QUALITY-OF-LIFE ASSESSMENT

TRAINING MODULE

Prepared by
The Anna and Harry Borun Center for
Gerontological Research,
a joint program of the
UCLA Medical Center and
the Jewish Home for the Aging
of Greater Los Angeles

ABOUT THE BORUN CENTER

This training manual presents the work of researchers at the Anna and Harry Borun Center for Gerontological Research, a joint venture between the UCLA School of Medicine and the Jewish Home for the Aging (JHA) of Greater Los Angeles in Reseda.

Established in 1989 and housed at JHA, the Borun Center is an interdisciplinary center for applied research that focuses on creating, testing, and promoting the adoption of behavioral interventions to improve daily care and quality of life in nursing homes. The Center's mission encompasses three objectives:

- Identify factors that affect the quality of life of frail nursing home residents.
- Develop and test interventions to improve life quality for this population.
- Disseminate these interventions via a website, http://borun.medsch.ucla.edu, as well as through publications, conferences, and collaboration, and ensure their adoption by providing a system of training and expert support.

The Center's work, designed to help nursing homes make the most of the resources they have on hand to enhance patient care and improve clinical outcomes, is exceptional for several reasons:

- The Center's interventions address everyday nursing home routines that profoundly impact quality of life for residents, including incontinence management, weight loss prevention, pain assessment, mobility decline prevention, quality-of-life assessment, and pressure ulcer prevention.
- Center interventions in each of these areas have proven effective in research trials, and most were evaluated in randomized controlled trials, the gold standard for research studies.
- The Center's work has yielded validated, reliable protocols that serve as easy-to-follow step-by-step instructions for implementing resident assessments and daily care interventions. These self-explanatory protocols enable nursing home staff to readily implement the assessments and interventions with minimal need for outside assistance.
- The Center also has developed quality control protocols for managing interventions and ensuring quality of care over time.

To the best of our knowledge, no other research center in the nation can lay claim to a body of work of comparable breadth, depth, and quality.

Under the direction of John F. Schnelle, Ph.D., Borun Center researchers have won wide acclaim for their non-invasive, cost-conscious, and effective methods for enhancing nursing home management and improving quality of life for frail residents. Their work has been funded by 18 grants from the highly selective National Institutes of Health and reported in more than 160 publications in professional books and journals. Ω

-- Summer 2004

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INTRODUCTION

ABOUT THIS TRAINING MODULE

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

- identifying nursing home care processes that need improvement, and
- designing and evaluating quality improvement interventions.

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

The next two sections describe procedures for conducting quality assessment interviews with residents:

- *Fundamentals for a New Assessment Strategy* and
- Our *Interview Protocol*

In our Forms section, we included a resource bank of assessment questions that we have used and evaluated in our research. Please feel free to adopt or adapt these ready-made questions for use in your quality improvement efforts.

Plan on spending about 20 minutes to read through this "how to" portion of module.

Elsewhere in this module—Links, FAQs, Related Studies—we provide guidance and referrals to other resources that can help you assess quality of life among your residents. And via our discussion board you can chat with other healthcare providers about the topic. Visit us at:

http://borun.medsch.ucla.edu

CONTACT US

We've tried to be comprehensive, but if there is something you can't find, or if you have unanswered questions, comments, or concerns, please feel free to contact us at the Borun Center, 7150 Tampa Ave., Reseda, CA 91335. Telephone: (818) 774-3347; Fax: (818) 774-3346; Email: rahmananna@yahoo.com. Ω

LEARNING OBJECTIVES

LEARNING OBJECTIVES

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

- Identify two mistakes commonly made when assessing quality of life (QOL) in nursing homes.

- Assess the ability of nursing home residents to answer questions about their daily care.

- Demonstrate knowledge of the pros and cons of each of these QOL assessment questions: direct satisfaction questions, discrepancy questions, open-ended questions.

- Construct discrepancy and open-ended questions that assess QOL among nursing home residents.

- Describe at least three conditions that should be met when interviewing nursing home residents about their quality of life. Ω

QUALITY-OF-LIFE ASSESSMENT

Learn how to design a quality-of-life assessment strategy that produces useful information for: 1) identifying nursing home care processes that need improvement, and 2) designing and evaluating quality improvement interventions.

ASSESS FOR PR VALUE OR QUALITY IMPROVEMENT?

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

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

REASONS TO IMPROVE IMPROVEMENT EFFORTS

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

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

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

FUNDAMENTALS FOR A NEW ASSESSMENT STRATEGY

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

A COMMON CONSUMER SURVEY

Every year Nursing Facility A sends questionnaires to its residents' family representatives, asking them to respond, on behalf of their loved ones, to a series of satisfaction questions: How satisfied is your resident with the food here? With the social activities offered? With the staff? With the care they receive? The responses received back are stunning: Almost everyone—at least eight of ten respondents—reports high levels of satisfaction with each and every item on the questionnaire.

Sound too good to be true? It probably is, especially considering that facility A, like an estimated 90% of all nursing homes in the nation, has too few workers to provide proper care to residents.

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

RULE #1: RESIDENTS BEFORE THEIR REPS

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

significant others to assess quality of care is both more time-efficient and reliable than asking the residents themselves to do it. Presumably healthy (or healthier) and cognitively intact, family members can capably respond to a mailed questionnaire (no need to interview them in person) with meaningful answers.

