



State Long-Term Care
Ombudsman Program

Person-Centered Care

Video Series Teaching Guide



Revised June 2025

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About the Teaching Guide

This instructor guide is designed to be used by anyone who wants to promote person-centered care, especially for direct care staff of nursing facility residents. The Person-Centered Care Video Training Series demonstrates person-centered approaches to care that contribute to creating quality of care and quality of life for residents.

All seven videos can be viewed on the [Texas HHSC YouTube Channel](#)

Permissions

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Training Materials

This manual is available on the Office of the Long-Term Care Ombudsman "Publications and Reports" page of the Texas HHSC website.

Videos are publicly available on the Texas HHSC and the Texas Long-Term Care Ombudsman YouTube Channels.

Course Description

This *Person-Centered Care Video Training Series* uses seven brief videos that demonstrate best practices for providing person-centered care to individuals living in long-term care settings.

Training Objectives

Participants will understand:

- 1) The philosophy and guiding principles of person-centered care.
- 2) The vital role of direct caregivers, especially Certified Nurse Aides (CNAs), in providing person-centered care.
- 3) Residents are central to decision making.
- 4) How to support residents in decision making and keep residents at the center of decision making.

Target Audience

- 1) Nursing home staff.
- 2) Paid and family caregivers.
- 3) Advocates.
- 4) Regulators.

Key Messages

Key messages list the main points of each video.

Review Before Teaching

Review Before Teaching provides background information on each video topic. This section may help instructors prepare to teach.

Resources

A list of resources appears at the end of every lesson. It lists references and other resources that may be helpful to review prior to teaching.

Design

Each video in this training series is designed as an independent module and may be taught alone or in any combination. Instructors choose which video lesson to teach based on need and available time.

Each video lesson has an estimated teaching time. Optional activities may be used to lengthen training.

Pre-test and Post-test

Time: 5 minutes

Distribute pre- / post-test to all trainees. Each question relates to one of the videos in the series. Ask trainees to put their name and the date on the test. The test answers are at the end of this guide.

Pre-Test / Post-Test

Your Name:

Today's Date:

Select the best answer and write the corresponding letter on the line.

1. Who is the primary decision maker for planning a resident's care?
 - a. Social worker
 - b. DON
 - c. Resident's representative
 - d. Certified Nurse Aide
 - e. Resident
2. Choose all that apply. Which of the following people may residents invite to attend their care plan meeting?
 - a. Housekeeper
 - b. Certified nurse aide
 - c. Physician
 - d. Ombudsman
 - e. Family member or friend
3. Which of the following statements is an example of person-centered language?
 - a. Mr. Davis suffers from dementia.
 - b. Mr. Davis has a diagnosis of dementia.
 - c. Mr. Davis is confused.
 - d. Mr. Davis is a walkie talkie.
 - e. None of the above
4. Choose all that apply. Walking rounds:
 - a. Utilize the SBAR method.
 - b. Are a tool for improving shift handoff communication.

- c. Take the meeting to the resident.
 - d. Keep residents more involved in their care.
 - e. Take a resident on a walk with you around the building.
5. For music to be most effective, who should create music playlists for residents with dementia?
- a. Certified nurse aide
 - b. Social worker
 - c. Resident
 - d. Resident's family
 - e. c and d
6. Fill in the blank. Nursing facilities are considered to practice consistent staffing assignments when at least _____% of staff shift assignments are caring for the same residents.
- a. 25%
 - b. 50%
 - c. 75%
 - d. 85%
 - e. 95%

Answer True (T) or False (F)

- ___ 7. Staff at nursing homes should work with residents to plan their schedules.
- ___ 8. Nursing home staff should partner with a resident to make decisions about the resident's care.
- ___ 9. Residents have the right to participate in planning their care, to ask questions, to be fully informed, and to refuse treatment.
- ___ 10. Residents should not be included in decisions about their medications.

Video 1 – Person-Centered Language

Put residents first to recognize the whole person and do not let disabilities define a resident.

Length of Video: 1 minute 27 seconds.

Link to Video: [Video 1 - Person-Centered Language](#)



Key Messages

- When staff use person-centered language, they recognize the whole person and do not let disabilities define a resident.
- Ask residents how they like to describe themselves and use the language they prefer.



Lesson Supplies

Internet opened to the YouTube link above for the Person-Centered Language video and queued to play.

See the Optional Activity on Page 12 for additional supplies required.



Review Prior to Teaching

Person-Centered Thinking

Person-centered is a way of thinking and doing things that recognizes residents are partners in planning, developing, and monitoring their care.

Person-centered thinking:

- 1) Puts residents at the center of decision-making.
- 2) Recognizes residents as experts about their lives.
- 3) Acknowledges residents are people who have individual interests, needs, and abilities.
- 4) Emphasizes person-first language to eliminate stereotypes and labeling.

Person-Centered Language

Ask residents about their language preferences. Some people prefer person-first language while others prefer identity-first language.

Person-First Language

Generally, refer to the person first and a diagnosis or disability second. Residents are not their diagnosis. They are first and foremost, people. For example, say:

- 1) A resident with dementia instead of A demented resident.
- 2) A resident who uses a wheelchair instead of A wheelchair bound resident.

Identity-First Language

Some people see their disability as a part of who they are and prefer to be identified with their disability first. This is called identity-first language. Identity-first language can validate a person's identity related to a disability.

For example:

- 1) "A Deaf person" instead of "a person who is deaf."
- 2) "An autistic person" instead of a "person with autism."

Neutral Language

Use neutral language. Do not use words that paint a person as lacking or defective. Examples of language that are not neutral include "victim of" or "suffers from."

- 1) Not neutral: Mr. Smith is a stroke victim.
- 2) Neutral: Mr. Smith had a stroke.
- 3) Neutral: Mr. Smith is recovering from a stroke.

Labeling

Labels are words or phrases that describe someone instead of using his or her name. They can be positive or negative and can shape others' perceptions. Examples are idiot, genius, combative, honey, or sweetie.

If a group of residents watching television is called confused or nonverbal, this may have the unintended consequence of making others believe that

each person in that group is unable to communicate and are unable to answer questions or state their needs. Caregivers may ignore each person's abilities.

Do not mention residents' disabilities unless the disability is vital to a request or comment. The fact that a resident has a mental health diagnosis may not be relevant to a resident's request for pain medication or to see a doctor. The fact that a group of residents watching television all have a diagnosis of dementia may not be relevant to a conversation about providing care to those residents.



Lesson

Teaching Time: 10 minutes.



Play Video

Video 1 - Person-Centered Language approximate run time is 1½ minutes.

? Discussion Questions

Lead discussions about the following topics.

Person-Centered Language

Ask

- 1) What do you think *person-first language* means? Can you give me an example?
 - a) Put the resident first then the resident's health.
 - b) Mr. Davis has dementia.
- 2) When Sara spoke to a coworker about Mr. Davis, how did Sara remain person-centered when talking about Mr. Davis? Sara:
 - a) Put the resident first then the resident's health.
 - b) Put residents first when she tells others what residents like to do. Mr. Davis enjoys walking.
 - c) Avoided giving nicknames to residents.

- d) Used neutral language. She avoided using negative language like “suffers from” dementia.
 - e) Asked residents how they like to describe themselves.
- 3) Using words that paint residents as lacking or defective should be replaced with neutral language. For example, Ms. Durham has a speech deficit. How can we say this in a way that does not make Ms. Durham sound defective?
- a) Ms. Durham needs extra time to respond.
 - b) Give Ms. Durham extra time to tell you what she needs.
- 4) When Sara does not know how residents describe themselves, what does Sara do?
- a) She asks the resident.

Labeling People and Nicknames

Ask:

- 1) What does the video mean when it says Sara does not label residents or give them nicknames?
 - a) Sara does not use a word, term, or short phrase to describe a resident instead of using his or her name. She does not use words like old, disabled, or confused.
- 2) What are a few examples of labels, nicknames, or stereotypes that someone might use to talk about residents living in a nursing facility?
 - a) Confused, Walker, Talker, Combative, Disabled, Disgruntled, Angry, or etc.
- 3) What are some outcomes for residents who are discussed using negative labels? The person may....
 - a) Act how they are labeled: combative, disgruntled, or angry.
 - b) Feel judged before people get to know him or her.
 - c) Feel they are treated differently by caregivers and staff.
 - d) Have low self-esteem, or feel ashamed, or feel self-conscious.

Person-Centered Thinking

Ask:

- 1) In the video, the narrator said, "By building relationships and thinking people first, staff treat residents with the respect they deserve. Think people first."

What does people-first or person-centered thinking mean?

- a) Keep the focus on the residents we support.
- b) Put residents at the center of decision-making.
- c) Consider residents experts about their lives.
- d) Acknowledge residents are people who have individual interests, needs, and abilities.
- e) Emphasize person-first language to eliminate stereotypes and labeling.

Say:

Words have power. Labels, nicknames, and language that is not neutral can impact attitudes and create assumptions about people we serve.

Optional Activity for Video 1: I Am Not a Label.

Use this activity to expand teaching time for the Video 1 module.

