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The National Long-Term Care Ombudsman Resource Center

INITIAL CERTIFICATION TRAINING CURRICULUM FOR LONG-TERM CARE OMBUDSMAN PROGRAMS

Module 3: Putting the Resident First

WELCOME AND INTRODUCTION

Section 1

Welcome

- Your name
- Where you are from
- One thing you learned from Module 2
- What you hope to learn since the last module


ANY
QUESTIONS
?
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Today's Agenda

Section 1: Welcome and Introduction (15 minutes)

Section 2: Person-Centered Care (60 minutes)

Section 3: Decision Making (30 minutes)

Section 4: Advanced Planning and Third-Party Decision-Makers (20 minutes)

-----BREAK----- (10-15 minutes)

Section 5: Empowerment (30 minutes)

Section 6: Resident Assessments and Care Plans (30 minutes)

Section 7: Resident Councils and Family Councils (15 minutes)

Section 8: Conclusion (15 minutes)

Module 3 Learning Objectives

- Person-centered care
- Advance planning and decision-making authority
- The importance of empowerment
- Assessment and care plans
- Resident Councils and Family Councils

PERSON-CENTERED CARE

Section 2

Person-Centered Care

- Person-centered care is a process for selecting and organizing the services and supports that an older adult or person with a disability may need to live to their fullest potential.

The Resident Decides

- Activities
- Bathing
- Care
- Death and dying
- Dining
- Dressing
- Community involvement
- Medication administration
- Relationships
- Staff assignments
- Work

Person-Centered Care: Person-Centered Language

Person-Centered Care Based in Law

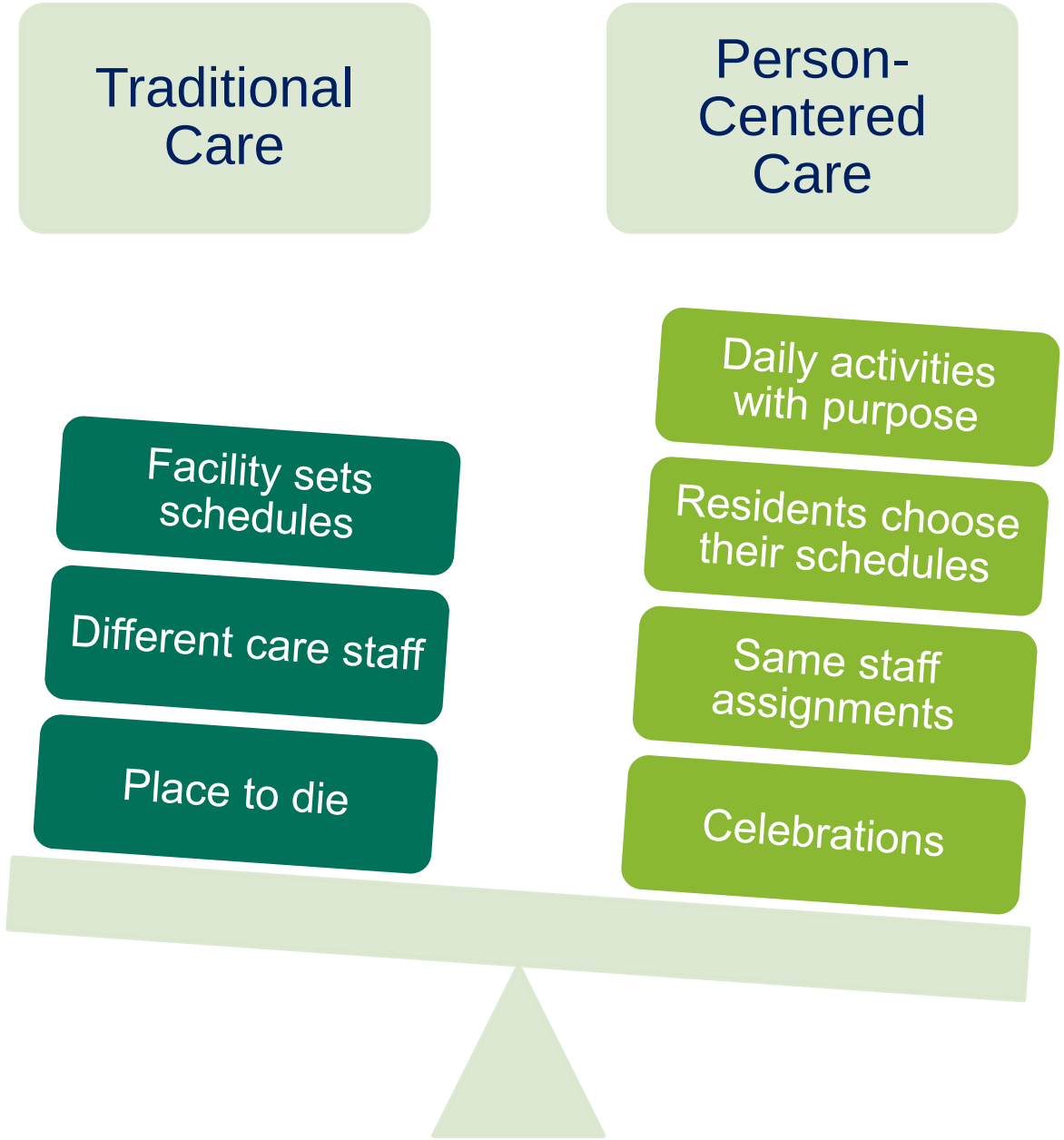
- Nursing Home Reform Act (OBRA)
- Federal Requirements for States and Long-Term Care Facilities

