HATCh
Holistic Approach to Transformational Change

Consistent Assignment

Definition: Consistent assignment (sometimes called primary or permanent assignment) refers to the same caregivers (RNs, LPNs, CNAs) consistently caring for the same residents almost (80% of their shifts) every time they are on duty. The opposite of consistent assignment is the practice of rotating staff from one group of residents to the next after a certain period of time (weekly, monthly, or quarterly). Facilities who have adopted consistent assignment never rotate their staff.

A few strong arguments for adopting consistent assignment include:

- Relationships are the cornerstone of culture change.

- Residents who are cared for by the same staff members come to see the people who care for them as "family."

- Staff that care for the same residents form a relationship and get great satisfaction from their work.

- When staff care for the same people daily they become familiar with their needs and desires in an entirely different way, and, their work is easier because they are not spending extra time getting to know what the resident wants. They know from their own experience with the resident.

- When staff and residents know each other well, their relationship makes it possible for care and services to be directed by the resident's routines, preferences and needs.

- Relationships form over time. We do not form relationships with people we don't often see. To encourage and support relationships, consistent assignment of both primary staff and ancillary staff is recommended.

- When staff routinely work together, they can problem-solve and find creative ways to reorganize daily living in their care area.

- Consistent assignment forms the building block for neighborhood-based living.

Typical issues: When employees are not given a consistent assignment, they are not as likely to build relationships with their co-workers or with residents that create a deep sense of satisfaction and "knowing." Rotating staff means that each time there is a rotation or change in assignment the staff person has to take the time to figure out what the needs are of each new resident they are caring for and how to work with their co-workers for the day. This constant changing is hard for both residents and staff. Most of the care being done is very intimate personal care and residents find it hard to have strangers caring for their in-

timate needs, and to have to explain their needs time after time to new caregivers. When staff is unfamiliar with each other it is harder for them to have good teamwork.

Barriers: Many times frequent changes in shift and assignment are the result of short staffing. When there is not enough staff, the organization responds by plugging holes in the schedule with an available CNA. In other situations, the policy of the nursing home is not to let people get attached to each other in the mistaken belief that if a close relationship develops and the resident dies the staff member will be inconsolable. Certain nursing homes don't think friends should work together. Still others prefer that everyone is trained on every unit and available everywhere. Others do not want staff to be "stuck" with "hard-to-care-for" residents. Ironically, inconsistent assignment exacerbates instability in staffing and conversely, consistent assignment fosters stability. Call outs and turnover are reduced when meaningful relationships develop in which workers know they are being counted on and respond by making sure that the care that is needed is given.

Regulatory Support: There is no regulatory requirement mandating the practice of consistent assignment. However, this practice can contribute to successfully meeting regulations found under the *Quality of Life* and *Quality of Care* requirements of the federal regulations in OBRA '87.

The interpretive guidelines for *F240 Quality of Life* states, "The intention of the quality of life requirements specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident." Additionally, regulatory language found under *F241 Dignity, F242 Self-Determination and Participation, and*

F246 Accommodation of Needs all include the nursing home's responsibility to create and maintain an environment that supports each resident's individuality.

The practice of consistent assignment provides staff and residents the opportunity to build strong relationships that result in staff knowing and supporting each resident as an individual. It helps create an environment that promotes staff to learn about and support a resident's likes, preferences and interests, which is directly supported by the intent of the quality of life requirements.

Strong caregiver-resident relationships can also lead to positive quality of care outcomes. Meeting the intent of the *Quality of Care* requirements found in OBRA '87 is heavily dependent on the direct caregiver implementing the resident's care plan *(F282 Services provided by qualified person in accordance with each resident's written plan of care)*. If staff has the opportunity to work with residents on a consistent basis, then staff will be more familiar with care plan goals and treatment objectives. This can result in consistent implementation of care plan approaches. It also provides opportunities for staff to promptly identify when care plans need revision due to a resident's refusal, preferences related to treatment, or a decline in the resident's condition *(F280 A comprehensive care plan must be – (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.)*.

The better that staff know each individual resident they work with, the more likely the intent of the Quality of Life and Quality of Care requirements will be met.

Goals:

- To strengthen and honor care-giving relationships

- To stabilize staffing and establish strong relationships between residents and staff and among co-workers to provide continuity, consistency, and familiarity in care giving.

Making the Change: There are many ways to undergo the change process. A good start is to think about who can help and to plan in a systematic way the necessary steps, ensuring that it is not a top-down edict but a shared commitment on the part of the community based on need creates a climate ripe for change. A helpful tool can be the Model for Improvement that uses the PDSA Cycle (Plan-Do-Study-Act). This is a way to systematically go through a change process in a thoughtful way.

With your committees and groups ask:

1. What are we trying to accomplish? (Example: Better relationships; less turnover of staff; greater satisfaction among families and residents?)
   Naming and articulating what it is that you are trying to accomplish will help you months from now (when you are in the thick of things!) to remember the original intention of the change.

2. How will we know a change is an improvement? This is the question that begs a measurement response.

3. What changes can we make that will result in an improvement? Go study your subject-find out what others have done, take a road trip, phone a friend, go to a Pioneer conference, talk with experts-ask others to do the same.

Sometimes after having this conversation, a committee will be energized and ready to try everything. After all, they are all great ideas that will benefit residents and staff in the long run. It's also a homegrown solution to a problem or challenge faced by the organization. Though tempting, it is important not to try all of these ideas at once. Try one idea, roll it out on a small sample or pilot, test it, measure it. If it's not working tweak it. This process is called a PDSA cycle. It looks like this.

Plan: Each PDSA cycle has an objective and a measure. In this phase, create it.

Do: Activate the plan and collect data using the method the team decided upon to measure your success. As much as possible do this on a small scale. Don't try the change on the whole home; try it on a few people or a wing, unit or neighborhood. Small is better. You can keep tweaking and adding to your sample as you see success.

Many teams go as far as Plan-Do. Some teams become very involved in the doing but sometimes find themselves in the midst of many failures without knowing what went wrong or why. The process invites the team to study their activity to ensure they are heading in the right direction. Even finding that one is heading in the wrong direction can offer valuable feedback to a committed team. The next step then, is the study phase.

Study: Test the hypothesis out. Stay open to the possibilities. There are many things you might find happen that you didn't expect. Be sure to note these unexpected gains.

Sometime, after having this conversation a committee will be energized and ready to try everything. After all, they are all great ideas that will benefit residents and staff in the long run.

It's also a homegrown solution to a problem or challenge faced by the organization. Though tempting, it is important not to try all of these ideas at once. Try one idea, roll it out on a small sample or pilot, test it, measure it. If it's not working tweak it. This process is called a PDSA cycle. It looks like this.

Act: Once you have completed the process identified above, you will have a more complete understanding of the challenge or problem. Now armed with very specific information and data you have three options:

- Adapt the change
- Adopt the change
- Abort the change

This entire process can be done in a very public way by using storyboards to journey the process. Remembering to celebrate the success of the process is an important feature of the story helping staff, families and resident alike to witness the ongoing efforts made to improve the home.

Measuring Success: Here is a simple way to calculate/measure consistent assignment efforts.

1. Collect one week per month of staff assignment sheets (filled out by the nurse on the unit at the beginning of each shift). Gather this information for each unit in the facility for both day shift and PM shift from the past 3 months.

2. Choose 4 full-time (5 shifts per week) CNAs to track, 2 from day shift and 2 from PM shift from one unit.

3. The goal is to measure how often these CNAs took care of the same residents. In order to determine which residents/rooms to track with each CNA, look at the first 3 days of assignment sheets and determine the group of residents/rooms each care giver has been assigned to. For example, if one of the CNAs was assigned to a group for two of the three days you were looking at, this would be the group that you would assume the caregiver is consistently assigned to. This will be the group of residents to track with the CNA.

4. Now, look at all 21 days worth of assignments and calculate how often each CNA was assigned to the same rooms that you established was their primary assignment.

