"WHO I AM" RESIDENT CENTERED CARE TOOL

INRODUCTION

Resident Centered Care is providing care that has been outlined by the resident's preferences. This starts with gathering accurate information from the resident, family and/or responsible party about the person's unique interests, likes, dislikes, and usual daily routine. Acting on that information by customizing the care for that resident accordingly is the step that is often missed in skilled nursing centers.

The ***"Who I Am: Resident Centered Care Tool***" was created by the California Association of Health Facilities' (CAHF) Quality Improvement Government Relations Committee. This tool was created to assist facilities in gathering personal details of a resident's life style, beliefs and preferences that will help the certified nursing assistants (CNAs) provide a personal touch to their care. It is intended to be a guide for CNAs, and other caregivers, on how to individualize care for your residents. Nursing facilities are as individual as the people. Hopefully this tool will fit the culture of your facility.

HOW TO USE THE TOOL:

The Resident Centered Care Tool is a web based document that providers should save to a computer, flash drive, or other electronic media stick. It is a writeable document that can be saved to a general file or directly to a resident's electronic record, if compatible with the facility's electronic medical record.

Each section of the tool includes a note pad link that provides a list of suggested questions to be used when interviewing the resident. These are suggested questions, but the facility may choose to use their own questions.

Providers who are unable to save the document to a computer, or opt to use the document in a hard paper format, can refer to the list of suggested questions attached to this introduction.

Instruction for Printing. A printed version has character limits per section. There is a number next to each heading. That number represents the approximate total character limit to show when printed, this includes spaces.

Sections of the tool include:

1. Who I Am (412)
   - Purpose – To develop an 'I Care Plan' and providing the CNAs with a guide to caring for the resident.
   - Responsible Staff – All staff
2. My Medical Conditions (206)
   - Purpose - To provide an insight as to how the resident sees themselves and how the medical conditions may impact their lifestyle.
   - Responsible Staff – Licensed Nurses
3. ADLs (312)

- Purpose - To identify where the resident feels assistance is needed with their daily personal care, mobility, and possibly higher independent ADLs.
- Responsible Staff - All nursing staff

4. Meal Food / Drink Preferences (312)
   - To ensure the resident has a person-centered dining experience with emphasis on special occasional and spiritual preferences.
   - Responsible Staff – Dietary

   "It is the position of the American Dietetic Association (ADA) that the quality of life and nutritional status of older residents of long term care facilities may be enhanced by liberalization of the diet prescription".
5. My Preferred Routine / Sleep (416)
   - Purpose – To identify the resident's prior lifestyle that can be implemented into the resident's centered care plan.
   - Responsible Staff – Licensed Nurses and CNAs
6. My Religious / Spiritual / End of Life Preferences – (206)
   - Purpose - To identify the resident's individual spirituality and end of life wishes, including need for religious Chaplin contact.
   - Responsible Staff – Social Services, Activities, Physician
7. If I am Feeling (624)
   - Purpose – To ensure that all staff are aware of how to cope with the resident's behaviors.
   - Responsible Staff – CNAs, Social Services, Activities
8. Activities / Socialization (721)
   - Purpose – To identify diversional activities that the resident enjoys to do individually in the privacy of their own room, with others or with family.
   - Responsible Staff – Activities
9. Additional information you should know about me (515)
   Any additional information the resident/their responsible party or the staff believe is important to the care of this individual.

The finished tool should be printed and be accessible to all staff but particularly the CNAs. It is recommended that the care tool be filed in a binder that is in a private location around the nursing station, not accessible to the public.

HOW TO IMPLEMENT THE TOOL:

It is recommended that the facility's administration delegates resident interviews to staff across disciplines, including the admission nurse, social services, activities and the CNAs who provide care to the resident. If the resident cannot be interviewed, staff should interview the family members and/or the responsible parties who have knowledge of the resident's history and preferences. Multiple members of the interdisciplinary team should come together to create a picture of how to incorporate this information into daily care. Information gathering should not be rushed, but a relaxed time of sharing information between the staff and resident/family.

It is recommended that the task of gathering data begins with the admission nurse entering information such as the medical conditions into the care tool upon admission. Each discipline thereafter that

gathers data could add to the **Resident Centered Care Tool**, creating an interdisciplinary generated document that is centered to the resident's needs and preferences. For example:

- Dietary may add the resident's preferences, consistency of beverages and assistive devices that may be needed for the resident to safety feed himself/herself.
- Nursing may add the level of assistance that is needed for activities of daily living (ADLs) so to ensure the resident's safety.

A workable **Resident Centered Care Tool** should be reviewed and updated routinely by not only those members of the interdisciplinary team who collect the data, but those who will use the tool to provide person centered care such as the CNAs. Consider having the CNAs participate in the interdisciplinary team review, soliciting input from the CNAs is a very effective way to get an accurate picture of the resident.

RECOMMENDED UPDATES:

Keeping up with a resident's preferences is critical to providing care that meets their needs, whether they are directly or indirectly impacting care. It is the recommendation of the QI committee that providers utilize the tool during care conferences, updating the information based on the resident's and family's input. Reviewing each section of the **Resident Centered Care Tool** during the care conference will enable the resident to be engaged in the care planning process regarding how they want to be treated and any new preferences they may have since their admission to the facility.

As updates are made, don't forget to print out the updated version and file it in the binder for the CNAs reference.

ADDITIONAL RESOURCES:

Additional resources available to CAHF members can be found in the Clinical/Quality Section of the Member Resources on the CAHF website http://member.cahf.org/Operations/ClinicalQuality/PersonCenteredCare.aspx. Other sites that may be helpful in the development of a person-centered care program in your facility include:

- **Person Centered Care: Seven Simple Steps to Success**
  https://www.nhqualitycampaign.org/goalDetail.aspx?g=PCC

- **Resources for Person Centered Dementia Care in Long Term Care Settings**,
  https://apps.state.or.us/Forms/Served/se0935.pdf

- **Just in Time Toolkits for Person Centered Care**
  https://www.pioneernetwork.net/Providers/JustInTime/

- **Consistent Assignment Toolkit**
  http://www.calculturechange.org/

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