Resident Choice and the Survey Process: The Need for Standardized Observation and Transparency

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Purpose: To describe a standardized observation protocol to determine if nursing home (NH) staff offer choice to residents during 3 morning activities of daily living (ADL) and compare the observational data with deficiency statements cited by state survey staff. Design and Methods: Morning ADL care was observed in 20 NHs in 5 states by research staff using a standardized observation protocol. The number of observations in which choice was not offered was documented for 3 morning ADL care activities and compared with deficiency statements made by surveyors. Results: Staff failed to offer choice during morning ADL care delivery for at least 1 of 3 ADL care activities in all 20 NHs. Observational data showed residents were not offered choice about when to get out of bed (11%), what to wear (25%), and breakfast dining location (39%). In comparison, survey staff issued only 2 deficiencies in all 20 NHs relevant to choice in the targeted ADL care activities, and neither deficiency was based on observational data. Implications: Survey interpretative guidelines instruct surveyors to observe if residents are offered choice during daily care provision, but standardized observation protocols are not provided to surveyors to make this determination. The use of a standardized observation protocol in the survey process similar to that used by research staff in this study would improve the accuracy and transparency of the survey process.

Key Words: Survey process, Choice, Assessment, Observational protocol, Quality of life

Resident- or patient-centered care is a concept that is embraced across all health care settings, including long-term care. The concept of resident-centered care encompasses a wide range of options, but the common theme that defines most efforts centers on determining consumer preferences and encouraging choice about care (Rahman & Schnelle, 2008; Saliba & Schnelle, 2002). In nursing home (NH) settings, where residents both live and receive medical care, the concept of resident-centered care focuses on offering residents choices about all aspects of their lives, including those aspects that affect daily life quality.

The interest in providing choice to NH residents is reflected on a national level by a large coalition of NH care providers and advocates who have given rise to what is popularly known as the “culture change movement” (Weiner & Ronch, 2004). This movement encompasses a broad range of interests, but at its core is the emphasis on resident autonomy and the importance of offering residents choices about their care and how they spend their daily life. There is a growing emphasis in the federal regulatory process on resident-centered care and choice when assessing NH care quality as part of the federal survey. The interpretative guidelines for quality assessments in the federal survey include instructions in many areas, such as incontinence,
to document residents’ care preferences. In addition, survey deficiencies for quality of life include language that specifically addresses residents’ care preferences and choice (Interpretive Guidelines State Operations Manual, 2008). Deficiencies in specific domains of care required by regulation are labeled as F-tags and given a number. The F-tags most obviously relevant to the issue of choice are 241 (dignity), 242 (self-determination and participation), and 246 (accommodation of needs and preferences). For example, F-tag 246 specifies that a resident has the right to “reside and receive services in the facility within reasonable accommodations of individual needs and preferences except when the health or safety of the individual resident or other residents would be endangered.”

Despite the consensus that the availability of choice is important to residents’ quality of life, there is little specificity as to how NH survey staff or direct care providers can measure whether choice is being offered to residents during daily care provision. The guidelines about how to observe whether choice is offered to residents during care are particularly vague. For example, the interpretative guidelines relevant to dignity and self-determination encourage survey staff to observe if “staff show respect to residents,” “staff pay attention to residents as individuals,” “staff make adjustments to allow residents to exercise choice and self-determination,” and “staff respond in a timely manner to resident requests for assistance.”

These nonspecific guidelines for observations result in two implications for the survey process and the ability of NH care providers to understand how they are evaluated on this aspect of care. First, one cannot expect hundreds of even highly competent surveyors to translate these observational guidelines into a consistent and accurate method of observation during the survey process. The lack of specificity in the guidelines violates the most basic rules of measurement in that it does not define how or what to observe. For example, what behaviors are observed that demonstrate “respect,” and what “adjustments” count as “honoring choice”? The absence of specifically defined measurement protocols in this and other survey areas is a major factor contributing to criticism that the survey process is inconsistent and inaccurate. Second, one cannot expect NH care providers to improve care in this area if they are unable to determine how often staff are not offering and honoring residents’ choices during daily care. Accurate and timely observational data are especially important for quality improvement in NHs due to the limitations of other available data sources, namely, medical record documentation (Schnelle, 2007). Observational data are particularly critical to measure residents’ quality of life because there is little to no medical record data relevant to how staff interact and communicate with residents during daily care provision.

