

Rhode Island Department of Health Office of Facilities Regulation



Individualized Care Pilot TOOLBOX

Module 1

Recommendations and Dilemmas

November 2008

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Individualized Care Pilot Overview November 2008

The Individualized Care Pilot (ICP), a project of the Rhode Island Department of Health, Office of Facilities Regulation, sought to influence and promote individualized, resident-centered quality care in nursing homes via the regulatory process. The project was supported by Centers for Medicare and Medicaid Services (CMS) and funded in part by The Commonwealth Fund. Beginning in December 2006, the project has accomplished the following:

- Piloted supplemental questions and observations as part of every standard federal recertification survey in Rhode Island between November 1, 2007 and April 30, 2008 (51 surveys);
- Conducted enhanced surveyor training prior to and during the pilot period; and
- Provided information about individualized, resident-centered care practices to nursing homes during and after the pilot period in collaboration with its educational partner for the project, Quality Partners of Rhode Island, the quality improvement organization for Rhode Island.
 - 42 surveyed facilities received educational on-site visits from Quality Partners of Rhode Island during or soon after the survey.
 - All Rhode Island nursing homes received a binder with educational resources, including copies of the CMS broadcasts, “From Institutional to Individualized Care – Parts 1-4.”
 - 10 volunteer facilities participated in a guided change process with Quality Partners of Rhode Island to implement practices to promote individualized, resident-centered care, i.e., consistent assignment, noise reduction, or resident-directed choice of waking and sleeping.
 - All educational materials are available on the ICP website at:
<http://www.health.ri.gov/hsr/facilities/icp.php>

Supplemental survey interviews and observations during the pilot period targeted three areas related to individualized, resident-centered care:

1. Resident-directed choice of waking, sleeping, and bathing.
2. Personalized environment regarding sound levels, personalized rooms, access to public/common areas, homelike bathrooms, and dining alternatives.
3. Staff-resident relationships that supported quality care and quality of life via consistent assignment and the resident being known as a person whose concerns were sought after, known, and responded to satisfactorily.

CMS granted pilot status to surveys conducted by the project from November 1, 2007 through April 30, 2008 so that any federal deficiency identified solely through the questions or observations specific to the ICP, with the exception of any circumstance indicating an immediate jeopardy (IJ), was not cited for the record. All such non-compliant practices were investigated and documented according to existing criteria for citing federal deficiencies and were submitted to each nursing home as part of a non-regulatory Summary of Survey Data report. The Summary of Survey Data report documented information from selected interviews and observations made during the survey at each facility, including notation, when applicable, of practices that appeared to support individualized, resident centered care.

- Among the 51 facilities surveyed there were 7 deficiencies cited under the pilot in 7 separate facilities:
 - 5 were F242 Self-Determination and Participation; 2 were F258 Comfortable Sound Levels.

Based on the training, materials, and expertise developed during the pilot period, the Rhode Island State Survey Agency has continued to inspect for consistent compliance with regulations related to individualized, resident-centered care and quality of life. It has also continued to encourage nursing home providers to access information to implement practices in their homes to support such compliance. Dr. David Stevenson from Harvard Medical School, Department of Health Care Policy, is conducting an independent evaluation of the project.

As a product of the Individualized Care Pilot, a Toolbox has been developed with separate modules that detail and share the project design, surveyor training, survey tools, and educational components of the ICP, as well as recommendations and dilemmas. This module, Recommendations and Dilemmas, offers recommendations to State Survey Agencies and Culture Change Coalitions and describes dilemmas encountered as part of the Individualized Care Pilot.

Module 1 - Recommendations and Dilemmas

The experience of the Individualized Care Pilot can hopefully be of benefit to all who are interested in promoting individualized, resident-centered care for nursing home residents. This module offers reflections in the form of recommendations and dilemmas that are relevant particularly to State Survey Agencies and members of Culture Change Coalitions. It also presents general lessons learned by the project and key organizational lessons that may have relevance to many long term care stakeholders. Additional “Tips for SSAs” can be found in the modules on Project Design and Information and Education for Providers, while explicit details for implementation are available in the modules on Surveyor Training and Survey Tools.

Note that the project’s National Advisory Panel offered recommendations and comments regarding this Toolbox in a meeting on May 29, 2008. Their comments are interspersed, where applicable, throughout the modules of the Toolbox.

Recommendations for State Survey Agencies and Culture Change Coalitions

For Culture Change Coalitions and State Survey Agencies, hopefully working as collaborators, there are five important and inter-related recommendations based on the experience of the Individualized Care Pilot.

1. Ensure the mandated regulatory process promotes compliance with quality of life regulations. The State Survey Agency (SSA) can accomplish this by training surveyors to recognize and enforce compliance with federal and state quality of life regulations and through clear communication with providers regarding the meaning of the regulations.
 - Training surveyors includes assuring they understand the spirit and detail of quality of life regulations, are familiar with what individualized care practices look like in action, are prepared for typical surveying scenarios that can be problematic, examine personal attitudes about quality of life regulatory issues, and become aware of the power of the questions they ask and the relational manner in which they ask them. The SSA communicating about the meaning of the regulations includes creating transparent and open lines of communication with providers regarding the regulatory facts, and being available to answer providers’ questions.
2. Create educational collaborations or connections between the SSA and the Quality Improvement Organization (QIO), or other qualified partner, to assure that providers have the resources needed to implement individualized, resident-centered care practices in keeping with regulatory expectations.
 - When providers in a state or region can openly communicate about any perceived regulatory barriers to implementing new practices **and** are supported by the SSA in their quality improvement efforts, there is excellent potential for system-wide change. The SSA’s participation in an education-regulation partnership is a powerful way to accomplish that. It is a pragmatic format in which to offer resources to providers at all levels of interest and readiness for the journey from institutional to individualized care. QIOs have the quality improvement expertise and resources to be an excellent candidate to partner with the regulatory authority.
3. Promote opportunities for providers to share their successes, challenges, and solutions so that others can benefit and credibility about new practices grows.

