, in our achievement-oriented society. However, what is the real essence of looking toward the future? It is involvement with a dynamic present which is in process of change. Included here is interest in the community, the United States, the world-- the ongoing nature of life; movements, social change, society's pathology, the elections, the world series, the races, the weather, seasonal changes, holidays, etc.

The second is IDENTITY, per se: who one is the most important element of identity, those facets and characteristics which make one a unique individual. Not the least of these is one's surname -- and Mrs. or Miss -- or other title, as "doctor" -- it is our social "status" symbol. There is much identifying data which is not customarily confidential, which can individualize a person and which when known by others, can begin to delineate him as a particular individual, with bonds in common as well as differences from others. One has to think of what goes into individuality: work, skills, artistic ability, marital status, achievement of forebears and descendants, interests, hobbies, political opinions, philosophy of life. One sociologist has said that when one moves from one town to another, one arrives as a nonentity, and has to make oneself known, sometimes even aggressively stating who and what one is, before social communication and security (comfortableness) can be attained. This is true for those entering an institution.

The third is INDEPENDENCE: This includes freedom of movement and the basic rights guaranteed by the Constitution-- and these are guaranteed to the aged person unless he has been legally declared incompetent; spontaneity (within the law and the rights of others); self-direction, opportunity for choice. This includes the right to open one's mail, freedom of movement without permission.

The fourth is PRIVACY. And in congregate living this is difficult. But there are such things as cards denoting occupancy of a toilet, for example; bed screens when privacy is considered important; and there is always privacy of mind, the most precious asset of us all which needs to be respected. For this reason we have not invaded the privacy of the past with routine formal studies of life histories.

The fifth is STABILITY -- a nucleus of certainty, an anchorage of security, the things in life we can count on. One of these is a "home base." Although the long-term care institution is the only "home" of the majority of its residents, there is not the security of being sure of having a particular bed, or room,, or even institution. When hospitalization is required, even if one later returns to the same home, the chances of being returned to the same room are very slight. Sometimes rooms are rearranged for administrative purposes. Clothing may be lost in the laundry. Possessions may be taken. There is little that is one's "own." There can be some lessening of insecurity if changes (as of rooms) are anticipated with the resident before these occur. He may be just as upset, but his feeling of confidence in the institution will be greater. Possessions could be safeguarded by having locked lockers, as some homes do have.

The sixth is MEANINGFUL LIVING. The resident has nothing expected of him, no task, no responsibility, is not "productive" in any sense. In one home, a small group of women residents prepare the fresh vegetables for cooking, in another a resident takes care of the garden, a few residents make their own beds. These are all part of traditional living at home. In contrast to passive living, residents need to be encouraged to participate in the preparations for parties and holiday festivities.

The last of the personal and social needs is the will to live -- a "REASON FOR BEING." We have defined the essence of this as one's meaning something to someone else -- to someone in one's family, neighborhood or group.

Residents can assist one another, and do; but this needs to be fostered, encouraged and given recognition. There are few residents of nursing homes who could look around without seeing someone who needs them. This may be formalized through a resident volunteer program.

These are all antidotes to withdrawal and deterioration. These remedies are simple but require total institutional staff participation. And staff participation depends on the conviction that these needs are essential.

We think we have found some of the answers. We are implementing them now. We feel optimistic because the problem is not unsolvable.

RESIDENT ASSESSMENT
THE SPRINGBOARD TO QUALITY OF CARE AND QUALITY OF LIFE FOR NURSING HOME RESIDENTS

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PART 2—MEDICAID PROGRAM

SEC. 4211. REQUIREMENTS FOR NURSING FACILITIES.

“(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

“(1) QUALITY OF LIFE.—

“(A) IN GENERAL.—*A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.*

“(B) QUALITY ASSESSMENT AND ASSURANCE.—*A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies.*

“(2) SCOPE OF SERVICES AND ACTIVITIES UNDER PLAN OF CARE.—*A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which—*

“(A) *describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;*

“(B) *is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and*

“(C) *is periodically reviewed and revised by such team after each assessment under paragraph (3).*

“(3) RESIDENTS' ASSESSMENT.—

“(A) REQUIREMENT.—*A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—*

“(i) *describes the resident's capability to perform daily life functions and significant impairments in functional capacity;*

“(ii) *is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);*

“(iii) *in the case of a resident eligible for benefits under this title, uses an instrument which is specified by the State under subsection (e)(5); and*

“(iv) *in the case of a resident eligible for benefits under part A of title XVIII, includes the identification of medical problems.*

“(B) CERTIFICATION.—

“(i) IN GENERAL.—*Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.*

“(ii) PENALTY FOR FALSIFICATION.—

“(I) *An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment*

"(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

"(III) The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1128A.

"(iii) USE OF INDEPENDENT ASSESSORS.—If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

"(C) FREQUENCY.—

"(i) IN GENERAL.—Such an assessment must be conducted—

"(I) promptly upon (but no later than 4 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

"(II) promptly after a significant change in the resident's physical or mental condition; and

"(III) in no case less often than once every 12 months.

"(ii) RESIDENT REVIEW.—The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

"(D) USE.—The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

"(E) COORDINATION.—Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

"(F) REQUIREMENTS RELATING TO PREADMISSION SCREENING FOR MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS.—A nursing facility must not admit, on or after January 1, 1989, any new resident who—

"(i) is mentally ill (as defined in subsection (e)(7)(G)(i)) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental illness, or

"(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii)) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental retardation.

"(4) PROVISION OF SERVICES AND ACTIVITIES.—

"(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

"(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

"(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

"(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

"(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

"(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident; and

"(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident.

The services provided or arranged by the facility must meet professional standards of quality.

"(B) QUALIFIED PERSONS PROVIDING SERVICES.—Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

"(e) <u>State Requirements Relating to Nursing Facility Requirements</u>.—As a condition of approval its plan under this title, a State must provide for the following:

* * *

"<u>(5) Specification of resident assessment instrument</u>.—Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

"(A) one of the instruments designated under subsection (f)(6)(B), or

"(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

"(f) <u>Responsibilities of Secretary Relating to Nursing Facility Requirements</u>.—

"<u>(6) Specification of resident assessment data set and instruments</u>.—The Secretary shall—

"(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

"(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

"(g) <u>Survey and Certification Process</u>.—

"<u>(2) Surveys</u>.—

"(A) <u>Annual standard survey</u>.—

"(i) <u>In general</u>.—Each nursing facility shall be subject to an standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1128A. The Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

"(ii) <u>Contents</u>.—Each standard survey shall include, for a case-mix stratified sample of residents—

"(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

"(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

"(III) a review of compliance with residents' rights under subsection (c).

"(B) <u>Extended surveys</u>.—

"(i) <u>In general</u>.—Each nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

"(ii) <u>Timing</u>.—The extended survey shall be conducted immediately after the standard survey (or, if not practical, not later than 2 weeks after the date of completion of the standard survey).

"(iii) <u>Contents</u>.—In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

§ 483.10 Level A requirement: Resident rights.

(d) *Level B requirement: Free choice.* The resident has the right to—

(1) Choose a personal attending physician;

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

§ 483.15 Level A requirement: Quality of life.

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

(a) *Level B requirement: Dignity.* The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(b) *Level B requirement: Self-determination and participation.* The resident has the right to—

(1) Choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care;

(2) Interact with members of the community both inside and outside the facility; and

(3) Make choices about aspects of his or her life in the facility that are significant to the resident.

(e) *Level B requirement: Accommodation of needs.* A resident has the right to—

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

(2) Receive notice before the resident's room or roommate in the facility is changed.

§ 483.20 Level A requirement: Resident assessment.

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(a) *Level B requirement: Admission orders.* At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

(b) *Standard: Comprehensive assessments.*

(1) The facility must make a comprehensive assessment of a resident's needs, which—

(i) Effective October 1, 1990, is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the State; and

(ii) Describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The comprehensive assessment must include at least the following information:

(i) Medically defined conditions and prior medical history;

(ii) Medical status measurement;

(iii) Functional status;

(iv) Sensory and physical impairments;

(v) Nutritional status and requirements;

(vi) Special treatments or procedures;

(vii) Psychosocial status;

(viii) Discharge potential;

(ix) Dental condition;

(x) Activities potential;

(xi) Rehabilitation potential;

(xii) Cognitive status; and

(xiii) Drug therapy.

(3) [Reserved]

(4) *Frequency.* Assessments must be conducted—

(i) For individuals admitted on or after [effective date of regulation], no later than 14 days after the date of admission;

(ii) For individuals admitted on or after October 1, 1990, no later than 4 days after the date of admission;

(iii) For current residents of a facility, not later than October 1, 1991;

(iv) Promptly after a significant change in the resident's physical or mental condition; and

(v) In no case less often than once every 12 months.

(5) *Review of assessments.* The nursing facility must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

(6) *Use.* The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care, under paragraph (d) of this section.

(7) *Coordination.* Effective October 1, 1990, the facility must coordinate assessments with any State-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.

(c) *Level B requirement: Accuracy of assessments.* (1) *Coordination.* (i) Each assessment must be conducted or coordinated, with the appropriate participation of health professionals.

(ii) Effective October 1, 1990, each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.

(2) *Certification.* Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(3) *Penalty for Falsification.* Effective October 1, 1990, an individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties. The implementing regulations for this statutory authority are located in Part 1003 of this chapter.

(4) *Use of independent assessors.* Effective October 1, 1990 if a State determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph (c)(3) of this section, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(d) *Level B requirement: Comprehensive care plans.* (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment.

(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that effective October 1, 1990, includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and with the participation of the resident, the resident's family or legal representative, to the extent practicable; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must—

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(e) *Level B requirement: Discharge summary.* When the facility anticipates discharge, a resident must have a discharge summary that includes—

(1) A recapitulation of the resident's stay;

(2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

(3) A post-discharge plan of care that developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

(f) *Level B requirement: Preadmission screening for mentally ill individuals and individuals with mental retardation.* (1) A nursing facility must not admit, on or after January 1, 1989, any new resident with—

(i) Mental illness as defined in paragraph (f)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, whether—

(A) Because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, the individual requires active treatment for mental illness; or

(ii) Mental retardation, as defined in paragraph (f)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission whether—

(A) Because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, the individual requires active treatment for mental retardation.

(2) *Definition.* For purposes of this section—

(i) An individual is considered to have "mental illness" if the individual has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition as described in 42 CFR 435.1009.

§ 483.25 Level A requirement: Quality of care.

Each resident must receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and plan of care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) *Level B requirement: Activities of daily living.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—

(i) Bathe, dress and groom;

(ii) Transfer and ambulate;

(iii) Toilet;

(iv) Eat; and

(v) To use speech, language or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(b) *Level B requirement: Vision and hearing.* To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—

(1) In making appointments; and

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(c) *Level B requirement: Pressure sores.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(d) *Level B requirement: Urinary Incontinence.* Based on the resident's comprehensive assessment, the facility must ensure that—

(1) A resident who is incontinent of bladder receives the appropriate treatment and services to restore as much normal bladder functioning as possible;

(2) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and

(3) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(e) *Level B requirement: Range of motion.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion and/or receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

(f) *Level B requirement: Psychosocial functioning.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who displays psychosocial adjustment difficulty, receives appropriate treatment and services to achieve as much remotivation and reorientation as possible; and

(2) A resident whose assessment did not reveal a psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

(g) *Level B requirement: Naso-gastric tubes.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.

(h) *Level B requirement: Accidents.* The facility must ensure that—

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

(i) *Level B requirement: Nutrition.* Based on a resident's comprehensive assessment, the facility must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when there is a nutritional problem.

(j) *Level B requirement: Hydration.* The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(k) *Level B requirement: Special needs.* The facility must ensure that residents receive proper treatment and care for the following special services:

(1) Injections;

(2) Parenteral and enteral fluids;

(3) Colostomy, ureterostomy or ileostomy care;

(4) Tracheostomy care;

(5) Tracheal suctioning;

(6) Respiratory care;

(7) Podiatric care; and

(8) Prostheses.

(l) *Level B requirement: Drug Therapy.*—(1) *Unnecessary drugs.* Each resident's drug regimen must be free from unnecessary drugs.

(2) *Antipsychotic Drugs.* Based on a comprehensive assessment of a resident, the facility must ensure that—

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, drug holidays or behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

(m) *Level B requirement: Medication Errors.* The facility must ensure that—

(1) It is free of significant medication error rates; and

(2) Residents are free of any significant medication errors.

Improving the Quality of Care in Nursing Homes

Committee on Nursing Home Regulation

Institute of Medicine

EXCERPTS ON QUALITY OF CARE AND ASSESSMENT

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Concepts of Quality, Quality Assessment, and Quality Assurance

This chapter discusses three basic concepts: (1) what is meant by quality of care and quality of life in nursing homes; (2) what is known about the techniques available for quality assessment--that is, for determining how good the quality of care and quality of life are in a nursing home; and (3) how these concepts should affect the design of a regulatory system that would effectively ensure that nursing homes provide care of acceptable quality.

The discussions in the chapters that follow presume understanding of these concepts.

QUALITY OF CARE IN NURSING HOMES

The attributes of quality in nursing homes are very different from those in acute medical care settings such as hospitals. The differences stem from the characteristics of the residents of nursing homes, their care needs, the circumstances and settings in which the care is provided, the expected outcomes, and the fact that for many residents the nursing home is their *home*, not merely a temporary abode in which they are being treated for a medical problem. Thus, quality of life is very important for its own sake (that is, as an outcome goal) and because it is intimately related to quality of care in nursing homes.

Characteristics of the Residents

According to the 1977 National Nursing Home Survey,[1] 70 percent of nursing home residents were 75 years of age or older, about 70 percent were women, only 12 percent had a living spouse, and they had a wide range of physical, emotional, and cognitive disabilities. Nursing home residents differ in their social circumstances compared with noninstitutionalized persons of the same age group. Thirteen percent of residents had no visitors in the course of a year, but about 62 percent had visits from family or others on a daily or weekly basis. Nursing home residents are disproportionately single, widowed, and childless, and they are poorer than the elderly population in general.[2] These data are important because of the links that have been shown to exist between social support and health service needs and outcomes.[3-7]

Residents fall into two broad categories classified by length of stay. The largest group, the "long stayers," consists of those who are no longer able to live outside of institutions and who generally reside in the nursing home for many months or years, often until they die. The second group, the "short stayers," generally comes from hospitals and will be discharged home or will die in a fairly short period of time.[8]

Care Needs

Nursing home residents vary in the amount and types of care they require as well as in their lengths of stay. Many of the "short stayers" require intensive nursing and rehabilitative services. For these, the goal of nursing home care is rehabilitation and discharge home. Some are rehabilitated and discharged; some die either in the nursing home or shortly after discharge. The "long stayers" present a spectrum of care requirements, ranging from those who are relatively independent and require only modest amounts of care to those who are physically very disabled, mentally impaired, and incontinent and who require assistance in all activities of daily living (ADL). In a special study commissioned by the committee, longitudinal data derived from monthly assessments of all residents in 107 nursing homes in 11 states and the District of Columbia were analyzed.[9] In these nursing homes, about 63 percent of new residents either died or were discharged within 3 months of admission. That is, a substantial proportion of persons admitted to the nursing homes stayed for a relatively short period of time. But those who remain in the homes for long stays account for most of the resident bed-days. About 70 percent of all residents in bed on a particular day in all of these nursing homes were still alive and in the same nursing home 18 months later. On the basis of standard assessments of all residents and a standard way of estimating nursing time required per day, the residents on any day in this set of nursing homes fell into three broad categories: 10.8 percent required little care (40 to 60 minutes per day); 48.9 percent required "medium" care (61 to 134 minutes per day) and 40.3 percent required "heavy" care (135 to 268 minutes per day).

The Care Setting

Nursing home care is both a treatment and a living situation. It encompasses both the health care and social support services provided to individuals with chronic conditions or disabilities and the environment in which they live.[9] Nursing homes are "total institutions" in which care-givers, particularly nurse's aides, represent a large part of the social world of nursing home residents and control their daily schedules and activities.[10] This is the total environment for many nursing home residents for the duration of their stay, which may be several years. As a result, deficiencies in medical or nursing care or in housekeeping or dietary services, which could perhaps be tolerated during a brief hospital stay, become intolerable and harmful to well-being when they are part of an individual's day-to-day life over a longer period.

The physical, psychosocial, and environmental circumstances and outcome expectations of nursing home residents distinguish the goals of nursing home care from those of acute medical care. In acute care, treatment goals are based on medical diagnosis. In nursing homes, the care goals are based on physical and psychosocial assessment. They focus on restoration, maintenance or slowing of the loss of function, and on alleviation of discomfort and pain.[11,12]

Requirements for High-Quality Care

The characteristics of nursing home residents, their care needs, and the care setting underlie the three central requirements for providing high-quality nursing home care: (1) a competently conducted, comprehensive assessment of each resident; (2) development of a treatment plan that integrates the contributions of all the relevant nursing home staff, based on the assessment findings; and (3) properly coordinated, competent, and conscientious execution of all aspects of the treatment plan. The assessments should be repeated periodically and the treatment plan adjusted accordingly.

Most nursing home residents suffer from various medical problems, and accurate, careful medical diagnosis and problem identification are very important. But a major determinant of care goals in nursing homes is functional status, that is, the ability of the individual to perform the activities of daily living (bathing, dressing, toileting, transfer, feeding, and continence).[11]

Functional status is a sociobiologic construct that can be used to indicate the existence of chronic conditions and to objectively measure their severity. It also can be used to determine service needs and outcomes resulting from service use among homogenous groups of patients. For example, the Index of Activities of Daily Living, or its variants, has been used to study chronically ill people, including those with hip fracture, cerebral infarction, multiple sclerosis, paraplegia, quadriplegia, rheumatoid arthritis, and other chronic conditions among institutionalized and noninstitutionalized people.[13-19]

The importance of functional status in predicting outcomes is also suggested by studies that were designed to measure the relationship between process and outcome measures of quality care. Those studies found residents' initial functional status to be the best predictor of health care outcomes.[20-22]

Mental status also predicts disability levels and service needs among nursing home residents.[23-25] An estimated 50 to 66 percent of nursing home residents have some type of mental or behavioral problem.[1,26] A substantial amount is attributable to senile dementia of various types, but depression and psychosis also are prevalent. In part, this is attributable to the massive discharges of patients from state mental hospitals during the 1970s. During that period, the number of elderly persons in mental hospitals decreased by about 40 percent, while the mentally ill in nursing homes increased by over 100 percent.[27]

Although the elderly suffer from disorders that affect younger persons (for example, neuroses, alcoholism, schizophrenia), the two most frequent diagnoses among those in nursing homes are depression and intellectual impairment (organic brain syndrome, confusional states, dementia, and so on).[28] Contrary to the beliefs of many health professionals, age *per se* is no bar to effective psychiatric treatment. This is particularly true for depression.[29]

Planning and Providing Care

The initial comprehensive assessment of a resident should include the resident's functional status, medical and dental conditions and needs, mental and emotional status, social interactions and support, personal activity preferences, and financial circumstances. This entails a team effort involving, at a minimum, a nurse, a physician, a social worker, and a physical therapist. The knowledge and specialized skills of other professionals, such as dentists, psychologists, audiologists, speech therapists, occupational therapists, and podiatrists, should be drawn on as needed. Assessments must be recorded in such a way in the resident's medical records that they can be understood and used by all staff responsible for providing care--including nurse's aides.

The plan of care developed to meet the resident's needs requires participation by all professional staff in the nursing home because there is almost no aspect of care that is the exclusive domain of one professional group or another. Physicians need to know from nursing staff the effectiveness of efforts to deal with depressed patients and whether drugs should be adjusted in dosage or the regimen altered; nurse's aides need to be instructed on specific rehabilitation efforts--such as range-of-motion exercises--that should be incorporated as part of the ADL support provided to residents; staff in the recreation department need to know that a close watch is being kept on certain residents for the side effects of drugs. Clear, easily understood records are essential to carry out such coordinated care because there is seldom time for meetings to share all of the necessary information. Moreover, staff on duty evenings and weekends have to rely on records to make critical decisions.

In sum, long-term care is directed primarily at relieving conditions that result from chronic physical or mental disorders or the chronic after-effects of acute disorders. Equally important is relief of pain and discomfort. Assessing functional competence or impairment gives direct information about these conditions, which is needed for care planning.

Chronic conditions generally require restorative or maintenance services with an emphasis on attaining small improvements or preventing undue decline, rather than the intensive efforts of acute medicine that usually aim for cures, remissions, or other substantial improvements.

Many residents in nursing homes will remain there for long periods, often until death. Their well-being is affected by the environment, by the quality of the medical/nursing and social support services they receive, and by the nature of their health problems.

QUALITY OF LIFE

The quality of life experienced by anyone is related to that person's sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem.[30,31] For nursing home residents this includes a basic sense of satisfaction with oneself, the environment, the care received, the accomplishment of desired goals, and control over one's life.[32] For instance, a resident's quality of life is enhanced by close relationships and meaningful interchange with others, an environment supporting independence and incorporating personal belongings, and the opportunity to exercise reasonable control over life decisions. Opportunities for choice are necessarily somewhat limited in a nursing home, but they need not be as limited as they are in some nursing homes.[33] Participation in care planning is one important aspect of personal autonomy. But even such seemingly small choices as mealtimes, activities, clothing, or times to rise and retire greatly enhance the sense of personal control that leads to a sense of well-being. Lack of privacy for visits with family and friends, for medical treatment, and for personal solitude contributes to lack of self-esteem. Opportunities to engage in religious, political, civic, recreational, or other social activities foster a sense of worth. The quality and variety of food are often cited as some of the most important attributes of quality from the resident's perspective.[31,34] Quality of life also includes such life circumstances as personal assets, financial security, physical and mental health, personal safety, and security of one's possessions.[35-37]

Many aspects of nursing home life that affect a resident's perceptions of quality of life--and therefore, sense of well-being--are intimately intertwined with quality of care. This is evident in the findings of a study conducted during 1984-1985 by the National Citizens' Coalition for Nursing Home Reform.[34] The study was designed to obtain nursing home residents' views on quality of care. Its findings are based on a series of discussions held in 15 cities involving 455 residents from more than a hundred nursing homes. The sample of residents was drawn from a group who volunteered to be in the study, who were able to attend three meetings outside of their own facility, and who were able to participate actively in group discussions.

The highest importance was attached by residents to the qualifications, competence, attitudes, and feelings of staff, and the quality of the interactions among staff and residents. This follows from the circumstance that 80 to 90 percent of the care is provided by nurse's aides and the quality of their interactions with the residents--how helpful, how friendly, how competent, how cheerful they are and how much they treat each resident as a person worthy of dignity and respect--makes a big difference in the quality of a resident's life.

Success in improving function and greater independence are associated with enhanced sense of well-being.[8,38] A number of writers have stated that, because the major concern of quality of care is with improving or maintaining function, care should routinely incorporate rehabilitation exercises. This means reliance on nurse's aides to see that these exercises are done as prescribed. There are indications that some functional impairments in the elderly may be the result of inactivity and disuse and that even very elderly residents respond to rehabilitation exercises.[38-42]

Conflicts of values and ethics are inherent in nursing home care--for example, conflicts between care requirements, as judged by professionals, and the rights and preferences of the resident. Should a very old, perhaps mildly demented resident, who is not legally incompetent and who declines to eat, be fed by nasogastric tube even if he strongly objects to it? What about residents who decline to take medication or other treatments prescribed to manage their chronic disease? Should dietary preferences of a resident override adherence to a medically prescribed dietary regimen? Should a frail, unsteady resident with osteoporosis, who insists on walking by herself, be permitted to walk around unescorted even though there is a substantial risk that she will fall and suffer a hip fracture?

The quality of medical and nursing care provided, the way it is provided, the quality of the interaction between staff and residents, the range of services and amenities available to residents and their ability to make personal choices and to influence the range of choices, and the facility's ambiance--all affect residents' functional, physical, and mental health status (objective well-being) and subjective well-being. Subjective well-being includes such factors as the extent of depression-demoralization, satisfaction-dissatisfaction, absence of discomfort-pain. For the very sick and disabled, the quality of the care and the way it is provided are probably the most significant contributors to well-being.

QUALITY ASSESSMENT CRITERIA

The widely accepted criteria used in assessing medical care quality can be used for assessing quality of nursing home care. They have structural, process, and outcome components.[43]

Structure

Structure refers to the health care facility's or provider's capacity to provide good-quality care. Structural criteria include the training, experience, and number of the care-givers; the organizational arrangements within which they function; the safety and appropriateness of the environment; and the adequacy and appropriateness of the equipment and other available technology. Structural factors are relatively easy to assess, although determining what technology, equipment, staff qualifications and numbers, and organizational arrangements are necessary to provide good medical care is a matter of professional judgment and subject to change as new knowledge is acquired and new technology developed. Moreover, structural factors have only a potential relationship to quality: the availability of the capacity to provide good care does not mean that good care is delivered.[43] The use of structural criteria to assess quality of care in nursing homes is based on the assumption that such criteria represent necessary, although minimal, conditions associated with acceptable levels of resident care services and outcomes.[44] The evidence to support this assumption is mixed. Studies on the linkages between structural measures and the process of care in nursing homes have not found them to be strong.[45-48] But there is evidence that environmental circumstances influence personal well-being.[32,49-51] Environments that foster autonomy, integration, and personalized care promote better morale, life satisfaction, and adjustment.[52-55] They also have positive effects on staff attitudes and behavior.

There also is evidence that, in some circumstances, structural criteria directly affect the process of care. One study that investigated the use of psychotropic drugs in nursing homes found that staff-to-resident ratios are associated with rates of use of such drugs. That is, understaffed facilities may make excessive use of antipsychotic drugs to substitute for inadequate numbers of nursing staff.[56] Moreover, in such areas as life safety codes, structural measures of quality clearly predict outcomes.[12] In general, however, structural capacity, the care actually provided, and the outcomes of care are not always associated. Although the capacity to provide care may exist, it may not be used appropriately, or not be applied in sufficient quantity or with adequate skill.

Process

Process criteria assume that quality is related to the services provided, how they are provided, and the resources used in doing so. Some studies conducted on relationships between process measures and resident outcomes in nursing homes have yielded mixed findings,[20,22,57] but a few have shown positive relationships under certain circumstances.[46,58-60] (The studies vary in scientific quality; many are descriptive rather than controlled.) These recent studies, and professional experience, suggest that process measures should not be ignored. If care related to improving function is neglected (for example, exercises to avoid contractures, bed positioning to avoid bed sores), residents' quality of life is affected adversely.[61]

Outcomes

Outcomes are changes in a resident's functional or psychosocial health that are associated with the care provided. Outcome measures of care have received a great deal of attention as the most direct way to approach the assurance of quality in long-term care. Proponents argue that a focus on outcomes avoids arguments about effectiveness of structure and process factors by letting the results, resident outcomes, speak for themselves. The use of outcomes allows providers flexibility in determining the most cost-effective means of achieving specific outcomes, an important consideration in "low-technology" care where substitution of personnel and technique seems possible.[31,49,62]

Two kinds of outcomes are measured: subjective and objective. For nursing home residents, the subjective components may include a basic sense of satisfaction with oneself and one's environment and the level of satisfaction with a range of aspects of nursing home care. The objective components of outcome include such things as changes in functional and mental status.

Some outcomes have been defined and measured in long-term care. For example, rehabilitation outcomes have been studied, as have patient discharge rates.[22,48,63] Studies also have associated particular attributes of individuals to ranges of outcomes. Social isolation and intellectual decline have been linked with premature death.[64,65] Health status has been tied to morale and to behavior.[57,66-70] And expected intermediate and final outcomes have been studied for a number of specific conditions such as stroke and hip fracture.[18,71-73]

In sum, for quality assurance purposes, structural, process, and outcome criteria can contribute useful, complementary information for assessing the quality of care and the well-being of nursing home residents.

ASSESSING QUALITY OF CARE

The development and use of valid and reliable instruments to measure quality of care are critically important to quality assurance and to regulation. Moreover, good measurement has strong positive effects on the planning and provision of care. The practices of the regulatory system and of the nursing home industry in general have not been up to the state of the art for some time.

Much research has been devoted to this question in recent years. For example, about 15 years ago the Public Health Service supported research to develop a uniform terminology with which to describe residents' needs. An important result of this effort was the "Patient Classification for Long-Term Care," a collaborative effort of four research groups published in 1973.[74] In 1980 the Technical Consultant Panel on the Long-Term Health Care Data Set of the National Committee on Vital and Health Statistics recommended that all public and voluntary reporting systems for long-term health care clients and services collect a minimum set of information to establish standard measurements, definitions, and classifications for long-term care.

The information needs of the patient classification system and the minimum data set are similar and include sociodemographic items, functional competency/impairment, intellectual impairment/behavioral problems, and medical status. This and other information relevant to quality assurance, such as indicators of subjective well-being, must be obtained through valid and reliable data collection instruments.

Functional Competency/Impairment

This is defined in terms of discrete task performance in independently transferring, ambulating or wheeling, dressing, toileting, bathing, eating, and grooming. Other tasks also can be tested and the details of performance and assistance added. There is now wide agreement that a number of relatively brief assessment instruments and procedures can be used reliably by trained professionals from various disciplines. These instruments have been tested extensively for validity and reliability. More importantly, they can be used reliably by trained nonprofessionals. The following are examples:

1. The Katz Index of Activities of Daily Living provides rating scales of six functions: bathing, dressing, going to the toilet, transferring from bed to chair, continence, and feeding.[18]
2. The Barthel Index provides scores on self-care abilities.[75]
3. The Kenny Self-Care Evaluation is used to measure functional ability in 17 activities that fall into 6 functional impairment categories: bed activities, transfers, locomotion, personal hygiene, dressing, and feeding.[76] The instrument has been found to successfully predict rehabilitation and the timing of discharge.[77]
4. Linn's Rapid Disability Scale includes 16 ADL and related items that are scored according to severity or frequency of occurrence. Predictive validity has been demonstrated for physicians' prognoses, length of stay, and 6-month mortality.[78] Interrater reliability and test/retest reliability are high.

A number of states are using resident classification instruments that predict service use and nursing home cost. West Virginia assesses residents for dependency in functional impairment on the basis of 15 categories of service need, and Ohio on the basis of 14 categories.[79] The Resource Utilization Groups (RUGS) classification system,[80] which will be used to establish Medicaid reimbursement rates in New York state,[81] categorizes residents into five clinically distinct and statistically different groups on the basis of the resources used to meet resident service needs. Each clinical group is further divided by an ADL index score into subgroups distinguished by level of physical functioning.

Instruments also have been developed by nursing home chains for purposes of rate setting and internal quality assurance. For example, the Patient Care Profile System assesses functional impairment in personal hygiene, bathing, dressing, mobility, eating, and positioning, as well as the presence of incontinence and decubitus ulcers, and the need for skilled procedures and restorative nursing. This system is being installed in over 300 Hillhaven Corporation nursing homes.[82] The National Health Corporation has developed the Patient Assessment Computerized system[83] to collect standardized information on functional impairment in the areas of walking, ADL, bladder and bowel continence, decubitus ulcers, special senses, communication, orientation, and behavior. Reliability is measured by quarterly audits of a 10 percent sample of residents' forms by nurse consultants. The state of Montana uses this instrument to obtain case-mix information for use in its Medicaid payment determinations.

These and other instruments (only a few have been mentioned) are useful for quality assurance because they make it possible to reliably identify residents who have similar characteristics--that is, similar levels of disability, need for personal assistance and nursing, likelihood of discharge, chance of recovery, and risk of mortality. By collecting the same assessment data on the same residents at regular intervals, longitudinal data on the distribution of outcomes for residents with similar characteristics can be obtained.

Intellectual Impairment/Behavioral Problems

Among nursing home residents, this debility usually occurs as dementia of the Alzheimer's or multi-infarct type. It can be assessed with brief interview techniques that are reliable in the hands of both trained professionals, such as nurses and social workers, and trained nonprofessionals. For example,

1. The Mental Status Questionnaire has been used widely in geriatric research and practice.[84,85] It consists of 10 short questions testing cognitive function that have been correlated with clinical diagnosis of organic brain syndrome. It has demonstrated high reliability and can be administered without extensive training. The Philadelphia Geriatric Center Mental Status Questionnaire is an extension of the Mental Status Questionnaire and includes items that are sensitive to the specific situation of nursing home residents.[86]
2. The Mini-Mental State Examination measures cognitive functioning using items similar to those of a clinical mental-state examination.[87] External validity has been demonstrated on the basis of clinical assessments of the presence/absence of cognitive disorder.
3. The Comprehensive Assessment and Referral Evaluation Instrument (CARE), which includes the Geriatric Mental Status Schedule, is designed to replicate clinical judgments among community and institutional populations.[88] Instrument reliability and validity have been tested in various ways.

The information obtained from these instruments and others makes it possible to place residents into comparable groups with defined characteristics such as probability of being intellectually incapacitated (demented), needing special investigations, having a behavior problem (such as wandering), requiring supervision, progressively deteriorating, and dying. The measurements are repeatable. Additional information, such as duration and course, increases the relevance to quality assurance.

Corresponding evidence exists for other key content areas. Subjective well-being (demoralization-depression; dissatisfaction-complaints) has been measured and associated with social functioning, physical health status, mental status, and activity levels.[50,89,90] Standardized instruments have been used to assess residents' satisfaction with nursing home care and relationships between satisfaction and nursing home characteristics.[63,91,92] Behavior problems have been described, measured, and associated with specific service interventions as a part of nursing home management systems (for example, the National Health Corporation's Patient Assessment Computerized system) and in research studies.[93-95]

PERSPECTIVE ON QUALITY ASSURANCE

At the most general level, quality assurance is a mechanism or process for promoting excellence in the performance of services or the production of goods. It entails

- specification of criteria and standards of performance quality,
- collection of accurate information about the quality of current performance,
- comparison with information on desired or acceptable standards of performance,
- analysis of the reasons for the differences between actual performance and desired standards of performance and determination of what needs to be done to eliminate these differences,
- adoption of the changes necessary to eliminate the differences between current performance and desired standards of performance,
- repeated collection of information to monitor the extent to which resolution of differences is taking place, and
- periodic iterations of these linked steps.

Quality assurance--or quality control--is generally practiced with varying degrees of formality by providers of services and producers of goods, by consumers and clients, and by government regulatory authorities. In the nursing home industry, the main reliance has been on government regulation, but a significant responsibility for quality assurance rests on the nursing homes themselves. Other factors affecting quality in nursing homes are important. They include the role of consumer advocacy groups (including ombudsmen), industry self-regulatory efforts (including accreditation), and efforts to increase the professional standards and training of administrators and other staff. These factors are discussed in Chapter 6.

INTERPRETING AND USING INFORMATION FOR QUALITY ASSURANCE

Measurement of Care Quality

In long-term care, there are areas where the medical needs of a subpopulation can be defined and the outcomes of care measured. Many measures used in general medical practice may be used in long-term-care settings: reduction in the blood pressure of hypertensives; reduction in pain and improvement in functional status of patients with angina; visual improvement for patients with cataracts; restoration of function and reduction of pain in patients requiring hip replacement.

Measures of effectiveness of care quality more specific to nursing homes include the level of restoration of function following such events as hip fractures and new strokes, infection rates in residents with indwelling catheters, skin breakdown in at-risk bedridden residents, and improvements in mood in depressed residents.

The choice of measure for evaluating quality of care depends not only on the innate value of that measure but on the context of its use as well. A measurement device that is satisfactory for a large-scale research project may be too expensive, too lengthy, or require too much training for regulatory purposes. Similarly, the nature and size of the target population must be considered. Restoration of function after hip replacement may be a very effective measurement of care quality when applied to an acute rehabilitation facility associated with an active orthopedic referral center, but it would be completely useless in measuring the effectiveness of rehabilitation services in a small nursing home in which only one or two hips are replaced per year. Many of the measuring devices described here have limited applicability for regulatory purposes because the numbers of residents with even a common condition will be small within a single nursing home.

Measurement for regulatory purposes must be clear-cut and reliable. Both the regulated and the regulators must be able to understand easily what is being measured and why it is being used for regulatory purposes. Disagreements about a particular measurement must be capable of arbitration. The application of regulatory quality measures must be satisfactory as legal evidence in court.

The kinds of outcomes that have been suggested for use as a part of the regulatory process are mostly avoidable events that can occur across a fairly large subset of the population if care is insufficient: decubitus ulcers in the bedridden and catheter-induced infections are two examples. Others are discussed in Appendix F.

Standards

Interpreting information on the structure, process, or outcome of care in order to evaluate quality of care and well-being requires comparison with some standards of reference. Relative quality is more readily assessed than absolute quality. The standards of reference are specific to a given condition or circumstance since the definition of good care or a good outcome may vary with the particular circumstance or condition. Thus, when comparing an observed level of care with a given standard (for example, from institutions performing at a level above an agreed percentile of performance), the comparison must be made between residents with comparable conditions, or, when making group comparisons, between groups with comparable conditions.

Standards may be constructed on the basis of professional experience and judgment, as reflected in professional practice norms or standards, or by comparison with information that can be collected under defined circumstances:

- from institutions judged to be exemplary,
- from the same institution at an earlier point in time, or
- from the same or other institutions under varying conditions.

These standards (professional judgment and systematic comparisons) are not mutually exclusive. Professional judgment is informed by more systematic comparisons. It also may be necessary when systematic comparison data are not available. But systematic comparisons have the major advantage of objectivity and can be refined over time. Valid comparisons require that the information be collected uniformly and reliably and on a large scale. Also, the standards must be reviewed periodically and revised to keep them up to date.

Case Mix

Case-mix stratification entails grouping residents according to a select number of their characteristics (age, sex, functional status, mental status, and so on) and needs for services. Measurements of functional impairment, intellectual impairment, and subjective well-being, all of which predict needs for care, can be used to define case-mix reference groups. Thus the care given, as well as the changes in resident well-being associated with the care given, can be measured and evaluated for groups of residents with similar care needs.

Case mix is essential for measuring outcomes. The outcomes of care can be measured by changes in the health and functional status of residents. A study conducted by Jones and colleagues in Massachusetts in the early 1970s first demonstrated the feasibility of this approach to quality assessment in long-term care.[96] Outcomes also can be related to groups in which members have similar expected outcomes. A series of studies of residents of "high-quality" nursing homes has been undertaken by Kane in an attempt to link nursing home payment to resident outcomes and nursing home costs.[63] Data collected on residents included a broad set of functional aspects covering six domains: physical, functional (ADL), cognitive, affective, social, and satisfaction, with measurements made at 3-month intervals. The study introduced the concept of "prognostic adjustment factor" (PAF) as an outcome measurement of quality of care. The PAF reflects the extent to which the actual outcome of care exceeds or falls short of an expected level. The system is based on resident data that are used to generate a predicted course for the resident based on the experience of similar residents: the resident gets better, stays the same, or gets worse. Comparing the actual status of the resident with the predicted status after a suitable period of time gives the PAF for that resident over that time interval.

Morris and colleagues did a longitudinal analysis of a multi-year data set on the residents of 107 facilities located in 11 states and the District of Columbia. The data were obtained from the National Health Corporation and the state of Montana.[8] The authors developed a resident classification scheme differentiating among major categories of residents, classified by physical and mental functioning domains and care requirements. These characteristics were measured against a range of indicators that have quality-of-life implications, including ADL, communication, behavior, activities, outside contacts, family contacts, and decubitis ulcers. New admissions and current residents were studied over 1 year and the changes in these quality-of-life-related indicators, controlling for case mix, were shown. The study shows the powerful potential for monitoring outcomes and establishing standards that this type of data--collected regularly--can provide.

Standard Instruments

The use of standard instruments increases the power of interpreting and using information for quality assurance purposes. Standard information is necessary to make comparisons across institutions, which can lead to industrywide reference standards against which nursing homes can be evaluated for quality assurance purposes.

Such instruments are currently being used by some nursing homes and nursing home chains, and by state regulatory bodies.

Nursing homes and nursing home chains are increasingly using standardized instruments to collect resident information for the purpose of service determination, internal quality assurance, and rate setting. As mentioned earlier, the National Health Corporation has used such an instrument in its Patient Assessment Computerized (PAC) system for about a dozen years. The PAC data include sociodemographic, medical, functional, and social components as well as service needs in determining case mix. The data are obtained from every resident each month and entered into a computer file. The instrument is used in conjunction with the Management Minutes System, an algorithm that uses resident assessment data to calculate daily nursing time requirements for each resident.[97] PAC data can be used to establish the costs of care, resident charges, and to budget nursing labor. The data also can be used for various longitudinal analyses, including outcome-based quality-of-care measures. The PAC system is being used by Montana for its Medicaid case-mix reimbursement system.

A similar effort has been undertaken by the Hillhaven Foundation in the development and implementation of the Patient Care Profile (PCP) system.[82] This instrument includes 19 variables related to functional status and service needs that form the lowest common denominator of need for nursing care, regardless of the resident's medical diagnosis. The PCP is used to help determine initial placement in the nursing home and to set rates for private-pay residents. On the basis of assessment findings, residents are grouped according to service need and mental status to promote resident satisfaction and effective use of human and material resources. The PCP is also used as an internal quality assurance tool to assess the effects of care on residents' physical performance over time.

A range of research and demonstration projects has standardized case-mix instruments to establish service needs and costs of care. For example, in 1983 the New York State Department of Health initiated a major study to develop a case-mix reimbursement system for long-term care facilities.[81] The major objective was to develop a reimbursement methodology that matches residents' needs to services and resources. The system will also provide incentives for rehabilitation, discharge, and better outcomes for residents. The system is based on Resource Utilization Groups (RUGS II).[82] It uses a classification instrument that categorizes residents into groups, each of which is different in clinical terms and different in resource use. The system will be implemented on a statewide basis in 1986.

National, Regional, and Local Uses

Interpretation of information for quality assurance is clearly critical to efficient regulation of nursing homes. Information collected through federal demonstration projects being conducted by state regulatory agencies is currently being used to categorize nursing home residents on the basis of service needs and costs of care.

Most state-level case-mix systems collect information for purposes of reimbursement. The same or similar information can be used for quality assurance by comparing the services actually received and resident outcomes with those expected for residents in comparable case-mix groups. The "expected" outcomes are determined empirically by collecting longitudinal assessment data on large numbers of residents.

The interpretation of information along the lines described here can also be of great value when practiced by the administrators and staff of the nursing homes themselves:

- to monitor the quality of their own performance in providing care
- to track gains in productivity
- to review unexpected outcomes
- for planning and monitoring resource use to meet changing case-mix requirements.

As noted earlier, nursing homes and nursing home chains have interpreted and used information about residents' characteristics and service needs for one or more of these purposes.

Such comparative statistical information about nursing home performance, developed from local, regional, or national sources, can also be useful to consumers by helping them to become better informed and, therefore, able to play a more effective role in the process of quality assurance.

QUALITY ASSURANCE AND THE REGULATORY SYSTEM

The current goals of federal regulation of nursing homes for quality assurance purposes are to ensure the safety of residents and the adequacy of their care. In practice, as used by most states and the federal government, the term "adequate" has been interpreted to mean "minimum" acceptable standards. This grew out of the original circumstances prevailing when the Medicare and Medicaid programs began. At that time, strict application of higher-quality standards would have made most existing nursing homes ineligible for certification. So two things were done: the proposed standards were lowered and the concept of "substantial compliance" was introduced to allow many homes to participate in the Medicare and Medicaid programs while they undertook the necessary actions to bring them into compliance with the minimum standards. This established a tradition of allowing inadequate facilities to continue operating while the state regulatory agencies exerted varying amounts of pressure to bring them into compliance. (See Appendix A.)

In the last 10-15 years, however, there has been sufficient experience to enable the setting of more ambitious regulatory goals. It is now feasible for federal and state governments to strengthen their regulatory criteria, inspection processes, and enforcement procedures so that the regulatory system can be expected to reliably detect and quickly eliminate nursing home care

3

Regulatory Criteria

THE ISSUES

Government regulation of nursing homes for quality assurance purposes has three components: (1) the criteria used to determine whether a nursing home is providing care of acceptable quality in a safe and clean environment, (2) the procedures used to determine the extent to which nursing homes comply with the criteria, and (3) the procedures used to enforce compliance. The three components are like the legs of a three-legged stool: All are equally important. This chapter deals only with quality criteria. Chapters 4 and 5 discuss the other components.

Two sets of federal certification criteria for nursing homes currently exist: one for skilled nursing facilities (SNFs) and one for intermediate care facilities (ICFs). SNFs and ICFs are defined as being capable of providing different "levels" of care. SNFs are required to be staffed and equipped to provide more skilled nursing and rehabilitation services than are ICFs. The SNF criteria consist of 18 "conditions of participation" each of which contains one or more standards that must be met to comply with the condition. There are 90 SNF standards contained in the 18 conditions. The regulations containing these

of unacceptably poor quality that occurs anywhere in the country. It also is reasonable to expect that better quality assurance capabilities should result in improvement in the level of performance of facilities that are providing only marginally adequate care. Many of these facilities are continuously in and out of compliance. The strengthened quality assurance criteria and procedures also are likely to exert a positive effect on all other facilities so that the level of performance of "average" nursing homes can be expected to improve. This would increase overall levels of quality of care and quality of life provided to most residents in most nursing homes throughout the country.

To achieve these goals, the current regulatory system will have to make major changes in quality assessment criteria, inspection techniques and procedures, information systems, and enforcement policies and procedures. Chapters 3, 4, and 5 examine the current regulatory system and recommend changes that are designed to provide it with the increased capabilities that are now possible.

Recommendation 3-1: The regulatory distinction between SNFs and ICFs should be abolished. A single set of conditions of participation and standards should be used to certify all nursing homes. The current SNF conditions and standards, with the modifications and additions recommended below, should become the bases for new certifying criteria.

This is a recommendation that requires a change in the law. It may lead to increases in Medicaid budgets in several states because it will require increased RN and LPN staffing in many nursing homes in those states. (This is discussed more fully in the last section of this chapter.) Some time will be needed to implement this change in states with many ICFs. But whatever the transition problems, applying one set of regulatory standards to all nursing homes is essential if the goal is to achieve overall improvement in the quality of care being provided to nursing home residents. The nursing home industry has matured in the past 15 years. The shortage of nurses--advanced as one of the important reasons for creating ICFs--that may have existed some years ago has eased, in part as a result of sharp drops in hospital bed occupancy rates, and the consequent reductions in hospital employment. Moreover, a better understanding of what is required to provide high-quality care in nursing homes exists today than existed 15 years ago.

RESIDENT ASSESSMENT

Providing high-quality care requires careful assessment of each resident's functional, medical, mental, and psychosocial status upon admission, and reassessment periodically thereafter, with the changes in status noted. Current regulations do not require a standardized assessment of any kind, although the development of individual plans of care clearly depend on resident assessments. The outcomes of care are defined by changes in functional, medical, mental, and psychosocial status. As discussed in Chapter 2, much research over many years has developed successful techniques and instruments that can produce valid, reliable assessment data that can be used for these purposes. Moreover, it has been demonstrated that these instruments can be used reliably by LPNs who have been trained to use them, as well as RNs.

The resident assessment data have several very important uses both for facility management and for government regulatory agencies. For the facility, standard resident assessment data, obtained on admission and periodically thereafter, are an essential tool for quality-of-care purposes and for other management uses. A careful assessment of every resident is needed to formulate a care plan for that resident. Typically, the resident care plan contains information on physical and mental function, health risk factors, diagnoses, prognoses, short- and long-term goals, as well as key social history items. Periodic reassessment--for example, every month for the first 2 months after admission, and quarterly thereafter--is essential for two reasons: (1) to check on the resident's status changes, and (2) to see what, if any, modifications in the care plan should be made. The data can be used by management for two other purposes: (1) to provide very precise information on case mix in the nursing home, how it is changing, and how appropriately residents, staff, and other resources are--or should be--distributed in the home; and (2) to conduct longitudinal studies on quality of care, controlled for case mix. For example, problems in particular bed sections--possibly attributable to inadequate nursing care--could be identified promptly and steps taken to remedy them. One nursing home chain has been using similar data for over 10 years for monitoring the case mix, staffing, and the quality-of-care performance in its 50 nursing homes from its central office.[4]

Standard, longitudinal assessment data are also essential for four state regulatory functions: (1) for obtaining case-mix information in each nursing home for use in sampling for survey purposes (see Chapter 4), (2) for obtaining outcome information by examining longitudinal assessment data in resident records, (3) for utilization review to assure that residents meet the eligibility requirements of Medicaid or Medicare, and (4) for case-mix information needed for Medicaid payment (reimbursement) calculations (in states where case mix is used as a factor in Medicaid payment policy).

The standards for this condition should specify the items to be used in making the assessment, the qualifications of the staff authorized to do the assessing (for example, licensed nurses), the training they should receive before being authorized to do the assessments, how often assessments of each resident are required--for example, on admission, once a month for the first 2 months, once every 3 months thereafter, and at discharge. The standards should specify that these assessment records should be retained in the resident's medical record. Auditing by the state regulatory agency also should be covered in a standard, and acceptable error rates specified. Once the system has been in operation for some time, unacceptably high error rates by facilities should be viewed as indicators of inferior performance and subject to sanctions by the survey agency.

Introducing and phasing in this new set of requirements will take time. Several major steps are necessary. The assessment items will have to be selected. The assessment data should include (but not be limited to) medical problem identification (diagnoses), measures of physical function such as activities of daily living and mobility, and measures of mental and psychosocial functioning such as appropriate behavior, cognitive ability and depression. An operations manual will have to be written for the ultimate users--licensed nurses. Training programs and training materials will have to be developed. A major training effort will have to be initiated by the HCFA and continued by the states, possibly with the help of the state provider associations. All state nurse surveyors will need to be trained in collecting this standard data in a consistent manner since they will be responsible for auditing the facilities. Federal regional office surveyors also will have to be trained in addition to the thousands of facility staff. Auditing procedures and standards for the kinds and amounts of acceptable discrepancies between auditor's findings and facility data should be based on the findings of careful empirical studies.

The requirement for nursing homes to do standard assessments of all residents should not be immediately coupled to a requirement that the data be entered into a computer file. Eventually, computer access will be essential to be able to use the data for some of the important purposes noted above. But it will take at least 2-3 years to get the manual system installed and used with acceptable accuracy by most nursing homes.

During the period that this system is being developed and installed, there will be an opportunity to undertake simultaneously a careful study of the policy and technical problems involved in computerizing resident assessment data, and to agree on the use of such data by state and federal governments. The product of such a study should be a specific plan for doing so. This is discussed in Chapter 7.

Recommendation 3-2: A new condition of participation on resident assessment should be added. It should require that in every certified facility a registered nurse who has received appropriate training for the purpose shall be responsible for seeing that accurate assessments of each resident are done upon admission, periodically, and whenever there is a change in resident status. The results should be recorded and retained in a standard format in the resident's medical record.

REVISING AND STRENGTHENING THE CONDITIONS AND STANDARDS

The conditions of participation were introduced by the Medicare law in 1965. SNFs must comply with them to be eligible for certification under Medicaid or Medicare. There are 18 SNF conditions governing the following areas: state licensing, governing body, medical direction, physician care, nursing, dietary, specialized rehabilitation, pharmacy, lab and x-ray, dental, social services, patient activities, medical records, transfer agreement, physical environment, infection control, disaster preparedness, and utilization review. If a

APPENDIX E

Key Indicators of Quality of Care

Key indicators are resident outcomes that suggest the presence of either good or bad care. They should be chosen because they indicate the extent of a facility's compliance with regulatory criteria, that is, the elements, standards, and conditions of participation. Key indicators of inadequate care are *prima facie* evidence of a problem, but further investigation is required to determine whether the problem stems from bad care or from factors that are not within the facility's control. Key indicators can be used to distinguish between adequate and poor-quality care and between adequate and good or excellent care.

The following illustrative list contains key indicators that have been tested and used by various states or facilities. Some apply to all residents, others only to residents in one or two of the four case-mix groupings proposed in Chapter 4.

EXAMPLES OF KEY INDICATORS OF CARE QUALITY TO BE USED BY SURVEYORS

Medications. Excessive use of tranquilizers and antipsychotic drugs, medication errors, and adverse drug interactions are evidence of poor quality in nursing homes.[1-7] Thus, one means of measuring the quality of a nursing home's performance would be to examine the use of chemical restraints and medication errors.

Survey procedures and protocols for determining proper medication administration for nursing home residents have been developed and are being used.[8-12] Elements from these protocols for proper drug administration could be used in examining facility records, observing medication passes for a sample of residents in the facilities, and observing residents. Using the "case-mix referencing" system for selecting samples of residents, the survey could focus its observation on those particularly at risk for overmedication (for example, residents with depression or anxiety).

Decubitus Ulcers. Another potential indicator of poor quality of care is the development of bed sores.[13,14] Protocols have been developed for identifying and measuring the severity of such skin breakdowns and pressure sores.[10,13-15] The survey would particularly concentrate on a sample of very physically dependent residents (those who are bed- and chair-fast) and measure the incidence and severity of decubiti.

Urinary Tract Infections. The development of infections among nursing home residents with indwelling urinary catheters may also be a sign of poor care.[16-20] One measure of quality, for purposes of comparing facility performance, would be the incidence of urinary tract infections among the residents in the facility who are catheterized.

Management of Urinary Incontinence. Another indicator of quality might be the use of indwelling catheters as opposed to bladder training programs and prompt staff attention to individuals when they need to urinate. Many view the excessive use of indwelling catheters as a sign of poor care, and protocols have been developed for their proper use.[10,14,16,17,21,22] Thus another measure of quality would be the number of indwelling catheters among incontinent residents in nursing homes. The survey should take into account whether the facility has attempted a bladder training program for catheterized residents.

Dehydration. Dehydration among nursing home residents is frequently cited by physicians in admitting hospitals as a major problem.[23,24] It is also a predictor of poor care and has been proposed as one of the sentinel health events that should be preventable, given adequate care. As Himmelstein and colleagues note,[24] in the absence of documentation in the resident's record of rapid free water loss, dehydration usually indicates inadequate attention to fluid intake. The survey would focus in particular on every physically dependent and severely mentally impaired resident in surveying for dehydration.

Other Examples of Medical, Nursing, and Rehabilitative Care Indicators. Other key indicators of medical and rehabilitative care include the blood pressure of hypertensive residents (because elevated diastolic pressure has been shown to correlate directly with events such as heart attack and stroke), changes in weight, contractures, existence of physical restraints, decline in functional status, and the ability to perform the activities of daily living (ADL).

Nursing and Personal Care. Issues relating to nursing and personal care are very relevant to both quality of care and quality of life experienced by nursing home residents and to their sense of well-being, satisfaction, and mental and social functioning.[26] In their outcome-oriented licensure survey, the Iowa Department of Health utilizes an index of service delivery on 17 nursing and personal care items, involving observation and resident interviews.[8,9] When the observations and interviews are completed on all 17 items, a score is constructed to indicate the level and quality for this service. A similar set of items and scoring procedures could be developed for the federal survey. Examples of items include whether residents' hair and nails are clean and neat, whether they are dressed in their own clothing, whether the clothing is clean, and whether residents receive daily oral hygiene. In addition, the surveyors might observe whether call lights and other resident requests for assistance are promptly acknowledged, whether indwelling catheter tubes are clean, and whether catheter tubes and bags touch the floor.

Mental Status. While the elderly in nursing homes suffer from mental disorders that affect younger persons (for example, schizophrenia, neuroses), the two most frequent diagnoses among nursing home residents are depression and intellectual impairment (organic brain syndrome, confusional states, dementia).[27] In the case of depression, the elderly are just as responsive to psychiatric treatment as younger people.[28] Depression, demoralization, and social isolation have been measured and associated with social functioning,[26] physical health status, premature mortality,[29-32] and activity levels.[33] Thus, greater attention should be paid to mental health aspects of care, including appropriate assessment and management techniques for mental and behavioral problems, and specialized activities programs.[27]

One possible indicator of quality in this domain is appropriate use of medications for this population, particularly for residents with depression. Some measures of resident satisfaction (discussed below) may also capture important elements of mental status, particularly depression, demoralization, and social isolation.

There is substantial evidence that environmental circumstances of older persons have an influence on personal well-being.[34,35] For example, environments that foster autonomy, integration, and personalized care promote higher morale, life satisfaction, and better adjustment.[36,37] Some of the measures of facility-level capacity and performance, such as availability and appropriateness of activities, and some of the residents' satisfaction items, will be relevant to this domain of quality.

Diet, Nutrition, and Food Service. Diet, nutrition, and food service are especially important to quality of care and life for residents of a nursing home. Therapeutic diets, for instance, are vital to the physical health status of some residents (for example, those with conditions such as hypertension and diabetes). Adequate nutrition is essential to the physical health status of all residents. Residents with functional impairments may require assistance in eating or special utensils. Without such needed assistance, the quality of the diet or

menu is meaningless, since such residents may not, in effect, "receive" the food they require and the facility provides. Finally, the quality of the food--whether it is warm when served, well seasoned, and whether residents have some choice in their menus--has been found to be a major element of their rating of the "quality" of a facility.[38,39] As Rosalie Kane observes,[40]
"Most people sit down to meals rather than to diets; the criteria for a satisfying meal may not be the same as those for a satisfactory diet, yet both are relevant." A key indicator of food quality, adequacy, and choice could be the proportion of residents not eating their entire meals or residents' personal observations about food quality.

Activities and Social Participation. A variety of activities and choices among activities have been shown to be significant elements of residents' concepts of quality.[38] Environmental circumstances, the availability of individualized activities, opportunities for social interaction and participation in activities inside and outside the nursing home that reduce social isolation are associated with improved mental and physical status.[34-37,40]

Quality of Life. The quality of the living environment, particularly cleanliness and the ability of residents to have personal possessions and furnishings in their rooms, is one of the prime components of residents' concepts of quality.[40] The quality of the living environment is related to the physical safety of residents (for example, in bathrooms) and their health (cleanliness is related to risk of infection). Staff attitudes and treatment of residents also affect quality of life. The dignity with which residents are treated and the friendliness and caring of staff, especially aides, are critical prerequisites to a quality life experience. Opportunities for personal choice in the details of daily life--mealtimes, time to rise and retire, activities, and clothing--can allow residents a small but important measure of control over their surroundings and personal lives and significantly enhance the quality of life in a nursing home.

OPERATIONAL USE OF KEY INDICATORS

The proposed standard survey relies on key indicators to determine whether a facility is providing high quality, moderate but acceptable quality, or potentially poor quality of care and quality of life. Taken together, the indicators must therefore discriminate among the degrees of quality. And the "pass/fail" score for each must be developed. For facilities failing the key indicators in the standard survey, a full or partial extended survey will be conducted, more fully to investigate whether there are care or life deficiencies and the reasons for them.

Following is a brief illustrative list of possible key indicators in various domains of quality of care and life and the types of follow-up investigation that would be required in the extended survey.

Nursing Care. Key Indicator: A given percentage of residents with weight loss of 5 pounds within 30 days (source of data: medical records and observations of residents). In the extended survey, the procedures would include examining records for acceptable reasons for weight loss (diagnosis of cancer, obesity, recent physical activity level changes), examining the current dietary program (caloric intake), observing residents for treatable conditions (poor or missing teeth, depression), observing meal presentation (temperature and taste of food), observing and interviewing residents regarding eating habits, need for assistive devices or staff assistance, food preferences, and investigating nursing staff levels and policies regarding food supplementation and nursing assistance in eating.

Key Indicator: A given proportion of residents with urinary tract infections associated with indwelling catheters (source of data: medical records). The extended survey procedures would include interviewing nursing staff and examining nursing procedures regarding fluid administration; investigating nursing staff levels; and investigating physician oversight of residents' care.

Key Indicator: A given percentage of residents physically restrained (source of data: observation of residents, medical records). In the extended survey, surveyors would investigate reasons for restraints to determine justification from medical records and staff interviews; investigate quality of care for restrained residents by observing positioning, release, and exercising of residents (from medical record reviews and staff interviews); and investigate nursing staff levels and nursing procedures.

Mental Status. Key Indicator: A given percentage of mentally unimpaired residents with depression (source of data: resident mental status interviews and medical records). The extended survey would encompass investigating the causes (physical disability, drugs, dissatisfaction with quality of care or life); and determining whether depression has been diagnosed and noted in the record and whether a plan of treatment has been formulated and is being carried out.

Medical Care. Key Indicator: Number of medications per resident exceeding a threshold level (source of data: medical records, resident interviews, and observation of medication administration). The extended survey would entail review of medical records and care planning procedures to determine whether medications are reconsidered monthly; review of drug interactions; investigation of the adequacy of pharmacy review; investigation of the extent of Medical Director involvement in the drug prescription process; investigation of nursing procedures regarding physician contacts; investigation of nursing oversight of medication complications; and investigation of the adequacy of care planning.

Dietary Service. Key Indicator: Are a given percentage of residents eating most of the food served? (Source of data: observation of meal service.) The extended survey would investigate nursing staff levels; investigate availability of assistive devices; investigate whether residents not eating are missing teeth or have other dental or medical problems impeding eating; interview residents as to whether they are given an opportunity to make choices and express preferences for food; and investigate excessive and rigid use of therapeutic diets.

Quality of Life. Key Indicator: Do a given percentage of residents report having friends among the staff? (Source of data: resident interviews.) The extended survey would investigate whether resident isolation has been identified and recorded in medical record and review care plan to determine if it is being addressed, and investigate staff training by interviewing staff and examining training procedures.

Key Indicator: Do a given percentage of resident rooms have personal memorabilia, rugs, curtains, pictures, plants? (Source of data: observation.) The extended survey would involve interviews with residents to determine why rooms lack personalization, and interviews with staff and the administrator. Facility policies regarding personal possessions in rooms would also be reviewed.

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RESIDENT ASSESSMENT
THE SPRINGBOARD TO QUALITY OF CARE AND QUALITY OF LIFE
FOR NURSING HOME RESIDENTS

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SECTION III - THE RESIDENT ASSESSMENT INSTRUMENTS

MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)
BACKGROUND INFORMATION/INTAKE AT ADMISSION

I. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	______________________ (First) (Middle Initial) (Last)	
2.	DATE OF CURRENT ADMISSION	☐☐ — ☐☐ — ☐☐☐☐ Month Day Year	
3.	MEDICARE NO (SOC. SEC or Comparable No. if no Medicare No.)	☐☐☐☐☐☐☐☐☐☐☐☐	
4.	FACILITY PROVIDER NO.	☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Federal No ☐☐☐☐☐☐☐☐☐☐☐	
5.	GENDER	1. Male 2. Female	☐
6.	RACE/ ETHNICITY	1. American Indian/Alaska Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin	☐
7.	BIRTHDATE	☐☐ — ☐☐ — ☐☐☐☐ Month Day Year	
8.	LIFETIME OCCUPATION	______________________	
9.	PRIMARY LANGUAGE	Resident's primary language is a language other than English 0. No 1. Yes ______________ (Specify)	☐
10.	RESIDENTIAL HISTORY PAST 5 YEARS	*(Check all settings resident lived in during 5 years prior to admission)*	
		Prior stay at this nursing home	a. ☐
		Other nursing home/residential facility	b. ☐
		MH/psychiatric setting	c. ☐
		MR/DD setting	d. ☐
		NONE OF ABOVE	e. ☐
11.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or any other mental health problem? 0. No 1. Yes	☐
12.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status, that were manifested before age 22, and are likely to continue indefinitely)*	
		Not applicable—no MR/DD (Skip to Item 13)	a. ☐
		MR/DD with Organic Condition	
		Cerebral palsy	b. ☐
		Down's syndrome	c. ☐
		Autism	d. ☐
		Epilepsy	e. ☐
		Other organic condition related to MR/DD	f. ☐
		MR/DD with no organic condition	g. ☐
		Unknown	h. ☐
13.	MARITAL STATUS	1. Never Married 2. Married 3. Widowed 4. Separated 5. Divorced	☐
14.	ADMITTED FROM	1. Private home or apt. 2. Nursing home 3. Acute care hospital 4. Other	☐
15.	LIVED ALONE	0. No 1. Yes 2. In other facility	☐
16.	ADMISSION INFORMATION AMENDED	*(Check all that apply)*	
		Accurate information unavailable earlier	a. ☐
		Observation revealed additional information	b. ☐
		Resident unstable at admission	c. ☐

II. BACKGROUND INFORMATION AT RETURN/READMISSION

1.	DATE OF CURRENT READMISSION	☐☐ — ☐☐ — ☐☐☐☐ Month Day Year	
2.	MARITAL STATUS	1. Never Married 2. Married 3. Widowed 4. Separated 5. Divorced	☐
3.	ADMITTED FROM	1. Private home or apt. 2. Nursing home 3. Acute care hospital 4. Other	☐
4.	LIVED ALONE	0. No 1. Yes 2. In other facility	☐
5.	ADMISSION INFORMATION AMENDED	*(Check all that apply)*	
		Accurate information unavailable earlier	a. ☐
		Observation revealed additional information	b. ☐
		Resident unstable at admission	c. ☐

III. CUSTOMARY ROUTINE (ONLY AT FIRST ADMISSION)

1.	CUSTOMARY ROUTINE (Year prior to first admission to a nursing home)	*(Check all that apply. If all information UNKNOWN, check last box only.)*	
		CYCLE OF DAILY EVENTS	
		Stays up late at night (e.g., after 9 pm)	a. ☐
		Naps regularly during day (at least 1 hour)	b. ☐
		Goes out 1+ days a week	c. ☐
		Stays busy with hobbies, reading, or fixed daily routine	d. ☐
		Spends most time alone or watching TV	e. ☐
		Moves independently indoors (with appliances, if used)	f. ☐
		NONE OF ABOVE	g. ☐
		EATING PATTERNS	
		Distinct food preferences	h. ☐
		Eats between meals all or most days	i. ☐
		Use of alcoholic beverage(s) at least weekly	j. ☐
		NONE OF ABOVE	k. ☐
		ADL PATTERNS	
		In bedclothes much of day	l. ☐
		Wakens to toilet all or most nights	m. ☐
		Has irregular bowel movement pattern	n. ☐
		Prefers showers for bathing	o. ☐
		NONE OF ABOVE	p. ☐
		INVOLVEMENT PATTERNS	
		Daily contact with relatives/close friends	q. ☐
		Usually attends church, temple, synagogue (etc.)	r. ☐
		Finds strength in faith	s. ☐
		Daily animal companion/presence	t. ☐
		Involved in group activities	u. ☐
		NONE OF ABOVE	v. ☐
		UNKNOWN—Resident/family unable to provide information	w. ☐

END

Signature of RN Assessment Coordinator: ______________________________

Signatures of Others Who Completed Part of the Assessment:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1	ASSESSMENT DATE	☐☐–☐☐–☐☐☐☐ Month Day Year	
2	RESIDENT NAME	(First) (Middle Initial) (Last)	
3	SOCIAL SECURITY NO	☐☐☐–☐☐–☐☐☐☐	
4	MEDICAID NO (if applicable)	☐☐☐☐☐☐☐☐☐☐☐☐	
5	MEDICAL RECORD NO	☐☐☐☐☐☐☐☐☐☐☐	
6	REASON FOR ASSESSMENT	1 Initial admission assess. 2 Hosp/Medicare reassess 3 Readmission assessment 4 Annual assessment 5 Significant change in status 6 Other (e.g., UR)	☐
7	CURRENT PAYMENT SOURCE(S) FOR N.H STAY	*(Billing Office to indicate, check all that apply)* Medicaid a ☐ Medicare b ☐ CHAMPUS c ☐ VA d ☐ Self pay/Private insurance e ☐ Other f ☐	
8	RESPONSIBILITY LEGAL GUARDIAN	*(Check all that apply)* Legal guardian a ☐ Other legal oversight b ☐ Durable power attrny health care proxy c ☐ Family member responsible d ☐ Resident responsible e ☐ *NONE OF ABOVE* f ☐	
9	ADVANCED DIRECTIVES	*(For those items with supporting documentation in the medical record, check all that apply)* Living will a ☐ Do not resuscitate b ☐ Do not hospitalize c ☐ Organ donation d ☐ Autopsy request e ☐ Feeding restrictions f ☐ Medication restrictions g ☐ Other treatment restrictions h ☐ *NONE OF ABOVE* i ☐	
10	DISCHARGE PLANNED WITHIN 3 MOS.	*(Does not include discharge due to death)* 0 No 1 Yes 2. Unknown/uncertain	☐
11	PARTICIPATE IN ASSESSMENT	a. Resident 0 No 1 Yes b Family 0 No 1 Yes 2 No family	a. ☐ b. ☐
12	SIGNATURES	Signature of RN Assessment Coordinator __________ Signatures of Others Who Completed Part of the Assessment __________ __________ __________ __________ __________ __________	

SECTION B. COGNITIVE PATTERNS

1	COMATOSE	*(Persistent vegetative state/no discernible consciousness)* 0 No 1 Yes *(Skip to SECTION E)*	☐
2.	MEMORY	*(Recall of what was learned or known)* a. Short-term memory OK—seems/appears to recall after 5 minutes 0 Memory OK 1 Memory problem b Long-term memory OK—seems/appears to recall long past 0 Memory OK 1 Memory problem	a. ☐ b. ☐
3.	MEMORY/ RECALL ABILITY	*(Check all that resident normally able to recall during last 7 days)* Current season a ☐ Location of own room b ☐ Staff names/faces c ☐ That he/she is in a nursing home d ☐ *NONE OF ABOVE* are recalled e ☐	
4	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	*(Made decisions regarding tasks of daily life)* 0 Independent—decisions consistent/reasonable 1 Modified independence—some difficulty in new situations only 2 Moderately impaired—decisions poor; cues/supervision required 3 Severely impaired—never/rarely made decisions	☐
5	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS	*(Check if condition over last 7 days appears different from usual functioning)* Less alert, easily distracted a ☐ Changing awareness of environment b ☐ Episodes of incoherent speech c ☐ Periods of motor restlessness or lethargy d ☐ Cognitive ability varies over course of day e ☐ *NONE OF ABOVE* f ☐	
6	CHANGE IN COGNITIVE STATUS	Change in resident's cognitive status, skills, or abilities in **last 90 days** 0 No change 1 Improved 2 Deteriorated	☐

SECTION C. COMMUNICATION/HEARING PATTERNS

1	HEARING	*(With hearing appliance, if used)* 0 Hears adequately—normal talk, TV, phone 1 Minimal difficulty when not in quiet setting 2 Hears in special situations only—speaker has to adjust tonal quality and speak distinctly 3. Highly impaired/absence of useful hearing	☐
2	COMMUNICATION DEVICES/ TECHNIQUES	*(Check all that apply during last 7 days)* Hearing aid, present and used a ☐ Hearing aid, present and not used b ☐ Other receptive comm. techniques used (e.g., lip read) c ☐ *NONE OF ABOVE* d ☐	
3.	MODES OF EXPRESSION	*(Check all used by resident to make needs known)* Speech a ☐ Writing messages to express or clarify needs b ☐ Signs/gestures/sounds c ☐ Communication board d ☐ Other e ☐ *NONE OF ABOVE* f ☐	
4	MAKING SELF UNDERSTOOD	*(Express information content—however able)* 0. Understood 1 Usually Understood—difficulty finding words or finishing thoughts 2 Sometimes Understood—ability is limited to making concrete requests 3 Rarely/Never Understood	☐
5	ABILITY TO UNDERSTAND OTHERS	*(Understanding verbal information content—however able)* 0 Understands 1 Usually Understands—may miss some part/intent of message 2 Sometimes Understands—responds adequately to simple direct communication 3. Rarely/Never Understands	☐
6	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand or hear information has changed over **last 90 days** 0 No change 1 Improved 2 Deteriorated	☐

SECTION D. VISION PATTERNS

1	VISION	*(Ability to see in adequate light and with glasses if used)* 0 Adequate—sees fine detail, including regular print in newspapers/books 1 Impaired—sees large print, but not regular print in newspapers/books 2 Highly Impaired—limited vision, not able to see newspaper headlines, appears to follow objects with eyes 3 Severely Impaired—no vision or appears to see only light, colors, or shapes	☐
2	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) a ☐ Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes b ☐ *NONE OF ABOVE* c ☐	
3.	VISUAL APPLIANCES	Glasses, contact lenses, lens implant, magnifying glass 0 No 1 Yes	☐

☐ = Code the appropriate response ☐ = Check all the responses that apply

August 20, 1990

SECTION E. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1	ADL SELF-PERFORMANCE—***(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)*** 0 *INDEPENDENT* — No help or oversight — OR — Help/oversight provided only 1 or 2 times during last 7 days 1 *SUPERVISION* — Oversight, encouragement or cueing provided 3+ times during last 7 days — OR — Supervision plus physical assistance provided only 1 or 2 times during last 7 days 2 *LIMITED ASSISTANCE* — Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times — OR — More help provided only 1 or 2 times during last 7 days 3 *EXTENSIVE ASSISTANCE* — While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times — Weight-bearing support — Full staff performance during part (but not all) of last 7 days 4 *TOTAL DEPENDENCE* — Full staff performance of activity during entire 7 days			
2	ADL SUPPORT PROVIDED — ***(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*** 0 No setup or physical help from staff 1 Setup help only 2 One-person physical assist 3 Two+ persons physical assist		(1) SELF PERF	(2) SUPPORT
a	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c	LOCO-MOTION	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
d	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
e.	EATING	How resident eats and drinks (regardless of skill)		
f	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal), transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
3	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. ***Code for most dependent in self-performance and support.*** Bathing Self-Performance codes appear below) 0 Independent—No help provided 1 Supervision—Oversight help only 2 Physical help limited to transfer only 3 Physical help in part of bathing activity 4 Total dependence	a.	b.
4	BODY CONTROL PROBLEMS	*(Check all that apply during last 7 days)*		
		Balance—partial or total loss of ability to balance self while standing	a	
		Bedfast all or most of the time	b	
		Contracture to arms, legs, shoulders, or hands	c	
		Hemiplegia/hemiparesis	d	
		Quadriplegia	e	
		Arm—partial or total loss of voluntary movement	f	
		Hand—lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid)	g	
		Leg—partial or total loss of voluntary movement	h	
		Leg—unsteady gait	i	
		Trunk—partial or total loss of ability to position, balance, or turn body	j	
		Amputation	k	
		NONE OF ABOVE	l	
5	MOBILITY APPLIANCES/ DEVICES	*(Check all that apply during last 7 days)*		
		Cane/walker	a	
		Brace/prosthesis	b	
		Wheeled self	c	
		Other person wheeled	d.	
		Lifted (manually/ mechanically)	e.	
		NONE OF ABOVE	f.	

6.	TASK SEG-MENTATION	Resident requires that some or all of ADL activities be broken into a series of subtasks so that resident can perform them 0 No 1 Yes	
7	ADL FUNC-TIONAL REHABILI-TATION POTENTIAL	Resident believes he/she capable of increased independence in at least some ADLs	a
		Direct care staff believe resident capable of increased independence in at least some ADLs	b
		Resident able to perform tasks/activity but is very slow	c
		Major difference in ADL Self-Performance or ADL Support in mornings and evenings (at least a one category change in Self-Performance or Support in any ADL)	d
		NONE OF ABOVE	e
8	CHANGE IN ADL FUNCTION	Change in ADL self-performance in last 90 days 0 No change 1 Improved 2 Deteriorated	

SECTION F. CONTINENCE IN LAST 14 DAYS

1	CONTINENCE SELF-CONTROL CATEGORIES ***(Code for resident performance over all shifts)*** 0 CONTINENT — Complete control 1 USUALLY CONTINENT — BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT — BLADDER, 2+ times a week but not daily; BOWEL, once a week 3 FREQUENTLY INCONTINENT — BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4 INCONTINENT — Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time		
a.	BOWEL CONTI-NENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b	BLADDER CONTI-NENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	
2	INCONTIN-ENCE RELATED TESTING	*(Skip if resident's bladder continence code equals 0 or 1 AND no catheter is used)*	
		Resident has been tested for a urinary tract infection	a
		Resident has been checked for presence of a fecal impaction, or there is adequate bowel elimination	b
		NONE OF ABOVE	c
3	APPLIANCES AND PROGRAMS	Any scheduled toileting plan	a
		External (condom) catheter	b
		Indwelling catheter	c
		Intermittent catheter	d
		Did not use toilet room/ commode/urinal	e
		Pads/briefs used	f
		Enemas/irrigation	g
		Ostomy	h
		NONE OF ABOVE	i
4	CHANGE IN URINARY CONTINENCE	Change in urinary continence appliances and programs in last 90 days 0 No change 1 Improved 2 Deteriorated	

SECTION G. PSYCHOSOCIAL WELL-BEING

1	SENSE OF INITIATIVE/ INVOLVE-MENT	At ease interacting with others	a
		At ease doing planned or structural activities	b
		At ease doing self-initiated activities	c
		Establishes own goals	d
		Pursues involvement in life of facility (e.g., makes/keeps friends, involved in group activities, responds positively to new activities, assists at religious services)	e
		Accepts invitations into most group activities	f
		NONE OF ABOVE	g
2	UNSETTLED RELATION-SHIPS	Covert/open conflict with and/or repeated criticism of staff	a
		Unhappy with roommate	b
		Unhappy with residents other than roommate	c
		Openly expresses conflict/anger with family or friends	d
		Absence of personal contact with family/friends	e
		Recent loss of close family member/friend	f
		NONE OF ABOVE	g
3	PAST ROLES	Strong identification with past roles and life status	a
		Expresses sadness/anger/empty feeling over lost roles/status	b
		NONE OF ABOVE	c

SECTION H. MOOD AND BEHAVIOR PATTERNS

1	SAD OR ANXIOUS MOOD	*(Check all that apply during last 30 days)*	
		VERBAL EXPRESSIONS of DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief)	a.
		DEMONSTRATED (OBSERVABLE) SIGNS of mental DISTRESS	
		— Tearfulness, emotional groaning, sighing, breathlessness	b.
		— Motor agitation such as pacing, handwringing or picking	c.
		— Failure to eat or take medications, withdrawal from self-care or leisure activities	d.
		— Pervasive concern with health	e.
		— Recurrent thoughts of death—e.g., believes he/she about to die, have a heart attack	f.
		— Suicidal thoughts/actions	g.
		NONE OF ABOVE	h.
2.	MOOD PERSISTENCE	Sad or anxious mood intrudes on daily life over last 7 days — not easily altered, doesn't "cheer up" 0. No 1. Yes	
3	PROBLEM BEHAVIOR	*(Code for behavior in last 7 days)* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently	
		WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	a.
		VERBALLY ABUSIVE (others were threatened, screamed at, cursed at)	b.
		PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused)	c.
		SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	d.
4	RESIDENT RESISTS CARE	*(Check all types of resistance that occurred in the last 7 days)*	
		Resisted taking medications/injection	a.
		Resisted ADL assistance	b.
		NONE OF ABOVE	c.
5.	BEHAVIOR MANAGEMENT PROGRAM	Behavior problem has been addressed by clinically developed behavior management program. (Note: Do not include programs that involve only physical restraints or psychotropic medications in this category) 0. No behavior problem 1. Yes, addressed 2. No, not addressed	
6	CHANGE IN MOOD	Change in mood in last 90 days 0. No change 1. Improved 2. Deteriorated	
7	CHANGE IN PROBLEM BEHAVIOR	Change in problem behavioral signs in last 90 days 0. No change 1. Improved 2. Deteriorated	

SECTION I. ACTIVITY PURSUIT PATTERNS

1	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	*NONE OF ABOVE*	d.
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	0. Most—more than $^2/_3$ of time 1. Some—$^1/_3$ to $^2/_3$ of time		2. Little—less than $^1/_3$ of time 3. None	
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*			
		Own room	a.	Outside facility	d.
		Day/activity room	b.	*NONE OF ABOVE*	e.
		Inside NH/off unit	c.		
4	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	*(Check all PREFERENCES whether or not activity is currently available to resident)*			
		Cards/other games	a.	Spiritual/religious activities	f.
		Crafts/arts	b.	Trips/shopping	g.
		Exercise/sports	c.	Walking/wheeling outdoors	h.
		Music	d.	Watch TV	i.
		Reading/writing	e.	*NONE OF ABOVE*	
5	PREFERS MORE OR DIFFERENT ACTIVITIES	Resident expresses/indicates preference for other activities/choices 0. No 1. Yes			

SECTION J. DISEASE DIAGNOSES

Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list old inactive diagnoses.)

1	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*			
		HEART/CIRCULATION		**PSYCHIATRIC/MOOD**	
		Arteriosclerotic heart disease (ASHD)	a.	Anxiety disorder	p.
		Cardiac dysrhythmias	b.	Depression	q.
		Congestive heart failure	c.	Manic depressive (bipolar disease)	r.
		Hypertension	d.	**SENSORY**	
		Hypotension	e.	Cataracts	s.
		Peripheral vascular disease	f.	Glaucoma	t.
		Other cardiovascular disease	g.	**OTHER**	
		NEUROLOGICAL		Allergies	u.
		Alzheimer's	h.	Anemia	v.
		Dementia other than Alzheimer's	i.	Arthritis	w.
		Aphasia	j.	Cancer	x.
		Cerebrovascular accident (stroke)	k.	Diabetes mellitus	y.
		Multiple sclerosis	l.	Explicit terminal prognosis	z.
		Parkinson's disease	m.	Hypothyroidism	aa.
		PULMONARY		Osteoporosis	bb.
		Emphysema/Asthma/COPD	n.	Seizure disorder	cc.
		Pneumonia	o.	Septicemia	dd.
				Urinary tract infection—in last 30 days	ee.
				NONE OF ABOVE	ff.
2.	OTHER CURRENT DIAGNOSES AND ICD-9 CODES	a ________________	☐☐☐.☐☐		
		b ________________	☐☐☐.☐☐		
		c ________________	☐☐☐.☐☐		
		d ________________	☐☐☐.☐☐		
		e ________________	☐☐☐.☐☐		
		f	☐☐☐.☐☐		

SECTION K. HEALTH CONDITIONS

1	PROBLEM CONDITIONS	*(Check all problems that are present in last 7 days unless other time frame indicated)*			
		Constipation	a.	Pain—resident complains or shows evidence of pain daily or almost daily	j.
		Diarrhea	b.	Recurrent lung aspirations in last 90 days	k.
		Dizziness/vertigo	c.	Shortness of breath	l.
		Edema	d.	Syncope (fainting)	m.
		Fecal impaction	e.	Vomiting	n.
		Fever	f.	*NONE OF ABOVE*	o.
		Hallucinations/delusions	g.		
		Internal bleeding	h.		
		Joint pain	i.		
2.	ACCIDENTS	Fell in past 30 days	a.	Hip fracture in last 180 days	c.
		Fell in past 31-180 days	b.	*NONE OF ABOVE*	d.

3	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, or behavior status unstable—fluctuating, precarious, or deteriorating	a.
		Resident experiencing an acute episode or a flare-up of a recurrent/chronic problem	b.
		NONE OF ABOVE	c.

SECTION L. ORAL/NUTRITIONAL STATUS

1	ORAL PROBLEMS	Chewing problem			a.
		Swallowing problem			b.
		Mouth pain			c.
		NONE OF ABOVE			e.
2	HEIGHT AND WEIGHT	*Record height (a.) in inches and weight (b.) in pounds. Weight based on most recent status in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.*	HT (in.) a.	WT (lb.) b.	
		c Weight loss (i.e., 5%+ in last 30 days, or 10% in last 180 days) 0 No 1 Yes			c.
3.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods	a.	Regular complaint of hunger	d.
		Insufficient fluid; dehydrated	b.	Leaves 25%+ food uneaten at most meals	e.
		Did NOT consume all/almost all liquids provided during last 3 days	c.	*NONE OF ABOVE*	f
4	NUTRITIONAL APPROACHES	Parenteral/IV	a.	Dietary supplement between meals	f.
		Feeding tube	b.	Plate guard, stabilized built-up utensil, etc.	g.
		Mechanically altered diet	c.	*NONE OF ABOVE*	h.
		Syringe (oral feeding)	d.		
		Therapeutic diet	e.		

SECTION M. ORAL/DENTAL STATUS

1	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures and/or removable bridge	b
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses, ulcers or rashes	e.
		Daily cleaning of teeth/dentures	f
		NONE OF ABOVE	g.

SECTION N. SKIN CONDITION

1.	STASIS ULCER	(open lesion caused by poor venous circulation to lower extremities) 0. No 1 Yes	
2.	PRESSURE ULCERS	*(Code for highest stage of pressure ulcer)* 0. No pressure ulcers 1 Stage 1 A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved 2. Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater 3. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue 4 Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone	
3.	HISTORY OF RESOLVED/CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/cured in last 90 days 0. No 1 Yes	

4	SKIN PROBLEMS/CARE	Open lesions other than stasis or pressure ulcers (e.g., cuts)	a
		Skin desensitized to pain, pressure, discomfort	b
		Protective/preventive skin care	c
		Turning/repositioning program	d
		Pressure relieving beds, bed/chair pads (e.g., egg crate pads)	e
		Wound care/treatment (e.g., pressure ulcer care, surgical wound)	f
		Other skin care treatment	g
		NONE OF ABOVE	h

SECTION O. MEDICATION USE

1	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*	
2	NEW MEDICATIONS	Resident has received new medications during the last 90 days 0. No 1 Yes	
3.	INJECTIONS	*(Record the number of days injections of any type received during the last 7 days)*	
4	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of days during last 7 days; enter "0" if not used; enter "1" if long-acting meds. used less than weekly)*	
		Antipsychotics	a.
		Antianxiety/hypnotics	b.
		Antidepressants	c.
5.	PREVIOUS MEDICATION RESULTS	*(SKIP this question if resident currently receiving antipsychotics, antidepressants, or antianxiety/hypnotics—otherwise code correct response for last 90 days)* Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences) 0. No, drugs not used 1 Drugs were effective 2. Drugs were not effective 3 Drug effectiveness unknown	

SECTION P. SPECIAL TREATMENT AND PROCEDURES

1	SPECIAL TREATMENTS AND PROCEDURES	SPECIAL CARE—*Check treatments received during the last 14 days*			
		Chemotherapy	a.	IV meds	f
		Radiation	b	Transfusions	g
		Dialysis	c	O_2	h
		Suctioning	d	Other ______	i
		Trach. care	e	*NONE OF ABOVE*	j
		THERAPIES—*Record the number of days each of the following therapies was administered (for at least 10 minutes during a day) in the last 7 days:*			
		Speech—language pathology and audiology services			k.
		Occupational therapy			l.
		Physical therapy			m.
		Psychological therapy (any licensed professional)			n.
		Respiratory therapy			o.
2.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90-days? 0 No 1 Yes 2. No tests performed			
3.	DEVICES AND RESTRAINTS	*Use the following codes for last 7 days:* 0. Not used 1 Used less than daily 2. Used daily			
		Bed rails			a.
		Trunk restraint			b.
		Limb restraint			c.
		Chair prevents rising			d.

