Neighborhood Assistants Pilot:

A Program Evaluation of Person-Centered Staffing

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CHAPTER 1

BACKGROUND

The Francis E. Parker Memorial Homes initiated an innovative pilot program introducing a new staffing line called the Neighborhood Assistant (NA). The NA would be a recent Certified Nursing Assistant (CNA) who would be a support person to the existing CNAs on a unit. "The pilot program was designed to support Parker's strategic imperatives of quality operational excellence, talent development and strategic growth, as well as Parker's culture. The purpose of the program is to support the Direct Care Partners (CNA) by empowering them to partner with the NAs to regain person-centered moments-opportunities to provide residents with person-centered approaches such as engaging the residents in their care, and increase interaction during cares" (from the Parker Neighborhood Assistants Pilot Program Document 12/12/13).

The program objectives included the following: (taken from the Parker Neighborhood Assistants Pilot Program Document 12/12/13).

1. "The creation of Neighborhood Assistants in skilled nursing care will take up a number of non-person-centered care related tasks currently completed by Direct Care Partners (e.g., bed making, filling water pitchers, putting resident clothes away), thereby offering more time to provide direct care and opportunities for person-centered approaches (e.g., engaging in meaningful conversation while rendering care, offering preferred activity moments to residents)."
2. "Direct Care Partners, by teaming with the NA will be able to reach and support more residents in the Neighborhood at any given time, thus responding in a more individualized way."
3. "Additionally the program will enable Direct Care Partner participation in resident/family and care team meetings (e.g., pre-admission and weekly care plan)."
4. "The program will also support Parker employees individualized development goals, talent development of Direct Care Partners (education/coaching on how to mentor others), provide opportunities to further develop staffing models/delivery of person-centered care in Monroe, and/or future sites, and serve as a feeder for staffing these other sites."

The program's desired outcomes will include "increasing social/meaningful engagement of residents by Neighborhood staff, positively impacting resident mood/behavior and employee engagement/satisfaction, and increasing Direct Care Partner participation at resident/family meetings." To this end, this evaluation project was designed to address objectives #1-3 above six months after implementation of the NA Program.

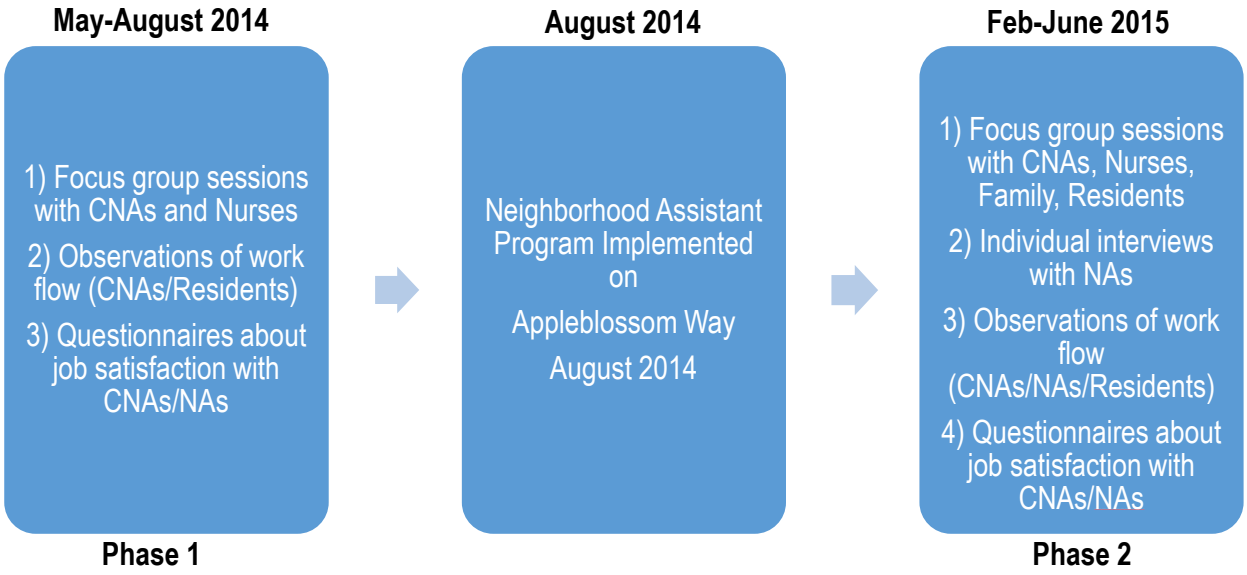
STUDY APPROACH

The evaluation of the Neighborhood Assistant (NA) Program took place in two phases at the River Road location. The study was designed to be able to compare observations and questionnaire responses prior to the implementation of the NA Program and six months after the implementation of the program. The focus groups conducted prior to the NA Program implementation were instructive to the crafting of the program while the focus group sessions after implementation asked about how the program has been going.

The first phase occurred prior to the NA Programs implementation. First, a "Train the Trainer" program for the *Emotion Focused Communication Program* was provided to 15 Parker employees at the Abramson Center for Jewish Life in June 2014. All participants were led through the training and given template power point slides and leader manuals in order to provide the training to Parker employees. Second, focus group sessions were held with nurses and direct care workers to seek input on the development and implementation of the Neighborhood Assistant Program (June 2014). Third, observations of direct care employee work flow were conducted to identify a baseline sample for behaviors that were expected to be influenced by the NA Program, such as how much time CNAs spent with residents (June and July 2014). Fourth, CNAs and newly hired NAs were asked to complete questionnaires with measures of job satisfaction, caregiver stress, and confidence in caregiving.

The NA Program was implemented in August 2014 and in discussions with Michael, Paula, and Megan we determined that the follow-up evaluation would occur six months after implementation (see Figure 1). The second phase of data collection included focus group sessions with nurses, CNAs, residents, and family members. These groups were asked to talk about how the NA Program was going and if they had any recommendations for improvements. Individual interviews were conducted with the two NAs. Observations were conducted on the staff members who were observed at baseline and questionnaires with measures of job satisfaction, caregiver stress, and confidence in caregiving were re-administered.

Figure 1. Timeline of Neighborhood Assistant Evaluation



This report is formatted to present each method of data collection separately with the baseline and follow-up data used for comparison. Findings and recommendations are found in chapter 5. There were staffing changes during the study period. Of the two originally hired NAs, one was still employed during Phase 2 follow-up and one had been working in the position for a few months. Of the eight original CNAs observed, seven participated in Phase II data collection efforts (One CNA was no longer working at the facility during Phase 2).

CHAPTER 2. FOCUS GROUP SESSIONS

Phase I

Suggestions for the Development and Implementation of the NA Program

The following results were shared with Parker immediately following the sessions held on 5/21/14 and are provided here to document the findings.

Focus Group with CNAs

Eight CNAs total – four from day shift, two from evening shift and one who works both shifts.

Reaction and Thoughts about the Neighborhood Assistant Position:

- *"We always need an extra hand."*
- We need help on Appleblossom – *"We are dying over here."*
- CNAs could have more time to talk and work with residents if they have someone to help them.
- CNAs are happy that their voices are heard.

Additional tasks the CNAs suggested that would be helpful if the Neighborhood Assistant could:

- Assist with care when the CNAs are short staffed
- Feed during meals
- Assist with toileting
- Assist with emergencies

Challenges/Obstacles:

- If the Neighborhood Assistants are not "licensed", then they are limited with what they can do and help with.
- If the Neighborhood Assistant is working with a resident and they are not "licensed," then they will have to get the CNA to take over if the resident needs something like toileting or care.

Additional Comments:

- Give the part-time CNAs a full-time position if they want it – this way they can assist with care.
- What would be more beneficial for the CNAs is someone who is a CNA who can assist with toileting or care when help is needed.
- One on One assignments with restless residents are currently working.

Focus Group with Nurses

Four Registered Nurses, One Licensed Practical Nurse

Reaction and Thoughts about the Neighborhood Assistant Position:

- Positive reaction
- Description of the position is something that the nurses do not have the time to do
- Having an extra person will decrease everyone's stress level
- Other neighborhood's need the assistance too, although Appleblossom is definitely the neighborhood to pilot this in because additional help is needed

Additional tasks the nurses suggested that would be helpful if the Neighborhood Assistant could:

- Feed during meal times
- Pass out nourishments for the nurses
- Sit outside with the residents who want to go outside
- Assist with restless residents

Challenges/obstacles:

- Everyone really needs to knows what the Neighborhood Assistants' role is so there is no confusion of tasks the person in the new role can and cannot do (for example – will they be allowed to take someone to the bathroom – because the CNAs might say *"Well why can't she do that?"*)
- A special person would be needed for this position: Someone with a lot of patience, emotionally able to work with this population, able to just hold someone's hand

Additional Comments:

- An 12 p.m. – 8 p.m. position is beneficial to both shifts – especially when sundowning occurs

Phase II

Focus Group and Interview Findings

It was clear from the interviews and focus groups that there was an inherent conflict of interest in asking the CNAs and NAs to speak candidly about the NA Program. All participants were a bit reluctant to discuss challenges with the program because they wanted to see the program continue. The NAs did not want to lose their jobs and the CNAs wanted to make sure the program was kept because the help was greatly appreciated. However, it was clear that communication has been an issue between the NAs, CNAs, and nurses. The following sections highlight the major themes discussed by group. We use direct quotations from participants when possible.

