April 13, 2007

Agency for Health Care Administration
ATTN: Barbara Dombrowski, Contract Manager
2727 Mahan Drive, MS #51
Tallahassee, Florida 32308

RE: AHCA Funding Agreement No. AFA27

Dear Barbara:

This letter serves as the final report on Westminster Towers Orlando's Person Centered Model. Again we hope that you are pleased with how grant dollars are being utilized as we seek to better serve the residents of the State of Florida. We remain convinced that the positive outcomes will be evident and that this program will be considered by other nursing homes as well as the Agency to be an example of "Best Practices" and a model for the long-term care industry.

Part of the agreement stated in the State of Florida, AHCA Funding Agreement, Project Work Plan, Attachment A, Section B, Reporting, was that Westminster Towers Orlando send a final report on March, 2007.

The following areas were identified as a minimum by the Agency where specific information was to be reported:

- Number of residents exhibiting behaviors.
- Number of residents losing 3 pounds or more weight.
- Number of residents on food supplements.
- Monthly food cost.
- Number of activities per residents per day.
- Number of hospital visits.
- Number of medications used per month.
- Incontinent product usage.
- Number of bedsores.
- Number of residents and family complaints.
- Agency Staff usage.
- Increases in resident satisfaction.

Beginning March 1, 2006, baselines were established as a means for comparison throughout the year.

Number of Residents Behaviors:
Overall, residents are calmer, less agitated, and less combative since implementation of the Person Centered Care Model. This is evident by the decrease in the number of restraint and medication usage. **We realize that most of the residents' behaviors were resistant to the old institutional style of structured and regimented schedules**. Now residents are not forced to follow a schedule (e.g., time to getup, time to eat, time to take a shower, time to go to bed, etc.) but asked their preferences and they are not resisting or fighting. Numbers from the behavior log may not show significant changes because we are also aggressively identifying, reporting, and monitoring every behavior.

Decreases in Weight Loss:
Unplanned Significant Weight Change information is gathered monthly from the weight audit report. The number of residents losing 3 pounds or more has decreased significantly during the past year. The base line data reveals that prior to the implementation of the wheelchair buffet the number of residents losing 3 pounds or more **was 18** (**15%** of all residents) in the month of February 06. A comparative report for the month of February 07 reveals the number of residents losing 3 pounds or more was **8** (**6.67 %** of all residents). **This is an 8.33% improvement** in the number of all residents not losing weight from the start of this program; however a **55%** overall improvement from the initial total number of residents affected at the start of the program.

Decreases in Food Supplements:
Information was gathered from the "Historical Assessment Report" of the MDS (Minimum Data Set) from February 2006 through February 2007. Decreases in food supplements were expected as a direct result of decreases in the number of residents losing weight. The base line data reveals that prior to the implementation of the Person Centered Care model the number of residents using food supplements **was 90 (75%** of all residents) in the month of February 06. A comparative report for the month of February 07 reveals that the number of residents using food supplements decreased significantly **to 47 (39%** of all residents). **This is a 28% improvement** since the start of this program. The decrease **by 43 residents** represents **a 47% reduction** in number of residents using food supplements.

Decreases in Food Costs:
In addition to the savings from the decreased use of food supplements, food cost has dropped due to the decrease in food wastage. Food costs are based on the following accounts: Meat, Dairy, Produce, and Grocery accounts. Based on the Consolidated Statement of Operations average food costs during the month of February 06, prior to the implementation of the wheelchair buffet, **was $3.28** per resident per day. A February, 2007 comparative report to the baseline data reveals raw food costs averaged **$2.45** per resident per day, a 25% overall reduction. This is a **0.83 per resident, per day reduction** in food costs. When residents were giving a choice of using the buffet and deciding what they would like to eat, they picked what they felt like eating and they ate the food they selected so the food was not wasted.

Westminster Towers Orlando is a Continuing Care Retirement Community. All of the food is ordered and cooked in one central kitchen for all of the residents in the community including independent, assisted living, and health center residents. It is difficult to see an actual decrease in food costs for health center residents because of the savings divided among all residents of the community. Therefore, the above amounts may not be a true reflection of the food costs in the health center only. However, it should be noted that although actual purchased food costs have generally increased in the region over the past year, our food costs have decreased.

Number of bedsores:
Information was gathered from the nursing monthly report from February 06 to February 07. A base line data reveals **an average of 4 pressure ulcer per month** prior to starting the Person Centered Care Model in February 06. A comparative report reveals the number of residents with pressure ulcers in the month of February 07 had **dropped to 0, a 100% reduction**. Keeping people as active as possible by providing activities of their choice, good food of their choice, walking to the bathroom to use a regular toilet instead of wearing incontinent briefs, are all part of the Person Centered Care Model that improves the quality of life and the quality of care for our residents.

