Resident Choice: Embracing the Revised Conditions of Participation

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Providence Mount St. Vincent

Goals for today

- Define philosophical underpinnings of shared decision – making
- Describe a problem – solving framework for shared decision – making in common resident situations
- Use the problem – solving framework, organization structure, policies, and processes to resolve complex resident situations

Goals for today

And in doing all of that, show how we can achieve compliance with regulatory updates in the areas of

- Self-determination and resident rights
- Resident participation in care planning
- Approaching the goal of "resident-centered" care, aka person-directed care

Reflection

"It's not hard to make decisions when you know what your values are."

-- Roy Disney

Reflection

We are our choices."

-- Jean - Paul Sartre

Reflection

"May your choices reflect your hopes, not your fears."

-- Nelson Mandela

Reflection

"It always comes down to just two choices.
Get busy living, or get busy dying."
-- Stephen King

When we are honest with ourselves

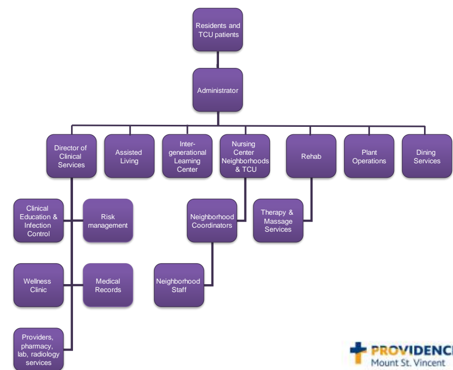
- This is the kind of care we want for ourselves and our loved ones.
- We don't need regulations to tell us the right thing to do.
- We need to ask residents about their values and preferences, listen to the answers, and work in partnership with them and their loved ones to deliver the care and services they wish to receive.

Our community "The Mount"

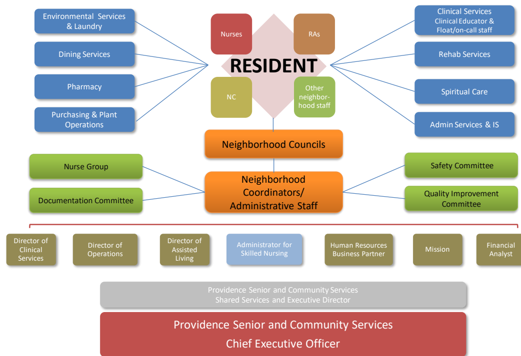
The Mount community

- Assisted living
- Longstay residents
- Short stay (Transitional Care) patients
- Intergenerational Learning Center
- Residence for retired Sisters of Providence
- Providence Elder Place (PACE) site

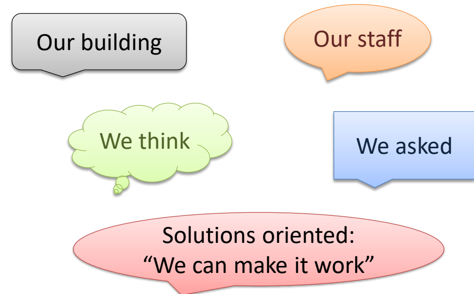
Physical plant



Accountability Chart: Shared Leadership



Leadership



PROVIDENCE Mount St. Vincent

Our care philosophy

- Resident-directed care emphasizing relationships and knowing the person
- Palliative care culture emphasizing quality of life and a dying process in accordance with resident values
- Providence Core Values: Respect, Compassion, Excellence, Justice, Stewardship

Acknowledgements & assumptions

- Ownership requirements & rewards
- Differences among state regulatory approaches
- Relative lack of resources
- Long tradition of NH culture, and current CMS and state approaches: quality = regulatory compliance and the CMS 5 Star Rating

Foundations of resident choice and the idea of shared decision – making

Nursing home regulations

- Exist for important historical reasons
- Are a detailed prescription for how to provide care and services
- Aren't needed as a guide when you are
  - Committed to doing the right thing
  - Know how to access resources and ideas
  - Hire people who share the commitment

Besides regulations, what other sources of ideas and inspiration do we have available to us?

Pioneer Network principles

All elders are entitled to self – determination wherever they live.

Choice (definition)

1. The act of choosing; selection.
2. The right, power, or opportunity of choosing; option.

Choice there is not, unless the thing which we take be so in our power that we might have refused it.