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

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

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

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

Our research shows similar results. In two studies, we set out to identify a simple cognitive screen that would accurately identify residents capable of providing meaningful responses to quality assessment questions (4, 5). Both studies showed that residents who score two or more on the Minimum Data Set Recall subscale (see page 43) can accurately describe the care they receive. Our more recent research shows even more encouraging results: About half of residents who score 1 or higher on the MDS Recall subscale can reliably self-report pain and symptoms of depression, express meaningful preferences for daily care (they can tell you, for example, what activities they like or where they would like to have their breakfast), and accurately describe care they receive on a daily basis (they can recall, for example, if staff helped them to the bathroom or provided walking assistance that day).

THE "GOLD STANDARD"

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

In addition, there's a side benefit to interviewing residents. Writes Kane et al. (3), "The very act of asking resident directly about their (quality of life) could engage staff directly and systematically with residents' opinions about

their daily existence in a way that seldom occurs in a typical (nursing facility). Such a process militates against the tendency to depersonalize residents, and to view them merely as care recipients rather than people who live out their lives in difficult circumstances (pg. 247)."

The implications for nursing home care providers are inescapable: If you want to evaluate consumer satisfaction, quality of life, quality of care, call it what you will, then you must capture the voices of residents, including cognitively impaired residents, in your assessment. Surveying family members is an acceptable practice; they are important stakeholders in long-term care. But don't canvass them at the cost of excluding their loved ones. Our Interview Protocol (see page 14) presents guidelines for selecting residents for assessment interviews.

RULE #2: QUESTION THE QUESTIONS

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

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

Any questionnaire can inadvertently elicit an acquiescence bias among respondents, but consumer satisfaction surveys conducted with nursing home residents are especially likely to do this for several reasons. Older adults, and

women in particular, tend to report higher rates of satisfaction with health care services; thus, there is a good chance that extremely old and frail nursing home residents, who are predominantly female, will report high rates of satisfaction with substandard or inadequate care. In addition, many residents over time in the facility lower their expectations for care. Their experience teaches them to expect and accept poor quality of care. The fact that residents also are dependent on staff for daily care and many are isolated from family and friends can only decrease their willingness to express dissatisfaction with care due to fear of reprisal.

In order to collect data useful for quality improvement, your assessment questions must reveal both your facility's strengths and weaknesses. You will not be able to identify areas that need improvement if resident responses to all or most of your questions cluster at the "highly satisfied" end of the scale, as responses to direct, forced-choice questions about satisfaction tend to do (6,7). You need, therefore, to ask questions that are more sensitive to differences in satisfaction levels.

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

FOUR TYPES OF QUESTIONS...

What are good alternatives to direct satisfaction questions? In two studies, we evaluated various interview strategies to identify questions that both tempered acquiescence response tendencies among residents and provided information useful for improving care (6, 8). We asked residents these four types of questions:

- Direct satisfaction questions about Activities of Daily Living (ADL) care (e.g., "Overall, are you satisfied with how often someone helps you to walk?")

- Discrepancy questions that compared residents' preferences for ADL care frequency to their perceptions of the ADL care actually delivered (e.g., "How many times during the day would you like staff to help you walk?" vs. "How many times during the day do staff help you to walk?")

- A second type of discrepancy question that compared residents' preferences for ADL care frequency to how often they actually received care based on our research staff's observations

- Open-ended questions that asked what residents wanted changed about ADL care.

...YIELD MIXED RESULTS...

Answers to our questions about walking assistance (7) are typical of the responses we received in other ADL care areas:

- When asked the direct satisfaction question, "Overall, are you satisfied with how often someone helps you to walk?" 80% of 111 residents interviewed said "yes," a finding that suggests the facility

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

is meeting the vast majority of residents' needs in this area.

- Responses to the discrepancy questions suggest otherwise, however. Overall, 81% of the respondents reported a preference for more walking assistance than was provided by staff. Specifically, their reported preferences showed that they wanted an average of two more walk assists per day than staff were actually providing to them.

- Open-ended comments spontaneously provided by residents revealed a desire for change in aspects of care other than the frequency of assistance. One resident told us, for example, that she "would like to have somewhere important to go [when walking], as opposed to just walking down the hall."

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

...BUT ANALYSES SHOW THAT SOME QUESTIONS TOP OTHERS

What do we make of these results? Satisfaction with care is subjective; so when a resident tells us that overall, she is satisfied with the amount of walking assistance she receives but would like more of it, we are obliged to accept both statements. (And no, our analyses show that this response pattern is *not* related to a resident's cognitive status.) That said, given our goal of collecting information useful for improvement efforts and given what we know of acquiescence, reduced expectations, and fear of reprisals

among nursing home residents, it is appropriate to question the questions. How effective is each type? Findings from our studies show the following (6,7):

- The proportion of residents reporting unmet needs for ADL care are significantly higher with the discrepancy and open-ended questions compared to the direct satisfaction questions. This suggests that the former questions are more sensitive to differences in satisfaction levels and that the latter questions are more limited by acquiescent response biases.

- Open-ended questions produce the most useful information for individualizing aspects of technical care and assessing the interpersonal quality of care.

- Discrepancy questions elicit specific information useful for changing the frequency or occurrence of ADL care; and, these questions are most sensitive to care quality improvements.