CNA Focus Group

Six CNAs participated in a follow-up focus group about the NA Program (May 2015) and felt the addition of the NA Program was *"good"*, *"a great help"*, and *"working great."*

> *"They help us with residents and they are making some of the beds or you know some of the residents are very challenging. You know when they have, when they have like um status change. They take over and help us which we used to do so that's a great help, really very helpful and they help us with the laundry so it's good."*

CNAs mentioned that the NAs also *"help us push residents to dining rooms and assist with feeding."* In addition, they help maintain the organization of residents' rooms and *"take care of the drawers and the closets. They clean them. They make them nice so I guess that is something good."* CNAs explained that their routines are less stressful since the addition of the NA and that they are *"on time"* for meals. When asked for an example of how the NA Program has allowed the aides to spend more meaningful time with residents one aide responded:

> *"Like when you are giving care, you don't have to watch because you know if anything comes up you know they will pick it up or if the bed has to be changed totally they will take care of that, you know. If you have a challenging resident you don't have to stop what you are doing and, you know, so that part is good."*

> *"Especially when you can communicate with them your work becomes lighter in a sense because instead of rushing, rushing to do everything. When you communicate with them it's better, its smoother for you and you spend more time with them [residents]."*

CNAs also mentioned that the neighborhood was *"quieter"* stating: *"Sometimes there is just too much noise, someone scream here. You're running because someone is falling but no more*

because you have someone that is helping with that." That led to the discussion of the aides perceiving that the neighborhood was safer for residents.

> *"I am just thinking the safety too. More safe for the residents because sometimes we will be doing something and they are in the hallway and they can get up so you know the neighborhood assistant are always around; by the time you call them they are there or most of the time they are with them so you don't have to worry about their safety. So the safety you know is improved. Greatly improved."*

CNAs mentioned that the only difficulty with the program was negotiating how to working as a team and resolve conflict. One aide mentioned how *"a little attitude problem"* can get in the way of working well as a team. Another aide stated *"attitude, you know personality problem."* There appeared to be a misunderstanding as to the best way to resolve conflict on the unit. It was unclear if this reflected a lack of training, understanding of the culture on the unit, or a lack of confidence in the nurse being able to manage conflict among the CNAs and NAs.

> *"We make the beds together or push together. We all feed together. All of us we do things now all together. We do not leave everything for them. We do things together. They help us with a challenging residents but if there is a problem go to the nurse. We talk about it before you go to the supervisor. That's the only little problem. Other than that they are doing an excellent job. They are very helpful. Everything is very good."*

> *"But sometimes let's work together. I mean, if you come to us, I mean if you make a mistake and you come to us say this or you go to the nurse then the nurse come [s to] address it to all of us instead of going to the boss. Because when you take it to the boss the boss is going to believe what you say. She is not going to come back to us. Then I am going to be mad, this one going to be mad. This one going to be mad. That's the only problem."*

CNAs said it would be helpful if the NAs assisted residents who could walk and go to the toilet.

> *"I was just thinking that if you are busy sometimes and the residents that can walk or stand. Can they not toilet them and change them? I think they are not supposed to do that, but I just want to know if they cannot do that."*

> *"Yes, somebody like the challenging residents. Like we have [Mary*]. [Mary] walks perfectly well. She will go to the bathroom. Sometimes she won't go to the bathroom by herself. I mean if a neighborhood assistant can walk in with her. She is in the bathroom if they can help…just to pull up her pants."*

*Names of residents have been changed to protect confidentiality.

One NA spoke about how she did walk with a resident to the toilet and sit with her to make sure she didn't fall.

> *"I may assist her to the bathroom, like, if she can walk. Like not the ones that can't walk and all that like Joan, I may escort her to the bathroom, you know. If she can sit down I can sit there with her and make sure she doesn't fall or anything. 'Cause I know how to do that too, but not with the other residents. Only with one's that can walk and normally she is the only one on this unit here can walk like, you know, can walk really."*

CNAs said that *"more hours would be better"* especially to help with dinner feeding. Suggestions were to shift the hours to 11 a.m. - 7 p.m. or extend the current hours until 8 p.m. They also suggested extending the program down other hallways noting that their coworkers on other units were *"jealous"* that they did not have the NA Program because *"they have challenging residents too."*

Neighborhood Assistant Interviews

The two NAs were interviewed separately to ask how they felt the program was going. Overall, the NAs felt that the program was *"working good"* and *"going smoothly."* Both NAs acknowledged competing priorities and that *"sometimes there are two CNA's coming at me to help at the same time and sometimes I have to see which one is the most needed priority to perform."* One also felt that in the beginning their role was *"a little misunderstood by the CNAs…but now it is working."* A similar theme developed as with the other groups that the timing of the shift needs. One NA suggested *"In my opinion, [to] be honest with you, my opinion, they need one person in the morning and one person in the evening because it's hard to be in the two shift at the same time. This time is really hard sometimes when I am leaving and [Resident] [is] act[ing] up."*

The NAs said they spent time putting laundry away, filling water pitchers, spending time with residents who needed on-to-one attention, escorting residents to activities, feeding residents, making resident beds, and assisting the CNAs with Hoyer lifts. The NAs acknowledged that every day was different and that they recognized that their role was to *"just try and pitch in and do whatever."* They perceived that the program is helping the overall environment in Appleblossom stating it is *"more calm and even that, even the nurse, she is able to do her job. Like, you know, you can't concentrate if you are hearing someone yelling right there in front of you when you are trying to do your work. It's hard no matter what you try it's hard. So it helped them too."*

The NAs mentioned that families are pleased that the closets and drawers are in order and that it is easier to find needed items. The NAs said they are also available for family members if they are trying to locate items in the residents' rooms or elsewhere in the facility. One NA gave an example of resident's wife coming in and asking for his personal towels that he wears during meals. The NA was able to respond right away to her request and go to the laundry room to locate the residents' personal towels so he had them for dinner time.

In addition, The NAs mentioned that they have gotten to know the residents and can often notice if someone is acting differently.

> *"As I am in the room, I talk to the residents like, "How are you today?" and um "Nice day." I mean, I try and make a conversation if they look like they're down or sometimes some days are better, I guess, for them than other days….I just like to know how they are feeling during the day why they be- you know, for different physical or behavior or something look differently let the nurse know that she is not talking to me today or she is not feeling, seems in a different mood today or something. I just try and let the nurse."*

The NAs felt they were able to spend time with residents in meaningful ways.

"Sometimes, I just walk in their rooms; just talk to them throughout the day… "Hello." Make them smile. I smile when I go in there. I love to smile so, you know, I smile and I know that's a way of communicating with them too sometimes."

"Sometimes I sit and I listen to their stories…when I have conversations with them. Sometimes I just mention it to the nurse and it, maybe, a joke or something they tell me and I just share it along… I just talk with them, however, that's a difference every day cause you never know what they are going to say to you. And I just love working with them, I like working with them the elderly. That's a challenge, too. You learn something new every day. They teach me something. Sometimes they tell me things like, you know, sometimes they give me some real stories or talk about the families or something interesting, always."

"I think, we as the neighborhood assistant, we are closer to the resident and we know them, not better than the CNAs because they do the care and everything, but what they want the stuff the way they want it and the CNAs don't have the time because they probably have ten residents or five residents. I don't know how many residents they got. They cannot spend that time with them and we as the neighborhood assistant we can spend the time with them."

Both NAs acknowledged that their affect and mood impacts the residents and that *"if we are getting upset we transmit that to the resident…..sometimes you get aggravated and you give that to the resident. I have been noticing that when you get upset…that energy, you give it to them and they are reacting. They started having a bad behavior."* The NAs felt that needed to *"be relaxed and come in with a relaxed mind when you come in to work with them and enjoy what you do."* One acknowledged that:

"Sometimes it's not easy, sometimes I get aggravated because no matter what I do she [resident] doesn't calm down. Sometimes she says she has a lot of pain or sometimes, um, I guess she wants to see her daughter or her husband, and sometimes when she is in pain she says "I want to see a doctor I want to see a doctor." Sometimes, you know, I can calm her down and I say, "Yes, we are going to see the doctor. The doctor is coming." and then she calms down. But sometimes it's really, really hard to calm her down."

It's the little things that are really big things. The NA and family members mentioned that little things mean a lot to residents and family members. *"The CNAs, they are so busy. They forget about little things that we think it's not important….are important for the resident."*

The NAs picked up on resident preferences for activities and care and said that residents complain about doing the *"same old thing."* The NAs feel empowered to ask *"What do you like*

to do?" because they wanted to be able to spend time with residents doing activities they prefer doing.

Nurse Focus Group

Three nurses from the first and second shift participated in a focus group to reflect on the program. They stated that the program is a big help because it's *"extra hand"* on deck. In other words, the NAs are extra hands who do not have a specific assignment so *"They're free. They can go here and go there you know…that's a little better where they're needed."* The nurses felt it would be helpful to have the NAs stay until 8 p.m.

> *"I mean I think if it would be a little bit later that that might be a bigger help because, like, sometimes you know we were not quite finished with dinner in the dining room and they leave, you know, to come to get the beds together instead of being able to stay there the whole time and help us, like, get the residents out of the dining room. I think that might be a bigger help and then come and do whatever they need to do with the beds. You know I think if it was a little bit longer it might be even more help, but I mean I think it's a value to us."*

The nurses acknowledged that there were *"misunderstandings"* and *"confusion"* with the NA role early on, but stated that *"it's getting better."* The nurses stated that they are "*kind of guiding them [NAs] as to where the need is and I think it is working better that way*." With regards to the program's impact on the CNAs, the nurses stated *"It's freeing up the CNAs, too, to spend more time with the residents and to do their job."* Nurses identified indicators of the success of the program as now they are *"getting to the dining room on time"*, having "*no issues with laundry"*, and able to *"help spot if they need another pair of eyes."*

A theme that ran throughout all the sessions was that the NAs could spend one-to-one time with challenging residents.

> *"The more challenging residents that we have get one-to-one attention that they need, because some of them just want someone to be with them, which the CNAs can't do because they have seven eight other people to do. So when they come and sit with them walk with them, it's…it's very helpful."*

The nurses felt that this one-to-one time with challenging residents led to a decrease in the Behavioral and Psychological Symptoms of Dementia.

