

HOW TO EVALUATE THE QUALITY OF RESIDENTIAL CARE FOR PERSONS WITH DEMENTIA

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Pat Summitt, her family and friends have chosen East Tennessee Foundation to receive and manage contributions to Pat's fund, and to facilitate their grantmaking in support of the mission.

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A CONSUMER GUIDE FOR CAREGIVERS:
HOW TO EVALUATE THE QUALITY OF RESIDENTIAL CARE FOR PERSONS WITH DEMENTIA

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ACKNOWLEDGEMENTS

This Guide was produced with support from the Pat Summitt Foundation Fund of the Community Foundation of Middle Tennessee.

INTRODUCTION

The purpose of this guide is to help consumers select a dementia care setting for a loved one and effectively monitor that person's care quality after placement. There are other guides available to help consumers select a long-term care facility (see *Resources*). In addition, the federal agency called the Centers for Medicare and Medicaid Services (CMS) publishes online "report cards" that evaluate the quality of services in long-term-care, including in facilities that provide specialized dementia care. This publicly-available information has value but is limited in several important ways:

1. Much of the publicly-available information currently used to evaluate long-term care quality is based on information reported by facility staff to federal and state regulatory agencies (e.g., CMS) or is reported for publicity materials in for-profit care settings. As a result, the information is inherently biased towards *over-estimating* care quality because facilities understandably want to be perceived by regulators and consumers as providing good care. Some publicly-available long-term care information does come from state and federal survey inspections, but the focus of these surveys is on identifying poor care quality facilities (e.g., via care deficiencies and citations). Moreover, these survey reports have been criticized for being subjective and inconsistent in identifying poor care facilities because they rely too heavily on the view of the survey team at one point in time, which might not accurately reflect the quality of care provided to residents on a daily basis. As a result, these reports may be helpful to consumers in identifying facilities that have a history of care quality problems but may not be that informative for choosing a "good" facility among the remainder of facilities.
2. Most of the information available from either facility or survey reports is not specific to people with dementia or their quality of life. Instead, the information is largely focused on "clinical indicators" of care quality, such as how many people in the facility have incontinence or pressure sores. This focus reflects a narrow definition of care quality that does not consider aspects of a person's quality of life, such as how staff members interact with the person and how the person spends his or her day. Moreover, some studies have found that people with dementia are at increased risk for poor quality of life in care settings in part because staff members erroneously assume that these individuals no longer benefit from the same level of social and physical activity as other less cognitively-impaired individuals in the same care setting.
3. Finally, some consumer advocacy groups, recognizing the limitations of the quality reports published by long-term-care facilities and survey agencies, have themselves created consumer guides that describe questions to ask and what to observe when visiting a long-term care facility (National Consumer Voice for Quality, National Senior Citizens Law Center, see *Resources*). These guides, however, provide general advice that is not accompanied by specific instructions about what to observe in nursing homes or residential care facilities or how to interpret the results of those observations. When such advice is offered, it is often not linked to research findings and may not include dementia care.

This guide addresses these limitations by describing specific methods — observations of care delivery and interviews with staff — that consumers can use to collect information about quality in both long-term-care and assisted-living environments that offer dementia care services. The observation and interview procedures described in this guide are more specific and thus, we hope, more user-friendly, than what is presented in other publicly-available guides. We developed and refined these recommended procedures while conducting more than 20 years of research at major universities. Most importantly, this guide addresses the essential aspects of care and quality of life most salient to people with dementia. This guide also describes specific methods that consumers can use to collect and interpret information about care quality that is independent of information reported by facilities themselves, which may represent the best

The intent of this guide is to give consumers, many of whom have little or no experience with dementia care facilities, the tools they need to identify quality-of-care problems as well as care strengths in the same way an experienced expert would do – in fact, in the same way the authors of this guide would do, based on their years of research and clinical experience.

rather than the most accurate picture of a facility's care. The intent of this guide is to give consumers, many of whom have little or no experience with dementia care facilities, the tools they need to identify quality-of-care problems as well as care strengths in the same way an experienced expert would do – in fact, in the same way the authors of this guide would do, based on their years of research and clinical experience. This guide will help consumers: (1) identify high-quality dementia care settings for their loved ones, and (2) serve as effective advocates and partners for ensuring care quality after placement.

We also recommend that professionals responsible for quality improvement in dementia care facilities (i.e., owners, administrators, regional managers, and unit managers) use the methods described in this guide to assess the quality of their care services on a routine basis. Any quality rating system should rely heavily on people doing independent observations of services. This approach is used widely in the hotel and hospitality industry because it helps ensure that staff members are prompt and friendly in how they respond to guests and encourages them to consistently provide high quality services. The methods described in this guide are consistent with this logic and could be easily adopted by professionals who want to assure high quality in dementia care.

CHAPTERS

<i>Chapter 1:</i>	Overview of dementia care services: nursing homes and residential care facilities	Page 8
<i>Chapter 2:</i>	Overview of publicly-available information about care quality.....	Page 14
<i>Chapter 3:</i>	Who to interview and what questions to ask.....	Page 19
<i>Chapter 4:</i>	The power of observation.....	Page 34
<i>Chapter 5:</i>	Strategies for how to serve as an advocate for care quality and a listing of other resources.	Page 44
 <i>Appendices:</i>		
Appendix A.	Nurse Aide Staffing Interview	Page 47
Appendix B.	Satisfaction Assessment Interview	Page 51
Appendix C.	Probable Chronic Pain Screening Interview	Page 53
Appendix D.	Food Service Satisfaction Interview.....	Page 54
Appendix E.	Observations of Care Provision	Page 55

CHAPTER 1

Overview: This chapter describes the types of dementia care facilities currently available and identifies key differences among them that will help you determine which type of facility is best for your loved one. Initial screening questions are provided that you can use to identify the places you want to visit to conduct more in-depth interviews and observations, which are described in subsequent chapters.

With the growth of our elderly population, there also has been a growing demand for dementia care services. While these services are most often designed for individuals with Alzheimer’s Disease, most facilities that provide dementia care services will accept individuals with various types of dementia including, but not limited to, Alzheimer’s Disease. The most common dementia care services are provided either in long-term care (nursing home) facilities or in assisted-living (residential care) facilities, although it is worth mentioning that home health care services sometimes enable a person with dementia to remain at home for long periods, effectively postponing placement in a dementia care facility. The focus of this guide, however, is on choosing a nursing home or residential care facility for someone with dementia.

The terminology used for different types of dementia care services vary by state. For the purpose of this guide, we use the term “long-term care” or “nursing home” to refer to any type of skilled nursing home facility that provides 24-hour licensed nurse supervision (i.e., a Registered Nurse, RN, is always on staff, 24-hours per day, 7-days per week). We use the term “assisted-living” or “residential care” facility to refer to any type of facility that provides some support services (e.g., meals, laundry, medication delivery) but not 24-hour licensed nurse supervision.

Long-Term Care or Nursing Homes

There are more than 18,000 nursing homes nationwide serving over 1.5 million older adults. Nursing homes are licensed and regulated by state agencies, with federal oversight provided by a government agency known as the Centers for Medicare and Medicaid Services (CMS). Facility profiles of all nursing homes overseen by CMS—which is to say, virtually all nursing homes in the U.S. — can be reviewed on the CMS “Nursing Home Compare” web-site at <http://www.medicare.gov/nursinghomecompare>.

Nursing homes are appropriate care facilities for individuals who require 24-hour licensed nurse supervision due to the presence of chronic medical conditions as well as the need for assistance with multiple activities of daily living such as bathing, dressing, toileting, and eating. Most nursing homes report that they provide Alzheimer’s or dementia care services, but only about one-third report having separate units or wings specifically designated for dementia care. Specialized dementia care units typically consist of a secured wing or unit, where the doors are locked or alarmed or, alternatively, the residents wear monitors. In addition, specialized dementia care units also typically require that staff members receive specialized training in Alzheimer’s Disease and other related dementias and are usually assigned to the same residents each day, so that they get to know their residents well. Dementia care

units may or may not have more staff members relative to the rest of the facility, although it is good if they do (*see Chapter 2: Staffing*).

Medicare and Medicaid programs may pay for nursing home care, although you should be aware that Medicare typically covers only short stays of no more than 100 days following a hospital stay. Long-term care insurance may also cover expenses. Nursing homes have their own Medical Director and practicing physicians who oversee the care provided by licensed nurses and nurse aides. The physicians typically see residents only once per month whereas the licensed nurses and nurse aides are responsible for daily care.

Assisted Living or Residential Care Facilities

Many older adults with dementia may not need the intensive care provided by nursing homes because they do not have chronic medical conditions that require 24-hour nursing supervision. To better serve this population, there are a growing number of residential care facilities. Nationwide, an estimated 36,000 residential care facilities serve over one million older adults. Residential care facilities provide an alternative type of care for older adults who need some help with activities of daily living (e.g., meal preparation, laundry, medication oversight, possibly some help with bathing or dressing) but do not require the more intensive care and nursing supervision provided by nursing homes. These facilities are, in fact, group residential programs that are not licensed as nursing homes. Thus, residential care facilities do not operate under the same federal regulations and care quality requirements as nursing homes. Instead state regulations, which vary between states, serve as oversight for residential care.

Many states have recently expanded their regulations to address the growth in dementia care units for residential care residents with Alzheimer's disease and other dementias. You can view residential care ("assisted-living") regulations by state, including those specific to dementia care, by visiting the web-site by the National Center for Assisted Living: www.ncal.org. An estimated 30% to 50% of these residents have some degree of cognitive impairment, and many residential care facilities now offer specialized dementia care services. However, it should be noted that there are no minimum staffing requirements for these facilities other than that facilities should be staffed to "meet resident care needs," and residents receiving dementia care services within these facilities are considered a high care needs group. Thus, consumers should use caution when selecting a residential care facility for dementia care to ensure that there are adequate staff and services to meet the needs of their loved one. Dementia care units within a residential care facility should, in fact, have higher staffing levels relative to the rest of the facility (*see Chapter 2: Staffing*).

Because state regulations vary, residential care facilities also vary in the types of residents they are willing to accept and the types of services they provide. Some residential care facilities are devoted solely to dementia care whereas others accept a wider range of residents and offer dementia care services within a larger facility. "Move-in/Move-out" criteria can differ significantly from place to place, so it is important that consumers understand these criteria when choosing a facility (*see Initial Screening Questions in this Chapter*). Some of these facilities have adopted an "aging in place" philosophy wherein additional care services can be added as the resident needs them; however, any increase in care services often will result in an increase in cost. The cost of residential care can be a significant factor in placement decisions, and costs can vary significantly both within and between states. Dementia care

within residential care facilities is paid mostly via private-pay resources and Social Security disability benefits, although there is Medicaid coverage available in some states for a portion of this care. In addition, there are also veteran (VA) health care benefits that apply to residential care. Usually, residents who reside in a residential care facility continue to see their own primary care physician.

Initial screening questions to help consumers select facilities to visit for observations of care delivery and staff interviews:

First, consider how close the facility — nursing home or residential care — is to you and the ease with which you are able to visit your loved one. While visits are not imperative, they help many families feel more comfortable with their choice and also allow family members to be more involved in ensuring that their relative receives quality care after placement. Some research suggests that proximity to family is a major factor that affects facility choice for most consumers. Second, consider the cost of the various options and what is financially affordable given your and your loved one's resources (e.g., long-term care insurance, Medicare/Medicaid, private monies, VA benefits). Once you have decided on a geographic area and your cost limitations, call each of the facilities you are considering and ask the administrator or admissions counselor the following questions. Answers to these questions will help you narrow your list to the subset of facilities that will best meet your loved one's and family's needs:

Screening Interview Questions:

1. ***Do you have a waiting list? If so, how long is it?*** Typically, higher quality facilities have fewer rooms, or “beds”, available and often have a waiting list. Thus, if you are considering placement, it is best to start the search process as early as possible to allow extra time (1-3 months) for this potential waiting period. Often, families make placement decisions during a time of crisis (e.g., after a fall or some other mishap at home that threatened the individual's personal safety and/or health) which can make the decision that much more stressful. While it is often not possible, it is certainly preferable and to your advantage to plan ahead. If your relative has a diagnosis of a progressive dementia such as Alzheimer's disease, where there is a gradual decline in their abilities over time, it is reasonable to expect that placement will be necessary at some point in the disease process.
2. ***Do you offer private rooms, shared rooms and/or companion-living and what are the cost differences among the various types of rooms available?*** Some families have a strong preference for a private room or may even be seeking placement for a couple who want to room together (companion-living). Nursing homes have mostly shared rooms (at least 2 roommates and sometimes more) with very few, if any, private rooms. In contrast, residential care facilities typically offer both private and shared/companion-living rooms, with shared accommodations being less expensive than private. You may be able to move in to a shared room while you wait for a private room, if one is not immediately available.
3. ***Do you offer other support services that my family and I can use while we wait for a room or bed to become available for our loved one?*** Some facilities offer adult day care for individuals with dementia; short-term respite care, so that family members can take a break from care or go on vacation for a short period; and/or family caregiver counseling groups that meet regularly. These services might be beneficial to you while you and your family wait for a room in the facility that is preferable to all of you and also allow you to become familiar with the facility staff, programs and services.