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

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

In the next section, we present a quality-of-life assessment protocol that takes into account these findings as well as the mandate, born of research, not regulations, to interview residents as the best

reporters of their quality of life. You can use this protocol to develop and implement an effective assessment strategy for your facility.

YOUR ASSIGNMENT

- Pick an ADL care area—incontinence management, walking assistance, feeding assistance, to name a few—in need of improvement in your facility.

- Develop a discrepancy question set that assesses residents' preferences for care in this area. One question, for example, might ask how often the resident receives care in this area. The companion question would then ask how often the resident would *like* to receive care in this area. For examples, see our quality-of-life assessment forms at the back of this module.

- You can score such questions by subtracting the second answer from the first. For example, if a resident says he receives a shower 3 times per week but prefers a shower 5 times per week, then the discrepancy score is -2 (i.e., 3-5 = -2). The negative difference signals unmet needs.

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

Share your results with us. Please contact us via our website, http://borun.medsch.ucla.edu/. We will report your feedback in updates to this site.

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QUALITY-OF-LIFE ASSESSMENT: INTERVIEW PROTOCOL

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

In this section we present a protocol for conducting quality-of-life assessment interviews with nursing home residents that not only elicits information useful for improvement efforts but also is feasible to implement given the time- and cost-constraints in most facilities.

Based on research we conducted over the past eight years, the protocol provides instruction on how to design and implement an assessment strategy that aims to achieve either or both of two goals:

- identifies nursing home care processes in need of improvement
- yields information useful for designing and evaluating improvement interventions

In keeping with a fundamental tenet of quality improvement, it recognizes resident self-reports as the gold standard for assessing quality of life and satisfaction with care.

PROTOCOL PURPOSE

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

--John F. Schnelle (1)

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

WHEN SHOULD QUALITY IMPROVEMENT INTERVIEWS WITH RESIDENTS BE CONDUCTED?

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

- At admission, when you are required to assess, as part of the Minimum Data Set (MDS), a new resident's care preferences, and again two weeks later, during the mandated reassessment for new residents. If completing the MDS plus a quality improvement (QI) interview takes too long for one sitting, then schedule the QI interview for the next day or as close to the MDS as

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

possible. Tying your quality care assessment to the MDS will help ensure that it is completed in a time-efficient manner.

- Just before an improvement intervention or a change in care practice is implemented, and then again after sufficient time has passed for residents to have registered the change in routine. You need interview only those residents who are the target of your improvement effort. You can compare findings from the before and after assessments to determine whether your intervention or change in practice is making a positive difference in the lives of residents.

WHO SHOULD BE INTERVIEWED?

As a general rule, you should interview residents who score 2 or more on the Minimum Data Set (MDS) Recall subscale (see page 43). Our research shows that these residents consistently provide reliable information useful for quality improvement efforts (2, 3). Ideally, the four MDS items that comprise the Recall subscale should be completed by nursing home staff who are most familiar with the resident, as opposed to relying on recent MDS assessment data, which may be as much as three months old at any point in time.

If your questions ask about services or care processes that occur *daily*, as opposed to less frequently, then you should also interview

residents who score 1 (or more) on the MDS Recall subscale. Our research shows that the majority of these residents can reliably self-report pain and depression, express meaningful preferences for daily care (they can tell you, for example, what activities they like or what food they want for breakfast), and accurately describe care they receive on a daily basis (they can recall, for example, if someone on the staff helped them to the bathroom or to walk that day).

If you are assessing quality of care for a specific activity of daily living (ADL), interview residents (with appropriate MDS Recall subscores) who require any level of staff assistance (supervision to total dependence) for that ADL. You can use MDS ADL ratings (see page 44) to identify appropriate interview candidates.

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

WHO SHOULD CONDUCT THE INTERVIEWS?

Interviews should always be conducted in-person with residents. This enables a range of cognitively and physically impaired residents to

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

participate. In-person interviews also provide an opportunity to clarify questions, which can lead to more accurate responses.

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

WHERE SHOULD INTERVIEWS BE CONDUCTED?

Interview each resident in a private room to ensure confidentiality. The room should be quiet so that the resident is not distracted and can hear you more easily.

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

Determine whether the resident you are about to interview needs a hearing device and if so, whether the device is available. When we conduct interviews, we arrive prepared to offer residents the use of amplifying earphones (available from most electronic stores).

Also, find out whether the resident has any particular needs (e.g., has difficulty speaking) or personality characteristics that might affect participation in the interview (e.g., is shy or withdrawn). Find out about the resident's background and current family situation. Then use this information to approach him or her.

HOW SHOULD INTERVIEWS BE CONDUCTED?

Introduce yourself and spend a few minutes establishing rapport with each resident. Develop rapport by finding a way to connect with the

resident based on his or her background information. For example, you might open with: "I hear that you lived in Berkeley. I also used to live in the Bay Area…"

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

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

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

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

WHAT QUESTIONS ARE MOST USEFUL FOR QUALITY IMPROVEMENT PURPOSES?

You can develop interview questions that specifically address the care areas and aspects of

quality of life that are the focus of your facility's improvement efforts. In general, interview questions should:

- Require a simple yes/no response.

- Be direct, short, and concrete.

- Focus on daily occurrences, because these are most recent and tangible in the resident's memory. Ideally, questions should be posed shortly after the occurrence of the care or other activity in question.