The accuracy, consistency, and transparency of the survey process will only be improved if the protocols used to measure quality and compliance with regulatory standards meet the minimal standards that guide reliable measurement. In the case of observational protocols, these minimal standards require that the care to be measured and rules of measurement (what, when, and how) be explicitly defined. The evidence that these measurement criteria are met for a specific domain, such as choice, requires that acceptable interobserver agreement be demonstrated when different surveyors observe the same resident care episode. None of these criteria has been demonstrated for the survey process in general or for quality-of-life areas relevant to choice, in particular. In fact, given the vague language describing the regulatory requirements that surveyors must work with, it is not possible to establish interobserver agreement even if decisions were made to do so.

The purpose of this study was to describe a standardized observation protocol to determine if NH staff offered choice to residents during three morning activities of daily living (ADL) and compare the observational data with deficiency statements cited by survey staff relevant to choice. The following research questions were addressed:

1. What proportion of residents is offered a choice or have their preferences honored when research staff use a standardized observation protocol that meets minimum observation standards for consistent and accurate measurement?
2. Is there a relationship between results based on the observation protocol and deficiencies relevant to choice cited by survey staff in the same NHs where observations are conducted?

Methods

Participants and Setting

The data for this study were collected as part of a larger project to evaluate a new survey process (White et al., 2007). Twenty NH site visits were
conducted in five states (four site visits per state) where the new survey process was being pilot tested. Nursing home sites were selected because they were scheduled for an annual state survey in which they are required to participate if they receive Medicare/Medicaid funds. Research staff were made aware of the survey schedule by the Centers for Medicare and Medicaid Services (CMS) because the larger project was funded by CMS to evaluate the survey process and the study design required that research staff be present at the same time as survey staff. Research staff agreed to not contact NHs before the visit and arrived at the NH 1–2 hr after survey staff. Two sites in each state received their annual survey using the new survey process, and two sites in each state that were matched to the first pair on size, ownership status, and deficiency history received their annual survey using the standard survey process. The analyses in this study were conducted by aggregating the data from all 20 NH sites because there were no differences between survey types on any of the observational or survey deficiency measures of interest. The study received an exemption from two separate institutional review boards based on the exemption category 45 CFR 46.101(b) (5) because this project qualified as a research demonstration project.

The larger survey evaluation study required residents to have a length of stay less than 1 year and be at risk for incontinence, pressure ulcers, or unintentional weight loss. The primary risk factors used to identify the resident sample for the larger study included medical record documentation of incontinence status, history of unintentional weight loss or pressure ulcers, and dependence on staff for eating or repositioning. The intent was to select a minimum of 10 residents per NH who had one or more of these risk factors for the larger survey evaluation study. Because some residents had multiple risk factors, this method resulted in a sample size ranging from 11–31 residents per NH site.

A subsample of residents from the larger study who met the aforementioned criteria and who had a Minimum Data Set (MDS) recall score of 2 or more as well as an MDS transfer score of 2 or more (i.e., requires staff assistance with transfer out of bed) were selected for the choice observations in this study. The rationale for these inclusion criteria was that these residents would remain capable of accurately reporting their preferences for care; yet, they would also need staff assistance to perform the ADLs targeted for observation in this study. An MDS recall score of 2 or greater has been shown to reliably identify NH residents capable of accurately describing the care they receive (Simmons & Schnelle, 2001). In addition to residents selected for observation based on the aforementioned criteria, residents who were in the same proximity (most often roommates but occasionally residents in adjacent rooms) also were observed if they were provided care during the same time period as the targeted residents. This resident selection strategy was used to maximize the number of observations that could be conducted in the time frame available for the observational data collection. Approximately 33% of all morning ADL observations were for residents in close proximity who received care during the same time period as the targeted residents. For residents in close proximity to the targeted residents, observers were instructed to discontinue the observation if the resident did not respond to verbal prompts from NH staff during the care episode on the assumption that these residents may not be capable of expressing a choice. However, due to limited research staff time, the medical record information of these residents was not retrieved to verify cognitive status (e.g., MDS recall score). At least two separate NH staff members were observed in each site.

Finally, care plans were reviewed for targeted residents (excluding those observed in close proximity) to determine if there were specific care instructions related to resident preferences in the three ADL areas or a rationale for why residents should not be offered choice at the point of care. For example, a resident might have a fixed preference for when to get up (e.g., always 8:00 a.m.) and prefer not to be asked each morning. No specific language could be found to indicate that a resident should not be offered choice at the point of care for any of the residents in the sample.

