



Quality of Life Assessment: Training Module

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About This Training Module

This training module provides instructions on how to design and implement a quality-of-life assessment strategy that produces useful information for:

- Identifying resident’s individual preferences for care planning and resident-centered care delivery;
- Identifying nursing home care processes that need improvement, and
- Designing and evaluating quality improvement interventions.

It starts with a list of learning. Following this, we briefly discuss reasons to improve quality-of-life assessment in your facility.

The next two sections describe procedures for conducting quality-of-life assessment interviews with residents.

We’ve also included a resource bank of assessment questions that we have used and evaluated in our research. Please feel free to adopt or adapt these ready-made questions for use in your resident-centered care planning and quality improvement efforts.

Elsewhere in this module—Links, FAQs, Related Studies—we provide guidance and referrals to other resources that can help you assess quality-of-life among your residents.

CONTACT US

We’ve tried to be comprehensive, but if there is something you can’t find, or if you have unanswered questions, comments, or concerns, please feel free to contact us at the Center for Quality Aging:

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Learning Objectives

At the end of this training module, you will be able to:

- Identify two mistakes commonly made when assessing quality-of-life (QOL) in nursing home residents.
- Assess the ability of nursing home residents to answer questions about their daily care preferences.
- Demonstrate knowledge of the pros and cons of each of these QOL assessment questions: direct satisfaction questions, discrepancy questions, open-ended questions.
- Construct discrepancy and open-ended questions that assess QOL for nursing home residents.
- Describe at least three conditions that should be met when interviewing nursing home residents.

Quality of Life Assessment

Learn how to design a quality of life assessment strategy that produces useful information for: 1) identifying resident's individual preferences for care planning and resident-centered care delivery purposes; 2) identifying nursing home care processes that need improvement, and 3) designing and evaluating quality improvement interventions.

ASSESS FOR PR VALUE OR QUALITY IMPROVEMENT?

Nursing homes that set out to assess resident and/or family satisfaction with care or resident quality-of-life in their facilities face a sticky choice between two conflicting goals: Do you want to conduct an assessment that yields high satisfaction levels but is virtually useless from a care planning and quality improvement standpoint? Or, this time, do you want to design an assessment whose findings will enable you to provide resident-centered care, improve care in a particular area or identify areas that need improvement?

We do not deny the public relations allure of the first assessment type. It is especially attractive to an industry such as the nursing home industry, which must constantly defend itself against often scathing criticism by the media. But if you want to quell that criticism, then your facility should also consider conducting care quality assessments of the second type. While they may not make your services look as good, their results can be used to provide more

resident-centered care and actually improve care so that, in fact, your services *are* good.

REASONS TO IMPROVE IMPROVEMENT EFFORTS

In today's long-term-care environment, nursing homes have compelling reasons to improve their improvement efforts. First and foremost is the availability—since November 2003—of public report cards for virtually every nursing home in the nation. The Centers for Medicare and Medicaid Services (CMS) publishes these reports on its website, www.medicare.gov/NHCompare, not only to help consumers make informed decisions but also to motivate nursing homes to improve their daily care practices and resident outcomes. Field reports suggest that this long-term-care improvement initiative has indeed sparked new interest among nursing homes in enhancing their services.

The other impetus for change is that the nation's tsunami wave of baby boomers has begun to eye nursing homes as possible residences for their elderly parents. This demanding, very vocal generation is notorious for its ability to transform the institutions it cares about. Though the baby boomers, acting on behalf of their frail parents, have only recently begun to flex their consumer muscle in the long-term-care industry, nursing facilities are taking note and redesigning their services to meet this generation's expectations.

“In today's long-term-care environment, nursing homes have compelling reasons to improve their improvement efforts.”

Fundamentals for a New Assessment Strategy

Learn whom to ask and what to ask them in this section on improving quality-of-life assessments in nursing homes.

A COMMON CONSUMER SURVEY

Every year Nursing Facility A sends questionnaires to its residents' family representatives, asking them to respond, on behalf of their loved ones, to a series of satisfaction questions: How satisfied is your resident with the food here? With the social activities offered? With the staff? With the care they receive? The responses received back are stunning: Almost everyone—at least eight of ten respondents—reports high levels of satisfaction with each and every item on the questionnaire. Sound too good to be true? It probably is, especially considering that Facility A, like an estimated 90% of all nursing homes in the nation, has too few workers to provide quality care to residents.

But if Facility A's actual quality of service does not deserve such high ratings, then what accounts for them? The questionnaire's design—one commonly used by nursing homes—and in particular its choice of respondents and its reliance on direct satisfaction questions. Let's take a look at how these design features influence responses.

RULE #1: RESIDENTS BEFORE THEIR REPS

With half of all residents showing some degree of cognitive impairment, many nursing homes believe that asking

respective family members and significant others to assess quality of care is both more time-efficient and reliable than asking the

residents themselves. Presumably healthy (or healthier) and cognitively intact, family members can capably respond to a mailed questionnaire (no need to interview them in person) with meaningful answers.

There are two objections to this reasoning. First, it assumes that residents and their family members share the same preferences for service and perceptions of care quality. Often they don't, however. Writes Social Work professor Scott Miyake Geron of Boston University (1), "...the findings of researchers who have explored consumer perceptions of long-term care (are) that consumers' definitions of quality of long-term-care services are simply different from those of professionals, family members, and other stakeholders (pg. 69)." Similar perceptions? Maybe. Identical? Hardly. Adds Kane (2): "Proxy inaccuracy may be compounded for nursing home residents if families visit infrequently or staff are not well acquainted with residents (pg. 32)."

Also objectionable is the presumption that all cognitively impaired residents are suspect evaluators of care quality and, in particular, of their own preferences for care. Recent research, by us and others, shows that the majority of residents with mild to moderate cognitive impairment can indeed provide useful, reliable information about the care they receive, the services they prefer, and their quality of life. In one study, Kane et al. (3) were able to interview 1,988 residents from 40 nursing homes in five states and, based on the results, develop Quality-of-Life scales for about 60% of them. "This was achieved," the authors write, "even though at

least half of the sample included the more impaired levels on a cognitive performance scale; only 19% of the sample had a perfect cognitive score, and 17% had the worst possible cognitive score (pg. M245)."

Our research shows similar results. In one study, we interviewed 111 incontinent residents to assess their satisfaction with incontinence and mobility care processes (4). To qualify for the study, incontinent residents had only to pass a simple responsiveness screen: They were asked to state their name or identify two common items, and were given chances on two separate days to pass the screen. An analysis of their responses showed that 75% of the sample provided logically consistent and stable answers to our interview questions about their received and preferred care levels.

In two other studies, we set out to identify a simple cognitive screen that would accurately identify residents capable of providing meaningful responses to satisfaction and preference questions (5, 6). Both studies showed that residents who score two or more on the *Minimum Data Set Recall subscale* can accurately describe the care they receive. Our more recent research shows even more encouraging results: About half of residents who score 1 on the MDS Recall subscale can reliably self-report pain and symptoms of depression, express meaningful preferences for daily care (they can tell you, for example, what activities they like or where they would like to have their breakfast or if they prefer to take an afternoon nap), and accurately describe care they receive on a daily basis (they can recall, for example, if staff helped them to the bathroom or provided walking assistance).

"The majority of residents with cognitive impairment can provide reliable information about the care they receive."

THE "GOLD STANDARD"

Based on these findings, there is growing consensus that residents' self-reports represent the "gold standard" for measuring their care preferences as well as their quality of life—an inherently subjective construct that includes such domains as relationships, autonomy, privacy, and enjoyment—and are integral to quality of care assessments. After all, residents are the direct recipients of long term care—not their respective family members or health care providers.

In addition, there's a side benefit to interviewing residents. Writes Kane et al. (3), "The very act of asking resident directly about their (quality of life) could engage staff directly and systematically with residents' opinions about their daily existence in a way that seldom occurs in a typical (nursing facility). Such a process mitigates the tendency to depersonalize residents, and to view them merely as care recipients rather than people who live out their lives in difficult circumstances (pg. 247)."

The implications for nursing home care providers are inescapable: If you want to evaluate consumer satisfaction, quality of life, quality of care, call it what you will, then you must capture the voices of residents, including cognitively impaired residents, in your assessment. Surveying family members is an acceptable practice; they are important stakeholders in long-term care. But don't canvass them at the cost of excluding their loved ones. Our *Interview Protocol* on the next page presents guidelines for selecting residents for interview.

RULE #2: QUESTION THE QUESTIONS

We turn now to the question of the questions themselves. Direct satisfaction questions, like those used by Nursing Facility A (“How satisfied are you with...[fill in the blank]?”), are a staple of consumer satisfaction surveys, but they are not an ideal choice for querying nursing home residents for two reasons.

The first is that they are prone to an acquiescent response bias; that is, residents will tend to respond favorably to these questions, despite known problems with the quality of care they are receiving. In effect, residents are giving answers they think *you* want, not necessarily expressing their own views.

Any questionnaire can inadvertently elicit an acquiescence bias among respondents, but consumer satisfaction surveys conducted with nursing home residents are especially likely to do this for several reasons. Older adults, and women in particular, tend to report higher rates of satisfaction with health care services; thus, there is a good chance that extremely old and frail nursing home residents, who are predominantly female, will report high rates of satisfaction with substandard or inadequate care. In addition, many residents lower their expectations for care as they reside in the facility over time. Their actual experience teaches them to expect and accept substandard quality of care. The fact that residents also are dependent on staff for daily care and many are isolated from family and friends can only decrease their willingness to express dissatisfaction with care due to fear of reprisal.

In order to collect data useful for quality improvement, your assessment questions must reveal both your facility’s strengths and

weaknesses. You will not be able to identify areas that need improvement if resident responses to all or most of your questions cluster at the “highly satisfied” end of the scale, as responses to direct, forced-choice questions about satisfaction tend to do (4,7,8). You need, therefore, to ask questions that are more sensitive to differences in satisfaction levels.

Your questions also should elicit information that will help guide improvement efforts. A second problem with direct satisfaction questions is that they fail to do this. Though they may be able to tell you whether residents are generally satisfied or dissatisfied with a certain aspect of care, they shed no light on how to correct identified problems or how to tailor care to the individual; that is, how to provide more resident-centered care. Does the person want more privacy or less? Does she want to eat in the dining room or her own room? Does he receive enough help with toileting or does he want more? With quality improvement, as with many things in life, the devil is in the details. But the details are absent in direct satisfaction questions.

FOUR TYPES OF QUESTIONS...

What are good alternatives to direct satisfaction questions? In two studies, we evaluated various interview strategies to identify questions that both tempered acquiescence response tendencies among residents and provided information useful for improving care (4, 7). We asked residents these four types of questions:

- Direct satisfaction questions about Activities of Daily Living (ADL) care (e.g., “Overall, are you satisfied with how often someone helps you to walk?”)
- Discrepancy questions that compared residents' preferences for ADL care

frequency to their perceptions of the ADL care actually delivered (e.g., “How many times during the day would you like staff to help you walk?” vs. “How many times during the day do staff help you to walk?”)

- A second type of discrepancy question that compared residents’ preferences for ADL care frequency to how often they actually received care based on research staff observations
- Open-ended questions that asked what residents wanted changed about ADL care.

...YIELD MIXED RESPONSES...

Answers to our questions about walking assistance (4) are typical of the responses we received in other ADL care areas:

- When asked the direct satisfaction question, “Overall, are you satisfied with how often someone helps you to walk?” 80% of 111 residents interviewed said “yes,” a finding that suggests the facility is meeting the vast majority of residents’ needs in this area.
- Responses to the discrepancy questions suggest otherwise, however. Overall, 81% of the respondents reported a preference for more walking assistance than was provided by staff. Specifically, their reported preferences showed that they wanted an average of two more walk assists per day than staff were actually providing to them.
- Open-ended comments spontaneously provided by residents revealed a desire for change in aspects of care other than the frequency of assistance. One resident told us, for example, that she “would like to have somewhere important to go [when walking], such as an activity she was interested in attending, as opposed to just walking down the hall.”

From 80% satisfied, it now appears that 81% are *dissatisfied*, at least with the *amount* of walking assistance they receive.

“Your questions also should elicit information that will help guide improvement efforts.”

...BUT ANALYSES SHOW THAT SOME QUESTIONS TOP OTHERS

What do we make of these results? Satisfaction with care is subjective; so when a resident tells us that overall, she is satisfied with the amount of walking assistance she receives but would like more of it, we are obliged to accept both statements. (And no, our analyses show that this response pattern is *not* related to a resident’s cognitive status.) That said, given our goal of collecting information useful for improvement efforts and given what we know of acquiescence, reduced expectations, and fear of reprisal among nursing home residents, it is appropriate to question the questions. How effective is each type? Findings from our studies show the following (4,7):

- The proportion of residents reporting unmet needs for ADL care are significantly higher with the discrepancy and open-ended questions compared to the direct satisfaction questions. This suggests that the former questions are more sensitive to differences in satisfaction levels and that the latter questions are more limited by acquiescent response biases.
- Open-ended questions produce the most useful information for individualizing aspects of technical care and assessing the interpersonal quality of care.
- Discrepancy questions elicit specific information useful for changing the frequency or occurrence of ADL care;

and, these questions are most sensitive to care quality improvements.