Supplies

- 10 index cards with 2 holes punched into the top (long side).
- 10 three-foot lengths of string.
- Two people are required. One to play the part of the resident and one person to conduct the activity.

Preparation

Number and label each index card using the list below. There should be one number and label per card. Print large enough the audience can read each label from a distance.

Punch two holes at the top of each index card. Run a length of string through the holes at the top of each card. Each label should easily fit over someone's head to hang around their neck or off an extended arm.

- 1) OLD
- 2) DIABETIC
- 3) COMPLAINER
- 4) DEMENTIA
- 5) STROKE
- 6) AGITATED
- 7) WANDERER
- 8) INCONTINENT
- 9) FEEDER
- 10) USED TO BE



Instructions

Person 1 – The “Resident”

- 1) Labels are hung either around the resident’s neck or on one of the resident’s extended arms during the activity.
- 2) The resident stands in front of a chair and may choose to stand with arms extended perpendicular to the floor.

Person 2 – Handler

- 1) The handler keeps the labels stacked in numerical order.
- 2) The handler turns the music on and off. When ready, the handler starts the music.
- 3) Next, the handler hangs the labels one by one around the resident’s neck or extended arm(s). It may be helpful to show the audience the label prior to hanging it on the resident.

Place the Labels

1 -OLD

The handler shows the “OLD” label to the audience and then places it around the resident’s neck (or arm). The resident looks at the label and then looks at the audience with an “Oh well, no big deal” look.

2 -DIABETIC, 3 - COMPLAINER

The handler shows the “DIABETIC” and “COMPLAINER” labels to the audience and then places them around the resident’s neck or extended arm. The resident looks at the labels. The resident’s face can express anger, irritation, or annoyance.

4 -DEMENTIA

The handler shows the “DEMENTIA” label to the audience and then places it around the resident’s neck or arm. The resident’s expression should reflect how he or she would respond if someone told them they have dementia.

5 -STROKE

The handler shows the STROKE label to the audience and then places it around the resident's neck or arm. Person 2 then encourages the resident to sit down by gently pressing on the resident's shoulders. The resident sits briefly then stands up again.

6 -AGITATED

The handler shows the audience the "AGITATED" label and then places it around the resident's neck. Next, the handler gently presses the resident's shoulders again to encourage the resident to sit down.

The resident sits and remains seated this time.

7-WANDERER, 8 - INCONTINENT, 9 - FEEDER

The handler places the "WANDERER," "INCONTINENT," and "FEEDER" labels on the resident's neck or arms.

10 -USED TO BE

"USED TO BE" is the last label placed on the resident and should be placed where the audience easily reads it, around the resident's neck.

After the "USED TO BE" label is placed on the resident, the handler turns off the music.

Silence is important. This part of the exercise is most effective if done in silence.

After the music is turned off, the resident stands, takes all the labels off, and throws them on floor.

The resident reads the following section to the group. First, the resident says, "I am not a label." Next, the resident reads one of the statements that represents his or her gender. Person 1 (the resident) may also create a statement that represents his or her own individuality or meaningful life experience prior to starting the activity. The resident then reads the remainder of statements to the group.

- 1) I am not a label. PAUSE
- 2) I am a businesswoman and a mother. I am proud of all that I have accomplished.

- 3) I am a fisherman and a father. I find peace out on the lake with my son.
- 4) I am a teacher. I provide the tools that children need to be successful in life.
- 5) I am a construction worker. When I help build a project from start to finish, I feel proud.
- 6) I am an attorney. I love outwitting my opponent in court.
- 7) I am an advocate. I find purpose in promoting independence in our elders.
- 8) I am not a label. I am a unique individual, and that is how I want to be treated.

Important Note!

The way this demonstration is presented, the audience assumes “the resident” is talking about his or her own character until several of the statements are read. The statements represent a range of meaningful life experiences to reinforce that each resident is a unique individual.

? Discussion Questions for Optional Activity

The group answers the following questions.

- 1) What does this activity demonstrate?
 - a) It demonstrates how we may not see or know the whole person if we judge someone only what we can see now.
- 2) How can we get to know residents better, so we can see the whole person?
 - a) Ask the resident.
 - b) Read their admission and social history.
 - c) Take a few minutes each day to encourage each resident to talk with you or sit together a moment.
 - d) Ask about personal objects, photos, or memories.
 - e) Be patient and listen.



Resources

- 1) *I Am Not a Label* activity was adapted from an activity from the 2009 Pioneer Network Conference, Little Rock, AR.
- 2) Hyams, K., Prater, N., Rohovit, J., & Meyer-Kalos, P. (2018, April). Center for Practice Transformation, University of Minnesota. *Person-Centered Language, Clinical Tip No. 8*. Retrieved February 15, 2020, from, <https://practicetransformation.umn.edu/clinical-tools/person-centered-language/>.
- 3) Ladau, E. (2015, July 20). Think Inclusive. Why Person-first Language Doesn't Always Put the Person First. Retrieved February 15, 2020, from, <https://www.thinkinclusive.us/why-person-first-language-doesnt-always-put-the-person-first/>.
- 4) NCAPPS. (n.d.). National Center on Advancing Person-Centered Practices and Systems (NCAPPS). *Resources*. Retrieved February 15, 2020, from <https://ncapps.acl.gov/>.
- 5) Pioneer Network. (2017, July). Pioneer Network. *Commitment to Person-Centered Language*. Retrieved February 15, 2020, from, <https://www.pioneernetwork.net/wp-content/uploads/2017/07/Commitment-to-Person-Centered-Language-Training.pdf>.
- 6) Williams, K., Kemper, S., & Hummert, M. L. (2003). Improving Nursing Home Communication: An Intervention to Reduce Elderspeak. *The Gerontologist*, 43(2), 242–247. doi: 10.1093/geront/43.2.242. Retrieved May 5, 2020, from, <https://www.ncbi.nlm.nih.gov/pubmed/12677081/>.

Video 2 – Walking Rounds

Walking rounds at shift changes keep residents involved in their care and provide staff with real-time information about each resident's condition and care.

Length of Video: 1 minute 57 seconds

Link to Video: [Person-Centered Care: Walking Rounds](#)



Key Messages

- If staff use walking rounds at the beginning and end of shifts, they can improve communication and include residents in their care.
- Walking rounds and the SBAR checklist help staff learn critical information and practice person-centered care.



Lesson Supplies

Video 2 – Walking Rounds queued to the YouTube link found above and ready to play.



Review Prior to Teaching

What is a patient or resident hand-off?

"A hand-off is a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care."¹

Huddles

According to B&F Consulting, a huddle is a quick meeting to share and discuss important information.

¹ The Joint Commission Center for Transforming Healthcare. Improving transitions of care: Hand-off communications. Oakbrook Terrace, Illinois: The Joint Commission, 2014.

There are several types of huddles, including start of shift and end of shift huddles.

Huddles can be done in a stand-up meeting or as room-to-room walking rounds with the charge nurse and CNAs together checking on each resident.²

Walking Rounds

Walking rounds are room-to-room in-person shift change communications that include the resident. They are a real-time transfer and acceptance of resident information from one staff or caregiver to another to ensure continuity of resident care.

They have been recognized as a tool for improving efficiency and communication.³

Walking rounds:

- 1) Are a person-centered practice since they include the resident in the assessment.
- 2) Can be multidisciplinary.
- 3) Must include clear goals, structure, and leadership.
- 4) Provide up-to-date information regarding each resident's care, treatment and services, condition, and any recent or anticipated changes.
- 5) Minimize information loss by providing the opportunity for interactive questioning among staff and residents.
- 6) Make sure off-going shift is not leaving a resident in distress.
- 7) Promote resident safety by putting eyes on each resident.
- 8) Help residents know who is taking care of them on the next shift.
- 9) Promote resident satisfaction.
- 10) Build and maintain a teamwork environment.
- 11) Promote staff satisfaction.

² B&F Consulting for Pioneer Network's National Learning Collaborative on Using the MDS as the Engine for High Quality Individualized Care. Tip Sheet – Huddles.

³ Institute for Healthcare Improvement. www.ihl.org and The Joint Commission. www.jointcommission.org.

Barriers to implementing bedside reporting include staff who:

- 1) Are comfortable with existing process and do not want to change.
- 2) Are uncertain about what to say and do (uncertain of the structure of communication at bedside).
- 3) Have HIPPA (privacy) concerns when other residents, family members, or friends are present.
- 4) Are concerned that oncoming staff will be late or that management will not schedule enough shift overlap.⁴

SBAR

SBAR is an acronym for **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation. It is a communication technique that enables swift communication. It provides the framework for staff to communicate effectively about a resident's condition with one another and allows for vital information to be conveyed accurately. Staff can add identify (I) to make the acronym ISBAR.⁵

- 1) **I**dentify (I). Identify self and role. Identify the resident and room number.
- 2) **S**ituation (S). What is going on with the resident? Briefly state the problem, when it happened or started, and how severe it is.
- 3) **B**ackground (B). Provide relevant medical history or context.
- 4) **A**ssessment (A). State the assessment or recommendation based on the situation.
- 5) **R**ecommendation (R). Explain any necessary actions or requests.