Who decides?

The resident!

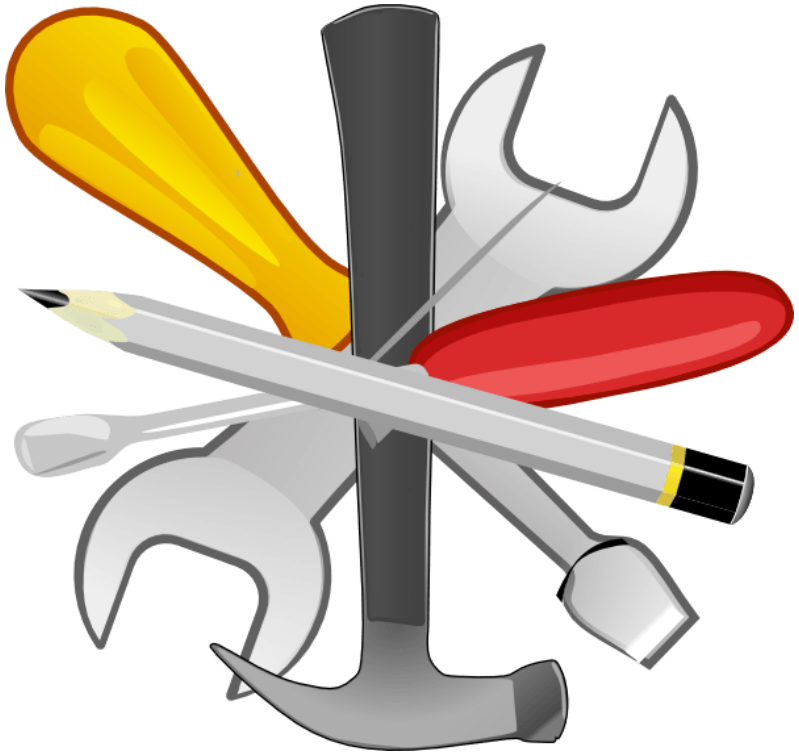
→ Add State-Specific Regulations Regarding Person-Centered Care

My Personal Directions for Quality of Life


Traditional Care
Person-Centered Care
Facility sets schedules
Different care staff
Place to die
Daily activities with purpose
Residents choose their schedules
Same staff assignments
Celebrations