> *"..And the behaviors. You know we spoke about that if somebody is acting up and they just need that one-to-one [to] take her for a walk or whatever. So that she's not sitting in her chair screaming and everybody in the neighborhood is saying make her stop make her stop. That's a big help."*

Additional outcomes the nurses perceived included fewer complaints from family and increased resident satisfaction. Nurses saw a *"decrease in complaints from family members that*

don't like to hear [resident] screaming" and in complaints about not being able to find things in the closets and drawers, *"It's a big help to us when we don't hear complaining."*

> *"I think it's improved on resident satisfaction too. A lot. Just having somebody there to talk to them or sit with them."*

> *"…one of our alert and oriented residents - so for somebody like her who can talk you know when they question her about like is everything ok she saying yeah because she's getting that personalized attention you know more than what we can give her when we can't be there somebody else is there so that little bit of talk time and taking her outside makes a big difference for her when it comes time to you know um them asking her about the facility or you know if someone's questioning her are you happy here that makes her more happy you know and she's always giving up something positive when she has like she goes outside and stuff like that."*

Some animosity was detected by the nurses from staff on other neighborhoods and may reflect a misunderstanding by the staff.

> *"They're kinda like almost not spiteful but spiteful in a sense that they don't wanta bring our residents down to their rooms like they normally would because they feel like we have more help. Like they don't understand that the neighborhood assistant is for Apple and they try to give them jobs in their neighborhoods and try to tell them to go down there and get their residents. So it's a little of a I guess like a jealousy thing too. Kinda of. It's a little bit of a problem like they can't understand that it's just Apple. They're there just for Apple as a trial thing you know what I mean. Even though you explain it to them they still do not understand it."*

Family Focus Group

One focus group was held with family members in May 2015. Five family members participated and three had loved ones on the unit with Neighborhood Assistants and two had loved ones on other Neighborhoods. Overall, family members were impressed with the NA and felt that *"the more help the aides and nurses can get the better."* They perceived the NA position as beneficial because it *"helped free the CNA up to give care."* They felt that the aides were busier and had more people to care for with greater needs. They observed the NA sorting laundry, straightening resident's closets, and drawers. They also saw the NA as help during busy times to help spot the CNA when lifting a resident and to take an anxious resident for a walk who was not allowed to walk on her own.

They greatly appreciated that the NA was *"kind and able to interact well with people."* Finally, family members felt that the addition of the NA would not change the behavior of some CNAs they perceived as *"goofing off"* or *"disappearing to another neighborhood"*, or *"wasting time on the computer." "The good aides are going to do a good job whether there is a neighborhood assistant or not. It makes it easier if there is a NA there for them to spend time with the resident."* A final concern was mentioned was that more help was needed with feeding during meal times.

With respect to meaningful interactions, family members felt that *"any kind of interaction is good."* For example, staff who say hello and use the resident's name even if they don't work on her neighborhood was viewed positively, even if the resident was unable to respond back to the staff member. Additional examples that family members gave were aides that commented on the resident's hair after returning from the beauty parlor, putting jewelry (earrings/necklace) or makeup (lipstick) on the resident. Having the resident in matching clothes illustrated to family members that the aides were paying attention and they interpreted that as better care. *"When they take a little extra care, you know, I'm thinking that they care too."* One family member mentioned that she knew which aide and nurse were working based upon how her husband acted or what her husband looked like. They perceived aides that *"knew"* their loved ones as people that would speak to their loved one throughout the caregiving process. Aide behaviors during interactions with residents such as talking, smiling, patting the residents shoulder and, hugging were all meaningful to family members. They viewed staff that had meaningful interactions with residents as being consistently *"warm"* while others were not. Family members were also aware of the overall care environment and appreciated that Parker had developed an atmosphere that was *"uniform, quiet, restful and non-threatening for the residents."* They acknowledged that if there was *"tension within staff you can tell" and "residents can feel that."*

Inconsistency in care was an indicator of poorer staff and care quality. For example, one family member explained that his wife drooled and that some days she had a bib or clothing protector on and other days she didn't. He perceived this as a difference in the care provided by aides because *"you expect the staff to see that she should have this [towel/bib]."* The family

members all agreed that there was turnover among the staff and that the *"weekend crews are not the same here."* They observe more impersonal care. For example, they notice more staff members *"talking amongst themselves"* instead of to the residents. The family members perceived that the care was good, but that on occasion, they had to advocate on behalf of their loved one. They stated that residents with family coming regularly received *"better"* care than residents who don't have family visiting. One family member stated that she *"see[s] things that I don't want to see at times."* For example, she observed an aide put a food tray down for another resident that was *"three feet away from him."* The resident was also in a reclined chair and the chair was not repositioned to allow the resident to eat. This family member wanted to unwrap his food, put the tray in front of him, or fix his chair, but knew it was not allowed. She stated *"I feel bad for some of them."* Seeing things like this were motivators for family to keep coming and to continue to advocate for their loved one. They felt that *"the staff should be more attentive to residents who don't have family visiting."*

They also observed aides and nurses taking *"shortcuts"* or *"trying to speed up the process."* For example, one nurse wrote on the lunch ticket that 100% of the resident's food had been consumed and it was only five minutes into the meal and the resident was not done eating. When the family member stated *"Do you really think its 100%? He hasn't even finished yet."* The nurse responded that he *"always eats 100%."* The family member said that that was not the case, but perceived that the nurse *"just wanted to get the task done."* Finally, family members perceived some aides to be lower quality staff members when they were observed to be *"unsmiling, unreceptive, militant, unfriendly, or resentful"* when asked to do something. Family members said that a few aides were unpleasant, uncomfortable to be around, and at times family *"felt unwelcome." "You wonder what in the world they are doing here."* One family member gave the example of an aide who was unapologetic for making the resident wait to go to bed and *"grunted and walked away"* after the family member requested something.

One family member stated *"No matter how good the care, you still want the best."* Family acknowledged that being an aide was a challenging job that required patience. They also recognized the challenges inherent to care for residents with behavioral and psychological symptoms of dementia. Finally, family members mentioned that the housekeepers, as a group, were an integral part of the care at Parker. They mentioned that they interacted well and were *"lovely to residents."*

Overall, kindness mattered to family members and the NA is not only helping the aides and residents, but family members too. For example, two male family members mentioned that NAs and CNAs were helpful in giving information about clothes their wives needed. It was a new experience for them to buy clothing items, such as bras for their wives. They were very appreciative for suggestions, such as buying front clasps or sports bras since they were easier for the aide to help put on.

Resident Focus Group

Eight residents from all three Neighborhoods of River Road participated in a focus group in June 2015. They were asked to describe a meaningful interaction they have had with an employee. One resident stated that *"meaningful interactions are when the staff are not looking at the clock or the door of the room in hopes of hurrying away."* Another resident added that "being friendly, unrushed, understanding, and hopeful make good caregiver qualities." Another resident stated *"if they are friendly and say hello to you and know who you are. Can't expect them to do everything."* Residents felt that a good staff member is *"one that comes when I call to help me get in or out of chair."* While another resident stated that she is *"surprised all the time by [employees] I think I've never seen before call me by my name."* Meeting resident preferences was another way that residents interpreted having meaningful interactions with employees. *"They know the everyday things that come up." "They get to know what you like and dislike to do. You have to tell them."* Another resident stated:

> *"If you want to walk, [employee] usually comes around in the afternoon they can take you for a walk. Other than that there is no walking. I have my aide in the morning that walks me to breakfast every single morning when she is on duty and I find that very helpful. It helps me walk and helps me to continue to walk."*

Residents felt that staff having *"to rush off to do something else"* prevented them from having meaningful interactions. *"They always seem so busy." "I try to do as much as I can by myself." "And I do everything by myself. They are busy, I leave them alone and they leave me alone, and that works out all right. I don't think I need to bother them unless it's necessary."* A final sentiment echoed by the residents was that *"Some aides are better than others."*

Residents had the perception that Parker was *"understaffed"* due to long waiting times and being too busy. One resident stated *"Sometimes when I ask for something they say they are busy and can't do it and sometimes it never gets done."* Another resident said *"I've developed patience over time to wait for staff [because] when you have your call bell on and nobody comes. They come and say 'Someone will be with you later.'"* There's also the fact that someone will say *"I'll be right there, that might be ½ an hour."* This final sentiment seemed to resonate with all the residents.

> *"I find it's very difficult to spend the rest of your life in a nursing home to begin with. So I have the patience now to wait. When I call somebody, I have the patience for them to come. Not unless they take a half an hour, but at least I'm willing to wait for them to take care of me. I find that I'm handicap and unhappy about being in a nursing home. But I also feel that this is the best place for me. So [it's] just the way I feel."*

Similarly to the family focus groups, the residents spontaneously commented that the staff *"cut corners for people with dementia"* because they perceive that the resident is not aware. They

offered that the staff could not possibly understand what it is like to live in a nursing home *"How could they understand? They've never had that experience."* Another sentiment was *"You don't know until you live in one."*

> *"I think the one word that is important for all of us is acceptance, it takes a little while to, uh, when you have lost your freedom. For example, the one thing I miss very much is driving. However, I, uh, know that sooner or later I have to give it up……You must learn to accept the conditions under which you must live now. Nobody likes to live in a nursing home……This is your new home, you get used to it."*

> *"When you've been independent all your life it's hard – you just have to go with the flow and you'll find out yourself one day too that one day it becomes harder. You must have patience and acceptance."*

A final recommendation from the residents was for staff to have name tags on their shirts that are in a font size large enough for them to see because they would like to be able to know staff names and they sometimes *"forget."*

Focus Group Findings from Leadership RE: Meaningful Interactions

One focus group was held with members of the Executive Leadership at Parker. The goal was to understand what meaningful engagement meant from the point of view of people who are in leadership positions at Parker. Clear and consistent leadership support of person-centered care initiatives leads to higher quality of care for residents and benefits the direct care staff with a greater sense of autonomy and empowerment (*Common Sense for Caring Organizations* see Appendix C for link to report). The following information represents what *"meaningful interactions"* look like to Parker Leadership.

