A GUIDE TO

ADDRESSING RESIDENT GOALS, PREFERENCES AND PRIORITIES (GPP)

MOVING FORWARD
NURSING HOME QUALITY COALITION

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BACKGROUND & PURPOSE

BACKGROUND, PURPOSE, AND OBJECTIVES

Over the past two decades, increasing attention has been placed on autonomy, community, dignity, meaning, optimism, excellent clinical support, and accountability in long-term care. Many nursing homes are working to improve the way they gather residents' goals, preferences & priorities (GPPs), develop a person-centered care plan, and assess whether care delivered is consistent with each person's goals. These efforts are vital to nursing home residents receiving the individualized services, care and support they need and want. The purpose of this Guide is to support nursing home staff in addressing each resident's GPPs.

There is a need to develop and implement a standardized set of questions related to GPPs and a process to obtain, document, update, and address GPPs for nursing home residents. This GPP Guide is written for nursing home staff and offers resources and recommendations to implement a standardized process to address residents' GPPs. This GPP Guide specifically focuses on processes addressing a resident's GPPs - and is not intended to address the entire care planning processes.

The intent of federal and state regulations is to position residents at the center of their own lives, directing *What Matters* to them. Despite those regulations, in some nursing homes, staff do not consistently and reliably collect information about resident GPPs, or residents' responses are not added to each person's care plan. Furthermore, what is in the care plan is not always addressed during actual care delivery with each resident. The Moving Forward Coalition has heard from nursing home staff and residents that how the GPP process takes place and who is involved in those processes vary greatly across nursing homes.

After reading the guide, nursing home staff should be able to:

1. Contrast person-centered care experiences with using the model articulated in the Guide.
2. Identify ways in which identifying, documenting, and delivering resident care preferences promotes person-centeredness in your community.

3. Strategize opportunities for improving person-centered care that are aligned with resident GPPs for care, services, and environments.

How to Use the GPP Guide

This GPP Guide is intended to be a resource to nursing home care teams to co-design and implement a basic framework for identifying, documenting, and implementing resident GPPs in care planning. It is not intended to be a recipe or set of requirements. The GPP Guide lays out steps to consider that each nursing home may use or adapt for the individual residents who live in that home. Additional resources are provided for nursing home staff members who wish to learn more about other elements of the care plan process related to GPPs.

GPP Guide Getting Started Checklist

- Review the Guide as a team.
- Identify care plan facilitator(s) or who on the team will meet with the resident to ask about their GPPs.
- Select a small workgroup to review the GPP identification and assessment tools in the Guide.
- From the Guide, select the GPP identification and assessment tool/questions for your team to use with residents.
- Review the current GPP identification and assessment tools that are being used.
- Remove duplications from the newly selected tool(s) with the questions that are already being used.
- Transfer the selected GPP identification and assessment tool into a format that is best for your organization (i.e. electronic, printable, etc.)
- Determine what documentation and implementation processes from the Guide you want to adopt as a team.
- Develop a plan and timeline for how you will update systems to implement the new processes and resources (i.e. mini care plans, Their Choice, Your Voice, etc.).
- Develop a plan and timeline for how you will train teams of the new systems.
- Once all tools are ready and staff are trained, set a start date to begin the new GPP process.
- Regularly meet as a core team (key leaders, core care plan team, and care plan facilitators) to work out challenges and make changes to the process as needed.

What are Goals, Preferences, and Priorities?

In this section, we provide definitions for certain basic terms in this Guide and associated care planning processes. These may be shared with the care plan team (staff members) to generate a common understanding and use of these terms. Nursing homes may edit or adapt these definitions, but all staff should use the same set of definitions when speaking with one another and when talking with residents, family members, friends or any other individual the resident may designate as their representative.

How to use the definitions:

- These lay definitions can be discussed with residents, care partners, or staff when talking about the purpose of care planning conversations.
- Use the definitions with examples from daily life in your community to make the conversation about the use of these terms more relevant.
- You may wish to remind residents, care partners, and staff of these definitions periodically to be certain they understand the scope and purpose of care planning conversations (both formal and informal conversations).

CARE: Any activity between the resident and other individuals that supports achievement of the resident's optimal physical, mental, emotional, spiritual or social health. Care-related activities should be provided in ways and in places that support and respect who the resident is and what is important to them. Care should take into account an individual's:

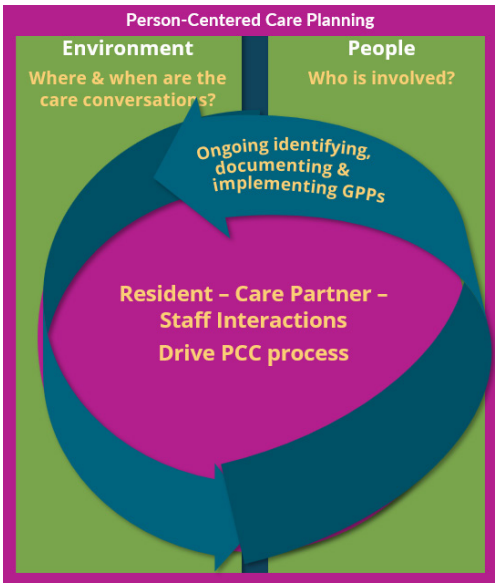
- Identity such as gender, race, ethnicity, sexual orientation, or current or past family and career roles;
- Values, beliefs, and worldview; and
- Culture and ethnicity, including customs and traditions, and ways of life and should be continually reviewed for needed or desired changes.

GOAL: A desired result--that the resident defines based on things that matter to them--that is related to the resident's physical, mental, emotional, spiritual, or social health, their ability to function in daily life, their physical or social environments, or any other aspect of their life in this community. Also consider how the resident's goals might change as their health and environment changes.

PREFERENCE: The resident's unique wishes about any aspect of their physical, mental, emotional, spiritual, or social health, their ability to function in daily life, or their physical or social environments, or any other aspect of their life in this community. These preferences can be very specific (e.g., "I like to get up before 8:00 AM each day" or "I like to go outside at least once daily." Or they can be more abstract e.g., "I want to feel valued"). Also consider that the resident's wishes might change depending on what they perceive as available options.

PRIORITY: The relative importance of the resident's goals, their care activities, and/or their preferences. Based on any existing limitations (e.g., time, ability, environment, staffing), how would the resident rank their health goals, their care-related activities, and their preferences in order of importance, so that individuals providing care know how to plan and organize care and services for the resident?

Engaging Nursing Home Residents, Care Partners and the Interprofessional Team for Addressing GPPs



Engaging Nursing Home Residents

Each nursing home resident is at the center of the care planning process as much as possible. Residents should direct the process as much as possible, including sharing their goals, preferences, and priorities when they enter the nursing home and throughout their stay.

In some cases, nursing home residents may

request assistance during care planning from a family member, friend, designated health care agent, or other individual. If the resident is able to make this request, the team should include those care partners in helping to identify the resident's GPPs.

If a resident has been determined to be unable to evaluate the risks and benefits of various decisions, and the health care agent or proxy has been invoked, then that individual should direct the care planning process on behalf of or along with the resident.

A diagnosis, by itself, does not necessarily mean that the resident is unable to state their GPPs or direct their care plan. Each resident should be evaluated for their ability to make or participate in decisions throughout the care planning process.

Engaging the Interprofessional Team

The composition of the interprofessional (sometimes called interdisciplinary or multidisciplinary) care plan team is important. Teams should include all staff members who interact with residents directly, even if not every day. Members of the interprofessional team who know the resident best should participate in care plan development and co-lead care plan meetings with that resident. Not all team members may attend each care plan meeting, but all team members and disciplines are important to gathering information and providing input on each resident's care. The interprofessional team may include the following:

Care Plan Core Team	• CNAs/CMAs • Nurse(s) • Social Worker • Activities/Life Enhancement/Therapeutic Recreation • Nutrition and Food Services

Other Potential Participants (depending on need and discussion)	• Nurse Practitioners, Physician's Assistants • Physicians • Mental or Behavioral Health professionals • Dietitian and Nutritionist • Physical Therapist • Occupational Therapist • Speech Therapist • Chaplain or faith-based leader • Environmental Services: Housekeeping, Maintenance, Laundry • Pharmacist

Understanding Federal Regulations Related to Addressing GPPs

Full understanding or misinterpretation of guidance often happens with new regulations such as F655 Comprehensive Person-Centered Care Planning. The guidance for this regulation states that the facility or nursing home should focus on the resident as the center of control and support each resident in making his or her own choices. Specifically, that "person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home" as referenced on page 239 in the State Operations Manual.

In the same manual, the 'Intent' of the regulation is that the nursing home will identify, implement, and document that "each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs" as referenced on page 238 in the State Operations Manual.

To further understand or clarify regulations related to addressing GPPs, the State Operations Manual gives further guidance that there may be some cases when "a resident may wish to refuse certain services or treatments that professional staff believes may be indicated to assist the resident in reaching his or her highest practicable level of well-being or to keep the resident safe". The facility should attempt to

find alternatives to address the identified risk/need and have those documented in the care plan. Additionally, "the facility should determine how the resident's decisions may increase risks to health and safety, evaluate the resident's decision-making capacity, and involve the interdisciplinary team and the resident's representative, if applicable, in the care planning process" as referenced on page 240 in the State Operations Manual.

Training to Support Person-Centered GPP Processes

The Purpose of Training Modules

Engaging residents more deeply and consistently about their goals, preferences, and priorities requires attention to several fundamental principles that the Moving Forward Coalition participants determined were largely missing from nursing home trainings. These principles - personhood, human potential, ageism, and dignity of risk - are essential to advance meaningful person-centeredness but are not widely understood in the field. Residents notice this lack of understanding and often experience it as feeling misunderstood, unworthy, or objectified.