Incontinent product usage:
Information was gathered from the nursing supplies records from February 06 to February 07. A base line data reveals an average usage **of 4236** incontinent pads and briefs prior to February 06 before starting Person Centered Care Model. A comparative report reveals an average usage **of 1275** incontinent pads and briefs during the month of February 07, a **69.9% reduction** in overall usage. Giving people the choice of walking to the bathroom, if all possible, to use a regular toilet instead of wearing incontinent briefs or bringing a commode close to the bed at night time not only just prevents bedsores but also saves a lot of money.

Medication Use:
Medication usage information was gathered from the monthly pharmacy report from February 06 to February 07. A base line data reveals that prior to the implementation of the Person Centered Care model the number of medication usage **was 1907** per month in the month of February 06. A comparative report reveals that the number of medication usage **decreased to 1661** per month in the month of February 07, showing a **12.89% decrease** in medication use. Residents with fewer behaviors need less medication to control their behaviors. Residents who sleep when they want need less sleep medication. Active and healthy residents need less medication. Residents with rested bodies and less pain need less pain medications. Emotionally satisfied residents need fewer medications. Decrease in medication usage is one of the by products of the improved quality of life provided by the Person Centered Care Model.

Hospital Visit:

Information was gathered from the hospital transfer log from February 06 to February 07. A base line data reveals an average **of 40 visits to the hospital** for the quarter (December 05, January 06, and February 06) prior to implementing Person Centered Care Model and 13 visits to hospital in the month of March 06. A comparative report reveals an average of **20 visits to the hospitals** for the last quarter (December 06, January 07, and February 07) and 1 hospital visit in February 07. The **drastic decrease in hospital visits** is a sign of healthy people. The Person Centered Care Model keeps people as active and as healthy as possible by providing food of their choice and activities of their choice. A decrease in the number of visits to the hospital by **50%** means, **billions of dollars of savings to Medicare every year nation wide.** That is why every nursing home in the country needs to implement the Person Centered Care Model. Less visits to the hospital means people are healthier. The Person Centered Care Model keeps people as healthy as possible by providing the food of their choice and the activities of their choice. People can sleep when they want, eat what and when they want, and participate in activities of their choice when they want.

Number of activities per residents per day:
Keeping people as active as possible is one of our missions. We accomplish that by providing them **choices and activities of their interest**. There are two kinds of activities: one is planned and scheduled activities provided by the activity department, the other is spontaneous and continuous activities provided by the Team Leaders and other staff. Spontaneous activities are decided at the daily neighborhood meetings to respect residents' wishes and honor their desires. Since spontaneous activities occur continuously on the spot by all staff, they may not reflect in the total daily activities per resident, per day. On a daily basis a lot of spontaneous activities are provided now than prior to the implementation of the Person Centered Care Model.

Number of residents and family complaints:
Information was gathered from complaints log from February 06 to February 07. A base line data reveals an average of **1 per month** in February 06, prior to implementing Person Centered Care Model and it **dropped to 0 per month** in February 07. Decreases in resident and family complaints reflect that residents are happier and satisfied.

Agency Staff usage:
Before starting Person Centered Care Model, Westminster Towers Orlando **had the highest usage** of agency staff among all of the communities in our corporation**. Now we have eliminated agency staff completely** and have not used agency for almost a year. When staffing requirements increased in January, we managed to survive without agency usage. Our sister communities, who have not yet implemented Person Centered Care Model yet, are still showing a very high usage of agency staff. Happy employees don't quit their jobs as often as unhappy employees and give better care than dissatisfied employees.

The Person Centered Care Model is good for residents and **it also provides a fun and enjoyable work place for our staff**. When residents are going out shopping, fishing,

picnicking, and eating out, our staff who go with residents are also enjoying the day. The same number of staff takes care of the same number of residents either in the health center, at a picnic or at Wal-Mart. The only difference is that during the outings they have more help from volunteers and family members.

Increases in resident satisfaction:

This is what the Person Center Care Model is all about: keeping people happy, healthy, active, and satisfied. This was reflected in our most recent resident satisfaction survey. Resident's survey reports completed on November of 2006 shows significant improvement from 2005 in the categories listed below.

- 12% increase: Like **meals** served.
- 17% increase: **Food** served is hot (or cold) enough.
- 13% increase: Health center offers enough **activities**.
- 17% increase: There are programs that **stimulate interest** in the world around me.
- 23% increase: A wide variety of wellness programs are available to **fit my needs.**
- 13% increase: Involved with religious programs **as much as I like**.
- 15% increase: Programs help me make **good choices** about health and wellness.