4. **What are the facility’s “move-in” and “move-out” requirements?** Be sure to ask about **both**, especially if the facility is a residential care facility. The answers are likely to be very important in determining: a) whether your loved one is even eligible to move in to the facility, **and** b) at what point your loved one may be required to move out. For example, many residential care facilities require that residents be able to walk; if residents become wheelchair-dependent or unable to get out of bed on their own, they may not be allowed to stay. If your relative is already in the middle to late stages of dementia, it is likely that he or she will need to move to a nursing home rather than a residential care facility. Bear in mind that moving can be emotionally stressful for both the person with dementia and his or her family members. In fact, many older adults with dementia often become even more confused and disoriented after a move. Thus, it is worth considering how long your relative will be able to stay at a place before he or she moves in to avoid multiple transitions in care.
5. **Do you have an “aging in place” philosophy of care? How is additional services added and what is the charge to add a new service?** Facilities with an “aging in place” philosophy typically allow residents to remain throughout the middle to late stages of dementia with additional support services. Some even provide hospice or other end-of-life care services. Most nursing homes, but not all residential care facilities, have an “aging in place” philosophy of care. Keep in mind that a resident still may be required to move to a different room or unit within the facility even if they are allowed to stay until the end stages of their dementia disease. However — and especially in residential care facilities — any additional services often come with additional fees. For this reason, make sure you understand what, if any, increase in cost you will incur if your loved one needs additional care after placement as their dementia progresses in severity over time. Other additional care costs worth asking about in advance may include the following: average annual increases imposed by the facility, cost by level of care, costs for additional services (e.g., medication management, incontinence, laundry, specialized programming).
6. **How often do you assess residents to determine their care needs?** This is related to the facility’s “move-in/move-out” requirements as well as the determination of level of care and the need for additional services. You want to know how often care needs are assessed and who is responsible for making that assessment so that you can be sure that, after your loved one moves in, the facility continues to be the right place for him or her. Be aware that most adults with dementia will experience some decline over time such that their care needs are likely to increase. As a result, most residential care facilities will increase their fees for care as the resident’s care needs increase, either by transitioning the resident to a higher overall “level of care” payment category or by adding services as needed such as incontinence care, medication management or bathing assistance, for example, and charging separately for each added service. By contrast,

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nursing home costs for long-term care are generally fixed. Ideally, care needs assessments should be completed routinely after admission (e.g., every 3 to 6 months) by a licensed nurse and/or licensed therapists (e.g., physical, occupational, or speech therapists). It is best if the assessment relies more on directly observing a resident's abilities (e.g., the person's ability to walk, get out of bed, or feed himself or herself) than on a staff member's report of what the person can do, which can be much more subjective and prone to error.

7. ***Do you offer a trial “move-in” period?*** Some residential care facilities allow a customer to stay for 2 to 4 weeks at low or no cost so that the person can see whether he or she likes the facility. This is a great option, especially if the facility has a waiting list, and may help both the person with dementia and his or her family members feel more at ease with their choice. Although, keep in mind that it usually takes at least 1-3 months for an older adult to completely adjust to a new living environment and sometimes even longer for someone with dementia. Nursing homes also have “short-stay” rooms, but these are reserved for individuals who are being admitted to the facility following a hospital stay.
8. ***Do you offer specialized dementia care services? If so, what types of services do you provide?*** Examples of these services are a special wing or floor designated for dementia care; a secured unit; additional staff members who are routinely assigned to dementia residents; staff training focused on dementia care; and organized activities geared toward different levels of cognitive impairment. If there are particular challenges your relative faces and you are concerned about the staff's ability to handle his or her care, ask about those aspects of care directly (e.g., “*My relative can become aggressive sometimes. How does your staff handle this type of behavior?*”).
9. ***What types of programs do you offer that are designed for those with dementia? Are you able to send me materials that describe your programs and/or a calendar of scheduled events for this past month?*** Facilities vary greatly in regard to the types of programs and services they offer for those with dementia. Nursing homes will have an “Activity Director” who is responsible for scheduling and overseeing organized, social group activities for all residents in the facility. You may ask for a copy of the social activities calendar for the current month so that you can get an idea of the kinds of activities available. Residential care facilities also should have an activities calendar of events they can share with you. If there are certain types of activities that your family member enjoys, ask about the availability of those activities directly. For example, if your family member enjoys being outside to walk or garden, ask if residents have access to an outdoor area that is secure and then ask to see this area when you visit. If your relative enjoys social outings, such as trips to the movies or local stores, ask if there are routine group trips that are well supervised and accessible. One of the biggest challenges in activities programming for those with dementia is having programs in place that are appropriate for different levels of impairment. It is best if there are separate activities available for those with no to mild impairment versus those with moderate to severe impairment so that activities can be designed at an appropriate level for each group. Also, these programs should reflect a combination of exercise (e.g., stretching, dancing, yoga, strength), cognitive tasks (e.g., current events, debates, word games), and socialization (social interaction with staff and other residents). While residents should be allowed to participate based on their own interest, facility staff should have a routine in place that strongly encourages participation through personal reminders and invitations to attend and follow up with the residents to determine their interests. Those with dementia typically need a routine structure of activities and lots of

staff encouragement to attend because they will often not remember the day/time/location of a scheduled event or may become easily agitated in a new setting. The facility staff description of their programming should indicate they are sensitive to these types of challenges for those with dementia.

10. Do you provide medication management? If yes, what is the training requirement of the staff responsible and do we have to pay an additional fee for this service?

All nursing homes manage all routine and “as needed” medications for no additional fee and medication management is conducted by a licensed nurse (typically an LPN or LVN). However, not all residential care facilities provide medication management and those that do typically charge an extra fee for this service. Medication management in residential care also should be conducted by a licensed nurse or trained professional. If your relative takes one or more medications routinely and you feel that he or she needs staff supervision to ensure that medications are taken as prescribed, you should inquire about this service and the training requirements of the staff responsible for this service.

11. How long have most of your staff been working here?

High turnover rates for staff are common, particularly in nursing homes. This means that the same staff members do not work in the facility for very long before leaving. A facility that has had many of the same staff for a long time (i.e., for more than 2 or 3 years) is typically a better place to work (for the staff) and live (for the resident). A steady staff also gives you – the consumer – an opportunity to develop ongoing relationships with the workers who provide care for your loved one. It can otherwise be frustrating for families to find new staff members at every visit, especially if their relative requires special care.

You need not ask *all* of the above questions, and some of them, as we’ve pointed out, are more relevant to residential care facilities than nursing homes. Consider these questions as a first-step guide for gathering the information you need to decide whether a particular facility is worthy of further consideration. These screening questions allow you to narrow your list of possible places to those that are the most promising and appropriate for your loved one. Subsequent chapters will focus on more in-depth staff interviews and observations of care delivery for your ‘short-list’ of potential places to visit.

CHAPTER 2

Overview: This chapter describes publicly-available information about nursing home care quality and discusses how this information should be interpreted and used when choosing a facility. Similar information is not publicly-available for residential care facilities because these facilities do not receive federal oversight and state-level regulations vary by state. There may be state-specific or facility-specific information that you can access for residential care facilities online.

Based on our decades of work and research, we strongly believe that the best way for consumers to judge care quality in dementia care settings is to visit promising facilities to directly observe the care provided and pose their own questions directly to the staff members who provide care. This guide offers specific instructions for using both strategies — direct observations and staff interviews — in either nursing homes or residential care facilities. This guide differs from other guides currently available in numerous ways, but most importantly for its focus on using observations to evaluate care quality. It provides instructions for the consumer similar to what supervisors within a dementia care setting should be using routinely to ensure optimal care quality.

The best reason to rely on your own observations to judge care quality is that the information you collect is independent of the information supplied by the facility staff or the facility ownership. Not surprisingly, people who provide dementia care services, including those who directly care for residents, are likely to present the best picture of their care rather than the most accurate. This common

bias (we're all subject to similar biases) does not reflect on the honesty of dementia care providers. In fact, there is *no* work setting that can be objectively evaluated based on the information supplied only by people with a vested interest in the setting. Dementia care settings are no different in this regard. In fact, it should be noted that, like many healthcare organizations, most dementia care facilities are operated as for-profit businesses charging you – the customer – for their care services. Thus, as with any other consumer service, it is important for the consumers themselves to be able to judge the quality of those services. This guide provides instructions for how to gather the most accurate information related to the quality of dementia care services.

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To set the stage, we review in this chapter the information about nursing home care quality currently available from public sources. In Chapter 3, we describe the kinds of questions you should ask staff. We also provide guidance about how to interpret this information. As noted earlier, however, we believe that directly observing care

services is the most important way for you to judge quality. Thus, Chapter 4 discusses how to observe care and interpret your observations so that you can make the most informed choice related to dementia care for your loved one.

Publicly Available Quality Information

The Centers for Medicare and Medicaid Services (CMS), the government agency responsible for assuring that nursing homes comply with federal quality standards, provides information about virtually every nursing home in the nation, including its staffing levels; its survey deficiencies or citations (i.e., the results of an independent evaluation by federal or state surveyors that indicate a problem in the nursing home in some aspect of care); and measures, of “quality indicators,” which reflect residents’ clinical conditions. An example of a quality indicator is the percentage of residents within a nursing home at one point in time who have incontinence, or the percentage of residents who have experienced a pressure ulcer. Bear in mind that all of this information, with the exception of the survey deficiencies, is reported by nursing home providers themselves; that is, by the staff members who work in the facility. Thus, while this information is useful in some ways, it provides only one view of care quality—the staff’s view. You can review the CMS nursing reports on the CMS “Nursing Homes Compare” Web site:

<http://www.medicare.gov/nursinghomecompare>. This Web site also allows you to search for nursing homes within a particular geographical area and compare facilities on one or more of the various quality measures. The site also reports comparison information, so you can assess how one facility compares to others within the same state, geographic region, or the nation. This publicly-available information serves as a helpful starting point for screening nursing homes, especially when combined with the pre-screening questions recommended in Chapter I. As with facility answers to the pre-screening questions, you can use the publicly-reported information to help narrow your search to those facilities worthy of a follow-up visit to interview the staff (Chapter 3) and directly observe the care (Chapter 4).

This publicly-available information serves as a helpful starting point for screening nursing homes, especially when combined with the pre-screening questions recommended in Chapter I.

Nursing Home and Dementia Care Staffing Levels: What You Need to Know

In general, more staff is almost always better than less staff because older adults with dementia typically require a lot of staff attention for their daily care; so, having a sufficient number of staff members present is absolutely essential to ensure optimal care quality. In general, studies show that higher staffed facilities provide significantly better care than lower staffed facilities in most care areas.

In nursing homes, staffing levels are reported for two main groups: 1) Licensed nurses, who include Registered Nurses (RNs) and Licensed Practical/Vocational Nurses (LPNs or LVNs); and 2) Certified Nursing Assistants or Technicians (CNAs/CNTs). Most residential care facilities that provide dementia care services also employ a combination of licensed nurses and nurse-aide-level staff; however, licensed nurses will be fewer in these care settings because there is less overall need for medical oversight; and, unlike nursing homes, residential care settings are not required to provide 24-hour licensed nurse supervision. Some residential care facilities still may provide 24-hour licensed nurse supervision, especially on their dementia care units, even though it is not mandated by the state.

Registered nurse (RN) staffing levels are important for managing nursing care, medications, and medical conditions. Studies have shown, for instance, that the presence of more registered nurses within a facility is associated with fewer pressure ulcers among residents and a lower rate of hospitalizations

and urinary tract infections. In addition, licensed practical nurses (LPNs, LVNs) provide important care to residents such as medication delivery, wound treatments, and monitoring of vital signs (e.g., heart rate, blood pressure). The minimum recommendations for licensed nurse staffing in nursing homes ranges from 1.3 to 1.85 total *nurse hours per resident per day*. This means that each resident should receive at least 1.3 to 1.85 hours of direct care and attention from a licensed nurse each and every day. More specifically, the minimum recommendations for one resident call for 45 minutes of care daily from an RN and about 30 minutes of care daily from an LPN/LVN. Levels below these recommendations can lead to harm or unsafe care practices for residents. The more medical care your loved one requires, the more important licensed nurses are to your relative's care. Licensed nurse staffing levels are reported to CMS by all community nursing homes and this information is updated routinely on the CMS Web site: <http://www.medicare.gov/nursinghomecompare>

Nurse aides (CNAs/CNTs) are responsible for assisting residents with activities of daily living such as getting out of bed, bathing, dressing, eating, and using the toilet. Minimum staffing recommendations for nurse aides range from 2.8 to 3.2 total *hours per resident per day*. Nursing homes with this level of nurse aide staffing have been shown to provide significantly better care for many aspects of daily living. For instance, residents in these facilities tend to get out of bed earlier in the day, receive more frequent help to the toilet, and receive more assistance with eating at mealtimes. Residents with dementia typically require assistance with multiple aspects of daily living and may otherwise be relatively healthy (i.e., they have few chronic medical conditions and need fewer routine medications). The more assistance the resident needs with daily care activities, the more important nurse aides are to ensuring the resident's optimal care quality and quality of life. In particular, residents who are completely dependent on staff to get out of bed, dressed, and transported to the dining room for meals or to other common areas for activities need a sufficient number of staff available so that they don't have to wait for long periods of time to receive care and don't spend most of their day in bed. A nursing home that has a dementia care unit or a residential care facility that specializes in dementia care should have higher nurse aide staffing levels both during the day and the evening relative to the rest of the facility.