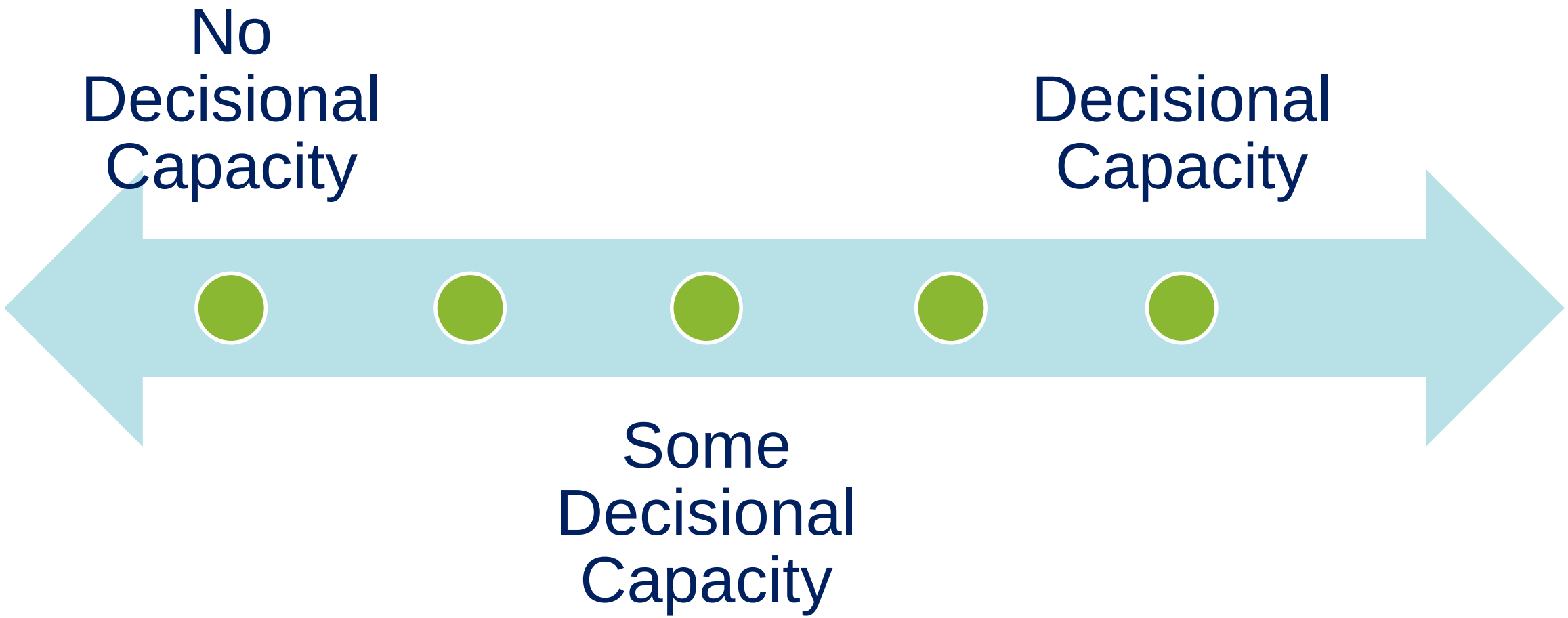
How the Ombudsman Program Promotes Resident-Centered Care

- Educate and Empower
- Model Person-Centered Behavior
- Utilize the Care Plan Process