- Knowing resident preferences, what is important to them, knowing names of family members.
- Formalized process for obtaining information about the resident through home visit via psychosocial assessment (simple pleasures, hobbies, activities, travel, what resident likes to do, who they were).
- Communicating information about the resident occurs through team meetings when resident moves into Parker. Rec Staff completes a *"get to know resident"* form by the door so staff who may not have attended meeting can read the information. Information is also listed in the EMR.
- Parker encourages residents/families to bring in meaningful objects that can serve as conversation starters.
- Meaningful interactions evoke emotion in residents – you *"see that they light up."*
- Meaningful interactions can include residents accomplishing a task such as household chore of folding laundry or watering plants.
- Time is needed for meaningful interactions five - ten minutes. Staff can't feel rushed.
- Flexibility for the staff member to capitalize on an opportunity for a meaningful interactions is important.
- Supervisors and managers need to show support and allow employees freedom to engage.

For residents who are unable to communicate?

- Staff need to *"know their language"* – the resident expressions or the way they move or a change in a repetitive noise. Facial expressions help to know if resident is engaged.
- Basic are the same, you have to know someone's likes and dislikes. It's harder to do and some staff struggle with people who are not able to verbalize because there is *"no sense of satisfaction or thank you from the resident."* Staff need to take joy in knowing they provided something meaningful. *"It is a struggle"* to work with people who are unable to communicate.
- Meaningful interactions do not have to be verbal, they could be through music, dancing, or positive touch. Staff who can share in those activities create meaningful interactions.
- While much is planned, there is opportunity for spontaneity.
- Role modeling and capturing Parker Eden Moments helps to train staff on what a meaningful interaction look and feel like.
- Staff need to support each other and learn from one another by breaking down barriers between disciplines.
- Barriers include the traditional medical model being *"most efficient"*, balancing the safety of the resident with quality of life, work load of staff, regulatory practices *"you still have to be compliant."*

CHAPTER 3. OBSERVATION FINDINGS

CNA Observations

During Phase I, observations of CNA work flow were conducted to identify a baseline sample for behaviors that were expected to be influenced by the NA Program, such as how much time CNAs spent with residents (June/July 2014). Four CNAs on the day shift and four evening shift CNAs were observed on two different days for approximately one hour (two hours total observation per CNA). The CNAs who were observed were selected by Paula based on the criteria that: 1) the CNAs normally are assigned to work on Appleblossom Way and; 2) were expected to continue working on Appleblossom Way during the implementation phase of the NA position and the follow-up evaluation phase. The reasoning behind two separate days of observations was to obtain a larger sample of work flow for each CNA since what may occur on the unit and the care that residents require can vary greatly from day to day.

Phase 2 follow-up observations took place from mid-February to the end of March 2015. For Phase 2, the same four CNAs on the day shift were observed and three of the same evening shift CNAs were observed (one was no longer employed). Baseline observational data from the CNA who was no longer employed was not included in this report since we did not have follow-up data to use for comparison.

Observation Procedures

During both phases, CNAs where shadowed on the Appleblossom Way Hallway and to main areas of the facility such as Center Court, Activities Room and dining areas. To maintain resident privacy, the observer (Justine Sefcik) remained in the hallway when personal care was being provided to residents in their rooms. When shadowing the CNAs individually, the total time the CNAs were providing assistance to each resident was recorded. This information was used to determine the total time each CNA spent providing assistance to residents, as well as the total number of residents they worked with, during the one hour period. The goal was to observe the CNAs for one hour, however some observations were just under 60 minutes depending on CNAs break time and leaving the unit or just over 60 minutes because they were in the middle of providing care to a resident toward the end of the observation period.

Day shift CNA observations occurred during the hours of 10 a.m. and 10:35 a.m. and lasted for approximately one hour. Start time was dependent on CNA break time and locating the CNA to start the observation if they were in the middle of care behind a closed door (care was not interrupted and the observation period started when the CNA emerged from the resident room). During this time period, CNAs were primarily working with residents who required extensive assistance and were providing them with morning care and assisting them out of bed. CNAs would be in the residents' rooms for long periods of time when working with these residents, and sometimes coming out of the room during care to retrieve items such as linens or lift machines and/or obtaining assistance from another CNA (or NA during Phase 2) or the nurse on the unit. In

addition CNAs were observed assisting residents to the bathroom who were already dressed for the day and sitting in chairs either in the hallway or their rooms. The CNAs would also transported residents in wheelchairs to other locations of the building such as Center Court for activities, the hairdresser or to the dining areas for lunch. The CNAs had an increased number of short interactions with more residents closer to lunch time while wheeling them to their assigned dining location. CNAs were also observed for short periods of time interacting with residents who were sitting in their wheel chair near the nursing desk on the Appleblossom Way Hallway and distributing nourishments to specific residents who received them. Some of the CNAs were observed working to calm residents who were agitated.

Evening shift CNA observations started between the hours of 3:30 p.m. and 4:02 p.m. and lasted approximately one hour. Evening CNAs were primarily observed delivering clean linens from a cart to residents' rooms and assisting residents who required extensive assist to get out of bed for dinner. As with the morning CNA observations, evening CNAs would be in the residents' rooms for long periods of time, periodically coming out of the room to retrieve items and/or obtaining assistance from another CNA (or NA during Phase 2) or the nurse on the unit. They were also observed working to calm residents who were agitated. The closer the observation period was to dinner, there was an increase in shorter interactions with more residents as they were wheeled to their assigned dining location.

Table 1 displays a side by side comparison data from Phase 1 and Phase 2 CNA observations. Overall, we find mixed results in the percentage of time CNAs spent with residents. Day shift CNAs increased in the percentage of time spent with residents while the evening shift decreased. This finding is not unexpected due to the fact that we only conducted two hours of observation per CNA. Longer observation periods would have led to more stable results of how CNAs spent their time, but was not economically feasible. However, if we combine the percentage of time spent with residents with the average number of residents served we find that during Phase 2, CNAs provided care to fewer people. This may indicate that CNAs were spending more time with residents.

Table 1. Phase 1 and Phase 2 Comparison of CNA Time Spent with Residents (rds.) Overall and by Shift

Phase 1		**Phase 2**	
Overall		**Overall**	
Avg. total time observed	*59 min*	Avg. total time observed	*60 min*
% of time CNAs with rds.	65% (range 19 – 94%)	% of time CNAs with rds.	63% (range 47 - 87%)
Amount of time spent with rds. during observation	*10 min 31 s – 59 min*	Amount of time spent with rds. during observation	*28 min 17 s – 52 min 19 s*
Avg. # rds. CNAs assisted	8 (range 3-17)	Avg. # rds. CNAs assisted	6 (range 3-11)
Day Shift CNAs		**Day Shift CNAs**	
Avg. total time observed	*57 min*	Avg. total time observed	*59 min*
% of time CNAs with rds.	55% (range 19 – 78%)	% of time CNAs with rds.	64% (range 47 – 87%)
Amount of time spent with rds. during observation	*10 min 31 s – 46 min 50 s*	Amount of time spent with rds. during observation	*28 min 17 s – 52 min 19 s*
Avg. # rds. CNAs assisted	6 (range 3-15)	Avg. # rds. CNAs assisted	5 (range 3-7)
Evening Shift CNAs		**Evening Shift CNAs**	
Avg. total time observed	*61 min*	Avg. total time observed	*60 min*
% of time CNAs with rds.	77% (range 62 – 94%)	% of time CNAs with rds.	62% (range 54 – 75%)
Amount of time spent with rds. during observation	*36 min 54 s – 59 min*	Amount of time spent with rds. during observation	*32 min 13 s – 44 min 46 s*
Avg. # rds. CNAs assisted	9 (range 5-17)	Avg. # rds. CNAs assisted	7 (range 4–11)

rds. = residents

Phase 1

As can been seen in Table 1, the average overall observation time for all seven CNAs on both Day and Evening shift during Phase 1 was 59 minutes and during these observation periods CNAs spent on average 65% of their time working with residents (range 19% – 94%) and provided assistance to an average of eight residents (range 3–17). *Day shift* CNAs were observed for an average of 57 minutes each and during the observation period CNAs spent on average 55% of their time working with residents (range 19% – 78%) and provided assistance to an average of six residents (range 3–15). *Evening Shift* CNAs were observed for an average of 61 minutes each and on average spent 77% of their time working with residents (range 62% – 94%) and provided assistance to an average of six residents (range 3–9).

When not working directly with residents, Phase 1 DAY shift CNAs were:
• Documenting on computer, checking email (range 0 – 34 *min*) • Taking care of garbage and dirty linens • Cleaning rooms • Working with personal linen cart, getting linens from closet • Washing hands • Locating another CNA and/or nurse for assistance with resident, "spotter" for lift • Locating lifting machine • Cleaning up breakfast trays • Taking extra hangers out of residents closets • Interacting with other CNAs, nurse, nursing supervisor and other departments (housekeeping) • Helping another CNA on the computer • Attending impromptu meeting with administration to discuss role changes of administration
When not working directly with residents, Phase 1 EVENING shift CNAs were:
• Delivering linens to rooms via linen cart • Taking garbage and dirty linens out of room • Getting items from linen cart • Locating lift machine, putting lift away • Washing hands • Attending impromptu meeting with administration to discuss role changes of administration • Cleaning up left over trays from lunch • Prepping for dinner – getting hand wipes

Phase 2

The average overall observation time for all seven CNAs on both Day and Evening shift during Phase 2 was 60 minutes and during these observation periods CNAs spent on average 63% of their time working with residents (range 47% – 87%) and provided assistance to an average of six residents (range 3–11). *Day shift* CNAs were observed for an average of 59 minutes each and during the observation period CNAs spent on average 64% of their time working with residents (range 47% – 87%) and provided assistance to an average of five residents (range 3–7). *Evening Shift* CNAs were observed for an average of 60 minutes each and on average spent 62% of their time working with residents (range 54% – 75%) and provided assistance to an average of seven residents (range 4–11).