Lesson

Teaching time: 8 minutes

⁴ Douglas S. Wakefield, PhD; Roland Ragan, RN; Julie Brandt, PhD; Megan Tregnago, MEd, MHA. June 2012. Making the Transition to Nursing Bedside Shift Reports. *The Joint Commission Journal on Quality and Patient Safety*. Volume 38, Number 6.

⁵ Agency for Healthcare Research and Quality (AHRQ), Improving Patient Safety in Long-Term Care Facilities, Training Modules. Module 2: Communicating Change in a Resident's Condition, Session 2.



Play Video

Video 2 - Walking Rounds approximate run time is 2 minutes.



Discussion Questions

Lead discussions about the following topics.

Walking Rounds

Ask:

- 1) According to the video, what are walking rounds?
 - a) Walking rounds are staff communications done at the beginning and at the end of a shift.
 - b) It is a “hand-off” of information from one staff person before they leave for the day to the next as they begin their workday.
- 2) What are the benefits to Sara and other staff using walking rounds?
 - a) They are a way to put eyes on every resident.
 - b) Walking rounds are a way to notice changes in a resident’s condition or mood from one day to the next and at different times of the day.
 - c) Walking rounds are a way to learn from other staff about each resident, and communicate what staff know.
- 3) Why is important for Sara and other staff to “put eyes” on each resident at the start and end of a shift?
 - a) It is important for resident safety.
 - b) Putting eyes on each resident makes sure no resident is left in distress or without needed care.
 - c) It informs each resident about who is taking care of them.
- 4) What are some benefits for residents of bedside hand-off communication?
 - a) It keeps residents informed about who is taking care of them.
 - b) It promotes resident safety by putting eyes on each resident during shift change.
 - c) It helps improve resident satisfaction – as well as staff satisfaction.

- d) It is a way to include residents in care, keep them at the center of decision-making, and keep them updated.
 - e) It is a person-centered practice.
 - f) It is real-time communication which allows staff to ask questions and get answers from the resident.
- 5) How do you communicate information from one shift to the next?
- a) Expect a variety of answers.
 - b) Shift report.
 - c) Shift report given in person and includes front line staff (CNA)

SBAR

In the video, Sara checks in with Ms. Durham and the staff person who is just ending her shift. They use the SBAR checklist.

Ask:

- 1) What does the SBAR acronym stand for?
 - a) Situation
 - b) Background
 - c) Assessment
 - d) Recommendation
- 2) How does using the SBAR checklist during shift change communications help Sara and the staff who are at the end of their shift?
 - a) It quickly transfers information.
 - b) It helps give a report on the important factors.



Resources

- 1) AHRQ. (n.d.). Agency for Healthcare Research and Quality (AHRQ). Module 2: Communicating Change in a Resident's Condition. Retrieved February 15, 2020, from, <https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod2sess2.html#Tools>.

- 2) AHRQ. (2012, July). Agency for Healthcare Research and Quality (AHRQ). Improving Transitions of Care: Hand-Off Communications. Retrieved February 15, 2020, from, <https://psnet.ahrq.gov/issue/improving-transitions-care-hand-communications>.
- 3) B & F Consultants. (2016, October). Pioneer Network. Tip Sheet Huddles. Retrieved February 15, 2020, from, <https://www.pioneernetwork.net/wp-content/uploads/2016/10/Huddles-Tip-Sheet.pdf>.
- 4) QIO. (2016, September 16). Quality Improvement Organizations. Train-the-Trainer Series, Team STEPPS in LTC: Communication Strategies to Promote Quality and Safety. Retrieved February 15, 2020, from, <https://qioprogram.org/teamstepps%C2%AE-ltc-communication-strategies-promote-quality-and-safety#handoffs>.
- 5) The Joint Commission Center for Transforming Healthcare. Improving transitions of care: Hand-off communications. Oakbrook Terrace, Illinois: The Joint Commission, 2014.
- 6) Wakefield, D., Ragan, R., Brandt, J., & Tregnago, M. (June 2012). Making the transition to nursing bedside shift reports. Joint Commission Journal on Quality and Patient Safety, 38(6), 243-53. Retrieved February 15, 2020, from, <https://pubmed.ncbi.nlm.nih.gov/22737775/>.

Video 3 – Consistent Staff Assignments

Consistent staff assignments build trust between residents and caregivers and improve residents' quality of care.

Length of Video: 1 minute 57 seconds.

Link to Video: [Person-Centered Care: Consistent Staff Assignments](#)



Key Messages

- Keys to improving quality of life for residents are knowing each person, building relationships, and trust.
- When nursing home teams have consistent assignments to residents, staff build trust and improve the lives of residents.
- Staff focus on residents rather than a list of tasks.



Lesson Supplies

Video 3 – Consistent Staff Assignments queued to the YouTube link above and ready to play. Approximate run time is 2 minutes.



Review Prior to Teaching

Consistent Staffing

Consistent staffing is when the same employees are primarily assigned to work with the same residents. It is necessary for continuity of care.⁶

According to provider experts, facilities practice consistent assignment when at least 85% of staff shift assignments are caring for the same residents.⁷

⁶ Pioneering Change to Promote Excellent Alternatives in Kansas Nursing Homes (PEAK) Strengthening Staff Education Lesson, Center on Aging, Kansas State University

⁷ Farrell, Davide MSW, and McLaughlin, Marguerite MA, Quality Partners of Rhode Island. A Case For Consistent Assignment. June 2006. *Provider*.

Continuity of Care

Continuity of care is quality of care over time. Continuous and caring relationships between residents and caregivers. Improved relationships between residents and caregivers. Staff knowing residents' routines - which allows them to provide better care.

Benefits of Consistent Staffing

Consistent staffing affects residents by improving resident satisfaction. Making residents feel better cared for and building trust that staff know how to meet their needs.⁸ Consistent staffing affects facility staff by improving staff satisfaction and reducing staff turnover.

According to B&F Consulting when staff are consistently assigned to the same residents, unscheduled absences decrease. When staff know they are valued, they are more dependable and there are fewer unplanned absences.



Lesson

Teaching time: 6 minutes.



Play Video

Video 3 – Consistent Staff Assignments approximate run time is 2 minutes.



Discussion Questions

Lead a discussion about the following topic.

Consistent Staff Assignments

Ask:

- 1) What is meant by consistent staffing or consistent assignments?
 - a) The same employees are assigned to work with the same residents each day of work.

⁸ Case For Consistent Assignment. June 2006. *Provider*.

- 2) How did Sara's consistent assignment to support Mr. Davis improve his quality of care or quality of life?
 - a) Sara noticed that Mr. Davis had a change of condition. Sara noticed Mr. Davis was struggling to stand.
 - b) Sara knew what Mr. Davis likes to do and encouraged him to do it.
 - i) Sara told Mr. Davis that there are people playing a game he enjoys.
 - ii) Sara told Mr. Davis his favorite sport is on TV.
 - iii) She made sure Mr. Davis had choices for activities that match his preferences.
 - c) Sara knew Mr. Davis's needs and preferences; therefore, trust was built between Sara and Mr. Davis.
 - d) Sara focused on residents, like Mr. Davis, not a list of tasks.
 - e) Mr. Davis and other residents that Sara cares for may feel safer since Sara is familiar to them.
 - f) Sara feels confident and satisfied in her job.
- 3) Instead of reassigning Sara to another hall when another caregiver is unexpectedly absent, how can management in Sara's home make sure an unscheduled absence is covered?
 - a) Employees are scheduled as "Floaters," and they pick up duties as needed and during heavy labor times.
 - b) Divide up the assignment of the absent person among co-workers.
 - c) See if a consistent back-up for the neighborhood or unit can come in even for a partial shift.
- 4) How are unscheduled absences handled at your facility?
 - a) Answers will vary.
- 5) Can you think of ways management at Sara's facility can minimize unscheduled staff absences?
 - a) Answers will vary.
 - b) Give rewards for good attendance.
 - c) Provide support and flexibility to staff whose personal lives create attendance challenges.

- d) Allow staff who “share an assignment” to cover for each other, within company policies or guidelines.
 - e) Designate a “floater” – help during heavy labor times, help when someone is absent.
 - f) Use a process for weighting and balancing assignments. Rate each resident for physical, non-physical or time intensive, little time.
 - g) Track absences. Assign a point person to track and enforce attendance policies.
- 6) How do you think consistent staff assignments will benefit you in your role?
- a) Answers will vary.

Review the following information that is on the pre-test and post-test about consistent staff assignments.

Say:

According to experts, facilities practice consistent assignment of staff when at least 85% of staff shift assignments are caring for the same residents.⁹

⁹ Farrell, David MSW, and McLaughlin, Marguerite MA, Quality Partners of Rhode Island. Provider Magazine. A Case For Consistent Assignment. June 2006.



Resources

- 1) AHRQ. (2019, March). Agency for Healthcare Research and Quality (AHRQ). *Module 1: Detecting Change in a Resident's Condition*. Retrieved February 15, 2020, from <https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod1.html>.
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Video 4 – Person-Centered Care Plans

Residents have the right to be fully informed and to participate in the development and implementation of their person-centered care plan.