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND

LEGEND:

● Automatic Trigger—Go directly to RAP Instructions

▲ Potential Trigger—Go to RAP Instructions for more detailed trigger definitions

Instructions: Match MDS Item codes with trigger codes below. Proceed to RAP Instructions as indicated by symbol. Circle all RAPs that are "triggered," based on your review.

MDS Item	Code	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL Functional/Rehabilitation Potential	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavior Problem	Activities	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints
B2 a or b	1		▲																
B3 a.b.c.d	lower than 3 ✓		▲																
B4	0,1,2				▲														
	1,2,3		▲																
B5 a.b.c.d.e	any ✓	●																	
B6	2	●													▲				
C4	2,3				▲														
C5	1,2,3		▲																
	2,3				▲	▲													
C6	2	●																	
D1	1,2,3			●															
D2 a	✓			●															
E1 a.b.c.d.e.f	3,4					▲													
E3 a	3,4					▲													
E4 a.b.d.e.h.j	any ✓											▲							
E7 a.b	any ✓					▲													
E8	2														▲				
F1 b	2,3,4						▲												
F3 b.c.d.f	any ✓						▲												
G2 a.b.c.d	any ✓							●											
G3 b	✓							●											
H1 a.b.c.d.e.f.g	any ✓								●										
H1 d	✓														▲				
H2	1								●										
H3 a.b.c or d	1,2									●									
H6	2	▲																	
H7	2	●																	
I2	0,2,3										▲								
I5	1										●								
J1 ee	✓														▲				
J2	260, 261, 262												●						
	263, 263.0, 263.1												●						
	263.2, 263.8, 263.9												●						
	276.5														▲				
	291.0, 292.81	●																	
	293.0, 293.1	●																	
K1 b.c.f.h.n	any ✓														▲				
K2 a.b	any ✓											●							
L1 c	✓															●			
L2 c	1												●		▲				
L3 a.d.e	any ✓												●						
L3 b	✓														●				
L3 c.e	✓														▲				
L4 a.b	any ✓														▲				
L4 a.c.d.e	any ✓												●						
L4 b	✓													●					
M1 a.c.d.e	any ✓															●			
M1 f	not ✓															●			
N2	1,2,3,4												●				●		
N4 c.d.e.f.g	none ✓																▲		
O4 a.b.c	1-7									▲		▲						▲	
P3 b.c. or d	1,2									▲									●

Resident's Name:	Medical Record No.:

Signature of RN Assessment Coordinator: ____________________

RESIDENT ASSESSMENT PROTOCOL SUMMARY

1. For each RAP area triggered, show whether you are proceeding with a care plan intervention.
2. Document problems, complications, and risk factors; the need for referral to appropriate health professionals; and the reasons for deciding to proceed or not to proceed to care planning. Documentation may appear anywhere the facility routinely keeps such information, such as problem sheets or nurses' progress notes.
3. Show location of this information.

RAP Problem Area	Care Planning Decision		Location of Information
	Proceed	Not Proceed	
DELIRIUM	☐	☐	
COGNITIVE LOSS/DEMENTIA	☐	☐	
VISUAL FUNCTION	☐	☐	
COMMUNICATION	☐	☐	
ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐	☐	
URINARY INCONTINENCE AND INDWELLING CATHETER	☐	☐	
PSYCHOSOCIAL WELL-BEING	☐	☐	
MOOD STATE	☐	☐	
BEHAVIOR PROBLEM	☐	☐	
ACTIVITIES	☐	☐	
FALLS	☐	☐	
NUTRITIONAL STATUS	☐	☐	
FEEDING TUBES	☐	☐	
DEHYDRATION/FLUID MAINTENANCE	☐	☐	
DENTAL CARE	☐	☐	
PRESSURE ULCERS	☐	☐	
PSYCHOTROPIC DRUG USE	☐	☐	
PHYSICAL RESTRAINTS	☐	☐	

RESIDENT ASSESSMENT PROTOCOL: DELIRIUM

I. PROBLEM

Delirium (acute confusional state) is a common indicator or nonspecific symptom of a variety of acute, treatable illnesses. It is a serious problem, with high rates of morbidity and mortality, unless it is recognized and treated appropriately. Delirium is never a part of normal aging. Some of the classic signs of delirium may be difficult to recognize and may be mistaken for the natural progression of dementia, particularly in the late stages of dementia when delirium has high mortality. Thus careful observation of the resident and review of potential causes are essential.

Delirium is characterized by fluctuating states of consciousness, disorientation, decreased environmental awareness, and behavioral changes. The onset of delirium may vary, depending on the severity of the cause(s) and the resident's health status; however, it usually develops rapidly, over a few days or even hours. Even with successful treatment of cause(s) and associated symptoms, it may take several weeks before cognitive abilities return to pre-delirium status.

Successful management depends on accurate identification of the clinical picture, correct diagnosis of specific cause(s), and prompt nursing and medical intervention. Delirium is often caused and aggravated by multiple factors. Thus, if you identify and address one cause, but delirium continues, you should continue to review the other major causes of delirium and treat any that are found.

II. TRIGGERS

Delirium problem suggested if:

1. ANY Indicator of Disordered Thinking **[B5a, B5b, B5c, B5d, B5e = any checked]**

2. Cognitive/Communication/Behavior Decline **[B6 = 2 or C6 = 2 or H7 = 2]**

3. Mood Decline **[H6=2]** AND ANY of following:

   - Motor Agitation **[H1c = checked]**
   - Withdrawal **[H1d = checked]**
   - Hallucinations/Delusions **[K1g = checked]**

4. Alcohol Withdrawal, Drug-induced, Acute or Subacute Delirium
   [J2 = 291.0, 292.81, 293.0, or 293.1]

III. GUIDELINES

Detecting signs and symptoms of delirium requires careful observation. Knowledge of a person's baseline cognitive abilities facilitates evaluation.

- Staff should become familiar with residents' cognitive function by regularly observing the resident in a variety of situations so that even subtle but important changes can be recognized.

When observed in this manner, the presence of any trigger signs/symptoms may be seen as a potential marker for acute, treatable illness.

An approach to detection and treatment of the problem can be selected by reviewing the items that follow in the order presented. Also refer to the RAP KEY for guidance on the MDS items that are relevant.

DIAGNOSES AND CONDITIONS

By correctly identifying the underlying cause(s) of delirium, you may prevent a cycle of worsening symptoms (e.g., an infection-fever-dehydration-confusion syndrome) or a drug regimen for a suspected cause that worsens the condition. The most common causes of delirium are associated with circulatory, respiratory, infectious, and metabolic disorders. However, finding one cause or disorder does not rule out the possibility of additional contributing causes and/or multiple interrelated factors.

MEDICATIONS

Many medications given alone or in combination can cause delirium.

- If necessary, check doctor's order against med sheet and drug labels to avoid the common problem of medication error.
- Review the resident's drug profile with a physician.
- Review all medications (regularly prescribed, PRN, and "over-the-counter" drugs).

Number of medications. The greater the number, the greater the possibility of adverse drug reaction/toxicity.

- Review meds to determine need and benefit (ask if resident is receiving more than one drug class of drug to treat a condition).
- Check to determine whether nonpharmacological interventions have been considered (e.g., a a behavior management program rather than antipsychotics to address the needs of a resident who is physically or verbally abusive).

New medications.

- Review to determine whether there is a temporal relationship between onset or worsening of delirium and start of new medication.

Drugs that cause delirium.

1. PSYCHOTROPIC
   Antipsychotics
   Antianxiety/hypnotics
   Antidepressants
2. CARDIAC
   Digitalis glycosides (Digoxin),
   Antiarrhythmics, such as quinidine, procainamide (Pronestyl), disoprymide (Norpace)
   Calcium channel blockers, such as verapamil (Isoptin), nifedipine (Procardia), and diltiazem (Cardizem)
   Antihypertensives, such as methyldopa (Aldomet), propanolol (Inderal)
3. GASTROINTESTINAL
   H2 antagonists such as cimetidine (Tagamet) and ranitidine (Zantac)
4. ANALGESICS such as Darvon, narcotics (e.g., morphine, dilaudid)
5. ANTI-INFLAMMATORY
   Corticosteroids such as prednisone
   Nonsteroidal anti-inflammatory agents such as ibuprofin (Motrin)
6. OVER-THE-COUNTER DRUGS, especially those with anticholinergic properties
   Cold remedies (antihistamines, pseudoephedrine)
   Sedatives (antihistamines, e.g., Benadryl)
   Stay-awakes (caffeine)
   Antinauseants
   Alcohol

PSYCHOSOCIAL

After serious illness and drug toxicity are ruled out as causes of delirium, consider the possibility that the resident is experiencing psychosocial distress that may produce signs of delirium.

Isolation.

- Has the resident been away from people, objects and situations?
- Is resident confused about time, place and meaning?
- Has the resident been in bed or in an isolated area while recuperating from an illness or receiving a treatment?

Recent loss of family/friend. Loss of someone close can precipitate a grief reaction that presents as acute confusion, especially if the person provided safety and structure for a demented resident.

- Review the MDS to determine whether the resident has experienced a recent loss of a close family member/friend.

Depression/sad or anxious mood. Mood states can lead to confusional states that resolve with appropriate treatment.

- Review the MDS to determine whether the resident exhibits any signs or symptoms of sad or anxious mood or has a diagnosis of a psychiatric illness.

Restraints. Restraints often aggravate the conditions staff are trying to treat (e.g., confusion, agitation, wandering).

- Did the resident become more agitated and confused with their use?

Recent relocation.

- Has the resident recently been admitted to a new environment (new room, unit, facility)?
- Was there an orientation program that provided a calm, gentle approach with reminders and structure to help the new resident settle into the environment?

SENSORY LOSSES

Sensory impairments often produce signs of confusion and disorientation, as well as behavior changes. This is especially true of residents with early signs of dementia. They can also aggravate a confusional state by impairing the resident's ability to accurately perceive or cope with environmental stimuli (e.g., loud noises; onset of evening). This can lead to the resident experiencing hallucinations/delusions and misinterpreting noises and images.

Hearing.

- Is hearing deficit related to easily remedied situations — impacted ear wax or hearing aid dysfunction?
- Has sensory deprivation led to confusion?
- Has physician input been sought?

Vision.

- Has vision loss created sensory deprivation resulting in confusion?
- Have major changes occurred in visual function without the resident's being referred to a physician?

DELIRIUM RAP KEY

TRIGGERS

Delirium problem suggested if:

1. ANY indicator of Disordered Thinking **[B5a, B5b, B5c, B5d, B5e = any checked]**
2. Cognitive/Communication/Behavior Decline **[B6 = 2 or C6 = 2 or H7 = 2]**
3. Mood Decline **[H6 = 2]** AND ANY of following:
   - Motor Agitation **[H1c = checked]**
   - Withdrawal **[H1d = checked]**
   - Hallucinations/Delusions **[K1g = checked]**
4. Alcohol Withdrawal, Drug-induced, Acute or Subacute Delirium **[J2=291.0, 292.81, 293.0, or 293.1]**

GUIDELINES

Factors that may be associated with signs and symptoms of delirium:

1. **Diagnoses and Conditions.** Cardiac dysrhythmias **[J1b]**, CHF **[J1c]**, CVA **[J1k]**, Emphysema/Asthma/COPD **[J1n]**, Pneumonia **[J1o]**, Anemia **[J1v]**, Cancer **[J1x]**, Diabetes **[J1y]**, Hypothyroidism **[J1aa]**, Septicemia **[J1dd]**, Urinary tract infection **[J1ee]**, Fecal impaction **[K1e]**, Fever **[K1f]**, or Dehydration **[L3b]**. Myocardial infarction, any viral or bacterial infection (e.g., meningitis, infectious diarrhea), Surgical abdomen, Head trauma, Hypothermia, Hypoglycemia, Hyperthyroidism, or Transient Ischemic Attack (TIA) **[J2 and medical record]**.
2. **Medications.** No. of meds **[O1]**, New meds **[O2]**, Antipsychotics **[O4a]**, or Antianxiety/hypnotics **[O4b]**, Cardiac meds, GI meds, Analgesics, Antiinflammatory, Anticholinergics **[from med charts]**.
3. **Psychosocial.** Isolation **[G2e; from record]**, Recent loss **[G2f]**, Sad or anxious mood **[H1]**, Restraints **[P3b, P3c, P3d]**, or Recent relocation **[Intake I2]**.
4. **Sensory impairment.** Hearing **[C1]** or Vision **[D1]**.

Clarifying information to be considered in establishing a diagnosis: Alzheimer's **[J1h]**, Time of onset within hours to days **[from record or observation]**; Sleep disturbance **[from record or observation]**

Environment conducive to reducing symptoms: Quiet, well-lit, calm, familiar objects **[from observation]**; Task segmentation **[E6]**

RESIDENT ASSESSMENT PROTOCOL: COGNITIVE LOSS/DEMENTIA

I. PROBLEM

Approximately 60% of residents in nursing facilities exhibit signs and symptoms of decline in intellectual functioning. Recovery will be possible for less than 10% of these residents — those with a reversible condition such as an acute confusional state (delirium). For most residents, however, the syndrome of cognitive loss or dementia is chronic and progressive, and appropriate care focuses on enhancing quality of life, sustaining functional capacities, minimizing decline, and preserving dignity.

Confusion and/or behavioral disturbances present the primary complicating care factors. Identifying and treating acute confusion and behavior problems can facilitate assessment of how chronic cognitive deficits affect the life of the resident.

For residents with chronic cognitive deficits, a therapeutic environment is supportive rather than curative and is an environment in which licensed and nonlicensed care staff are encouraged (and trained) to comprehend a resident's experience of cognitive loss. With this insight, staff can develop care plans focused on three main goals: (1) to provide positive experiences for the resident (e.g., enjoyable activities) that do not involve overly demanding tasks and stress; (2) to define appropriate support roles for each staff member involved in a resident's care; and (3) to lay the foundation for reasonable staff and family expectations concerning a resident's capacities and needs.

II. TRIGGERS

A cognitive loss/dementia problem is suggested if two or more of the following deficits are present:

- Short-term Memory Problem [B2a = 1]
- Long-term Memory Problem [B2b = 1]
- Two or More Memory Recall Problems [B3a, B3b, B3c, B3d = fewer than three checked]
- Some Decision-making Problem [B4 = 1, 2 or 3]
- Problem Understanding Others [C5 = 1, 2 or 3]
- Diagnosis of Alzheimer's Disease [J1h = checked]; Dementia other than Alzheimer's [J1i = checked]; Mental Retardation [INTAKE I12 b-f = any checked]; Parkinson's Disease [J1m = checked]; or Aphasia [J1j = checked]

III. GUIDELINES

Review the following MDS items to investigate possible links between these factors and the resident's cognitive loss and quality of life. The three triggers identify residents with differing levels of cognitive loss. Even for those who are most highly impaired, the RAP seeks to help identify areas in which staff intervention might be useful. Refer to the RAP KEY for specific MDS items and other specific issues to consider.

NEUROLOGICAL

Fluctuating Cognitive Signs and Symptoms/Neurological Status. Co-existing delirium and progressive cognitive loss can result in erroneous impressions concerning the nature of the resident's chronic limitations. Only when acute confusion and behavioral disturbances are treated, or when the treatment effort is judged to be as effective as possible, can a true measure of chronic cognitive deficits be obtained.

Recent Changes in the Signs/Symptoms of the Dementia Process. Identifying these changes can heighten staff awareness of the nature of the resident's cognitive and functional limitations. This knowledge can assist staff in developing reasonable expectations of the resident's capabilities and in designing programs to enhance the resident's quality of life. This knowledge can also challenge staff to identify potentially reversible causes for recent losses in cognitive status.

Mental Retardation, Alzheimer's Disease, and Other Adult-Onset Dementias. The most prevalent neurological diagnoses for cognitively impaired residents are Alzheimer's disease and multi-infarct dementia. But increasing numbers of mentally retarded residents are in nursing facilities, and many adults suffering from Down's syndrome appear to develop dementia as they age. The diagnostic distinctions among these groups can be useful in reminding staff of the types of long-term intellectual reserves that are available to these residents.

MOOD/BEHAVIOR

Specific treatments for behavioral distress, as well as treatments for delirium, can lessen and even cure the behavioral problem. At the same time, however, some behavior problems will not be reversible, and staff should be prepared (and encouraged) to learn to live with their manifestations. In some situations where problem/distressed behavior continues, staff may feel that the behavior poses no threat to the resident's safety, health, or activity pattern and is not disruptive to other residents. For the resident with declining cognitive functions and a behavioral problem, you may wish to consider the following issues:

- Have cognitive skills declined subsequent to initiation of a behavior control program (e.g., psychotropic drugs or physical restraints)?
- Is decline due to the treatment program (e.g., drug toxicity or negative reaction to physical restraints)?
- Have cognitive skills improved subsequent to initiation of a behavior control program?
- Has staff assistance enhanced resident self-performance patterns?

CONCURRENT MEDICAL PROBLEMS

Major Concurrent Medical Problems. Identifying and treating health problems can positively affect cognitive functioning and the resident's quality of life. Effective therapy for congestive heart failure, chronic obstructive pulmonary disease, and constipation can lead, for example, to functional and cognitive improvement. Comfort (pain avoidance) is a paramount goal in controlling both acute and chronic conditions for cognitively impaired residents. Verbal reports from residents should be one (but not the only) source of information. Some residents will be unable to communicate sufficiently to pinpoint their pain.

FUNCTIONAL LIMITATIONS

Extent and Rate of Change of Resident Functional Abilities. Functional changes are often the first concrete indicators of cognitive decline and suggest the need to identify reversible causes. You may find it helpful to determine the following:

- To what extent is resident dependent for locomotion, dressing and eating?
- Could the resident be more independent?
- Is resident going downhill (e.g., experiencing declines in bladder continence, locomotion, dressing, vision, time involved in activities)?

SENSORY IMPAIRMENTS

Perceptual Difficulties. Many cognitively impaired residents have difficulty identifying small objects, positioning a plate to eat, or positioning the body to sit in a chair. Such difficulties can cause a resident to become cautious and ultimately cease to carry out everyday activities. If problems are vision-based, corrective programs may be effective. Unfortunately, many residents have difficulty indicating that the source of their problem is visual. Thus, the cognitively impaired can often benefit if tested for possible visual deficits.

Ability to Communicate. Many individuals suffering from cognitive deficits seem incapable of meaningful communication. However, many of the seemingly incomprehensible behaviors (e.g., screaming, aggressive behavior) in which these individuals engage may constitute their only form of communication. By observing the behavior and the pattern of its occurrence, one can frequently come to some understanding of the needs of individuals with dementia. For example, residents who are restrained for their own safety may become noisy due to bladder or bowel urgency.

- Is resident willing/able to engage in meaningful communication?
- Does staff use non-verbal communication techniques (e.g., touch, gesture) to encourage resident to respond?

MEDICATIONS

Psychoactive medications can be a factor in cognitive decline. If necessary, review Psychotropic Drug Use RAP.

INVOLVEMENT FACTORS

Opportunities for Independent Activity. Staff can encourage residents to participate in the many available activities, and staff can guard against assuming an overly protective attitude toward residents. Decline in one functional area does not indicate the need for staff to assume full responsibility in that area nor should it be interpreted as an indication of inevitable decline in other areas. Review information in the MDS when considering the following issues:

- Are there factors that suggest that the resident can be more involved in his/her care (e.g., instances of greater self-performance; desire to do more independently; retained ability to learn; retained control over trunk, limbs, and/or hands)?
- Can resident participate more extensively in decisions about daily life?
- Does resident retain any cognitive ability that permits some decision making?
- Is resident passive?
- Does resident resist care?
- Are activities broken into manageable subtasks?

Extent of Involvement in Activities of Daily Life. Programs focused on physical aspects of the resident's life can lessen the disruptive symptoms of cognitive decline for some residents. Consider the following:

- Are residents with some cognitive skills and without major behavioral problems involved in the life of the facility and the world around them?
- Can modifying task demands, or the environmental circumstances under which tasks are carried out, be beneficial?
- Are small group programs encouraged?
- Are special environmental stimuli present (e.g., directional markers, special lighting)?
- Do staff regularly assist residents in ways that permit them to maintain or attain their highest predictable level of functioning (e.g., verbal reminders, physical cues and supervision regularly provided to aid in carrying out ADLs; ADL tasks presented in segments to give residents enough time to respond to cues; pleasant, supportive interaction)?
- Has the resident experienced a recent loss of someone close (e.g., death of spouse, change in key direct care staff, recent move to the nursing facility, decreased visiting by family and friends)?

FAILURE TO THRIVE

Cognitively impaired residents can reach the point where their accumulated health/neurological problems place them at risk of clinical complications (e.g., pressure ulcers) and death. As this level of disability approaches, staff can review the following:

- Do emotional, social, and/or environmental factors play a key role?
- If a resident is not eating, is this due to a reversible mood problem, a basic personality problem, a negative reaction to the physical and interactive environment in which eating activity occurs, or a neurological deficit such as deficiency in swallowing or loss of hand coordination?
- Could an identified problem be remedied through improved staff education — trying an antidepressant medication, referral to OT for training or an innovative counseling program?
- If causes cannot be identified, what reversible clinical complications can be expected as death approaches (e.g., fecal impaction, UTI, diarrhea, fever, pain, pressure ulcers)?
- What interventions are or could be in place to decrease complications?

COGNITIVE LOSS/DEMENTIA RAP KEY

TRIGGERS

A cognitive loss/dementia problem deficit and retained abilities suggested if two or more of the following deficits are present:

- Short-term Memory Problem **[B2a = 1]**
- Long-term Memory Problem **[B2b = 1]**
- Two or More Memory Recall Problems **[B3a, B3b, B3c, B3d = less than 3 checked]**
- Some Decision-making Problem **[B4 = 1, 2, or 3]**
- Problem Understanding Others **[C5 = 1, 2 or 3]**
- Diagnosis of Alzheimer's **[J1h = checked]**; Dementia other than Alzheimer's **[J1i= checked]**; Mental Retardation **[INTAKE I12b-f = any checked]**; Parkinson's **[J1m = checked]**; or Aphasia **[J1j = checked]**

GUIDELINES

Factors to review for relationship to cognitive loss:

1. **Neurological.** Delirium **[B5]**, Cognitive decline **[B6]**, Alzheimer's and other dementias **[J1h, J1i]**, MR/DD status **[INTAKE I12]**.

Confounding Problems that may require resolution or suggest reversible causes:

2. **Mood/behavior.** Sad mood or Mood decline **[H1, H6]**, Behavior problem or behavior decline **[H3, H7]**, Anxiety disorder **[J1p]**, Depression **[J1q]**, Manic depressive disorder **[J1r]**, Other psychiatric disorders **[J2]**.
3. **Concurrent medical problems.** CHF **[J1c]**, Other cardiovascular disease **[J1g]**, CVA **[J1k]**, Emphysema/Asthma/COPD **[J1n]**, Cancer **[J1x]**, Diabetes **[J1y]**, Hypothyroidism **[J1aa]**.
4. **Functional limitations.** ADL task segmentation **[E6]**, Decline in ADL or continence **[E8; F4]**.
5. **Sensory impairment.** Hearing/visual problems **[C1; D1]**, Rarely/never understands **[C5]**, Impaired tactile sense **[N4b]**.
6. **Medications.** Antipsychotics, Antianxiety/hypnotics, Antidepressants **[O4]**.
7. **Involvement factors.** New admission **[INTAKE I2]**, Trunk or chair restraint **[P3]**, Withdrawal from activities **[H1d]**, Encouragement of small group programs **[from record]**.
8. **Failure to thrive.** Terminal prognosis **[J1z]**, Clinical complications **[K1; L3; N2]**.

RESIDENT ASSESSMENT PROTOCOL: VISUAL FUNCTION

I. PROBLEM

The aging process leads to a gradual decline in visual acuity: a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark, and diminished ability to discriminate color. The aged eye requires about 3-4 times more light in order to see well than the young eye.

The leading causes of visual impairment in the elderly are macular degeneration, cataracts, glaucoma, and diabetic retinopathy. In addition, visual perceptual deficits (impaired perceptions of the relationship of objects in the environment) are common in the nursing home population. Such deficits are a common consequence of cerebrovascular events and are often seen in the late stages of Alzheimer's disease and other dementias. The incidence of all these problems increases with age.

In 1974, 49% of all nursing home residents were described as being unable to see well enough to read a newspaper with or without glasses. In 1985, over 100,000 nursing home residents were estimated to have severe visual impairment or no vision at all. Thus vision loss is one of the most prevalent losses of residents in nursing facilities. A significant number of residents in any facility may be expected to have difficulty performing tasks dependent on vision as well as problems adjusting to vision loss.

The consequences of vision loss are wide-ranging and can seriously affect physical safety, self-image, and participation in social, personal, self-care, and rehabilitation activities. This RAP is primarily concerned with identifying two types of residents: 1) Those who have treatable conditions that place them at risk of permanent blindness (e.g., Glaucoma; Diabetes, retinal hemorrhage); and 2) those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances. Further, the assumption is made that residents with new acute conditions will have been referred to followup as the conditions were identified (e.g., sudden loss of vision; recent red eye; shingles; etc). To the extent that this did not occur, the RAP KEY followup questions will cause staff to ask whether such a referral should be considered.

II. TRIGGERS

The Visual Function RAP triggers three types of residents:

1. Residents with treatable conditions that place them at risk of permanent blindness (e.g., Glaucoma; Diabetes, retinal hemorrhage). For glaucoma, the issue to be considered will revolve around proper use of eye medications; for diabetes, the issue centers on the possible referral for laser treatment to arrest retinal hemorrhage.

   Some Vision Impairment but not functionally blind [D1=1 or 2] AND presence of Glaucoma OR Diabetes [J1t, J1y = any checked].

2. Residents with visual problems who are able to understand others AND make themselves understood. In most instances, these residents are able to participate in a thorough eye exam, including testing of visual acuity. The key question for these residents centers on whether current daily functioning is seriously limited by visual acuity problems.

   Vision impairment OR Side Vision problems [D1 = 1, 2 or 3 or D2a = checked] AND Can Both Make Self Understood AND Understand Others [C4 = 0, 1 or 2 and C5 = 0, 1 or 2]

3. Residents with visual problems who are not able to understand others OR make themselves understood. In most instances these residents are unable to cooperate in a thorough eye exam, including testing of visual acuity. They are triggered to ensure screening for disease that might put them at risk of blindness, as well as to determine whether the resident or family have concerns about how the visual deficit is restricting the resident.

Vision impairment <u>OR</u> Side Vision problems [D1=1, 2 or 3 or D2a = checked] <u>AND</u> Cannot Make Self Understood OR Understand Others [C4=3 or C5=3]

III. GUIDELINES

Visual impairment may be related to many causes, and one purpose of this section is to screen for the presence of major risk factors and to review the resident's recent treatment history. This section also includes items that ask whether the visually impaired resident desires or has a need for increased functional use of eyes.

<u>Eye medications</u>: Of greatest importance is the review of medications related to glaucoma (phospholine iodide, pilorarpine, propine, epineprin, Timoptic or other Beta-Blockers, diamox, or Neptazane).

- Is the resident receiving his/her eye medication as ordered?
- Does the resident experience any side effects?

<u>Diabetes Cataracts, Glaucoma, or Macular Degeneration</u>: Diabetes may affect the eye by causing blood vessels in the retina to hemorrhage (retinopathy). All these conditions are associated with decreased visual acuity and visual field deficits. If resident is able to cooperate it is very possible to test for glaucoma and retinal problems.

<u>Exam by ophthalmologist or optometrist since problem noted</u>:

- Has the resident been seen a consultant?
- Have the recommendations been followed (e.g. medications, refraction [new glasses], surgery)?
- Is the recommendation compatible with the resident's wishes (e.g., medical rehab. vs. surgery)?

<u>If neurological diagnosis or dementia exam by physician since problem noted</u>. Check the medical record to see if a physician has examined the resident for visual/perceptual difficulties. Some residents with diseases such as myethenia gravis, stroke, and dementia will have such difficulties associated with central nervous system in the absence of diseases of the eye.

<u>Sad or anxious mood</u>: Some residents, especially those in a new environment, will complain of visual difficulties. Visual disorganization may improve with treatment of the sad or anxious mood.

<u>Appropriate use of visual appliances</u>: Residents may have more severe visual impairment when they do not use their eyeglasses. Residents who wear reading glasses for walking, for example, may misperceive their environment and bump into objects or fall.

- Are glasses labelled or color coded in a fashion that enables the resident/staff to determine when they should be used?
- Are the lenses of glasses clean and free of scratches?
- Were glasses recently lost? Were they being recently used, and now they are missing?

Functional need for eye exam/new glasses: Many residents with limited vision will be able to use the environment with little or no difficulty, and neither the resident nor staff will perceive the need for new visual appliances. In other circumstances, needs will be identified, and for residents who are capable of participating in a visual exam, new appliances, surgery to remove cataracts, etc. can be considered.

- Does resident have peripheral vision or other visual problem that impedes his/her ability to eat food, walk on the unit, or interact with others?
- Is resident's ability to recognize staff limited by a visual problem?
- If resident is having difficulty negotiating his environment or participating in self-care activities because of visual impairment has he/she been referred to low vision services?
- Does resident report difficulty seeing TV/reading material of interest?
- Does resident express interest in improved vision?
- Has resident refused to have eyes examined? How long ago did this occur? Has it occurred more than once?

Environmental modifications: Residents whose vision cannot be improved by refraction, or medical and/or surgical intervention may benefit from environmental modifications.

- Does the resident's environment enable maximum visual function (e.g. low-glare floors and table surfaces, night lights)?
- Has the environment been adapted to resident's individual needs (e.g. large print signs marking room, color coded tape on dresser drawers, large numbers on telephone, reading lamp with 300 watt bulb)? Could the resident be more independent with different visual cues (e.g., labeling items, task segmentation) or other sensory cues (e.g., cane for recognizing there are objects in path)?

Acute Problems that may have been missed: Eye pain, blurry vision, double vision, sudden loss of vision: These symptoms are usually associated with acute eye problems.

- Has resident been evaluated by a physician or ophthalmologist?

Residents with communication impairments may be very difficult to assess. Residents who are unable to understand others may have problems following the directions necessary to test visual acuity.

VISUAL FUNCTION RAP KEY

TRIGGERS

Potential for acute, reversible visual function problems suggested if:

1. Some Vision Impairment but not functionally blind [D1 = 1 or 2] AND Glaucoma OR Diabetes [J1t, J1y = any checked]

Potential for improved visual function suggested if:

2. Vision Impairment OR Side Vision problems [D1 = 1, 2 or 3 or D2a = checked] AND Can Make Self Understood AND Can Understand Others [C4 = 0, 1 or 2 and C5 = 0, 1 or 2]
3. Vision Impairment OR Side Vision problems [D1 = 1, 2 or 3 or D2a = checked] AND Cannot Make Self Understood OR Understand Others [C4 = 3 or C5 = 3]

GUIDELINES

Issues and problems to be reviewed that may suggest need for intervention:

1. Eye medications [from record]
2. Diabetes [J1y], Cataracts, Glaucoma or Macular Degeneration [J1s, J1t; J2]
3. Exam by ophthalmologist since problem noted [from record]
4. Neurological diagnosis or dementia [J1h, J1i, J1j, J1k, J1m; J2]
5. Sad or Anxious Mood [H1]
6. Appropriate use of visual appliances [D3; from record, observation]
7. Functional need for eye exam/new glasses [from observation]
8. Environmental modifications [from record, observation]
9. Other acute problems: Eye pain, blurry vision, double vision, sudden loss of vision [from record, observation]

RESIDENT ASSESSMENT PROTOCOL: COMMUNICATION

I. PROBLEM

Good communication enables residents to express emotion, listen to others, and share information. It also eases adjustment to a strange environment and lessens social isolation and depression.

EXPRESSIVE communication problems include changes/difficulties in: speech and voice production, finding appropriate words, transmitting coherent statements, describing objects and events, using nonverbal symbols (e.g., gestures), and writing. RECEPTIVE communication problems include changes/difficulties in: hearing, speech discrimination in quiet and noisy situations, vocabulary comprehension, vision, reading, and interpreting facial expressions.

When communication is limited, assessment focuses on reviewing several factors: underlying causes of the deficit, the success of attempted remedial actions, the resident's ability to compensate with nonverbal strategies (e.g., ability to visually observe nonverbal signs and signals), and the willingness and ability of staff to engage with residents to ensure effective communication. As language use recedes with dementia, both the staff and the resident must expand their nonverbal communication skills — one of the most basic and automatic of human abilities. Touch, facial expression, eye contact, tone of voice, and posture all are powerful means of communicating with the demented resident, and recognizing and using all practical means is the key to effective communication.

II. TRIGGERS

The resident has the potential for improved communication and the RAP should be completed when the following problems are present.

Potential for improved communication is suggested if:

1. Poor Expression or Understanding [C4 = 2 or 3 or C5 = 2 or 3] AND
   Some Decision-Making Ability [B4 = 0, 1 or 2]

2. Poor Expression or Understanding [C4 = 2 or 3 or C5 = 2 or 3] AND
   No Decision-Making Ability [B4 = 3] AND
   No CVA or Neurological Problems [J1h, J1i, J1j, J1k, J1m = none checked]

Potential for improved hearing is suggested if:

3. Some Decision-Making Ability [B4 = 0, 1 or 2] AND ANY Hearing Problem [C1 = 1, 2 or 3]

III. GUIDELINES

The communication trigger suggests residents for whom a corrective communication treatment program may be beneficial. Specify those residents with potentially correctable problems. An effective review requires a special effort by staff to overcome any preconceived notions or fixed perceptions they may have about the resident's probable responsiveness to treatment. These perceptions may be based on the failure of prior treatment programs, as well as on assumptions that may not have been recently tested about the resident's unwillingness to begin a corrective program.

The triggers identify three types of residents:

1. Those with serious communication deficits who have retained some ability to make decisions. Such residents should have some ability to participate in a restorative communication treatment program.
2. Those with serious communication deficits in addition to no apparent ability to make decisions but no underlying CVA or neurological problems. These residents may have behavioral, mood, or environmental limitations that complicate their communication problem.
3. Those with hearing deficits and some ability to make decisions. These residents should have the intellectual ability to be considered for participation in a restorative hearing program.

Review items listed on the RAP KEY as follows:

Confounding Problems.

As these confounding problems lessen or further decline is prevented, the resident's communication abilities should be reviewed.

Components of Communication.

Details of resident strengths and weaknesses in understanding, hearing and expression are the direct or indirect focus of any treatment program.

Possible Links with Causes of Communication Deficits.

- For chronic conditions that are unlikely to improve, consider communication treatments or interventions that might compensate for losses (e.g., for moderately impaired residents with Alzheimer's, the use of short, direct phrases and tactile approaches to communication can be effective).
- Are there acute or transitory conditions which if successfully resolved may result in improved ability to communicate?
- Are medications in use that could cause or complicate communication deficits, where titration or substitution may result in improved ability to communicate?
- Are opportunities to communicate limited in ways that could be remedied — e.g., availability of partners?

Treatment/Evaluation History.

- Has resident received an evaluation by an audiologist or speech-language pathologist? How recently?
- Has the resident's condition deteriorated since the most recent evaluation?
- If such an evaluation resulted in a plan of care, has it been followed as specified?

COMMUNICATION RAP KEY

TRIGGERS

Potential for improved communication suggested if:

1. Poor Expression or Understanding [C4 = 2 or 3 or C5 = 2 or 3] AND Some Decision-Making Ability [B4 = 0, 1 or 2]
2. Poor Expression or Understanding [C4 = 2 or 3 or C5 = 2 or 3] AND No Ability to Make Decisions [B4 = 3] AND No CVA/Neurological Problems [J1h, J1i, J1j, J1k, J1m = none checked]

Potential for improved hearing suggested if:

3. Some Decision-Making Ability [B4 = 0, 1 or 2] AND ANY Hearing Problem [C1 = 1, 2 or 3]

GUIDELINES

Confounding problems that may require resolution:

1. Decline in cognitive status [B6]
2. Decline in ADL status [E8]
3. Increased mood problems [H6]

Components of communication to be considered:

1. Hearing/Vision [C1; D1]
2. Comm. devices/Modes of expression [C2, C3]
3. Decline in communication/hearing [C6]
4. Medical status of ear — discharges, cerumen accumulation, hearing changes [from record or exam]

Factors to be reviewed for possible relationship to communication problems:

1. **Chronic Conditions.** Alzheimer's/Other dementia [J1h, J1i], Aphasia [J1j], CVA [J1k], Parkinson's [J1m], Emphysema/Asthma/COPD [J1n], Cancer [J1x], Psychiatric disorders [J2]
2. **Transitory Conditions.** Delirium [B5], Depression [J1q], Infections [J1o, J1dd, J1ee; K1f], Acute episode [K3b]
3. **Medications.** Psychotropics [O4], Narcotics, Parkinson's meds, Gentamycin, Tobramycin, Aspirin toxicity [from record]
4. **Opportunities to Communicate.** Quality/quantity of communication is (or is not) commensurate with apparent ability to communicate [staff judgement]

Clarifying issues to be considered:

1. Memory [B2; B3]
2. Recent audiology/language pathology evaluation [P1k; from record]

RESIDENT ASSESSMENT PROTOCOL: ACTIVITIES OF DAILY LIVING—FUNCTIONAL REHABILITATION POTENTIAL

I. PROBLEM

Personal mastery of ADL and mobility are as crucial to human existence in the nursing home as they are in the community. The nursing home is unique only in that most residents require help with self-care functions. ADL dependence can lead to intense personal distress — invalidism, isolation, diminished self-worth, and a loss of control over one's destiny. As inactivity increases, complications such as pressure ulcers, falls, contractures, and muscle-wasting can be expected.

The ADL RAP assists staff in setting positive and realistic goals, weighing the advantages of independence against risks to safety and self-identity. In promoting independence staff must be willing to accept a reasonable degree of risk and active resident participation in setting treatment objectives.

Rehabilitative goals of several types can be considered:

- To restore function to maximum self-sufficiency in the area indicated:
- To replace hands-on assistance with a program of task segmentation and verbal cueing;
- To restore abilities to a level that allows the resident to function with fewer supports;
- To shorten the time required for providing assistance;
- To expand the amount of space in which self-sufficiency can be practiced;
- To avoid or delay additional loss of independence; and
- To support the resident who is certain to decline in order to lessen the likelihood of complications (e.g., pressure ulcers and contractures).

II. TRIGGERS

The three MDS triggers suggest the types of residents for whom special care interventions may be most important. Such residents may have either the need and potential to improve or the need for services to prevent decline.

The two rehabilitation triggers will select all residents:

(1) Who have some ability to make decisions and who have more substantial ADL problems: or
(2) Who are more self-sufficient but who are thought to have potential for increased ADL self-sufficiency.

The maintenance trigger selects residents who lack cognitive skills. These individuals depend totally on others to ensure that their ADL status does not decline precipitously and that they do not develop complications.If a resident falls into one of these groups, the RAP should be completed.

Rehabilitative/Restorative plans suggested if resident has:

1. Some Ability to Make Decisions **[B4 = 0, 1 or 2]** AND Extensive Assistance/Total Dependence in 1 or more ADL areas **[E1a, E1b, E1c, E1d, E1e or E1f = 3 or 4 OR E3a = 3 or 4]**

2. Some Ability to Make Decisions **[B4 = 0, 1 or 2]** AND Needs no more than Limited Assistance in All ADL areas **[E1a, E1b, E1c, E1d, E1e and E1f = 0, 1 or 2 AND E3a = 0, 1 or 2]** AND Potential for More Self-Sufficiency Noted **[E7a, E7b = any checked]**

Maintenance/Complication Avoidance plans suggested if resident has:

3. No Ability to Make Decisions **[B4 = 3]** AND No Memory **[B2a = 1 AND B2b =1]** AND Some or Rare/No Understanding **[C5 = 2 or 3]**

III. GUIDELINES

Base an approach to a resident's ADL difficulty on clinical knowledge of:

- The causes of dependence;
- The expected course of the problem(s); and
- Which services work or do not work.

The MDS goal is to assist the clinician in identifying residents for whom rehabilitative/restorative goals can be reasonably established. Many ADL-restricted residents can regain partial ability for self-care. Certain types of disease-generated losses will respond to therapy. In addition, the removal of inappropriate restraints and the close monitoring of potentially toxic medications can often result in increased functioning.

Use the items in the ADL RAP KEY to consider the resident's risk of decline and chance of rehabilitation. Responses to these items permit a focused approach to specific ADL deficits (i.e., selecting and describing the specific ADL areas where decline has been observed or improvement is possible). The first thing that needs to be considered is the possible presence of confounding problems that may require resolution before rehabilitation goals can be reasonably attempted.

The second task is to clarify the resident's potential for improved functioning. The clinician might find the following sequence of questions useful in initiating an evaluation:

- Does the resident have the ability to learn? To what extent can the resident call on past memory to assist in current problem-solving situations?
- What is the resident's general functional status? How disabled is the resident, and does status vary?
- Is mobility severely impaired?
- Is trunk, leg, arm and/or hand use severely impaired?
- Are there distinct behavioral problems?
- Are there distinct mood problems?
- Is the resident motivated to work at a rehabilitative program?

Where rehabilitation goals are envisioned, use of the ADL Supplement will help care planners to focus on those areas that might be improved, allowing them to choose from among a number of basic tasks in designated areas. Part 1 of the Supplement can assist in the evaluation of all those triggered into the RAP. Part 2 of the Supplement can be helpful when a treatment program is under consideration.

ADL SUPPLEMENT
(Attaining maximum possible independence)

PART 1: ADL Problem Evaluation INSTRUCTIONS: For those triggered— In areas physical help provided, indicate reason(s) for this help.	DRESSING	BATHING	TOILETING	LOCOMOTION	TRANSFER	EATING
Mental Errors: Sequencing problems, incomplete performance, anxiety limitations, etc. **Physical Limitations:** Weakness, limited range of motion, poor coordination, visual impairment, pain, etc. **Facility Conditions:** Policies, rules, physical layout, etc.						

PART 2: Possible ADL goals				If wheelchair, check: ☐		
INSTRUCTIONS: For those considered for rehabilitation or decline prevention treatment— Indicate specific type of ADL activity that might require: 1. Maintenance to prevent decline. 2. Treatment to achieve highest practical self sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in).	Locates/ selects/ obtains clothes	Goes to tub/shower	Goes to toilet (include commode/ urinal at night)	Walks in room/ nearby ☐	Positions self in preparation	Opens/pours/ unwraps/cuts etc.
	Grasps/puts on upper/ lower body	Turns on water/adjusts temp.	Removes/ opens clothes in preparation	Walks on unit ☐	Approaches chair/bed	Grasps utensils and cups
	Manages snaps, zippers, etc.	Lathers body (except back)	Transfers/ positions self	Walks throughout building (uses elevator) ☐	Prepares chair/bed (locks pads, moves covers)	Scoops/spears food (uses fingers when necessary)
	Puts on in correct order	Rinses body	Eliminates into toilet	Walks outdoors ☐	Transfers (stands/sits/ lifts/turns)	Chews, drinks, swallows
	Grasps, removes each item	Dries with towel	Tears/uses paper to clean self	Walks on uneven surfaces ☐	Repositions/ arranges self	Repeats until food consumed
	Replaces clothes properly	Other	Flushes	Other ☐	Other	Uses napkins, cleans self
	Other		Adjusts clothes, washes hands			Other
			Other			

ADL FUNCTIONAL/REHABILITATION POTENTIAL RAP KEY

TRIGGERS

REHABILITATION/RESTORATIVE plans suggested if:

1. Some Ability to Make Decisions **[B4=0, 1 or 2]** AND Extensive Assistance/Total Dependence in 1 or more ADL areas **[E1a, E1b, E1c, E1d, E1e or E1f = 3 or 4 OR** E3a = 3 or 4**]**
2. Some Ability to Make Decisions **[B4=0, 1 or 2]** AND Needs no more than limited assistance in ALL ADL areas **[E1a, E1b, E1c, E1d, E1e, and E1f = 0, 1 or 2 AND E3a = 0, 1 or 2]** AND Potential for More Self-Sufficiency noted **[E7a, E7b = any checked]**

MAINTENANCE/COMPLICATION AVOIDANCE plans suggested if:

3. No Ability to Make Decisions **[B4 = 3]** AND No Memory **[B2a = 1 AND B2b = 1]** AND Some or Rare/No Understanding **[C5 = 2 or 3]**

GUIDELINES

Confounding problems that may require resolution:

1. Delirium **[B5]**
2. Persistent mood problem [H2]
3. Daily behavior problem [H3]
4. Decline in mood/behavior [H6, H7]
5. Unstable/acute health problem [K3]
6. Use of Psychoactive medications [O4]

Clarifying issues to be considered:

1. Prior improvement in cognition, ADLs, mood, or behavior [B6; E8; H6; H7]
2. Communication and vision [C; D]
3. Explicit terminal prognosis [J1z]
4. Trunk/limb control and ability to stand [E4]
5. Complete ADL Supplement Part 1 for all triggered residents; for a resident with rehabilitation potential, complete ADL Supplement Part 2

RESIDENT ASSESSMENT PROTOCOL:
URINARY INCONTINENCE AND INDWELLING CATHETER

I. PROBLEM

Urinary incontinence is the inability to control urination in a socially appropriate manner. Nationally, 50% of nursing home residents are incontinent. Incontinence causes many problems, including skin rashes, falls, isolation, and pressure ulcers, and the potentially troubling use of indwelling catheters. In addition, continence is often an important goal to many residents, and incontinence may affect residents' psychological well-being and social interactions. Urinary incontinence is curable in many elderly residents but realistically not all will benefit from an evaluation. Catheter use increases the risk of life-threatening infections, bladder stones and cancer. Use of catheters also contributes to patient discomfort and the needless use of toxic medications often required to treat the associated bladder spasms. For many (but not all) residents, urinary incontinence is curable, and safer and more comfortable approaches are often practical for residents with indwelling catheters.

This RAP, the purpose of which is to improve incontinence, goes far beyond bladder training. Even if a patient is not believed to be a candidate for bladder training, the assessment should still be done since many other treatable conditions may be found, the treatment of which will not only improve incontinence, but the overall quality of life for the patient.

The goal of this assessment is to detect reversible causes of incontinence, such as infections and medications, and situationally induced incontinence; to identify individuals whose incontinence is caused by harmful conditions such as bladder tumors or spinal cord diseases; and to consider the appropriateness of catheter use. Staff judgment is clearly required to realize these aims. Detailed instructions are provided to facilitate this clinical process.

Continence depends on many factors. Urinary tract factors include a bladder that can store and expel urine and a urethra that can close and open appropriately. Other factors include the resident's ability (with or without staff assistance) to reach the toilet on time (locomotion), his/her ability to adjust clothing so as to toilet (dexterity), cognitive function and social awareness (e.g., recognizing the need to void in time and in an appropriate place), and the resident's motivation. Fluid balance and the integrity of the spinal cord and peripheral nerves will also have an effect on continence. Change in any one of these factors can result in incontinence, although alterations in several factors are common before incontinence develops.

II. TRIGGERS

A urinary continence or indwelling catheter problem is suggested if:

1. Occasional, Frequent, or Frank Urinary Incontinence [F1b = 2, 3 or 4]
2. Use of Catheter or Pads [F3b, F3c, F3d, F3f = any checked]

Exclusions for Triggers: Comatose [B1] or Explicit terminal prognosis [J1z]. Other exclusions may apply especially after the reversible problems have been addressed. These are noted at the beginning of each section.

III. GUIDELINES

For residents with incontinence (including those with condom catheters), all MDS items described in Section A should be addressed, unless exclusionary criteria have been met. If incontinence persists, complete Section B and, if necessary, Section C. For residents with indwelling catheters, first complete Sections A and B and then complete Section D.

A. ITEMS NECESSARY TO EVALUATE INCONTINENCE OR NEED FOR CATHETER

Review the reversible problems listed on the RAP KEY. Virtually all are easily diagnosed, and their treatment will improve not only incontinence but functional status as well. Also, most of these factors can be identified by a nurse, but some will take a physician's order to carry out.

UTI.

Urinary tract infections are common causes of incontinence, especially new incontinence. Therefore, they should be looked for in all residents. If a clean catch urine is not feasible and the resident both has no memory recall and requires at least extensive assistance in self-transfer [E1b = 3 or 4] you may choose to forego catheterization to obtain a specimen, since identification and treatment of UTIs in this population has not been shown to make a difference.

- Send a clean catch or sterile urine specimen for microscopic analysis. If >5 WBC are found, send a fresh and sterilely obtained specimen for urine culture. If UTI is found, consider treatment.
- For residents with an indwelling catheter, a new catheter should be sterilely inserted to obtain the specimen.

Fecal Impaction.

Impaction is very common and can cause incontinence by preventing the bladder from emptying well. Thus, check for impaction in all residents who are incontinent.

- To find bowel impaction, insert a gloved finger into resident's rectum.
- The finding of no stool or small amount of soft stool indicates that impaction is unlikely to be the cause of incontinence. A record demonstrating that the resident has recently passed stool is not sufficient to rule out bowel impaction.

Delirium.

If present, this is the most important problem. Often when delirium is treated, incontinence will resolve. In the meantime, regular toileting will help.

Lack of toilet access.

Daily use of restraints can result in a resident's inability to get to the toilet; quick staff response is necessary. The toilet may also be too far away for a resident who does not get adequate warning (e.g., there may not be a toilet room near the activities room). Environmental modifications such as a bedside commode, urinal, or a room closer to the toilet can be useful. To remain continent, residents may also require more staff support, such as more timely responses to requests for assistance.

Immobility.

Immobility correlates highly with incontinence in many nursing home residents. Improving the resident's ability in transferring, locomotion and toileting will often reduce incontinence, as will providing timely staff assistance when needed.

Depression.

Severe depression can result in loss of the motivation to stay dry. Prompted toileting is often helpful as a means of positive reinforcement.

Congestive Heart Failure (CHF) or Pedal Edema.

CHF and pedal edema are especially troublesome when the resident is lying down: diuresis overwhelms the bladder. Treatment of these conditions is not difficult and will improve both incontinence and functional status.

Recent Stroke.

Once the resident is stable, delirium has cleared, and locomotion has improved, continue workup if incontinence persists. Most stroke patients are continent at this point.

Diabetes Mellitus.

Diabetes with persistently high blood sugar causes fluid loss that can cause or worsen incontinence. Treatment will improve incontinence and functional status.

Medications.

Many medications can affect the bladder or urethra and result in incontinence. Physicians would usually discontinue suspect medication if possible, weighing the risks and benefits of doing so. For instance, where a calcium channel blocker is used for mild hypertension, another medication might be easily substituted; a medication for arrhythmia, however, might not have an appropriate substitute.

- Review all medications — regularly prescribed, occasional or "PRN", and any nonprescribed ("over-the-counter") medications.

Medications that can affect continence include the following classes and types of drugs:

1. Diuretics, especially those that act quickly, such as furosemide (Lasix), bumetanide (Bumex), and metolozone (Zaroxylyn), and, less frequently, thiazide agents such as hydrochlorothiazide.
2. Sedative hypnotics, i.e., sleeping pills and antianxiety drugs such as diazepam (Valium), lorazepam, Xanax, Halcion, and Dalmane.
3. Any drug with anticholinergic properties:
    - Antipsychotics (e.g., Haldol, Mellaril)
    - Antidepressants (e.g., Elavil, Triavil)
    - Narcotics (e.g., Morphine, Dilaudid, Darvon)
    - Medication for Parkinson's disease (except Sinemet and Deprenyl)
    - Disopyramide
    - Antispasmodics (e.g., Donnatal, Bentyl)
    - Antihistamines (e.g., medications for colds)
4. Calcium channel blockers (e.g., verapamil, nimodipine, nicardipine, nifedipine, and diltiazem).
5. Drugs that affect the sympathetic nervous system:
    - Alpha blockers (e.g., prazosin and phenoxybenzamine)
    - Alpha stimulants (e.g., ephedrine, pseudoephedrine, phenylpropanolamine, and nosedrops)

B. OTHER POTENTIAL CAUSES OR FACTORS CONTRIBUTING TO INCONTINENCE OR USE OF CATHETERS

Much of the information asked for above will appear in a completed MDS. However, other items of information should be obtained and reviewed if incontinence persists. Identification and treatment of these factors will frequently not only improve incontinence, but may prevent further deterioration such as paralysis. However, in the resident who both has no memory recall [B3e = checked], requires at least extensive assistance in self-transfer [E1b = 3 or 4], and is free of related pain, there is, as of yet, no evidence that identification and treament of such factors would benefit the resident.

Pain

Pain in the bladder, or related to urination, is a distinctly rare and abnormal symptom in the incontinent patient, and often indicates another pathological process, which may be treatable. Physician evaluation is recommended.

Excessive or Inadequate Urine Output

If daily urine output is less than 1 liter, incontinence may worsen because of very strong, concentrated urine. A daily output over 1.5 liters can overwhelm the bladder. If present, the identification of the underlying cause of the high urine output (e.g., diabetes, high calcium, or excessive fluid intake) is required before restricting fluids.

- The amount of fluid excreted daily should be measured for 1 to 2 days. This can be done using a voiding record or, if patient is severely incontinent, by inserting a temporary catheter.

Atrophic Vaginitis

Caused by reduced amount of the female hormone estrogen, this condition causes or contributes to incontinence in many women.

- Examine vagina for evidence of estrogen deficiency.

Optimally, a pelvic exam checks for signs of atrophic vaginitis.

If a resident is impaired, or appropriate equipment is not readily available, an exam may be done in the resident's bed by spreading the labia and looking inside for redness, dryness, pinpoint hemorrhages, or easy bleeding.

- Pain or irritation during the insertion of a catheter is another useful sign of the condition (catheterization normally may be uncomfortable, but should not be painful).
- Atrophic vaginitis can be treated with a low dose of oral conjugated estrogens. Contraindications to estrogen therapy include a history of breast or endometrial cancer.

Abnormal Lab Values

Several conditions detectable only by laboratory tests can cause incontinence. These include high blood calcium or glucose and Vitamin B12 deficiency. It is also important to check the blood urea nitrogen (BUN) or creatinine because some causes of incontinence also can damage the kidneys. All of these tests should have been done within the last 60 days, except the B12, which should have been checked within the past 3 years.

Serious Conditions That Cause or Accompany Incontinence (To Be Considered By Primary Doctor).

A doctor or a nurse practitioner can identify potentially life-threatening conditions that cause or accompany urinary incontinence. These include bladder cancer or bladder stones, prostate cancer, spinal cord or brain lesions (such as slipped discs and metastatic tumors), poor bladder compliance, and tabes dorsalis.

- Bladder cancer or stones are suggested by the presence of any amount of blood in the urine (even in microscopic amounts) without evidence of UTI. To investigate for bladder cancer, the first morning urine is sent for 2 or 3 days for cytology examinations. Residents more likely to have bladder cancer are men, smokers, and those with suprapubic pain or discomfort, a history of work exposure to certain dyes, or recent onset of urge incontinence. The physician will decide who is worked up or referred to a urologist.
- Suspected prostate cancer can be detected by a rectal exam.
- Spinal cord diseases are detected by a neurological exam.
- Decreased bladder compliance can result in damage to the kidneys and should be suspected in residents with a history of conditions that result in decreased bladder compliance (pelvic radiation therapy, abdominal/pelvic resection, radical hysterectomy or prostatectomy, or spinal cord disease).
- Another cause of incontinence is tabes dorsalis (an advanced stage of syphilis), which is treatable with antibiotics.

C. FINAL EVALUATION IF INCONTINENCE PERSISTS

After the above causes of easily treatable incontinence have been eliminated and the most serious underlying conditions have been investigated, conclude the evaluation with an assessment of the four causes of incontinence that are due to abnormalities within the bladder itself. The following section first describes these abnormalities and then describes the tests to detect their presence. A variety of treatment options is available for each type of incontinence, including treatment and care plans appropriate for every resident. In each case, the care plan can be tailored to the needs and characteristics of the resident with dementia, immobility, etc. Notably, bladder training and medications have been shown to significantly improve incontinence in even severely demented residents. The options are discussed in full detail in the educational material.

Exclusions: Although demented residents have been shown to benefit from targeted therapy, certain patients have a low probability of responding. Therefore, if a resident has no memory recall [B3e = checked], is extensively dependent in self-transfer [E1b or c = 3 or 4], and the facility's ability to toilet the resident on a regular schedule is limited, then the patient may not benefit from this part of the evaluation, and should be managed with pads, frequent turning and changing, or external catheters. Indications for an indwelling catheter are: the resident is in a coma or has terminal illness, a stage 3 or 4 pressure ulcer in an area affected by the incontinence, untreatable urethral blockage, the need for exact measurement of urine output, a history of being unable to void after having a catheter removed in the past, or a resident with quad/paraplegia who failed a past attempt to remove a catheter.

The bladder abnormalities can be simply understood: either (1) the bladder contracts when it should not ("uninhibited bladder"), abruptly soaking the patient ("urge incontinence"); or (2) the bladder fails to contract when it should ("atonic" or underactive bladder), so that urine builds up and spills over as "overflow incontinence." Alternatively the urethra, through which the bladder empties, is either (3) blocked by an obstruction (e.g., a large prostate) or (4) unable to close tightly enough ("stress incontinence").

By doing a "stress test" and measuring the amount of urine that remains in the bladder after voiding (Post Void Residual — PVR) these conditions can be separated: the uninhibited bladder generally has little residual urine (<100 ml) and a negative stress test, while the atonic bladder has a much larger residual (e.g., >400 ml). Women with stress incontinence (it is rare in men) generally have <100 ml residual urine and a positive stress test. Men with a blocked urethra (rare in women) generally have >100 ml residual urine and a negative stress test.

Post-Void Residual (PVR).

The PVR (post-void residual) is the amount of urine left in the bladder after a void. Research has shown that many elderly people have large amounts left in the bladder after a void, even though they demonstrate no signs of this. That is, they do not feel full or uncomfortable, they have a good urine output, and do not seem to have a large bladder by palpation or percussion. Also, in men, a high PVR can signal a variety of problems, and in both men and women, knowledge of the PVR can help guide the selection of medication. Therefore, a PVR should be determined in all patients who reach this point of the evaluation. In some cases, a physician's order may be necessary to perform a PVR. If the physician chooses not to allow this, it should be documented in the chart.

- When the resident feels relatively full, he/she should void as normally as possible into a commode, bedpan, urinal, or a toilet equipped with a collection device (hat). Measure volume voided. Within 15 minutes of voiding, under sterile conditions, insert a nonpermanent catheter to measure the residual volume (PVR). Adding the volume voided to PVR gives the Total Bladder Volume (TBV).

Attention to several points will ensure that the test is done correctly. First, if the resident cannot void intentionally, do the test after an episode of incontinence. Second, after allowing the urine to drain, apply gentle pressure with your hand to the abdomen to increase the drainage. When the urine has stopped draining, withdraw the catheter slowly, continuing to press on the lower abdomen. If possible, have the resident sit up during the catheter withdrawal. Under sterile conditions, the risk of causing an infection is under 3%. Residents with known valvular heart disease (who receive antibiotic prophylaxis for dental work) probably should receive a dose of antibiotics before the PVR is checked.

Kidney Ultrasound Test for Men With a PVR Greater Than 100 ml.

- Ultrasound of the kidneys is indicated in male residents with a PVR greater than 100 ml to rule out hydronephrosis (inability of the kidneys to drain properly), which could be due to bladder obstruction and result in preventable kidney damage.

This test has no risks (compared to the risk of the dye injection in an IVP). Evidence of urine backing into the kidneys strongly suggests the need for urologic referral; if this is not done, the resident needs chronic indwelling catheterization.

Bladder Stress Test for Female Patients.

- Bladder Stress Test. When the resident has a relatively full bladder, but not a strong urge to void, have her stand or assume as upright a position as possible, relax, and cough vigorously or strain. The test is positive if there is immediate leakage similar in volume and circumstance to usual incontinence. The stress test is negative if there is a delay of more than 5 seconds, no leakage, or leakage of only a few drops, or if it is dissimilar to the usual volume and circumstance of leakage.
- Measure void plus PVR as described above (i.e., calculate Total Bladder Volume).
- Repeat Stress Test. If the bladder stress test is negative AND the Total Bladder Volume is less than 200 ml, another test is needed for verification. Insert a sterile catheter into the bladder (preferably do this while the catheter for PVR measurement is still in the bladder) and fill it with at least 200 ml of sterile water, if possible. Remove the catheter, have the patient stand up (if possible), and repeat the stress test as above.

D. FINAL EVALUATION FOR RESIDENTS WITH INDWELLING CATHETERS

After the resident with an indwelling catheter has been treated for infection and all the other treatable conditions listed above, a voiding trial can be attempted — unless the resident has terminal illness, stage 3 or 4 pressure ulcers, or untreatable urethral blockage. This trial may reveal that the catheter is not necessary after all.

Exclusions: The resident is in a coma or has terminal illness, a stage 3 or 4 pressure ulcer in an area affected by the incontinence, untreatable urethral blockage, the need for exact measurement of urine output, a history of being unable to void after having a catheter removed in the past, or a resident with quad/paraplegia who failed a past attempt to remove a catheter.

- If appropriate, institute a voiding trial.

(1) Before removing the catheter, record urine output every 6 hours for one or two days. Use this record to plan when to remove the catheter so that the expected urine will not be over 800 mls during the time of the voiding trial.

(2) Remove catheter and observe. For example, if the resident usually puts out 500 ml on the day shift, remove the catheter at the beginning of that shift and observe; if resident has not voided by the end of the shift, wait until the volume gets higher, but do not exceed a volume of 800 ml.

(3) If resident is able to void, check the PVR, as detailed in Section C.

- If volume is greater than 400 ml, reinsert indwelling catheter permanently or until resident can be referred to a urologist.
- If PVR is between 100 and 400 ml, observe resident carefully as urinary retention may redevelop over a few days to a few weeks. If not, check for presence of incontinence: if present, complete **Section C** (above).
- If PVR is less than 100 ml, check for presence of incontinence; if present, complete **Section C** (above).

(4) If resident has not voided by the time the expected volume is 800 ml, and there is no sensation of fullness, no urge to void, and no void, reinsert an indwelling catheter and record the volume. Residents who fail the voiding trial need either urologic referral, if appropriate, or permanent catheterization.

(5) If the resident has no memory recall, is unable to transfer independently, and has incontinence that is resistant to all therapy for more than 2 weeks after removing the catheter, a catheter may be reinserted if deemed appropriate by the staff.

URINARY INCONTINENCE AND INDWELLING CATHETER RAP KEY

TRIGGERS

Incontinence care plan suggested if:

1. Incontinent 2+ Times a Week
   [F1b = 2, 3 or 4]

2. Use of Catheter or Pads
   [F3b, F3c, F3d, F3f = any checked]

EXCLUSIONS: Comatose **[B1 = 1]** or Explicit terminal prognosis **[J1z = checked]**

GUIDELINES

Possible reversible problems to be reviewed in evaluating incontinence or need for catheter:

1. Conditions: UTI **[F2a; J1ee]**, Fecal Impactions **[F2b; K1e]**, Delirium **[B5]**, Depression **[J1q]**, Edema **[K1d]**
2. Environment: Locomotion **[E1c]**, Lack of access to toilet, Barriers **[observation]**, Restraints **[P3]**
3. Diagnoses: CHF **[J1c]**, CVA **[J1k]**, Parkinson's **[J1m]**, Diabetes **[J1y]**
4. Medications: Diuretics, Parkinson's meds, Disopyramide, Antispasmodics, Antihistamines, Drugs that stimulate or block sympathetic nervous system, Calcium channel blockers (verapomil, nifedipine, diltiozem), Narcotics **[from record]**
5. Psychoactive Medications: Antipsychotics, Antianxiety/hypnotics, Antidepressants **[O4]**

Other Potential factors contributing to incontinence or use of catheter:

1. Conditions: Pain; Excessive or inadequate urine output, Atrophic vaginitis, Cancer of bladder, prostate, brain, or spine, tabes dorsalis **[from record or exam]**
2. Abnormal Lab Values: High blood calcium, high blood glucose, low B_{12}, High BUN or Creatinine **[from record]**

Final evaluation if incontinence persists:

1. Specific Tests: Not indicated when Comatose **[B1]** or both No memory recall **[B3e]** AND Dependent in Transfer, Locomotion **[E1b, E1c]**, for others, do: Post Void Residual, bladder stress test for females, reflux test (kidney ultrasound) for males with PVR >100 ml

Final evaluation for residents with indwelling catheters:

If indwelling catheter **[F3c]**, do Voiding Trial unless terminal illness **[J1z]**, stage 3/4 pressure ulcer **[N2]** and/or untreatable urethral blockage **[J2]**

RESIDENT ASSESSMENT PROTOCOL: PSYCHOSOCIAL WELL-BEING

I. PROBLEM

Well-being refers to feelings about self and social relationships. Positive attributes include initiative and involvement in life; negative attributes include distressing relationships and concern about loss of status. On average, 30% of residents in a typical nursing facility will experience problems in this area, two-thirds of whom will also have serious behavior and/or mood problems. When such problems coexist, initial treatment is often focused on mood and behavior manifestations. In such situations, treatment for psychosocial distress is dependent on how the resident responds to the primary mood/behavior treatment regimen.

II. TRIGGERS

A psychosocial well-being problem is suggested if:

1. One or More Problems With Relationships **[G2a, G2b, G2c, G2d = any checked]**

2. Grief Over Lost Status/Roles **[G3b = checked]**

III. GUIDELINES

Sequentially review the items found on the RAP KEY.

Confounding Problems.

Treatment for mood/behavior problems are often immediately beneficial to well-being.

- Do mood/behavior problems affect well-being?
- Did the mood/behavior problems appear before the reduced sense of well-being?
- Have ongoing treatment programs been effective?

Situational Factors That May Impede Ability to Interact With Others.

Environmental and situational problems are often amenable to staff intervention without the burden of staff having to "change the resident."

- Have key social relationships been altered/terminated?
- Have changes in the resident's environment altered access to others or to routine activities — for example, room assignment, use of physical restraints, assignment to new dining area?

Resident Characteristics That May Impede Ability to Interact With Others.

These items focus on areas where the resident may lack the ability to enter freely into satisfying social relationships. They represent substantial impediments to easy interaction with others and highlight areas where staff intervention may be crucial.

- Do cognitive/communication deficits or a lack of interest in activities impede interactions with others?
- Does resident indicate unease in social relationships?

Lifestyle Issues.

Residents can withdraw or become distressed because they feel life lacks meaning.

- Was life more satisfactory prior to entering the nursing facility?
- Is resident preoccupied with the past, unwilling to respond to the needs of the present?
- Has the facility focused on a daily schedule that resembles the resident's prior lifestyle?

Additional Information to Clarify the Nature of the Problem.

Supplemental assessment items can be used to specify the nature of the well-being problem for residents for whom a well-being care plan is anticipated. These items represent topics around which to phrase questions and to establish a trusting exchange with the resident. Each item includes the positive and negative end of a continuum, representing the possible range that staff can use in thinking about these issues. Staff can use or not use the items in this list. For those items selected, the following issues should be considered:

- How do staff/resident perceive the severity of the problem?
- Has the resident ever demonstrated (while in the facility) strengths in the area under review?
- Are corrective strategies now being used? Have they been used in the past? To what effect?
- Is this an area that might be improved?

PSYCHOSOCIAL WELL-BEING RAP KEY

TRIGGERS

Well-being problem suggested if:

1. One or More Problems With Relationships
   [G2a, G2b, G2c, G2d = any checked]
2. Grief Over Lost Status/Roles
   [G3b = checked]

GUIDELINES

Confounding problems:

1. Increasing/persistent sad mood **[H2, H6]**
2. Increasing/daily disturbing behavior **[H3, H7]**

Situational factors that may impede ability to interact with others:

1. Loss of family member, friend, or staff close to resident **[G2f; from record]**
2. Initial use of physical restraints **[P3]**
3. Change in room assignment or new admission **[Intake I2; from record]**

Resident characteristics that may impede ability to interact with others:

1. Delirium/cognitive decline **[B5, B6]**
2. Communication deficit/decline **[C4, C5, C6]**
3. Locomotion deficit/use of wheelchair **[E1c, E5c, E5d]**
4. Ill at ease interacting with others **[G1]**
5. Diseases that impede communication — Alzheimer's **[J1b]**, Other dementia **[J1l]**, Depression **[J1q]**, terminal prognosis **[J1z]**, Mental retardation **[Intake I12]**
6. Uninvolved in activities **[I2, I4]**

Lifestyle issues:

1. Strong identification with past roles/status **[G3a]**
2. Incongruence of current and prior style of life **[Intake III]**
3. Length of time problem existed **[from record]**

Supplemental problem clarification issues [from resident/family if necessary]:

1. Ability to relate to others
   - — Skill/unease in dealing with others
   - — Reaches out/distances self
   - — Friendly/unapproachable
   - — Flexible/ridiculed by others
2. Relationships resident could draw on
   - — Supported/isolated
   - — Many friends/friendless
3. Dealing with grief
   - — Moving through grief/bitter and inconsolable
   - — Religious faith/feels punished

RESIDENT ASSESSMENT PROTOCOL: MOOD STATE

I. PROBLEM

About 15% of nursing home residents will have a major depression; about 30% will exhibit noticeable symptomatic signs of a mood state problem. Such signs are often expressed as sad mood, feelings of emptiness, anxiety or unease. They are also manifested in a wide range of bodily complaints and dysfunctions, such as loss of weight, tearfulness, agitation, aches and pains.

II. TRIGGERS

A Mood State problem is suggested if any of the following are found:

1. Verbal Expressions of Sad or Anxious Mood [H1a = checked].
2. Demonstrated (observable) Signs of Mental Distress [H1b, H1c, H1d, H1e, H1f, H1g = any checked].
3. Persistent Sad or Anxious Mood [H2 = 1].

III. GUIDELINES

Specific conditions stated below suggest the need for an altered/new care strategy. They are not exhaustive; other situations may arise in which staff decide that an altered care plan is necessary. The most obvious are instances of drug-induced side effects (addressed in Psychotropic Drug Use RAP). Residents whose mood problems do not call for care plan alterations are those with stable behavior and no unusual confounding problems.

Many of the questions and issues that follow relate to the MDS items listed on the Mood State RAP KEY. An altered care strategy is suggested when specified conditions are met.

<u>Have Mood State Problems Recently Intensified?</u>

- Were mood problems present 6 months ago?
- Does resident have a cyclic history of decline and improvement in mood state?
- Has loss of appetite with accompanying weight loss occurred?
- Has interest in activities declined, even though resident remains physically capable?

<u>Mood Unimproved and Potentially Reversible Causes Present.</u>

Resolution of delirium (fluctuating consciousness) behavioral, relationship and/or communication problems often affect a resident's mood state. Only when these conditions have been addressed can the nature of a mood problem be fully understood.

- Review record to determine whether there has been a sudden onset or worsening of cognitive symptoms or communication skills following initiation of treatment (e.g., medications)
- Review to determine whether the resident is using any medications known to cause mood shifts, such as: psychotropics; antihypertensives, such as clonidine (Catapres), quanethedine (Ismelin), methlydopa (Aldomet), propeneral (Inderal), and reserpine; cimetidine (Tagamet); cytoxic agents; digitalis; immunosuppressives; sedatives; steroids; or stimulants.

Also, consider the possible presence of other complicating factors, such as:

- Delirium
- Review recent changes in the life of the resident (e.g., death of a child, transfer to new environment, separation from loved ones, loss of functional abilities or change in body image, loss of autonomy)
- Review nature and intensity of relationship and/or behavior problems

ADL decline can be both a cause and a consequence of distressed mood. Reviewing the sequence of ADL and mood decline may be informative. In any case, where mood seems to impair ADL functioning, useful strategies include modifying the physical environment, separating the resident's performance of ADL activities into a series of subtasks, and using verbal reminders and cues.

When Staff/Family Try to "Cheer Up" Resident, Is Mood Unchanged? Does the Resident Lack Initiative?

The passive resident with distressed mood may be overlooked. Such a resident may be erroneously assumed to have no mood state problem.

- Does the resident show little/no initiative?
- Does he/she remain uninvolved in activities (alone or with others)?
- Is the sad mood persistent?

Are There Indications of New or Intensified Problems With Conditions That May Affect Mood Problems?

These conditions include: Alzheimer's Disease, cancer, cardiac disease, metabolic and endocrine disorders (e.g., hypercalcemia, Cushing's disease, Addison's disease, hypoglycemia, hypokalemia, porphyria), Parkinson's disease, stroke, or other neurological disease, and thyroid disease.

Does Sad Mood Appear to Respond to Treatment (e.g., Drug Regimen)?

- Has the mood problem remained relatively unchanged for the last 90 days, or has it improved with the current treatment program?
- Have there been cycles of decline and improvement?
- Is resident receiving medications and/or psychosocial therapy?

MOOD STATE RAP KEY

TRIGGERS

A mood problem suggested if:

1. Verbal Expression of Sad/Anxious Mood **[H1a = checked]**
2. Any Demonstrated Sign of Mental Distress **[H1b, H1c, H1d, H1e, H1f, H1g = any checked]**
3. Mood Persistence **[H2 = 1]**

GUIDELINES

Indicators of the need to consider a new/altered care strategy:

1. Mood decline [H6]
2. Mood unimproved [H6] AND reversible conditions present
   - — Delirium/cognitive decline; Hallucinations/ delusions [B5, B6; K1g]
   - — Communication decline [C6]
   - — ADL decline [E8]
   - — Grief due to loss of loved one [G2]
   - — Recent move into/within facility [INTAKE I2]
   - — Use of meds known to cause mood shifts (e.g., antihypertensives, cimetidine, clonidine, cytoxic agents, digitalis, guanethidine, immunosuppressive, methyldopa, nitrates, propranolol, reserpine, steroids, stimulants) [from record]
3. Mood unimproved [H6] AND indication of cognitive ability/memory, decision-making ability, and ability to understand [B2, B4; C5] AND ANY of following:
   - — Little or no initiative shown [G1]
   - — Little or no involvement in activities [I2]
   - — No medications [O1]
   - — No psychological therapy [P1n]
4. Relationship and/or behavioral problems present [G2; H3]

Confounding issues to be considered:

1. Communication skills [C4; C5]
2. Diseases: Neurological disease [J1h, J1i, J1j, J1m], CVA [J1k], Anxiety [J1p], Depression [J1q], Manic depressive [J1r], Thyroid disease [J1aa], Hypercalcemia, Cushing's, Addison's, Hypoglycemia, Hypokalemia, Porphyria, Psychosis [J2]

RESIDENT ASSESSMENT PROTOCOL: BEHAVIOR PROBLEM

I. PROBLEM

Between 60% and 70% of residents in a typical nursing facility exhibit emotional, social, and/or behavior disorders; about 40% have purely behavioral problems (i.e., wandering, verbal abuse physically aggressive and/or socially inappropriate behaviors). Residents with behavior problems also frequently have other related problems. Over 80% of those who have behavior problems will have some type of cognitive deficit; about 75% will have mood and/or relationship problems.

Problem behaviors are often seen as a source of danger and distress to the residents themselves and sometimes to other residents and staff. Nursing facilities often find such residents difficult to cope with, and physicians often seem unaware of the wide range of available treatment and management options. As a result, overuse of physical restraints or psychotropic drugs is not uncommon. About one-half of residents who exhibit "problem" behaviors will be physically restrained, and about one-half will receive psychoactive medications — antipsychotics (neuroleptics), antianxiety agents, and, to a lesser extent, antidepressants. These interventions, however, have potentially serious negative side-effects, and many nurses in nursing facilities report being uncomfortable using only physical restraints and/or psychotropics to manage residents with behavior problems. As a result, there is an increasing trend toward using other interventions and treatments in addressing problem behaviors.

II. TRIGGERS

The MDS trigger items identify two types of residents for whom further review is suggested: residents who exhibit the problem behaviors of wandering, being verbally abusive, being physically aggressive and/or exhibiting socially inappropriate behaviors AND residents who are not currently exhibiting problem behaviors but who are receiving treatment or intervention that might mask or prevent the manifestation of the behavior (e.g. no wandering because restrained).

Review of behavior status is suggested if resident has:

1. One or More Behavior Problems **[H3a, H3b, H3c or H3d = 1 or 2]**

The possibility of elimination or reduced treatment/intervention is suggested if:

2. Behavior Improved **[H7 = 1]** AND Use of Antipsychotics OR Antidepressants **[O4a or O4c = 1 - 7]**

3. Behavior Improved **[H7 = 1]** AND Use of Trunk OR Limb Restraints **[P3b or P3c = 1 or 2]**

III. GUIDELINES

The items in this RAP (and in the RAP KEY) begin with those items that help to draw the distinction between serious behavior problems and others that can be more easily accommodated. This is followed by a section on potential causes or factors involved in the manifestation of problem behaviors the resolution of which might reduce or eliminate the behavior(s).

EVALUATING THE SERIOUSNESS OF BEHAVIOR PROBLEMS

The first trigger identifies residents who currently exhibit some type of problem behavior for which additional or new treatment programs may be considered. Not all behaviors need an extensive intervention. Some behaviors neither endanger nor distress the resident or others. For example, many hallucinations and delusions (when not a sign of a psychosis or an acute condition such as delirium) are benign. Residents with such behavioral manifestations may be accommodated (e.g., tolerated, behavior rechanneled or redirected) within the environment of the nursing facility. Thus, determining whether a particular behavioral manifestation is a problem is an important step and involves determining the nature and severity of the behavior(s) in question and the effects of the behavior(s).

Observing Specific Behavioral Manifestations in the Most Recent 7-Day Period.

- Review to determine the intensity, duration, and frequency of behavior problems over the last 7-day and 14-day periods. Did these change or vary over time?
- Is there a pattern to the behavior manifestations based on observations over a 7-14 day time period? (Consider such factors as time of day, nature of the environment, what the resident and others were doing at the time the problem behavior was manifested.)

Identifying Stability/Change in the Nature of Behavioral Problems.

Identifying patterns of behaviors over time may help clarify the underlying causes of problem behaviors. For example, such a review may reveal a pattern in which a resident's catastrophic reactions typically occur only in the presence of a particular combination of stressors (e.g., a person who can tolerate large groups for singing but not for meals). Similarly, observing a resident over time may reveal that a resident's seemingly random behaviors are associated with particular events (e.g., yelling/screaming associated with objecting to someone changing the channel during a favored television program; wandering associated with the need to toilet). Addressing the causes of such patterns may reduce or eliminate the behavior.

- How did behavior develop over time? Were problem signs evident earlier in the resident's stay or even earlier in the resident's life?
- Has resident experienced recent changes (e.g., movement to a new unit, assignment of new nonlicensed direct care staff to the unit, change in medication, withdrawal from a treatment program, decline in cognitive status)?

Determining the Ways in Which Behavior Problem Impinges on Other Functioning.

Understanding that a behavior can — but does not always — interfere with a resident's self-performance and treatment regimens is useful in considering the need for interventions. This view can also help to ensure that aggressive treatments or interventions (e.g., physical restraints or antipsychotics) are not introduced simply to keep the resident "looking normal."

- Does the behavior endanger the resident? Others? If so, in what ways does it endanger the resident or others?
- Are behavior problems related to daily variations in functional performance? If so, how?
- Does behavior problem lead to resistance to care?
- Does it lead to difficulties dealing with people and coping in the facility?

REVIEW OF POTENTIAL CAUSES OF BEHAVIOR PROBLEMS

Many behaviors, however, are problematic for the resident or others. Many are directly associated with acute health conditions, neurological diseases, or psychiatric conditions. Still others originate in the resident's reaction to external factors, such as psychotropic medications, the use of physical restraints, and stressors in the environment (e.g., loud noises, changes in familiar routines). Identifying the various factors involved in the manifestation of problem behaviors is critical. Such a process may reveal conditions that can be resolved, thus eliminating or reducing the problem behaviors. Further, distinguishing among potential causes or interrelationships is essential to developing an appropriate care plan (e.g., distinguishing between behaviors originating with neurological condition as contrasted to a psychotic syndrome). Consideration of the items in the Behavior Problem RAP KEY (as well as in related RAPs as indicated) should facilitate this process.

Cognitive Status Interactions.

Decision-making ability is a key indicator of effective cognitive skills. Resolving acute confusional state or delirium, a potentially reversible problem, can be critical to behavior management. (See Delirium RAP if a diagnosis or signs and symptoms of delirium are present.)

For many residents with chronic progressive dementia, certain behaviors may continue in spite of remedial treatments or interventions. In some instances, the behaviors will be distressing; however, in many instances behaviors can be accommodated. For example, many residents who wander can be accommodated without restraints in a hazard-free environment. Similarly, the needs and patterns of demanding residents or those with catastrophic reactions can often be anticipated or the most disrupting reactions to the distress alleviated. The Cognitive Loss/Dementia RAP refers to several issues that can be considered for such residents. Thus, that RAP should be completed prior to this RAP on Behaviors for residents who have cognitive problems.

Presence of Disturbed Mood and/or Relationship Interactions.

Mood and relationship problems often produce disturbed behaviors. If the underlying problems are resolved, the behavior may lessen or stop.

- Does the resident have an unresolved mood state or relationship problem that may lead to behavior problems (e.g., anxiety disorder and agitation; depression or isolation and verbally abusive behavior)? Refer to the Psychosocial Well-Being RAP and to the Mood State RAP.

- Is there an association among mood state, relationship, and behavior problems?
- Can a cause and effect relationship be determined?
- Does the resident experience a sense of frustration because of rejection by family? If so, does this frustration result in the resident verbally abusing staff or other residents?

Relationship Difficulties That May Affect Behavior.

- Does the presence or absence of other persons precipitate an event?
- Was a combative act prompted by paranoid delusions about another's motives or actions?
- Did recent loss of a loved one, change in staff, an intrafacility move, or placement with a roommate with whom the resident cannot communicate lead to disruptive behavior?

Environmental Conditions.

A review of the resident's behaviors over time may, as noted earlier, reveal a pattern of behaviors that helps identify the causes of the behaviors. Because environmental conditions often have a profound effect on residents' behaviors, these factors should be given special consideration.

- Are staff sufficiently responsive? Do they recognize stressors for the resident and early warning signs of problem behavior?
- Do staff follow the resident's familiar routines?
- Do noise, crowding or dimly lit areas affect resident's behavior?
- Are other residents physically aggressive?

Illness/Conditions.

Sometimes, the onset of acute illnesses and/or the worsening of a chronic illness produces disturbed behaviors. Often identification and treatment of the illness will resolve the problem behavior. In addition, a resident with certain chronic conditions, particularly difficulties in making his/her needs understood or in understanding others may also exhibit problem behaviors that can be eliminated or reduced if more effective methods of communication are adopted by staff and families. Sensory impairments (vision, hearing) may also produce disruptive behaviors that would lessen or disappear if the underlying condition were addressed.

- Can physical health factors close in time to the disturbed behavior be identified (e.g., pain or discomfort from physical conditions such as arthritis, constipation, or headache)?
- Can the observed behavior be associated with an acute illness (e.g., urinary tract infection, other infections, fever, hallucinations/delusions, sleep deprivation, physical trauma, nutritional deficiencies, weight loss, dehydration/insufficient fluids, electrolyte disorder, or acute hypotension)?
- Can the observed behavior be associated with the worsening of a chronic illness (e.g., congestive heart failure, diabetes, psychoses, Alzheimer's disease or other dementia, CVA, or hypoglycemia for a diabetic)?
- What was the role of impaired hearing, vision, or ability to communicate?

Current Treatment Procedures: Positive and Negative Consequences.

A number of treatment or management interventions may affect a resident's behavior. Some may have had a positive effect, while others may exacerbate existing problem behaviors — or produce new problems. Both are important to consider in reaching a decision about whether to proceed with a care plan intervention. For example, review the resident's interest in, use of, or participation in psychological treatment program(s). This review will be especially important for residents who have recently experienced improved behavioral status. For some residents and some management programs, continuation of treatments may be central to maintaining their new-found control. In other cases, either the interventions can be normally reduced (at least on a trial basis), or the side effects of the intervention may be so severe that alterations in the treatment regimen should be considered. For example, a drug or restraint program may result in increased confusion and agitation, reduced ADL self-performance, a decline in mood, or a general decrease in the quality of life for the resident. On the other hand, breaking tasks of daily life down into smaller steps that the resident can comprehend and perform may reduce stress and prevent problem behavior.

- Has the resident been reviewed by a psychiatrist, etc.? When?
- Are there indicators that treatments have helped resident gain increased control over life? What were they?
- Can improvement be attributed to an identifiable treatment?
- If behavioral problems have lessened, can medication or behavior management programs be withdrawn?
- Is the onset or change of behaviors associated with the start of (or change in prescription of) a medication(s)?
- Is the behavior associated with the use of a physical restraint (e.g., increased agitation and anger)?
- Has the resident received care in a specially designed therapeutic unit?
- Are there special staff training/support programs that focus on managing behavior problems? What disciplines are involved? How frequent/consistent is the training?
- Has task segmentation been used to maximize resident involvement?

BEHAVIOR PROBLEM RAP KEY

TRIGGERS

Review of behavior status suggested if:

1. One or More Behavior Problems [**H3a, H3b, H3c or H3d = 1 or 2**]

Review of treatment intervention suggested if:

2. Behavior Improved **AND** Use of Antipsychotics or Antidepressants [**H7 = 1 AND O4a or O4c = 1-7**]
3. Behavior Improved and Use of Trunk or Limb Restraints [**H7 =1 AND P3b or P3c = 1 or 2**]

GUIDELINES

Review and describe problem behavior:

1. **Evaluating the seriousness and stability/ change of behavior problems.** Review of intensity, duration, frequency and, if any, pattern of behaviors, their development over time, and their effect on the resident and others [**from record**].

Review potential causes that could be addressed or resolved:

1. **Cognitive status problems.** Delirium/periodic disordered thinking [**B5, J2**], Alzheimer's [**J1h**] or other dementia [**J1l**], effects of stroke [**J1k; from record**].
2. **Mood and/or relationship problems.** Unsettled relationships [**G2**], sad or anxious mood [**H1**], psychiatric diagnosis [**J1p, J1q, J1r**].
3. **Environmental conditions.** Staff responses, presence of stressful conditions or physically aggressive resident, departure from resident's normal routines [**from record; interviews with staff, resident**].
4. **Illness/conditions.** Onset of acute illness, worsening of chronic illness, and other related problems, such as CHF [**J1c**], pneumonia [**J1o**], diabetes [**J1y**], septicemia [**J1dd**], UTI [**J1ee**] or other infection [**from record**], constipation [**K1a**], fever [**K1f**], hallucinations/delusions [**K1g**], pain [**K1j**], fall with physical trauma to head [**K2; from record**].
5. **Communication deficits.** Difficulty making self understood [**C4**] and/or understanding others [**C5**].
6. **Sensory impairments.** Hearing/visual problems [**C1; D1**].
7. **Treatment/management procedures.** Antipsychotics, antianxiety/hypnotics, antidepressants [**O4**], trunk, limb or chair restraints [**P3**], behavior management program [**H5; from record**].