Other areas are also showing improvements:

In addition of the above areas, identified as a minimum by the Agency, showing improvement several additional areas are also showing improvement including but not limited to the following:

- We have noticed a **decreased in the Workers' Comp claims** filed since we have implemented this program. Our Workers' Comp claims have dropped from an average of 20 claims ($38K) for last year to 16 claims ($29K) for this year.
- We have had **no law suits** filed since we have started this program.
- Decreased bedsores have resulted in **decreased wound nurse hours** and **wound care product (**nurses' time and nursing supplies).
- Increased staff **teamwork**, **productivity,** and **loyalty**.
- Improved **volunteer interests** and support.
- **Improved image** in the community at large and **increased census**.

A comparative study of all communities that have implemented the Person Centered Care Model shows that the common factor in those communities is a great improvement in strong leadership. Top Management believes in giving the residents choices and respecting their wishes, empowering employees to be resident advocates, and providing good training for all staff. Communities that have not implemented this Model still show a high staff turnover, high agency usage, and no improvement in their resident satisfaction survey. Common factors about the communities showing weak improvements or resistance to implementing Person Centered Care Model are changes in upper management, lack of strong leadership, unwillingness to take risks by empowering front line staff and delegating authority to staff, fears that resident demands may grow out

of control, and fears that surveyors may give some citations as a result of changing from the institutional style to the Person Centered Care Model.

How can every Florida nursing home adopt the Person Centered Care Model?
We are so excited with the success and positive outcomes we have had using this model that we want to encourage every Florida nursing home to adopt it by following our step-by-step guidelines. We would like to invite the staff from all Florida nursing homes to visit our community to see the Person-Centered Model in action and learn how to implement it in their community by following our footsteps. Our staff can also provide advice on how to overcome staff resistance and other challenges. According to Mr. Eric Haider, Founder of the Person Centered Care Model, **"this model can be implemented in any nursing home with a minimum amount of training."**

When the directives became clear that we were embarking on a voyage toward a "**New Person-Centered Model"**, it was evident that a culture change was in effect and there was no turning back. Person-Centered Model supports the beliefs that every person is unique and deserves personal attention. Each person would like to live in a manner consistent with the habits, routines, and pastimes learned over a lifetime. Person-Centered Model makes resident feel happy, well cared for, and truly loved. It makes our staff proud as they connect with those in their care and reach new levels of professional achievement. This was in contrast to the **"Old Institutional Style"** where residents had to change their lifelong rituals to meet the highly regimented standards and procedures of the institution; when residents were asked to get up when it was convenient for staff, to eat when it was convenient fro staff, to take a bath according to the day and time that it was conveniently scheduled by staff, and of course to play bingo according to the pre-planned schedule dictated by staff.

Person-Centered Model already comes with its guidelines, but it takes people's involvement to make it successful as you thrive to improve resident's quality of life and quality of care in your community.

The core of the program includes six critical components described within specific parameters, **neighborhoods**, **activities of choice**, **restaurant-style dining**, **respect for personal preferences**, **individualized living space**, and **opportunity for personal growth and contribution**.

A top down commitment must be felt from the start in order to influence those on the frontlines that have to breed the culture. An introductory meeting was held specifically to give an overview of the Person-Centered Model and to persuade community management staff to change. This meeting was led by Eric Haider, Culture Change Specialist, and founder of Person-Centered Model. The meeting lasted for a little bit over two hours. It was the first time we were all introduced to the program that we would eventually need to make our own.

Eric, at this point, asks the question, why change? Due to people's reluctance to change, he felt that in his first meeting with the managers, he needed them to answer that

question, and if they believe that a change was indicated, then it would alleviate the resistance with which the program was accepted. I must say, to our surprise, the managers were quite welcoming of the program in their acceptance of the change that needed to occur. I believe by the first meeting Eric had managed to gain the commitment of all the managers. Managers walked out of that meeting with a renewed sense of hope and commitment for the future of our community along with the belief that management services always provided guidance that help ensure and promote continued success for all communities.

The top five reasons that were given as to why change was imminent include the beliefs that this Person-Centered Model would **improve** quality of life and quality of care for residents in our community; **focus** on each person's positive outcomes, not on inflexible procedures; **offer** the lifestyle freedom of choice that people have always enjoyed at home; **provide** a more enjoyable and rewarding work environment for the staff; and **help** fulfill our mission to provide quality services and to honor each person's dignity, rights, self-respect and independence.

Now the real work begun as we move into the planning and organizing components of PCM (Person-Centered Model). Staff wants to see that the leaders in the community invest as much time if not more in implementing the program in order for them to follow through as they are told.

We initially held three Planning Meetings. At this point, we were meeting once every week and took away homework to be prepared for the next meeting's agenda.