DECISION MAKING

Section 3


No Decisional Capacity
Decisional Capacity
Some Decisional Capacity

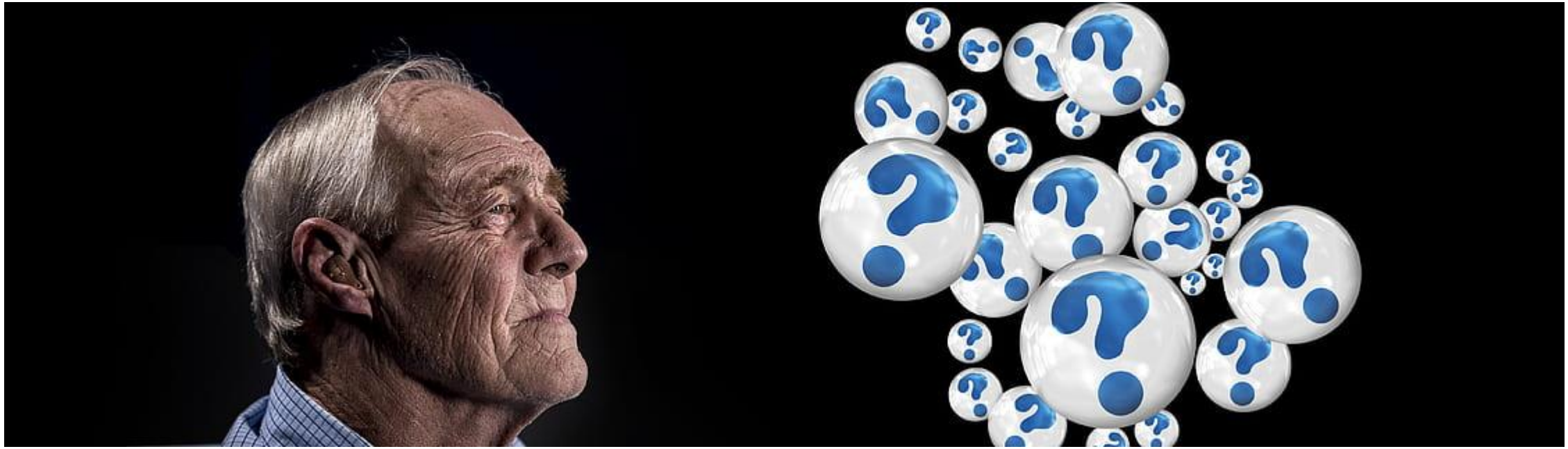
Decision-Making Capacity

- Does the resident understand the information?
- Can the resident relate the information to their situation?
- Does the resident understand the possible outcomes of their decision?
- Can the resident retain the information long enough to make a decision?
- Can the resident communicate their decision in some way?

→ Add State-Specific Policies and Procedures: When Decisional Capacity is Unclear

If the resident's ability to make decisions is still not clear, or the status of the resident's capacity is uncertain, you may consider the following:

- Ask the resident for permission to speak with their representative
- Follow your state program policies and procedures
- Consult with your supervisor for guidance



- Use language and manner the resident can understand
- Discuss choices and outcomes fairly and evenly
- Let the resident talk to a reliable person
- Give the resident enough time

→ State-Specific Information on Advance Planning

- Cardiopulmonary Resuscitation (CPR) Directive
- Power of Attorney (POA)
- POLST = Portable Medical Orders
- Supported Decision-Making

ADVANCED PLANNING AND THIRD-PARTY DECISION-MAKERS

Section 4

Advance Planning

CPR Directive

A medical order

Signed by patient & doctor

Instructs providers on resuscitation if the person's heart or breathing stops

Also called an Out-of-the-Hospital DNR.

POLST

Treatments and goals of care

Transfers from setting to setting

Life-limiting condition

State-specific form

Completed by a health care professional & the patient

Also called POST, MOLST, MOST, etc.

Supported Decision-Making

What is it?

- It is a written arrangement
  - a list of decisions for which the resident wants assistance
  - it identifies who will help make those decisions
- Allows resident to maintain as much control as possible
- Provides for some assistance with making important life, medical or financial decisions

Third-Party Decision-Makers

Assigned ***by*** the Resident

- Power of Attorney (POA)
  - Appointed by the individual
  - Does not remove rights
  - Different types of POAs

Assigned ***for*** the Resident

- Guardianship
- Conservatorship
  - Appointed by the court
  - Removes the individual's rights
  - Deems the individual incapable of administering their own affairs

Power of Attorney (POA)

“Power of Attorney” is the document.

“Principal” is the person appointing the decision-maker (agent).

“Agent” is the person who is appointed by the principal.

Agents are required to act with the highest degree of good faith.

An agent’s authority can be revoked by the principle.

→ State-Specific Information: Guardianship/Conservatorship

Representative Payee

Resident Representative

Does the resident have:

- An advance planning directive?
  - If so, what kind of directive?
- A supported decision-maker?
- A guardian or conservator?
- Is there evidence of the individual's authority?

Resident Representative Role

Review the forms!

Under what circumstances do you follow the direction of the resident representative?

What authority does the resident representative have?

What decisions can the resident make?

What rights does the resident have?