(Hooker quoted in Merriam-Webster)

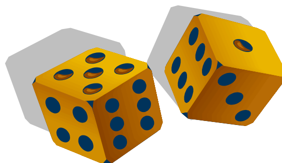
Pioneer principle: Risk taking is a normal part of life.

"I'm still riding my Harley-Davidson, painted lavender with little daisies. It's magnificent! It's freedom, is what it is. And a little bit of danger. There is no freedom without at least some risk."

Ann-Margret, age 75
AARP The Magazine
March, 2017

Risk (definition)

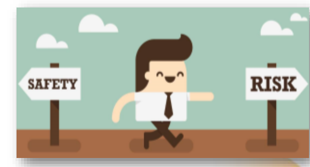
Original meaning of risk: likelihood of something happening, and using statistics to estimate that chance (or "risk")



Risk and the power of "might"

Current meaning of risk:

- minimizes role of chance or accidents
- fear of future harm leads to attempts to manage risk (what "might" happen)
- risk is nearly always thought of in negative terms



Alaszewski, A., & Burgess, A. (2007). Risk, time and reason. *Health, Risk & Society, 9*, 349-358.

Pioneer Network Nurse Competencies for Nursing Home Culture Change

9. Problem solves complex medical/ psychosocial situations related to resident choice and risk.

Pioneer Network
HARTFORD INSTITUTE FOR GERIATRIC NURSING
NEW YORK UNIVERSITY COLLEGE OF NURSING
May 27, 2010
Nurse Competencies for Nursing Home Culture Change
INTRODUCTION

PROVIDENCE Mount St. Vincent

Pioneer Network Nurse Competencies for Nursing Home Culture Change

10. Facilitates team members, including residents and families, in shared problem-solving, decision-making, and planning.

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A clinical model of shared decision-making*

*Elwyn G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A. et al. (2011.) Shared decision-making: A model for clinical practice. *J Gen Intern Med 27*: 1361-1367.

PROVIDENCE Mount St. Vincent

Principles of SDM

- Individual self-determination is a desirable goal.
- Clinicians must support persons to achieve self-determination whenever possible.
- Recognizes the need to support autonomy by
  - Building good relationships
  - Respecting individual competence
  - Recognizing interdependence of person with others.

Elwyn G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A. et al. (2011.) Shared decision-making: A model for clinical practice. *J Gen Intern Med 27*: 1361-1367.

PROVIDENCE Mount St. Vincent

Principles of SDM

More than simply giving information for the purpose of "informed consent" . . . It requires honoring the person's preferences, which can be called "informed preferences".

Elwyn G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A. et al. (2011.) Shared decision-making: A model for clinical practice. *J Gen Intern Med 27*: 1361-1367.

PROVIDENCE Mount St. Vincent

Principles of SDM

Provider/caregiver must be committed to the underlying principles. In plain (Mount) language:

- Residents are the experts on their own lives.
- They have the right to choose, including the right to make what others view as bad decisions.
- Our job is to provide information for an informed decision, and to support the resident in ways she wishes, once a decision has been made.

Elwyn G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A. et al. (2011.) Shared decision-making: A model for clinical practice. *J Gen Intern Med 27*: 1361-1367.

PROVIDENCE Mount St. Vincent

Shared decision-making

- A process, not an event
- Must recognize uniqueness of each individual
  - Desire (or not) to participate in decision-making about care and services
  - Cultural influences, not only on choices made, but on who makes decisions
  - Health literacy
  - Individual goals and priorities with regard to self-defined quality of life

Elwyn G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A. et al. (2011.) Shared decision-making: A model for clinical practice. *J Gen Intern Med 27*: 1361-1367.

Quality of life domains influencing decision-making

Relationship with spouse or significant other	Occupation, work	Physical safety
Relationships with children	Activities that help others	Environmental quality
Family relationships	Civic activities	Religious & spiritual beliefs & expressions
Friendships	Recreational activities	Creativity, personal expression
Material well-being, financial security	Health	Intellectual development

Steps in SDM model

- “Choice talk”: Convey idea that a choice exists.
- “Option talk”: Share detailed information about options.
- “Decision talk”: Support the person in exploring what matters most to them.
- “Informed preferences”: Personal choice based on what matters most to the person, and based on an understanding of the most relevant benefits and risks.

Elwyn G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A. et al. (2011.) Shared decision-making: A model for clinical practice. *J Gen Intern Med 27*: 1361-1367.