RESIDENT ASSESSMENT PROTOCOL: ACTIVITIES

I. PROBLEM

The Activities RAP targets residents for whom a revised activity care plan may be required to identify those residents whose inactivity may be a major complication in their lives. Resident capabilities may not be fully recognized: the resident may have recently moved into the facility or staff may have focused too heavily on the instrumental needs of the resident and may have lost sight of complications in the institutional environment.

Resident involvement in passive as well as active activities can be as important in the nursing home as it was in the community. The capabilities of the average resident have obviously been altered as abilities and expectations change, disease intervenes, situational opportunities become less frequent, and extended social relationships less common. But something that should never be overlooked is the great variability within the resident population: many will have ADL deficits, but few will be totally dependent; impaired cognition will be widespread, but so will the ability to apply old skills and learn new ones; and sense may be impaired, but some type of two-way communication is almost always possible.

For the nursing home, activity planning is a universal need. For this RAP, the focus is on cases where the system may have failed the resident, or where the resident has distressing conditions that warrant review of the activity care plan. The types of cases that will be triggered are: (1) residents who have indicated a desire for additional activity choices; (2) cognitively intact, distressed residents who may benefit from an enriched activity program; (3) cognitively deficient, distressed residents whose activity levels should be evaluated; and (4) highly involved residents whose health may be in jeopardy because of their failure to "slow down."

In evaluating triggered cases, the following general questions may be helpful:

- Is inactivity disproportionate to the resident's physical/cognitive abilities or limitations?
- Have decreased demands of nursing home life removed the need to make decisions, to set schedules, to meet challenges? Have these changes contributed to resident apathy?
- What is the nature of the naturally occurring physical and mental challenges the resident experience in everyday life?
- In what activities is the resident involved? Is he/she normally an active participant in the life of the unit? Is the resident reserved, but actively aware of what is going on around him/her? Or is he/she unaware of surroundings and activities that take place?
- Are there proven ways to extend the resident's inquisitive/active engagement in activities?
- Might simple staff actions expedite resident involvement in activities? For example: Can equipment be modified to permit greater resident access of the unit? Can the resident's location or position be changed to permit greater access to people, views, or programs? Can time and/or distance limitations for activities be made less demanding without destroying the challenge? Can staff modes of interacting with the resident be more accommodating, possibly less threatening, to resident deficits?

II. TRIGGERS

The following sets of MDS based conditions indicate those residents who will require further review, as well as the types of the action that may be required:

1. Revised activity plan suggested if:

Resident Prefers More or Different Activity Choices [I5 = 1]

2. Revised activity care plan suggested to help resident overcome resident distress when ALL THREE of the following conditions met:

   a. Little/No involvement in activities **[I2 = 2 or 3]**
   b. One/More of following indicators of Distress:

      - Unsettled relationships in any area **[G2a ,G2b, G2c, G2d = Any checked]**
      - Sadness over lost roles/status **[G3b = checked]**
      - Verbal expressions of sad mood **[H1a = checked]**
      - Withdrawn — as indicated by complete absence of General Activity Preferences **[I4j = checked]**

   c. Two or more of following indicators of Communication/Cognitive Ability:

      - Short-term memory OK **[B2a = 0]**
      - At least some decision-making ability **[B4 = 0, 1, or 2]**
      - Understood/usually understood by others **[C4 = 0 or 1]**
      - Understood/usually understand others **[C5 = 0 or 1]**

3. Review of activity care plan to determine if its modification might help to overcome resident distress when either of the following conditions met:

   - -a- and -b- conditions above AND resident is bedfast **[E4b = checked]**
   - -a- and -b- conditions above AND resident has No or Only One of the four indicators of Communication/Cognitive ability (c. above).

4. Review of activity care plan suggested if: Most involvement in activities **[I2 = 0]** AND Two or more checked in measurement of time awake **[I1a, I1b, I1c = more than 1 checked]**

III. GUIDELINES

The followup review looks for factors that may impede resident involvement in activities. Although many factors can play a role, age as a valid impediment to participation can normally be ruled out. If age continues to be linked as a major cause of lack of participation, a staff education program may prove effective remedying what may be overprotective staff behavior.

Is Resident Suitably Challenged, Overstimulated? To some extent, competence depends on environmental demands. When the challenge is not sufficiently demanding, a resident can become bored, perhaps withdrawn, may resort to fault-finding and perhaps even behave mischievously to relieve the boredom. Eventually, such a resident may become less competent because of the lack of challenge. In contrast, when the resident lacks the competence to meet challenges presented by the surroundings, he or she may react with anger and aggressiveness.

- Do available activities correspond to resident lifetime values, attitudes, and expectations?
- Does resident consider "leisure activities" a waste of time — he/she never really learned to play, or to do things just for enjoyment?
- Have the resident's wishes and prior activity patterns been considered by activity and nursing professionals?
- Have staff considered how activities requiring lower energy levels may be of interest to the resident — e.g., reading a book, talking with family and friends, watching the world go by, knitting?
- Does the resident have cognitive/functional deficits that either reduce options or preclude involvement in all/most activities that would otherwise have been of interest to him/her?

Health-related factors that may affect participation in activities. Diminished cardiac output, an acute illness, reduced energy reserves, and impaired respiratory function are some of the many reasons that activity level may decline. Most of these conditions need not necessarily incapacitate the resident. All too often, disease-induced reduction of activity may lead to progressive decline through disuse, and further decrease in activity levels. However, this pattern can be broken: many activities can be continued if they are adapted to require less exertion or if the resident is helped in adapting to a lost limb, decreased communication skills, new appliances, and so forth.

- Is resident suffering from an acute health problem?
- Is resident hindered because of embarrassment/unease due to the presence of health-related equipment (tubes, oxygen tank, colostomy bag, wheelchair)?
- Has the resident recovered from an illness? Is the capacity for participation in activities greater?
- Has an illness left the resident with some disability (e.g., slurred speech,necessity for use of cane/walker/wheelchair, limited use of hands)?
- Does resident's treatment regimen allow little time or energy for participation in preferred activities?

Recent decline in resident status — cognition, communication, function, mood, or behavior. When pathologic changes occur in any aspect of the resident's competence, the pleasurable challenge of activities may narrow. Of special interest are problematic changes that may be related to the use of psychoactive medications. When residents or staff overreact to such losses, compensatory strategies may be helpful — e.g., impaired residents may benefit from periods of both activity and rest; task segmentation can be considered; or available resident energies can be reserved for pleasurable activities (e.g., using usual stamina reserves to walk to the card room rather than to the bathroom) or activities that have individual significance (e.g., sitting unattended at a daily prayer service rather than at group activity program).

- Has staff or the resident been overprotective? Or have they misread the seriousness of resident cognitive/functional decline? In what ways?
- Has the resident retained skills, or the capacity to learn new skills, sufficient to permit greater activity involvement?
- Does staff know what the resident was like prior to the most recent decline? Has the physical/other staff offered a prognosis for the resident's future recovery, or change of continued decline?
- Is there any substantial reason to believe that the resident cannot tolerate or would be harmed by increased activity levels? What reasons support a counter opinion?
- Does resident retain any desire to learn or master a specific new activity? Is this realistic?
- Has there been a lack of participation in the majority of activities which he/she stated as preference areas, even though these types of activities are provided?

Environmental factors. Environmental factors include recent changes in resident location, facility rules, season of the year, and physical space limitations that hinder effective resident involvement.

- Does the interplay of personal, social, and physical aspects of the facility's environment hamper involvement in activities? How might this be addressed?
- Are current activity levels affected by the season of the year or the nature of the weather during the MDS assessment period?
- Can the resident choose to participate in or to create an activity? How is this influenced by facility rules?
- Does resident prefer to be with others, but the physical layout of the unit gets in the way? Do other features in the physical plant frustrate the resident's desire to be involved in the life of the facility? What corrective actions are possible? Have any been taken?

Changes in availability of family/friends/staff support. Many residents wil experience not only a change in residence but also a loss of relationships. When this occurs, staff may wish to consider ways for a resident to develop a supportive relationship with another resident, staff member or volunteer that may increase the desire to socialize with others and/or to attend and/or paticipate in activities with this new friend.

- Has a staff person who has been instrumental in involving a resident in activities left the facility/been reassigned?
- Is a new member in a group activity viewed by a resident as taking over?
- Has another resident who was a leader on the unit died or left the unit?
- Is resident shy, unable to make new friends?
- Does resident's expression of dissatisfaction with fellow residents indicate he/she does not want to be a part of an activities group?

Possible Confounding Problems to be Considered for Those Now Actively Involved in Activities. Of special interest are cardiac and other diseases that might suggest a need to slow down.

ACTIVITIES RAP KEY

TRIGGERS

1. Revised activity plan suggested if: Resident Prefers More or Different Activity Choices [I5 = 1]
2. Revised activity plan suggested to help resident overcome distress if ALL of the following:
    a. Little or no involvement in activities [I2 = 2 or 3]
    b. Distress: Any indicators of unsettled relationships **[G2a, G2b, G2c, G2d = any checked] OR** Sadness over lost roles/status **[G3b = checked] OR** Verbal expressions of sad mood **[H1a = checked] OR** Absence of general activity preferences **[I4j = checked]**
    c. Two or more indicators of intact Communication and/or Cognitive Ability:
        — Short-term memory OK **[B2a = 0]**
        — Some decision-making ability **[B4 = 0, 1 or 2]**
        — Understood/usually understood by others **[C4 = 0 or 1]**
        — Understands/usually understands others **[C5 = 0 or 1]**
3. Revised activity plan suggested to determine whether modifications might help resident overcome distress if all of the following:
    a. Little or no involvement in activities [I2 = 2 or 3]
    b. Distress: Two or more indicators of unsettled relationships **[G2a, G2b, G2c, G2d = two or more checked] OR** Sadness over lost roles/status **[G3b = checked] OR** Verbal expressions of sad mood **[H1a = checked] OR** Absence of general activity preferences **[I4j = checked]**
    c. Resident is bedfast **[E4b = checked] OR** None or Only One indicator of intact Communication and/or Cognitive Ability:
        — Short-term memory OK **[B2a = 0]**
        — Some decision-making ability **[B4 = 0, 1 or 2]**
        — Understood/usually understood by others **[C4 = 0 or 1]**
        — Understands/usually understands others **[C5 = 0 or 1]**
4. Review of activity plan suggested if: Resident has Most time involvement in activities **[I2 = 0] AND** is awake all or most of time **[I1a, I1b, I1c = more than 1 checked]**

GUIDELINES

Problems to be considered as activity plan is developed:

1. Cognitive status [B]
2. Unstable/acute health conditions [K3]
3. Number of treatments received [P1]
4. Time in Facility [INTAKE I2]
5. Use of psychoactive medications [04]

Confounding problems to be considered:

Cardiac dysrhythmias [J1b], Hypertension [J1d], CVA [J1k]

RESIDENT ASSESSMENT PROTOCOL: FALLS

I. PROBLEM

Falls are a common source of serious injury and death among the elderly. Each year, 40% of nursing home residents fall. Up to 5% of falls result in fractures; an additional 15% result in soft tissue injuries. Moreover, most elders are afraid of falling, and this fear can limit their activities.

In about one-third of falls, a single potential cause can be identified; in two-thirds, more than one risk factor will be involved. Risk factors that are internal to the resident include the resident's physical health and functional status. External risk factors include medication side effects, the use of appliances and restraints, and environmental conditions. Identification and assessment of those who have fallen and those who are at high risk of falling are the goals of this RAP.

II. TRIGGERS

Residents who have fallen at least once are at high risk for future falls, unless underlying causes of the falls can be identified and resolved. Thus, review is suggested if there is potential for <u>additional falls</u>.

1. Fell in Past 30 Days [**K2a = checked**]

2. Fell in Past 31-180 Days [**K2b = checked**]

Identifying and addressing risk factors is also an important preventive step for individuals who are at <u>very</u> high risk of falls but have not yet fallen. The resident who has not yet had a fall is at highest risk when all three conditions listed in the third trigger are met. Elderly persons with all three risks have a nearly certain probability of falling within six months, unless risks can be reduced. Thus, review is suggested for a resident with <u>high risk for initial falls</u>:

3. No Indication of Fall [**K2a, K2b = not checked**] <u>AND TWO OR MORE</u> of following:
   - Use of Any Psychoactive Drugs [**O4a, O4b or O4c = 1-7**]
   - Impaired Sense of Balance [**E4a, E4j = any checked**]
   - Bedfast or Hemi/Quadriplegia or Poor Leg Control [**E4b, E4d, E4e, E4h = any checked**]

III. GUIDELINES

To reach a decision on a care plan, begin by reviewing whether one or more of the major risk factors listed on the RAP KEY are present. Clarifying information on the nature of the risk or type of issue to be considered for the RAP KEY items follows.

<u>Is There a Previous History of Falls, or was the Fall an Isolated Event?</u>

Refer to the MDS, reports of the family, and incident reports.

<u>Internal Risk Factors</u>.

Review to determine whether the items listed on the RAP KEY under the following headings are present. Each of these represents an underlying health problem or condition that can cause falls and may be addressed to prevent future falls.

- <u>Cardiovascular</u>.
- <u>Neuromuscular/functional</u>.
- <u>Orthopedic</u>.
- <u>Perceptual</u>.
- <u>Psychiatric or cognitive</u>.

External Risk Factors.

These risk factors can often be modified to reduce the resident's risk of falls.

- **Medications.** Certain drugs can produce falls by causing related problems (hypotension, muscle rigidity, impaired balance, other extrapyramidal side effects [e.g., tremors], and decreased alertness). These drugs include: antipsychotics, antianxiety/hypnotics, antidepressants, cardiovascular medications, and diuretics.

- Were these medications administered prior to or after the fall?
- If prior to the fall, how close to it were they first administered?

- **Appliances and Devices.**

- If the resident who falls (or is at risk of falling) uses an appliance, observe his/her use of the appliance for possible problems.
- Review the MDS and the resident's record to determine whether restraints were used prior to the fall and might have contributed to the fall (e.g., causing a decline function or an increase in agitation).

- **Environmental/Situational Hazards.** Many easily modifiable hazards (e.g., poor lighting, patterned carpeting, poorly arranged furniture) in the environment may cause falls both in relatively healthy and in frail elderly residents.

For Those Who Have Fallen Previously, Review the Circumstances Under Which the Fall Occurred.

Attempt to gather information on most recent fall. Needed information includes:

- Time of day, time since last meal.
- Was resident doing usual or unusual activity?
- Was he/she standing still or walking? Reaching up or down? Not reaching?
- Was resident in a crowd of people? Responding to bladder/bowel urgency?
- Was there glare or liquid on floors? Foreign objects in walkway? New furniture placement or other changes in environment?
- Is there a pattern of falls in any of the above circumstances?
- If you know what the resident was doing during the fall, have her/him perform that activity and observe (protect resident to ensure that a fall does not occur during this test).

Take necessary vital signs:

- At time of fall, obtain supine and upright blood pressure and heart rate, IF the resident does not have a serious injury such as a fracture of the hip or lower extremity.
- When reproducing circumstances of a fall (e.g., if the resident fell 10 minutes after eating a large meal, take vital signs 10 minutes after the residents eats).
- Measure blood pressure and heart rate when the resident is supine AND 1 and 3 minutes after standing; note temperature and respiratory rate.

For Residents At Risk of Future Falls, Review Environmental/Situational Factors to Determine Whether Modifications Are Needed

- Observe resident's usual pattern of interaction with his/her environment — the way he/she gets out of bed, walks, turns, gets in and out of chairs, uses the bathroom. Observations may reveal environmental solutions to prevent falls.
- Observe him/her getting out of bed, walking 20 feet, turning in a 360° circle, standing up from a chair without pushing off with his/her arms (fold arms in front), and using the bathroom.

FALLS RAP KEY

TRIGGERS

Potential for ADDITIONAL FALLS suggested if:

1. Fell in Past 30 Days [K2a = checked]
2. Fell in Past 31-180 Days [K2b = checked]

High Risk for INITIAL FALL suggested if:

3. No Indications of Falls [K2a, K2b = not checked] AND TWO OR MORE of the following:
   - — Use of any Psychotropic Drugs [O4a, O4b or O4c = 1-7]
   - — Impaired Sense of Balance [E4a, E4j = any checked]
   - — Bedfast or Hemi/Quadriplegia or Poor Leg Control [E4b, E4d, E4e, E4h = any checked]

GUIDELINES

Review risk factors for falls to identify problems that may be addressed/resolved:

1. **Multiple Falls.** [K2a, K2b]

2. **Internal Risk Factors.**
   a. Cardiovascular: Cardiac dysrhythmia [J1b], Hypotension [J1e], Syncope [K1m]
   b. Neuromuscular/functional: CVA [J1k], Parkinson's [J1m], Chronic/acute condition makes unstable [K3], Hemiplegia [E4d], Loss of leg or arm movement [E4f, E4h], Unsteady gait [E4i], Incontinence [F1], Decline in functional status [E8], Seizure disorder [J1cc]
   c. Orthopedic: Arthritis [J1w], Joint pain [K1i], Osteoporosis [J1bb], Fracture of the hip [K2c]
   d. Perceptual: Impaired hearing [C1], Dizziness/vertigo [K1c]
   e. Psychiatric or cognitive: Decline in cognitive skills [B6], Alzheimer's [J1h], Other Dementia [J1i], Delirium [B5], Manic depressive [J1r]

3. **External Factors.**
   a. Medications: Psychotropic meds [O4a, O4b, O4c] cardiovascular meds and diuretics [from record]
   b. Appliances/devices (time started): pacemaker/walker/cane [E5a; from record]; physical restraints [P3b, P3c, P3d]
   c. Environmental/situational hazards and, if relevant, circumstances of recent fall(s): glare; poor illumination; slippery floors; uneven surfaces; patterned carpets; objects in walkway; new arrangement of objects; recent move into/within facility; proximity to aggressive resident; time of day; time since meal; type of activity; standing still/walking; in a crowded area; reaching/not reaching; responding to bladder/bowel urgency

RESIDENT ASSESSMENT PROTOCOL: NUTRITIONAL STATUS

I. PROBLEM

Malnutrition is not a response to normal aging; it can arise from many causes. Its presence may signal the worsening of a life-threatening illness, and it should always be seen as a dramatic indicator of the resident's risk of sudden decline. Severe malnutrition is, however, relatively rare, and this RAP focuses on signs and symptoms that suggest that the resident may be at risk of becoming malnourished. For many who are triggered, there will be no obvious, outward signs of malnutrition. Prevention is the goal, and early detection is the key.

Early problem recognition can help to ensure appropriate and timely nutritional intervention. For many residents, simple adjustments in feeding patterns may be sufficient. For others, compensation or correction for food intake problems may be required.

Within a nutrition program, food intake is best accomplished via oral feedings. Tube (enteral) feeding is normally limited to residents who have a demonstrated inability to orally consume sufficient food to prevent major malnutrition or weight loss. Parenteral feeding is normally limited to life-saving situations where both oral and enteral feeding is contraindicated or inadequate to meet nutrient needs. Oral feeding is clearly preferred. Depending on the nature of the problem, residents can be encouraged to use finger foods; to take small bites; to use the tongue to move food in the mouth from side to side; to chew and swallow each bite; to avoid food that causes mouth pain, etc. Therapeutic programs can also be designed to review for the need for adaptive utensils to compensate for problems in sucking, closing lips, or grasping utensils; to help the confused resident maintain a fixed feeding routine, etc.

II. TRIGGERS

Nutritional problem suggested if any of following observed:

1. Nutrition Deficiency ICD codes [**J2 = 260, 261, 262, 263, 263.0, 263.1, 263.2, 263.8 or 263.9**]

2. Weight Loss — Significant unintentional weight loss in the past month (5% or more) or six months (10% or more) is a major risk indicator. [**L2c = 1**]

3. Taste Alterations [**L3a = checked**]. Some diseases can disrupt the sense of tastes, and this can affect food intake. For example, some residents undergoing cancer therapy may find protein-like foods to be repugnant; other foods may taste bitter, overly sweet, or have no taste at all.

4. Hunger [**L3d = checked**]. In the absence of weight loss and in the presence of well-balanced and adequate meals, hunger is inconsistent with a good quality of life. In the presence of weight loss or in the absence of a well designed nutrition program at the facility, hunger can be an early indicator of a deficient food service program for this resident.

5. Parenteral/IV feeding [**L4a = checked**]. Tube or parenteral feedings may be essential for the resident who is unable to swallow oral nutriment without choking or aspirating (as in cases of Parkinson's disease and amyotrophic lateral sclerosis [ALS]), or if staff have not been able to maintain or improve the resident's nutritional status through oral intake alone.

6. Mechanically altered diet, syringe (oral) feeding, or therapeutic diet [**L4c, L4d, L4e = any checked**]. An overly managed diet may cause malnutrition because of the resident's refusal to eat a narrow group of selected foods or because of disinterest in the available food. The resident on such a diet must also be monitored to ensure that there is no unintended weight loss.

7. **Leaves 25% of food uneaten at most meals [L3e = checked].** Assuming that portions are not excessive, this is an important indicator of the need to identify the cause of the problem. Several factors may account for this pattern: poor appetite secondary to mental or confusional problems or other disease (e.g., Alzheimer's disease, confusion, depression, cancer, food intolerances, gastroparesis secondary to diabetes mellitus, constipation); food quality may be questionable; resident may not be permitted to state food preferences; mealtimes may be poorly spaced; or quality of the food service andwr dining experience may be unacceptable.

8. Presence of pressure ulcers [N2 = 1, 2, 3 or 4]. Malnutrition and weight loss can cause pressure ulcers; pressure ulcers, in turn, can cause malnutrition. Stage II, III, and IV pressure ulcers and major stasis ulcers increase the resident's requirement for calories, protein, and fluid, and, to a lesser extent, vitamin C, zinc, and most other nutrients.

III. GUIDELINES

RESIDENT FACTORS THAT MAY IMPEDE ABILITY TO CONSUME FOOD

Chewing problems.

Residents with oral abscesses, ill-fitting dentures, teeth that are broken, loose, carious or missing, or those on mechanically altered diets frequently cannot eat enough food to meet their calorie and other nutrient needs. Significant weight loss can, in turn, result in poorly fitting dentures and infections that can lead to more weight loss.

Swallowing problems.

Swallowing problems arise in several contexts: the long-term result of chemotherapy, radiation therapy, or surgery for malignancy (including head and neck cancer); fear of swallowing because of COPD/emphysema/asthma; stroke; hemiplegia or quadriplegia; Alzheimer's disease or other dementia; and ALS.

Reduced ability to feed self.

Reduced ability to feed self can be due to arthritis, contractures, partial or total loss of voluntary arm movement, hemiplegia or quadriplegia, vision problems, inability to perform activities of daily living without significant assistance, and coma.

Possible Medical Causes.

Numerous conditions and diseases can result in increased nutrient requirements (calories, protein, vitamins, minerals, water, and fiber) for residents. Among these are cancer and cancer therapies, Parkinson's disease with tremors, septicemia, pneumonia, gastrointestinal influenza, fever, vomiting, diarrhea and other forms of malabsorption including excessive nutrient loss from ostomy, burns, pressure ulcers, COPD/emphysema/asthma, Alzheimer's disease with concomitant pacing or wandering, and hyperthyroidism.

Malignancy and nutritional consequences of chemotherapy, radiation therapy/surgery. For the resident undergoing therapy aimed at remission or cure, aggressive nutritional support is necessary to achieve the goal; for the resident with incurable malignancy who is undergoing palliative therapy or is not responding to curative therapy, aggressive nutritional support is often medically inappropriate.

- Have the wishes of the resident and family concerning aggressive nutritional support been ascertained?

Anemia (nutritional deficiency, not malnutrition). A hematocrit of less than 41% is predictive of increased morbidity and mortality for residents.

- Are shortness of breath, weakness, paleness of mucous membranes and nailbeds, and/or clubbing of nails present?

Chronic COPD increases calorie needs and can be complicated by an elevated fear of choking when eating or drinking.

Shortness of breath (frequently seen with congestive heart failure, hypertension, edema, and COPD/emphysema/asthma). This is another condition that can cause a fear of eating and drinking, with a consequent reduction in food intake.

Constipation/intestinal obstruction/pain can inhibit appetite.

Drug-induced anorexia often causes decreased or altered ability to taste and smell foods.

Delirium.

PROBLEMS TO BE REVIEWED FOR CAUSAL LINK

Mental problems.

Dementia, depression, paranoid fears that food is poisoned, and mental retardation can all lead to anorexia, resulting in significant amounts of uneaten food and subsequent weight loss.

Behavior patterns and problems.

Residents who are fearful, who pace or wander, withdraw from activities, cannot communicate, or refuse to communicate, often refuse to eat or will eat only a limited variety and amount of foods. Left untreated, behavior problems that result in refusal to eat can cause significant weight loss and subsequent malnutrition.

- Does resident use food to gain staff attention?
- Is resident unable to understand the importance of eating?

Inability to Communicate.

For most residents, enjoying food and mealtimes crucially affects quality of life. Inability to make food and mealtime preferences known can result in a resident eating poorly, losing weight, and being unhappy. Malnutrition due to poor communication usually indicates substandard care. Early correction of communication problems, where possible, can prevent malnutrition.

- Does the area in which meals are served lend itself to socialization among residents? Is it a place where social communication can easily take place?
- Has there been a failure to provide adequate staff and/or adequate time in feeding or assisting residents to eat?
- Has there been a failure to recognize the need and supply adaptive feeding equipment for residents who can be helped to self-feed with such assistance?
- Is the resident capable of telling staff that he/she has a problem with the food being served — e.g., finds it to be unappetizing or unattractively presented?

Amputation.

Weight loss may be due to an amputation.

NUTRITIONAL STATUS RAP KEY

TRIGGERS

Malnutrition problem suggested if:

1. Nutritional Deficiency [J2 = 260, 261, 262, 263, 263.1, 263.2, 263.8 or 263.9]
2. Weight loss [L2c = 1]
3. Taste alterations [L3a = checked]
4. Hunger [L3d = checked]
5. Parenteral/IV feeding [L4a = checked]
6. Mechanically altered diet, syringe (oral feeding), or therapeutic diet [L4c, L4d, L4e = any checked]
7. Leaves 25% or more food uneaten at most meals [L3e = checked]
8. Pressure sores [N2 = 1, 2, 3 or 4]

GUIDELINES

Factors that impede ability to consume food:

1. Chewing problems [L1a]
2. Swallowing problems [L1b]
3. Reduced ability to feed self [E2e]
4. Possible medical causes: Cancer [J1x], cancer therapies [P1a, P1b], septicemia [J1dd], pneumonia [J1o], fever [K1f], diarrhea [K1b], ostomy losses [F3h], anemia [J1v], shortness of breath [K1l], and nutrient/medication interactions (e.g., antipsychotics, cardiac drugs, diuretics, laxatives, antacids) [from record]

Problems to be reviewed for possible relationship to nutritional status problem:

1. **Mental problems:** fear that food is poisoned [from record; H1a, H1e], Alzheimer's [J1h], other dementia [J1l], anxiety disorders [J1p], depression [J1q]
2. **Behavior problems:** Slowness in self feeding [E7c], pacing [H1c], wandering [H3a], failure to eat and withdrawal from activities [H1d], throwing food [H3d]
3. **Inability to communicate:** Comatose [B1], unable to make food and mealtime preferences known [C3f], and difficulty making self understood [C4], difficulty understanding others [C5], aphasia [J1j]
4. **Amputation** [E4k].

RESIDENT ASSESSMENT PROTOCOL: FEEDING TUBES

I. PROBLEM

The efficacy of tube feedings is difficult to assess. When the complications and problems are known to be high and the benefits difficult to determine, the efficacy of tube feedings as a long-term treatment for individuals requires careful evaluation.

Where residents have difficulty eating and staff have limited time to assist them, insertion of feeding tubes for the convenience of nursing staff is an unacceptable rationale for use. The only rationale for such feedings is demonstrated medical need to prevent malnutrition or dehydration. Even here, all possible alternatives should be explored prior to using such an approach for long-term feeding, and restoration to normal feeding should remain the goal throughout the treatment program.

Use of nasogastric and nasointestinal tubes can result in many complications including, but not limited to: agitation, self-extubation (removal of the tube by the patient), infections, aspiration, unintended misplacement of the tube in the trachea or lungs, inadvertent dislodgement, and pain.

This RAP focuses on reviewing the status of the resident using tubes. The Nutritional Status and Dehydration/Fluid Maintenance RAPs focus on resident needs that may warrant the use of tubes. To help clarify the latter issue, the following guidelines indicate the type of review process required to ensure that tubes are used in only the exceptional and acceptable situation. As a general rule, residents unable to swallow or eat food and unlikely to eat within a few days due to physical problems in chewing or swallowing (e.g., stroke or Parkinson's disease) or mental problems (e.g., Alzheimer's depression) should be assessed regarding the need for a nasogastric or nasointestinal tube or an alternative feeding method. In addition, if normal caloric intake is substantially impaired with endotracheal tubes or a tracheostomy, a nasogastric or nasointestinal tube may be necessary. Finally, tubes may be used to prevent meal-induced hypoxemia (insufficient oxygen to blood), which occurs with patients with COPD or other pulmonary problems that interfere with eating (e.g., use of oxygen, bronchodilators, tracheostomy, endotracheal tube with ventilator support).

1. Assess causes of poor nutritional status that may be identified and corrected as a first step in determining whether or not a nasogastric or nasointestinal tube is necessary (see Nutritional Status RAP).

    (a) Eating, swallowing and chewing disorders can negatively affect nutritional status (low weight in relation to height, weight loss, serum albumin level, and dietary problems) and the initial task is to determine the potential causes and period of time such problems are expected to persist. Recent lab work should also be reviewed to determine if there are electrolyte imbalances, fluid volume imbalances, BUN, creatinine, low serum albumin, and low serum protein levels before treatment decisions are made. Laboratory measurement of sodium and potassium tell whether or not an electrolyte imbalance exists. Residents taking diuretics may have potassium losses requiring potassium supplements. If these types of imbalances cannot be corrected with oral nutrition and fluids or intravenous feedings, then a nasogastric or nasointestinal tube may be considered.

    (b) Determine whether fluid intake and hydration problems are short-term or long-term.

    (c) Review for gastrointestinal distention, gastrointestinal hemorrhage, increased gastric acidity, potential for stress ulcers, and abdominal pain.

    (d) Identify pulmonary problems (e.g., COPD and use of endotracheal tubes, tracheostomy, and other devices) that interfere with eating or dehydration.

(e) Review for mental status problems that interfere with eating such as depression, agitation, delirium, dementia, and mood disorders.

(f) Review for other problems such as cardiovascular disease or stroke.

2. Determine the need for such a tube. Examine alternatives.

   Alternatives to nasogastric and nasointestinal tubes should always be considered. Intravenous feedings should be used for short-term therapy as a treamtent of choice or at least a first option. Jejunostomy may have some advantages for long-term therapy, although may increase the risk for infection. A gastrostomy is better tolerated by agitated patients and those requiring prolonged therapy (more than 2 weeks). Gastrostomy with bolus feedings is preferable to nasogastric or nasointestinal tubes for long-term therapy for comfort reasons and to prevent the dislodgement and complications associated with nasal tubes. It is also less disfiguring as it can be completely hidden under clothing when not in use.

3. Assure informed consent and right to refuse treatment. Informed consent is essential before inserting a nasogastric or nasointestinal tube. Potential advantages disadvantages, and potential complications need to be discussed. Resident preferences are normally given the greatest weight in decisions regarding tube feeding. State laws and judicial decisions must also be taken into account. If the resident is not competent to make the decision, a durable power of attorney or living will may determine who has the legal power to act on the resident's behalf. Where the resident is not competent or no power of attorney is in effect, the physician may have the responsibility for making a decision regarding the use of tube feeding. In any case, when illness is terminal and/or irreversible, technical means of providing fluids and nutrition can represent extraordinary rather than ordinary means of prolonging life.

4. Monitor for complications and correct/change procedures and feedings when necessary. Periodic changing of the nasogastric and intestinal tubes is necessary, although the appropriate interval for changing tubes is not clear. Assessment and determination of continued need should be completed before the tube is reinserted. Specific written orders by the physician are required.

   Individuals at risk of pulmonary aspiration (such as those with altered pharyngeal reflexes or unconsciousness) should be given a nasointestinal tube rather than a nasogastric tube, or other medical alternative. Those at risk for displacement of a nasogastric tube, such as those with coughing, vomiting, or endotracheally intubated, should also be given a nasointestinal tube rather than a nasogastric tube or other medical alternative.

II. TRIGGER

1. Tubes currently in use. [L4b = checked]

III. GUIDELINES

COMPLICATIONS OF TUBE FEEDING

To reiterate, serious potential negative consequences include agitation, depression, mood disorders, self-extubation (removal of the tube by the patient), infections, aspirations, misplacement of tube in trachea or lungs, pain, and tube dysfunction. Abnormal lab values can be expected and should be reviewed.

Infection in the trachea or lungs. Gastric organisms grow as a result of alkalizing (raising) the gastric pH. Gastric colonization results in transmission of gastric organisms to the trachea and the development of nosocomial pneumonia. In one study, colonization in 89% of patients within 4 days in ventilated patients with enteral nutrition was found with nosocomial respiratory infection in 62% of the patients studied. Symptoms of respiratory infections to be monitored include coughing, shortness of breath, fever, chest pain, respiratory arrest, delirium, confusion, and seizures.

Aspiration of gastric organisms into the trachea and the lungs. The incidence is difficult to determine, but most studies suggest it is relatively high.

Inadvertent respiratory placement of the tube is the most common side effect of tube placement. In one study, 15% of small-bore nasogastric tubes and 27-50% of nasointestinal tubes were found to be out of their intended position upon radiographic examination without any other evidence of displacement. Respiratory placement can occur in any patient, but is most likely in those who are neurologically depressed, heavily sedated, unable to gag, or endotracheally intubated. Detecting such placement is difficult; the following comments address this issue:

- Radiologic detection is the most definitive means to detect tube displacement. Under this procedure, pneumothorax and inadvertent placement in the respiratory tract can be avoided by first placing the feeding tube in the esophagus with the tip above the xiphoid process and then securing the tube and confirming placement with a chest x-ray. Then the tube may be advanced into the stomach and another x-ray taken to confirm the position. The stylet can then be removed and tube feeding begun. Unfortunately, nursing homes are highly unlikely to have appropriate radiological technology and it is normally unreasonable to expect them to make arrangements to have patients transported to available radiology.

- pH testing of gastric aspirates to determine whether a tube is in the gastric, intestine, or the respiratory area is a promising method for testing feeding tube placement. However, parameters for various secretions from the three areas have not yet been clinically defined.

- Aspiration of visually recognizable gastrointestinal secretions, although a frequently used method of determining placement of tubes, is of questionable value as the visual characteristics of secretions can be similar to those from the respiratory tract.

- Ausculatory method: although "shooshing" or gurgling sounds can indicate placement in the stomach, the same sounds can occur when feeding tubes are inadvertently placed in the pharynx, esophagus and respiratory tract. Although small-bore tubes make the ausculatory method more difficult to use, large-bore nasogastric tubes may also be placed inadvertently in the respiratory tract producing false gurgling.

Inadvertent dislodgement of the tubes. Nonweighted tubes appear to be more likely to be displaced than weighted tubes (with an attached bolus of mercury or tungsten at the tip).

Other complications include: pain, epistaxis, pneumothorax, hydrothorax, nasal alar necrosis, nasapharyngitis, esophagitis, eustachitis, esophageal strictures, airway obstruction, pharyngeal and esophageal perforations. Symptoms of respiratory infections are to be reviewed.

Complications of gastric tract infections and gastric problems. Symptoms include abdominal pain, abdominal distention, stress ulcers, and gastric hemorrhage. There is also a need to monitor for complications including diarrhea, nausea, abdominal distention, and asphyxia. Such complications signal the need for a change in the type of formula or diagnostic work for other pathology.

Complications for the cardiovascular system. Symptoms of cardiac distress or arrest to be monitored include chest pain, loss of heart beat, loss of consciousness, and loss of breathing.

Periodic tests to assure positive nitrogen balance during enteral feeding. Where positive balance is not achieved, a formula with high nitrogen density is needed. The absorptive capacity is impaired in many elderly patients so that serum fat and protein should be monitored. Effective nutrients should result in positive nitrogen balance, maintenance or increases in body weight, triceps skinfold and midarm muscle circumference maintenance, total iron binding capacity maintenance, and serum urea nitrogen level maintenance. Caloric intake and resident weight should be monitored on a regular basis.

FEEDING TUBES RAP KEY

TRIGGERS

Feeding Tube present **[L4b = checked]**

GUIDELINES

Factors that may impede removal of tube:

1. Comatose **[B1]**
2. Failure to eat **[H1d]** AND Resists assistance in eating **[H4b; from record]**
3. Diagnoses: CVA **[J1k]**, gastric ulcers, gastric bleeding **[J2]**
4. Chewing problem **[L1a]**
5. Swallowing problem **[L1b]**
6. Mouth pain **[L1c]**
7. Length of time feeding tube has been in use **[from record]**

Potential complications of tube feeding:

1. Diagnostic conditions: delirium **[B5]**, agitation **[H1]**, anxiety **[J1p]**, depression **[J1q]**, lung aspirations **[K1k]**
2. Self-extubation (removal of tube by resident) **[from record]**
3. Limb restraints in use to prevent self-extubation **[P3c]**
4. Infections in lung/trachea: fever **[K1f]**, shortness of breath **[K1l]**, pneumonia **[J1o]**, placement or dislodgement of tube into lung **[from exam, record]**
5. Side-effects of enteral feeding solutions: constipation **[K1a]**, diarrhea **[K1b]**, fecal impaction **[K1e]**, abdominal distention or pain **[exam]**, dehydration **[L3b]**
6. Respiratory problems: pneumothorax, hydrothorax, airway obstruction, acute respiratory distress, respiratory distress **[J2; from observation, record]**
7. Cardiac distress/arrest: chest pain, loss of heart beat, loss of consciousness, loss of breathing **[from observation, record]**
8. Abnormal lab values **[P2]**

RESIDENT ASSESSMENT PROTOCOL: DEHYDRATION/FLUID MAINTENANCE

I. PROBLEM

On average, one can live only four days without water. Water is necessary for the distribution of nutrients to cells, elimination of wastes, regulation of body temperature, and countless other complex processes.

Dehydration is a condition in which water or fluid loss (output) far exceeds fluid intake. The body becomes less able to maintain adequate blood pressure, deliver sufficient oxygen and nutrients to the cells, and rid itself of wastes. Many distressing symptoms can originate from this conditions, including:

- Dizziness on sitting/standing (blood pressure insufficient to supply oxygen and glucose to brain);
- Confusion or change in mental status (decreased oxygen and glucose to brain);
- Decreased urine output (kidneys conserve water);
- Decreased skin turgor, dry mucous membranes (symptoms of dryness);
- Constipation (water insufficient to rid body of wastes); and
- Fever (water insufficient to maintain normal temperature).

Other possible consequences of dehydration include: decreased functional ability, predisposition to falls (because of orthostatic hypotension), fecal impaction, predisposition to infection, fluid and electrolyte disturbances, and ultimately death.

Nursing home residents are particularly vulnerable to dehydration. It is often difficult or impossible to access fluids independently; the perception of thirst can be muted; the aged kidney can have a decreased ability to concentrate urine; and acute and chronic illnesses can alter fluid and electrolyte balance.

Unfortunately, many symptoms of this condition do not appear until significant fluid has been lost. Early signs and symptoms tend to be unreliable and nonspecific; staff will often disagree about the clinical indicators of dehydration for specific cases; and the identification of the most crucial symptoms of the condition are most difficult to identify among the aged. Early identification of dehydration is thus problematic, and the goal of this RAP is to identify any and all possible high risk cases, permitting the introduction of programs to prevent the condition from occurring.

When dehydration is in fact observed, treatment objectives focus on restoring normal fluid volume, preferably orally. If the resident cannot drink between 2500-3000 cc's every 24 hours, water and electrolyte deficits can be made up via other routes. Fluids can be administered intravenously, subcutaneously, or by tube until resident is adequately hydrated and can take and retain sufficient fluids orally.

II. TRIGGERS

Dehydration suggested if either of following conditions apply:

1. Insufficient fluid/dehydration — actual fluid deficit [L3b = checked]

2. Two or more of the following are present:
   - Deteriorated cognitive status [B6 = 2]
   - Deteriorated ADL status [E8 = 2]
   - Failure to eat or take medications [H1d = checked]
   - UTI [J1ee = checked]
   - Dehydration diagnosis [J2 = 276.5]
   - Diarrhea, fever, or internal bleeding [K1b, K1f, K1h = any checked]
   - Dizziness/vertigo [K1c = checked]
   - Vomiting [K1n = checked]
   - Recent weight loss [L2c = 1]
   - Did not consume all liquids provided [L3c = checked]
   - Leaves 25%+ food uneaten [L3e = checked]
   - Parenteral/IV or feeding tube [L4a, L4b = any checked]
   - Taking diuretic [from record]

III. GUIDELINES

RESIDENT FACTORS THAT MAY IMPEDE ABILITY TO MAINTAIN FLUID BALANCE

Moderate/severely impaired decision-making Ability.

- Has there been a recent unexplainable change in mental status?
- Does resident seem unusually agitated or disoriented?
- Is resident delirious?
- Is resident comatose?

Comprehension/Communication problems.

- Does dementia, aphasia or other condition seriously limit resident's understanding of others, or how well others can understand the resident?

Body control problems.

- Does resident require extensive assistance to transfer?
- Does resident freely move on the unit?
- Has there been recent ADL decline?

Hand dexterity problem.

- Can resident grasp cup?

Swallowing problems.

- Does resident have mouth sore(s)/ulcer(s)?
- Does resident refuse food, meals, meds?
- Can resident drink from a cup or suck through a straw?

Use of Parenteral/IV.

- Are feeding tubes in use?

RESIDENT DEHYDRATION RISK FACTORS

Dehydration risk factors can be categorized in terms of whether they decrease fluid intake or increase fluid loss. The higher the number of factors, the greater the risk of dehydration. Ongoing fluid loss through the lungs and skin occurs at a normal rate of approximately 500 cc/day and increases with rapid respiratory rate and sweating. Therefore, decreased fluid intake for any reason can lead to dehydration.

Purposeful Restriction of Fluid Intake.

- Has there been a decrease in thirst perception?
- Is resident unaware of the need to intake sufficient fluids?
- Has resident or staff restricted intake to avoid urinary incontinence?
- Are fluid restricted because of diagnostic procedure or other health reason?
- Does sad mood, grief, or depression cause resident to refuse foods/liquids?

Presence of infection, fever, vomiting/diarrhea/nausea, excessive sweating (e.g., a heat wave).

Frequent use of laxatives, enemas, diuretics.

Excessive urine output (polyuria).

Excessive urine output (polyuria) may be due to:

- Drugs (e.g., lithium, phenytoin), alcohol abuse
- Diseases (e.g., diabetes mellitus, diabetes insipidus)
- Other conditions (e.g., hypoaldosteronism, hyperparathyroidism)

Other test results.

Relevant test result to be considered:

- Does systolic/diastolic blood pressure drop 20 points on sitting/standing?
- On inspection, do oral mucous membranes appear dry?
- Does urine appear more concentrated and/or decreased in volume?

DEHYDRATION/FLUID MAINTENANCE RAP KEY

TRIGGER

Dehydration Suggested if:

1. Insufficient Fluid/dehydration [L3b = checked]

2. Two or More of following are Present:

   - Deteriorated cognitive status [B6 = 2]
   - Deteriorated ADL status [E8 = 2]
   - Failure to eat or take medications [H1d = checked]
   - UTI [J1ee = checked]
   - Dehydration diagnosis [J2 = 276.5]
   - Diarrhea, fever, or internal bleeding [K1b, K1f, K1h = any checked]
   - Dizziness/vertigo [K1c = checked]
   - Vomiting [K1n = checked]
   - Recent weight loss [L2c = 1]
   - Did not consume all liquids provided [L3c = checked]
   - Leaves 25%+ food uneaten [L3e = checked]
   - Parenteral/IV or feeding tube [L4a, L4b = any checked]
   - Taking diuretic [from record]

GUIDELINES

Resident Factors That May Impede Ability to Maintain Fluid Balance:

1. Moderate/severely impaired decision-making ability [B4]
2. Comprehension/communication problem [C4, C5]
3. Body control problems [E4, E8]
4. Hand dexterity problem [E4g]
5. Swallowing problem [L1b]
6. Use of Parenteral/IV [L4a]

Resident Dehydration Risk Factors:

1. Purposeful restriction of fluids [from record]
2. Presence of infection [J1o, J1dd, J1ee], diarrhea [K1b], fever [K1f], vomiting [K1n], nausea [from record], excessive urine loss [from record, exam]
3. Frequent laxative/enema/diuretic use [from record]
4. Excessive urine output [from record]
5. Other tests: Standing/sitting blood pressure, status of oral mucous membranes, urine output volume [from record; exam]

RESIDENT ASSESSMENT PROTOCOL: DENTAL CARE

I. PROBLEM

Having teeth/dentures that function properly is an important requisite for nutritional adequacy. Having teeth/dentures that are clean and attractive can promote a resident's positive self-image as well as personal appearance thereby enhancing social interactions among residents, residents and staff, and residents and visitors. Good oral health can decrease a resident's risk of oral discomfort and in some instances, systemic illness from oral infections/cancer. Residents at greatest risk due to impaired abilities are primarily those with multiple medical conditions and medications, functional limitations in self-care, and communication deficits. Also at risk are more self-sufficient residents who lack motivation or have no consistent history of performing oral health functions. Residents with a history of alcohol and/or tobacco use have a greater risk of developing chronic oral lesions.

II. TRIGGERS

The Dental Care RAP triggers two types of residents:

- residents with oral hygiene problems; and
- residents with oral/dental health problems who may benefit from dental evaluation

A dental care problem is suggested if the following signs are present:

1. Mouth debris **[M1a = checked]** OR Less than daily cleaning of teeth/dentures **[M1f = not checked]**

Potential for oral/dental health problems is suggested if any of the following signs/symptoms are present:

1. Mouth pain **[L1c = checked]** OR Broken, loose, carious teeth **[M1d = checked]** OR Inflamed gums, oral abscesses, swollen or bleeding gums, ulcers, rashes **[M1e = checked]**

2. Some/all natural teeth lost —does not have or does not use dentures (or partial plates) **[M1c = checked]**

III. GUIDELINES

CONFOUNDING PROBLEMS

Debris on teeth, gums, and oral tissues may consist of food and bacteria-laden plaque that can begin to decay teeth or cause foul denture odors if not removed at least once daily. The purpose of this section is to examine confounding problems (from the MDS) which may be prohibiting a resident from adequately removing oral debris.

Impaired cognitive skills.

- Does the resident need reminders to clean his/her teeth/dentures?
- Does he remember the steps necessary to complete oral hygiene?
- Would he benefit from task segmentation or supervision?

Impaired ability to understand:

- Can the resident follow verbal directions or demonstrations for mouth care?
- If the resident has language difficulties, does he/she know what to do when handed a toothbrush/toothpaste and placed at the bathroom sink?

Impaired vision.

- Is resident's vision adequate for performing mouth care or checking its adequacy?

Impaired personal hygiene.

- Did the resident receive supervision or assistance with oral/dental care during the last 7 days?
- Has he/she been assessed to see if he/she could do it independently?
- Does the resident have partial/total loss of voluntary arm movement or impaired hand dexterity that interferes with self-care?
- What would the resident need to be more independent?

Motivation/Knowledge of resident who is independent in oral/dental care but still has debris or perfoms care less than daily.

- Is he/she brushing adequately?
- Does he/she know that it is most important to brush near the gumline?
- Does he/she need to be shown how or be given reinforcement for maintaining good hygiene?

Adaptive equipment for oral hygiene.

- Has the resident tried or would he/she benefit from using a built-up, long-handled, or electric toothbrush, or suction brush for cleaning teeth?
- If resident has dentures, does he/she have denture cleaning devices (e.g., denture brush, soaking bath)?

Resists ADL assistance:

- Does the resident resist mouth care? If so, why (e.g., would rather do own care, painful mouth, apathy related to depression, not motivated—never cared for teeth/mouth, approach of staff, fear)?

Dry mouth from dehydration or medications.

- Dry mouth can contribute to the formation of debris. Is the resident's lips, tongue, or mouth dry, sticky, or coated with film?
- Is the resident taking enough fluids? Is lip balm being applied to resident who has painful, cracking or bleeding lips?
- Is he/she taking any medications that can cause dry mouth (e.g., decongestants, antihistamines, diuretics, antihypertensives, antidepressants, antipsychotics, antineoplastics)?
- If these medications are necessary, has the resident tried saliva substitutes to stimulate moisture?

TREATMENT HISTORY AND OTHER RELEVANT FACTORS

Mouth pain or sensitivity can be related to either minor and easily treatable (e.g., gum irritation from ill-fitting dentures, localized periodontal problem) or more serious problems (e.g., oral abscess, cancer, advanced tooth decay or periodontal disease). The presence of pain may prevent the resident from eating adequately. Residents with cognitive impairment and/or those who have difficulty making their needs known are difficult to assess. They may not complain specifically of mouth pain but may instead have decreased food intake or changes in behavior.

The presence of lesions, ulcers, inflammation, bleeding, swelling, or rashes may be representative of a minor problem (e.g. irritation from wearing dentures for 24 hours/day), which resolves when the cause is alleviated (e.g., combination of mouth care and leaving dentures out). However, these signs may also indicate more serious problems, even dental emergencies (e.g., infection). If the problem does not resolve with specific local treatment after a couple of days, OR if these signs are accompanied by pain, fever, lymphadenopathy (swollen glands) and/or other signs of local infection (e.g., redness), chewing or swallowing problems, or changes in mental status or behavior, a dental consult should be considered.

- Review mouth for Candidiasis (white areas that appear to be able to be removed — anywhere in mouth, mostly on tongue) for lethargic residents who have one or more of following diagnoses: stroke, Alzheimer's, Parkinson's, anxiety disorder, depression, diabetes, osteoporosis, or septicemia.

Broken, loose, or carious teeth may progress to more severe problems (e.g., dislodging a decayed tooth and swallowing or aspirating it). Although, not emergencies, a dental consult should be considered.

If a resident has lost some or all of his/her natural teeth and does not have dentures (or partial plates) staff should consider if the resident has the cognitive ability and motivation to wear dentures.

- Has a dentist evaluated resident for dentures?
- Why doesn't resident use his/her dentures (or partial plates)?
- Are teeth in good repair?
- Do they fit well?
- Are they comfortable to wear when eating or talking?
- Does the resident like the way he/she looks when wearing them?
- Has a dentist evaluated resident for dentures?
- Has a dental hygienist interviewed and made recommendations regarding oral hygiene care?

Exam by dentist since problem noted. When evaluating a resident with mouth pain or the presence of any of the other trigger signs, check the record to see if a dentist has examined the resident since the problem was first noted.

- Was the current problem addressed?
- What were the recommendations?

Use of anticoagulants.

- Is the resident on coumadin or heparin that would put him/her at risk for bleeding if dental work is necessary?
- Is it noted on the medical record?

Valvular heart disease or prosthesis (e.g., heart valve, false hip, etc.).

- Are either of these conditions present?
- If so are they clearly noted in the medical record so that necessary precautions be taken prior to dental work?

DENTAL CARE RAP KEY

TRIGGERS

Dental Care problem suggested if:

1. Mouth Debris [M1a = checked] OR Less Than Daily Cleaning of Teeth/Dentures [M1f = not checked]

Potential for oral/dental health problems suggested if:

2. Mouth Pain [L1c = checked]; Broken, Loose or Carious Teeth [M1d = checked] OR Inflamed Gums, Oral Abscesses, Swollen/Bleeding Gums, Ulcers, Rashes [M1e = checked]

3. Some/All natural teeth lost and does not have or does not use dentures [M1c = checked]

GUIDELINES

Confounding problems to be considered:

1. Impaired cognitive skills [B1, B4]
2. Impaired ability to understand [C1, C5]
3. Impaired vision [D1]
4. Impaired personal hygiene [E2g]
5. Motivation/knowledge [from observation]
6. Adaptive equipment for oral hygiene [from record]
7. Resists ADL assistance [H4b]
8. Dry mouth from hydration [L3b, L3c] or from medications [from medication sheet]

Treatment history/relevant factors:

1. Mouth pain or sensitivity [L1c]
2. Presence of lesions, ulcers, inflammation, bleeding, swelling or rashes [M1e]
3. Broken, loose or carious teeth [M1d]
4. Natural teeth loss/no dentures [M1c]
5. Exam by dentist/dental hygenist since problem noted [from record]
6. Use of anticoagulants [from record]
7. Valvular heart disease or valvular appliance [J1, J2]

RESIDENT ASSESSMENT PROTOCOL: PRESSURE ULCERS

I. PROBLEM

Between 3% and 5% (or more) of residents in nursing facilities have pressure ulcers (pressure sores, decubitus ulcers, bedsores). Sixty percent or more of residents will typically be at risk of pressure ulcer development. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. However, they are one of the most common, preventable and treatable conditions among elderly who have restricted mobility. Successful outcomes can be expected with preventive and treatment programs.

Assessment goals are: (1) to ensure that a treatment plan is in place for residents with pressure ulcers; and (2) to identify residents at risk for developing a pressure ulcer who are not currently receiving some type of preventive care program.

II. TRIGGERS

1. Pressure Ulcer Present. **[N2 = 1, 2, 3 or 4]**

2. Risk Factors for Pressure Ulcer. One or more of the following problems AND NOT receiving any skin care program **[N4c, N4d, N4e, N4f, N4g = not checked]**: (NOTE: these are listed in the order in which they appear in the MDS and RAP KEY — not by type or severity of risk.)

   Impaired Transfer or Bed Mobility. **[E1a or E1b = 3 or 4]** Increased risk occurs when a resident's impaired ability prevents repositioning at regular intervals.

   Bedfast, Hemiplegia, Quadriplegia. **[E4b, E4d, E4e = any checked]** These conditions predispose a resident to immobility, and the extended time (2 hours or less) spent in one position will generate sufficient pressure to cause skin breakdown. Pressure relief at regular intervals (2 hours is maximum) through repositioning can alleviate the problem. Maximum time varies because of other differences in individual skin integrity and presence of other risk factors. A pressure-reducing device (e.g., foam mattress, water mattress, or specialized bed) is helpful, but it can not replace regular repositioning.

   Urinary or bowel incontinence. **[F1a or F1b = 3 or 4]** The presence of urine or feces on the skin for a prolonged time can lead to skin maceration (softening) and subsequent breakdown. Bowel incontinence requires evaluation for the presence of neurologic disorder, bowel disorder, drug side effects, or acute illness.

   Peripheral vascular disease. **[J1f = checked]** Poor circulation places resident at risk of pressure ulcer formation, especially in heels and ankles. Any decrease in blood flow permits ischemia (lack of tissue oxygenation) in areas where pressure is applied. This can happenquite rapidly (i.e., within 2 hours). If peripheral vascular disease is present, physician referral should be considered.

   Diabetes mellitus. **[J1y = checked]** Diabetes, particularly insulin-dependent diabetes, increases risk, probably from the effects of diabetes on vasculature or blood flow. Although not proven, control of blood sugar may minimize this risk factor.

   Hip fracture. **[K2c = checked]** Recent fracture of hip (or lower limb) increases risk in that a fracture can lead to decreased mobility and increased time spent in one position.

   Weight loss. **[L2c = 1]** Weight loss should raise concerns about malnutrition. Malnutrition can lead to decreased skin integrity and muscle weakness, which can impair repositioning ability. Malnutrition also impedes healing.

Pressure ulcer history. [N3 = 1] Persons with a history of pressure ulcers are at risk for a recurrence. Current risk factors should be assessed.

Impaired tactile sensory perception. [N4b = checked] Skin that is not sensitive to pain, pressure or discomfort may impede ability to change position because of blunted response to pain, which can be a warning that skin pressure is excessive and breakdown imminent.

Medications. [O4a = 7] Daily use of antipsychotics, can retard mobility, exacerbate incontinence, or lead to mental confusion — conditions that increase the risk of pressure ulcer formation.

Restraints. [P3b, P3c or P3d = 2] Daily use of restraints leads to immobility, increases the time spent in one position, and decreases an individual's ability to change positions. As pressure to a particular area increases (e.g., buttocks or hips), pressure ulcer risk increases.

III. GUIDELINES

Review the MDS items listed on the RAP KEY for relevance in understanding the type of care that may be required.

Complicating Conditions and Treatments.

Consider carefully whether the resident exhibits conditions or is receiving treatments that may either place the resident at higher risk of developing pressure ulcers or complicate their treatment. Such conditions include:

Alzheimer's Disease and other dementias. An impairment in cognitive ability, particularly in severe end-stage dementia, can lead to immobility.

Edema. The presence of extravascular fluid can impair blood flow. If prolonged or excess pressure is applied to an area with edema, skin breakdown can occur.

Antidepressants and antianxiety/hypnotics. These medications can produce or contribute to lessened mobility, worsen incontinence, and lead to or increase confusion.

Things to Consider if the Resident Develops a New Pressure Ulcer or an Ulcer Being Treated is not Resolved.

A variety of factors may explain this occurrence; however, they may suggest the need to evaluate current interventions and modifications of the care plan.

- Review the resident's medical condition and other risk factors to determine whether the care plan (for prevention or cure) addresses all potential causes or complications.
- Review the care plan to determine whether it is actually being followed (e.g., is the resident being turned often enough to prevent ulcer formation).

Things to Consider if the Resident is At Risk for Pressure Ulcers But is Not Receiving Preventive Skin Care.

Even if pressure ulcers are not present, determine why this course of prevention is not being provided to a resident with risk factors.

- Is the resident new to the unit?
- Do few or many risk factors for the development of pressure ulcers apply to this resident?
- Are staff concentrating on other problems (e.g., resolution of behavior problems) so that the risks pressure of ulcers are masked?

PRESSURE ULCERS RAP KEY

TRIGGERS

1. Pressure Ulcer Present [N2 = 1, 2, 3 or 4]
2. At Risk for Pressure Ulcer when <u>Both</u> of Following (a&b) True:

   a. <u>One or More of the Following are Present</u>:

   - Bed mobility/Transfer Problem [E1a or E1b = 3 or 4]
   - Bedfast, Hemiplegia, Quadriplegia [E4b, E4d, E4e = any checked]
   - Incontinence [F1a or F1b = 3 or 4]
   - Peripheral Vascular Disease [J1f = checked]
   - Diabetes Mellitus [J1y = checked]
   - Hip Fracture [K2c = checked]
   - Weight Loss [L2c = 1]
   - Previous Pressure Ulcer [N3 = 1]
   - Impaired Tactile Sense [N4b = checked]
   - Daily Antipsychotics [O4a = 7]
   - Daily Trunk, Limb or Chair restraints [P3b, P3c or P3d = 2]

   b. <u>Absence of ALL of the Following Treatments</u>:

   - Protective/Preventive skin care [N4c = not checked]
   - Turning/repositioning [N4d = not checked]
   - Pressure relieving beds/chair pads [N4e = not checked]
   - Wound care/treatment [N4f = not checked]
   - Other skin care/treatment [N4g = not checked]

GUIDELINES

Other factors that address or may complicate treatment of pressure ulcers or risk of ulcers:

1. **Diagnoses:** Alzheimer's disease [J1h], Other dementia [J1i], Edema [K1d]
2. **Interventions/Programs:**
   Protective/preventive skin care [N4c]
   Turning/repositioning [N4d]
   Pressure relieving beds/chair pads [N4e]
   Wound care/treatment [N4f]
   Use of restraints [P3]
3. **Medications:**
   Antipsychotics [O4a]
   Antianxiety/hypnotics [O4b]
   Antidepressants [O4c]

RESIDENT ASSESSMENT PROTOCOL: PSYCHOTROPIC DRUG USE

I. PROBLEM

Psychotropic drugs are among the most frequently prescribed agents for elderly nursing home residents. Studies in nursing facilities suggest that 35% to 65% of residents receive psychotropic medications.

When used appropriately and judiciously, these medications can enhance the quality of life of residents who need them. However, all psychotropic drugs have the potential for producing undesirable side effects or aggravating problematic signs and symptoms of existing conditions. An important example is postural hypotension, a condition associated with serious and life-threatening side effects. Severity of delirium side effects is dependent on: the class and dosage of drug, interactions with other drugs, and the age and health status of the resident.

Maximizing the resident's functional potential and well-being while minimizing the hazards associated with drug side effects are important goals of therapy. In reviewing a psychotropic drug regimen there are several rules of thumb:

- Evaluate the need for the drug (e.g., consider amount and type of distress, response to nonpharmacologic interventions, pros and cons of drug side effects in relation to distress without the drug). Distinguish between treating specific diagnosed psychiatric disorders and treating symptoms. Specific psychiatric disorders (e.g., schizophrenia, major depression) have specific drug treatments with published guidelines for dosage and duration of treatment. However, a recorded diagnosis of a psychiatric disorder does not necessarily require drug treatment if symptoms are inactive.
- Start low, go slow. If needed, psychotropic drugs should be started at lowest dosage possible. To minimize side effects, doses should be increased slowly until either there is a therapeutic effect, side effects emerge, or the maximum recommended dose is reached.
- Each drug has its own set of actions and side effects, some more serious than others: these should be evaluated in terms of each user's medical-status profile, including interaction with other medications.
- Consider symptoms or decline in functional status as a potential side effect of medication.

II. TRIGGERS

The RAP should be completed when the resident takes <u>any psychotropic drug</u> and one or more of the following 5 combinations of MDS conditions are present:

Potential for Drug-Related Hypotension if:

1. Antipsychotic AND/OR Antidepressant Use [O4a or O4c = 1-7] AND ANY of the following:
    - **Hypotension [J1e = checked]**
    - **Dizziness/Vertigo [K1c = checked]**
    - **Syncope [K1m = checked]**
    - **Accidents [K2a, K2b, K2c = any checked]**

Potential for Drug-Related Movement Disorder if:

2. Antipsychotic Use [O4a = 1-7] AND ANY of the following:
   - Parkinson's Disease [J1m = checked]
   - Poor Balance [E4a = checked]
   - Unsteady Gait [E4i = checked]
   - Difficulty Positioning/Turning [E4j = checked]
   - Tardive Dyskenisia [J2 = 333.82]
   - Partial/Total Loss of Voluntary Arm/Leg Movement [E4f, E4h = any checked]
   - Motor Agitation [H1c = checked]
   - Chewing/Swallowing Problem [L1a, L1b = any checked]

Potential for Drug-Related Gait Disturbance (other than antipsychotic induced) if:

3. Antianxiety/hypnotic Use [O4b = 1-7] AND ANY of the following:
   - Poor Balance [E4a = checked]
   - Unsteady Gait [E4i = checked]
   - Difficulty Positioning/Turning [E4j = checked]
   - Dizziness/Vertigo [K1c = checked]
   - Accidents [K2a, K2b, K2c = any checked]

Potential for Drug-Related Cognitive/Behaviorial Impairment if:

4. Any Psychotropic use [O4a, O4b or O4c = 1-7] AND ANY of the following:
   - Delirium/Disordered Thinking [B5a, B5b, B5c, B5d, B5e = any checked]
   - Withdrawal [H1d = checked]
   - Depression [J1q = checked]
   - Hallucinations/Delusions [K1g = checked]
   - Major Difference in ADL Self-Performance [E7d = checked]
   - Deterioration in Cognition, Communication, ADL, Continence, Mood and/or Behavior [B6=2 or C6=2 or E8=2 or F4=2 or H6=2 or H7=2]

Potential for Drug-Related Discomfort if:

5. Any Psychotropic [O4a, O4b or O4c = 1-7] use AND ANY of the following:
   - Constipation [K1a = checked]
   - Fecal Impaction [K1e = checked]
   - Urinary Retention [J2 = 788.2]

III. GUIDELINES

If any of the triggered conditions are present, complete the following:

Step One:

Conduct the following reviews:

1. Drug review (from record)
   - Length of time between when the drug was first taken and onset of problem
   - Dose of drug and how frequently taken
   - Number of classes of psychotropics taken
   - Reason drug prescribed
2. Review resident's conditions that impair drug metabolism/excretion
   - Acute condition(s)
   - Dehydration
   - Impaired liver/renal function
3. Review behavior/mood/psychiatric status
   - Current problem status
   - Recent change in mood behavior
   - Behavior management program
   - Psychiatric conditions

Step Two:

Compare the drugs the resident is currently taking with common side effects listed below. Refer to Tables A, B, and C for clarification.

POTENTIAL PSYCHOTROPIC DRUG-RELATED SIDE EFFECTS

Hypotension.

Postural (orthostatic) hypotension (decrease in blood pressure upon standing) is one of the major risk factors for falls related to psychotropic drugs. It is commonly seen with the low-potency antipsychotic drugs (chlorpromazine, thioridizene) and with tricyclic antidepressants. Both classes of drugs have anticholinergic properties. Within each class, drugs with the most potent anticholinergic properties also seem to produce the greatest hypotensive effects. Symptoms of dizziness/vertigo upon sitting or standing from a lying position, syncope (fainting), and falls/fractures should be seriously considered as potential indicators of psychotropic drug-induced hypotension. In addition, these symptoms may be due to a disturbance of heart rhythm, which could be aggravated by a tricyclic antidepressant. The occurrence of any of the aforementioned symptoms requires assessment of postural vital signs and heart rhythm.

- Measurement of postural vital signs. Measure blood pressure and pulse when the resident is lying down. Remeasure blood pressure and pulse after the resident has been on his/her feet for one to five minutes (if unable to stand, ensure after the resident has been sitting). Occasionally, further drops in blood pressure occur after the person has been up for some time. While a drop of more than 20 mm Hg systolic is always abnormal, it is particularly significant if accompanied by dizziness, loss of balance, or standing blood pressure of less than 100 mm Hg. A large drop may be clinically significant even if the lower pressure is not abnormally low, particularly in residents who have some degree of cerebrovascular disease.

Movement Disorder.

High fever AND/OR muscular rigidity. Antipsychotic drugs can interfere with temperature regulation, which can lead to the potentially fatal problem of hyperthermia. Also, when high fever is accompanied by severe muscular rigidity, "neuroleptic malignant" syndrome must be suspected. Fever above 103 degrees in a resident on an antipsychotic drug is a medical emergency because of the disturbed temperature regulation. Even lesser degrees of fever, if accompanied by severe muscular rigidity, are medical emergencies. Temperature must therefore be monitored especially closely in residents on psychotropic drugs with anticholinergic properties. In addition, nonantipsychotic drugs with anticholinergic properties, such as antidepressants, may aggravate fever by impairing sweating.

Parkinson's disease. This condition is known to be aggravated by all antipsychotic drugs. At times it is difficult to know whether parkinsonian symptoms (e.g., tremors, especially of hands; pill-rolling of hands; muscle rigidity of limbs, necks, trunk) are due to Parkinson's disease or to present or recent antipsychotic drug therapy. There should be a strong bias in favor of reducing or eliminating antipsychotic drugs in residents with Parkinson's disease unless there are compelling behavioral or psychotic indications. Antiparkinson drugs should be considered when antipsychotic drugs are clinically necessary in residents with Parkinson's disease.

Five movement disorders are commonly encountered in residents on antipsychotic drugs. All of these disturbances can adversely affect a resident's quality of life as well as increase his/her risk of accidents. The triggered MDS items in Group 2 are signs/symptoms of these disorders. To clarify whether the resident is suffering from one of these disorders, all residents on antipsychotic drugs should be periodically screened for the following conditions:

Parkinsonism. As with Parkinson's disease, this condition may involve ANY combination of tremors, postural unsteadiness, and rigidity of muscles in the limbs, neck, or trunk. Although the most common is a pill-rolling or alternating tremor of the hands, other kinds of tremors are occasionally seen. Occasionally, a resident with Parkinsonism will have no tremor, only rigidity and shuffling gait. Symptoms respond to antiparkinson drugs, but not always completely. Dosage reduction or substitution of nonantipsychotic drug, when feasible, is the preferred management.

Akinesia. This condition is characterized by marked decrease in spontaneous movement, often accompanied by nonparticipation in activity and self-care. It is managed by reducing the antipsychotic drug or adding an antiparkinson drug.

Dystonia. This disorder is marked by holding of the neck or trunk in a rigid, unnatural posture. Usually the head is either hyperextended or turned to the side. The condition is uncomfortable and prompt treatment with an antiparkinson drug can be helpful.

Akathisia — the inability to sit still. The resident with this disorder is driven to constant movement, including pacing, rocking, or fidgeting, which can at times persist for weeks, even after the antipsychotic drug is stopped. The condition responds occasionally to antiparkinson drugs, but less consistently than parkinsonism or dystonia. Sometimes benzodiazepines or beta-blockers are helpful in treating the symptom, although dosage reduction is the most desirable treatment when possible.

Tardive dyskinesia — persistent, sometimes permanent movements induced by long-term antipsychotic drug therapy. Most typical are thrusting movements of the tongue, movements of the lips, or chewing or puckering movements. These involuntary movements can clearly interfere with chewing and swallowing. When they do, the dyskinesia can be suppressed by raising the dose of the antipsychotic drug, but this will make the problem more permanent. When possible, it is usually preferable to reduce or eliminate the antipsychotic drug, because the symptoms of dyskinesia will often decrease over time after drug discontinuation.

Other variations of tardive dyskinesia include abnormal limb movements, such as peculiar and recurrent postures of the hands and arms, or rocking or writhing trunk movements. There is no consistently effective treatment. Withdrawal of the antipsychotic drug leads to eventual reversal of the symptoms over many months in about 50% of cases.

Gait Disturbance (Other Than That Induced by Antipsychotics).
Long-acting benzodiazepine antianxiety drugs have been implicated in increasing the risk of falls and consequent injury by producing disturbances of balance, gait, and positioning ability. They also produce marked sedation, often manifested by short-term memory loss, decline in cognitive abilities, slurred speech, drowsiness in the morning/daytime sedation, and little/no activity involvement. If an antianxiety drug is needed to treat an anxiety disorder, a short-acting benzodiazepine or buspirone would be preferable to a long-acting benzodiazepine. Buspirone is nonsedating and takes several weeks to work. Dosage should be increased slowly.

Cognitive/Behavior Impairment.

Periodic disordered thinking/awareness. These MDS items, which tap the syndrome of acute confusion or delirium, can all be caused or aggravated by psychotropic drugs of any of the major classes. If the resident does not have acute confusion related to a medical illness or severe depression, consider the psychotropic drug as a cause. The most helpful information in establishing a relationship is the linkage between starting the drug and the occurrence of the change in cognitive status.

Depression. Both anti-anxiety and antipsychotic drugs may cause symptoms of depression as a side effect, or may aggravate depression in a resident with a depressive disorder who receives these drugs rather than specific antidepressive therapy.

Hallucinations/delusions. While these are often symptoms of mental illness, all of the major classes of psychotropic drugs can actually produce or aggravate hallucinations. The antidepressant drugs, the more anticholinergic antipsychotic drugs, and the shorter-acting benzodiazepines such as triazolam and lorazepam are most implicated in causing visual hallucinations. Visual hallucinations in the aged are virtually always indicative of brain related disturbance (e.g., delirium) rather than a psychiatric disorder.

Major differences in AM/PM self-performance. All classes of psychotropic drugs can have an effect on a resident's ability to perform activities of daily living. Establishing a link between the time a drug is taken and the change in self-performance is helpful in evaluating the problem.

Decline in cognition/communication. Decline in these areas signals the possibility that the decline is drug-induced and the need to review the relationship of the decline with initiation or change in drug therapy. All major classes of psychotropics can cause impairment of memory and other cognitive skills in vulnerable residents. While memory loss in nursing facility residents is caused primarily by dementing disorders and other neurologic disease, psychotropic drugs, particularly those with anticholinergic side effects, and long-acting benzodiazepines, definitely contribute to memory impairment. In contrast, treatment of depression or psychosis can actually improve usable memory, which is very much disrupted by severe psychiatric illness. If memory worsens after initiating or increasing the dose of a psychotropic drug, consider reducing or discontinuing the drug, or substituting a less anticholinergic drug. For a resident with anxiety, a short-acting benzodiazepine or buspirone is preferable to a long-acting benzodiazepine.

Decline in mood. (See reference to Depression above.)

Decline in behavior. Problem behaviors may be aggravated and worsened by psychotropic drugs as they can contribute to confusion, perceptual difficulties, and agitation.

Decline in ADL status. Drug side effects must always be considered if a resident becomes more dependent in ADLs. In addition, psychotropic drugs can precipitate or worsen bladder incontinence either through a change in cognition or through a direct action on bladder function.

Discomfort

Constipation/fecal impaction. Any psychotropic drug with anticholinergic effects can cause or aggravate constipation; the effects are pronounced with tricyclic antidepressants and with low-potency antipsychotic drugs such as chlorpromazine or thioridizine. Milder cases of constipation can be treated with stool softeners, bulk-forming agents, and increased fluid; more severe constipation is best managed by substituting a less anticholinergic agent, or decreasing or discontinuing the psychotropic drug if possible. Antianxiety drugs can contribute to constipation if they sedate the resident to the point that fluid intake or exeresis is impaired. The problem can be handled by switching to a less sedating drug, decreasing dosage, or discontinuing the drug if possible.

Urinary retention. This condition may be manifested by the inability to urinate, or new onset or worsening of urinary incontinence (caused by overflow of urine from a full bladder that cannot empty properly). Any psychotropic drug with anticholinergic properties can produce or aggravate urinary retention. The problem is best managed by substituting a less anticholinergic agent, or decreasing or discontinuing the psychotropic drug if possible.

Dry mouth. This symptom is a common side effect of any psychotropic drug with anticholinergic properties. Dry mouth can aggravate chewing and swallowing problems. Substituting a less anticholinergic drug may be helpful. Other remedies include artificial saliva or sugar-free mints or candies (sugar contributes to cavity formation).

WHEN TO DISCONTINUE DRUG TREATMENT

1. Drug treatment that is ineffective after a reasonable trial should be discontinued or changed. The definition of a reasonable trial depends on the drug class and therapeutic indication.

2. When a medication is effective, but produces troublesome side effects, either the dose should be reduced or the medication should be replaced by a therapeutically equivalent agent less likely to cause the problematic side effect. If this is not feasible, or if doing it leads to a recurrence of symptoms, specific medical therapy for the troublesome side effects should be considered. For example, if the best drug for treating a resident's depression causes constipation, stool softeners, laxatives, or bulk-forming agents can be prescribed.

3. When a medication is effective and does not cause troublesome side effects, it should be continued for a defined period, and then efforts should be made to taper and eventually discontinue the drug.

4. Psychotropic medication should be prescribed on a permanent basis only if symptoms have recurred on at least two previous attempts to taper the medication after a defined period of therapy.

COMMONLY PRESCRIBED PSYCHOTROPIC DRUGS AND THEIR SIDE EFFECTS

TABLE A. ANTIPSYCHOTIC (NEUROLEPTIC) DRUGS

		Incidence of Side Effects			
Generic Name	**Brand Name**	**Sedation**	**Hypotension**	**Anti-cholinergic Symptoms[1]**	**Extra-pyramidal Symptoms[2]**
Chloropromazine	Thorazine	Marked	Marked	Marked	Mild
Thioridizine	Mellaril	Marked	Marked	Marked	Mild
Acetophenazine	Tindal	Mild	Mild	Moderate	Mild
Perphenazine	Trilafon	Mild	Mild	Moderate	Moderate
Loxapine	Loxitane	Mild	Mild	Moderate	Moderate
Molindone	Moban	Mild	Mild	Moderate	Moderate
Trifluoperazine	Stelazine	Mild	Mild	Mild	Marked
Thiothixene	Navane	Mild	Mild	Mild	Marked
Fluphenazine	Prolixin	Mild	Mild	Mild	Marked
Haloperidol	Haldol	Minimal	Minimal	Mild	Marked

TABLE B. ANTIDEPRESSANT DRUGS

		Incidence of Side Effects		
Generic Name	**Brand Name**	**Sedation**	**Hypotension**	**Anti-cholinergic Symptoms[1]**
Cyclic antidepressants				
Imipramine	Tofranil	Mild	Moderate	Mod-strong
Desipramine	Norpramin	Mild	Mild-mod	Mild
Doxepin	Adapin Sinequan	Mod-strong	Moderate	Strong
Amitriptyline	Elavil Triavil	Strong	Moderate	Very Strong
Nortriptyline	Aventyl Pamelor	Mild	Mild	Moderate
Maprotiline	Ludiomil	Mod-strong	Moderate	Moderate
Amoxapine[*]	Asendin	Mild	Moderate	Moderate
Fluoxetine	Prozac	Variable	Nil	Nil
Triazolopyridine Antidepressant				
Trazodone	Desyrel	Mod-strong	Moderate	Mild
MAO inhibitors[·]	Nardil	Mild	Moderate	Mild
Phenelzine	Parnate	Mild	Moderate	Mild
Tranylcypromine				
	Wellbutrin	None	Nil	Nil
Other		May cause agitation High incidence of seizures		
Bupropion				

[*] Also a neuroleptic drug with all the neuroleptic side effects.

[·] Special diet required; many drug interactions.

[1] Anticholinergic sypmtoms include: dry mouth, constipation, urinary retention, blurred vision, confusion, disorientation, short-term memory loss, hallucinations, insomnia, agitation and restlessness, picking behaviors, fever.

[2] Extrapyramidal symptoms include: movement disorders, such as Parkinsonism, dyskinesias, and akathisia (described in text). Antidepressants (except Amoxapine) and antianxiety/hypnotics do not produce extrapyramidal side effects.

COMMONLY PRESCRIBED PSYCHOTROPIC DRUGS AND THEIR SIDE EFFECTS (cont.)

TABLE C. ANTIANXIETY AND HYPNOTIC DRUGS

Generic Name	Brand Name	Duration of Action
Benzodiazepines		
Triazolam	Halcion	Very short
Oxazepam	Serax	Short
Temazepam	Restoril	Short
Lorazepam	Activan	Short
Alprazolam	Xanax	Medium
Chlorodiazepoxide	Librium	Long
Diazepam	Valium	Long
Chlorazepate	Tranxene	Long
Flurazepam	Dalmane	Very long
Barbiturates		
Antihistamines		
Dephenhydramine	Benadryl	Moderate
Hydroxyzine	Vistaril	Moderate
Chloral hydrate	Noctec	Long
Other		
Buspirone	Buspar	Not meaningful

PSYCHOTROPIC DRUG USE RAP KEY

TRIGGERS

Potential for Drug-Related Hypotension if:

1. Antipsychotic AND/OR Antidepressant Use [O4a or O4c = 1-7] AND ANY of the following:
   - — Hypotension [J1e = checked]
   - — Dizziness/Vertigo [K1c = checked]
   - — Syncope [K1m = checked]
   - — Accidents [K2a, K2b, K2c = any checked]

Potential for Drug-Related Movement Disorder if:

2. Antipsychotic Use [O4a = 1-7] AND ANY of the following:
   - — Partial/Total Loss of Voluntary Arm/Leg Movement [E4f, E4h = any checked]
   - — Unsteady Gait [E4i = checked]
   - — Partial/Total Loss of Ability to Position, Balance, Turn Body/Balance While Standing [E4a, E4j = any checked]
   - — Motor Agitation [H1c = checked]
   - — Parkinson's [J1m = checked]
   - — Tardive Dyskinesia [J2 = 333.82]
   - — Chewing/Swallowing Problem [L1a, L1b = any checked]

Potential for Drug-Related Gait Disturbance (other than antipsychotic-induced) **if:**

3. Antianxiety/hypnotic Use [O4b = 1-7] AND ANY of the following:
   - — Poor Balance [E4a = checked]
   - — Unsteady Gait [E4i = checked]
   - — Difficulty Positioning/Turning [E4j = checked]
   - — Dizziness/Vertigo [K1c = checked]
   - — Accidents [K2a, K2b, K2c = any checked]

GUIDELINES

If resident is triggered, review the following:

1. Drug review [from record] Length of time between when the drug was first taken and onset of problem; Doses of drug and how frequently taken; Number of classes of psychotropics taken; Reason drug prescribed
2. Review resident's conditions that affect drug metabolism/excretion
   Acute condition [K3b]; dehydration [L3b]; impaired liver/renal function [J2; P1c; from record]
3. Review Behavior/Mood Status:
   Current problem status [H1, H2, H3]
   Recent changes [H6, H7]
   Behavior management program [H5]
   Psychiatric Diagnoses [J1p, J1q, J1r; J2]

Then Consider:

- **Clarifying Information For Hypotension:**
  1. Postural changes in vital signs [from exam]
  2. Drugs with marked anticholinergic properties [from record]
- **Clarifying Information For Movement Disorder:**
  1. High Fever [K1f] AND/OR Muscular rigidity [from record, observation]
  2. Tremors, especially of hands; pill-rolling of hands; muscle rigidity of limbs, neck, trunk (Parkinsonism) [from record, observation]
  3. Marked decrease in spontaneous movement (Akinesia) [from record, observation]
  4. Rigid, unnatural, uncomfortable posture of neck or trunk (Dystonia) [from record, observation]
  5. Restlessness, inability to sit still (Akathisia) [from record, observation]
  6. Persistent movements of the mouth (e.g., thrusting of tongue, movements, of lips, chewing/puckering) AND/OR peculiar and recurrent postures of limbs, trunk (Tardive dyskinesia) [from record, observation]

Potential for Drug-Related Cognitive/Behavioral Impairment if:

4. ANY Psychotropic Use [O4a, O4b or O4c = 1-7] AND ANY of the following:
   - — Delirium/Disordered Thinking [B5a, B5b, B5c, B5d, B5e = any checked]
   - — Withdrawal [H1d = checked]
   - — Depression [J1q = checked]
   - — Hallucinations/Delusions [K1g = checked]
   - — Major Difference in ADL Self-Performance [E7d = checked]
   - — Deterioration in Cognition, Communication, ADL, Continence, Mood and/or Behavior [B6 = 2 or C6 = 2 or E8 = 2 or F4 = 2 or H6 = 2 or H7 = 2]

Potential for Drug-Related Discomfort if:

5. ANY Psychotropic Use [O4a, O4b or O4c = 1-7] AND ANY of the following:
   - — Constipation [K1a = checked]
   - — Fecal Impaction [K1e = checked]
   - — Urinary Retention [J2 = 788.2]

- **Clarifying Information For Gait Disturbances:**

1. Long-acting benzodiazepines [from med record]
2. Recent dosage increase [from med record]
3. Short-term memory loss; Decline in cognition; Slurred speech [B2, B6; observation]
4. Decreased AM wakefulness; Little/no activity involvement [I1, I2]

- **Clarifying Information For Cognitive/ Behavioral Impairment:**

If neither of the following are present, psychotropic drug side effects can be considered as a major cause of problem:

1. Acute confusion (delirium) related to medical illness [B5]
2. Depression [H1, H2]

- **Clarifying Issues For Drug-Related Discomfort:**

1. Dehydration [L3b]; Reduced dietary bulk; Lack of exercise [from record]

Other potential drug-related discomforts that may require resolution:

2. Dry mouth, if on antipsychotic or antidepressant [observation]

RESIDENT ASSESSMENT PROTOCOL: PHYSICAL RESTRAINTS

I. PROBLEM

Studies of nursing homes show that between 30 and 40% of residents are physically restrained. This is quite serious since negative effects of restraint use include declines in residents' physical functioning (e.g., ability to ambulate) and muscle condition, contractures, increased incidence of infections, and development of pressure sores, delirium, agitation, and incontinence. Moreover, restraints have been found in some cases to increase the incidence of falls and other accidents (e.g., strangulation). Finally, residents who are restrained face the loss of autonomy, dignity and self-respect. In effect, the use of physical restraints undercuts the major goals of long-term care — to maximize independence, functional capacity, and quality of life. Thus, the goal of minimizing or eliminating restraint use has become central to both clinical practice and federal law.

The primary reason given for applying restraints is to protect residents from falls and accidents. Facilities are also concerned about potential lawsuits and malpractice claims that might result if residents should fall. Other reasons cited for restraint use include to provide postural support or positioning for residents, to facilitate treatment (e.g., preventing residents from pulling out IV lines or NG tubes), and to manage behaviors such as wandering or physical aggressiveness.

The experience of many health care providers suggests that facility goals can often be met without the use of physical restraints and their negative side effects. In part, this involves identifying and treating health, functional, or psychosocial problems that may be causing the condition for which restraints were ordered (e.g., falls, wandering, agitation). Minimizing use of restraints also involves care management alternatives, such as: modifying the environment to make it safer; maintaining an individual's customary routine; using less intrusive methods of administering medications and nourishment; and recognizing and responding to residents' needs for psychosocial support, responsive health care, meaningful activities, and regular exercise.

II. TRIGGERS

Definition: Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot easily remove and that restricts freedom of movement or normal access to his/her body.

ANY use of trunk restraint, limb restraint, or chair that prevents rising [P3b, P3c or P3d = 1 or 2]

III. GUIDELINES

In evaluating and reconsidering the use of restraints for a resident, consider needs, problems, conditions, or risk factors (e.g., for falls) which, if addressed, could eliminate the need for using restraints. Refer to the RAP KEY for specific MDS items to consider as you review the following issues.

WHY ARE RESTRAINTS USED?

The first step in determining whether use of a restraint can be reduced or eliminated is to identify the reasons a restraint was applied.

- Review the resident's record and consult primary caregivers to determine reason for use.

Ask the following questions:

- Why is the resident restrained?
- What type(s) of restraint is used?
- During what time of day is each type(s) used?
- Where is the resident restrained (e.g., own room in bed, chair in hallway)?
- How long is the resident restrained each day?
- Under what circumstances (e.g., when left alone, after family leave, when not involved in structured activity, when eating)?
- Who suggested that the resident be restrained (e.g., staff, family, resident)?

CONDITIONS ASSOCIATED WITH RESTRAINT USE

It may be possible to identify and resolve health/functional/psychosocial needs, risks, or problems that caused restraints to be used. By addressing the underlying condition(s) and cause(s), the facility may eliminate the apparent need for the restraint(s). In addition, a review of underlying needs, risks, or problems may help to identify other potential kinds of treatments. After determining why and how a restraint is used, review the appropriate areas described below.

Problem Behavior.

To determine presence of a behavior problem, review the MDS. If the behavior for which the resident is restrained was not exhibited in the last 7 days, was it because the restraint prohibited the behavior from occurring (e.g., resident was restrained and could not wander)? If a behavior problem was present during the last 7 days or the resident was restrained to prevent a problem behavior, consider the resident to have a behavior problem and review Behavior Problem RAP as indicated.

Many problem behaviors are manifestations of unmet health, functional, and/or psychosocial needs that can often be reduced, eliminated, or managed by addressing the conditions that produced them. (See RAP on Behavior Problem). Conditions associated with problem behaviors and restraint use include:

- Delirium (acute confusional state)
- Impaired cognition
- Impaired communication (e.g., difficulty making needs/wishes understood or understanding others)
- Unmet psychosocial needs (e.g., social isolation, disruption of familiar routines, anger with family members)
- Sad or anxious mood
- Resistance to treatment, medication, nourishment
- Psychotropic drug side effects (e.g., motor agitation, confusion, gait disturbance)
- If a behavior management program is in place, does it adequately address the causes of the resident's particular problem behaviors?