5. Because there are seven days in a week but the CNAs only work five, caring for the same group of residents five out of seven days equals 100%. Four out of seven days equals 80%, etc.

6. Add up all four of the CNAs numbers over the three weeks you examined to get the total percentage of time the same CNAs care for the same residents.

Example: For one unit

CNAs	Week 1	Week 2	Week 3	Total
Mary	3/5	5/5	4/5	12/15
Jay	5/5	4/5	5/5	14/15
Sam	4/5	4/5	5/5	13/15
Maria	3/5	5/5	2/5	10/15
Total				**49/60**

82% of the time (49/60), the full-time CNAs care for the same residents on this unit.

Note: This assumes that the leadership team is not rotating the CNAs quarterly.

Questions to Consider:

- How does familiarity and routine help increase comfort and competence?
- How important are relationships to residents? To caregivers? To co-workers? To quality care?
- How does teamwork help improve care?
- Would you like different people toileting and bathing you each day?
- Would you like having a different team each day?
- What do residents experience when they have frequent changes in their caregivers?
- What do staff experience when their assignment is routinely changed? How does that affect their relationship to their work?

Change Ideas:

- Make a mutual commitment to consistent assignment. For staff that commit to a certain set schedule, commit back that they can count on that schedule.
- Find out from staff what their preferred schedule and assignments would be.
- Create teams that work regularly together.
- Ask teams to work with each other to provide back-ups and substitutes for when they need to change their schedule or call in on a scheduled shift.
- Find out who on staff enjoys floating or prefers various assignments rather than destabilizing the whole staff by making everyone float.
- Have inter-shift communications among all staff from each work area, in which personal information about how each resident did for the day is shared, so as to ensure a smooth hand-off.
- Figure out when the busiest times are in accordance with the residents' patterns, and adjust schedules to have the help that is needed during those times.
- Have regular housekeeping and food-service staff working with each care area.

When new staff are brought on, assign them to one work area so that they are familiar with a group of residents and co-workers and acclimate to the work with them.

Process to change from rotating assignment to consistent assignment:

1. Bring together CNAs from each shift. This might require having a number of separate meetings. Be sure everyone is included.

2. Begin the meeting by explaining that nursing homes that have switched to consistent assignment have proven to improve the quality of care and life of the residents and the quality of work life for the staff. Suggest that we pilot test consistent assignment and see how it works.

3. Place each resident's name on a post it note and place all of the post it notes on the wall.

4. Next, ask the group to rank each of the residents by degree of difficulty with number 1 being relatively easy to care, number 3 in the middle and number 5 being very difficult to care for (time consuming, emotionally draining, etc.). Let the CNAs discuss each resident and come to an agreement. Write the number on the resident's post it note.

5. Then, allow the CNAs to select their assignments. Assignments are fair when the numbers assigned to each resident add up to the other totals of the other CNA assignments. Therefore, if one assignment has six residents and another has eight residents but the degree of difficulty numbers total 27 then the assignments are fair. Relationships with residents are important and also should be part of the decision making process. The sequence of rooms is less important.

6. Meet every three months to reexamine that the assignments, based upon degree of difficulty, are still fair.

Resources:

1. Centers for Medicare & Medicaid Services (CMS). 5.0. What a difference management makes! Nursing staff turnover variation within a single labor market [Online]. From: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Phase II Final Report, Dec 2001. Available: http://www.cms.hhs.gov/medicaid/reports/rp1201-5.pdf, 15 Sep 2004.
2. Weech-Maldonado R, Meret-Hanke L, Neff MC, Mor V. Nurse staffing patterns and quality of care in nursing homes. Health Care Manage Rev. 2004 Apr-Jun; 29 (2): 107-16.
3. *"What a difference management makes!"* by Susan Eaton, Chapter 5, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes (Phase II Final Report, December 2001). U.S. Department of Health and Human Services Report to Congress.
4. "PEAK: Pioneering Change to Promote Excellent Alternatives in Kansas Nursing Homes" by Lyn Norris-Baker, Gayle Doll, Linda Gray, Joan Kahl, and other members of the PEAK Education Initiative. http://www.ksu.edu/peak/booklet.htm
5. Burgio L.D., et al. Quality Of Care in the Nursing Home: Effects of Staff Assignment and Work Shift. *The Gerontologist* 2004 44(3): 368-377.
6. Campbell S., Primary Nursing: It Works in Long-Term Care. *Gerontological Nursing* 1985, issue 8, 12-16.
7. Cox, C., Kaesner, L., Montgomery, A., Marion, L. Quality of Life Nursing Care: An Experimental Trial in Long-Term Care. *Journal of Gerontological Nursing* 1991, issue 17, 6-11.
8. Patchner, M. Permanent Assignment: A Better Recipe for the Staffing of Aides. *Successful Nurse Aide Management in Nursing Homes* 1989, 66-75.
9. Grant, L. Organizational Predictors of Family Satisfaction in Nursing Facilities. *Seniors Housing and Care Journal* 2004, volume 12, 3-13.

Created and distributed by:

Creating Home

Background: Nursing homes, over the years, have often adopted an institutional environment lacking warmth and personal charm. Having been modeled after hospitals many nursing homes find themselves mirroring the style of care, culture and environment found in hospital settings. Hospitals though, are designed as institutions in which sick or injured persons are given medical or surgical treatment. They are not designed as home. Nursing homes become home to 1.4 million people per year. Efforts currently underway are designed to create home—personal, cozy and individualized settings where people will be happy to live and enjoy their day-to-day lifestyle.

Barriers: Enormous opportunity presents itself when redesigning the environment within nursing homes. One barrier is the perception that to create individualized care one must build a new facility. The fact is that there are many steps and phases along the journey of individualized care that can precede the necessity for new building.

Another barrier is the perception that environment denotes the physical plant when in fact environment is much more comprehensive. Home is a "strong, intimate, fluid relationship with the environment" [i] that is characterized by a number of unique features as described by Judith Carboni. She describes home as an environment in which an individual experiences:

- Identity
- Connectedness
- Lived Space
- Privacy
- Power/Autonomy
- Safety Predictability
- Journeying

Regulatory Support: OBRA '87 fully supports this area of change by requiring nursing homes to create an environment that supports each resident's individuality. There are several regulatory requirements that provide support for homes to move away from the institutional model toward an individualized model.

The regulatory language for *F252 Environment* states, *"The facility must provide – A safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible."* The interpretive guideline for this regulation defines *"homelike environment"* as:

"one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A personalized, homelike environment recog-

nizes the individuality and autonomy of the resident, provides an opportunity for self-expression and encourages links with the past and family members."

This definition makes it clear that the environment created by a nursing home is more comprehensive than just the physical plant alone. This concept of *"environment"* is further supported in the quality of life requirements. The interpretive guidelines for **F240 Quality of Life** states, *"The intention of the quality of life requirements specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident."* Additionally, regulatory language found under **F241 Dignity, F242 Self-Determination and Participation, and F246 Accommodation of Needs** all include the nursing home's responsibility to create and maintain an environment that supports each resident's individuality and autonomy.

Some providers have voiced that there are conflicting requirements in OBRA '87 that prevent them from creating an individualized environment also required by OBRA '87. For example, many homes moving away from the institutional model would like to replace the traditional nurses' station (either physically and/or functionally) with a kitchen area, living room, activity area and/or dining area, but are hesitant to make such a change in fear of not being compliant with **F463 Resident Call System.** This requirement states, *"The nurses' station must be equipped to receive resident calls through a communication system from – (1)Resident rooms; and (2)Toilet and bathing facilities."* In December 2006, the Centers for Medicare & Medicaid Services (CMS) provided the following language clarification regarding this requirement:

"To meet the intent of the requirement at F463, it is acceptable to use a modern pager/telephone system which routes resident calls to caregivers in a specified order in an organized communication system that fulfills the intent and communication functions of a nurse's station."