PMSV model

- Assess our resident
- Recommend care and services to meet assessed needs
- Discuss potential benefits and risks of following, or not following, our recommendations
  - “What matters to you?”
- Resident chooses (maybe each time, maybe once and for all)
  - remind, offer, explain
- We document the process

Case study

Harold moves to the long-stay neighborhood after a stay on TCU, during which he was treated for a serious pressure ulcer that resulted from sitting in a chair too long at home. He is incontinent of bowel and bladder.

The first evening, he tells staff he wants to stay up in his chair all night, but they are able to convince him to go to bed. The next day, he tells the nurse that he wants to get up in the morning and stay in his chair all day without being changed, unless he has a BM.

Staff are concerned that Harold will develop new ulcers as a result of his preference to sit in the chair all the time. What can be done in this situation?

Apply our process to Harold’s situation

- Assess our resident
- Recommend care and services to meet assessed needs
- Discuss potential benefits and risks of following, or not following, our recommendations
  - “What matters to you?”
- Resident chooses (maybe each time, maybe once and for all)
  - remind, offer, explain
- We document the process

Case study

Violet doesn't want to live at the Mount, and tells staff constantly that she is going to go home. She often declines care, and is verbally abusive toward staff at times.

Violet is adamant that she never wants to be weighed, even though no additional effort is required by her, as the lift used to put her in the bath tub has a built-in scale. When an RA presses the button to weigh her one day, she is furious.

What can staff do in this situation?

Apply our process to Violet's situation

- Assess our resident
- Recommend care and services to meet assessed needs
- Discuss potential benefits and risks of following, or not following, our recommendations
  - "What matters to you?"
- Resident chooses (maybe each time, maybe once and for all)
  - remind, offer, explain
- We document the process

Case study

Chad, age 55, has MS and is bed-bound by choice as he prefers to limit his interactions with others. He takes his pills slowly and deliberately, and doesn't like the nurse to watch him.

How can we honor Chad's preference to take his meds in private while fulfilling our responsibility to account for the medications?

Apply our process to Chad's situation

- Assess our resident
- Recommend care and services to meet assessed needs
- Discuss potential benefits and risks of following, or not following, our recommendations
  - "What matters to you?"
- Resident chooses (maybe each time, maybe once and for all)
  - remind, offer, explain
- We document the process

Case study

Florence has advanced dementia and has stopped eating most of her meals, except for dessert. Staff find that she will eat anything chocolate -- milk shakes, Hershey bars, chocolate ice cream, and candy – but little else. They offer her these foods throughout the day, and so far, her weight has remained stable.

Florence's family wants her to eat a more balanced diet, and mealtimes can be tense when they assist her with dining.

How can we navigate this situation and ensure that Florence's goals are met?

Apply our process to Florence's situation

- Assess our resident
- Recommend care and services to meet assessed needs
- Discuss potential benefits and risks of following, or not following, our recommendations
  - "What matters to you?"
- Resident chooses (maybe each time, maybe once and for all)
  - remind, offer, explain
- We document the process

Case study

Pauline has significant facial hair, and when unshaved, she has a noticeable beard. She often declines to be shaved by staff.

Other residents sometimes comment on Pauline's facial hair, and her son gets angry at staff when she hasn't been shaved.

How can we honor Pauline's decision while preserving her dignity and addressing her son's concerns?

Apply our process to Pauline's situation

- Assess our resident
- Recommend care and services to meet assessed needs
- Discuss potential benefits and risks of following, or not following, our recommendations
  - "What matters to you?"
- Resident chooses (maybe each time, maybe once and for all)
  - remind, offer, explain
- We document the process

Case study

Rocky is a big man who has had several strokes. His cognition is not affected, and he travels about the Mount in a motorized wheelchair.

Speech therapy recommends thickened liquids for Rocky. However, he goes to the gift shop daily for a latte, and he wants it unthickened. In several care conferences, Rocky says he understands the risk, and wants gift shop staff to remind him daily. However, he always declines to have his latte thickened.

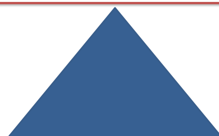
What can neighborhood and gift shop staff do in this situation?