- Direct satisfaction questions are the least useful for designing improvement interventions and the most unreliable (when residents were re-interviewed within a day or two of their first interview, they were most likely to change their answers to questions of this type).

In sum, the direct satisfaction questions—most commonly used in nursing home surveys—proved the least useful and reliable. The discrepancy and open-ended questions are better choices for both care planning and quality improvement purposes.

In the *next section*, we present a quality-of-life assessment protocol that takes into account these findings as well as the mandate, born of research, not regulations, to interview residents as the best reporters of their care preferences and related quality of life. You can use this protocol to develop and implement an effective assessment strategy for your facility.

TRY THIS QUICK ASSIGNMENT

- Choose an ADL care area in need of improvement in your facility.
- Develop a discrepancy question set that assesses residents' preferences for care in this area. One question, for example, might ask how often the resident receives care in this area. The companion question would then ask how often the resident would like to receive care in this area. For examples, see our *quality-of-life assessment forms*.
- You can score such questions by subtracting the second answer from the first. For example, if a resident says he receives a shower 3 times per week but prefers a shower 5 times per week, then the discrepancy score is -2 (i.e., 3-5 = -

2). The negative difference signals unmet needs.

- To assess resident satisfaction with other aspects of the care process (e.g., the way staff actually provides showers), pose a structured open-ended question: "If you could change something about your shower schedule or the way staff help you with your shower, what would it be?" You may find, for example, that in addition to preferring 5 showers per week, the resident also prefers that his shower be given in the morning before breakfast and that staff are not always careful about keeping him covered when transporting him to and from the shower room.

Share your results with us. Please. We plan to report your feedback in site updates so that others can benefit from your experience.

www.vanderbiltcqa.org

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Quality of Life Assessment Interview Protocol

Learn how to design and conduct quality of life assessment interviews that not only elicit information useful for improvement efforts but also are flexible and feasible to implement given the time and cost constraints in most nursing homes.

PROTOCOL PURPOSE

“The question now is not, ‘Should we improve the quality assessment process by interviewing more residents? But rather, ‘How do we interview more residents within the cost constraints of the quality assessment process?’”

-John F. Schnelle. (2003). Improving Nursing Home Quality Assessment: Capturing the Voice of Cognitively Impaired Elders. *J of Geron, Med Sci*, 58A(3): 238-239.

In this section we present a protocol for conducting quality-of-life assessment interviews with nursing home residents that not only elicits information useful for improvement efforts but also is feasible to implement given the time- and cost-constraints in most facilities. In addition to quality improvement efforts, these assessments also allow for the identification of resident’s individual care preferences for care planning and more resident-centered care provision.

Based on research we conducted over the past eight years (see *Related Studies*), the protocol provides instructions on how to design and implement an assessment strategy that aims to achieve any one or all

three of the below goals:

- Identifying resident’s individual preferences for care planning and resident-centered care delivery;
- Identifying nursing home care processes in need of improvement, and
- Designing and evaluating quality improvement interventions.

In keeping with a fundamental tenet of both resident-centered care and quality improvement (see *Fundamentals for a New Assessment Strategy*), it recognizes resident self-reports as the gold standard for assessing care preferences and quality of life.

The protocol is flexible, so it allows you to develop an assessment strategy that takes into account your resident population and facility resources. It presents general guidelines to work within, but leaves most of the decision-making to you: Do you want to interview all residents or a sub-group? Do you want to assess current residents or only new admissions? Do you want to evaluate quality of care across a broad range of domains or narrow the focus to a single care process? Though it is now common practice to assess consumer satisfaction in the managed care and hospital industries, such assessment is a relatively new practice in the long-term-care business. Often with new practices, the hardest part is just getting started. This protocol can help you clear that obstacle.

The protocol, presented below, is organized around commonly asked questions.

WHEN SHOULD INTERVIEWS WITH RESIDENTS BE CONDUCTED?

If your facility, like most nursing facilities, does not routinely interview residents to assess their care preferences and quality of life, then we recommend that you start small, focusing first on a subset of residents, such as new admissions, or on a single care process or other activity you want to improve, such as walking assistance or shower/bathing process. With this in mind, here are two suggestions for when to conduct resident interviews:

- At admission, when you are required to assess, as part of the Minimum Data Set (MDS), a new resident's care preferences, and again two weeks later, during the mandated reassessment for new residents. If completing the MDS plus a quality improvement (QI) interview takes too long for one sitting, then schedule the QI interview for the next day or as close to the MDS as possible. Tying your quality care assessment to the MDS will help ensure that it is completed in a time-efficient manner. In addition, using more structured interview questions, such as those in our protocol, to assess resident's care preferences will allow for more complete and accurate information for care planning and resident-centered care delivery purposes.
- Just before an improvement intervention or a change in care practice is implemented, and then again after sufficient time has passed for residents to have registered the change in routine. You need interview only those residents who are the target of your improvement effort (e.g., residents on a given unit or floor). You can compare residents' self-report from the before and after assessments to determine whether your

change in practice is noticeable to the residents and making a positive difference in their daily life quality.

“Often with new practices, the hardest part is just getting started. This protocol can help you clear that obstacle.”

WHO SHOULD BE INTERVIEWED?

As a general rule, you should interview residents who score 2 or more on the *Minimum Data Set (MDS) Recall subscale*. Our research shows that these residents consistently provide reliable information useful for quality improvement efforts (1, 2). Ideally, the four MDS items that comprise the recall scale should be completed by nursing home staff familiar with the resident based on the most recent seven-day period, as opposed to relying on the most recent MDS assessment data, which may be three months or more old at any one point in time.

If your questions ask about services or care processes that occur *daily*, as opposed to less frequently, or subjective aspects of care (e.g., food preferences) then you should also *interview residents who score 1 (or more) on the MDS Recall subscale*. Our research shows that the majority of these residents can reliably self-report pain and depression, express meaningful preferences for daily care (they can tell you, for example, what activities they like, what food they want for breakfast and where they like to eat their meals).

If you are assessing quality of care for a specific activity of daily living (ADL), interview residents (with appropriate MDS Recall scores) who require any level of staff assistance (supervision to total dependence) for that ADL, excluding only residents who are either completely independent or completely unable to do the activity (e.g.,

unable to walk, even with assistance). You can use *MDS ADL ratings*) to identify appropriate interview candidates:

Residents should be asked questions about only the care activities that are relevant to them. Do not, for example, ask a bed-bound resident questions about getting in and out of bed or ask a resident completely incapable of walking questions about walking assistance.

WHO SHOULD CONDUCT THE INTERVIEWS?

Interviews should always be conducted in-person with residents. This enables a range of cognitively and physically impaired residents to participate. In-person interviews also provide an opportunity to clarify questions, which can lead to more accurate responses.

Because most daily care is provided by certified nursing assistants, a different staff member should conduct the interviews so that residents feel sure their reports are confidential. Ideally, a social worker or licensed nurse should conduct the interviews.

Interviews should always be conducted in-person with residents to enable a range of cognitively and physically impaired residents to participate/

WHERE SHOULD THE INTERVIEW BE CONDUCTED?

Interview each resident in a private room to ensure confidentiality. The room should be quiet (turn off television, radio) so that the resident is not distracted and can hear you more easily.

IS THERE ANYTHING I NEED TO DO BEFORE CONDUCTING THE INTERVIEW?

Determine whether the resident you are about to interview needs a hearing device and if so, whether the device is available. When we conduct interviews, we arrive prepared to offer residents the use of amplifying earphones (inexpensive and available from most electronic stores). Also, find out whether the resident has any particular needs (e.g., has difficulty speaking) that might affect participation in the interview. Review the resident's most recent MDS assessment so that you are aware of which ADL care activities the resident requires assistance to perform and which aspects of the interview may not be applicable to the resident due to complete independence or inability.

HOW SHOULD INTERVIEWS BE CONDUCTED?

Introduce yourself and spend a few minutes establishing rapport with each resident or simply socially interacting with the resident.

Follow good interviewing techniques: Your mouth should be clearly visible to the resident; you can help the resident focus his or her attention by using the person's name and by using touch. Situate yourself so that you are as level as possible with the resident's eyes.

Make sure the resident can hear you and understands each question, to the greatest extent possible. You may need to check the person's hearing aide.

Reassure the resident that his or her responses will be kept confidential. Feel free to adopt the preface we often use: "Everything you tell me will be kept private. I

will not tell the staff (the people who work here) what you say. Some of these questions are personal, so if there are any questions you feel uncomfortable answering, you don't have to answer. Also, some of my questions may seem silly but please try to answer as many as you can. You may discontinue this interview at any time and it will in no way affect the care you receive. (Our state) law requires that I report abuse. If this occurs, I will tell you exactly what I plan to tell the social worker here, and you will be protected from any further harm from staff."

Avoid awakening residents or interrupting social visits, meals, or activities to conduct an interview.

WHAT QUESTIONS ARE MOST USEFUL FOR QUALITY IMPROVEMENT PURPOSES?

You can develop interview questions that specifically address the care areas and aspects of quality of life that are the focus of your facility's improvement efforts and/or resident-centered care delivery program. In general, interview questions should:

- Require a simple yes/no response.
- Be direct, specific and concrete.
- Focus on daily occurrences, because these are most recent and tangible in the resident's memory. Ideally, questions should be posed shortly after the occurrence of the care or other activity in question.
- Should include discrepancy questions that compare residents' preferences for care to their perceptions of the care they actually receive (e.g., "How many times during the day would you like the staff to help you to the bathroom?" vs. "How many times during the day do the staff help you to the bathroom?"). You can

score such questions by subtracting the second answer from the first. For example, if a resident says he is provided toileting assistance once a day but he prefers to receive assistance three times a day, then the discrepancy score is -2 (i.e., $1-3 = -2$). The negative difference signals unmet needs.

Although discrepancy questions are most appropriate for evaluating care frequency preferences, they can also be used to evaluate other aspects of care, such as dining location ("Where do you like to have breakfast? versus "Where do you have breakfast?"), or timeliness of care (e.g., "What time do staff help you out of bed in the morning?" versus "What time would you like for staff to help you out of bed in the morning?")

- Should include some structured open-ended questions (e.g., "If you could change something about the toileting schedule or the way staff help you to use the toilet, what would it be?").

Question sets that meet all these criteria are available in this training module for the following care areas:

- Toileting assistance
- Walking assistance
- Dressing and personal hygiene assistance
- Getting in and out of bed
- Social activity participation
- All of the above care areas

Feel free to adopt or adapt these questions, all of them tested in our own research, for use in your facility. Each interview protocol requires approximately 10 to 15 minutes to complete per resident.

WHAT TYPES OF QUESTIONS SHOULD BE AVOIDED?

Avoid using these types of questions:

- Direct satisfaction questions (e.g., “Are you satisfied with the nursing care?”). They are not very informative from a quality improvement standpoint and tend to elicit an acquiescent response bias among residents (see our section on *Fundamentals of a New Assessment Strategy*).
- Questions that use abstract constructs (e.g., “Do the staff treat you with dignity and respect?”). A better way to assess “dignity and respect” within care delivery is to ask about concrete staff behaviors, such as: “Do the people who work here:
 - knock on your door before entering the room?”
 - pull your curtain before helping you to get dressed?”
 - address you by name when they see you?”
 - tell you when they will be back to check on you again?”
- Questions that require residents to rate their satisfaction along any type of rating scale (e.g., a three- or five-point scale or along a scale with responses such as, very satisfied, moderately satisfied, unsure, moderately dissatisfied, very dissatisfied). Many residents are simply unable to use these complex multiple point scales.
- Questions that require residents to remember details about infrequent events (e.g., a monthly visit from a primary care physician that occurred several weeks prior to the interview).

HOW DO I ANALYZE RESPONSES?

For many, perhaps most, interview

questions it is sufficient to simply calculate the frequency of the various responses to each question: What percentage of the residents interviewed responded “yes” to the question? What percentage responded “no”?

If the question asks for a number in response (e.g., How many times during the day does someone who works here help you to use the bathroom?), then in addition to response frequencies, you may want to calculate an overall average for the question. This single number helps outline the big picture.

Consider creating an excel database that can quickly calculate frequencies and averages for you.

Responses to some questions require special handling:

- *Discrepancy questions:* As noted earlier, these come in sets of two and compare residents' preferences for care to their perceptions of the care they actually receive. If, for example, the first question asks, “How many times during the day would you like the staff to help you to the bathroom?” then its companion question will ask, “How many times during the day do the staff help you to the bathroom?” To make full use of these questions, you should calculate a “discrepancy score” for each individual by subtracting the second answer from the first. For example, if a resident says he receives toileting assistance once a day but he prefers toileting assistance three times a day, then the discrepancy score is -2 (i.e., $1-3 = -2$). The negative difference signals unmet needs. You can use the discrepancy scores for all residents interviewed to calculate an overall average discrepancy score.