EMPOWERMENT

Section 5

Empowerment

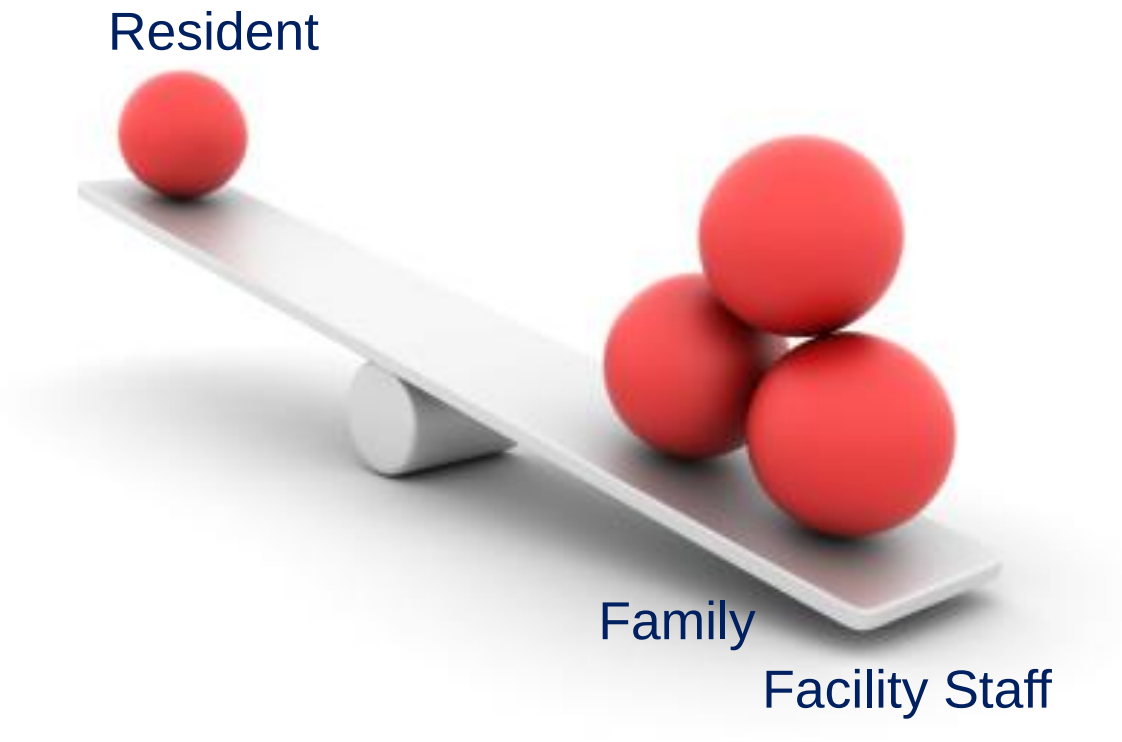
Becoming stronger

More confident

Controlling one’s life

Claiming one’s rights

Imbalance of Power



Barriers to Empowerment

I'm afraid

I don't want to get anyone in trouble

Last time I complained, staff were mean to me

I don't want them to think I'm difficult

Resident Experiences

Video: Voices Speak out Against Retaliation

1. What reasons are given for not reporting poor treatment or problems within the facility?

2. What concerns or fears are brought up by the residents?

3. What examples of retaliation did you hear from the video?

4. What examples to overcome the fear of retaliation are discussed in the video?

Retaliation

- Call lights not answered or delayed in being answered
- Staff ignoring resident requests for help
- Nurses withholding pain medication or late when distributing medication

- Rough care
- Abusive treatment
- Eviction
- Withholding food and water

Partnering with Residents for Self-Advocacy

- Listen
- Educate
- Explain options
- Encourage
- Talk about who can help
- Explain how to file a complaint

Resident Rights and Empowerment *video*

RESIDENT ASSESSMENTS AND CARE PLANS

Section 6

The Minimum Data Set Assessment (MDS)