Apply our process to Rocky's situation

- Assess our resident
- Recommend care and services to meet assessed needs
- Discuss potential benefits and risks of following, or not following, our recommendations
  - "What matters to you?"
- Resident chooses (maybe each time, maybe once and for all)
  - remind, offer, explain
- We document the process

Benefits versus risks

Benefits	Risks
Joy	Injury or illness
Autonomy/self-determination	"Behavior"
Normal life	Disrupt staff routines
Contributing/meaningful life	Perceived need to know/control
Belonging/community	Fear of regulatory system
QOL domains important to person	Existential fear



Resident choice: Embracing the revised conditions of participation

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Resident Choice: Embracing the Revised Conditions of Participation

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Seattle, WA

August 1, 2017

PROVIDENCE Health & Services

RESIDENT DINING

Affected Program(s)

■	Nursing Center	■	Rehab		ILC		Adult Family Home		Admin		**HOUSE WIDE**
	Assisted Living		Clinic		Adult Day	■	Dining Services		Plant Op		Admissions

Policy

In accordance with the Providence Mount St. Vincent philosophy to provide residents with the least restrictive care environment, Nursing Center residents may choose to eat their meals off their neighborhood. This freedom is balanced with staff, visitor, volunteer, and resident efforts to ensure that residents with medical orders for altered diets are offered food consistent with those orders. If, despite these efforts and education on risks and benefits of all options, the resident chooses foods that are not consistent with medical orders, the resident's choice prevails.

Policy Interpretation & Implementation

1. Residents and their family members/responsible party* work with interdisciplinary team members to develop a diet plan that matches resident preferences with medical needs. Residents and family are informed of their primary care provider's dietary recommendations. Staff document resident/responsible party response to the discussion, including whether the resident wishes to follow the recommendation, or expresses the intention or desire to do so.

2. Some residents with medical orders for an altered diet establish a regular pattern of eating meals in the gift shop, café, or dining room. Residents who can remember or request the recommended diet are free to order food according to their preferences. When residents are not able to remember or request the recommended diet, the following interventions occur:

   a. Neighborhood staff educate or remind resident and family about the medical orders.

   b. Neighborhood staff alert dietician when residents who have an altered texture dining plan are eating frequently off the neighborhood in the café or dining room.

      i. The dietitian notifies dining services staff about the medical orders, and gives them a written copy of the recommendation and a resident photo. The information given varies in accordance with resident preferences. For example, some residents wish to be reminded about the recommendations and choose what to eat at each meal, while others prefer not to be reminded every time.

      ii. Dining services staff suggest alternatives when the resident requests food that is not consistent with the prescribed diet, and the resident has asked to be reminded about the medical orders. Ultimately, resident choice prevails in what foods they eat.

   c. Neighborhood staff and the registered dietitian review changes in diet orders at monthly weight meetings. Dining services staff are notified of changes.

   d. TCU patients have the same right to choose what to eat as long-stay residents. Staff approaches to making recommendations are the same as for long-stay residents:

      i. The Speech – Language Pathologist assesses the patient and makes recommendations for diet texture and liquid consistency.

      ii. SLP educates the patient and family about the recommendations. Additional teaching about options within the recommendations are reinforced by the dietitian and nursing staff.

iii. Patients and families are reminded about the diet recommendations when meals, snacks, and drinks are served on the neighborhood.

iv. Ultimately, patients choose whether to follow the recommendations. Because few TCU patients eat off the neighborhood and their activities can be unpredictable or unknown to staff (e.g., when family take the patient to the cafeteria without informing staff), educational efforts take place on the neighborhood. The need to involve dining staff in public areas is determined in accordance with the individual patient care plan.

3. House wide Activities: Residents who normally eat on the neighborhood may be offered or ask for food that is inconsistent with their diet prescription. Efforts to ensure that residents eat food that is consistent with their diet order are aimed at maintaining a high level of awareness on the part of all staff involved in food events. These efforts may include:

a. discussion of strategies for this situation in event planning and share with all staff assisting in the event;
b. discussing strategies in regular meetings of activity staff;
c. department orientation or periodic inservices.

*"Family" may mean a family member or other responsible party.

PROVIDENCE
Mount St. Vincent

RESIDENT-DIRECTED MEDICATION AND TREATMENTS

Affected Program(s)

■	Nursing Center		Rehab		ILC		Admissions		Admin		**HOUSE WIDE**
	Assisted Living		Clinic		Adult Day		Dining Services		Plant Op		

Policy

Nurses give residents their medication and treatments in accordance with resident preferences. These preferences are documented in the Medication Administration Record (MAR) and Treatment Administration Record (TAR). General principles that guide medication administration are that: residents are not woken at night unless they request it; the frequency of medications is minimized; medications are reviewed often for continued necessity; administration times are flexible unless residents request otherwise or the provider orders specific times.