The purpose of these four modules is to introduce the foundational principles of person-centered care and demonstrate how they support current regulatory requirements. Each module briefly explains the basic components of each concept and offers case scenarios that exemplify the concept. In addition, we offer explanations of how the concepts relate to the regulations and we provide resources and suggested readings for more information. You will be able to find the training modules in the Training to Support Person-Centered GPP Processes resource attached to this Guide.

IDENTIFYING, DOCUMENTING AND IMPLEMENTING RESIDENT GPPS

INTRODUCTION

In the next sections, we provide practical guidance to operationalize efforts to put individual resident GPPs into practice. It is a how-to guide for translating GPPs into care practices on a daily basis.

Ideally, the process of learning about a resident's goals, priorities, and preferences starts before he/she/they move into your nursing home and continues throughout their stay. A person-centered care approach to identify GPPs considers the whole person and strives to develop rapport with the resident and their advocate(s) from the start. Admission and care planning processes are dominated by clinical assessments and questions, often missing key details that help caregivers understand who residents are and what matters most to them. It is essential to broaden these processes to include collecting GPP information as well as clear systems for documenting and sharing GPP information with all those involved in the resident's care and integrating this information into care delivered.

Note that the following suggestions are not intended to add to processes that are currently in place. Instead, they are intended to replace or be integrated into processes that currently do not identify, document, or implement residents' GPPs well.

Addressing GPPs with Individual

Resident Checklist

- Identify the newly admitted resident. Ask permission to conduct the interview.
- Ask resident if they would like to participate in the interview independently or with a family member/care partner or health care agent or proxy.
- Confirm the resident's primary language and if a translator is required.
- Determine if the resident requires assistance due to reduced hearing or vision, anxiety, pain, fatigue, mobility or other issues.
- Explain the purpose of the interview to the new resident. Define or describe terms that will be used, including person-centeredness and the care planning process.

- Assess whether the resident understands the process and is comfortable asking and answering questions.
- Using the selected tool as a guide, begin to ask the resident relevant questions. The interviewer may decide to skip over non-relevant questions or add new questions based on the resident's situation and needs.
    - Stop periodically and ask the resident if they are getting tired and would like to stop or pause the interview.
    - Staff member may pause the interview (if resident appears tired or is no longer following the questions) and return at a later date or time to continue.
    - Any questions that are skipped but are important should be flagged so that someone may return to them later.
- At the conclusion of the interview, staff member should reinforce that the resident may change their GPPs at any time. Encourage the resident to request to speak with staff members if they would like to discuss their GPPs further.
- Review the care planning process and next steps. Ask resident if they have any questions.
- Document in the health record. Communicate with the care team.

GPP Domains

Domains are topics or ideas to consider when developing a list of questions to ask each nursing home resident about their goals, preferences, and priorities (GPPs).

The list below is a *general guide* – it is not all-inclusive or intended to be the only resource for identifying resident GPPs. Some of these topics may not be appropriate for all residents, so the team may select some of these topics and not others for each person.

Consider using simple, plain language in your description of each topic and give examples to help each person understand the questions.

Follow your nursing home's policies and procedures for how and where to document GPP information on each resident so that it is accessible to all relevant members of the care team.

Autonomy: each resident's subjective feeling of being able to make and carry out decisions over various aspects of their daily life, including personal choices and actions. It emphasizes the freedom to choose and act according to one's preferences.

Control/Agency: each resident's ability to exercise control over their lives and setting and pursuing personal goals. It emphasizes intentionality, self-direction, and self-realization.

Physical Environment: the conditions and surroundings in which residents live, encompassing their ease of getting around, comfort and security of surroundings, and the ownership of personal possessions and space.

Staff-Related Care: the quality of interactions and support provided by staff members to residents, including access to staff assistance as needed, respectful treatment, establishment of meaningful connections, and effective communication.

Goals for Care: the practice of establishing each resident's priorities and needs for care that align with their individual preferences.

Social Engagement: each resident's ability to make choices regarding their desired level and manner of interaction with others in a way that is important to them.

Identity: how each resident wants to be recognized and acknowledged by others, including culture, religion, occupation, personal history, upbringing, sexual orientation/gender identity, race/ethnicity.

Everyday Living Preferences: each resident's preferences regarding daily activities, routines, leisure activities, and dietary preferences, including hobbies, meals, and daily schedules.

Safety: each resident being protected from harm, treated with dignity, and provided with the necessary support and assistance when needed

Privacy: each resident having a sense of control over their personal space, belongings, relationships, and interactions, allowing them to be alone or engage in private activities as desired. This includes not sharing and respecting residents' personal information.

GPP Identification & Assessment Tools

After an extensive search of currently available GPP assessment tools, six tools have been identified that generate information on residents' GPPs. No tool is perfect, and some tools will work better in some nursing homes than others.

Below you will find a table describing each of the tools, what information they generate, and some key information about each tool to help you decide whether to use one of them or develop/adapt your own tool to assess GPPs. An interprofessional team should review the information below and decide on an approach that is the best fit for your organization.

Tool Name	Covered Topics (Domains)	Tool Format	Tool Length	Link
This is me	Identity, Physical Environment, Social Engagement, Everyday Living Preferences	Open-ended	24 items/ questions	Click here for link
ComPASS-16	Everyday Living Preferences	Open-ended & close-ended	71 items/ questions	Click here for link
Well-being Toolkit	Identity, Social Engagement, Autonomy, Safety	Mostly open-ended	15 items/ questions	Click here for link
Goal Setting Practice Tool	Other: Treatment/ health-related goal setting	Open-ended	2 items/ questions	Questions #25 and #26 in the Set of Questions Organized by the Moving Forward Coalition

PELI (Preferences for Everyday Living Inventory)	Physical Environment, Social Engagement, Everyday Living Preferences, Autonomy, Safety	Open-ended & close-ended	>72 items/ questions	Click here for link
Preferences for Activity and Leisure (PAL) Cards	Similar topics as PELI but has a different mode of delivery (not a check box)	Open-ended	No limit on the number of items but has to fit on a card (average of 6)	Click here for link
Set of Questions Organized by the Moving Forward Coalition	This set of questions references the tools in this table and aligns with the 8 GPP domains listed above.	Open-ended & close-ended	52 items/ questions	Find the set of questions attached to the Guide

Once you have identified or adapted a preferred tool, it is important to remove any duplications from other tools or assessments currently in use to gather GPP information.

IDENTIFYING, DOCUMENTING & IMPLEMENTING GPPS

Now that you have selected or adapted a tool, it is time to work with the resident (and possibly their care partner(s)). This next section outlines processes to identify, document and implement GPPs. The time points in which GPPs should be addressed are: prior to admission, at admission, initial care plan meeting, quarterly care plan meeting, annual care plan meeting, and when there is a significant change in the care plan.

Identifying GPPs

Prior to admission, ask the resident and/or their care partner(s) the GPP questions from the tool you chose.

- For long-stay residents, include at least some priority GPP questions in your screening tools.
- For short-stay residents, it may be more difficult to gather GPP information. You may have to wait until admission.
- If a resident is transferring from one part of your organization (ex. assisted living to skilled care), you should use the same screening process as you would if they were coming from outside your organization. The caregivers in skilled care are different and need to begin getting to know the resident even before admission.

At the time of admission, determine who will complete the GPP tool that you selected. That position/individual will set up time with the resident and/or their care partner(s) to complete the admission section of this tool.

- Tip: Consider giving the resident and/or their care partner(s) the questions prior to your meeting so they can work on it ahead of time.

Identify care partner(s) that the resident wishes to include in the care planning/GPP process, as applicable.

- Note: Residents who have decisional capacity may wish to participate in the care planning process independently.

CARE PLANNING

Care planning is an important component of identifying and implementing GPPs. Consider including an explanation of your care planning process in the resident admission/welcome packet and reviewing it with residents and their care partner(s). Here are links to a template for short-stay residents and long-stay residents.

We highly recommend identifying a designated person to serve as a care plan facilitator in your organization. It can be one facilitator for the nursing home, or there may be different facilitators in different areas depending on the size and layout of your organization. Someone may serve in that role now, and it is not necessary to hire an additional person or change the name of the role. See the following description for the care plan facilitator role. Introduce the resident and their care partner(s) to the care plan facilitator who will work with the resident.

Meetings

The initial care plan meeting should be scheduled within 14 days of admission to have a comprehensive care plan in place on day 21. Refer to the care plan examples of how to integrate GPPs for best practices for making GPPs a central component of care plan meetings.

For quarterly care plan meetings, the care plan facilitator contacts the resident and advocate(s) to schedule the care plan meeting within the appropriate window of time (within 92 days of the last care plan).

For annual care plan meetings, the care plan facilitator contacts the resident and advocate(s) to schedule the care plan meeting within the appropriate window of time (annual assessment must be completed within 366 days of the most recent comprehensive assessment).

Significant change assessments should be completed within 14 days following the determination of a significant change.

Meeting process

All team members complete their assessments before the meeting and prepare to discuss key information. Best Practice: It is essential that direct caregivers are a part of care plan meetings. Consider ways to support direct caregivers in getting to the resident's actual care plan meeting for at least 15 minutes to contribute to the discussion and be available for the resident and advocate(s) to ask questions.

- Tip: Consider using Their Choice; Your Voice tool to gather key information for the team so direct caregivers have a resource to bring with them to the care plan meeting.

At the close of each care plan meeting, the team should make an action list for follow up, including the resident's GPPs. The care plan facilitator will take the lead in making sure that these actions are addressed.

- Write the resident's care plan. See the documentation section of this guide for more details on including GPPs.

- Create or update the direct caregiver (i.e., CNAs) mini care plans. See the documentation section of this guide for more details.

- Discuss format for or changes with all caregivers through organization communication systems (i.e. huddles, report, and electronic record system alerts). The care plan facilitator will follow up with resident and/or advocate(s).

Successful homes:

- Work out coverage for direct caregivers attending the care plan meetings.
- Provide guidance for direct caregivers attending care plan meetings for the first time. Dedicate the first part of the care plan meetings to actively talk about day-to-day care topics to maximize the direct caregiver's time in the meeting.
- Provide caregiver worksheets available to all caregivers from all shifts to gather input on care and brought to the care plan meeting by the attending caregiver.