Length of Video: 2 minutes

Link to Video: [Person-Centered Care: Care Plans](#)



Key Messages

- A care plan must be individualized, embracing a resident's needs and choices.
- Residents are partners in the planning process.
- A resident's social and emotional life are just as important as physical health.
- Problem solving is a key part of care plan meetings.



Lesson Supplies

Video 4 - Person-Centered Care Plans queued and ready to play using the YouTube link above.

See the Optional Activity on Page 43 for additional supplies required.



Review Prior to Teaching

Care planning is directed by the resident and supported by others selected by the resident.

The following are federal regulations and CMS Guidance that describe residents' rights related to care planning and care planning requirements.

Definition for Person-Centered Care¹⁰

Person-centered care. For purposes of this subpart, person-centered care means to focus on the resident as the locus of control and support the

¹⁰ e-CFR, 42 C.F.R., § 483.5. Definitions.

resident in making their own choices and having control over their daily lives.

Residents' Rights and Exercising Rights¹¹

(a) *Residents' rights.* The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. [...]

(b) *Exercise of rights.* The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

(i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the resident representative.

(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of

¹¹ e-CFR, 42 CFR § 483.10 Resident rights.

rights, except as limited by State law.(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under State law.

(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.

(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.

(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. [...]

Excerpts from CMS State Operations Manual (SOM) Appendix PP.

Definitions – 42 C.F.R. §483.10(b)(3)-(7)¹²

“Court of competent jurisdiction” means any court with the authority to hear and determine a case or suit with the matter in question.

¹² CMS State Operations Manual Appendix PP.

“Resident representative” For purposes of this subpart, the term resident representative may mean any of the following:

- 1) An individual chosen by the resident to act on behalf of the resident to *support* the resident in decision-making; access medical, social, or other personal information of the resident; manage financial matters; or receive notifications;
- 2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or
- 3) Legal representative, as used in section 712 of the Older Americans Act; or
- 4) The court-appointed guardian or conservator of a resident.

Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

Planning and Implementing Care¹³

(c) *Planning and implementing care.* 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.

(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

¹³ e-CFR, 42 CFR § 483.10 Resident rights.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iii) The right to be informed, in advance, of changes to the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must—

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.

(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.

(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary.

Excerpts from the SOM Appendix PP

INTENT §483.10(c)(2)-(3)¹⁴

To ensure facility staff facilitates the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to their daily routines and goals to potentially return to a community setting.

GUIDANCE §483.10(c)(2)-(3)

Residents and their representative(s) must be afforded the opportunity to participate in their care planning process and to be included in decisions and changes in care, treatment, and/or interventions. This applies both to initial decisions about care and treatment, as well as the refusal of care or treatment. Facility staff must support and encourage participation in the care planning process. This may include ensuring that residents, families, or representatives understand the comprehensive care planning process, holding care planning meetings at the time of day when a resident is functioning best, providing sufficient notice in advance of the meeting, scheduling these meetings to accommodate a resident's representative (such as conducting the meeting in-person, via a conference call, or video conferencing), and planning enough time for information exchange and decision making.

A resident has the right to select or refuse specific treatments options before the care plan is instituted, based on the information provided as required under §483.10(c)(1), (4)-(5), F552. While Federal regulations affirm a resident's right to participate in care planning and to refuse treatment, the regulations do not require the facility to provide specific medical interventions or treatments requested by the resident, family, and/or resident representative that the resident's physician deems inappropriate for the resident's medical condition.

A resident whose ability to make decisions about care and treatment is impaired, or a resident who has been declared incompetent by a court,

¹⁴ CMS State Operations Manual Appendix PP.

must, to the extent practicable, be kept informed and be consulted on personal preferences.

The resident has the right to see the care plan and sign after significant changes are made.

Self-Determination and Choice¹⁵

(f) *Self-determination.* The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.

(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part.

(2) The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.

Comprehensive Person-Centered Care Planning¹⁶

(b) *Comprehensive care plans.*

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25, or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of

¹⁵ e-CFR, 42 CFR § 483.10(f)(1)-(2) Resident rights.

¹⁶ e-CFR, 42 CFR §483.21(b) and (c) Comprehensive person-centered care planning.

rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv) In consultation with the resident and the resident's representative(s)—

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to—

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. [...]

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(i) Meet professional standards of quality.

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(iii) Be culturally-competent and trauma-informed.

(c) *Discharge planning*—

(1) Discharge planning process. The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at §483.15(b) as applicable and—

(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.

(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.

(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.

(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.

(vi) Address the resident's goals of care and treatment preferences.

(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.

(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:

(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to

authorized persons and agencies, with the consent of the resident or resident's representative.

(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter).

(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.



Lesson

Teaching time: 15 minutes



Play Video

Video 4 – Person-Centered Care Plans approximate run time is 2 minutes.



Discussion Questions

Lead discussions about the following topics.

Care Plan Meetings

Ask:

- 1) Who did you see in Ms. Durham's care plan meeting?
 - a) Nurse
 - b) Family Member
 - c) Doctor
 - d) Nurse Aide
 - e) Ombudsman

- 2) How was Ms. Durham treated as a partner in the care planning process?
 - a) She was asked who she wanted to invite.
 - b) Staff encouraged Ms. Durham to discuss new things she would like to try.
 - c) They involved Ms. Durham in problem solving and talked with her about why she is reluctant to shower.
 - d) Staff followed up with Ms. Durham to see how the changes to her care plan are working.
- 3) In the video, how did Sara and other facility staff reinforce Ms. Durham's right to direct what services she receives? Staff:
 - a) Listened and heard Ms. Durham's concerns.
 - b) Recognized Ms. Durham as a partner in the planning process.
 - c) Invited her to her care plan meeting.
 - d) Invited people Ms. Durham wanted to participate in her care plan meeting.
 - e) Encouraged Ms. Durham to participate and share information, especially during her care plan meeting.
- 4) Why is it important for direct care staff, like Sara, to be involved in resident care planning? Direct care staff / certified nurse aides:
 - a) Know the person.
 - b) Understand what is important to the person.
 - c) Understand the person's communication style and may best interpret nonverbal communication.
 - d) Have a trusting relationship with the person.
 - e) Support the person in different environments.
 - f) Can be the person the resident turns to for assistance and support.
- 5) Some staff and others important to the resident may be unable to attend the meeting. How can they participate? They can:
 - a) Attend the meeting by conference call.
 - b) Schedule the meeting when they are available or when most people are available.

- c) Send notes.
- d) Share information with the nurse or other clinical staff before or after the meeting.

Audience Experience with Care Plan Meetings

Ask:

- 1) Who has attended or participated in a resident care plan meeting? Tell us about your experience.
 - a) Answers will vary.
 - b) Some staff may not have attended one.
 - c) Be prepared to share some thoughts about your experiences to help the audience get insight into care plan meetings to support residents.
- 2) How can residents who are unable to go to the meeting room attend or participate in their care plan meeting?
 - a) Hold the meeting in the resident's room.
- 3) How can staff ensure residents, whose ability to make decisions about care and treatment is impaired, participate in their care plan to the best of their ability?
 - a) Plan enough time for information exchange and decision making.
 - b) Ask residents who they would like to attend the meeting to support them in decision making.

Residents and Care Plans

Review the following information about care plans by reading the information below to the audience.

Say:

- 1) A care plan meeting is a key opportunity for facility staff to develop individualized care plans for residents. It is the resident's meeting.
Residents should be asked:
 - a) Who they want to invite.
 - b) How the current care plan is working for them.
 - c) If any changes need to be made.

- d) If they are currently experiencing any problems or challenges and whether they want help from staff with them.
- e) If they reached any goals, had any improvements, or had any successes to share.

The Optional Activity starting on Page 43 may be used to expand Video 4 teaching time.

Optional Activity – The Mystery Game

Objective: Learn to develop person-centered solutions.

Teaching Time: 30 minutes.

Number of players: 4 to 12 players is ideal. For larger groups, give one card to each person in the audience.

It is helpful to have two instructors for this activity, but it is not required.



Supplies

- 42 Mystery Game Clue Cards – See Pages 49-62.
- Sticky Flip Chart Pad
- Black Marker



Preparation

Clue Playing Cards

- Print and laminate the two-sided Mystery Game Clue cards. Lamination is optional.
- Cut out each card to make the deck of clue playing cards.

Flip Chart

Prepare seven flip chart pages. At the top of each page, write one of the following questions and its associated number.

- 1) What are Mr. McNally's strengths and interests?
- 2) How are staff or facility routines are contributing to Mr. McNally's decline?
- 3) What do staff need to do differently? What facility routines need to change?
- 4) What changes in Mr. McNally's routine need to be made?
- 5) How can staff use Mr. McNally's strengths and interests to make a person-centered care approach?
- 6) What additional information is needed?
- 7) Who else needs to be involved?



Instructions

Tell the Story of Mr. McNally

Mr. McNally lives in a nursing home. He moved in six months ago to recover from a broken hip. Lately facility staff complain frequently to the Director of Nurses and Mr. McNally's daughter. They say Mr. McNally is hard to care for because Mr. McNally is combative and gets easily agitated.