Most facilities fall into the middle, or "average", staffing ranges for both licensed nurses and nurse aides. A small percentage of facilities (fewer than 10% nationwide) are considered "high staffed" homes and are identified as such on CMS's "Nursing Homes Compare" Web site. These nursing homes often serve mostly private-pay residents; thus, they can afford to employ more staff.

Facilities with "average" staffing levels may still provide good quality care because they are sometimes very creative about using non-nursing staff for some tasks (e.g., training housekeepers and activities staff members to assist with mealtimes; hiring extra staff to deliver snacks between meals; using volunteers to enhance social activities; using nursing students to augment nursing care). The more people that facilities have available to assist with various aspects of care, the better. Turn to Chapter 3 for a list of specific staff interview questions for you to ask related to staffing.

Survey Deficiencies and Citations: What You Need to Know

Federal and state surveys, or evaluations, of nursing homes are conducted annually or when there is a reported complaint. The purpose of the survey process is to identify major problems or care quality concerns within nursing homes; thus, surveys are designed to generate citations or identify deficiencies in care. Citations and deficiencies may be written in response to an isolated incident (e.g., a family complaint) or a more widespread problem (e.g., medication management). The CMS Web site (<http://www.medicare.gov/nursinghomecompare>) reports survey results for the most recent year as well as prior

years. Ideally, a nursing home will have few or no citations and deficiencies, although sometimes the ones listed are relatively minor (e.g., problems with lighting or the location of power outlets, etc.).

The results of the most recent survey are the most important for you to consider because these results reflect the care quality provided most currently by the staff in the nursing home. Staff turnover rates in all positions are high in many nursing homes. In other words, many staff members do not stay in the same nursing home for long periods. As a result, survey results from prior years may not reflect a facility's present care quality. Consumers should not be shy about printing a nursing home's most recent survey results from the CMS Web site and asking the facility's administrator or director of nursing how the issues identified in the most recent survey were addressed or resolved. If facility staff are open to your questions and provide you with a description of specific steps that were taken to correct the problem, it is a good sign that the facility staff are effective in addressing care quality concerns.

Quality Indicators: What You Need to Know

Nursing homes are required to report "quality indicators" to CMS on a quarterly basis. Residential care facilities are NOT required to report similar information. As described earlier, quality indicators are really measures of the residents' clinical conditions, such as the percentage of residents within a facility at one point in time who have incontinence or the percentage of residents in the facility who have experienced a recent unintentional weight loss. The underlying assumption of quality indicators is that a nursing home with a lower proportion of residents who experience a poor clinical condition are providing better care than facilities with a higher proportion of residents with that same clinical condition. Thus, for example, it is assumed that a nursing home in which 10% of the residents are incontinent is providing better incontinence care than a facility in which 20% of the residents are incontinent. This assumption, however, may not always be accurate. For instance, nursing homes may differ on their admission criteria, such that some nursing homes end up serving sicker residents than other nursing homes. There is also evidence that, at least for some quality indicators, a higher prevalence rate indicates better treatment and management of the clinical condition. Examples include quality indicators related to the prevalence of pain and the prevalence of depression. In both cases, studies have found that nursing homes that reported higher rates of pain and depression among their residents had licensed nurses who were doing a much better job of identifying these problems and treating them; by contrast, in facilities that reported lower rates, licensed nurses were not detecting pain and depression as well and, thus, also not treating these problems. In short, the quality indicators on CMS's "Nursing Homes Compare" Web site should be interpreted with caution, much like other information that is publicly-available or reported by facility staff members themselves. Consumers should consider what clinical conditions pose a challenge for their loved one (e.g., incontinence, pressure ulcers, unwanted weight loss, depression, pain) and ask a facility staff questions about how they address these specific care issues in terms of routine assessments, treatment options, and staffing levels to meet the associated care needs.

Star-Rating System: What You Need to Know

Because it is easy to get lost in all the information reported on the CMS Web site, CMS also reports a single, summary rating for each nursing home. This rating also can be used to compare nursing homes. CMS's rating system ranges from 1 star ("much below average") to 5 stars ("much

above average”), with 3 stars considered “average.” Based on this system, nursing homes with a lower star rating generally report lower staffing levels (although there is also a star rating specific to staffing alone), receive more survey deficiencies and citations, and report a higher percentage of residents with poor clinical conditions, such as pressure ulcers or unintentional weight loss, which might reflect poorer care quality. Presumably, five-star nursing homes provide better overall care than lower star nursing homes. However, CMS qualifies its rating system by stating that a star rating for any one nursing home should not be used to make a final decision about care quality within that facility. This is an important qualification because there is controversy about how well the star rating system, or any other publicly-available information, accurately reflects care quality in and between facilities.

Furthermore, the nursing home information reported on the CMS Web site does not evaluate care quality specifically provided to residents residing in dementia care units (rather, it evaluates care *throughout* each nursing home). It also does not apply to dementia care services provided outside of nursing homes in residential care settings. Despite these limitations, if you are considering a nursing home for your loved one, the CMS website will give you useful information for evaluating and comparing possible facilities to visit for more in-depth interviews and observations. Minimally, the CMS web-site may help you to identify facilities that you do not want spend time visiting based on a recent history of low staffing levels, poor quality indicators and/or deficiencies and citations.

CHAPTER 3: WHO TO INTERVIEW AND WHAT QUESTIONS TO ASK.

Overview: This chapter offers specific advice related to what questions to ask staff members, who to ask, and how to interpret the information provided to help you, the consumer, make an informed decision about a dementia care setting.

Our focus, instead, is on two areas that we believe are particularly relevant for residents with dementia and that allow you to distinguish between excellent facilities and those that are merely typical, or average: nurse aide staffing levels and satisfaction with care.

Several consumer guides list questions you should ask staff when visiting nursing homes, and these questions are equally applicable to dementia care units in residential care facilities. We list these guides in the “other resources” section at the end of chapter 5. We will not revisit these questions here, and you might find these other guides to be helpful in different ways. Our focus, instead, is on two areas that we believe are particularly relevant for residents with dementia and that allow you to distinguish between excellent facilities and those that are merely typical, or average: nurse aide staffing levels and satisfaction with care. We provide specific advice about what questions to ask, whom to ask, and how to interpret the information provided by the staff. To further help you, the consumer, understand how to interpret responses from staff interviews, we also provide a

scoring system that allows you to summarize the information into an overall quality score for each of the two areas.

Direct Care Staff: Nursing Assistants or Technicians

Certified nursing assistants (CNAs) or certified nursing technicians (CNTs) provide the majority of daily care to residents. This daily care includes, but is not limited to, the following: help with getting in and out of bed; dressing and grooming assistance, which includes helping with oral hygiene and bathing; mealtime assistance, including feeding, and provision of snacks between meals; incontinence care and help with using the toilet or bedpan; transport to social activities and other appointments (e.g., the beauty shop); changing of clothes and bed linens as needed; and repositioning and turning for residents at risk for skin breakdown.

The overwhelming majority of nursing home residents, in particular those with dementia, require staff assistance in multiple areas of daily care. Similarly, an estimated 60% to 90% of dementia care residents within residential care settings require such assistance. In addition, both nursing home and residential care residents with dementia experience significant decline over time in their ability to perform daily tasks on their own such as eating, going to the toilet, getting out of bed, and dressing. Because of the high daily care needs of residents with dementia, regardless of the care setting (nursing home or residential care), many experts believe that the number of and quality of training for nurse aides and technicians (or other similarly trained staff who assist residents with daily care activities) constitute the most important determinants of care quality. In fact, research suggests that a staff-to-resident ratio

of one staff member to every 5 to 7 residents is necessary to provide all aspects of daily care. Ideally, this level of staffing should be present during both the day (typically 7am - 3pm) and evening (typically 3pm - 11pm) due to the continued need for mealtime assistance, incontinence care, and getting into bed that occurs during the evening. Minimally, extra staff should be available for some portion of the evening (e.g., 5pm - 8pm) for mealtime and bedtime care. Many facilities have fewer staff members available during the evening than during the daytime. Dementia care units should maintain higher levels of nursing assistant and technician staffing both during the day and evening shifts relative to the rest of the facility or units.

Most guides recommend you ask about staffing levels and training but do not provide specific advice about whom to ask or how to interpret information from staff interviews. These are very important considerations because it is easy to get staffing information that may be misleading or difficult to understand in terms of its implications for care quality.

With regard to whom to ask about staffing, we suggest that you talk directly to nurse aides or those staff members otherwise responsible for providing assistance with daily care needs – some facilities, in particular, residential care facilities, may have another term for these staff members (e.g., care partners). Ideally, you want to talk to direct care workers privately, away from licensed nurses or the administrator. You should ask the person who is giving you a tour of the facility if this is possible. If not, then ask to interview some direct care staff members while a supervisor is present. The bottom line is that the individuals who provide the most direct care to the residents are in the best position to tell you about their workload. In our experience, their reports are usually more accurate than those of administrators or supervisors, and even more accurate than the information reported on the CMS Web site (see Chapter 2. Staffing Levels). What these other information sources sometimes fail to take into account—but that the line staff will report—is that some facility staffs end up working “short-staffed” due to unexpected absenteeism or because supervisors do not routinely schedule adequate numbers of direct care workers every day or for all shifts. For example, weekends are more likely to be short-staffed than weekdays and evening and night-time shifts are more likely to be short-staffed than daytime shifts due to unexpected absenteeism or poor scheduling of staff.

Below are suggested questions to ask nurse aides or other staff members who provide direct, hands-on daily care for residents with dementia. This staff interview is also shown in Appendix A to allow you to more easily take a copy with you to the facility. To start, you want to know how long the person has worked in the facility, whether he or she is a routine staff member, and what days and shifts the person usually works. Questions 1-4 will help you gather this information, which will give you an idea of how familiar the staff member is with the residents and staffing levels and which days and shifts the person’s answers represent. If possible, you want to talk to *routine* staff members (as opposed to temporary or on-call personnel) and you want to talk to *more than one staff member*. For instance, you might talk to one staff member who works day shifts and one who works evening shifts; or one who works weekdays and someone else who works weekends. We recommend that, if possible, you visit during the late afternoon so that you are present for both the day (typically 7am to 3pm) and evening (typically 3pm to 11pm) shifts. This way, you can approach different staff members during a single visit. It isn’t absolutely necessary to talk with several staff members, but doing so will give you a better idea of how consistent staffing is across different days and shifts. Remember: the more consistent the staff, the better it may be for your loved one. Typically, the day shift (7am to 3pm) during weekdays tends to be the highest staffed, so it is important to interview at least one staff member who works either evenings or on weekends as well. Staff members should be willing to talk to you and answer any questions you have about staffing and other care quality issues. If staff members appear uncomfortable or apprehensive about talking to you, it may indicate problems within the facility.

Appendix A. Nurse Aide Staffing: Questions, Scoring Guide, and Rationale

Approaching Staff for an Interview:

Introduction: *“Hi, I am a family member and I am considering placing my relative in this facility. I would like to ask you a few questions about your work experience here. It should only take about 10-15 minutes. Would that be okay?”*

1. How long have you been working here?

- Less than 1 year 1-2 years More than 2 years

2. Are you a routine staff member or a temporary (“on call”) staff member?

- Routine (works weekly)
 Temp/On call (works once a month or less in this facility)

3. What days of the week do you usually work?

- Weekdays Weekends Both weekdays and weekends

4. What time periods (“shifts”) do you usually work?

- Day (7am-3pm) Evening (3pm-11pm) Night (11pm-7am)

Note: Some facilities have staff work 10 or 12-hour shifts in which case 7am-7pm is considered “day/evening” and 7pm-7am is considered “night”.

Questions and Scoring Guide:

Listed below are 11 total questions that you can ask, along with the most common possible responses, to each question. We also indicate how each possible response should be scored for questions 1-10. Please note that question 11 is not scored. There are 14 total points possible.