Recommendations:
In Planning Stage include the following staff on the committee:
• Executive Director (if applicable)
• Health Services Administrator
• Director of Nursing
• RLS Coordinator (if applicable)
• Social Services Director
• Activity Director
• Staffing Coordinator
• Staff Trainer
• Director of Dining Services
• Director of Housekeeping
• Director of Maintenance
• Other key dept heads

Planning Meeting 1
Agenda Items
Attended by: Executive Director, Health Services Administrator, RLS Coordinator, Regional Vice President, and Culture Change Specialist

Led by: Highest administrative person at the community
• Review “benefits” of the Person Centered Model
• Review “obstacles” to the program and possible solutions
• Review major “steps to implement”
• Review role of “Steering Committee”
• Have attendees take Quiz “Do We Need a Culture Change?”
• Select “PCM Leader”
• Start planning/scheduling All Staff Introductory In-Services

Planning Meeting 2
Agenda Items
Attended by: Executive Director, Health Services Administrator, RLS Coordinator, Regional Vice President, Culture Change Specialist, and all Department Managers
Led by: Highest administrative person at the community
• Introduction of the Person Centered Model to department managers
• Have department managers take Quiz “Do We Need a Culture Change?”
• Review role of “Steering Committee”
• Introduce the PCM Leader
• Plan All Staff Meeting to introduce the Person Centered Model

Planning Meeting 3
Agenda Items
Attended by: Executive Director, Health Services Administrator, RLS Coordinator, Regional Vice President, Culture Change Specialist, and all community staff
Led by: PCM Leader
• Introduction of PCM Leader
• Introduction of the Person Centered Model to all community staff
• Introduce Steering Committee
• Introduce Team Leader Concept
  O Criteria for Team Leaders
  O Role and Responsibilities of Team Leaders
  O Selection process for Team Leaders
• Plan Staff Training

Through this planning process we had managed to establish staff training guidelines for our community and also had established the purpose of the Steering Committee and its composition.

Department Staff Training – 30 minutes
Training done by: Culture Change Specialist
Attended by:
• All rehab staff
• All activity staff

• All Dining Services staff
• Maintenance, Housekeeping, Laundry staff
• Marketing and Administration staff

Nurses Training – RNs/LPNs – 30 minutes
Training done by: Culture Change Specialist
Attended by: All nurses/all shifts (inc. DON, MDS, Wound nurse, etc)
Purpose: Understand role of Nurses in the Person Centered Model
• Nurses role - Quality of Care
• Team Leader role - Quality of Life
• How to transfer duties to Team Leaders
• Timing for implementation of program
• Provide support for Team Leaders

Purpose of the Steering Committee:
• Set the goals for the community
• Review goals and accomplishments
• Review and analyze progress, success, and setbacks
• Update standards and guidelines
• Empower team leaders
• Provide guidance for team leaders

The Team Leaders selection was tough since we had many senior aides. Although loyal and consistent with certain aspect of their work, they did not meet the outline that characterized the value of a team leader thus excluded them from the chosen list. We wanted from the beginning to select a strong group that would pioneer this program and invite others to respond to the challenge and do the same.

Team Leaders – Selection
Selecting Team Leaders
• Select a Team Leader for each neighborhood for each shift
• Give every employee an equal opportunity to be a team leader
• Announce to all staff that team leaders are being selected
• Post information on the roles and responsibilities of team leaders

Criteria for Team Leaders
• Preferably CNA or Restorative Aide
• Positive attitude
• Dependability
• Strong work ethic
• Strong leadership skills
• Strong organizational skills
• Strong communication skills
• Respected by others

We followed the criteria as outlined and looked at each potential team leaders to possess all the skills and the right attitude for selection. We had actually interviewed each potential candidate and spoke with their co-workers to develop a profile that would indicate how they would fit within the spectrum. Their strength varied per criterion, but overall encompassed all aspects of the criteria that make a team leader.

One of the problems we faced from the beginning and still facing is finding candidates for team leader training on the 11-7 shift that can cover all four neighborhoods. We were successful in finding quality staff for the other shifts, and then it was time to begin training. The next challenge was to get all these candidates to come to all the scheduled training sessions with the support of their respective managers and co-workers. Training took place weekly and was taught by Eric Haider, our Culture Change Specialist. All managers were encouraged to attend. We believed at the onset that by knowing what was expected of the team leaders, then we can better support them on the floor. The team leader training outline included six sessions that were to be completed in six weeks before the group of team leaders could graduate and have the title of **C.N.A./Team Leader** affixed on their badges for all to recognize.