- Resource sharing or cross-pollination among providers regarding culture change practices is a valuable activity for a culture change coalition, the State Survey Agency, the QIO, local trade organizations or preferably all of them in collaboration. System-wide change depends ultimately on providers having confidence in the economic and pragmatic benefits of new practices. There is no better way to convince a provider that a change is do-able and financially viable than hearing it from another provider.
4. Inform residents and families of their regulatory right to quality of life in nursing homes, including the SSA routinely informing them during the survey's group interview. Coordinate information for consumers with the Ombudsman's office and other key advocates. Explore ways to involve consumers in understanding and exercising their rights.
 - Culture change coalitions and SSAs need to find ways to respond to a key finding of this project: that nursing home residents often did not know they had the right to choices of schedule or a personalized environment – or did not want to “rock the boat” by asking for what they wanted. The educational handout developed by Rhode Island SSA and distributed routinely at the group interview during surveys is a step in the direction of addressing that lack of knowledge. Any SSA can replicate it. But larger efforts to inform consumers at the national, state and local levels are needed, and coordination of those efforts among all key players is required.
 5. Change state regulations and application processes to support individualized, resident-centered care, if needed.
 - The SSA and culture change coalition members need to work together to examine existing state nursing home and long term care regulations for obstacles to culture change practices and to support legislation to remove them. At the same time they must, when appropriate, propose and garner support for new regulations. The question of whether federal regulations alone are sufficient to define and assure quality of life for nursing home residents is a key topic for all members of culture change coalitions. State licensing application procedures can be updated, as well, to include clear expectation of individualized, resident-centered practices.

Lessons Learned from the Individualized Care Pilot

Lesson Learned #1 - Pilot status granted by CMS offered multiple benefits in promoting systems change toward regulatory compliance.

Pilot status was a powerful mechanism to promote regulatory compliance in the areas of individualized, resident centered care. It gave Rhode Island nursing home providers and surveyors time and latitude needed to fully understand and integrate regulatory implications. Pilot status could accomplish similar goals with any targeted regulatory topic.

Lesson Learned #2 - A strong SSA-QIO partnership succeeded in advancing regulatory understanding and quality improvement concurrently.

The regulation-education collaboration between the Rhode Island SSA and Quality Partners of Rhode Island (Rhode Island's QIO) was extremely successful in promoting both compliance and quality improvement related to the targeted regulatory topics. It demonstrated a model for other states/regions. The SSA-QIO partnership offered resources to nursing home providers at all levels of interest and readiness for the journey from institutional to individualized care, conveyed a consistent message about the seriousness with which the targeted topics were regarded, and contributed significantly to the effective training of surveyors.

Lesson Learned #3 - Effective surveyor training was accomplished in a relatively short period of time through multi-faceted and aligned mechanisms.

It was possible to influence surveyors' understanding and competence in the targeted regulatory areas of individualized care in a relatively short period time through three aligned mechanisms:

- A multi-faceted training initiative that included in-service learning and written educational materials in collaboration with Rhode Island's QIO;
- Consistent quality control processes that supported the training objectives, including debriefs with surveyors after each survey and on-site supervision when possible; and
- Use of written prompts, probes, and guidance that supported the surveyor in carrying out the existing CMS protocol in the targeted regulatory areas.

The Individualized Care Surveyor Training module created by the project can be directly utilized by other SSAs or by CMS. The success of the training initiative demonstrates a model for training in other targeted regulatory topics.

Lesson Learned #4 - Informing residents of quality of life regulatory rights is a missing piece of accomplishing the intent of OBRA'87.

The ICP identified through interviews that many times residents and their families expressed they were unaware they had choices regarding their daily schedules and other quality of life decisions. In response, the project developed an educational brochure to be distributed as part of the survey Group Interview to provide residents with information about their regulatory rights as nursing home residents, including the regulatory concepts of Quality of Care and Quality of Life. The brochure was also occasionally given to interviewed residents and families. This brochure can be a template for State Survey Agencies to inform residents of their regulatory rights to quality of life, as well as quality of care.

The Rhode Island SSA believes that to accomplish the intent of OBRA'87, interpretive guidelines for **F242 Self-Determination and Participation** should be further clarified to specify that the facility must actively seek information from each resident regarding interests, preferences, and choices that are/were customary for, or important to, the resident. However, neither of these changes would fully address the larger conundrum of how quality of life regulatory facts can become well known among nursing home residents, their families, and the public in general. It points to the need for a targeted effort among all long-term care national stakeholders, such as CMS, Ombudsmen, consumer organizations, nursing home trade organizations, and Pioneer Network, to inform the public of the letter and spirit of OBRA'87 regarding quality of life and quality of care.

Lesson Learned #5 - Misperceived regulatory barriers can be corrected among providers and surveyors through targeted education and communication.

The ICP identified that there were common misperceptions among nursing home providers regarding federal regulatory obstacles to individualized, resident-centered care. Among the most common were frequency of meals, approved food sources, staff and residents dining together, food temperatures, refrigerators in resident's rooms, nurses' stations, and medication times. The project actively corrected such misperceptions in Rhode Island through a combination of informational communications and educational mechanisms.

We are aware that CMS has clarified many of these misperceived regulatory issues individually in various Memorandums to State Survey Agency Directors. The National Advisory Panel of the Individualized Care Pilot recommended, and the project concurs, that for a national audience a more user-friendly webpage that summarizes the factual information regarding such regulatory issues would be a significant contribution to clarifying how regulations support quality of life. Such a webpage, e.g., “Regulatory Mythbusters” could be part of the CMS website or CMS could officially verify information for such a webpage hosted by other national organizations. It would assist nursing home providers, surveyors, and the general public in understanding the intent and detail of OBRA '87 regarding individualized, resident centered care.

Key Organizational Lesson: Leadership and Team

A key lesson learned from the Individualized Care Pilot (ICP) is that organizational leadership and effective participatory teamwork are essential to the success of a system-change initiative. This lesson applies to the implementation of the ICP itself within the Rhode Island SSA and can be applicable to systems change within other SSAs, as well as among nursing home providers, and culture change coalitions.

In less than 18 months, the Rhode Island SSA developed and improved a supplemental survey process to promote individualized care, trained more than 20 surveyors in its background and implementation, surveyed 51 facilities with the process, issued non-regulatory reports for those facilities, disseminated educational materials and cross-pollination opportunities to all nursing home providers in Rhode Island, and communicated extensively with local and national stakeholders concerning the process.

This would not have been possible without committed leadership of the Director of the Rhode Island Department of Health, Dr. David Gifford, and Raymond Rusin, Chief of the Office of Facilities Regulation. With their support, the initiative was conceived and carried out by a newly convened team within the SSA that became enthusiastic about the benefits of the initiative. That team included the Office of Facilities Regulation Chief of Operations, Quality Improvement/Training Coordinator, key surveyors, and a newly hired Program Manager. This team interfaced with all surveyors in the design, development, implementation, and revision of the initiative. However, this team quickly understood that it only as part of a larger team could it most effectively influence change among nursing home providers.

