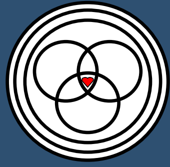

HATCh Holistic Approach to Transformational Change

Individual Choice

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

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

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

As a result, the complete absence of control, choice and personal preferences given to residents is demonstrated by:

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

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

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

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

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

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

3. Fear of regulatory deficiencies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Questions to Consider:

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

Innovative Change Ideas:

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

Resources:

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

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