- 1. How many residents are you assigned today?* (Allow staff member to give you a number without offering them the response options below directly)

- 11 or more residents (0 points, low staffing)
- 8 to 10 (1 point, average staffing)
- 7 or fewer (2 points, high staffing)

2. ***How many residents are you usually assigned?*** (Allow staff member to give you a number without offering them the response options below directly)

- 11 or more residents (0 points, low staffing)
- 8 to 10 (1 point, average staffing)
- 7 or fewer (2 points, high staffing)

3. ***Are you usually assigned to the same residents or does your resident assignment change often?***

- Assigned residents changes daily or weekly (0 points)
- Usually the same residents (1 point)

4. ***How often do you “work short” – that is, take care of more residents because a co-worker doesn’t show up and there is no one to replace that person?***

- Often: At least once a week or more (0 points)
- Occasionally: Once-Twice a month (1 point)
- Rarely, less than once/month (2 points)

5. ***Are there other staff members who assist with some aspects of daily care?*** (e.g., restorative nurse aides who assist with walking and other mobility exercises; hydration technicians who offer residents additional foods and fluids between meals?)

- Yes (1 point)
- No (0 points)

6. *Have you received any additional special training related to dementia care beyond the training you received to be a nurse aide?* Yes (1 point) No (0 points)

7. *If you are providing care to a person with dementia who can still talk to you, but he or she does not always make sense, how do you know when or if the resident needs assistance?* (Allow staff member to respond without providing the specific response options below, which reflect the most typical responses)

Care is provided on a routine schedule and/or we know what residents want. (0 points)

Residents are asked multiple times per day what they need or want. (1 point)

Care is provided both on a routine schedule and by asking resident multiples times per day what they need or want. (1 point)

8. *If you are providing care to a person with dementia how do you know if the person is in pain?* Score 1 point each (for a total of 2 points) if the staff member says that residents are asked directly about pain on a daily basis and other signs of pain or discomfort are acknowledged for residents who are completely unable to communicate verbally.

Refers to medical chart for pain-related diagnoses and routine pain medications because resident is unable to tell staff about his or her pain; and/or, the staff is already aware of who has pain. (0 points)

Asks resident directly on a **daily** basis when providing other routine care. (1 point)

Pays special attention to the non-verbal body language of residents who are completely non-communicative (in the late stages of dementia). Non-verbal indicators of pain or discomfort include facial grimacing, moaning and groaning, and other signs of agitation or aggression. (1 point)

9. *If you are providing care to people with dementia, how do you determine their preferences for when they want to get out of bed, what they want to wear, and where and when they want to have their meals?* Score 1 point if the staff member says that he or she asks residents directly each day what they want or otherwise offers residents a choice among reasonable options.

Refers to the residents' care plans or medical records to determine preferences or asks the residents' family members. (0 points)

- Asks the residents **each day** what they want or offers them options. (1 point)
- Both refers to care plans and medical charts and asks residents **each day** about their preferences. (1 point)

10. During mealtimes, how do you determine whether a resident might want something different to eat than what he or she is given initially? Score 1 point if the staff member indicates that either a resident can make a request or the staff member offers to get the resident something else when he or she notices that the resident is eating poorly.

- The menu is posted along with the alternatives available each day or at each meal. (0 points)
- Residents make their menu choices in advance. (0 points)
- I will offer other meal choices if the resident is complaining about the meal or makes a request for something different. (1 point)
- If I notice that a resident is not eating well, I will offer to get him or her something else and will let the person know what options are available. (1 point)

11. Is there anything else you think I should know about this facility and the care provided here that would help me to make my decision? Answers to this optional question are not counted in the scoring. You may also use this question to ask about some aspect of care that might be specific to your loved one such as, “my relative likes to stay up late at night. Will he be allowed to do so here?”

Total Score: Add the points for *questions 1-10*, which will yield a total score of 0 to 14 points.

- 10 or more points = Excellent
- 7-9 points = Above Average
- 4-6 points = Average;
- 0-3 points = Below Average

Scoring Rationale

Questions 1 and 2 - Staff workload: The “average” nurse aide workload in most nursing homes ranges from 8 to 10 residents during the day and from 12 to 15 residents during the evening. There is solid research and strong clinical evidence, however, that staff members responsible for direct care to residents (e.g., nurse aides) can provide good quality care only if each worker is assigned 7 or fewer residents. Facilities often justify higher nurse aide workloads by contending that their residents are less physically dependent on the staff for care or that staff members in their facility work more efficiently. Research evidence that supports 5 to 7 residents to one nurse aide as the most optimal assignment, however, takes into account that the typical nursing home serves residents, including those with dementia, who present with a range of care needs. It also assumes that the staff works at an optimum level of efficiency. Thus, an assignment of 7 or fewer residents is reasonable for ensuring optimal care quality, especially for dementia care facilities.

Questions 3- Consistent staff-resident assignment: Family members and residents generally prefer that nurse aides consistently provide care to the same group of residents on a daily basis. Such “consistent assignment” makes it easier for family members to communicate with the staff about care issues and residents’ preferences and is also conducive to ensuring better care quality through familiarity. Thus, numerous dementia care advocacy groups strongly support the idea of consistent staff-resident assignments. While there is relatively little research that examines the benefits of consistent assignment, we have included this practice as an important quality measure because families tend to prefer it and because of the widespread expert consensus that a good facility incorporates this in their staffing model, especially for dementia care services.

Question 4 – Working short-staffed: Nurse aides often have to take responsibility for extra residents due to unexpected staff absenteeism. Most facilities have an “on call” or “temporary staff” system in place to cover absentees, but this system does not always work properly (e.g., a replacement worker may not be available). As a result, there is often a gap between the number of staff members scheduled to work on a given day or shift and the number who are actually present. Working “short” can be a common problem that interferes with the staff’s ability to provide good care on a consistent basis, so you should be aware of how often it occurs in the facilities you are considering. If a staff member reports being assigned to care for more residents on a given day (Question 1: “*How many residents are you assigned today?*”) than he or she is usually assigned (Question 2: “*How many residents are you usually assigned?*”), then you have a good indication that the staff is, in fact, working short on the day of your interview.

Question 5 – Other staff: Facilities with “average” nurse aide staffing levels may augment these levels by using other types of staff members for certain tasks or during certain times. For instance, dietitians might help at mealtimes or the social worker might assist residents to afternoon activities. This “extra” assistance can be very helpful and can really make a difference in care quality if routinely used. The presence and assistance of additional staff members during any portion of the day or for any aspect of care that would otherwise be the sole responsibility of the nurse aide is helpful because it gives the nurse aide more time to perform other assigned care tasks. Some common extra staff include “hydration technicians” who take responsibility for supplement and snack delivery between meals and “restorative nurse aides” who take responsibility for walking assistance and other exercises.

Question 6 – Specialized dementia care training: Nurse aides will often say that “dementia care” was part of their initial training, but many experts contend that the total number of educational hours required to become a certified nursing assistant—usually 75 to 100 hours, depending on the state—is too low for any aspect of care, so the portion of total training designated to dementia care is likely to be very small. Given this, you should find out how much *additional* training specific to dementia care the nurse aides have received. This information is especially pertinent for staff members who are routinely assigned to a “dementia care unit” or who work in a residential care facility that specializes in dementia care. Feel free to ask staff members to describe the amount (i.e., the number of hours) and content of this additional training. Training content should include how to effectively handle residents with problem behaviors (e.g., socially inappropriate behaviors, verbal or physical aggression, resistance to care, wandering) and also how to communicate with residents who have dementia in a manner that encourages their independence, to the greatest extent possible (e.g., providing verbal cues and prompts instead of physical help) as well as reduces the likelihood of agitation (e.g., short, simple instructions in a calm tone of voice).

Question 7 – Staff communication about need for assistance: Staff members may report that they either provide care in a routine manner each day (e.g., residents are always assisted out of bed around the same time each day, served meals at the same time and in the same location daily) or, alternatively, they wait for residents to notify them of their care needs (e.g., via the call light or direct requests for assistance). Though such practices may seem reasonable, they are not desirable because residents with dementia are often too confused to ask for help when they need it. Also troubling is any staff report that implies that it is not useful to ask residents with dementia what they need or want because these residents are unable to express their preferences. On the contrary, studies have shown that many residents with dementia are capable of expressing their preferences for care, in particular simple aspects of daily care such as when to get out of bed and what to wear. Staff members should routinely be asking residents about their care preferences unless a resident is completely unable to communicate. Choices should be offered by staff in a way that the resident can understand and which is feasible for staff to do (e.g., offer a choice between getting up now or in 30 minutes, or offering a choice between eating breakfast in bed or the dining room).

Question 8 – Staff assessment of pain: Many staff members rely on either medical record documentation of pain-related diagnoses (e.g., osteoarthritis, osteoporosis, cancer, or a recent fracture) or prescribed routine pain medications as a primary indicator that a particular resident has pain. In addition, nurses rely on residents’ self-report of pain and requests for medication. Based on these information sources, nurses often assume that they are well aware of who has pain and who doesn’t and, thus, they often dismiss the importance of *routinely asking residents*, especially those with dementia, about their pain status. Ideally, staff should ask residents directly on a *daily* basis simple, direct questions about pain (e.g., “Do you have pain anywhere right now?” or “Are you in any pain right now?”) because a resident’s pain status may change from day to day or even within the same day. Studies show that most residents with dementia remain capable of expressing pain or discomfort. For this reason, experts recommend that *all* residents be asked *daily* about their pain unless a resident is completely unable to communicate verbally. For residents who are in the late stages of dementia and completely non-communicative, staff members should report to you that they pay attention to the residents’ non-verbal body language such as facial grimacing, moaning and groaning, and other signs of agitation or aggression that might be indicative of pain or discomfort.

Question 9 – Staff determination of resident’s daily care preferences: Most commonly, staff members simply refer to a resident’s “care plan” or other medical record documentation to determine

the resident's daily care preferences (e.g., when the person likes to get out of bed, where he or she likes to eat breakfast, etc.). The problem with this approach is that residents' daily care preferences are often not well documented by staff (e.g., preference questions were not asked at all due to the resident's dementia) and preferences are often only assessed—if assessed at all—at one point in time (typically upon first admission to the facility). The important point here is that staff members should recognize that residents' preferences can change *daily* and so residents should be asked directly *each day* what they want or, alternatively, should be given reasonable options to choose from (e.g., “Do you want to have breakfast in bed or in the dining room this morning?”). These practices facilitate care provision consistent with a resident's preferences. Again, staff should not assume that residents with dementia are unable to express their preferences, especially for simple aspects of daily care such as when to get out of bed, where to have breakfast, and whether or not they want to attend a scheduled activity.

Question I0 – Mealtime alternatives: All nursing homes are required to post the menu for the day and make at least one alternative menu item available to each served meal. Some facilities also will ask residents to select their menu choices in advance, either the day prior to a meal or as much as one week in advance. Unfortunately, neither of these approaches works well for residents with dementia because they are often unaware of the menu options available to them and may forget what they requested day(s) prior to a meal. They may also simply change their mind once the meal is served (e.g., chosen meal might not look appealing or taste good once served). The key point is that staff members should notice whether a resident is eating poorly or otherwise appears to not like the served meal and, when this occurs, should offer to get the resident something else to eat; residents, especially those with dementia, often do not make requests on their own. (Note: You can further assess staff assistance at mealtimes using direct observations of mealtime care. Refer to Chapter 4).

Questions 7-10: In general, studies have shown that older adults with dementia rarely make requests for care or otherwise complain about care, even when facility staff do not provide care in a timely manner or according to the resident's preferences. In short, many residents, but especially those with dementia, tend to be very passive recipients of care – even poor care – for a number of reasons, including depression or not wanting to be viewed by staff as someone who complains. Thus, it is critical that staff members recognize the importance of giving each resident numerous opportunities for care and choice throughout the day. If a staff member waits for a resident to request care or complain, then hours could go by with no staff attention to a resident who really needs it.

Consumer Satisfaction Surveys: What You Need to Know

Many facilities (both nursing homes and residential care facilities) assess family and resident satisfaction with their services and some facilities make this information available to consumers. It is most common for only family satisfaction to be assessed but a few facilities also include residents and sometimes staff members as well. Feedback from both residents and families regarding their care experiences is important; thus, it is *not* a good sign if the facility does *not* have a system in place to assess consumer satisfaction. However, satisfaction information can be misleading to both facility managers and families who attempt to use it to evaluate care quality. The most common reason why consumer satisfaction information can be misleading is because the primary intent of many facilities when conducting “satisfaction surveys” is to use this information for publicity purposes; that is, facilities want to report high satisfaction rates as a way to attract more people to their facilities. As a result, you will often see this information highlighted in facility handouts, such as “98% of families report

being very satisfied with our care!” Thus, most facilities that voluntarily share this information with consumers generally report very high rates of satisfaction. As a consumer, you should be cautious about assuming that high satisfaction ratings for a specific facility are either unique or reflect better care quality. Additional reasons why satisfaction information should be interpreted with caution include the following:

- › Facilities assess consumer satisfaction infrequently (only once per year or less).
- › Facilities often vary in the type of surveys they use, which makes it difficult to compare one facility to another on “satisfaction” ratings.
- › Survey questions tend to be very general. For example, a commonly used question asks, “Overall, rate how satisfied you are with the care your relative receives.” Possible ratings often range from “very dissatisfied” to “very satisfied.” This, and similarly general questions, are not helpful in identifying specific aspects of care that need to be improved, even if consumers report being “very dissatisfied.” Moreover, research shows that families tend to report higher rates of satisfaction to such general questions. By comparison, they report lower rates of satisfaction when asked about specific aspects of care (e.g., attractiveness of the facility’s food; the facility’s laundry service and frequency of lost items; bathing schedules; visiting hours).
- › Many facilities have a very low “return rate” for these surveys. Some facilities selectively ask only a small proportion of families to complete the survey, so the results represent only a very small group of families.
- › Residents are often not surveyed at all due to an assumption by the staff that any resident with dementia cannot reliably report his or her satisfaction with care. In fact, many residents with mild to moderate cognitive impairment are capable of reporting their satisfaction with care as long as specific, simple questions are asked (e.g., “Do you like the food here?”, “Are there activities that you enjoy?”, “Are you able to get out of bed and return to bed when you like?”).