Medication and treatment administration are documented in the MAR and TAR. Assessment of resident responses to medications and treatments is documented in the MAR and progress notes, and care plans are revised when needed.

Policy Interpretation & Implementation

1. Medication and treatment records are created for each resident upon move-in.
   a. Upon move-in, nurses interview the resident or family member about preferences and past practices in taking medications. These preferences and practices form the basis for determining when medications are taken while s/he is a resident at the Mount.
   b. MAR/TAR denotes days and times meds/treatments are to be administered. Whenever possible, and in accordance with resident preferences and physician orders, times are given in ranges or represent a general time of day. See appendix for times and terms used to represent them.
   c. The resident's preferences for how meds are taken (whole, with food, crushed, etc.) are entered into the MAR.
   d. Treatments are clearly described so the nurse performing it can easily understand how it is to be done.
2. At the end of each month, or sooner, the primary nurse reviews the use of prn medications. Discontinuation is considered if meds have not been given. Conversion to standing orders is considered if meds have been given frequently.
3. Assessment of resident responses to medication and treatment plans is documented in the interdisciplinary progress notes. Care plans are revised as needed as a result of these assessments.
4. Medication reconciliation is performed in accordance with the policy: Medication orders and reconciliation.

APPENDIX

Resident-Directed Medication Administration
Flexible Medication Schedules

- Resident preferences for medication administration times are entered into the MAR, including notation of preferences for "likes meds on schedule" or "flexible about med times".
- Specific times are scheduled when ordered by a provider, though there should be few of these.
- The MAR also specifies meds that shouldn't be given at the same time.
- After determining resident preferences, most medications are scheduled as follows:
    - AM (0600 - 1000)
    - MID (1130 – 1400)
    - PM (1500 – 1900)
    - HS (2000 – 2359)
- For residents whose preferences vary widely during the day, the following schedule can be used for daily, BID, and TID medications. Flexible med times are not appropriate for medications given more often than three times daily:
    - DAY (0600-1400)
    - EVE (1400-2200)
    - DAY/EVE. If BID, the MAR specifies the minimum amount of time between doses. Actual time of administration of each dose is indicated in the MAR.
    - FLEXIBLE TID (0600 – 1000, 1200 – 1400, 1600 – 1900). If TID, the MAR specifies the minimum amount of time between doses. Actual time of administration of each dose is indicated in the MAR.
- Additional flex times are available for special needs:
    - Once daily at 5 PM (1700 – 2000)
    - BID (0600 – 1000, 1500 – 1900)
    - AM/HS (0700 – 0900, 1900 – 2100)
- When BID or TID flex times are used, nurses check times prior doses were given that day to ensure adequate spacing between doses.

PROVIDENCE Mount St. Vincent

RESIDENT VISITORS

Affected Program(s)

	Nursing Center		Rehab		ILC		Admissions		Admin	■	**HOUSE WIDE**
	Assisted Living		Clinic		Adult Day		Dining Services		Plant Op		

Policy

In keeping with the Providence Mission and Core Values, Providence Mount St Vincent practices person-directed care philosophy. Visits that increase residents' physical, psychosocial, and spiritual well-being are always encouraged and supported.

Providence Mount St. Vincent reserves the right to limit or discontinue a visitor's stay at any time, in the event of a threat to resident or community well-being, safety, or security.

POLICY INTERPRETATION AND IMPLEMENTATION

For purposes of this policy, visitors include individuals in personal, professional, or legal relationships with the resident. This policy does not apply to persons visiting on behalf of a governmental entity (e.g., DSHS, DOH, ombudsman, and others noted in the State Operations Manual, F172 Access and Visitation Rights section 483.10(j)1, parts i - v), whose visits are unrestricted. However, these visitors must identify themselves to staff upon entry by identification badge or business card.