Documenting & Implementing GPPs

You have identified a resident's GPPs, it is now time to translate them into care by documenting and implementing. Documenting means storing information in a way that is accessible to all people who need it, and implementing means incorporating GPPs into daily resident care.

Direct caregivers and team members, who will work closely with the resident, must have access to this information to start building rapport and trust with new residents. It can also help people feel more comfortable with any transition.

Information should: Be in a consistent place in the health record, care plan, or other communication tools.

Caregivers should: Know where and how to access the information.

Examples of how nursing homes have made information accessible include, but are not limited to:

- Uploading it in the electronic health system kiosk, accessible to all staff.
- Creating a GPP tool or one-pager on each resident that is stored in a notebook and updated as needed.

- Creating mini care plan sheets for daily use. Sometimes GPPs are written as goals or as interventions. GPPs can be addressed as a separate care plan and/or integrated throughout the entire care plan. Check out these care plan samples for ideas.

Once GPPs are documented, it is important to translate key identified interventions into a readily accessible, easy to use format for direct caregivers. A common best practice is to create a "mini" care plan or resident care sheets for direct caregivers that are either on paper or housed in a kiosk or other electronic system. Review your current direct caregiver care sheets or interfaces and integrate key resident GPP information. Here are a few direct caregiver mini care plan templates that include GPP information.

Input from residents and observations by caregivers is happening in real time, so communication and updates should also happen in real time. Determine a process with your team (include direct caregivers) to make GPP updates and educate caregivers on the types of changes they can make to the care plan, how to make these changes, and how to communicate these changes with other team members.

When developing a system for caregivers to communicate GPP changes, consider two key elements:

1. The system does not rely on verbal communication only; include written/electronic and other communication methods.
2. The system includes prompt follow-up on input to make official changes.

TOOLS & TEMPLATES

GPP Guide Getting Started Checklist

- Review the Guide as a team.
- Identify care plan facilitator(s) or who on the team will meet with the resident to ask about their GPPs.
- Select a small workgroup to review the GPP identification and assessment tools in the Guide.
- From the Guide, select the GPP identification and assessment tool/questions for your team to use with residents.
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- Remove duplications from the newly selected tool(s) with the questions that are already being used.
- Transfer the selected GPP identification and assessment tool into a format that is best for your organization (i.e. electronic, printable, etc.)
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- Develop a plan and timeline for how you will train teams of the new systems.
- Once all tools are ready and staff are trained, set a start date to begin the new GPP process.
- Regularly meet as a core team (key leaders, core care plan team, and care plan facilitators) to work out challenges and make changes to the process as needed.

Resident Checklist

- Identify the newly admitted resident. Ask permission to conduct the interview.
- Ask resident if they would like to participate in the interview independently or with a family member/care partner or health care agent or proxy.
- Confirm the resident's primary language and if a translator is required.
- Determine if the resident requires assistance due to reduced hearing or vision, anxiety, pain, fatigue, mobility or other issues.
- Explain the purpose of the interview to the new resident. Define or describe terms that will be used, including person-centeredness and the care planning process.
- Assess whether the resident understands the process and is comfortable asking and answering questions.
- Using the selected tool as a guide, begin to ask the resident relevant questions. The interviewer may decide to skip over non-relevant questions or add new questions based on the resident's situation and needs.
- Stop periodically and ask the resident if they are getting tired and would like to stop or pause the interview.
- Staff member may pause the interview (if resident appears tired or is no longer following the questions) and return at a later date or time to continue.
- Any questions that are skipped but are important should be flagged so that someone may return to them later.
- At the conclusion of the interview, staff member should reinforce that the resident may change their GPPs at any time. Encourage the resident to request to speak with staff members if they would like to discuss their GPPs further.
- Review the care planning process and next steps. Ask resident if they have any questions.
- Document in the health record. Communicate with the care team.

SET OF GPP QUESTIONS TO ASK RESIDENTS ORGANIZED BY THE MOVING FORWARD COALITION

This set of questions was organized by the Moving Forward Coalition. These questions reference items from the GPP identification and assessment tool. in the Guide. The questions also align with the 8 GPP domains in the Guide. The following questions are suggestions for your consideration. Each nursing home may want to customize what is asked depending on the population of nursing home residents and existing assessments

1. **What is the name you would like to be called?**

2. **What are the most important things for you to be in control of, or in charge of, either in your daily routine or more generally in your life?**

3. **How important is it to you to be involved in choosing your roommate?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": Which of the following is important to you when choosing a roommate?

General Characteristics:

- ○ Age
- ○ How long they have lived here

Usual Habits:

- ○ Keeps area clean
- ○ Keeps lighting level low
- ○ Quiet/keep noise level low

Functional ability:

- ○ Level of disability
- ○ Hearing ability

Olfactory:

- ○ Does not wear perfume
- ○ Hygiene (body odors, gas, etc.)
- ○ Not a smoker

Personality traits:

- ○ Quiet
- ○ Active
- ○ Polite
- ○ Social
- ○ TV habits: amount, time, volume

Other: _____

4. **How important is it to you to do things away from here?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": Which kinds of things do you like to do away from here?

- ○ Visit family
- ○ Visit friends
- ○ Visit old neighbors
- ○ Go shopping/to the store
- ○ Go to a restaurant
- ○ Go to a movie
- ○ Go to a concert
- ○ Go to the theater
- ○ Go to a sporting event
- ○ Sightsee
- ○ Go for a car ride

Other:

If “very important” or “somewhat important”: How long do you like to spend away from here?

- ○ For an hour or two
- ○ For a day, overnight

Other:

If “very important” or “somewhat important”: Whom do you like to be with if you are away from here?

- ○ Family: _____
- ○ Friends: _____
- ○ Residents: _____
- ○ Recreation therapist: _____
- ○ Nurse: _____

Other:

5. **Which people do you like involved in discussions about your care?**

- ○ Spouse: _____
- ○ Significant other: _____
- ○ Children: _____
- ○ Brother: _____
- ○ Sister: _____
- ○ Grandchildren: _____
- ○ Friends: _____
- ○ Nurse: _____
- ○ Doctor: _____
- ○ Social worker: _____
- ○ Daily caregiver: _____
- ○ Other (free text) _____

6. **Who are the people who know you best?**

7. **How important is it to you to go outside to get fresh air?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": In which type of weather do you like to go outside?

- ○ Sunny
- ○ Cloudy/overcast
- ○ Rainy
- ○ Snowy
- ○ Hot warm
- ○ Cool
- ○ Cold

Other: _____

If "very important" or "somewhat important": What do you like to do outside when the weather is nice?

- ○ Garden
- ○ Play
- ○ Walk
- ○ Work/outdoor tasks
- ○ Water/drink
- ○ Nap
- ○ Sit
- ○ Smoke
- ○ Talk/visit
- ○ Tanning
- ○ Watch the birds/wildlife

Other: _____

If "very important" or "somewhat important": How many times do you like to go outside in a week?

- ○ Daily
- ○ 2-3 times a week
- ○ 4-5 times a week
- ○ Once a week

Other: _____

8. **How important is it to you to set up your own room the way that you want it?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": How do you like furniture and other items arranged in your room?

If "very important" or "somewhat important": What things do you like to decorate your room with?

- ○ Personal keepsakes
- ○ Photos
- ○ Holiday decorations
- ○ Picture/art
- ○ Décor
- ○ Curtains

Other:

If "very important" or "somewhat important": What items do you like to keep by your bed?

- ○ Clock
- ○ Telephone
- ○ Tissues
- ○ Water
- ○ Eyeglasses
- ○ Lamp/light

Other:

9. **How important is it to you to set up your bed for comfort?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": How do you like to set up your bed for comfort?

If "very important" or "somewhat important": Which things are important to you in setting up your bed for comfort?

Pillow

- ○ Number: _____
- ○ Position: _____

Blankets

Number: _____

- ○ Loosen blanket
- ○ Tuck blanket

Room

- ○ Adjust bed height/settings
- ○ Change the room temperature
- ○ Nightlight on

Doors

- ○ Open bedroom door
- ○ Shut bedroom door

Windows

- ○ Open windows
- ○ Close windows
- ○ Open curtains
- ○ Close curtains

Other:

10. **How important is the gender of your daily caregiver?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": Which gender caregiver do you like for personal care?

11. **How important is it to you for staff to show you respect?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": In which ways do you like staff to show you respect?

- ○ Saying hello
- ○ Calling you Mr/Ms/Mrs/Miss/Dr
- ○ Calling you by your commissioned rank
- ○ Knocking before entering your room
- ○ Helping you/asking what you need
- ○ Responding quickly to requests
- ○ Not talking down to you
- ○ Honoring your feelings
- ○ Thanking you
- ○ Listening to you
- ○ Being pleasant

Other:

12. **How important is it to you to do things with groups of people?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": What do you like to do with groups of people?

If "very important" or "somewhat important": Who do you enjoy in your group?

- ○ Friends
- ○ Other residents
- ○ Roommate
- ○ Family members

Other:

13. **Who are the people you want to stay most connected with?**

14. **What is the best way for you to stay connected to them?**

15. **How important to you is it to be able to use the phone in private?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": Where do you like to use the phone in private?

- ○ Bedroom
- ○ Secured space with the door shut

Other:

16. **What daily routines are important to you?**

17. **What do you like to eat and drink?**

18. **How important is it to you to have snacks available between meals?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": Which of the following foods do you like to snack on?

- ○ Fruits
- ○ Vegetable
- ○ Chips
- ○ Pretzels
- ○ Crackers
- ○ Candy
- ○ Chocolate
- ○ Ice cream

If "very important" or "somewhat important": When do you like to snack?