- Should include discrepancy questions that compare residents' preferences for care to their perceptions of the care they actually receive (e.g., "How many times during the day would you like the staff to help you to the bathroom?" vs. "How many times during the day do the staff help you to the bathroom?"). You can score such questions by subtracting the second answer from the first. For example, if a resident says he is provided toileting assistance once a day but he prefers to receive assistance three times a day, then the discrepancy score is -2 (i.e., 1- 3 = -2). The negative difference signals unmet needs. Although discrepancy questions are most appropriate for evaluating care frequency preferences, they can also be used to evaluate other aspects of care, such as dining location ("Where do you like to have breakfast? vs. "Where do you have breakfast?"), or timeliness of care (e.g., "What time do staff help you out of bed in the morning?" vs. "What time would you like for staff to help you out of bed in the morning?").

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

would it be?").

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

- Toileting assistance (page 38)
- Walking assistance (page 39)
- Dressing and personal hygiene assistance (page 40)
- Getting in and out of bed (page 41)
- Social activity participation (page 42)

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

WHAT TYPES OF QUESTIONS SHOULD BE AVOIDED?

Avoid using these types of questions:

- Direct satisfaction questions (e.g., "Are you satisfied with the nursing care?"). They are not very informative from a quality improvement standpoint and tend to elicit an acquiescent response bias among residents.

- Questions that use abstract constructs, such as "Do the staff provide your care with dignity and respect?" A better way to assess "dignity and respect" within care delivery is to ask about concrete staff behaviors, such as: "Do the people who work here:
    - knock on your door before entering the room?"
    - pull your curtain before helping you to get dressed?"
    - address you by name when they see you?"
    - tell you when they will be back to check on you again?"

- Questions that require residents to rate their satisfaction along any type of rating scale (e.g., a three- or five-point scale or along a scale with responses such as, very satisfied, moderately satisfied, unsure, moderately dissatisfied, very dissatisfied). Many residents are simply unable to use these complex multiple-point scales.

- Questions that require residents to remember details about infrequent events (e.g., a monthly visit from a primary care physician that occurred several weeks prior to the interview).

HOW DO I ANALYZE RESPONSES?

For many, perhaps most, interview questions it is sufficient to simply calculate the frequency of the various responses to each question: What percentage of the residents interviewed responded "yes" to the question? What percentage responded "no"?

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

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

Responses to some questions require special handling:

- *Discrepancy questions*: As noted earlier, these come in sets of two and compare residents' preferences for care to their perceptions of the care they actually receive. If, for example, the first question asks, "How many times during

the day would you like the staff to help you to the bathroom?" then its companion question will ask, "How many times during the day do the staff help you to the bathroom?" To make full use of these questions, you should calculate a "discrepancy score" for each individual by subtracting the second answer from the first. For example, if a resident says he receives toileting assistance once a day but he prefers toileting assistance three times a day, then the discrepancy score is -2 (i.e., 1-3 = -2). The negative difference signals unmet needs. You can use the discrepancy scores for all residents interviewed to calculate an overall average discrepancy score.

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

The method follows three steps:

1. Ask whether each comment indicates a desire for change, that is, for something other than the status quo (e.g., "I would like to walk more often"). Code as yes or no.

2. If a change is desired, then ask whether interaction with staff is needed to bring about the change (e.g., "I would like more encouragement to walk"). Code as yes or no.

3. If interaction with staff is required, then ask whether the comment refers to the manner of care delivery (e.g., "When they dress you they are rough, not kind."). Also ask whether it refers to technical aspects of care, such as frequency or timeliness (e.g., "I would like a shower every day"). Code as either one or the other (manner of care vs. technical care) or both.

HOW DO WE INTREPRET OUR FINDINGS?

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

Bear in mind that you are collecting two types of data: 1) individual data, or the responses from each person who answers your questions, and 2) group data, as represented by the statistical picture you derive from analyzing all responses. Conclusions drawn from the individual data may be very different from conclusions drawn from group data. Moreover, one data type may be more useful than the other type in guiding your improvement efforts.

Consider your goals: If, for example, you want to offer social activities that most residents will enjoy, then examine resident responses as a group. In this case, it is appropriate for majority preferences to outweigh individual preferences.

More frequently, improvement efforts in nursing homes are intended to enhance care and daily life for the individual. If one resident prefers to get out of bed in the morning at 6 a.m. but his

roommate prefers 8 a.m., you meet neither one's preference if you decide to split the difference and help them both to get up at 7 a.m. When the goal is to tailor care and services to meet personal needs and preferences, then your improvement efforts must be driven by the individual responses of each resident you interview.

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

YOUR ASSIGNMENT

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

- Use our In and Out of Bed Schedule assessment form (on page 41) to interview residents on one hallway.
- For this assignment, after introducing yourself, you need only ask residents questions 1 and 3 on our assessment form:
    - Q1: About what time do you get out of bed in the morning?
    - Q3: About what time do you like to get out of bed in the morning?
- Analyze results. Identify those residents who say they would *like* to get up at a time different from when they say they do get up.
- Create a checklist of these "dissatisfied" residents' names and the time of morning each would like to get up from bed.
- The next day, check it out: Stroll down the hallway in the morning and make a note of who's out of bed at the preferred time and who's not.
- What can your staff do to improve results?