Key Organizational Lesson: Collaborate Toward Systems Change

The importance of multiple stakeholders participating simultaneously in systems change cannot be overstated. It became clear to the Rhode Island SSA team that regulation was only one of multiple forces that affect the lives of nursing home residents, i.e., that regulations are a necessary, but not sufficient, cause to optimally create change among nursing home providers and the residents they serve. Therefore, at the local and national levels during the ICP, the Rhode Island SSA collaborated with multiple stakeholders. The biggest factor limiting the degree of collaboration with other stakeholders was the availability of staff time for the outreach, ongoing communication, and joint meetings that are required for establishing relationships, clarifying common ground, sharing information, engaging in planning, and working together to accomplish activities. These are time-consuming functions that are all too often “extra” duties on top of a full plate of operational responsibilities within an organization. Unfortunately, the potential of some of these collaborations was not fully realized during the ICP due to time constraints, however, the seeds of collaboration that have been sown will hopefully continue to grow over time.

Local Stakeholders:

As described in other modules of this Toolbox, collaboration with the local QIO, Quality Partners of Rhode Island, became an innovative working partnership that serves as a model for other states. For a regulatory agency with the limited mission of enforcement and dissemination of information, collaboration with a local organization as an educational partner fills the obvious missing link in effective systems change. It was well worth the staff time and energy it required.

Another key stakeholder in Rhode Island was the RI State Ombudsman for Long-Term Care. The Project Co-Director kept the Ombudsman's office informed of the ICP activities and was very pleased when the Ombudsman office helped to convene an informational meeting for other stakeholders in August 2007 regarding the ICP at the offices of the RI Health Care Association, the state's largest nursing home trade association. Attendees were invited from the RI Association of Facilities and Services for the Aging (RIAFSA), RI-Generations (the former RI Culture Change Coalition), the Alzheimer's Association-RI Chapter, AARP, American Medical Director Association – RI Chapter, Quality Partners of RI, RI Department of Elderly Affairs, RI Attorney General's Office, and RI Department of Human Services. A limited number of invitees attended and further outreach to these and other potential stakeholders was not possible due to limited staff time available for this function. However, presentation of the final products from this project may create another forum for such outreach.

The project continued to communicate with the Ombudsman's office regularly throughout the project, sharing newly developed materials for consumers and inviting them to all activities for providers that were sponsored by the project. RI-Generations, the Rhode Island culture change coalition, was also kept informed of the project's activities on a regular basis at its monthly meetings where the Rhode Island SSA is an active member. Similarly the two trade associations were regularly informed of project activities as part of the process of informing providers. It is hoped that some aspects of the ICP may become part of the agenda and activities of one or more of these important stakeholders in the future.

Stakeholders within State Government:

An important group of stakeholders that became apparent as the ICP project evolved were other government departments or agencies that play a role in nursing home regulation and funding. As part of the ICP, staff from the Office of Facilities Regulation:

- Coordinated with the Department of Health, Office of Food Protection, in clarifying state food regulations as they related to nursing homes;
- Facilitated communication between the Rhode Island QIO and the Nursing Assistant Licensing Board concerning required education curriculum for Nursing Assistants; and
- Advised the Department of Health, Office of Health Systems Development, to include questions that specifically address individualized care systems in Change in Effective Control Applications, i.e., licensure applications when there is a change in ownership, operator or lessee of an existing health care facility.

National Stakeholders:

Collaboration with stakeholders at the national level was built into the project design from its inception via a Technical Expert Panel and National Advisory Panel. As the project unfolded, it became clearer what a crucial role national stakeholders would play as representatives of organizations with the opportunity to integrate, adopt, or transform any of the project's contributions to their fullest potential.

The foremost of the national stakeholders that supported and cooperated with the project throughout its duration was the Centers for Medicare and Medicaid Services (CMS). Under the leadership of Thomas Hamilton, Director of the Survey and Certification Group, CMS provided representatives to both the project's Technical Expert Panel and the National Advisory Panel. In addition, CMS granted pilot status to the project for a six-month period, a significant aid in promoting the goals of the project. The project was honored to be included in the CMS 2008 Action Plan for (Further Improvement of) Nursing Home Quality.

Other key national stakeholders who were engaged via the projects' National Advisory Panel were the American Association of Homes and Services for the Aging, the American Health Care Association, the Association of Health Facility Survey Agencies, National Association of State Long-Term Care Ombudsman Programs, National Citizen's Coalition for Nursing Home Reform, National Senior Citizens Law Center, and the Pioneer Network. The manner in which each of these national organizations will participate in disseminating and promoting the findings, products, and implications of the Individualized Care Pilot will continue to unfold after the end of the project. For instance, the Pioneer Network has made the culture change coalition portion of its website available to link to some of the final products of the project.

National stakeholders will hopefully build on some of the accomplishments of the project and apply them to broader contexts. For example, during a meeting of the National Advisory Panel in May 2008, two ideas were pinpointed by attendees for potential future development by national experts based on the project's activities:

1. A consumer handout about nursing home resident's regulatory rights to quality of life topics, including choice and a personalized environment; and
2. A "Mythbusters" resource for nursing home providers that dispels misconceptions about regulatory obstacles to individualized, resident centered care.

Regulatory Dilemmas

There were important dilemmas that arose and became clear as the implementation of the Individualized Care Pilot unfolded. None were expected, and none have been fully resolved. They are presented here as points of information and discussion for all others treading the path of using the regulatory process as a means to assure individualized, resident-centered care.

Dilemma 1: What is the role and obligation of the surveyor, the SSA, and CMS in informing residents about their rights to individualized care under OBRA '87?

The ICP found it was commonplace for nursing home residents to be unaware they had a right to choice and participation in decision-making about their daily routines, such as when they awake, go to sleep, or bathe. In response to this realization, during the last half of the pilot period, the ICP developed an informational handout for residents and families about these rights as outlined in OBRA '87. (See Appendix for Resident Educational Brochure – Group Interview Handout.)

The ICP protocol required the handout to be given to residents at the Group Interview during the survey. Surveyors were also instructed that it could be given to any resident or family member during an interview. The handout was shared for distribution with the Rhode Island State Ombudsman's office. It has been recommended to CMS that a similar handout be part of the Group Interview process. The handout has also been offered to representatives on the project's National Advisory Panel as a model for similar efforts at consumer education that might originate as a coordinated product at the national level.

Explicitly informing residents of their rights to individualized care through the group handout during the survey process is just one way that an SSA might promote information for residents. The SSA might also engage in broader educational activities outside the survey, such as visits to Family and Resident Councils, press releases about the topic, and collaborative presentations for providers and consumers with the Ombudsman's office. But the parameters are not clear regarding the role and obligation of an SSA to inform residents and their families about their rights. Should the SSA take the initiative in informing residents of their regulatory rights during surveys? Is it the job of the SSA or CMS to inform residents about their regulatory rights outside the survey process?