- *Open-ended questions:* Responses to these questions, as well as spontaneous comments to other types of questions, provide valuable information for individualizing care that forced-choice questions by their very nature cannot capture. For starters, then, you should make it a point to simply listen carefully and take into consideration what your residents have to say. If you go one step further and codify their comments, you can analyze this data quantitatively, adding it to the Big Picture of care quality in your facility. In a recent study, we evaluated a simple, reliable method for coding residents' comments (9).

The method follows three steps:

1. Ask whether each comment indicates a desire for change, that is, for something other than the status quo (e.g., "I would like to walk more often"). Code as yes or no.
2. If a change is desired, then ask whether interaction with staff is needed to bring about the change (e.g., "I would like more encouragement to walk"). Code as yes or no.
3. If interaction with staff is required, then ask whether the comment refers to the manner of care delivery (e.g., "When they dress you they are rough, not kind."). Also ask whether it refers to technical aspects of care, such as frequency or timeliness (e.g., "I would like a shower every day"). Code as either one or the other (manner of care versus technical care) or both.

HOW DO WE INTERPRET OUR FINDINGS?

Our best advice is simply this: Let common sense guide you.

Bear in mind that you are collecting two types of data: 1) individual data, or the responses from each person who answers your questions, and 2) group data, as represented by the Big Picture you derive from considering all responses together. Conclusions drawn from the individual data may be very different from conclusions drawn from group data. Moreover, one data type may be more useful than the other type in guiding your improvement efforts. For example, the individual data is useful for care preference assessment and related care planning, as required by the MDS, to allow for resident-centered care; where as, the group data is useful for determining aspects of care in need of improvement for most residents in your facility. For example, if you want to offer social activities that most residents will enjoy, examine resident responses as a group.

More frequently, improvement efforts in nursing homes are intended to enhance care and daily life for the individual. If one resident prefers to get out of bed in the morning at 6am but his roommate prefers 8am, you meet neither one's preference if you decide to split the difference and help them both to get up at 7am. When the goal is to individualize care and services to meet personal needs and preferences, *resident-centered care provision*, then your improvement efforts must be driven by the individual responses of each resident you interview.

You can use group data to set and measure performance goals, however. For example, an intervention designed to improve toileting assistance may aim to earn an average discrepancy score of 0, meaning that on average, residents who require toileting assistance receive as much of this assistance as each person wants.

TRY THIS ASSIGNMENT

Find out whether residents on one hallway or unit are getting helped out of bed in the morning at the times they prefer.

- Use our *In and Out of Bed Schedule assessment*.
- Interview the residents. For this assignment, after introducing yourself, you need only ask residents questions 1 and 3 on the form:
 - Q1: About what time do you get out of bed in the morning?
 - Q3: About what time do you like to get out of bed in the morning?

Note: If residents have difficulty providing a specific time, an alternative way to ask these questions is:

- Q1: Do you get out of bed before breakfast or after breakfast?
 - Q3: Would you like to get out of bed *before* breakfast or *after* breakfast?
-
- Analyze results. Identify those residents who say they would like to get up at a time different from when they say they do get up.
 - Create a checklist of these “dissatisfied” residents’ names and the time of morning each would like to get up from bed.
 - The next day, check it out: Stroll down the hallway in the morning and make a note of who’s out of bed at the preferred time and who’s not.
 - What can the staff do to improve results?

Share your findings with us. Please *contact us* . We plan to report your feedback in site updates so that others can benefit from your experience.

www.vanderbiltcga.org

When the goal is to tailor care and services to meet personal needs and preferences, then your improvement efforts must be driven by the individual responses of each resident you interview.

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Resident Centered Care

There is a significant risk among NH residents of becoming “institutionalized” and accepting or being forced to adhere to staff schedules as opposed to a life schedule consistent with one’s individual preferences.

RESIDENT-CENTERED CARE: WHAT DOES IT MEAN?

Resident- or patient-centered care is a concept that is widely embraced across all health care settings, including long-term care. The concept encompasses a wide range of options, but the theme that defines most efforts in this area centers on determining consumer preferences and encouraging choice. In long-term-care settings, where residents both live and receive medical care, there is consensus that it is important to offer residents choice about all aspects of their lives, including those aspects that affect daily life quality. Expert consensus methodology has been used to validate quality indicators related to residential life in (NHs). Many of these indicators are related to identifying resident preferences and offering residents choices.¹⁻

³ It is difficult to believe or argue that choice is unrelated to the quality of life of NH residents, who often require assistance with activities of daily living (ADL) and hence, are dependent on staff for such basic life functions as movement and toileting. In fact, there is a significant risk among NH residents of becoming “institutionalized” and accepting or being forced to adhere to staff schedules as opposed to a life schedule consistent with one’s individual preferences.

NATIONAL INITIATIVES TO IMPLEMENT RESIDENT-CENTERED CARE PRINCIPLES IN NURSING HOMES

There is widespread and growing interest in resident-centered care provision in NHs. This interest is reflected on the national level by a recent report from the Institute of Medicine that endorses resident-centered care and a coalition of providers and advocates who have given rise to what is popularly known as the NH culture change movement.⁴⁻⁷ This movement encompasses a broad range of interests, from transforming physical settings to redefining staff roles, but at its core it emphasizes resident autonomy and the importance of offering residents choices about their care and life.⁵⁻⁷ In 2005, the Center for Medicare services (CMS) recognized the culture change movement as a force for improving quality of life when it directed state Quality Improvement Organizations in their 8th scope of work to work with NHs to improve organizational culture.⁸ In September 2006, CMS launched a nursing home quality campaign whose eight goals include creating a culture of person- centered care and an empowered work force in NHs.

The federal NH regulatory industry also is placing increased emphasis on resident-centered care and choice in federal surveys of NH quality. The interpretive guidelines for conducting federal quality assessments include instructions throughout that residents’ preferences for care be identified. Survey deficiencies (or F tags) for quality of life have been designated, with language that specifically addresses resident preferences and choice¹. Consider, for example, F tag 242: “The resident has the right to choose activities, schedules and health care consistent with his or her

interests, assessments and plans of care.” Surveyors are instructed to ask residents whether they are offered choices about daily life activities such as bedtimes and to observe whether resident choice and individuality is honored during daily care. F tags or care deficiencies can be cited if the surveyors find evidence that resident choice is not being honored.¹

WHO CAN BE INTERVIEWED AND WHAT TYPES OF QUESTIONS SHOULD BE ASKED?

The high prevalence of depression and cognitive impairment among NH residents raises questions about which and how many residents can express meaningful preferences when interviewed. A series of studies led by Dr. Sandra Simmons has demonstrated that between 50 and 90% of residents could answer questions in a stable fashion across two interviews about their pain status and their preferences for care in the following areas: pain medication, walking assistance, incontinence care, out of bed times and dining location for meals.⁹⁻¹² A study by another research team that measured resident perceptions of quality of life in a nationwide sample of NHs found that a similar percentage of residents could be interviewed about their preferences and life quality.¹³ When considered together, these studies lead to the conclusion that most NH residents can express their preferences for care; thus, it follows that NH medical records (MDS assessments, care plans) should include documentation of residents’ preferences for daily care. Unfortunately, documentation of residents’ daily care preferences is often absent or erroneous when compared to independent assessments by research staff using standardized resident interview protocols.

We provide in this Quality-of-Life assessment module criteria to select residents appropriate for interview because staff have a tendency to erroneously assume that most residents are incapable of answering questions about their daily care preferences due to cognitive impairment. We also provide guidelines for how to structure interview questions to allow residents with mild to moderate cognitive impairment to reliably answer such questions. In addition, we developed a resident interview protocol specifically for the purpose of assessing resident’s daily care preferences in three activities of daily living: getting out of bed, toileting and dressing. You can start by asking residents about just one of the three care activities, although we focused on these three because the care is typically provided at the same time (during morning ADL care delivery). Remember that residents often report preferences that reflect reduced expectations for care and the established staff routine because they believe that they really don’t have alternative choices available to them. Thus, the person conducting the interview should be different from the person who typically provides the care (nurse aides); and, the interviewer should be sensitive to residents’ expression of reduced expectations in response to the interview questions (e.g., comments such as, “it’s okay, the way it is”; “the staff do what they can”; “I’m not the only person who lives here, you know”).

We also developed a corollary observational protocol that supervisory-level staff can use to determine if direct care staff are offering resident’s choice during daily care provision – providing “resident-centered” care – in these three care areas. The advantage of the observation protocol is that a supervisory-level staff person can observe a small group of residents who reside on the

same hallway during morning care provision to document the following aspects of resident-centered care provision:

- Did staff greet the resident?
- Did the resident state a spontaneous care preference (e.g. "I would like to get up now.")
- Did staff offer the resident a choice? (e.g., "would you like to get up now or later?")
- Did staff honor a resident's stated preference or choice?
- What was the resident's reaction to care delivery? (e.g. cooperative, resists care verbally or physically)

We targeted these three ADL care activities for two main reasons. First, in/out of bed times and dressing are given as examples in the federal guidelines for areas wherein surveyors should inquire and observe if NH staff provides residents with choice. Second, morning care offers a predictable and time-efficient opportunity to observe how staff provides care to residents. For example, residents are usually assisted out of bed, dressed and served breakfast. There are few other times during the day that so many care activities important for resident choice occur in a short, predictable time period, other than bedtime in the evening.

Related to staff offers of choice, our research shows it is important to differentiate between "active" versus "passive" choice during care provision. For example, we noticed that a typical style of communication between residents and direct care staff was a variation of the following: "Hi Ms. Smith, its time to get up now, okay?" Or "Let's go to the dining room, okay?" This type of communication implied choice but was more in the direction of soliciting assent to care than alternative, direct

communications of choice such as "*Do you want to get up now?*" Or "*Where would you like to have your breakfast – in your room or the dining room?*" We believe the latter type of communication, which promotes active choice, is preferable and should be the goal of resident-centered care provision.

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Frequently Asked Questions

Nursing home providers speak of assessing both quality of care and quality of life. What's the difference?

In nursing homes, "quality of care" generally refers to the adequacy of medical and other health-related services, including assessment and treatment of such common problems as depression, dehydration, weight loss, incontinence, pain, bedsores, and the like. "Quality of life (QOL)" is a multidimensional construct that encompasses emotional, health, and functional domains but reaches beyond these to embrace additional dimensions of life. In a recent study, Kane, who has written extensively on the topic, identifies 11 QOL domains pertinent to nursing home life: comfort, functional competence, autonomy, dignity, privacy, individuality, meaningful activity, relationships, enjoyment, security, and spiritual well-being (1).

There is a tendency among many—nursing home staff, policy makers, researchers, even family members—to view nursing homes as places that take care of often very sick people and ignore the fact that they are also places where people live out their lives. As a result, improvement efforts often suffer the same bias, focusing almost exclusively on quality of care, not other aspects of daily life in the nursing home.

You can use our *Interview Protocol* to develop questions that specifically assess QOL domains other than those related to health care. Our *ready-to-use assessment instruments* primarily address quality of care, but include questions that probe such QOL dimensions as daily care preferences, availability of choices, dignity, and enjoyment. Be sure to include some open-

ended questions that invite residents to comment on what is most important to them.

Is our facility obligated in any way to share results of a quality improvement assessment with outside surveyors?

No. Federal regulations require nursing homes to establish internal quality assessment and assurance (QA) committees that meet at least quarterly to identify and respond to quality deficiencies within the facility. But according to the U.S. Office of the Inspector General (2), "surveyors do not have access to QA committee minutes due to the confidentiality of these documents mandated (by law)." Surveyors assess compliance with the regulations by interviewing a facility's administrative staff "to determine that it has a QA committee and that its required membership and frequency of meetings comply with (regulations)" as well as to identify the process the facility uses to respond to quality deficiencies (2).

Besides interviews with residents, are there other ways to assess quality of care and quality of life?

While resident self-reports are considered the gold standard for assessing quality of life, preferences for care and satisfaction with care, nursing home care quality also can be evaluated using other methods, including proxy reports by family members and staff members who presumably know the resident well, direct observations of residents and staff, and review of medical charts and Minimum Data Set (MDS) assessments. Before adopting any of these methodologies, you should understand the strengths and limitations of each approach.

Proxies: In light of research that shows discordant viewpoints between nursing home residents and their proxies, it seems “unjustified to use proxies as the sole source of data when residents themselves can self-report (3).” Proxies are best consulted for a second, separate opinion or when the resident is unable to communicate at all.

Direct Observations: Structured observations of residents and the care they receive provide an objective measure of care quality, which is useful for determining whether residents are receiving the type and amount of care recommended in clinical practice guidelines and that they themselves prefer. Are residents, in fact, helped in and out of bed at the times they prefer? Are they engaged in social activities that they reportedly like most? Are they actually offered a choice of foods at mealtimes? Though the vast majority of residents, including those with cognitive impairment, can reliably answer these and similar questions (4, 5), we nevertheless recommend a periodic double-check based on direct, independent observations. These, our research has found, provide a stable measure of the status quo and unlike resident reports, are not subject to an acquiescent response bias. Direct observations of care delivery also yield information that is significantly more accurate than medical record documentation of daily care delivery.