Risk of Falls.

Although restraints have not been shown to safeguard residents from injury, one of the most common reasons given by facilities for restraining residents is to prevent falls. In some instances, restraints have been reported to contribute to falls and injuries. Because of the complications associated with restraint use, many physicians and geriatric clinicians recommend exploring alternatives for preventing falls, such as treating health problems and making environmental modifications.

- Review risk factors for falls on RAP KEY. Refer to Falls RAP if these risks are present or if the restraint is being used to prevent falls.

Treatment Regimens.

Another reason facilities give for using restraints is to prevent a resident from removing tubes.

If the resident is being restrained to manage resistance to any type of tube or mechanical device (e.g., indwelling/external catheter, feeding tube, intravenous line, oxygen mask/cannula, wound dressing), review the following to facilitate decision-making:

- Is the tube/mechanical device used to treat a life-threatening condition?
- Does the resident actually need a particular intervention that may be potentially burdensome to him/her? Are there less intrusive treatment options?
- Why is the resident reacting to the tube/mechanical device with resistance? (e.g., Does the device produce discomfort or irritation? Is the resident really resisting or is the device just something to fidget with? Is the treatment compatible with the resident's wishes? Does the resident understand the reason for the method of treatment? Has the resident/family been informed about the risks and benefits of treatment options?)

HCFA Guideline: "If there are medical symptoms which are life threatening (such as dehydration, electrolyte imbalance, urinary blockage) then a restraint may be used temporarily to provide necessary lifesaving treatment. Physical restraints may be used for brief periods to allow medical treatment to proceed, if there is documented evidence of resident or legal approval of the treatment."

- If an indwelling or external catheter is present, review the Urinary Incontinence RAP for alternatives.
- If a feeding tube is present, review the Feeding Tubes RAP

ADL Self-Performance.

In rare instances, a restraint can enhance a resident's ability to be more self-sufficient, IF the restraint use is supportive and time-limited.

Review the MDS to determine if the restraint contributes to the resident's self-performance of an activity (e.g., wheelchair belt supports trunk while resident wheels self, geri-chair used only at meals enables wandering resident to attend to feeding self).

Other Factors.

Resident's Response to Restraints

In evaluating restraint use, it is important to review the resident's reaction to restraints (e.g., positive and negative, such as passivity, anger, increased agitation, withdrawal, pleas for release, calls for help, constant attempts to untie/release self). This will help determine whether presumed benefits are outweighed by negative side effects.

Review MDS items on other potential negative effects of restraint use, such as declines in functional self-performance, body control, skin condition, mood and cognition, since restraints have been in use.

Alternatives to Restraints

Many interventions may be as effective or even more effective than restraints in managing a resident's needs, safety risks, and problems. To be effective the intervention must address the underlying problem. Examples of alternatives include: use of familiar, comfortable chairs; activities that are meaningful to resident; behavior management programs; judicious use of psychotropic drugs to treat active psychiatric disorders (e.g., psychoses, panic disorders); cheduled toileting plans; and regular exercise for agitated residents.

- Review resident's record and confer with staff to determine whether alternatives to restraints have been tried.
- If alternatives to restraints have been tried, what were they?
- How long were the alternatives tried?
- What was the resident's response to the alternatives at the time?
- If the alternative(s) attempted were ineffective, what else was attempted?
- How recently were alternatives other than restraints attempted?

Philosophy and Attitudes.

In reconsidering the use of restraints for a resident, consider the philosophy, values, attitudes, and wishes of the resident regarding restraint use, as well as those of his family/significant others, and caregivers. Consider the impact of restraints on facility environment and morale.

- Is there consensus or differences among affected parties in choosing between resident independence and freedom in favor of presumed safety?

PHYSICAL RESTRAINTS RAP KEY

TRIGGERS

Potential for decline if:

1. ANY use of Trunk Restraint, Limb Restraint, or Chair that Prevents Rising [P3b, P3c or P3d = 1 or 2]

GUIDELINES

Review factors and complications associated with restraint use:

Problem Behavior: Motor agitation [H1c], Any problem behavior [H3], Part of behavior management program [H5]

Risk of Falls: Falls [K2a, K2b];
Antidepressant [O4c];
Impaired balance [E4a, E4j];
Bedfast or Hemi/Quadriplegia or Poor leg control [E4b, E4d, E4e, E4h]

Conditions and Treatments:
Unstable/acute condition [K3a, K3b];
Hip fracture [K2c]; Catheter [F3b, F3c];
Parenteral/IV and/or feeding tube [L4a, L4b];
Wound care/treatment [N4f]; IV meds [P1f];
Respiratory/Oxygen [P1h]

ADL Self-Performance [E1]

Confounding problems to be considered:

1. Delirium [B5]
2. Cognitive loss/dementia [B2, B3, B4]
3. Impaired communication [C4, C5]
4. Unmet psychosocial needs [G1, G2, G3]
5. Sad/anxious mood [H1, H2]
6. Resistance to treatment/meds/nourishment [H4a; observation]
7. Psychotropic drug side effects [O4]

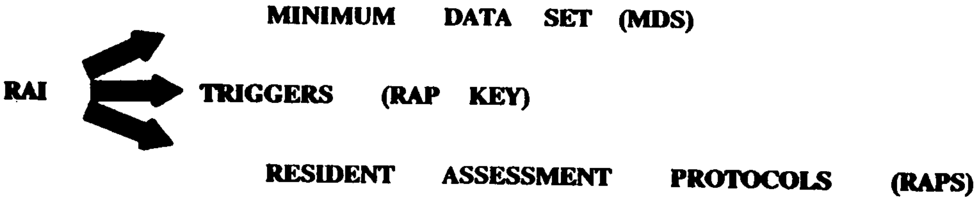
Other factors to be considered:
Resident's response to restraint(s); use of alternatives to restraints; resident/family/staff philosophy, values, wishes, attitudes about restraints [record, observation, discussion]

OBRA

RESIDENT ASSESSMENT

Manor HealthCare Corporation

WHAT IS THE RESIDENT ASSESSMENT INSTRUMENT?



RAI

MINIMUM DATA SET (MDS)

TRIGGERS (RAP KEY)

RESIDENT ASSESSMENT PROTOCOLS (RAPS)

WHAT DOES THE RAI DO?

- PROVIDES INFORMATION ON THE RESIDENT'S CONDITION
- HELPS DEVELOP A PLAN OF CARE
- MEANS OF TRACKING CHANGES IN RESIDENT STATUS

WHO DO WE USE IT ON?

- ALL RESIDENTS REGARDLESS OF PAYOR SOURCE

WHAT INFORMATION SOURCES DO WE USE?

- OBSERVATION OF THE RESIDENT
- COMMUNICATION WITH THE RESIDENT
- DISCUSSION OF RESIDENT'S PERFORMANCE WITH NURSING ASSISTANTS ON ALL SHIFTS
- DISCUSSION OF RESIDENT'S STATUS WITH PHYSICIAN
- DISCUSSION OF RESIDENT'S STATUS WITH FAMILY MEMBER
- DISCUSSION OF RESIDENT'S STATUS WITH OTHER LICENSED HEALTH PROFESSIONALS
- REVIEW OF THE RESIDENT'S RECORD

WHO IS RESPONSIBLE?

- REGISTERED NURSE
- ANY INDIVIDUAL WHO COMPLETES A PORTION MUST CERTIFY THE ACCURACY

WHAT IS RN RESPONSIBLE FOR?

- RESPONSIBLE FOR CONDUCTING OR COORDINATING
- RESPONSIBLE FOR CERTIFYING COMPLETION OF THE ASSESSMENT

WHO COULD COMPLETE THE MDS?

- ADMISSIONS
- SOCIAL SERVICES
- RECREATIONAL THERAPY
- DIETARY
- PHYSICAL THERAPY
- OCCUPATIONAL THERAPY
- SPEECH THERAPY
- NURSING

WHERE IS MDS KEPT?

- ALL COMPLETED RESIDENT ASSESSMENTS ARE PART OF RESIDENT'S PERMANENT RECORD
- ASSESSMENTS COMPLETED IN LAST TWO YEARS MUST BE EASILY RETRIEVABLE (ON THE ACTIVE RECORD)

WHAT DOES SIGNIFICANT CHANGE MEAN?

- DETERIORATION IN TWO OR MORE ADLs OR COGNITIVE ABILITIES THAT APPEAR PERMANENT
- PERMANENT LOSS OF ABILITY TO FREELY AMBULATE OR USE HANDS TO GRASP SMALL OBJECTS
- DETERIORATION IN BEHAVIOR, MOOD OR RELATIONSHIPS THAT CANNOT IMPROVE UNLESS STAFF INTERVENES
- DETERIORATION IN RESIDENT'S HEALTH STATUS
- MARKED OR SUDDEN IMPROVEMENT IN RESIDENT'S HEALTH STATUS

NOTE: "LIKELY TO BE PERMANENT" -- HAVE FOURTEEN DAYS TO DECIDE

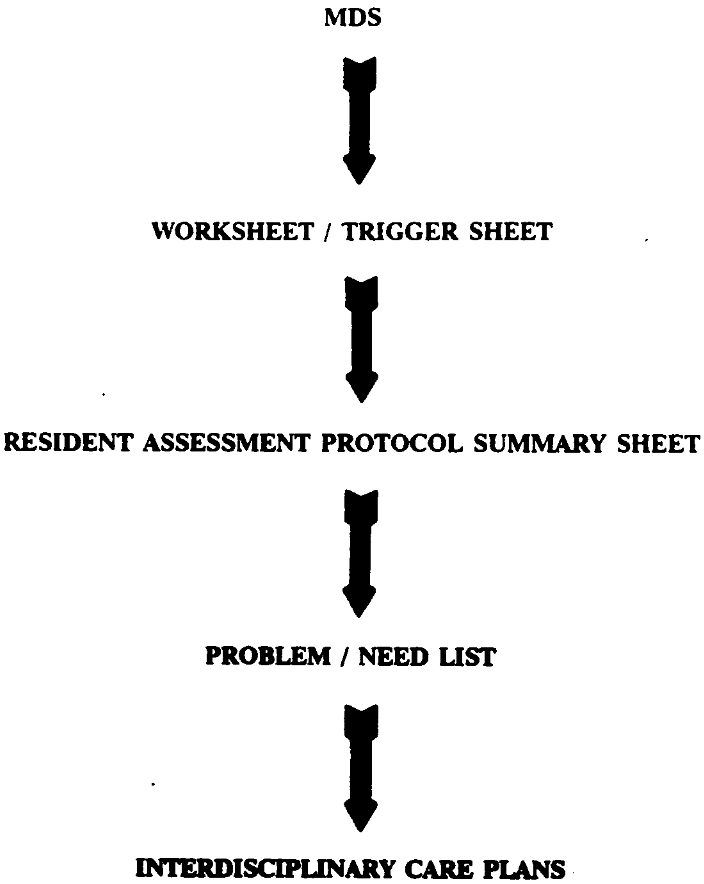
FREQUENCY OF ASSESSMENT / REASSESSMENT

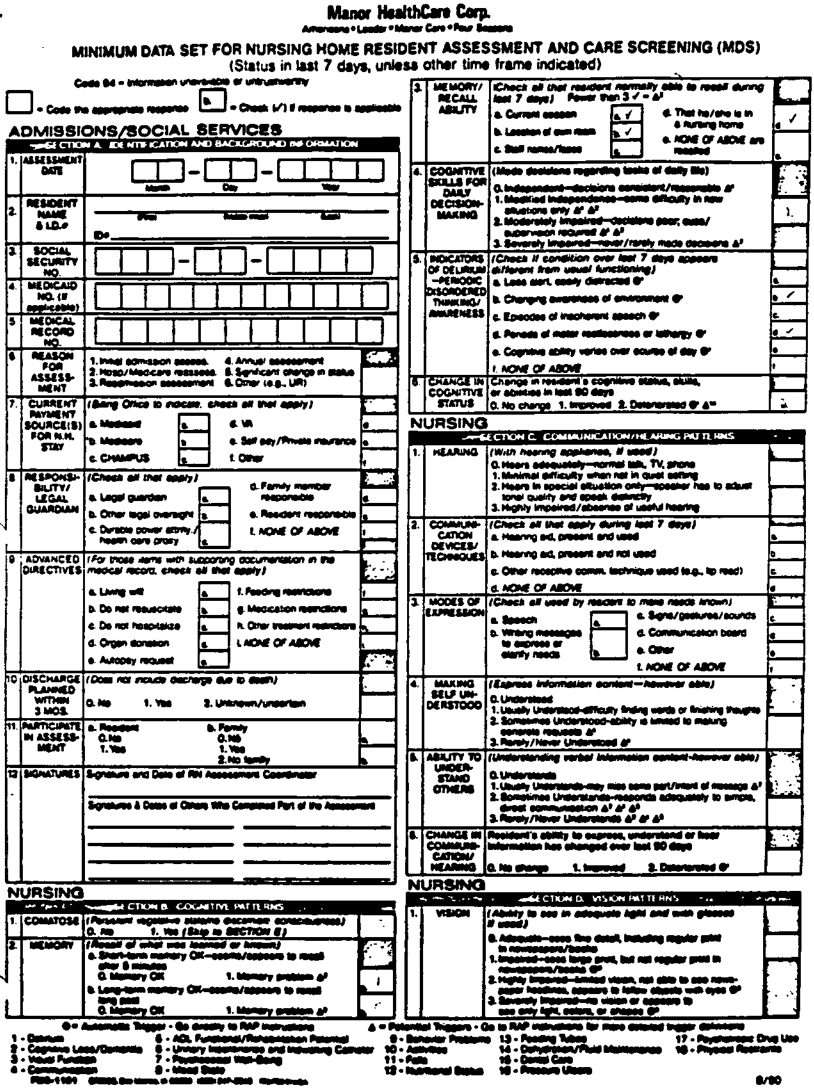
- WITHIN FOUR WORKING DAYS OF ADMISSION
- ANNUALLY (7 days before or after anniversary date of last full MDS assessment)
- PROMPTLY AFTER SIGNIFICANT PHYSICAL OR MENTAL CHANGE
- QUARTERLY MDS (every 90 days) ADL [illegible]
- READMISSION

WITH CHANGE IN CONDITION: CONDUCT FULL MDS

WITH NO CHANGE IN CONDITION: DO NOT CONDUCT FULL MDS

FLOW OF RAI-ICP INFORMATION





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MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)
(Status in last 7 days, unless other time frame indicated)

Code 94 = information unavailable or untrustworthy

☐ = Code the appropriate response ☐ = Check (✓) if response is applicable

ADMISSIONS/SOCIAL SERVICES

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	ASSESSMENT DATE	☐☐ - ☐☐ - ☐☐☐☐ Month Day Year	
2.	RESIDENT NAME & I.D.#	________________ (First) (Middle Initial) (Last) ID# ____________	
3.	SOCIAL SECURITY NO.	☐☐☐ - ☐☐ - ☐☐☐☐	
4.	MEDICAID NO. (If applicable)	☐☐☐☐☐☐☐☐☐☐☐☐	
5.	MEDICAL RECORD NO.	☐☐☐☐☐☐☐☐☐☐☐	
6.	REASON FOR ASSESS-MENT	1. Initial admission assess. 4. Annual assessment 2. Hosp/Medicare reassess. 5. Significant change in status 3. Readmission assessment 6. Other (e.g., UR)	☐
7.	CURRENT PAYMENT SOURCE(S) FOR N.H. STAY	(Billing Office to indicate, check all that apply) a. Medicaid ☐ d. VA ☐ b. Medicare ☐ e. Self pay/Private insurance ☐ c. CHAMPUS ☐ f. Other ☐	
8.	RESPONSI-BILITY/ LEGAL GUARDIAN	(Check all that apply) a. Legal guardian ☐ d. Family member responsible ☐ b. Other legal oversight ☐ e. Resident responsible ☐ c. Durable power attny./health care proxy ☐ f. NONE OF ABOVE ☐	
9.	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply) a. Living will ☐ f. Feeding restrictions ☐ b. Do not resuscitate ☐ g. Medication restrictions ☐ c. Do not hospitalize ☐ h. Other treatment restrictions ☐ d. Organ donation ☐ i. NONE OF ABOVE ☐ e. Autopsy request ☐	
10.	DISCHARGE PLANNED WITHIN 3 MOS.	(Does not include discharge due to death) 0. No 1. Yes 2. Unknown/uncertain	☐
11.	PARTICIPATE IN ASSESS-MENT	a. Resident 0. No 1. Yes b. Family 0. No 1. Yes 2. No family	a. ☐ b. ☐
12.	SIGNATURES	Signature and Date of RN Assessment Coordinator ____________ Signatures & Dates of Others Who Completed Part of the Assessment ______ ______ ______ ______ ______ ______ ______ ______	

NURSING

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (Skip to SECTION E)	☐
2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem △ b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem △	a. 1 b. ☐
3.	MEMORY/ RECALL ABILITY	(Check all that resident normally able to recall during last 7 days) Fewer than 3 ✓ = △ a. Current season a. ✓ d. That he/she is in a nursing home d. ✓ b. Location of own room b. ✓ e. NONE OF ABOVE are recalled e. ☐ c. Staff names/faces c. ☐	
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. Independent—decisions consistent/reasonable △ 1. Modified independence—some difficulty in new situations only △ △ 2. Moderately impaired—decisions poor; cues/supervision required △ △ 3. Severely impaired—never/rarely made decisions △	1
5.	INDICATORS OF DELIRIUM —PERIODIC DISORDERED THINKING/ AWARENESS	(Check if condition over last 7 days appears different from usual functioning) a. Less alert, easily distracted ● b. Changing awareness of environment ● c. Episodes of incoherent speech ● d. Periods of motor restlessness or lethargy ● e. Cognitive ability varies over course of day ● f. NONE OF ABOVE	a. ☐ b. ✓ c. ☐ d. ✓ e. ☐ f. ☐
6.	CHANGE IN COGNITIVE STATUS	Change in resident's cognitive status, skills, or abilities in last 90 days 0. No change 1. Improved 2. Deteriorated ● △	2

NURSING

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	(With hearing appliance, if used) 0. Hears adequately—normal talk, TV, phone 1. Minimal difficulty when not in quiet setting 2. Hears in special situation only—speaker has to adjust tonal quality and speak distinctly 3. Highly impaired/absence of useful hearing	☐
2.	COMMUNI-CATION DEVICES/ TECHNIQUES	(Check all that apply during last 7 days) a. Hearing aid, present and used b. Hearing aid, present and not used c. Other receptive comm. technique used (e.g., lip read) d. NONE OF ABOVE	a. ☐ b. ☐ c. ☐ d. ☐
3.	MODES OF EXPRESSION	(Check all used by resident to make needs known) a. Speech ☐ c. Signs/gestures/sounds ☐ b. Writing messages to express or clarify needs ☐ d. Communication board ☐ e. Other ☐ f. NONE OF ABOVE ☐	
4.	MAKING SELF UN-DERSTOOD	(Express information content—however able) 0. Understood 1. Usually Understood-difficulty finding words or finishing thoughts 2. Sometimes Understood-ability is limited to making concrete requests △ 3. Rarely/Never Understood △	☐
5.	ABILITY TO UNDER-STAND OTHERS	(Understanding verbal information content-however able) 0. Understands 1. Usually Understands-may miss some part/intent of message △ 2. Sometimes Understands-responds adequately to simple, direct communication △ △ △ 3. Rarely/Never Understands △ △ △	☐
6.	CHANGE IN COMMUNI-CATION/ HEARING	Resident's ability to express, understand or hear information has changed over last 90 days 0. No change 1. Improved 2. Deteriorated ●	☐

NURSING

SECTION D. VISION PATTERNS

1.	VISION	(Ability to see in adequate light and with glasses if used) 0. Adequate—sees fine detail, including regular print in newspapers/books 1. Impaired—sees large print, but not regular print in newspapers/books ● 2. Highly impaired—limited vision, not able to see newspaper headlines, appears to follow objects with eyes ● 3. Severely impaired—no vision or appears to see only light, colors, or shapes ●	☐

● = Automatic Trigger - Go directly to RAP instructions △ = Potential Triggers - Go to RAP instructions for more detailed trigger definitions

1 - Delirium
2 - Cognitive Loss/Dementia
3 - Visual Function
4 - Communication
5 - ADL Functional/Rehabilitation Potential
6 - Urinary Incontinence and Indwelling Catheter
7 - Psychosocial Well-Being
8 - Mood State
9 - Behavior Problems
10 - Activities
11 - Falls
12 - Nutritional Status
13 - Feeding Tubes
14 - Dehydration/Fluid Maintenance
15 - Dental Care
16 - Pressure Ulcers
17 - Psychotropic Drug Use
18 - Physical Restraints

[illegible]

8/90

2.	VISUAL LIMITATIONS/ DIFFICULTIES	a. Side vision problems—decreased peripheral vision; (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) $●^{3}$	a.
		b. Experiences any of the following: sees halos or rings around lights, sees flashes of light, sees "curtains" over eyes	b.
		c. NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; lens implant; magnifying glass 0. No 1. Yes	

NURSING

SECTION E. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. ADL SELF-PERFORMANCE *(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)*

0. *INDEPENDENT*—No help or oversight—OR—Help/oversight provided only 1 or 2 times during last 7 days.
1. *SUPERVISION*—Oversight encouragement or cueing provided 3+ times during last 7 days—OR—Supervision plus physical assistance provided only 1 or 2 times during last 7 days.
2. *LIMITED ASSISTANCE*—Resident highly involved in activity, received physical help in guided maneuvering of limbs, or other nonweight bearing assistance 3+ times—OR—More help provided only 1 or 2 times during last 7 days.
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   - Weight-bearing support
   - Full staff performance during part (but not all) of last 7 days.
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days.

2. ADL SUPPORT PROVIDED—*(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist

			1 SELF-PERFORMANCE	2 SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed 3 or 4 for self-perf = Δ^{5}		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet) 3 or 4 for self-perf = Δ^{5}		
c.	LOCOMOTION	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair 3 or 4 for self-perf = Δ^{5}	3	2
d.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis 3 or 4 for self-perf = Δ^{5}		
e.	EATING	How resident eats and drinks (regardless of skill) 3 or 4 for self-perf = Δ^{5}		
f.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes 3 or 4 for self-perf = Δ^{5}		
g.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
3.	BATHING	How resident takes full-body bath, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below.) 3 or 4 for (a) = Δ^{5} 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence	a.	b.

4.	BODY CONTROL PROBLEMS	*(Check all that apply during last 7 days)*			
		a. Balance—partial or total loss of ability to balance self while standing Δ^{11}	a.	g. Hand—lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid)	g.
		b. Bedfast all or most of the time Δ^{11}	b.	h. Leg—partial or total loss of voluntary movement Δ^{11}	h.
		c. Contracture to arms, legs, shoulders, or hands	c.	i. Leg—unsteady gait	i.
		d. Hemiplegia/hemiparesis Δ^{11}	d.	j. Trunk—partial or total loss of ability to position, balance, or turn body Δ^{11}	j.
		e. Quadriplegia Δ^{11}	e.	k. Amputation	k.
		f. Arm—partial or total loss of voluntary movement	f.	l. NONE OF ABOVE	l.

5.	MOBILITY APPLIANCES/ DEVICES	*(Check all that apply during last 7 days)*			
		a. Cane/walker	a. ✓	d. Other person wheeled	d.
		b. Brace/prosthesis	b.	e. Lifted (manually/ mechanically)	e.
		c. Wheeled self	c.	f. NONE OF ABOVE	f.

6.	TASK SEGMENTATION	Resident requires that some or all of ADL activities be broken into a series of subtasks so that resident can perform them. 0. No 1. Yes	
7.	ADL FUNCTIONAL REHAB. POTENTIAL	a. Resident believes he/she capable of increased independence in at least some ADLs Δ^{5}	a.
		b. Direct care staff believe resident capable of increased independence in at least some ADLs Δ^{5}	b.
		c. Resident able to perform tasks/activity but is very slow	c.
		d. Major difference in ADL Self-Performance or ADL Support in mornings and evenings (at least a one category change in Self-Performance or Support in any ADL)	d.
		e. NONE OF ABOVE	e.
8.	CHANGE IN ADL FUNCTION	Change in ADL self-performance in last 90 days 0. No change 1. Improved 2. Deteriorated Δ^{5}	

NURSING

SECTION F. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES
(Code for resident performance over all shifts.)

0. CONTINENT—Complete control
1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. OCCASIONALLY INCONTINENT—BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. INCONTINENT—Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time.

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed 2, 3 or 4 = Δ^{6}	
2.	INCONTINENCE RELATED TESTING	*(Skip if resident's bladder continence code equals 0 or 1 AND no catheter is used)*	
		a. Resident has been tested for a urinary tract infection	a.
		b. Resident has been checked for presence of a fecal impaction, or there is adequate bowel elimination	b.
		c. NONE OF ABOVE	c.

3.	APPLIANCES AND PROGRAMS	a. Any scheduled toileting plan	a.	e. Did not use toilet room/ commode/urinal	e.
		b. External (condom) catheter Δ^{6}	b.	f. Pads/briefs used Δ^{6}	f.
		c. Indwelling catheter Δ^{6}	c.	g. Enemas/irrigation	g.
		d. Intermittent catheter Δ^{6}	d.	h. Ostomy	h.
				i. NONE OF ABOVE	i.
4.	CHANGE IN URINARY CONTINENCE	Change in urinary continence/appliances and programs in last 90 days 0. No change 1. Improved 2. Deteriorated			

SOCIAL SERVICES

SECTION G. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	a. At ease interacting with others	a.
		b. At ease doing planned or structured activities	b.
		c. At ease doing self-initiated activities	c.
		d. Establishes own goals	d.
		e. Pursues involvement in life of facility (i.e., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		f. Accepts invitations into most group activities	f.
		g. NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	a. Covert/open conflict with and/or repeated criticism of staff $●^{7}$	a.
		b. Unhappy with roommate $●^{7}$	b.
		c. Unhappy with residents other than roommate $●^{7}$	c.
		d. Openly expresses conflict/anger with family or friends $●^{7}$	d.
		e. Absence of personal contact with family/friends	e.
		f. Recent loss of close family member/friend	f.
		g. NONE OF ABOVE	g.

● = Automatic Trigger - Go directly to RAP instructions

Δ = Potential Triggers - Go to RAP instructions for more detailed trigger definitions

1 - Delirium
2 - Cognitive Loss/Dementia
3 - Visual Function
4 - Communication
5 - ADL Functional/Rehabilitation Potential
6 - Urinary Incontinence and Indwelling Catheter
7 - Psychosocial Well-Being
8 - Mood State
9 - Behavior Problems
10 - Activities
11 - Falls
12 - Nutritional Status
13 - Feeding Tubes
14 - Dehydration/Fluid Maintenance
15 - Dental Care
16 - Pressure Ulcers
17 - Psychotropic Drug Use
18 - Physical Restraints

3.	PAST ROLES	a. Strong identification with past roles and life status	a.
		b. Expresses sadness/anger/empty feeling over lost roles/status @'	b.
		c. *NONE OF ABOVE*	c.

SOCIAL SERVICES

SECTION H. MOOD AND BEHAVIOR PATTERNS

1.	SAD OR ANXIOUS MOOD	*(Check all that apply during last 30 days)*	
		a. VERBAL EXPRESSIONS of DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief) @	a.
		DEMONSTRATED (OBSERVABLE) SIGNS of mental DISTRESS	
		b. Tearfulness, emotional groaning, sighing, breathlessness @	b.
		c. Motor agitation such as pacing, handwringing or picking @	c.
		d. Failure to eat or take medications, withdrawal from self-care or leisure activities @ Δ	d.
		e. Pervasive concern with health @	e.
		f. Recurrent thoughts of death—e.g., believes he/she is about to die, have a heart attack @	f.
		g. Suicidal thoughts/actions @	g.
		h. *NONE OF ABOVE*	h.
2.	MOOD PERSISTENCE	Sad or anxious mood intrudes on daily life over last 7 days—not easily altered, doesn't "cheer up" 0. No 1. Yes @	
3.	PROBLEM BEHAVIOR	*(Code for behavior in last 7 days)* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently	
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) 1 or 2 = @	a.
		b. VERBALLY ABUSIVE (others were threatened, screamed at, cursed at) 1 or 2 = @	b.
		c. PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused) 1 or 2 = @	c.
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings) 1 or 2 = @	d.
4	RESIDENT RESISTS CARE	*(Check all types of resistance that occurred in the last 7 days)*	
		a. Resisted taking medications/injection	a.
		b. Resisted ADL assistance	b.
		c. *NONE OF ABOVE*	c.
5	BEHAVIOR MANAGEMENT PROGRAM	Behavior problem has been addressed by clinically developed behavior management program. (Note: Do not include programs that involve only physical restraints or psychotropic medications in this category.) 0. No behavior problem 1. Yes, addressed 2. No, not addressed	
6.	CHANGE IN MOOD	Change in mood in last 90 days 0. No change 1. Improved 2. Deteriorated Δ'	
7.	CHANGE IN PROBLEM BEHAVIOR	Change in problem behavioral signs in last 90 days 0. No change 1. Improved 2. Deteriorated @'	

ACTIVITIES

SECTION I. ACTIVITY PURSUIT PATTERNS

1	TIME AWAKE	*(Check appropriate time periods—last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	
		a. Morning ☐ a.	c. Evening c.
		b. Afternoon ☐ b.	d. *NONE OF ABOVE* d.
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	0. Most—(more than 2/3 of time) Δ 1. Some—(1/3 to 2/3 time)	2. Little—(less than 1/3 of time) Δ 3. None Δ
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*	
		a. Own room ☐ a.	d. Outside facility d.
		b. Day/activity room ☐ b.	e. *NONE OF ABOVE* e.
		c. Inside NH/off unit ☐ c.	

4.	GENERAL ACTIVITIES PREFERENCES (adapted to resident's current abilities)	*(Check all specific preferences whether or not activity is currently available to resident)*	
		a. Cards/other games ☐ a.	f. Spiritual/religious activ f.
		b. Crafts/arts ☐ b.	g. Trips/shopping g.
		c. Exercise/sports ☐ c.	h. Walking/wheeling outdoors h.
		d. Music ☐ d.	i. Watch TV i.
		e. Read/write ☐ e.	j. *NONE OF ABOVE* j.
5.	PREFERS MORE OR DIFFERENT ACTIVITIES	Resident expresses/indicates preference for other activities/choices. 0. No 1. Yes @	

NURSING

SECTION J. DISEASE DIAGNOSES

Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list old/inactive diagnoses.) (If none apply, check the NONE OF ABOVE box)

1.	DISEASES	**HEART/CIRCULATION**	r. Manic depressive (bipolar disease) r.
		a. Arteriosclerotic heart disease (ASHD) ☐ a.	**SENSORY**
		b. Cardiac dysrhythmias ☐ b.	s. Cataracts s.
		c. Congestive heart failure ☐ c.	t. Glaucoma t.
		d. Hypertension ☐ d.	**OTHER**
		e. Hypotension ☐ e.	u. Allergies u.
		f. Peripheral vascular disease ☐ f.	v. Anemia v.
		g. Other cardiovascular disease ☐ g.	w. Arthritis w.
		NEUROLOGICAL	x. Cancer x.
		h. Alzheimer's ☐ h.	y. Diabetes mellitus y.
		i. Dementia other than Alzheimer's ☐ i.	z. Explicit terminal prognosis z.
		j. Aphasia ☐ j.	aa. Hypothyroidism aa
		k. Cerebrovascular accident (stroke) ☐ k.	bb. Osteoporosis bb
		l. Multiple sclerosis ☐ l.	cc. Seizure disorder cc
		m. Parkinson's disease ☐ m.	dd. Septicemia dd
		PULMONARY	ee. Urinary tract infection-in last 30 days Δ ee
		n. Emphysema/asthma/COPD ☐ n.	ff. *NONE OF ABOVE* ff
		o. Pneumonia ☐ o.	Nutritional deficiencies (ICD-9 codes 260-263.9) @
		PSYCHIATRIC/MOOD	Volume depletion (ICD-9 code 276.5) Δ
		p. Anxiety disorder ☐ p.	
		q. Depression ☐ q.	Delirium (ICD-9 codes 291.0-293.1) @
2.	OTHER CURRENT DIAGNOSES AND ICD-9 CODES	a. b. c. d. e. f.	

NURSING

SECTION K. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems that are present in last 7 days unless other time frame indicated)*	
		a. Constipation ☐ a.	j. Pain—resident complains or shows evidence of pain daily or almost daily j.
		b. Diarrhea Δ ☐ b.	
		c. Dizziness/vertigo Δ ☐ c.	
		d. Edema ☐ d.	k. Recurrent lung aspirations in last 90 days k.
		e. Fecal impaction ☐ e.	
		f. Fever Δ ☐ f.	
		g. Hallucinations/delusions ☐ g.	l. Shortness of breath l.
			m. Syncope (fainting) m.
		h. Internal bleeding Δ ☐ h.	n. Vomiting Δ n.
		i. Joint pain ☐ i.	o. *NONE OF ABOVE* o.
2.	ACCIDENTS	a. Fell—past 30 days @ ☐ a.	c. Hip fracture in last 180 days c.
		b. Fell—past 31-180 days @ ☐ b.	d. *NONE OF ABOVE* d.

3.	STABILITY OF CONDITIONS	a. Conditions/diseases make resident's cognitive, ADL, or behavior status unstable—fluctuating, precarious, or deteriorating.	a.
		b. Resident experiencing an acute episode or a flare-up of a recurrent/chronic problem.	b.
		c. *NONE OF THE ABOVE*	c.

DIETARY

SECTION L. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	a. Chewing problem ☐ a. b. Swallowing problem ☐ b. c. Mouth pain ●^{15} d. *NONE OF ABOVE*	c. d.
2.	HEIGHT AND WEIGHT	*Record height (a) in inches and weight (b) in pounds. Weight based on most recent status in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.* HT (in.) a. WT (lb.) b.	
		c. Weight loss (i.e., 5% + in last 30 days, or 10% in last 180 days) 0. No 1. Yes ●^{12} ▲^{14}	c.
3.	NUTRITIONAL PROBLEMS	a. Complains about the taste of many foods ●^{12} ☐ a. b. Insufficient fluid; dehydrated ●^{14} ☐ b. c. Did NOT consume all/almost all liquids provided during last 3 days ▲^{14} ☐ c. d. Regular complaint of hunger ●^{12} e. Leaves 25%+ food uneaten at most meals ●^{12} ▲^{14} f. *NONE OF ABOVE*	d. e. f.
4.	NUTRITIONAL APPROACHES	a. Parenteral/IV ▲^{14} ●^{13} ☐ a. b. Feeding tube ▲^{14} ●^{13} ☐ b. c. Mechanically altered diet ●^{12} ☐ c. d. Syringe (oral feeding) ●^{12} ☐ d. e. Therapeutic diet ●^{12} f. Dietary supplement between meals g. Plate guard, stabilized built-up utensil, etc. h. *NONE OF ABOVE*	e. f. g. h.

NURSING

SECTION M. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night ●^{15}	a.
		b. Has dentures and/or removable bridge	b.
		c. Some/all natural teeth lost—does not have or does not use dentures (or partial plates) ●^{15}	c.
		d. Broken, loose, or carious teeth ●^{15}	d.
		e. Inflamed gums (gingiva), oral abscesses, swollen or bleeding gums, ulcers, or rashes ●^{15}	e.
		f. Daily cleaning of teeth/dentures If not checked = ●^{15}	f.
		g. *NONE OF ABOVE*	g.

NURSING

SECTION N. SKIN CONDITION

1.	STASIS ULCER	(i.e., open lesion caused by poor venous circulation to lower extremities) 0. No 1. Yes	
2.	PRESSURE ULCERS	*(Code for highest stage of pressure ulcer)* 0. No pressure ulcers 1. Stage 1 A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved ●^{12} ●^{16} 2. Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater ●^{12} ●^{16} 3. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue ●^{12} ●^{16} 4. Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone ●^{12} ●^{16}	
3.	HISTORY OF RESOLVED/CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/cured in last 90 days 0. No 1. Yes	
4.	SKIN PROBLEMS/CARE	a. Open lesions other than stasis or pressure ulcers (e.g., cuts)	a.
		b. Skin desensitized to pain/pressure/discomfort	b.
		c. Protective/preventive skin care ▲^{16}	c.
		d. Turning/repositioning program ▲^{16}	d.
		e. Pressure-relieving beds, bed/chair pads (e.g., egg crate pads) ▲^{16}	e.
		f. Wound care/treatment (e.g., pressure ulcer care, surgical wound) ▲^{16}	f.
		g. Other skin care/treatment ▲^{16}	g.
		h. *NONE OF ABOVE*	h.

NURSING

SECTION O. MEDICATION USE

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used.)*	
2.	NEW MEDICATIONS	Resident has received new medications during the last 90 days 0. No 1. Yes	
3.	INJECTIONS	*(Record the number of days injections of any type received during the last 7 days.)*	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of days during last 7 days; *Enter "0" if not used; enter "1" if long-acting meds used less than weekly)*	
		a. Antipsychotics 1-7 = ▲^{1} ▲^{11} ▲^{17}	a.
		b. Antianxiety/hypnotics 1-7 = ▲^{1} ▲^{11} ▲^{17}	b.
		c. Antidepressants 1-7 = ▲^{1} ▲^{11} ▲^{17}	c.
5.	PREVIOUS MEDICATION RESULTS	*(SKIP this question if resident currently receiving antipsychotics, antidepressants, or antianxiety/hypnotics—otherwise code correct response for last 90 days)* Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences). 0. No, drugs not used 1. Drugs were effective 2. Drugs were not effective 3. Drug effectiveness unknown	

NURSING

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS AND PROCEDURES	SPECIAL CARE—*Check treatments received during the last 14 days.* a. Chemotherapy ☐ a. b. Radiation ☐ b. c. Dialysis ☐ c. d. Suctioning ☐ d. e. Trach. care ☐ e. f. IV meds g. Transfusions h. O₂ i. Other __________ j. *NONE OF ABOVE*	f. g. h. i. j.
		THERAPIES—*Record the number of days each of the following therapies was administered (for at least 10 minutes during a day) in the last 7 days:*	
		k. Speech—language pathology and audiology services	k.
		l. Occupational therapy	l.
		m. Physical therapy	m.
		n. Psychological therapy (any licensed professional)	n.
		o. Respiratory Therapy	o.
2.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90-day period? 0. No 1. Yes 2. No tests performed	
3.	DEVICES AND RESTRAINTS	*Use the following code for last 7 days:* 0 Not used 1 Used less than daily 2 Used daily	
		a. Bed rails	a.
		b. Trunk restraint 1,2 = ▲^{1} ●^{18}	b.
		c. Limb restraint 1,2 = ▲^{1} ●^{18}	c.
		d. Chair prevents rising 1,2 = ▲^{1} ●^{18}	d.

● = Automatic Trigger - Go directly to RAP Instructions ▲ = Potential Triggers - Go to RAP Instructions for more detailed trigger definitions

1 - Delirium
2 - Cognitive Loss/Dementia
3 - Visual Function
4 - Communication
5 - ADL Functional/Rehabilitation Potential
6 - Urinary Incontinence and Indwelling Catheter
7 - Psychosocial Well-Being
8 - Mood State
9 - Behavior Problems
10 - Activities
11 - Falls
12 - Nutritional Status
13 - Feeding Tubes
14 - Dehydration/Fluid Maintenance
15 - Dental Care
16 - Pressure Ulcers
17 - Psychotropic Drug Use
18 - Physical Restraints

MINIMUM DATA SET SECTIONS

A.	IDENTIFICATION AND BACKGROUND INFORMATION
B.	COGNITIVE PATTERNS
C.	COMMUNICATION/HEARING PATTERNS
D.	VISION PATTERNS
E.	PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS
F.	CONTINENCE IN LAST 14 DAYS
G.	PSYCHOSOCIAL WELL-BEING
H.	MOOD AND BEHAVIOR PATTERNS
I.	ACTIVITY PURSUIT PATTERNS
J.	DISEASE DIAGNOSES
K.	HEALTH CONDITIONS
L.	ORAL/NUTRITIONAL STATUS
M.	ORAL/DENTAL
N.	SKIN CONDITION
O.	MEDICATION USE
P.	SPECIAL TREATMENTS/PROCEDURES

MDS TRIGGERS

1. DELIRIUM
2. COGNITIVE LOSS/DEMENTIA
3. VISUAL FUNCTION
4. COMMUNICATION
5. ADL FUNCTIONAL/REHABILITATION POTENTIAL
6. URINARY INCONTINENCE AND INDWELLING CATHETER
7. PSYCHOSOCIAL WELL-BEING
8. MOOD STATE
9. BEHAVIOR PROBLEMS
10. ACTIVITIES
11. FALLS
12. NUTRITION STATUS
13. FEEDING TUBES
14. DEHYDRATION/PLAIN MAINTENANCE
15. DENTAL CARE
16. PRESSURE ULCERS
17. PSYCHOTROPIC DRUG USE
18. PHYSICAL RESTRAINTS

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND

LEGEND:

● Automatic Trigger - Go directly to RAP instructions

▲ Potential Trigger - Go to RAP instructions for more detailed trigger definitions

Instructions: Match MDS item codes with trigger codes below. Proceed to RAP instructions as indicated by symbol. Circle all RAPs that are "triggered," based on your Review.

	MDS Pattern	MDS Item	Code	1 Delirium	2 Cognitive Loss/Dementia	3 Visual Function	4 Communication	5 ADL Functional/Rehabilitation Potential	6 Urinary Incontinence and Indwelling Catheter	7 Psychosocial Well-Being	8 Mood State	9 Behavior Problems	10 Activities	11 Falls	12 Nutritional Status	13 Feeding Tubes	14 Dehydration/Fluid Maintenance	15 Dental Care	16 Pressure Ulcers	17 Psychotropic Drug Use	18 Physical Restraints
NURSING	B. COGNITIVE PATTERNS	B2 a or b	1		▲																
		B3 a,b,c,d	Fewer than 3 ✓		▲																
		B4	0,1,2				▲														
			1,2,3		▲																
		B5 a,b,c,d,e	any ✓	●																	
		B6	2	●													▲				
	C. COMMUNICATION/ HEARING PATTERNS	C4	2,3				▲														
		C5	1,2,3		▲																
			2,3				▲	▲													
		C6	2	●																	
	D. VISION PATTERNS	D1	1,2,3			●															
		D2 a	✓			●															
	E. PHYSICAL FUNCTIONING/ STRUCTURAL PROBLEMS	E1 a,b,c,d,e,f	3,4					▲													
		E3 a	3,4					▲													
		E4 a,b,d,a,h,i	any ✓											▲							
		E7 a,b	any ✓					▲													
		E8	2														▲				
	F. CONTINENCE	F1 b	2,3,4						▲												
		F3 b,c,d,f	any ✓						▲												
SOCIAL SERVICES	G. PSYCHOSOCIAL WELL-BEING	G2 a,b,c,d	any ✓							●											
		G3 b	✓							●											
	H. MOOD/ BEHAVIOR	H1 a,b,c,d,e,f,g	any ✓								●										
		H1 d	✓														▲				
		H2	1								●										
		H3 a,b,c, or d	1,2									●									
		H6	2	▲																	
		H7	2	●																	
				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18

				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
ACT.	I. ACTIVITY PURSUIT	I2	0,2,3										▲								
		I5	1										●								
NURSING	J. DISEASE DIAGNOSES	J1 ee	✓														▲				
		J2	260, 261, 262												●						
			263, 263.0, 263.1												●						
			263.2, 263.8, 263.9												●						
			276.5														▲				
			291.0, 292.81	●																	
			293.0, 293.1	●																	
	K. HEALTH CONDITIONS	K1 b,c, f,h,n	any ✓														▲				
		K2 a,b	any ✓											●							
DIETARY	L. ORAL/ NUTRITIONAL	L1 c	✓															●			
		L2 c	1												●		▲				
		L3 a,d,e	any ✓												●						
		L3 b	✓														●				
		L3 c,e	✓														▲				
		L4 a,b	any ✓														▲				
		L4 a,c,d,e	any ✓												●						
		L4 b	✓													●					
NURSING	M. ORAL/ DENTAL STATUS	M1 a,c,d,e	any ✓															●			
		M1 f	not ✓															●			
	N. SKIN CONDITION	N2	1,2,3,4												●				●		
		N4 c,d,e,f,g	none ✓																▲		
	O. MEDICATION USE	O4 a,b,c	1-7									▲		▲						▲	
	P. TREATMENT/ PROCEDURES	P3 b,c, or d	1,2									▲									●
				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18

WORKSHEET

Manor HealthCare Corp.
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INSTRUCTIONS FOR RAP SUMMARY:

1. For each RAP area triggered, show whether you are proceeding with a care plan intervention.

2. Document problems, complications, and risk factors; the need for referral to appropriate health professionals; and the reasons for deciding to proceed or not to proceed to care planning. Documentation may appear anywhere the facility routinely keeps such information, such as problem sheets or nurses' progress notes.

3. Show location of this information.

RAP PROBLEM AREA	DISCIPLINE(S) INITIATING ICP	CARE PLANNING DECISION		LOCATION OF INFORMATION ICP = Interdisciplinary Care Plan PN = Progress Note, Other
		Proceed	Not Proceed	
1. Delirium	N, S	☐	☐	
2. Cognitive Loss/Dementia	N	☐	☐	
3. Visual Function	N	☐	☐	
4. Communication	N	☐	☐	
5. ADL Functional/ Rehabilitation Potential	N	☐	☐	
6. Urinary Incontinence & Indwelling Catheter	N	☐	☐	
7. Psychosocial Well-Being	S	☐	☐	
8. Mood State	S	☐	☐	
9. Behavior Problems	S	☐	☐	
10. Activities	A	☐	☐	
11. Falls	N	☐	☐	
12. Nutritional Status	N, D	☐	☐	
13. Feeding Tubes	D	☐	☐	
14. Dehydration/Fluid Maintenance	N, S, D	☐	☐	
15. Dental Care	N, D	☐	☐	
16. Pressure Ulcers	N	☐	☐	
17. Psychotropic Drug Use	N	☐	☐	
18. Physical Restraints	N	☐	☐	

* Please note: Disciplines assigned to each RAP problem area above are to initiate the care plan but all disciplines are expected to be involved in the short term goals and approaches. N = Nursing, D = Dietary, S = Social Services, A = Activities

Signature of RN Assessment Coordinator: ______________________ Date: ______________

Resident's Name (Last, First, MI)	Attending Physician	Room Number	ID Number

[illegible]

RESIDENT ASSESSMENT PROTOCOL SUMMARY

[illegible]

#1 DELIRIUM

RELATED TO (TRIGGER):

- **Disordered Thinking**
- **Cognitive Decline**
  - **Memory Problem**
  - **Memory Recall Disability**
  - **Daily Decision-Making Disability**
- **Communication Decline**
  - **Inability to express information**
  - **Inability to understand information**
  - **Inability to hear information**
- **Behavior Decline**
  - **Wandering**
  - **Verbally Abusive**
  - **Physically Abusive**
  - **Socially Inappropriate Behavior**
- **Mood Decline and any of the following:**
  - **Motor Agitation**
  - **Withdrawal**
  - **Hallucinations/Delusions**
- **Alcohol Withdrawal, Drug-Induced, Acute or Subacute Delirium**

SHORT TERM GOAL

THE RESIDENT ('s) WILL /WILL BE ABLE TO

- be alert and oriented to __________[time, place, person]__________[indicate frequency]
- speak clearly and content will be related to topic______________[indicate frequency]
- not exhibit motor agitation_________[pacing, handwringing, picking]________[indicate frequency]
- make independent decisions in all situations
- make reasonable, consistent decisions about routine daily tasks and ADLs ________[selecting clothing, attends activities of choice, etc. [Modified Independence: some difficulty in new situations only]
- make simple choices about daily tasks and ADLs with reminders, cues, and supervision [Moderately impaired: decisions poor; cues supervision required]
- express, understand, and hear information as evidenced by __________[stating needs, following directions, and responding correctly to questions]
- participate at ______[level] in __________activity programs________[times/week]
- not injure self or others
- not _________[threaten, scream, or curse] at others
- not _________[hit, shove, scratch or sexually abuse] others
- not exhibit socially inappropriate behaviors ________[disrupting sounds or noises, scream, self-abusive acts, disrobe in public, smear/throw food or feces, rummage through others' belongings]
- not experience hallucinations/delusions
- take medications/treatments as ordered
- _____________[independent/assist] in ADLs ________________ with ________________[verbal reminders, assistive devices, physical cues and supervision

APPROACHES	DISCIPLINES
• Orient to time, place, and person PRN	N, D, SS, ACT
• Encourage resident to elaborate on reality-based ideas	N, SS, ACT
• Correct misconceptions about self, environment and/or experiences through recall of events and use of problem-solving	N, D, SS, ACT
• When resident experiences anxiety, change topic, If resident is able to discuss topic of anxiety, encourage him/her to express self	N, SS, ACT
• Avoid sensory over-stimulation (e.g., watching TV, listening to radio for prolonged time periods)	N, SS, ACT
• If resident's responses are incorrect provide correct information in kind and gentle manner	N, D, SS, ACT
• Listen carefully to attempts to speak	N, D, SS, ACT
• Avoid interrupting resident	N, D, SS, ACT
• Allow time for communication efforts	N, D, SS, ACT
• If inappropriate behavior is exhibited, attempt to distract resident but do not criticize him/her	N, SS, ACT
• Provide positive feedback to reinforce positive behaviors and accomplishments	N, SS, ACT
• Give simple step-step directions (task segmentation) to foster positive behaviors	N, SS, ACT
• Avoid reinforcing hallucinations/delusions	N, SS, ACT

#1 DELIRIUM

APPROACHES	DISCIPLINES
• Provide consistent daily routine	N, SS, ACT
• Provide consistent environment	N, SS, ACT
• Provide a calm environment	N, SS, ACT
• Encourage family to bring in familiar objects, e.g., family pictures, afghan, etc.	N, SS, ACT
• Neuro assessment: Freq:__________	N
• Encourage attendance at activities	N, SS, ACT
• Test for possible visual and hearing deficits	N
• Use non-verbal communication techniques, e.g., touch, eye contact, facial expressions, posture, tone of voice, and gestures to encourage resident to respond	N, D, SS, ACT
• Encourage independent/participation in self-care activities	N
• Involve resident as much as possible in daily decision-making	N, D, SS, ACT
• Modify tasks, time-frame, demands, and environment to encourage independence	N, SS, ACT
• Provide special environmental stimuli, e.g., directional markers, special lighting	N, SS, ACT
• Provide verbal reminders, physical cues, and supervision to aid in carrying out ADLs	N
• Observe for changes in usual behavior/daily routine	N, D, SS, ACT

MINIMUM DATA SET SECTIONS	NURSING DIAGNOSIS
B. COGNITIVE PATTERNS	COGNITIVE DEFICIT R/T
D. VISION PATTERNS	VISUAL DEFICIT R/T
E. PHYSICAL FUNCTIONING	ADL DEFICIT:_(SPECIFY) SELF-CARE DEFICIT: (SPECIFY) Bed Mobility Transfer Locomotion Dressing Eating Toilet Use Personal Hygiene Bathing
STRUCTURAL PROBLEMS	BODY CONTROL PROBLEM R/T MOBILITY DEFICIT R/T BALANCE CONTRACTURE HEMIPLEGIA LACK OF MANUAL DEXTERITY AMPUTATION

MANAGEMENT OF THE RAI

ISSUES	SOLUTIONS
TIME	INTERDISCIPLINARY TEAM
TRAINING	TRAINING MANUAL
SCHEDULING	REVISE TICKLER FILES
CARE PLAN	WRITTEN PRIOR TO CONFERENCE
DETAIL/COMPLEXITY	COMPUTERS AND JOB AIDS
INFORMATION USE	CREATIVE EXPLORATION
INTERFACE WITH CURRENT ASSESSMENTS	MDS AS LAUNCHPAD

THE RAI AND LTC NURSING

THE FUTURE IS BRIGHT!

- RESPECTS NURSING PROCESS (assessment, planning, implementation and evaluation)
- STANDARDIZES LANGUAGE
- STRENGTHENS ASSESSMENTS
- STANDARDIZES APPROACHES
- STRENGTHENS DELIVERY OF QUALITY CARE
- ESTABLISHES LTC NURSING DATA BASE (national identification of resident problems and needs)
- ESTABLISHES COST OF NURSING SERVICE

RESIDENT ASSESSMENT
THE SPRINGBOARD TO QUALITY OF CARE AND QUALITY OF LIFE FOR NURSING HOME RESIDENTS

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And *This* Is Home?

Carter Williams

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In *Webster's New World Dictionary*, a home is defined as "a place where one likes to be; [the] place thought of as the center of one's affections; [a] restful or congenial place." In contrast, an institution is defined as "an organization having a social, educational or religious purpose, [such] as a school, church, hospital, reformatory, etc." (1). The dictionary does not confuse home and institution, nor should we, but we are dealing with an environment where the essential qualities of the two must meet for the benefit of the people living in it.

It has been my privilege over the past 10 years to work with many persons in their eighth, ninth, and tenth decades of life for extended periods of time both before and after they entered long-term care institutions. Because of this experience and my knowledge of nursing homes through consulting work, I have accepted the challenge of speaking for others—that is, for the people living in institutions.

Recognizing that one can only figuratively walk in another's shoes or sit in a restraint in another's wheelchair, we shall enter into the lives of some people I have known and worked with. In this way, we can perhaps gain a common basis of understanding about the problems with which these individuals are trying to cope. We can then proceed to some questions about how teaching and research activities in long-term care facilities may affect them and, in turn, the job of the health care professional.

The transition from home to institution is a time of crisis for all involved, but most especially for the person making the move, so a look at this period serves as a good starting point for understanding the experience of institutional living. We now meet a woman who was my neighbor for many years, whom we shall call Mrs. Eckland, just as she is experiencing this transition.

Mrs. Eckland was 90, divorced following a brief marriage in her 30s, and was living alone in her small third-floor apartment, which she had occupied for 25 years. A licensed practical nurse, she had worked part-time into her early 80s. She had never had children, and her only close relatives were two sisters almost as old as she, both in institutions and both largely alienated from her and from each other. She was tremendously proud of her career as a nurse in a period when most women were not financially independent. And she was proud that her earnings had been substantial enough to result in Social Security payments that allowed her to meet her monthly expenses and pay for a personal care aide for a half day each week. She was also proud of her family background, which included early settlers in the city, and of her past relationships with a number of influential people. She was an avid reader, keenly interested in politics, vehement in her political opinions, and a warm supporter of the women's movement.

Along with this pride in family and in her own accomplishment ran a prickly, at times tempestuous, personality. This temperament, accompanied by increasing immobility, meant that she had few relationships: one or two by telephone and a few in the neighborhood. Her world had shrunk into the three rooms of her apartment. Always, she told me, she was complimented by others on the transformation she had wrought there. She recounted in detail her choice of the deep blue rug, her delight in her beautiful pink bathroom, her dressing table with the fabric ordered from a certain store, and the set of gold-plated toilet articles carefully arranged on top. There were her books, too, four shelves of them, and her family pictures, the clothes she cared so much about, and the mementos from her trips to India. She sat in her fanback chair and controlled her world, with spirited comments about the failure of the politicians in Washington to manage their world as well.

This home, special and beautiful to her, was to others an attic apartment, poorly lighted and inconveniently arranged. The blue rug was usually covered with lint, and the odor of urine was strong. There were many piles of books and papers about her room.

However, she persevered in her full determination to remain at home where she was content to be, selecting resources she wanted to use from those I told her about, and she brushed aside with anger attempts to discuss future planning and consideration of entering a long-term care facility.

Then, as had happened four or five times previously within the year, she fell. But this time she lay on the floor many hours, unable to reach either of her telephones, which had been appropriately lowered according to instructions from a consulting occupational therapist. Her *Daily Hello* caller alerted a neighbor when she received no answer, and Mrs. Eckland was admitted to the hospital for the second time in several months in severe congestive heart failure.

With this background, we may now picture her after a period in the hospital on the way to a nursing home, which her doctor has told her can no longer be avoided. She is out of the hospital gown for the first time in many weeks and is wearing her familiar raincoat and her fur hat. She is expressing

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conflicting feelings of hope and apprehension as we make the trip in the chairmobile.

There is no one to greet us at the door. Mrs. Eckland is wheeled upstairs by the chairmobile attendent and helped to sit in a chair beside a bed in a double room. The nurse in charge on the floor introduces herself and welcomes Mrs. Eckland to her new home. She is thinking and responding slowly and does not do very well with the questions addressed to her. She tries to focus as others come in to see her: the social worker, the dietitian, and an aide in fairly rapid succession. Some address her by her first name or call her "honey" though they do not know her, and most speak in loud voices though she is only slightly hard of hearing. All speak kindly, but rapidly, and she does not quickly apprehend what is expected of her in the discussion of food preferences, nor does she seem to comprehend some of the routines they describe. Some try to take time to listen to her, but they are obviously under pressure of time; their responses tend to be stereotyped.

From controlling her own small domain at home, Mrs. Eckland has been thrust into a 24-hr-a-day situation in which she is to live by a schedule decided by others in a setting where she cannot even maintain control over the position of the items on her bedside table, or for that matter what she wishes to have on top of the table and what is to be in the drawer, a detail that throughout her year and a half in the nursing home particularly annoyed her.

To observers this loss of control seemed appropriate to her condition, which included lack of urinary control, inability to walk, and some lack of judgment. To her this experience meant loss of identity. All material clues as to who she was and what her life had been were absent—no royal blue carpet to reflect her taste, no books, no family pictures, no closets of clothes, no mementos of her travels. Wiped away also were the freedoms of living at home: sitting up reading into the early morning hours, perhaps never going to bed, or sleeping until 11 a.m., and eating when and what she wanted. And, finally, the loss of freedom was literally and figuratively signified by the experience of being placed in a vest-like garment with long belts attached by which she was tied into her chair because of her tendency to slip out of it.

Psychologically, environmentally, and socially, Mrs. Eckland's familiar world had disappeared. She had lost control of most aspects of daily living. She felt vulnerable, acted upon by others. Her personal living space was greatly reduced and was often invaded by other people. There was little privacy and no solitude. From the limited social contacts she had at home at times of her own choosing, she was thrust into constant contact with others, beginning with a roommate who was a complete stranger. And she was visibly imprisoned in her wheelchair. Small wonder then that I would find her in her first days sitting in her chair almost bent double, her eyes closed. She handed me on my visit to her the day after her admission this message written on the back of the card I had left her the previous day with a message of love on it from me and my husband. This is what she wrote:

> Dear Carter——You know this was not the place I wanted to come. Please come to see me and really prove that you love me. Also please get Mr. B. (my lawyer) to come here. I must talk to him. I loved you more than you loved me and trusted you. How can I trust you now?

A long period of grieving and depression followed in which Mrs. Eckland questioned the value of living. She was accusatory toward staff and her few visitors, including her lawyer. The staff social worker and I did what we could to ameliorate the situation, with varying degrees of success: cherished items of her selection were brought from home as soon as possible—her chair, family pictures, and clothing both precipitated more grieving and very gradually helped her to begin to reestablish her sense of identity and self-respect. She decided which pictures she wanted hung and where they were to be placed. Aides were encouraged to ask her to select what she wanted to wear each day, but this was only minimally successful because aides were constantly rotated. Her hair style also changed with the aide of the day, varying from loose and free-flowing to tight knots and coy ornaments and bows. Sometimes spots of rouge and very bright lipstick were applied, though she had never used cosmetics previously. Mealtime was often difficult; she had to sit at table for a half hour or more while others gathered, and she longed for a really hot cup of coffee and real china and metal cutlery rather than the array of plastic with which she had to cope.

Gradually, several distinctly positive developments occurred: she formed good trusting relationships with the social worker and two aides. She began to discover that she could help some other residents through her conversational ability and the encouragement she offered them. And through the chaplain, she was reunited with her church from which she had long been estranged.

Mrs. Eckland's story has elements common to the experience of the many older people in our communities who are precipitously transferred from home to institution via the hospital because of major health crises. But as hard as the move to an institution was for her, it was probably not as great a change as some people experience. She also had greater coping abilities than many who have led more protected and circumscribed lives. She did not have to be separated from a spouse or other family members, nor did she leave behind a treasured pet. She also had no language problems. One must try to imagine what it must be like for the aged immigrant who has learned little or no English to enter an institution, or for a black person or others of another racial cultural minority to enter our overwhelmingly white institutions. What must it be like for people who have lost much of their hearing to enter the nursing home environment, experiencing all the loss of identity and control that Mrs. Eckland did and in addition hardly being able to communicate with others?

What lies ahead for people who make their homes in long-term care institutions if teaching and research functions are added? Even without the advent of research and teaching, the medical and nursing routines of long-term care facilities tend to medicalize the smallest details of life. For example, Miss Cohen cannot enjoy her Sabbath Eve challah when it is reduced from the warm fragrant chunk she has enjoyed Friday evenings all her life to a thin cold slice because of her restrictive diet. So great is her indignation, that her response is to refuse all food. And how can Mr. Denby, the courtly, dignified former executive, be saved from embarrassment and identity loss when he is unable to rise to greet or bid farewell to his guest because he is tied to his chair out of fear of his falling? He tries at times to work up a little levity about the restraint by calling it his "male brassiere," but another day he says quietly, "It's a terrible thing to lose your freedom." Indeed, his sense of imprisonment is so great that I found him in tears on another occasion because he was certain the doors were locked and his wife, who was soon to return from a trip, would not be allowed in by the jailor to see him. And where is there privacy for him and his wife when he shares a double room, and not only is the roommate present but at unexpected moments a loud voice comes over the intercom demanding to know where this or that aide is? These are hardly the circumstances and setting in which two people can share intimate moments, whether they be times of quiet conversation or longed-for sexual intimacy.

For anyone who has been in an acute hospital bed, these experiences, and many more, often strange and dehumanizing, are familiar. But we must remember, the long-term care facility is usually the person's permanent home, and the problems are chronic and have to be dealt with not for a limited number of days but, for most, for the rest of their lives.

Will the meaningful events of every-day life, already so greatly reduced, be further medicalized by teaching and research activities? When planning and carrying out these functions, will health professionals take time to plan their interventions into the lives of residents so that their contacts enrich them and lighten their loads rather than add to their burdens? If the health professional recognizes Mrs. Eckland as the proud woman who struggled for a means of supporting herself after what was at the time the disgrace of divorce and rejection by her family, he/she will contribute to the regaining and affirming of individual identity. One also hopes that he/she will take the time to look for her strengths and not only for her frailties and weaknesses. If one goes further to discover how life feels to Mrs. Eckland now, a new relationship will result. If this relationship can be of enough duration to provide some enrichment and dependability in her life, he/she will avoid becoming a part of another bewildering parade of faces. For, unfortunately, some homes deliberately rotate aides every week. The rationale offered for this policy is that they do not want individual residents to become attached to any one aide. Yet this practice runs exactly counter to what the sick, older person needs in terms of familiar faces, procedures, and continuing dependable relationships. There is a slight possibility of unhealthy relationships developing. But with monitoring for signs of destructive behaviors, this practice of cutting off people living in institutions from attachments to staff can be avoided. Grief is always involved when a relationship ends, but with appropriate support both to the older person and to staff, this grief can be worked through. The risk of loss, after all, is one we take throughout our lives. If we deny ourselves and others all attachments because of the potential of pain, we deny something essential to us as human beings.

When one has given up much that was formerly meaningful and has lost a large measure of personal freedom, one is particularly sensitive to an attitude of being used—used as an object of teaching or research. So to every resident of a nursing home who may participate in any project, careful explanation and feedback about what has been learned by such research are needed. And time is needed as well to avoid mistaking diminished hearing, sight, and voice strength for lack of response capabilities.

One research nurse wrote me of her experience in this regard as follows:

> In our institution, we take great care with the consent process. We approach each person slowly, carefully assessing ability to see, hear, and communicate, to understand, judge, and reason, and the level of comfort or discomfort. It is a slow process. We explain the consent, verbatim, if necessary. For one deaf, partially sighted man, we copied key parts of the consent onto poster board in large letters so he could read it for himself. We go back the next day or week if the [person] is unsure and wishes to talk with family or friends, or just wants to think it over. We also tell [people] how to reach us if they change their minds or have questions (P. Tabloski, Monroe Community Hospital, *personal communication*, 1984).

As to the important matter of contributing to a person's sense of control over her/his environment, this may come mainly through accretion of many small details—through consultation and agreement with each person on timing, on who the personnel will be, on whether one takes pains to leave things in the person's room as they were when found, whether one is careful to knock before entering, to ask permission to speak with the resident, or to return at a more convenient time; whether one remembers to sit down so that he/she is on the same eye level as the person being visited and to speak slowly, avoiding jargon and "medicalese."

A word about families, which I have so far neglected. All will agree that their understanding of the goals of the teaching and research are crucial, so time needs to be allowed for contacts with them. They will be needed as very important sources of backup, interpretation, and support to their institutionalized family members. There are varieties of families, carrying their own particular constellations of relationships to their sick older relatives living in the institution.

What of the person like Mrs. Eckland who, in effect, has no family? Again, on the basis of personal experience, any such person is so very vulnerable that it is essential that someone accept an advocacy role with and for him/her. Mrs. Eckland, for example, needed frequent interpretation about what happened to her in the nursing home. She needed to be able to turn to someone outside the home for help and reassurance. My suggestion is that everyone who is without close family and friends have an advocate, who could be a volunteer trained much as the ombudsman is and who could be recruited from the community through churches, temples, and service organizations.

This discussion with the questions it raises has been presented to sensitize us to the possible pitfalls of introducing teaching and research to the home of the older person with chronic illness. In some of the institutions where these functions already exist, there are encouraging reports of positive results for the residents. For example, participation in a research project often does result in a welcome increase in attention and enrichment in relationships. It adds interest and sense of purpose to the individual's life. Results of some studies can bring about certain immediate improvements in care. And there is a positive spin-off in the added interest teaching and research may bring to the work of the staff if they are properly prepared for it and are not too overworked. One physician, highly experienced in research in long-term care facilities, reports that he does not set foot on a floor to talk to any resident until extensive meetings have been held with all nursing staff in which a full understanding of goals and procedures has been reached lest rumors and apprehensions abound (D. Bentley, University of Rochester, *personal communication*, 1984). When staffing ratios are poor, as I have known them to be at times in all institutions, but particularly in the smaller proprietary facilities, it is recommended that the teaching and research projects bring in some additional personnel. The good reports of successful teaching and research are always accompanied by this proviso: time must be spent to prepare the people participating as subjects as well as their family members, advocates, and staff at all levels.

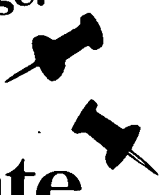
We need to learn so much more about the health and well-being of people who live in chronic-care institutions and the diseases and systems that affect them. What about the system that emerges from the maternalistic attitude that pervades most nursing homes—is it beneficial to the people living there? They are, after all, adults and not kindergartners. We need research to learn how to protect those for whom a fall is dangerous without the sense of imprisonment and punishment restraints produce. We urgently need to know more about how to teach personnel successfully at all levels about those things that make for personalization, dignity, and a sense of worth, so that a nurse does not address all she cares for as "honey" or "dear," so that the dining room assistant in front of a person newly admitted doesn't call over to her supervisor in a loud voice, "Does Smith feed herself?" which brings the immediate, indignant response from Mrs. Smith, "Of course I feed myself!" And we need to learn ways of expanding the institution-bound

social worker's understanding and creativity, possibly by providing work partly outside the institution. The list of questions regarding all aspects of care—medical, nursing, social, administrative—is unending.

It is my hope that as one explores these questions, he/she will include sensitivity to the person being studied as an essential component of research, education, and clinical care. By procedures that personalize, by our findings and their application, we will help to remove some of the bitterness from the question with which we began: "And *this* is home?"

Moving Ahead with the Challenge:

Meeting the OBRA Mandate



Alan Friedlob, Lois Steinfort,
Vittorio Santoro, and Emma Luten

On October 1, 1990, the Health Care Financing Administration's (HCFA) Office of Survey and Certification, through its regional offices and the state survey and certification agencies, will implement a revised survey and certification process to assess nursing facilities' compliance with statutory and regulatory requirements for participation in the Medicare and Medicaid programs. This survey process responds to regulatory changes in requirements for participation first proposed by HCFA in October 1987 and to Congressional mandates for nursing home reform found in the Omnibus Budget Reconciliation Act of 1987 (OBRA).

This article discusses four components of the survey—the quality of care assessment, review of residents rights and quality of life, environmental quality assessment, and dietary services systems assessment. For each area, we examine how these procedures support surveyors evaluating the principal goal underlying the new long term care requirements and OBRA—that nursing facilities individualize care in ways that will assist each resident attain or maintain his or her highest practical physical, mental, and psychosocial well-being.

Quality of Care Assessment

Since August 1986, HCFA has required state and federal nursing facility surveyors to focus on evaluating resident care outcomes, and to de-emphasize review of structural measures of quality of care, such as policies and procedures. The new resident assessment and quality of care requirements found at 483.20 and 483.25 extend this outcomes oriented emphasis and reflect the following behavioral expectations for nursing facilities.

- *"The facility must make a comprehensive assessment of a resident's needs which describes the resident's capabilities to perform daily life functions" (483.20(b)(ii)).*

All care provided by the facility should flow from the resident's comprehensive assessment and subsequent care plan.

- *"Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care" (483.25).*

This requirement embodies the expectation that the facility develop restorative and rehabilitative care goals and that care and treatment meet these goals.

- *"A resident's abilities in activities of daily living do not diminish unless circumstances of the resident's clinical condition demonstrate that diminution was unavoidable" (483.25(3)(i)).*

Similar language appears in many of the other quality of care requirements. Such language underscores the importance of considering change in the resident's condition when surveyors evaluate facility performance in maintaining or attaining a resident's highest practicable well-being.

The Interpretive Guidelines ask that surveyors review the quality of a resident's care longitudinally in terms of care transition—of residents improving, declining, and maintaining their physical, mental, and psychosocial status over time. For example, the level of the resident's dependency in activities of daily living (ADL) changes over time, and the direction and rate of change can move toward either improvement or decline. The surveyor must consider the underlying reasons why disability occurred. Based on a surveyor's review of a resident's comprehensive assessment and plan of care, the surveyor must consider for each resident: what changes in ADL level can be expected and why?

In conducting a quality of care assessment, surveyors should presume that facility interventions can improve residents' functioning, except under certain clinical circumstances described in the Interpretive Guidelines. Surveyors should further assume that declines in functioning can often be delayed through application of appropriate restorative and preventative care programs.

For some residents, maintaining or attaining the highest practicable physical, mental, or psychosocial well-being may be observed easily by the surveyor. For example, a resident arrives in the facility discharged from a hospital and is discharged ambulatory to their own home. However, for many residents, restorative goals and resulting positive outcomes are less dramatic, though no less significant in contributing to that resident's quality of life. For example, through staff intervention, a resident may be able to wash his or her own face; transfer from the bed to a chair with the help of one person; learn to use a fork with an adaptive device so he or she can once again feed himself or herself; or increase the amount of time spent sitting from 10 minutes to one hour so that he or she can visit with family in a chair.

The revised long term care survey process provides surveyors guidance as to how to conduct this outcome-oriented care review. The foundation of this evaluation is the requirement that each resident must have annual comprehensive assessment upon admission, with a review of that assessment every three months, and a reassessment after a "significant change in status."

Beginning October 1, 1990, HCFA requires all nursing facilities to conduct a comprehensive assessment of all residents using a uniform minimum data set (UMDS) of resident characteristics specified by the Secretary of Health and Human Services. The UMDS forms the core of a "resident assessment instrument," which the secretary will also specify. All nursing facilities within a state will be required to use the same resident assessment instrument, either the one specified by the secretary or a comparable instrument selected by the state and approved by the secretary. All approved instruments must contain the UMDS as specified by the secretary. By October 1, 1991, nursing facilities participating in the Medicare or Medicaid programs will have completed assessments on all residents using an approved resident assessment instrument that includes the UMDS.

The UMDS and resident assessment instrument will provide surveyors throughout the country with a single common structure for examining relationships between how the nursing facility assesses a resident's needs and the outcomes it achieves in meeting these needs. By October 1, 1991, a surveyor opening a resident's record anywhere in the country should see the same set of core elements, that is, the UMDS, collected by all nursing facilities in a uniform manner, that is, adhering to one set of definitions for these core elements prescribed by the secretary.

In the event the surveyor observes a negative outcome(s), or a failure to achieve a desired outcome, that is, a failure of the resident to achieve his highest practicable well-being that can be attributed to a failure by the facility to provide needed care and treatment or to take reasonable efforts to mitigate known risk factors, then the surveyor will trace the origins of this negative outcome back to the assessment and care planning process.

In summary, we expect that in conducting quality of care assessments for residents, surveyors will need to master an understanding of relationships between resident assessment care planning and care outcomes.

Resident Rights

The new long term care requirements and revised survey procedures increase the emphasis nursing facilities place on concerns of residents rights and quality of life. Currently, approximately 6 percent of skilled nursing and 17 percent of intermediate care facility conditions of participation address resident rights and quality of life issues. By contrast, approximately 30 percent of the new nursing facility requirements relate to these concerns. These requirements are found at 483.10. Resident rights: 483.12. Admission, transfer and discharge rights: 483.13. Resident behavior and facility practices: and 483.15. Quality of life.

Similar to quality of care, surveyors must review resident rights and quality of life from an outcome perspective. The new requirements do not focus on written policies and procedures that nominally assure these rights. Rather, facilities must demonstrate how they positively influence residents maintaining or attaining their highest practicable autonomy.

Surveyors review of residents rights and quality of life reduce to one basic task; evaluating how much control over their lives residents living in a nursing facility have. Essential to the revised survey procedures concerning resident rights and quality of life is surveyors learning from residents how the facility provides opportunities to enhance residents' ability to exercise independence, self-control and competence in a congregate living environment.

A nursing facility needs rules of behavior that are clear to staff and residents. However, the new nursing facility requirements challenge the assumption that these rules unduly restrict personal autonomy. Rather, surveyors must assume that the nursing facility's social and physical environment is neutral with respect to residents' autonomy. The degree to which residents' exercise their autonomy depends on the manner in which the facility sets up its institutionalized practices. Set up in one way, the facility is receptive to autonomy; set up in another way, it limits autonomy.

The core of the survey procedures directed at evaluating how residents exercise independence, self-control, and competence in their everyday lives is standardized interviews held with individual residents; a residents group, either organized such as a resident's council or ad hoc if an organized group does not exist; and family members or legal representatives of residents with dementia or other cognitive impairments who are unable to speak for themselves.

Individual and family interviews focus on 13 areas related to residents rights and quality of life. Examples of areas covered in the interview are: matters of eating, care routines, decisions about care and treatment, security and personal property, and privacy. Groups interviews focus on four areas: participation in resident and family groups; grievances; notice of rights and services; and resident security and personal property. Interviews provide surveyors with information about what the facility does to aid residents' autonomous participation in everyday life, as viewed from the resident's perspective.

Surveyors must realize that residents may or may not seize these opportunities. Bringing resident flexibility or choice into the nursing facility does not mean eliminating all rules affecting living in a congregate environment. Rather it means organizing the facility in specific ways that encourage residents to exercise their self-control, competence, and independence. Through these interviews, surveyors also learn how the facility allows residents to have an on-going role in shaping the institution—to have a say in how the facility functions and the rules that shape staff and residents behavior.

Thus in determining compliance of the facility with resident rights and quality of life requirements, the surveyor must examine an individual's ability to exercise autonomy in the context of a complex, heterogeneous group setting.

The concept of resident autonomy is also bolstered in the way in which the new long term care requirements and interpretive guidelines treat the use of physical restraints in nursing facilities. The requirement concerning restraint use states:

"The resident has the right to be free from any physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience, and not required to treat the resident's medical symptoms."

In the Interpretive Guidelines, physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body, which the individual cannot remove easily because it restricts freedom of movement or normal access to one's body.

In enforcing the requirements, surveyors will look for the use of restraints as a means of coping with staffing shortages (that is, "for purposes of convenience") or managing resident behavior in the absence of a comprehensive assessment of a resident's needs (that is, "for purposes of discipline"). Surveyors are directed to examine the appropriateness of the clinical objectives for which the restraint is used. They will look at how the facility has sought to use less restrictive supportive devices prior to using physical restraints as defined in this guideline.

We want to direct surveyors to review the use of restraints from an outcome-oriented perspective, that is, monitoring the effects of restraint use on resident's psychosocial and physical functioning. Using the UMDS and resident assessment instrument, surveyors will be able to examine better the possibility that failure to provide aggressive competent rehabilitation and other care over time leads to the inevitable use of restraints.

> "...surveyors may need to balance potentially conflicting demands of the requirements."

Environmental Quality Assessment

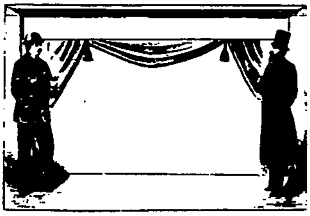
In the revised survey process, surveyors will increase the scope of their review of the physical environment to go beyond the traditional environmental health concerns of cleanliness, sanitation, and safety to include a more rigorous review of how nursing facilities adapt the physical environment to accommodate residents' needs.

The new nursing facility requirements expect providers to maintain a physical environment that supports their residents' highest practicale well-being. A nursing facility's physical environment affects the behavior and functioning of residents. In reviewing the physical environment, surveyors are instructed that there are no ideal or perfect solutions to spatial organization or interior design in a nursing facility. However, they must learn to recognize that there are many workable and inexpensive environmental adoptions that facilities can make to assist residents to maintain or attain their highest practicable functioning levels. Surveyors will focus on identifying positive examples of the fit between the residents and their environment, that is, situations where the physical environment aids residents in maintaining their independence and competence.

A major concern of nursing facility providers has been surveyors citing deficiencies related to the physical environment. For example, facilities may be cited for having a single light bulb burnt out, and yet there is no documented evidence of a facility-wide pattern of accidents or serious falls attributable to poor lighting. To remedy this type of situation, the environmental quality assessment has developed ratings of environmental factors affecting residents' quality of life such as sound levels, odors, ventilation, and spatial requirements, most of which are found at 483.15, quality of life and 483.70 physical environment.

The intent of this rating system is to introduce consistency into the evaluation of a nursing facility's physical environment, and the influence of the physical environment on residents' quality of life. As such, the environmental quality assessment becomes outcome-oriented. In conducting this assessment, surveyors will concentrate their observations on the residents' living space, that is, their rooms, common areas, corridors, and bath and toilet facilities. By breaking the facility's environment into a number of discrete observations, application of the uniform environmental quality assessment rating system will promote surveyor consistency.

In this review, surveyors may need to balance potentially conflicting demands of the requirements. For example, facilities that have liberal policies about the



amount of personal property residents can retain, a policy that encourages resident self-control, may experience increased incidence of theft and loss. Thus, it is critically important that surveyors apply principles of reasonableness in reviewing the extent to which the nursing facility arranges or modifies the physical environment to accommodate residents' functional and social needs.

Dietary Services

While the new nursing facility requirements and OBRA changed significantly in the areas of residents rights, quality of care, and quality of life, requirements for dietary services remain essentially unaltered. The dietary services requirement, 483.35 states: "The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of *each* resident" (emphasis added).

In reviewing dietary and nutritional services, surveyors must view nutritional services as having environmental health, quality of care, and quality of life elements. To this end, survey procedures for dietary and nutritional services have four components: to evaluate food sanitation, preparation, and distribution; to rate the environmental quality of facility congregate dining areas; to assess the quality of life aspects of the dining experience through observing individual residents; and to link these dining observations to individual appraisals of nutritional status based on the resident's comprehensive assessment and plan of care.

The first part of the dietary services system assessment focuses on inputs and the process of delivering nutritional services to residents. Surveyors will observe and rate the preparation and quality of food served for a designated meal using standardized evaluation criteria adapted, in part, from food service sanitation measures developed by the federal Food and Drug Administration. In addition, inclusion of a standard protocol that guides surveyors in tracking a meal from its preparation to service will enhance surveyor consistency in measuring facility compliance with dietary requirements.

In addition to assessing food preparation and service, surveyors must also ascertain quality of life outcomes associated with dining. This is accomplished through direct observation of residents included in the standard survey sample while they are eating. Through these observations, surveyors will determine the residents' use and need for assistive devices, the quality of the assistance the resident receives in dining and the efforts facility staff take to assist residents maintain independent functioning in eating, the amount of food eaten, and whether what the resident eats conforms with diet orders.

The most innovative feature of the dietary services assessment is that it is an integrative process. Because surveyors evaluate the quality of dining for all residents in the standard survey sample, whether they eat in the dining room or are bedbound, it is possible to link this information to the review of each resident's nutritional status, which is based on resident and staff observations and review of the residents' comprehensive assessment and plan of care. Information obtained from individual and group interviews about matters of eating will be integrated with these direct observations of nutritional status to provide a holistic appraisal of a facility's compliance with dietary and nutritional services requirements. For example, obtaining the residents' perspective about food in the facility provides insights into how the exercise of autonomy in food selection and individual nutritional decisions contributes to nutritional outcomes.

Related Activities

We have outlined some of the innovations to the long term care survey process that we believe will enhance the outcome-based orientation to evaluating the quality of care and quality of life in the nation's nursing facilities and enforcing long term care requirements for participation in the Medicare and Medicaid programs. We will continue to refine this process.

HCFA is also committed to other efforts to meet its Congressional mandate to improve the effectiveness of its long term care review systems, especially the consistent performance of state and federal surveyors. In fall 1990, we will design and implement a national proficiency test for state and federal surveyors of long term care facilities as required by OBRA. We believe that the resident-centered, outcome-based evaluation focus of the new survey process places greater demands on the clinical and professional competencies of surveyors.

Surveyor competency is assured through enhanced and on-going training. To this end, HCFA has developed and distributed to each of the nation's approximately 4,000 surveyors a self-instructional training manual. Nursing facility providers can also purchase this training material from the National Technical Information Service, Department of Commerce.

HCFA is also committed to a formal evaluation of the new survey process. This evaluation will commence around January 1991, after surveyors and providers have become thoroughly familiar with the new requirements and survey procedures. HCFA is particularly interested in learning about the difficulties providers have in complying with the new requirements and in their perceptions about the validity and consistency of the revised survey process compared to the current long term care survey. In designing this evaluation, HCFA will seek the active involvement of state and federal surveyors, resident advocates, and nursing facility providers.

Finally, HCFA is developing a notice of proposed rule making on survey and certification of nursing facilities and skilled nursing facilities and enforcement procedures. This rule will provide for a number of remedies to be imposed on facilities that fail to comply with federal participation requirements, including specified remedies, in lieu of or in addition to termination for facilities that are out of compliance and specified remedies for state survey agencies that do not meet surveying requirements. This regulation will implement provisions of OBRA that were further amended by 1988 and 1989 legislation. ■

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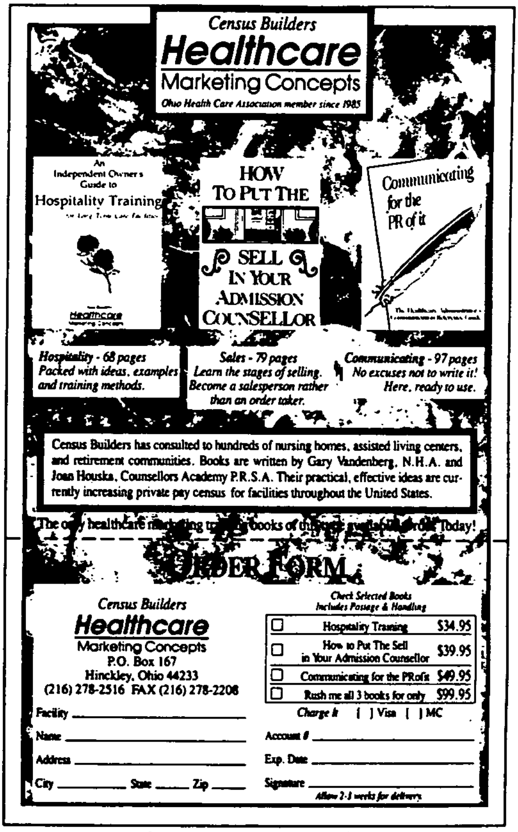


TRAINING SESSIONS PROVIDE INSIGHT INTO NEW PROCESS

Jenean Erickson

The Requirements of Participation (RoPs), often touted as the most extensive regulatory change in long term care over the last 15 to 20 years, will be applied to both skilled and intermediate facilities beginning October 1, 1990. Combine that dramatic change with the Health Care Financing Administration's (HCFA) reported intent to further shift the survey process from paper compliance to actual outcomes of resident care, and the necessity of being survey-ready becomes imminent. Nursing facility management staff MUST begin to focus more time and energy on survey management.

This article provides readers with important information regarding these changes and the intent of the new requirements, based on two [illegible] surveyor training sessions recently attended.

Some insight into the process can be gleaned from comments made by Wayne Smith, HCFA Director of Survey and Certification. He has [illegible]

"Even though there will be some minor adjustments in the 'final final' Interpretative Guidelines, there will be no radical change in the new requirements, as they exist today. The regulations bring into focus the real outcome-oriented survey process, but will deal with the same residents, the same buildings, the same professional staff members, and in many cases, the same surveyors...

"The new regulations raise the expectations of nursing facility outcomes only for those that have not been aggressively delivering rehabilitation care and services. There is nothing new about well-done assessments and a team approach to care planning...

"The regulations articulate specifically that nursing facilities must make every effort to halt, reverse, slow down, and/or refocus the degenerative process as aggressively as possible...

"Surveyors will ask whether facilities employed all of their resources to gain the highest possible goals for each of the residents it has accepted for care...

"The RoPs intent is to keep 'bad things' from happening to residents and to ensure that the facility has expectations for good things to happen to each resident."

As facility management staff plan implementation, there are four factors that must be integrated.

The Preamble

First, the preamble to the regulations (*Federal Register* 2/2/89) contains major themes and HCFA intent. As implementation decisions are made, the information in the preamble should be used with confidence as intended by HCFA guidelines.

The Regulations

A second factor vital to understanding the scope of the RoPs are the regulations themselves. Know and understand the new regulations and compare them with the regulations you currently have in place. To better understand the new expectations, focus on the environmental quality of life segment, the quality of care section, and the resident rights section.

Physical environments must do more that "look good." Nursing facilities must use available space and the entire environment as a partner in the functional independence goals for residents. The environment should reflect a home-like image and promote independence at all times.

Nursing facilities must also make reasonable accommodations for individual preferences; residents should have some control over their environment, including temperature, lights, and noise.