**Standardized Observation Protocol**

The observation protocol targeted three ADL care activities during the morning hours: transfer out of bedtime, dressing, and breakfast dining location. Specifically, the observation protocol required research staff to document if NH staff greeted the resident, if the resident stated a spontaneous care preference (e.g., “I would like to get up now.”), if NH staff offered choice (words used by NH staff were recorded by research staff observers verbatim), if NH staff honored a resident’s stated preference or choice, and the resident’s reaction to care delivery (e.g., cooperative, resists care verbally...
or physically). These three ADL care activities were targeted for two main reasons. First, bedtime and dressing are given as examples in the guidelines for areas wherein surveyors should inquire and observe if NH staff provide residents with choice. Second, morning ADL care offers a predictable and time-efficient opportunity to observe how NH staff provide care to residents. For example, residents are usually assisted out of bed, dressed and groomed, and provided breakfast. There are few other times during the day that so many ADL activities important for resident choice occur in a short predictable time period.

Observations were conducted during the morning hours between 6:30 a.m. and 9:30 a.m. Research staff either observed care from the hallway through an open doorway or accompanied NH staff into resident rooms if the door was closed or the curtain pulled to provide care. If research staff entered resident rooms, they positioned themselves as unobtrusively as possible for observation. Standardized scripts were prepared to introduce NH staff to the observations and answer staff or resident questions. If asked, residents and staff were both told the research staff member’s name and that the purpose of their presence was to observe morning care. Residents seldom inquired about what research staff were doing and no resident or staff member refused the observations. The acceptance of the observations among NH staff was likely due to the fact that a state survey was being conducted in the facility, although survey staff were not present during the observations. In addition, the acceptance of the observation protocol by both staff and residents also may reflect the unobtrusiveness of the trained research staff conducting the observations. Research staff did not shadow surveyors within the same NH sites while the surveyors conducted their own ADL care observations based on survey guideline instructions. Thus, it was not determined in this study if surveyors observed ADL care for the same residents targeted by research staff during any part of the survey process.

The following key NH staff behaviors were observed for each of the three ADL care activities:

1. Did residents express a spontaneous preference for the ADL care activity (e.g., getting up) prior to staff either talking to them or providing assistance?
2. Did staff use words with the resident that implied that the resident was being offered a choice?
3. Did staff honor the resident’s preference if the resident made a choice in response to a prompt or otherwise (e.g., spontaneously) expressed a preference?

Interrater agreement (above 90%) was established between three different pairs of observers in a training site prior to formal evaluations in the 20 participating NH sites undergoing survey. Reliability was established by having two staff observe the same resident care episode(s) until there was documented agreement above 90%. After reliability was established at a level above 90% among all research staff observers during initial training, one research staff person observed each resident during data collection in each of the 20 participating NHs.

During initial training, an important measurement issue arose related to the definition of “offering choice.” A typical style of communication between residents and staff was a variation of the following: “Hi Ms. Smith, it’s time to get up now, okay?” or “Let’s go to the dining room, okay?” This type of communication implied choice but was more in the direction of soliciting assent to care than alternative direct communications of choice such as “Do you want to get up now?” or “Where do you want to have breakfast?” There is no clear advice in the survey guidelines or the research literature that defines what types of communication meet the intent of the guidelines for offering choice. Thus, for the purpose of this study, either type of communication was counted as staff offering choice to residents.

However, a secondary qualitative data analysis was conducted to discriminate between the two styles of communication. The words or phrases staff used to communicate with the resident during morning ADL care were recorded verbatim by research staff. These comments were then reliably coded into either active choice (e.g., “When do you want to get up?”) or passive choice/assent (e.g., “It’s time to get up now, okay?”) by trained research staff different from those who conducted the observations. Coding was based on the transcripts of the verbatim comments recorded by research staff observers. Coding instructions provided key words and examples that defined passive choice/assent (e.g., “time to get up, okay”) and active choice (“do you want to get up now or later?”), and two raters independently coded all comments. The percent of comments for which there was agreement for active and passive choice was then calculated and documented to be above 90%.
Survey Deficiencies

Survey results that render the NH out of compliance with survey regulations are written in CMS Form 2567. The survey process does not document instances when care is in compliance. F-tags written for the quality-of-life areas most relevant to choice (i.e., dignity, accommodation of needs, self-determination) were easy to identify and relate to the specific data source used by the surveyor to identify a problem. However, there are no specific rules for how survey findings should be converted into F-tags and different F-tags can be cited for the same finding. This was demonstrated in a recent study that showed that different surveyors often cite different F-tags for the same findings (Lee, Gajewski, & Thompson, 2006). Thus, all the F-tags cited at the study NHs were analyzed to determine if there was specific language that indicated a care problem potentially related to choice. For example, facilities were cited for not providing residents with access to their money whenever they wanted, for serving pureed bread in place of pureed pancakes, and for pushing a wheelchair for an independent resident. F-tags other than dignity, accommodation of needs, or self-determination were written in all these cases. Therefore, these citations were liberally interpreted as possible instances of decisions or actions made for residents without their input and instances relevant to not offering or encouraging choice. Using this liberal definition, two research staff achieved 80% agreement on the identification of F-tags relevant to choice.