- Quality of Care
- Quality of Life
- Highest Practicable Level

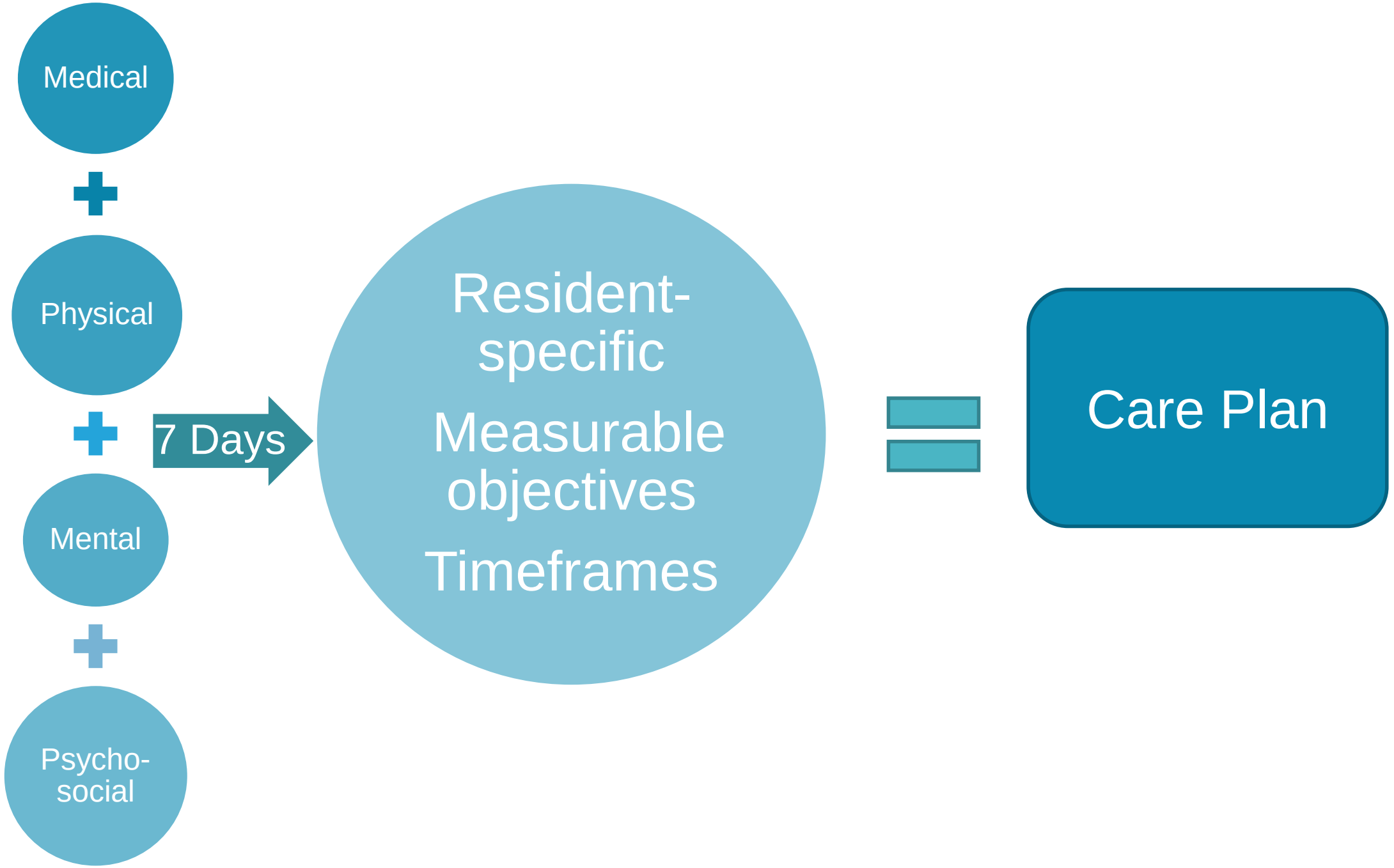
How Often are Residents Assessed?