Share your findings with us. Please contact us via our website, http://borun.medsch.ucla.edu/. We will report your feedback in updates to the site.

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

FREQUENTLY ASKED QUESTIONS

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

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

There is a tendency among many—nursing home staff, policy makers, researchers, even family members—to view nursing homes as places that take care of often very sick people and ignore the fact that they are also places where people "live out their lives (1)." As a result, improvement efforts often suffer the same bias, focusing almost exclusively on care, not other aspects of life.

You should take pains to devise a quality improvement assessment strategy that avoids this mistake. You can use our Interview Protocol (see page 14) to develop questions that specifically assess QOL domains other than those related to health care. Our ready-to-use assessment instruments primarily address quality of care, but include questions that probe such

QOL dimensions as security, autonomy, individuality, dignity, and enjoyment. Be sure to include some open-ended questions that invite residents to comment on what is most important to them.

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

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

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

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

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

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

Direct observations, however, can be time consuming and difficult to conduct. We don't recommend them when the care routines in question occur sporadically throughout the day, such as incontinence care and repositioning. They are most feasible when the targeted routines or behaviors are expected to occur within a specific time period in a known place, such as at mealtimes, bedtimes, or during morning and afternoon social activities. On these occasions, a staff person, preferably a licensed nurse or social worker, can stand ready, checklist in hand, to witness and record elements of usual care. For an example of a standardized

observational protocol, see our Mealtime Observational Protocol or our Quality Improvement Observation Form for Meals, both available on our website, http://borun.medsch.ucla.edu/.

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

Although medical chart and especially MDS data are widely used to evaluate quality of care in nursing homes—the quality measures publicly reported by the Centers for Medicare and Medicaid Services are derived from MDS data, for example—we have repeatedly found some of this information to be inaccurate (4-6) and so recommend its use only in conjunction with data gleaned from other assessment strategies, such as resident reports or direct observations.

Q: **What is the Nursing Home Quality Initiative?**

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

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

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

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

Read on to find out more about Quality Improvement Organizations.

Q: **What are Quality Improvement Organizations?**

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

The website of the Centers for Medicare and Medicaid Services (CMS) describes the role of QIOs: "For purposes of the Nursing Home Quality Initiative, QIOs have been given the responsibility to promote awareness and use of publicly reported nursing home quality measures, and to provide assistance to nursing homes in their State which seek to improve performance. QIOs will seek to accomplish this by conveying the message that some nursing

homes do better than others in regards to quality measures that are important to beneficiaries and their caregivers, and by making available information and assistance to facilities about how they can achieve better performance."

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

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

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

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

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

For nursing homes, particularly those with poor scores on their report cards, the quality measures are a concern, as they are meant to be. As such, they have successfully sparked new improvement efforts in nursing homes nationwide. From a quality improvement standpoint, the measures, essentially prevalence rates, provide meager information to guide improvement programs. Though some signal a serious problem within a facility, none show how to correct it. For that kind of guidance, this module and other training modules available on our website, http://borun.medsch.ucla.edu/, can help (see our Training Modules), as can the state Quality Improvement Organizations and other organizations found in our Links section (see page 35).

MORE FAQs

Our Interview Protocol (see page 14) includes answers to these FAQs:
- When should quality improvement interviews with residents be conducted?
- Who should be interviewed?
- Who should conduct the interviews?
- Where should interviews be conducted?
- Is there anything I need to do before conducting the interview?
- How should interviews be conducted?
- What types of questions are most useful for improvement purposes?

- What types of questions should be avoided?
- How do I analyze responses?
- How do we interpret our findings?

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RELATED STUDIES

SELECTING RESIDENTS TO INTERVIEW

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

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

- **The Identification of Residents Capable of Accurately Describing Daily Care: Implications for Evaluating Nursing Home Care Quality**
Sandra Simmons, John F. Schnelle, 2001, in *The Gerontologist,* 41(5):605-611.

This study confirmed findings from the study cited above but also simplified the resident selection criteria for ease of use in practice by both nursing home and survey staff. Specifically, this study showed that the Minimum Data Set (MDS) derived Recall subscale (see page 43), which is part of the Cognitive Performance Scale (CPS), can be used to identify residents who can provide accurate self-reports of their care. Based on interview responses from 186 incontinent residents, the study showed that selecting residents who scored *two or more* on the four orientation items that comprise the recall subscale correctly identified accurate self-reporters 70% of the time. Surprisingly the use of a standardized cognitive performance test (i.e., the Mini-Mental State Exam) did not improve upon the predictive value of the MDS Recall subscale. The authors write: "Based on the results of this study, the most time-efficient and simple approach to identify incontinent NH residents capable of accurately describing the care that they receive would be to calculate the MDS Recall subscale score and include all residents in the interview who score 2 or higher on this scale. This calculation could be completed quickly if one has access to the MDS information, which is available for all NH residents." The use of the highly efficient MDS Recall scale to identify residents capable of accurate self-report is preferable to the subjective approaches to screening often used in nursing homes. Moreover, it is even preferable to use of the MDS-derived CPS scale, which is much more difficult to calculate.

- **Improving Nursing Home Quality Assessment: Capturing the Voice of Cognitively Impaired Elders**
John F. Schnelle, 2003, in *J. Gerontol. A Biol. Sci. Med. Sci.,* 58:M238-M239.