Session 1 – Overview of the Person Centered Model
1. What is the Person Centered Model?
2. Why should we implement the Person Centered Model?
3. Difference between the old style and the new style?
4. The six components of the Person Centered Model

Session 2 – Leadership Skills
1. A leader is. . . . . .
2. What employees want from a leader?
3. Six rules on how to give orders
4. A good leader should be . . . . . .
5. Traits of a good leader

Session 3 – Team Building
1. A Team is . . . . . .
2. Team/Group
3. Team Work
4. Team Players
5. Make each team member accountable
6. Great Team = Great Success

Session 4 – Role and Responsibilities of Team Leaders
1. Authority
2. Monitoring
3. Limitations

Session 5 – How to . . . .
1. Use Resident Personal Preference Forms
2. Use Resident Wants and Desires Log
3. Conduct Daily Neighborhood Meetings
4. Conduct Spontaneous Neighborhood Activities

Session 6 – Communication
1. Practice speaking in public
2. Learn how to communicate with confidence to other staff, residents and family members about the Person Centered Model

We threw a huge party to celebrate this great achievement. We invited residents from all levels of care, management services, the staff, families and friends to partake as we pledged the first group of team leaders. Then it was on to the next episode which was the creation of neighborhoods. You say, why neighborhoods...then, let me explain to you the reason for that.

Why neighborhoods?
- Keep same staff in same neighborhood
- Keep same staff with same residents
- Empower direct care staff as individual advocates

Divide community into neighborhoods
The number of neighborhoods you have depends on size and layout of community
- Determine Neighborhoods
- Assign team leaders to neighborhoods
- Assign staff to teams
- Select names for each neighborhood
- Over time transition neighborhoods to “care levels”

How to select Neighborhoods

- Factors influencing selection of neighborhoods
  - Number of nurses' stations
  - Number of nurses on night shift
  - Number of C.N.A.s on Night shift
  - Number of dining rooms
- Ideally, each neighborhood should have
  - Dining room
  - Nurses' station
  - At least one nurse
  - At least the minimum number of required C.N.A.s on every shift

Now that we have our neighborhoods and team leaders, how do we get the people in those neighborhoods communicating? Let's find out…

Daily Neighborhood Meetings

- Attended by residents and staff
- Conducted by team leader
- Lasts 5 – 10 minutes
- In the dining room
- At breakfast or lunch

Purpose of Meeting

- Decide on daily activity of choice
- Plan for the rest of the day
- Collect ideas to improve the quality of life for the residents
- Improve communication among team members
- Promote team efforts
- Resolve conflicts

Those guidelines have to be followed effectively for those neighborhood meetings not to turn into gripe sessions. I repeat not to turn into gripe session. I would suggest initially that management staff attend so that the rest of the staff can give the meeting the proper attention it deserves. There is this saying in our organization, **"employee respects what management inspects".** That saying has proven its worth in gold throughout the rolling of PCM.

Now we were ready to embark on a fun-filled adventure into the world of **Activities of Choice**. After establishing the neighborhoods and determining the team leaders for the respective neighborhoods, it became time to "let the cat out of the bag" and let the staff know how much latitude they had in ensuring that we "respect residents' wishes and honor their desires". But before we can do that, we had to establish the rules. Team leaders along with the neighborhood team are responsible to conduct one spontaneous resident-driven activity per day. That is aside from the pre-planned activities of the day that are run by our fellow co-workers in the Activity department. Staff was told to honor

those wishes as long as they were reasonable, ethical, and not infringing on the safety of the residents and others, and most of all if the request is beyond our financial means that the resident was able to provide the means for the desired wish to occur. The staff took on these initiatives running. Every day there were many ongoing spontaneous activities for each neighborhood. Residents and staff were going fishing; to the movies; staff learned how to drive our buses and were taking residents on excursions; staff assisted residents in developing their own club of interest (domino club, bridge club, bingo club, garden club…). Those clubs are still in existence and are all chaired by residents. The goal is to empower residents to make their own decisions and also to have the freedom to choose.

We tried not to put the cart before the horse in the way we rolled out PCM to make sense to the staff. At this point, I would say a good fifty percent of the community had been exposed to PCM whether through our ongoing training session upon orientation or live on the floor as it is being practiced. We felt strongly that it was about time to generate a community-wide education to re-expose community staff to PCM as we keep the fire burning to move on to the next component which was **Restaurant-style Dining**.

In the background there was a team working on the feasibility of the project since it involved placing a buffet line on each floor of the health center for immediate resident access to the food. That process is in direct contradiction with the old style of relying on the kitchen to bring up the carts for each neighborhood. The old process we knew yielded nothing but more complaints from residents about their food being cold by the time it gets to the floor. We knew about it and now had the opportunity to create a change. Needless to say that we were all excited and could not wait to get this restaurant/buffet-style dining on the go. In the midst of all the preparation that was needed to bring this component to life, we set up a temporary buffet and ran the residents through it and started staff training in anticipation of the real thing. We hit many road blocks. First, we had to decide, do we keep doing the menus or not? Then figure out a way to make our residents understand that there will always be enough food for all therefore there is no reason to fight for first in line. Restaurant-Style Dining was in the making and below is what we figured out we needed to do in order to be successful in our community.