Direct observations, however, can be time consuming and difficult to conduct. We don’t recommend observations when the care routines in question occur sporadically throughout the day, such as incontinence care and walking assistance. Observations are most feasible when the targeted care routines or staff behaviors are expected to occur within a specific time period in a

known place such as mealtimes, bedtimes, or during morning and afternoon social activities. On these occasions, a supervisory-level staff person can stand ready, checklist in hand, to witness and record elements of usual care. For an example of a standardized observational protocol, see our *Mealtime Observational Protocol* or our *Quality Improvement Observation Form: Meals*.

MDS and Medical Chart Data: Evidence of often blatant inaccuracies recorded in medical charts and MDS assessments dictate against using these as the sole data sources for quality improvement efforts. Through a combination of care requirements that exceed industry resources and a survey process dependent on chart reviews, we have created a culture of inaccurate documentation in nursing homes. Under the current system, nursing homes risk penalties if their staff fails to record that such tasks as feeding assistance and repositioning are occurring regularly. So staff members make sure to chart the care as provided consistent with federal regulations, but too often do not actually deliver it. Surveyors, however, cannot easily detect this ultimate failure.

Although medical chart and especially MDS data are widely used to evaluate quality of care in nursing homes—the quality measures publicly reported by the Centers for Medicare and Medicaid Services are derived from MDS data, for example—we have repeatedly found some of this information to be inaccurate (4-6) and so recommend its use only in conjunction with data gleaned from other assessment strategies, such as resident reports or direct observations. In fact, we strongly encourage you to use our resident interview protocols to more accurately assess residents’ care preferences, for the purpose of both MDS assessment and care planning.

What is the Nursing Home Quality Initiative?

The initiative's government sponsor, *the Centers for Medicare and Medicaid Services*, explains:

"In November 2002, the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, began a national Nursing Home Quality Initiative (NHQI). The goals of the initiative are essentially twofold:

1. To provide consumers with an additional source of information about the quality of nursing home care by providing a set of MDS-based quality measures on Medicare's Nursing Home Compare web site, and
2. To help providers improve the quality of care for their residents by providing them with complementary clinical resources, quality improvement materials, and assistance from the Quality Improvement Organizations in every state.

"Many nursing homes have already made significant improvements in the care being provided to residents by taking advantage of these materials and the support of Quality Improvement Organization staff."

Read on to find out more about Quality Improvement Organizations.

What are Quality Improvement Organizations?

Quality Improvement Organizations (QIOs) are government-sponsored organizations that work to improve the quality of health care provided by physicians, hospitals, home health agencies, and nursing homes. QIOs—one in each state—have new

responsibilities under the Nursing Home Quality Initiative to help nursing homes improve care quality.

The *website of the Centers for Medicare and Medicaid Services (CMS)* describes the role of QIOs: "For purposes of the Nursing Home Quality Initiative, QIOs have been given the responsibility to promote awareness and use of publicly reported nursing home quality measures, and to provide assistance to nursing homes in their State which seek to improve performance. QIOs will seek to accomplish this by conveying the message that some nursing homes do better than others in regard to quality measures important to beneficiaries and caregivers, and by making available information and assistance to facilities about how they can achieve better performance."

You can find your state's QIO by using the QIO Locator on the website of the *American Health Quality Association*. You may also want to visit the websites of other state QIOs to see what materials and information they offer nursing homes.

The Centers for Medicare and Medicaid Services (CMS) reports quality measures for the nation's nursing homes. Are these accurate indicators of care quality?

The CMS quality measures—there are 11 of them pertaining to chronic care—report the prevalence of such common conditions in nursing homes as weight loss, incontinence, and the use of physical restraints. The underlying assumption is that differences in the quality of care provided by facilities explain differences in their prevalence quality measures. Thus, for example, if the percentage of residents who experienced a weight loss episode is 10% in Nursing Home A and 35% in Nursing Home B, then Nursing Home A presumably is doing a better job of

assessing risk and preventing weight loss than Nursing Home B.

Such assumptions can be fallacious, however. In a series of studies, we found that some quality measures did indeed reflect differences in care quality between facilities (4), while others did not (5-7). In one case, we found that, contrary to popular assumption, nursing homes reporting a higher prevalence of chronic pain among residents did a better job of assessing and treating pain than homes reporting a lower prevalence (4). Overall, we found that very few nursing homes were adequately addressing any of the common problems reflected in the quality measures.

CMS notes that its quality measures are “dynamic” and continue to be refined based on recommendations from a National Quality Forum comprised of nursing home providers, consumers and researchers. It cautions consumers that the “quality measures are only one thing to consider when deciding about nursing home care” and recommends that they visit nursing homes to evaluate care and review other facility information from additional sources—recommendations that we wholeheartedly endorse.

For nursing homes, particularly those with poor scores on their report cards, the quality measures are a concern, as they are meant to be. As such, they have successfully sparked new improvement efforts in nursing homes nationwide. From a quality improvement standpoint, the measures, essentially prevalence rates, provide meager information to guide improvement programs. Though some signal a serious problem within a facility, none show how to correct it. For that kind of guidance, this website can help (see our *Training Modules*) as can the state *Quality Improvement*

Organizations and other organizations found on our *Links page*.

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Quality of Life Assessment: Related Studies

SELECTING RESIDENTS TO INTERVIEW

Selecting Nursing Home Residents for Satisfaction Surveys

Sandra F. Simmons, John F. Schnelle, Gwen C. Uman, A.D. Kulvicki, K.O. Lee, and Joseph G. Ouslander, 1997, in *The Gerontologist*, 37(4):543-550.

Many cognitively impaired nursing home (NH) residents are excluded from interviews measuring quality of life or care, even care preference assessment, based on the belief that these residents cannot accurately answer questions. These exclusions are based on subjective criteria and ignore individual differences among cognitively impaired NH residents. This study describes a screening rule based on Minimum Data Set (MDS) data that provides an objective method for identifying residents capable of accurate report. Sixty percent of a sample of 83 NH residents who could answer yes or no questions about their care could do so accurately. Eighty-one percent of the sample was correctly classified by the MDS Cognitive Performance Scale (CPS). The MDS-derived CPS score ranges from 0 (cognitively intact) to 6 (severely impaired); and, residents with CPS scores of 2 or less were capable of accurately describing the daily care that they received from staff. The disadvantage of using MDS-derived CPS to select residents for interview is that it is somewhat cumbersome to calculate.

The Identification of Residents Capable of Accurately Describing Daily Care: Implications for Evaluating Nursing Home Care Quality

Sandra Simmons, John F. Schnelle, 2001, in *The Gerontologist*, 41(5):605-611.

This study confirmed findings from the study cited above but also simplified the resident selection criteria for ease of use in practice by both nursing home and survey staff.

Specifically, this study showed that the *Minimum Data Set (MDS) derived Recall Subscale*, which is part of the Cognitive Performance Scale (CPS), can be used to identify residents capable of accurate self-report of their care. Based on interview responses from 186 incontinent residents, the study showed that selecting residents who scored *two or more* on the four orientation items that comprise the recall subscale correctly identified accurate self-reporters 70% of the time. Surprisingly the use of a standardized cognitive performance test (i.e., the Mini-Mental State Exam) did not improve upon the predictive value of the MDS Recall subscale. The authors write: "Based on the results of this study, the most time-efficient and simple approach to identify incontinent NH residents capable of accurately describing the care that they receive would be to calculate the MDS Recall subscale score and include all residents in the interview who score 2 or higher on this scale. This calculation could be completed quickly if one has access to the MDS information, which is available for all NH residents." The use of the efficient MDS Recall scale to identify residents capable of accurate self-report is preferable to the subjective approaches to screening often used in nursing homes. Moreover, it is even preferable to use of the MDS-derived CPS scale, which is more difficult to calculate. It is recommended, however, that the four orientation items on the MDS recall subscale be completed based on the most recent 7-day period for individual residents, when selecting residents appropriate for interview, instead of relying on their most recent MDS assessment, which is likely to be several months old.

Improving Nursing Home Quality Assessment: Capturing the Voice of Cognitively Impaired Elders

John F. Schnelle, 2003, in *J. Gerontol. A Biol. Sci. Med. Sci.*, 58:M238-M239.

In this editorial, a commentary on a research report by *Kane, et al.* in the same issue (1), Dr. Schnelle argues that “the current quality assessment process should bolster efforts to obtain information directly from nursing home (NH) residents, partly because no one is better positioned to comment on quality than residents themselves, but also because their reports will provide balance to the extensive information currently obtained from staff reports. As it now stands, the state and federal survey process for evaluating NH home care is biased against resident assessments of the care they receive. Although some NH residents are interviewed about their care during on-site survey visits ...many more residents could be interviewed than is currently the case.” He identifies a need for further work to ensure that quality assessments based on resident interviews are time- and cost-efficient to implement, do not unduly burden residents, and are designed so as to minimize acquiescence response bias. But noting that specific guidelines for selecting residents to interview are now available (*see the first two studies on this page*) he concludes: “The question now is not, ‘Should we improve the quality assessment process by interviewing more residents?’ but rather, ‘How do we interview more residents within the cost constraints of the quality assessment process?’”

DESIGNING AND ANALYZING INTERVIEW QUESTIONS

Strategies to Measure Nursing Home Residents’ Satisfaction and Preferences Related to Incontinence and Mobility Care: Implications for Evaluating Intervention Effects

Sandra F. Simmons and John F. Schnelle, 1999, in *The Gerontologist*, 39(3):1-11.

This study compared four different interview strategies to measure 111 incontinent nursing home residents’ “met needs” related to incontinence and mobility care. In one method—perhaps the most commonly used strategy in nursing homes—residents were asked direct satisfaction questions (e.g., “Overall, are you satisfied with how often someone helps you to walk?”). A second method asked residents about their preferences for care (e.g., “Would you like for someone to help you walk more often?” “How many times during the day would you like someone to help you to walk?”) The last two methods compared resident reports about how often they preferred to receive care to how often they actually did receive care based first on research staff observations (Method 3) and then according to their own self-reports (Method 4). Incontinent residents who passed a simple responsiveness screen (residents were asked to state their name or identify two common items) were interviewed. Each resident was interviewed on two occasions to evaluate the stability of their responses. Results showed that 75% of the residents provided logically consistent responses, a finding that dispels the widespread assumption that only a small subset of cognitively intact residents can provide meaningful information about the care they receive.

Of the four methods tested, the third method proved superior with respect to response

stability. Method 1 yielded the most unstable responses. The third method also revealed comparatively higher levels of “unmet need,” but by doing so, is considered more useful for guiding improvement efforts. The authors acknowledge that Method 3 is the most time-consuming to implement because it requires objective, direct observations of the care actually provided to residents. They argue, however, that this type of monitoring should be conducted at least annually in any case and, ideally, more often for on-going quality improvement efforts.

A Comparison of Methods to Assess Nursing Home Residents’ Unmet Needs

Lené Levy-Storms, John F. Schnelle, and Sandra F. Simmons, 2002, in *The Gerontologist*, 42(4):454-461.

This study compared three interview methodologies to assess nursing home residents’ unmet needs for daily care. The researchers interviewed 70 residents across seven Activity of Daily Living (ADL) care domains using three types of questions:

- direct satisfaction questions about ADL care (e.g., “Overall, are you satisfied with how often someone helps you to walk?”),
- questions that compared residents’ preferences for ADL care frequency to their perceptions of the ADL care received (discrepancy measure, e.g., “How many times during the day would you like staff to help you walk?” vs. “How many times during the day do staff help you to walk?”), and
- open-ended questions that asked what residents wanted changed about ADL care.

Estimates of the proportion of residents with unmet needs were significantly higher with the discrepancy and open-ended measures as compared to the direct satisfaction measures across most ADL care domains.

The analysis of residents’ responses to open-ended questions produced the most useful information for individualizing aspects of technical care and assessing the interpersonal quality of care, whereas the discrepancy questions elicited specific information useful for changing the frequency or occurrence of ADL care. Interview methodologies that directly ask residents questions about satisfaction with ADL care are the least useful for designing improvement interventions.

The authors underscore the importance of including open-ended questions in nursing home care assessments, while acknowledging that these questions require significantly more time and skill to record and code than closed-ended questions. They recommend asking open-ended questions at the start of an improvement project, and converting the information elicited by the open-ended questions into closed-ended preference questions, which can then be asked at regular intervals to continuously monitor care quality.

Nursing Home Residents’ Perceptions of Care: A Method for Coding Their Comments into Unmet and Met Needs

Lené Levy-Storms, Sandra F. Simmons, Veronica F. Gutierrez, Dana Miller-Martinez, Kelly Hickey, and John F. Schnelle. Under review at *The Gerontologist*

This study reports on a reliable method for coding nursing home residents’ comments about the care they receive and the care they would like to receive. Nursing homes—and the researchers who study them—often use close-ended questions to assess residents’ satisfaction with care. Recent studies, however, suggest that answers to these questions may be skewed by response acquiescence, or the tendency of residents to provide mostly satisfied responses, even when problems with the quality of care are known to exist. Open-

ended questions and spontaneous remarks by residents during interviews have not been analyzed systematically in most studies, in part because a standardized coding protocol has been lacking.