Visitor Guidelines

1. Residents have the right to have visitors of their choosing 24 hours a day. Residents must consent to be visited, and may place restrictions on who visits or the conditions of the visit.
2. Residents are informed of the PMSV visitor policy upon move-in.
3. Visitors are asked to be respectful of other residents, employees, and PMSV property.
4. Visitors must comply with posted signs and warnings on campus, including postings intended to discourage visits by people ill with infectious diseases, and other infection-prevention and –control instructions (including adherence to isolation precautions).
5. Visitation limits may apply to conditions on non family visitors when:
   a. It becomes necessary to emphasize our goal to protect the safety and security of all residents,
   b. Reason to believe a resident is potentially subject to abuse, exploitation, or coercion
   c. Presence or potential to commit criminal acts;
   d. A visitor is impaired by drug or alcohol use,
   e. A visitor is loud or disruptive
   f. Reported concerns regarding resident or community safety

6. Providence Mount St. Vincent will follow standard and consistent practice to address any and all concerns regarding resident and/or PMSV community safety and well-being. Actions

taken to ensure patient and PMSV community safety may include, but are not limited to the following:

   a. Request that the visitor leave the building and premises
   b. Re-visit PMSV visitor policy with the resident to ensure acknowledgement and expectation with regard to acceptable visiting conditions;
   c. Referral to the state ombudsman, DSHS, or both;
   d. Consult or notify law enforcement.

7. Building doors are locked in the evening for security reasons. Visitors are encouraged to visit during the resident's usual waking hours to promote the health and well-being of the resident. When possible, after hours visits should be (1) arranged in advance; and (2) during resident waking hours, unless the resident is acutely ill or in life-to-death transition. Visitors arriving after doors are locked will be asked to show identification prior to entry. If staff have concerns about resident safety related to an after-hours visitor, they may deny entry to the visitor.
8. Residents living in shared rooms are encouraged to visit outside the resident's room to respect the privacy of both residents. Roommates of residents with visitors may request that visits take place outside the shared room. Normally, visitors should not be in the room when their residents is not present.
9. Minor children must be accompanied by a responsible adult (who is not the resident) at all times.
10. PMSV places a high value on providing a dying experience that is in accordance with resident wishes. When these wishes include not wanting to die alone, staff make every effort to accommodate visits (including overnight) by family or others close to the dying resident. However, residents and families must be aware that overnight stays cannot always be accommodated in shared rooms.
11. Neither family nor non-family visitors have the right to be at PMSV for any reason other than visiting their residents.
12. Failure of visitors to honor the visitor policy, contracts, or other agreements about acceptable behavior may result in the person no longer being permitted to visit the resident on site. A decision to prohibit visitation will be made after all efforts at negotiation, contracting, and advocacy (via ombudsman office) have been tried.

PROVIDENCE
Mount St. Vincent

PREVENTING ABUSE & EXPLOITATION IN INTIMATE RELATIONSHIPS

Affected Program(s)

	Nursing Center		Rehab		ILC		Admissions		Admin	■	**HOUSE WIDE**
	Assisted Living		Clinic		Adult Day		Dining Services		Plant Op		

Policy

Assisted living and long-stay residents have the right to engage in the full range of relationships that community-dwelling adults enjoy. At times, residents with dementia and other cognitive impairments form new intimate relationships with other adults who may or may not have similar impairments. Residents with advanced dementia and other impairments are at risk for abuse or exploitation because of impaired decision-making capacity[1]. PMSV staff take the following steps to assess, plan for, and monitor relationships that pose a risk to residents with dementia and other impairments.

At all times, sensitivity and privacy are observed in discussions with residents, their families and legal representatives, and staff. Situations requiring special sensitivity include those involving residents who have a living spouse or domestic partner, and relationships that represent a change from prior patterns of sexuality (e.g., historically heterosexual, but involved in a same-sex relationship, or the reverse).

Policy Interpretation & Implementation

1. When staff identify new, potentially intimate relationships between a resident with dementia and another resident, a risk – benefit assessment is made. See Figure 1 for a sample decision tree to guide the assessment process. An assessment of her/his ability to consent to the relationship may guide the assessment of benefit (see "Assessing Consent to Sexual Activity in Older Adults").
   a. Social work and nursing staff, in consultation with providers if needed, assess both residents for verbal and non-verbal indicators of benefit (including happiness, satisfaction, comfort/ease in the relationship, other indicators of positive mood) and risk of harm (evidenced by negative mood, such as expressions of anxiety, fear, anger, dis-ease or discomfort).
      i. Residents' previously-held values, possible depression, grieving over loss of a spouse, and ability to say "no" to intimacy are also assessed, though values may have changed as dementia has progressed.
      ii. Risk of harm is evaluated with the following in mind: degree of probability harm will occur; seriousness of potential harm; importance of the activity to the resident; and availability of less risky alternatives (Vancouver Coastal Health Authority, 2009).
      iii. For residents who can't participate in a verbal assessment, staff observations form the basis for determining the consensual nature of the relationship, and the response of residents to the relationship. Accurate assessment may require observation by multiple staff over a period of days.
   b. The interdisciplinary team works collaboratively with residents' legal representatives, if any, to determine a plan of action. If staff and representatives cannot agree on a plan, see item 4 below.
   c. If one resident has normal cognition, s/he is counseled on the risks for abuse and exploitation (or allegations of these), and is encouraged to maintain open communication with social work staff so that concerns can be addressed promptly.