Results

The bed size of the 20 participating NHs ranged from 85 to 269 beds. Fourteen of the 20 NHs were for profit. Staffing data are absent from this study, but one NH in this sample received a citation for inadequate staffing. The number of residents observed by research staff across the 20 NHs for each of the three targeted ADL care activities was as follows: transfer out of bed, n = 132; dressing, n = 110; and breakfast dining location, n = 118. The numbers differed for each ADL care activity because care did not consistently occur for all three activities during the time frame for the observations (6:30 a.m. to 9:30 a.m.).

Observational Data

The number of observations in which a resident expressed a preference that was honored or made a choice in response to a staff prompt (active or passive choice) that was honored was 118 of 132 observations (89%) for transfer out of bed time, 82 of 118 observations (71%) for breakfast dining location, and 75 of 110 observations (68%) for clothing choice. In all other cases, there was no communication between NH staff and residents during care that could be interpreted as NH staff offering choice or the resident spontaneously expressing a preference. Most typically, NH staff simply provided care without talking to the resident about their preference in the specific ADL area. There were no instances when residents’ preferences were not honored when stated, but the data could not be separated between staff honoring spontaneously stated preferences and staff honoring preferences solicited by prompts. The observational form included a section with the following label: “Did staff use words that offered choice or did resident express a preference prior to prompting from staff?” Thus, spontaneously stated preferences by the resident could not be separated from staff prompts of choice because the original intent of the observation protocol was only to measure if residents’ preferences were honored by NH staff during daily care provision. The observation protocol has been further refined since this study to make this distinction. Analyses of the language used by staff to communicate with residents showed that much of the communication was coded as passive choice/assent for care provision. This was particularly true of communications related to transfer out of bedtime in which 28% were coded as passive (e.g., “It’s time to get up now, okay?”).

Survey Deficiency Data

A total of 28 F-tags written for care across the 20 NHs could be liberally interpreted as relevant to choice, although relatively few of these citations were in the areas most relevant to choice. Two of the citations were in the category of self-determination (F-tag 242), one in dignity (F-tag 241), and five in accommodation of needs (F-tag 246). Furthermore, deficiencies were documented for only two of the ADL areas that were the focus of this study. One resident was documented as not being able to get up when he or she wanted and one for not being able to dress according to his or her choice. In the case of dressing, the source of evidence used to support the deficiency was resident’s self-report during an interview as opposed to observations of morning ADL.
care. In the other case (out of bed), the deficiency was based on an observation by the surveyor that the resident’s preference was not honored, although it could not be determined if this surveyor observation was based on one of the same residents observed by research staff.

There was a wide range between NHs on the percent of observations in which choice was offered based on research staff observations (0%–43%). In only one NH was choice offered during every observation period (0% failure). However, despite the variability between sites based on research staff observations, there was no difference between NHs for choice-related F-tags cited by surveyors. There were eight NHs that received no choice-related citations from surveyors, but research staff observational data showed that residents were not offered choice during an average of 25% of the observations (n = 146 observations) across these eight sites. In comparison, there were 12 NHs that did receive a choice-related citation by surveyors, and research staff observational data showed that residents were not offered choice during an average of 23% (n = 214 observations) of the observations across these 12 sites.

Discussion

The results of this study demonstrate that a standardized observation protocol can be used to determine if NH staff offer and honor choice for residents during morning ADL care delivery for three aspects of morning care (i.e., out of bedtime, dressing, and breakfast dining location). The observation protocol was reliable, feasible, and produced data that suggested significant areas for improvement. Specifically, the observational data showed that resident preferences were consistently honored when stated, but a significant number of residents either did not spontaneously state a preference or were not offered a choice by NH staff for two of the three targeted ADL care activities. The exception was transfer out of bedtime wherein 89% of the observations indicated that choice was either spontaneously expressed or solicited and honored by NH staff. However, even in this case, much of the communication from NH staff was categorized as passive choice (i.e., soliciting assent) rather than active choice (27%). It should be noted that survey was being conducted in the study sample of NHs while research staff were conducting observations related to choice; thus, the presence of survey might have increased the probability that NH staff offered choice to residents during morning ADL care delivery.

Survey documentation showed NH staff failure to offer choice to residents only twice in 20 NHs for the three targeted ADL care activities—one case based on surveyor observation and the second case based on resident interview. Surveyor documentation indicating only two instances of NH staff failure to offer residents’ choice across the 20 NHs likely reflects the ambiguity of the instructions in the interpretative guidelines about how to make this determination. These aspects include defining how care relevant to choice can be recognized as well as when or how to observe care relevant to choice.