When not working directly with residents, Phase 2 DAY shift CNAs were:

- At desk – documenting on the computer and talking to nurse (range of time at the desk – 0 to 25 *min*)
- Emptying garbage and dirty linen carts
- Going into the linen room to get items related to resident care
- Washing hands
- Answering nurse's questions
- Interacting with nurses and CNAs on unit, and staff from other hallways and other departments (housekeeping, maintenance, activities)
- Interacting with visitors
- Looking for location of Hoyer lift

Tasks NA observed completing while day CNAs are being observed:

- Working with linen carts, tracking what she is doing on clipboard paper
- Walking with resident on and off unit
- Working to calm resident before her agitation escalates
- Assisting CNAs in residents rooms, including providing assistance with Hoyer lift (bringing it in and out of room, providing a "spot")
- Wheeling residents to Center Court for activities
- Getting items for CNAs while they are providing care – such as extra linen from linen room
- Delivering message to CNA in room providing care that another resident needs to use the bathroom

Even though in the focus groups the nurses and CNAs said that the NA position was working out smoother than when it was first implemented, unresolved issues with NA position were still observed on the day shift.

Mid-February

- RN observed talking to NA about prioritizing what she is doing – working with residents versus fixing closets
- RN was observed talking to NA at desk (10 a.m.), CNAs on unit were standing there listening in, NA was obviously upset (unable to hear conversation)
- Lack of confidence observed by NA when a resident's companion asked the NA if she was allowed to do something – NA shrugged shoulders and turned up palms of hands, continued to follow CNA to complete task
- CNA asks NA for a "spot" to transfer resident at 10:30 a.m., NA responds that she is supposed to stay with the particular resident she is working with. At 11 a.m., two CNAs come to the unit to help get residents up because the unit is "short staffed." One CNA asked where the NA was. The NA had been off the unit with the resident. (11:10 a.m.) NA returns to the unit with the resident and the resident appears calmer than when they left

When not working directly with residents, Phase 2 EVENING shift CNAs were:
• Documenting on the computer (range 0 – 19 *min*) • Interacting with nurse at desk • Delivering linens (one CNA was observed for 10 *min* delivering linens to room) • Taking care of garbage and dirty linens • Looking for Hoyer lift • Talking about staffing issues and assignments • Off unit talking to supervisor • Interacting with staff from other units and staff from other departments (housekeeping and maintenance) • Delivering ice to residents (observed only one time)
Tasks NA observed completing while evening CNAs are being observed:
• "Spotting" transfers with lifts and assisting CNAs in residents rooms • Wheeling residents out of rooms, wheeling residents to Center Court, wheeling residents to dining rooms • Getting items for CNAs while they are providing care – such as incontinent products • Checking in on resident yelling in room • Talking to resident who was getting agitated in an effort to reduce her agitation • Taking over for CNA who is having issues with agitated resident • Taking care of call bells (making sure they are answered and turned off) • Assisting a CNA to get a resident into a chair who was not turning when walking • NA once observed running up the hallway to assist a resident who was walking without walker and almost fell

Better communication observed between the CNAs and the NAs on the evening shift compared to the day shift

- NA finished helping CNA #1 and then says to CNA #2 *"I'm with you"* – indicated she was done helping the first CNA and ready to start helping the second CNA
- On evening shift the NA was working closely with a CNA (one CNA was late for shift) – example: NA would assist CNA with a resident and then wheel the resident to the TV area in Center Court and meet the CNA in the next resident room

One unresolved issue with NA position was observed on the evening shift:

Mid-March

- NA and CNA (12-8 p.m.) talking down hallway – I can hear NA say *"What I'm doing is what I'm supposed to be doing"*

Overall, when comparing Phase 1 observations to Phase 2 observations it is difficult to determine if CNAs are spending more time with residents in *"meaningful interactions"* since implementation of the NA position. However, the NAs were observed having multiple meaningful interactions with residents in Phase 2, particularly with one resident who had behavioral disturbances which required one-to-one attention. One limitation to these observations is that the unit is constantly in a state of fluctuation based on resident census and acuity, behavioral disturbances of residents, and staff composition each day (full time CNAs versus having floats on the unit and number of staff assigned to work each shift). Therefore it is difficult to compare one day directly with a second day, and Phase 1 to Phase 2. Below are two examples of how residents changed from Phase 1 to Phase 2 to illuminate how resident changes affect CNA workflow and cannot be predicted.

Significant Resident Changes on Appleblossom Way Hallway Pre and Post Introduction of NA

In Phase 1, Mary (pseudonym) was restless and tried often to get up out of her chair alone, however she needed to walk with someone. CNAs were observed going on lengthy walks with Mary to try to reduce her agitation. Mary would often clap her hands and yell out contributing to noise on the hallway. For some of the observation period she was hospitalized.

In Phase 2, Mary had some level of agitation during almost every observation. CNAs would still take Mary for a walk and work with her to try to reduce her agitation, however it was obvious during the observations that the NA was expected to work with Mary one-to-one when she started to get agitated or the CNA working with her was not successful in reducing her agitation. The NAs spent a great deal of time walking with Mary and working to calm her agitation.

In Phase 1, Rebecca (pseudonym) was ambulatory and would wander into other residents' rooms and upset them requiring the CNAs to redirect Rebecca. She would become agitated and yell/shout out when ambulating and during redirection.

In Phase 2, Rebecca's functional ability had declined and she primarily sat in a wheelchair and required assistance and encouragement to ambulate short distances. Rebecca's affect was usually non-animated and was not heard yelling/shouting out and becoming agitated like she did in Phase 1.

Change of Shift Observations

Change of shift observations were conducted from 2:30 p.m. to 3:30 p.m. during both Phase 1 and Phase 2. Five observations were completed in both phases and occurred during the week and on the weekend. The observer, Justine Sefcik, sat close to the nursing desk to observe what was happening on the unit during this time frame. Overall the unit was quiet during both Phase 1 and Phase 2, unless a resident was exhibiting a behavioral disturbance and yelling out which did not occur during every change of shift observation. Call bells and bed alarms were answered quickly by the nursing staff. It was common to see residents sitting in the hallway in their wheelchairs/geriatric chairs near the nursing desk. They were often staring off and not engaged with anyone or their environment.

During the 2:30 p.m. to 3 p.m. observation time frame, the day shift nurse primarily reviewed Medication Administration Records (MARs) at the nursing desk, documented on the computer, and asked questions to the CNAs about residents. The evening shift nurse arrived to the unit at 3 p.m. Report was given and the narcotic count was completed between the day shift and evening shift nurse. During the 3 p.m. to 3:30 p.m. time frame, the evening shift nurse ensured that the CNA staffing for the shift was set, gave the CNAs report and conducted rounds on the unit. Then the nurse organized the medication cart for the shift and began a medication pass.

Table 2 outlines activities the CNAs were observed engaged in during shift change in both Phase 1 and Phase 2. In the Phase 2 column, there is additional information on activities the NAs were engaged in when they were in view during the change of shift observation.

Table 2. Activities of CNAs and NAs during Phase 1 and Phase 2 Observations	
Phase 1	**Phase 2**
2:30 p.m. to 3 p.m. CNAs were observed: • Going into rooms providing care to residents, assisting residents to lay down in bed • Taking a restless resident for a walk • Documenting on the computer • Delivering clean personal clothing from the blue cart in the hallway to residents' rooms • Collecting empty hangers from closets • Leaving the unit as their shift was ending Specific resident interactions observed: • CNA provided nail care to resident sitting in hallway • CNA attempted unsuccessfully to shave resident with electric razor • CNA gave a resident in the hallway a newspaper to read **3 p.m. to 3:30 p.m.** CNAs were observed: • Not always on the unit when the shift started at 3 p.m. • Going room to room delivering clean linens to the rooms • Talking to nurse	**2:30 p.m. to 3 p.m.** CNAs were observed: • Going into rooms providing care to residents, assisting residents to lay down in bed • Seen talking to each other at desk • Talking to nurse • Documenting at the desk • Interacting with staff from other departments (housekeeping) • Walking with restless resident • Getting ready to leave for the day • Completing in-service on computer in library No specific resident interactions were noted NAs were observed: • Delivering clean personal clothing from the blue cart in the hallway to residents' rooms • Trying to redirect disruptive resident who is agitated • Taking agitated resident for long walks off the unit • Talking with nurse **3 p.m. to 3:30 p.m.** CNAs were observed: • Not always on the unit when the shift started at 3 p.m. • Going room to room delivering clean linens to the rooms • Laying down a resident per visitors request • Assisting resident out of her room • Talking to nurse NAs were observed: • Continuing to deliver clean personal clothing to resident rooms • Answering call bells • Going into rooms with CNAs to assist them • Taking a restless resident for a walk • Assisting a resident into the library to visit with her husband

During Phase 1 and Phase 2, the day shift portion of the change of shift (2:30 p.m. to 3 p.m.), CNAs were present some of the time at the desk. They were also seen talking in the hallways together. Conversations were heard about resident care, staffing and "call outs", and at times was causal and not work related. The nurses were sometimes involved in the conversations. Employees from other departments were also seen on the unit such as housekeeping and activities staff, at times they were engaging with the nursing staff at the desk or in the hallway. The evening shift CNAs were not always on the unit at 3 p.m. for the start of their shift. Once they arrived on the unit they generally began delivering clean linens to the rooms via a cart. They were occasionally seen talking with the day shift CNAs and/or nurse before they left and other departments such as housekeeping, and the evening shift nurse, CNAs, and the NA in Phase 2.