2. When the assessment indicates that both residents are satisfied with the relationship and there is no abuse or exploitation occurring, a plan for periodic assessment is put in place. Initially, residents are

assessed for ongoing benefit by social workers monthly. If the relationship is stable for 3 months, assessments may be done quarterly. If a significant change in condition occurs (e.g., worsening dementia), more frequent assessment may be indicated.

3. If the assessment raises questions about whether the relationship is consensual or that risks may outweigh benefits for a resident with dementia, the social worker counsels the resident with normal cognition regarding the concerns, and works with the resident to address them. If both residents have dementia and counseling will be ineffective, monitoring frequency is increased and efforts are made to engage both residents in other activities and relationships.

4. Family or legal representatives are informed of intimate relationships as soon as staff become aware of them, and they are kept fully informed of the status of the relationship. In accordance with PMSV policy on healthcare decision-making, residents in relationships assessed to be positive have the right to choose to participate regardless of their legal representative's preference. While acknowledging the inherent complexity and potential conflict in a situation where staff assessment of benefit and the legal representatives' preferences are not in alignment, the primacy of residents' right to choose is consistent with PMSV policy and practices regarding healthcare decision-making, dining preferences, and daily activities.[2]

5. If a determination is made that the risk – benefit balance of a relationship has shifted to potential harm and intervention is needed (see Figure 2), interventions must meet the following criteria: intervention must be effective; it must not create harms greater than those it is intended to prevent; it should be the least intrusive or disruptive as possible. Ideally, it should be justifiable to the extent that it is acceptable to the resident affected (Vancouver Coastal Health Authority, 2009).

   If there is no reasonable way to prevent harm while maintaining the relationship, and residents are not willing to terminate the relationship, staff must consider alternate placement of one or both residents.

6. If staff formal or informal assessment suggests the possibility of abuse or exploitation, a report is made promptly to the DSHS Hotline, resident protections are put in place, and an investigation is conducted. If a crime is suspected, law enforcement is notified.

[1]All SNF and AL residents are vulnerable to numerous kinds of abuse, neglect, and exploitation. In the context of this document, the term "vulnerable residents" refers specifically to residents with cognitive impairment (usually due to dementia, but also including TBI, s/p CVA, and other causes) or mental health disorders that can affect impulse control, safety judgment, and decision-making. "Dementia" is used throughout this document because it is the most common impairment in the Mount resident population, and for clarity. However, all parts of the process described here apply to all residents with this special type of vulnerability, regardless of the underlying cause.

[2] Designated decision-makers (power of attorney or guardian over the person) have the legal right to prohibit the relationship, but practical enforcement of the prohibition may be very difficult. In this situation, staff work closely with the legal representative to develop a plan for the resident that respects the resident's personhood and apparent preferences, while responding as much as possible to the representative's concerns. This approach is called "harm reduction" (Vancouver Coastal Health Authority, 2009).

Reference:

Vancouver Coastal Health Authority, 2009. Supporting Sexual Health and Intimacy in Care Facilities:Guidelines for Supporting Adults Living in Long-Term Care Facilities and Group Homes in British Columbia, Canada.

Assessing Consent to Sexual Activity in Older Adults

1. Ability to express choices/consent
    a. Ask:
        1) What are your wishes about this relationship?
        2) Does your sexual partner make you happy?
        3) Do you enjoy sexual contact?
    b. Consider:
        1) Observations and non-verbal clues when older adult is unable to verbalize choices (facial expressions and body language)
        2) Emotion and mood, before and after sexual contact
2. Ability to appreciate sexual activity
    a. Ask:
        1) Do you know what it means to have sex?
        2) What does it mean to you/your partner?
        3) What would you do if you wanted it to stop?
        4) What if your partner wanted it to stop?
    b. Consider:
        1) Nature of the relationship (monogamous)
        2) Emotion and mood, before and after sexual contact
3. Personal quality of life choices in the here and now
    a. Ask:
        1) Was and is intimacy important in your life?
        2) What are your social and companionship needs?
        3) What brings happiness or fulfillment to your day?
    b. Consider:
        1) Past and present relationships (including family)
        2) Impact of cognitive impairment (not an automatic reason to deny relationship)
        3) Privacy and intimacy rights
        4) Responsibility to uphold older adults' choices
        5) Policies for staff education and practice
        6) Impact of third party objectives or values on assessment process.