The absence of specific criteria about how to define and measure choice was addressed with the observation protocol used in this study. However, these criteria were defined by research staff for the explicit purpose of obtaining interobserver agreement for the observation protocol. Given the importance attached to resident-centered care and the availability of choice for NH care quality, it is important to develop a broader consensus about how to define and measure the larger construct of resident-centered care and the specific aspect of offering residents choice during daily care provision across a range of daily care activities including, but not limited to, the three aspects of care targeted for this study (i.e., out of bed time, dressing, and breakfast dining location).

Two measurement issues were encountered in this study that should be the focus of such a consensus discussion. First, we suspect that including staff communications that solicit assent in the same category as staff communications that offer more active choice will be a debatable point; many would not regard communications to solicit assent as true choice. Second, although there were many observations in which a resident did not express a preference and was not encouraged to do so, there were also no instances when residents complained about lack of choice in ADL care. It appears as though residents accept routine NH care even though there was no documentation in the care plan to indicate a standard preference for a routine in these care areas. Is it acceptable to not offer choice at the point of care delivery if a resident does not actively request choice or complain about lack of choice, or does this phenomenon reflect reduced expectations for care and acclimation to an NH care environment predominately driven by staff routines as opposed to resident preferences?
One could argue the issue either way, but it is clear that if NHs are to be evaluated in the survey process regarding choice, then a standard definition and observation protocol that can be used by all surveyors is necessary to produce consistency.

The use of standardized observation protocols and definitions should not add significant time to the survey process if surveyors are following the intent of the instructions in existing survey protocols that prescribe observation. The only way the use of standardized observations would add time to the survey process is if surveyors are not consistently conducting observations or if they are doing so in an informal manner that is of doubtful validity. In this regard, it is also important to note that data have not been collected about how feasible it is for surveyors to implement all the recommended evaluation strategies in the interpretative guidelines and particularly all the observational strategies. Observations of care, if done accurately, can be time consuming and the interpretative guidelines recommend observation for many care domains other than choice (e.g., falls and incontinence). If it is not feasible to conduct all the recommended observations, then surveyors will be forced to make individual decisions about what and how to observe, and these individual decisions will contribute to inconsistency in the survey process even if standardized protocols are available and surveyors are initially trained to achieve interobserver agreement.

Two fundamental principles that guide consistent and accurate measurement are that evaluators be trained to observe the same resident care episode using the same standardized protocol to produce agreement on quality conclusions and it is feasible to implement the standardized protocol in practice. Documentation that such interrater agreement was obtained for surveyors during training or that they have time to implement standardized protocols is not apparent for any aspect of the survey process. There is recent evidence that CMS is aware of some of these training, feasibility and reliability, or agreement issues and is investing resources in improving survey consistency.

The absence of clear definitions and standardized protocols limits the ability of surveyors to prove reliability of their evaluations and contributes to the perceptions of NH providers that the survey is inconsistent and subjective. One cannot expect NHs to accept or prepare for a survey process that does not clearly delineate the protocols used to define and measure quality. If surveyors used standardized observation protocols to measure if NH staff offered choice to residents, then NH providers likely would be motivated to use the same protocols for internal staff management and quality improvement efforts.

However, there may be other barriers to improving how NHs train direct care staff to offer residents choice during daily care provision other than an ambiguous survey process and the absence of accurate information about staff communication behavior during care delivery. There is a possibility that individualizing care based on residents’ choices at the point of care delivery may be more labor intensive than usual care practices, which may limit the ability of direct care staff to provide choice to all residents. This point is particularly salient given evidence that many NHs already may not be adequately staffed to provide all care recommended in survey guidelines (Schnelle, Simmons, & Cretin, 2001).

In sum, offering choice to residents is an important aspect of quality of life and, as such, it deserves the same rigorous attention to measurement that more clinical aspects of care receive. The development and implementation of observation protocols, such as that described in this study, are needed to improve the survey process as well as the internal quality improvement process relevant to resident-centered care in NHs.

Acknowledgments

The analyses upon which this publication is based were performed under contract number 500-00-0032, task order no. 7, entitled “Evaluation of the Quality Indicator Survey” sponsored by the CMS, Department of Health & Human Services. The content of this publication does not necessarily reflect the views or policies of the Department of Health & Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The authors assume full responsibility for the accuracy and completeness of the ideas presented.

References


Received May 29, 2008
Accepted August 28, 2008
Decision Editor: William J. McAuley, PhD