Asking about preferences is educational to consumers:

In addition to information dissemination to residents via the handout, ICP resident and family interviews acted as de facto consumer education by consistently asking about preferences. The protocol required surveyors to ask a resident about the particulars of his/her schedule and then inquire, "Is that your preference?" The response had to be recorded as a "yes" or a "no." The surveyor proceeded with gathering more information if the answer was "no," depending on whether the resident had told the facility of his/her preference. Sometimes, however, the surveyor noted that the resident did not know s/he had a right to such a preference. Then the surveyor could explicitly inform the resident that s/he did have the right to participate in decision-making about his/her daily schedule.

Sometimes this interaction between the surveyor and the resident was the impetus for the resident to express his/her choice to the facility with the result that the facility accommodated it. Here is an excerpt from surveyor notes describing an occasion during the ICP when a surveyor encouraged the resident to express her rights to choice of a schedule:

Resident ID #3 revealed to this surveyor that she would prefer to have her shower not only on Mondays and Thursdays, but every day and also in the evening instead of the morning. During our interview I encouraged her (to express her choice and) that individualized choice was important. She informed me that she never voiced her choice to any staff.

Next day entry:

Resident ID #3 informed me that she spoke with the nurse and is now receiving her shower each evening. She was very pleased.

However frequently residents did not want to express their preferences, choices, or dissatisfaction to the facility.

Dilemma 2: What to do with a resident who will not express dissatisfaction to facility?

A frequent scenario was one in which the resident or family member was unwilling to express his/her choice to the facility even after the surveyor informed him/her of this right. Sometimes this was true even when the resident was dissatisfied with the current schedule. The reasons for this ranged from "I don't want to rock the boat" to "My mother told me never to complain" to "They're so busy here with everyone else" to "They're doing the best they can." Current CMS guidance to surveyors about how this kind of response relates to F242 is not clear. In response to CMS proposed revisions to surveyor guidance, the Rhode Island SSA commented on September 19, 2008. Suggestions included that interpretive guidelines to F242 be revised to assure that the facility elicits and assesses choices from every resident and that the content of the Individualized Care Investigative Protocol be added to F242 as guidance to surveyors to address this issue. (See Appendix for Individualized Care Investigative Protocol.)

In the absence of that guidance, Rhode Island surveyors appeared to handle this situation in a variety of different ways. Here is an excerpt from surveyor notes describing how it was handled during one ICP survey:

Surveyor interviewed Resident ID #6 who stated s/he was awakened every day for pills between 7:00 – 7:30 AM, which was not his/her preference. However neither resident nor significant other wanted to cause problems by bringing this to attention of the facility.

Interview with Med Tech confirmed that Med Tech wakes resident between 7:00 – 7:30 AM to give Zantac. However Med Tech stated that resident never complains, just says, “It’s you again waking me up with a pill” and then goes back to sleep.

Surveyor later spoke to resident and significant other again who stated they still preferred not to “cause any problems,” even though this particular medication could wait till later.

Surveyors mentioned this issue in general terms to the Administrator as part of the ICP exit conference, but did not state there was a dissatisfied resident in order to preserve the anonymity of the resident.

Because of this issue, the ICP asked surveyors in a questionnaire administered at the end of the pilot period in April 2008 “When you know a resident’s preference is not being met, yet the resident is hesitant to express dissatisfaction to you or to the facility, what do you usually say to the resident (or family member)? What do you do?”

General categories of surveyor responses included:

- Encourage resident to say something to facility staff because nothing will change if they don’t express their preference;
- Offer to inform the facility on the resident’s behalf about the lack of preference;
- Maintain confidentiality, but bring the lack of preference to the attention of the facility in the form of an “anonymous” resident or as a general group issue without indicating the number of residents potentially affected;
- Investigate anyway on the basis of an “anonymous” resident’s lack of choice/preference; or
- Take the refusal to express preferences or dissatisfaction as the resident’s choice and end the matter without any action or further investigation.

This question to surveyors was asked within the context of assuming each resident is responsible for expressing preferences and/or dissatisfaction to the facility. But this raises another dilemma discussed below, i.e., the relationship between each resident’s responsibility to express choices and the facility’s responsibility to elicit information from residents regarding those choices.

Dilemma 3: Is deficient practice dependent upon the resident or the facility’s system?

By what measure does a surveyor assess the facility’s regulatory responsibility to elicit individual preferences and choices regarding daily schedules, activities, and any aspect of life that the resident regards as significant? For example, from a surveyor’s perspective, should a resident’s unwillingness to express his/her preference to be regarded as an individual choice or the possible characteristic of a deficient system or both? Furthermore, is it the business of SSAs and CMS to take resident institutionalization into account during investigation of Quality of Life regulations by citing deficient systems when residents are unwilling to express their dissatisfaction/lack of choices, or must deficient practice be cited only when a resident states dissatisfaction?

During the ICP, surveyors observed that residents and providers often exhibited institutionalization, i.e., unconscious acceptance of a medical model of regimented care and services designed for the efficiency of the nursing home organization, rather than to meet the preferences of each resident. One of the characteristics of residents who live within such a system is that they do not think it is reasonable to ask for individualized care or are unwilling to do so, possibly out of fear. In addition, as discussed in the earlier dilemma about lack of knowledge of the regulations, they may not know it is a possibility. But when a surveyor informs a resident it is a possibility, such a resident may still be internally bound by the assumptions of the institutional paradigm in which s/he lives.

From one regulatory perspective, the unwillingness of such a resident to express his/her preference might be viewed as a choice that must be respected by the surveyor and, therefore, requires no further investigation. From another regulatory perspective, it may be the indicator of an institutionalized system that neither solicits nor encourages resident preferences and choices. The primary difference between these views is whether the investigative trigger for deficient practice is dependent upon the willingness of an individual resident to express dissatisfaction/lack of preference or whether it is dependent upon an observable system that does not solicit and/or accommodate resident preferences and choices about their schedule. It is important here to note that accommodation of expressed dissatisfaction or need (F246) is not the same as meeting the intent of F242 Self-Determination and Participation. How would an SSA determine if a facility is systemically doing what is necessary to solicit and/or accommodate residents' preferences and choices about their schedule?

The ICP developed a prompt for surveyors that maximizes the effectiveness of the current survey process in identifying potential systems that might be related to lack of individualized choice. Used at the start of the survey during the Facility Tour, the prompts assure that surveyors ask facility staff and residents specific questions regarding choices of schedules for bathing, waking, and sleeping on both an individual and systemic level. (See Appendix for Individualized Care - Tour Observations.) Depending on the responses, these prompts increase the likelihood of adding "choices" as an area of concern in Phase I of the survey. The number of individual residents who will be interviewed about this topic is increased, which gives the survey team a larger sample in which to possibly find one or more residents who may express lack of choices and/or dissatisfaction with choices. It has been recommended to CMS that the observations made at the start of the survey on the facility tour, as well as the interpretive guidelines to F242 defining the responsibility of the facility to elicit choices, be revised to clarify this issue.