In this study, 67 residents in one nursing facility were asked both closed- and open-ended questions about their perceptions of care in eight domains: social activities, walking, mealtime, dressing, showering, getting in and out of bed, toileting, and incontinence care (pad changes). Their comments were then codified as to whether they indicated a desire for change. If the comment did not indicate a desire for change, then it was assessed for indicators of reduced expectation (e.g., "They do the best they can."). Overall, 66% of the residents made comments indicative of unmet needs in at least one care domain. Of these residents, 52% and 84% had unmet emotional support (ES) or instrumental support (IS) needs, respectively, in at least one of the eight domains. Among residents with met needs, 26% had reduced expectations for care.

Coding and analyzing residents' comments supplements information from closed-ended questions in several ways. First, over 30% of the residents provided comments to *only* open-ended questions, so their viewpoints would have been missed by using only closed-ended questions. Second, by recording residents' own words, subtle but often specific aspects of both technical and interpersonal care delivery were assessed. And finally, this study's methodology was sensitive enough to identify reduced expectations among residents who otherwise reported only met needs.

NURSING HOME REPORT CARDS

Designing a Report Card for Nursing Facilities: What Information is Needed and Why

Charlene Harrington, Janis O'Meara, Martin Kitchener, Lisa Payne Simon, and John F. Schnelle, 2003, in *The Gerontologist*, 43: 47-57.

Abstract from the paper: "This article presents a rationale and conceptual framework for making comprehensive consumer information about nursing facilities available. Such information can meet the needs of various stakeholder groups, including consumers, family/friends, health professionals, providers, advocates, ombudsman, payers, and policy makers. The rationale and framework are based on a research literature review of key quality indicators for nursing facilities. The findings show six key areas for information: (a) facility characteristics and ownership; (b) resident characteristics; (c) staffing indicators; (d) clinical quality indicators; (e) deficiencies, complaints, and enforcement actions; and (f) financial indicators. This information can assist in selecting, monitoring, and contracting with nursing facilities. Model information systems can be designed using existing public information, but the information needs to be enhanced with improved data."

The Minimum Data Set Weight Loss Quality Indicator: Does it Reflect Differences in Care Processes Related to Weight Loss?

Sandra F. Simmons, Emily T. Garcia, Mary P. Cadogan, N.R. Al-Samarrai, Lené Levy-Storms, Dan Osterweil, and John F. Schnelle, in *Journal of the American Geriatrics Society*, 2003;51(10):1410-1418

Federal regulations require nursing homes to complete resident assessments periodically using the Minimum Data Set (MDS) assessment protocol. Results are used to generate quality indicators (QI) for each facility as a means of identifying poor

outcomes in a number of clinical areas. The use of QIs as a measure of quality of care is controversial due in part to concerns about the accuracy of staff-generated MDS data.

This study collected independent data that showed that the MDS-derived “prevalence of weight loss” QI does indeed discriminate between nursing homes with a high percentage of residents at risk for weight loss and those with a much lower percentage of at-risk residents. A desirable, low score on this QI, however, did not mean that the facility provided better nutritional care to its residents. In fact, results indicated that all the facilities needed to improve the adequacy and quality of feeding assistance care provision. The one consistent, between-group difference in care quality was that staff in low-weight loss prevalence homes were more likely to interact socially and verbally prompt residents to eat than staff in high-weight loss prevalence homes. Other studies have shown that verbal encouragement to eat and social interaction at mealtimes leads to increased food consumption among the elderly.

A Minimum Data Set Prevalence of Pain Quality Indicator: Is it Accurate and Does it Reflect Differences in Care Processes?

Mary P. Cadogan, John F. Schnelle, Noriko Yamamoto-Mitani, Georgina Cabrera, and Sandra F. Simmons, accepted for publication in *Journal of Gerontology:Medical*, 2004;59A(3):281-285.

Federal regulations require nursing homes to complete resident assessments periodically using the Minimum Data Set (MDS) assessment protocol. Results are used to generate quality indicators (QI) in a number of clinical areas for each facility, which consumers can then use to compare nursing homes. The use of QIs as a measure of quality of care is controversial due in part to concerns about the accuracy of staff-generated MDS data.

This study, conducted in 16 nursing homes, collected independent data that showed that the MDS quality indicator “prevalence of pain” does indeed accurately discriminate between facilities. Interpretation of the pain indicator requires caution, however. Rather than reflecting poor quality, a high prevalence of pain according to the MDS was associated with better pain assessment and treatment care processes. This study reports results from eight nursing homes that scored in the upper 75th percentile on the prevalence of pain QI and eight nursing homes that scored in the lower 25th percentile for the same QI. Research staff collected data through interviews with 255 residents and medical record reviews.

In high prevalence homes, 47% of the participating residents had pain documented on their most recent MDS and the same percentage reported symptoms of chronic pain during interviews with research staff. By contrast, in low prevalence homes, 9% of the participating residents had pain documented on their most recent MDS, but 27% reported chronic pain symptoms in interviews. On every measure of pain-related care quality independently evaluated in this study (detection, assessment, treatment, and documentation), nursing homes with a high reported prevalence of pain on the MDS performed better than nursing homes with low MDS pain prevalence. One explanation, according to the authors, is that a higher prevalence of pain among residents sensitizes nursing home staff to the need for better overall pain care.

The Minimum Data Set Urinary Incontinence Quality Indicators: Do They Reflect Differences in Care Processes Related to Incontinence?

John F. Schnelle, Mary P. Cadogan, June Yoshii, Nahla R. Al-Samarrai, Dan Osterweil, Barbara M. Bates-Jensen, and Sandra F. Simmons, 2003, in *Medical Care*, 41(8):909-922.

Federal regulations require nursing homes to complete resident assessments periodically using the Minimum Data Set (MDS) assessment protocol. Results are used to generate quality indicators (QI) for each facility as a means of identifying poor outcomes in a number of clinical areas. The use of QIs as a measure of quality of care is controversial due in part to concerns about the accuracy of staff-generated MDS data.

This study, conducted in 14 nursing homes, collected independent data that showed that the only two currently used MDS incontinence QIs—"prevalence of incontinence" and "prevalence of incontinence without a toileting plan"—do *not* reflect differences in the quality of incontinence care provided to residents. None of the facilities, for example, evaluated residents' responsiveness to toileting assistance. Residents who received toileting assistance were comparatively less cognitively and physically impaired, which suggests that staff used invalid resident characteristics to determine who received scheduled toileting assistance. Although facilities with better scores on both MDS incontinence QIs were more likely to document in medical records that residents received toileting assistance, there was no difference between homes in resident reports of the assistance they actually received. Across all facilities, participants capable of accurate self-report said they received an average of 1.8 toileting assists per day (range 1.6-2.0), which is insufficient to improve urinary incontinence but consistent with the findings from previous

studies. There also were no differences in reports of received assistance between residents noted in the MDS as being on scheduled toileting and those who were not. This finding points to disturbing discrepancies between the toileting assistance care documented in medical charts and the care actually provided to incontinent residents.

The Minimum Data Set Pressure Ulcer Indicator: Does it Reflect Differences in Care Processes Related to Pressure Ulcer Prevention and Treatment in Nursing Homes

Barbara M. Bates-Jensen, Mary Cadogan, Dan Osterweil, Lené Levy-Storms, Jennifer Jorge, Nahla Al-Samarrai, Valena Grbic, and John F. Schnelle, 2003, in *J Am Geriatrics Society*, 51(9):1203-12.

This study showed that, despite assumptions to the contrary, nursing homes with low prevalence rates for pressure ulcers (PU) do not provide better PU care than homes with high prevalence rates. In general, all 16 nursing homes in this study performed poorly on screening and preventing PUs, though they did better at management once a PU was present.

The study examined 16 quality indicators related to PU care in two groups of nursing homes: Six homes with a high prevalence of PU and 10 with a low prevalence of PU. At the time of the study, prevalence of PU as reported in Minimum Data Set (MDS) resident assessments was a publicly reported quality indicator for nursing homes. (This quality indicator has since been revised.) The researchers observed care, interviewed caregivers, reviewed medical records, and obtained data from wireless thigh movement monitors.

They found few differences between the two study groups. Homes with low PU prevalence rates—and low scores on the MDS PU quality indicator—did not provide

better care. Nursing homes with higher rates of PU, however, were more likely to use pressure-reduction surfaces and were better at documenting wound characteristics.

None of the facilities documented PU risk on admission and once a week for four weeks following admission, though most clinical guidelines recommend periodic reassessments for high risk residents. Also of concern was a wide discrepancy between medical record documentation and actual care delivery. For example, neither high- nor low-prevalence homes routinely repositioned PU risk residents every two hours, as recommended in clinical practice guidelines, even though two-hour repositioning was documented in the medical record for nearly all participating residents.

“These data raise questions about the usefulness of this (PU quality) indicator for improvement, survey, or consumer education purposes,” the investigators conclude (JF Schnelle quote). “In particular, it should not be assumed that homes that score well (low prevalence) on the MDS PU quality indicators are providing good or better care than homes that report a high prevalence. A more accurate interpretation is that all homes provide relatively poor preventive care and that improvement is needed in most care process areas other than treatment once a PU is present.”

**Resident choice and the survey process:
The need for standardized observation
and transparency**

JF Schnelle, R Bertrand, D Hurd, A White, D Squires, M Feuerberg, K Hickey, SF Simmons. In *The Gerontologist* 2009 (in press).

The purpose of this nation-wide study was to describe a standardized observation protocol to determine if nursing home (NH) staff offer choice to residents during three morning Activities-of-Daily Living (ADL) care

activities and compare the observational data to deficiency statements cited by state survey staff. Morning ADL care was observed in 20 NHs in five states by research staff using a standardized observation protocol. The number of observations in which choice was not offered was documented for three morning ADL care activities and compared to deficiency statements made by surveyors. Results showed that NH staff failed to offer choice during morning ADL care delivery for at least one of the three ADL care activities in all 20 study homes. Observational data showed residents were not offered choice about when to get out of bed (11%), what to wear (25%), and/or breakfast dining location (39%). In comparison, survey staff issued only two deficiencies in all 20 NHs relevant to choice in the targeted ADL care activities, and neither deficiency was based on observational data. Survey interpretative guidelines instruct surveyors to observe if residents are offered choice during daily care provision but standardized observation protocols are not provided to surveyors to make this determination. The use of a standardized observation protocol in the survey process similar to that used by research staff in this study would improve the accuracy and transparency of the survey process. In addition, the researchers advocate the use of the standardized observational protocol by internal, supervisory-level NH staff to monitor daily care provision on an on-going basis to ensure that residents are offered choice during daily care.

OTHER QUALITY-OF-LIFE STUDIES

Family Members' Preferences for Nutrition Interventions to Improve Nursing Home Residents' Oral Food and Fluid Intake

Sandra F. Simmons, Helene Y. Lam, Geetha Rao, and John F. Schnelle, 2003, in *Journal of the American Geriatrics Society*, 51(1):69-74.

What nutrition interventions do family members prefer for relatives in nursing homes who are at risk for undernutrition and weight loss? Given a choice of six possible interventions, the 105 resident representatives, mostly family members, who completed this study's written questionnaire, rated them, in order of preference, as follows:

- Improve quality of food
- Improve quality of feeding assistance
- Provide multiple small meals and snacks throughout the day
- Place resident in preferred dining location
- Provide oral liquid nutrition supplements
- Provide an appetite stimulant medication

These findings indicate a clear preference among residents' significant others for behavioral and environmental approaches over the use of supplements or pharmacological approaches to improve food and fluid intake. The authors point out that resident preferences could not be assessed directly in this study due to the questionnaire's rather complex design, but future studies should attempt to correct this shortcoming.

Quality Assessment in Nursing Homes by Systematic Direct Observation: Feeding Assistance

Sandra F. Simmons, Sarah Babineau, Emily Garcia, and John F. Schnelle, in *Journal of Gerontology: Medical Sciences*, 2002, 57(10): M665-M671.

This study showed that a standardized protocol that calls for direct observations of care can be used to accurately measure the adequacy and quality of feeding assistance in nursing homes. The observational protocol, designed for routine use by licensed nursing home staff, is a practical alternative to reviewing medical chart information to monitor quality of care. Prior studies have shown that chart information is unreliable in that it consistently overestimates residents' food and fluid intake and feeding assistance care provision. The observational protocol assesses the ability of nurse aides to accomplish four tasks deemed critical to the delivery of adequate feeding assistance. These tasks include: 1) accurately identifying residents with clinically significant low oral food and fluid intake during mealtimes; 2) providing feeding assistance to at-risk residents during mealtimes; 3) providing feeding assistance to residents identified in the Minimum Data Set as requiring staff assistance to eat; and 4) providing a verbal prompt to residents who receive physical assistance at mealtimes. The study showed that the protocol is reliable, replicable, and feasible to implement. One staff person can use it to reliably observe 6 to 8 residents during one mealtime period.

Urinary Incontinence Treatment Preferences in Long-Term Care

Theodore M. Johnson, Joseph G. Ouslander, Gwen C. Uman, and John F. Schnelle, 2001, in *Journal of the American Geriatrics Society*, 49:710-718.