This clarification clearly supports nursing homes to move away from the institutional model/function of nurses' stations and toward creating an environment where caregivers and not *"nurses' stations"* receive resident calls for assistance. It also provides nursing home providers with some assurances that the regulations and regulatory agencies are supportive of individualized, resident-centered care. To view the entire CMS clarification go to CMS's website at: http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-07.pdf

For other examples of homes that have experienced great success in creating change in their homes consistent with federal regulations, see the CMS broadcasts, "From Institutional to Individualized Care, Parts I, II, III, and IV" at http://cms.internetstreaming.com

Goal: To create home for individuals who live in nursing homes focusing on key attributes: choice, freedom, connection, personal comfort, privacy and safety, identity and predictability.

Infrastructure Helpful to Support the Change:
Open and honest conversations with family, staff and residents can help to shape thinking around creating home.

Educating staff, family and residents to the attributes of environment and helping them to discover for them where the organization fares as a home in the most literal sense.

Making the Change: There are many ways to undergo the change process. A good start is to think about who can help and to plan in a systematic way the necessary steps. Ensuring that its not a top-down edict but a shared commitment on the part of the community based on need creates a climate ripe for change.

A helpful tool in this process can be the Model for Improvement that uses the PDSA Cycle (Plan-Do-Study-Act). The Plan – Do – Study – Act Cycle is a way to systematically go through quality improvement in a thoughtful way.

With your committees and groups ask:

1. What are we trying to accomplish? (Example: Greater choice for residents, a less institutionalized setting, home!) Naming and articulating what it is that you are trying to accomplish will help you months from now (when you are in the thick of things!) to remember the original intention of the change.

2. How will we know a change is an improvement? This is the question that begs a measurement response. (Example: "We had low satisfaction in the area of environment and now look! As a result of this change, people are gathering in places that ordinarily, no one did; our bathroom looked like something from a fifties movie. Since we made the change, there are far less incidences of combative behavior; there are more people who come out of their room!")

3. What changes can we make that will result in an improvement? (Example: We can update the way in which people come into our organization; we can explore changes that are needed to make the place more homey; we can talk to staff about the practices that are still institutional and keep residents and families at arms length) Go study your subject-find out what others have done, take a road trip, phone a friend, go to a Pioneer conference, talk with experts-ask others to do the same.

Plan: Each PDSA cycle has an objective and a measure. In this phase, create it.

Do: Activate the plan and collect data using the method the team decided upon to measure your success. As much as possible do this on a small scale. Don't try the change on the whole home; try it on a few people or a wing, unit or neighborhood. Small is better. You can keep tweaking and adding to your sample as you see success.

Many teams go as far as Plan-Do. Some teams become very involved in the doing but sometimes find themselves in the midst of many failures without knowing what went wrong or why. The process invites the team to study their activity to ensure they are heading in the right direction. Even finding that one is heading in the wrong direction can offer valuable feedback to a committed team. The next step then, is the study phase.

Study: Test the hypothesis out. Stay open to the possibilities. There are many things you might find happen that you didn't expect. Be sure to note these unexpected gains.

Act: Once you have completed the process identified above you have a more complete understanding of the challenge or problem. Now armed with very specific information and data you have three options:

- Adapt the change
- Adopt the change
- Abort the change

This entire process can be done in a very public way by using storyboards to journey the process. Remembering to celebrate the success of the process is an important feature of the story, helping staff, families and resident alike to witness the ongoing efforts made to improve the home.

Questions to Consider: What would we need to stop doing within this organization to more effectively create home for everyone?

- Overhead paging
- Tray-lines
- Walking into people's room unannounced
- Cattle calls (examples: meds, baths, dining)

What do we need to do to create home for people?

- Paint/soften/brighten areas within the building that are particularly institutional
- Honor/enhance naturally occurring gathering areas (by the front door where many residents like to watch visitors and staff enter, by the dining room or elevators)
- Ensure that residents have personal items that reflect their identity
- Know people's preferences and dislikes
- Personal leisure time supplies and materials with a space to do them
- Support for spontaneity
- Ensure that residents have food and treats that are of their choosing
- Residents can determine the personal daily schedule they would like to follow
- Freedom/security

Innovative Change Ideas:

1. Focus on admissions policies and procedures that set an institutional tone. Is the process cold, institutional? Does the new person and their family feel like they are moving to a new home? Remember, no one is "admitted" to a home.

2. Ask people "what they would like to accomplish while they are living here."

3. What was home like; a typical day in the life?

4. Can there be refrigerators, pets, and visits any time of day or night?

Resources:

1. Carboni JT. "Homelessness Among The Institutionalized Elderly." *Journal of Gerontological Nursing* 1990 July; 16(7): 32-7.
2. Almost Home-PBS video
3. Norton, Lavrene-A Way Back Home (video)

QUALITY PARTNERS
OF RHODE ISLAND

The Dining Experience

Background: In moving from Institutional to Individualized Care many homes identify their dining program and structure to be in need of drastic change in order to better serve residents choice, enjoyment and sense of home and community. This key area of nursing home life can either provide a lovely and much anticipated experience that by nature supports a sense of community, and is at the heart of the rhythm of daily life *or* an environment straight out of a cowboy western with a chuck wagon "head 'em up and move 'em out" mentality.

Typical Issues: Nursing homes that felt the need to transform their food and dining programs did so after much study and deliberation. Surveys often revealed an array of complaints from dissatisfied residents, family and staff. Here are a just few. Dining is on a schedule regardless of hunger, want or need. The use of trays and institutional place settings and covers provide an aesthetically unappetizing presentation; "feeding" tables are used for the benefit of staff. Centralized dining often creates transportation problems to and from the dining area with an ensuing sense of chaos, dread, noise and disruptions. Centralized dining perpetuates

an institutional model of care with hallmarks that include control of portions, diets and seating outside of the resident's ability to choose. The dining room can be an unappetizing social and physical environment. Other food-related issues include limited access to food outside of the designated dining times and an unlikely chance that brands and varieties of snacks are those enjoyed at home. Centralized dining is associated with a wide array of complaints including taste, temperature, texture, dining partners, limited choice and logistics.

Barriers: Changing the dining experience can be among the more challenging changes that an organization can undertake. It presents a multi system dilemma. Dining affects almost every system within a nursing home. It is a pivotal point around which many daily events are timed, from activities to med passes. In order to change, it requires enormous buy-in, flexibility and good interdepartmental communication.

Regulatory Support: *OBRA '87* fully supports this area of change. The regulatory interpretive guidelines for *F240 Quality of Life,* found in *OBRA '87* states, *"The intention of the quality of life requirements specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident." F242 Self-Determination and participation,* includes language that gives the resident the right to *"choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care…."* It also provides the resident the right to, *"make choices about aspects of his or her life in the facility that are significant to the resident."* Providing a dining program that is structured around resident

choice, preferences, and an in environment that provides a sense of home/community is clearly supported by these regulatory requirements.

The provision of food in a nursing home is a multi-layered system that can impact all departments. Having a full understanding of all the regulatory requirements for dietary services is a key component to a successful transformation of a dining program that moves away from the traditional institutional model to an individualized model. Some regulatory requirements for dietary services that homes should be aware of to ensure a successful dining program transformation include food temperature requirements and the frequency of meals requirement.

Some nursing homes have voiced food temperature requirements as a barrier to implementing such dining alternatives as buffet style, restaurant style, family style, and open dining. Although it is true that food temperature requirements need to be considered when implementing any dining program, it is possible to readily meet current regulatory requirements and to institute an individualized approach to resident dining. A common misperception is that hot foods must be *maintained* at 140 degrees F after leaving the kitchen (such as in family style dining when there maybe bowls of food placed on a table for residents to share from.) The regulatory requirement, *F371- §483.35(i) Sanitary Conditions*, for food temperatures includes:

"Hot foods which are potentially hazardous should leave the kitchen (or steam table) above 140 degrees F and cold foods at or below 41 degrees F…"

The intent of this requirement is that potentially hazardous foods are served at the proper temperatures to minimize the risk for food borne illness. It does **not** require that temperatures be maintained at 140 degrees F after being served.