- At the time of admission
- When readmitted following hospitalization
- Quarterly
- Annually
- After a significant change in condition
- When a significant change to a prior assessment needs to be made
- At the time of discharge

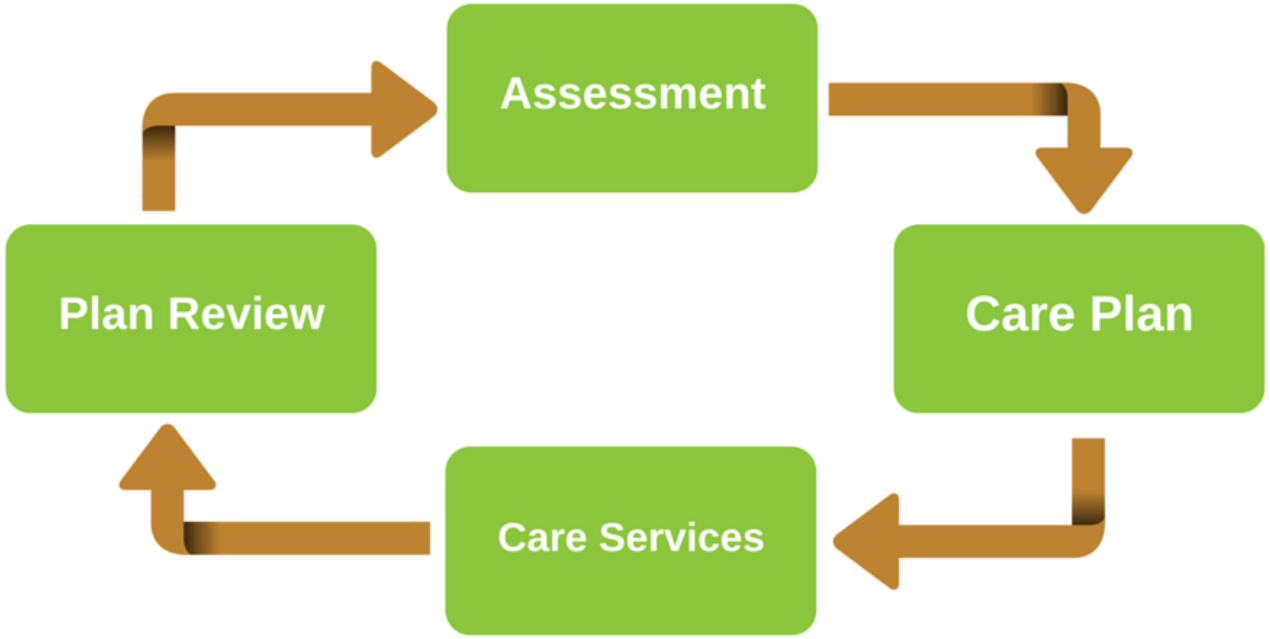
What is Your Role in an Assessment?

- Suggest residents prepare
- Remind residents that they can make requests
- Help residents resolve any issues related to assessment interview procedures

- The initial goals of the resident
- A summary of the resident's medications and dietary instructions
- Any services and treatments to be administered by the facility


Medical
Physical
Mental
Psycho-social
7 Days
Resident-specific
Measurable objectives
Timeframes
Care Plan

Care Plan



- Individualized
- Specific
- Comprehensive
- Written in a language everyone can understand
- Reflective of the resident's concerns, preferences, and goals
- Supportive of the resident's well-being, abilities, and rights
- Accessible to staff providing supports and services

Care Planning Rights

- Participate in the planning process
- Identify individuals or roles to be included in the planning process
- Request a care plan meeting
- Request revisions to the care plan
- Participate in establishing goals and outcomes of care
- Participate in all factors related to the effectiveness of the care plan

- Be informed, in advance, of changes to the plan of care
- Receive the services and/or items included in the plan of care
- See and have a copy of the care plan
- Sign the care plan after significant changes have been made

Care Plan Meeting

21 days

Every 3 months

After a significant change

Person-Centered Planning in Home and Community-Based Services (HCBS)

- The HCBS Rule applies to all settings in which an HCBS recipient lives or receives the HCBS services, including residential care communities that accept Medicaid coverage for services.

- Similar to federal nursing facility requirements for assessment and care planning, the HCBS Rule requires the development of a person-centered service plan that is developed using a person-centered planning process driven by the individual receiving services.

- Choices for services and living options are discussed, and the individual can request meetings to update/change their choices. Additionally, the information provided should be in plain language that is accessible to the individual.