Explain the Clue Cards

Say:

We have a Mystery. These cards (show cards) have clues to help Mr. McNally. Everyone will receive at least one card; some people may receive more than one card. You are going to help staff find and understand the clues to help them establish some person-centered approaches to Mr. McNally's care.

Deal the Cards to Participants

Hand out the Clue cards, facedown, as if dealing a deck of playing cards. All cards must be handed out. Everyone should have at least one card.

Ask Questions 1 and 2

Tell the trainees to raise their hand if they think they hold a card that contains a clue related to Question 1. Each person who raised their hand will read their card to the group.

Write each correct clue underneath the question on the Question 1 flip chart page. Repeat for Question 2.

Question 1: What clues do you have about Mr. McNally's strengths and interests?

Clues

- 1) Sweet when he first came to facility.
- 2) Loves to make breakfast.

- 3) Loves the smell of bacon cooking.
- 4) Interested in gardening – photos & hands-on gardening.
 - a) Picture of roses in a garden in his shadow box.
 - b) Grandkids brought him a potted plant which is doing well.
 - c) Hums when he gardens.
- 5) Interested in birds and feeding birds since he used to have a bird feeder.
- 6) Likes to visit with the night maintenance person.
- 7) Likes the Red Sox – baseball – Red Sox sticker in his shadow box.
- 8) Interested in firefighters.
 - a) Worked the evening shift at the fire department.
 - b) Drove a hook and ladder for the fire department.
- 9) Likes to walk.
- 10) Likes to stay up late.
 - a) Night owl.
 - b) Worked the evening shift at the fire department.
- 11) Possibly prefers to go to the restroom instead of using briefs.
 - a) Can use toilet by himself.
 - b) Hates incontinence briefs.
- 12) He is religious (Catholic)
- 13) His daughter visits regularly

Question 2: What clues do you have about how staff or facility routines are contributing to Mr. McNally's decline?

Clues

- 1) Recommended an increase in medications for agitation.
- 2) Sleeping pills order as PRN.
- 3) Identification of incidents but no solutions proposed (bathing, suppository, morning care) incident hitting nighttime aide.
 - a) Incident report while in Hoyer lift bathing.
 - b) Incident occurred while giving him a suppository.
 - c) Incident occurred during morning care.

- d) This is his third incident.
 - e) Taking medications for anxiety and agitation
- 4) Recovering from a broken hip:
- a) Fell 2nd night at facility.
 - b) Sleeping pills prescribed PRN.
 - c) Toileting clues:
 - i) Can use toilet by himself.
 - ii) He hates incontinence briefs.
 - iii) He needs incontinence checks at night.
 - iv) He has an UTI.
 - v) He is constipated.
 - c) Agitation clues:
 - i) He talks back to the overhead announcements coming through speakers.
 - ii) He gets easily agitated when bed alarms sound off.
- 5) He has lost 5 pounds since admission.

Hang the Question 1 and 2 flip chart pages so the audience can see and refer to them to answer the next set of questions.

Ask Questions 3-7

Questions 3–7 require the trainees to use the clues listed under Questions 1 and 2 to problem-solve. Using the clues, trainees brainstorm what changes need to be made to help Mr. McNally. Direct them to focus on person-centered care approaches or interventions.

Question 3: What changes in facility routine need to happen so Mr. McNally's personal routines can be restored?

Clues

- 1) Find ways to engage with him at night.
- 2) Let him sleep late in a.m.
- 3) Find and implement activities that Mr. McNally is interested in.
- 4) Make breakfast a big thing for him, regardless of time of day, and include bacon as appropriate.

- 5) Reduce overhead announcement or stop them all together if the announcements agitate him.
- 6) Possibly provide more supervision and check-ins from staff instead of a bed alarm if the alarm causes agitation.
- 7) Instead of increasing medications for agitation, find the source causing Mr. McNally's agitation.

Question 4: What changes in Mr. McNally's routine need to be made?

Clues

- 1) Bedtime: Allow him to stay up late.
- 2) No sleeping pills are needed: The sleeping pills are prescribed as needed (PRN) but Mr. McNally is a night owl.
- 3) Incident report on him for hitting the night aide: Staff need to respect Mr. McNally's right to stay up late.
- 4) Incident report on him for hitting the night aide: Staff need to plan and provide activities and other engagements for Mr. McNally.
- 5) Incident while giving him a suppository, hates briefs, needs incontinence checks at night: Provide more frequent and regular trips to the restroom.

Question 5: How can staff use Mr. McNally's strengths and interests to start a person-directed approach that may reverse his decline?

Clues

- 1) Record Red Sox baseball games and television shows about firefighters for him to watch late at night.
- 2) Ask the fire department if firefighters might take turns coming visit Mr. McNally occasionally to "talk shop."
- 3) Invite him to visit with staff while folding laundry or during other duties that might allow visiting.
- 4) Create the opportunity for him to garden and feed birds.
- 5) Provide an opportunity for him to help with breakfast that includes bacon.

Question 6: What additional information is needed?

Clues

- 1) Answers will vary.
- 2) Can the resident talk?
- 3) Can he make decisions or most decisions?
- 4) Are briefs being used for staff convenience?
- 5) Does a Catholic church provide services at the nursing home?
- 6) Can Mr. McNally stand on his own to walk or does he require the Hoyer to transfer?

Question 7: Who else needs to be involved in discussions about Mr. McNally's schedules and care?

Clues

- 1) Resident
- 2) Resident's daughter (if Mr. McNally requests her participation)
- 3) Dietary personnel
- 4) Activity director
- 5) Nurse in charge of his care
- 6) Night shift aide if they successfully work with resident

Print

Print The Mystery Game playing cards on Pages 49-62. Print two sided so the words "The Mystery Game and Clue" appear on the front of the card and the clue about Mr. McNally is printed on the back of the card. Cut the playing cards out. There are a total of 42 cards.

List of Clues

A complete list of clues from cards is found on Page 63.



