

CRITERIA AND STANDARDS FOR VA COMMUNITY LIVING CENTERS (CLC)

- 1. REASON FOR ISSUE.** This is a new Veterans Health Administration (VHA) Handbook providing procedures for the implementation of culture transformation in the Department of Veterans Affairs (VA) VHA Nursing Home Programs and it authorizes the official change of name from VA Nursing Home Care Units (NHCU) to Community Living Centers (CLC).
- 2. SUMMARY OF CHANGES.** This VHA Handbook contains updated procedures for care in CLC programs. It establishes the changes in work practices, care practices, and environmental modifications that serve as the principles guiding short and long stay services and care in CLCs.
- 3. RELATED ISSUES.** VHA Directive 1142 (to be published).
- 4. FOLLOW-UP RESPONSIBILITY.** The Office of Geriatrics and Extended Care within the office of Patient Care Services is responsible for the contents of this Directive. Questions may be referred to (202) 461-6779.
- 5. RESCISSIONS.** None.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for re-certification on or before the last working day of August 2013.

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CRITERIA AND STANDARDS FOR VA COMMUNITY LIVING CENTERS (CLC)

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides guidance to the field for transforming the culture of VHA nursing home care and provides direction for the official change in the title of these facilities from Nursing Home or Nursing Home Care Unit (NHCU) to Community Living Centers (CLC).

2. BACKGROUND

Nursing home care delivery has experienced a significant change in philosophy of care, complexity of care, levels of service, length of stay, architecture, demographics of populations served, and new generational cohorts of residents requiring care that can only be provided in nursing homes. This has resulted in an initiative to transform the culture of nursing home care in VHA from a medical model where the care is driven by the medical diagnosis to a person-centered model where the care is driven by the needs of the individual, as impacted by medical conditions. It is timely to provide guidance to the field regarding the changes in the mission and philosophy of care in a Department of Veterans Affairs (VA) NHCU. In personalizing the delivery of care, the transformation of the culture of nursing home care challenges care providers to deinstitutionalize care and workplace practices, the environment of care itself, and to replace the name of the program to reflect the dynamic nature of the services provided. *NOTE: The services provided in the CLC are listed in Appendix A.*

3. SCOPE

a. **Resident Needs.** The mission of VA CLCs is to provide a dynamic array of services in person-centered environments that meet the individual needs of residents, providing excellent health care and quality of life. Because the resident cohorts represent several different generations, special attention is paid to age and generation specific needs such as veterans returning from recent combat as Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). This is accomplished by transforming work practices, care practices, and the environment of care.

b. **Work Practices.** Work practices include, but are not limited to: alterations in shifts and work schedules for all disciplines including nursing, permanent staff assignments for continuity of care, and empowerment of direct care staff. VA CLCs provide a supportive work environment, which engages employees in all aspects of decision-making and information sharing.

c. **Care Practices.** Care practices include, but are not limited to: creatively enhancing dining practices such as offering continental breakfast and a greater selection of meals (liberalized diets and ethnic foods), liberalizing bathing and grooming schedules, offering creative approaches for meaningful use of time, and allowing resident choice in sleep and wake times. The goals of care are achieved in an environment where the resident is respected, treated with dignity, and is invited to be an active participant in the resident's own care.

d. **Environment of Care.** Environment of care includes, but is not limited to creating environments for bedroom, living room, and kitchen to create space that reflects a home-like ambience and a greater attention to privacy and comfort. The environment needs to create neighborhoods or households that engage residents, family and staff to name, decorate, and own their place of residence and work. Facilities should consider implementing concepts, such as Eden Alternative or Greenhouse which provide frameworks or structure for transforming the delivery of care.