Rhode Island surveyors were asked at the end of the pilot to respond rate the effectiveness of this approach. Surveyors were provided with this statement: "The ICP protocol, which looks at care systems early in the survey in order to help identify Quality of Life focus areas, is a useful tool." In response, eighty-five percent (85%) of Rhode Island surveyors rated it as 4 or higher on a scale of agreement from 1 (Disagree) to 5 (Agree Strongly).

Dilemma 4: Should an SSA routinely inquire of facility administrative staff about systemic practices related to individualized care?

The ICP survey protocol included questionnaires and/or interviews for the Administrator, Director of Nursing Services (DNS), and Medical Director of each surveyed facility focusing on standard systems of practice related to individualized care. See Appendix for these tools. During the pilot period, the goal of the questionnaires/interviews was to convey information to the administrator through the power of the question and to gather data that could aggregate for the benefit to other facilities after the pilot. The Rhode Island SSA believes these questionnaires were very effective in bringing to the attention of administrative staff implicit considerations regarding the topics targeted by the Individualized Care Pilot.

It is important to realize, however, that asking such questions during a regulatory survey outside of the protection of a pilot period may contribute to citation of deficient practice. For example, Administrators and DNSs were asked:

- What systems are in place to involve residents in making decisions and choices about their own care, daily schedules and activities?
- What is the home's system for determining when, how, and how often residents are bathed? How are residents' preferences considered in the process of determining bathing arrangements? How is information about bathing that is gathered on the MDS upon admission used to determine bathing schedules/types?
- How does the breakfast schedule and system for administering medications influence sleep for residents?
- What system(s) does the home use to assure that the resident's choices, preferences, likes and dislikes are communicated among all caregivers?

The answers to such questions could have direct regulatory links in the case of a dissatisfied resident. Or if CMS guidance in the future indicates that a deficient system can be cited whether or not a resident is willing to express dissatisfaction, these answers could be potential evidence.

Another way for an SSA to ask such systemic questions of administrative staff is to separate them from the annual federal and state survey process. For instance, the entire Administrator/DNS Questionnaire or Medical Director Questionnaire could be mailed to all facilities simultaneously at a date before or soon after the start of an initiative to promote individualized care. Or a limited number of questions from these tools could be selected and combined with other issues an SSA might want to highlight, such as gathering the number and type of personal safety alarms in use in each facility on a particular date. Furthermore, it need not be the SSA that does this inquiry about systems. It could be the activity of a Culture Change Coalition that is attempting to gather information and heighten awareness of particular resident-centered care issues.

Finally, an important venue through which to inquire to nursing homes about systemic forms of individualized, resident-centered care is the application process for new licenses or other regulatory applications. In Rhode Island, a precedent was set for requiring this kind of systemic information from nursing homes that apply for Change in Effective Control. As of 2007, the Department of Health, Office of Health Systems Development, application for change in effective control includes the following:

Based on the format below, please provide a summary of the applicant's administrative and operational policies and procedures to provide individualized and resident-centered care, services, and accommodations, and a sense of peace, safety, and community, and clearly identify how the proposal would advance these areas:

- a. Resident's physical environment:
 - i. Accommodations for privacy vs. congregate and common areas;
 - ii. Choice and autonomy in personal space, fixtures, furniture;
 - iii. Access to and involvement in decentralized services, such as, community kitchen(s), laundry, activities;
 - iv. Access to outdoors and outdoor activities (e.g., sunrooms, patios, gardens and gardening).
- b. Resident-centered systems of care:
 - i. Security systems and care delivery systems to foster autonomy, choice, and negotiated risk;

- ii. *Individualized daily/nightly scheduling (e.g., daily rhythm, going to bed, waking);*
- iii. *Dining flexibility (e.g., time, access to dining style and menu choice);*
- iv. *Lifestyle/activities flexibility.*

c. Workforce administration:

- i. *How do staffing schedules and assignments ensure consistent delivery of resident services and foster relationship building?*
- ii. *Administrative status strategies for dealing with licensed staff turn-over (e.g., Registered nurses, Licenses Practical nurses, Nursing Assistants).*

<p>National Advisory Panel Comments</p>	<ul style="list-style-type: none"> • National organizations such as Pioneer Network, NCCNHR, Ombudsman, and CMS should partner for a contemporary consumer education brochure that applies regulations and rights to individualized care practices. • CMS should create a “Mythbusters” resource for nursing home providers that dispels misconceptions about regulatory obstacles to individualized, resident centered care. • Consumer education is crucial. It’s difficult to enforce a rights violation without a resident attempting to exercise that right. • Does a right include the knowledge to the right? Maybe compare to Miranda rights, where the right to not incriminate yourself includes the right to be informed of that right. • What about saying “Is this your choice?” rather than “Is this your preference?” “Choice” seems less judgmental. • Add Quality of Life and F242 to Nursing Home Compare.
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Module 1 – Recommendations and Dilemmas - Summary

Recommendations for State Survey Agencies and Culture Change Coalitions

For Culture Change Coalitions and State Survey Agencies, hopefully working as collaborators, there are five important and inter-related recommendations based on the experience of the Individualized Care Pilot.

- Ensure the mandated regulatory process promotes compliance with quality of life regulations. The State Survey Agency (SSA) can accomplish this by training surveyors to recognize and enforce compliance with federal and state quality of life regulations and through clear communication with providers regarding the meaning of the regulations.
- Create educational collaborations or connections between the SSA and QIO (or other qualified partner) to assure that providers have the resources needed to implement individualized, resident-centered care practices in keeping with regulatory expectations.
- Promote opportunities for providers to share their successes, challenges, and solutions so that others can benefit and credibility about new practices grows.
- Inform residents and families of their regulatory right to quality of life in nursing homes, including the SSA routinely informing them during the survey's group interview. Coordinate information for consumers with the Ombudsman's office and other key advocates. Explore ways to involve consumers in understanding and exercising their rights.
- Change state regulations and application processes to support individualized, resident-centered care, if needed.

Five general lessons learned from the Individualized Care Pilot were:

1. Pilot status granted by CMS offered the project multiple benefits in promoting systems change toward regulatory compliance.
2. A strong SSA-QIO partnership succeeded in advancing regulatory understanding and quality improvement concurrently.
3. Effective surveyor training was accomplished in a relatively short period of time through multi-faceted and aligned mechanisms.
4. Informing residents of quality of life regulatory rights is a missing piece of accomplishing the intent of OBRA'87.
5. Misperceived regulatory barriers can be corrected among providers and surveyors through targeted education and communication.