The Mystery Game

Clue

The Mystery Game

Clue

The Mystery Game

Clue

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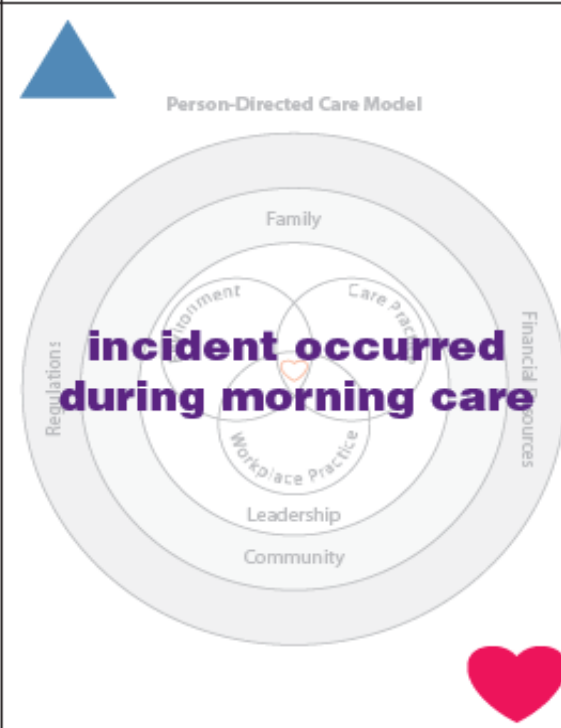
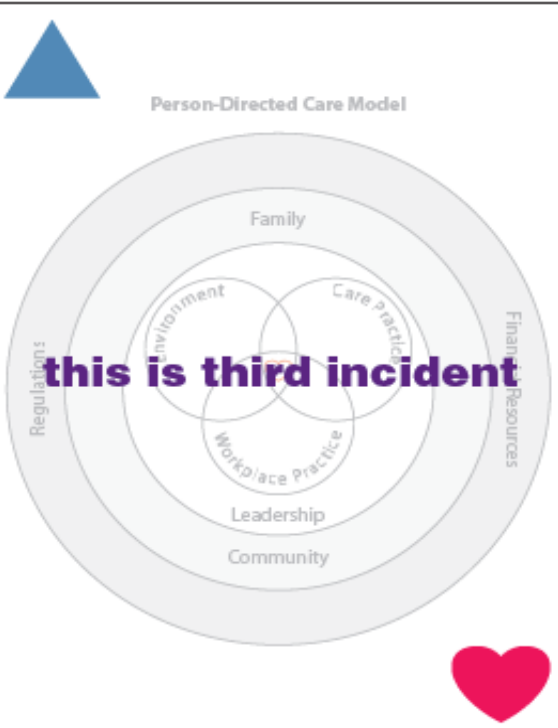
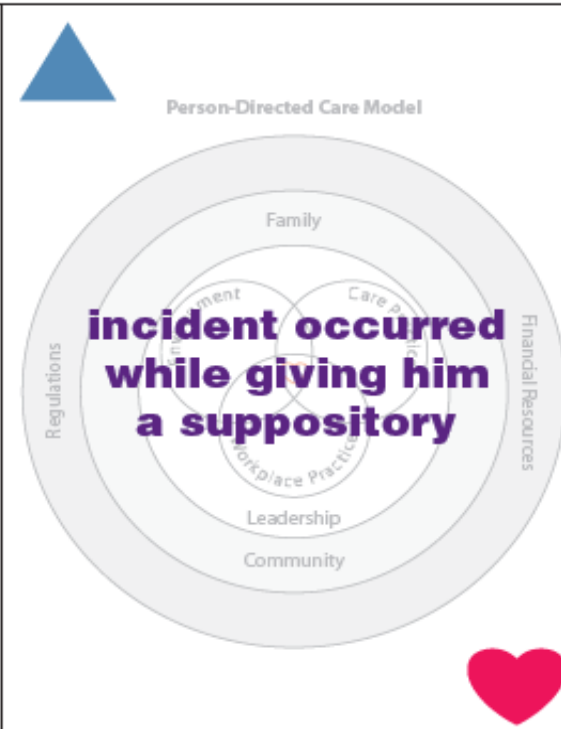
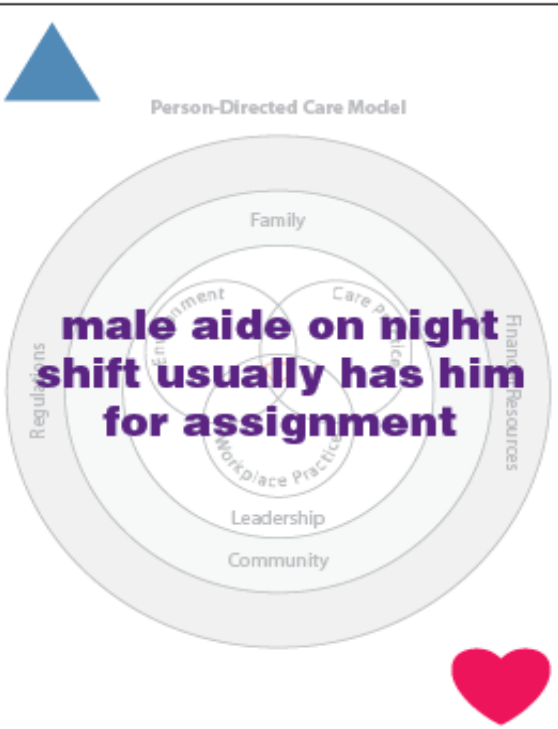
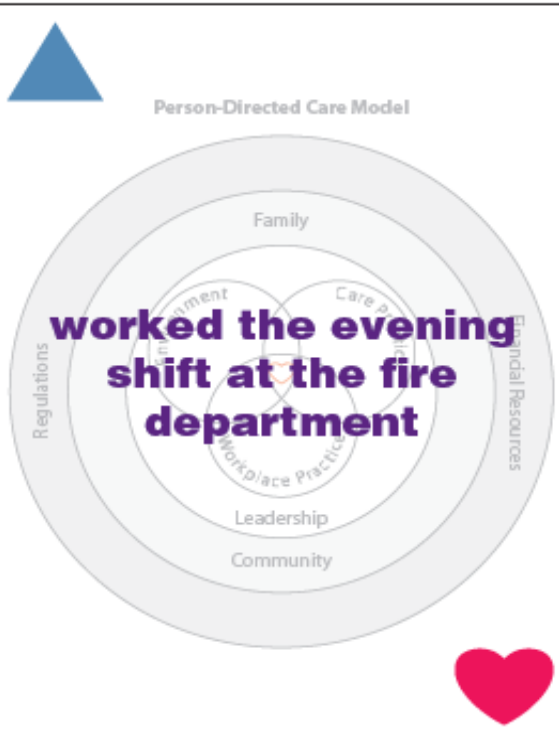
Clue

The Mystery Game

Clue

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The Mystery Game

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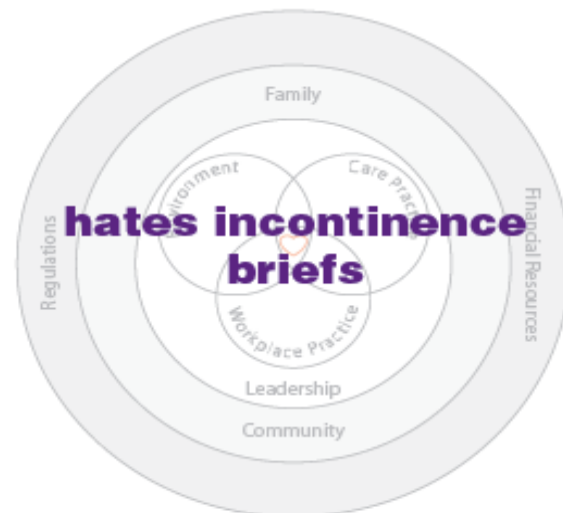
Person-Directed Care Model



Person-Directed Care Model



Person-Directed Care Model



Person-Directed Care Model



Person-Directed Care Model



Person-Directed Care Model



The Mystery Game

Clue

The Mystery Game

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The|Mystery Game

Clue

List of Clues from Activity Cards

- 1) Recommend increase meds for agitation.
- 2) Lost 5 pounds.
- 3) Talks back to the overhead announcements (pager system).
- 4) Used to love to make breakfast.
- 5) Was "very sweet" when he first moved into the facility.
- 6) He hums when he gardens.
- 7) He is Catholic.
- 8) Admitted through short term.
- 9) Fell his 2nd night in facility.
- 10) Sleeping pills are prescribed PRN (as needed).
- 11) He came to the facility two months ago (for short-term stay).
- 12) Has a few "choice" words in the morning.
- 13) He gets easily agitated.
- 14) Needs incontinence checks at night.
- 15) His daughter usually visits on the weekends.
- 16) Recovering from a broken hip.
- 17) Bed alarms (are in use).
- 18) He ambulates (walks) twice per day.
- 19) Worked the evening shift at the fire department.
- 20) Male aide on night shift is usually assigned to care for him.
- 21) Incident occurred while giving him a suppository.
- 22) Has Red Sox sticker in his shadow box.
- 23) This is his third incident.
- 24) Incident occurred during morning care.
- 25) His grandkids brought him a potted plant and it is doing well.

- 26) Sometimes the night maintenance person talks with him while doing the floors.
- 27) Hates incontinence briefs
- 28) Has lived alone a long time and developed his own ways.
- 29) Used to keep a bird feeder.
- 30) Incident occurred during bathing, while in a Hoyer lift.
- 31) Is a night owl.
- 32) Drove a hook and ladder truck for the fire department.
- 33) Wife was Shirley.
- 34) Wife died a while ago.
- 35) Has a picture of roses in a garden in his shadow box.
- 36) Used to love the smell of bacon cooking.
- 37) Incident report on him for hitting the night nurse.
- 38) Constipated.
- 39) Has a UTI (urinary tract infection).
- 40) Is taking meds for anxiety and agitation.
- 41) Can use the toilet by himself.
- 42) Widower for 12 years.



Resources

- 1) Calkins, M., Schoeneman, K., Brush, J., & Mayer, R. (2018, August). Preference Based Living. Honoring preferences when the choice involves risk: A process for shared decision making and care planning. Retrieved February 15, 2020, from <https://preferencebasedliving.com/sites/default/files/honoring-preferences-when-the-choice-involves-risk-8-2018.pdf>.
- 2) Centers for Medicare & Medicaid. (n.d.). CMS. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. Retrieved February 15, 2020, from

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

- 3) Federal Nursing Facility Regulations. ECFR. C.F.R. Title 42 Part 483 Requirements for States and Long-Term Care Facilities. Retrieved February 15, 2020, from https://ecfr.io/Title-42/cfr483_main.

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Video 5 – Medication Administration

Practice person-centered care by partnering with residents to make decisions about their care, including decisions about their medications.

Length of Video: 1 minute 51 seconds.

Link to Video: [Person-Centered Care – Medication Administration](#).



Key Messages

- Nursing home staff promote person-centered care by including residents in decisions about their medications.
- Residents have the right to be informed about their health, ask questions, change schedules, and refuse treatment.
- Instead of following rigid schedules, medication administration should follow residents' schedules, when approved by their physician.



Lesson Supplies

Video 5 – Medication Administration queued and ready to play using the YouTube link above.



Review Prior to Teaching

Staff can collaborate with physicians and nurses to change from standard medication times to upon arising, with meals or food, and at bedtime.

Self-Determination and Choice¹⁷

(a) *Residents' rights.* The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each

¹⁷ eCFR, 42 CFR §483.10(a) Resident rights and eCFR, 42 CFR §483.10(f)

resident's individuality. The facility must protect and promote the rights of the resident. [...]

(f) *Self-determination*. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.

(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part.

(2) The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.

Planning and Implementing Care¹⁸

(c) *Planning and implementing care*. 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. [...]

(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

The Eight Rights of Medication Administration¹⁹

"The eight rights of medication administration are intended to help reduce medication errors. These are the right:

- 1) Patient (use patient identifiers).
- 2) Medication (check the medication is the one ordered).
- 3) Dose (check the order is appropriate for the patient).
- 4) Route.