The main difference observed between Phase 1 and Phase 2 during shift change observations was that during Phase 1 the day shift CNAs were often busier working with residents in their rooms, working with residents in the hallway (providing nail care to one resident) or delivering clean personal clothing to the resident rooms compared to Phase 2. In Phase 2 the NAs were responsible for delivering clean personal clothing to resident rooms and the CNAs were no longer observed completing this task at the end of their shift. Although not specifically timed, overall in Phase 2 it appeared through observations that the CNAs spent more time at the end of their shift interacting with each other, the nurse, and other staff around the desk. This could be that the CNAs have more time available at the end of the day shift with the help of the NAs on the unit. The CNAs however were not observed taking advantage of this extra time to interact and meaningfully engage residents as they waited for their shift to end.

However, this should be interpreted cautiously because each CNA varied in their effort put forth at the end of the day shift during both phases. One example is that during Phase 1 there was an observation where it appeared that a CNA did not want to assist a resident to lay down close to the end of the shift who was a two person Hoyer lift transfer; however she did go with the other CNA who said to her *"that's the job."* A counter example is a day shift CNA in Phase 2 taking a restless resident for a walk close to the end of the shift despite the NA being on the unit delivering clean personal clothing and could have been available to do this.

In Phase 2, the NAs were observed working during the shift change and appeared to be engaged in their work of delivering personal clothing and working with a restless resident. They continued to deliver the personal clothing at the start of the evening shift until they completed the task. Then they were observed going room to room with the evening shift CNAs to assist residents out of bed for dinner.

Meal Observations

For meal observations the observer, Justine Sefcik, sat in a location where staff and resident interactions could easily be observed. Numerous lunch and dinner observations were completed during Phase 1 and Phase 2. Because the units/nursing staff were assigned to rotate dining locations each week not all observations have a matched observation from both phases in terms of the time of the meal and location. However, four observations from Phase 1 have a direct comparison

observation in Phase 2. This is an Activities Room lunch observation, a Center Court lunch and dinner observation, and a Main Dining Room dinner observation. All meal observations have been taken into consideration for the results of this section.

During Phase 2, NAs were observed assisting a great amount during meal time. Just prior to lunch and dinner the NAs were observed wheeling residents to their assigned dining locations. They were observed sitting residents up for meals at tables, distributing clothing protectors and assisting residents with wiping their hands prior to the eating. The NAs were observed assisting residents with drinks while waiting for the food to be delivered. One of the NAs was observed setting residents up for dinner and then proceeding to calm a resident who was becoming anxious waiting for her meal in Center Court. The NAs assisted feeding residents when food arrived. The NAs were observed on some occasions at approximately 5:30 p.m. wheeling residents away who were done with dinner and not returning back to the dining room to assist other residents at the end of dinner. During one observation the NA was seen close to the end of her 6 p.m. shift pulling down the covers on residents' beds while the CNAs and nurses were wheeling residents out of the dining room area.

With the addition of the NAs available to assist during meals it was observed that the nurses spent more time at one table assisting residents with eating their meal and did less circulating around the room to assist other residents at different tables. The extra person to assist with meals was observed to be a benefit as residents were fed their meal closer to the time that it arrived in front of them. An observed exception to this is when the NA is needed to work with an agitated resident and is unable to help set up for the meal or to be in the dining area assisting with residents eating.

Overall, there were no major differences observed in staff to resident interactions from Phase 1 to Phase 2. Staff spent limited time talking with the residents they were feeding. Staff, however, did appear to be less tense and stressed during meals in Phase 2 compared to Phase 1. There are exceptions to this though such as one lunch observation in the activities room where the staff were heard saying they were *"short today"* even with the presence of the NA.

CHAPTER 4. QUESTIONNAIRE FINDINGS

CNAs and NAs were asked to complete a questionnaire with three standardized measures including job satisfaction, caregiver confidence, and caregiver stress (see Appendix A). The hypothesis was that the NA Program would increase job satisfaction and caregiver confidence from baseline to follow-up while decreasing caregiver stress. We asked the CNAs and NAs on Appleblossom Way to complete the questionnaire and return to Justine Sefcik in July/Aug 2014 for a baseline measurement point. In order to ensure confidentiality we did not put names or IDs on the questionnaires so the results we present are from the aggregate group that completed baseline questionnaires. We were not able to obtain responses from all participants, despite multiple reminders. A total of eight people completed a baseline questionnaire (six CNAs and two NAs) and a total of seven people completed the follow up questionnaire. One NA who was initially hired was no longer employed. Since we did not have a baseline measure for the newer NA we did not ask her to complete the follow-up questionnaire. *A note of caution needs to be mentioned in interpreting these results as the number of participants is so small, which means that one person can vastly skew results*.

The job satisfaction scale has a possible range from 18-72 with higher scores indicating greater job satisfaction. The overall baseline results for this study show a range of 41-65 with a mean of 54.6 (8.5 SD). Means of each individual item were analyzed and the three items with the lowest ratings (least satisfaction) included: 1) The pace or speed at which you have to work, 2) The teamwork between Direct Care Partners and other staff, and; 3) Your opportunities for promotion. The items with the highest ratings (most satisfied) included: 1) The way this facility is managed, and; 2) Your fringe benefits.

Follow-up scores for overall job satisfaction increased slightly by 1.7 points. The range was also slightly higher from 46-68 with a mean of 56.3 (6.7 SD). The three items with the lowest ratings (least satisfied) changed and included: 1)The way employee complaints are handled, 2) The amount of control you have over your job, and; 3) The attention paid to your observations or opinions. The highest ratings (most satisfied) also changed slightly to include: 1) The supplies you use on the job, and; 2) Your job security, and the way the facility is managed tied for second.

The next measure was the caregiver confidence in using activities questionnaire. Questions along with the average score at baseline and follow-up are shown below. Mean confidence levels increased across all questions.

How confident are you in your ability to…

1. Identify the daily (dressing, bathing, grooming) or recreational activities your residents are capable of doing?

Not confident 0 1 2 3 4 5 6 7 8 9 10 Very confident
Baseline MEAN 6.0
Follow-up MEAN 7.6

2. Involve your residents in daily and/or recreational activities?

Not confident 0 1 2 3 4 5 6 7 8 9 10 Very confident
Baseline MEAN 6.6
Follow-up MEAN 8.9

3. Use activities to distract your residents?

Not confident 0 1 2 3 4 5 6 7 8 9 10 Very confident
Baseline MEAN 8.4
Follow-up MEAN 9.1

4. Use meaningful or pleasant activities to manage boredom, upset or agitation in your residents?

Not confident 0 1 2 3 4 5 6 7 8 9 10 Very confident
Baseline MEAN 6.7
Follow-up MEAN 9.3

5. Set-up an activity (e.g., dressing, bathing, recreational activity) for your residents to participate in?

Not confident 0 1 2 3 4 5 6 7 8 9 10 Very confident
Baseline MEAN 6.5
Follow-up MEAN 7.7

The final measure used was the Caregiver Stress Inventory (CSI). The CSI is a 43-item questionnaire developed to measure the extent of stress experienced by staff associated with the care of residents with dementia. Each item is self-rated by staff members on a 7-point Likert scale (1 = not stressful, 7 = extremely stressful). The range for the overall scale is from 43-301 with higher scores indicating more stress. Baseline scores for this study averaged 139.6 (77.4 SD) and follow-up scores increased by 10.1 points to 149.7 (64.7 SD). Again the small sample means that the responses of one or two people can greatly influence the results. When analyzed by item, the three highest stressors for staff at baseline included: 1) I am afraid residents will choke, aspirate or get pneumonia because they forget to swallow, 2) When residents are so agitated and difficult to handle that I think I am doing my job badly, and; 3) When residents are uncooperative even when they apparently understand instructions. The three lowest stressors at baseline included: 1) When residents cuss at me when I am delivering their care 2) Some residents do not urinate in the urinal or toilet, and; 3) When residents constantly repeat *"I'm hungry"* or *"I want food."* At follow-up the three highest stressors included: 1) Some residents are uncooperative due to not understanding my instructions, 2) When resident's mood changes suddenly, and; 3) I worry that the care provided is not what the residents really need. The lowest stressors for staff at follow-up included: 1) Some residents walk around dressed inappropriately, 2) I feel I lack knowledge about how to best care for and help residents (e.g., how to help with eating, how to help maintain independence with ADLs), and; 3) When residents constantly repeat *"I'm hungry"* or *"I want food."*

Overall, these three measures, if administered across all direct care staff periodically, can lend insight to potential areas for staff training as well as determine what areas staff are satisfied and confident in their caregiving abilities.

CHAPTER 5. RECOMMENDATIONS

Findings and recommendations presented in this chapter are organized by the goals and objectives of the NA Program identified in the *Parker Neighborhood Assistants Pilot Program Document 12/12/13*.

1. **Did implementation of the NA Program lead to the "NAs performing non-person-centered care related tasks (e.g., bed making, filling water pitchers, putting resident clothes away), thereby offering more time for the Care Partners to provide direct care and opportunities for person-centered approaches (e.g., engaging in meaningful conversation while rendering care, offering preferred activity moments to residents)?"**

Based upon observations and focus group sessions, the NAs were performing tasks such as bed making, filling water pitchers, and putting resident clothing away. They were also engaged in feeding residents, escorting residents to activities and meals, assisting the Care Partners with Hoyer lifts, and spending one-to-one time with residents who were expressing behavioral and psychological symptoms of dementia (persistent vocalizations, agitation, and aggression). There was some confusion about whether or not NAs should be assisting with toileting residents who are able to walk. **We recommend that Parker continue to clarify the NA role and communicate roles and responsibilities to staff**. **We also recommend that Parker discuss the continuation of the NA Program versus adding a Care Partner to the team who is not specifically given an assignment of residents, but acts as a "float" to assist where needed. This would include completing tasks on the unit (e.g., bed making, filling water pitchers, putting resident clothes away) as well as providing personal care and toileting residents when there is a need. For example, if the "float" was working one-on-one with a restless resident they would be able to assist the resident to the bathroom instead of asking the assigned CNA to assist the resident.**

The quantitative data we collected from observations of the Care Partners did not suggest that Care Partners were spending more time engaging in meaningful conversations while rendering care. However, we did notice that the NAs were involved in spending a great deal of time in meaningful interactions with residents while performing their tasks. In the skilled nursing environment, we do not find support for tasks being separated as person-centered and non-person-centered. In order to provide person-centered care, all staff need to be aware of resident likes and dislikes. For example, we heard from residents that they have preferences for how their clothes are organized in their closets. Not only have the NAs picked up on these preferences, but they are engaging them in conversations while performing these tasks. NAs expressed that they know the residents *"as well as"* the Care Partners. We cannot stress enough that **e*very interaction matters***. We heard from residents that meaningful interactions *"are when the staff are not looking at the clock or the door of the room in hopes of hurrying away."* Families also observe staff behaviors and felt that it was these *"little things"* that made them more satisfied with their loved one's care. Aide behaviors during interactions with residents such as talking, smiling, patting the residents shoulder and, hugging were all meaningful to family members.