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

improve the quality assessment process by interviewing more residents?' but rather, 'How do we interview more residents within the cost constraints of the quality assessment process?'"

DESIGNING AND ANALYZING INTERVIEW QUESTIONS

- **Strategies to Measure Nursing Home Residents' Satisfaction and Preferences Related to Incontinence and Mobility Care: Implications for Evaluating Intervention Effects**
Sandra F. Simmons and John F. Schnelle, 1999, in *The Gerontologist*, 39(3):1-11.

receive.

Of the four methods tested, the third method proved superior with respect to response stability. Method 1 yielded the most unstable responses. The third method also revealed comparatively higher levels of "unmet need," but by doing so, is considered more useful for guiding improvement efforts. The authors acknowledge that Method 3 is the most time-consuming to implement because it requires objective, direct observations of the care actually provided to residents. They argue, however, that this type of monitoring should be conducted at least annually in any case.

- **A Comparison of Methods to Assess Nursing Home Residents' Unmet Needs**
Lené Levy-Storms, John F. Schnelle, and Sandra F. Simmons, 2002, in *The Gerontologist*, 42(4):454-461.

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

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

Estimates of the proportion of residents with

unmet needs were significantly higher with the discrepancy and open-ended measures as compared to the direct satisfaction measures across most ADL care domains. The analysis of residents' responses to open-ended questions produced the most useful information for individualizing aspects of technical care and assessing the interpersonal quality of care, whereas the discrepancy questions elicited specific information useful for changing the frequency or occurrence of ADL care. Interview methodologies that directly ask residents questions about satisfaction with ADL care are the least useful for designing improvement interventions.

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

- **Nursing Home Residents' Perceptions of Care: A Method for Coding Their Comments into Unmet and Met Needs** Lené Levy-Storms, Sandra F. Simmons, Veronica F. Gutierrez, Dana Miller-Martinez, Kelly Hickey, and John F. Schnelle. Under review at *The Gerontologist.*

This study reports on a reliable method for coding nursing home residents' comments about the care they receive and the care they would like to receive. Nursing homes—and the researchers who study them—often use close-ended questions to assess residents' satisfaction with care. Recent studies, however, suggest that answers to these questions may be skewed by

response acquiescence, or the tendency of residents to provide mostly satisfied responses, even when problems with the quality of care are known to exist. Open-ended questions and spontaneous remarks by residents during interviews have not been analyzed systematically in most studies, in part because a standardized coding protocol has been lacking.

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

Coding and analyzing residents' comments supplements information from closed-ended questions in several ways. First, over 30% of the residents provided comments to *only* open-ended questions, so their viewpoints would have been missed had only closed-ended questions been used. Second, by recording residents' own

> **Over 30% of the residents provided comments to *only* open-ended questions, so their viewpoints would have been missed had only closed-ended questions been used.**

words, subtle but often specific aspects of both technical and interpersonal aspects of care delivery were assessed. And finally, this study's methodology was sensitive enough to identify reduced expectations among residents who otherwise reported only met needs.

NURSING HOME REPORT CARDS

- **Designing a Report Card for Nursing Facilities: What Information is Needed and Why**
  Charlene Harrington, Janis O'Meara, Martin Kitchener, Lisa Payne Simon, and John F. Schnelle, 2003, in *The Gerontologist,* 43: 47-57.

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

- **The Minimum Data Set Weight Loss Quality Indicator: Does it Reflect Differences in Care Processes Related to Weight Loss?**
  Sandra F. Simmons, Emily T. Garcia, Mary P. Cadogan, N.R. Al-Samarrai, Lené Levy-Storms, Dan Osterweil, and John F. Schnelle, 2003, in *Journal of the American Geriatrics Society*; 51(10):1410-1418

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

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

- **A Minimum Data Set Prevalence of Pain Quality Indicator: Is it Accurate and Does it Reflect Differences in Care Processes?** Mary P. Cadogan, John F. Schnelle, Noriko Yamamoto-Mitani, Georgina Cabrera, and Sandra F. Simmons, in *Journal of Gerontology:Medical Sciences*, 2004;59: M281-M285.

This study, conducted in 16 nursing homes, collected independent data that showed that the Minimum Data Set (MDS) quality indicator (QI) for "prevalence of pain" accurately discriminates between facilities. Interpretation of the pain indicator requires caution, however. Rather than reflecting poor quality, a high prevalence of pain according to the MDS was associated with better pain assessment and treatment.

This study reports results from eight nursing homes that scored in the upper 75th percentile on the prevalence of pain QI and eight nursing homes that scored in the lower 25th percentile for the same QI. Research staff collected data through interviews with 255 residents and medical record reviews.

In high prevalence homes, 47% of the participating residents had pain documented on their most recent MDS and the same percentage reported symptoms of chronic pain during interviews with research staff. By contrast, in low prevalence homes, 9% of the participating residents had pain documented on their most recent MDS, but 27% reported chronic pain

> **"Rather than reflecting poor quality, a high prevalence of pain according to the MDS was associated with better pain assessment and treatment."**

symptoms in interviews. On every measure of pain-related care quality independently evaluated in this study (detection, assessment, treatment, and documentation), nursing homes with a high reported prevalence of pain on the MDS performed better than nursing homes with low MDS pain prevalence. One explanation, according to the authors, is that a higher prevalence of pain among residents sensitizes nursing home staff to the need for better overall care for pain.