Surveyors will also be noting if the environment promotes social interaction between residents.

Significant emphasis will be placed on determining if each resident is receiving the highest possible care and services needed to attain and maintain his or her highest physical, mental, and psychosocial well-being, as stated in the comprehensive assessment and plan of care.

The survey approach to resident rights is intended to be holistic. Surveyors will be instructed to focus on the whole individual and the entire interaction with the facility and staff. They must be specific, yet discreet.

The Interpretive Guidelines

The third factor will be an understanding of the Interpretive Guidelines, which explain how surveyors are supposed to interpret the regulations and survey. It will be critical for providers to understand how the new survey process will work as they determine how they plan to comply. Education and serious management attention are imperative.

The final factor will be the survey process itself.

The Survey Process

The resident sample will be chosen at random, but weighted toward heavy care. Nurses on the survey team will follow the heavy care throughout the survey process. The observation process will start with a record review noting such things as:

- Does the assessment accurately reflect the resident?
- Does the plan of care reflect the assessment?
- Are all appropriate disciplines involved?
- Does drug therapy reflect the assessment and the regulations?

Surveyors will then continue observing the resident and the staff, keeping in mind the assessment and plan of care. They will evaluate the care that is given and then decide if regulations for this resident were met at the time of the survey.

As you plan, keep in mind that the resident assessment must be comprehensive enough to provide sufficient information to evaluate the resident's highest practical level of functioning and MUST be coordinated by appropriate professionals representing each of the disciplines involved.

Assessment results should be used to develop the plan of care, which must have measurable objectives and timetables. It must involve the interdisciplinary team, be in accordance with the highest professional standards, and emphasize a post-discharge plan for each resident.

The Institute of Medicine Study called for reform of both nursing home standards and the survey process. There will be a new emphasis on consistent and accurate surveyor decision making.

Surveillance is a critical component of the nursing home quality picture. Nursing homes must constantly evaluate their own performance and see opportunities to improve care and services. External surveillance can enhance this effort. But, surveillance is only valuable if the results are accurate.

The survey belongs to your facility. It is time for facilities to challenge unfair allegations in the survey process when they occur and, in the interest of accurate public information and in support of dedicated staff members, to ensure survey consistency and accurate reports. ■

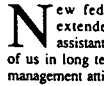
Jenean Erickson is administrator at Yorkshire Manor Health facility in Minneapolis, Minnesota. She is a member of AHCA's facility standards committee.

What We Need Is A New Attitude

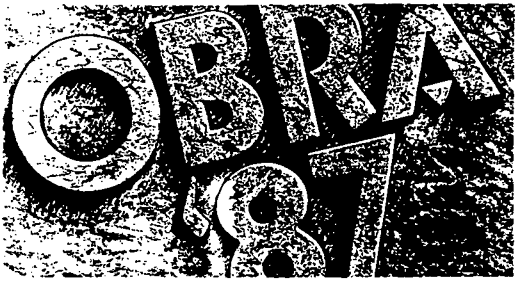
Nancy E. Hinkley

New federal requirements for extended and enhanced nurse assistant training now force those of us in long term care to examine our management attitudes toward, and expectations of, training and human resource development. For the nursing home in particular, 75 hours of training for each nurse assistant represents a significant investment. The prudent administrator and manager will take every step to assure that this investment is not only cost effective but also contributes to quality care.

Training does not guarantee improved performance and quality. Nevertheless, we are in the beginning stages of implementing a costly new training program in the long term care industry. The Congressional Budget Office of the U.S. government has predicted that the cost of implementing the nurse assistant training component of OBRA for the first year will be $55 million from federal funds and $45 million from state funds. This is a one-year cost of $100 million that will be borne by taxpayers, residents, families, and providers. The training cost is in addition to whatever is now being spent for orientation and training of total staff in the long term care facility. No one knows how accurate this figure is—but we can use it for illustration purposes.



Nancy E. Hinkley, EdD, is president of The Hillhaven Foundation, Takoma, Washington, where she is responsible for staff and activities expansion, funding sources, and the development of a research function. The Hillhaven Foundation has a 17-year history of commitment to improving the quality of long term care in a variety of settings.



Although the federal government has prescribed the amount of 75 hours training—not to include orientation—for nurse assistants and has identified specific content areas, it has left to the individual states the task of developing or approving the requisite 75-hour training programs and means for evaluating skills and performance through demonstration and knowledge and understanding through a written test. States are now designing their own systems for nurse assistant training and competency evaluation.

In a preliminary draft, one state proposes that the skills examination will consist of the individual demonstrating five skills, one from each of five skill categories; the nurse assistant will have three opportunities to pass the skills examination. The written exam will consist of 50 multiple-choice questions written at a 3rd to 5th grade reading level; the nurse assistant will have two hours to complete the exam and, at the option of the provider, may have three chances to pass this exam. This is very likely similar to procedures being developed in other states.

But $100 million spent so that nurse assistants can each demonstrate five skills and answer 50 multiple-choice questions written at the 3rd to 5th grade reading level is not "getting our money's worth!" Over the next few years, hundreds of millions of dollars will be spent on training in the nursing homes of this country. We have to remember:

- Training is not cheap.
- Training is not a quick fix.
- Training will not change the quality of care.
- Training will not guarantee performance.
- Training does not exist in a vacuum.

Given that this nurse assistant training will begin and will continue over time, given that it is a costly program, how can we "get our money's worth" out of this enormous investment? It will require a new role for administrators, managers, and corporate consultants, directors, and executives. As never before we will all need to be a part of a facility's training program. This applies whether the training is done in the facility or elsewhere, for the training program must be seen as only one element of the human resource development function of the facility.

An Open System

The facility itself must be understood as an open system of organization, wherein all people are interrelated and everyone affects the outcome of the organization. For example, as author R. Stryker points out in the book, *Reducing Turnover in Nursing Homes*, trained and well-qualified nurse assistants will move on if we don't provide them opportunities for job satisfaction. "We need trained nurse assistants to give improved care, but a well-trained effective nurse assistant is surely not going to remain with an employer who pays poorly, has capricious personnel practices, provides inadequate supervision, does not provide opportunities for expression of ideas, or lacks a host of other positive organizational factors."

Administrators and managers, *not* the trainer, must bear the ultimate responsibility for performance outcomes. Administrators and managers must also bear the ultimate responsibility for quality. There needs to be a *commitment* from the top down to the notion that people can and want to learn and want to do a good job. Also, there must be a positive *attitude* toward employees that emphasizes caring and communicating expectations. In addition, human resources development in a facility is an organization-wide *program* that includes orientation, coaching, appropriate and trained supervision, training and education, counseling, goal setting, and performance analysis.

When administration and management look more fully at the organization as a system and also embrace these three concepts—commitment, attitude, program—there will be the possibility of positive results of investments in training. Let's take a look at the facility as a system. Have you ever heard an employee return to the floor from an inservice only to be told, "Oh, don't pay any attention to what she (the trainer) said—we don't do it that way here on the floor!" That scene is probably repeated hundreds of times everyday in nursing homes throughout the country. A training problem? No, a systems problem. In their article, "The Systems View of Human Performance," authors Remmler and Brache write, "Most attempts to improve human performance in organizations are doomed to failure from the start....Any time we try to improve an individual's output solely by changing the input of knowledge or information or skills to that individual, we are making the naive assumption that the person exists in a performance vacuum. We are ignoring that the performance environment—that 'system'—has an enormous impact on the way people do their jobs and on the results the organization achieves."

What we learn from systems theory is that instead of always assuming that training is what is needed—how many times do we see the phrase "have an inservice" in a facility's plan of correction—we look to the entire system, including staffing, supervision, peer pressure, and management philosophy. We also learn that when we speak of goals or mission for the training function, we do not speak of the numbers trained or numbers passed or certified, but rather in terms of improving the organization's performance Then we begin to understand why we need to look beyond the training function—job performances takes place where? Out there. When? All the time. How? As a part of the system. Formalized classroom training or informal training will not produce long term changes in performance back on the job unless the atmosphere of the work environment forces individuals to use what they have learned and supervisors provide positive reinforcement.

THE SIMPLISTIC MYTH

Learning = Job Performance = Results

THE PRACTICAL MODEL

Learning = CAPACITY TO DO

Capacity To Do + Reinforcing Job Environment =
CHANGES IN JOB PERFORMANCE

Changes in Job Performance + Relevance To Real Needs +
Favorable Outside Conditions =
RESULTS AND PAYOFF

Management Commitment

The trainer can teach, the learner can learn, the learner can pass a test and demonstrate competencies, but none of these guarantees performance. In the open system, success takes place where there is a commitment to the notion that people can and want to learn and want to do a good job. Acting on this premise, learning, working, and succeeding together become a way of life for the organization. The administrator becomes the coach, as Peters and Austin eloquently describe in *A Passion for Excellence*: "There is no magic: only people who find and nurture champions, dramatize company goals and direction, build skills and teams, spread irresistible enthusiasm. They are cheerleaders, coaches, storytellers, and wanderers. They encourage, excite, teach, listen, facilitate. Their actions are consistent. Only brute consistency breeds believability: they say people are special and they treat them that way—always."

Role modeling as a coach will provide daily examples for staff. The simplest example is that of an athletic coach —rather than assuming a person can't do something or hasn't learned something, there are often words of support, "I know that you can do it." Our long term care staff need to hear that—especially nurse assistants who in many cases have had more than their share of negative life,

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'PUT YOURSELF IN THE PLACE OF THE RESIDENT...'

Stephen C. Biondi

For the past two years, OBRA '87 has lurked before us casting a shadow of doubt and anxiety among all operational facility staff. It is not so much the content of the OBRA regulations that is creating this anxiety. We believe whole-heartedly that the changes in OBRA will improve and enhance resident care throughout the country. The problem arises in implementing the changes consistently and appropriately throughout our facilities.

The first step in attacking OBRA implementation by each facility is to fully assess the changes identified in OBRA and disseminate and communicate those changes to key management and staff and department heads. In order for the new regulations to be a success, it is important that everyone have a full understanding of what the changes are as well as who is going to be responsible for ensuring that those changes occur. Obviously, it is necessary for the management staff of the facility to delineate responsibility for each of the components and create a plan with target dates to manage the implementation. The plan itself should incorporate training throughout all layers of the facility's organization while ensuring that a return demonstration technique is utilized for proper understanding.

The Admission

There are several key issues in OBRA that require potential changes in a facility. The first of these involves the admission process. Generally, facilities have admission documents and literature that they share with prospective residents and families prior to and upon admission. Under new OBRA regulations which stress residents' rights, these admission documents must be clear, concise, easy to understand, and be given to residents so that they will have an opportunity to review them after the admission has been completed. Due to specificity in terms of residents' rights, generally, residents will need to sign more documents upon admission. This may be viewed negatively by some, but overall it will ensure that both the resident and the facility are protected in terms of notification. It is also important that the admission process be carefully evaluated and revised.

Issue of Restraints

Another key issue that is inherent in OBRA as well as the new survey process is the reduction in the use of physical and chemical restraints. Obviously, facilities have an obligation to utilize restraints only when no other alternative is feasible. This means that the resident's behavioral manifestations and other psychosocial approaches must be fully assessed before a physician is approached regarding restraint usage. This requires a re-education of nursing staff and all staff in the facility to understand that observed wandering may be acceptable if it is not detrimental to the resident or problematic to other residents.

Security systems at doorways are most appropriate in assisting facility staff in managing the wandering patient. Considerable re-education is needed for staff to become accustomed to the reduction of restraints, both chemical and physical. It is also important that the state and federal survey staff understand the concepts employed by the facility upon entering into an agreement so that deficiency avoidance occurs. Facilities should share their approaches and plan for "restraint proper" concepts with state and federal survey offices so that a clear understanding exists. It is also important that families and friends of the residents fully understand what is occurring relative to the facility's approach. Meetings for educational purposes work well in informing interested parties of the facility's efforts.

Like anyone else, nursing home residents are most content when their environment suits their needs. Therefore, facility staff need to be cognizant of what residents prefer in terms of room accommodations, room lighting, personal effects, personal furniture, and other quality of life concerns. For example, one resident may wish to clutter her overbed table with personal memorabilia since that is how she preferred it in her home. Another resident may wish to wear the same dress five days a week after bathing since that is what she has done in the past. In order to understand the resident's prior history, a complete assessment must be done, and these personal factors should be addressed during that assessment.

Assessment of the resident upon admission and routinely as a resident's needs change is a cornerstone of how we care for that resident. All staff must be re-educated on how to properly assess each individual. This could be accomplished quite efficiently through a monthly training plan that is broken out into small, tangible components. Over time, nursing and other professional staff could become more adept at assessing the resident's needs and identifying the appropriate plan of care.

The Power of Choice

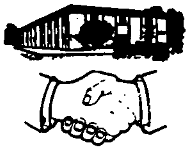
How many of you like to choose an entree when going to a restaurant or going through a cafeteria line? Well, most of us prefer to choose. It is important that certain choices be made available to residents in all areas of care. For example, when preparing entrees and vegtables for a meal, a facility should offer a second choice of entree and vegetable so that the resident can exercise his or her right to choose. If evaluated properly, a choice of entrees can be just as cost effective as providing one major entree for each meal. Perhaps the facility can start out with a choice of two or three different desserts and eventually go to entrees and salads as choice items.

What about shower times or whether to take a shower or bath on a certain day? Providers can set up a system in their facility to request resident choices upon admission and a mechanism for them to alter their choices as time goes on.

The key component in OBRA is the implementation of a quality assurance committee and program. Through a quality assurance program, a facility can identify areas that are weak and recognize those that are performing well. One of easiest ways is to incorporate existing standing committees and expand their role to be quality assurance oriented. Providers can take key aspects of the new survey process and utilize those as audit criteria to determine how well they're doing. Be sure to specify quantifiable outcomes so that success can be measured against a standard.

Although we have a few months remaining to complete our implementation of the changes addressed in OBRA, I feel that our industry as a whole will do so with enthusiasm and creative ingenuity. Each step that we take to improve the lives of the residents within our facilities is a step closer to being in harmony with our expectations for care if we were the recipients for that care. One parting thought to providers: If you are unsure as to whether your approaches to implementing OBRA have been successful or not, put yourself in the place of the resident and honestly share your opinions. ■

Stephen C. Biondi is vice president of quality assurance and clinical services for Unicare Health Facilities, Inc., in Milwaukee, Wisconsin.



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work, and educational experiences. We cannot afford to say that we don't have time to be a coach; we cannot afford to say that it's not our style to be a coach; we cannot afford to say that coaching is someone else's job.

Administration and management must have a positive attitude toward employees that emphasizes caring—the human part of human resource development. It is not reasonable to expect our employees to be more caring to our residents than we are to them as employees. Nurse assistants will treat residents the way that they perceive that they are treated. Can we learn to put ourselves in that particular nurse assistant's shoes? Additionally, administration and management must have a positive attitude toward the training function. We must see it not only as a requirement and an administrative responsibility, but also as the single most important tool to help achieve goals of high-quality care and financial stability.

Human Resource Development System

Human resource development is a program, a system unto itself, not merely a collection of inservice classes offered to meet minimum requirements, not merely the offering of 75 hours of nurse assistant training, not merely the perfunctory required 16 hours of orientation, but a meaningful system that works toward individual and organizational goals. The system is so effective that line managers naturally work with and take over responsibility from the trainer. Transfer of learning from the classroom to the work setting is expected, for supervisors and managers are held responsible for the day-to-day job performance and the employee's integration of new skills. There is an old adage, "When there is a problem, do not fire the doer, fire the supervisor." Harsh language perhaps, but it lays it on the line—the trainer is responsible for learning and evaluation, the supervisor is responsible for daily job performance. Most of us tend to believe the simplistic myth: Learning =Job Performance= Results. We need instead to consider a more practical model: Learning = Capacity to Do; Capacity to Do + Reinforcing Job Environment = Changes in Job Performance; Changes in Job Performance + Relevance to Real Needs = Favorable Outside Conditions = Results and Payoff (see charts on page 16).

The Hidden Challenge

We have taken a giant step forward with OBRA-related nurse assistant training. We need trained caregivers. The nursing link lies in the day-to-day environment created by management. Only careful attention by management to the second and third steps of this practical model will make the job training worthwhile. So, what can we conclude?

- Training will not guarantee quality care.
- Training will not guarantee a caring and productive staff.
- Training will not guarantee leadership—at any level.
- Training cannot compensate for underfunded programs.
- Training cannot compensate for understaffing.
- Training cannot compensate for language/communications barriers.
- Training cannot compensate for lack of understanding of the systems of the organization.

With first-year start-up costs for OBRA required training estimated at $100 million, we must be assured that we will get full value for this investment. Training is needed—but alone it offers no guarantee of performance. Management and trainers alike must understand the concept of transfer of learning. We should remember that passing a competency test is no guarantee of desirable work performance. The facility should be seen as an open system in which the administrator and managers, not the trainer, bear ultimate responsibility for performance outcomes. The work environment must motivate individuals to use what they have learned, and supervisors must be available to monitor performance and to provide positive reinforcement.

Finally, the expenditure of time and dollars for OBRA-related or any other type of staff training must be viewed as an investment rather than a requirement, so that trainers and managers alike become accustomed to looking for ongoing performance outcomes rather than the results of paper compliance competency testing. ■

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POSITION STATEMENTS

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Table of Contents

ADVANCE DIRECTIVES

Every American has the right to self-determination as set forth in the Bill of Rights and echoed in the Code of Ethics of the American College of Health Care Administrators.

This right includes the ability to make decisions regarding the quality and duration of one's life.

When an individual becomes physically or mentally unable to make informed decisions regarding their medical treatment, that person's power of self-determination can be preserved through advance medical directives.

Through a living will and the designation of a spouse, family member, friend or legal counsel as having durable power of attorney for health care, the individual retains control over life-affecting decisions. These documents help ensure that the wishes of the individual are known and carried out to the extent legally possible.

The American College of Health Care Administrators supports efforts to bring about advance directives in every state in the nation.

The College recommends that multidisciplinary committees be established to institute advance directives in states where they do not currently exist. These committees would include members of the medical, nursing and legal professions, general citizens, elderly groups, and health care administrators.

Upon adoption of advance directives in their state, health care administrators are encouraged to institute skill-development programs to train personnel in the implementation of the directives. The creation of ethics committees within nursing facilities are also recommended for problem-solving on a case-by-case basis.

Furthermore, the College actively supports efforts by administrators to promote the use of advance directives both within the nursing home milieu and in the community-at-large.

February 1990

ADMINISTRATOR'S RESPONSIBILITY

Whereas, the administrators of long-term care facilities place the health, welfare, safety, and happiness of the patient/resident before all else; and

Whereas, the ACHCA National Standards of Practice for Long Term Care Administrators delineates the scope of practice and defines the administrator's role in setting and implementing policies to ensure quality patient/resident care; and

Whereas, the role and responsibilities of other licensed health professionals such as physicians and nurses are governed by relevant practice acts; and

Whereas, the conduct of such licensed health professionals is subject to review by the appropriate state licensure board;

Now be it therefore resolved that the ACHCA affirms that the administrator shall establish and implement to the best of his/her ability measures which assure that patient/residents health and safety are not endangered; and

Be it further resolved that the administrator shall not be held culpable for the professional practice of other licensed health professionals unless such culpability is the direct result of administrative negligence in performing the role as delineated in the ACHCA *National Standards of Practice for Long-Term Care Administrators.* (***Journal of Long-Term Care Administration,*** Vol.15. No. 1, Spring 1987, p. 11.)

March 1988

RESOLUTION ON LONG-TERM CARE NURSING

Whereas, The American College of Health Care Administrators is committed to quality patient/resident care; and

Whereas, the caring and competent nurse is the linchpin in direct provision of quality care in long-term care settings; and

Whereas, all nursing personnel involved in direct patient care, specifically, registered nurses, licensed practical nurses/licensed vocational nurses, and nurse aides have a direct impact on the quality of care and the quality of life of long-term care patients/residents; and

Whereas, the shortage of nursing personnel at all levels is critical within the long-term care sector.

Be it therefore resolved that the American College of Health Care Administrators supports efforts to enhance the image of the long-term care nurse, to recruit individuals into long-care nursing, and to encourage nursing personnel to make career commitments to long-term care; and

Be it further resolved that the American College of Health Care Administrators desires to facilitate communication and work with other long-term care and nursing organizations to make long-term care nursing a desired, respected, and rewarded career.

March 1988

LICENSURE OF LONG-TERM CARE ADMINISTRATORS

Within the therapeutic milieu of the long-term care facility, the administrator is the key individual who not only provides leadership in policy determination, but also sets the tone for the total program.

The knowledge and attitudes of the administrator have a critical impact on medial care, as well as on the entire staff's sensitivity to emotional, social, behavioral and mental problems among the residents. Moreover, the administrator is the primary contact with families of the residents and the community.

The critical role the administrator plays in the delivery of quality care and the enhancement of quality of life for the residents of long-term care facilities has long-been recognized by professionals in the field. The American College of Health Care Administrators has a quarter-century history of dedication to quality services through competent and caring administration.

The College requires adherence to a Code of Ethics for its membership and has in place a strong self-regulatory system for monitoring and taking action on alleged violations of that Code of Ethics. The Code includes assurance of quality for those we serve.

National Standards of Practice for nursing home administrators which define acceptable procedures for providing quality care to nursing home patients and residents have been established and will be used by state licensure boards when reviewing nursing home administrators.

Through a major grant from W.K. Kellogg Foundation and with support from Procter and Gamble, the College developed a professional certification program for long-term care administrators. This voluntary certification program has been cited as a model for other health professions, in that the program includes measures of both knowledge and skills and comparisons of individual results with national standards of competency for professional administrators.

Through the Foundation of the American College of Health Care Administrators, research efforts and other policy determination activities are conducted to increase the knowledge base and enhance decision making in the long-term care arena.

Educational programs which keep professional administrators on the cutting edge of new technologies and management skills required in these changing times of health care are developed and evaluated.

It is the College's position that professional standards of excellence, specifically the Code of Ethics, Standards of Practice, and Professional Certification Program, should be incorporated by all licensure boards and regulatory bodies in determining criteria for admission to retention in, and reciprocity for, the practice of long-term care administration. Furthermore, all administrators of long-term care services, including hospital based facilities, foster care programs, Veterans Administration facilities, and any other program or facilities which provide long-term health care, should be held to the same standards.

January 1987

RESOLUTION OF PATIENT CARE

Whereas, the administrators of long-term care facilities are faced with one of the most complicated and consequential assignments in today's society; and

Whereas, many people seeking admission to long-term care facilities are more frail and in more serious physical condition than in previous times; and

Whereas, regulatory and reporting requirements place increasing time consuming documentation demands on administrators; and

Whereas, administrators are under increasing pressure to be responsive to varied and splintered segments of society, including governmental bodies, consumer groups, third-party payors, regulatory agencies, and others.

Now therefore be it resolved that the American College of Health Care Administrators affirms that patient/resident care is the foremost concern of long-term care administrators. Ensuring the quality of services to the nation's elderly is a paramount responsibility of the long-term care field.

Be it further resolved that the administrator will place the health of the patient resident before all other role expectations and dedicate his/her career to achieving quality patient resident care.

May 1986

PRINCIPLES OF LONG-TERM CARE FINANCING

Long-term care financing is a paramount concern of all professions related to aging. Representatives of five major national organizations associated with long-term care and aging began meeting in mid-1985 to develop a policy statement on long-term care financing that would cut across disciplinary interests and provide generic solutions.

These organizations were the ACHCA, the American Association of Retired Persons, the American Health Care Association, The American Association of Homes for the Aging, and the National Association for Home-Care. The work of this group resulted in a document titled, ***"Principles of Long-Term Care Financing."*** The ACHCA Board of Governors adopted the principles in September, 1986.

Central to these principles is a commitment to quality patient-resident care based on sound financial support. Protection against catastrophic cost accompanying long-term care services would be based on the concept of risk pooling.

Universal coverage for all ages would be provided within the parameters of a single system of care.

The financing systems would be developed with private-sector emphasis, (a minimal government role), and employ case management utilization control to assure that services were being delivered in a setting that was congruent with patient needs. The benefits under the financing arrangement would be provider-neutral.

The informa-case network (primary family) would maintain its vitality and viability. Flexibility, competition, and individual choice would also be preserved.

September 1986

QUALITY CARE

The major focus of the American College of Health Care Administrators is on quality assurance activities that enhance the knowledge and skills of professional administrators and assure quality care and quality of life for nursing home patients and residents.

The American College of Health Care Administrators supports the following premises related to quality assurance:

I. Voluntary credentialing, accreditation, and self-regulatory programs are more effective in assuring quality care than government regulations and surveillance programs. Voluntary programs reflect a professional commitment to providing quality care. They both protect the public and facilitate the identification of competent professionals and quality institutions.

The individual's participation in the voluntary assessment, analysis, and remedial action programs of certification and accreditation assures the integrity of the quality assurance efforts.

During the past several years, there have been a number of instances of increased government regulation of the nursing home industry and, thereby, the profession. Yet reports such as the *Institute of Medicine Study* (1986) and the *Heinz Study* (1986) highlight poor quality care. It appears as though the amount of government regulation and current surveillance techniques do not correlate positively with quality care.

Instead, surveillance techniques to assure compliance with government regulations indeed may have a major negative impact on quality care.

A recent study by Mullen(1985) demonstrates a direct relationship between dealing with regulatory agencies and causes of stress among nursing home administrators. This important study revealed the following conditions to be the greatest source of stress for nursing home administrators: (1) inconsistencies among government surveyors' interpretations of rules and regulations; (2) negative attitudes of surveyors; and (3) negative attitudes and conduct supporting such attitudes by legislators.

In another 1985 study of nonrenewers of membership by the ACHCA, it was found that approximately 34% had left the profession.

The ACHCA supports many of the conclusions of the *Institute of Medicine Study*, and in fact has testified before the Committee on Nursing Home Regulations of the Institute of Medicine (Siebel, 1984) to endorse:

A. Implementation of a revised system of surveys that at a minimum, incorporates the following elements:

1. A flexible survey cycle of 90 days to two years, based on the history of the facility.

2. Adoption of a system of both screening surveys and abbreviated surveys that would allow for a predetermination of the need for a full survey.

QUALITY CARE

3. Licensure and certification that could be granted for variable periods of up to three years.

4. A reevaluation of the current set of standards, with the goal of reducing the number of items to focus on patient care-related items and eliminating the sources of elements and factors that have little relationship to quality.

B. In conjunction with our first recommendation above, a system to make better use of the complaint investigation procedure already in place, in lieu of frequent surveys of all facilities regardless of past performance. In increasing the importance of the complaint system, it should be required that complainants identify themselves to the regulatory agency for their complaints to be investigated but continue to remain unidentified to the facility involved.

C. Broader authority to the survey agencies to have access to the owners of facilities when a facility administrator cannot or will not provide necessary corrective action to identified problems. While guidelines would be needed to avoid abuse of this increased authority, we understand that there are instances when a facility administrator, despite being the licensed professional responsible for the operation of the facility, is not in a position to make changes. In those instances, regulators need access to those entities that hold ultimate control, and we support well written guidelines which provide that authority.

D. Expand the scope and nature of the "exit conference" to insure that all surveyors who participate in the survey are available to the facility personnel at the conference, and strengthen the requirements that all standards or conditions that are being placed out of compliance be divulged and discussed at the exit conference.

E. Eliminate placing the facility as a middleman between the regulators and any physician who has a patient in a nursing home. Instead, regulatory agencies should discipline those physicians who feel they are not following the intent of the rules.

F. Expand the use of geriatric nurse practitioners in nursing homes to assist in the monitoring of quality of care and to provide those patient-related services that, by training and experience, they are capable of providing.

G. Expand the scope of the present survey process for state licensure and Medicare/Medicaid certification by including a facility administrator and, possibly, a facility director of nursing on the survey team.

H. Allow for the inclusion of a citizen, who may or may not be a family member of a resident, to participate both in survey of a facility and in the analysis of a state survey agency.

I. Establish minimum suggested guidelines for surveyors, which would include requirements for formal education, experience in the health care field in general and in long-term care specifically, minimum salary levels, and continuing education to keep surveyors abreast of changes in the field they are regulating.

J. Establish criteria to open lines of communication between regulators and facility professionals, outside of the formal survey process. Periodic meetings, including joint in-service training on changes in the field and discussions of ways to improve the process, should be encouraged.

K. Work together to remove the barriers to wider use of nongovernmental programs to improve quality.

L. Begin work cooperatively, instead of competitively, with regulators and third-party payors, particularly Medicare and Medicaid.

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The ACHCA does fully share the conclusion in the Institute of Medicine Study that regulation is not sufficient for high-quality care. The ACHCA supports a complementary and synergistic combination of government regulations to deter poor care by facilities and voluntary programs to assure quality of life for nursing home patients and residents.

II. Standards for entry into a profession, professional competencies (both initial and continuing), professional practice, and ethical behavior should be national in scope; should be established and monitored by the professional society; and should adhere to the principles of professional peer review, with input from the public. Professional codes protect consumers, enhance public health and safety, and effectively encourage the maintenance of high standards of conduct. Input from the public is an important safety valve for professional societies. Operationally, the ACHCA effects this philosophy through the election and selection of peers and public members on its Professional Certification Committee which develops standards and review applications for professional certification.

III. The government is vigorously encouraged to provide incentives to voluntary programs through recognition of such programs in governmental licensure requirements, facility certification programs, and third-party reimbursement programs. If voluntary programs are assumed to be more effective in assuring quality care than government surveillance and regulations, then the government ought to recognize successful involvement in these programs as an alternate to governmental surveillance programs.

IV. The long-term care profession and industry are at a distinct disadvantage among the health professions and within the health industry with regard to substantial acceptance of voluntary standards of programs for several reasons:

A. The industry as a "health care" provider and the profession are relatively young.

B. Because of the newness of the industry and profession, national standards and self-regulatory programs had not been fully developed or implemented before the 1970s, when, as a result of its role as purchaser of services, the federal government began to exert control over the industry and profession through an external regulatory system.

C. Concurrent with this new plethora of government regulation and surveillance in the 1970s was the rise of the consumer movement in the United States. The industry and the profession dealt with one of the most emotionally laden issues in America: the placement of a loved one in a nursing home. The consumer movement helped to expose certain nursing home practices that resulted in poor quality care. The effect of this consumerism no doubt was increased sensitivity by providers, as well as consumers and the government, to programs that assure quality care to nursing home patients and residents. Unfortunately, the route to quality assurance selected by the government and consumer groups has been only increased government regulations and surveillance.

As voluntary programs were developed during the 1970s and 1980s, and were tested and found to be valid and reliable ways of assuring quality, it was difficult to educate an emotionally involved group of consumers already biased toward government intervention regarding the value of voluntary certification and accreditation.

D. The ACHCA acknowledged the need for, and supports the con-

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cept of, continued research on and development of quality assurance strategies for long-term care with emphasis on the predictive validity of the voluntary certification and accreditation standards, on determining indicators of quality of life in long-term health care, and on measuring the relationship between quality-care and quality-of-life indicators and the costs of assuring them. Clearly, a standardized data collection system to form a data base on long-term health care is required for these efforts. The ACHCA supports the development of this kind of national data base.

It is unfortunate that the response of the national media to the Institute of Medicine Study has focused only on the negative aspects of care provided by nursing homes in the United States today. The public is left with the impression that quality assurance activities do not exist. The truth is that there exist a number of effective voluntary programs that assure quality care and quality of life for nursing home residents.

The ACHCA has long been active in quality assurance activities. It has developed national standards of practice for nursing home administrators that define acceptable procedures for providing quality care to nursing home patients and residents.

The ACHCA is constantly developing educational programs that keep professional administrators on the cutting edge of new technologies and management skills required in these ever-changing times of health care delivery. Presently, the College offers 42 educational programs, with 59 nationally acclaimed experts serving as faculty.

Through a major grant from the W.K. Kellogg Foundation, the College has developed a professional certification program for long-term care administrators. This voluntary certification program has been cited as a model for other health professions, in that the program includes measures of both knowledge and skills and a comparison of individual results with national standards of competency for professional administrators.

Candidates for professional certification assess their knowledge and skills during a three-day examination process; review the results in relation to the national standards of competency; prepare a professional development plan designed to strengthen any areas of weakness; have the plan reviewed by a panel of nationally elected peers and public members; and implement the plan over a five-year period. A reassessment occurs every five years.

Even those professionals whose knowledge and skills meet or exceed the national competency standards are encouraged to develop a plan to assure that their knowledge and skills are continually upgraded.

The College requires adherence to a Code of Ethics for its membership and has in place a strong self-regulatory system for monitoring and taking action on alleged violations of that Code of Ethics. The Code includes assurance of quality care for those we serve.

It is incumbent upon the profession and the media to inform the public about the quality assurance activities of organizations such as the ACHCA in order to relieve the anxiety caused by the media to nursing home patients, their families, and the families of potential nursing home patients who are in the process of making a very difficult personal decision. It is equally important and necessary that the federal government recognize and support voluntary quality assurance efforts in order to most effectively insure quality care and quality of life for nursing home residents.

September 1986

RESOLUTION ON RECIPROCITY

Whereas the Professional Certification Program has been organized to promote quality patient/resident care through better long-term care administration; and

Whereas state licensure boards have an important responsibility recognized, by the Professional Certification Program, to assure that individuals entering the profession meet "minimal, entry level requirements in the protection of the public's health, safety, and welfare..."

Now therefore be it resolved that the American College of Health Care Administrators (ACHCA) endorses the principle of cooperation between state licensure boards and the Professional Certification Program in relation to professional standards for nursing home administrators; and

Be it further resolved that ACHCA recommends that each individual state licensing agency responsible for nursing home administration consider the granting of state licensure by reciprocity for professionally certified and licensed administrators who can suitably demonstrate knowledge of state rules and regulations; and

Be it finally resolved that ACHCA recommends that each state consider granting a partial waiver of continuing education requirements to those individuals who are currently certified by the Professional Certification Program.

January 1982

CODE OF ETHICS

AND

STANDARDS OF PRACTICE

AMERICAN COLLEGE OF HEALTH CARE ADMINISTRATORS
325 South Patrick Street ▲ Alexandria, Virginia, 22314-3571 ▲ (703) 549-5822

THE AMERICAN COLLEGE OF HEALTH CARE ADMINISTRATORS

CODE OF ETHICS

PREAMBLE

The preservation of the highest standards of integrity and ethical principals is vital to the successful discharge of the professional responsibilities of all long-term health care administrators. This Code of Ethics has been promulgated by the American College of Health Care Administrators (ACHCA) in an effort to stress the fundamental rules considered essential to this basic purpose. It shall be the obligation of members to seek to avoid not only conduct specifically proscribed by the code, but also conduct that is inconsistent with its spirit and purpose. Failure to specify any particular responsibility or practice in this Code of Ethics should not be construed as denial of the existence of other responsibilities or practices. Recognizing that the ultimate responsibility for applying standards and ethics falls upon the individual, the ACHCA establishes the following Code of Ethics to make clear its expectation of the membership.

EXPECTATION I — Individuals shall hold paramount the welfare of persons for whom care is provided.

PRESCRIPTIONS: The Health Care Administrator shall:

Strive to provide to all those entrusted to his or her care the highest quality of appropriate services possible in light of resources or other constraints.

Operate the facility consistent with laws, regulations and standards of practice recognized in the field of health care administration.

Consistent with law and professional standards, protect the confidentiality of information regarding individual recipients of care.

Perform administrative duties with the personal integrity that will earn the confidence, trust, and respect of the general public.

Take appropriate steps to avoid discrimination on basis of race, color, sex, religion, age, national origin, handicap, marital status, ancestry, or any other factor that is illegally discriminatory or not related to bona fide requirements of quality care.

PROSCRIPTION: The Health Care Administrator shall *not*:

Disclose professional or personal information regarding recipients of service to unauthorized personnel unless required by law or to protect the public welfare.

EXPECTATION II — Individuals shall maintain high standards of professional competence.

PRESCRIPTIONS: The Health Care Administrator shall:

Possess and maintain the competencies necessary to effectively perform his or her responsibilities.

Practice administration in accordance with capabilities and proficiencies and, when appropriate, seek counsel from qualified others.

Actively strive to enhance knowledge of and expertise in long-term care administration through continuing education and professional development.

PROSCRIPTIONS: The Health Care Administrator shall *not*:

Misrepresent qualifications, education, experience, or affiliations.

Provide services other than those for which he or she is prepared and qualified to perform.

EXPECTATION III — Individuals shall strive, in all matters relating to their professional functions, to maintain a professional posture that places paramount the interests of the facility and its residents.

PRESCRIPTIONS: The Health Care Administrator shall:

Avoid partisanship and provide a forum for the fair resolution of any disputes which may arise in service delivery or facility management.

Disclose to the governing body or other authority as may be appropriate, any actual or potential circumstance concerning him or her that might reasonably be thought to create a conflict of interest or have a substantial adverse impact on the facility or its residents.

PROSCRIPTION: The Health Care Administrator shall *not*:

Participate in activities that reasonably may be thought to create a conflict of interest or have the potential to have a substantial adverse impact on the facility or its residents.

EXPECTATION IV — Individuals shall honor their responsibilities to the public, their profession, and their relationships with colleagues and members of related professions.

PRESCRIPTIONS: The Health Care Administrator shall:

Foster increased knowledge within the profession of health care administration and support research efforts toward this end.

Participate with others in the community to plan for and provide a full range of health care services.

Share areas of expertise with colleagues, students and the general public to increase awareness and promote understanding of health care in general and the profession in particular.

Inform the ACHCA Standards and Ethics Committee of actual or potential violations of this Code of Ethics, and fully cooperate with ACHCA's sanctioned inquiries into matters of professional conduct related to this Code of Ethics.

PROSCRIPTION: The Health Care Administrator shall *not*:

Defend, support or ignore unethical conduct perpetrated by colleagues, peers, or students.

April 1989

STANDARDS OF PRACTICE FOR LONG-TERM CARE ADMINISTRATORS

AMERICAN COLLEGE OF HEALTH CARE ADMINISTRATORS

September 1986

Preamble

The long-term care administration profession is committed to providing comprehensive health, personal, and social services for persons who require various therapeutic, protective, and supervised environments and milieus. As leaders of the profession, members of the American College of Health Care Administrators are dedicated to advancing the general welfare through education, research, professional achievement, and a code of ethics. The Board of Governors of the College attests to this commitment by adopting, publishing, disseminating, and applying the following *Standards of Practice*. These *Standards of Practice* are the profession's statement of conditions and performances which are essential for quality long-term care. As an overriding principle, the long-term care administrator is expected to exercise sound judgment and decision making, assume leadership in his/her facility and community, and exemplify an administrative philosophy in congruence with the mission and goals of the organization.

I. General Administration

A. Develops long and short range objectives in order to assure that facility programs and resident care are maintained and improved.

B. Interprets the philosophy and goals of the facility in order to provide staff with adequate information to select appropriate objectives to attain the goals.

C. Sets an example of good resident relations and care for staff by demonstrating desired supervisory techniques and resident and family interaction.

D. Delegates responsibility and authority to appropriate staff in order to carry out the work of the facility.

E. Evaluates the quality of resident care and the efficiency of services in order to maintain care standards by reviewing the achievement or non-achievement of the facility's goals, objectives, patient care plans, and adherence to management policy and procedures.

F. Coordinates departmental activities to assure departments work together toward the achievement of goals and activities by developing an information and communication system between departments which keeps them informed and allows the administrator to be informed of their activities.

G. Communicates with staff to solve problems through the selection of the appropriate communication techniques, staff meetings, department head meetings, counseling, and coordination of written information.

H. Prepares or assures the preparation of an annual budget of the facility in order to appropriately allocate resources to meet the facility's financial and program objectives and to prepare in advance potential cost control and managerial actions which may be required.

I. Ensures that the facility complies with federal, state, and local laws and regulations to meet standards of quality resident care.

J. Maintains a safe and productive working environment for staff in order to provide quality care through the use of regular inspections, allocation of resources for facility maintenance and construction, and periodic evaluations of staff morale and productivity.

K. Improves the information and administrative skills of oneself through professional development activities in order to direct effectively and efficiently the operations of the facility to assure high quality care.

Requisite knowledge and skill areas include:

- Communications
- Goal setting and implementation
- Health care system
- Long-term health care directions and state of the art practice
- Management science and practice
- Needs assessment (facility, organizational, and personal)
- Planning, implementation, evaluation strategies, and methodologies
- Problem solving/decision making
- Resource allocation/management

With expertise in:

Resident care
Personnel management
Financial management
Marketing, public/community relations
Physical resource management/safety
Public sector/regulation

II. Resident Care

A. Ensures quality resident care through planning, implementation, and evaluation of nursing services to maintain maximum health potential; social services to meet psychological and social needs and rights; dietary services to meet nutritional requirements and needs; medical services to ensure appropriate medical care; activities to meet the social recreational and therapeutic recreational needs; medical records program to ensure continuity of care; pharmaceutical program to support appropriate medical care; and rehabilitation services that will maintain and/or maximize potential of residents; auxiliary services as necessary to enhance quality of life for residents; and environmental services to provide a pleasing environment.

B. Recruits, hires, and provides ongoing education for a health care team in order to assure quality care of the long-term care resident.

C. Obtains and coordinates consultant services as needed for total care (dental, speech and hearing, pharmacist, OT, PT, mental health, etc.) by matching needs of residents with services of consultants.

D. Coordinates the development and evaluation, with the health care team, of resident care goals and policies in order to assure that adequate resources, environments, and services are available to the residents.

E. Meets regularly with health care team to assure good care is being delivered.

F. Recruits a qualified medical director and develops a professional relationship with the medical director that ensures a well planned and implemented medical care program.

G. In cooperation with the medical director, maintains strong relationships with community medical practitioners including attending physicians and physician extenders.

H. Develops communication between facility staff and the residents in order to assure a caring environment with appropriate nursing and psychosocial services.

I. Develops facility standards for resident care by identifying those factors which affect care, as well as variables within each factor which can be adjusted and evaluated.

J. Develops program to assure staff adherence to Patient Bill of Rights.

Requisite knowledge and skill areas include:

- Communication methods for dissemination and implementation of patient care policies
- Current literature, research, and regulations on the establishment of care standards and relevant factors (i.e., nursing, medical care, etc.)
- Family counseling/consultation
- Interpersonal relations
- Legal rights of residents including privacy, right to information, and informed consent
- Medical and psychosocial needs of the elderly and chronically ill
- Nursing, medical care, social services, activities, food services, medical records, pharmacology, and rehabilitation
- Resident care plans and goals
- Psychology of aging
- Quality assurance
- Responsibility of health care team in developing resident care plans, goals, and policies
- Roles and practices of clinicians
- Social, emotional, physical, and financial needs of residents and their families
- Staffing patterns necessary for quality care

III. Personnel Management

A. Coordinates the development of and disseminates written personnel policies and procedures including job descriptions, employee expectations, employer benefits, and performance appraisal processes.

B. Demonstrates adherence to established personnel policies and procedures.

C. Promotes productivity and good morale among personnel to assure good resident care by providing motivation, a good working environment, and recognition for quality work.

D. Creates a positive atmosphere for communication between management and the work force through receptive management and the use of various media.

E. Establishes clear lines of authority and responsibility within the staff in order to assure understanding and production of quality work and the methods for its accomplishment.

F. Recruits and hires departmental supervisors who are qualified to meet the requirements of their position by identifying a number of qualified individuals, screening applicants, interviewing, and hiring the person who most closely meets the requirements.

G. Coordinates the development and implementation of personnel policies and procedures based on the goals of the organization in order to assure fair and efficient procedures are followed in recruitment, hiring, employment, and termination of staff.

H. Establishes wage and salary scales which attract competent staff while maintaining costs within budget.

I. Plans, implements, and evaluates a training program to facilitate adjustment of employees to the organization and the job through appropriate educational methodology.

J. Plans, implements, and evaluates a program which will provide an opportunity for the personal growth and development of employees through a performance evaluation process.

Requisite knowledge and skill areas include:

- Analysis of absenteeism and turnover rate
- Development of personnel policies, regulations, and laws including grievance procedures, job descriptions,

continued

labor, tax, minimum wage, and EEOC laws, workmen's compensation and other fringe benefit requirements and wage and benefit scales for staff and the current market value of labor in different job description categories
- Employee recruitment, assessment, motivations, and recognition methodologies
- Information and communication channels within the facility
- In-service training needs assessment program planning, costs, implementation, and evaluation
- Organizational theory, lines of authority and responsibility, job description development and maintenance
- Recruitment and interview techniques, job description development, hiring practices and wage scales for different supervisory positions
- Staffing methodologies and patterns including job analysis techniques
- Written and oral communication techniques for effective employee relationships

IV Financial Management

A. Plans, implements, and evaluates an integrated financial program to meet the facility's goals

B. Coordinates the development of a budget which assures allocation of fiscal resources to meet regulatory requirements and provide quality services at a reasonable cost

C. Evaluates the implication of budget on the quality of care

D. Uses generally accepted accounting practices in accordance with sound financial management

E. Establishes financial controls, checks, and balances in order to keep facility operations within budget

F. Projects and monitors cash flow, investments, and capital expenditures to ensure financial stability

G. Projects income and identifies revenue sources in order to meet the financial goals of the facility

H. Transfers the financial goals of the governing body into management plans and budgets in order to achieve these goals by selecting appropriate objectives such as facility size, growth, structure, level of care and service, staffing, etc., to meet these goals.

I. Plans future programs and estimates costs in order to reach decisions on growth, expansion, building, staffing, and investment by identifying objectives of the future programs and their cost

J. Projects insurance needs of facility and secures appropriate coverage

K. Analyzes current financial performance to ensure conformance with long-term goals and standards of quality

Requisite knowledge and skill areas include:
- Ancillary and other revenue-producing sources
- Capital budgeting
- Cost components for service programs, expansion of facility, and new construction
- Economic trends/industry trends
- Financial analysis (i.e., resources, revenues, financial ratios)
- Generally accepted accounting practices (i.e., budgeting, cash flow, inventory, banking, auditing procedures, fixed costs, variable costs, investments, collection, billing, purchasing, etc.)
- Industry standards
- Interpreting financial results for Board and/or appropriate staff
- Insurance needs of facility
- Loan acquisition
- Materials management
- Patient financial screening, banking procedures, and account management
- Payroll procedures
- Regulatory requirements for budgeting
- Reimbursement regulations
- Tax laws and reporting
- Techniques for determining reasonable costs/pricing

V Marketing, Public/Community Relations

A. Plans, implements, and evaluates a public relations program to enhance the positive image of long-term care services

B. Establishes and maintains community relationships which enhance the image and services of the facility in the community by providing outreach services and information to the community

C. Establishes and maintains programs which enhance relationships among residents, their families, and the facility

D. Plans, implements, and evaluates a marketing program to advertise and provide the services of the facility

E. Seeks to maintain occupancy of the facility at an optimum level in order to assure adequate financial resources by applying marketing and outreach techniques, knowing financial requirements of the facility, and delivering quality resident care at a reasonable cost.

Requisite knowledge and skill areas include:
- Community organizations (civic, religious, social, etc.) and importance of participation in community organizations
- Effective public speaking
- Forecasting techniques for demand for care
- Marketing of long-term care services and programs
- Media relations
- Medical/health care providers in community
- Information dissemination techniques for community awareness of services of the facility
- Outreach services, their cost and impact on referrals and community opinion
- Public relations principles

VI Physical Resource Management/Safety

A. Plans, implements, and evaluates a program for maintenance of building, grounds, and equipment

B. Plans, implements, and evaluates a program of environmental services, which will provide a clean and attractive home for residents/patients

C. Implements and evaluates a safety plan which will ensure the health, welfare, and safety of residents/patients, staff, and visitors

D. Plans, implements, and evaluates employee health, safety, and educational programs which minimize the nursing home's exposure to liability

E. Develops, implements, and evaluates a fire and disaster plan to protect the safety and welfare of residents, staff, and property

Requisite knowledge and skill areas include:
- Architectural/environmental design for the elderly and the handicapped
- Building codes
- Community emergency resources
- Effective training and practice resources and procedures for emergencies
- Evaluation procedures for housekeeping and physical plant
- Housekeeping procedures
- Infection control
- Materials management
- Preventive maintenance
- Procedures for designating responsibility in emergency planning
- Pest control
- Safety and fire regulations in Life Safety Codes as well as local ordinances
- Sanitation procedures
- Security measures

VII. Governance/Regulations

A. Interprets federal and state regulations as they relate to the facility in order to assure compliance and efficient integration of these regulations with the established policies and procedures of the facility

B. Directs compliance of facility with government regulations in order to provide good resident care by knowing these regulations and how to meet their requirements

C. Monitors medical reporting, staffing, and procedures in order to assure compliance with regulations and quality care

D. Evaluates staff work procedures and policies to assure compliance with federal and state regulations

E. Keeps the governing body informed by preparing management reports in order to facilitate decision making by the governing body

F. Interprets the governing body's philosophy and goals to the staff in order to assure that the board's intent is followed and established policies and procedures reflect the governing board's philosophy

G. Acts as liaison between the governing body and regulatory agencies

Requisite knowledge and skill areas include:
- Affirmative Action/Equal Employment laws and regulations
- Area agencies on aging and ombudsman function
- Decision making process of the governing body
- Government regulations and guidelines (facility, life and safety, resident care, etc.)
- Governing body's philosophy and goals
- Information needs of the governing body
- Labor laws
- Legislative process
- Licensure and certification
- Long-term care survey process and procedures
- Medicare and Medicaid
- Methods for complying with government regulations and guidelines
- Preparation and format for management reports
- Procedures to monitor facility compliance with reporting, charting, review, and staffing requirements
- Professional licensing boards
- Quality assurance
- Regulations affecting reimbursement, capital expenditure, ownership, disclosure, and reports
- Regulatory agency practices
- Resident Bill of Rights
- Responsibility of administrator and governing body for compliance with regulations
- Tax laws (proprietary and nonprofit)

by SUSAN M. SMITH, JANIS M. CAMPBELL and HELEN C. LUKSIC

I-C-9

Secrets of Success in Long-Term Care

Flexibility and participative management provide an atmosphere conducive to excellent patient care and staff job satisfaction.

Why are there "good" long-term care nursing facilities and "excellent" ones? How do you facilitate successfully the operations of a nursing facility when multiple factors impact on day-to-day events? How do you develop at all levels an enthusiastic, caring, competent staff, who are responsive both to short-term and long-term care needs of the residents? The answer lies with nursing management, those who provide the leadership and direction and serve as catalysts for needed change.

Successful nurse administrators in long-term care (LTC) expertly identify the problems and issues hindering the accomplishment of organizational and resident care objectives, plan alternatives to solve these problems and issues and persistently strive to implement needed changes through organizing and directing the staff's activities. To continue the management cycle, they diligently evaluate, evaluate *and* evaluate the effects of the changes, making modifications and adjustments as needed in the original plan and implementation process. Sound vaguely familiar? It should — it's the nursing process all over again. It is also the universal conception of management, better known as the "traditional model" described by the acronym PODC (planning, organizing, directing and controlling).[1]

The key nurse administrator in an LTC facility is the Director of Nursing (DON). Considering the reimbursement rate of long-term care, the ever-looming recruitment competition of desperate acute-care facilities, and the devalued "image" of long-term care nursing staff, how can the DON recruit competent and stable staff so that resident care is provided expertly, with both intelligent and compassionate continuity? It is possible, and is being done successfully by Friendship Village in the greater Dayton, Ohio metropolitan area. Founded in 1972, this is a multi-level retirement community composed of 385 residential units for independent living and 97 skilled care beds in the health care center.

At Friendship Village, the key to success can be attributed to the persistent efforts of the DON in fostering an environment which encourages participatory management and shared responsibility. Under the leadership of a 32-year nursing veteran, and with the support of the facility's administration and Board of Directors, the changes made at Friendship Village over the last 12 years have earned it the right to be called "state-of-the-art" in care provision for older adults. Dedication and hard work, a strong belief in restorative care, and an intense interest in the ongoing development and monitoring of the nursing staff have been important contributors to that success.

The nursing philosophy at Friendship Village is refreshingly straightforward and simple — "the belief is in rehabilitative and restorative care for the older adult versus maintenance care ... the staff is taught that they are caring for a loved one and they are held accountable for care outcomes." A conscious effort is made by nursing management to be available to residents and their families and to the nursing staff, to discuss concerns and to help solve problems.

When Friendship Village's DON took the position, major changes occurred to foster nursing stability and staff commitment. The facility's administration agreed to allow the DON full authority to make the changes needed in order to enhance resident care. A "confrontation-negotiation" style of leadership became necessary to meet issues directly and enable resolution in a limited time.[2] Risk-taking became a daily occurrence, and changes were proposed with the realization that some efforts would be rewarded with positive outcomes and others would not.

The events which followed paralleled the rational model of organizational change: recognition of the problem, identification of possible courses of action to achieve the desired performance and implementa-

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tion of the chosen action within the organization.[3] Because the provision of quality care to residents was the motivating concern for change, problems were approached related to specific needs of the residents rather than in terms of the mechanics of the problem itself.[3] Despite confrontations, the final stage of the rational model, adoption (acceptance of the implemented change by organizational players) also was achieved — although not without a price. For the first six years, long, sometimes frustrating, hours were devoted to encouraging the changes and promoting the teamwork needed to facilitate the adoption stage.

Significant changes

The first action initiated was to correct a performance gap in care provision by undertaking a major overhaul of the staff. Hiring focus was on identifying personnel who not only were enthusiastic about caring for older adults, but viewed their work as a career rather than "just a job." An Assistant DON (ADON) was hired to assist with staff development, policy and procedure development and to monitor compliance with federal and state regulations for reimbursement.

Adhering to the restorative care framework, new emphasis was placed also on the physical therapy department. In the past, a physical therapist (PT), hired on a contractual basis, was the sole person in the therapy department. Personnel changes included hiring a full-time PT, supported by a Rehabilitation Aide and a Restorative Nursing Aide. A major policy change also was implemented that required *all* residents to receive a mandatory PT evaluation. Friendship Village now boasts a staff of six in the PT Department, who work closely with the nursing staff to achieve restorative care goals.

The next priorities were to promote staff professionalism, education and flexibility. Capitalizing on the belief that the older residents tended to identify the nurses as the "ones in white," the professional nursing staff changed from their multi-colored uniformed attire to their traditional white uniforms and caps. This change was applauded unanimously by the residents and inspired a new sense of confidence and purpose in the care providers.

To address the problem of retaining dedicated and competent nursing staff, scheduling flexibility was initiated. For the professional nursing staff (RNs and LPNs), the typical eight-hour shifts were replaced with 12-hour shifts. Full-time status was defined as three 12-hour shifts a week, with the requirement to rotate working every other weekend. The 12-hour shift change had the active support of the nurses and substantially improved staff morale and productivity, as well as reducing the nursing shortage problem.

A concentrated effort was placed on staff education in order to train adequately newly hired staff members and retain the seasoned ones. Providing knowledgeable, competent and satisfied nursing professionals was the overall goal. The largest percentage of the health center's budget, beyond salary needs, is devoted to staff training. Every newly hired nurse participates in a planned orientation program which includes the typical review of policies and procedures, along with inservice education about normal changes and common chronic and clinical conditions in older adults. This information is augmented by practical application of the knowledge on the nursing units with mentoring provided by an experienced RN staff member. Additionally, each nursing staff member is required to take the Cardiopulmonary Resuscitation (CPR) and Emergency Medical Training (EMT) courses offered by the American Red Cross and area hospitals. These initial courses and annual refresher courses are paid for, without hesitation, by Friendship Village.

Under the supportive guidance of the DON, ADON, and other nursing staff members, the nurses continue to develop and nurture their repertoire of assessment skills which are essential for providing quality long-term care nursing. Peer support and inter-staff education and sharing are encouraged. Since the aging process causes many changes in the older person which are not seen in other parts of the population, careful, on-going assessment of the older adult is directed at preventing complications and maximizing functional abilities. Skilled monitoring and implementation of medical interventions (i.e., medications and treatments) and nursing actions directed at preventing the undesired consequences of these interventions also are required. Educational emphasis is on instilling the importance of the staff member as the resident's personal advocate and liaison with the medical and nursing staff. Nursing care plans, utilizing the nursing process and the nursing diagnosis format, assist the staff in communicating the priority needs of residents.

Staff flexibility was advocated to enhance the quality of care for the residents. Versatility of the staff was viewed as an essential component of smooth operations. Although continuity of care is an important consideration, the professional staff is interchanged among the four skilled nursing care wings. This approach is successful in preventing the possible boredom which could come with a long-term care caseload. Additionally, it tends to increase the nurse's assessment objectivity, resulting in an increase in frequency of nursing interventions when providing resident care.

Flexibility also extends to the nonprofessional staff. For example, to ensure that the residents received hot breakfasts, arrangements were made with the housekeeping staff to begin their shift at 7:30 am (rather than the customary time of 8 am), in order to feed the residents who require help. PT aides also are required to replace nurse aide positions when sick calls and vacation days occur. These displays of teamwork and inter-staff cooperation have strengthened the feeling of camaraderie among staff members and have added to the goal of improving resident care.

Using participative management theory, full-time professional staff members are given the opportunity to assume administrative responsibilities that are necessary to resident care and required by federal and state regulations. Decentralizing these responsibilities places the decision-making responsibility on the persons directly involved in the residents' care, and thus improves the overall quality of care provision. Additionally, the pride of being solely responsible for a specific area heightens nurses' self-esteem and confidence, which is reflected noticeably in direct care provision. These opportunities for additional responsibility include coordination of professional staff education, education and supervision of nurse aides, monitoring infection control issues in the health care center and care plan coordination with the professional staff members. The extra time devoted to these additional responsibilities is rewarded with compensatory time, taken at the discretion of the nurse and the DON, and with paid attendance at formal educational programs directly related to the chosen area of additional responsibility. No problem has been identified in finding nurses willing to assume the additional work; instead, they are eager to accept these duties, have performed exceptionally well and have enjoyed extra recognition for completing work beyond their role's usual expectations.

Although nursing autonomy and independent judgment are valued highly at Friendship Village, nursing management believes in regular supervision to monitor and maintain standards of care. Reinforcement of positive caring behaviors and prompt feedback to discourage undesirable staff behaviors are considered paramount to successful care provision. The DON makes nursing rounds at least once daily, while the ADON completes unit rounds regularly throughout the day. Both resident and staff feedback are elicited in order to identify any performance gaps in care. Walkie-talkies are used to ensure accessibility of nursing management to the facility staff.

In summary, the care at Friendship Village is "state-of-the-art" for many reasons. The key variable in the formula for success is the ability of the DON to provide strong leadership and apply creative and effective management techniques. Staff members are motivated because nursing administration takes an active role in interdependent decision-making and care provision. Quality care can flourish and thrive only in an atmosphere conducive to openness, trust and support from management. ☐

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ENSURING QUALITY CARE THROUGH PARTICIPATIVE MANAGEMENT

Linda C. Pulley

New regulations, budget cuts, staffing shortages, and maximum utilization of staff are all familiar issues in today's long term health care environment. Therefore, it is imperative that employee productivity increases so that residents receive quality care. The guidelines for implementing quality assurance programs are clear. The challenge, however, is to reach expected outcomes despite fiscal constraints and staff shortages. This can be accomplished by ensuring a quality work life for nursing staff and by establishing a participative style of management. Together, these measures can assure quality resident care.

Nursing's role in the quality assurance process is paramount because of its impact on the entire long term care facility. The quality of care that a resident receives can easily be overlooked or compromised when there are limited resources and a lack of focus. The nursing staff's quality of work life can also be ignored when faced with a multitude of demands. Effective management of these concerns will yield results that are beneficial to the resident, staff, department, and facility.

Meeting the Challenge

Quality assurance programs monitor and evaluate the quality of resident care. A key ingredient to any quality assurance program is providing employees with a quality work life through the practice of participative management. Quality work life is essentially the fulfillment of employee needs by the employer. This occurs, for example, when employers provide each employee with opportunities for personal growth and development, and enhancement of self esteem.

> ***"Quality circles incorporate and use staff knowledge to guarantee quality."***

Participative management allows those employees who are directly involved with the work functions to participate in their organization's decisionmaking process. For example, in a nursing home, participative management would encourage input from the nurse assistant, who spends more time with the resident than any other discipline. This technique also permits workers to find solutions to problems that they have identified.

Quality care cannot be rendered by a dissatisfied employee who has no stimulus for increased productivity. Quality of work life and quality circles are both concepts of participative management. Increased morale, commitment, and greater job satisfaction are all signs of a concerned, satisfied employee. They are also natural byproducts of a quality work life.

Program Structure

The implementation of a successful quality assurance program in nursing is a challenge. Management sets the tone, and its commitment—reflected through support, training, and reinforcement—determines the program's success.

The quality assurance program begins at the department committee level. The committee, which consists of nursing management and a representative of staff from all levels, plans the program and identifies goals and objectives. Education and training are the key to implementation. The committee must understand the definition of quality assurance, reasons for implementation, roles and expectations of staff, motivational and problemsolving techniques, and team-building concepts.

Utilizing Quality Circles

Quality circles incorporate and use staff knowledge to guarantee quality. They focus on the voluntary involvement of groups of employees in the decisionmaking process. The groups, consisting of approximately 3 to 10 employees, are trained in problemsolving techniques. The object of the quality circle is to identify, analyze, and develop solutions to work-related programs, while making recommendations to management at appropriate levels for implementation.

Quality circles work particularly well at the unit level because the managers have a knowledge and an understanding of the employee for whom they are responsible. Unit-level staff meetings (all three shifts), chaired by the charge nurse/unit manager, provide an opportunity to focus on quality assurance issues, and they permit staff to identify problems. Resident falls, medication errors, and infections are problems that are applicable to quality assurance/quality circles. A trained manager welcomes the input and is able to motivate staff to find solutions. The opportunity for a smooth, continuous flow of information, as well as recognition and achievement of staff, are natural outgrowths of quality circles.

The utilization of participative management and quality circles is not the panacea to all of the problems in nursing. However, these management techniques are inherent to a quality work life, and they can increase productivity while being cost effective. Most importantly, the use of participative management and quality circles can be an assurance that residents are receiving quality care. ■

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Quality of Care

Team Approach Makes This NY Dementia Care Unit Work

A multidisciplinary team approach and one-on-one attention from a primary care-giver offer numerous advantages to dementia patients served by Morningside House in the Bronx, NY. This 386-bed not-for-profit facility provides special programs to its residents as well as to persons in the community.

The facility established its first dementia care program in 1977, after its leadership observed that a large number of "ambulatory confused" patients could not be categorized easily as requiring either intermediate or skilled care, recalled Cynthia Wallace, RN, MS, executive vice president of Morningside House and of Aging in America, an affiliated agency serving community-based elderly.

An integral part of the organization's success in managing dementia patients is its "whole team approach," she said, which combines therapeutic recreational programming, family support, and multidisciplinary assessments involving a physician, nurse, dietitian, and social worker.

Nurse aides, serving as primary caregivers, also are assigned to specific patients indefinitely. As a result, they "don't have to guess, 'Does this woman wear glasses? Does this woman have a hearing aid?' They get to know their patients very well ... and are able to notice a changing condition and call someone's attention to it much more quickly," she said.

The primary care concept worked so well on the Alzheimer's unit that Morningside House has expanded it throughout the facility. "Now all residents have a primary care giver, and all units have a team," said Wallace. For example, each unit has its own recreational therapist and dietitian.

Because New York's resource utilization group (RUGs) reimbursement methodology for nursing homes initially left out Alzheimer's patients, many of these patients remained in the community with their families. To offer some respite to these families, Morningside House decided in 1986 to open an adult day care program, again using the whole team approach. The facility now operates two such programs in the Bronx and in Westchester, each serving mostly Medicaid clients.

The program worked so well that Morningside House established a similar in-house day care program for its residents "to improve the quality of their lives. The residents with Alzheimer's come off their regular nursing unit and spend the day in what we call our SHARE (Specialized Help for Alzheimer's in a Residential Environment) program," Wallace said.

A nursing-social work-physician team operates the program, which serves about 50 residents. One group of 25 residents attends the program three days a week, and another group of 25 attends two days a week.

To be eligible for adult day care, patients must have a diagnosis of Alzheimer's disease or some type of dementia. "They come in the early stages; they come in wheelchairs; and they come incontinent," Wallace noted.

Administrators who are planning special programs for dementia patients should consider ways to provide a full spectrum of services, she recommended. "If you are interested in providing continuity of care to a patient with Alzheimer's, this is a great way to do it because you're serving them while they're still in the community. Then you have quality programs in place to support them when they do come into your facility."

Associate Degree Nursing

Nursing Home

National League for Nursing
10 Columbus Circle
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Partnerships Between Nursing and Nursing Home Residents

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Consumers fully appreciate the critical role of nurses in nursing homes. Nurses are in the forefront of creating and maintaining a healthy living and working nursing home environment. Still, nurses can and must be doing much more if all nursing homes are to provide quality care and life for their residents. Those nurses who do make a difference do so in partnership with allies within the nursing home and within the community. In our remarks, we draw on the inspiration and direct experience of very special nurses who have shown us what can be done.

PARTNERSHIP

Partnership between nursing and nursing home residents starts with personal caregiving. Nurses must see themselves as partners to residents and must see residents in all their strength and ability, not just in the context of their needs and disabilities. Many nurses have experienced situations in which residents who had appeared out of touch or unable to relate to their circumstances actually connected in astute and powerful ways when new or different caring practices were used or new opportunities or choices provided. It is a necessary challenge for all of us continually to seek strength in the people we serve. But as nurses focus on residents' well-being, in the broadest sense of the word, they must necessarily reach beyond immediate interactions with residents.

To build partnership with residents, nurses need to build partnerships with everyone else concerned with quality care, including community friends and advocates, other caregivers within the nursing home, and the entire nursing staff, especially nurses' aides. Each of these allies in the effort to achieve quality care in nursing homes has an important role to play and needs the support of others committed to the same end.

Beyond the care setting, nurses can have a major impact in the policy arena as advocates for development, implementation, and enforcement of the laws and regulations necessary to achieve quality care.

The bottom line in partnership is mutual support for mutual effort. Nurses can not and should not shoulder the effort alone. By relying on others inside and outside the nursing home who are committed to quality care, nurses can accomplish a great deal more. Nurses are in the forefront of leadership when they are open to the community, to other professionals, to co-workers and staff, and to residents.

Partnerships with the Community

Community involvement takes many forms. Long-term care ombudsmen serve as officially designated advocates for residents. Other community groups may also advocate for residents, as a natural extension of the friendships that develop through visiting and other outreach programs. Some assist in support of resident and family councils. Many advocacy groups promote extension of community services and social activities to nursing home residents. Community organizations often provide public education about nursing homes and encourage public involvement in policy development and discussion.

The National Citizens' Coalition for Nursing Home Reform (NCCNHR) works to support all of these endeavors. Ultimately, our vision is that nursing homes will be viewed as a vital part of a neighborhood and that the community will relate to nursing home residents as friends and neighbors. Advocates know fully that no institution can, or should be asked to, meet all the needs of all who live there. Communities need to do a great deal more to serve their neighbors in nursing homes. Nursing home nurses can support community involvement and help channel it where it can be of greatest help to residents.

In this effort, it is necessary to first work cooperatively with the long-term care ombudsman program. Ombudsmen optimally are facilitators and can help amplify the voices of residents. While ombudsmen/advocates and residents raise concerns, they do not expect perfection in every aspect of human interaction within the nursing home. Advocates hope to find, among nursing home staff and management, an openness to listen to residents and a genuine desire to respond constructively and cooperatively to their concerns.

Because ombudsmen/advocates and nurses alike share a common goal—to achieve quality care in nursing homes—they need each other's support, information, and perspective. Ombudsmen/advocates can serve as strong allies in support of needed changes within the nursing home, community, or public policy arena.

While it is natural to be sensitive about criticism, it is important to remember that the ombudsmen/advocates' role is to voice concerns that already exist, that have not been resolved, and, therefore, need to be addressed. If nurses can see ombudsmen/advocates as partners in the effort to achieve quality care, then they can be catalysts to assist the facility to face problems that staff are well aware of but unable to address alone. Ombudsmen/advocates can facilitate needed discussion within the community of people who live and work in the facility. Ombudsmen/advocates can provide leverage and support to staff who want to do a good job but cannot on their own overcome the constraints that exist by choice or circumstance within the nursing home.

Ombudsmen/advocates need cooperation as they work to understand your nursing home, what may be causing problems that concern residents, and what may be the best way to resolve such problems. Residents need your support to reach out for outside assistance when needed. The ombudsmen/advocates' effectiveness depends on the full and willing participation of nursing home staff who ultimately must believe in and carry out any activities to resolve identified problems.

Ultimately, ombudsmen/advocates and nursing home staff should be able to call upon each other to assist in efforts of mutual benefit, such as petitioning the community-at-large for more support and services to residents and working for regulatory and legislative reforms.

Nurses are welcome advocates on all issues affecting nursing home care, not just on issues specific to their profession. When nurses call for more support for social workers, activities professionals, and others, they lend great strength to efforts to achieve needed services by other qualified professionals. When nurses advocate for stronger residents' rights protections, better inspections and enforcement, and prohibitions against Medicaid discrimination, they help build a system that will allow and promote more humane treatment for residents.

Working to strengthen public policy in relation to all aspects of nursing home care, instead of focusing narrowly on nursing-specific issues, can help make the nursing home environment a healthier place in which to work and live.

Partnership Among Nursing Home Staff

The same principle holds true in each individual nursing home. Nurses need to work in mutual collaboration and support with the other professions within the home. As true partners to residents, nurses need to advocate for the best care residents can receive from all qualifieid professionals.

When professionals expend energy debating who is in charge or who is better qualified to direct or perform a given service, it is residents who lose needed services and support. Service providers also lose because, regardless of whether or not they are better qualified to conduct a particular activity, no individual or individual discipline alone is able to do *all* that needs to be done.

To be partners with residents, nurses need to draw on the best possible participation their co-workers can have in every aspect of a resident's care. In turn, nurses need to respond positively when called upon to support and participate in aspects of care that do not originate in their domain but in which their assistance is needed.

Given the complex human dynamics in nursing homes, most care situations are multi-dimensional and require multi-disciplinary approaches. Participation by all appropriate professionals in the assessment and care planning process is essential. Nurses are in a prime position to advocate for interdisciplinary involvement. Nurses must approach care delivery from an interdisciplinary point of view as well. Nurses can support the work of activities professionals by directing staff to be available to bring residents to scheduled activities. Nurses can benefit from counseling by a social worker when a resident faces emotional stresses that affect his or her condition or his or her responsiveness to medical interventions. It is basic good nursing care to advocate for the involvement of other professionals to support residents' physical, mental, or psychosocial well being.

Nurses can do much to weave cooperation among disciplines into the very fabric of nursing home life. Nurses can:

- Use the new quality assurance committee mandated by the 1987 Nursing Home Reform Amendments (contained in *PL 100-203*) as a vehicle for identifying problems and solutions among disciplines.
- Routinely seek consultation and share information to maintain a collective understanding of residents' needs and strengths and to support each others' efforts to create a good nursing home environment.
- Establish routine formal and informal interdisciplinary care planning sessions.

- Include other department heads in preservice and inservice training sessions for aides and bring other disciplines into the nursing school classroom.
- Assign student nurses to rotations with other health professionals during the clinical part of their training.
- By their actions, set an example for student nurses and aides that multidisciplinary teamwork helps everyone do their job better, for the benefit of residents and staff.

Partnerships Among Nursing Staff

Teamwork among all nursing personnel is essential. Nurses need to see licensed practical nurses (LPNs) and nurse aides as partners and support their efforts to care for residents. Providing a good working environment fosters better care. Aides, in particular, need appropriate supervision and support, training, sufficient numbers of co-workers with the right mix of skills, and enough supplies and equipment to respond to residents' needs.

Aides need to be treated with dignity to influence their ability to do their job with loving kindness. They need continuity in their job assignments and a good match with co-workers and residents. In NCCNHR's work with residents, we consistently find that residents identify interaction with nurse aides as the key to quality care. Kind, caring staff who provide opportunities for choice, treatment with dignity, and respect for their individuality were identified as key by residents in NCCNHR's 1985 study, *A Consumer Perspective on Quality Care: The Residents' Point of View*. When nursing home staff discuss what makes their work satisfying, their rapport with residents is a prominent factor.

Continuity of job assignments enables residents and staff to establish rapport sensitive to residents' individuality. Aides need proper orientation to the specific residents to whom they will be assigned, including proper training in special skills that may be needed to provide care to those residents.

Teamwork, communication, and role-modeling that draws on the strengths of staff are basic principles of good management. Nurse supervisors can do much to enable staff to support residents' dignity and autonomy. For aides and LPNs under their charge, nurse supervisors can:

- Provide more flexibility in the work routine to accomodate residents' personal preferences.
- Build more restorative care exercises and social interaction time into the caregiving routine.
- Schedule time for personnel to help residents attend planned activities or pursue their own individual or group interests.

- Encourage all personnel to call upon and work with other health disciplines to learn about and share insights about residents' strengths, weaknesses, interests, and needs.
- Establish support groups in which all personnel raise questions, air concerns, share experiences, and provide their perspective on how to improve living and working conditions within the home.
- Take a team approach to caregiving, among staff and across care disciplines.
- Include all nursing personnel in assessment and care-planning sessions for residents to whom they are assigned.
- Conduct frequent mini-care conferences to determine how individual assignments are progressing and how the unit is functioning overall.

These ideas are drawn from care practices that work in nursing homes. Good mangement practices keep lines of communication open among staff and between staff and supervisors. They provide opportunities for employees to contribute their knowledge and experience to evaluate and improve overall facility operations and individual care situations.

Nurses can offer a powerful voice in public policy debate, advocating for policies that create a better working environment, such as sufficient staffing levels, training for aides, better wages and benefits, recognition of the important work aides do, and certification to acknowledge aides' achievement of a certain level of competence. Aides have the most direct and consistent contact with residents of any staff in the nursing home. They face an almost impossible work challenge and need the support, trust, and encouragement of nurse supervisors and the nursing profession to care for residents in a humane and empowering manner.

Partnership with Residents and Families

As partners to nursing home residents and their representatives, nurses must work in a way that supports residents' self-determination and helps residents to be the most able they can be. The care agenda must be resident driven.

How Residents Define Quality Care. In our 1985 study, *A Consumer Perspective on Quality Care: The Residents' Point of View*, we convened discussions among groups of residents in 15 cities. We asked what made life good for them and what could make their lives better. Across the country, the most frequent answer was *staff*. Residents described the following factors as important characteristics of staff:

- Helpful.
- Kind, nice, good to residents.

- Enough numbers of staff.
- Respectful of residents' dignity.
- Polite and courteous.
- Friendly, cheerful, pleasant.
- Patient, interested, takes time with residents.
- Listens, talks, takes residents seriously.
- Relates to others positively with good personality.
- Qualified, trained, skilled.
- Well-supervised.
- Continuity/tenure.

Residents discussed how important choice and self-determination are to the quality of their lives. They identified their interest in exercising choice in:

- Food.
- Time to get up and go to bed.
- To come and go in and out of the facility.
- Privacy.
- Activities.
- Roommate and room assignment.
- Bathing.
- Doctor and medications.
- Meeting with the administrator and staff regarding problems.
- Personal care attendant.
- Whether to have the television on or off; noise level and channel.
- To help oneself or not.
- To participate in outside activities with transportation.
- To do by ourselves what we are able to do.
- To live in a nursing home or not.
- The kind of choices we would have if we lived in the community.
- Simple choices of daily living.
- To know what our choices are.

The message from residents in our 1985 study was clear and affirming of the best instincts of many service providers. Their needs are quite simple and basic. Yet our ability to meet their needs has been elusive. Why don't these basic ingredients to quality care occur routinely in nursing homes?

Why Residents Don't Receive Quality Care as They Define it. Society is plagued by low expectations of what kind of life nursing home residents can actually live. Residents and caregivers share these low expectations that also pervade nursing home care and nursing home regulation.

Most people come to live in a nursing home in the face of growing disability or significant losses in their personal lives. The losses are real and would set back individuals of any age or circumstance. But at other stages of life, people are expected to bounce back. People who enter nursing homes, however, are expected to become more dependent and limited.

Just as at any other stage in life, here too, nursing home residents need tremendous support to work hard and fight their way back from the physical and emotional setbacks that have brought them to the nursing home. At this point, the way they are treated by staff can dictate the qualtiy of the rest of their lives. Staff need to move beyond compassion to help empower each nursing home resident to regain control of his or her life to the greatest degree possible.

How Does Our View of Residents Affect Their Care? The challenge to residents and service providers alike is to see and work toward residents' potential rather than to focus on and aim toward their weakness.

Many service providers have experienced turn-arounds when residents who seemed so disabled or disoriented were clearly able and very oriented. Often what made the difference was an opportunity for the resident to contribute or connect. We must be aware of how much a resident's circumstances and environment affect his or her behavior and abilities, as would be true for any of us in any situation.

Our own perspective in a given situation certainly impacts on a resident's self-view. For example, do we see a cane as a sign of dependence? Perhaps that cane is a sign of independence because it is an enabler—enabling an otherwise dependent individual to remain mobile and steady on his or her feet.

How can We Overcome These Artificial Limitations. We need continually to relate to each individual's strength and provide opportunities for each resident to do the same. We must draw on who each is as a person—how they have survived until now—what they bring to where they are. We must start where they come from, with what is important to them. We know full well that physical rehabilitation and restoration of ability is a painful process. Emotional rehabilitation—restoring nursing home residents' ability to rely on themselves and exercise self-determination—requires painful practice as well. Any of us who have faced emotional challenge know that after the grief and the loss, we gain strength, ever so slowly, and the process of survival and recovery usually makes us stronger. Caregiving in nursing homes needs to provide emotional as well as physical healing and rehabilitation.

We fully recognize that some individuals suffer tremendous mental disability. Though they present a greater challenge, many residents who are unable to function mentally on traditionally healthy levels are still able to express preferences and react with pain, sorrow, delight, and pleasure to their circumstances. More able nursing home residents often have learned how to live beside others with mental disability and have found creative ways to communicate with and understand their neighbors, methods that can serve as valuable models for nursing home staff.

Operationalizing Empowerment in Caregiving. How staff talk with residents, how staff care for residents, what choices are routinely available to residents, how staff explain services and options, how much control residents may actually exercise over their lives—each of these situations provides an opportunity for nursing home staff to foster resident empowerment and autonomy in the daily operation of the facility. Here are some specific ideas:

- Involve residents and their representatives in the assessment and care-planning process.
- Provide help and services geared toward self-help, such as restorative nursing and maintenance therapy.
- Encourage residents to continue to try to do as much as they can for themselves.
- Staff sufficiently to allow time for staff to encourage and wait for residents to act independently.
- Be open to alternatives and creative in balancing residents' rights and staff responsibilities.
- Seek and utilize advice from individuals and groups of residents in all service areas, such as dietary, acitivities, nursing, quality assurance, and housekeeping.
- Utilize residents' energy and talents to improve life for other residents (for example, ask residents to welcome and orient new residents).
- Foster connection and activities among residents that promote friendship and social and intellectual interaction.
- Provide opportunities for residents to feel more at home (for example, have areas available for residents who may wish to visit guests privately).
- Involve residents in hiring, orienting, and evaluating staff.
- Involve residents in orientation of new staff assigned to their care.
- Utilize residents in providing inservice programs on residents' rights, communication skills, and nursing skills.

- Routinely ask residents to help evaluate the home's care and identify how care should be improved.

Fostering Sensitivity to Residents' Empowerment in the Nursing Classroom. Nursing schools provide opportunities for students to become sensitive to resident empowerment as a critical part of their role as nurses. A few ways to do this include:

- Utilize residents in the classroom for residents' rights discussions and to provide the care recipient's perspective on basic nursing skills (for example, have a resident talk about the experience of being spoon fed or washed or being incontinent).
- Place greater emphasis on residents' rights and quality of life in the nursing curriculum. Offer communication and management skills classes. Generate debate on how to resolve apparent conflicts between residents' rights and staff responsibilities.
- Assign students to work with resident and family councils, and with other nursing home staff as part of a clinical experience.
- Role play disabilities so students can begin to understand how it feels to be dependent. Ask residents with disabilities to talk about how they compensate for their losses and how they survive.
- Collect and disseminate best nursing practices which promote empowerment.

Speak Out. In the classroom, in the nursing home, in public policy debates, nurses must continue to join in the call for nursing home improvements for:

- Sufficient staffing levels, among all echelons of nursing and non-nursing personnel.
- Better wages and benefits for all nursing home staff.
- Comprehensive aide training consistent with the needs and educational characteristics of aides.
- Comprehensive multi-disciplinary assessment.
- Requirements for qualified professionals in nursing homes, such as activities directors, social workers, dietitians, and others.
- Strong resident and family councils.
- Strengthened ombudsman programs.
- A good inspection system and effective enforcement of standards.
- De [illegible] imbursement levels and accountability for public funds

CONCLUSION

Those nursing home nurses who do speak out have already provided a powerful voice in the struggle to achieve quality care in nursing homes. Yet the silence among the majority of nursing home nurses is deafening and disheartening. NCCNHR fully appreciates the difficult challenge faced by nurses in nursing homes and believes nursing home nurses have not yet tested the full weight of their influence. Nurses must stand up for quality care and residents' rights, drawing upon experiences that serve as models and visions of what is possible in nursing homes.

Nurses can reach out to the concerned public, ombudsman/advocacy programs, co-workers, and residents, to break down the barriers to quality nursing home care. Expanding the vision of what is possible, nurses join the ranks of courageous residents, staff, and advocates who work toward what can be a more positive nursing home environment.

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Primary Nursing:

It Works in Long-Term Care

Adaptation is the byword in implementing a successful primary nursing system in nursing homes.

by Susanne Devine Campbell, MS, RN, C

How can gerontological nurses assure the delivery of individualized, high quality care which results in therapeutic attainments for the older adult? Nursing's goal in long-term care facilities has been to provide individualized nursing care which guarantees each elderly person the opportunity to reach his or her maximal level of physical, mental, social, and spiritual well-being. This challenge—to develop and implement individualized programs of care incorporating both reactive and proactive interventions—has been ever present. The triumphs and, at times the failures, of health professions to reach this goal within the nursing home field are real.

In the past years, the scandals within the nursing home industry drew national attention to our shortcomings.[1,2,3] While one may attribute some of these horror stories to sensationalized reporting, the exposure required the nurse to reflect on the deficiencies and competencies existing within both the practice and delivery systems. In questioning this it was felt an evaluation of the limitations imposed by the "team" modality of delivering nursing care was necessary.

Team nursing, the traditional nursing care delivery system in long-term care, operates by dividing the nursing staff into task-oriented teams aimed at meeting the patient care needs.[4] There are some intrinsic difficulties one encounters when operating within this system.

A significant factor that interferes with insuring continuous, responsible nursing care is that the team of people assigned to care for the patient today may not be the same team assigned to care for that patient tomorrow. There may be day-to-day accountability, but no one person is assigned the responsibility for developing and implementing a holistic plan of care for the elderly patient. While the work may get done, the nursing care delivered is often fragmented, with no one nurse responsible for the care delivered.

From a management perspective, the head nurse is generally given the authority and responsibility for insuring the quality of nursing care on a particular unit. Because of this, family members, patients, and multidisciplinary team members may all seek audience with the leadership person. This frequently leads to an inunduated and ineffectual middle manager.

Attempts to effect change within the team system through such approaches as corrective action or recognition of quality nursing care may be difficult to realize, given the limitations imposed by the staffing pattern and the centralization of authority.

The nontherapeutic outcomes of the team delivery system can be seen in many areas. With few people rehabilitated to lower levels of care, both staff and patients often begin to regard the nursing home as the "last home." Concomitantly, the middle manager, professional, and auxiliary staff alike may experience a general sense of job dissatisfaction from an inability to fulfill their commitment to the older adult. Consequently, a major problem experienced in many long-term care facilities is a high nursing turnover rate.[5]

While not all the above consequences are exclusively linked with the team delivery system, the method through which care is delivered is a critical factor. If the goal of the nurse is to provide individualized nursing care which will maximize human potential and treat the person's response to illness, then what is needed is a conceptual framework which allows for and promotes this comprehensive, therapeutic approach. It became obvious within our long-term care facility that if we wanted to realize the delivery of quality nursing care, we needed to change the care delivery system.

Primary Nursing: Definition

At the Primary Nurse Convention (1977), primary nursing was defined as:

> The delivery of comprehensive, coordinated, continuous, individualized patient care through the professional nurse who has autonomy, accountability and authority on a 24 hour basis.[6]

Essential elements of the system, as outlined by the University of Minnesota Hospitals include:

1. The assignment of each patient to a nurse who has primary responsibility for assessing, planning, and coordinating the nursing care delivered to the patient throughout the hospital course of stay;
2. The provision of 24 hour respon-

CONCEPTUAL MODEL

Team nursing LTC	Primary nursing LTC
Noncontinuous nursing care fragmented	Individualized nursing care
Fragmented nursing care	Holistic nursing care
Custodial nursing care	Rehabilitative nursing care
Job dissatisfaction	Job satisfaction

sibility for the nursing care delivered for the primary patients; and

3. The processing of information related to the patient, including information pertaining to discharge planning and insuring continuity of care.[7]

These components assist one in understanding the structural elements of the primary nurse delivery system. However, the model of practice needs to be viewed not only as a staffing pattern, or as a different patient assignment regime, but also as a philosophy—a way of thinking about patient care. It requires a commitment from the nursing profession to deliver the best possible care according to the gerontological nurse's level of expertise. The nurse is called to become an advocate for the patient within the health care system.[8] Additionally, there needs to be a strong conviction among those in nursing administration that supports and encourages decentralization—the delegation of authority to the primary nurse—so that the primary nurse is accountable for the care delivered.

In seeking an alternative to the team system, the primary nursing model appeared to offer a framework that enabled the gerontological nurse to meet acceptable standards of practice. However, in reviewing the literature, it was noted that much of the discussion focused on primary nursing within the acute care setting rather than the long-term care setting. Some inherent differences between the environments of acute care versus long-term care may account for primary nursing's receiving greater attention in the hospital.

Primary nursing is described as a patient care delivery system implemented by the registered professional nurse. Owing to the lower reimbursement rate, long-term care would not be able to support an exclusive RN staffing pattern. Neither would an RN unit be considered cost-effective, given the physical care needs of the patients. Another difficulty in meeting this requirement lies in the fact that nursing homes often have greater difficulty attracting a sufficient number of registered nurses.

How then does one implement primary nursing in the long-term care setting? In view of the essential differences between the acute care and long-term settings in terms of philosophy, purpose, population, and staffing ratios, the mission before us was to adapt the elements of the primary nursing model to the long-term care setting, while at the same time preserving the spirit of the decentralized model.

The aim of implementing primary nursing was seen as twofold: to create an environment and a process for maximizing the health care for the skilled nursing patients, and to enable the nurse to practice with accountability, authority, and autonomy. The dilemma and suggested resolution are shown in the Figure.