What treatments for urinary incontinence are preferred for nursing home residents? This study asked this question of frail older adults, family members of nursing home residents, and long-term-care nursing staff. Among all respondents, 85% “definitely” or “probably” preferred diapers, and 77% “definitely” or “probably” preferred a prompted-voiding toileting protocol to indwelling catheterization. There were, however, differences among the respondent groups. Nurses preferred prompted-voiding to diapers more than did older adults or family members. Older adults, compared with family and nurse respondents, more strongly preferred medications to diapers. In open-ended responses, older adults (nine of them nursing home residents and 70 residential care residents) said they would choose a treatment based in part upon criteria of feeling dry, being natural, not causing embarrassment, being easy, and not resulting in dependence. The comments also indicated that older adults and family members did not believe nursing home staff would provide prompted-voiding often enough to improve continence. Because of the divergence of opinions among different proxy respondents, the researchers recommend that, when possible, nursing home residents be asked first for their incontinence treatment preferences.

A Cost and Value Analysis of Two Interventions with Incontinent Nursing Home Residents

John F. Schnelle, Emmett Keeler, Ron D. Hays, Sandra F. Simmons, Joseph G. Ouslander, and Albert L. Siu, 1995, in *Journal of the American Geriatrics Society*, 43:1112-1117.

In this study, family members of nursing home residents and older board-and-care residents were asked in a written survey to compare the value of interventions that improve continence and mobility to other nursing home perks such as improved meals or moving to a more private room. By wide margins, the respondents rated the functional improvement programs higher than the other, more customary options. The top-rated programs were a physical therapy program that provides 15 additional minutes of supervised activity and exercise a day, an incontinence prevention program that reduces the number of wetness episodes in half for a resident, and a program that improves the amount a resident can walk by a few minutes a day. These services were significantly preferred to any of the bottom-rated, non-rehabilitative services, which included having one additional nurse aide on the unit during the day shift, moving from a triple room to a single, from a triple room to a double, and from a double room to a single. The researchers point out that while nursing home consumers often complain about privacy and food issues, they rarely request services that improve continence and walking, most likely because they are unaware of such rehabilitative programs.

Links and Other Resources

Agency for Health Care Quality and Research

Report (1999): Long-Term Care: Quality of Care is Most Important Nursing Home Measure

<http://www.ahcpr.gov/research/jun99/ra7.htm>

American Geriatrics Society (AGS)

Position Statement: Measuring Quality of Care for Nursing Home Residents - Considering Unintended Consequences

http://www.americangeriatrics.org/products/positionpapers/unintended_conseq.shtml

American Health Quality Association

www.ahqa.org

Center for Health Systems Research and Analysis

University of Wisconsin at Madison
Developed the nursing home quality measures used by the Centers for Medicare and Medicaid Services

<http://www.chsra.wisc.edu>

Centers for Medicare and Medicaid Services

Nursing Home Quality Initiative

<http://www.cms.hhs.gov/quality/nhqi/>

Commonwealth Fund

Report (2001): Promoting Quality in Nursing Homes: The Well Spring Model

http://www.cmf.org/programs/elders/reinhard_wellspring_432.pdf

Medicare: Nursing Homes Compare

<http://www.medicare.gov/NHCompare/include/DataSection/Questions/SearchCriteria.asp>

National Citizens Coalition on Nursing Home Reform

<http://www.nccnhr.org/default.cfm>

U.S. General Accounting Office

Report (2002): Nursing Homes: Quality of Care More Related to Staffing than Spending

<http://www.gao.gov/new.items/d02431r.pdf>

U.S. Office of the Inspector General

Report (2003): Quality Assurance Committees in Nursing Homes

<http://oig.hhs.gov/oei/reports/oei-01-01-00090.pdf>

Quality of Life Assessment: Forms

Nursing Home Resident Interview Forms to Assess Care Preferences For:

- [Toileting assistance](#)
- [Walking assistance](#)
- [Dressing and personal hygiene assistance](#)
- [Getting in and out of bed](#)
- [Social activity participation](#)

Nursing Home Resident Interview Forms to Assess:

- [Food service complaints and dining location preferences](#)
- [Depression](#)
- [Chronic pain](#)

Forms for Targeting Interviews:

- [MDS Recall Subscale](#)
- [MDS Ratings for Assistance with Activities of Daily Living](#)
- [Cognitive Performance Scale \(CPS\) Calculator](#)

Resident Center Care Forms:

- [ADL Choice Observation Protocol](#)
- [Morning ADL Choice Interview](#)

NURSING HOME RESIDENT INTERVIEW: MET NEEDS AND CARE PREFERENCES

RESIDENT NAME/ ID# _____

DATE: ____/____/____

FACILITY/ROOM #: _____

INTERVIEWER NAME: _____

DK = "Don't Know" ; NR = "no response" or "nonsense response"

INCONTINENCE CARE: Toileting Assistance

Interviewer: "I would like to ask you some questions about the help you receive to use the toilet".

1. Has somebody who works here helped you to use the toilet today? ___Yes ___No ___DK/NR

2. How many times during the day does someone who works here help you to use the toilet (bedpan,urinal)?

___0 ___1 ___2 ___3 ___ More than 3 ___INDEPENDENT ___DK/NR

If DK, NR, or unclear response: Do you think you get help to use the toilet (bedpan, urinal)

___Not at all/0 times ___1 time/day or ___More than 1 time/day

3. Are you ever afraid to ask the staff to help you to use the toilet? ___Yes ___No ___DK/NR

4. IF resident reports receiving toileting assistance from staff, ask:

Do you have to wait a long time for someone to help you use the toilet? ___Yes ___No ___DK/NR

5. How many times during the day would you like someone to help you use the toilet (bedpan, urinal)?

___0 ___1 ___2 ___3 ___ More than 3 ___DK/NR

6. If you could change something about the toileting schedule or the way staff help you to use the toilet (bedpan, urinal), what would it be?

NURSING HOME RESIDENT INTERVIEW: MET NEEDS AND CARE PREFERENCES

RESIDENT NAME/ ID# _____

DATE: ____/____/____

FACILITY/ROOM #: _____

INTERVIEWER NAME: _____

DK = "Don't Know" ; NR = "no response" or "nonsense response"

MOBILITY ASSISTANCE: Walking

Interviewer: "I would like to ask you some questions about the help you receive to walk".

1. Has somebody who works here helped you to walk today? ___Yes ___No ___DK/NR

2. How many times during the day does someone who works here help you walk?

___0 ___1 ___2 ___3 ___ More than 3 ___INDEPENDENT ___DK/NR

___ Other (e.g., 3 times / week): _____

If DK, NR, or unclear response: Do you think you get help to walk

___Not at all/0 times ___1 time/day or ___More than 1 time/day

3. Are you ever afraid to ask the staff to help you to walk? ___Yes ___No ___DK/NR

4. Does someone help you to walk when you want to walk? ___Yes ___No ___DK/NR

5. How many times during the day would you like someone to help you to walk?

___0 ___1 ___2 ___3 ___ More than 3 ___DK/NR

6. If you could change something about your walking schedule or the way staff help you to walk, what would it be?

NURSING HOME RESIDENT INTERVIEW: MET NEEDS AND CARE PREFERENCES

RESIDENT NAME/ ID# _____
FACILITY/ROOM #: _____

DATE: ____/____/____

INTERVIEWER NAME: _____

DK = "Don't Know" ; NR = "no response" or "nonsense response"

DRESSING, GROOMING, and PERSONAL HYGIENE ASSISTANCE

Interviewer: "I would like to ask you some questions about the help you receive to get dressed."

1. Did someone who works here help you get dressed today? ___YES ___NO (Independent)
___DK/NR

2. Did someone who works here help you to:

a. Comb your hair today? ___YES ___NO (Independent) ___NO (Didn't get done) ___DK/NR

b. Clean your mouth/teeth today? ___YES ___NO (Independent) ___NO (Didn't get done)
___DK/NR

3. Did you have to wait a long time for someone to help you get dressed today?

___YES ___NO (Independent) ___DK/NR

4. If you could change something about the way staff help you to get ready or the things they do for you, what would it be?

5. How often do you have a shower or bath?

___Every Day ___1/week ___2/week ___3/week #Stated by Resident: _____

6. How often would you like to have a shower or bath?

___Every Day ___1/week ___2/week ___3/week #Stated by Resident: _____

7. If you could change something about your shower/bath schedule or the way staff help you to take a shower or bath, what would it be?

NURSING HOME RESIDENT INTERVIEW: MET NEEDS AND CARE PREFERENCES

RESIDENT NAME/ ID# _____

DATE: ____/____/____

FACILITY/ROOM #: _____

INTERVIEWER NAME: _____

DK = "Don't Know" ; NR = "no response" or "nonsense response"

IN and OUT of BED SCHEDULE

Interviewer: "I would like to ask you some questions about your bedtime schedule."

1. About what time do you get out of bed in the morning? _____(Fill in time) ___DK/NR

If DK/NR: Do you get out of bed before or after breakfast? ___Before breakfast ___After breakfast

2. Do you have to wait a long time for someone to help you out of bed?

___YES ___NO ___SOMETIMES ___DK/NR

3. About what time do you like to get out of bed in the morning? _____(Fill in time) ___DK/NR

If DK/NR: Do you like to get out of bed before or after breakfast? ___Before ___After breakfast

4. Do you go back to bed for a nap during the day? ___YES ___NO ___SOMETIMES ___DK/NR

5. Do you like to take naps during the day? ___YES ___NO ___SOMETIMES ___DK/NR

6. About what time do you go back to bed at night? _____(Fill in time) ___DK/NR

If DK/NR: Do you go back to bed before or after dinner? ___Before dinner ___After dinner

7. About what time do you like to go back to bed at night? _____(Fill in time) DK NR

If DK/NR: Do you like to go back to bed before or after dinner? ___Before dinner ___After dinner

8. If you could change something about your bedtime schedule and/or the way staff help you in and out of bed, what would it be?

NURSING HOME RESIDENT INTERVIEW: MET NEEDS AND CARE PREFERENCES

RESIDENT NAME/ ID# _____

DATE: ____/____/____

FACILITY/ROOM #: _____

INTERVIEWER NAME: _____

DK = "Don't Know" ; NR = "no response" or "nonsense response"

SOCIAL ENVIRONMENT

Interviewer: "I would like to ask you some questions about the kinds of activities you enjoy."

1. Do you go to any of the activities here? (Provide examples of activities offered by the facility)

___YES ___NO ___SOMETIMES ___DK/NR

2. Do the people who work here tell you about the activities (that are scheduled for the day)?

___YES ___NO ___SOMETIMES ___DK/NR

3. Do you enjoy going to the activities here? ___YES ___NO ___SOMETIMES ___DK/NR

3a. Which activities do you enjoy the most? (Prompt with activities offered by the facility)

4. If you could change something about the activity schedule or the activities offered here, what would it be?

Interviewer: "Now I would like to ask you a few questions about the people who work here."

5. Do the people who work here talk to you in a nice way when they are helping you (e.g., to walk, eat, get dressed)? ___YES ___NO ___SOMETIMES ___DK/NR

6. Do you feel rushed when they are helping you (e.g., to walk, eat, get dressed, use the toilet)?

___YES ___NO ___SOMETIMES ___DK/NR

7. Do the people who work here tell you when they will be back to check on you again?

___YES ___NO ___SOMETIMES ___DK/NR

8. If you could change something about the care or the staff here, what would it be?

Nutrition and Food Complaints

Resident Name: _____ Staff Interviewer: _____

Date of Interview: ____/____/____
mm dd yy

Check Response

DK = Don't Know NR = No Response or Nonsense Response REF=Refusal to answer question

Food Complaints:

1. Do you like the food here? _____ YES _____ NO _____ SOMETIMES _____ DK/NR/REF

IF NO, what would you change to make it better?(i.e., *more salt, sugar, no restricted diet*)

2. Do you feel that there enough variety / food choices? _____ YES _____ NO _____ SOMETIMES _____ DK/NR/REF

3. Does the food look good / appetizing / attractive to you? _____ YES _____ NO _____ SOMETIMES _____ DK/NR/REF

4. Is the food served at the right temperature (i.e., *coffee and soup served hot; jello served cold*)?
_____ YES _____ NO _____ SOMETIMES _____ DK _____ NR

5. If you don't like the food that you are given, can you get something else instead? (or do you just have to wait until the next meal is served and hope that you will like that)?
_____ YES _____ NO _____ SOMETIMES _____ DK/NR/REF

TOTAL SCORE FOOD COMPLAINTS (Total number of "no"s to Questions 1-5): _____

PRESENCE OF FOOD COMPLAINTS (Any "no" answer to Questions 1-5): Complaints No Complaints

Do not calculate total score only if all responses to questions 1-5 were DK/NR/REF
A response of "sometimes" should be treated as a "no" (1 point) in scoring.

Food and Dining Location Preferences:

6. Would you like to have a snack (e.g., *fruit, pudding, cookies, juice*) between meals (*breakfast, lunch, dinner*)?
_____ YES _____ NO _____ SOMETIMES _____ DK _____ NR

IF YES, What kinds of foods/drinks would you like to have for a snack?