- **The Minimum Data Set Urinary Incontinence Quality Indicators: Do They Reflect Differences in Care Processes Related to Incontinence?** John F. Schnelle, Mary P. Cadogan, June Yoshii, Nahla R. Al-Samarrai, Dan Osterweil, Barbara M. Bates-Jensen, and Sandra F. Simmons, 2003, in *Medical Care,* 41(8):909-922.

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

insufficient to improve urinary incontinence but consistent with the findings from previous studies. There also were no differences in reports of received assistance between residents noted in the MDS as being on scheduled toileting and those who were not. This finding points to disturbing discrepancies between the toileting assistance care documented in medical charts and the care actually provided.

- **The Minimum Data Set Pressure Ulcer Indicator: Does it Reflect Differences in Care Processes Related to Pressure Ulcer Prevention and Treatment in Nursing Homes**
Barbara M. Bates-Jensen, Mary Cadogan, Dan Osterweil, Lené Levy-Storms, Jennifer Jorge, Nahla Al-Samarrai, Valena Grbic, and John F. Schnelle, 2003, in *J Am Geriatrics Society*, 51(9): 1203-12.

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

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

indicator—did not provide better care. Nursing homes with higher rates of PU, however, were more likely to use pressure-reduction surfaces and were better at documenting wound characteristics.

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

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

OTHER QUALITY-OF-LIFE STUDIES

- **Family Members' Preferences for Nutrition Interventions to Improve Nursing Home Residents' Oral Food and Fluid Intake**
Sandra F. Simmons, Helene Y. Lam, Geetha Rao, and John F. Schnelle, 2003, in *Journal of the American Geriatrics Society*, 51(1):69-74.

What nutrition interventions do family members

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

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

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

- **Quality Assessment in Nursing Homes by Systematic Direct Observation: Feeding Assistance**
  Sandra F. Simmons, Sarah Babineau, Emily Garcia, and John F. Schnelle, 2002, in *Journal of Gerontology: Medical Sciences;* 57 (10): M665-M671.

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

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

What treatments for urinary incontinence are preferred for nursing home residents? This study asked this question of frail older adults, family members of nursing home residents, and long-term-care nursing staff. Among all respondents, 85% "definitely" or "probably" preferred diapers, and 77% "definitely" or "probably" preferred prompted voiding to indwelling catheterization. There were, however, differences among the respondent groups. Nurses preferred prompted voiding to diapers more than did older adults or family members. Older adults, compared with family and nurse respondents, more strongly preferred medications to diapers. In open-ended responses, older adults (nine of them nursing home residents and 70 residential care residents)

said they would choose a treatment based in part upon criteria of feeling dry, being natural, not causing embarrassment, being easy, and not resulting in dependence. The comments also indicated that older adults and family members did not believe nursing home staff would provide prompted voiding often enough to improve continence. Because of the divergence of opinions among different proxy respondents, the researchers recommend that, when possible, nursing home residents be asked first for their treatment preference.

- **A Cost and Value Analysis of Two Interventions with Incontinent Nursing Home Residents**
  John F. Schnelle, Emmett Keeler, Ron D. Hays, Sandra F. Simmons, Joseph G. Ouslander, and Albert L. Siu, 1995, in *Journal of the American Geriatrics Society,* 43:1112-1117.

privacy and food issues, they rarely request services that improve continence and walking, most likely because they are unaware of such rehabilitative programs.

REFERENCES

1. Kane RA, Kling KC, Bershadsky B, et al.. Quality of life measures for nursing home residents. *J Gerontol Med Sci.* 2003;58A:240-248. Ω

> **"...while nursing home consumers often complain about privacy and food issues, they rarely request services that improve continence and walking, most likely because they are unaware of such rehabilitative programs."**

LINKS AND OTHER RESOURCES

RELATED LINKS AND RESOURCES

Agency for Health Care Quality and Research
Report (1999): Long-Term Care: Quality of Care
is Most Important Nursing Home Measure
http://www.ahcpr.gov/research/jun99/ra7.htm

American Geriatrics Society (AGS)
Position Statement: Measuring Quality of Care
for Nursing Home Residents - Considering
Unintended Consequences
http://www.americangeriatrics.org/products/posit
ionpapers/unintended_conseq.shtml

American Health Quality Association
www.ahqa.org

Center for Health Systems Research and Analysis
University of Wisconsin at Madison
Developed the nursing home quality measures
used by the Centers for Medicare and Medicaid
Services
http://www.chsra.wisc.edu

Centers for Medicare and Medicaid Services
Nursing Home Quality Initiative
http://www.cms.hhs.gov/quality/nhqi/

Commonwealth Fund
Report (2001): Promoting Quality in Nursing
Homes: The Well Spring Model
http://www.cmwf.org/programs/elders/reinhard_
wellspring_432.pdf

Medicare: Nursing Homes Compare
http://www.medicare.gov/NHCompare/include/
DataSection/Questions/SearchCriteria.asp

National Citizens Coalition on Nursing Home Reform
http://www.nccnhr.org/default.cfm

U.S. General Accounting Office
Report (2002): Nursing Homes: Quality of Care More Related to Staffing than Spending
http://www.gao.gov/new.items/d02431r.pdf

U.S. Office of the Inspector General
Report (2003): Quality Assurance Committees in Nursing Homes
http://oig.hhs.gov/oei/reports/oei-01-01-00090.pdf Ω

FORMS

FORMS TO ASSESS RESIDENT PREFERENCES FOR:

- Toileting assistance, page 38
- Walking assistance, page 39
- Dressing and personal hygiene assistance, page 40
- Getting in and out of bed, page 41
- Social activity participation, page 42

FORMS TO ASSESS:

- Nutrition and food complaints
- Depression
- Chronic pain

….are available on our website, http://borun.medsch.ucla.edu/.