Implementing Primary Nursing

According to Schein[9]: if change is to be accepted and become part of the regular system, the involved parties must be active early in the diagnostic and change planning process. With this in mind, a planning meeting was called with the key leadership personnel. At this time, an assessment tool on the team nursing delivery system was distributed to management personnel who would be responsible for instituting the change.

Head nurses were asked to identify the need for change as well as the strengths of the present team system. Results of the assessment revealed that a change was needed to insure better planning and continuity of care, and to increase the accountability for care delivered. It was anticipated that primary nursing would lead to and result in greater job satisfaction among nursing staff members. We sought to strengthen nursing efforts in rehabilitation and communication with other disciplines, coworkers, and the patients' family members.

Concerns raised that needed consideration prior to implementing the model included educating the staff, adjusting staffing patterns, and exploring ways to address potential burnout. Subsequent planning meetings were held to address these issues, to raise consciousness regarding the need for change, and to obtain a managerial commitment to the philosophy and concept of primary nursing and goal achievement. In retrospect, it is apparent that these efforts to include key leadership persons in the change process were essential to the success of the program.

Douglas and Bevis[10] stress the need for the change agent to provide as much information as possible. Considering this axiom, articles on primary nursing were distributed on the skilled nursing units, and staff development programs were conducted by management.

Since primary nursing is **not** merely a reorganization of tasks but a redefinition of professional function,[11] the planned reorganization called for a restructuring of the framework. The philosophy and purpose of the nursing division was rewritten to emphasize the aim of providing individualized patient care. The new philosophy used the goal that each patient would reach and maintain his or her maximum level of functioning.

Job descriptions for all levels of nursing staff were redefined to reflect the decentralized nursing care system. For example: the head nurse's title and job description were changed. The nursing manager on the skilled nursing unit was given the title of "Health Care Coordinator." The primary function of the health care coordinator became organizing the care delivered by the primary nurses. Particularly in the early stages, a key component of this role was for the health care coordinator to deliberately and consistently reinforce the decentralized model by referring people to the primary nurse. Both the job description and the conscious actions of the leaders were needed to illustrate and cement the changing expectations and roles within our new primary nursing system.

Structural changes were also made. The 60 bed units were divided into four color-coded districts, each district having 15 residents. A primary nurse was assigned to each district. Whenever possible, full-time registered nurses were appointed primary nurses. They then assumed the responsibility, authority, and accountability for care delivered to patients within the assigned districts.

One real obstacle to implementing primary nursing in long-term care is the issue of staffing. How does one make use of licensed practical nurses and nursing assistants within the primary nurse system?

It was decided that licensed practical nurses who had demonstrated leadership potential and high levels of competency would be considered for district responsibility, and given the title of "Associate Primary Nurse." However, due to differences within the regulated scope of practice, LPNs, regardless of individual competence, require closer observation and support from supervisory personnel. Therefore, the role of assistant health care coordinator was created on each skilled nursing unit. This person, under the direction of the health care coordinator, had responsibility for providing more direct consultation for the LPNs, for conducting unit staff development programs, and for responding to staffing/unit needs that might arise. In this way, the assistant was able to provide the necessary guidance for the LPNs, and the unit had a built-in backup system for meeting both unit and patient care needs.

The established plan was to staff each district with one primary/associate nurse who had responsibility for assessing patient care needs on the assigned district. This nurse was also required to ensure patient care delivery. Working with this nurse would be either two regularly assigned nursing assistants or an LPN/aide mix, depending on the nursing staffing pattern on a given unit.

Initially, it was thought that it would be better to have the primary nurse work with two assistants. This would decrease role confusion. However, in practice there were several advantages to the primary/LPN/aide mix. The LPN provided the primary nurse with greater flexibility owing to the ability to delegate a broader range of activities. Such functions as participating in multidisciplinary conferences and presenting patient care conferences were more easily accomplished with this complement of staff.

Central to the success of implementing primary nursing in long-term care was the creation and institution of communication tools and processes. In addition to formulating new job descriptions, the appraisal system, policies, and procedures were revised to coincide with the changes in job responsibilities.

The nursing Kardex® was revised to provide the nurse with a communication format outlining a holistic, 24 hour nursing care plan. Tools were developed and/or obtained to assist the primary nurse with organizing and delegating the nursing care. For example, treatment books were utilized to outline the nursing treatments and nursing orders for patients within the district. Subsequently, treatment carts were purchased to be used by the nurse in administering the treatments more efficiently. Assignment sheets were developed and used by all shifts to outline daily nursing responsibilities.

Signs were posted listing each district's primary nurse. In this way, people new to the unit, family members, and visitors were familiarized with the primary nurse system and providers of care.

Other means of communication included regularly scheduled district meetings and primary nurse meetings. These gatherings were useful in disseminating information, problem solving, discussing patient care goals and progress to date. Without these established networks there may have been more staff conflict and fragmentation. Discussion in these meetings reduced staff concerns and miscommunications.

Grand Rounds, forums where the primary nurse presented a case study and requested peer review, were also established and regularly conducted to reinforce excellence in nursing practice and to foster continuity of care.

Once primary nursing was firmly established on the day shift, the goal of incorporating the concept of primary nursing on the evening and night shifts was pursued. Evening and night supervisors, together with the health care coordinators, met to explore methods of implementing the primary nurse process.

Modifications were made in the rudiments of the primary nurse system, and global aspects of the concept were applied. Districts were assigned to primary care aides. The aides were supervised by nurses called "primary nurse extenders." These nurses were assigned responsibility for primary care areas in two districts.

The primary nurse maintained responsibility for the care provided by soliciting feedback from the 24 hour nursing staff. A procedure for "flexible" time was developed and instituted with the primary nurses. From this broader perspective, the primary nurse was able to assess more accurately the

QUESTIONNAIRE RESULTS

	Primary nursing	Team nursing	Percentage difference
Care delivered			
Individualized	4 18	3.0	+23%
Knowledge of resident	4.1	3.0	+22%
Meeting of resident needs	3.9	2.6	+26%
Maximizing resident potential	3.8	2.8	+20%
Perceptions of resident's response to nursing care	4.3	3.2	+22%
Perceptions of family's response to nursing care	4.5	3.0	+30%
Relationship with others			
Interaction with peers/same shift	4.0	3.2	+16%
Collaboration with other disciplines	4.0	3.0	+20%
Interaction with peers/other shifts	3.3	2.3	+20%
Staff meetings	3.8	2.8	+20%
Relationship with HCC	4.2	3.3	+18%
Relationship with nursing administration	3.6	2.7	+22%
Professional nursing practice			
Professional satisfaction	3.9	2.6	+26%
Level of accountability	4.6	3.2	+26%
Ability to implement nursing decisions	4.4	2.4	+40%
Ability to implement nursing care using nursing process	4.2	3.1	+22%

patient status,[9] and subsequently evaluate the delivery of nursing care more effectively.

Evaluating Effectiveness

To measure the effectiveness of primary nursing, several variables can indicate goal achievement. Since our administrative aims were to increase the quality of care, we used patient care outcomes (such as incidence of decubiti, increase in ambulatory status, discharges to lower levels of care, etc.) to assess the efficacy of the primary nursing model. A secondary aim was to increase job satisfaction. Therefore, we examined the turnover rate before and after primary nursing was instituted. Additionally, we solicited nursing feedback by means of a questionnaire we developed to determine the effectiveness of primary nursing in meeting the outlined goals.

Patient Outcomes—There was a dramatic difference in the number of residents sustaining decubitus ulcers. One year after the primary nursing system was instituted, a 75% reduction in the incidence of decubiti was realized.

Improvement in rehabilitative nursing care practices can be measured in part through discharges to lower levels of care and through death rate. Comparing statistics before and after the implementation of primary nursing, it was found that there was an 11% increase in patient discharges to lower levels of care, and an 18% decrease in the patient death rate.

The concept of decentralized nursing care filtered through to the nursing assistants who were responsible for conducting a "Preventacare" exercise program. Results of this are shown in the 36% increase in the number of ambulatory patients two years after primary nursing was established.

Primary Nurse Questionnaire—A questionnaire was distributed to all nurses one year after the primary nurse concept had been introduced to the staff. Staff members were asked to evaluate the effects of primary nursing with respect to care delivered, professional nursing practice, relationship with other disciplines, and individual job satisfaction. The staff were asked to rate each category on a zero to five scale, with zero being low and five being high. Those staff members who had worked under team nursing and primary nursing were asked to rate the category as it applied to team nursing and then to primary nursing. The two ratings were compared and the results of the questionnaire can be seen on the Table.

It is difficult to accurately measure the effectiveness of the primary nurse model compared to team nursing using solely subjective responses. However, it is noteworthy that staff related that they felt more accountable for the outcome of professional acts (by 26%), more able to make and implement nursing decisions for patients in assigned districts (by 40%), and more able to plan and implement nursing care using the nursing process (by 22%).

Probably the most significant and dramatic difference can be seen in the turnover rate, a figure which is conventionally used to measure job satisfaction. One year after the implementation of primary nursing, turnover rate was reduced by 29%.

In closing, having been part of the birth and delivery of primary nursing within a long-term care facility, one is in a position to reflect upon how it happened and how it could be done better. Educational efforts were focused on nursing staff members. Presenting information formally to the other disciplines may have increased the openness with which the idea was received by multidisciplinary team members. Sharing the model through such established forums as the family council may have resulted in greater family involvement.

There was some tension among those LPNs who were chosen as associate primary nurses. This group voiced a request that they be given the title of primary nurse. This request warrants consideration.

Not all of the positive outcomes can be attributed solely to the implementation of primary nursing. As Shukla[12] points out, other possibilities need to be recognized. For instance, other changes that took place concurrently with the phasing in of primary nursing included the introduction of a tissue trauma nurse and a decubiti reporting system, the addition of a mental health nurse, and the distribution of a cost-of-living adjustment. However, the way in which primary nursing decentralized authority and empowered the nurse to meet patient needs was integral to the improvements noted.

One drawback that was observed was that staff began to lose a sense of unit responsibility as reflected in statements such as "That's not my patient." To minimize this trend, each staff member was assigned a unit responsibility to foster the sense of unit-wide commitment. This decreased tension on the unit and contributed to a more organized unit environment.

Another factor that needs consideration is that the change to primary nursing involves a large investment from nursing administration. Much time and energy is consumed by providing staff with the necessary tools, job descriptions, guidance, and refinement of the system.

Belief in the nursing staff: to respond to change, to be flexible, and in the inherent ability of the nurse to respond willingly and competently to the patient needs, are essential assumptions that must be made by all levels of nursing. An openness to learning, and an acceptance of mistakes and the limitations of how much can be accomplished in a day, are attitudes which need to be fostered and endorsed. Lastly, confidence in the primary nurse to make an effective difference in the delivery of quality nursing care contribute to making primary nursing a workable reality in the long-term care setting.

Primary Nursing

KEY POINTS Campbell SD: Primary nursing: It works in long-term care. *J Gerontol Nurs* 1985; 11(12):12-16.

1. Key to the success of implementing primary nursing in a long-term care facility was the creation and institution of communication tools. In addition to formulating new job descriptions, the appraisal system, policies and procedures were revised to coincide with the changes in job responsibilities.

2. The nursing Kardex® was revised so that it provided nurses with a format which outlined and incorporated a holistic, 24 hour nursing care plan.

3. Tools were developed and/or obtained to assist the primary nurse with organizing and communicating the nursing care. For example, treatment books were utilized to outline the nursing treatments and nursing orders for patients within the district.

4. Probably the most significant and dramatic difference can be seen in the turnover rate, which is used to measure job satisfaction. One year after the implementation of primary nursing, turnover rate was reduced by 29%.

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The author would like to dedicate this article to the skilled nursing staff at Loretto Geriatric Center, Syracuse, NY.

Using ethnographic data, the two worlds of the nurse's aides were examined, the world in which they live and the world in which they work. Because the institutional culture of the nursing home often adds to the adversity of their personal life, the nurse's aides move between the two milieus in a self-perpetuating negative cycle. Aides carry to the bedside of elderly residents the affective and psychological burden these two worlds place on them.

Key Words: Long-Term care, Elderly people, Nursing homes, Nurse's aides, Quality of care

Quality of Care and the Burden of Two Cultures: When the World of the Nurse's Aide Enters the World of the Nursing Home[1]

V. Tellis-Nayak, PhD[2] and Mary Tellis-Nayak, RN, MSN[3]

The National Citizens' Coalition for Nursing Home Reform (NCCNHR, 1985) concluded from a national study that what nursing home residents value most is good staff. Good staff, in the words of some residents, mean everything in a nursing home. Despite this telling clue, however, NCCNHR neglected to pursue an obvious line of inquiry: What specific role do the nurse's aides play in the life of residents?

Nurse's aides loom large in the life of nursing home residents for an obvious reason. On an average, the nursing staff includes 15% registered nurses, another 14% licensed practical nurses, and a hefty 71% nurse's aides (Institute of Medicine, 1986). And it is these aides who provide six times as much personal care as registered nurses and five times as much as licensed practical nurses (Administration on Aging, 1980). Moreover, nurse's aides care for residents in the most intimate way, helping them to dress, groom, bathe, feed, and toilet.

Good training, skills, and knowledge are not what residents prize most in the staff; they place staff credentials way down, ninth, on their wish list. Residents do not even ask most for adequate staffing; they place it third on the list. Rather, what the frail residents of nursing homes treasure most is staff attitude: They appreciate staff who are willing to be helpful, to be "kind, nice and good to you." Repeatedly, residents say how much they value the human qualities of their helpers. They cherish it when the staff are "polite," "courteous," "respectful," "friendly," "cheerful," and "pleasant." They appreciate being treated with dignity; when staff are patient, concerned, and sympathetic; when they listen and take their complaints seriously (NCCNHR, 1985).

As advancing age strips elderly individuals of their symbols of independence and authority and shrinks their social world, nurse's aides assume a larger-than-life role in the life of the residents in the nursing home. Thus, dependent residents pay less attention to the qualifications, training, and skills of the aides; but they indeed appreciate when the aides assist readily without complaint, take time to listen, show sympathy without condescension, and respect both the frailty and the dignity of old age.

Thus, researchers face a crucial question: how can residents be assured of caring and sympathetic concern from nurse's aides? Advocates are often troubled that the meager training of nurse's aides and their heavy turnover profoundly affect the residents (Holbur, 1982; Waxman et al., 1984). They often bemoan their poor wages and inadequate fringe benefits as well as shoddy management practices that do little to evoke a commitment from nurse's aides. Seldom, however, do advocates take into account the two most profound influences that determine the commitment of nurse's aides. To begin with, they ignore the unique milieu from which the average aide comes to the nursing home. It is a world apart, and, in metropolitan areas, it can leave deep scars on an individual's emotional life. From such a setting the nurse's aide enters the nursing home and may find that in ways both subtle and overt the home compounds her problems; it erodes her fragile optimism and hardens her attitude. Thus, unkind life-experiences at home and in the nursing home shape attitudes of indifference, apathy, and cynicism. Then it is the vulnerable resident who reaps the bitter harvest.

Too often researchers frame staff issues as problems of attitude, motivation, training, and incentives; they commonly ignore the wider cultural and organizational context in which these problems have their origin. To explore the two worlds in which the nurse's aides live, this study relies on an ethno-

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[1] This research was partially supported by the Illinois Department of Public Aid, Springfield, IL.

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graphic approach, which regrettably is used too sparingly in gerontology (Fry & Keith, 1986). It discusses how nursing home quality is tied closely both to the social background of the staff and the institutional culture of nursing homes. The analysis follows not dissimilar ethnographic attempts such as Stannard's (1973) study of resident abuse in nursing homes emanating from institutional conditions and staff background; Gubrium's (1975) investigation of the culture of the nursing home in which he uses the concepts of "worlds" to convey the separate and distinct interactional logics and staff troubles; and Vesperi's (1983) inquiry into how the institutional concept of old age sets the stage for poor quality of care in a nursing home.

Method

In this study the data is mostly drawn from that collected in the course of two major projects sponsored by the Illinois Department of Public Aid. The first project was focused on eight representative nursing homes in Illinois that were noted for their excellent quality and that were contrasted with some mediocre homes. Uncovered in the analysis were six different strategies that model homes pursue to achieve high quality (Tellis-Nayak, 1988). Examined in the second project was the role of the residents' families in improving the quality of care in nursing homes (Tellis-Nayak, 1987).

From the copious data from these two field studies, ethnographic data were culled that pertain to the life of nurse's aides in a metropolitan setting. The primary sources of information were structured interviews with 132 nurse's aides in 8 nursing homes; nonstructured interviews with 53 nurse's aides in 12 homes; nonstructured interviews with 31 persons in management positions in 11 homes; numerous conferences with nursing home residents, their families, nursing home operators, staff, surveyors, and others familiar with nursing home life; and ongoing ethnographic observation of life in 8 nursing homes.

This inquiry, therefore, is focused on the social ecology of nurse's aides and on the institutional milieu of the average, and often less-than-superb, nursing home in the metropolitan Chicago area. Bearing in mind Vladeck's (1980) discussion of quality in an average home, and given the nature of the settings of this study, its conclusions would, in all probability, prove relevant to nursing homes in other metropolitan contexts. The analysis, however, sidesteps the achievement of nursing homes of exceptional character that succeed in transforming their nurse's aides into caring caregivers. Their success rests precisely on creating an institutional culture in which the harshness of their personal world is mitigated (Tellis-Nayak, 1988).

Findings

The Social Origins of Nurse's Aides

The diverse social roots. — Nurse's aides come to the nursing home from disparate contexts. In rural and small-town America they are often white and retain firm roots in the community; on the average they are older than their metropolitan counterparts and they may have worked at the same institution for longer years. In contrast, nursing homes in urban centers attract a variety of workers. In the Chicago area, the largest portion of aides are blacks who are, however, distributed unevenly in the area. Around the central city, nursing homes are often exclusively staffed by black aides; towards the city's fringes black aides decline in number but still predominate; and they do so also in the immediately contiguous suburbs. They become less visible in nursing homes farther removed from the city. Still, the picture is complicated by the variable presence of the white nurse's aide. White aides outnumber black ones in homes located in the staunchly white ethnic enclaves of Chicago, or in its suburbs. But as neighborhoods change, and as nonwhite labor becomes available nearby, racial composition among staff shifts rapidly.

Around Chicago, both white and black nurse's aides come from lower-income families. On average neither group enjoys much better than a high school education; and frequently they have only slight saleable skills. They seek work in nursing homes for various reasons, and rarely as their first, most desired choice. Many of the younger ones have come to test the health care job market, or to hold down a job while still students, or, occasionally, urged on by a youthful idealism. Many of the older ones have served for longer periods, because not infrequently they are short both on self-confidence and career opportunities.

The Chicago area nursing homes hire another type of aides that a small town rarely sees: foreign-born workers with diverse backgrounds. At one end of the spectrum are some Polish, Chinese, Filipino, and other Asians sometimes trained as nurses, pharmacists or other professionals in their native land. Once here, they find the hurdles of language and entry exams insurmountable. So they enjoy little choice but to work at low-status jobs in the health care field. These foreign-born aides almost always choose to work in nursing homes located in mostly white or nonblack ethnic neighborhoods and suburbs. In such homes they can account for as much as 1 in 5 among the nurse's aides, and occasionally for even more. Curiously, however, Chicago area nursing homes rarely employ Hispanic aides. At the opposite extreme among these foreign-born aides are the undocumented immigrant aides mostly from Central America and the Caribbean. They are generally unskilled and little educated. There is no way to determine how prevalent they are, although some nursing home operators, it is said, have in the recent past maintained discrete links with these sources of cheap labor. They may pay these aides below minimum wage and hardly any fringe benefits.

Despite their diversity, nurse's aides share a common denominator: their socioeconomic class. They are mostly women and belong to the lowest rung of the health care labor market: they are the least educated, the least skilled, and the least paid, often barely above the minimum wage, and they endure a low occupational status. They share the lower class lifestyle, perched precariously, as most of them are, just above the poverty line, straddling that uneasy fence that separates the two lowest classes, the working class and the lower class.

The cultural ambiance: Four profiles. — Economic conditions alone do not define the social milieu of the nurse's aides. To appreciate what informs their viewpoint, what explains their apathy and what evokes their commitment, it is necessary to examine the distinctive ethos in which the nurse's aide's life is rooted. For it is their subculture that both mirrors and shapes their attitudes, values, and lifestyles. To provide a glimpse into that subculture, four ethnographic portraits of nurse's aides in a metropolitan setting are sketched here. These portraits are true-to-life accounts, although names have been changed to protect their identity. Although the profiles do not fully describe the diverse social roots of nurse's aides even in a metropolitan setting, they are representative; they highlight the themes in the social ambiance at the bottom of the economic scale, and how they shape their sensibility and color their manner.

April Jones: April, an attractive 27-year-old black woman, works as a nurse's aide in a large nursing home in Chicago. April moved out of her mother's apartment over a year ago because she could not take the wretched ways of her stepfather and the passes he made at her. April's own father, an alcoholic and an inveterate womanizer, left home years ago. The stepfather holds a good job at a pharmacy, but rarely brings home a penny, and lives off his wife, with whom he maintains a love-hate relationship.

April's mother, Gail, is a licensed practical nurse and the mainstay in the family of five children. She demanded and received good behavior and good grades when April was in high school. April made the honor roll in the inner-city school she attended, but never told her mother about the abortion she had at the age of 15.

The nursing home was not April's first choice for employment. But jobs were hard to come by, or the hours bad, or the racial and sexual harassment not always bearable. April makes just over $4 an hour on the evening shift, but gets hardly any fringe benefits. The union takes a bite of her wages. Whenever she can, April works extra hours, because she has to scrape to pay the 18% interest on the over $2,000 she owes on her credit card, which she charged mostly to set up her apartment. She has even received court summonses when she has fallen seriously behind.

Her one-bedroom apartment is in an old, stately neighborhood that has seen better days and is now infested by drug dealers. April pays $290 a month for it. She is on her second used car in 2 years; she does not insure it, because she cannot afford to. But she needs the car, because the nursing home is half an hour's drive, and she is not imprudent enough to take the train home at night.

April also depends on her car to attend college 20 minutes in the opposite direction. Without the car she could not make it to work when her classes get over at 2 p.m. At $204 a college credit, April can ill afford her nurse's training; so she has taken a student loan, and after 3 years of schooling, she is almost a junior now. But she is afraid that her poor grades may put her on academic probation again. But the bills keep piling up, and the strain shows by the third week every month, especially when a stern professor will not yield on the deadline for exams and term papers.

Last month April missed work and school for 2 weeks just when the mid-term exams came around. A persistent pain in her abdomen meant that she had to see a physician. April cannot afford, and therefore does not carry, health insurance, just like 36 million other non-poor Americans whom Medicaid does not cover. After hours on the waiting line, she was finally examined and then admitted to the Cook County Hospital. "As soon as I was discharged, I went after Loren with a crowbar," says April. "The doctor says he must have given me that infection. And now I may never be able to bear a baby." April knows that Loren has a wandering eye, and worse, he makes no secret of it. He has lived off of her for 2 years, but he never visited her in the hospital

Martina Davis: Despite all her struggles, April considers herself luckier than Martina Davis, another black nurse's aide who is April's friend. Martina's is a grim background. Whatever semblance of family-life she had was brutish; it has left an indelible mark.

Martina knows little about her father, because her mother has had several entanglements over the years; the four siblings bear four different last names. Her mother was hardly around when Martina grew up. "Once she even stole my savings and went to the Bahamas with her sugar daddy, leaving the kids with me," says Martina without much feeling. "At the age of 16 I could roll in at night at 2 a.m., and she would not look up in bed and ask where I had been."

Martina was introduced to drugs early; she has been raped twice; she has not completed high school. Now at the age of 23, she is pregnant again with no prospective father in sight; her little boy, 3 years old, seems to get ill too often. But for the moment she feels lucky that she is a certified nurse's aide. Her working conditions are worse than April's, and she missed 2 days this week because her molar ached so badly that she finally went to the doctor. Martina does not keep in touch with her mother, and her grandmother is the only person in the family she is close to.

All the pressure sometimes pushes Martina off the deep end. It is then that she seeks solace in drugs, and dark suicidal thoughts haunt her. Martina has been somewhat stable since April took her and her baby under her wing. Mother and child have lived with April for 4 months, carefully avoiding being detected by the landlord.

Emelie Chin: Emelie, a nurse's aide in a for-profit nursing home, is a Chinese woman in her late 40s. A genial and kindly attitude can be sensed behind her worn face. Her English limps badly and is heavily accented, but the residents hardly mind, because Emelie has that caring touch they all prize.

The director of nursing values her even more because Emelie is a workhorse, she never complains, she never falls ill, she is always ready to work the extra shift, and she gives excellent care. After 5 years she has moved up to a $5.05-an-hour wage. In those 5 years Emelie has never come in late and never called in sick.

Emelie, her husband, Seng, and her two children came from Taiwan 5 years ago. Back home she had worked for 20 years as a professional nurse in a famous teaching hospital, and Seng was a lawyer with the government for 30 years. Unlike other Taiwanese emigrés they know, they were fortunate that the family of four came together to the United States. Many among the former have prospered in this country. But as for herself, try as she may, Emelie has never been able to get through the nursing board exam. The intricacies of the English language and the psychology part of the test have always proved to be her undoing.

But it is even worse with Emelie's husband: Seng has yet to make the first base with English. So Emelie talked with her director of nursing and got him a job at minimum wage in the laundry at the nursing home. But first she carefully wrote out all the laundry instructions in Chinese, so that Seng was spared the strain of deciphering his boss's orders.

Rather than live in Chinatown 5 miles away, they first lived in an apartment in the shadow of the nursing home. It spared them the cost of owning a car. They all worked hard, scrimped, and in 5 years bought a house and a car. The older daughter, now 19, is pursuing nuclear engineering at the University of Illinois in Champaign.

Both husband and wife always look for overtime work. Emelie can find it easily, because over 90% of the nurse's aides leave work in a year at the nursing home. In an average week she chalks up 32 hours of overtime, and not long ago in one 2-week period she put in an unbelievable 100 overtime hours in addition to her 80 regular working hours! She is also on call at a recruiting agency that supplies temporary nurse's aides to hospitals and nursing homes. With that heavy schedule, she still attends a community college 2 nights a week because the dream of becoming an RN drives her on.

Emelie is hardly home, so Seng does all the household chores. Husband and wife care very much about each other's well-being. True to Chinese tradition, the family is very close and a source of strength, especially because no Chinese live in the neighborhood.

Emelie and Seng are well-liked at work, but they have made no close friends. The black, white, Haitian, and Filipino aides all move in their own circles, each group finds little in common with the other, each stereotypes the other, considers it clannish, and accuses it of gossip. Being the only Chinese, they do not seem to belong anywhere. But Emelie's family gets together with the friends they knew in Taiwan. Although most of them have moved up socially, they do not seem to notice that Emelie is still a nurse's aide and Seng a laundry worker.

Rita Pucci: Rita, a 55-year-old white woman, and a nurse's aide for 22 years, is 1 of only 3 white aides at a very large nursing home west of Chicago. She has worked there for the last 17 years.

Rita got pregnant when she was a junior in high school, dropped out, and got married. It was hellish living with a severe alcoholic, but she bore him two children before she got a divorce. That experience did not deter Rita from jumping right into another marriage. She has now been married for 23 years to a construction worker, a man with a slight handicap, who seems out of work more than he works. The marriage shows no passion and little affection; it has produced no children. Husband and wife rarely do anything together.

Rita sought work as a nurse's aide early in her second marriage when her children were still young and there was not enough money coming in. Certification was not considered important back then. But Rita learned quickly on the job. Part of what she learned was not to get involved too much. In her 17 years there, she has seen the nursing home change hands five times. Administrators and directors of departments have come and gone. And so have the staff and residents with great frequency. She has witnessed all the unsavory aspects of how a nursing home is run, and has learned to keep her peace.

For the last 3 years her daughter, freshly divorced, has moved in and brought along Rita's grandchild. So Rita babysits during the day and works on the night shift. The arrangement suits her, as she is very fond of her grandchild and does not have to be home at night with her husband. She is friends with the other 2 white nurse's aides at the home, who, like Rita, are both older women and live close to the facility. They socialize whenever they get the occasion.

With all her experience, Rita only makes $5.50 an hour. These days she tires easily, and her weight is only part of the problem. After all these years, there is very little she does not know about nursing home care. But like most other aggravations of nursing home life, she accepts it without a word when so often a new supervisor or an eager consultant sets up classes to teach the aides new techniques of care.

The subcultural ghetto. — These four true-to-life accounts of April, Martina, Emelie, and Rita illustrate how the majority of the nurse's aides exist in big-city America. They live in an underclass subcultural ghetto. The analysis has profiled them as falling roughly into two categories: the Aprils and Emelies belong among the group of the determined Strivers, whereas the Martinas and the Ritas belong to the group of the disaffected Endurers.

No ready statistics can be used to document how these two patterns prevail in the nursing homes. But the data support the common impression that nursing homes hire Strivers far more than the Endurers, perhaps by a margin of 2 to 1. But because the Strivers keep their sights high, they often make up the great nursing home staff exodus. Thus, at any one time, Strivers form only a minority among the nurse's aides in a given nursing home.

Strivers like April have triumphed against the cruel odds of their personal circumstances. Some, like Emelie, are even blessed with special family and other resources. With sheer effort, with singular determination and at a heavy price, these Aprils and Emelies seek a way out of an oppressive lifestyle. And eventually they will succeed and, sadly, will be lost to the nursing homes.

But the Endurers, Martina and Rita among them, will continue to live precariously on the edge, some caught in exploitative marriages or heartless liaisons, some as single parents valiantly seeking a better future for their children, some full of dreams but with few skills to match their hopes, and others turned cynical because, being realists, they have little hope left. Most of them had looked elsewhere for a job, but they all ended up at the nursing home. The nursing home is always short of nurse's aides.

It is a distinctive social world from which most metropolitan nursing homes recruit the caregivers of elderly people. They come to the nursing home weighed down with economic hardships. And moreover, those who have existed for some time in that rugged world bring with them as well a view of life tempered by a hardy existence. An abbreviated childhood may have exposed them early to life's seamier side. Their tough attitudes and values have helped them survive and even triumph in that demanding environment.

And now if in a middle-class work setting nurse's aides appear to be dispassionate and indifferent at times, it is because life has been a good teacher. A skeptical and wary attitude has served them well. That attitude is born of experience; it has become a part of their character and of the self-concept some nurse's aides bring with them to the nursing home.

The Institutional Culture of the Nursing Home

Some nursing homes in the Chicago area endure over a 100% staff turnover each year (Day & Berman, 1989). This constant outflow not only drains dollars (Stryker, 1982), but also cruelly disrupts the fragile social world of elderly residents. Personal care suffers when aides leave and take with them the knowledge of residents' idiosyncrasies, habits, and medical conditions. Relationships are severed and the precious semblance of continuity in the life of elderly residents disappears, especially when the home routinely relies on temporary help from nursing pools.

The temporaries and the part-time nurse's aides only underscore the principal frustration of residents: personal care without commitment. It is not that the aides neglect, but it is the soulless service, the cheerless attitude, the coldness in the touch that bothers the residents. Why does the aide ignore when she sees the need? Why does she seem not to hear when summoned? Why does she not take a complaint seriously? Why does she make that sarcastic remark within earshot? Why does she sometimes not say as much as a friendly word when she helps groom or bathe?

The impersonal old-age business. — Of course the elderly resident is not privy to all that weighs on the aide. Her child is ill at home, and she has not bought the medicine the doctor prescribed; her rent is overdue, and she needs a different excuse this time; and she did not get the advance on her wages that she needs to fix the car. Being in a loveless marriage, her husband is again gone for 2 days, and she pretty well knows where. Returning home from her evening shift in this white neighborhood, last night she endured more jeers from a clutch of white young men, and a flying rock just missed her as she quickly made it to the train station.

Such cares dog many a nurse's aide as she serves her 12 heavy-care elderly charges. Aides would have to be sanguine optimists, blessed with uncommon psychological reserves, not to let these personal troubles intrude on their work. The nursing home, of course, offers no counselling service, which they sorely need, but can ill-afford on their own. The supervisors have little time for, and less interest in, their personal problems; they have heard all these tales before. The nursing home is an institution, after all, and an institution can be impersonal, and even heartless; how can it cater to the private needs of all its workers?

In turn, nurse's aides learn to keep their distance, and even feel cynical. How else can they react when what the management always says so blatantly contradicts what they in fact do? The pious platitudes about "commitment" and "caring" seem only a thin mask for what they really want: productivity and efficiency. Why else would they skimp on staff? Why would they bargain so hard to keep wages down and cut fringes? How come they eagerly install new carpets and fancy decor, yet begrudge the necessary supplies? How come they show more concern for paper compliance than for the caring touch? Clearly, they are in the old-age business; they pay aides to do the caring. And aides understand it all; nobody need teach them how to play by the cynical rules of an uncaring game.

Routine indignities. — Neither do aides harbor any illusion as to how much the nursing home values them and their work. The cues are everywhere, like the poster that hangs jokingly in the office of an administrator: "A New Incentive Plan: Work Or You Are Fired!" No matter that they work hour after hour changing underpads, cleaning dentures, bathing, toileting, feeding, and doing other repetitive, menial body-and-bed tasks. They better find satisfaction in their daily toil and not expect anyone to pat them on the back. They know that the management carefully watches when they arrive or depart, and how long they linger on their lunch break; the management supervises them ceaselessly, gives them little room for initiative and rarely much benefit of the doubt. After all, their work ranks lowest in status and wages, it calls for no exceptional skill, and merits no advancement. An aide, in fact, is expendable.

When in private, mediocre managers even express their disdain freely, as one did to one of the authors:

> I can't expect responsibility from the aides, because they are not responsible in their private lives. They live harsh lives and exist in a violent subculture. So I can't expect too much caring from my aides.

So, rather than create a climate to relieve the pressures of their arduous personal world, he adopted a style that reminded his aides of how little they were really worth as persons and as workers.

Nursing homes often change ownership, hire new management, and alter their policies. Managers hire endless consultants, bearing the state inspectors in mind. With all these changes come more staff inservices, which experienced aides suffer through in silence. They have seen it all before, they understand how the game is played, and so they endure the implicit assault on their experience, maturity, and insight.

Little comfort or gratitude. — There is little in a nursing home that compensates for such routine indignities. Their fellow workers may not offer aides much help. When the work force is mixed, aides tend to move in cliques formed along racial and ethnic lines. Such factions are a rich source of gossip, rivalry, and backbiting. They may even secretly align with the management to win favor or to settle a score with the rivals.

Nurse's aides cannot depend much on their elderly wards either. Aides come not to expect much gratitude from them. Rather, aides learn to endure those among the confused elderly who will kick or strike, the artful ones who become incontinent only to spite or to get attention, and the stubborn ones who refuse to cooperate.

Aides are often remarkably tolerant and understanding. They even enjoy their wards, especially their remarkable life-stories. Yet aides will point to their share of the crusty, disgruntled elders, who can be "too demanding," "impatient," "ungrateful," and even "foul mouthed." Nursing homes are not a racial paradise, and some elderly people are not above acting on their ethnic stereotypes and throwing racial slurs: "Why don't you go back to Africa?" "You are a Nazi, you know that?" And the visiting families are hardly much different.

In sum, the nursing home is just a workplace, rarely very inviting, and hardly a refuge for aides' personal problems. The work is menial and monotonous, the setting often cold and impersonal, the managers and clientele hard to please; scarcely a context suited to bolster the aides' self-worth. Rather, the institution helps turn the malaise of their personal life into alienation, it strains the fragile idealism of the Strivers like April and Emelie, its adds to the hopelessness the Endurers like Martina and Rita experience. The Strivers, their optimism and commitment sorely tested, find an added reason to leave long-term care. The Endurers, calloused and detached, continue to play the passionless game.

Fortunately for the elderly residents, nursing homes continue to draw the young and the idealist caregiver. The Strivers, and those particularly blessed with uncommon family resources and personal strength, survive the institutional inequity, just the way they have prevailed over their social constraints. But typically these optimists move on, leaving behind the Endurers. And these latter hold out in the nursing home as they do in life, protected by the cover of indifference and skepticism.

Personalizing the institutional problem. — The elderly residents and nurse's aides behave the way most humans do. Rather than point the finger at institutional inequities, they personalize life's problems and make each other the target for their frustration. Thus, if elderly residents lead less than dignified lives in many nursing homes, the blame should rest principally on society's indifferent commitment to them. For it devalues old age, it provides the skimpiest resources to nursing homes, it calls upon the least skilled of workers to provide the care, and it then holds nursing homes in scant respect (Vladeck, 1980). The elderly resident, however, scarcely ponders on these societal issues. Rather, in the day-to-day interaction, the anxious resident particularizes the problem and blames the frustration on the lackadaisical ways of the nurse's aide (Vesperi, 1983).

On their part, nurse's aides barely fault society for their personal circumstances or for their poor working conditions. Not that they are unaware how society has uncaringly dumped the frail elderly residents into their care, nor how the profit-seeking nursing home invests minimum resources, seeks maximum returns, and creates difficult work conditions (Rango, 1982). They sense that some elderly people seek to protest their institutional indignities through incontinence, refusal to eat, and untoward behavior.

But in too many nursing homes the institutional culture prevails. Within it aides are only hired hands; no one provides for their affective needs nor cares if it alienates them. And being in the constant company of dependent elderly residents, the aides, too, begin to individualize their problems. They make their wards the ready target of their discontent and resentment.

And that completes the vicious cycle. Two parties, both powerless, little respected, and hardly recognized by society are made to face each other in a difficult setting not of their own making. They are bound in an intimate association, but enjoy little intimacy. Neither party controls the institutional environment in which they exist, neither can break the negative cycle, and so the problem feeds on itself.

Conclusion

The national discourse on quality of life in the nursing homes has scarcely addressed the serious issue concerning the front-line caregiver. It is not merely the skill of nurse's aides, but above all it is their commitment that determines the quality of the care they give. The personal world of nurse's aides, however, is far removed from the culture, and largely shielded from the eyes, of middle class America, which largely populates and runs the nursing homes. Thus the institutional culture of the average nursing home not only ignores the affective needs of the nurse's aides, but it even assaults their self-esteem.

In their concern for quality, advocates and policymakers alike often take the easy way out: they reduce a complex problem to the simple issues of staffing and training. They ignore the social history behind staff apathy and unconcern, and they seldom recognize how the institution may estrange an aide. Such a simple-minded approach is not unlike the ingenuous production strategies that have created the crisis of modern business. Successful Japanese, American, and European companies, however, bear eloquent witness that worker morale, commitment, and productivity respond well to a management policy that respects the social, psychological, and organizational needs of the employees (Chira, 1986; England, 1987; Lohr, 1987a; Lohr, 1987b).

There indeed are exemplary nursing homes that break the hopeless cycle that spawns a common affliction that befalls many nursing homes: severe staff attrition, sagging morale, and indifferent care. These homes create an institutional structure that remains sensitive to nurse's aides' needs, nurtures their idealism, and values their central role. They boost their self-esteem and foster a family spirit that compensates for the troubles of their personal world. They evoke their loyalty and devotion. Loyal nurse's aides become attached to the residents and they walk the extra mile to serve them. That, however, is the substance of another study (Tellis-Nayak, 1988).

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Establishing a Restorative Nursing Program in LTC Facilities

Creative strategies involving both educative and administrative approaches may hold the key to maximizing functional performance of residents.

by Catharine A. Kopac

Given the current personnel shortages in nursing and rehabilitation, and the prospective payment systems that are affecting all health care delivery, long-term care is particularly vulnerable to the effects of staffing problems and cost-containment strategies.

This comes at a time when the number of elderly is increasing, particularly the number of frail elderly with multiple health care problems. Nurse managers are confronted with the task of providing quality care that moves beyond the "bed and body" routines to an individualized restorative focus.

Nursing's Responsibility. Restorative care for many nurses is synonymous with rehabilitation and, because of this perspective, a feeling persists that restoration is the responsibility of the physical therapist. Restorative nursing, however, is the responsibility of nursing. A physical therapist, occupational therapist or speech therapist sees a resident usually for less than one hour per day. During that time, the rehabilitation professional focuses on skilled assessment and evaluation, the establishment of protocols and the provision of skilled services.

Despite interdisciplinary care planning meetings, restorative protocols that require the support and participation of nursing personnel are rarely developed for the nursing care staff. In addition, those routine, repetitive procedures (e.g., learning to dress oneself, learning to transfer, passive and active range of motion exercises, supported ambulation, etc.) that require nursing time are often seen as less important than distributing medications, keeping residents clean and dry, and feeding them. Unfortunately, it is the repetitive, time-consuming tasks that constitute the bulk of restorative care.

Photo courtesy of J. Robert Strickler

The following case is all too familiar: A frail, older person is admitted in an ambulatory state to a long-term care facility. During the first few days that he is in the facility the staff observe that he is weak and unsteady on his feet. Fearing that he will fall, he is instructed not to walk without assistance. He is "caught" several times attempting to ambulate independently and after several days is restrained to prevent ambulation without assistance. Within one month after admission the older resident is weaker, less able to ambulate and is more dependent than at the time of admission.

The downhill course that this scenario describes can and often does apply to other activities of daily living as well. How a long-term care facility chooses to address maximizing the functional performance of its residents is a question that often goes unanswered. Perhaps the solution lies in addressing the need from both an educative and administrative approach.

The Educative Approach. Nursing educators know that the basic elements of restorative nursing are taught during the introductory fundamental course at the beginning of a nurse's education. It is at this time that transfer techniques, range of motion and body mechanics are addressed.

Unless the nursing curriculum has a specific focus on rehabilitation, a nursing student rarely receives further instruction that would prepare him/her for restorative procedures. It should be mentioned that this is often accompanied by limited education in nursing care specific to the aged, and the majority of nurses in practice today have received their knowledge of nursing care of the aged through limited continuing education offerings.

Consequently, a nurse manager is often confronted with nursing personnel, both professional and paraprofessional, who have basic nursing skills but who have had limited instruction in care for the aged and no instruction in restorative care beyond some very basic procedures taught in a fundamentals course. Because restorative procedures do not require advanced skills or instruction, nurses often believe that they know what to do and do not need further education in restorative care. This is not true.

For example, many nurses do not understand the difference in the teaching of transfer, or the transferring of a resident who has had a "right-sided" stroke versus one who has had a "left-sided" stroke. And, a resident with Parkinson's disease who requires assistance with ambulation is approached very differently from one with a fractured hip despite the fact that both residents may be learning how to use a walker.

If restorative procedures are to become a part of the daily nursing care of a long-term care facility, then the nursing care staff (professional and paraprofessional) will have to be taught restorative procedures. Nothing is more frustrating for a rehabilitation professional than to spend several days working with a resident in an attempt to teach independent transfer only to find that the nursing staff transfers the resident or the resident is transferred inappropriately.

The Administrative Approach. Education by itself cannot create a restorative nursing care program. Such a program needs the support of a facility's administration, not only to educate the staff, but to create a system that will allow for the performance of restorative procedures. Such a system must take into account the current staffing shortages and type of procedures that make up the preponderance of restorative care. It must also address the interdisciplinary nature of restorative care because without the collaborative efforts of nursing and the rehabilitation staff, a restorative program cannot be successful.

RESTORATIVE NURSING ASSISTANT

Programs of Responsibility RNAs May Be Trained In:

- Basic Therapeutic Exercise
- Positioning and Range of Motion
- Ambulation
- Activities of Daily Living
- Application of Modalities (Hot Packs, Ice Packs, Massage)
- Support Assistance to Rehabilitation Professionals Evaluations, Tests and Complex Treatments

One approach to providing ongoing restorative care is to train nursing assistants in restorative procedures. This training is above and beyond the training mentioned earlier. In this training, one or two nursing assistants (the number depends on the size of the facility) are carefully selected by the nursing administration for a four- to six-week training period, during which the nursing assistant works directly with a physical therapist and learns specific non-skilled procedures and protocols that can be carried out at the direction of the physical therapist. The restorative nursing assistant does not need to be under the direct supervision of the rehabilitation professional but can be supervised by a nursing professional once training is complete.

The remaining nursing assistants who have been trained, but not as intensively, give nursing care that is supportive to the restorative program, for example, performing transfers correctly.

The restorative nursing assistant works with those residents who have been evaluated by a rehabilitation professional and had protocols established. When there is no need for skilled services and a resident is placed on a restorative program, he/she should be evaluated at least monthly to determine the effect of the program and whether there is a need to change the protocol.

The restorative nursing assistant (RNA) provides a natural "bridge" between nursing and the rehabilitation professionals. The RNA can be administratively responsible to nursing while being programmatically responsible to the physical therapist or the occupational therapist who determines the protocol for the patient.

This arrangement enables nursing to supervise the work of the RNA and determine if the nursing care staff is providing the support for the restorative programming. It enables the rehabilitation professionals to monitor and evaluate non-skilled restorative procedures for which they may have neither the time nor a reimbursement mechanism to provide the service. It enables nursing to have effective carry-through on restorative procedures because if a trained RNA is assigned to perform only restorative care, then those procedures which often are ignored in favor of "bed and body care" are a part of a particular individual's job description and, therefore, are more likely to be carried out.

Summary. Nurse managers in long-term care are confronted with providing quality care despite personnel shortages and decreasing monies. Creative strategies need to be used to move toward and/or maintain a nursing care focus that goes beyond "bed and body" services to one of individualized, restorative care.

One such strategy is to use both educative and administrative approaches and create a restorative nursing program. Such a program has the advantages of having educated staff, designated personnel, and administrative support to carry out procedures and protocols that make a difference in the everyday functioning of long-term care residents. **B.O.N.**

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RA COORDINATED REHABILITATIVE EXERCISE IMPROVES QUALITY

Nancy Farnham and Judy Moffett

For eight years, Villa Maria, a 132-bed skilled long term care facility in Fargo, North Dakota, used restorative care aides (RCAs) to assist in the rehabilitation of patients not requiring physical or occupational therapy. The RCAs provided assistance with resident activities such as walking and range of motion (ROM) exercises. In 1987, however, we decided to eliminate the restorative care assistant positions and reassign those duties to resident assistants (nurse assistants). The change has proven to be very effective.

Need for Change

The RCA position had many inherent problems associated with it. One area of great concern was the way residents were scheduled into time slots to walk or do ROM exercises. The RCA approach did not take into account the resident's time frame. A person's activity desires or other interests became secondary to the restorative care aides' time schedule. Villa Maria's pride in being a resident-directed facility did not coincide with the impersonal scheduling practices associated with the existing program.

Neither did the RCA approach provide any motivation. A restorative care aide might walk a resident the length of the hallway and back to his or her room at 10:30 a.m. every day. The walk itself would have no purpose other than the brief physical exercise.

Another area of concern with the RCA method was that it fragmented the residents' care. We have worked with holistic primary care for several years and found it is essential for each resident to forge a consistent relationship with a caregiver. This allows the resident someone who understands all of his or her specific needs, instead of having to deal with several different caregivers who each treat only a portion of those needs.

RCAs worked with residents who no longer required the higher level of therapy. One side-effect of this was that the primary caregiver had little direct contact with the physical therapist, thus inhibiting communication. Adding to the inconsistency, RCAs were only on duty Monday through Friday, leaving residents without any exercise assistance on weekends. Restorative care aides often commented that, for some residents, it was "like starting over" every Monday.

Reassigning exercise duties to resident assistants (RAs) had many positive effects. The procedures are now done in a more functional, meaningful manner. For instance, exercises are done while dressing in the morning, increasing a resident's awareness and motivation for the exercise. The resident finds it is easier to put on a sweater by stretching an arm out just a little bit farther.

Many residents are leaving their wheelchairs to walk to activities or to the dining room for meals. This gives walking a purpose and also allows people to use regular chairs for meals. Sitting closer to the table makes it easier to eat unassisted, and the decrease in wheelchairs has made the room less congested.

The change has also meant that the person who is walking with the resident knows him or her very well and is aware of how he or she is feeling on a day-to-day basis, which can affect activity levels.

The relationship resident assistants have with residents is motivational because residents trust their caregivers and realize the RAs understand their capabilities and limitations. RAs know each resident's routine and activity interests, which enables them to fit exercise into the residents' schedules in a convenient, functional way. And since resident assistants are on duty seven days a week, residents receive more consistent exercise.

The elimination of the RCA position has opened up the lines of communication from the physical therapist to the RAs. This means the direct caregivers are getting expert advice firsthand, maximizing their ability to provide high-quality care.

A New Start

Implementation of this new approach took three months. During this time we conducted several educational sessions for resident assistants, including a workshop for the RA team leaders with the physical and occupational therapists on walking safety, positioning, and ROM exercises. Written material was available for all RAs on these subjects. The RCAs worked side-by-side with RAs to show their approaches with different residents.

The physical therapist also worked with the RAs, checking techniques and offering suggestions for individual residents. A new communication system was put in place to make sure residents did not "fall through the cracks" when they no longer needed physical therapy. We also developed a documentation system for the RAs' new duties.

The quality of care at Villa Maria has improved markedly through this new approach. Moving rehabilitative exercise within the responsibility of the RA is not only more efficient, it is a much more effective way to serve the resident. ■

Nancy Farnham, RMT-BC, LSW, is the coordinator of the rehabilitation and recreation department of Villa Maria. Judy Moffet, RN, C, MS, is an aging services specialist with Lutheran Hospitals and Homes Society (LHHS), a health care multisystem which owns and leases 35 facilities in 11 states. Villa Maria is a subsidiary of LHHS and both are located in Fargo, North Dakota.

Quality Care ADVOCATE
National Citizens' Coalition for Nursing Home Reform
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Removing Restraints: Changing The Face of Long Term Care

New Hampshire nursing home administrator Jeanne Sanders no longer sees unshackling residents from physical and chemical restraints in the relatively narrow terms of changing a standard of practice. A year after the New Hampshire Health Care Association declared New Hampshire would become the first restraint-free state, she has acquired a new vision of nursing homes.

"A place where visitors like to visit and employees like to work," she says. "Where residents can increase their level of functioning, enjoy themselves, even go home again."

Sanders, who is president of the NHHCA and owner/administrator of Golden View Health Care Center in Meredith, says she has seen changes in her facility in one year that make her question why dread and family guilt have to accompany nursing home placement. She has released 126 residents from restraints and seen people acquire a new zest for life after entering the nursing home.

"They're animated, smiling, they have more visitors," she says.

Residents whose sole exercise used to be passive range of motion go on their own to a mobility room where their activities include punching a boxing bag. A native of Sweden who was both physically and chemically restrained has a tutor helping him learn to read in English.

Maine ombudsman Joan Sturmthal, who is applying for funds to bring a program like New Hampshire's to her state, calls Golden View "amazing."

"The morale of the staff is just

see New Hampshire, p. 3

Quality Care Advocate is supported by the American Association of Retired Persons

Providers Find No Magic Formula: 'You Have to Assess! Assess! Assess!'

New Hampshire, from p. 1

incredible," she says.

Sturmthal visited Golden View with an administrator she knew. She said he observed the smiling, active residents in Sanders' facility and told her, "Your residents are in much better shape than ours."

"But they *weren't*," Sanders told him.

Eliminating Restraints

Sanders is committed to *eliminating*, not reducing, physical and chemical restraints, but several Golden View residents are still chemically restrained.

"It hasn't been an easy time," she says, stressing that her nursing home, like other pioneers, is groping to find underlying causes and treatment for conditions that cause aggression, wandering, screaming and falls.

More formal research about these conditions is needed, but meanwhile, providers are relying heavily on their own assessments of residents' needs.

"Assess, Assess, Assess!"

"Everyone wants to know what's the formula," says Sanders. "I tell them everyone is different — you have to assess, assess, assess!"

In looking back at how residents came to be restrained, she says, staff often find a one-time situational occurrence.

For example, a new resident is admitted, becomes disoriented, and falls. The nurse calls the physician, who orders a physical restraint, which makes the resident belligerent. A chemical restraint is then prescribed to control the belligerence. By now, the resident has acquired behaviors that make staff afraid to remove the restraints.

Now, says Sanders, staff keep asking why residents act as they do.

"We tell staff everybody here is somebody just like you are. Put yourself in their place."

Inspiration for Movement

The inspiration behind the movement to end restraints in New Hampshire is Vivienne Wisdom, executive director of the NHHCA. Wisdom says *her* inspiration came from NCCNHR consultant Sarah Burger.

"If it could be done," Wisdom decided after listening to Burger, "I decided my members should have the information."

Since the spring of 1989, at least 34 percent of NHHCA's members have become "virtually restraint free and maintain a restraint-free philosophy," she told the American Health Care Association in June. "The other 66 percent have made significant progress."

NHHCA's Guru

The "guru" of NHHCA's training program is Eileen Bateman, a rehabilitation nurse who was involved in mental health reform in the 1950s and 1960s.

"What we're doing in nursing homes is a piece of cake by comparison," she tells nursing home staff of the days when mental hospitals were releasing physical restraints and remotivating institutionalized patients who were sometimes violent.

Bateman's training is in demand throughout New England, and Wisdom and her members have addressed providers in numerous states, including Kentucky, Indiana, Oklahoma, Iowa, New York and Arkansas.

Joan Sturmthal says Bateman "makes so much sense you wonder why nobody thought of this before."

Sturmthal has talked to several New Hampshire administrators who have followed Bateman's program on eliminating restraints.

"It's like they've been converted to a new religion," she says. "Once people have the tools, they feel a lot more confident."

Training Program

The first recommendation Bateman gives is not to try to become restraint-free overnight. Releasing more than two residents a week may overwhelm staff.

see New Hampshire, p. 4

Phyllis Foster and Jeanne Sanders of Golden View Health Care Center in Meredith, N.H., and Vivienne Wisdom, president of the New Hampshire Health Care Association, shared their experiences with restraint reduction with other providers at an American Health Care Association meeting in Washington, D.C. When Golden View decided to become restraint-free, it held a restraint-burning party to let the community know about its philosophy.

'Expectations Have Changed, And We Can Change with It'

New Hampshire, from p. 3

Bateman says individual residents cannot be rushed, either. They should be assessed for medications that contribute to loss of blood pressure, dizziness and falls. If drugs are reduced or discontinued, residents need a few weeks to get them out of their system.

"Releasing restraints is making us look at all drugs — cardiac, hypertensive," says Jeanne Sanders. "Five years from now we'll realize we give too much of all of them."

Mobility Program

A mobility program to get unused muscles moving again also is essential, says Bateman. She warns that residents whose muscles are severely contracted or whose joints are diseased by arthritis may not be able to stand or even to sit in a chair without some kind of restraining device.

"We may never retrieve *these* people," she says, "but 95 percent can be released."

Bateman helps nursing homes set up mobility rooms where residents can continue to build physical strength and increase activity.

Bateman says eliminating restraints does not require more staff in nursing homes that comply with regulatory requirements to release and reposition residents at least once every two hours. Restrained residents require more time than those who are able to take care of their own needs.

Fear of Injuries

Fear of injuries and lawsuits creates provider resistance to removing restraints, but Bateman and Wisdom agree with research showing that falls cause fewer injuries — and less serious injuries — than restraints. [See page 5.]

"There are 40 to 50 deaths a year from restraints," Bateman says, "and not just from improper use of Poseys."

"I address the negatives up front," says Sanders. "Falls, litigation, runaways — some negative things will happen."

Even so, says Sanders, most falls at her facility have not occurred among residents who would have been restrained.

"The standard of practice in the past was safety with no risk-taking," says Wisdom. "Now the standard of practice will be independence to the greatest extent possible, which will include some risks."

Families

Bateman tells providers to educate families about the risks of using, as well as not using, restraints. She recommends that nursing homes hold a social event where the new federal guidelines are posted and surveyors' expectations are explained.

If family members or legal guardians want a resident to be restrained, she recommends requiring them and the resident to sign a form acknowledging they have been informed of the dangers.

Jeanne Sanders says when families at Golden View were resistant to removing restraints, staff asked them how *they* would feel in their parents' place.

"What would their mother do if she made the judgment? As they saw what was happening, they embraced our philosophy."

Meeting Expectations

Wisdom does not believe in reproaching providers who have used restraints.

"We were meeting expectations. Now those expectations have changed and we can change with it."

Addressing the American Health Care Association in June, Wisdom told fellow providers, "Restraint reduction is changing the public's perception of us. It will change the face of long term care."

For more information, contact Jeanne Sanders, Golden View Health Care Center, RFD 3, Box 51, Rte. 104, Meredith, NH 03253. (603)279-8111. Vivienne Wisdom, New Hampshire Health Care Association, 125 Airport Rd., Concord, NH 03301. (603)225-0900. Or Eileen Bateman, RR 3, Box 716, Wells, ME 04090. (207)646-7329. ■

Consumers, Providers Respond to Call For Training to Reduce Restraints

Consumer advocacy groups, ombudsmen and industry associations throughout the country are responding to the opportunity to educate their constituents about eliminating restraints.

Washington State Nursing Home Resident Councils, for example, and the Land-of-Sky Regional Council in North Carolina have sponsored conferences that involved consumers and offered continuing education credits for nursing home personnel. The Canton, Ohio, Alzheimer's Association held a workshop on reducing physical and chemical restraints as part of a series on Quality of Life Issues for Nursing Home Residents.

A number of state trade associations are sponsoring training and other educational programs for their members. The Kentucky Association of Health Care Facilities reports it is "advocating a healthy restraint free environment and doing everything possible to educate our members on the best possible way of achieving this goal."

The New Hampshire Health Care Association recommends that states develop their own experts, model facilities and programs to address problems, such as falls, that concern their constituents.

"Use someone from outside for the first exposure," says director Vivienne Wisdom, "but you'll have members succeeding very soon who can share."

Change of Pace For Alzheimer's Patients

Patiently prompting a severely demented resident to manage ADLs can be more appropriate activity therapy than hurrying her off for conventional recreation.

JEANINE NIEMOLLER

When the interdisciplinary team walked into the dining room in our nursing home, the noise was deafening. One resident was shouting "Here, here. You, come here." Another was reciting the Hail Mary in time to the banging of her spoon. Few residents were eating.

The caregivers themselves looked harried and unhappy. The activity board read "Ring Toss at 1:30," and the activity aide was urging staff members to hurry up and "get these folks down to the activity room."

The residents included people with Alzheimer's and other dementias, cortical atrophy, and cerebrovascular accident or disease. They had memory loss, language deficits, and behavior problems; many were withdrawn or loud. All of these residents had previously been separated from the alert and oriented patients in other parts of the nursing home.

Despite our best efforts, the unit was floundering, and our staff was frustrated. The Medicare survey team had suggested the recreational program was lacking.

Help Them Help Themselves

The multidisciplinary team—an occupational therapist, physical therapist, activity director, social worker, a nurse practitioner, nurses' aides, and the director of nursing—got together to brainstorm.

We wanted better care for these residents and staff satisfaction. For any expenditures from the corporation, such as for added staff, we needed a goal and justification. We started by putting our philosophy in writing: *To enhance the quality of care and dignity of life for residents by allowing them opportunity for participation in activities of daily living including mobility, eating, dressing, grooming, hygiene, toileting, and decision making in these activities.*

This seemed very simple and basic, but we felt that hurried, marginal

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Jeanine Niemoller, RN-C, is assistant director of nursing at Ivinson Memorial Hospital Extended Care Facility, Laramie, WY. She earned the NADONA/LTC Founder's Award for this project.

care had evolved in our desire to meet schedules for meals, recreation, and other activities. Up to now, caregivers had found it more expedient to perform grooming, dressing, and other tasks rather then encourage the residents to care for themselves. It seemed more efficient to place residents in wheelchairs rather than encourage them to walk part way to the dining room. Because they were messy and reluctant to eat, it was faster to feed the residents than let them use a spoon.

In our new program, activities of daily living would be considered *activity therapy*. This change would reduce the number of other "recreational" activities planned for these mentally limited residents, who frequently found standard recreation to be beyond their mental capacity. Traditional recreation would be replaced by simple self-care activities tailored to each person's abilities and needs.

This new concept was introduced to the staff in inservice courses. Most staff thought of activity therapy only in terms of games, music, and parties. Hair and nail care, washing, and walking were seen as aide duties rather than resident activities. As we promoted the new unit as a Rehabilitation Unit, other interested and caring staff people were recruited to work with our special team.

Administration agreed to additional staffing hours. Several new staff members were hired, including a new staff nurse who cared for only these patients.

The social worker and occupational therapist taught the staff how to use validation instead of reality therapy with severely demented residents. The physical therapist introduced rehabilitation concepts and techniques.

Measuring Self-Sufficiency

Now that we had decided how we wanted to change things, we needed a way to tell if the changes were improving the functioning of our elders. The director of nursing and the occupational therapist couldn't find a useful measurement tool, so we designed our own.

As part of an activity consultation the occupational therapist and the nurses documented personal information including family history, resident likes and dislikes, previous hobbies and life experiences, and the resident's medical diagnoses. The occupational therapist, physical therapist, and director of nursing evaluated each resident in five areas:

- Sensorimotor function: reflexes, fine and gross motor coordination, muscle strength, physical endurance, body awareness.
- Cognitive function: orientation, conceptualization, comprehension.
- Psychosocial function: decision making and ability to interact.
- Daily living skills: physical and psychological abilities, capacity for work, play, and leisure.
- Therapeutic adaptation: ability to manipulate the environment.

A treatment plan with short- and long-term goals was developed for each participant. Three-month reviews were done to measure change, and care plans were adjusted as changes occurred. The major activities evaluated were toileting, dressing, grooming, fluid intake, meal transfer, and mobility. Levels of participation were listed for leisure/helping activities and social/mental status.

Nurses' aides had master sheets that enabled them to record residents' level of participation in each activity every day for one month. For each activity, this sheet offered three levels of participation the aide could circle: *self, prompting,* and *with help.*

Giving Creative Assistance

For each activity, the caregivers were instructed to allow self-care first, then try prompting. If necessary, the aide could provide set-up and some assistance. Only after several trials would the aide perform the activity for the patient.

The caregivers were instructed to give verbal cues and discuss the task in relationship to the resident's past. For example, during hair care, the aide might ask if the resident had ever gone to a beauty shop; this might cause the resident to associate the care with a more pleasurable experience and bring about discussion.

Talking about children was particularly helpful during grooming. Even the most resistant of residents would usually respond to this topic. The response was so favorable, it prompted the social worker to purchase a doll for a resident to "mother." When the resident was allowed to care for her "baby," her resistance to caring for herself declined and, at times, disappeared entirely. Grooming became a positive experience instead of a battle. Residents were observed dressing, feeding, talking to the dolls, and being caregivers.

At the end of one year, we had a mountain of data. We felt the program had made a difference, but until the data were analyzed, we had no clear picture. The University of Wyoming School of Nursing's Research Center helped us sort through it. In all, we were able to use data from 17 of the 21 residents in the sample who were involved for the year. Indicators of improvement or loss of ability were identified, and status was recorded as improved, unchanged, or exhibiting loss of ability. Loss of ability was rare.

At the end of the study, 7 (41%) of 17 residents improved in sensory motor skills and 4 (24%) had better cognitive function. The most observable change was psychosocial, where 8 (47%) improved. Therapeutic adaptation showed no change in all but two residents. Two residents declined or showed no improvement in all areas. We felt the improvements were significant as all participants were expected, by virtue of their diagnosed illnesses, to decline in ability.

Now, after a year, the picture in the dining room is noticeably different: The noise level is lower; repetitious noise and self-stimulating behavior are gone. The resident who a year ago was shouting "here, here," now smiles and waves hello. And the caregivers themselves are smiling as they give one-on-one care.

Is this type of program worth the extra cost? Our corporation thought so. After seeing our results, they kept the extra nursing staff that had been hired, and also kept the occupational therapist as a consultant. They agreed that the program we designed had made a big difference. GN

The Medical Director: A Job Description For The 1990s

Medical directors wear many hats, and it doesn't look like there will be many dull moments in the future, either.

by Roman M. Hendrickson, M.D.

A great diversity exists in the responsibilities of medical directors within their respective institutions. Few, if any, facilities have evolved a firm job description replete with guidelines. There exists no mechanism for certification or licensing of such individuals, and there are no uniform methods set forth for evaluation of their activities within long-term care facilities.

Looking forward to the 1990's, we need to address where the medical director has come from, where he currently finds himself (or herself), and where medical directors will be in the future.

Mandated by federal legislation in 1974, the medical director was to be responsible for "overall coordination of medical care within the facility, and to insure the adequacy and appropriateness of the medical services provided to patients." Additionally, "the medical director was to maintain surveillance of the health status of the employees, including freedom from infection and routine health exams."

Dramatic Expansion. The position of medical director has expanded dramatically from its original limited description in 1974 to encompass many major areas of activity within long-term care facilities. Shaped by the geographic, administrative and financial characteristics, and restraints of each locale, and given the individual talent and styles of medical directors as individuals, the job description emerges as slightly different at each facility.

Although no one medical director will perform each task described herein, most would agree that the tasks described represent the spectrum of activity addressed by medical directors of long-term care facilities today. Using this base, a more standardized approach to the generation of a job description for all medical directors can evolve for the coming decade.

The medical director serves in many administrative roles. These include, but are not limited to, the following activities:

- Meeting and working regularly with the administrator and director of nursing.
- Creating and monitoring the mechanisms for enforcing institutional policies and procedures, and maintaining their review periodically. (Legislation mandates review at least annually.)
- Keeping the medical staff informed of any changes in policy and procedures.
- Developing medical criteria for admissions, discharges, and utilization.
- Participating in utilization review, infection control, patient care, pharmacy, and safety committees.
- Reviewing medical staff credentials, as well as organizing and monitoring the medical staff.
- Maintaining communication between administration and all providers of professional services within the facility.
- Monitoring and evaluating the psychosocial and physical environment of the facility.
- Identifying social, medical, and economic changes and incorporating them into policies and procedures in an effective fashion.
- Maintaining knowledge and skill needed to address ethical issues related to long-term care.
- Participating in any required disciplinary action of the professional caregivers within the facility.
- Participating in establishing and monitoring criteria for employment, as well as employee effectiveness.
- Preparing the medical director's written report to the administrator (at least quarterly).

An Educator's Role. The medical director must also act as an educator in a variety of circumstances. These include education of family members, administrators, insurers, regulators, political figures, patients and patients' families, as well as attending physicians and other professional caregivers within the institution. Some of the tasks specific to this role include:

- Attending and conducting regular meetings with the professional nursing staff to develop and conduct educational programs.
- Identification and development of appropriate topics for in-service training, pertinent to the specific institution, evolved through observation and evaluation of an on-going patient care within that institution.
- Ensuring medical education addressing new care techniques and diseases.
- Participating in educational pro-

grams for patients, patients' family members, and the community at large.

- Providing educational offerings to the professional staff concerning ethical, regulatory, and legislative matters.
- Obtaining and ensuring his or her own personal continuing education for self improvement in areas related to geriatrics and long-term care, as well as appropriate governmental regulatory matters.
- Where appropriate, writing articles for in-house publications.

Service Coordination. The medical director must also act as a coordinator of physicians and professional services relating to the delivery of patient care. It is within his or her job description to define the responsibilities and establish systems of accountability for the delivery of professional services. Some of the tasks involved in this area include:

- Organizing the medical staff.
- Developing and instituting periodic review of the by-laws governing physicians services within the facility.
- Ensuring compliance by the professional staff with local, state, national, and facility requirements.
- Facilitating the activities of inter-disciplinary team activities in patient care.
- Arranging for and ensuring the availability of qualified consultative staff. Assisting in the responsibility of assessing and assuring quality, timeliness, and appropriateness of services rendered to patients within the facility, as well as their appropriate documentation and maintenance of quality records.
- Providing medical coverage for emergency situations of all individual patients within the facility, as well as assuring that appropriate emergency equipment and drug supplies are kept available to meet emergency patient needs.
- Assuring the availability of services and staff necessary to carry out the goals of the facility.
- Participating in the development of PRO contracts, and monitoring PRO activities.
- Developing policy and procedures related to those individuals participating in educational activities within the facility, including physicians, residents, medical students, and student nurses.
- Reviewing and being prepared to make summary decisions concerning admission, orders, and/or transfers which might be considered inappropriate.
- Conducting regular meetings with providers within the facility.
- Participating in patient care plan generation and review, not only for his or her own patients, but the patients of the facility as a whole.

Care Evaluation. Involvement in medical care evaluation so as to assure appropriateness and quality of patient care is imperative for the medical director of today's long-term care facilities. Programs designed to assess quality care also ensure compliance with governmental regulations. Tasks directed in this vital area include:

- Establishing basic standards and criteria for quality medical care and physician performance.
- Monitoring physician performance as it pertains to patient care within the facility.
- Evaluating and reporting the results of on-going medical care evaluation studies to the medical staff and nursing home staff.
- Making recommendations that lead to revision or creation of policies and procedures within the institution, stemming from the results of quality assurance program activities.
- Participating in committee activities responsible for implementing policies and procedures, including those mandated by law, such as drug level monitoring, laboratory indicator monitoring, etc.
- Maintaining knowledge and implementing national standards of care where appropriate.
- Reviewing, on a regular basis, admissions, transfers, and discharges of patients so as to assure appropriateness.
- Establishing criteria and participating in the monitoring of quality of life within the facility, and assuring that the confidentiality of information concerning residents and staff is maintained.
- Participating in the monitoring and evaluation of injuries and illnesses among employees and residents of the facility.

Public Relations. The medical director acts as the representative of the long-term care facility to the medical profession as well as the lay community. It is his or her responsibility to articulate the facility's mission within the medical and lay community. He or she must be prepared to explain, define, and plan the role for that facility.

It is the medical director who identifies issues and negotiates solutions to problems involving outside institutions and programs where possible. In this role, he or she acts as an advocate for the facility within the community and promotes a more positive image for the facility. Tasks relative to this function include:

- Participating in the activities of the local medical care community, including those activities of the hospitals, hospices, professional organizations, and charitable organizations of the lay community.
- Assisting the community, both medical and lay, in achieving a realistic understanding of the facility's capabilities and services through public appearances and other communication vehicles.
- Encouraging and facilitating community involvement within the facility's activities.
- Participating in health care planning for the community.
- Participating in geriatric committees and long-term care committees of medical organizations where possible.
- Networking with all appropriate community, lay and medical groups.
- Representing the facility in the event of untoward events.

Health And Welfare. Employee health surveillance, health promotion, and maintenance of safety is an additional responsibility assigned to the medical director and mandated by federal regulations.

The medical director should have input into evaluation of employee skills and competency, as well as the health and welfare of the staff, and by doing so will also help promote and improve motivation and competence of the staff. His or her role in participation of the pre-employment assessment, wellness program, as well as back to work program for the injured and, where appropriate, care for the injured and ill employee is in this direction. Specific tasks associated with this role of the medical director include:

- Participating in a pre-employment process on employees that includes a physical capacity assessment.
- Participating in a program to monitor, evaluate, and modify activities of employees so as to prevent in-

jury and disease where possible.

- Developing and monitoring policy to help ensure the health and safety of visitors, volunteers, and residents.
- Promoting employee wellness programs, such as weight reduction, exercise, moving and lifting therapy, etc.
- Assisting in the development and monitoring of programs to control patient behavior and prevent employee injury.
- Helping to develop a modified work program more appropriate for injured employees.
- Encouraging the use of assistive devices by employees.
- Participating in the activities of the safety committee.
- Working with a program for employees with social or substance abuse, including intervention and rehabilitation, when appropriate.
- Monitoring community trends in infectious diseases.
- Helping to identify community resources available for employees with psychological or social problems.
- Helping to develop policies and procedures to monitor and control health hazards for employees.

On-going Expertise. Maintenance and application of on-going expertise in social, regulatory, political, and economic factors relating to patient care services is also an imperative for the medical director of today. Assurance that the medical director is informed and active in this area can avert an adversarial relationship with local, state, and federal regulatory agencies who are more and more active in the monitoring of health care delivery within long-term care facilities. Specific tasks associated with this role for the medical director include:

- Continuing efforts on the part of the medical director to maintain current knowledge and updates on federal rules and regulations, as well as those of local and state regulatory agencies.
- Maintaining a current understanding of the mechanisms involved in long-term care reimbursement.
- Maintaining an on-going effort to achieve adequate reimbursement for medical directors and attending physicians.
- Actively participating in cost-containment decisions that affect medical care, such as the use of formularies, contracts, appropriate lab equipment, etc.
- Participating in the facility budget process to assure availability of resources for medical functions.
- Maintaining competence in interpretation and communication to the administration of the facility, of the social, regulatory, political and economic factors that affect medical care within that long-term care facility.

Leadership. The leadership role in research and development activities within long-term care facilities is an expected role of the medical director. Where appropriate, applied research activities may serve as a planning tool and allow the medical director an opportunity to develop and implement the results of such studies, including the federally mandated medical care evaluation studies, so as to increase the effectiveness and efficiency of patient care. Some of the tasks relative to this area include:

- Serving as a chairman of an institutional committee to review research projects, with special attention to assure that proper safeguards are implemented for patients involved within those research projects.
- Serving as a mentor to medical school students, physicians in training, other physicians, and other health care professionals who might be involved in a training role within the institution.
- Understanding and maintaining confidence in basic research methodology.
- Applying pertinent research findings to policies and procedures as well as quality assurance.
- Fostering a facility-wide attitude that is supportive of research and open to change.
- Assuming responsibility for development and implementation of informed consent/permission forms for research participants.
- Utilizing sound research methodology when conducting medical care evaluation studies.
- Promoting educational opportunities that exist within the long-term care facility for students preparing for positions in the health care professions.

Ethical And Legal. Medical director participation in ethical and legal activities within the long-term care facility is another important role. His or her participation in the establishment of policies and procedures that are designed to assure the rights of all individuals within the facility is required. Specific tasks related to this ethical-legal role include:

- Using the patient bill of rights as a guide to assuring patients' rights.
- Establishing a system for identifying and monitoring abuse developing a profile of the potent abuser.
- Assuring that policies and procedures reflect the intent of the patients' bill of rights.
- Establishing a mechanism for ensuring that ethical and legal rights of incompetent patients are respected.
- Maintaining current understanding as it applies to established legal precedents relating to residents' rights.
- Identifying community resources available to help resolve ethical and legal issues, like the health department, ministerial association, etc.
- Helping to assure the rights of patient self-determination through the use and promotion of living wills and durable powers of attorney.
- Assisting to assure that family concerns are addressed in patient care plans.
- Establishing policies and procedures for physicians to follow in determining a limited treatment pl such as "No Code" and variati thereof.
- Participating in the activities of the institutional biomedical ethics committee, where one exists.
- Ensuring the patients' rights to privacy and confidentiality.

A Consensus Opinion. The aforementioned nine roles and the myriad of tasks associated with each reflect a consensus opinion generated by a group of nationally prominent medical directors. They were produced at a consensus conference held in January 1988, under the direction of Dr. James J. Pattee at the University of Minnesota. This conference was convened in an attempt to better define the role of the medical director, and how it should evolve. This presentation was excerpted from the opinions generated during that conference, and it is hoped will give some direction to current medical directors in further evolving their own job description for the 1990s. **CLTC**

Roman M. Hendrickson, M.D., president-elect of the American Medical Directors Association.

TOPICS
IN GERIATRIC MEDICINE AND NURSING HOME CARE

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The Role of the Medical Director in the Nursing Home

James J. Pattee, M.D.

In the fourteen years since the federal articles of participation required that a physician serve as a medical director in a nursing home, there have been attempts to eliminate the position, as well as attempts to define the role. At the present time, there are no empirical data that support the role of the medical director in the nursing home. Boards of directors, administrators and directors of nursing all have varying opinions concerning the importance and effectiveness of medical direction. In this article I will describe some historical events in the development of the role of the medical director, a consensus conference that was held in Minneapolis in 1988, and then describe the course which has developed as a result of the consensus conference.

On three separate occasions since 1975, the federal government has attempted to rewrite the articles of participation. In each draft, initially, there was an attempt to eliminate the requirement for a medical director. Each attempt to eliminate the requirement was defeated because of the overwhelming support of consumer groups for the medical director requirement. The American Medical Directors Association, the American Medical Association, and the American Geriatric Society all voiced their support. However, the voice of consumer groups was most persuasive. Society expects physicians to be involved in the care of residents of nursing homes, and the consumer groups felt that the requirement for a medical director was one way to assure physician involvement. Even the recent OBRA regulations proposed at one time that a nurse take over the functions of the nursing home medical director. This proposal was rejected, but not without some serious discussion.

In the early 1980s, at a national convention of the American Health Care Association in New Orleans, the delegates to the convention hotly debated the proposed elimination of the medical director requirement. AHCA support for the requirement to retain the medical director requirement narrowly passed. Obviously, among the administrators and other providers of care within the nursing home, there still exists a question about the value of the medical director. The ambiguity that surrounds the role of the medical director is probably a source of some of the differences of opinion.

The Role Depends on Who Defines It

What is the role? Every nursing home has group decision-makers, such as the board of directors or owner, the administrator, the director of nurses, and attending physician, as well as the medical director. Each of these individuals has a role to play in the organization. This role is determined by the expectations of each of the individuals within the nursing home organization. The behavior of the administrator is determined by the expectations of the board of directors, the director of nurses, and the physicians in the community. This behavior is the manifestation of what the administrator thinks other people expect him to do--thus the role of the administrator is cast. Administrators have expectations of a medical director; different administrators may have different expectations. Therefore, we have different behaviors of medical directors in different nursing homes--that is, decision-makers within an organization may vary in their expectations. Therefore, the medical director's role within the nursing home has been slow to evolve and remains shrouded in ambiguity.

A national survey of medical directors by Dr. Fenderson and myself was reported in *Topics* about a year ago and clearly demonstrated that there was no unanimity among the medical directors over their role in the nursing home. Some stated that they made no decisions, since all the decisions were made at corporate headquarters. Others commented that they

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Association
of
Nursing Home Medical Directors

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enjoyed their work and were closely involved with the board of directors, the directors of nurses, and the administrator in decision-making within the nursing home.

1988 Consensus Conference

In 1988, a consensus conference was held in Minneapolis to identify the role, function, and tasks of the medical director in the nursing home. This group of 14 medical directors who met for a day and a half also had extreme difficulty articulating their role, since each perceived the role differently. This difficulty reinforced our impression that the decision-makers in nursing homes have differing expectations of the position of medical director.

The consensus conference was a turning point in the understanding of the role of medical director. While the medical directors in attendance could not agree on a clear definition of the role, they had no trouble in identifying the functions of the medical director, that is, what do they do to carry out the role of the medical director in the nursing home? Initially, they identified twelve functions which, after editing, were reduced to the following seven functions.

1. The medical director participates in administrative decision making and recommends and approves policies and procedures.
2. The medical director participates in the development and conduct of education programs.
3. The medical director organizes and coordinates physician services and services provided by other professionals as they relate to patient care.
4. The medical director participates in the process to ensure the appropriateness and quality of medical and medically-related care.
5. The medical director helps articulate the long-term care facility's mission to the community.
6. The medical director participates in surveillance and promotion of the health, welfare, and safety of employees.
7. The medical director acquires, maintains and applies a knowledge of social, regulatory, political, and economic factors that relate to patient-care services.

After listing the functions, the medical directors identified tasks that they perform to carry out each function.. For each function, 20 or 30 tasks were developed. Each medical director did not perform every task, but someone in the group carried out the task that was described. Since tasks were often performed for more than one function, there was much duplication of tasks throughout the process. The following tasks were felt to be the most important tasks for Function 1.

Function 1: The medical director participates in administrative decision making and recommends and approves policies and procedures.

Tasks:

Highest Priority

1. Meets regularly with the administrator and the director of nursing.
2. Organizes and monitors medical staff.
3. Keeps medical staff informed of changes in nursing home policies, procedures, and state and federal regulations.

Priority

1. Ensures the medical staff has necessary credentials.
2. Maintains communication between administration and providers of professional services in the nursing home as well as organizing and integrating interdepartmental and interdisciplinary activities in the facility.
3. Develops and provides leadership needed to achieve medical care goals.
4. Uses all means available to stay informed of internal and external changes in long-term care.

A Course that Helps Medical Directors Understand Their Role and Functioning

Following this consensus conference, Dr. Tom Altemeier and I have identified competencies helpful in performing the functions and have developed objectives for an educational program for medical directors. During the year 1988-89, we held two medical directors training courses in Minneapolis, which were attended by a total of 45 physicians. This year we have another group of 34 physicians going through the training course. These medical directors are from throughout the United States. We are seeking funding to "metastasize" the training program to other sites in 1990-91. If successful, we will attempt to establish several training sites for these kinds of educational opportunities.

A syllabus and books are distributed to those in attendance to augment the lectures and encourage self-study. The course is presented over a six-month period at three three-day sessions. One purpose is to increase the knowledge in areas of administration, management, organizational culture, leadership, and organizational problem solving. A second focus is quality assurance, focusing on the concepts underlying an effective quality assurance program, as well as suggesting tools that might be useful in the program. A third focus addresses the medical director's role in promoting effective medical care, staff motivation, enhancement of professionalism in the staff, and worker's compensation. Other content areas are biomedical ethical issues, the medical director's role in developing policies and procedures in the nursing home that respect patient autonomy while protecting the interest of everyone: the resident, other residents, families, and staff. Other areas of discussion are committees, group dynamics, working with families, and the medical director as an educator.

Concepts underlying medical organization and administration and the quality assurance program are stressed. Real efforts are made to enhance the value of medical care evaluations. The entire program is less concerned with providing hands-on tools, although some are available, than with developing the concepts which give rationale and support for an effective role of medical direction.

Because the course lasts only nine days (accredited for 63 hours of Category I AMA credits and AAFP credits), a major intent is to stimulate the medical directors to broaden their understanding by seeking out literature and educational opportunities. It is our desire to develop modules of the course that they can be presented in half-day or one-day segments. However, this is rather an ambitious project, since the modules must have consistency in both the strategies for teaching and the competence of instructors.

The American Medical Directors Association has been very supportive of the progress of this educational effort. It is the intent of the organization to develop criteria which will be used to identify individuals who have increased their competence in geriatric medicine and in administrative abilities through attendance at specified continuing medical education courses. When these criteria are met, the American Medical Directors Association will issue a certificate recognizing the educational achievements of a medical director. The intent of this certificate is to provide boards of directors and administrators of nursing homes some help in identifying physicians within the community who have increased competency in medical direction.

The development and participation in this medical directors training course has been a very rewarding experience for me and other members of the medical directors' community. The evaluations from those who have attended and periodic feedback from them state that the course has been exceptionally stimulating to their thinking as well as providing them with a unique background which enables them to effectively and efficiently provide better medical leadership in the nursing home.

In my opinion, without physicians actively participating in the decision-making in the nursing home, the quality of care in the nursing home will be limited. With the active involvement of the medical director and the attending physicians, the level of care can be raised. This opinion is not intended to question the integrity or abilities of other professionals in the nursing homes. However, the knowledge and experience of each player makes a contribution. Each decision-maker has a unique value. The medical directors need to continue to negotiate their roles by identifying the expectations of the other decision-makers in the nursing home. The development of the medical director's course has identified the potential function and tasks of the medical director, and as these become more generally appreciated and accepted, the role of the medical director will be more clearly identified.

Why Is There So Much Controversy Over the Role of the Medical Director in the Nursing Home?

R. B. Breitenbucher, M.D.

Dr. Pattee's discussion should provoke some thought. Undoubtedly, early governmental attempts to rid nursing homes of medical directors may have stemmed in large part from the controversy over the medical versus the social model of nursing homes. In the past, when intermediate care residents predominated, it was easier to understand the basis for controversy. But in today's nursing home there can be no doubt that medical problems predominate. In just eight years, the proportion of skilled care patients in the Extended Care system of Hennepin County Medical Center has gone from less than 50% to 70%. Furthermore, the number requiring heavily skilled care has increased dramatically. Many patients in nursing homes now were kept in hospitals with daily visits by their physicians in the not too distant past. Should this care now be relegated entirely to nurses with monthly visits from a physician? Why is the question of need for a medical director even asked? Why was the vote to retain medical directors only narrowly approved by administrators?

Dr. Pattee points out that the function of administrators is largely influenced by ownerships who have an over-riding concern with the business aspects. This, however, should be all the more reason for desirability of a strong medical director role in decisions that influence patient care. Are the nay sayers among the administrators those who have only used medical directors in a pro forma role where their value is regarded only in terms of conforming to regulation? I have come across some of these, but in my experience, the majority of administrators have been eager to get opinion from the medical director. Could it be that a significant number of administrators have been disappointed in the lack of direction and by the indecisive role of their medical directors?

I suspect those of us who have been medical directors for a number of years sort of fell in or were pushed into the job and have grown in the role by experience. But the job is more difficult and demanding now. In my view, education for new medical directors should be a prime concern for AMDA. Dr. Pattee's course certainly fulfills a need. In a smaller way, it is hoped that *Topics* can also help.

Urinary Incontinence in the Nursing Home

R. B. Breitenbucher, M.D.

Urinary incontinence is a common affliction of the elderly, affecting 5% to 15% living in the community and 50% or more in most nursing homes. Despite the fact that it is not an irremediable consequence of aging, considerable apathy about it exists among physicians, nurses, and patients alike. Economic costs amount to 0.5 to 1.5 billion dollars per year for institutionalized elderly. Even more important are the social and psychological costs of incontinence including embarrassment, isolation, and depression. It is important to recognize that most incontinence in the elderly can either be ameliorated or cured and that long-term catheterization should be employed only as a last resort. The all too common practice of dealing with urinary incontinence in elderly hospitalized patients by use of indwelling catheters and then sending them to nursing homes without performing even elementary studies to ascertain probable factors is to be deplored.

Anatomy of the Lower Urinary Tract

The bladder wall consists of an intertwined mesh of smooth muscle bundles which differentiate into three layers at the bladder outlet. Muscle bundles from the outer and inner layers sweep down and intermesh themselves over the entire length of the female urethra and most of the length of the male urethra to perform the function of the internal sphincter, under autonomic control. At the level of the proximal urethra there is also a ring of striated muscle, distinct from a peroneal musculature of the pelvic diaphragm, and comprises the external sphincter. It is under voluntary control. The surrounding peroneal striated muscles are also under voluntary control and can be used to augment sphinteric function for short periods, being subject to muscle fatigue. Since the bladder neck is normally above the pelvic diaphragm, the effects of intra-abdominal pressure upon the dome of the bladder is offset by similar pressure upon the bladder neck and proximal urethra. Under pathologic conditions, an imbalance is created when the bladder neck descends below the level of the pelvic diaphragm and is a factor in stress incontinence.

In pre-menopausal females the thickness of the estrogen sensitive urethral mucosa contributes to urethral resistance.

Neurophysiology

Maintenance of continence and proper voiding requires well coordinated functioning of the autonomic nervous system.