We recommend that Parker view the tasks that NAs perform as being person-centered. We also recommend that Parker provide NAs additional training in the area of communicating with residents with dementia. The NAs expressed that they *"have to have the right words for [residents], to comfort them."* Providing the *Emotion Focused Communication Training* would be beneficial because NAs are engaged in demanding one-to-one work with residents who are in their words *"challenging."* Staff need to have specific education and skills development in order to feel confident in their ability to provide care to residents with behavioral and psychological symptoms of dementia. **We also recommend that River Road formally adopt the informal dementia education model used in Evergreen Way. Specifically, the way in which the Dementia Care Coordinator spends time observing, discussing, and modeling responses to resident behavior with staff members in conjunction with viewing the CMS training modules.** This strategy, which is part problem solving and part education is an excellent strategy to support staff members who have traditionally little formal education experience. The process is valuable to take concepts learned during the modules and apply them to specific residents in current care. There is research evidence showing that CNAs are typically visual/experiential learners who prefer learning through demonstrations as opposed to reading materials. Using an educational method such as modeling a response to a specific resident's emergent behaviors is recommended as opposed to a classroom lecture or on-line training with general approaches to quality care.

2. **Did implementation of the NA Program lead to the "Direct Care Partners, by teaming with the NA, to be able to reach and support more residents in the Neighborhood at any given time, thus responding in a more individualized way?"**

Based on the observations conducted, it cannot be confirmed that the NA Program has enabled the Direct Care Partners to reach and support more residents in the Neighborhood, in a more individualized way. In fact, Care Partners provided care to fewer residents during day and evening shift Phase 2 observations. The NAs, however, were observed being able to reach and support multiple residents in an individualized way in Phase 2. This appears to be the value of the program. **We recommend that Parker view the flexibility stemming from the combined teamwork of the NA and Direct Care Partners as being able to reach and support more residents.**

In terms of teamwork, there was some existing tension observed between the CNAs and the NAs. This may be the result of the NAs having multiple competing priorities. These competing priorities at any given time may be two-five Direct Care Partners requesting their assistance, a nurse or nursing supervisor making a request, residents requesting assistance and a pre-existing list of tasks for the NA to complete such as delivering clean personal clothing to resident rooms. The CNAs may not realize how many requests for assistance the NA may have received at the same time and easily become frustrated if the NA is not available right away. We also learned that while the NAs realize how busy the CNAs are during their shift, they are not completely aware of the CNAs responsibilities as one NA stated *"They probably have ten residents or five residents. I*

don't know how many residents they got." **We recommend that Parker, to improve the teamwork atmosphere among the CNAs and NAs, stress the importance of the CNAs being instrumental in the success of the NAs on the unit. This can be accomplished through: 1) Having CNAs involved in the interviewing and hiring process of NAs so that the CNAs feel they are important in the process and invoke feelings of wanting to see the newly hired NAs succeed, 2) During the NAs orientation to the unit have them shadow the CNAs for their full shift to gain an understanding of the CNAs routine and learn the culture of the unit and, 3) Provide continuing education and support to the CNAs on the topic of mentorship.**

Although many benefits of the implementation of the NA position have been observed and expressed throughout this report, we want to offer some additional information on the observed Pros and Cons of the NA role for Parker to consider moving forward in Table 3.

Table 3. Observed Pros and Cons of NA Position

Pro	Con
Lower resident/aid ratio leading to more 'hands on deck'. For example, the NA is an extra person to answer call bells	Has to deliver messages to CNAs – such as a resident needing to use the bathroom because the NA is not allowed to assist with toileting (even residents who are limited assist)
Assists CNAs with *"spotting"* during mechanical lift transfers and reduces time that CNAs and residents have to wait for someone additional to be available	There is an observed tension between going with the CNA to "spot" a transfer and staying with a resident who is agitated
Provides extra assistance with meals: assists residents to their assigned dining locations, sets residents up to eat, feeds residents	There is observed tension between assisting with meal time and working with an agitated resident. Staff are now used to the NAs assistance with meals
NA can spend long lengths of time walking with a resident, on and off the unit	Staff are often questioning where the NA is if she is not in sight
NA is an extra person on the unit to help prevent falls – can answer bed alarms, can get walkers that are left behind when someone gets up and starts to walk without it	NA might not necessarily be able to provide the resident the assistance they need and have to get CNA or nurse

3. **Did the implementation of the NA Program enable "Direct Care Partner participation in resident/family and care team meetings (e.g., pre-admission and weekly care plan)?"**

Care partners have not attended care planning meetings. We were told that this was *"largely a scheduling issue"* and not related to the NA Program. **We recommend that Parker revisit this goal and strongly consider overcoming scheduling barriers to include Care Partners/NAs in resident conferences. There are numerous studies that have shown that one of the greatest barriers to providing person-centered care is the lack of CNA access to resident conferences**. Including direct care workers in care conferences/resident conference empower staff who are

typically a marginalized group in health care. "Their lack of inclusion on planning teams could lead to the focus on safety and bath and bowel functions to the exclusion of PCC. PCC requires staff who are empowered and who engage in interpersonal relationships with residents, families, and other staff members. These skills can be intentionally taught and nurtured." (Kolanski, Van Haitsma, Penrod, Hill, & Yevchak, 2015, pg. S57).

In addition, having the Care Partner and/or NA attend care planning meetings sends a message that their voice is important in the care of the resident and would be a good opportunity to work to *"break down disciplinary barriers"* (mentioned as a concern during the leadership focus group session) by sharing successful strategies for interacting with residents. Care conferences can also be a method for brainstorming about behaviors or sharing information about successful practices with particular residents. Encouraging family members to attend care conferences is also recommended. Families can help staff with learning about preferences and or problem solve especially when first transitioning to the new environment.

4. **"The program will also support Parker employees individualized development goals, talent development of Direct Care Partners (education/coaching on how to mentor others), provide opportunities to further develop staffing models/delivery of person-centered care in Monroe, and/or future sites, and serve as a feeder for staffing these other sites."**

We did not collect data to be able to specifically respond to this objective. However, we do see an opportunity to further develop staffing models and the delivery of person-centered care. While Parker does an excellent job of assessing preferences and learning about each resident prior to moving into the facility, it is very difficult to translate preferences into actionable steps for direct care workers. In addition, we have found that preferences change over time and *"depend on"* contextual factors. Therefore, we again **recommend that CNAs and NAs be included in care conferences where discussions about interpreting preferences into care are explicit. We also recommend that Parker develop a recreation therapy/NA (or CNA) coaching program to assist in managing the behavioral and psychological symptoms of dementia.** In this program, NAs can ask residents with dementia about their recreation and leisure preferences using *The Preferences for Everyday Living (PELI: See Appendix B).* If residents are not able to communicate, NAs can consult with family members, or use their own observations of the resident's preferences. The interdisciplinary care team can meet to review preferences and identify three activities suited to the resident's current interests and abilities and the CNA/NA can choose the one activity they would most enjoy leading. The CNA/NA can be coached by recreation staff to learn to deliver the activity for 10 minutes, two-three times per week. This type of intervention has been found to increase resident happiness and reduce anger compared to a control group. A peer-reviewed journal article with more details has been provided in Appendix C. We would also recommend that Parker explore using resident preferences as a way of grouping residents in future sites. This would allow recreation staff to focus on meeting a set of similar preferences, while adjusting the activity based on functional, cognitive, and physical ability.

5. While not one of the objectives this evaluation, the original document guiding the NA Program developed by Parker (12/12/13) stated: **"By shifting basic Neighborhood tasks from direct Care Partner to NA, and growing a partnership between the two, our Eden culture will be fostered: together they will collaborate to nurture staff to resident relationships and promote a sense of companionship, provide spontaneous pleasures to alleviate boredom, and respond to each resident's ever changing needs and preferences. As a consequence, resident quality of life and care will be enhanced, and Parker employees will feel valued and supported to grow and learn – professionally and personally."**

While we did not see evidence of *"spontaneous pleasures to alleviate boredom"* we did find support that the quality of life of the Neighborhood *as a whole* was improved. For example, having the NA spend one-to-one time with residents who express behavioral and psychological symptoms of dementia improved the quality of life of the whole Neighborhood and was expressed by staff, residents, and family members. Care Partners explained that their routines were less stressful, residents were *"on-time"* to meals, and residents were fed their meal closer to the time that it arrived in front of them. Family members had fewer complaints about not being able to find resident belongings.

If Parker chooses to continue/expand the NA Program, **which we recommend**, **we encourage Parker to continue to tack caregiver stress, confidence, and job satisfaction (see Appendix A). Using the measures we include is recommended if existing measures are not sensitive enough (e.g., responses are all at the maximum [ceiling effect]). In addition, we recommend that Parker track outcomes that were not initially considered. Family satisfaction, resident satisfaction, safety (i.e., falls), and behavioral disturbances were all qualitatively mentioned as outcomes affected by the addition of the NA staffing line.**

In addition, one issue that arose was the perception by both residents and family members that residents who could not speak for themselves and were without advocates received care that was below the level of care that residents received who could speak for themselves or who had advocates visiting the facility frequently. These perceptions were spontaneously offered during the resident and family member focus groups and exemplar observations were shared to support why the participants felt this way. A similar concern was noted in the leadership focus group. Discussions about how to have meaningful interactions with residents who are unable to communicate *"are a struggle"* for staff. This is indeed a challenging area for research and practice.