The important point is that the primary interest of facility staff should be on identifying specific aspects of care that potentially need improvement so that they—the staff members—are aware of any issues or problems that need to be addressed on a routine basis – not just once a year.

All of the above reasons combine to create satisfaction survey information that is not very informative and may even be misleading to both consumers and dementia care staff. A much better approach is for the facility staff to make a genuine effort to monitor care quality on an ongoing basis for “quality improvement” purposes based on both resident and family member perspectives. Facilities should also ask staff members for their suggestions for improvement. The important point is that the primary interest of facility staff should be on identifying specific aspects of care that potentially need improvement so that they—the staff members—are aware of any issues or problems that need to be addressed on a routine basis – not just once a year. In fact, a facility that has good systems in place for routinely assessing resident and family satisfaction with care might even have *lower* satisfaction ratings related to at least some aspects of care precisely because they are actively asking

families and residents to identify areas in need of improvement. For example, a useful survey might have questions about specific aspects of care that are important to families such as, “Have you experienced any problems with your relative’s belongings being lost or misplaced?” or “Does your relative seem to like the food here?”. The questions below are designed to give you an idea of how specifically and routinely satisfaction with care is assessed within a facility. These questions should be posed to either a facility administrator and/or public outreach person. The admissions coordinator should be able to direct you to the right staff member for questions related to satisfaction information. The below Satisfaction Assessment Interview Guide also is shown in Appendix B.

Appendix B. Satisfaction Assessment: Questions, Scoring Guide and Rationale

1. Does the facility conduct a satisfaction survey?

- No and/or unable to provide a copy of the survey showing the questions (0 points)
- Yes and able to provide a copy of the survey showing the questions (1 point)

IF NO to Question #1, discontinue the interview. Facility receives 0 total points.

2. How often does the facility conduct satisfaction surveys?

- Less often than once per year (0 points)
- At least once per year or more often (1 point)

3. Does the facility survey both residents and family members?

- Yes, but unable to show you recent survey results (0 points)
- Yes, surveys one group and able to show you recent survey results (1 point)
- Yes, surveys both groups and able to show you recent survey results (2 points)

4. *What percentage of families and/or residents provided survey information based on the most recent survey?*

- Less than 50% of families responded and/or surveys were not mailed to all families and/or less than 25% of residents responded and/or all residents with dementia were excluded (0 points).
- More than 50% of families responded and surveys were mailed to ALL families of current residents (1 point).
- More than 25% of residents responded and only residents with moderate to severe dementia were excluded from the survey (2 points).

5. *Are there any survey questions that ask about specific ways in which the facility can improve care quality?* (Example questions: “Are there any aspects of care you feel are in need of improvement?” Or, “Have you experienced any problems with your relative’s personal clothing being misplaced or lost by the laundry service?”)

- No, only general satisfaction questions are asked (0 points)
- Yes, specific questions are shown on survey form and/or most recent survey results were shared that identified specific problems (1 point)

6. *Are staff members at all levels, including nurse aides, encouraged to make suggestions about how to improve care quality on a routine basis?*

- No, staff are not asked directly for their suggestions on a routine basis (0 points).
- Yes, staff are asked directly but only supervisory-level staff (1 point)
- Yes, staff at ALL levels are asked directly and routinely and staff can describe how this process is encouraged (e.g., a “suggestion box” open to all staff which is reviewed during monthly staff meetings) (2 points).

Total Score: Add points for Questions 1-6 to yield a total score range from 0 (below average) to 9 (Excellent).

- Total points of 8-9 = Excellent
- 5-7 points = Above Average
- 2-4 points = Average
- 0-1 points = Below Average

Scoring Rationale

Questions 1 and 2: Facility approach to assessing satisfaction: These first two questions are intended to assess the specificity and frequency of satisfaction assessment. Most facilities will report that they have methods in place to monitor consumer satisfaction, and many will be able to provide information about how well their facility is rated by consumers. They may report, for instance, that “over 90% of our families report that they are satisfied with the care here” or “our facility has one of the highest satisfaction ratings in the area.” Such information, however, should be interpreted with caution for reasons discussed earlier in this chapter. If the facility does, in fact, routinely and objectively assess consumer satisfaction, they should be able to easily share with you a copy of the actual survey questions and tell you how frequently the questions are asked. Ideally, facilities should ask both residents and families about their care experiences within the first six months of admission and then at least annually thereafter.

Question 3 and 4: Inclusion of both families and residents: If the facility cannot show you results from their most recent satisfaction surveys of residents and families or if they report that residents are not formally interviewed due to cognitive impairment or dementia, then you should conclude that the facility does not have a well-designed program for monitoring consumer satisfaction. At least 25% of residents in most nursing homes retain the capacity to answer simple questions about their care, even if they have some degree of cognitive impairment. This percentage is even higher in most residential care facilities, including those who provide dementia care services. We describe later in this chapter a simple method that families can use to determine whether their loved one can meaningfully answer questions about their care preferences and daily care experiences. Obtaining such feedback directly from your loved one is a valuable way for you to assure care quality after your relative has moved in to a facility. As a general rule, facilities that are serious about obtaining representative information about their services should have procedures in place to assure that they receive satisfaction reports from at least 60% of families and 25% of residents.

Question 5: Usefulness of questions for quality improvement: Well-designed satisfaction surveys will include at least some questions that specifically and explicitly ask for ways in which the facility can improve. Such questions might ask, for example, “Are there ways in which we can improve our services?” or “What suggestions do you have for how we could do a better job?” A facility with a well-organized survey system should be able to show you not only numbers and percentages (e.g., the percentage of survey respondents who report high satisfaction), but also a list of respondents’ suggestions for improvement. Such a list serves as evidence that the facility is always actively seeking ways to make care better, which is a good indicator of a better place to live. If specific suggestions have been made, feel free

to follow-up with questions about how the facility is addressing them. Does the facility have an “action plan” for resolving an identified issue? For instance, if families complained about personal clothing getting lost or misplaced due to the laundry service, what changes has the facility made to address this issue?

Question 6: Staff suggestions are welcome: Facilities should encourage staff members at all levels – including nurse aides – to make suggestions for quality improvements on an ongoing basis. There should be a system in place to minimally encourage, and ideally even reward, suggestions made by staff. For example, a facility might have an anonymous “suggestion box” that is checked by the facility administrator weekly or monthly, with any suggestions discussed in routine staff team meetings. Even better is if the facility administrator or admissions coordinator can provide you with a recent staff suggestion and show how it was addressed. This serves as stronger evidence that the quality improvement system is working in a positive manner. It also provides evidence that the facility is always striving to improve and encourages staff input in this process.

Other suggestions for interviews: Beyond the nurse aide and satisfaction survey questions just reviewed, consumers might also obtain useful facility assessment information by asking to attend the next regularly-scheduled family council meeting and using this opportunity to talk directly to families about their care experiences and satisfaction with the facility. Typically, family councils meet monthly and are attended by family members who visit often or who have care concerns. Additionally, you might check other guides for suggestions for questions to ask facility staff not covered here. We list some of these guides in the “other resources” section.

Interview Screening Guide for Residents

Is your family member able to meaningfully answer your questions about their daily care experiences? Should he or she be included in consumer satisfaction interviews by staff?

Research shows that residents who show some awareness of their surroundings, such as knowing where they are and who they are talking to, are able to meaningfully answer questions about aspects of their daily care. The questions below can be used to assess that ability after the resident has had time to adjust to a new care setting; that is, after the person has become familiar with his or her own room location and the staff members.

1. *What season is it right now?” (Knows current season)*
2. *Where is your room? (Knows location of room/unit or floor)*
3. *Shows recognition of staff either by name and/or face (ask: “Who is s/he?” after someone comes to the room to provide care).*
4. *What is the name of this place? Or, Where do you live? (Knows that s/he lives in a facility)*

These one-page interview forms—on pain and on food service—simply provide you with an easy way to gather helpful information from your loved one and share it with relevant staff members to improve their care provision.

If your loved one can give reasonably accurate answers to 2 or more of these 4 questions, he or she also should be able to answer other questions about his or her daily care experiences. Such questions include, “What activities did you enjoy today?” “How do you like the staff?” “How do you like the other residents,” “Did someone on the staff help you to walk today (or use the toilet today)?” Your loved one may not always be able to relay accurate information about his or her day; after all, the person presumably still has some level of confusion due to dementia. However, your relative’s ability to answer 2 or more of these 4 questions suggests that it is worthwhile for you to ask him or her directly if you want to know how your relative is being treated and how he or she spends their day.

Beyond the ability to answer questions about daily care experiences, studies show that most residents with mild to moderate cognitive impairment are capable of answering simple questions about their experience of pain (see Appendix C. Probable Chronic Pain interview) and their likes and dislikes related to the food service (see Appendix D. Food Service Satisfaction Interview). If your loved one has a history of pain or diagnoses that are likely to cause pain (e.g., cancer, osteoarthritis, osteoporosis, recent fracture, pressure ulcers), we encourage you to use the brief pain interview in Appendix C as a way to facilitate better pain management for your loved one. Bear in mind that licensed nurses are often unaware of residents’ pain complaints and, thus, pain may go undetected and untreated. The licensed nurses within the facility, as well as the resident’s primary care physician, should be receptive to any pain information you gather. Similarly, if your loved one has a history of unintentional weight loss or you consider him or her to be a “poor eater,” the person’s answers to questions in Appendix D about the food service can provide insights into what might be done to encourage better eating. Here, the facility dietitian should be open to any suggestions you offer from your interview. These one-page interview forms—on pain and on food service—simply provide you with an easy way to gather helpful information from your loved one and share it with relevant staff members to improve their care provision.

CHAPTER 4: THE POWER OF OBSERVATION

Overview: This chapter discusses: (1) what and how to observe when you are selecting a dementia care facility; (2) what and how to observe once your relative lives in a care facility; and (3) how to interpret the information from your observations.

Observations of Care Quality

Almost all consumer guides make recommendations about observing the quality of the environment and care when selecting a nursing home or residential care facility, and the majority contends that such observations are the most important source of information about care quality. We strongly agree that observations represent a key information source because we ourselves have conducted extensive research on dementia care quality based largely on observations of care. Thus, we extend the advice offered in other guides by providing specific information about what, when, and how long to observe care and how to interpret the information from these observations. Our advice is based on both research evidence and clinical experience in a large number of facilities nationwide. Our goal is to provide you, the consumer, with simple observation guidelines that you can use to screen and select a facility for your loved one and continue using afterward to monitor your relative's care quality. Again, we provide guidance that is not only based on years of research but reflects the approach we would use in making these difficult choices for our own family members.

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What, When, and How Long to Observe

The first three questions that need to be addressed before visiting a facility to observe care are: (1) what to observe, (2) when to observe, and (3) how long to observe. Answers to these questions determine how you will plan your visit so that it is as informative as possible within the least amount of time. Answers may vary depending on your purpose. Initially, observations can be useful when you are selecting a facility. Afterwards, observations can be useful when you want to ensure that care quality is maintained over time (e.g., as new staff members are hired or as your relative's care needs increase). Observations can serve both purposes; but importantly, consumers should *not* assume that observations are not needed once a facility is selected and your relative has moved in. This holds true even if you are confident about a facility's high quality of care at the time of placement. There are many reasons why care quality might change within a facility over time but the two most significant factors are staff turnover and an increase in the care needs of someone with dementia over time. A good facility will encourage and support frequent visits and your continued involvement in care and will ask you to notify the staff of any concerns. A good facility also should follow-up with you if you express

concerns to see whether the issues have been resolved to your satisfaction. We recommend that you also share with supervisors and direct care providers themselves your observations of good care or exemplary staff performance. This will help facilitate a positive relationship with the staff, one that is conducive to a shared partnership in ensuring care quality as opposed to one that is adversarial. For example, if there is a particular nurse aide or licensed nurse whom you are impressed with in terms of how he or she interacts with your relative, be sure to let the person's supervisor know what a good job that staff member is doing. If you also have areas of concern, staff members are likely to be more receptive to your requests because you have demonstrated that you are equally willing to acknowledge good care.