Bladder contraction is mediated primarily by the parasympathetic nervous system. Beta adrenergic stimulation produces minimal relaxation of the bladder. Closure of the internal urethral sphincter is mediated by alpha adrenergic stimulation. The micturition center in the brain stem is primarily responsible for coordinating and governing reflex arc loop 2 (figure 1). An inhibitory center in the frontal lobe (loop 1) monitors the micturition center. It inhibits loop 2 and bladder contraction until the bladder is full. Sensory input of loop 3 inhibits tonic motor impulses to the pelvic floor musculature, producing passive relaxation of the pelvic floor during bladder filling. Loop 4 maintains volitional control over the pelvic floor muscles and external urethral sphincter.

"Urinary Incontinence in the Nursing Home" to be continued in March 1990 issue of *Topics in Geriatric Medicine and Nursing Home Care*.

REPRINTED WITH PERMISSION OF
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AN ATTENDING PHYSICIAN'S GUIDE TO THE MEDICAL ROLE IN NURSING HOME CARE

Prior to admission

- personally approve a resident's admission to a facility, and the level of care
- advise the facility if you know that a mentally ill or mentally retarded prospective NF admission has not been appropriately screened by a state mental health agent prior to admission

On admission

- assess the resident, and write admission orders
- indicate whether the individual has discharge potential
- place a medical assessment on the chart within 48 hours of admission, which includes a medical review of past history and current status, and an evaluation of physical and psychological condition and functional status;
- advise the staff about a resident's decision-making capacity
- help ensure that the resident is informed of his health status, including medical condition, in a comprehensible language
- certify when residents are incapable of self-administration of medications
- help other staff understand the relationship of the medical plan of care with those of other professional disciplines
- write admission orders which reflect an individual's physical and psychological needs, and wishes, as much as possible;
- designate an activity level consistent with condition and prognosis, as well as specify pertinent limitations to, or precautions for, such activities
- consider whether the patient meets the criteria for receiving Pneumovax or flu vaccine.

Physician visits

- arrange, or provide for, alternative coverage in case you are unavailable
- at each visit, review the resident's total care plan, including medications and treatments, and write, sign, and date a progress note
- in the SNF, visit a resident at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter
- in the NH, visit the resident at least once every 30 days for the first 90 days after admission, and at least once every 90 days thereafter
- make scheduled visits within 10 days of the scheduled date
- make the initial visits personally
- arrange, where desired, for alternate visits to be made by an appropriately supervised physician assistant or nurse practitioner

During the resident's stay, as needed

- perform or request an appropriate assessment of functional levels and rehabilitation potential, and request or approve specific rehabilitative services
- write appropriate orders for the use of restraints, protective devices, and psychotropic medications
- consider and order, as indicated, specific treatments or services that may help the staff maintain or enhance a resident's quality of life and self-determination
- prescribe activity levels consistent with a resident's needs, condition, and interests
- order appropriate measures to try to prevent and manage declines in ADL function
- order appropriate treatment and assistive devices to try to maintain vision and hearing capabilities

- order appropriate measures to prevent or treat pressure sores
- order appropriate evaluation and management of urinary incontinence
- appropriately assess behavior and mental status changes, and consider the possibility of treatable medical illness or psychiatric dysfunction as a cause
- order evaluation and treatment to try to maximize movement and prevent contractures
- order appropriate intervention, testing, and treatment to try to improve or maintain psychosocial functioning
- order appropriate evaluation, diet, or treatment to maintain adequate nutritional and hydration status
- order tube feedings appropriately and judiciously
- order appropriate measures and assistive devices to try to reduce a resident's risk of accidents
- order appropriate therapeutic diets, as indicated
- strive to order medications judiciously, and observe for untoward side effects and complications --especially regarding psychotropic medications
- monitor for possible drug complications in specific residents
- periodically review and sign off on an interdisciplinary care plan
- provide relevant medical information to other caregivers
- periodically reevaluate a resident's physical status and needs, psychiatric and behavioral status and needs; mobility; functional limitations; nutritional status; rehabilitation potential and needs; activity level; and oral status and needs
- request evaluations, consultations, or tests as needed to help clarify a resident's condition, prognosis, and potential to benefit from programs and services
- respond in a timely manner to notification of problems or changes in condition, and status, and order appropriate monitoring, tests, treatments or transfers
- consider the value of certain primary, secondary, and tertiary preventive measures which might improve function, reduce pain and discomfort, enhance autonomy, reduce morbidity and mortality, prevent the spread of communicable illness, reduce subsequent need for more costly and prolonged medical care, or permit a more comfortable dying process
- periodically document in orders and progress notes the reason for the continuation of protective devices
- periodically review the resident's use of, and need for, PRN medications
- specify whether a resident will require medications during a short- or long-term leave of absence, and authorize appropriate supplies
- periodically review the resident's level of care, to ensure that the resident's needs are being met and the placement is appropriate for that level of care
- write necessary medical orders for: pads, mattresses, or cushions; splints or orthotic devices; protective devices; supplemental oxygen; respiratory therapy equipment, or suctioning
- write orders for appropriate special precautions, consistent with an individual's condition or illness

Moving the resident

- certify and document the medical necessity or appropriateness of admissions, transfers, and discharges
- provide an appropriate discharge summary, which includes information about: diagnoses, post-discharge rehabilitation potential, clinical course, current medical orders, and other information pertinent to the individual's care
- as necessary, make or facilitate transfer arrangements.
- provide a pertinent and timely discharge summary

General

- ensure that your orders comply with established policies and procedures, and are consistent with standards of appropriate geriatric care
- respond appropriately and in a timely fashion to questions or items raised by the pharmacist consultant
- provide appropriate orders for necessary laboratory and radiology testing, and follow up in a timely fashion on the results of these reports
- include pertinent assessments, medical care plans, and progress notes in the medical record
- review and cosign physician assistant or nurse practitioner notes and orders on subsequent visits, as required by law or regulations
- complete medical information on the death certificate, in accordance with legal requirements
- as needed, fill out and sign the medical portion of any appropriate incident reports or forms.

Special situations

- assist the medical director and facility in prevention, management, and reporting of significant infections and outbreaks
- order appropriate precautions, preventive measures, vaccinations, or treatment of actual infections, consistent with accepted standards of geriatric medical practice
- assist the medical director in informing staff caring for residents with potentially serious or reportable communicable illnesses
- ensure that the admission of any AIDS patient is consistent with applicable regulations, facility policy, and the capacity of staff to provide needed care
- assist the staff in dealing with difficult families, by providing adequate and timely information and support

Resident rights and ethical issues

- attempt to help other staff respect and enhance certain resident rights, including the right:
    1) to know the identity of his primary attending physician
    2) to information from a physician about his condition and prognosis
    3) to know about procedures and who will do them
    4) to refuse to be a research subject
    5) to freedom from restraints, except as specified by a physicians for justifiable medical and psychiatric needs
    6) to transfer or discharge only for medical reasons or personal welfare
    7) to be involved in care planning and decisions about care and treatment
    8) to exercise free choice of medical care
    9) to preserve personal privacy and confidentiality

- inform the medical director if the resident's wishes, needs, or condition limit or restrict your ability to provide adequate and appropriate care
- offer the resident or family member appropriate information about care and treatment, or any changes in that care or treatment
- help ensure that the resident (unless incompetent or incapacitated) participates in planning care and treatment
- discuss the use of feeding tubes with the resident, or with family or other substitute decision maker, as appropriate, before ordering them
- assist the facility's staff in managing the terminally ill resident, including understanding the condition, prognosis, and care plan

- upon admission, clarify the status of any resident with a known terminal illness or condition
- determine, or request a review of, the resident's decision-making capacity
- inform the facility staff if you are aware of the existence of any documents, such as durable power of attorney or living will, or other statements of the resident's or family wishes
- encourage the resident and family or other substitute decision maker to complete appropriate forms and documents to provide ample written evidence of their wishes and intentions
- order any appropriate medications to help relieve pain or make the dying process more comfortable
- help provide the resident, family, and facility staff with pertinent information about condition, prognosis, treatment options, and possible or likely outcomes of treatment
- consider whether the individual has previously expressed any treatment preferences, or issued any specific instructions for care
- present the treatment options to the competent resident, or to the substitute decision maker for the incompetent resident
- as necessary, inform the administration of any need for the facility's assistance in obtaining an appropriate substitute decision maker consistent with state law
- periodically review a DNR order after reassessing the resident's condition, to ensure that the order remains appropriate, and consistent with the resident's needs and wishes
- clarify any implications of the advance directives for specific treatments such as antibiotic usage or transfer to an acute care facility.

NATIONAL ASSOCIATION OF SOCIAL WORKERS

Social Work Services in Long-Term Care Settings

Social work services in long-term care settings focus on the emotional and social impact of physical and/or mental illness or disability. Goals of social work services may include:

- preserving and enhancing physical and social functioning,
- promoting conditions essential to assure maximum benefits from long-term health care services,
- preventing increased disability or dysfunction, if possible, and
- promoting and maintaining physical and mental health and an optimal quality of life.

The social work service functions which respond to these goals generally include, but are not limited to:

- planning for preadmission and discharge,
- providing psychosocial assessment at periodic intervals,
- care planning as a member of the interdisciplinary team,
- counseling and other psychotherapeutic services,
- developing and utilizing community resources,
- assisting in the preservation of family and other social relationships,
- maintaining community ties,
- working with other nursing home staff to facilitate residents' adjustment to the facility,
- advocating for patients' rights, and
- promoting understanding of each resident as an individual.

The social worker in a long-term care facility should participate in the following:

- policy development and program planning,
- counseling to residents, families and groups at the time of admission and throughout the placement as required,
- development of a therapeutic environment in the facility,
- assessment and care planning to meet the psychosocial and mental health needs of the residents,
- work with resident and/or family councils, and
- quality assurance.

Recommended Qualifications for Social Workers in Long-Term Care Settings

For recommended qualifications for social workers see:

"NASW Standards for Social Work Services in Long-Term Care Facilities".

For more information contact:

Joan Levy Zlotnik, ACSW
Staff Director
NASW Commission on Family and Primary Associations
301/565-0333

MATCHING SOCIAL WORK SKILLS WITH FACILITY REQUIREMENTS: AN INTERACTIVE PROCESS - APRIL 28, 1989

"Social Work in Long-Term Care: Whom Does It Help?"

Sylvia R. Cohen, L.C.S.W., A.C.S.W.

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American Physical Therapy Association

Standards of Practice for Physical Therapy

PREAMBLE

The physical therapy profession is committed to provide an optimum level of care and to strive for excellence in practice. The House of Delegates of the American Physical Therapy Association, as the responsible body representing this profession, attests to this commitment by adopting, publishing, disseminating, and applying the following *Standards of Practice*. These *Standards of Practice* are the profession's statement of conditions and performances which are essential for quality physical therapy. They provide a foundation for assessment of physical therapy practice.

ADMINISTRATION OF PHYSICAL THERAPY SERVICE

I. **Purposes and Goals**

A written statement of purposes and goals exists for the physical therapy service which reflects the needs of the individuals served, the physical therapy personnel, the facility, and the community.

- Define scope and limitation of service
- Contain current description of purpose
- List objectives and goals of services provided
- Are appropriate for the population (community) served
- Provide a mechanism for annual review

II. **Organizational Plan**

A written organizational plan exists for the physical therapy service.

- Describes the interrelationships within the overall organization
- Provides for direction of service by a physical therapist
- Defines supervisory functions within the program/service
- Reflects current personnel functions

III. **Policies and Procedures**

Written policies and procedures, which reflect the operation of the service, exist, and are consistent with the purposes and goals of the physical therapy service.

- Address pertinent information about the following:
  - clinical education
  - clinical research
  - criteria for access, initiation, and termination of care
  - equipment maintenance
  - fire and disaster
  - infection control
  - job description
  - medical emergencies
  - patient care policies and protocols
  - patient rights
  - personnel-related policies
  - quality assurance
  - record keeping
  - safety
  - staff orientation
  - supervisory relationships
- Meet requirements of external agencies and state law
- Meet requirements of overall organization
- Are reviewed on a regular basis

IV. **Administration**

A physical therapist is responsible for the direction of the physical therapy service.

- Assures that the service is consistent with established purposes and goals
- Assures that the service is provided in accordance with established policies and procedures
- Assures compliance with local, state, and federal requirements
- Complies with current APTA Standards of Practice and Guide for Professional Conduct
- Reviews and updates policies and procedures as appropriate
- Provides appropriate education, training, and review of physical therapy support personnel

Staffing

The physical therapy personnel are qualified and sufficient in number to achieve the purposes and goals of the physical therapy service.

- Meets legal requirements regarding licensure and/or certification of appropriate personnel
- Provides expertise appropriate to the case mix
- Provides adequate staff to patient ratio
- Provides adequate support staff to professional staff

VI. **Physical Setting**

1. The physical setting is designed to provide a safe and effective environment that facilitates the achievement of the purposes and goals of the physical therapy service.
   - Meets all applicable legal requirements for health and safety
   - Meets space needs appropriate for the number and type of patients served
2. Equipment is safe and sufficient to achieve the purposes and goals of the physical therapy service
   - Meets all applicable legal requirements for health and safety
   - Meets equipment needs appropriate for the number and type of patients served
   - Provides for routine safety inspection of equipment by a qualified individual

VII. **Fiscal Affairs**

Fiscal planning and management of the physical therapy service is based upon sound accounting principles.

- Include preparation and use of a budget
- Conform to legal requirements
- Are accurately recorded and reported
- Provide for optimum use of resources
- Include a plan for audit control
- Establish the basis for a fee schedule consistent with cost of service and within customary norms of fair and reasonable

VIII. **Quality Assurance**

A written plan exists for the assessment of, and action to assure, the quality and appropriateness of the physical therapy service.

- Provides for a current written plan for assessment of the service

- Provides evidence of ongoing review, evaluation of the service
- Resolves identified problems
- Is consistent with requirements of external agencies

IX. **Staff Development**
A written plan exists which provides for appropriate ongoing development of staff.
- Is reflected by evidence of ongoing education or attendance at continuing education activities

PROVISION OF CARE

X. **Initial Evaluation**
The physical therapist performs and records an initial evaluation and interprets results to determine appropriate care for the individual.
- Is initiated prior to treatment
- Is performed by the physical therapist in a timely manner
- Is documented, dated, and signed by the physical therapist who performed the evaluation
- Identifies physical therapy needs of the client
- Includes pertinent information of the following:
  - history
  - diagnosis
  - problem
  - complication and precautions
  - physical status
  - functional status
  - critical behavior/mentation
  - social/environmental needs
- Provides sufficient data to establish time-related goals
- The physical therapist shall render care within the scope of the physical therapist's education and experience. Appropriate referral to other practitioners shall be made when necessary
- The physical therapist utilizes objective measures to establish a baseline at the time of the initial evaluation
- Is documented, dated, and signed by the physical therapist who performed the evaluation

XI. **Plan of Care**
1. The physical therapist establishes and records a plan of care for the individual, based on the results of the evaluation.
   - Includes realistic goals and expected outcome
   - Is based on identified needs
   - Includes effective treatment, frequency, and duration
   - Recommends appropriate coordination of care with other professionals/services
   - Is documented, dated, and signed by the physical therapist who established the plan of care
2. The physical therapist involves the individual/significant other in the plan, implementation, and revision of the treatment program.
3. The physical therapist plans for discharge of the individual, taking into consideration goal achievement, and provides for appropriate follow-up or referral.

XII. **Treatment**
1. The physical therapist provides or delegates and supervises the physical therapy treatment consistent with the results of the evaluation and plan of care.
   - Is under the ongoing personal care or supervision of the physical therapist
   - Reflects that delegated responsibilities are commensurate with the qualifications of the physical therapy personnel
   - Is altered in accordance with changes in individual status
   - Is provided at a level consistent with current physical therapy practice
2. The physical therapist records, on an ongoing basis, treatment rendered, progress, and change in status relative to the plan of care.

XIII. **Reevaluation**
The physical therapist reevaluates the individual and modifies the plan of care as indicated.
- Is performed by the physical therapist in a timely manner
- Reflects that the individual's progress is reassessed relative to initial evaluation and plan of care
- Is documented, dated, and signed by the physical therapist who performed the evaluation

EDUCATION

XIV. **Professional Development**
The physical therapist is responsible for his/her individual professional development and continued competence in physical therapy.

XV. **Student**
The physical therapist participates in the education of physical therapy students and other student health professionals.

RESEARCH

XVI. The physical therapist utilizes research findings in practice, promotes, and encourages or participates in research activities.

COMMUNITY RESPONSIBILITY

XVII. The physical therapist participates in community activities to promote community health.

LEGAL/ETHICAL

XVIII. **Legal**
The physical therapist fulfills all the legal requirements of the jurisdictions regulating the practice of physical therapy.

XIX. **Ethical**
The physical therapist practices according to the Code of Ethics of the American Physical Therapy Association.

American Physical Therapy Association
1111 North Fairfax Street
Alexandria, VA 22314

OCCUPATIONAL THERAPY SERVICES FOR THE ELDERLY

Occupational therapy uses goal-directed activity in the evaluation or treatment of persons whose ability to function is impaired by normal aging, illness, injury or developmental disability. Treatment goals in occupational therapy include the promotion of functional independence, prevention of disability and maintenance of wellness.

Therapeutic activities are designed to assist individuals in adapting to their social and physical environment, given their functional capacity, through mastery of essential living tasks. Examples of important services in gerontic occupational therapy are:

- education and retraining in daily living skills such as bathing, dressing, and eating,
- therapeutic adaptations, such as assistive equipment and physical environmental design to promote in-home and community mobility,
- sensorimotor treatment for strengthening, endurance, range of motion, coordination and balance,
- daily living adaptation to sensory loss such as impaired vision or hearing,
- therapeutic activities for memory, orientation, cognitive integration, and the life review process,
- prevention and health promotion through pre-retirement planning for leisure time, self-management skills, socialization, energy conservation, body mechanics and joint protection,
- care of the terminally ill through maintenance of independent living skills and meaningful activity.

Occupational therapy personnel provide services to the elderly in many settings such as:

- hospitals
- home health programs
- community-based health care centers
- hospices
- congregate living facilities
- outpatient rehabilitation facilities
- senior centers
- long term care facilities
- adult day care programs
- community service agencies
- retirement housing

Currently, approximately 30% of the 40,000 certified occupational therapy personnel in the United States work primarily with persons over age 65.

OCCUPATIONAL THERAPY: A VITAL LINK TO PRODUCTIVE LIVING

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10/86

OCCUPATIONAL THERAPY SERVICES IN LONG-TERM CARE

What are the goals of occupational therapy treatment?

Occupational therapy treatment helps those whose lives have been disrupted by illness and injury to:

- restore, maintain, or improve daily living skills
- participate as fully as possible in meaningful work, leisure, and social activities
- cope with the physical and emotional effects of long term disability
- prevent further deterioration through health education such as energy conservation and joint protection
- access community resources and services to help promote independence
- organize the living environment and make use of adaptations which promote safety

Who should receive occupational therapy services in long term care?

- individuals who have limitations in their abilities to carry out self-care activities
- individuals whose strength and endurance are at risk
- those people whose ability to function in the community has been impaired
- individuals who would benefit from special adaptive equipment to aid in semi-independent or independent living

Where are occupational therapy services provided?

Occupational therapy is provided within the many different settings which comprise long-term care such as:

- individuals' home
- comprehensive outpatient rehabilitation facilities
- adult day care centers
- residential facilities
- health maintenance organizations
- hospitals
- nursing homes
- hospices

Who pays for occupational therapy services?

Medicare, Medicaid and private insurers pay for occupational therapy services depending upon the specifics of the case and the individual insurance policy.

What specialized education and experience do occupational therapy personnel bring to long term care?

Occupational therapy education is based on the physical and psychological implications of illness, injury, and aging, and analysis of the components of activity. The clinician's knowledge of adapting tasks and modifying the environment to compensate for functional limitations is used to increase the involvement of clients, and to promote safety and success.

OCCUPATIONAL THERAPY: A VITAL LINK TO PRODUCTIVE LIVING

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Roles and Functions of Occupational Therapy in Long-Term Care: Occupational Therapy and Activity Programs

The American Occupational Therapy Association, Inc. (AOTA), submits this paper to reaffirm and illustrate the role of occupational therapy in the promotion of health and the prevention of disability for individuals requiring long-term care.

Occupational therapy facilitates the functional independence of individuals needing long-term care through the use of self-care, play/leisure, and work occupations. Occupational therapy services range from the selection of therapeutic activities to restore, maintain, and enhance function, to the implementation of planned activities to arouse, stimulate, and sustain interests and activity levels. In providing these services, occupational therapy personnel may serve as providers of occupational therapy, as coordinators or directors of activities programs, or as indirect service providers.

The purpose of this paper is to distinguish between the use of activities in occupational therapy and in activities programs, and to clarify the functions of the occupational therapist, registered (OTR), and the certified occupational therapy assistant (COTA) in regard to these services.

Individuals experiencing problems in daily living as a result of developmental disabilities, the aging process, or medical problems are served by occupational therapy in long-term care programs. The independence and quality of life of these individuals may be threatened by chronic disability as well as by immobility and restricted environmental stimulation. Long-term care may be provided in institutional and community settings such as skilled and intermediate care facilities, adult day care centers, half-way houses, congregate living facilities, and private residences.

Philosophical Base of Occupational Therapy

The philosophical base for the practice of occupational therapy, adopted in 1979 (1), identifies the contribution occupational therapy makes to health care through its accent on human activity as a health determinant.

"Man is an active being, whose development is influenced by the use of purposeful activity. Using their capacity for intrinsic motivation, human beings are able to influence their physical environment through purposeful activity. Human life includes a process of continuous adaptation. Adaptation is a change in function that promotes survival and self-actualization. Biological, psychological, and environmental factors may interrupt the adaptation process at any time throughout the life cycle. Dysfunction may occur when adaptation is impaired. Purposeful activity facilitates the adaptive process."

Occupational therapy is based on the belief that purposeful activity (occupation), including its interpersonal and environmental components, may be used to prevent and mediate dysfunction and elicit maximum adaptation. Activity, as used by the Occupational Therapist, includes both an intrinsic and a therapeutic purpose.

Definitions:

Occupational Therapy: Occupational therapy is the application of occupation or goal-directed activity to achieve optimum function, to prevent dysfunction, and to promote health. The term *occupation*, as used in occupational therapy, refers to any activity engaged in for evaluating, specifying, and treating problems interfering with functional performance (2).

Activities Programs: Activities programs consist of planned events and tasks designed to provide incentive and opportunity to engage in continuing life experiences and hence, to satisfy interests and meet general activity needs. Activities programs contribute to the prevention of deterioration of mental, physical, and social abilities (3)

History/Legal: The involvement of occupational therapy in long-term care may be traced to the early 1900s when occupational therapy programs were introduced in psychiatric hospitals and tuberculosis sanitoriums to counteract the deleterious effects of inactivity and idleness. The role of occupational therapy in long-term care was extended in 1965 by the passage of the Medicare legislation that provides coverage for restorative inpatient services while on part A coverage, and home health occupational therapy as an adjunctive service. The Omnibus Reconciliation Act of 1981 enables clients to receive occupational therapy under the home health benefit even after their need for skilled nursing, physical therapy, or speech therapy ends. States have the option to provide home health services, including occupational therapy, as part of their Medicaid provisions. Activities programs are included as part of the routine care provided for residents in institutional settings.

Occupational Therapy and Activities Programs: Occupational therapy and activities programs differ in: (a) the purpose for which activity is used, (b) the process of selecting activity, (c) the role of interests in the selection process, and (d) the scope of services.

Both occupational therapy and activities programs make use of self-care, play/leisure, and work activities. However, these activities are used for different purposes. In occupational therapy, activities are used to alleviate present or potential functional problems resulting from medical or developmental conditions or restricted environmental stimulation. Once a client's maximum functional capacity has been achieved and discharge plans have been instituted to maintain function, occupational therapy is discontinued. In activities programs, activities are introduced to provide an adequate level and balance of normal activity to promote and maintain health. Individuals requiring long-term care may need assistance in using their abilities because of their functional limitations. Assistance may also be needed because many normal daily activities are not easily carried out in long-term care settings. In contrast to occupational therapy that is problem-specific and time-limited, activities programs serve normal activity needs and are ongoing. In occupational therapy, for instance, a client may learn how to overcome arthritic hand deformities in order to do ceramic sculpture. Once the skill has been learned, however, the activities program would provide opportunities for using that skill.

In both occupational therapy and activities programs, the selection of activity is based on an individualized assessment of the client's needs and interests. For activities programs, the primary objective of assessment is to describe the tasks and events the client wants and is able to participate in. These data are used to judge the adequacy of the client's general activity level and to plan individual and group activities that provide a variety of physical, mental, and social stimulation. In occupational therapy, the selection of activity relies on problems discerned in self-care, play/leisure, and work occupations, and on a detailed assessment of the client's sensorimotor, cognitive, and psychosocial abilities. Comprehensive assessment is needed to discern functional limitations that are amenable to treatment, and to institute the appropriate kind of remedial, maintenance, or preventive activity. The choice of therapeutic activity depends on an in-depth analysis of the characteristics of the activity as well as of the client, and a thorough understanding of associated disease process. For example, for persons with thought disorders, such as those associated with Alzheimer's disease or schizophrenia, occupational therapy may use a structured activity requiring few repetitive steps (e.g., one color tile trivet) and progress to that requiring a sequence of steps and more flexibility (e.g., a mosaic design using several colors and textures) if the client improves.

In activities programs, the client's interests serve as a primary determinant in meeting general activity needs. Although client interests are accommodated in occupational therapy, they must serve the therapeutic goal. For instance, if a client needed practice in picking up and placing objects to increase hand dexterity, checkers or a tile project would be selected in occupational therapy, rather than a book discussion group, regardless of interest.

In addition to the use of self-care, play/leisure, and work, occupational therapy also incorporates therapeutic procedures that do not overlap with activities programs. These procedures include splinting, body mechanics, positioning, the prescription of self-help devices, neuromuscular facilitation, joint protection, facilitation of sensory integration, and time management.

Education—OTR and COTA

The theoretical base for occupational therapy is drawn from the medical, biological, and behavioral sciences. Productivity and self-reliance are viewed as a function of the interaction between an individual and the surrounding physical and social environment. The occupational therapy curriculum concentrates on three major areas. The first is normal human development over the life span. Emphasis is on the biological, psychological, social, and architectural factors required for competence in daily living skills. The second area is the functional disabilities associated with disease, trauma, developmental disorders, the aging process, and environmental deprivation. The third is the occupational therapy process, and provides knowledge of the evaluation, remediation, and prevention of functional disabilities through occupation. In each of the three curricular areas the knowledge and skills of the professionally educated therapist (OTR) are more complex and comprehensive than those of the occupational therapy assistant (COTA). The educational program for registered therapists (OTR) prepares them for independent practice in occupational therapy, whereas that of the certified assistant (COTA) prepares them to practice occupational therapy under the supervision of an OTR. The OTR maintains supervisory responsibility for all tasks delegated to the COTA, although the COTA may function independently in conducting activities programs.

The employment of an OTR or a COTA as an activities coordinator does not convert an activities program into occupational therapy. However, the educational background of the OTR and COTA, especially with regard to normal human development, medical pathology, and activity analysis, allows activities programs conducted under their supervision to have a more rehabilitative quality than those conducted by personnel without this educational background. Knowledge of functional skills and medical pathology is used by the OTR or COTA to guide the selection of activities appropriate for the client's needs and abilities. Knowledge of adapting tasks, of positioning clients, and of modifying equipment to compensate for functional limitations is used to increase the involvement of clients, to facilitate safe performance, and to promote success. In the case of severely disabled clients, the knowledge and skills of the OTR or COTA may enable participation that otherwise may have been precluded. The educational preparation of the OTR and COTA also includes knowledge of activities that are contraindicated for certain medical conditions.

Occupational Therapy: Direct Client Care

Occupational therapy provides restorative, supportive, and preventive services, which aid clients to achieve the highest possible degree of functional independence. Therapy is based on a screening and assessment process.

Screening:
Screening to identify problems in daily functioning is done by the OTR or COTA. The need for evaluation is based on an appraisal of the client's life style and general functional capacity in self-care, play/leisure, and work occupations. Screening is generally accomplished through observation, interview, and a review of medical records.

Assessment:
The OTR evaluates the client to determine the nature of the functional problems. The work appraisal covers household management (cooking, shopping, and cleaning), volunteer and paid jobs. The leisure assessment considers the client's ability to participate in recreational, educational, and cultural events. The self-care assessment includes feeding, dressing, hygiene, and mobility. The assessment extends to the underlying subcomponents of these functional skills, such as motivation, cognition, muscular strength, and coordination. Environmental factors that hinder function are also evaluated. Observing, interviewing, and testing are used to evaluate the client. Information may also be gathered from family, friends, and other health care providers. These evaluative data are used to formulate treatment goals consistent with the needs of, and acceptable to, the individual or responsible person.

Treatment:
The treatment plan is developed by the OTR and implemented by the OTR or the COTA under OTR supervision. The treatment program may be directed toward restoration of function, maintenance of function, or prevention of dysfunction. The restorative program focuses on the correction of disability whether physical or psychosocial. Such correction may be achieved through remediation or compensation. For example, an elderly person with a right upper-extremity hemiparesis may be retrained in using the right hand (remedial), or may be trained to use the left hand in a skilled fashion (compensatory), or a combination of both. Specific treatment procedures are based on the factor interfering with function. Clients, for instance, may not dress themselves because they lack adequate muscular strength, because they cannot recall the dressing sequence, or because they see no reason to dress. Although the end result is the same, each causal factor requires a different treatment approach. In addition to intervening with the client, treatment may also require environmental adaptations to encourage and support functional skills. Programs focused on maintaining function are instituted for clients who have reached their highest level of function and require assistance in retaining their abilities. Maintenance programs provide practice in the functional skills acquired through restorative programs. Preventive programs are directed toward the prevention of functional disabilities. They are begun at the first signs of difficulty in performing daily life tasks and are designed to assist clients to develop adaptive patterns conducive to long-term function.

Activities Programs: Direct Client Care

The activities program is designed to provide physical, intellectual, social, spiritual, and emotional challenges much the same as in everyday life. Participation is based on an assessment of interests and activity needs.

Assessment:
The OTR or COTA as activities coordinator assesses the interests of each client to determine the activity needs and preferences. The interest survey may be done by observing, interviewing, or testing. Family members, friends, and staff may also be contacted for information.

Activities Plan:
An activities plan is developed for each client. The plan identifies the client's interests, general activity needs, states goals, and gives the activities to be used to achieve these goals. The client's needs are reassessed regularly and the activities plan is adjusted accordingly.

Activities Program:
The OTR or COTA, as activities coordinator, collaborates with the clients to plan, execute, and evaluate a diversified program suited to identified needs and interests. Programs are planned to provide a balance of activities perceived by the participants as useful work and service, and activities viewed as recreational, spiritual, and educational. Activities programs are varied so that individual as well as group activities are offered. The OTR and COTA as activities coordinator routinely evaluates the effectiveness of the activities program.

Occupational Therapy and Activities Programs: Functions Related to Client Care

Indirect services such as management and supervision, education, and consultation, facilitate the provision of client care.

Management Role: Occupational therapy personnel support the premise that good management results in the effective care of the client. Management responsibilities include but are not limited to: documentation, program administration and development, and committee or team participation.

Documentation refers to the written record of information to ensure the continuity of care of clients. Documentation includes information on each client's problems and goals. Revisions of the occupational therapy program or activities plans and the effects these changes have on clients' performance are recorded. Records are completed in accordance with the policies and procedures of the long-term care setting. Documentation of overall effectiveness of the service is also required.

Program administration refers to the planning, organizing, directing, and coordinating functions needed to carry out the occupational therapy or activities programs. Responsibility is assumed for the efficient management of material and human resources, including staff, students, and volunteers to achieve program goals.

Committee or team participation refers to involvement in meeting with other health care team members to coordinate the client's overall health plan. Participation on committees, such as discharge planning, budget, or utilization and review, permits occupational therapy personnel to address the occupational needs of clients.

Educational Role: In conjunction with the educational role, family members, friends, and staff are educated in the promotion of health through activity. Providing fieldwork experiences for students in occupational therapy and other health fields also provides a mechanism for participating in the education of personnel for long-term care.

Consultant Role: Consultation is the process by which expertise is transmitted for the purpose of solving existing or potential problems. Consultation is provided to individuals, families, or program staff serving those with long-term care needs. The consultant collaborates with the administrator to develop the plan and objectives of consultation.

Examples of tasks undertaken by the consultant include: instructing staff in technical skills, advising the management team on program development, and diagnosing problems in program management. A request for consultation is often initiated by the desire to upgrade the activities program or by code requirements for consultation.

The consultant functions within federal and state codes that address the qualifications of staff, program content, physical facilities, and practice. The consultant must be aware of the code requirements as well as related professional standards.

Occupational therapy philosophy and theory are particularly appropriate for the delivery of long-term care based on a wellness rather than a medical model. Hence, occupational therapy consultation is well suited to program developments aimed at such services as functional assessment, preventing premature institutionalization, re-integration into community living, palliative care of the dying, and increasing vocational performance of those needing supportive care.

Summary

There is a difference between occupational therapy and activities programs. The nature of the services provided are different as well as the qualifications of the personnel who provide them.

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Purposeful Activities

The American Occupational Therapy Association, Inc., submits this paper to clarify the use of the term purposeful activities with regard to occupational therapy. Occupational therapists are committed to the use of purposeful activities (1). Purposeful activity is an important legitimate tool used by occupational therapists to evaluate, facilitate, restore, and maintain function (2).

Individuals engage in purposeful activity as part of their daily life routine. Purposeful activity, in this natural context, can be defined as tasks or experiences, in which the person actively participates. Engagement in purposeful activity requires and elicits coordination between one's physical, emotional, and cognitive systems. An individual who is involved in purposeful activity directs attention to the task itself, rather than to the internal processes required for achievement of the task. Activities may yield immediate results or require sustained effort and multiple repetition. They may represent novel and singular responses or be part of complex long-standing patterns of behavior (3). Purposeful activities, influenced by the individual's life roles, have unique meaning to each person (4).

Occupational therapists treat individuals whose capacity to function effectively is impaired due to injury, illness, psychosocial stress, changing developmental and environmental demands, or lack of skill. This impairment can diminish an individual's ability to produce, have positive self-image, or perform life-enriching activities, and can affect the ability to fulfill desired life roles.

Occupational therapy education in activity analysis and the behavioral and biological sciences provide the background necessary to use activities as therapeutic modalities for clients with a variety of physical, cognitive, emotional, and social disorders. Occupational therapists evaluate clients to determine an individual's activity goals, the capacity to plan and perform purposeful activities, the ability to meet the functional demands of the environment. Based on this evaluation, the occupational therapist designs activity experiences that offer the client opportunities for effective action. These activities are purposeful in that they assist and build upon the individual's abilities and lead to achievement of personal goals.

A purposeful activity, as used by the occupational therapist, leads to the fulfillment of simultaneous goals. One may be the client's goal to complete the overall task satisfactorily. The other may be identified by the occupational therapist as: to promote balance, increase muscle strength, increase attention span. "The activity is in itself an end, as well as being a means to a larger end." (5).

Occupational therapists divide activities into component parts to determine which skills are necessary to complete the task. This information allows the occupational therapist to adapt, grade, and combine activities into therapeutic modalities.

Occupational therapists adapt activities in different ways to promote performance. Activities are adapted by modifying or changing the sequence of the activity, or both, such as the position of the client, the position of the material, the size, shape, weight, or texture of the material, the procedures and the nature and degree of interpersonal contact. Adaptation involves the process of continually modifying an activity to meet the specific changing needs of the client.

In each individual situation, occupational therapists determine whether the activity will be adapted to compensate for a functional deficit, or to promote restoration. This decision is based on the extent of the client's disability, as well as their current level of performance. Purposeful activities cannot be routinely prescribed.

Occupational therapists may present a series of activities, or change the steps within the activity. Such grading provides skill development and therapeutic exercise to respond to the dynamic changes of the client.

Occupational therapists artfully modify routine activities within the client's daily life in order to promote psychological or physical development. At first functional tasks may be introduced in a controlled environment. As treatment progresses, the occupational therapist gradually changes the environment until the client demonstrates the level of skills necessary to function in their real life environment (6).

Occupational therapists use current rehabilitation procedures to enhance a client's skill development or task performance. Throughout the activity, occupational therapists modify their method of personal interaction to achieve the desired results of the activity.

In summary, occupational therapists enable individuals to engage in purposeful activities to achieve competence in work, self-care, and play/leisure. Activities provide direct and objective feedback about the client's performance, both to the occupational therapist and to the client. Successful performance of purposeful activities promotes feelings of competence and provides opportunities for individuals to achieve mastery of their environments (7).

Purposeful activities involve the "doing processes which require the use of thought and energy and are directed towards an intended or desired end." (8).

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John Farace, OTR, Chair

Approved by the Representative Assembly, April 1983

ACTIVITY PURSUITS

ACTIVITY PURSUIT REFERS TO ANY ACTIVITY

1.) OUTSIDE OF ADLS

2.) WHICH A PERSON PURSUES IN ORDER TO OBTAIN A SENSE OF WELL-BEING

INCLUDES ACTIVITIES WHICH PROVIDE BENEFITS IN THESE AREAS:

SELF-ESTEEM
PLEASURE
COMFORT
HEALTH
EDUCATION
CREATIVITY
SUCCESS
FINANCIAL INDEPENDENCE
EMOTIONAL INDEPENDENCE

ACTIVITY ASSESSMENT

1. FUNCTIONING
2. LIFESTYLE & PERSONALITY
3. AMOUNT OF PARTICIPATION
4. INDIVIDUAL & GROUP PREFERENCES
5. TYPE OF ACTIVITY PREFERENCES
6. MEANING OF ACTIVITY PURSUITS

LIFESTYLE & ACTIVITY PURSUITS

ACTIVITY PURSUITS

ASSESS

AMOUNT OF ACTIVITY PARTICIPATION
INDIVIDUAL OR GROUP PREFERENCES
TYPE OF ACTIVITY PREFERENCES
MEANING OF ACTIVITY PURSUITS

Stepping Forward with Activities by Ruth Perschbacher, Bristlecone Consulting Company

Bristlecone
CONSULTING COMPANY

FOCUS ON OUTCOMES
THE CENTER OF GOOD PROFESSIONAL PRACTICE

OUTCOMES ARE BASED ON THE FOLLOWING:

- COMPREHENSIVE ASSESSMENT INCLUDING AT LEAST:
    - PHYSICAL, SOCIAL, COGNITIVE, EMOTIONAL FUNCTIONING
    - INTERESTS, ABILITIES, CUSTOMARY ROUTINE
    - COMPARISON OF CURRENT & PAST HISTORY WITH REGARD TO FUNCTIONING, INTERESTS, ABILITIES, & CUSTOMARY ROUTINES
    - CLEAR IDENTIFICATION OF STRENGTHS WHICH COULD LEAD TO POSITIVE OUTCOMES
    - CLEAR IDENTIFICATION OF WEAKNESSES WHICH COULD LEAD TO NEGATIVE OUTCOMES
- OTHER FACTORS AFFECTING OUTCOMES
    - LENGTH OF ILLNESS
    - LENGTH OF TIME IN FACILITY
    - PROGNOSIS

ACTIVITY OUTCOMES

AN ACTIVITIES PROGRAM SHOULD RESULT IN THE FOLLOWING THERAPEUTIC OUTCOMES

SUPPORTIVE OUTCOMES AS EVIDENCED BY RESIDENT PARTICIPATION IN ACTIVITIES WHICH PROVIDE STIMULATION OR SOLACE TO RESIDENTS

MAINTENANCE/RESTORATIVE OUTCOMES AS EVIDENCED BY RESIDENT PARTICIPATION IN ACTIVITIES WHICH PROMOTE OR RESTORE PHYSICAL, COGNITIVE, SOCIAL & EMOTIONAL HEALTH.

EMPOWERMENT OUTCOMES THAT PROMOTE INCREASED SELF-RESPECT AS EVIDENCED BY RESIDENT PARTICIPATION IN ACTIVITIES WHICH PROVIDE OPPORTUNITIES FOR SELF-EXPRESSION, PERSONAL RESPONSIBILITY, & CHOICE.

Bristlecone
Consulting Company

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Activities for Low-Functioning Residents

Therapies reach out to senses, memories and emotions

by Anne Hegland

Activity programs, traditionally geared toward group endeavors, are now incorporating one-to-one activities that reflect the needs of low-functioning residents.

With surveyors now focusing on resident outcomes, activity directors are challenged with providing stimuli to the bed-bound and documenting the results.

New Approach. Using techniques such as touch, a smile or conversation, the entire staff can stimulate a resident's senses, memories and emotions, suggests Nancy DeBolt and Mary Ellen Kastner in their book, "'I'm In Here!' Strategies for One-to-One Activities," published by Lutheran Health Systems, Fargo, ND.

Using these simple approaches, success can be measured by the squeeze of a hand, or by achieving eye contact, the authors said. More importantly, these activities can be incorporated into the daily care routine and performed by the entire staff, rather than just those in the activities department, noted DeBolt.

Formerly bingo, the Bible and birthday parties dominated the activities calendar, DeBolt told *Contemporary Long-term Care*. Over the last four years, however, regulatory changes (PaCS survey process and OBRA '87) have forced activity directors to develop one-to-one activities for residents who cannot or will not participate in group activities, she noted.

An even greater challenge for activity directors, DeBolt said, is documenting outcomes that show residents have achieved their highest practicable emotional, mental and physical well-being as mandated under federal law, effective Oct. 1. Examples of how to document these outcomes are provided in the book.

"You have to show that what's being

done is meaningful and that some response is achieved," DeBolt commented.

Relationships Stressed. Positive results can be achieved by developing relationships with residents, rather than delivering perfunctory stimuli, she pointed out.

"An activity becomes a one-to-one relationship, rather than 'Here I am; I've got something. I'm going to see how you respond, and then write it down.' You can't do things *to* people. You must do it *with* them," said DeBolt, activity director at Goshen County Memorial Nursing Home, Torrington, WY.

Using this premise, DeBolt and Kastner have redefined activities as an "outward expression of the inner person." The staff should determine how they can establish relationships with patients to bring them out of their pain or withdrawn state, DeBolt said.

Relationships are established through techniques that stimulate senses, which in turn provoke memories and emotions, according to the book.

For example, sensory stimulation can begin by touching the resident's hand, with a return squeeze signaling a positive response and an attempt by the person to reach out.

Building upon these small responses, the staff can work toward establishing a relationship. Once the resident's trust is secured, activities that stimulate memories and emotions can be incorporated.

While the use of touch in sensory stimulation is fundamental, DeBolt pointed out that most touch in the nursing home is invasive. Therefore, the approach taken is important to ob-

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On this and the preceding page, activities directors use a touch, smile and conversation to stimulate residents' senses, memories and emotions.

LOW FUNCTION

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taining a response.

Memory Stimulation. One example of a memory stimulation exercise is called reality orientation. Here, a resident verbalizes that she is confused and is visually upset by this. The staff member reassures the resident that she understands more than she's willing to give herself credit for, and reorients the resident to the time, date and location. During this reorientation, the staff person is also asking the resident questions about her previous home and husband's name.

This exercise allows the resident to relate something of herself to the present day and time.

Formerly bingo, the Bible and birthday parties dominated the activities calendar, but over the last four years regulatory changes have forced activity directors to develop one-to-one activities for residents who cannot or will not participate in group activities

Evoking Emotions. Oftentimes, nursing home residents who are bed-bound or withdrawn become one-dimensional because they have no opportunities to vent their emotions.

DeBolt and Kastner's book recommends one-to-one exercises such as active listening, reassurance and conversation which will allow the resident to express emotions both verbally and through body language.

Although appealing to the senses, memory and emotions of residents may result in very limited responses, DeBolt stresses that these are successes nonetheless, and a foundation from which to build relationships.

Working Together. To maintain the continuity of a one-to-one activities program, it is important that the activities staff and nursing staff work together. With the activities director as a member of the comprehensive assessment team, her input in developing the resident's plan of care can include approaches on how the entire staff can help meet the person's activities needs and requirements, DeBolt explained.

She suggested scheduling a facility-wide inservice to educate all staff on how to integrate these techniques into their daily routines.

Also, DeBolt encouraged activity directors — who are more accustomed to group activities — to educate themselves on ways to incorporate activities for the bed-bound and withdrawn residents. **B.O.H.**

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Prepared by Ruth A. Morgan for presentation to the Kentucky Health Care Associations training for Activity Directors September, 1990.

EVALUATING ACTIVITIES FOR CHOICE

INDIVIDUALITY AND DIGNITY

A. Looking At The Individual Resident

- Was the individual activity plan driven by resident likes, dislikes and strengths as identified on the comprehensive assessment?
- Is the individual activity plan consistently implemented?
- Are changes made in activity plans when the resident fails to meet the goals?
- Are changes made in the activity plan when the initial goal is achieved?
- Is the resident aware of the activity goal and is this the resident's goal for him/herself?
- Was consideration given to the risk factors and unique needs of the resident?
- Is the resident involved in activities that enhance mobility skills or increases stamina?
- Are the activities engaged in similar to the activities that interest the resident?
- Has the resident made friends in the facility?
- How is information about the resident given to those who need it to ensure that resident fully participates in the activities he/she chooses to participate in?

B. Looking At The Program

- Are there several empowerment activities that promote increased self-respect by providing opportunities for self-expression, personal responsibility and choice (i.e. resident councils, current event discussion groups)?
- Are these several maintenance activities that provide a schedule of events that promote physical, cognitive, social and emotional health?
- Are there supportive activities that provide stimulation or solace to residents who cannot generally benefit from maintenance or empowerment activities (i.e. playing music to increase alertness)?
- Are residents generally satisfied with the times activities are offered; the number of activities offered and variety of activities offered?
- Do the activities help residents make friend and promote socialization?
- Does the activity program have a recognizable routine upon which staff and visitors can depend?
- How are activities publicized? Is there an activity calendar? Is the time and place of activities indicated in large enough print that residents can read it? Are activities actually held at the time and place indicated?

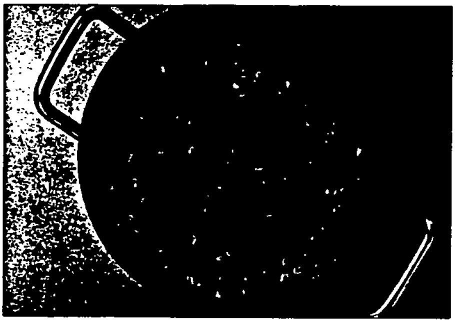
- Are there adequate supplies for the activities selected?
- Do residents attend activities groomed in the manner that they wish (i.e. well, fitted clothing, hair combed, beard shaved or trimmed) and that enhances a resident's self-worth.
- Are there activities offered that involve family and others from the community?
- Are there weekend activities?
- Are the religious needs of residents met or is only one religious perspective offered?
- Is there a current list of residents on which precautions are noted regarding any restrictions on activities?
- Can residents refuse activities or suggest activities?
- Do you use "teachable moments" during activities to encourage residents to exercise their rights as residents?

C. Looking At The Facilities

- Are the areas where activities held free of accident hazards?
- Are there several program areas where activities are held? Is there a balcony, porch, patio, courtyard or solarium where residents can sit and enjoy fresh air either inside or outside?
- Is there an inside area used primarily for activities?
- Is the activity room illuminated suitably to the tasks performed and to support independent functioning?
- Is it adequately furnished to accommodate the specific activities offered by the facility and are furnishings functional to resident needs?
- Is there sufficient space to accommodate all activities (i.e. No evident crowding)? Do residents using mobility aids have difficulty in passage? Do they have equal access?

D. Looking At Staff

- What is the training of the person carrying out the activity program?
- Is there adequate staff to ensure that all residents can participate to the fullest extent of their ability?
- Is there coordination with the nursing staff to ensure a team approach?
- During activities do staff members speak to resident in a respectful manner, listen to them carefully and address them by the name of their choice?
- Does the physical contact and other staff residents interaction during activities support resident independent functioning.



COOK UP AN OBRA SOLUTION

Meeting new dietary regs

BY SALLY WEERTS, M.S., R.D.

Administrators, managers and staff in long-term care facilities this fall will be working with a new "dietary care" concept. Many provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1987 take effect on Oct. 1, mandating important changes in resident feeding procedures.

In its simplest form, OBRA is a budget bill with a quality-driven philosophy. The concept: No quality, no government money and the game is up in federally certified facilities.

Conceptually clear but definitively vague, the specifics of OBRA are currently couched in interpretive guidelines.

Food service activities are still covered under OBRA's dietary services language. But the nutritional care activities integrated throughout the regulations and guidelines have, in effect, added a page to dietary managers' job descriptions.

Broad, conceptual terms like "resident rights," "resident assessment" and "highest functional ability" reflect OBRA's goal of attaining the "highest practicable quality of life" for residents and the "highest practicable quality of care" for facilities. But what do these terms really mean, and how will the long-term care industry deal with them?

The term "functional ability" is one of the more clearly defined concepts with a direct bearing on dietary care. Residents must now be able to achieve their highest practical level of eating. For example, a person who tolerates whole buttered bread should not receive it softened in milk. If he or she chews, swallows and enjoys bread softened in milk, it need not be sent pureed.

The kitchen may now follow a policy that accommodates individual abilities, regardless of standards in a diet manual.

But the interpretive guidelines of OBRA extend well beyond the kitchen.

OBRA is a resident-intensive, resident-centered law. Standards are based on the well-being of each resident, and OBRA surveys will start and end with the resident.

In support of that position, OBRA insists that each resident be treated as an individual, not as a member of a group. Each resident, the reasoning goes, has his or her set of nutritional requirements which may be distinctly different from the requirements of others in a similar age, sex or activity group. These needs should be accommodated, according to OBRA, with the consent and participation of each resident.

The intent of the law is to recognize the needs, desires and even demands of the individual and the individual's family. It's up to the dietary team to negotiate a satisfactory menu agreement which meets residents' nutritional needs and satisfies their personal preferences.

"Negotiate" is an operative word with OBRA. Suppose some residents don't want to come to the dining room for breakfast. The dietary staff now has the obligation to negotiate. They may offer the group a cold breakfast in their rooms as an alternative to a hot meal in the dining room. Or they may suggest an alter-

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nate-day schedule between room meals and the dining room.

Creative solutions depend on a balance between rights of the resident and responsibilities of the facility. OBRA means more latitude, in general, for both residents and dietary staff, but it presents challenges in menu planning.

The challenge is obvious: How to meet the 'highest practicable quality of life" target for residents who are unwilling or unable to eat, eat right, or eat enough. How does a dietary manager find enough time to be creative, negotiate, and still get the food prepared? Finally, how can dietary managers comply with the mandates, guidelines and spirit of OBRA without going crazy?

Enter the first law of dietary care: Get out of the kitchen and away from those pots and pans. Go out on the floor and visit with residents. Ask them how the food is. Look for signs of well-being and indications of problems.

The ticket out of the kitchen and onto the floor is a systematic approach to food service that provides one menu to the house. This one menu offers sufficient variety to meet the 'individual" requirements of OBRA, but gives the dietary manager freedom from the routines of daily menu planning.

A one-menu system limits diet orders to the few needed by most residents. It alters ingredients in hundreds of recipes or modifies portions to accommodate low sodium, diabetic and other therapeutic diets. And a one-menu system adjusts total and edible portion yields of recipes to ensure accuracy when the cook aspires to 'highest quality" standards.

Nutrient analysis of all meals verifies that dietary care meets OBRA's mandates.

Secondly, assess resident nutrition. Establish each resident's status based on diagnoses, weight changes, food intake, medications and clinical signs/symptoms. This data should be collected (a form is available) and saved in the chart where a progress note also is written.

Next, review the assessments. Sit down with the consultant dietitian and identify the nutritional considerations of each resident.

The next step is problem solving. Talk with each resident about his or her problems or needs. If a resident is losing weight and eating poorly, ask her about it. She may be depressed or she may have a medication complication which affects her appetite. Try to determine the source of the problem.

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Surveyors want to be assured that a facility's staff is aware of residents' conditions, that problems have been acted upon and that the "highest practicable quality of care" is being provided

Then, go for a solution. Generate a plan of action which solves the problem. The approach may include dietary changes alone or need other disciplines (e.g., social, medical or nursing) to be effective.

Now, integrate. This is the teamwork stage where solutions to resident nutrition problems are communicated to the care planning team and included in the overall care plan. It's essential to function as a team while assessing and planning care.

If a resident is losing weight, the nursing and dietary team players need to talk. When an intake check shows decreases in all pureed food eaten, the dietary staff and nurse aide feeder have things to discuss.

If a resident begins dozing at mealtime, it's time for the dietary manager and consultant dietitian to ask the director of nursing about potential causes for the mealtime naps. Going a step further, if the resident is on a new medication that may cause drowsiness, the dietary, nursing and medical players form the team.

Creative solutions depend on a balance between rights of the resident and responsibilities of the facility

Finally, monitor for results. The monitoring process should include progress notes to document responses to planned approaches. The documentation of residents' conditions will be a critical part of the OBRA compliance process.

Surveyors will look for systematic and written agreement between a resident's observed condition and plan of care.

Surveyors want to be assured that a facility's staff is aware of individual residents' conditions, that problems associated with the conditions have been acted upon and that the 'highest practicable quality of care" is being provided for the residents. And they'd like to see it written down in nutrition assessment, care planning and progress note formats.

Does this make OBRA some heavy-handed sword about to come crashing down on the dining tables of LTC facilities? No. With some estimates of malnutrition running as high as 50% in LTC facilities, OBRA can only be viewed as a help.

OBRA encourages a teamwork concept. It brings new (and welcome) depth to the meaning of dietary care — nutritional care to residents through food preparation and delivery by dietary staffs. And it makes 'highest practicable quality" the standard measurement of resident care. CLTC

Sally A. Weerts, M.S., R.D., is founder and president of Dietary Care Systems, Inc., Mankato, Minnesota.

GUIDELINES
for
Assessing the Quality of Drug Regimen Review Long Term Care in Facilities

FORWARD

The quality of care provided to long term care residents is an important concern of the public as well as of government, nursing home administrators and health care professionals. As part of the health care team, consultant pharmacists share the responsibility of providing quality services and, by assuring the quality of their drug regimen review activities, have a significant influence on residents' health outcomes and quality of life.

GOAL

The intent of this document is to identify objective and measurable components of quality drug regimen review. Many of these objectives may be considered as intermediate outcomes that are necessary steps in achieving the overall goal of improved resident care and health.

These guidelines have been designed as normative standards, ie. they are the current standard of practice and define a quality of care in the drug regimen review process that all consultant pharmacists should provide to the residents under their care. Additionally, these guidelines may be used in a self-assessment evaluation, with the results providing guidance in planning for improvements.

In reviewing this document, the consultant pharmacist should keep in mind that, just as drug regimen review is only one of many services provided by consultant pharmacists, these guidelines represent only one aspect of an overall quality assurance program. Furthermore, ASCP recognizes that many consultant pharmacist go beyond these standards and provide care which in many, if not all, regards would be considered optimal. As normative guidelines, this document defines the standard of care all consultant pharmacists should provide, but is in no manner intended to discourage or limit consultant pharmacists in their efforts to provide optimal care.

Evaluating Medication Orders

The consultant pharmacist determines whether the resident's medication orders represent optimal therapy for that individual.

A resident's medication order represents optimal therapy for that individual when its use is based on an accurate diagnosis for which drug therapy is the best method of treatment. Furthermore, the medication selected must represent the drug of choice based on the health and characteristics of the individual. Additionally, the drug must have been prescribed in the formulation, dose, frequency, and duration best suited for the individual. As part of drug regimen review, the consultant pharmacist evaluates these aspects of the medication order and verifies their documentation.

- Routine medication orders are supported by a current written diagnosis or identified need and relevant diagnostic data (CBC, total chemistry, etc.).
- As needed (prn) medication orders include specificwritten indications for use.
- Medication orders' indications for use are consistent with current medical literature.
- Therapeutic goals have been established in writing for all medication orders.
- Medications selected have a favorable benefit-to-risk ratio. This includes consideration of medical history, the significance of any past drug reaction, and cost.
- Drug products, if generic, are accepted as bioequivalent to the innovator's drug product by the FDA publication "Approved Drug Products with Theapeutic Equivalence Evaluations" with (Orange Book).
- Medication orders that duplicate other medication orders currently in the resident's regimen include a written rationale for that duplication.

- The prescribed route of administration is appropriate for the resident, considering absorption, bioavailability, onset of action, metabolism and excretion factors.
- The dosage form chosen is compatible with the resident's needs and/or abilities, including consideration of texture (solids or liquid) and taste.
- The prescribed dose is appropriate to the resident's clinical status.
- The prescribed schedule of administration is appropriate for the resident, including consideration of side effects (such as sedation) and of compatibilty with the resident's diet and other medications.
- The duration of drug therapy is indicated and appropriate for the resident.

Monitoring Medication Administration

The consultant pharmacist evaluates medication administration to verify that the resident has received his/her medications in conformance with prescriber's orders and facility policies.

As part of providing optimal drug therapy to the resident, it is necessary to assure that the correct medication is given as prescribed, in the correct amount, at the correct time, and to the correct resident. Although not directly responsible for administering medications, the consultant pharmacist should monitor procedures, techniques, and personnel responsible for this function and intervene when necessary.

- Medications are administered at the frequencies and times indicated in the resident's chart.
- "Stop order" policies are observed.

- Alteration of dosage forms have not impaired the therapeutic response. For example, medications should not be crushed when this may change bioavailability.
- The consultant pharmacist observes the drug administration techniques of staff and/or instructs supervisory staff in this process as needed.
- Residents are evaluated for refusal or inability to take medications.
- Administration of medications is documented including the frequency and reason for administration of prn medications.
- Residents who self-administer medications are counseled regarding the correct technique of administration and routinely evaluated by the pharmacist in the following areas: therapeutic response, refill frequency, storage conditions and medication information.

Evaluating Response to Drug Therapy

The consultant pharmacist evaluates the resident's response to drug therapy.

Evaluation and recommendations for adjustment of drug therapy is the cornerstone of the consultant pharmacist's role in assuring that each resident receives optimal drug therapy. The status of the resident's disease state, response to medication, side effects, adverse drug reactions, and interactions are among those aspects which should be evaluated. Based on this evaluation, the consultant pharmacist then makes recommendations regarding adjustments in the resident's drug therapy.

- The resident's response to drug treatment is evaluated through the use of laboratory data, physical assessment, medication administration record and other objective and subjective information to determine if therapeutic goals have been achieved.

- Side effects, adverse reactions, and interactions (drug-drug, drug-lab, drug-nutrient, and drug-disease) are evaluated; and modifications or alternatives are considered.

- Based on the resident's therapeutic condition and response to drug therapy, the resident's drug regimen is evaluated for unnecessary medications.

- The risk/benefit of each medication is re-evaluated on an ongoing basis.

- Non-compliance is evaluated by the consultant pharmacist.

- Recommendations, including identification of the concern, specific means to correct the situation, how and when improvements will be measured are communicated to all appropriate personnel (prescriber, nursing staff, director of nursing, administration, medication administration personnel, resident).

Communicating Observations and Recommendations

The consultant pharmacist communicates observations and recommendations regarding residents' drug therapy to those with authority and/or responsibility to implement the recommendations and verifies that there has been a response.

Following evaluation of drug therapy, the consultant pharmacist must make recommendations necessary for improved resident care. Information should be communciated in a manner which promotes interaction with other heath care professionals and is likely to elicit a response in a timely fashion. Furthermore, the consultant pharmacist's responsibility goes beyond the initial recommendation and includes follow-up to determine that a response has been made.

- A record of the consultant pharmacist's observations and recommendations is available in an easily retrievable form.
- Comments and recommendations concerning drug therapy are communicated in a timely fashion. The timing of these recommendations should be sufficient to enable a response prior to the next drug regimen review.
- Observations and recommendations are presented in a format promoting dialogue and interaction between all appropriate individuals.
- The consultant pharmacist follows up on his/her recommendations to verify they have been acted on.
- Recommendations to residents who are self-administering medications are presented in a straightforward and clear manner and include written as well as oral information when appropriate.
- Recommendations regarding facility policies, procedures, and/or methods of administration of medications are made by the consultant pharmacist when practices jeopardize the provision of optimal care to residents.

Supportive Environment

The long term care facility supports pharmacy practices that promote quality care.

Effective drug regimen review is best achieved in a supportive environment that recognizes the value of the consultant pharmacist as part of the facility's health care team while the long term care facility's administrative and medical staff have the greatest responsibility for creating this environment, the consultant pharmacist shares *this responsibility as well. Drug regimen review related activities, such as participation in committees, projects, and special studies, provide both an opportunity to foster interprofessional relationships and a reflection of current attitudes and cooperation.*

- Organizational authority exists for and support is given to the drug regimen review process.
- The long term care facility uses the consultant pharmacist as an active participant on the pharmacy services committee.
- The long term care facility assures that the consultant pharmacist is a participant in the facilitiy's infection control process.
- The long term care facility uses the consultant pharmacist in peer review of personnel affecting drug therapy, for example, physicians, nursing, and pharmacists.
- The long term care facility works with the consultant pharmacist in establishing drug utilization protocols for specific drug categories, such as antibiotics and investigational drugs.
- The long term care facility supports the consultant pharmacist's efforts in performing regular drug utilization studies and medical care evaluation studies.
- The long term care facility supports the consultant pharmacist's provision of in-service education to all pertinent facility personnel (nurses, aides, physicians, residents, and familes).
- The long term care facility provides the consultant pharmacist with the opportunity to be involved in responding to questions and comments from licensing agencies and to participate in resident discharge consultation.

- The long term care facility's policies and procedure for storage and inventory of medications subject to abuse are in accordance with state and federal regulations pertaining to those medications. Furthermore, those policies and procedures are observed in daily practice.

- All medications are stored and handled in a manner that maintains product quality, purity, integrity, and security.

- The long term care facility supports the consultant pharmacist's participation in the evaluation of residents being considered for self-administration of medications and in the detection and prevention of medication errors.

Pharmacy

LONG TERM CARE PHARMACISTS TO PLAY A MORE PROACTIVE ROLE

Lauren Tackel

The structures of health care delivery and services are changing all around us. The role of the consultant pharmacist has drastically changed since the passage of Title XVIII and XIX of the Social Security Act in 1965. With the implementation of OBRA on October 1, 1990, both the nursing home industry and consultant pharmacy will face even greater challenges. All of these events lead up to a two-pronged question: Who is your consultant pharmacist and are your pharmacy services valuable?

Assessing the pharmaceutical services in your facility must begin with a review of what services your pharmacy is supposed to provide and whether those services are being provided to your satisfaction. One scenario would be to survey your nursing staff about the expectations and reality of pharmacy services; input from physicians and interdisciplinary team members could be helpful.

Available Year-Round

Your pharmacy should be supplying the facility with a drug distribution system that fits the needs of the facility, not one that fits the needs of the pharmacy. This system must be tightly controlled and account for all doses and treatments given to each patient. Medications should be ordered in a simple manner and delivered on a timely basis. Your pharmacist and pharmacy must be available 24 hours a day, 365 days of the year.

This may sound simple to achieve, but in reality, it is not easily accomplished. It is your pharmacist, not necessarily the pharmacy, who can make or break any service agreement. As an ancillary provide, he or she needs to be adaptable to change. With ever-changing regulations in the long term care industry, your facility's pharmacy must be up-to-date. Does your pharmacy keep you abreast of the changes in federal and state regulations on an ongoing basis, or are you the one informing your pharmacist?

> *"With the ever-changing regulations in the long term care industry, your facility's pharmacy must be up-to-date."*

Long List of Responsibilities

Long term care pharmacists have numerous responsibilities, including monitoring the facility's drug-administration system and assessing nursing staff performance in the delivery of pharmaceutical services. They also must evaluate the facility's compliance with federal and state laws and regulations regarding the acquisition, disposition, handling, and storage of medications.

Pharmacists are held accountable for ensuring the correct transcription of physician orders to the medication administration record. They conduct monthly drug regimen reviews which include checking for drug interactions with other prescribed drugs, allergies, diets, disease states, and/or diagnostic laboratory tests.

In addition to the above-mentioned responsibilities, long term care pharmacists provide inservice programs to nursing staff and physicians; cost-benefit reviews in terms of decreasing the number of prescriptions per patient and/or decreasing the amount of nursing time spent on medication administration; and revisions of pharmacy policies and procedures manuals (updating to comply with state and federal regulations).

Expanded Role

The new Medicare and Medicaid Requirements for Long Term Care Facilities further expands the role of the long term care pharmacist. In addition to the current responsibilities, your pharmacist will now be shouldering the monitoring of the use of antipsychotic drugs, recommending drug holidays or dose reductions for those residents using antipsychotic medications. He or she will see to it that no resident receives an "unnecessary drug" and that there are proper distribution systems for any residents who wish to self-adminster their medications. In addition, your pharmacist will assess the drug distribution system of the facility to be sure that the facility remains free of significant medication errors.

In evaluating current pharmacy and pharmacist services, the administrator, director of nurses, and medical director must be aware of what the pharmacist is doing. Both the pharmacy and pharmacist must be an integral part of any facility. Your pharmacist's knowledge and input can make or break your survey.

As regulations in the long term care industry evolve, pharmacy will play a more proactive role. Your pharmacist must have the insight to learn from the past, be able to act decisively today, and be prepared to plan for the future. ■

Lauren Tackel, RPh, is director of consulting services for Specialized Pharmacy Services, Inc., in Livonia, Michigan.

RESIDENT ASSESSMENT
THE SPRINGBOARD TO QUALITY OF CARE AND QUALITY OF LIFE FOR NURSING HOME RESIDENTS

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SECTION V – IMPACT OF OBRA QUALITY CARE STANDARDS ON COST

Moving Ahead with the Challenge:

Making Sense of OBRA

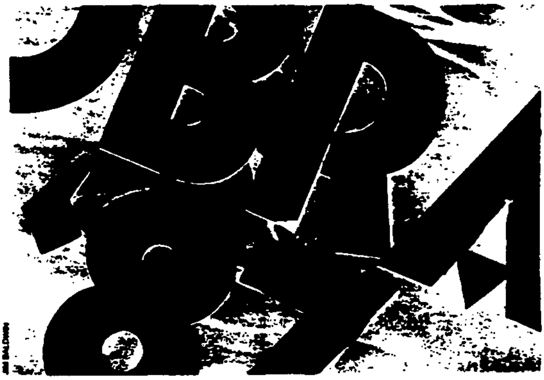
Thomas Hoyer

The Omnibus Budget Reconciliation Act of 1987 (OBRA) is good for nursing homes, just as it is good for the states, the federal government, and the residents. It is good for a number of reasons, and the fact that implementing it will not be easy or quick does not detract from its real value.

It is often argued that regulations, however detailed, do not compel good nursing home care: that only a caring staff, a strong knowledge base, and the will to succeed can produce that result. In its most fundamental sense, that is true. Really wanting to do the job is essential. I also believe, though, that it is a wholesome thing for the rules that govern the job to relate as closely as possible to the task at hand. It is wholesome for the people involved in the job to think seriously about what they are doing from time to time, to reevaluate their jobs and their goals, and to view things afresh. Nursing home reform is the catalyst that makes it possible to achieve these results.

Legislative Expression of Consensus

Though enacted almost overnight in 1987, nursing home reform is not a new set of ideas. It is the legislative expression of a consensus that has been building all through the 1970s and 1980s; that had its expression in the nursing home reform efforts of the late 1970s and the early 1980s; that appeared more fully developed in the Institute of Medicine's Report, *Improving the Quality of Care in Nursing Homes*, and that appeared in the Department of Health and Human Services' proposed nursing home reform regulations in late 1987.



There is no real dispute about the fundamental objectives of nursing home reform even though there have been myriad disagreements about the details of the legislation and the regulations that have been drafted to implement it. The most fundamental objections to nursing home reform have little to do with its principles. They are related more to apprehension and to reluctance to abandon established requirements and to establish a new way of describing what must be done, of measuring what has been done, and of paying for what has been done. In many respects, it is the cognitive dissonance that arises from this reluctance that is the major benefit of nursing home reform.

The typical person who knows about nursing home care may well say that a good facility is as easy to spot as a sunrise, but it does not require very many minutes of discussing outcome measures for care—the kinds of statements that now appear in our quality of care requirements—to discover that these people do not agree on what makes the sun come up. A group of individuals, all with the same end in mind, cannot discuss an issue, like the use of restraints, without disagreeing among themselves over means. The lengthy public discussions over the nuts and bolts of nursing home reform have given us all — providers, regulators, advocates, residents, and their families — a chance to reconsider our ideas about what kinds of results we want nursing homes to produce, how they should produce them, and at what price.

Resistance to Change

Commenters on the enforcement system we have been using for nursing homes over the past twenty years will not hesitate to say that it is a process that does not produce consistent results. Also, the current enforcement system makes it difficult to focus on the scope and severity of problems, especially those problems that may not be what are now known as condition level deficiencies. Despite almost universal agreement on this, however, we have encountered great difficulty in achieving change and have only painfully worked toward a consensus among representatives of providers, advocates, and states. Why? A good share of the problem is a fundamental resistance to the new, an unwillingness to risk the potential consequences of a new system when one at least understands the strengths and flaws of the old system. I am convinced that the effort the Health Care Financing Administration is making to develop a new enforcement process, with its all-important survey methodology and sanctions package, will benefit nursing homes as well as their residents. Again, the reason is that our efforts are forcing all of us to focus our attention on what is important in nursing home care.

Reexamine Product and Price

Finally, observers of the continuous yet healthy debate over Medicaid payment levels for nursing home care will readily concede that the longstanding nursing home coverage and participation requirements have long since stopped being a major consideration for either the States or providers in rate setting. The annual debate has most often been over the extent to which a state may increase (or decrease) a rate to reflect inflation. The Medicaid payment debate rages over many issues of course, but the product has been the same for so long that the emphasis has been primarily on the price. The nursing home reform law requires each state to examine its nursing home rates and determine what adjustments may be needed to pay for the improvements required by that law. The law also contains provisions regarding state disclosure of the data and assumptions that underlie the payment changes.

This provision is good for the states and for nursing homes because it creates a context in which they can reexamine not just the price as compared with last year's price but the price as a reflection of the new product which will result from nursing home reform. We have all heard the fears of various parties that the payments may be too large or too small, but there is no avoiding the task and it is a fundamentally healthy activity for states and nursing homes to re-examine both the product and the price.

End Result is Improvement

The one consistent theme I have identified in the last few years of work on nursing homes is disagreement among the parties. Not, I believe, fundamental disagreements on the ends that should be achieved, but disagreements on the means by which they should be achieved. The disputes I have encountered have to do with issues as various as the nature of institutional life, the methods by which quality of care and quality of life can be measured, and the threshold level of services appropriate to a nursing home environment. Neither these issues, nor the host of other issues I have not mentioned here, are easy ones. I am under no illusion that the end of this process will be the happy agreement of all parties to the result. I do believe, however, that the end result of this process will be a lasting improvement over the system we have known for the past 20 years. It will be an improvement because all of us—providers, advocates, and residents, —have taken a new look at what it is we are doing, and why we are doing it and we are making a new commitment to succeeding in our efforts. ■

> ***"The nursing home reform law requires each state to examine its nursing home rates and determine what adjustments may be needed to pay for the improvements required by that law."***
>
> Thomas Hoyer

Richard Rau

From the perspective of a provider c services, quality is not necessarily something that can be bought and paid for in the traditional sense. Quality, in regard to nursing home services, is as much a feeling about how one is being cared for as it is related to the technical and professional expertise of the treatment.

Likewise, it is true that spending additional sums of money will not guarantee an increased level of "quality" of and by itself. It is also true that simply formulating regulations and enforcing or attempting to enforce them on an industry such as the nursing home industry will not necessarily enhance quality to a measurable degree. It may enhance "quality" at the lower end of the spectrum, but it will have minimal if any effect at the high end of the scale.

Our industry is essentially a "people taking care of people" industry. Considering the myriad of personalities of our residents and staff, obtaining a correct and harmonious balance is definitely going to be one of the many great challenges of the 90's and beyond.

Challenge and Curse

As we enter 1990, the Omnibus Budget Reconciliation Act of 1987 (OBRA) loor as both a challenge and a curse. Sever items within that piece of legislation will necessitate expensive changes in the operation of our nation's long term care facilities.

In this area, the one issue that has received the most recognition is nurse assistant training and inservicing. From the somewhat limited exposure I have had to the OBRA costing studies that have been done in several states, it is clear that nurse assistant training will have a profound impact on the cost of operating facilities. While the implementation regulations soon to be released may to a small degree lessen the onerous costs associated with this issue, it will surely cost a large number of dollars to, in effect, create a new group of "certified" nurse assistants.

Cost Not Limited to Training/Testing

It is important to understand that the cost associated with this item is not limited to the cost of training and testing. This process will undoubtedly lead to a shrinking of the work force and will inevitably result in higher wages for current as well as future nurse assistants. There will be a "ripple" effect throughout the wage structure of facilities, which must recognized by the government payors as not to place another financial stress on the industry. This recognition must be both immediate and complete in its payment of these costs. Currently many reimbursement mechanisms reimburse costs but with a lag time of up to 30 months or more. This is not acceptable and cannot be tolerated by the industry in regard to costs associated with nurse assistant training as well as other OBRA-related costs.

Another item of OBRA which, in reality, may wind up costing more than nurse assistant training is the area of resident assessment. While it is hard to assess the full cost of this provision at this time due to the fact that final regulations have not been issued, it is at the same time important to recognize that this change will potentially cause dramatic changes to be accomplished within a facility's internal operating systems. These changes will be associated with the new formats, timetables, and other requirements of this area. Once again, full and current recognition of the costs associated with this item are a prerequisite for facilities being able to provide "quality" care to their residents.

The list of individual requirements which will cause financial stress on our nation's nursing home industry could be detailed for pages upon pages. However, the issue that is of paramount importance behind the changes is the need for current and full recognition of the additional costs. Whether it is the costs associated with changing from the present SNF/ICF facility designation to NF (nursing facility) designation or the various components of the new federal requirements for participation, the payment mechanism must adequately address the cost of operations of our nation's facilities.

Many dates have been issued as the implementation dates for various components of these pieces of legislation. Probably the most important date is April 1, 1990, when the Medicaid State Plan Amendments regarding coverage of OBRA costs must be submitted to the Health Care Financing Administration (HCFA). It is imperative that these State Plan Amendments receive more than a cursory review by HCFA in order to appropriately assure that adequate reimbursement for these costs has been provided for in the various state Medicaid plans. As previously stated, this recognition and payment for costs must be both full and timely in order to allow our nation's long term care facilities to be able to comply with the provisions of these regulations and at the same time provide "quality care" to the residents living in our facilities.

Other Concerns

Two other issues which I believe are of great importance in this area, although not specifically related to OBRA or the new regulations, are both the applicability of the Boren Amendment to state Medicaid plans and the issue of spousal impoverishment.

It has long been held that the Boren Amendment, and its component which mandates that reimbursement systems must recognize the costs of "efficiently and economically" operated (EEO) facilities, must continue to have application to the Medicaid reimbursement programs of the various states. There must be a reevaluation of many states' definition of EEO, which too often surrounds issues such as paying the costs of only 50 percent of the state's facilities. This type of arbitrary guideline is unrealistic considering the difference between the patient mix at various facilities within a state or region. Just as local and regional taxing authorities use equalized value as a method for assuring equity in regard to local taxation, any payment formula must in the future include a mechanism for realistically assessing and taking into account different patient mixes so as to adequately reflect the costs of providing care. A simple arbitrary 50th percentile guideline used on a statewide basis is both unrealistic and borders on unconscionable under the current situation. As a proponent of case mix systems for many years, I feel that an adequately funded case mix system is the only accurate and realistic system of Medicaid reimbursement for the future. It is also important to stress that any Medicaid plan should include both components mentioned above. The components of adequate funding and a true case mix system are separate and distinct. Too many people believe that a case mix system encompasses both classification and funding. This is far from the truth. The state of Wisconsin has had many discussions over this issue in the last couple of years. A result of that discussion is recognition of the fact that changing a classification system without changing the funding vehicle only serves to redistribute (some would say more equitably) the dollars that are being paid for care, but will do little to satisfy a statewide underfunding problem.

Spousal Impoverishment

The area of spousal impoverishment is another area of recent regulatory efforts that undoubtedly will have an affect on our industry. The raising of limits on assets and income will have the effect of increasing the number of Medicaid residents for those states which were below these limits prior to enactment of new regulations. Some say that this will have a dramatic impact on our nation's facilities. However, if implementation of these new limits is accompanied by an overall enhancement of the divestment regulations, the bottom line affect on the industry could be positive. One of the current issues most affecting the industry is the area of divestment. As long as state programs underfund the industry, it is and will continue to be necessary to supplement revenue through private pay residents of the facility.

Since this source of revenue is coming under increased scrutiny and pressure, it is imperative that throughout the implementation of these new, and any future, regulations that there be a full and immediate recognition of a facility's operating costs if quality care is to be provided.

In conclusion, then, I would reiterate the idea that while cost and funding are not the only issues within OBRA, they are clearly of great importance and must be dealt with in a responsible and timely manner. Without appropriate funding, OBRA will cause problems that could, in fact, reduce rather than improve the quality of our nation's long term care system. ■

> ***"Without appropriate funding, OBRA will cause problems that could, in fact, reduce rather than improve the quality of our nation's long term care system."***
>
> **Richard Rau**

Robert Freisness

Since enactment of the original legislation over a year and a half ago, the Omnibus Budget Reconciliation Act of 1987 (OBRA) has consistently been the *Number One* topic of discussion at nearly every gathering of nursing home providers, consumer advocates, and Medicaid officials. As Richard Rau pointed out in his article, cost and funding are not the only issues involved in this complex situation although they frequently form the foundation upon which other topics are necessarily built. Without appropriate funding, OBRA may be not only a hollow dream but indeed a veritable nightmare. But note particularly Tom Hoyer's comment that OBRA can and should provide an opportunity for all individuals involved in the long term care industry to take a fresh look at not only payment mechanisms but also the entire methodology through which we conduct our business. He indicates that a re-evaluation of the industry as a whole can and will occur as we seek to implement the provisions of OBRA. More significantly, he indicates that, in his opinion, this re-evaluation will be a healthy exercise for all concerned, and will eventually result in a stronger and more responsive long term care system.

General Agreements with Concepts

Interestingly, the major consumer advocacy groups appear to be in general agreement with these concepts. Barbara Frank states that some long term care facilities have allowed basically unacceptable situations to become routinized and thus no longer particularly noticeable. To at least some degree, this is probably true. It is indeed very easy to become accustomed to less than perfect conditions. Thus she would presumably also agree that Mr. Hoyer's suggested re-evaluation of all of our underlying long term care assumptions could yield productive results, not only in care delivery but also in payment methodology.

However, consumer representatives and others must also remember that a long term care facility never operates in a vacuum. In addition to state surveyors, facilities are constantly subject to outside scrutiny by family members, ombudsmen, and consumer advocate groups. Thus, while short-term problems may indeed arise, they normally cannot persist without appropriate corrective actions being taken, either voluntarily or involuntarily. Under OBRA, this scrutiny will undoubtedly become more severe and onerous (or more effectively designed to protect long term care residents, depending upon your point of view). Our facilities want to meet these increased demands as best they can. However, realistic funding levels will necessarily be a major factor in determining whether or not we are able to effectively do so.

There can be little question that the lot of staff in many long term care facilities is not a particularly happy one. Staffing shortages caused by the unavailability or qualified RNs, LPNs, and nurse assistants as well as staffing shortages directly related to inadequate funding combine to produce tremendous stress factors within the working environment for many of our employees. These factors necessarily restrict the quality of the product which we seek to deliver. Payment rate structures that address these problems are necessary for any viable solution to be developed. However, merely throwing money at a problem will not solve that problem. Payment systems must be designed to provide incentives which accurately target the problems to be solved. Thus, in some states, one of the great challenges of OBRA will be to improve upon payment systems which fall short of inducing desired outcomes. In other states, however, where innovative and effective payment methodologies are already in place, the solution does indeed boil down to a straight-forward matter of dollars.

Partnerships Must Evolve

In order to actually create an environment which will be conducive to improved resident care, it is necessary for the provider community to work with consumer advocates as well as governmental agencies and legislators. Particularly at the state level, coalitions must be built to ensure that the provisions of OBRA are implemented in a timely and orderly fashion, and that payment structures will be improved to accommodate the resultant costs. As you can clearly see in Mr. Hoyer's article, the Health Care Financing Administration has taken a responsible and reasonable approach to the funding of OBRA costs by working with both providers and consumers in order to develop regulations which will significantly improve the Medicaid State Plan review process.

Regardless of how good the state plan review process may become, however, it will be of little value unless providers cooperate with their state associations to develop accurate and defensible OBRA cost estimates. Once these estimates are developed, a true three-way partnership must evolve among providers, consumers, and governmental officials at the state level if OBRA is indeed to have any real meaning. Barbara Frank's comments relative to ensuring that the new regulations do not merely create "rote paper exercises" are precisely on target—OBRA can and should mean much more than creating procedures which may comply with the letter of the new law but ignore its spirit.

It should be clear by now that, while each interest group may look to OBRA to meet its own specific needs, a common thread must be found to link all of these interests together. Finding and developing that common thread amongst a myriad of politically and economically diverse positions may indeed prove to be the greatest challenge presented by OBRA. ■

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Barbara Frank

OBRA elevates to public policy the principle that each person who lives in a nursing home should ive care and services to "attain or maintain the highest practicable physical, mental and psychosocial well-being." In setting this new standard, OBRA supports the best efforts of every nurse and administrator, social worker and aide who has put heart and soul into quality care over the years.

Consumer advocates know that the words of OBRA will be fully realized only with: (1) a public commitment to provide the resources necessary to support humane and comprehensive care for nursing home residents and (2) a private commitment by nursing home owners and administrators to target resources available to support quality care.

OBRA can become a rallying point to support increased public resources as long as consumers can trust that new dollars will be used to provide better care.

Focus on Resident Needs

OBRA provides an opportunity to center the debate about resources directly on good care practices and the needs of residents. Focusing on residents' needs and the new possibilities for better care under OBRA places the choices rely and forcefully before state leg- atures and Congress.

Most of OBRA, and the February 2, 1989 Long Term Care Facility Requirements, are designed to support fundamental change in care expectations and practices with new tools such as multidisciplinary resident assessment and care planning, new measures for quality of life and residents' rights, and training for nurse assistants.

These new requirements help build the case for more resources. The new resident assessment process provides a format to describe the complicated needs people living in nursing homes have, and the amount of effort required to respond fully to them. For example, as nursing homes discover new ways to support more freedom for people who once were restrained, we find graphic examples of the difference careful assessment and coordinated care delivery can make in someone's life.

We are learning about the costs and benefits of improved care. We cannot accept new reimbursement systems based on current practices in nursing homes which are not cheap, cost effective, or good for residents. What does care cost in long run when people become totally pendent after being restrained? As health professionals are realizing that 90 percent of restraints are not necessary or beneficial, suddenly we see with a new eye what care is possible. What else do we accept? Theft? Odor? Boredom? Staff turnover? Dissatisfaction with the food? Loneliness? We know many nursing homes have overcome these conditions and found it cost-effective to do so. It is not in anyone's best interest to accept these situations as unchangeable.

Providers who re-evaluate their care practices and discover new possibilities for residents can provide the necessary documentation about any increased costs. Good care is good business. Good nursing home managers know how well their staff respond to a good working environment and that improvements in care practices will likely reduce turnover. It means more to work a job as nurse assistant when you've received training. It's more rewarding to work in an atmosphere of restorative nursing where you see progress because of your efforts.

Provider Commitment Essential

We are heartened by progressive providers all over the country who have achieved these changes and whose work was used to develop OBRA. The provider contribution in shaping OBRA was invaluable; provider commitment to its full implementation is essential.

Sadly, the voice of the caring professional committed to the struggle to improve services to residents is not always the vocal voice in the provider community. It is troublesome to advocates to hear OBRA's costs politicized by industry representatives who, on the one hand, maintain that providers already meet the OBRA requirements, and on the other hand, argue that OBRA will cost billions of dollars.

This argument reduces OBRA provisions—such as calling family members when there is a change in condition—to rote exercises occurring in a vacuum. Advocates see such provisions as vehicles to improve care. Of course staff benefit when they have good contact with the family. If OBRA simply becomes a new series of line items for the accountants or rote paper exercises for nursing home management then every one of us loses.

> ***"…both advocates and providers must discuss nursing home reimbursement based on residents' needs and what it will take for nursing homes to meet those needs."***
>
> Barbara Frank

OBRA provisions like resident assessment must be valued for the contribution they make to a facility's ability to provide care, rather than being criticized as an additional paperwork burden. We will not get more public dollars to fill out forms. We may get more public dollars when those forms tell the story of someone who learned to walk again or received enough staff support to live without restraints.

As we discuss reimbursement changes to support OBRA, we will advocate that they come hand in hand with changes in care practice. When we face proposals such as wage pass-throughs or case mix reimbursement, advocates will be strong in support of more resources for staff. But we will question disparities in staffing from one nursing home to another and why the public should support spending priorities that do not support good care. And we will question discrimination in access and services based on source of payment.

Addressing these issues will be essential to receive public support for increased funding because the public knows that while more money is important, it is not the only factor affecting care in nursing homes. The public is fully aware that management decisions affect the quality of nursing home care no matter what a state's reimbursement rate. The public needs to be able to trust that meeting residents' needs will be the bottom line for nursing home owners and managers.

It is as unproductive for nursing home reform advocates to base our position on mistrust as it is for nursing home operators to argue solely that they are not paid enough. While neither can discard these concerns, both advocates and providers must discuss nursing home reimbursement based on residents' needs and what it will take for nursing homes to meet those needs.

Let us build our discussion of nursing home cost by supporting the changes required by OBRA, rather than opposing them, because the changes mean better care, a better working environment, and better service to the public. If a good assessment process costs more money than is currently available, let us talk about the value of the assessment. Let us talk about resources needed to hire more and better qualified nurses, social workers, activities directors, therapists, and aides. Let us talk about the contribution to quality care a full team of health care providers will make. Let us direct the funds available to support improvements in care.

We will only be successful in generating public support for more resources if those resources will result in significant improvements for residents. ■

Policy Perspective

REIMBURSEMENT WILL ENSURE OBRA'S FOCUS ON CARE OUTCOMES

Lori Costa

The Omnibus Budget Reconciliation Act of 1987 (OBRA) ended a decade of legislation and regulation designed to change the "scandalous" practices that were found in some nursing homes during the seventies. Not since the enactment of Medicare and Medicaid programs in the mid sixties has there been such a comprehensive change in the federal nursing home requirements for participation. However, the question remains: will OBRA provide the same magnitude of change that was brought about by the enactment of Medicare and Medicaid, which not only fulfilled the need for comprehensive standards for health care delivery in nursing homes, but also provided a much needed infusion of dollars for the delivery of that care?