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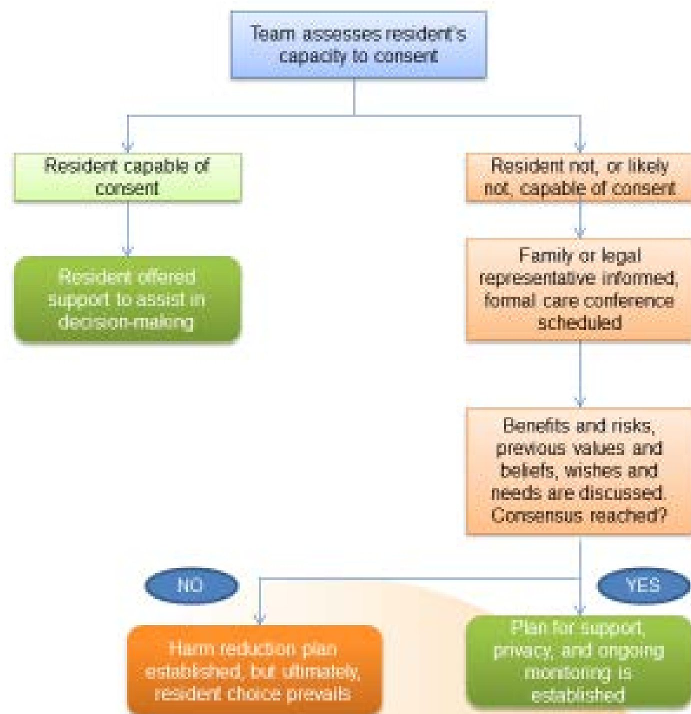
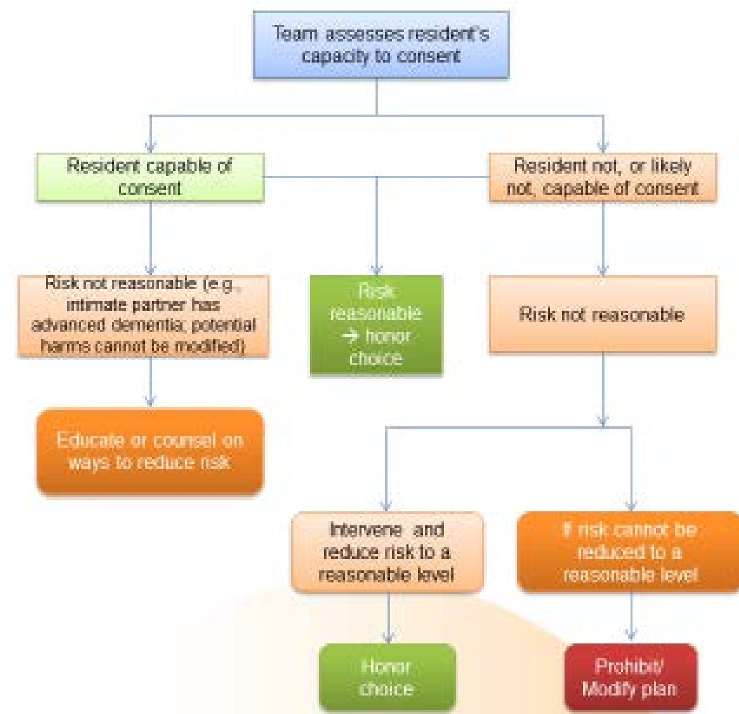
Figure 1
Sample decision-making process



Vancouver Coastal Health Authority, 2009. Supporting Sexual Health and Intimacy in Care Facilities:Guidelines for Supporting Adults Living in Long-Term Care Facilities and Group Homes in British Columbia, Canada

Figure 2
Assessment of potential risk



Vancouver Coastal Health Authority, 2009. Supporting Sexual Health and Intimacy in Care Facilities:Guidelines for Supporting Adults Living in Long-Term Care Facilities and Group Homes in British Columbia, Canada