- ○ Morning
- ○ Afternoon
- ○ Evening/night
- ○ Whenever I want

19. **What helps you sleep?**

20. **How important is it to take a nap when you wish?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": When do you usually like to take a nap?

- ○ Morning
- ○ Afternoon
- ○ Evening/night
- ○ Whenever I want

21. **What are your favorite activities?**

22. **What are your preferences for bathing?**

23. **How important is it to you to have privacy?**

- ○ Very important
- ○ Somewhat important
- ○ Not very important
- ○ Not important at all
- ○ Important but can't do
- ○ No response

If "very important" or "somewhat important": Which of these activities do you like to keep private?

- ○ Using the toilet/bedpan
- ○ Getting dressed/changing clothes
- ○ Attending to my medical needs

Other:

If "very important" or "somewhat important": Which information do you like to keep private?

- ○ Your family
- ○ Your medical condition/care
- ○ Your finances

Other:

24. **What helps you feel secure or safe?**

25. **What are your three most important concerns?**

26. **What are your three most important goals?**

27. **Is there anything else you want to share about how we can support your well-being?**

28. **Tell us three things about your life that are important for us to know (that are not medical conditions):**

29. **What would make you feel more comfortable here, physically, emotionally?**

RESIDENT AND CARE PARTNER ORIENTATION TEMPLATES

RESIDENT AND CARE PARTNER ORIENTATION TEMPLATE (SHORT-STAY RESIDENTS)

Welcome Packet:

Care Plan Orientation for Resident and Care Partner(s)

Nursing home care is a partnership. To be a true care partner, you and/or your chosen friend, family, or representative help develop the plan that guides the care you receive while you are here. The aim of person-centered care planning is to learn what goals, preferences and routines are important to you. For instance, is your goal to return home? Is your routine to wake at 7:00 a.m. and have a cup of coffee? Our team will assess your needs. Together, we will develop a plan to meet those needs in the context of your goals, preferences, and routines. Care plans are living documents that change as your needs change.

You can expect to have an initial care plan meeting and one every three months from then on. If you have a significant change in your condition or needs, we will hold an additional meeting. We are also happy to meet upon your request. The meetings can be held in person, by video chat or by phone.

Residents have rights and one of those rights is self-determination. The resident's ideas, goals, psychosocial needs, and preferences may not align with what their support person's goals are or the resources available. The care plan should reflect the resident's choices and preferences. When issues around cognitive impairment arise, we will work with decision-making representatives to prioritize resident rights, dignity, and control.

The goal of care planning for your short term stay is to get the care resources and support you need to integrate back into your life at home or prior level of living.

Prior to the meeting, you can expect…

- To be contacted by your care plan facilitator to set up a time and date for this meeting. The care plan facilitator will lead and assure an effective person-centered care planning process.
- Conversations about discharge planning—what are your plans for your time here and where you are going after your stay?
- To be asked about goals, preferences, and priorities. For example, what do you want out of your time here? What do you need to do to be able to go home?
    - We will help put goals in context of your life and what you were able to do before you came to the nursing home.
- Assessments by several disciplines, such as
    - In-depth medication review and updates

    - Social history evaluation to understand your story and what is most important to you.
    - Nursing assessments such as the condition of your skin, fall risk and mobility, evaluation of any wounds, needs for bathroom support and personal hygiene.
    - All disciplines learning about your preferences around your typical routines, habits, interests,and cultural and spiritual needs that you wish to continue while you are here.
    - Ultimately, what we need to know about you to help you succeed here

During this preparatory period, you should communicate any grievances or concerns you have with the care plan facilitator.

At the meeting, you can expect....

- [Who will be there-insert names and/or disciplines].
- [Where located- insert location of meeting and/or weblink for a virtual meeting].
- [How long- insert time, including expected duration of the meeting].
- To receive contact information for the care plan facilitator.
- For you and/or your chosen person to attend [insert at what interval? initial, quarterly, annual, sig change].
- The meeting will start with you or your chosen person sharing what is most important to you to get out of the meeting.
- To share problems, issues, concerns, and successes since the previous meeting.
- To follow up on any previous issues addressed.
- Although all your concerns may not be addressed in the meeting, the meeting should provide a plan and a contact to continue working through concerns.
- To review current medications and recent or upcoming appointments.
- To share specific preferences or requests (ex. you want to wear your own underwear or brand of briefs)—and have those preferences integrated into care.
- For the meeting to take place in the resident and/or family's primary language and the nursing home to provide an interpreter or translator if needed.
- For staff to confirm who you want the nursing home to call for care issues and questions. In general, staff will call one person; that person should contact other concerned family members/friends.

Following the meeting, you can expect…

- The care plan facilitator will contact you to report on the action items list.
- The staff to document the care plan decisions into the care plan.
- The team to communicate care plan changes to all staff involved in your care.
- Formal complaints/grievances to be documented on the nursing home form and the nursing home policy to be followed.

Above all else, we want to encourage you and your chosen person(s) to have open communication with our team. For all care planning needs the care plan facilitator will be your primary contact and [*insert*] will be your secondary contact. These individuals are not solely responsible for your care, but they will make sure the team is aware of your needs and will follow up with you when you express a need or concern.

We are excited to have you in our home and look forward to being your care partner.

RESIDENT AND CARE PARTNER ORIENTATION TEMPLATE (LONG-STAY RESIDENTS)

Nursing home care is a partnership. To be a true care partner, you and/or your chosen friend, family, or representative help develop the plan that guides the care you receive while you are here. The aim of person-centered care planning is to learn what goals, preferences and routines are important to you. For instance, is your goal to return home? Is your routine to wake at 7:00 a.m. and have a cup of coffee? Our team will assess your needs. Together, we will develop a plan to meet those needs in the context of your goals, preferences, and routines. Care plans are living documents that change as your needs change.

You can expect to have an initial care plan meeting and one every three months from then on. If you have a significant change in your condition or needs, we will hold an additional meeting. We are also happy to meet upon your request. The meetings can be held in person, by video chat or by phone.

Residents have rights and one of those rights is self-determination. The resident's ideas, goals, psychosocial needs, and preferences may not align with what their support person's goals are or the resources available. The care plan should reflect the resident's choices and preferences. When issues around cognitive impairment arise, we will work with decision-making representatives to prioritize resident rights, dignity, and control.

The goal of care planning for a long-term stay is to ensure that you are living your highest possible quality of life here.

Prior to the meeting, you can expect…

- The care plan facilitator will lead and assure an effective person-centered care planning process..

- To be asked about goals, preferences, and priorities. Some examples are: What do you like to do with your time? Who do you want to remain connected to outside the nursing home and how can we help?
    - We will help put goals in context of your life and what you were able to do before you came to the nursing home.
- Assessments by several disciplines, such as
    - In-depth medication review and updates
    - Social history evaluation to understand your story and what is most important to you.
    - Nursing assessments such as the condition of your skin, fall risk and mobility, evaluation of any wounds, needs for bathroom support and personal hygiene.
    - All disciplines learning about your preferences around your typical routines, habits, interests,and cultural and spiritual needs that you wish to continue while you are here.
    - Ultimately, what we need to know about you to help you succeed here
    - During this preparatory period, you should communicate any grievances or concerns you have with the care plan facilitator.

At the meeting, you can expect….

- [Who will be there-insert names and/or disciplines].
- [Where located- insert location of meeting and/or weblink for a virtual meeting].
- [How long- insert time, including expected duration of the meeting].
- To receive contact information for the care plan facilitator.
- For you and/or your chosen person to attend [insert at what interval? initial, quarterly, annual, sig change].
- The meeting will start with you or your chosen person sharing what is most important to you to get out of the meeting.
- To share problems, issues, concerns, and successes since the previous meeting.
- To follow up on any previous issues addressed.
- Although all your concerns may not be addressed in the meeting, the meeting should provide a plan and a contact to continue working through concerns.
- To review current medications and recent or upcoming appointments.
- To share specific preferences or requests (ex. you want to wear your own underwear or brand of briefs)—and have those preferences integrated into care.

- For the meeting to take place in the resident and/or family's primary language and the nursing home to provide an interpreter or translator if needed.
- For staff to confirm who you want the nursing home to call for care issues and questions. In general, staff will call one person; that person should contact other concerned family members/friends.

Following the meeting, you can expect…

- The care plan facilitator will contact you to report on the action items list.
- The staff to document the care plan decisions into the care plan.
- The team to communicate care plan changes to all staff involved in your care.
- Formal complaints/grievances to be documented on the nursing home form and the nursing home policy to be followed.

Above all else, we want to encourage you and your chosen person(s) to have open communication with our team. For all care planning needs the care plan facilitator will be your primary contact and [insert] will be your secondary contact. These individuals are not solely responsible for your care, but they will make sure the team is aware of your needs and will follow up with you when you express a need or concern.

We are excited to have you in our home and look forward to being your care partner.

CARE PLAN FACILITATOR ROLE

CARE PLAN FACILITATOR ROLE

To help achieve the most optimal results in the care planning process, we encourage one person, the Care Plan Process Facilitator (CPPF), assume many of the care planning responsibilities that are often spread amongst team members. It is not intended to be a new dedicated staff position. In addition, having one person lead the effort of person-centered care planning may become so valuable for the care and support of residents and for your team that you may choose to implement this role more formally. The CPPF will provide the key to assuring three critical aspects of an effective person-centered care planning process—1) development of a person-centered care plan that identifies and meets the clinical needs and what matters most for each person; 2) effective implementation of the plan and identification of triggers to revise the plan; and 3) assurance of constant quality improvement in each home's care planning process.

The CPPF is primarily an educator, coach, and contact for the resident whose job it is to *facilitate learning for*:

1. the interdisciplinary team as it develops living care plans that are centered in the strengths and needs of each resident
2. staff members with responsibility for implementing the plan
3. the continuous improvement in the overall capability of the home as it relates to the care planning process.

The CPPF will provide education to the residents, their family members, and the members of the staff team on all levels and in all departments to ensure a person-centered, clinically appropriate, empowering and regenerative care planning process occurs for each person. The home's expertise at successful implementation of the process becomes deeply embedded in the home's culture.