Why Restaurant-Style Dining?

- Residents choose to eat when they want - 24 hours a day
- All meals served with choice of buffet style or ordering from menu

How to accomplish 24 hour meal service

- Set Breakfast times from 7:00 a.m. – 9:00 a.m.
- Set Lunch from 11:30 a.m. – 1:30 p.m.
- Set Supper times from 4:30 p.m. – 6:30 p.m.
- Refrigerator in dining with food accessible to residents 24 hours a day
- Food requests during off-dining hours will be served from refrigerator in dining room
- Resident can choose to eat out if they can afford it

• Dining Services staff is responsible for keeping refrigerator stocked with food
• Nursing staff is responsible for recording food in-take of residents

Buffet Elements
• Two or more meats, veggies salads, etc.
• Special diets orders should be followed and food available on buffet (e.g., pureed, ground, diabetic)
• Portion control needs to be followed according to dietary manual guideline (e.g., make sure there is 3 ounces of protein on plate)
• If staff brings residents to the buffet 14/4 hour rule needs to be followed
• Residents going to buffet on their own can come when they desire

To get residents use to change, start with buffet only for 3-6 months. We found out that we needed to use menus only for residents that did not want to come out of their rooms. Once we were close to being ready, a letter was sent to all residents and families announcing the grand opening of our Restaurant/Buffet-style dining along with a brochure that explains the program's goal. We followed those steps above as enumerated with minimum fine-tuning required. The outcome of the Restaurant/Buffet-Style dining was tremendous. Residents who never came out of their rooms for meals suddenly appeared at the buffet line eager to see what this new venture was going to bring. Needless to say, they ended up liking what they experienced to the point where on average we are now serving 48 residents in our dining room per floor (each floor has 60 beds capacity with an average census of 112) from about half of that size before.

Further in the report, you will see how that also affected positive outcomes in our meal cost per resident over the months, and also our residents' weight and behavior how that changed for the better in general. During our state survey this year, it was reported to us by few surveyors that of the eight residents that were interviewed, all unanimously reported that the food service was excellent. Food lines no longer get congested as residents realized there was enough food always for the time-span the buffet line was open. Staff struggled with it at first. For one thing they had to develop the server skills needed to create the right climate in the dining room. They had to learn to offer the residents choices of meal and respect the portion size they requested for that matter. For the residents, they were happy to know that they could do all that and even choose which table they want to join for socializing. And now we look back and say why we not thought of that earlier.

Talking about respect; a great portion of PCM talks about **Respect for Personal Preferences** on an ongoing basis. In our steering committee, we developed a questionnaire for the team leaders to complete with all residents, and/or families which will help us in honoring their wishes and respecting their desires. This form is completed upon admission, re-admission (if indicated), on a quarterly basis, and for significant changes; typically, the schedule for completion of the questionnaire mimics that of the care plan. As a matter of fact, team leaders for each neighborhood are expected to share

its content during the care plan meeting as it pertains to the resident. It is considered in essence part of the residents' care plan.

Many of the components of PCM at this point were running concurrently and staff were systematically taught to allow residents to maintain their own lifelong daily rituals where now residents can choose to get up when they want, bathe and shower when and as often as they like. You can only imagine the staffs' reluctance in making this happen as that caused them to lose control of their own daily routines. But simply because it makes sense logically, they became more inclined to relinquish that hold on that regimented routine to allow the residents to have more autonomy in their own lives. This change was viewed as simply a transfer of power back to the residents for over the years we have managed as an industry to gradually seize it from them. It was hard but necessary.

One of the six components of PCM that presents a greater challenge to us thus far is getting residents and families to be consistent with their understanding of the concept of **Individualized living space**. Families tend to go over board once they hear that personal items can be brought in. All of a sudden, the idea that furniture must fit in the room, turns into mother's king size bed that occupies half of a semi-private room. A mini refrigerator grows into a fancy one with side by side doors that can barely make it into the room. Needless to say, we have to be on top of it at all times to ensure that all safety standards are met. This is what we try to capture with the promotion of an individualized living space.

What is Individualized Living Space?
- Creating a home like atmosphere in resident rooms
- Give residents a choice of bringing their own furniture from home
- Let residents decorate the room as they want using their pictures and other items to make it their home

How Can We Help Residents Individualize their Living Space?
- Set-up a model room to show prospective residents.
- Ask residents permission to show prospective residents their rooms.
- Train marketing people to show those rooms.
- Encourage family members to be involved in the process.