We recommend that Parker specifically target residents who are unable to communicate and do not have regular family visiting for pilot testing the one-to-one tailored activity intervention mentioned in #4 above. After identifying an activity that a resident prefers, CNAs/NAs can be coached by recreation staff to learn to deliver a tailored one-to-one activity for 10 minutes, two-three times per week. Leadership recognition of the difficulties in working with residents who are unable to communicate can be a recurring theme during care conferences to support and encourage direct care workers in their attempts to meaningfully interact with these

residents. In addition, www.nursinghometoolkit.com is a resource for nonpharmacologic approaches for addressing behavioral and psychological symptoms of dementia. Many of the evidenced based approaches included in the toolkit are person-centered in nature.

Overall, it is our assessment that the NA staffing line is an innovative program that did improve the quality of life on Appleblossom Way and can lead to Parker's ability to provide high quality person-centered care.

Appendix A

Staff Questionnaire

How satisfied are you with……

	Very Satisfied	**Satisfied**	**Dissatisfied**	**Very Dissatisfied**
1. The recognition you get for your work?				
2. The amount of responsibility you have?				
3. The way this facility is managed?				
4. The attention paid to suggestions you make?				
5. Your job security?				
6. Your fringe benefits?				
7. The amount of time you have to get your job done?				
8. The teamwork between direct care partners and other staff?				
9. The attention paid to your observations or opinions?				
10. The supplies you use on the job?				
11. The pace or speed at which you have to work?				
12. The way employee complaints are handled?				
13. The feedback you get about how well you do your job?				
14. The amount of control you have over your job?				
15. The way management and direct care partner staff work together?				
16. Your opportunities for promotion?				
17. The amount of time you have to discuss resident problems with other direct care staff?				

Next, how confident you feel in your ability to do daily and recreational activities with residents under your care.

On a scale from 0 to 10, with 0 being not confident and 10 being very confident

How confident are you in your ability to…

1. Identify the daily (dressing, bathing, grooming) or recreational activities your residents are capable of doing?

Not confident 0 1 2 3 4 5 6 7 8 9 10 Very confident

2. Involve your residents in daily and/or recreational activities?

Not confident 0 1 2 3 4 5 6 7 8 9 10 Very confident

3. Use activities to distract your residents?

Not confident 0 1 2 3 4 5 6 7 8 9 10 Very confident

4. Use meaningful or pleasant activities to manage boredom, upset or agitation in your residents?

Not confident 0 1 2 3 4 5 6 7 8 9 10 Very confident

5. Set-up an activity (e.g., dressing, bathing, recreational activity) for your residents to participate in?

Not confident 0 1 2 3 4 5 6 7 8 9 10 Very confident

DIRECTIONS: Each of the following statements describes the behavior of a resident or a circumstance of care. You are asked to indicate the extent to which each of the statements is currently a cause of stress for you as you care for residents. Please circle the number on the scale provided that corresponds to the extent each statement describes a source of stress for you.

	Not Stressful						**Very Stressful**	**Behavior Did Not Occur**
1. Some residents are uncooperative due to not understanding my instructions.	1	2	3	4	5	6	7	99
2. Some residents do not urinate in the urinal or toilet.	1	2	3	4	5	6	7	99
3. Some residents constantly (or for frequent long periods) yell loudly or laugh shrilly.	1	2	3	4	5	6	7	99
4. Some residents strike or try to strike me.	1	2	3	4	5	6	7	99
5. Some residents rummage through or use staff belongings (e.g., belongings at the nursing desk).	1	2	3	4	5	6	7	99
6. Some residents keep trying to go home or each day think they are going home.	1	2	3	4	5	6	7	99
7. Some residents become agitated when taken off the unit (e.g., in a car or to unfamiliar surroundings).	1	2	3	4	5	6	7	99
8. Some residents are constantly agitated and cannot be calmed.	1	2	3	4	5	6	7	99
10. Some residents walk around dressed inappropriately.	1	2	3	4	5	6	7	99
11. Some residents continue to repeat inappropriate behavior after staff have intervened and corrected them.	1	2	3	4	5	6	7	99
12. When a resident's mood changes suddenly.	1	2	3	4	5	6	7	99

	Not Stressful						Very Stressful	Behavior Did Not Occur
13. When residents fall due to unsteadiness when standing or walking.	1	2	3	4	5	6	7	99
14. When Residents are uncooperative even when they apparently understand instructions.	1	2	3	4	5	6	7	99
15. When residents constantly repeat *"I'm hungry"* or *"I want food."*	1	2	3	4	5	6	7	99
16. When residents' behaviors indicate that something is wrong, but they cannot tell you what.	1	2	3	4	5	6	7	99
17. When residents are so agitated and difficult to handle that I think I am doing my job badly.	1	2	3	4	5	6	7	99
18. When residents talk constantly.	1	2	3	4	5	6	7	99
19. When residents cuss me when I am delivering their care.	1	2	3	4	5	6	7	99
20. When residents require help to eat, but refuse help.	1	2	3	4	5	6	7	99
21. When residents require constant reminding to eat, bathe, or toilet.	1	2	3	4	5	6	7	99
22. I worry that residents will hurt themselves due to their constant agitation.	1	2	3	4	5	6	7	99
23. When residents have periods of extremely inappropriate behavior that lasts for several hours.	1	2	3	4	5	6	7	99
24. I worry that the care that is provided is not what the residents really need.	1	2	3	4	5	6	7	99
25. When residents will not stay in bed at night.	1	2	3	4	5	6	7	99
26. When residents follow me or stay at my side all the time, asking questions, forgetting or not accepting my answers.	1	2	3	4	5	6	7	99

		Not Stressful						Very Stressful	Behavior Did Not Occur
27.	When a great deal of staff time and attention are required to complete simple tasks.	1	2	3	4	5	6	7	99
28.	When residents rummage in other residents' rooms.	1	2	3	4	5	6	7	99
29.	When residents are poorly groomed.	1	2	3	4	5	6	7	99
30.	When residents require my attention even though I am busy with other necessary tasks.	1	2	3	4	5	6	7	99
31.	When residents put their possessions in inappropriate places (e.g., toilet, waste basket).	1	2	3	4	5	6	7	99
32.	When residents refuse their medication.	1	2	3	4	5	6	7	99
33.	I am afraid residents will choke, aspirate or get pneumonia because they forget to swallow.	1	2	3	4	5	6	7	99
34.	When residents will not stay in chairs or bed.	1	2	3	4	5	6	7	99
35.	I feel I lack knowledge about how to best care for and help residents (e.g., how to help with eating, how to help maintain independence with ADL's).	1	2	3	4	5	6	7	99
36.	The amount of patience needed to work with residents (e.g., the amount of time it takes, inappropriate behavior).	1	2	3	4	5	6	7	99
37.	The lack of resources (agency commitment) to care appropriately for the residents.	1	2	3	4	5	6	7	99
38.	The lack of a unified approach among all disciplines and administration to care for and assume responsibility for the residents' care.	1	2	3	4	5	6	7	99

	Not Stressful						Very Stressful	Behavior Did Not Occur
39. Visitors often do not understand the residents' behavior, do things to provoke agitation and I often do not know what I can do to counsel the visitors.	1	2	3	4	5	6	7	99
40. When residents are unpredictable (e.g., cooperative and calm and then suddenly angry, scream, grab or hit me).		2	3	4	5	6	7	99
41. I worry about residents irritating each other, getting into fights, and hurting each other.	1	2	3	4	5	6	7	99
42. The current physical arrangement for caring for the residents.		2	3	4	5	6	7	99
43. Being constantly reminded about how to respond to behavior of residents.	1	2	3	4	5	6	7	99

Appendix B

Recreational and Leisure Items from the Preferences for Everyday Living Inventory

(Resident, family, or staff member can respond)

How important is it to you…

1. To do things with groups of people
2. To spend time one-on-one with someone
3. To participate in religious services or practices
4. To reminisce about the past
5. To be around animals such as pets
6. To be involved in cooking
7. To keep up with the news
8. To watch or listen to TV
9. To listen to music you like
10. To exercise
11. To participate in cultural traditions
12. To play games
13. To go outside to get fresh air when the weather is good
14. To use the computer
15. To take care of plants
16. To go shopping
17. To attend entertainment events
18. To do outdoor tasks
19. What are the resident's favorite hobbies? How important is it to you to do your favorite hobbies?
20. What are the resident's favorite activities? How important is it to you to do your favorite activities?

Response Options: Very Important, Somewhat Important, Not Important, Important but can't do

Plan recreation/leisure activities based upon very important preferences.

Appendix C

Resources

1. A Randomized Controlled Trial for an Individualized Positive Psychosocial Intervention for the Affective and Behavioral Symptoms of Dementia in Nursing Home Residents.
2. "Wish we would have known that!" Communication Breakdown Impedes Person-Centered Care.
3. Common Sense for Caring Organizations: Results from a Study of High-Performing Home Care Agencies and Nursing Homes. Can be retrieved at this link:

   https://osuwmcdigital.osu.edu/sitetool/sites/odswpublic/documents/StrakerFinalReportv1(1).pdf

4. "It Depends": Reasons Why Nursing Home Residents Change their Minds About Care Preferences.
5. The Consistency of Self-Reported Preferences for Everyday Living: Implications for Person-Centered Care Delivery.
6. Promoting positive behavioral health: A nonpharmacologic toolkit for senior living communities. http://www.nursinghometoolkit.com/