What, When, and How Long to Observe When Choosing a Facility

Two of the most important areas to get information about are how staff members interact with residents and how sensitive they are to residents' care needs. There are several different time periods during which you should be able to observe multiple aspects of care within a reasonable timeframe. The two time periods we suggest are: (1) mid-morning, which should include the mid-day meal or lunch (approximately 10:30am – 12:30pm, depending on the facility's meal service); or (2) late afternoon to early evening, which should include the evening meal or dinner (approximately 4pm – 6pm). You need only be present during *one* of these two time periods to gain useful information. If you happen to be present during both, use the opportunity to approach nurse aides during each time period for an interview (*see Chapter 3: Nurse Aide Staffing Interview*).

These two time periods will allow you to determine:

- how many residents are out of bed;
- whether residents are given choices during care delivery; and,
- whether staff members are sensitive to residents' care needs.

We recommend that you ask an administrator or supervisor for permission to observe in the hallways connecting residents' rooms and then in the dining room during the scheduled meal. The form shown below and in Appendix E can be used to record your observations and score the facility. Later, you can compare the scores from all the facilities you visited for observation. This form is a simplified version of observational forms used in our research studies to evaluate dementia care quality and to distinguish between facilities that vary in care quality.

Appendix E. Observations of Care Provision

Date: _____/_____/_____ Day of the Week: _____

Time Period: 10:30am-12:30pm (to include lunch)
 4pm-6pm (to include dinner)
 Other: Start Time: _____ End Time: _____ (Meal Observed: _____)

Care Area	Observation	Score
I. Staff-Resident Interactions	Check if staff behavior was observed	(0-2)
a. No care provided OR Care provided with little to no communication b. "Elder speak" used c. Request(s) for care not attended to by staff d. Choices offered to residents e. Warmth, Kindness, Respect f. Other:		
2. Percent out-of-bed Specific Time: ____ : ____ am/pm	Total # residents in-bed: ____ <i>Divided by:</i> Total # of residents on unit/in facility (as reported by staff): ____ Percentage in-bed:	
3. Percent in dining room for meal Meal(s) Observed: _____ *Count all dining areas	*Total # residents in dining area(s): ____ <i>Divided by:</i> Total # of residents on unit/in facility (same as Item #2): ____ Percentage in dining area(s):	
4. Mealtime Care Practices a. Dining environment is appealing b. Menu options are made available c. Staff recognizes poor eaters and offer alternatives and/or encouragement to eat. d. Staff is talking to residents.		
Overall Total Score across all areas Additional Comments/Observations		

Observational Tool: Scoring Rationale

Item I. The quality of staff-resident interactions: The form’s first item, which is also typically recommended in other consumer guides, can be completed based on your subjective overall judgment about how well staff members interact with residents during your observation period. There is little more to say about this item other than that all staff members whom you observe – regardless of their position or job title – should appear friendly, kind, and patient, based on *your* definitions of those terms. You should pay attention to all staff members who interact with the residents; the more types of staff members you observe, the better. There are many different types of staff in a dementia care facility (e.g., licensed nurses, nurse aides, social activities personnel, housekeepers, therapists, etc.), and you should feel comfortable with how each staff member approaches and speaks to any resident in the facility. This item is intended to reflect your own personal opinion and, as such, there is no standard against which to compare your subjective rating. That said, we want to note that studies show that “elder speak” is common and regarded by many as disrespectful and demeaning or condescending. “Elder speak” is language that an adult might more typically use with a child because it often has a tone of “I know best.” Staff members in nursing homes and residential care facilities are using “elder speak” when they tell residents what to do in either an authoritative manner or a manner that implies the resident is incapable of making decisions for themselves. Here are a few examples of the kind of language that constitutes “elder speak”:

- 】 The use of terms of endearment that may be considered disrespectful of an older person (e.g., honey, sugar, baby, mama, Granny, Pop, buddy, etc.). Many consider it better to address residents by name.
- 】 Using slang terms to refer to bodily functions (e.g., asking residents if they need to go “pee-pee” or “poop” or “use the potty” instead of asking if they need help to use the bathroom).
- 】 Telling the resident what to do in an authoritative tone (“It’s time to get up now.”) instead of asking the resident what he or she wants (“Are you ready to get out of bed?”) or offering the resident a choice (“Would you like to get up now or a little later?”).

If you observe staff-resident interactions similar to these, or any type of interaction that makes you feel uncomfortable, it reflects poorly on the quality of the staff training and supervision; thus, we recommend that the facility be given a lower rating on this item. Similarly, studies show that many staff members simply do not talk to residents at all, or very little, while providing care to them. This is especially common when a resident has dementia because staff members tend to assume that these residents cannot respond in meaningful ways. The absence of any communication (or staff members talking to each other rather than to the resident) is also noteworthy when you are conducting observations. Such lapses, we believe, reflect as poorly on staff training as incidences of “elder speak.” Minimally, staff members should be addressing each resident by name and telling the resident why he or she (the staff member) is there and what care he or she is offering to provide (e.g., “Good morning, Mrs. Smith, I am here to take you to the dining room for lunch”). Staff members should do this routinely, even with residents who are too impaired to respond meaningfully. Again, score this item based on *your* own personal opinion and comfort level and how *you* feel about the resident-staff interactions during care provision that you are observing. Below are our own suggested guidelines for scoring this item. The other types of observations we recommend are more specific, and so we provide more explicit guidance about how to interpret and score them.

Scoring Guidance Item 1:

Excellent = 2 points (multiple staff-resident interactions occurred during the observation period; each interaction involved a staff member talking directly to a resident in a desirable manner; staff members responded to resident requests or complaints, if expressed; staff members offered residents choices when providing care [e.g., “I am here to take you to lunch. Do you want to eat in your room today or the dining room?”]).

Average to Above Average = 1 point (at least one staff-resident interaction occurred; the staff member spoke directly to the resident in a desirable manner; the staff member told the resident why he or she (the staff member) was there and explained the care being provided but did not offer the resident a choice about care provision [e.g., “I am here to take you to lunch. It’s time to go to the dining room.”]).

Below Average = 0 points (no staff-resident interactions occurred; or, at least one interaction involved a staff member not speaking to the resident at all or speaking to the resident in an undesirable manner [e.g., using “elder speak”]; or, staff members failed to respond to residents’ requests for care or other complaints, if expressed).

Item 2. Percentage of residents in bed: Early in your observation period, you should walk down the room hallways and count the number of residents who are still in bed (i.e., either at 10:30am or 4pm, if you are observing during the suggested time frames). If a resident’s bedroom door is closed, you are not allowed to open the door, but closed doors suggest that residents are still in their rooms and likely receiving some type of care (e.g., staff assistance with dressing or toileting), especially in nursing home facilities and dementia care units. One caveat to this is that some residential care facilities allow residents to have their own private rooms, and doors are kept closed when these residents are not in their rooms; however, this is typically not the case on dementia care units within residential care facilities. You can ask administrators or supervisors what their facility policies are about opened and closed doors on the dementia care units. On most such units, residents’ room doors are kept open. If this is the case, you should be able to get a reasonably accurate count of how many residents remain in bed at the time of your observation. It is best to walk down each hallway on the unit to get an overall estimate. This estimate can be converted into a percentage by dividing your estimate by the total number of residents within the unit or facility (note: ask the administrator or Charge Nurse for this number; he or she should be able to easily provide it, or at least a close estimate). In other words, divide the total number of residents in bed by the total number of residents on the unit. This “percentage of residents in bed” at mid-morning (10am-11am) or late afternoon (4pm-5pm) is an excellent indicator of how well staff provide care in a time-efficient manner, such that residents do not have to wait a long time to receive care (such as help with getting out of bed). In addition, this percentage is a good indicator of how much effort the staff puts forth to encourage residents to spend time outside of their rooms and engaged in other meaningful activities throughout their day. Residents who spend most of their day in their room or in bed tend to receive less staff attention, be more socially isolated, eat more poorly, and show more symptoms of depression – not to mention the increase risk for decline in their physical health.

Studies of care quality have also shown that residents who are still in bed at mid-morning (10-11am) are more likely to *not* receive other aspects of morning care, such as changing of soiled bed linens or undergarments, help with using the bathroom, dressing, and bathing. In short, in these studies, these residents remained in bed for most of the morning and had few opportunities for care or socialization

because of much lower levels of interaction with the staff and other residents. Similarly, residents in these studies who were in bed during the late afternoon (4-5pm) were often put back into bed after the midday meal (lunch) and then *stayed in bed* for the remainder of the day, including the evening meal (dinner). This pattern also means that residents spend a significant portion of their day in bed and possibly alone in their rooms. In fact, studies have shown that nursing homes in which nurse aides were assigned 9-10 residents (*Refer to Chapter 2. Nurse Aide Staffing Interview, Questions 1 & 2*) were more likely to have a higher percentage of residents in bed during these time periods compared to facilities in which nurse aides were assigned 7 or fewer residents. In general, facilities with more nurse aides (or similar staff members) tend to do a better job of getting residents out of bed and out of their rooms so that residents have ample opportunities to engage in meaningful activities and socialize with both staff members and other residents throughout their day.

We consider a facility to be “excellent” if you see less than 30% of the residents in bed during your observation. This rating is based on findings from studies that examined the relationship between staffing levels, the amount of time residents spend in bed, and other care quality measures. It should be noted that the percentage of residents in bed will likely never be “0” because there will almost always be at least a small proportion of residents who prefer to be in bed or who may not be feeling well at the time of your observation. For instance, a resident may have just returned from a hospital stay or have some type of infection or virus, so bed rest is appropriate. Otherwise, the majority of residents should be encouraged to get out of bed by mid- to late-morning and to remain out of bed for most of the day, including for the evening meal. If facility staff members report or imply that a high percentage of residents prefer to stay in bed, consider this a poor reflection on the staff’s efforts to encourage residents to get out of bed and to offer them timely assistance to do so. It also reflects poorly on the facility’s social activities program and the staff members whose job it is to motivate residents to get out of their rooms.

Scoring Guidance Item 2:

Excellent = 2 points (less than 30% of residents were observed in bed)

Average to Above Average = 1 point (30% to 40% of residents were observed in bed)

Below Average = 0 points (more than 40% of residents were observed in bed)

Item 3. Percentage of residents in the dining room for the scheduled meal: Mealtime in a dementia care facility is an important daily care activity because it occurs three times per day, seven days per week, and has been shown in research studies to significantly contribute to a resident’s quality of life. It offers multiple opportunities each day for social engagement, and many residents rate their satisfaction with the food service as the most important contributor to their daily quality of life. Moreover, many residents with dementia are at high risk for under-nutrition, dehydration, and unintended weight loss because they do not eat or drink enough each day. Studies show, however, that when residents eat their meals in the dining room, or in any group setting, as opposed to alone in their rooms, they are significantly more likely to:

- Eat and drink a larger proportion of the served meal;
- Receive more staff attention, including assistance and encouragement to eat;
- Experience more socialization with both staff members and other residents;
- Receive more staff offers of alternatives to the served meal when eating poorly; and,

- » Be identified by staff members as potentially experiencing a nutritional problem when they eat poorly.

In short, residents who dine outside of their rooms for most meals are more visible to staff and, thus, receive the attention and supervision they need to ensure optimal nutritional care quality. In addition, as mentioned previously, dining outside of one's room also provides multiple opportunities each day for socialization with others, which helps to improve overall quality of life. Given the many benefits of group dining, residents with dementia should be strongly encouraged to eat *at least* two meals per day outside of their room—and all meals if possible. If your loved one has experienced a recent unintended weight loss or you have concerns about his or her nutritional status, dining with others and in the presence of staff members becomes even more important. Similar to item #2, studies have shown that the percentage of a nursing home's residents who eat their meals in the dining room is a good indicator of both nurse aide staffing levels and nutritional care quality. In these studies, facilities in which 9-10 residents were assigned to each nurse aide (*Refer to Chapter 2. Nurse Aide Staffing Interview, Questions 1 & 2*) had a much lower percentage of residents who ate in the dining room (less than 50%) compared to facilities in which only 7 or fewer residents were assigned to each nurse aide (more than 75% of residents in these facilities went to the dining room for meals). These findings guide our suggested scoring for this care quality measure. Keep in mind that some facilities have more than one dining room and some also have other common areas where residents dine, such as an activity room or sunroom. If you do not already know how many dining areas are in the facility, ask a staff member so that you can be sure to count all residents who are dining with others outside of their room. Your total count can be divided by the total number of residents in the facility or the dementia care unit (use same denominator as Item #2). The most common meal that residents take outside of their own rooms is the midday meal or lunch. By contrast, both breakfast and dinner are commonly served in residents' rooms. One observation during lunch and one during dinner would be the most informative in terms of facility practices related to dining. If you can only observe one meal, then focus on the dinner (evening) meal for scoring this item.

Scoring Guidance Item 3:

Excellent = 2 points (more than 75% of residents are in the dining room).