However, there is another regulatory requirement, *F364 - §483.35(d) Food,* for food temperatures that states:

"Each resident receives and the facility provides food that is palatable, attractive, and at proper temperature."

The intent of this requirement is that, *"…Food should be palatable, attractive and at the proper temperature as determined by the type of food to ensure resident satisfaction."* This requirement should not be confused with holding temperatures. Rather, after food leaves the kitchen or steam table (*above 140 degrees F)* it gets to the resident at a temperature that is preferable to the resident (hot foods are served hot and cold foods are served cold). Obtaining ongoing resident feedback regarding their dining experience is necessary to ensure that food is being provided at satisfactory temperatures.

Another common misperception is the interpretation of *F368 - §483.35(f) Frequency of Meals.* This regulation requires each resident to receive and the facility provide at least three meals daily. It also includes that there must be no more than 14 hours between a substantial evening meal and breakfast the following day. Some providers have interpreted this language to mean that all residents must actually eat promptly by the 14th hour, which makes it difficult to honor a specific resident's request to refuse a night snack and then sleep late. Based on this interpretation, nursing homes are often hesitant to implement an individualized, resident-centered approach to meal service for fear of being noncompliant with this regulation. However, this interpretation is not necessarily intended by the regulation.

In December 2006, the Centers for Medicare & Medicaid Services (CMS) provided the following language clarification regarding frequency of meals:

*The regulation language is in place to prevent facilities from offering less than 3 meals per day and to prevent facilities from serving supper so early in the afternoon that a significant period of time elapses until residents receive their next meal. The language was not intended to diminish the right of any resident to refuse any particular meal or snack, nor to diminish the right of a resident over their sleeping and waking time. These rights are described at **Tag F242, Self-determination and Participation**. It is correct in assuming that the regulation language at F368 means that the facility must be offering meals and snacks as specified, but that each resident maintains the right to refuse the food offered. If surveyors encounter a situation in which a resident or residents are refusing snacks routinely, they would ask the resident(s) the reason for their customary refusal and would continue to investigate this issue only if the resident(s) complains about the food items provided. If a resident is sleeping late and misses breakfast, surveyors would want to know if the facility has anything for the resident to eat when they awaken (such as continental breakfast items) if they desire any food before lunchtime begins.*

This clarification clearly promotes a resident's right to choose and to exercise his or her autonomy. It also provides nursing home providers with some assurances that the regulations and regulatory agencies are supportive of individualized, resident-centered care that provides options for resident choice of meal times in conjunction with full accessibility to nourishing snacks. To view the entire CMS clarification go to CMS's website at:
http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-07.pdf

For examples of homes that have experienced great success in creating change in the dining experience consistent with federal regulations, see the CMS broadcast, "From Institutional to Individualized Care, Part II and Part III"
http://cms.internetstreaming.com

Goal : To offer a wide array of opportunity for residents to participate in meal choice, time, dining partners, seating location in order to maximize their enjoyment of mealtimes while enhancing socialization and improving nutrition.

Infrastructure Helpful to Support the Change: Invite a committed team of individuals including staff, families and elders to begin conversations that identify the current process and begin to create a vision for the changes needed. Because of the complexity and interconnectedness of the dining systems it is imperative that there be existing evidence of good teamwork and interdepartmental communication. These are skills that can be grown using an array of useful resources. If your teams have not quite reached a level of maturity, try something a bit smaller in scale.

Making the Change: There are many ways to undergo the change process. A good start is to think about who can help and to plan in a systematic way the necessary steps. Ensuring that its not a top-down edict but a shared commitment on the part of the community based on need creates a climate ripe for change. A helpful tool can be the Model for Improvement which uses the PDSA Cycle (Plan-Do Study-Act). This is a way to systematically go through a change process in a thoughtful way.

With your committees and groups ask:

1. What are we trying to accomplish? (Example: Greater choice for residents, a

less institutionalized setting, resident choice of dining time spread out over two hours, less waste, less weight loss?)
Naming and articulating what it is that you are trying to accomplish will help you months from now (when you are in the thick of things!) to remember the original intention of the change.

2. How will we know a change is an improvement? This is the question that begs a measurement response.
   (Example: We had low satisfaction in the area of dining and now look! As a result of this change, we have more people than ever coming to dinner in the evening! Nine of our residents have gained a little weight! Our dining room looked like something from a fifties movie. Since we made the change more people come; seventeen people chose peanut butter and jelly for dinner regularly. Now, no one does!)

3. What changes can we make that will result in an improvement?
   (Example: Chefs cooking in the dining room; all staff on deck during meals-pouring coffee, talking with folks, creating an environment of enjoyment and caring; three, two hour meal opportunities so residents can eat when they choose, with whom they choose and at a time that matches their former lifestyle.)
   Go study your subject-find out what others have done, take a road trip, phone a friend, go to a Pioneer conference, talk with experts-ask others to do the same.

Plan: Each PDSA cycle has an objective and a measure. In this phase, create it.

Do: Activate the plan & collect data using the method the team decided upon to measure your success. As much as possible do this on a small scale. Don't try the change on the whole home; try it on a few people or a wing, unit or neighborhood. Small is better. You can keep tweaking and adding to your sample as you see success.

Many teams go as far as Plan-Do. Some teams become very involved in the doing but sometimes find themselves in the midst of many failures without knowing what went wrong or why. The process invites the team to study their activity to ensure they are heading in the right direction. Even finding that one is heading in the wrong direction can offer valuable feedback to a committed team. The next step then, is the study phase.

Study: Test the hypothesis out. Stay open to the possibilities. There are many things you might find happen that you didn't expect. Be sure to note these unexpected gains.

Act: Once you have completed the process identified above you have a more complete understanding of the challenge or problem. Now armed with very specific information and data you have three options:

- Adapt the change
- Adopt the change
- Abort the change

This entire process can be done in a very public way by using storyboards to journey the process. Remembering to celebrate the success of the process is an important feature of the story helping staff, families and resident alike to witness the ongoing efforts made to improve the home.

Innovative Change Ideas: Homes that have undergone change in the dining experience:

- Use menus with an array of choices which are served by an army of smartly dressed service staff who are well-schooled in hospitality
- Have moved away from food trucks, and trays and instead, serve or cook in the dining area using grills and steam tables.
- Involve residents in menu planning by developing a council or advisory group (in some cases residents offered recipes of their own)
- Develop snack pantries or snack nooks where healthy options are available 24/7

Resources:

1. B Evans, N Crogan, J Armstrong Shultz. Quality dining in the nursing home: the residents' perspective. J Nutr Elder 2003 Jun; 22(3): 1-16.

Created and distributed by:

QUALITY PARTNERS
OF RHODE ISLAND

Individual Choice

Background: Individualized Care in the context of long-term care settings describes a philosophy of care that puts the needs, interests, and lifestyle choices of individuals at the center of care. It provides for individuals to exercise control and autonomy over their own lives to the fullest extent possible.

Attention to this concept became a matter of federal policy with the passage of the Nursing Home Reform Law of **OBRA '87**. OBRA required nursing homes to care for each resident's in a manner that allows for them to *"attain or maintain the highest practicable physical, mental, and psychosocial well-being"* using an interdisciplinary resident assessment and care planning process. Over the next several years, the federal government developed regulations, surveyor guidelines, and resident assessment protocols for quality of life and psychosocial well-being. While the implementation of these regulations and guidelines has become fairly regimented, at their outset, they generated a rethinking of nursing home care that was meant to focus on the needs, desires and lifestyle choices of each individual. Moving now in the direction that deinstitutionalizes nursing homes and ushers in an elder-directed care model is the next step in the journey.