¹⁸ eCFR, 42 CFR §483.10(c)(1) and (6) Planning and implementing care.

¹⁹ Lisa Bonsall, MSN, RN, CRNP. May 2011. 8 rights of medication administration. Nursing Center Blog. Lippincott Nursing Center.

- 5) Time.
- 6) Documentation.
- 7) Reason.
- 8) Response.”

What is a resident driven medication pass?²⁰

A resident driven medication pass is a resident-centered program for medication management. It uses the following terminology: upon rising, with lunch, at bedtime, with meals.

- 1) It is flexible.
- 2) It expands the home-like environment.

Examples

- 1) Once daily dosing = Medication is given upon rising or at bedtime, as defined by the resident.
- 2) Three times daily = Upon rising, afternoon, and bedtime as defined by the resident.



Lesson

Teaching time: 5 minutes



Play Video

Video 5 – Medication Administration approximate run time 2 minutes.



Discussion Questions

Lead discussions about the following topics.

²⁰ Hardesty, J. PharmD, FASCP and Vaughan, W. BSN, RN. Presentation at PACAH Spring Conference. April 2016. Medication Management, Regulations and Resident Centered Care: What Could Possibly Go Wrong?

Privacy

Ask:

- 1) Why did Sara give Mr. Davis his medications in his room?
 - a) Privacy
 - b) Resident convenience
- 2) How did Sara prepare prior to taking Mr. Davis his medication?
 - a) She reviewed the purpose, dose, brand.
 - b) Sara realized the medication looked different because it is generic for the pills Mr. Davis usually received & was prepared to explain.

Right to Be Informed, Ask Questions, and Refuse Care

Ask:

- 1) What did Sara do when Mr. Davis asked questions about his medication?
Sara:
 - a) Honored Mr. Davis's right to refuse treatment.
 - b) Encouraged Mr. Davis to share his concern.
 - c) Listened to understand Mr. Davis's concern.
 - d) Fully informed Mr. Davis about his medication.
 - e) Informed a nurse that Mr. Davis prefers medication at another time so the nurse can talk to Mr. Davis's doctor.
- 2) Does Mr. Davis have the right to refuse care?
 - a) Yes. See 42 CFR §483.10(c)(6).
- 3) How do you manage situations where residents refuse care, medication, or other treatments?
 - a) Answers will vary.

Medication Administration Schedules

Ask:

- 1) Does Mr. Davis have the right to choose his medication schedule (resident driven medication pass)?

- a) Yes – Careful clinical review of Mr. Davis’s medication orders should be conducted to determine which, if any, medications are eligible for a resident driven medication pass.
- 2) Why should medication administration schedules follow residents’ schedules instead of rigid schedules set by a facility?
 - a) When living at home, many residents took many of their medications upon rising, at meals or with food, and at bedtime.
 - b) They are person centered and resident directed.



Resources

- 1) Alabama Nursing Home Association. (2015, August 17). Alabama Nursing Home Association. *A Person-Centered Approach to Medication*. Retrieved November 15, 2019, from <https://anha.org/a-person-centered-approach-to-medication/>.
- 2) Bonsall, L. (2017, May 11). Nursing Center Blog. *8 rights of medication administration*. Retrieved February 15, 2020, from <https://www.nursingcenter.com/ncblog/may-2011/8-rights-of-medication-administration>.
- 3) Federal Nursing Facility Regulations. eCFR - Title 42 - Part 483 - Requirements for States and Long Term Care Facilities, from
- 4) https://ecfr.io/Title-42/cfr483_main, Hardesty, J., & Vaughn, W. (2016, April 29). PACAH Spring Conference 2016. *Medication Management, Regulations and Resident Centered Care: What Could Possibly Go Wrong?* Retrieved November 15, 2019, from <http://www.pacahpa.org/Pages/default.aspx>. Misiorski, S., & Rader, J. (n.d.). Pioneer Network. *Medication Administration*. Retrieved November 15, 2019, Artifacts of Culture Change.

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Video 6 – Health Care Schedules

Practice person-centered care by partnering with residents to plan their schedules. By adapting schedules to residents' wants and needs, staff will improve residents' quality of life.

Length of Video: 1 minutes 27 seconds

Link to Video: [Person-Centered Care: Health Care Schedules](#)



Key Messages

- Long-term care staff can practice person-centered care by collaborating with residents to plan their schedules.
- By adapting healthcare schedules to a person's wants and needs, staff will improve a resident's quality of life.



Lesson Supplies

Video 6 – Health Care Schedules queued and ready to play using the YouTube link above.

See the Optional Activity that starts on Page 77 for additional supplies required.



Review Prior to Teaching

Definition of Person-Centered Care²¹

Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

²¹ eCFR 42 CFR §483.5 Definitions.

Residents' Rights, Preferences, Self-determination, Choice, and Decision-Making²²

(a) *Residents rights.* The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. [...]

(f) *Self-determination.* The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.

(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part.

(2) The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. [...]



Lesson

Teaching time: 5 minutes



Play Video

Video 6 – Health Care Schedules approximate run time is 1½ minutes.

²² eCFR 42 CFR §483.10(a)(1) and (f)(1) and (2) Resident rights and Self-determination.



Discussion Questions

Lead discussions about the following topics.

Problem Solving

Ask:

- 1) What problem did Sara identify when she went to get Ms. Durham for her scheduled shower?
 - a) Ms. Durham was still sleeping.
- 2) What did Sara decide to do?
 - a) She decided to let Ms. Durham sleep.
- 3) Why did Sara decide to let Ms. Durham sleep?
 - a) When Sara noticed that when she wakes Ms. Durham up in the morning for her shower, Ms. Durham falls asleep during the day.

Planning Care

Ask:

- 1) What happened at Ms. Durham's next care plan meeting?
 - a) Ms. Durham attended her care plan.
 - b) Sara attended Ms. Durham's care plan.
 - c) Staff talked with Ms. Durham about her schedule.
 - d) Staff honored Ms. Durham's choice for staff to not wake her on her shower days.
 - e) The team agreed to let Ms. Durham call staff when she wants to shower.
- 2) How does adapting residents' schedules and care plans to their wants or needs improve residents' lives?
 - a) It puts residents at the center of decision making.
 - b) It aligns with regulations related to residents' rights.
 - c) It increases trust between staff and residents.
 - d) It shows residents that staff support their decisions.
 - e) It creates a more home-like atmosphere.

3) If residents tell you they want to change or adapt an existing schedule, what do you do to make that happen?

a) Answers will vary.

4) Follow-up: Can you give me an example?

Optional Activity for Video 6 – What Is Important to Me

Objective: Understand how important routines and schedules are for residents and why it is important to involve them in planning their care.

Teaching Time: 10-15 minutes.

Number of players: 2 to 30 players.

- A volunteer from the audience or a 2nd instructor is needed to take notes on #4 and #6 in this activity.



Supplies

- Flipchart
- Marker
- Mobile phone with stopwatch or timer



Preparation

Read the facilitation questions prior to conducting the activity.



Instructions

Ask for a volunteer to take notes on the flipchart.

Say:

Find a partner, preferably someone sitting next to you.

You each have 30 seconds each to tell your partner about the most important parts of your morning routine. These are the things you do day after day. For example, I feed my cat, make a cup of coffee, watch the news headlines, shower, dress, and leave for work. You have a total of 1 minute.

Ask:

What happens when your routine is interrupted, and you cannot do things the way you usually do them?

Say:

Each of us has our own routine in the morning. We are all different. But what we have in common is how we feel when we do not get to have our morning routine.

Say:

Get back with your partner. Tell your partner some ways that you accommodate a resident's morning routine. You have 30 seconds each (total time is 1 minute).

Ask:

Will someone please share with the group how you accommodate a residents' morning routine?

**Resources**

- 1) Abbott, K., & Van Haitsma, K. (2017, November 11). Preference Based Living. PELI Tip 5 Ensuring Resident Choice. Retrieved February 15, 2020, from, <https://www.preferencebasedliving.com/about-us/>.
- 2) Bump, L. (2016, September 06). Pioneer Network. The Kitchen: The Heart of the Home. Retrieved October 15, 2019, from, <https://www.pioneernetwork.net/kitchen-heart-home/>.
- 3) Federal Nursing Home Regulations. eCFR - Title 42 - Part 483 - Requirements for States and Long Term Care Facilities, from, https://ecfr.io/Title-42/cfr483_main.
- 4) Pioneer Network Resources. Frank, B. (2016, October). Pioneer Network. Tip Sheet Individualizing Nighttime Routines. Retrieved September 15, 2019, from, <https://ptnnow.com/>.

Video 7 – Personalized Music for Dementia Care

Improve the well-being of residents with dementia by adding music as a part of their care.

Length of Video: 1 minute 30 seconds.

Link to Video: [Person-Centered Care: Personalized Music For Dementia Care](#)



Key Messages

- Using personalized music in a resident's care improves their well-being.
- Family members participate in creating a resident's personalized playlist.
- Residents' music is integrated into their care plans.