The person serving as CPPF will be a member of the interdisciplinary team and can come from any discipline or department, including direct care partners. They will facilitate learning in specific situations of planning and implementation and organization wide learning. They will be responsible for the multidisciplinary team's learning to increase its capacity to involve each resident along with their essential supports and representatives in the process so the team will better know and respond to the clinical, and psycho-social-spiritual needs of each resident. It is important to note that these may be new ideas or a new way of thinking about the existing care planning process, and there may be a need to reorganize the existing staff time being dedicated to care planning.

ASSESSMENT TOOL FOR DIRECT CAREGIVERS: THEIR CHOICE YOUR VOICE WORKSHEET TEMPLATE

ASSESSMENT TOOL FOR DIRECT CAREGIVERS: THEIR CHOICE, YOUR VOICE WORKSHEET TEMPLATE

This tool may be used to guide CNAs through conversations with residents about their goals, preferences, and priorities related to the resident's daily life and care. This tool can help CNAs get to know residents well.

"Their Choice, Your Voice"
Care Plan Information Gathering Worksheet

Resident's Name: _____
Date of Care Plan: _____
CNA Attending the Care Plan: _____

	Are you seeing verbal or physical expressions of frustration, fear and anger? Give examples.	What makes me happy? What makes me unhappy?	What is the best time of day to engage me? What are my best and worst times of day?	Is it taking more time for me to participate in ADLs with caregivers? Give examples.	Am I experiencing any challenges participating in things or activities I want to do? If so, what? Why?
CNA 1 (Daytime)					
CNA 2 (Evening)					

CNA 3 (Over-night)					

	Are there things you think I might want to do if I had more help or more time?	What makes my dining experience go well? Not go well? What tips have you picked up on that help?	What changes have you seen with my appetite?	What makes my sleep experience go well? Not go well? What tips have you picked up on that help?	What is my preferred rest period?
CNA 1					
CNA 2					
CNA 3					

	What makes my bathing experience go well? Not go well? What tips have you picked up on that help?	What have you noticed makes me feel comforted or secure? What makes me nervous?	What changes have you seen when I move about the home (ambulation)?	What changes have you seen in the amount or kind of pain I am having?	What changes have you seen with my skin?
CNA 1					
CNA 2					
CNA 3					

	Have you noticed that I seem bored? Lonely? Useless? Provide examples. Are there things that you have noticed help during these times?	Does this individual have a hard time communicating? What have you found to be the best way to communicate with me?	Ask the resident the following two questions and record their responses.	Resident question: If I were caring for you in your home, are there things that you would be doing there that you aren't doing here? What?	Resident question: What is a good day for you? How do you find meaning or purpose in your day?
CNA 1					
CNA 2					
CNA 3					

Top three items my caregivers need to know about me.

MINI CARE PLAN TEMPLATE AND EXAMPLE

MINI CARE PLAN TEMPLATE AND EXAMPLE

This tool gives examples of how information about a resident's GPPs may be documented in a mini-care plan (used by CNAs and other direct care team members). Reminders and notes may be particularly helpful in communicating resident GPPs.

TEMPLATE

ROOM#: _____

Resident Name _____

Diet: _____

Transfers: _____

Night Checks: _____

Assistive Devices	
Cognition	
Favorite Foods	
Bathing Preferences	
Using the Toilet	
Quality of Life Information	

Last Updated: _____

EXAMPLES

ROOM#:

Sally Miller

Diet:
Smooth pureed and nectar thick liquids with pills only.

Transfers:
Handheld assist with all transfers.

Night Checks:

- Motion sensor in place
- Wears pull-ups
- 1 person assist
- Offer help to the toilet and/or check and change if noted to be awake during HS hours.

Assistive Devices	• Glasses • Dentures
Cognition	• Alert and oriented to self • Engages in conversation easily
Favorite Foods	• Loves soda • Enjoys ice cream
Bathing Preferences	• Likes a bath in the evening or early morning
Using the Toilet	• Incontinent of bladder, at times • Continent of bowel; occasionally does not always make it to the bathroom in time • Needs assistance with peri-care • Wears large pull-up briefs
Quality of Life Information	• She enjoys visiting with her sister, Mae • Enjoys reading the Bible • Enjoys watching the Price is Right

EXAMPLES

ROOM#:

Wan Chen

Diet:
Regular Diet

Transfers:
Stand by assist

Night Checks:

- Wears pull-ups
- 1 person assist
- Offer help to the toilet and/or check and change if noted to be awake during HS hours..

Assistive Devices	• Glasses • Walker • Walks with stand-by assist; is very slow with transfers so be patient and leave for activities promptly • Wears Ted hose on in the AM and off at HS
Cognition	• Alert and oriented to self • Engages in conversation easily
Favorite Foods	• Enjoys ice cream and candy • Eats rice with all lunch and dinner meals
Bathing Preferences	• Please offer Wan a bath daily
Using the Toilet	• Continent of bladder and bowel • Large pull-ups
Quality of Life Information	• Enjoys visiting with other residents in the dining room area • Do not touch Wan on the top of the head unless bathing or assisting with care where it is required. It is a part of his culture. The head is considered sacred.

CARE PLAN EXAMPLES OF HOW TO INTEGRATE GPPS

CARE PLAN EXAMPLES OF HOW TO INTEGRATE GPPs

This tool gives examples of how resident goals may be integrated into their care plan, the interventions that could address desired goals, and what ideal outcomes would be.

Goal	Intervention	Outcome (in resident's own words)
Resident wants to start each day with newspaper and coffee.	Social worker will work with resident's family to ensure she has a subscription to the daily paper. Night shift CNA will get resident a cup of coffee from the kitchen before the end of the shift. OR Night shift CNA will prepare resident a cup of coffee in the unit Keurig before the end of the shift.	I will be satisfied with my daily routine.
Resident wants to be able to transfer in/out of a car to be able to attend her grandson's wedding in October.	PT/OT referral. CNA to assist resident with daily exercises as instructed by PT/OT. SW to work with resident's family to determine what vehicles are available to transport resident. Family will identify who will assist resident on wedding day and that person will work with PT/OT to learn safe transfer techniques.	I will attend my grandson's wedding.

Goal	Intervention	Outcome (in resident's own words)
Resident wants to remain connected to St. Abigail's Church where she has attended since 1985	Activities will contact St. Abigail's to determine if they have visitors available to come to NH PT/OT referral to determine the safest way for resident to travel to church services once a month. SW to determine if St. Abigail's livestreams their services and work with family to help resident acquire device to use to connect to service.	I will connect with someone from St. Abigail's at least once per week. I will express satisfaction with the level of engagement with St. Abigail's church.
Resident is at risk for falling due to an unsteady gait.	Make sure that her call bell is always within reach when in her room. At times the resident's knees and legs start hurting. This causes her to become unsteady on her feet. Please remind her to rest and ask for assistance while walking if needed. Follow fall protocols. Please ensure resident has proper footwear that fit her and are comfortable.	I will be free of falls with major injury through my next review date.

Goal	Intervention	Outcome (in resident's own words)
Resident wants to manage pain in her knees and lower legs.	Remind resident to take breaks by relaxing and putting her feet up in the recliner. When in pain, engage resident in an activity that she enjoys such as praying the rosary or looking out her window. Notify physician if resident has changes in pain, ineffective pain control or new onset of pain. Staff will evaluate resident's pain level each shift and document. Administer pain medications as ordered by physician. Monitor for adverse reactions. Notify my physician as needed of adverse reactions.	My pain will be controlled and remain at or below pain goal of 4.

TRAINING TO SUPPORT PERSON-CENTERED GPP PROCESSES

TRAINING TOPIC 1 - PERSONHOOD & IDENTITY

Introduction

Personhood and individual identity are at the heart of person-centeredness. Each one of us wants to be seen and known as the unique person we are. As providers, our daily challenge (opportunity?) is asking the questions and creating the environment that allows each resident to feel invited and safe in sharing meaningful details about themselves and how they see themselves and want others to see them -- even as their physical, mental, emotional, or social health may be changing in significant ways. True person-centered care, across departments, cannot be achieved without deeply knowing each resident.

Personhood & Identity

Successful care planning conversations require a genuine attempt to make all participants feel included and empowered to speak up and to feel that their requests, suggestions, ideas, and opinions matter. American culture has long undervalued the process of growing old and the contributions that we all continue to make to our communities as we age. The result is that older people feel less visible and less worthy, particularly if our aging is accompanied by changes in our physical and cognitive abilities, as it often is for nursing home residents.

We all have internalized the ageism that exists in American society and, as a result, extra effort and attention must be paid to counteracting and avoiding the many ways that older people experience a lack of worthiness. The material in this section is designed to heighten awareness of the care team to what it means to be a person with a unique identity and, despite age or declining health, still has opportunities to experience daily life events in ways that matter to each individual.

Personhood Summary

Transitions into Long-Term Care Settings

Concepts of personhood and identity include how we see ourselves and how we see ourselves in relation to how others view us or behave towards us. Individuals moving into long-term care often have experienced significant losses in the form of declining health, cognition, or a physical limitation. Transitioning into a care setting can be a jarring shift in our identity since we are no longer able to fully care for ourselves without assistance. We know that others may see us differently than in previous times during our lives and this results in longing to “feel known” by staff and other residents so we can feel connected to them.

Putting this into practice:

Case scenario

An 89-year-old retired university professor is admitted after safety lapses at home where she lived alone but with family support. She is moderately forgetful. She has a walker, but hates using it and often does not. She fell at home several times without injury. She is an admitted introvert, spends long hours reading, is dismissive of group activities and angry about having to leave her home; she doesn't want to be around "all these old people". She refuses to have meals in the dining room and has only come out of her room reluctantly when staff insist.

Practice tips

Consider the major adjustment she is making personally and professionally and her emotional state (e.g., anger).