Typical issues: Institutionalized care offered an orderly process wherein the systems of care were uniform, efficient, and met the needs of staff whose task it was to complete these tasks. From bathing to feeding to dressing to waking - all were set on a time table that allowed for the timely and orderly delivery of the most intimate of services with little regard for the residents input, preferences or lifestyle patterns.

As a result, the complete absence of control, choice and personal preferences given to residents is demonstrated by:
- the dire sounds of distress coming from bathing areas
- staff injuries caused from conflicts in administering care to residents who were not willing or ready to receive it
- resistance to pre-dawn suppositories
- activities that were driven by a calendar on the wall rather than personal former interests
- the lack of personal items, bathing products, snacks & treats as well as privacy
- the revolving of residents around institutional bathing, dining, medication, waking and sleeping schedules

Without a sense of efficacy, residents often lost all sense of control over their environment. Little by little without a say in their personal own care, their personal freedoms, their very lives, residents often slipped into a personal abyss known

as psychic despair that sheltered them from the sterile and often harsh world of institutional care.

Barriers: A few of the barriers that organizations have found in moving to a style of care that favors resident choice are:

1. Attitudes
   - Concerns on the part of staff that chaos will result
   - Comfort in working within the confines of tasks and routines
   - Need to control

2. Perpetuation of educational systems that continue to embrace the institutional model and are often taught by those who learned the institutional model and practices

3. Fear of regulatory deficiencies

Regulatory Support: The regulatory interpretive guidelines for *F240 Quality of Life,* found in *OBRA '87* states, *"The intention of the quality of life requirements specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident." F242 Self-Determination and Participation* includes language that gives the resident the right to *"choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care…."* It also provides the resident the right to, *"make choices about aspects of his or her life in the facility that are significant to the resident." F246 Accommodation of Needs* also has language in the interpretive guidelines that states, *"The facility should attempt to adapt such things as schedules, call systems, and room arrangements to accommodate residents' preferences, desires, and unique needs."*

Additionally, the resident assessment process and requirements outlined in *F272 Resident Assessment* also provide support for structuring care giving around the preferences and routines of each individual resident. This regulation requires nursing homes to use the Minimum Data Set (MDS) assessment to gather information necessary to develop a resident's care plan. Section AC. Customary Routines of the MDS includes areas regarding a resident's customary cycle of daily events, eating patterns, ADL patterns, and community involvement patterns. The Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 2.0 Manual includes the following language to explain the intent of gathering this information from residents upon their admission to a nursing home:

"…The resident's responses to these items also provide the interviewer with "clues" to understanding other areas of the resident's function. These clues can be further explored in other sections of the MDS that focus on particular functional domains. Taken in their entirety, the data gathered will be extremely useful in designing an individualized plan of care."

OBRA '87 requires nursing homes to care for each resident in a manner that supports residents to, *"attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."* Learning about and supporting residents' choices is a care practice that promotes positive outcomes for residents and moves nursing homes closer to meeting the original intent of OBRA '87.

If a resident's choice appears to potentially conflict with his/her health or safety, it is important for nursing home providers to understand the regulatory guidelines for these situations. The interpretive guidelines for *F280 Participate in planning care and treatment,* includes the following language, *"Whenever there appears to be*

a conflict between a resident's right and the resident's health or safety, determine if the facility attempted to accommodate both the exercise of the resident's rights and the resident's health, including exploration of care alternatives through a thorough care planning process in which the resident may participate."

Providers should also reference **F155 Right to refuse treatment**. The interpretive guidelines for this requirement includes the following language to assist nursing home's support a resident's right to refuse treatment, *"The facility is expected to assess the reasons for this resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatments, and continue to provide all other services."* **F155** also includes guidance for situations when a resident's choice results in a negative outcome. *"If a resident's refusal of treatment brings about a significant change, the facility should reassess the resident and institute care planning changes. A resident's refusal of treatment does not absolve a facility from providing a resident with care that allows him/her to attain or maintain his/her highest practicable physical, mental and psychosocial well-being in the context of making that refusal."*

For more information on implementing individualized care and supporting resident choice, see the CMS broadcasts, "From Institutional to Individualized Care, Parts I, II, III, and IV" at http://cms.internetstreaming.com.

Goal: The goal is to put the needs, interests, and lifestyle choices of individuals at the center of care and to create caregivers who recognize and support resident efficacy-a sense that what I want matters; what I do makes a difference.

Infrastructure Helpful to Support the Change: The most effective method employed by organizations is to create personalized training around many of the systems of care.

1. Ask:
   - How would this be for you?
   - How would you want it to happen for you?
   - How can we make it home for the people who live here?

2. As much as possible, have staff literally, put in this position. Wear briefs, lay in beds, jump in the tub. Begin the slow process and journey of making it personal. Take pictures; create storyboards.

3. Create opportunities for people to enter into deep and meaningful relationships. Work on this. Create exercises and events for this to take place.

4. Invite people into dialogue around areas and issues. Include families and residents.

5. Create teams that are given the tools and resources to create change.

Making the Change: Begin with "Daily Pleasures." Encourage staff to learn those things that have brought pleasure to a resident in their lifetime. Such things as reading the newspaper with a cup of coffee in PJs; using a particular beauty treatment; having a glass of wine before bed; watching a bird feeder; talking to a family member at a particular time each day. Can your organization ensure one or more daily pleasure for each resident?

There are many ways to undergo the change process. A good start is to think about who can help and to plan in a systematic way the necessary steps. Ensuring that it is not a top-down edict but a shared commitment on the part of the

community, based on need creates a climate ripe for change.

A helpful tool in this process can be the Model for Improvement that uses the PDSA Cycle (Plan-Do-Study-Act). The Plan – Do – Study – Act Cycle is a way to systematically go through quality improvement in a thoughtful way. With your committees and groups ask:

1. What are we trying to accomplish?
   (Example: Greater choice for residents, a less institutionalized setting, resident choice over all their daily needs and desires)
   Naming and articulating what it is that you are trying to accomplish will help you months from now (when you are in the thick of things!) to remember the original intention of the change.

2. How will we know a change is an improvement? This is the question that begs a measurement response.
   (Example: We had low satisfaction in the area of resident choice and now look!; as a result of this change we have more people able to ask for things and have their needs met!; nine of our residents have gained a little weight!; Our residents feel more involved and that they are heard; Since we made the change more people express their needs.

3. What changes can we make that will result in an improvement?
   (Example: Residents are on committees and serve in a consultant capacity; residents help to make the menu; we no longer chose the movies, parties or talent for events-residents do; they write the calendar of events; they have refrigerators in their rooms.) Go study your subject-find out what others have done, take a road trip, phone a friend, go to a Pioneer confe-

rence, talk with experts-ask others to do the same.

Sometimes after having this conversation, a committee will be energized and ready to try everything. After all, they are all great ideas that will benefit residents and staff in the long run. It's also a homegrown solution to a problem or challenge faced by the organization. Though tempting, it is important not to try all of these ideas at once. Try one idea, roll it out on a small sample or pilot, test it, measure it. If it's not working tweak it. This process is called a PDSA cycle. It looks like this.

Plan: Each PDSA cycle has an objective and a measure. In this phase, create it.

Do: Activate the plan and collect data using the method the team decided upon to measure your success. As much as possible do this on a small scale. Don't try the change on the whole home; try it on a few people or a wing, unit or neighborhood. Small is better. You can keep tweaking and adding to your sample as you see success.

Many teams go as far as Plan-Do. Some teams become very involved in the doing but sometimes find themselves in the midst of many failures without knowing what went wrong or why. The process invites the team to study their activity to ensure they are heading in the right direction. Even finding that one is heading in the wrong direction can offer valuable feedback to a committed team. The next step then, is the study phase.

Study: Test the hypothesis out. Stay open to the

Act: Once you have completed the process identified above you have a more complete understanding of the challenge or problem. Now

armed with very specific information and data you have three options:

- Adapt the change
- Adopt the change
- Abort the change

This entire process can be done in a very public way by using storyboards to journey the process. Remembering to celebrate the success of the process is an important feature of the story helping staff, families and resident alike to witness the ongoing efforts made to improve the home.