Opportunity for personal growth and contribution rose to its extreme as more doors became open through PCM for residents to be able to showcase their talent. Many residents from across the continuum, through our wellness initiatives, connoisseur and amateur alike, joined hands with the staff to help make successful the birth of our **Rooftop Garden** as a result of the grant, also fit for resident in wheelchairs. This rooftop garden became an oasis for all visitors, families, and friends, weather permitting, to bring their loved ones for an afternoon of socialization and refreshments. Residents from the community surprised us all when they asked for our help to put together a fashion show that became a newsworthy extravaganza as they showcase their abilities to do their dance on the catwalk accompanied by staff. Residents support our devotional services by

offering to sing, reading a biblical passage, and playing the piano or the violin. Residents are now participating in the “**Thirteenth Annual Westminster Communities Art Show**”. A number of our Health Center residents submitted a total of six art works as floor exhibits, which also will be evaluated for potential prizes. Residents learn new skills through “**Touchtown**”, our internal computer literacy program. They learn how to send emails and access the internet. This is just a small sample of the many doors that became opened once we were committed to respecting residents’ wishes and to honoring their desires.

Let me say this, Team Leader is the toughest job, by all means; yet, we have never fallen short of C.N.A.s qualifying for the Team Leader program. It became contagious once they saw the others having fun and enjoying all the different spontaneous activities that they are responsible to make happen such as taking the residents out fishing, to a ball game, on a bus ride around town, and at times going to Mc Donald, Burger King, Pizza Hut, Wendy’s, Steak and Ale, to name a few restaurants, to pick up residents’ orders. Many of our team leaders have interviewed and received promotions which come with substantial raises. The culture change that PCM has created is palpable and visible for residents and staff alike; there’s nothing abstract about it. Residents are having fun and staffs enjoy it the same.

What is Personal Growth and Contribution?

- Residents have opportunities to learn new skills.
- Residents have opportunities to teach their skills to others.
- Residents have opportunities to volunteer both on and off campus.

How Can We Provide these Opportunities?

- Find out what residents’ skills, hobbies, and interests are and what new things they would like to learn.
- Find other people with similar skills, hobbies, and interests.
- Encourage and support resident’s hobbies.
- Help organize supplies and space for residents to engage in their hobbies.
- Encourage and support residents teaching other residents their hobbies.
- Provide opportunities for residents to use their skills and to teach others those skills.
- Encourage and support resident participation in activities.
- Encourage and support resident volunteerism both in and outside the community.

Now comes the time to share with you some “**Helpful Hints**” for each of the components of PCM that will hopefully help you circumvent some of the uphill battles you will eventually confront if you choose to go forward and implement this model in your community.

Team Leaders:
If you are having a hard time finding good team leaders, you might want to start with the strongest shift. Don’t try to cover all the shifts at once if it is not possible at the time. The elected team leaders for that shift will have an impact on the rest of the community and eventually other team members will come out of their shells to accept the challenge toward making a difference.
Team Leaders and the C.N.As are responsible for the “**Quality of Life**” that our residents come to enjoy. They do so by taking care of their daily ADL needs; and from knowing their personal preferences they can also honor them. Quality of Life is residents’ matters that do not require the intervention of a licensed clinician. These matters are placed under the “**Quality of Care**” column and should be differentiated so that everyone understands the difference.
Celebrate the fact that they achieved the status of Team Leader and make sure that they receive new badges with their new Title “C.N.A/Team Leader”.

Steering Committee:
“No Steering Committee, No Success”. Run all ideas through this committee for review and approval. In order to track all the components of the agreement we had to devise several flow sheets to track and trend the progress of each component and come up with the most effective way through the use of our internal resources as well as through other sources (vendors, and pharmacy data sheets) to collect the most accurate information for reporting. Each member of the committee were responsible for tracking and trending data for a specific component of the agreement and be ready to discuss it during our weekly steering committee meetings. Be careful for these meetings not to turn into gripe sessions. Do not let any one person dominate the meeting. I will share something with you that we do that works every time. We have established as part of our meeting a component of what we come to know as the “**Learning Circle**”.

What is the Learning Circle?
The Learning Circle is a tool to use
• To conduct meetings more productively
• To generate solutions to problems

The Learning Circle:
• Encourages everyone in a meeting to speak up and share their thoughts.
Sometimes the quietest person has the best suggestion but never speaks up.

- Eliminates unnecessary, unimportant, and irrelevant discussion. Sometimes a few people dominate most of the meeting time and the other people attending have very little opportunity to say anything.
- Keeps everyone involved. People who are not directly involved n the topic of discussion tend to lose interest during the meeting.
- Helps people start thinking outside the box for new ideas and solutions.