Meeting the needs of residents and regulations

The resident has a right to a dignified existence, self-determination, and to be treated with respect and dignity. Staff must help residents maintain or enhance their self-esteem, self-worth, and incorporate their goals, preferences, and choices. Staff must also consider residents' physical limitations, assure communication, and maintain respect. (Regulatory requirement F550 – Resident Rights / Exercise of Rights).

Agency and Decision-Making Autonomy

As "persons", we have legal rights, agency, and moral accountability and an innate human need for autonomy and self-determination. Humans need to feel that we can make our own choices and exercise volition with a sense of competency to carry out the choices we make. Self-determination is the internal motivation we all feel to take action aligned with our own free choice and sense of purpose. Autonomy is the ability to "govern oneself"; to have control over one's physical and emotional self.

In long-term care, autonomy includes decisional autonomy, the ability and access to make decisions about aspects of daily life, and executional autonomy, the ability to carry out one's decisions and preferences. All persons - even those with cognitive changes - should have the opportunity to participate in care and service decisions and express preferences according to their ability. Self-determination and autonomy in long-term care must accommodate each resident's need to transition into and adapt to what might be a radically different environment. Supporting each resident in adapting safely, securely, and with feelings of trust and wellbeing is critical.

Putting this into practice

Case scenario

A school superintendent was discharged from the hospital with a leg fracture and admitted to post-acute rehab. His anticipated length of stay is 27 days. The patient wishes it was half the time and has expressed his desire to rehab at home. Patient has no cognitive impairment and feels humiliated by having to be in rehab. He feels there is no one with whom to have meaningful conversation. He feels he has to lower his standards due to the environment. He is surrounded by patients that are cognitively impaired and/or have a much higher acuity of care. He feels 'out of place.' He wants to stay busy, however, due to his immobility and range of motion challenges, is limited in his choice of activities. He was offered BINGO and was humiliated at the thought of 'playing a game.'

Practice tips

As you prepare to visit with the new resident, reflect on any notes from previous records and/or pre-planning visits with your team. Recognize the importance of first impressions. Prior to you entering the resident's room, they have already had multiple interactions. Take time to explain staff roles and their importance to the team.

Interaction with the resident: knock on the door, enter with permission, introduce yourself, greet the resident using their preferred name, and start the conversation about something that will capture their interest (e.g., school, academics, favorite subject, etc.).

A positive resident experience is the result of multiple factors and interactions throughout the resident journey. Ask the resident, "What do *you* hope we accomplish today?" It is important to have pre-visit planning to keep visits organized and certainly involve them in their care decisions. You can enhance the resident experience through practical steps, such as expanding visit options. In this scenario, provide a visit summary, and *thank* the resident for the opportunity to be part of their care team. This way you establish a sense of trust, continue the ongoing dialogue, and establish a plan of care. Think about it – you have also set expectations for your relationship by discussing communication and follow-up plans.

Meeting the needs of residents and regulations

The resident has a right to a dignified existence, self-determination, and to be treated with respect and dignity. Staff must help the residents to maintain or enhance their self-esteem, self-worth, and incorporate their goals, preferences, and choices. Staff must also consider residents' physical limitations, assure communication, and maintain respect. (Regulatory requirement F550 – Resident Rights / Exercise of Rights). The resident has the right to be informed of, and participate in, his or her treatment, including: (1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. (Regulatory Requirement F552 - Right to be Informed/Make Treatment Decisions).

The resident has the right to participate in the development/implementation of his or her person-centered plan of care, including identifying who should be included in the care planning process; requesting care plan meetings; requesting care plan revisions; participating in establishing goals and outcomes of care as well as any other factors related to the effectiveness of the care plan; being informed in advance to changes to the care plan; seeing the care plan – including the right to sign off on it after a significant change has been made. (Regulatory Requirement F553 - Right to Participate in Care Planning). A personalized, homelike environment recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and family members. The intent of the word "homelike" in this regulation is that the nursing home should provide an environment as close to that of the environment of a private home as possible. (Regulatory Requirement F584 - Safe/Clean/Comfortable/Homelike Environment).

Sudden or Undesired Life Changes & Difficulty Adapting

How well we adapt to sudden, undesired, or significant changes in our being or in our environment often depends on coping behaviors we have used in our adult lives. Individuals consciously or unconsciously strive for continuity -- of activity, of environments, of identity, of worldview. Learning about a resident's strategies in times of stress or transition for maintaining key elements of continuity in their sense of self (e.g., self-efficacy, empowerment) helps support them in a wholly unfamiliar environment.

Putting this into practice

Case scenario

Mr. Jackson, who is living with dementia (his spouse was his primary caregiver), has recently moved into a nursing home. He is navigating a new living environment resulting in expressions of frustration and social isolation. The unfamiliar surroundings have triggered anxiety and stress, causing Mr. Jackson to react to

interactions with staff, routines, or foods and surroundings that are unfamiliar. Additionally, he is constantly trying to go into other resident's rooms or leave the nursing home. Mr. Jackson is overwhelmed and confused by having a new and different caregiver each day let alone every eight hours.

Practice tips

Prepare residents for care planning conversations. A week or a few days before the care planning meeting, talk with the resident. Questions that could be asked include:

- What makes you feel valued or worthy?
- What helps you be willing to share your opinion?
- What makes you feel better about yourself?
- What helps you cope with stress or adversity?
- What helps you want to engage with day-to-day activities or try new things?
- Would you feel comfortable/or be willing to share [any of the above] in your care plan meeting on [insert date]?

Meeting the needs of residents and regulations

A resident who is diagnosed with dementia must receive the appropriate treatment and services to attain or maintain their highest practicable physical / mental / psychosocial wellbeing. The necessary care and services must be person-centered and reflect the resident's goals. Meaningful activities must address the resident's customary routines, interests, preferences, and choices to enhance their well-being. (Regulatory requirement F744 – Treatment / Service for Dementia). A personalized, homelike environment recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and

family members. The intent of the word "homelike" in this regulation is that the nursing home should provide an environment as close to that of the environment of a private home as possible. (Regulatory Requirement F584 - Safe/Clean/Comfortable/Homelike Environment).

How to Use with Direct Care Staff

Formal In-Service Training

The material in this module can be used in formal in-service training or orientation sessions. Feel free to use case scenarios from your own community for added emphasis and relevance. Ask staff to reflect on their own experiences, for instance, with stressful life transitions or health or life changes that caused them to feel that others perceived them differently.

Informal Reminders of Personhood Concepts in Daily Care

-Daily Huddles
-All Team Meetings
-Clinical and Non-Clinical Team Meetings
-Quality Circles / Learning Circles

Additional Resources

Person-Centered Care | CMS.
https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care

Wellbeing Toolkit – Ariadne Labs.
https://www.ariadnelabs.org/resources/downloads/wellbeing-toolkit/

The Patient Dignity Inventory.
https://dignityincare.ca/en/the-patient-dignity-inventory.html

Williams, K., Coleman, C. Changing Talk (CHAT) Implementation Toolkit.
https://www.kumc.edu/documents/chato/Changing%20Talk%20Online%20Training%20%28CHATO%29%20Implementation%20Toolkit.PDF

PELI-Nursing Home-MDS 3.0 Section F-Version 2.0 | Preference Based Living.
https://www.preferencebasedliving.com/for-practitioners/practitioner/assessment/peli-questionnaires/peli-nursing-home-mds-3-0-section-f-version-2-0/

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Higgs, P., & Gilleard, C. (2016). Personhood, identity and care in advanced old age. Policy Press.

TRAINING TOPIC 2 - RECOGNIZING HUMAN POTENTIAL IN LATE LIFE

Introduction

Humans change and grow throughout our lives, even as we arrive in late life and prepare to die. Each person at every stage of life has innate human potential that can and should be nurtured. Some scholars define human potential as growth towards our *true selves;* thus, how each person defines or expresses their capacity to grow in late life is unique. The concept of human potential relates to the positive aspects of humanity and the ability and opportunity for personal growth and to be our best and true selves. The idea of this "upside of the human experience" has been studied from many perspectives and many disciplines, but fundamentally relates to our collective human desire to "be virtuous and to grow".

What does human potential mean for an aging person?
Recognizing and attending to each resident's human potential is an essential element of person-centered care and one which takes on added importance as each resident nears end-of-life. As our human population grows older, scholars have explored what human potential and wellbeing mean in late life. American culture has historically considered aging as a period of decline and deterioration, rather than embodying growth and opportunity. However, current trends are recognizing the potential for growth even in late life. It may take many forms, including activities and reflections that support making sense of one's life, or acts of creativity, exposure to the arts and music, or reflecting on existential matters. Psychologists consider this a stage of human development and, accordingly, long-term care staff may wish to look for ways to support late life resident well-being.

Moving into a nursing home can make people feel like they don't have control over their lives. Things they used to have control over, like who they live with, what they eat, and who can come into their living space, are suddenly not in their control. All of this can lead people to turn inward and stop learning and creating like they used to.

How is it different for older people?
Human potential is most often used to talk about children or aspiring athletes, looking to maximize their performance and skills. Human potential is relevant for older adults too. There is a common misconception that once you reach old age, you no longer grow - your personality and interests stay the same. Studies have shown that older adults continue to grow and change right up until death. Old age provides unique opportunities to learn and grow. For many, retirement is the first time they do not have to work full time to support themselves. This allows people freedom to pursue hobbies and try new things that they couldn't try earlier in life. Unlike adolescents, many older adults have a stronger sense of self and more stable

relationships. This means that older adults might be more comfortable "going against the flow" and challenging old ideas in new ways. Some scholars think this is why so many revolutionary thinkers, like Gandhi, Copernicus, and Nelson Mandela, did their most influential work later in life. Below, we outline three important concepts related to human potential with short case studies designed to help you and your colleagues use these ideas in practice.