Person-Centered Care: Care Plans

Key Care Plan Meeting Participants

- Care Plan Coordinator
- Resident
- Resident's representative
- Physician(s)
- Nursing staff
- Dietary staff
- Therapy staff
- Social services staff
- Activities staff
- Anyone else invited by the resident (e.g., family members, representative of the Office)

What is Discussed at the Care Plan Meeting?

- Resident needs & preferences
- Supports and services
- Staff responsible for providing supports and services
- Resident’s preferred daily routines
- Dietary preferences, concerns, & needs
- Resident’s preferred activities & interests
- Medication
- Discharge goals

Preparing for the Care Plan Meeting

- Is the meeting held at a time of day best for the resident?
- Did the facility provide sufficient notice?
- Does the scheduled meeting accommodate the resident and others the resident wants to attend?
- Is there sufficient time to discuss all necessary information?

NO? Speak up!

- Offer to attend the care plan meeting
- Discuss the resident’s expectations, concerns, & goals
- Discuss the LTCOP’s role
- Prepare a list about what is important to the resident

During the Care Plan Meeting

LTCOP advocacy ensures

- The resident has an opportunity to speak
- Resident's questions are answered
- Preferences are addressed
- Supports and services options are discussed
- Resident understands and agrees with the care plan
- Resident receives a copy of the plan
- Knows who to talk to if there are changes to be made to the care plan

After the Care Plan Meeting

- Follow up with the resident
- Is the resident satisfied?
- Do changes need to be made to the care plan?
- Explain right to request a care plan meeting at any time

RESIDENT COUNCILS AND FAMILY COUNCILS

Section 7

A resident council is an independent group of residents living in the same facility who meet on a regular basis to discuss and seek resolution to concerns, develop suggestions to improve life in the facility, and plan activities to promote socialization with other residents.

The nursing facility must:

- provide a private space for meetings
- make residents aware of upcoming meetings
- provide a designated staff person who is approved by the resident council and the facility to provide assistance and respond to written requests from the resident council

- consider the views of a resident council and act promptly upon grievances and recommendations of the resident council concerning issues of resident care and life in the facility

  - The facility must provide a response and rationale for their response

  - The right to a response does not mean facilities are required to implement every request of the resident council

The resident council meetings are closed to staff, visitors, and other guests, unless invited.

→ State-Specific Resident Council in RCCs

Ombudsman Program and the Resident Council

- Required to assist when asked
- Encourages the use of resident councils to resolve concerns
- Benefits when the LTCOP attend resident councils
  - ✓Getting to know residents
  - ✓Being a familiar support to residents
  - ✓Getting a sense of how the residents are treated
  - ✓Observing how the facility is managed

- ✓ Communication
- ✓ Action
- ✓ Support
- ✓ Education

- Strength in numbers
- Fosters greater staff accountability
- Decreases possible neglect and abuse
- Streamlining concerns is efficient

Nursing facilities must:

- provide a private meeting space
- cooperate with the council's activities
- appoint a staff advisor or liaison to the family council
- respond to the group's concerns

The family council meetings are closed to staff, administrators, and visitors, unless invited by the council.

→ State-Specific Family Councils

Ombudsman Program and the Family Council

- Required to assist when asked
- Encourages the use of family councils to resolve concerns
- Provides education, support, and advocacy to family councils when asked
- May attend meetings if invited

CONCLUSION

Section 8

Module 3 Questions

1. Why is it important for a representative to know about advance planning and third-party decision-makers?

2. Explain what “empowerment” means to you.

3. When a resident is hesitant to speak up about a concern, what can you do to help?

4. Name four residents’ rights that are related to care planning.

5. Name two things a facility must do to assist Resident Councils and Family Councils.

True or False

a. The charge nurse is responsible for assuring the nursing care provided by other nurses and nursing aides meets federal and state requirements.

False

b. The care plan coordinator is a social worker who works with other facility staff, residents, and residents' family members to conduct assessments and to coordinate individual nursing care.

False

QUESTIONS?

ADDITIONAL RESOURCES

Refer to your trainee manual for other sources of information related to topics discussed in this module.

Contact Information

- INSERT PRESENTER CONTACT INFORMATION

The National Long-Term Care Ombudsman Resource Center (NORC)

www.ltcombudsman.org

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