Rules of the Learning Circle:

- Sit in a circle (around a table)
- Talk about only one specific topic at a time, for example:

O What kind of activities can we have for residents in our community?
O What can a housekeeper do to be a part of the team?
O What can we do to make Mr. Smith happier?
O What can we do to keep Mrs. B from misplacing her dentures?
O How can we prevent residents from lining up ½ hour before meals?
O What can we do to improve communication?

- One person generates the question
- Anyone can answer first. Then the person next to them (either left or right) answers, then the next person answers until everyone in the circle has had an opportunity to make a suggestion.
- Everyone must contribute a suggestion when it is their turn (no skipping people)
- Each person gives a quick (five to ten second) response
- No one can repeat any suggestions already made by someone else
- No talking across the table (everyone must wait their turn)
- One person takes minutes for the meeting and writes down every suggestion made for each question.

Neighborhoods:

Try to keep as much as you can Nurses, C.N.A.s and Team Leaders working in the same neighborhood. The idea is that they develop familiarity with the residents in creating a lifestyle indigenous to that neighborhood. Make sure that those neighborhood meetings are happening as they should and those spontaneous activities are occurring when they should. Be there to support the team and offer suggestions when they hit a road block.

Activities of Choice:

If residents are traveling more than 30 miles they must have a nurse and emergency supplies with them. Any off campus activities must be planned in advance. Staff may need to plan ahead for activities needing transportation. Record all positive comments from residents and family in a notebook. Residents can do anything they want to do as long as the request is not illegal, unethical, immoral, and unsafe for the resident or others,

and the resident can afford to pay for it. How simple is that, all you have to do is ask the residents what they want to do.

Restaurant-Style Dining:
To get residents use to change, start with buffet only for 3-6 months.
Use temporary buffet set-up to start
Invite state agency or monitor to visit before going to permanent set-up
Wheelchair buffet should be wheelchair height (28")
Start with the buffet for one meal (lunch) per day, every day as a trial
After two/three weeks add breakfast or supper
After two/three months add menu option
Refrigerator should stock food that can be cooked on table top (microwave or toaster oven)

Respect for personal preferences:
Here is a sample of a questionnaire that can serve as a guide. Develop a tool that is useful for the residents in your community.

SAMPLE
Resident Personal Preferences
Name ____

1. What time do you like to get up in the morning?
2. What time do you like to go to bed at night?
3. When do you like to eat?
   Breakfast:
   Lunch:
   Dinner:
4. What kinds of food do you like to eat?
   Breakfast:
   Lunch:
   Dinner:
5. How often do you like to have a bath or shower?

6. What time of day/night do you like to have a bath or shower?
7. What activities do you enjoy?
8. Is there anything in the room you would like to have changed?
9. Is there anything you need or want?
10. Is there anything you are unhappy with?
11. What can we do to make your life more pleasant?
12. Are there any comments you would like to make about our community?

Individualized Living Space:

1. Furniture must fit in room and not cause safety problems.
2. If furniture is not fireproof must have sprinkler system or a smoke detector in the room.
3. All material used on furniture and décor (drapes, bedspreads, etc.) needs to be sprayed with fireproof chemicals.
4. Need to tag items showing they have been sprayed with fireproof chemicals and include the following information on the tag: date, time, and done by whom.
5. Model room does not have to be an empty room.
6. With the resident's permission, you may show an occupied room.
7. Mark furniture belonging to the community and to the resident so there is no confusion as to the ownership at the end of the residency.
8. Remove resident's furniture at the end of the residency if the family no longer wants it and we do not want it.

Opportunity for Personal Growth and Contribution:

If residents are working as a volunteer they must have a doctor's order, charted and care planned to show how it will benefit the resident.
Residents serving as volunteers in the community can not replace an employee.
Residents should not feel as if they must, or are obligated to, perform any volunteer service.
Team Leader and Activity staffs need to help residents get started.
Involve family members to help initiate.
Delegate a small budget to motivate residents.
Make signs and posters to promote the resident's activities.

Commitment from management has a direct effect on the level of commitment displayed by the staff as each component of PCM is rolled out. Management has to be consistently part of the whole process, "pounding the pavement" right alongside the team.

Again Westminster Towers Orlando is pleased to be the recipient of your grant funding and we believe this innovative program has been a success over the past year. We also believe the Person Centered Model will continue to be an enhancement to our residents' lives and a model for the long-term care industry. Our doors are always open to anyone who would like to see firsthand how the program works and we would be happy to share our success with others at any time.

Thank you for giving us this opportunity.

Lesly Mompoint, N.H.A.
Health Services Administrator