Two key organizational lessons learned from the Individualized Care Pilot (ICP) were:

- Organizational leadership and effective participatory teamwork are essential to the success of a system-change initiative. This lesson applies to the implementation of the ICP itself within the Rhode Island SSA and is applicable to systems change within other SSAs, as well as among nursing home providers, and culture change coalitions.
- Systems change requires multiple stakeholders participating simultaneously. It became clear to the Rhode Island SSA team that regulations are a necessary, but not sufficient, cause to optimally create change among nursing home providers and residents. The ICP engaged multiple stakeholders at the local and national levels, including other regulatory divisions of state government, such as Food Protection. The foremost of the national stakeholders that supported and cooperated with the project throughout its duration was the Centers for Medicare and Medicaid Services (CMS). Other key national stakeholders who were engaged via the projects'

National Advisory Panel were the American Association of Homes and Services for the Aging, the American Health Care Association, the Association of Health Facility Survey Agencies, National Association of State Long-Term Care Ombudsman Programs, National Citizen's Coalition for Nursing Home Reform, National Senior Citizens Law Center, and the Pioneer Network.

There were important regulatory dilemmas that arose and became clear as the implementation of the Individualized Care Pilot unfolded:

What is the role and obligation of the surveyor, the SSA and CMS in informing residents about their rights to individualized care under OBRA '87?

The ICP found it was commonplace for nursing home residents to be unaware they had a right to choice and participation in decision-making about their daily routines, such as when they awake, go to sleep, or bathe. In response to this realization, during the last half of the pilot period, the ICP developed an informational handout for residents and families about these rights as outlined in OBRA '87. Parameters are not clear regarding the role and obligation of an SSA to inform residents and their families about their rights. Should the SSA take the initiative in informing residents of their regulatory rights during surveys? Is it the job of the SSA or CMS to inform residents about their regulatory rights outside the survey process?

What to do with a resident who will not express dissatisfaction to facility?

A frequent scenario encountered during the ICP was when the resident or family member was unwilling to express his/her choice to the facility even after the surveyor informed him/her of this right. Sometimes this was true even when the resident was dissatisfied with the current schedule. The reasons for this ranged from "I don't want to rock the boat" to "My mother told me never to complain" to "They're so busy here with everyone else" to "They're doing the best they can." Current CMS guidance to surveyors about how this kind of response relates to F242 is not clear.

Is deficient practice dependent upon the resident or the facility's system?

By what measure does a surveyor assess the facility's regulatory responsibility to elicit individual preferences and choices regarding daily schedules, activities, and any aspect of life that the resident regards as significant? Is it the business of SSAs and CMS to take resident institutionalization into account during investigation of Quality of Life regulations by citing deficient systems when residents are unwilling to express their dissatisfaction/lack of choices, or must deficient practice be cited only when a resident states dissatisfaction? The ICP developed a prompt for surveyors that maximizes the effectiveness of the current survey process in identifying potential systems that might be related to lack of individualized choice. Used at the start of the survey during the Facility Tour, the prompts remind surveyors to ask facility staff and residents specific questions regarding resident choices of schedules for bathing, waking, sleeping.

Should an SSA routinely inquire of facility administrative staff about systemic practices related to individualized care?

The ICP survey protocol during the pilot period included questionnaires and/or interviews for the Administrator, Director of Nursing, and Medical Director of each surveyed facility focused on systems in place in the home or standard systems of practice related to individualized care. These inquiries were very effective in bringing to the attention of administrative staff implicit considerations regarding the targeted topics. Asking such questions during a regulatory survey outside of the protection of a pilot period, however, may contribute to citation of deficient practice. An alternative is for a SSA to ask such systemic questions separately from the annual federal and state survey process. Another important venue through which to inquire to nursing homes about systemic forms of individualized, resident-centered care is the application process for new licenses or other regulatory applications.

Module 1 – Recommendations and Dilemmas

Appendix

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**Rhode Island Department of Health
Office of Facilities Regulation**

Individualized Care Pilot

Resident Educational Brochure – Group Interview Handout



INDIVIDUALIZED CARE

Information for Rhode Island Nursing Home Residents & Their Families

Nursing Home Reform Act

In 1987 the Federal Government passed the Nursing Home Reform Act. This law was passed to improve the lives of people living in nursing homes by setting new standards for federally funded nursing homes.

- The standards include four important categories: **Quality of Care, Quality of Life, Resident Environment, and Resident Rights**
- Nursing homes and regulatory agencies use these four categories as a basis for providing and ensuring quality services.
- The goal of these concepts is to create a nursing home environment that respects and supports every individual nursing home resident to live to his or her fullest potential – **Physically, Mentally, and Psychosocially.**

Quality of Care

The concept of “quality of care” means that your nursing home must provide the necessary care and services that you need (and have participated in deciding) to attain or maintain your highest possible level of physical, mental and psychosocial functioning.

It’s the quality of the care that is provided that helps you live to your fullest potential.

These care and services include (but are not limited to):

- **Eating**
- **Bathing**
- **Dressing**
- **Walking**
- **Skin Condition**
- **Continence**



Quality of Life

The concept of “quality of life” means that your nursing home must create an environment that treats you with dignity, respect, and as an individual. This includes knowing and honoring your choices and preferences.

It’s how the home provides/treats you with care and services that helps you live to your fullest potential.

What Should I Look For?

Dignity

Staff interacts with you and provide/conduct activities in a manner that maintains your self-esteem and self-worth.

Self-Determination & Participation

You can choose **activities, schedules, and health care** consistent with your interests, preferences, and aspects of your life in the home that are significant to you.

Accommodation of Your Needs

The home makes efforts to individualize your environment to help you achieve and/or maintain your independence, dignity and wellbeing to the extent possible, based on your preferences and interests.



Resident Environment

Your home should create and maintain a safe, clean, comfortable, and homelike environment. This means any area of the home that you frequently use, including:

- **Bedroom**
- **Activity Areas**
- **Bathroom**
- **Therapy Areas**
- **Hallways**
- **Dining Areas**

A personalized, homelike environment recognizes your individuality and autonomy.

What Should I Look For?

Some things to look for in your environment include:

- The home should support you to use personal belongings that support a homelike environment for you (photographs, books, magazines, mementos, computers, furniture).
- The sound level of the home should be comfortable for you (especially in the evenings and at night when you are sleeping.)
- There should be adequate lighting for your needs (reading, watching television, using the bathroom, eating, etc.)

WHAT ARE MY RIGHTS?

Under Federal and State laws you have rights and certain protections as a resident of a nursing home. You have the right to a dignified existence, self-determination, and communication with people and services inside and outside of the home.