Questions to Consider:
- In what areas do residents voice count? Where can they choose the ways in which they want their best life to be lived?
- Can they actually go to their own doctor (with support and communication that makes it possible)?
- Are residents really involved in their resident care conference?
- Do they choose waking sleeping times, daily routine, food preferences, spontaneous events and spur of the moment cravings or interests?
- In what areas do we (staff and administration) still control the decision? Why?
- How do we make sure we know resident's choices and needs? How do we effectively communicate these choices among all staff so that everyone who works with him/her supports the resident?
- How can we keep ensuring that we are giving residents the opportunity to live the life of their choice?
- Are we empowering, teaching and setting an example to staff members to ensure that they are allowing residents to choose their best life.

Innovative Change Ideas:

- Teach people about choice.
- Create a climate of openness that encourages people to creatively find ways to deliver on resident's choice.
- Work with staff to discover barriers that prevent resident choice from happening.
- Create an "I think we can" culture rather than a "No" culture with the first response from all staff being "I think we can."
- Create new systems of admissions to begin the "getting to know you" process.
- Get everyone on board. Slowly begin to get staff to share more about themselves.
- Involve direct care team members, residents and resident's family members in resident care planning on a regular basis.
- Create communication systems that always include discussion of resident choices and preferences, such as inter-shift information reports and meetings on units/neighborhoods.
- Daily Pleasures Worksheet

Resources:

1. Norton, Lavrene, A Tale of Transformation: 4 Stages to tell the story
2. PEAK-Ed: Culture Change Education Modules http://www.k-state.edu/peak/
3. Four Part Series: From Institutional to Individualized Care
4. Register and view at the CMS Survey and Certification Online Course Delivery System website:
   http://cms.internetstreaming.com

QUALITY PARTNERS™
OF RHODE ISLAND

Quality Partners of Rhode Island designed this material under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. Contents do not necessarily represent CMS policy.

Updated: August 31, 2007

Contributors include:
Quality Partners of RI
RI Department of Health
B&F Consulting

A Pleasant Bathing Experience

Background:

Quote: *"I take a bath all the time. I'll put on some music and burn some incense and just sit in the tub and think, wow! Life is great right now."* -Brian Austin Green

How many individuals destined to spend the rest of their life in long-term care would say this about their bathing experience? What makes a great bathing experience for a resident living in a nursing home and what does not? How can we be sensitive to people's pain, fear and privacy? The institutional model saw bathing as a functional task of cleansing to be completed efficiently and in a timely fashion. It often ignored life style preferences, privacy issues, pain and dementia. The call today by strong advocates like Joanne Rader, RN, FAAN, has revolutionized the way long-term care workers think about bathing and have opened up a wide array of

options to personalize the experience and make it a pleasant restorative experience.

Typical Issues: Many homes that changed their bathing experience for residents did so after a great deal of soul-searching recognizing that it was fraught with unhappiness for both residents and staff alike. Anxiety rules in many bathing areas creating injuries and a host of related events that damage relationships. Many residents complain of being wheeled down open, drafty hallways, partially exposed with nothing more than a bath towel or cape to protect their privacy. Baths often occur on a schedule that suit the needs and routines of the organization but neglect the individual's preference. Bathing areas are notoriously institutional in design and lack warmth or hominess and have little regard for privacy.

Barriers: The barriers to overhauling the bathing experience are few and the rewards are great. It can include modest to drastic changes to the environment that can affect budgets. In many homes small, economical changes that provided a sense of hominess to the setting made a huge difference for the lives of residents.

Reestablishing bathing patterns and times that accommodate resident's schedules and preference requires a committed group of folks sitting down together to address and redesign the plan. Many homes accomplish this with greater ease than expected.

Finding out when and in what fashion a resident would like to be bathed, what products they prefer, if they had previously bathed at night or in

the morning, whether bathing was utilitarian or a wine, candle and book affair are all important.

Regulatory Support: To offer every resident the opportunity to bathe in the style of their choosing and to create a positive individualized bathing experience is fully supported by *OBRA '87*. The regulatory interpretive guidelines for *F240 Quality of Life,* found in *OBRA '87* state, *"The intention of the quality of life requirements specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident." F242 Self-Determination and Participation* includes language that gives the resident the right to *"choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care…."* It also provides the resident the right to, *"make choices about aspects of his or her life in the facility that are significant to the resident." F246 Accommodation of Needs* also has language in the interpretive guidelines that states, *"The facility should attempt to adapt such things as schedules, call systems, and room arrangements to accommodate residents' preferences, desires, and unique needs."* Implementing bathing patterns and times that accommodate a resident's schedule and preference are clearly supported by these regulatory requirements.

Creating an individualized bathing experience is also supported in the language found in *F252 Environment – A safe, clean comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.* The interpretive guidelines in this section includes the following language to support this area of change:

For the purposes of this requirement, "environment" refers to any environment in the

facility that is frequented by residents, including the residents' rooms, bathrooms, hallways, activity areas, and therapy areas.

A determination of "comfortable and homelike" should include, whenever possible, the resident's or representative of the resident's opinion of the living environment.

A "homelike environment" is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment.

Additionally, the resident assessment process and requirements outlined in *F272 Resident Assessment* also provide support for structuring care giving around the preferences and routines of each individual resident. This regulation requires nursing homes to use the Minimum Data Set (MDS) assessment to gather information necessary to develop a resident's care plan. Section AC. Customary Routines of the MDS includes two areas regarding a resident's bathing patterns that should be assessed and considered when developing a care plan/bathing schedule for a resident:

1. Showers for bathing
2. Bathing in the PM

The Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 2.0 Manual includes the following language to explain the intent of gathering this information from residents upon their admission to a nursing home:

"…The resident's responses to these items also provide the interviewer with "clues" to understanding other areas of the resident's function. These clues can be further explored in other sections of the MDS that focus on particular functional domains. Taken in their entirety, the data ga-

For more information in creating an individualized bathing experience, see the CMS broadcast, "From Institutional to Individualized Care, Part I" at http://cms.internetstreaming.com.

Goal: To offer every resident the opportunity to bathe in the style of their choosing and to create a positive individualized bathing experience.

Infrastructure Helpful to Support the Change: As a first step in the bathing process and great starting point, watch the video Bathing Without A Battle by Joanne Rader, RN, FAAN, et al. This video was sent to every nursing home in the country by CMS. Go check your video library or get one at http://www.bathingwithoutabattle.unc.edu/. This will provide a wonderful grounding for staff and will leave no one unconvinced of the necessity for change.

A very useful practice that can make this process work easily is consistent assignment. By virtue of the same staff member always assisting the same resident, there grows a shared confidence in the relationship, a relative sense of modesty and a great strength in knowing what can be expected from each other.

Homes that organize around neighborhoods also benefit from the down-sizing of complicated traffic patterns that often keep bathing among the more institutional practices. In neighborhoods, there is greater ease in redesigning the systems that govern bathing and much greater opportunity for spontaneity.

On a smaller scale, a team empowered to study the bathing process and practices can really help to identify the needs of the resi-

current bathing practices, with participation from residents and families.

Also needed are adequate supplies for bed baths as well as the supplies and accessories making bathing rooms more private, warm and comfortable.

Making the Change: Homes that have undertaken the task of changing the bathing process asked these questions.

- Would you take a bath here? Some have even taken the plunge for themselves in swim gear to get a first hand experience!
- How close is our bathing process to the process that you yourself use in your home?
- Is it functional or personal?
- What would be the benefits of changing the process?
- What would you change?

There are many ways to undergo the change process. A good start is to think about who can help and to plan in a systematic way the necessary steps, ensuring that it is not a top-down edict but a shared commitment on the part of the community, based on need creates a climate ripe for change.

A helpful tool in this process can be the Model for Improvement that uses the PDSA Cycle (Plan-Do Study-Act). The Plan – Do – Study – Act Cycle is a way to systematically go through quality improvement in a thoughtful way.