Narratives for aging - Creativity

Creativity is intimately tied to our human potential; engaging in creative activities can offer meaning and purpose, put us in a state of flow, and elevate mood. There is a misconception that as we get older we no longer want to be creative, but as noted, some of the most creative thinkers did their best work at the end of their lives. While the ways that individuals can and want to be creative may change over the life course, creativity benefits everyone. Creating opportunities for creative engagement supports human potential. People living with memory loss are able to express their strengths when engaged in creativity. These activities reflect resilience. The Activity department plays a role in providing quality of life opportunities for engagement through interview and observation. It is a journey of discovery. Activities have been defined as any endeavor, other than routine ADLs, in which a resident participates that is intended to enhance their sense of well-being and to promote or enhance physical, cognitive, and emotional health. When we think of activity engagement, we often think of creativity.

Putting this into Practice

Case scenario

Ms. Albert, who is living with dementia and is non-verbal, is a resident at a nursing home. Her family shared during the assessment process that she was not engaged in anything at home and generally stayed in bed all day. During the first few months, the family brought in a few personal things, including a painting. When staff discussed the painting, it was shared that Ms. Albert had painted it. She was brought into the BINGO game on multiple occasions and the Activity staff provided Ms. Albert with painting materials while the other residents played. After several different attempts of providing painting materials on different days, Ms. Albert started to paint. She painted landscapes, birds, and then painted BINGO cards. Activity staff paid close attention to Ms. Albert's satisfaction: smiling, eye contact, and nodding her head. When staff asked if she wanted to play BINGO instead during one of the sessions, she nodded her head and was given a card. She was able to play the game successfully. After that she was out of bed daily and participated in the activities offered.

Practice tips

Key concepts for staff: creative potential, patience and persistence, close attention to resident cues
The staff practiced effective communication strategies with the resident which included patience. Engagement may not happen at once and the staff recognized this. Conducting a full assessment and continually assessment will help in understanding the person better as a human and help them reach their full potential.

Discussion Questions

1) Who are the residents who are hardest to engage? What are the ways you can find out about or watch for opportunities for creative engagement?
2) How do you and your team learn about each resident's interests beyond what might be in their bio? What are the ways you can use that information to support residents to be more creative?

Meeting the needs of residents and regulations

A resident who is diagnosed with dementia must receive the appropriate treatment and services to attain or maintain their highest practicable physical / mental / psychosocial well-being. The necessary care and services must be person-centered and reflect the resident's goals. Meaningful activities must address the resident's customary routines, interests, preferences, and choices to enhance their well-being. (Regulatory requirement F744 – Treatment / Service for Dementia and F679 - Activities).

Sense Making: Gerontranscendence

Many people think it is a normal part of aging to be depressed by death, but studies show that many older people do not dread dying. It's completely normal to have occasional sad thoughts about death, but a constant and persistent fear of death could be a sign of a deeper underlying problem like depression or anxiety. It could also be a sign that this individual has not been able to fulfill important life goals or go through the meaning-making process (like sharing life stories) in the way they wanted to.

Putting this into Practice

Case scenario

Ms. Nowak, is living with the risk of aspiration and is alert, oriented x3 and able to make her needs known. She has no family living or friends who support her. She has failed her swallowing evaluations and receives her nutrition through a g-tube. She was found eating bird seed and rabbit food at night in the activity room. She was also found sneaking food off the tray left in the hallway. After counseling on multiple occasions, Ms. Nowak expressed her desire to eat and understood the risks and benefits of potential aspiration pneumonia risks. Ms. Nowak signed the necessary

forms and enjoys eating meals with the other residents. She happily lived for six months before passing away from aspiration pneumonia. Before she passed, she shared how happy she was.

Practice tips

Key concepts for staff:

Towards the end of life, everyone wants to "make sense" of everything we have and haven't done in life. Working in long-term care, we have an opportunity to help residents find this peace. It may require some creativity on our part. What works for one resident might not work for another. Additionally, the rules and regulations within your nursing home may make it feel harder to honor residents' needs and wishes. However, cases like Ms. Nowak show how powerful simple changes can be for helping people write their own stories.

Discussion Questions:

1) What are some things we often don't allow residents to do in our facilities, but that we enjoy ourselves?
2) Have any current or former residents shared their goals, wishes, or preferences that are important to them as they approach death? If so, are there any that would be good for your whole team to know?

Meeting the needs of residents and regulations

The resident has a right to a dignified existence, self-determination, and communication. The resident has the right to be fully informed in advance by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment alternatives or treatment options and to choose the alternative or option he or she prefers. (F550, Resident Rights, F552, Planning and Implementing Care)

Constraints on Human Potential [Injustice, Inequity, Trauma]

Many residents arrive in long-term care having experienced often long-standing injustices, unequal or disparate treatment, or social or other marginalizations arising from intersections of age, ability, gender, race, sexual orientation, ethnicity, religion, class, or other non-dominant identities. Inequities often lead to internalized beliefs of being less valued or less worthy which, in turn, can be barriers to establishing new relationships in the community or participating in meaningful activities. The challenge for staff is to explore and understand each resident's historical and current views on growth opportunities and what stands in the way of taking advantage of them in later life.

Putting this into Practice

Case scenario

Joan Jones, recently widowed and living alone at home, began to show signs of confusion and unsafe activity (e.g., leaving the stove on) that alarmed her two adult children. Without talking to her about it, the children arranged to move her into the nursing home. Staff conversations with the adult children revealed a long history of emotional abuse by Joan's late husband and suspicions of occasional physical abuse. Joan was a homemaker all her life with a short stint as an elementary school teacher when her children moved out of the house. After a year or two, her husband insisted she stop working. Joan is submissive to her children but perks up in 1:1 conversations with certain staff. She denies interests or abilities and prefers to self-isolate, even when encouraged to meet other residents.

Practice tips:

Key concepts for staff: Understanding historic oppression and injustice, empowerment to re-engage with potential for positive engagement.

People deal with the anger, resentment, and frustrations of past oppression and trauma in different ways. Some people like to talk through it, while others do not, and people may change how they want to process trauma, especially as they age. Someone may have kept their trauma hidden for decades, but may process it in a new way as they age. This is a key part of human potential. The goal is for staff to understand 1) how a resident's past experiences of injustice, trauma, or oppression impact any current feelings of resignation, disengagement, or disempowerment, and; 2) how best to support them in feeling more personally empowered and inclined toward purposeful engagement, however they define that.

- Help residents recall and honor past positive activities and accomplishments and find ways to reconnect with them.Use conversation guides on how best to discuss and contextualize past oppression and marginalizations.

Discussion Questions:

- Have you had residents who need special attention or care because of previous injustices? How have you given that special care?
- Moving into a nursing home can make people feel like they've lost a lot of control. What are some ways we as a team can help residents keep more control over their space and body? Review concepts of *personhood* in the prior module.

Meeting the needs of residents and regulations

Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff, or volunteers must focus on assisting the resident in maintaining and enhancing their self-esteem and self-worth and incorporating the resident's goals, preferences, and choices. When providing care and services, staff must respect each resident's individuality, as well as honor and value their input. (F550 Resident Rights)

Increasingly diverse demographics among nursing home residents require nursing homes to provide culturally competent care. Cultural competency, which includes language, and cultural preferences, and other cultural aspects such as thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups, is an important aspect of person-centered care. These elements influence the beliefs surrounding health, healing, wellness, and the delivery of health services and are critical to reducing health disparities. (F699 Trauma-Informed Care)

Additional Resources

Live Oak Institute Cultivating Culture Change. http://liveoakinstitute.org/

O'Hern, K. (n.d.) The Path to Purposeful Engagement A Guide for Implementing a Community Approach to Purposeful Engagement That Residents Drive and Direct. https://www.pioneernetwork.net/wp-content/uploads/2021/03/The-Path-to-Purposeful-Engagement.pdf

Caring Across Generations - You Are Not Alone. (2016) https://caringacross.org/

Ryan, R., & Deci, E. (2001). On Happiness and Human Potentials: A Review of Research on Hedonic and Eudaimonic Well-Being. Annual Review of Psychology, 52, 141-166. http://dx.doi.org/10.1146/annurev.psych.52.1.141

Cohen, G. (2006). Research on Creativity and Aging: The Positive Impact of the Arts on Health and Illness. Generations: Journal of American Society of Aging, 30(1), pp. Langmann, E. (2022). Vulnerability, Aging, and Health: is it helpful to label older adults as a vulnerable group in health care? Medicine, Health Care and Philosophy (2023) 26:133–142 https://doi.org/10.1007/s11019-022-10129-5.

Ryff, C. D. (2018). Well-being with soul: Science in pursuit of human potential. Perspectives on Psychological Science, 13(2), 242-248.

McFadden, S., & Basting, A. (2010). Healthy Aging Persons and Their Brains: Promoting Resilience through Creative Engagement. Clinics in Geriatric Medicine, 26(1), 149-161

Matz, C., Sabbath, E., & James, J. B. (2020). An integrative conceptual framework of engagement in socially-productive activity in later life: implications for clinical and mezzo social work practice. Clinical Social Work Journal, 48, 156-168.

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TRAINING TOPIC 3 - AGEISM IN LONG-TERM CARE

Introduction

To avoid ageism, health care staff should adopt an individualized, person-centered care approach that defines non-ageist practices and attitudes and acknowledges the need to eliminate ageism in practice.

Ageism in Systems

Ageism is a widespread cultural phenomenon involving making both positive and negative generalizations (stereotypes) about older people. The underlying belief that drives ageism is that it is bad to be old, and good to be young. Ageist beliefs can influence our thinking, even if we do not act on them. However, ageist thinking and beliefs often do lead us to act in ways that reinforce these beliefs.

Powerful, cultural norms of ageism in our society have been absorbed unknowingly by many people, including the residents themselves and family members. What does this mean? Sometimes older people hold negative views of their own aging and/or of other older people, and sometimes family members hold negative views of their own aging and/or aging in general. It is critical to involve residents and family members in your organization's journey towards age inclusion so they can support the autonomy of older adults and contribute to a person-directed approach to care for residents.