Lesson Supplies

Video 7 – Personalized Music for Dementia Care queued and ready to play using the YouTube link above.



Review Prior to Teaching

Resident Communication

Elizabeth Long, DNP, APRRN, GNPC, states that agitation in residents with dementia may be exhibited “as demands for attention, pacing, wandering, going through other patients’ things, and/or refusal to participate in activities.”²³

²³ Long, M. The Effect of a Personalized Music Playlist on a Patient With Dementia and Evening Agitation. November 2016. *Annals of Long-Term Care: Clinical Care and Aging*. 2016;24(11):31-33.

According to research, music can reduce stress, anxiety, agitation, and improve the mood of individuals with Alzheimer's.²⁴

Music helps residents reconnect with the world through specific, music triggered memories.

Dan Cohen founded Music & Memory. Cohen believes a residents' favorite music taps into memories not lost to dementia.

"Alive Inside" is a documentary about Dan Cohen's work. Find clips from "Alive Inside" on YouTube which demonstrate the impact a personalized music playlist can have on someone with dementia. "Alive Inside" may be viewed at this link: <https://www.youtube.com/watch?v=fyZQf0p73QM>.

Resident Quality of Life²⁵

Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section, [...]

(c) *Activities.*

(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the

²⁴ Graff-Radford, M.D., J. Can music help someone with Alzheimer's? Mayo Clinic.

²⁵ eCFR. 42 C.F.R. §483.24(a)(1) and (c)(1).

interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. [...]

Excerpts from SOM Appendix PP²⁶

42 C.F.R. § 483.24 Quality of life - F675

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

INTENT

“The intent of this requirement is to specify the facility’s responsibility to create and sustain an environment that humanizes and individualizes each resident’s quality of life by:

- Ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and
- Ensuring that the care and services provided are person-centered, and honor and support each resident’s preferences, choices, values, and beliefs.”

DEFINITIONS §483.24

“Quality of Life” An individual’s “sense of well-being, level of satisfaction with life and feeling of self-worth and self-esteem. For nursing home residents, this includes a basic sense of satisfaction with oneself, the environment, the care received, the accomplishments of desired goals, and control over one’s life.”

42 C.F.R. §483.24(c) Activities - F679

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

INTENT §483.24(c)

To ensure that facilities implement an ongoing resident centered activities program that incorporates the resident’s interests, hobbies and cultural

²⁶ Centers for Medicaid & Medicare Services, State Operations Manual, Appendix PP – Guidance to Surveyors for Long-Term Care Facilities. Rev. 173, 11-22-17.

preferences which is integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence. To create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning).

DEFINITIONS §483.24(c)

"Activities" refer to any endeavor, other than routine ADLs, in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence.

NOTE: ADL-related activities, such as manicures/pedicures, hair styling, and makeovers, may be considered part of the activities program.

GUIDANCE §483.24(c)

Activity Approaches for Residents with Dementia

All residents have a need for engagement in meaningful activities. For residents with dementia, the lack of engaging activities can cause boredom, loneliness and frustration, resulting in distress and agitation. Activities must be individualized and customized based on the resident's previous lifestyle (occupation, family, hobbies), preferences and comforts.

Resident Quality of Care²⁷

"Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, [...]"



Lesson

Teaching time: 5 minutes

²⁷ eCFR. 42 C.F.R. §483.25.



Play Video

Video 7 – Personalized Music for Dementia Care run time is 1½ minutes.



Discussion Questions

Lead a discussion about the following topic.

Use Personalized Music with Residents

- 1) What did Sara do when she approached Mr. Davis with his headphones?
Sara:
 - a) Approached from the front.
 - b) Made eye contact.
 - c) Smiled.
 - d) Offered Mr. Davis music.
 - e) Showed the headphones to Mr. Davis.
- 2) Why did Sara suggest using personalized music with Mr. Davis?
 - a) Mr. Davis wanted to watch TV instead of other more active activities.
 - b) Mr. Davis was reluctant to walk.
 - c) Sara used music to help Mr. Davis feel more motivated to move.
- 3) Who should create Mr. Davis's music playlist?
 - a) Mr. Davis and Mr. Davis's family and friends who know what music he likes should create his playlist.
- 4) What did Sara recommend at Mr. Davis's next care plan meeting?
 - a) She recommended using music more often with Mr. Davis.
- 5) What does research suggest are the benefits of using music with residents with dementia?
 - a) Music may improve a resident's:
 - b) Emotions.
 - c) Ability to recall memories.
 - d) Mental performance.

- e) Well-being.
 - f) Music may reduce anxiety and agitation.
- 6) What have you done to encourage a resident to go to therapy or attend an activity?
- a) Answers will vary.



Resources

- 1) Centers for Medicare & Medicaid. (n.d.). CMS. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. Retrieved February 15, 2020, from, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf
- 2) Devine, J. (2019, June 12). Person-Centered Care: The Not So Secret Ingredient in Your Next Performance Improvement Plan. Pioneer Network Resource Library. Retrieved February 1, 2020, from, <https://www.pioneernetwork.net/person-centered-care-the-not-so-secret-ingredient-in-your-next-performance-improvement-plan/>.
- 3) Federal Nursing Home Regulations. eCFR - Title 42 - Part 483 - Requirements for States and Long Term Care Facilities https://ecfr.io/Title-42/cfr483_main.
- 4) Graff-Radford, J. M.D. (2019, April). Can music help someone with Alzheimer's? Mayo Clinic. Retrieved January 15, 2020, from, <https://www.mayoclinic.org/diseases-conditions/alzheimers-disease/expert-answer/music-and-alzheimer/faq-20058173>.
- 5) Harvey, A. (2018, May 27). Your brain on music. *Ted Talk TEDxPerth*. Retrieved February 15, 2020, from, <https://www.bing.com/videos/search?q=Ted+Talk+%2b+Music+and+the+brain&view=detail&mid=0AC8A9EC13DF72E0C9140AC8A9EC13DF72E0C914&FORM=VIRE>.
- 6) King, J., Goldberg, E., Rollins, M., Moffit, C., Naidu, S., Ferguson, M., Garcia-Leavitt, E., Amaro, J., Breitenbach, K., Watson, J., Gurgel, R., Anderson, J., & Foster, N. (2018). Increased Functional Connectivity After Listening to Favored Music in Adults With Alzheimer Dementia. *J Prev Alzheimers Dis*, 6(1), 56-62. doi:10.14283/jpad.2018.19. Retrieved February 15, 2020, from, <https://pubmed.ncbi.nlm.nih.gov/30569087/>.

- 7) Long, E. (November 2016). The Effect of a Personalized Music Playlist on a Patient With Dementia and Evening Agitation. *Annals of Long-Term Care: Clinical Care and Aging*, 24(11), 31-33. Retrieved February 15, 2020, from, <https://www.managedhealthcareconnect.com/article/effect-personalized-music-playlist-patient-dementia-and-evening-agitation>.
- 8) Music and Memory Current Research. Retrieved February 15, 2020, from, <https://musicandmemory.org/music-brain-resources/current-research/>.

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Answers: Pre-Test / Post-Test

Choose the best answer for each question below.

- e 1. Who is the primary decision maker for planning a resident's care?
- (a) Social worker
 - (b) DON
 - (c) Resident's representative
 - (d) Certified Nurse Aide
 - (e) Resident
- a-e 2. Choose all that apply. Which of the following people may residents invite to attend their care plan meeting?
- (a) Housekeeper
 - (b) Certified nurse aide
 - (c) Physician
 - (d) Ombudsman
 - (e) Family member or friend
- b 3. Which of the following statements is an example of person-centered language?
- (a) Mr. Davis suffers from dementia.
 - (b) Mr. Davis has a diagnosis of dementia.
 - (c) Mr. Davis is confused.
 - (d) Mr. Davis is a walkie talkie.
 - (e) None of the above
- a-d 4. Choose all that apply. Walking rounds:
- (a) Utilize the SBAR method.
 - (b) Are a tool for improving shift handoff communication.
 - (c) Take the meeting to the resident.
 - (d) Keep residents more involved in their care.
 - (e) Take a resident on a walk with you around the building.

- e 5. For music to be most effective, who should create music playlists for residents with dementia?
- (a) Certified nurse aide
 - (b) Social worker
 - (c) Resident
 - (d) Resident's family
 - (e) c and d
- d 6. Fill in the blank. Nursing facilities are considered to practice consistent staffing assignments when at least _____% of staff shift assignments are caring for the same residents.
- (a) 25%
 - (b) 50%
 - (c) 75%
 - (d) 85%
 - (e) 95%

Answer True (T) or False (F)

- T 7. Staff at nursing homes should work with residents to plan their schedules.
- T 8. Nursing home staff should partner with a resident to make decisions about the resident's care.
- T 9. Residents have the right to participate in planning their care, to ask questions, to be fully informed, and to refuse treatment.
- F 10. Residents should not be included in decisions about their medications.

For more information, call

800-252-2412

or email

ltc.ombudsman@hhs.texas.gov



**State Long-Term Care
Ombudsman Program**

*Long-term care ombudsmen advocate for
residents and are separate from HHS.*