With your committees and groups ask:

1. What are we trying to accomplish? (Example: a less stressful and potentially traumatic bathing process for all; a bathroom beautification/ deinstitutionalization initiative)
   Naming and articulating what it is that you are trying to accomplish will help you months from now (when you are in the thick of things!) to remember the original intention of the change.

2. How will we know a change is an improvement? This is the question that begs a measurement response.
   (Example: There is a decrease in agitation; there is a decrease in number of agitated residents and/or the number of incident reports related to bathing decreased. Our residents feel safer, happier about bathing; 85% say they enjoy the bathroom because it is far more pretty and relaxing.)

3. What changes can we make that will result in an improvement?
   (Example: Implement the strategies outlined in Bathing Without A Battle.)
   Go study your subject. Find out

what others have done, take a road trip, phone a friend, go to a Pioneer conference, talk with experts-ask others to do the same.

Sometimes after having this conversation, a committee will be energized and ready to try everything. After all, they are all great ideas that will benefit residents and staff in the long run. It's also a homegrown solution to a problem or challenge faced by the organization. Though tempting, it is important not to try all of these ideas at once. Try one idea, roll it out on a small sample or pilot, test it, measure it. If it's not working tweak it. This process is called a PDSA cycle. It looks like this.

Plan: Each PDSA cycle has an objective and a measure. In this phase, create it.

Do: Activate the plan and collect data using the method the team decided upon to measure your success. As much as possible, do this on a small scale. Don't try the change on the whole home; try it on a few people or a wing, unit or neighborhood. Small is better. You can keep tweaking and adding to your sample as you see success.

Many teams go as far as Plan-Do. Some teams become very involved in the doing but sometimes find themselves in the midst of many failures without knowing what went wrong or why. The process invites the team to study their activity to ensure they are heading in the right direction. Even finding that one is heading in the wrong direction can offer valuable feedback to a committed team. The next step then, is the study phase.

Study: Test the hypothesis out. Stay open to the

Act: Once you have completed the process identified above you have a more complete under-

standing of the challenge or problem. Now armed with very specific information and data you have three options:

- Adapt the change
- Adopt the change
- Abort the change

This entire process can be done in a very public way by using storyboards to journey the process. Remembering to celebrate the success of the process is an important feature of the story helping staff, families and resident alike to witness the ongoing efforts made to improve the home.

Innovative Change Ideas:
Some ideas from others who have made the change include:

- Ascertain the residents' former preferred behaviors, needs and schedule related to bathing.
- Ask the residents a series of questions about routines before moving to the nursing home or talking to family/friends of the resident.
- Does the resident need assistance with bathing? If not, resident can bathe on his/her own.
- Establish preference for bath or shower, time of day, leisurely activity (examples: book, glass of wine, 45 minutes minimum) vs. functional routine.
- Residents should be bathed in accordance to their response. A resident may enjoy bathing while enjoying a book and a glass of wine. The bathing experience should be duplicated as closely as possible.
- Create an environment that contains distractions that are pleasant. Ask the residents what they would like to see in the bathroom. Resident responses may include plants, music and other pleasantries.

- Take strides to create a more home-like environment by asking the residents what their bathrooms were like at their own homes before moving into the nursing home.
- Consider personal items that can be used in the tub with residents to make the process more pleasant. Examples include bubble bath, bath salts and bath pillow.
- Consider warming lights to avoid residents being chilly when getting out of the tub or shower.
- Consider what items could make the experience more comfortable, for example warm/soft/fluffy towel and caring conversation from a trusted caregiver.
- Provide as private an experience as possible by eliminating supplies and equipment storage in the shower area that will be needed by other staff.
- Provide a buffer curtain that will protect privacy.
- Utilize shower capes.

Resources:
1. Barrick, AL, Rader J, Hoeffer B, Sloane PD. Bathing Without a Battle: Personal Care of Individuals with Dementia. New York, New York: Springer Publishing Company. 2001.

The Sleeping & Waking Experience

Background: A facility's care routines can sometimes unwittingly deprive residents of deep restful sleep. These care routines are at the heart of the nursing home's culture. All work and assignments are organized around these routines. To change them will have an impact on the facility as a whole. The care routines continue because staff is not aware of the iatrogenic affects of sleep deprivation.

Typical Issues: Residents are awakened and put to bed according to the facility's schedule. To ease the burden on the in-coming day staff, the night shift awakens some residents and gets them ready for the day. Sleeping residents are awakened during the night to take temperatures, give medications, monitor for incontinence, insert suppositories, or even to hydrate them. Some homes have gone so far as to have the night staff provide care such as clipping toenails. Sleep, for many residents, is compromised by bed alarms. Facility floors are cleaned and shined with noisy machinery during the night when hallways are clear.

Residents who are sleep deprived experience a range of typical effects of sleep deprivation including: lethargy, loss of appetite, depression,

anxiety, agitation combative behavior, and other declines. Medications given in response to these effects, or to help residents sleep, often times exacerbate the situation.

Barriers: There are many "organizational efficiencies" that prevent organizations from providing residents with a good, full, restful night's sleep. Providing a climate where residents can sleep through the night and awakening based on their biological clock would require a great deal of rethinking about common ingrained institutional behavior. The changes have been successfully managed by many organizations that began the dialogue with the question, "What would it take to sleep through the night here?" People realized that the nightly skin checks, floor buffing schedules, and suppository schedules, to name just a few organizational efficiencies, would need to be redesigned.

Regulatory Support: *OBRA '87* fully supports this area of change. The regulatory interpretive guidelines for *F240 Quality of Life,* found in *OBRA '87* states, *"The intention of the quality of life requirements specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident."* *F242 Self-Determination and Participation* includes language that gives the resident the right to *"choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care…."* It also provides the resident the right to, *"make choices about aspects of his or her life in the facility that are significant to the resident."* *F246 Accommodation of Needs* also has language in the interpretive guidelines that states, *"The facility should*

attempt to adapt such things as schedules, call systems, and room arrangements to accommodate residents' preferences, desires and unique needs." Implementing care schedules around the natural rhythms of a resident's waking and sleeping routines are clearly supported by these regulatory requirements.

Additionally, the resident assessment process and requirements outlined in *F272 Resident Assessment* also provide support for structuring care giving around the preferences and routines of each individual resident. This regulation requires nursing homes to use the Minimum Data Set (MDS) assessment to gather information necessary to develop a resident's care plan. Section AC. Customary Routines of the MDS includes three areas regarding a resident's sleeping routine that should be assessed and considered when developing a care plan:

Section AC. Customary Routine
1. Stays up late at night (e.g., after 9 pm)
2. Naps regularly during the day (at least 1 hour)
3. Wakens to toilet all or most nights

Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 2.0 Manual includes the following language to explain the intent of gathering this information from residents upon their admission to a nursing home:

"…The resident's responses to these items also provide the interviewer with "clues" to understanding other areas of the resident's function. These clues can be further explored in other sections of the MDS that focus on particular functional domains. Taken in their entirety, the data gathered will be extremely useful in designing an individualized plan of care."

Implementing care schedules that support the natural rhythms of each resident's waking and sleeping preferences often impact other facility practices/routines. Many residents are awakened or put to bed due to a facility's internal routines for medication administration and mealtimes. There are no regulatory requirements for nursing homes to have routine medication times (i.e. TID medications routinely administered at 6:00 am, 12:00 pm, and 6:00 pm). Adjusting medication orders from routine frequencies such as BID and TID to, "upon arising, before lunch, before dinner, and at bedtime" can enable staff to support residents' preferences for waking and sleeping times. For more information in creating individualized caregiving schedules in relation to medication times, view the CMS broadcast, "From Institutional to Individualized Care, Part III" at http://cms.internetstreaming.com/.