Elderspeak

Language carries and conveys meaning which feeds assumptions and judgments that can lead to the development of stereotypes and discrimination. Elderspeak is an inappropriate simplified speech register that sounds like baby talk and is used with older adults, especially in health care settings. Research has shown that nursing staff extensively use elderspeak (infantilizing communication) in conversations with older adults in long-term care settings, especially during care providing activities of daily living. Elderspeak is perceived as patronizing and can precipitate communication breakdown and problem behaviors for cognitively intact elders.

Putting this into Practice

Case scenario

A new team member in memory care feels the only way the resident will cooperate with ADLs is 'baby talk.' This team member will use oversimplified language, infantile terms (e.g., baby, sweetie, honey), and/or a rhythmic tone of voice that a person might use for a child. The resident has verbally expressed to the team member that she does not appreciate being 'talked down to as a child' and finds her language 'degrading and condescending.' As a result, the resident has filed a complaint and requested this team member to not be involved in any of her care.

Practice tips

- Address people by their preferred name.
- Treat older adults like adults. Just because they are 'older' does not mean they want to be treated like a child.
- Match your communication to the person, not their age range.
- Use a normal tone at a normal pace.
- Avoid adjustments in your rhythm, sound, sentence structure, and meaning, such as a high-pitched, overnurturing voice and use of inappropriate terms of endearment (e.g., sweetie, honey).

Meeting the needs of residents and regulations

The resident has a right to a dignified existence, self-determination, and to be treated with respect and dignity. Staff must help the residents to maintain or enhance their self-esteem, self-worth, and incorporate their goals, preferences, and choices. Staff must also consider residents' physical limitations, assure communication, and maintain respect. (Regulatory requirement F550 – Resident Rights / Exercise of Rights)

Microaggression

A microaggression is a subtle, often unintentional, form of bias. Microaggression often takes the shape of an offhand comment, an inadvertently painful joke, or a pointed insult. For example, a person might comment that for an older person, they hear well or ambulate quickly without challenge or use of a cane or walker. Individuals may not have intended to offend anyone, but the comment (or action) still reminds the person who receives the microaggression that they are not fully accepted or trusted in their nursing home. People are often well-intentioned, and they want to consciously promote equality, but unconsciously they may act differently.[1]

Putting this into Practice

Case scenario

Mr. Smith resides in the nursing home and enjoys an active lifestyle. Visitors and other family members frequently make comments to him such as, 'Wow, you walk so well without any assistance! I wish my dad was in good physical shape like you!' While Mr. Smith tries to embrace the so-called compliment, he later tells staff he finds this talk offensive and insulting. Mr. Smith said other staff members hear people talk to him this way, but they never say anything hence the reason it still occurs. Mr. Smith asks you if staff are trained in how to recognize this type of ageist behavior.

1 https://www.psychologytoday.com/us/basics/microaggression

Practice tips

- Instead of dwelling on what makes a person different (e.g., person's gender, age, race, etc.)., notice it and move on.
- Try to avoid making a comment that highlights the difference as it may come across as insensitive. Meet*ing the needs of residents and regulations*

The resident has a right to a dignified existence, self-determination, and to be treated with respect and dignity. Staff must help the residents to maintain or enhance their self-esteem, self-worth, and incorporate their goals, preferences, and choices. Staff must also consider residents' physical limitations, assure communication, and maintain respect. (Regulatory requirement F550 - Resident Rights / Exercise of Rights)

Additional Resources

State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities Transmittals. (2023) https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf

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https://doi.org/10.1093/geroni/igab023

Washington, E., Birch, A., Roberts, L. (2020). When and how to respond to microaggressions. Harvard Business Review.
https://hbr.org/2020/07/when-and-how-to-respond-to-microaggressions

TRAINING TOPIC 4 - DIGNITY OF RISK IN LONG-TERM CARE

Introduction

Person-centered care, that is care that focuses on an individual's values, wishes, and preferences for everyday living and care, is the guiding force for meaningful care delivery. When person-centered care is delivered, individuals experience a more positive sense of worth, well-being, and quality of life. Literature supports the notion that preferences for care and activities remain relatively stable for older adults living in nursing homes, thus can be identified, and incorporated into plans of care. Yet, challenges exist when trying to incorporate resident preferences into plans of care. A few examples of these challenges include the physical/cognitive ability of residents to participate in care discussions, family involvement (or lack of involvement) in care planning, and risk perceptions of the care team.

The Concept of Dignity of Risk-Taking in Older Adulthood

Successful plans of care target improvements in the residents' dignity while living in the nursing home community. Dignity for nursing home residents is based on internal factors, such as their perceived self-worth, and external factors such as what they are willing to participate in and/or how they are treated by others.Persons living with dementia represent more than half of the nursing home population and are at greatest risk to lose dignity in care processes due to their diminished autonomy, altered sense of self-worth, lack of social roles, and limited interactions with others..

Caregivers can support a resident's dignity by assisting residents to maintain as much autonomy as possible in decision-making around their care and activity preferences, even when there is a potential risk to their health and safety.. This will require a degree of risk-taking that must be carefully managed by the care planning team. In doing so, this can result in personal growth and an improved quality of life that we seek for our residents. Thus – there is dignity in risk-taking for nursing home residents, even those with dementia, when they are afforded their individual right to express autonomy through risk-taking.

Nursing home staff have identified the need to engage in risk-taking to support resident preferences around the following:

- Food and fluid intake
- Showering and bathing
- Toileting
- Sleep timing
- Use of adaptive equipment
- Walking and ambulation
- Transferring from bed to chair and back

- Leisure activities
- Spending time alone and/or with others

Supported Decision Making with Persons Living with Dementia
Care planning in the nursing home community is a decision-making process . Persons living with dementia (PLWD), like anyone else, desire to be involved in decisions around their care processes yet are often left out of the decision-making process. Studies have indicated that PLWD, like their older adult counterparts, have stable preferences for care and activities such as those listed above . However, the involvement of a PLWD in the decision-making process varies, with final decisions about treatment and care made most often by family caregivers, with or without the involvement of the resident. In the nursing home environment, residents expect the support of nursing home staff to help them participate in decision-making around their preferences and expect families to support these decisions by providing tangible items, time, and advocacy.

Mitigating Potential Liability and The Risk of Harm

All residents can be supported in making decisions around their care using standardized procedures. Care planning and documentation of the care planning process is one way to mitigate potential risks of harm to the resident, the caregiver, and the organization, in support of safe and dignified resident care. As an emerging best practice, nursing home staff can use the decision-making in aging and dementia for autonomy (also known as DIGNITY) procedure to manage risk-taking that is required to support preferences for care and activities. This process currently involves the following steps:

1. Assessing and tracking resident preferences to identify potentially “risky” preferences.
2. Assessing and care planning health and safety risks associated with the “risky” preference.
3. Determining the impact of honoring the “risky” preference on the residents’ quality of life.
4. Documenting preferences that involve health and safety risk.
5. Engaging residents and families to mitigate the risks.
6. Working with organizational leadership and regulators to support resident preferences.

Putting this into Practice

Case Study

Cory is a 67-year-old single widowed woman living in the nursing home for about six months now with progressive dementia, and diabetes with bilateral above the knee amputations. Cory has been more withdrawn recently, not attending activities, tearful and requesting more frequent snacks between meals. Nursing home staff denied Cory her requests attempting to redirect the conversation because they are concerned that the frequent snacking will increase Cory's blood sugars, in addition to the concern that she will gain weight. This situation worsens as Cory is now beginning to refuse care such as blood sugar checks, bathing, and assistance with toileting.

Practice Tips

- Consider that you may have just identified an important and meaningful preference of Cory to snack between meals that carries a risk to her health or safety and enact a standard protocol, such as DIGNITY, to support risk-taking.
- Initiate a conversation with Cory to clarify why she is refusing care and what her preferences are for snacking between meals.
- Engage Cory, her family representative, and the interdisciplinary care team to evaluate the potential upsides and downsides of honoring Cory's request to snack between meals.
- Engage Cory, her family representative, and the interdisciplinary care team to weigh the potential of Cory's quality of life increasing with the risks of actual harm to Cory if the preference is honored.
- Make a shared decision with Cory, her family representative, and the interdisciplinary care team how to move forward with the preference (honor as is, compromise, or not honor but offer alternatives).
- Develop a plan to move forward with the shared decision using prompts from Honoring Preferences when the choice involves risk: a process for shared decision-making and care planning resource.
- Document and enact the plan by sharing the care plan amongst all involved.
- Determine when the plan will be evaluated for success and/or changing needs.

Meeting the Needs of Residents and Regulations

According to CMS regulations, the resident has the right to:

- Choose activities and schedules (Tag F242) F679 - Activities Meet Interest/ Needs of Each Resident
- Interact with members of the interdisciplinary team, friends, and family both inside and outside the care community (Tag F172 and Tag F242) F550 - Resident Rights/Exercise of Rights (communication with and access to persons and services inside and outside the facility or nursing home)

- Make choices about aspects of his or her life in the care community that are important to him or her (Tag F242)
- Participate in care planning (Tag F280) - F553 - Right to Participate in Planning Care
- Refuse treatment (Tag F155) - F578 - Request/Refuse/Discontinue Treatment
- Both quality of care (Tag F309) and quality of life (F240) that recognizes each individual and enhances dignity. F684 - Quality of Care
- Achieve the highest practicable level of well-being (Tag F309)
- The same rights as any resident of the United States (F151)

The resident has a right to a dignified existence, self-determination, and to be treated with respect and dignity. Staff must help the residents to maintain or enhance their self-esteem, self-worth, and incorporate their goals, preferences, and choices. Staff must also consider residents' physical limitations, assure communication, and maintain respect. (Regulatory requirement F550 - Resident Rights / Exercise of Rights)

Additional Resources

State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities Transmittals. (2023) https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf

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