7. Where do you like/prefer to eat:

Breakfast: _____ In Room _____ Outside of Room _____ Dining Room

Lunch: _____ In Room _____ Outside of Room _____ Dining Room

Dinner: _____ In Room _____ Outside of Room _____ Dining Room

<u>outcome</u>	<u>Interview</u>
Complete	_____ 1
Incomplete DK	_____ 2
Incomplete NR	_____ 3
Incomplete REF	_____ 4

Geriatric Depression Scale

Resident Name: _____ Staff Interviewer: _____

Date of Interview: ___/___/___
mm dd yy

Check Response

DK=Don't Know NR=No Response or Nonsense Response REF=Refusal to answer question

IF RESPONSE OF "SOMETIMES", RESTATE THE QUESTION: "How do you feel MOST of the time?"

- | | | | |
|---|---------|--------|---------------|
| 1. Are you basically satisfied with your life? | ___ YES | ___ NO | ___ DK/NR/REF |
| 2. Have you dropped most of your activities and interests? | ___ YES | ___ NO | ___ DK/NR/REF |
| 3. Do you feel that your life is empty? | ___ YES | ___ NO | ___ DK/NR/REF |
| 4. Do you often get bored? | ___ YES | ___ NO | ___ DK/NR/REF |
| 5. Are you in good spirits most of the time? | ___ YES | ___ NO | ___ DK/NR/REF |
| 6. Are you afraid that something bad is going to happen to you? | ___ YES | ___ NO | ___ DK/NR/REF |
| 7. Do you feel happy most of the time? | ___ YES | ___ NO | ___ DK/NR/REF |
| 8. Do you often feel helpless? | ___ YES | ___ NO | ___ DK/NR/REF |
| 9. Do you think it is wonderful to be alive? | ___ YES | ___ NO | ___ DK/NR/REF |
| 10. Do you feel worthless the way you are now? | ___ YES | ___ NO | ___ DK/NR/REF |
| 11. Do you feel full of energy? | ___ YES | ___ NO | ___ DK/NR/REF |
| 12. Do you feel that your situation is hopeless? | ___ YES | ___ NO | ___ DK/NR/REF |

SCORE > 4 = PROBABLE DEPRESSION

TOTAL SCORE: _____

Scoring System: Each BOLD-FACED answer counts one (1) point.

Do not calculate total score if more than 4 of the 12 questions have DK/NR/REF answers. Print note. "No score due to incomplete resident responses"

Interview outcome

Complete ___ 1
Incomplete DK ___ 2
Incomplete NR ___ 3
Incomplete REF ___ 4

Chronic Pain Assessment

Resident Name: _____ Staff Interviewer: _____

Date of Interview: ____/____/____
mm dd yy

Check Response

DK=Don't Know NR=No Response or Nonsense Response REF=Refusal to answer question

Interviewer: "I want to ask you some questions about pain."

1. Do you have pain right now? _____Yes ___No ___NR/DK/REF

1a. **IF YES**, ask: "On a scale 1 to 10 with 0 meaning no pain and 10 being the worse pain you can imagine, how much pain are you having now?" _____

2. Does pain ever keep you from doing things you enjoy (e.g., social activities, walking, going to dining room for meals, knitting, bingo, going outside)? _____Yes ___No ___DK/NR/REF

3. Does pain ever keep you from sleeping at night? _____Yes ___No ___DK/NR/REF

4. Do you have pain every day? _____Yes ___No ___DK/NR/REF

PROBABLE CHRONIC PAIN (3 or more "yes" responses or "yes" to question 4): Yes No

5. Would you like/prefer to take medication (pill, drug) for your pain? _____Yes ___No ___DK/NR/REF

The presence of probable chronic Pain is determined based on the resident's responses to questions 1 – 4. Probable chronic pain is present if the resident responds "yes" to 3 or more of the first four questions OR in response to question #4 alone (residents reports that he/she experiences pain daily). Presence or absence of probable chronic pain cannot be determined only if ALL 4 questions have DK/NR/REF answers. Question 5 is related to a resident's pain treatment preferences and is not included in scoring.

Interview outcome

Complete ___ 1
Incomplete DK ___ 2
Incomplete NR ___ 3
Incomplete REF ___ 4

MDS Recall Subscale

Resident's name: _____

Check all that the resident was able to accurately recall (in last 7 days):

- a. Current season: _____
 - b. Location of own room: _____
 - c. Staff names and/or faces: _____
 - d. He/she is in a nursing home: _____
- OR
- e. None of the Above: _____

Resident receives 1 point for each item (a-d) checked.

Application: As a general rule, you should conduct interviews for quality improvement purposes with all residents who score 2 or higher on the MDS Recall subscale. Our research shows these residents consistently provide reliable information useful for quality improvement efforts. If your questions ask about services or care processes that occur daily, as opposed to less frequently, then you should also interview residents who score 1 (or more) on the MDS Recall subscale.

MDS ADL Ratings for Assistance Needs (in the last 7 days):

If you are assessing quality of care for a specific activity of daily living (ADL), interview residents who require any level of staff assistance (supervision to total dependence) for that ADL. You can use MDS ADL ratings to identify appropriate interview candidates:

0=Independent (No help or staff oversight OR staff help/oversight provided only 1-2 times)

1= Supervision (Oversight, encouragement, or cueing provided 3 or more times OR supervision + physical assistance provided only 1-2 times)

2=Limited Assistance (Physical help in guided maneuvering 3 or more times OR limited assistance + more help provided only 1-2 times)

3=Extensive Assistance (Full staff assistance provided 3 or more times)

4=Total Dependence (Full staff assistance provided to resident during entire seven-day period)

Cognitive Performance Scale (CPS) Calculator - CMS

Resident Name: _____
 Surveyor Name: _____

Resident Room: _____
 MDS Date: _____

If a resident is comatose (B1 = 1), the CPS score is 7 - Stop!

If B1 = 0, proceed to Step 1.

Step 1: Enter points for each MDS item in the table below to calculate Total A.

Instructions for Scoring Total A:

1. Review item B2a (Short-term memory). If the resident's B2a = 1, score a 1 in the box to the right.
2. Review item B4 (Cognitive skills for daily decision making). If the resident's B4 = 1 or 2, score a 1 in the box to the right.
3. Review item C4 (Making self understood). If the resident's C4 = 1, 2, or 3, score a 1 in the box to the right.
4. Calculate the total for the three boxes.
The total cannot exceed 3.

Impairment Level	MDS Item	Step 1 Score
<i>Impairment</i> Add one point for each item	B2a = 1	
	B4 = 1 or 2	
	C4 = 1, 2 or 3	
	Total A (0 – 3)	0

Step 2: Enter points for each MDS item in the table below to calculate Total B

Instructions for Scoring Total B:

1. Review item B4 (Cognitive skills for daily decision making). If the resident's B4 = 2, score a 1 in the box to the right.
2. Review item C4 (Making self understood). If the resident's C4 = 2 or a 3, score a 1 in the box to the right.
3. Calculate the total for the two boxes.
The total cannot exceed 2.

Impairment Level	MDS Item	Step 2 Score
<i>Severe Impairment</i> Add one point for each item	B4 = 2	
	C4 = 2 or 3	
	Total B (0 – 2)	0

Step 3: Read across table (below) for MDS items B1 and B4, and Totals A and B to determine CPS score.

Instructions for Reading the Table:

1. Review the resident's MDS, items B1 and B4.
2. Note the impairment total counts from Steps 1 and 2.
3. Using the responses for B1 and B4, and Total A and Total B, read across the table to determine the CPS Score.

If B4 = 3 or more, use the resident's Eating score (G1h) to read across the table and determine the CPS score.

- If the resident's G1h = 0 – 3 (not totally dependent in eating), the CPS = 6.
- If the resident's G1h = 4 (totally dependent in eating), the CPS = 7.

MDS Item		Score Totals		MDS Item	CPS Score	
B1	B4	Total A	Total B	G1h		
0	0-2	0	0		1	Interviewable
		1	0		2	
		2-3	0		3	
		2-3	1		4	
		2-3	2		5	
	3		0-3		6	Non-Interviewable
1	3	4	7			

Date CPS Completed: _____

CPS Score: _____

ADL Choice Observation Protocol

Start Time: _____ End Time: _____ Total: _____ Day: 1 2 3 4 5 Observer: _____ Aide ID: _____ Resident: _____ ID#: _____ Name: _____ Rm#: _____	A) Aide Approach	E) Assistance Provided
	1) Knock on door: No Yes DK NA	Present (P) or Absent (A) Continuous
	2) Talk to Resident: No Yes DK NA	Physical
	3) Greet by Name: No Yes DK NA	
	4) State of Resident when enter room: Awake Asleep	Verbal
	5) Location of Resident: In Bed Out of Bed	Social
	6) Type of clothes Bed Street	Total Assistance Time:
	B) Out of Bed Care	
	Spontaneous expression of preference/assistance No Yes DK NA	Care Provided No Yes DK NA
		Honours resident choice No Yes DK NA
Comments:	Write verbatim aide prompt:	Write verbatim resident response to aide prompt:
	a)	a)
	Level of Communication Active Other Assent None	Resident Response to prompt: No Yes Now Later NA NR DK
	b)	b)
	Level of Communication Active Other Assent None	Resident Response to prompt: No Yes Now Later NA NR DK
	c)	c)
	Level of Communication Active Other Assent None	Resident Response to prompt: No Yes Now Later NA NR DK
	If resident stated later: How many minutes later? _____mins Expected time to return: _____	
	C) Toileting	
	Spontaneous expression of preference/assistance No Yes DK NA	Care Provided No Yes DK NA
		Honours resident choice No Yes DK NA
	Write verbatim aide prompt:	Write verbatim resident response to aide prompt:
	a)	a)
	Level of Communication Active Other Assent None	Resident Response to prompt: No Yes Now Later NA NR DK
	b)	b)
	Level of Communication Active Other Assent None	Resident Response to prompt: No Yes Now Later NA NR DK
	c)	c)
	Level of Communication Active Other Assent None	Resident Response to prompt: No Yes Now Later NA NR DK
	Location of Incontinence Care Bed Toilet Change NA	If resident stated later: How many minutes later? _____mins Expected time to return: _____

D) Dressing																
Spontaneous expression of preference/assistance			No	Yes	DK	NA	Care Provided No Yes DK NA				Honours resident choice No Yes DK NA					
Write verbatim aide prompt:						Write verbatim resident response to aide prompt:										
a)						a)										
Level of Communication			Active	Other	Assent	None	Resident Response to prompt:			No	Yes	Choice Made	NA	NR	DK	
b)						b)										
Level of Communication			Active	Other	Assent	None	Resident Response to prompt:			No	Yes	Choice Made	NA	NR	DK	
c)						c)										
Level of Communication			Active	Other	Assent	None	Resident Response to prompt:			No	Yes	Choice Made	NA	NR	DK	
Description of Chosen Clothes:						Check if notified NH staff about chosen clothes: ____ Were the clothes worn by the resident later: No Yes DK NA										
F1) Out of Bed Care - Follow-up 1 (*Note: Add assistance time from this section to Section E)																
Immediately Later NA - No Follow-up			Length of Assistance Time:			Care Provided No Yes DK NA				Honours resident choice No Yes DK NA						
Write verbatim aide prompt:						Write verbatim resident response to aide prompt:										
a)						a)										
Level of Communication			Active	Other	Assent	None	Resident Response to prompt:			No	Yes	Now	Later	NA	NR	DK
b)						b)										
Level of Communication			Active	Other	Assent	None	Resident Response to prompt:			No	Yes	Now	Later	NA	NR	DK
c)						c)										
Level of Communication			Active	Other	Assent	None	Resident Response to prompt:			No	Yes	Now	Later	NA	NR	DK
If resident stated later: How many minutes later? ____ mins						Expected time to return: _____										
F2) Out of Bed Care - Follow-up 2 (*Note: Add assistance time from this section to Section E)																
Immediately Later NA - No Follow-up			Length of Assistance Time:			Care Provided No Yes DK NA				Honours resident choice No Yes DK NA						
Write verbatim aide prompt:						Write verbatim resident response to aide prompt:										
a)						a)										
Level of Communication			Active	Other	Assent	None	Resident Response to prompt:			No	Yes	Now	Later	NA	NR	DK
b)						b)										
Level of Communication			Active	Other	Assent	None	Resident Response to prompt:			No	Yes	Now	Later	NA	NR	DK
c)						c)										
Level of Communication			Active	Other	Assent	None	Resident Response to prompt:			No	Yes	Now	Later	NA	NR	DK
If resident stated later: How many minutes later? ____ mins						Expected time to return: _____										

G) Toileting - Follow - up (*Note: Add assistance time from this section to Section E)												
Immediately Later NA - No Follow-up			Length of Assistance Time:			Care Provided No Yes DK NA			Honours resident choice No Yes DK NA			
Write verbatim aide prompt:						Write verbatim resident response to aide prompt:						
a)						a)						
Level of Communication			Active Other Assent None			Resident Response to prompt:			No Yes Now Later NA NR DK			
b)						b)						
Level of Communication			Active Other Assent None			Resident Response to prompt:			No Yes Now Later NA NR DK			
c)						c)						
Level of Communication			Active Other Assent None			Resident Response to prompt:			No Yes Now Later NA NR DK			
Location of Incontinence Care			Bed Toilet Change NA									
H) Resident Response to Total Care Episode						I) Overall Observation						
Resident able to express preference verbally or non-verbally? (i.e. refuse care, body language, etc.)			No Yes DK NA			Please circle ALL sections that were observed:			B) Out of bed Dressing		C) Toileting	D)