Your nursing home must protect and promote your rights. Your rights include but are not limited to:

- **Be informed of your rights**
- **Exercise your rights as a resident of the home and as a citizen/resident of the United States**
- **Participate in decisions about your care/treatment, including refusal of treatment**
- **Be free from abuse**
- **Choose a physician**
- **Privacy and confidentiality**
- **Voice complaints**
- **Privacy in sending and receiving mail and using a telephone**
- **Have visitors**
- **Retain and use personal possessions**
- **Share a room with a spouse**
- **Self-administer medication (if safe for you to do so).**

If you believe your rights are being violated:

Call Rhode Island Department of Health at
(401) 222-5200

OR

The Rhode Island Long-term Care
Ombudsman at **(401) 785-3340**



**Rhode Island Department of Health
Office of Facilities Regulation**

Individualized Care Pilot

Individualized Care Investigative Protocol

Individualized Care - Investigative Protocol

Determine if the resident's preferences/choices are being supported regarding his/her daily schedule, activities, and facets of his/her life that the resident considers to be important.

If a resident/family expresses that he/she **does not** have choices and/or opportunities to do things that are **meaningful or important** to him/her or are his/ her **preference/choice**, then use the following protocol to learn more.

Find out if the resident/family informed anyone in the home. If he/she did, then:

- Ask what happened? (F166, F242, F246)
- Ask which staff member he/she informed?
- Follow-up with appropriate staff interviews (Direct Care Staff, Charge Nurse, DNS, etc.) to determine the extent that staff were aware of the resident's preference(s)/choices(s) and what the resolution was.
- Review Section AC. of the MDS for Customary Routines, Social Service notes, Nursing Notes, applicable assessments, etc. to learn more about the resident's preferences and interests and the home's actions to support those preferences and interests. (F272, F278)
- Does the resident's care plan reflect the resident's goals and wishes regarding care/treatment and preferences as identified through applicable assessments? (F272, F279)

If the resident/family has never expressed his/her preference(s)/concerns to the home, then:

- Ask the resident /family why? (*Is it because the resident/family was not aware he/she could choose or voice concerns*)? (F156, F165, F166, F242)
 - Inform the resident that he/she has the regulatory right to make choices about daily schedules, activities, health care, and aspects of his/her life that are significant to the resident. If appropriate, offer the resident contact information for the State's Long Term Care Ombudsman.
- Ask the resident/family if he/she is invited to care plan meetings and does he/she participate? (F272, F280)
- Review Section AC. of the MDS for Customary Routines, Social Service notes, Nursing Notes, applicable assessments, etc. to learn more about the resident's preferences and interests and the home's actions to support those preferences and interests. (F272, F278)
- Does the resident's care plan reflect the resident's goals and wishes regarding care/treatment and preferences as identified through applicable assessments? (F279)
- Follow-up with appropriate staff interviews (Direct Care Staff, Charge Nurse, Social Worker, DNS, etc.) to learn about the home's ongoing system for learning about residents' preferences and interests and incorporating into the resident daily schedule and/or care plan. (F242, F246, F250, F272, F279, F280)

Individualized Care – Investigative Protocol
Regulatory Requirements for Consideration

F156 Resident Rights:

If a resident or family member indicates that he/she is **not aware** that he/she has a right to choose daily activities, schedules, and/or health care preferences or to voice concerns/grievances about his/her activities, schedules, health care or aspects of his or her life in the facility that are significant to the resident, check to see what information is provided to residents upon admission and during their stay regarding their rights. Refer to F156 Resident Rights for additional guidance.

F165 & F166 Grievances:

If staff were aware of a resident's concerns and have not attempted to resolve and/or communicate progress of a potential resolution then refer to F165 and F166 Grievances for additional guidance.

F242 Self-Determination and Participation:

If staff were aware of a resident's preferences (based on staff interview(s), MDS documentation, Social Service Notes, Nursing Notes, Assessments, etc.) and have not supported the resident to exercise choices and/or provide opportunities for self-determination or have not actively sought the resident's preferences, then refer to F242 Self-Determination and Participation for additional guidance.

F246 Accommodation of Needs:

If staff were aware a resident's preferences and failed to reasonably accommodate the resident or for issues regarding choice over arrangement of furniture and adaptations to the resident's bedroom and bathroom, then refer to F246 Accommodation of Needs for additional guidance.

F250 Social Services:

If the resident has expressed or the facility has failed to identify a medically-related need(s) that would assist the resident to attain or maintain his/her highest everyday functioning, then refer to F250 Social Services for additional guidance.

F272 Comprehensive Assessments:

If a resident or family member indicates that he/she was not involved in the comprehensive assessment process including information regarding the resident's "customary routine", then refer to F272 Comprehensive Assessment for additional guidance.

F278 Accuracy of Assessment:

If review of MDS documentation, Social Service Notes, Nursing Notes, Assessments, etc. are conflicting regarding resident preferences and/or choices then refer to F278 Accuracy of Assessment for additional guidance.

F279 Comprehensive Care Plans:

If the resident's care plan does not reflect needs, strengths, and preferences identified in assessments, then refer to F 279 Comprehensive Care Plans for additional guidance.

F280 Participate in Planning Care and Treatment

If a resident was not afforded the opportunity to participate in care and treatment planning, then refer to F280 Participate in Planning Care and Treatment for additional guidance.



**Rhode Island Department of Health
Office of Facilities Regulation**

Individualized Care Pilot

Individualized Care - Tour Observations

Individualized Care – Tour Observations

Facility:	Surveyor:	Date:
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When conducting the facility tour make note of any of the following areas for possible inclusion of Phase I focus areas.

Sound Levels: (F 258 - Comfortable Sound Levels)

- Do residents appear to be comfortable and not disturbed by noise from personal alarms, motion sensor alarms, door alarms, overhead paging/call system etc.?

Notes:

Personalized Environment: (F241 Dignity, F246 Accommodation of Needs, F252 Environment, F250 Social Services)

- Ask staff/residents during the tour how the home **assists residents** make their rooms homelike?

Observe during the tour:

- Do resident **rooms** show evidence of being personalized?
- Do residents with **dementia** have personalized rooms/items?
- Do residents have access to **common areas** or are areas locked?
- Are resident **bathrooms and shower rooms** comfortable and homelike?

Notes:

Resident Schedules & Choices for Sleeping: (F241 Dignity, F242 Self-Deter. & Part., F246 Accom. of Needs)

- Ask staff/residents during the tour what the home's practice for how residents choose when to wake-up in the morning and go to sleep at night?