Average to Above Average = 1 point (50% to 75% of residents are in the dining room)

Below Average = 0 points (less than 50% of residents are in the dining room)

Item 4. Offering choice and responding to residents' care needs: There is perhaps no better time to observe a facility's quality of care and how well the staff members interact with residents than during mealtimes in the dining room. This holds true particularly for residents with dementia. Not only does mealtime occur three times a day, seven days a week, but it typically occurs within a predictable timeframe, which makes it easy for you to observe mealtime activities.

Usually, the general appearance and ambiance of the dining room is most noticeable to consumers, and many dementia care facilities have recently made efforts to create homelike dining rooms and common areas with restaurant-style dining. Here are some aspects of the *dining environment* that we recommend:

- » The room should feature either natural light (via windows) or artificial lighting that is soft and

appealing (e.g., not stark, bright overhead lights)

- 】 The noise level should be low and comfortable (e.g., no loud music or televisions playing; no clattering of meal trays in service carts)
- 】 Staff members should be talking mostly to the residents, not to each other.
- 】 Tables should be pre-set with table cloths, napkins, and/or other place settings.
- 】 The meal should be served restaurant-style (menu options), family style (served from platters by staff), or buffet style (with staff assistance) to provide residents with more choices and easily accessible substitutions during the meal.
- 】 Residents should be seated in regular chairs at the table as opposed to wheelchairs, if possible.

These are all attractive features that can make mealtime in the dining room more pleasant for everyone. Beyond these environmental features, here is what you should look for related to the actual meal service provided by the staff:

- 】 *Availability of Choice:* Serving styles that offer a variety of food choices and encourage residents to eat and drink more while also enhancing residents' quality of life include these three options: restaurant-style, where residents are allowed to choose among options from a menu or are told directly by a server what their options are for that meal; buffet-style, where food platters are visibly displayed and servers are available to assist residents with selecting choices; and family-style, where servers bring platters and bowls of food directly to the table and serve each resident individually. A facility should receive credit for offering any of these three options, for each encourages choice in dining. *Note:* The Food Service Satisfaction Interview (Appendix D) includes a question (#5) about the availability of alternatives to the served meal. You can use this question to determine your relative's awareness of the menu options available. Staff members often report that alternative menu choices are available during meals, but many residents, especially those with dementia, are unaware of these options. If this is the case with your relative, then staff offers of alternative menu choices are all the more important (*see the next section*).

Most residents with dementia do not openly complain or otherwise request alternatives when they do not like the food they are given. Instead, they simply eat poorly or not at all. For this reason, it is critical that staff members pay attention to residents' food and fluid consumption during meals so that they, the staff members, notice whether a resident is eating poorly. Residents who consume less than half (50%) of what they are served should be identified by the staff as potentially not liking the served meal and or needing more staff attention to encourage eating. To encourage eating, a staff member might approach a resident early in the meal and ask the person directly if he or she wants something else. The staff member might say, for instance, "How are you feeling today, Mrs. Smith?" "You don't seem to be hungry for lunch. Do you not like it?" "May I get you something else?" "We have that soup you love".

Other resident behaviors during mealtime that staff members should notice and respond to include:

- 】 A resident is sleeping through the meal or otherwise appears tired and lethargic (e.g., the resident closes his or her eyes frequently for long periods). A staff member should make a point of alerting the resident and reminding him or her that it is time to eat. The staff member should continue to check on the resident intermittently throughout the meal to make sure that the

resident is staying awake and eating.

- 】 A resident leaves the table or dining room after eating very little or less than half of what is served. A staff member should notice the resident’s attempt to leave and remind the person that he or she needs to eat or offer to get the resident something else to eat.
- 】 A resident is having difficulty opening containers or holding cups or utensils (e.g., the resident is spilling foods or fluids frequently; some containers remain unopened throughout most of the meal). A staff member should offer to open containers, cut up meat, place a straw in the resident’s drink, and otherwise prepare the meal so that the resident can eat independently more easily;
- 】 A resident is seated alone at a table with little to no interaction with other residents. A staff member should offer to seat the resident with others or, alternatively, spend time socially interacting with the resident at various points during the meal.
- 】 A resident’s meal is taken away (i.e., the table is cleared) when the resident has eaten less than half of the served meal. Staff members should leave the resident’s food in front of the person for a longer period of time, encourage the resident to eat more (e.g., “Why don’t you eat some more of your soup?”) and offer to get the person something else.

We recommend that you identify a few residents in the dining room who are displaying any one or more of these behaviors (e.g., sleeping; having difficulty eating; not eating at all or very little; seated alone) and then continue to watch these residents throughout the meal to see whether staff members attend to them. As long as the staff is paying attention and responding in the ways that we describe above, the staff should be given credit for doing a good job, even if a resident still eats poorly. Some residents will continue to eat poorly, despite good care provided by staff members.

These examples of observation-based measures of care quality during meals are based on a series of studies in which our trained researchers conducted similar observations of residents with and without dementia in several nursing homes. Thus, we know from experience what commonly occurs and what staff in better facilities do differently. More importantly, we know that the best – in fact, the only – way to determine whether staff members are doing a good job at mealtimes is to observe them directly (see this Chapter and Appendix E for the observation form).

Scoring Guidance Item 4:

Excellent = 2 points (dining environment is appealing; menu options are readily available or are visible to residents; staff members seem to notice and respond appropriately to residents who are eating poorly; staff members are frequently talking to residents during the meal).

Average to Above Average = 1 point (dining environment is just “okay” – not appealing but also not noisy

and chaotic; menu options are available but choices are limited [e.g., just one alternative to each served meal]; staff members seem to notice and respond appropriately to *most* residents who are eating poorly; staff members are frequently talking to residents during the meal).

Below Average = 0 points (dining environment appears noisy and chaotic; menu options are neither readily available nor visible to residents, so the residents do not seem aware of their options; 3 or more residents are eating poorly and receiving little or no staff attention; staff members spend more time talking to each other rather than the residents).

CHAPTER 5: STRATEGIES FOR HOW TO SERVE AS AN ADVOCATE FOR CARE QUALITY

Interviews and Observations: When to Repeat the Process

Much of what you do to select a dementia care facility continues to be applicable to ensuring care quality after placement. The interview and observational tools described in previous chapters (and shown in the Appendices) can be used at any time to assess care quality. Don't feel that you need to repeat all the assessment activities described in this guide; you need only repeat those that are most relevant to your concerns at a given point in time. Repeat quality assessments should produce scores that are at least as high as your initial scores, if not higher. This indicates that the facility is truly engaged in ongoing quality improvement efforts. Most notably, you might want to reassess care quality when:

- (1) there has been significant changes in staff composition (e.g., a new administrator or director of nursing is hired; many nurse aides quit and are replaced with new staff members); or,
- (2) your loved one's cognition or health status has declined significantly since placement such that you now notice that he or she requires more care than previously (e.g., you note that your loved one has recently lost weight or eats less; your relative becomes incontinent or loses his or her ability to walk independently; your relative seems more confused or disoriented).

Changes in staff and increased care needs among residents, both of which are inevitable over time in dementia care facilities, can create new challenges to ensuring care quality. You want to know whether new staff members are being adequately trained and supervised such that they are doing as good a job as the staff member whom they are replacing. You also want to know whether the various staff members providing care are aware of your loved one's decline and his or her associated increased need for care.

What You Can Do to Benefit Your Loved One During Regular Visits

Facility staff members should welcome involved family members and friends who visit their loved one frequently and provide valuable insights into the resident's personal preferences, background, and history, and who can identify needs for referral or additional care services. As long as you interact with the staff in a calm and helpful manner, staff members should be receptive to your involvement. For example, you might say: "I have noticed lately during my visits that my mom is not eating as much as she used to. It seems I have to provide more help when I am here. I just want to make sure that the staff is aware that she needs this extra attention during mealtimes." Or you might report to a staff member, "I was walking with my mom today and she complained of pain in her hip. She is walking a lot slower lately and also seems more unsteady. Should I notify her doctor or the physical therapist?"

Visiting during mealtimes is a great way for you to assess mealtime care quality, as described in the previous chapter. It also gives you the opportunity to encourage your loved one to eat. Don't be shy about making requests for alternative menu items for your loved one or bringing in favorite foods for him or her. In fact, any time of day, including between meals, is an opportunity to offer your relative his or her favorite snacks. Most residents with dementia are at high risk for weight loss and dehydration and so can benefit from additional calories and extra fluids anytime of the day. Sharing a favorite

snack or mealtime treat with your loved one during a visit is a great way to help that person. Similarly, accompanying your loved one on a walk, especially outside, not only offers that person a welcome change of scenery but is also a terrific way to assist the staff in providing physical activity for your relative. Many dementia care facilities have walking trails or outside gardens, but do not permit residents to walk unaccompanied due to their elevated risk for falls. As a result, residents may rarely get to enjoy these outdoor spaces. Family visits can be a time for your loved one to enjoy these spaces and get some much-needed exercise. Be sure you are aware of your relative's walking ability and need for assistive devices before you venture out. If you have questions or concerns about your relative's safety, ask a nurse or nurse aide for advice.

Get Involved:

Most facilities have a family council that meets regularly, typically monthly. Ask to become a member, if interested. This will give you an opportunity to meet regularly with other family members and friends to discuss issues and concerns. The family council also sometimes hosts staff appreciation events to honor staff members who do an exemplary job and to show their gratitude for the work the staff performs. Most facilities also welcome volunteers' assistance with social activities and other events.

How to Handle Specific Concerns:

If you have a specific concern related to staffing or care quality, it is usually best to talk directly to the facility Administrator, Director of Nursing, Social Worker or other staff member identified as in charge of the facility or dementia care unit. In most cases, these professionals will respond to your concern in a thoughtful, timely manner and follow-up with you to make sure you are satisfied with how the issue was handled. If this is not the case and you feel strongly that your concern may pose a potential for threat or harm to one or more residents, report your concerns to your local ombudsman association, which is a federally supported organization that helps protect nursing home residents' rights. You can find your local ombudsman office by visiting the Web site of the National Long-term Care Ombudsman Resource Center at <http://www.ltombudsman.org/ombudsman>. The ombudsman typically will ensure that a state or federal survey is conducted to investigate your complaint.

OTHER RESOURCES

www.VanderbiltCQA.org: Vanderbilt School of Medicine, Center for Quality Aging Web site, where both Dr. Simmons and Dr. Schnelle are faculty members, reports on much of the research that supports the recommendations in this guide. This Web site is geared toward nursing home and dementia care providers, but can be equally useful to consumers who want to learn more about assessing care quality. References to published studies are listed within each section, or module, of the Web site.

<http://www.medicare.gov/nursinghomecompare>: Centers for Medicare & Medicaid Services - Your Guide to Choosing a Nursing Home. Official government booklet that explains how to find and compare nursing homes and how to pay for nursing home care. It also identifies nursing home resident rights and alternatives to nursing home care. See also the “Nursing Home Checklist” (pages 30-36) of the CMS Guide.

www.nhqualitycampaign.org: Advancing Excellence in America’s Nursing Homes Campaign provides consumers with helpful information about selecting a nursing home in their state. This Web site also provides a list of consumer fact sheets and other quality measures for nursing homes.

www.nccnhr.org; www.theconsumervoic.org: The National Consumer Voice for Quality Long Term Care (NCCNHR) publishes a “Consumer Guide to Choosing a Nursing Home” as well as guidelines for family involvement in nursing home care (Consumer Fact Sheet No. 3). This Web site also has a report for nursing home facilities by state that shows staffing levels, deficiency citations and other publicly-available quality measures.

www.nsclc.org: National Senior Citizens Law Center (NSCLC) published a report entitled “20 Common Nursing Home Problems – and How to Resolve Them,” which is a helpful resource for consumers after their loved one has moved into a nursing home.

www.alz.org: National Alzheimer’s Association’s “Encouraging Comfort Care: A Guide for Families of People with Dementia Living in Care Facilities” (2010 Alzheimer’s Association, Greater Illinois Chapter) discusses dementia and residential care facilities. It also explains: medical decisions you may face; what to do when you visit; and when it is time for hospice. Other helpful tips and resources are also offered along with a “Checklist for Encouraging Comfort Care” (see page 20).

Appendix A. Nurse Aide Staffing Interview and Scoring Guide

Approaching Staff for an Interview:

Introduction: *“Hi, I am a family member and I am considering placing my relative in this facility. I would like to ask you a few questions about your work experience here. It should only take about 10-15 minutes. Would that be okay?”*

1. How long have you been working here?

- Less than 1 year 1-2 years More than 2 years

2. Are you a routine staff member or a temporary (“on call”) staff member?

- Routine (works weekly)
 Temp/On call (works once a month or less in this facility)

3. What days of the week do you usually work?

- Weekdays Weekends Both weekdays and weekends

4. What time periods (“shifts”) do you usually work?

- Day (7am-3pm) Evening (3pm-11pm) Night (11pm-7am)

Note: Some facilities have staff work 10 or 12-hour shifts in which case 7am-7pm is considered “day/evening” and 7pm-7am is considered “night”.