RELATED FORMS

- MDS Recall Subscale, page 43
- MDS Ratings for Assistance with Activities of Daily Living, page 44
- Forms that enable you to score quality indicators for such daily care routines as incontinence management and feeding assistance are available on our website at http://borun.medsch.ucla.edu/ Ω

NURSING HOME RESIDENT INTERVIEW: MET NEEDS AND CARE PREFERENCES

RESIDENT NAME/ ID# _____   DATE:_____/_____/_____

FACILITY/ROOM #:_____

INTERVIEWER NAME:_____

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

INCONTINENCE CARE: Toileting Assistance

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

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

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

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

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

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

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

4. **IF resident reports receiving toileting assistance from staff, ask**:
Do you have to wait a long time for someone to help you use the toilet? ___Yes   ___No ___DK/NR

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

___0   ___1   ___2   ___3   ___ More than 3   ___DK/NR

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

NURSING HOME RESIDENT INTERVIEW: MET NEEDS AND CARE PREFERENCES

RESIDENT NAME/ ID# _____   DATE:_____/_____/_____

FACILITY/ROOM #:_____

INTERVIEWER NAME:_____

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

MOBILITY ASSISTANCE: Walking

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

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

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

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

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

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

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

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

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

  6.   How many times during the day would you like someone to help you to walk?
  ___0   ___1   ___2   ___3   ___ More than 3   ___DK/NR

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

NURSING HOME RESIDENT INTERVIEW: MET NEEDS AND CARE PREFERENCES

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

INTERVIEWER NAME:_____

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

DRESSING, GROOMING, and PERSONAL HYGIENE ASSISTANCE

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

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

2. Did someone who works here help you to:

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

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

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

___YES   ___NO (Independent)   ___DK/NR

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

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

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

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

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

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

NURSING HOME RESIDENT INTERVIEW: MET NEEDS AND CARE PREFERENCES

RESIDENT NAME/ ID# _____   DATE:_____/_____/_____

FACILITY/ROOM #:_____

INTERVIEWER NAME:_____

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

IN and OUT of BED SCHEDULE

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

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

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

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

    ___YES   ___NO   ___SOMETIMES   ___DK/NR

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

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

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

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

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

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

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

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

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

NURSING HOME RESIDENT INTERVIEW: MET NEEDS AND CARE PREFERENCES

RESIDENT NAME/ ID# _____   DATE:_____/_____/_____

FACILITY/ROOM #:_____

INTERVIEWER NAME:_____

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

SOCIAL ENVIRONMENT

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

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

    ___YES   ___NO   ___SOMETIMES   ___DK/NR

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

    ___YES   ___NO   ___SOMETIMES   ___DK/NR

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

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

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

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

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

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

7. Do the people who work here tell you when they will be back to check on you again?
    ___YES   ___NO   ___SOMETIMES   ___DK/NR

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

MDS Recall Subscale

Resident's name:_____

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

a. Current season: ____

b. Location of own room: ____

c. Staff names and/or faces: ____

d. He/she is in a nursing home: ____

OR

e. None of the Above: ____

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

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

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

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

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

1= Supervision (Oversight, encouragement, or cueing provided 3 or more times OR supervision +

physical assistance provided only 1-2 times)

2=Limited Assistance (Physical help in guided maneuvering 3 or more times OR limited assistance +

more help provided only 1-2 times)

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

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

QUALITY-OF-LIFE ASSESSMENT QUIZ

TRUE OR FALSE

1. ____ Family members' evaluations of a facility's care are an appropriate substitute for residents' evaluations.

2. ____ Residents who are capable of providing reliable reports of the care they receive can be identified through the Minimum Data Set's Recall subscale.

3. ____ In general, most nursing home residents will report high levels of dissatisfaction with their care.

MULTIPLE CHOICE

4. The best interviewer to ask a nursing home resident about the care he or she receives is: (Check only one answer.)

___a. A staff member who typically provides daily care to that resident
___b. A staff member who does not typically provide daily care to that resident
___c. Neither a. nor b.
___d. Either a. or b.

5. Which type of question is the least useful for identifying care areas in need of improvement? (Check only one answer.)

___ a. Open-ended questions (e.g., What would change about your care?)
___ b. Direct satisfaction question (e.g., Are you satisfied with staff assistance?)
___ c. Discrepancy type questions (e.g., How often would you like to be toileted? How often are you toileted?)
___ d. None of the above

6. What should you do before conducting an interview with a nursing home resident? (Check *all* that apply.)

___ a. Make sure there is a quiet room available for the interview
___ b. Introduce yourself and spend a few minutes establishing rapport with the resident
___ c. Ask the resident if he/she can hear you
___ d. Reassure the resident of confidentiality of his/her responses

Answers: 1. F; 2. T; 3. F; 4. b; 5. b; 6. a-d