Clarification Needed

The new nursing home reform law contains a great deal of detail with regard to the requirements for participation in the Medicare and Medicaid programs, the survey and certification process, and enforcement sanctions. Even with this detail, more clarification and interpretation is needed so that providers, surveyors and consumers can have a common understanding of what the provisions mean and how they are to be put into practice. It is clear that the quality of the resident's life and care are important and that an integral part of the quality is their right to be autonomous and have their individual needs accommodated within the nursing home's health care delivery system.

Another major theme embodied in OBRA is the continued movement away from the process/paper compliance evaluation to a care outcome focus. Both the regulations and the surveyor guidelines define these outcomes in terms of an aggressive, proactive rehabilitation goal designed to help the resident reach his or her optimum level of function. The earlier Medicare and Medicaid standards of prevention and maintenance have been replaced by this "can do" concept.

All of these aspects of nursing home reform are laudable, but the question remains: are they achievable, or will they continue to widen the gap that now exists between current standards for care and resources in the nursing home?

Expectation and Reality

Of concern for the nursing home are the shortages and capabilities of the labor pool, the inadequacy of reimbursement systems, the rising acuity levels of the nursing home resident, and the lack of developed quality standards, which resolve the disparity between consumer expectations and the realities of industry concerns.

Although the consumer is committed to raising the standard of care in nursing homes, commitment to the attainment of resources necessary to achieve those standards is not as strong. The consumer driven repeal of the Medicare Catastrophic Act resulted in a major blow to state Medicaid budgets, which will be the major funding source for OBRA implementation costs. The nursing home industry faces a tough challenge to ensure that reform standards are funded as required by OBRA. The government's dual role in defining standards for care and at the same time financing 60 to 70 percent of that care has always been a source of conflict. National policy is to contain escalating health care costs. The hiatus that exists between consumer expectations/regulatory requirements and reimbursement programs are currently causing crisis within the industry and endangering the survival of the system that is necessary to meet the growing demand for elder health services. It remains to be seen if government and consumer advocates are as committed to the funding as they were to the definition of nursing home reform standards.

A second concern of the industry is the major labor supply problem that is prevalent in nursing homes. The national nursing shortage is felt most severely in nursing homes because they lack the ability to compete with other health care settings for licensed nurses. Turnover rates for nursing staff, licensed and nonlicensed, are as high as 130 percent in some states. This necessitates the high utilization of temporary help which compromises the ability to provide for consistency and continuity of care that are so vital to any quality measurements.

The rising acuity levels of residents entering nursing homes raises a myriad of issues concerning the implementation of reform standards. Two of these, the continued inherent conflicts caused by the integration of the medical and social models of care delivery, and the requirement to accommodate "choice" are of major concern to the industry. Demographics show that the average age of the nursing home resident is increasing. The number of physical and mental deficits of each resident is also rising. The trend in the nursing home is shifting to require more "nursing."

The increase in technology caused by this shift will continue to cause conflicts with the "homelike" and social aspects of the reform requirements. The resident's right to make decisions about his or her care is extremely important, but will consumers and families be willing to accept the risks involved in those decisions? Untying the elderly will increase the risk

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of falls, refusing nutrition and hydration will increase the risk of pressure sores, and refusal of medications will increase the risk of untoward symptoms. How will the conflicts between the nursing home's responsibility to provide for the health, safety and welfare of the resident and the resident's rights be resolved?

The Survey Process

All of these issues will have a bearing on the survey process. The goal of the survey process in determining compliance or noncompliance with the reform requirements is to improve quality of care by making the process more resident outcome oriented and more accurate and reliable. In the guidelines to the requirements, surveyors are told to take into consideration the normal aging process and the pathogeneis of resident illnesses when determining whether or not the resident has received "...the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being..." Currently, there is a significant void in research and data on the "normal" progression of chronic diseases and the appropriateness and effects of interventions than in other health areas. Standards of gerontological medical and nursing practice are in the infancy stage in comparison to other fields of practice. Quality standards are far from being well defined.

. OBRA has made a quantum leap from focusing on the factors which identify the nursing homes capacity to give care, to outcomes of care without any consideration that the definition of the activities needed to achieve those outcomes is still in the early developmental stages. Even the new survey guidelines to the requirements support the fact that quality of care in terms of outcomes may be hard to measure, eg. "Since ideal body weight charts have not yet been validated for the institutionalized elderly, look at weight loss (or gain) as a guide in determining nutritional status."

How will surveyors cope with the measurement of quality in a chronic care setting where attainment of outcomes can be a slow process and occur in very small incremental stages? Where the physical, mental, and psychosocial stability of the resident is fragile at best and where outcome measurements for quality lack standardization? Where traditional indicators signifying lack of quality of care such as death, disability, disease, discomfort and dissatisfaction may not be useful? Hopefully the proposed emphasis on increased nursing home/surveyor communication, surveyor training and education, and better guidelines for regulatory areas requiring considerable judgement, will negate the need for increased documentation. The OBRA increase in nursing home staffing requirements would indeed be misused if the new survey process requires more "paper compliance" to satisfy enforcers of regulatory compliance.

OBRA has brought to the forefront such issues as the consumers' expectations of nursing home services, the need for a better approach to the definition of quality of care, the dilemma caused by the cost of quality care, and an appreciation of the issue of rationing services by default. The standards embodied in OBRA will be a quantum leap forward, but only if adequate financing and resources for their implementation are provided and better definition is given to the survey process. ■

TESTIMONY OF
SARAH BURGER, R.N.
NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM
Before the
HOUSE ENERGY AND COMMERCE COMMITTEE
July 20, 1990
Regarding H.R. 1649

Thank you for this opportunity to testify about the importance of supporting nursing home staff to assure quality of care and life for nursing home residents. My name is Sarah Burger. I am a Registered Nurse and I am giving my testimony on behalf of the National Citizens' Coalition for Nursing Home Reform.

The Nursing Home Reform Amendments of OBRA '87 set a framework for achieving this higher standard of care. Without adequate, well-supported staff we will not be able to fulfill the promise of OBRA. We applaud Congressman Walgren for opening for the discussion the critical issue of staffing, with his proposed legislation, H.R. 1649. We urge Congress to deliberate on these serious issues and take action to secure quality care for nursing home residents.

Our first organizational work was to address the Plight of the Nurses Aide with a working paper we issued in 1978. The issues we identified then had been documented in previous reports, including investigations by the Senate Special Committee on Aging and the House Trailer Committee on Aging. We find these problems still shape the atmosphere in nursing homes today.

Nurse aides provide 90% of the hands-on care that nursing home residents receive. Yet aides are often poorly trained, a situation that will change as the Nursing Home Reform Amendments of OBRA '87 are implemented, beginning in October of this year. While training is a critical issue, other problems affect the quality of the work environment.

The most critical issue is that of understaffing. Nurses and nurses aides work short-staffed as a matter of routine in most nursing homes. This means that nursing home residents must go unattended in their personal care needs and that vital services such as maintaining mobility often fall by the wayside. The atmosphere in too many nursing homes is one in which residents are restrained or over-medicated, slowly deteriorating physically and mentally because of the dismal surroundings and inability of hard-working staff to meet anything more than their most basic needs.

This is not the picture in all nursing homes and so we look to those nursing homes with a dynamic and healthy environment to discover what makes the difference. We see:

> <u>Good Management</u> which uses good supervision and support to create a sense of teamwork among staff. This includes hiring <u>sufficient numbers of staff</u> including nurses, nurses aides, activities staff, social services personnel, housekeeping, and dietary staff. In also includes <u>a sense that employees are valued</u>, including decent wages, benefits including leave time, and creative management strategies such as flexible work hours and support for the other demands in staff people's lives, such as child care assistance. Part of this is <u>valuing employees for what they know and can contribute</u>, such as including aides in the care planning conference, giving aides complete information about the residents they are caring for, having permanent assignments of aides so that they know and can develop a relationship with the residents that promote sensitive and knowledgeable care-giving.

Good care practices that support quality of life and are based on individualized care. If a nursing home provides good care and respects the quality of life of residents, it will also be a positive environment in which to work. We have seen dramatic examples of this in the way facilities which have re-examined their use of restraints have seen reduced staff turnover, and staff from other nursing settings asking to work at their homes. Staff would rather help people regain their strength and skills, than mop floors and change soiled clothing. The facilities which are redirecting their efforts toward the "highest practicable physical, mental and psychosocial well-being" of residents find their staff morale is high and that all employees are thinking creatively about how to overcome residents problems and achieve optimal care.

H.R. 1649 is essentially and basically about values. As Congressman Walgren has stated in introducing H.R. 1649, that are values are reflected in the kind of care "we expect for ourselves and our families."

A prime indicator of the quality of a society is how it cares for its weakest and frailest members. The frailest members of our society reside in nursing homes. The residents of nursing homes are our mothers and fathers, aunts and uncles, sisters and brothers, and daughters and sons, neighbors. Our citizens who reside in nursing homes are elderly, chronically ill and frail persons, with the most complex of care needs. These care needs cover the entire spectrum of the human condition -physical, mental and psycho-social well-being. In no other health care delivery setting are issues that deal with the essence of human existence so confronted on a daily, long term basis.

Some of the daily on-going care needs of the nursing home resident relate to death and dying, loss, grieving, human sexuality, ability to communicate, understanding, decision making, control, mood and behavior, in addition to activities of daily living and physical care. Some of these activities concern seeing, eating, walking, eliminating, sleeping, comfort -- all activities of daily living. All of these needs and activities relate to quality of care and quality of life.

As we review Mr. Walgren's bill we are concerned on four levels:

(1) It addresses only one part of the problem, that of wages for nurses and nurse aides. While this is important to do, we must remember that we need comprehensive solutions to complex problems. This includes attention to the work environment -- management and supervision supports for aides; education and training; good care practices; addressing the other pressures aides face in their lives that impinge on their ability to produce their best efforts.

It is clear that to provide quality of care which results in quality of life for nursing home residents, aides need total institutional support. While ninety percent of direct care is provided by nurse aides (who have the fewest skills and the least training and technical knowledge), the average ratio of nurse aide to resident is one nurse aide for fifteen residents. And the average ratio of registered nurse staff is one R. N. for 100 residents. There are not enough nurses and not enough nurses aides to meet residents' needs.

In addition, the knowledge, skills, and attitudes of nursing personnel must be extensive in order to meet the complex needs of each individual resident. The nurses that are there are not always able to provide the supervision, training and management aides need to carry out their duties. This is because there are not enough nurses to meet all the demands of their job and because nurses are often not well-trained in these skills with no commitment on the part of management to provide for the development of these skills. Too often nursing staff tasks are focused on an endless cycle of deterioration while staff try to keep up with increasing demands. Yet in facilities that have dynamic programs, such as restorative nursing care and engaging activities, residents stay healthier and staff can better meet their needs.

To provide care which addresses and attempts to meet these complex care needs requires extensive knowledge and skill and a humane attitude. It also requires on going and continuing education, constructive evaluation and supportive management.

The values of quality of care and quality of life for residents must be reflected in the nursing facility philosophy. Implementation of a resident-centered philosophy rests on the quality of the nursing staff as evidenced by institutional support assuring the following for nursing personnel:

- Adequate staffing reflecting the real acuity of residents
- Effective and on-going education and inservice
- Nursing supervision and evaluation which is constructive and instructive
- Individualized care plans based on adequate assessments
- Sufficient resources appropriately targeted to implement plans of care which can be reflected in quality of life.
- Wages and benefits for nursing personnel which reflect the value of the role and contribution in providing quality care.

Without support nurses experience job dissatisfaction leading to high staff turnover. Nursing personnel, working under such stress, are unable to provide quality of care and quality of life to residents. The owners and managers of nursing homes have an <u>institutional responsibility for quality care.</u>

There are many management strategies that contribute to staff retention:

■ Factors which relate to motivating staff to provide quality care are:
- Sensitivity to the needs of the adult learner and care giver,
- Participation in care planning and evaluation which indicates respect for the activity and resident experience of the worker,
- Recognition of good care giving
- Participation of decision making in the work environment,

■ One of the most important management activities for better staff morale, employee satisfaction, and low turnover rate is to respond to the life circumstances many nurse aides face. Aides are primarily adult females who are poor and have responsibilities, often as single parents. Benefits which reflect employee needs, such as child care, flexible work hours, medical insurance, retirement benefits and education benefits leading to career mobility make a tremendous difference. Nurse aides, as single parents, often, out of necessity must hold more than one job. Therefore, these workers come to the nursing facility stressed and exhausted and yet they are entrusted with care to the frail and elderly and are expected to be caring. Management strategies must reflect a sensitivity to the total life situation of its workers.

- Education is critical for aides and nurses. Aides often have minimal literacy skills. Education and constructive supervision is required, appropriate, and necessary on a daily basis to provide quality caring. Aides need appropriate education and training programs, and sensitive qualified staff to implement them. The challenge for the education, training and continuing education activities is to address the complex needs of residents and develop the appropriate knowledge, attitudes and skills aides need. Minimum education for nurse aides is now mandated by law. Resident assessments are also required by law. Licensed nurses must be taught how to perform these assessments and use the resulting information to provide quality care and quality of life for each resident.

- Clearly adequate staffing is necessary. High incidence of staff turnover is related to work load, burnout, and inability to function in an overstressed environment.

(2) Our Second concern about Mr. Walgren's bill is that even if we look exclusively at reimbursement solutions, increased wages by themselves will not lead to more staff in nursing homes. Nursing homes are limited in how many staff they can hire by state reimbursement systems that place a cap on direct nursing care expenses. Until we have comprehensive reimbursement reform so that dollars are directed to support residents' "highest practicable physical, mental and psychosocial well-being" we will continue to be understaffed.

Appropriate reimbursement certainly is one aspect of providing for quality in residents life and we support efforts to address the critical issue of wages. Reimbursement for nursing personnel which is comparable to other care giving settings indicates the value society places on those needing care and the value of providing that care. The Walgren Bill addresses one aspect of what is vital to provide quality care reflected in quality of life to our frailest citizens.

Although there are more nursing home residents than hospital patients in the United States, the nursing home settings employs less than 8 percent of all nursing personnel. The reimbursement level for nursing personnel entrusted with the care of our elderly and chronically ill is the lowest in all of the health care delivery system. For example, nurse aides who provide direct care in nursing homes receive the minimum wage, less than workers in fast food restaurants.

Why would nursing personnel choose the nursing home setting? In fact nursing home residents reported in our 1985 study, A Consumer Perspective on Quality care: The Residents' Point of View that "Good staff means everything" -- kind, caring treatment by well-trained staff in sufficient numbers is the number one factor affecting quality. Nurses aides report, in other studies that they share this feeling, that the primary reason they work in nursing homes is because they care for their relationships with residents. Dedicated nurses and nurses aides hang in there, in discouraging work environments where they are poorly rewarded, because they care about the people living there. The premise is that workers in these facilities care about residents.

All of this relates to the necessity to have quality staff committed to quality care-giving on a daily, long term basis. Adequate and comparable reimbursement is one factor in assuring job satisfaction, low turnover rate, and high morale on the job. This translates into a labor force which would be adequately reimbursed under the Walgren Bill in turn demonstrating society's values. Wages and benefits must reflect the fact that the institution cares about those providing care to residents. However, increased salaries cannot effect good care unless there is also increased staffing.

The Walgren Bill addresses one segment of nursing home reimbursement, when, in reality, the total system contributes to inadequate quality and quantity of staff leading to poor resident outcomes. For example, in some states the reimbursement level may be too low or a state cap may force nursing facilities to hire inadequate numbers or mix of nursing personnel. So nursing homes that try to use the wage pass-through to attract more staff will still face limits on the number of employees they can be reimbursed for under such a state's reimbursement system.

Reimbursement systems now are built around a complex array of cost limiters which rarely have much to do with the amount of resources necessary to provide quality care. When this is coupled with unacceptable provider practices, described below, residents and staff suffer. Even reimbursement systems that have gradations based on residents' acuity can have a perverse incentive for poor care -- especially if facility reimbursement goes up as a resident's condition declines.

We must review our reimbursement systems to make sure they promote and support improvement in people's physical, mental and psychosocial function, rather than paying more for unnecessary deterioration. We must not have caps on patient care that leave nursing home's short-staffed and undersupplied. We must discourage those who play real-estate games and engage in financial paper shuffles with our public dollars and the lives of our citizens.

Comprehensive reimbursement reform must target resources for care and must include auditing and accounting practices that assure the funds are spent on care.

(3) <u>Technically, we must assure that if we support wage pass-throughs, we have sufficient accounting and auditing practices to assure that public dollars are spent on residents' care.</u>

Reporting procedures must be implemented which would give a clear picture of how nursing facilities are utilizing pass-throughs. Some states that have used wage pass-throughs forgot to get baseline data on nursing home staff expenditures before the new monies were passed-through.

The public needs the guarantee that funding is used for direct care costs and not on indirect cost, profit, and/or administrative services. Auditing procedures are notoriously lax in most states and bear little connection to care practices. If the numbers add up, it rarely matters to the Medicaid auditors if a facility has been cited for numerous patient care deficiencies.

There need to be regular field audits of the financial records of nursing homes. And there needs to be an active cooperation between the efforts of the Survey and Licensure Agency and those of the Medicaid program. If the surveyors find conditions that warrant adverse actions, such as a ban on admissions, or civil fines, it may very well be appropriate for the Medicaid office to conduct a field audit to determine how public dollars are being spent by the facility.

(4) <u>We have little faith in the cost estimates associated with improved quality care. As the provider community has discussed its cost estimates related to implementation of the Nursing Home Reform Law, it has added up all the costs of increased staff without calculating the impact of staff on residents' conditions.</u>

Thus we hear how much resident assessment will cost, but not how valuable it will be to know a resident better and therefore be better able to take care of them. We hear how much aide training costs but not how valuable and more efficient it will be for aides to have the skills they need to perform their care-taking duties. We do not believe that all good care practices are necessarily more expensive. A facility that works short-staffed, will see serious declines in resident conditions -- residents become more and more dependent as they lose their mobility and other abilities in activities of daily living. They become more and more expensive and time-consuming to care for as their needs become more complex and intense. Thus we have been penny-wise and pound-foolish, saving a dollar on staffing so that we now must spend many more dollars on staff to care for a needlessly sicker person.

Prevention is more efficient and economical than treating results of poor care. Many of the more common reasons for neglect in nursing homes can be prevented. For example, decubiti is preventable by daily assessment and diligence. The financial cost of treating decubiti is $1.5 billion annually, by one recent estimate. The cost to the resident is physical and mental neglect and abuse. Increased staffing levels and higher wages and benefits can add to ensuring the prevention activities necessary to attain quality.

Proper bowel and bladder regimens are humane as well as more cost efficient than treating the results of incontinence. A study "Profile of Urinary Incontinent Elderly in Long Term Care Institutions" by Yu, et al Journal of the American Geriatric Society found that incontinence stems from other mental and physical disabilities which respond to prompted toileting, such as dementia and poor mobility, rather than primary bladder problems. Rehabilitation is more cost effective than treating the multiple ill effects of this individualized care.

Low staffing is used as an excuse for use of chemical and physical restraints. Restraints always lead to decreased quality of life and often to poor outcomes such as skin breakdown, urinary tract infections, pneumonia, and contractures. These outcomes are expensive to treat leading to increased skilled nursing services, hospitalizations and increased use of expensive supplies and drugs.

The HHS Commission on Nursing reported in November 1988 that the cost of increasing wages is offset by reducing staff turnover and decreasing recruitment costs. In addition, quality and quantity of nurses is higher, resulting in better care-giving and reduced numbers of costly poor outcomes. Finally, the frail older member of our society, who we will someday be, will be the beneficiary of individualized humane care.

Mr. Walgren is to be commended for bringing this important issue to the Congress and providing the catalyst for a thorough discussion of the factors that affect staffing in nursing homes. We have an opportunity to make public policy catch up with our values. The Nursing Home Reform Amendments of OBRA '87 were a good start. But we will not realize the full promise of those reforms until we invest financially and otherwise, in those staff persons who must carry out its mandate.

Nursing

IV-E-21

REHABILITATION PROGRAMS OFFER COST-EFFECTIVE RESIDENT CARE

Joanne M. Hamburg

Rehabilitation allows the geriatric or disabled residents of Sunshine Village Nursing Home in Pinellas Park, Florida, to achieve their maximum potential. It also enables residents to gain more independence and self-esteem. From a nurse's perspective, the reward of returning an individual to his or her highest level of physical, psychological, and mental functioning provides an indescribable feeling of excitement. Rehabilitation is nursing at its best—in any environment.

Parallels can be drawn between rehabilitation and the growth of an infant, where each day brings new triumphs. Through rehabilitation therapy, residents can relearn ambulation, feeding, grooming, and dressing. It is more rewarding for an individual to rehabilitate than to become inactive because inactivity can lead to pain, discomfort, and even depression. In short, rehabilitation can enable residents to become more social and gain a greater degree of independence.

Selecting a Program

Rehabilitation begins in the initial admission process. New admissions are often disabled, or they have a high potential for developing disabilities. If these residents become further disabled, they are likely to experience depression, confusion, anger, and denial. Rehabilitation can change that process by providing residents with encouragement and redirection of their disabilities.

Assessing resident weakness and needs can help to identify important factors for individualizing restorative care within your facility. For example, can the majority of residents ambulate, or does the potential for ambulation exist? Identify the number of residents who are admitted with contractures or who have a high potential for developing contractures. How many residents are unable to feed themselves? Identifying these areas provides a strong basis for providing residents with individualized care.

The Restorative Aide

Once you have decided on an individualized rehabilitation plan, it is necessary to select a strong, motivated individual who can carry out the program on a daily basis. At Sunshine Village, it takes an entire staff to provide daily, supportive rehabilitative service. The bulk of that support is provided by our restorative aides.

After successfully completing a one-month training course, the restorative aides acquire the skills to enable them to provide daily supportive rehabilitative service. Each aide works with 10 residents per day under the direction of the director of nursing and the physical therapist. The aide documents the care, which shows progress or the need for redirection if the current mode of rehabilitation does not bring the outcome any closer to a stated goal. In essence, the restorative aide's role forms a continuity in care.

Benefits of Rehabilitation

Rehabilitation services can improve patient care quality and cost effectiveness in the areas of incontinence, nutrition, range of motion, and human dignity and privacy.

The causes of incontinence are complex, and the costs associated with it are great. Ambulatory rehabilitative therapy is one way of decreasing these costs because ambulatory residents have been shown to maintain continence or show a decrease in incontinence patterns. Not only does ambulation decrease expenditures associated with incontinence products, but it also lifts the spirits of the residents. In addition, linen changes will not be as prevalent, which will decrease the amount of time laundry personnel spend changing linens.

When residents are mobile, they demonstrate an improved appetite. As residents eat a higher percentage of their food at meals, the need for supplemental feedings is eliminated. Rehabilitative feeding programs are also beneficial because they enable the residents to feed themselves—thereby increasing independence—and they free staff for other responsibilities. The cost of an adaptive utensil is approximately equal to one hour of staff time for feeding a resident. Once adaptive equipment is obtained, staff time can be used more beneficially. Adaptive equipment is also universal, so it can be used for individuals who have limited hand movement.

Range-of-motion activities attack two problem areas: pressure ulcers and resident falls. Ambulatory residents maintain skin integrity, thereby reducing the need for pressure ulcer products. Of course, it also reduces staff time and costly treatments associated with pressure ulcers. Providing ambulation on a daily basis improves the residents' gait, thus decreasing the incidence of falls, which lead to fractures. Bone fractures are costly, and they take away from the residents' valuable independence.

Finally, rehabilitative services help restore human dignity and privacy at a minimal cost. Grooming and dressing programs return independence in activities of daily living skills, which allow residents to feel more at home. These programs also reduce staff time.

At Sunshine Village, rehabilitation produces positive determination and increased morale for staff and residents—and it reduces the costs of care. Rehabilitation is economic nursing care: the savings can be tremendous. ■

Joanne M. Hamburg, RN, is director of nursing at Sunshine Village Nursing Home, a 120-bed skilled nursing facility in Pinellas Park, Florida.

This anthropological study describes and analyzes the clinical and social-structural factors contributing to the hospitalization of nursing home residents. In 48.2% of the cases, hospitalization could have been avoided. Factors such as an insufficient number of adequately trained nursing staff, the inability of nursing staff to administer and monitor intravenous therapy, lack of diagnostic services, and pressure for transfer from the staff and family contributed to hospitalization. In the United States each year, an estimated 216,000 nursing home residents who are hospitalized might be treated in the nursing home, for a cost savings of $942,763,530.

Key Words: Acute hospital, Transfers, Financial costs, Clinical conditions, Social-structural factors

Factors Contributing to the Hospitalization of Nursing Home Residents[1]

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Medicare's Prospective Payment System of Diagnostic Related Groups (DRGs) provides a current example of the "balloon effect"; squeezing down costs in one area merely causes them to expand in another. By reducing the length of hospital stays, the demand for nursing home care has increased (Lyles, 1986; Older American Reports, 1985; Sager et al., 1987; U.S. Congress, General Accounting Office, 1986), as has the acuity level within nursing homes (Smith & Molzahn-Scott, 1986; Stull & Vernon, 1986). Despite the prospective payment system, the average cost of hospitalization has continued to rise. In 1986 hospital bills in the United States rose 19% (Medical Economic Digest, 1988).

An often-repeated statistic — health care's consumption of 11% of the gross national product — is usually coupled with examples of life-sustaining technologies, such as open heart surgery, organ transplant, and kidney dialysis. Overlooked is the fact that high-cost users of health care are more likely to be persons with chronic medical problems who are repeatedly admitted to the hospital (Anderson & Steinberg, 1984; Schroeder et al., 1979; Zook & Moore, 1980). Equally lost is a less dramatic statistic, one as yet unexamined by health care economists: The use of the health care dollar for the care of nursing home patients in the acute hospital.

A few studies have focused on the clinical conditions that necessitate hospitalization of nursing home patients (Irvine et al., 1984; Zimmer et al., 1988), but little is known about the social-structural (i.e., nonclinical) factors that precipitate hospitalization. This paper describes the clinical conditions necessitating transfer of nursing home residents to an acute hospital. The emphasis, however, will be on the social-structural factors contributing to hospitalization.

Methods

These findings are part of a larger study that investigated the social-cultural factors and other circumstances influencing the decision-making process in the evaluation and treatment of acute illnesses in nursing homes. The study used participant observation; in-depth interviews with physicians, nursing staff, nursing home residents, and family members (100 in each category); and event analysis to gather data. Event analysis, an intensive study of a particular event, was the strategy used to study prospectively 215 acute-illness episodes in three nursing homes. Analysis of these data is underway. Reported here is an analysis of those nursing home residents who, when they became acutely ill, were transferred to an acute hospital for treatment.

Setting

The research was conducted over three years (1985-88) in three West Coast nursing homes, includ-

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ing a 1,200-bed government-owned long-term care facility (Facility A) and two proprietary nursing homes (Facility B with 135 beds, and Facility C with 182 beds).

Facility A was chosen for its unique features. First, it had a permanent on-site staff of about 30 physicians, largely internists; other specialists (e.g., cardiologists, surgeons, and gastroenterologists) were available for consultation. A physician visited each ward daily, and a doctor was on call at nights and on weekends. Second, laboratory, pharmacy, and x-ray services were provided on site. Third, the facility had an 18-bed acute-care ward where acutely ill patients could be transferred when they required more intensive medical and nursing care. This ward was staffed with only registered nurses (RNs) skilled in providing acute-care services, at a 1 to 3 ratio.

Nursing Homes B and C were similar to one another in that they were proprietary, had to rely on off-site physicians and diagnostic services, and did not have acute-care wards. They were dissimilar, primarily, in the socioeconomic status and ethnic composition of the patient populations. About half of the patients at Nursing Home B relied on Medicaid for payment of care and half were private pay; 95% of the residents were Caucasian. In Nursing Home C, 92% of the residents were on Medicaid; only 8% were private-pay patients. The residents at Nursing Home C were multicultural; about half were Caucasian, 40% Chinese, and there were a few black, Hispanic, and Filipino residents. These three facilities were deliberately chosen to provide a comparative vantage point to investigate the influence of specific social-cultural factors on the decision-making process.

Data Collection

Data were collected by two of the authors (JKJ and CLW) and six research assistants (medical and graduate nursing and sociology students), two in each facility. Data collection proceeded in two stages: An intensive 3-month period of participant observation, followed by a 12-month period during which participant observation continued, but the primary data collection strategy was event analysis.

Participant observation. — Participant observation, a research strategy associated with anthropological and sociological fieldwork, enables the researcher to immerse herself/himself in the lives of the people being studied and to observe precise details of their lives and daily activities.

During the first phase of data collection, fieldworkers visited the nursing homes three to four days a week, gathered data on a broad range of activities, and recorded in detail their observations. The primary goal of this research phase was to become totally familiar with the setting, the patients, their families, and the medical and nursing staff. Observations took place at all hours of the day, seven days a week and focused, for example, on the diagnostic and therapeutic services available in each setting; all relevant interactions (e.g., physician-patient, nurse-patient, nurse-physician, and family interactions with patient, nursing staff, and physician); the attitudes, beliefs, and behavior of health care providers, patients, and their families regarding treatment of acute illness; and the nursing home milieu and its effects on decisions regarding treatment of acute illness.

During this phase of research, the field-workers began to gather data informally on acute-illness episodes, specifically to identify factors influencing the decision-making process. These data were useful in refining the interview guide used during the project's second phase.

Event analysis. — In this phase, the focus shifted from global observations to the specific event. To obtain prospectively descriptive data on acute-illness episodes, selected events were intensively studied. Recognizing that seasonal fluctuations of acute illness may occur in the aged population (e.g., respiratory infections during the fall and winter), data on acute-illness episodes were collected at the rate of six per month in each of the three facilities over a 12-month period for a total of 215 cases.

The goal was to obtain detailed descriptive data of each acute-illness episode so as to characterize and explain the unique features of the event with an aim toward bringing together diverse information from many cases into a clear and unified interpretation (Pelto, 1970).

A purposive approach was used to obtain a representative sample of the different types of acute illnesses found in each nursing home, as well as to include patients who would provide a variation of significant variables such as mental and physical status, age, marital status, and ethnicity.

An acute illness was defined as a change in the individual's health associated with specific signs and symptoms of recent onset. To ensure uniformity of data collection, we provided the research assistants with the following outline of the procedure to be used.

1. Each week the research assistants will confer with the charge nurse, asking for a list of the acutely ill patients. From this list, one to three patients per week will be selected for investigation, using a purposive sampling approach;
2. The patient must have signs and symptom(s) considered indicative of an acute illness as observed and reported by the nurse in charge;
3. The nurse must call and report the patient's signs and symptom(s) to the physician in charge of the patient's care;
4. The patients who are treated will be followed until the acute illness is resolved;
5. Patients who are untreated will be followed until the signs and symptom(s) subside or until the patient dies;
6. Once patients enter the study sample, they will be followed for the remainder of the data col-

lection period to obtain data on subsequent acute-illness events;

7. *The International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM)* (CPHA, 1979) will be used to classify the acute-illness episodes.

A semistructured interview guide with open and closed questions was used. This guide included, for example, questions on the patient's diagnosis(es), signs and symptoms indicating the presence of an acute illness, date and time signs and symptoms first appeared, who identified them and when they were reported to the physician, the date and time the physician responded, and treatment prescribed. We also recorded if the patient was treated in the nursing home or transferred to an acute-care hospital for treatment.

The Katz Activities of Daily Living (ADL) was used to assess functional status (Katz et al., 1963). Since there was not a previous record of the patient's mental status on the chart, and because it was difficult and often impossible to administer a mental status examination to patients when they became acutely ill, the charge nurse was asked to evaluate the residents' mental status and place them in one of three categories: none to mild, moderate, or severe impairment.

Because we wanted to investigate the decision-making process in the evaluation and treatment of acute illness in nursing homes, patients were not followed to the acute hospital to observe and record the treatment they received while there. When patients returned to the nursing home, data describing their treatment were obtained from the hospital discharge summaries, which accompanied them on their return to the nursing home.

During this phase of the research, the research assistants, the principal investigator, and the project director were in the nursing homes four to five days a week. Much of the data were therefore obtained firsthand. When this was not possible, data were obtained retrospectively through informal interviews with doctors, nursing staff, patients, their families and friends, and from written sources such as the doctor's orders and progress notes, the nurses' notes, and laboratory and x-ray reports.

Data collected for each acute-illness episode were analyzed by the principal investigator (JKJ) and a physician (JCB) with longstanding experience in the care of nursing home patients. The physician, a key member of the research team, served as an adviser to the project and provided a medical judgment regarding the appropriateness of transfer and treatment. The criterion of appropriateness of transfer was based on whether the acute-hospital level of care was justified by the nature of the acute illness requiring treatment (e.g., surgery for a bowel obstruction). That is, could the acute episode of illness have been treated in the nursing home (e.g., IV therapy), or was the acute-hospital setting required?

Table 1. Place of Treatment of Acute-Illness Episodes in Facilities A, B, and C
(*N* = 215)

	A		B		C	
Treatment place	*N*	%	*N*	%	*N*	%
Long-term care ward within facility	50	63.4	—	—	—	—
Acute-care ward within facility	19	24	—	—	—	—
Nursing home	—	—	36	51.4	27	41.0
Acute-care hospital	10	12.6	34	48.6	39	59.0

Findings

Description of Patients Who Were Transferred to The Acute Hospital

Of the 215 patients followed, 79 (36.7%) were from Facility A, 70 (32.7%) from Facility B, and 66 (30.6%) from Facility C. In Facility A, nearly two-thirds (63.4%) of the patients who became acutely ill were treated on the long-term care ward in the facility; 24% were transferred to the acute-care ward for treatment, and only 12.6% were transferred to an acute hospital. In Facilities B and C a much greater proportion of patients, 48.6% and 59% respectively, were hospitalized when an acute illness occurred (see Table 1).

Of the 215 patients who experienced an acute illness during the study period, 80 (37.2%) were hospitalized for treatment; 3 were transferred twice for a total of 83 transfers. Forty-seven percent of the transferees were from Facility C, 41% from Facility B, and only 12% from Facility A. Most of the transferees were readmitted to the nursing home of origin following hospitalization; a few were admitted to another nursing home, and about 20 to 30% from each facility died while at the acute-care hospital (see Table 2). Table 3 presents the outcome for patients who were treated in the nursing home.

Fifty-three percent of the patients transferred were female and 47% male. They ranged in age from 33 to 102 years; only 6 were under the age of 60. Based on the Katz ADL instrument, the patients who were transferred were functionally very dependent; the

Table 2. Disposition of Patients Admitted to Acute-Care Hospital
(*N* = 83)*

	A		B		C	
Disposition	*N*	%	*N*	%	*N*	%
Readmitted to nursing home	5	50	27	79	28	72
Admitted to another nursing home	2	20	0	0	2	5
Died in acute hospital	3	30	7	21	9	23

*% is based on total number of patients in each facility who were hospitalized.

Table 3. Outcome for Patients Treated in Nursing Home
(*N* = 132)*

	Illness resolved		Died	
Facility	*N*	%	*N*	%
A	51	74	18	26
B	15	41.7	21	58.3
C	19	70	8	30

*% is based on total number of patients in each facility.

majority (74.4%) were severely impaired; 12.8% each were none to mildly or moderately impaired (Katz et al., 1963). Their mental status as evaluated by the charge nurses was: 26% severely impaired, 44% moderately impaired, and 30% none to mild impairment.

Clinical problems for which patients were transferred. — The illnesses for which patients were hospitalized were those that would be expected in a nursing home population (see Table 4). Respiratory conditions (25%), symptoms, signs, and ill-defined conditions (18%), and genitourinary problems (12%), were the conditions most often responsible for transfer.

Since the nursing staff reported the patients' signs and symptoms to the attending physician, and based on those symptoms an order for transfer was given, patients were reclassified using only the primary sign or symptom. As shown in Table 5, fever (41%) emerged as the most predominant sign or symptom followed by dyspnea, cough, and chest pain (16%). The patients who were hospitalized did not differ significantly from those who were treated in the nursing home. The only two diagnostic groups in which patients were more likely to be hospitalized were "diseases of the skin and subcutaneous tissues" (5 out of 7 patients) and "injury and poisoning" (9 out of 12 patients). The 5 patients hospitalized in the first group were residents who had developed severe and extensive decubitus ulcers, and 8 of the patients in the second group were hospitalized for fractures (femur and ankle).

Analysis of Qualitative Data

Qualitative analysis of the acute-illness episode data disclosed that in some cases social factors and structural constraints within the nursing home contributed to hospitalization of patients, as well as to the development of acute illnesses, (e.g., dehydration). To substantiate and quantify these observations, the physician on the research team analyzed

Table 4. Categorization of Acute-Illness Episodes by Disease Classification
(*N* = 215)

	Patients hospitalized (*N* = 83)		Patients treated in nursing home (*N* = 132)	
International Classification of Disease Diagnosis Group	*N*	%	*N*	%
001-139 Infections and parasitic diseases (exclusive of infections in other categories)	1	1.2	4	3
140-239 Neoplasms	3	3.6	3	2.3
240-279 Endocrine, nutritional, and metabolic disease and immune disorders	1	1.2	1	.7
390-459 Diseases of circulatory system	9	11	13	10
460-519 Diseases of respiratory system	21	25	32	24.2
520-579 Diseases of digestive system	9	11	11	8.3
580-629 Diseases of genitourinary system	10	12	24	18.2
680-709 Diseases of skin and subcutaneous tissue	5	6	2	1.5
780-799 Signs, symptoms, and ill-defined conditions	15	18	35	26.5
800-999 Injury and poisoning	9	11	3	2.3
290-319 Mental disorders	0	0	2	1.5
710-739 Diseases of musculoskeletal system and connective tissue	0	0	2	1.5
Total	83	100	132	100

Table 5. Categorization of Acute-Illness Episodes by Primary Symptom
(*N* = 215)

	Patients hospitalized (*N* = 83)		Patients treated in nursing home (*N* = 132)	
International Classification of Disease Symptom	*N*	%	*N*	%
Fever	34	41	57	43.2
Dyspnea, cough, and chest pain	13	16	17	13
Lower body skeletal pain and swelling	8	9.8	6	4.5
Acute gastrointestinal symptoms	7	8.4	10	7.5
Changes in emotional and cognitive status	5	6.0	13	10
Changes in cardiovascular status	3	3.6	7	5.2
Nausea and vomiting	3	3.6	0	0
Wounds and skin injury	2	2.4	4	3
Genitourinary symptoms	2	2.4	8	6
Decubitus ulcers and cellulitis	2	2.4	5	3.8
Anorexia and weight loss	1	1.0	5	3.8
Fall	1	1.0	0	0
Other	2	2.4	0	0
Total	83	100	132	100

each acute-illness episode and placed it in one of three categories.

Category I comprised patients whose medical condition necessitated transfer to the acute hospital, that is, the acute hospital was the appropriate level of care because of the nature of their condition. Forty-one of the transferees (49.4%), including patients with hip fractures, sepsis, or acute gastrointestinal bleeding, were placed in this group. Category II included patients whose condition did not warrant transfer to the acute hospital because their condition could have been definitively diagnosed and treated in the nursing home and did not require acute-hospital level of care. Remarkably, nearly half (48.2%) of the patients fell into this group. Category III consisted of patients who were sent to the local Veterans Administration Hospital for a routine physical exam; while there, an acute problem was diagnosed and they were hospitalized. Only two patients (2.4%) fell into this subdivision.

Analysis of Patients in Category II

Hospitalization is costly; it is also traumatic to the patient and may lead to hospital-acquired complications that otherwise might not have occurred (Zimmer et al., 1988; Steel et al., 1981). It is therefore important to describe those patients in Category II — patients whose condition might have been handled in the nursing home and did not require acute-hospital level of care.

Seventy percent of the patients (*n* = 28) in Category II could have been treated in the nursing home if IV therapy had been available, (e.g., IV antibiotics, parenteral diuretics or IV therapy for rehydration). In an additional 15% of the cases, patients were transferred because of pressure from the family or nursing staff. The family of a dying patient, for example, felt the nursing staff could not provide adequate care and insisted their relative be hospitalized. In several cases, the nursing staff asked physicians to transfer patients who required heavy nursing care (e.g., patients with extensive decubitus ulcers). These residents were seen as difficult to care for, and in some cases the administration wanted them moved because of fear of receiving a citation from state inspectors.

Another fifteen percent of the patients in Category II were transferred for the convenience of the physician or because of poor doctor-nurse communication. For example, two patients with nondisplaced ankle fractures were sent to the hospital, where short-leg casts were applied. The orthopedist refused to go to the nursing home because materials for casting were not readily available. In some cases, frustrated physicians hospitalized patients after having difficulty obtaining reliable information about the patient's condition from the nursing staff.

Social-Structural Factors Contributing to Hospitalization

While it is important to know which clinical conditions lead to the hospitalization of nursing home residents, it is also important to identify the social-structural factors responsible for transfer.

Analyses of data from the acute-illness episodes and participant observation disclosed that the nursing home setting shaped and structured decisions regarding transfer. The social-structural factors in the nursing home most commonly contributing to hospitalization of Category II patients were: lack of immediately available in-house support services (x-ray, laboratory, and pharmacy departments); nursing-medical issues (an insufficient number of adequately trained nursing staff, transfer for the physician's convenience, pressure from nursing staff for transfer, and poor nurse-physician communication); and family pressure for transfer. Often many of these factors interacted dynamically to influence the decision-making process.

Lack of support services. — Facilities B and C did not have laboratory, x-ray, or pharmacy departments. Laboratory work had to be sent out, increasing the time between the nurse's assessment of a change in the patient's condition and the physician's diagnosis and prescription of treatment. X-ray technicians had to be called in, presenting not only a time lag, but also decreasing the physician's confidence, since the quality of portable X rays was considered less accurate than those taken in a hospital radiology department. The lack of these services, therefore, precipitated hospitalization to accelerate the diagnostic process and to enhance accuracy. Conversely, for some patients who were not transferred, the delay in diagnosis increased the severity of the problem. A case in point was a woman who experienced hyperinsulinism that was not correctly assessed until five hours later, when the laboratory report showing a blood sugar of 38 mg/dl was returned. She was then immediately hospitalized and successfully treated.

Nursing/Medical Issues

Insufficient and inadequately trained nursing staff. — A large proportion (70%) of the patients could have been treated in the nursing home if the nursing staff had been able to administer IV therapy. Typically, these were patients with acute urinary or respiratory tract infections who needed IV antibiotics, or residents who needed IV fluids for rehydration. One woman with hyperinsulinism was sent to the hospital for IV glucose, and some patients were hospitalized for IV diuretics. While access to laboratory and x-ray services are necessary for treating such patients, just as important is a professional nursing staff who can monitor their response to treatment and effectively communicate with the physician.

Most of the nursing care, including the assessment of subtle changes in patients' physical and cognitive condition, was done by a small number of licensed vocational nurses (LVNs), but predominantly by nurse aides (NAs). These poorly paid, inadequately trained workers were ill equipped to deal with the large number of subacutely ill patients under their care. When the work load became too heavy, the

NAs put pressure on the licensed staff, who in turn urged the physician to hospitalize residents. When physicians thought the staff was unable to care adequately for patients whose conditions were deteriorating, they transferred them to the acute hospital.

Our data further suggest that in some cases an insufficient number of adequately trained nursing staff contributed to a gradual deterioration in the patient's condition, eventually leading to hospitalization. Inadequate and irregular suctioning of semicomatose and comatose patients, for example, undoubtedly contributed to lower respiratory tract infections. One nurse stated that a 55-year-old comatose woman with a tracheostomy should have been suctioned hourly, but due to a shortage of staff, was at best suctioned once every eight hours. This same nurse confided that patients with pneumonia who were treated with antibiotics might not recover because of lack of supportive nursing care. "The coughing and deep breathing exercises, chest physical therapy, these procedures just are not done here. And they work, but they are not going to be done because we do not have enough nursing staff." In some cases, undetected fluid accumulation associated with acute congestive heart failure was not acted upon, while in other cases an unnoticed decrease in fluid intake necessitated hospitalization for rehydration therapy.

The shortage of nursing staff also contributed to nutritional problems. In Facility C, for example, one NA was responsible for feeding five to six patients simultaneously. Eating was rushed and fluid intake was not encouraged and/or recorded, resulting in the dehydration and subsequent hospitalization mentioned above. Similarly, poor nutritional intake and a staff too busy to urge the patient to eat and take adequate fluids sometimes resulted in the placement of a nasogastric tube. An NA explained, "Tube feeding is a lot easier on us. It is so frustrating when they don't eat. That's one job that takes forever. Mrs. L has been tube fed for years, and she's doing just fine." While tube feeding may be convenient for the staff, it places the patient at increased risk for aspiration pneumonia; the unskilled, overworked staff were inattentive to positioning tube-fed patients properly.

In Facility B, one RN was responsible for the care of 135 patients on the evening and night shift. On one occasion, we observed that there were 8 patients in this facility with nasogastric tube feedings, a woman with a tracheostomy, 6 patients in a semicomatose or comatose condition, and a woman with Jakob-Creutzfeldt's disease, who was in a nearly continuous state of seizure. One RN was responsible for providing care for these 15 heavy-care patients; she also had to supervise the care of 120 other residents — an impossible task!

Convenience of the physician. — Physicians are poorly compensated — financially and psychologically — for their treatment of nursing home patients. Reimbursement rates for the one required monthly visit are low, and if a patient requires a second visit in the same month, it is often difficult and sometimes impossible to be recompensed. Physicians candidly admitted that it was more convenient to transfer the acutely ill nursing home patient to the emergency room (ER) of the acute hospital, where X rays and diagnostic work would be done quickly. The ER physician would help make the diagnosis, and house staff and the attending physician would follow the patient more efficiently. Further, physicians remarked that they were better paid for hospital than for nursing home care.

The time of day and day of the week were also considered. A physician with 37 patients in one nursing home remarked: "I am always trying to tailor the treatment to keep the calls down. If it is late afternoon, and the patient has a fever of 102° to 103°, I know it's either pneumonia or a urinary tract infection; if it means I'm not going to get the results of lab work, or a chest X ray, until 11 PM . . . I'd rather send them to the hospital to be evaluated." Physicians noted that they preferred to hospitalize patients because ancillary services were more readily available, the quality of nursing care higher, and they would be reimbursed by Medicare for one or more daily visits.

Pressure from nursing staff. — Nursing home administrators encouraged the admitting nurse to screen incoming patients assiduously in an attempt to keep a full census without placing undue stress on their already overworked staff. Since the work load increased as some residents inevitably became more disabled and dependent, directors of nursing sometimes pressed for transfer in order to keep the number of heavy-care patients as low as possible. In these cases, transfer was seen as an opportunity to extricate themselves from a patient considered burdensome. Physicians also spoke of "treating the nurse." If the nurse sounded anxious and insecure, the physician hospitalized the patient to avoid repeated calls. Furthermore, in an era of close surveillance by state inspectors, nursing homes sometimes urged transfer to avoid patients' dying in the nursing home; a death may attract close inspection of the chart and possible citation.

Poor nurse-physician communication. — State regulations require that physicians be notified of any change in the patient's condition — whether a small bruise or a slight elevation of blood pressure or temperature. The nursing staff reported that physicians were frequently difficult to reach, often did not return calls promptly, and were sometimes irritated by phone calls reporting what they perceived as insignificant signs and symptoms. On some occasions when the physician did not return the call promptly, the staff became alarmed, dialed an emergency number, and had the patient hospitalized without a physician's order.

Additionally, the physician's decision-making process was observed to be compromised by the poor assessment and communication skills staff demonstrated when calling to report a change in the patient's condition. In such situations, physicians lost confidence in the nursing staff and hospitalized patients where they were on "home ground" with a trustworthy staff.

Pressure from Family

Families reported feeling frustrated by what they identified as inadequate nursing skills and, fearful when their relative's condition worsened, sometimes urged the physician to transfer him/her to an acute hospital. Transfers also occurred when there was uncertainty about the severity of the patient's condition. In such cases, especially if a concerned family member was present, physicians hospitalized the patient out of indecision and/or fear of litigation. An illustration is the explanation made to the researcher by one physician: "When the family is involved, it's probably safer to transfer him. He may stroke out on me; he's fragile, there could be a clot."

The Cost of Transfer

This study initially did not focus on the cost of hospitalization. It became obvious, however, that the emotional cost to patients and their families, and the financial cost to society are considerable, and our data allowed us to make an estimate of the economic cost.

Emotional costs. — While financial costs are of great concern, no less important is the emotional cost of hospitalization. Foremost is the trauma experienced by the patient who is being transferred, often without adequate explanation, to an unfamiliar location, with unfamiliar staff and an unfamiliar physician. In some cases when patients were discharged from the hospital, their bed in the nursing home was not available. They were therefore placed in yet another strange environment, surrounded by strange caregivers.

Financial costs. — The hospitalization of nursing patients results in the expenditure of a vast amount of money. In this study, similar to the findings of Van Buren et al. (1982) it was found that 48% (40 patients) of those transferred might have been treated in the nursing home. In California the average length of hospital stay for patients over the age of 65 is 7.4 days and the average charge per patient day is $1,127 (Office of Statewide Planning and Development, 1987). The transfer of the 40 patients in Category II, therefore, resulted in a total of 296 hospital days at $1,127 per day for a net cost of $333,592.

When using this same formula to calculate the cost of Category II transfers throughout the United States, the figure becomes astronomical. Data from the 1985 National Nursing Home Survey (Sekscenski, 1987) disclosed that 430,000 patients are discharged annually from nursing homes to general or short-stay hospitals (excluding psychiatric units). An additional 20,000 are discharged to Veterans Hospitals, for a total of 450,000 discharges. If 48% of these transfers could be avoided, 216,000 patients are perhaps being hospitalized needlessly.

The national average length of hospital stay in the United States (for the quarter ending January 1989) for patients over the age of 65 was 6.6 days, and the average cost of hospital care per day was $661.31 (American Hospital Association, 1989). Thus, the transfer of 216,000 patients annually would result in an additional 1,425,600 hospital days at a total cost of $942,763,530, an unacceptable figure in a time of escalating health care costs.

When estimating national costs, it must be noted that Medicaid reimbursement policies vary from state to state. California has a prospective class or fixed-rate reimbursement rate. That is, a single rate is paid to all facilities regardless of the acuity level; there is no financial incentive for nursing homes to keep acutely ill or heavy-care patients. (For a full discussion of Medicaid reimbursement policies, see Swan, Harrington, & Grant, 1988). State Medicaid reimbursement rates may influence the transfer of patients to the acute hospital, and it could be argued that more transfers occur in California than in other states. With this caveat in mind, it is nevertheless clear that avoidable hospitalizations result in a large expenditure of money.

Discussion

The results of this study disclosed that in 48.2% of the cases, nursing home residents were hospitalized for social-structural (i.e., lack of support services, nursing/medical issues such as an insufficient number of adequately trained nursing staff and poor nurse-physician communication, and family pressure for transfer) rather than for clinical reasons. A major question that needs to be addressed is: Can nursing homes effectively provide acute-care services to the elderly? The findings presented here are consistent with those of Zimmer et al. (1988), who, in describing an innovative program that reduced the hospitalization of acutely ill nursing home patients, emphasized that providing acute care in nursing homes is dependent upon an adequate number of skilled nursing staff, the reimbursement of physicians for daily visits, and the availability of pharmaceutical and diagnostic services.

It is noteworthy that in Facility C only 30% of the patients who were treated in the nursing home died, while in Facility B nearly twice as many (59.3%) died. This is partially explained by the fact that Facility C seldom admitted patients who were terminally ill, and they also hospitalized a greater proportion (59%) of the patients who became acutely ill.

It is also noteworthy that in Facility A, only 12.5% of the residents who became acutely ill were hospitalized, while in facilities B and C, 48.6% and 59% respectively of the residents who became acutely ill were transferred. This was undoubtedly due to the fact that Facility A had laboratory, x-ray, and pharmacy services and physicians on site, and an acute-care ward adequately staffed with physicians and nurses trained to provide acute-care services.

Facility A is atypical, and due to its size (1,200 beds), it can support on-site medical, diagnostic and pharmaceutical services. Since most nursing homes are small (99 beds or less), it would not be economically feasible for them to provide support services on site. These services are generally available by contractual arrangements through commercial laboratories, pharmacies, and hospitals (Ouslander, 1988). Strengthening the professional nursing staff in nursing homes, however, is a strategy that would reduce the hospitalization of nursing home patients.

Strengthening the Professional Nursing Staff

Nursing care is the major service provided in nursing homes; yet while the average nursing home has about 41 full-time employees, less than 3 of those employees are RNs (Sirrocco, 1983). Furthermore, less than half of all skilled nursing facilities (SNFs) have an RN on duty 24 hours a day (U.S. Department of Health and Human Services, 1981). Medicare- or Medicaid-certified SNFs must have a full-time director of nursing and at least one RN on the day shift seven days a week, and a licensed nurse on duty 24 hours a day. The federal regulation, however, does not require that the licensed nurse be an RN. On evenings and nights, the charge nurse may be an RN or a licensed practical nurse (LPN). Some facilities have more professional staff than is required by federal regulation, while others meet only the minimum standard. Thus in many nursing homes LPNs are in charge of patient care, and the hands-on care is performed by the nurse aide, who typically is responsible for providing complete care for 10 to 15 patients on the day shift, 15 to 25 in the evening, and 40 to 50 during the night shift (Harrington, 1987).

It has been estimated that there are only 1.5 licensed nursing staff per 100 patients in nursing homes. By comparison, in acute-care hospitals there is one RN for every 4.5 patients (Harrington, 1987). Clearly, this dramatic reduction in professional nursing care is insufficient to meet the needs of patients who are being discharged, often in subacute conditions, from the acute- to the long-term care setting.

Given these conditions, it is not surprising that, of the identified social-structural factors contributing to hospitalization in this study, the insufficient number of adequately trained nursing staff stands out as the predominant problem. Correcting this problem would address three factors that contribute toward hospitalization: pressure for transfer from nursing home staff, poor nurse-physician communication, and pressure for transfer from families who lack confidence in the nursing staff. Ameliorating the staffing situation is essential for providing quality care to the acutely ill nursing home patient. Furthermore, without adequate nursing care, chronic conditions give rise to acute episodes of illness, and hospitalization inevitably occurs.

The problems of inadequately skilled and an insufficient number of nurses are separate but intertwined. Regarding skills, for example, staffing nursing homes with RNs capable of giving IV therapy would significantly reduce the number of hospitalizations, as was evident in Facility A. At Facility B, although the nurses were able to administer IV fluids and drugs, some physicians were unaware of this, and others questioned the nurses' ability to monitor IV therapy. At Facility C, the nursing staff did not administer IVs. Thus, many patients from Facilities B and C were hospitalized for IV therapy.

Nursing home residents are frail, very old, have multiple pathologies and physical disabilities, and many are mentally impaired. Their conditions can change rapidly; it is imperative that at least one RN be on duty 24 hours a day, seven days a week to assess patients and identify subtle changes indicative of an acute illness.

In addition to increasing the professional nursing staff, the use of the clinical nurse specialist (CNS) and the geriatric nurse practitioner (GNP) in nursing homes should be encouraged. Early studies have suggested that GNPs can improve the outcome for nursing home residents (Kane et al., 1976), and a recent study by Kane et al. (1988) found that, despite some difficulty in implementing their role in nursing homes, GNPs had a positive effect on resident outcomes. Some studies have demonstrated that GNPs contribute to the quality of care by changing the focus from custodial to rehabilitative care (Chaffin, 1976; Gray, 1982). Recent findings from the Robert Wood Johnson Foundation Teaching Nursing Home Program, (Mezey, Lynaugh, & Cartier, 1988) along with data from other demonstration projects have shown that GNPs markedly increase the ability of nursing homes to care for acutely ill patients and those with complex problems (Mezey & Scanlon, 1989.)

GNPs can play a particularly important role in the care of the acutely ill nursing home resident. In the absence of on-site physicians, the GNP could take the responsibility for ongoing patient assessment, early recognition of acute illness, and implementation of a plan of care. Further, the GNP could discuss the patient's condition with the physician to determine if 1) the situation can be handled via telephone, 2) the patient needs to be seen by the physician, or 3) the patient needs to be hospitalized.

The reimbursement of GNPs who provide services in nursing homes has been somewhat problematic. Mezey and Scanlon (1989) suggest that reimbursing the GNP under Medicare Part B for services for which physicians are currently being reimbursed could significantly improve quality of care, and it has the potential for being cost effective. (For a full discussion of reimbursement options see Mezey and Scanlon, 1989). While there is some evidence that the use of GNPs is cost effective, further studies are needed to determine cost estimates and savings.

Facility A was a nonprofit organization, while Facilities B and C were proprietary nursing homes. Given the increasing numbers of elderly and the escalating cost of health care, we in the United States must at some point decide if we can afford to sustain long-term care as a profit-making industry. If the money that is paid to the nursing home industry could be redirected to purchase additional professional services, the quality of care would surely improve.

In many states, nursing homes are not reimbursed for providing acute or subacute care (Ouslander, 1988). Numerous studies have addressed the problem of Medicaid reimbursement rates to nursing homes (Fries & Cooney, 1985; Grimaldi, 1982; Harrington & Swan, 1984; Swan, Harrington, & Grant, 1988). Medicaid reimbursement to nursing homes is a complex topic, not within the scope of this paper. In view of the rising cost of health care and the increasing number of older people, however, it is imperative that a mechanism for reimbursing nursing homes for providing subacute care be developed and implemented. Ouslander (1988) has discussed several strategies, such as the establishment of a level of care and reimbursement rates somewhere between the nursing home and the acute hospital. Innovative approaches are not without potential negative consequences, as nursing homes may deliberately increase patient dependency and level of care to maximize reimbursement (Swan, Harrington, & Grant, 1988).

This study has limited generalizability, because it was conducted in three facilities in one geographic area. Its strength lies in the rich qualitative data that facilitated the identification of social-structural factors contributing to hospitalization. Further studies are needed to determine under which conditions acutely ill patients can be treated successfully in nursing homes, and when patients must be hospitalized for treatment. Also necessary are studies focusing on which patients would benefit from hospitalization and how the outcomes differ for patients who are hospitalized in contrast to those who are not.

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DETRIMENTAL EFFECTS OF PHYSICAL AND CHEMICAL RESTRAINTS ON RESIDENTS

Developed by the
National Citizens' Coalition for Nursing Home Reform for the
National Center for State Long Term Care Ombudsman Resources
funded by the Administration on Aging

(These effects may be due to restraints and/or other conditions)

<u>EFFECT</u>	<u>CAUSE</u>	<u>PREVENTION</u>
<u>CARDIOVASCULAR</u>		
Swelling of ankle or lower leg/rings too tight/shoes too tight.	Older people may have a less efficient circulatory system. Without enough exercise,and changing of position fluid collects in hands and feet.	Release, Exercise every 2 hrs/ change position often. Lie flat in bed every two hours. Use alternative methods.
Death	Cardiovascular stress response as fearful resident struggles to be free from restraint.	Use alternative methods.

DETRIMENTAL EFFECTS OF PHYSICAL AND CHEMICAL RESTRAINTS ON RESIDENTS

EFFECT	CAUSE	PREVENTION
GASTRO-INTESTINAL GENITO-URINARY		
Decrease in appetite/ weight loss/sunken cheek bones/ sores around mouth (CR/PR)	Broken spirit/not interested in life. Discomfort of restraint/preoccupation with discomfort. No activity to work up appetite. Too drowsy from drug use to eat.	Use alternative methods. Release, exercise at least every two hours. Decrease drug dose.
Dehydration Dry skin/dry mouth/ sunken eyes/ fever/ acute confusion. (CP/CR)	Cannot reach water. Too drowsy to drink. Too depressed to drink. Does not recognize decreased sense of thirst.	Use alternative methods. Leave water within reach at all times. Offer fluids/ encourage to drink between meals and at meals.
Urinary Retention Distended lower belly/complains of needing to go to the bathroom/ dribbling when toileted instead of good stream/ presence of catheter with no other apparent cause. (CR)	Many psychoactive drugs effect ability to release urine.	Discontinue drug. Use alternative methods. Use alternative drug. Discontinue catheter use.
Incontinence Wet/ complain of not being taken to the bathroom/ agitation especially for resident with dementia/presence of catheter for no other apparent reason (CR/PR)	Not taken to bathroom/toileting done according to facility rather than individual pattern/drug action may cause incontinence	Release, toilet, exercise every two hours or more often if necessary Use alternative methods Discontinue drug Use alternative drug.

DETRIMENTAL EFFECTS OF PHYSICAL AND CHEMICAL RESTRAINTS ON RESIDENTS

EFFECT	CAUSE	PREVENTION
GASTRO-INTESTINAL GENITO-URINARY		
Urinary Tract Infections (CR/PR) Pain and frequency of urination, fever	Catheter use, not voiding regularly, low fluid intake	Toilet to avoid incontinence, increase fluid intake, use alternative methods
Constipation/ impaction Resident complains of stomach ache/ constipation Restlessness Decreased appetite/ confusion Preoccupied with bowels (CR/PR)	Lack of activity Inability to get enough fluids Not taken to bathroom according to lifelong bowel pattern.	Release, exercise, toilet every two hours or more often if necessary. Toilet according to lifelong pattern Offer fluids between meals and at meals Leave water within reach Use alternative methods
MUSCULO-SKELETON		
Decrease in mobility such as unable to walk, move own wheelchair. Wasting of muscles over time. Contractures in extremities recognized by hands in fist, bent elbows, knees bent toward chest and moved, if at all, only with difficulty and pain. Increased fractures. (CR/PR)	Prolonged inactivity causes loss of muscle in all ages, so that the person gradually loses ability to use them; bone loss results in increased fracture risk.	Use alternative methods: physical therapy, release, weight bearing exercise every 2 hours or more often if necessary. Range of motion exercises, fit chair to individual, use cushions, wedges and pillows for comfort.

DETRIMENTAL EFFECTS OF PHYSICAL AND CHEMICAL RESTRAINTS ON RESIDENTS

EFFECT	CAUSE	PREVENTION
NERVOUS SYSTEM		
Complains of tension or exhibits signs of tension (PR)	Restraints are not relaxing; stressful from having movement restricted	Use alternative methods, use restraints for very short periods of time. Discontinue drug or lower dose. Use alternative drug without that particular side effect.
Tardive Dystkinesia (CR) Repetitive movements of head, tongue, hands and feet.	Caused by some chemical restraints. Haldol is a commonly used drug with this effect and is irreversible.	Use lowest drug dose for shortest period of time. Keep in mind general rule of thumb: 1/2 adult dose for elderly-1/4 dose for elderly with dementia. (Of course there are exceptions to this) Note that continuous long term drug use seldom necessary
Coma/Death (CR)	Too large dose of psychoactive drug	Use small doses for short periods of time

DETRIMENTAL EFFECTS OF PHYSICAL AND CHEMICAL RESTRAINTS ON RESIDENTS

EFFECT	CAUSE	PREVENTION
PSYCHOLOGICAL		
Panic/ anxious expression/ combative/ increased confusion (PR/CR)	Frightened by PR. Does not like restraints. Does not understand why they are being used. Paradoxical reaction to a psychoactive drug; that is, it has the opposite effect intended.	Use alternative methods. Use CR and PR for short periods only. Use different drug, lower dose or no drug.
Lethargy/depression/ decreased social interaction (PR/CR)	Person gives up when restrained, withdraws, broken spirit. Staff ignore restrained resident. Drug in too large dose.	Use alternative methods. Increase opportunity to socialize. Frequent staff interaction. Decrease time restraint used. Decrease drug dose or change drugs.
Screaming/yelling/ calling out (CR/PR)	Use alternative options, identify and meet needs, comfort	Use alternative options, identify and meet needs, comfort

DETRIMENTAL EFFECTS OF PHYSICAL AND CHEMICAL RESTRAINTS ON RESIDENTS

EFFECT	CAUSE	PREVENTION
RESPIRATORY		
Resident complains that chest feels tight/says "can't breathe"/appears anxious	Chest/ vest restraint is too tight. Resident fears restraint and has anxiety attack Lack of movement	Use alternative methods Loosen restraint Decrease use of drugs Exercise every two hours or more often if necessary
Pneumonia (CR/PR) Acute confusion/ shortness of breath/ chest pain	Lack of movement allows secretions to pool, decreases efficiency of lungs with decreased oxygen exchange and increase confusion. Shortness of breath when active	same as above
Death (PR)	incorrectly applied restraint leads to death by strangulation	Apply restraint correctly/ use alternative methods.
SKIN		
Bruising/cuts/redness (PR)	Incorrectly applied restraint or improper size or type of restraint. Resident struggles against restraint	Apply restraint correctly according to manufacturer's direction Use alternative methods. Apply restraint for short periods only.
Pressure sores (PR/CR)	Resident in one position too long. Studies show two times number of pressure sores in restrained residents.	Release, exercise, at least every 2 hrs.- oftener if necessary. Use alternative methods.

Quality of Life

CONTRACTURE AVOIDANCE PROGRAM YIELDS UNEXPECTED DIVIDENDS

Martin E. Casper

When a patient care plan focuses on the prevention of a negative outcome as a goal, we talk about the maximization of a patient's life quality, if the goal is achieved. Our facility recently experienced a situation where a program to enhance the life quality of our residents at risk of developing or exacerbating contractures had the concomitant effect of improving the quality of life of another group of our residents.

The proposed new conditions of participation for skilled nursing facilities, issued by the Health Care Financing Administration (HCFA), were thoroughly discussed at our 324-bed skilled nursing facility's weekly patient care planning conferences. As a result of the proposed contracture standard in the quality of life condition, efforts to develop an effective contracture avoidance program had a very high priority in our discussions.

At the same time last fall, the new director of the office of licensure and certification in our state was placing a great emphasis on rehabilitative/restorative nursing programs. In addition, we were in the process of preparing for a survey from the long term care section of the Joint Commission on Accreditation of Healthcare Organizations, an organization which also considers these programs to be of great importance.

Objectives in these areas had not as yet been effectively implemented when Greynolds Park was surveyed by the state during an annual licensure and certification inspection in December 1987. We were fortunate to have two nurses on the inspection team who were versed in restorative/rehabilitative nursing. Although the facility received several citations in this area, the surveyor's input gave some impetus in better focusing on rehabilitative nursing objectives.

Responding to the Survey

Following the inspection, Greynolds Park hired a full-time RN, Peggy Posnick, as the rehabilitative nurse coordinator. This position required close interrelationships with our dietary, occupational therapy, physical therapy, speech pathology, social service, activities department, and housekeeping and maintenance departments, in addition to the rehabilitative nursing responsibilities. Our objective was to ensure that all departments look at each patient from the perspective of what we can do for that individual to enhance his or her life quality.

As one aspect of the rehabilitative nursing program developed, the staff picked up on the contracture avoidance program discussed earlier. The rehabilitative nurse coordinator found an obstacle in efforts to position patients properly because a variety of pillow sizes was necessary for the wide range of residents' flexation points. These sizes were not always available and, if available, the sizes were usually not exact.

Involving Residents

As this problem was being discussed at an interdisciplinary resident care planning meeting, our director of activities, Jane Adelstein, indicated that she had foam materials which could be cut into pillows of any shape or size necessary to accommodate all rehabilitative requirements. She also suggested that sewing and stuffing pillows would be a very effective activities program for the more able residents because they would be helping those less physically or mentally able than themselves.

The idea was wholeheartedly endorsed with the provision that the director of activities discuss the suggested program with the activities group and that a price per pillow be agreed upon and paid by the facility to the residents for their labor.

Our residents were enthusiastic about their proposed "cottage industry," and the program was begun. Egg crate material was acquired for pillow foam and it was agreed that the facility would pay residents $1.50 per pillow. Activities required for residents to create one pillow include cutting and sewing the case, cutting the foam into small pieces, pulling nylon thread from commercial cones, stuffing the pillow, and sewing it after it is stuffed. Residents who are limited to the use of one hand are able to cut foam when foam squares are secured to the table.

Mission and Purpose

Residents participating in the program had a distinct mission and purpose. They were helping less physically fortunate residents and could see, on a daily basis, tangible results from the fruits of their labor. In walking through the facility, this "handiwork" was visible in patient wheelchairs and beds, all protecting patients from developing or exacerbating contractures. This knowledge enhanced their self-esteem. Patients participating in the program might complain of not feel-

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Martin E. Casper is executive director of Greynolds Park Manor Rehabilitation Center, North Miami Beach, Florida, which is accredited by the long term care section of the Joint Commission on Accreditation of Healthcare Organizations. Mr. Casper has had over 15 years of experience in administration of health care facilities, and holds a master's degree in public health in hospital administration from Yale University. He is an associate professor of community medicine at Southeastern College of Osteopathic Medicine and a member of the Reimbursement and Rules and Regulations Committee, Florida Health Care Association.

Quality of Life

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ing well, but would get out of bed to make pillows because they "wanted to help other patients." These residents were truly feeling good about themselves.

Program Results

To date, our residents have produced 115 pillows. A total of 20 residents now participate in the program. Proceeds are sometimes spent on luncheons catered from outside restaurants. Occasionally, they will bring in Chinese, Italian, or delicatessen food. As a result, this program has greatly increased the sense of resident community in our facility.

Now when our resident care planning committee meets, it looks not only at the particular problem at hand but also at the potential for the solution to enhance the life quality of other residents.

An effective program of rehabilitative/restorative nursing requires staff to look at all residents, even those who have been in Greynolds Park long term, not only as they are today but also what they have the potential to become tomorrow, if they are encouraged and assisted in attaining that potential. For example, the fact that a resident who does not need to be in a wheelchair all day, but has used it continuously for five years, does not mean an effort should not be made to attempt to get him or her out of it. Our objective has been to maximize each individual's life quality based on his or her physical limitations. Our pillow program has helped us achieve that objective for pillow users and pillow producers alike. ■

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Nursing home incontinence project praises models

by John O'Connor

Dealing with her post-operative urinary incontinence could have been shrugged off to old age. Fortunately for "Mary," she was at the Boston, MA-based Hebrew Rehabilitation Center For Aged. There, it was discovered that one of her prescriptions was to blame. And when her medication was changed, the problem disappeared.

"We've learned that there are a lot of ways to treat incontinence. What's particularly important is that the patient has to be seen as a whole person, considering functional level and medical condition — as well as the incontinence problem itself," said Edna Laurino, M.R.N., a research associate at the 725-bed facility.

It's programs like Hebrew's that Diana Laskin Siegal is trying to publicize. As project director for the recently formed statewide Nursing Home Incontinence Project, she is attempting to identify and replicate successful programs already in place. Her other major goal is to further educate providers, the medical community and the general public about available treatment options.

"We're trying to encourage nursing homes to do a better job of treating incontinence," said Siegal, a public health researcher and co-author of the book, *Ourselves, Growing*

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Incontinence project

From page 1

Older

Siegal said that while incontinence is one of the most pervasive health problems facing adults, it remains one of the least understood. "There needs to be far more research and education on this subject," she said.

The demographics of incontinence

More than 50% of the residents in long-term care institutions are afflicted with urinary incontinence, according to an article in the *New England Journal of Medicine* (Vol. 313, No. 13) co-authored by Hebrew's Neil Resnick, M.D.

Resnick estimated the problem is costing nursing homes more than a billion dollars annually, while accounting for 3% to 8% of their operating budgets. The overall cost for the care of all incontinent elderly is more than $8 billion each year, according to Resnick in his article.

In *Medical Care* (Vol. 22, No. 1), Joseph G. Ouslander and Robert L. Kane argued that by increasing attention, providing a better diagnosis, and offering more appropriate treatments, doctors helped about two-thirds of those afflicted with incontinence in their study to overcome the problem.

Harmful side effects

But attempts to control the problem are often hampered by the psychological baggage that incontinence can bring. Anxiety, shame, guilt, depression and loss of self-esteem frequently accompany the problem, Siegal said.

According to her, these feelings isolate people. "It restricts activities and it makes them feel bad about themselves. There are a lot of people who won't even leave their homes because they are incontinent."

She added the problem is further exacerbated by a lack of physician training. "We cannot yet run a public education program that says 'don't take this for granted, go see your doctor,' because doctor's often don't know what to do, Siegel said."

It's crucial for internists in family practice and general medicine to get more training from urologists, because "they're the ones that need to be able to handle the issue as much as possible," Siegel explained.

One success story

The Hebrew Rehabilitation Center For Aged is a pioneering institution in the field of incontinence. One of less than a half dozen facilities nationwide designated as a teaching nursing home, it has been receiving research funding from the National Institute of Health since 1983.

"A lot of the work going on here is a reflection of Dr. Resnick's work," said Debbie Dunn Solomon, director of public relations.

Hebrew's Laurino, who assists Resnick's research at the center, said that the facility uses a "stepped" process to help identify and cure the problem.

Laurino explained that treatment begins with seeking reversible causes, analyzing medications, checking for mobility problems or determining whether a specific medical problem is to blame. Each resident then receives a tailor-made program.

Don't simply blame age

"We've found that it's not just age itself that causes the problems of incontinence. But as we age, other problems, such as a loss of mobility, take a toll on an already compromised aging bladder. But it's not necessarily just a matter of aging. We've got 100-year-olds here that don't have bladder problems," she said.

Laurino noted she's optimistic that the problem can eventually be eliminated, but added, "a lot more has to be learned about it."

Siegal said despite the dearth of available knowledge and medical training, she sees encouraging signs. As more is learned about incontinence, and as physicians, providers and the public learn more about what can be done, the problem will be more effectively dealt with and may eventually be conquered, she said.

Alan Balsam, director of the Elder Health Division of the state's public health department is also assisting in the project.

Other participants involved in the project include the state's self-help and advocacy organization, Living Is For The Elderly, the Massachusetts Federation of Nursing Homes and the Association of Massachusetts Homes for the Aging. □

McKnight's Long-Term Care News

Dramatic Decrease in Decubitus Ulcers

A VA quality assurance program stimulated changes in care that paid off handsomely.

MARJORIE F. BLOM

In the late 1970s, decubitus ulcers were a recurring problem at our Veterans Administration Medical Center, a long-term care facility located in the midwest. The patient population was then and is now predominantly male, with 53 percent 60 years old or over. Clinical areas of practice include psychiatry, intermediate medicine, and geriatrics.

Maintenance of skin integrity was one of our most strived-for goals, yet decubitus ulcers did occur in this population of elderly, chronically debilitated veterans.

The cost of skin breakdown in dollars and human suffering is overwhelming(1). Expenditures for the treatment of a single decubitus ulcer can range from $5,000 to $34,000. Other costs accrue to patients because of delayed discharge, prolonged sickness and dependence, time lost from work, and the emotional effects on the patients and their families(2).

Decubitus ulcers, or localized areas of skin and subcutaneous tissue necrosis, are produced by compression of the small blood vessels that carry nutrients to those areas(3). Anything that interferes with nourishing the cell, removing its waste products, or the exchange of fluid between cell and capillary will impair cell functions and eventually lead to cellular death.

While the primary cause of skin breakdown is sustained pressure, many other factors contribute. Among them are metabolic diseases, such as diabetes; peripheral vascular impairment; loss of vasomotor control, as in paraplegia and quadriplegia; intercurrent illness; anemia; nutritional inadequacy; infection; endotoxins (including a high blood urea nitrogen); stress; antiinflammatory drugs; and maceration of the skin by urine and feces(4-6).

Many of these predisposing factors were present in our elderly veteran population in late 1977 when the planning for a large construction project created an opportunity to review our caseload.

Preparations to install central air conditioning and adapt patient units for increased privacy required that some units be vacated. The average daily census decreased by 12 percent during 1978, and another 8 percent in 1979, when construction actually began. During 1980, the average daily census stabilized at 580. The patients' acuity of illness remained high throughout these three years, with the vast majority classified in the Veterans Administration's category I or II. Category I patients are acutely or critically ill and require intensive nursing care for extremely severe symptoms. Category II patients need considerable direct care for subsiding or impending serious illness or chronic conditions that make them almost completely dependent (see Figure 1).

Before the start of patient relocation in January 1978, workload data were submitted to the nursing service office from each of the 14 patient units. Among the many factors monitored was the incidence of decubitus ulcers and their classification. In January, 27 patients had ulcers. The lack of written guidelines for classifying the decubitus

FIGURE 1.

AVERAGE DAILY CENSUS and PATIENTS' ACUITY of ILLNESS

	1978	1979	1980
FIRST QUARTER January, February, March	740 75%*	643 73%	584 73%
SECOND QUARTER April, May, June	709 71%	646 77%	578 78%
THIRD QUARTER [illegible]	679 70%	607 77%	[illegible] 77%
[illegible]	[illegible]	[illegible]	[illegible]

*All percentages represent patients who were in category I because they required intensive nursing care for acute or critical illness, or patients in category II because they needed considerable direct care for serious illness or chronic conditions that caused almost complete dependence.

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ulcers resulted in subjective evaluations with such terms as minimal, moderate, or severe. The nursing quality assurance committee recognized that decubitus ulcers were a significant problem, and undertook an audit.

Quality assurance consists of activities that ensure patients a specified degree of excellence in care through continuous evaluation of structural components, goal-directed nursing process, and patient outcome.

Phase One

The nursing quality assurance coordinator collected baseline data from January to June 1978 on the number of patients with decubitus ulcers. This was the first six months of a three-year audit. The number of patients with such ulcers decreased from 27 to 18 in that six-month period. Seven patients were admitted with preexisting bedsores during that time. Of the 18 ulcers remaining in June 1978, 3 were classified as severe and 15 as moderate. The need for a more comprehensive evaluation system emerged from those findings.

In a study by Rubin, a weekly progress report was submitted on all patients with potential or actual decubitus ulcers. This information was drawn from the supervisor's daily patient report and used during weekly rounds by the supervisor, head nurses, and nursing audit committee(7).

Phase Two

A similar data collection system was begun by our nursing quality assurance committee in July 1978. This launched phase two of the audit; its objectives were to

- record the number of patients with decubitus ulcers
- monitor nursing care (including preventive interventions) for all patients at risk for skin breakdown
- identify factors predisposing to skin breakdown
- heighten nursing staff awareness that early detection is an important preventive measure.

In July 1978, head nurses on each unit identified patients for the audit population. Nursing units included were the 200-bed nursing home care facility, 96-bed medical service, 134-bed intermediate medicine section, and the 241-bed psychiatry service.

CHARACTERISTICS of PATIENTS SURVEYED

		Phase 2 July-Dec. 1978 N = 43			Phase 3 Jan. 1979-Dec. 1980 N = 73		
CHARACTERISTICS	CLASSIFICATION	NUMBER	%	$\bar{X}$ AGE	NUMBER	%	$\bar{X}$ AGE
Age	Under 60	2	5	55.5	1	1	38
	51 - 60	6	14	60.7	7	10	60
	61 - 70	12	28	64.5	15	21	64.9
	71 - 80	13	30	76.8	19	26	76.3
	Over 81	10	23	88.2	31	42	86.9
Mobility Status	nonambulatory (included [illegible] bedrest only)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	ambulatory	[illegible]	[illegible]	[illegible]	[illegible]	20	[illegible]
	ambulatory with assistance	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Mental Status	confused	23	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
General nursing [illegible]	alert	20	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

In phase 2, the average daily census was 665, and 73 percent of these patients were in category I or II. In phase 3, the ADC was 602; 76 percent were in category I or II.

Each patient with a decubitus ulcer was comprehensively assessed by the quality assurance coordinator. Individual data sheets containing the following elements were used for each patient: name, age, sex, diagnosis, mobility status, mental status, general physical condition, bowel and bladder status, location of decubitus ulcer, size of ulcer in centimeters, site, predisposing factors, treatments prescribed, and special nursing procedures or preventive measures used.

Every two weeks from July through December 1978, the quality assurance coordinator and a committee member inspected every ulcer and recorded information on the elements cited above. In addition, the presence of drainage, the cleanliness, and any need for debridement and changes in the treatment or nursing procedure were documented.

Survey visits were scheduled at least one day in advance so that the unit staff could plan dressing changes to coincide with the visit. Each visit included all patients previously surveyed, those with newly developed ulcers, and newly admitted patients who had decubitus ulcers. These additions to the survey population were identified through information from nursing staff and from the 24-hour nursing report.

Patients whose ulcer healed were followed for a minimum of one month to detect recurrence.

A verbal report was given to unit nursing personnel and the administrative staff following each survey. To follow trends, summaries were written monthly.

Phase Two Findings

Included in the phase two survey were 43 patients who had ulcers or whose ulcers healed during that phase. Thirteen, or 30.2 percent, were admitted with ulcers. These patients came from homes and health care facilities in the surrounding communities.

Data for this patient population, shown in Tables 1 and 2, included age, mobility status, mental status, predisposing factors or significant conditions, and ulcer site.

Mental status was classified as confused or alert, based on nursing assessment. Figures obtained concerning mental status did not indicate a significant influence on decubitus ulcer development. Data on nutritional state were not included because all patients in this survey period were classified as having good or adequate nutrition, as determined by nursing or dietetic assessment. Being well or adequately nourished was defined as being within the ideal limits of body weight and hydration as determined from standards set by the National Research Council and from the Metropolitan Life Insurance tables.

No ulcers recurred at the same site during this phase.

The nursing measures used included relief to pressure areas, maintenance of cleanliness, periodic turning and repositioning, frequent skin care, use of sheepskin or foam pads, padded siderails, and intermittent bed rest. A water mattress was provided to all patients on the two units that consistently cared for those patients at highest risk for skin breakdown. Mattresses were issued to the other units as needed.

Treatment of decubitus ulcers consisted primarily of

- irrigation to cleanse (peroxide, saline, aluminum acetate solution [Burow's Solution], acetic acid)
- debridement of necrotic tissue by surgery or an enzymatic agent (Travase, Debrisan, Elase)
- application of topical agents to promote healing, control infection, or both (povidine-iodine [Betadine Helafoam], aluminum and magnesium hydroxide [Maalox], thimerosal [Merthiolate], bacitracin, karaya, tincture of benzoin, gentamycin [Garamycin], betamethasone [Valisone], chloramphenicol [Chloromycetin], neomycin [Neosporin], Vitamin A and D Ointment, erythromycin [Ilotycin], polymixin B and zinc bacitracin [Polysporin])
- stimulation of circulation with massage or specialized equipment (whirlpool bath, warm moist packs, ultraviolet light).

Other Outcomes

Having two persons collect data increased objectivity and meant that unit staff members did not have to help position patients for observation of the ulcers.

Communication increased on the units—nurses talked about nursing and suggested ways to improve care and develop new approaches. While conducting surveys, the quality assurance coordinator was frequently consulted about the risk of skin breakdown in specific patients. These requests created excellent opportunities for reviewing the probable causative factors and for designing individualized preventive measures. These measures were recorded on the individual's data collection tool so that the results could be observed during the next survey.

Collecting data with guidance from the quality assurance committee led nursing staff to regard the surveys favorably. Repeat visits were requested if another patient developed an ulcer or an affected patient was admitted. Interest in the survey findings and competitiveness among nursing units were observed. Staff asked about new products that could help prevent decubitus ulcers, and about the treatment for prevention or healing used by other units in the medical center. Documentation in the patient's medical record became more accurate as ulcer measurements, condition, and healing; and plans for maintenance or continued healing were noted in writing.

After a review of the phase-two findings, the majority of the nursing staff overwhelmingly favored continuing the decubitus-ulcer survey on a monthly basis. At this point, a more precise scale to measure the degree of tissue involvement was developed by combining Rubin's classification of ulcer stages and Clark's grades for decubitus ulcers(7-8):

- First degree decubitus ulcer—skin red and blistered
- Second degree—superficial skin layers involved
- Third degree—full thickness of skin involved, including fat, muscles, and bone.

Phase Three

Data collection from January 1979, through December 1980 constituted the third phase of the audit; 73 affected patients were followed (Tables 1-2). Of these, 3 had first, 55 had second, and 15 had third degree ulcers. Twenty-one persons (29 percent) were admitted to the medical center with a pressure sore present; 52 (71 percent) developed one or more at this facility.

Conclusion

Analysis of the numbers of patients with pressure sores during the three phases of the audit showed a total of 27 patients in January 1978, with a decrease to five patients in December 1980. This represented an 81.5 percent overall reduction. The percentage of patients with decubitus ulcers based on total bed census in January 1978 was 3.7; in December 1980 the percentage was 0.9. The mean number of decubitus ulcers present in each phase of the audit was 20.8 in 1978, 13.2 in 1979, and 9.2 in 1980.

In evaluating the three-year audit, the nursing quality assurance committee considered the possible

[illegible] INFORMATION

	Phase 2: N=[illegible]		Phase 3: N=73	
[illegible]	NUMBER OF PATIENTS*	(% of [illegible])	NUMBER OF PATIENTS	(% of 73)
[illegible]	30	64	50	68
[illegible]	[illegible]	76	50	68
[illegible]	[illegible]	[illegible]	46	63
[illegible]	[illegible]	[illegible]	5	7
[illegible]	[illegible]	[illegible]	0	0
[illegible]	[illegible]	[illegible]	3	4
[illegible]	[illegible]	[illegible]	0	[illegible]
[illegible]	[illegible]	[illegible]	0	0
[illegible]	[illegible]	[illegible]	1 (single)	[illegible]
[illegible]	[illegible]	[illegible]	3	4
[illegible]	[illegible]	[illegible]	1	1
[illegible]	[illegible]	[illegible]	1	1
[illegible]	[illegible]	[illegible]	0	0
[illegible]	[illegible]	[illegible]	3	4
[illegible]	[illegible]	[illegible]	1	1
[illegible]	[illegible]	[illegible]	1	1
[illegible]	[illegible]	[illegible]	0	0
[illegible]	[illegible]	[illegible]	2	3
[illegible]	[illegible]	[illegible]	1	1
[illegible]	[illegible]	[illegible]	1	1

*Multiple predisposing factors were present in some patients.

role of the Hawthorne effect, or the human relations concept, on the decrease in the total number of patients with decubitus ulcers.

As Hayter and others have pointed out, when a new intervention is being tried, patients often receive more attention than usual, which could account for later improvement, rather than the new intervention(9).

No new treatments or nursing measures were initiated during the audit period. However, most patients with pressures sores, as well as those at high risk for skin breakdown, were cared for on two nursing units. Patients admitted with ulcers were usually placed on one of these units, and patients who developed ulcers after admission were transferred to one of the two units. The only "new" intervention was the audit itself. It seemed reasonable to conclude, therefore, that the attitude and interest of nursing management in decubitus ulcers, through the quality assurance program, stimulated the interest and productivity of nursing staff. At least partially, this focus helped reduce the number of patients with skin breakdown.

A high percentage of patients on the two units were in category I or II. Nearly all were incontinent, nonambulatory, or both. Incontinence and nonambulatory status were the two most frequent predisposing factors identified in phase two and three of the audit. To repeat, no one medical treatment, nursing measure, or device was determined to be effective for all patients.

Consequently, the decline in numbers of patients with ulcers confirms the quality assurance concept that a knowledgeable nursing staff providing care according to a documented, specified plan determined for each individual can improve patient outcomes.

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