Questions and Scoring Guide:

Listed below are 11 total questions that you can ask, along with the most common possible responses, to each question. We also indicate how each possible response should be scored for questions 1-10. Please note that question 11 is not scored. There are 14 total points possible.

1. How many residents are you assigned today? (Allow staff member to give you a number without offering them the response options below directly)

- 11 or more residents (0 points, low staffing)
 8 to 10 (1 point, average staffing)
 7 or fewer (2 points, high staffing)

2. ***How many residents are you usually assigned?*** (Allow staff member to give you a number without offering them the response options below directly)

- 11 or more residents (0 points, low staffing)
- 8 to 10 (1 point, average staffing)
- 7 or fewer (2 points, high staffing)

3. ***Are you usually assigned to the same residents or does your resident assignment change often?***

- Assigned residents changes daily or weekly (0 points)
- Usually the same residents (1 point)

4. ***How often do you “work short” – that is, take care of more residents because a co-worker doesn’t show up and there is no one to replace that person?***

- Often: At least once a week or more (0 points)
- Occasionally: Once-Twice a month (1 point)
- Rarely, less than once/month (2 points)

5. ***Are there other staff members who assist with some aspects of daily care?*** (e.g., restorative nurse aides who assist with walking and other mobility exercises; hydration technicians who offer residents additional foods and fluids between meals?)

- Yes (1 point) No (0 points)

6. ***Have you received any additional special training related to dementia care beyond the training you received to be a nurse aide?*** Yes (1 point) No (0 points)

7. *If you are providing care to a person with dementia who can still talk to you, but he or she does not always make sense, how do you know when or if the resident needs assistance?* (Allow staff member to respond without providing the specific response options below, which reflect the most typical responses)

- Care is provided on a routine schedule and/or we know what residents want. (0 points)
- Residents are asked multiple times per day what they need or want. (1 point)
- Care is provided both on a routine schedule and by asking resident multiples times per day what they need or want. (1 point)

8. *If you are providing care to a person with dementia how do you know if the person is in pain?* Score 1 point each (for a total of 2 points) if the staff member says that residents are asked directly about pain on a daily basis and other signs of pain or discomfort are acknowledged for residents who are completely unable to communicate verbally.

- Refers to medical chart for pain-related diagnoses and routine pain medications because resident is unable to tell staff about his or her pain; and/or, the staff is already aware of who has pain. (0 points)
- Asks resident directly on a **daily** basis when providing other routine care. (1 point)
- Pays special attention to the non-verbal body language of residents who are completely non-communicative (in the late stages of dementia). Non-verbal indicators of pain or discomfort include facial grimacing, moaning and groaning, and other signs of agitation or aggression. (1 point)

9. *If you are providing care to people with dementia, how do you determine their preferences for when they want to get out of bed, what they want to wear, and where and when they want to have their meals?* Score 1 point if the staff member says that he or she asks residents directly each day what they want or otherwise offers residents a choice among reasonable options.

- Refers to the residents' care plans or medical records to determine preferences or asks the residents' family members. (0 points)
- Asks the residents **each day** what they want or offers them options. (1 point)
- Both refers to care plans and medical charts and asks residents **each day** about their preferences. (1 point)

10. During mealtimes, how do you determine whether a resident might want something different to eat than what he or she is given initially? Score 1 point if the staff member indicates that either a resident can make a request or the staff member offers to get the resident something else when he or she notices that the resident is eating poorly.

- The menu is posted along with the alternatives available each day or at each meal. (0 points)
- Residents make their menu choices in advance. (0 points)
- I will offer other meal choices if the resident is complaining about the meal or makes a request for something different. (1 point)
- If I notice that a resident is not eating well, I will offer to get him or her something else and will let the person know what options are available. (1 point)

11. Is there anything else you think I should know about this facility and the care provided here that would help me to make my decision? Answers to this optional question are not counted in the scoring. You may also use this question to ask about some aspect of care that might be specific to your loved one such as, “my relative likes to stay up late at night. Will he be allowed to do so here?”

Total Score: Add the points for questions 1-10, which will yield a total score of 0 to 14 points.

- 10 or more points = Excellent
- 7-9 points = Above Average
- 4-6 points = Average;
- 0-3 points = Below Average

Refer to Chapter 3 for the Scoring Rationale for this Interview Guide.

Appendix B. Satisfaction Assessment: Questions and Scoring Guide

1. *Does the facility conduct a satisfaction survey?*

- No and/or unable to provide a copy of the survey showing the questions (0 points)
- Yes and able to provide a copy of the survey showing the questions (1 point)

IF NO to Question #1, discontinue the interview. Facility receives 0 total points.

2. *How often does the facility conduct satisfaction surveys?*

- Less often than once per year (0 points)
- At least once per year or more often (1 point)

3. *Does the facility survey both residents and family members?*

- Yes, but unable to show you recent survey results (0 points)
- Yes, surveys one group and able to show you recent survey results (1 point)
- Yes, surveys both groups and able to show you recent survey results (2 points)

4. *What percentage of families and/or residents provided survey information based on the most recent survey?*

- Less than 50% of families responded and/or surveys were not mailed to all families and/or less than 25% of residents responded and/or all residents with dementia were excluded (0 points).
- More than 50% of families responded and surveys were mailed to ALL families of current residents (1 point).
- More than 25% of residents responded and only residents with moderate to severe dementia were excluded from the survey (2 points).

5. *Are there any survey questions that ask about specific ways in which the facility can improve care quality?* (Example questions: “Are there any aspects of care you feel are in need of improvement?” Or, “Have you experienced any problems with your relative’s personal clothing being misplaced or lost by the laundry service?”)

- No, only general satisfaction questions are asked (0 points)
- Yes, specific questions are shown on survey form and/or most recent survey results were shared that identified specific problems (1 point)

6. *Are staff members at all levels, including nurse aides, encouraged to make suggestions about how to improve care quality on a routine basis?*

- No, staff are not asked directly for their suggestions on a routine basis (0 points).
- Yes, staff are asked directly but only supervisory-level staff (1 point)
- Yes, staff at ALL levels are asked directly and routinely and staff can describe how this process is encouraged (e.g., a “suggestion box” open to all staff which is reviewed during monthly staff meetings) (2 points).

Total Score: Add points for Questions 1-6, which will yield a total score from 0 to 9.

- Total points of 8-9 = Excellent
- 5-7 points = Above Average
- 2-4 points = Average
- 0-1 points = Below Average

Refer to Chapter 3 for the Scoring Rationale for this Interview Guide.

Appendix C. Probable Chronic Pain Screening Interview

Resident Name _____ **Date** ____/____/____

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

1. Do you have any pain right now? Yes No NR DK REF

IF YES, ask: “On a scale of 0 to 10 with 0 meaning no pain and 10 being the worst pain you can imagine, how much pain are you having now?”

0 1 2 3 4 5 6 7 8 9 10

2. Do you have pain every day? Yes No NR DK REF

3. Does pain keep you from sleeping at night? Yes No NR DK REF

4. Does pain keep you from doing things you enjoy? Yes No NR DK REF
(e.g. social activities, walking, going to dining room)

5. Do you tell the nurse about your pain? Yes No NR DK REF

6. Does the nursing staff ask you about pain? Yes No NR DK REF

7. Would you prefer to take medication for your pain? Yes No NR DK REF

Probable Chronic Pain: Present Absent Could not Determine

The presence of probable chronic pain is determined based on the resident’s responses to only questions 1 – 4. Probable chronic pain is present if the resident responds “yes” to 3 or more of the first four questions OR provides a “yes” response to question 2. Presence or absence of probable chronic pain cannot be determined if all 4 questions have DK/NR/REF answers. Question 5 and 6 are related to communication with staff about pain. Question 7 is related to a resident’s preference to take medication for pain. If probable chronic pain is present, share the results of this interview with the licensed nurses and the resident’s primary care physician for follow-up and possible treatment.

Appendix D. Food Service Satisfaction Interview

Resident Name: _____

Date of Interview: ____/____/____

Check Response to each question:

1. Do you like the food here?

YES/MOST OF THE TIME NO/SELDOM No Answer/Unclear Answer

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

2. Do you feel that there is enough variety / food choices?

YES/MOST OF THE TIME NO/SELDOM No Answer/Unclear Answer

3. Does the food look good to you?

YES/MOST OF THE TIME NO/SELDOM No Answer/Unclear Answer

4. Is the food served at the right temperature (i.e., *eggs, soup served hot; jello served cold*)?

YES/MOST OF THE TIME NO/SELDOM No Answer/Unclear Answer

5. If you don't like the food you are given, can you get something else instead?

YES/MOST OF THE TIME NO/SELDOM No Answer/Unclear Answer

6. Would you like to have a snack (e.g., *fruit, pudding, cookies, juice*) between meals?

YES SOMETIMES NO No Answer/Unclear Answer

IF YES or Sometimes, What kinds of foods/drinks do you like for a snack?

Make note of any other preferences related to food and dining (e.g., time or location; preferred seating arrangement; preferences for tablemates or dining location; special dietary needs; specific likes and dislikes) and share this information with the facility dietitian:

Appendix E. Observations of Care Provision

Date: _____/_____/_____ Day of the Week: _____

Time Period: 10:30am-12:30pm (to include lunch)
 4pm-6pm (to include dinner)
 Other: Start Time: _____ End Time: _____ (Meal Observed: _____)

Care Area	Observation	Score
I. Staff-Resident Interactions	Check if staff behavior was observed	(0-2)
g. No care provided OR Care provided with little to no communication h. "Elder speak" used i. Request(s) for care not attended to by staff j. Choices offered to residents k. Warmth, Kindness, Respect l. Other:		
2. Percent out-of-bed Specific Time: ____ : ____ am/pm	Total # residents in-bed: ____ <i>Divided by:</i> Total # of residents on unit/in facility (as reported by staff): ____ Percentage in-bed:	
3. Percent in dining room for meal Meal(s) Observed: _____ *Count all dining areas	*Total # residents in dining area(s): ____ <i>Divided by:</i> Total # of residents on unit/in facility (same as Item #2): ____ Percentage in dining area(s):	
4. Mealtime Care Practices a. Dining environment is appealing b. Menu options are made available c. Staff recognizes poor eaters and offer alternatives and/or encouragement to eat. d. Staff is talking to residents.		
Overall Total Score across all areas Additional Comments/Observations		

Observational Form Scoring Guidance:**Item 1:**

Excellent = 2 points (multiple staff-resident interactions occurred during the observation period; each interaction involved a staff member talking directly to a resident in a desirable manner; staff members responded to resident requests or complaints, if expressed; staff members offered residents choices when providing care [e.g., “I am here to take you to lunch. Do you want to eat in your room today or the dining room?”]).

Average to Above Average = 1 point (at least one staff-resident interaction occurred; the staff member spoke directly to the resident in a desirable manner; the staff member told the resident why he or she (the staff member) was there and explained the care being provided but did not offer the resident a choice about care provision [e.g., “I am here to take you to lunch. It’s time to go to the dining room.”]).

Below Average = 0 points (no staff-resident interactions occurred; or, at least one interaction involved a staff member not speaking to the resident at all or speaking to the resident in an undesirable manner [e.g., using “elder speak”]; or, staff members failed to respond to residents’ requests for care or other complaints, if expressed).

Item 2:

Excellent = 2 points (less than 30% of residents were observed in bed)

Average to Above Average = 1 point (30% to 40% of residents were observed in bed)

Below Average = 0 points (more than 40% of residents were observed in bed)

Item 3:

Excellent = 2 points (more than 75% of residents are in the dining room).

Average to Above Average = 1 point (50% to 75% of residents are in the dining room)

Below Average = 0 points (less than 50% of residents are in the dining room)

Item 4:

Excellent = 2 points (dining environment is appealing; menu options are readily available or are visible to residents; staff members seem to notice and respond appropriately to residents who are eating poorly; staff members are frequently talking to residents during the meal).

Average to Above Average = 1 point (dining environment is just “okay” – not appealing but also not noisy and chaotic; menu options are available but choices are limited [e.g., just one alternative to each served meal]; staff members seem to notice and respond appropriately to *most* residents who are eating poorly; staff members are frequently talking to residents during the meal).

Below Average = 0 points (dining environment appears noisy and chaotic; menu options are neither readily available nor visible to residents, so the residents do not seem aware of their options; 3 or more residents are eating poorly and receiving little or no staff attention; staff members spend more time talking to each other rather than the residents).

Refer to Chapter 4 for Scoring Rationale for each item.

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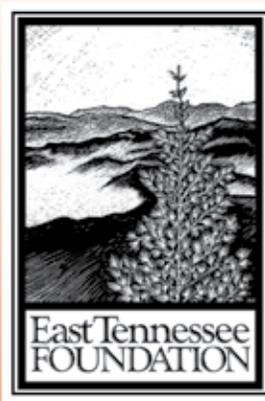
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