Some nursing homes have voiced concerns that the requirement for frequency of meals served to residents is a barrier to implementing care schedules based on a resident's customary waking and sleeping routines. *F368 - §483.35(f) Frequency of Meals* requires each resident to receive and the facility to provide at least three meals daily. It also includes that there must be no more than 14 hours between a substantial evening meal and breakfast the following day. Some providers have interpreted this language to mean that all residents must actually eat promptly by the 14th hour, which makes it difficult to honor a specific resident's request to refuse a night snack and then sleep late. Based on this interpretation, nursing homes are often hesitant to implement an individualized, resident-centered approach to waking and sleeping for fear of being noncompliant with this regulation. However, this interpretation is not necessarily intended by the regulation.

In December 2006, CMS provided the following language clarification regarding frequency of meals:

The regulation language is in place to prevent facilities from offering less than 3 meals per day and to prevent facilities from serving supper so early in the afternoon

*that a significant period of time elapses until residents receive their next meal. The language was not intended to diminish the right of any resident to refuse any particular meal or snack, nor to diminish the right of a resident over their sleeping and waking time. These rights are described at **Tag F242, Self-determination and Participation**. It is correct in assuming that the regulation language at F368 means that the facility must be offering meals and snacks as specified, but that each resident maintains the right to refuse the food offered. If surveyors encounter a situation in which a resident or residents are refusing snacks routinely, they would ask the resident(s) the reason for their customary refusal and would continue to investigate this issue only if the resident(s) complains about the food*

items provided. If a resident is sleeping late and misses breakfast, surveyors would want to know if the facility has anything for the resident to eat when they awaken (such as continental breakfast items) if they desire any food before lunchtime begins.

This clarification clearly promotes a resident's right to choose and to exercise his or her autonomy. It also provides nursing home providers with some assurances that the regulations and regulatory agencies are supportive of individualized care that provides options for resident choice of waking and sleeping routines and meal times. To view the entire CMS clarification go to CMS's website at:
http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-07.pdf

For more information in creating individualized care-giving schedules, see the CMS broadcast, "From Institutional to Individualized Care, Parts I and III" at
http://cms.internetstreaming.com.

Goal: To support residents' health and well being by helping them have deep sleep through the night, by shifting from institutionally driven routines to routines that follow people's natural rhythms of sleeping and waking. Another goal is to support better relationships between residents and their caregivers by allowing caregivers to respect people's individual routines and set their care giving schedules around what works for each resident.

Infrastructure Helpful to Support the Change: Establish a work group with staff from all departments to identify and implement the changes needed in order for residents to return to their natural patterns for sleeping and waking. Adjust clinical care, staffing schedules, and routines for food service, housekeeping and maintenance to accommodate individual residents' needs and preferences related to sleeping

and waking routines. Establish a system for learning about people's patterns as part of the welcoming in to the nursing home for new residents.

Making the Change: There are many ways to undergo the change process. A good start is to think about who can help and to plan in a systematic way the necessary steps. Ensuring that its not a top-down edict but a shared commitment on the part of the community based on need creates a climate ripe for change.
With your committees and groups ask:

- Number of residents who sleep through the night
- Number of residents who wake of their own accord
- Pre and post data on agitated behavior; anxiety meds; bowel and bladder continence; UTIs; skin care; weight change; mobility; social engagement; staff-resident relationships; staff workload.

PDSA Cycles: The Plan – Do – Study – Act Cycle is a way to systematically go through quality improvement in a thoughtful way.

With your committees and groups ask:

1. What are we trying to accomplish? (Example: Greater choice for residents, better sleep hygiene, a less institutionalized setting, resident choice over their desire to stay in bed, go to bed late)
Naming and articulating what it is that you are trying to accomplish will help you months from now (when you are in the thick of things!) to remember the original intention of the change.

2. How will we know a change is an improvement? This is the question that begs a measurement response.
(Example: We had low satisfaction in the area of resident choice and now look! As a result of this change we have more people able to ask for things and have their needs met! Our resident feel more rested, there are fewer combative incidences and less frequent falls.)

3. What changes can we make that will result in an improvement? (*Eliminating a harsh bed-check process in the night with lights on etc; Implementing a "gentle awakening process"; changing the way we think about breakfast to allow people to sleep. Go study your subject-find out what others have done, take a road trip, phone a friend, go to a Pioneer conference, talk with experts-ask others to do the same.*)

Sometime, after having this conversation a committee will be energized and ready to try everything. After all, they are all great ideas that will benefit residents and staff in the long run. It's also a homegrown solution to a problem or challenge faced by the organization. Though tempting, it is important not to try all of these ideas at once. Try one idea, roll it out on a small sample or pilot, test it, measure it. If it's not working tweak it. This process is called a PDSA cycle. It looks like this.

Plan: Each PDSA cycle has an objective and a measure. In this phase, create it.

Do: Activate the plan and collect data using the method the team decided upon to measure your success. As much as possible do this on a small scale. Don't try the change on the whole home; try it on a few people or a wing, unit or neighborhood. Small is better. You can keep tweaking and adding to your sample as you see success.

Many teams go as far as Plan-Do. Some teams become very involved in the doing but sometimes find themselves in the midst of many failures without knowing what went wrong or why. The process invites the team to study their activity to ensure they are heading in the right direction. Even finding that one is heading in the wrong direction can offer valuable feedback to a committed team. The next step then, is the study phase.

Study: Test the hypothesis out. Stay open to the possibilities. There are many things you might find happen that you didn't expect. Be sure to note these unexpected gains.

Act: Once you have completed the process identified above you have a more complete understanding of the challenge or problem. Now armed with very specific information and data you have three options:

- Adapt the change
- Adopt the change
- Abort the change

This entire process can be done in a very public way by using storyboards to journey the process. Remembering to celebrate the success of

the process is an important feature of the story, helping staff, families and resident alike to witness the ongoing efforts made to improve the home.

Plan: Engage a committed group of people to consider, discuss and explore better sleep hygiene for residents based on residents obvious sleep deprivation and associated problems.

Do: Track the sleep of five resident volunteers who have minimal medical, hydration or treatment needs. These volunteers will be given the opportunity to awaken by their own natural body clock for two weeks.

Study: What time they awaken over the two weeks, mood, and appetite using simple tools. Determine if residents have a greater sense of rest and peace.

Act: Consider a small group of people who have incontinence to initiate the next cycle. Explore how to maintain skin integrity while allowing for better sleep.

Innovative Change Ideas:
Homes that have undergone change in the domain of waking and sleeping considered these questions in their change process:

- Would you be comfortable sleeping here? With this bed and pillow?
- How can sleep be made comfortable?
- Where could you start your change process?
- What are all the factors that must be considered from each department in order to make this change?
- What could be improved in the following: lighting, noise, bed comfort, privacy and clinical care to help with sleep?
- What evening activity and food do people who like to stay up want available?
- If it the process changed how would staff and residents benefit?

- What are the medical consequences of sleep deprivation on health and well-being?
- What negative outcomes are we causing by constantly interrupting the sleep of our residents?
- How would residents and staff benefit from how awakening happens?
- What is the importance of sleep hygiene for physical and mental well-being?

Resources:

1. Cruise PA, Schnelle JF, Alessi CA, Simmons SF, Ouslander JG. The nighttime environment and incontinence care practices in nursing homes. *J Am Geriatr Soc* 1998 Feb; 46 (2): 181-6.
2. Esser S., Wiles A., Taylor H., et al. The sleep of older people in hospital and nursing homes. *J Clin Nurs* 1999; 8: 360-8.
3. O'Rourke DJ, Klaasen KS, Sloan JA. Redesigning nighttime care for personal care residents. *J Gerontol Nurs* 2001 Jul; 27 (7): 30-7.

Created and distributed by:

QUALITY PARTNERS
OF RHODE ISLAND

Quality Partners of Rhode Island designed this material under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. Contents do not necessarily represent CMS policy.

Updated: August 31, 2007

Contributors included:
Quality Partners of RI
RI Department of Health
B&F Consulting