ADL-Choice Observation Protocol

<p>A) Aide Approach</p> <p>For the following items it is important to note that depending on circumstance of resident a section may be excluded:</p> <p>4) State of Resident: IF asleep and unable to wake none of the sections may be observed.</p> <p>5) Location of Resident: IF resident is already out of bed Section B can not be observed.</p> <p>6) Type of Clothes: IF street clothes are already worn by resident then section D can not be observed.</p>
<p>B) Out of Bed Care C) Toileting D) Dressing</p> <p>1) If resident spontaneously instructs Aide as to what care is needed then skip to question 4 stating whether care was provided, honoured resident preference and encouraged resident.</p> <p>2) Level of Communication:</p> <p>Active: When aide offers resident a clear choice (i.e. Would you like to get out of bed now or later? Would you like to use the toilet or bed pan? Would you like to wear the yellow dress or black pants?)</p> <p>Passive: When aide forms a command in a question format giving the impression that the resident has a choice (i.e. Time to get out of bed, K? Time to use the toilet, K?, Time to get dressed, K?)</p> <p>No Choice: When aide does not attempt to offer resident any choice (i.e. Time to get out of bed, Time to use the toilet, time to get dressed)</p> <p>Note: Please be certain to write exactly what is stated between resident or aide because it may be difficult to decipher which form of communication was present. Also, this will help give an idea of other possible interactions that may exist (i.e. giving time limits to care, how resident responds to type of approach)</p> <p># of Prompts: take note of # of times aide prompts the resident to engage in a care episode/task.</p> <p>FOR PART D ONLY: Please be sure if Section D was observed and clothes were laid out upon resident choice that you go to scheduled Nursing Home Aide and notify them of the clothes that the resident has chosen to wear. Then at a later time check to see if the resident is wearing the earlier identified clothing.</p>

E) Assistance Provided

During the entire care episode it is important to note the length of time aide spent with the resident and whether the type of assistance is present or absent (by indicating a P or A in space provided).

Physical Assistance: Most common and considered any interaction with resident providing considerable assistance with walking, transferring, toileting etc.

Verbal Assistance: Any verbal communication about the care task being provided

Social Assistance: Any verbal communication that is **not** referring to the care task being provided.

Total Assistance Time: The total time of assistance including all assistance types.

F) Resident Response to Total Care Episode

This section is for the observer to decipher from the observation whether the resident was capable of offering meaningful responses to aides questions and prompts verbally or non-verbally.

G) Overall Observation

At the conclusion of the observation period please be sure to circle the sections observations were completed.

Overall comments gives space for any other interesting observations or situational circumstances that an observation was not complete other than options noted on the form. Please feel free to use space on the back of the form if needed.

G) Overall Observation		F) Resident response to total Care Episode				
Please circle ALL sections that were observed:	B) Out of bed	ANY meaningful verbal comment/response at ANY time observed?	Yes	No	DK	NA
	C) Toileting D) Dressing	Resident able to express preference verbally or non-verbally? (i.e. refuse care, body language, etc)	Yes	No	DK	NA

Date: ____/____/____

Resident ID#: _____

Facility: _____

Resident Preference Interview for Morning Care

Begin Time: _____

Staff Initials: _____

End Time: _____ am or pm

Total Time: _____

Interviewer Script: "I would like to ask you some questions about the help you receive from staff (the people who work here) in the morning." You don't have to answer the questions if you don't want to, and you may stop the interview at any time. If you choose not to answer it will not affect any aspect of your care. It will take approximately 10mins to complete. Is it okay for me to begin?"

Legend

If suggested options are not used by resident please use one of the following options and note in "Other Response" space:

NA = Not Applicable

NR = No/Nonsense Response

DK = Don't Know

DC = Don't Care

REF= Refused to answer

A) OUT OF BED PREFERENCE

1. Does someone help you get out of bed?

YES _____ NO(Independent) _____ Sometimes _____ Other Response: _____

2. Do you get out of bed before or after breakfast?

Before Breakfast _____ After Breakfast _____ Other Response: _____

3. Would you like to get out of bed earlier, later, or about the same time as you do now?

Earlier _____ Later _____ Same _____ Other Response: _____

a) If Earlier or Later is indicated by resident ask: How much Earlier or Later than you do now?

b) If resident is unable to give an open-ended response prompt:

<1hr _____ 1hr _____ 2hr _____ >2hr _____ Other Response: _____

4. Do the people who work here ask you each day when you want to get out of bed?

YES _____ NO _____ Sometimes / Some Staff _____ Other Response: _____

5. Do you want the people who work here to ask you each day when you want to get out of bed?

YES _____ NO _____ Sometimes / Some Staff _____ Other Response: _____

IF Resident stated "NO" to qu 4 and "YES" to qu 5 then ask: Why do you think they don't ask you when you would like to get out of bed?

IF Resident stated "NO", "DK", or "DC" to qu 5 then ask: Why wouldn't you want them to ask you when you want to get out of bed each day?

Would it be ok if they did ask you each day?

YES _____ NO _____ Sometimes _____

Other Response: _____

Discrepancy Index of (Un)Met Need for Out of Bed Time:

Is the resident's response to qu3 earlier or later?

YES ____ NO ____ Could Not Be Determined ____ (due to NA/NR/DK/DC/REF)

Code Responses from Question 5 comments into one of the following categories:

- 1) ____ Reduced expectations (e.g., "they do the best they can"; "it's alright, I'm not the only one who lives here")
 - 2) ____ Resident preference (e.g., "I like the way it is" "They take me when I want to go")
 - 3) ____ Routine (e.g., "they get me up at the same time every morning and that's okay with me")
 - 4) ____ Other (no comment; "nothing")
 - 5) ____ Self Proclaimed Independence (e.g. "I get myself up whenever I want"; "I don't need their help to get out of bed")
-

B) DINING LOCATION PREFERENCE

6. Where do you (most often) eat your breakfast?

Dining room ____ Room/Bed ____ Room/Chair ____ Other Response: _____

Other ____ (specify): _____

7. Where do you like to eat your breakfast?

Dining room ____ Room/Bed ____ Room/Chair ____ Other Response: _____

Other ____ (specify): _____

8. Do the people who work here ask you each day where you want to eat breakfast?

YES ____ NO ____ Sometimes / Some Staff ____ Other Response: _____

9. Do you want the people who work here to ask you each day where you want to eat breakfast?

YES ____ NO ____ Sometimes / Some Staff ____ Other Response: _____

IF Resident stated "NO" to qu 8 and "YES" to qu 9 then ask: Why do you think they don't ask you where you would like to eat breakfast?

IF Resident stated "NO", "DK", or "DC" to qu 9 then ask: Why wouldn't you want them to ask you where you would like to eat breakfast each day?

Would it be ok if they did ask you each day?

YES ____ NO ____ Sometimes ____

Other Response: _____

SECTION B Codes and Discrepancy Index

Discrepancy Index of (Un)Met Need for Dining Location:

Is there a different location stated by resident in qu 7 from qu 6?

YES ____ NO ____ Could Not Be Determined ____ (due to NA/NR/DK/DC/REF)

Code Responses from Question 9 comments into one of the following categories:

- 1) ____ Reduced expectations (e.g., "they do the best they can"; "it's alright, I'm not the only one who lives here")
 - 2) ____ Resident preference (e.g., "I like the way it is" "They take me when I want to go")
 - 3) ____ Routine (e.g., "they get me up at the same time every morning and that's okay with me")
 - 4) ____ Other (no comment; "nothing")
 - 5) ____ Self Proclaimed Independence (e.g. "I get myself up whenever I want"; "I don't need their help to get out of bed")
-

C) INCONTINENCE CARE PREFERENCES

10. Does someone help you to use the toilet?

YES ____ NO (independent) ____ Sometimes / Some Staff ____ Other Response: _____

11. Does someone help you to change wet clothes/soiled linens?

YES ____ NO (independent) ____ Sometimes / Some Staff ____ Other Response: _____

***Note:** Depending on whether toileting, changing wet clothes or both care tasks are needed word the following questions accordingly.

12. Do you get help to the toilet/with changing wet clothes before or after breakfast?

Before Breakfast ____ After Breakfast ____ Other Response: _____

13. Would you like help to the toilet/with changing wet clothes earlier, later, or about the same time as you do now?

Earlier ____ Later ____ Same ____ Other Response: _____

a) If Earlier or Later is indicated by resident ask: How much Earlier or Later as you do now?

b) If resident is unable to give an open-ended response prompt:

<1hr ____ 1hr ____ 2hr ____ >2hr ____ Other Response: _____

14. Do the people who work here ask you each day if you need help to the toilet?

YES ____ NO ____ Sometimes / Some Staff ____ Other Response: _____

15. Do you want the people who work here to ask you each day if you need help to the toilet?

YES ____ NO ____ Sometimes / Some Staff ____ Other Response: _____

IF Resident stated "NO" to qu 14 and "YES" to qu 15 then ask: Why do you think they don't ask you if you need help to the toilet/with changing wet clothes?

IF Resident stated "NO", "DK", or "DC" to qu 15 then ask: Why wouldn't you want them to ask you if you need help to the toilet/with changing wet clothes each day?

Would it be ok if they did ask you each day?
YES ____ NO ____ Sometimes ____
Other Response: _____

Section C Codes and Discrepancy Index

Discrepancy Index of (Un)Met Need for Incontinence Care:

Is the resident's response to qu 13 earlier or later?

YES ____ NO ____ Could Not Be Determined ____ (due to NA/NR/DK/DC/REF)

Code Responses from Question 15 comments into one of the following categories:

- 1) ____ Reduced expectations (e.g., "they do the best they can"; "it's alright, I'm not the only one who lives here")
- 2) ____ Resident preference (e.g., "I like the way it is" "They take me when I want to go")
- 3) ____ Routine (e.g., "they get me up at the same time every morning and that's okay with me")
- 4) ____ Other (no comment; "nothing")
- 5) ____ Self Proclaimed Independence (e.g. "I get myself up whenever I want"; "I don't need their help to get out of bed")

D) DRESSING ASSISTANCE PREFERENCE

16. Does someone help you with getting dressed in the morning?

YES ____ NO (independent) ____ Sometimes / Some Staff ____ Other Response: _____

17. Do you get dressed before or after breakfast?

Before Breakfast ____ After Breakfast ____ Other Response: _____

18. Would you like to get dressed earlier, later, or about the same time as you do now?

Earlier ____ Later ____ Same ____ Other Response: _____

a) If Earlier or Later is indicated by resident ask: How much Earlier or Later as you do now?

b) If resident is unable to give an open-ended response prompt:

<1hr ____ 1hr ____ 2hr ____ >2hr ____ Other Response: _____

19. Do the people who work here ask you each day what you would like to wear?

YES ____ NO ____ Sometimes / Some Staff ____ Other Response: _____

20. Do you want the people who work here to ask you each day what you would like to wear?

YES ____ NO ____ Sometimes / Some Staff ____ Other Response: _____

IF Resident stated "NO" to qu 19 and "YES" to qu 20 then ask: Why do your think they don't ask you what you would like to wear?

IF Resident stated "NO", "DK", or "DC" to qu 20 then ask: Why wouldn't you want them to ask you what you would like to wear each day?

Would it be ok if they did ask you each day?
YES ____ NO ____ Sometimes ____
Other Response: _____

Section D Codes and Discrepancy Index

Discrepancy Index of (Un)Met Need for Dressing Assistance:

Is the resident's response to qu18 earlier or later?

YES ____ NO ____ Could Not Be Determined ____ (due to NA/NR/DK/DC/REF)

Code Responses from Question 20 comments into one of the following categories:

- 1) ____ Reduced expectations (e.g., "they do the best they can"; "it's alright, I'm not the only one who lives here")
- 2) ____ Resident preference (e.g., "I like the way it is" "They take me when I want to go")
- 3) ____ Routine (e.g., "they get me up at the same time every morning and that's okay with me")
- 4) ____ Other (no comment; "nothing")
- 5) ____ Self Proclaimed Independence (e.g. "I get myself up whenever I want"; "I don't need their help to get out of bed")

Overall Status of Interview:

Section A: Complete ____ Incomplete ____ (If incomplete: DK/DC/NR/NA ____ REF ____ Other ____ (Please specify ____))

Section B: Complete ____ Incomplete ____ (If incomplete: DK/DC/NR/NA ____ REF ____ Other ____ (Please specify ____))

Section C: Complete ____ Incomplete ____ (If incomplete: DK/DC/NR/NA ____ REF ____ Other ____ (Please specify ____))

Section D: Complete ____ Incomplete ____ (If incomplete: DK/DC/NR/NA ____ REF ____ Other ____ (Please specify ____))