Observe during the tour:

- Are residents awakened for **breakfast**? Does the breakfast schedule influence the time that residents wake-up?
- Are residents awakened for **medications**? Does the home's system for administering medications influence the time that residents wake-up?
- Is resident choice and preference honored in the home's practices for waking and sleeping?

Notes:

Resident Schedules & Choices for Bathing: (F241 Dignity, F242 Self-Deter. & Part., F246 Accom. of Needs)

- Ask staff/residents during the tour what the home's practice for how residents choose their bathing schedules and preferences (bath or shower and how often)?
- Is it an individualized system or is it pre-determined by the home?

Notes:

Resident Schedules & Choices for Eating: (F241 Dignity, F242 Self-Deter. & Part., F246 Accom. of Needs)

- Ask staff/residents during the tour what the home's practice for how residents choose **where and when to eat**?
- Ask staff/residents during the tour how the home supports honoring resident food preferences including snacks?
- Is it an individualized system or is it pre-determined by the home?

Observe during the tour:

- Have residents eaten their breakfast or are meals at the bedside untouched?

Notes:



**Rhode Island Department of Health
Office of Facilities Regulation**

Individualized Care Pilot

Administrator/DNS Questionnaire

ICP ADMINISTRATOR & DNS QUESTIONNAIRE

Facility:	Date:
Administrator Name	DNS Name

Individualized, resident-centered quality care and quality of life are important goals of both federal and state nursing home regulations. As part of the Individualized Care Pilot (ICP) and the RI Department of Health's continuing efforts to promote and support individualized, resident-centered care, we have developed questions to learn about current practices in Rhode Island nursing homes related to resident-choice, staff/resident relationships, and a personalized environment. The answers to these questions will be aggregated anonymously at the end of the ICP and made public.

The Administrator and Director of Nursing should complete this form together. After the questionnaire is completed, a member of the survey team will meet with the Administrator and Director of Nursing to discuss the questions. This meeting will also provide an opportunity to share any other systems or activities, not covered in these questions, that the home has in place to promote individualized, resident-centered care.

I. Resident Choice

What systems are in place to involve residents in making decisions and choices about their own care, daily schedules, and activities?

Waking / Sleeping:

What is the home's practice for how residents wake in the morning and go to sleep at night?

How are residents' preferences considered in the process of determining waking/sleeping arrangements?

How does the breakfast schedule and system for administering medications influence sleep for residents?

ICP ADMINISTRATOR & DNS QUESTIONNAIRE

Bathing:

What is the home's system for determining when, how, and how often residents are bathed?

How are residents' preferences considered in the process of determining bathing arrangements?

How is information about bathing that is gathered on the MDS upon admission used to determine bathing schedules/types?

Meals:

How are residents' preferences part of the process of determining food choices and times to eat?

If a full meal is not available to a resident due to his/her choice of schedule, what alternatives are offered to the resident?

What kinds of home-like dining, if any, does the home provide? *Describe snack options: how, when, what.*

ICP ADMINISTRATOR & DNS QUESTIONNAIRE

II. Staff/Resident Relationships

Resident being known as a person (likes and dislikes):

What system is in place to assure that staff know residents as people and find out about residents' likes and dislikes in an ongoing manner?

What system(s) does the home use to assure that the resident's choices, preferences, likes and dislikes are communicated among all caregivers?

Consistent Assignment (Note: Consistent Assignment is not a regulatory requirement.)

How often are residents assigned to work with the same direct care staff: Describe current details of your system regarding:

- a) On what shifts?

- b) How does it vary by unit/hall/neighborhood?

- c) How are all days of the week covered?

- d) How are planned absences (e.g. vacations) and unplanned absences (call-outs) covered?

- e) If not previously described, what rotations, if any, exist and how are they determined?

- f) How much and what kind of input do direct care staff have in the determination of assignments to residents?

ICP ADMINISTRATOR & DNS QUESTIONNAIRE

How is this system for assigning residents to staff working in terms of staff-resident relationships and quality of care?

Quality Improvement

How does the home's QI committee monitor quality of life for residents?

How do you monitor residents' satisfaction of the staff that work with them?



**Rhode Island Department of Health
Office of Facilities Regulation**

Individualized Care Pilot

Medical Director Questionnaire

ICP MEDICAL DIRECTOR QUESTIONNAIRE

Name of Facility:	Survey Exit Date:
Medical Director's Name:	Medical Director's Signature:

Instructions: This questionnaire is provided to the Nursing Home Administrator at the entrance conference of the annual recertification/licensure survey. The Administrator is to assure that the Medical Director completes it by the end of the survey. The completed form can be returned to the survey team via the Nursing Home Administrator or faxed directly from the Medical Director to the Office of Facilities Regulation, attention Andrew Powers, at (401) 222-3999 by the survey exit date.

Individualized, resident-centered quality of care and quality of life are important goals of both federal and state nursing home regulations. As part of the Individualized Care Pilot (ICP) and the RI Department of Health's continuing efforts to promote and support individualized, resident-centered care, this questionnaire seeks to learn about some of this home's current practices that may promote such care. It is part of a series of interviews and observations that are being carried out at this facility during the annual recertification/licensure survey. Please note that information provided in this questionnaire cannot be used as the basis of a citation of non-compliance unless the non-compliance is at the level of Immediate Jeopardy.

Medical Director Responsibilities:

a) Do you personally provide care for residents at this facility?

(Please check answer) YES NO

b) Do you supervise other medical staff that provide care for residents at this facility?

(Please check answer) YES NO

Policies and Procedures:

a) What is your role as Medical Director in the development, implementation, and evaluation of resident care policies and procedures? (PLEASE PRINT)

b) How are the home's resident care policies and procedures supportive of resident choice?

ICP MEDICAL DIRECTOR QUESTIONNAIRE

Quality Improvement:

a) What is your role as a member of the home's Quality Improvement committee?

b) How does the home monitor quality of life for residents?

Current Practices:

Do you and/or your medical staff engage in any of the following practices that have been associated with successful integration of resident choice into nursing home quality of care and quality of life?

a) Adjust medication orders from routine frequencies (i.e. BID, TID, etc.) to directions such as "on arising, before lunch, before dinner, at bedtime" in order to enable each resident to sleep as long as he/she wants and to go to bed when he/she wants?

(Please check answer) YES NO

Please share your experience regarding the benefits or disadvantages associated with this practice.

b) Adjust diet orders to integrate resident choice of foods, e.g. preferences for a more liberalized vs. restrictive diet? (Please check answer) YES NO

Please share your experience regarding the benefits or disadvantages associated with this practice.

c) Talk about care and treatment with the nursing assistants assigned to care for each of your residents? (Please check answer) YES NO

Please share your experience regarding the benefits or disadvantages associated with this practice.