4. DEFINITIONS

a. **Community Living Centers (CLC).** In order to reflect the changing mission and philosophy set forth by this Handbook, the title Nursing Home Care Unit is being replaced with the title VA CLC. The VA CLC is a component of the spectrum of long-term care that provides a skilled nursing environment and houses a variety of specialty programs for persons needing short and long stay services. VA CLCs are typically located on, or near a VA medical facility and are VA-owned and operated but may be free-standing in the community. Provision of services is consistent with the long-term care standards set forth by The Joint Commission (TJC). *NOTE: For legal purposes, CLCs are subject to the laws and policies governing nursing home care in VA nursing homes (see Title 38 United States Code (U.S.C.) Sections 101(28), 1710, 1710A and 1710B).*

b. **Activities of Daily Living (ADL).** ADLs are specific personal care activities or tasks required for daily maintenance and sustenance. Residents may require the assistance of others to complete these essential activities. ADLs include activities such as: grooming, bathing, dressing, personal hygiene, toileting, eating, and mobility.

c. **Instrumental Activities of Daily Living (IADL).** IADLs are complex activities or tasks that a person does to maintain independence in the home and community. IADLs include activities such as: cooking, laundry, shopping, management of finances, making and keeping appointments, answering the telephone, and planning activities.

d. **Care Providers.** Care providers are all VA employees assigned to the CLC. This includes all disciplines, but not limited to: nursing, environmental management, volunteers, nutrition and food services, social work, psychology, recreation therapy, creative arts therapy, medicine, and chaplain service.

e. **Person-centered Care.** Person-centered care identifies an approach to care whereby the treatment plan reflects the specific needs of the resident and decisions are driven by the wishes, preferences, and lifelong habits of the resident. In this Handbook, person-centered care is used interchangeably with resident-centered care.

f. **Hospice.** Hospice is a mode of palliative care for those residents diagnosed with a known terminal condition who are expected to live less than 6 months and no longer seek aggressive and curative care.

g. **Palliative Care.** Palliative Care is a broader term that includes hospice care and other care that emphasizes symptom control. It does not necessarily require the presence of an imminently-terminal condition, a time-limited prognosis, or exclusion of all aggressive or

curative therapies. Palliative care aims to relieve symptoms and may include both comfort measures and curative interventions.

h. **Medical Nutritional Products (Medical Food).** Medical nutritional products are defined as commercially formulated products, to be consumed or administered enterally, under the supervision of a dietitian or physician. Medical nutritional products are intended as a support for the specific management of a disease or condition, in conjunction with Medical Nutrition Therapy intervention, provided by or supervised by a dietitian. For the purposes of this Handbook, medical nutritional products are limited to those supplements taken by mouth and excludes vitamin and mineral preparations.

i. **Food Supplements or Fortified Foods.** Food supplements are common food items, such as milk, milkshakes, instant breakfast drinks, pudding, ice cream, and peanut butter, which have high nutrient density. Fortified foods are standard menu items like soup, cereal, or mashed potatoes which have enhanced nutritional value due to fortification with added commercial enhancers or additional food protein or fat sources.

k. **Fortified Beverage Supplement.** A fortified beverage supplement is a beverage suitable to take with medications; it is low volume, nutrient dense, and high calorie. Typically, it provides 1.5-2.0 calorie per milliliter (ml) and is a convenient way to provide additional calories and protein.

l. **Certified Therapeutic Recreation Specialist (CTRS).** The CTRS credential requires a bachelor's degree or higher from an accredited institution of higher education in the area of therapeutic recreation (recreation therapy), an approved internship under the supervision of a professionally-credentialed CTRS, and the passing of a national certificate examination administered for the National Council for Therapeutic Recreation Certification (NCTRC) by the Educational Testing Service (ETS). The CTRS is a professional who specializes in assessment, planning, implementation, and evaluation of the meaningful use of time for residents admitted to CLCs. *NOTE: The CTRS is the preferred credential for therapeutic recreation specialists.*

m. **Resident.** The term resident is utilized to refer to a veteran living in the CLC for either short- or long-stay services. In this Handbook, the term resident is used interchangeably with veteran in reference to persons residing in nursing homes.

n. **Family.** For the purposes of this Handbook, the term family includes next-of-kin and close friends. Family is defined by the resident and the CLC needs to honor the resident's choice.

(1) **Next-of-Kin.** A relative (18 years of age or older) of the patient who may act as a surrogate in the following order of priority, as specified in Title 38 Code of Federal Regulations (CFR) 17.32, it is: spouse, child, parent, sibling, grandparent, grandchild.

(2) **Close Friend.** A close friend can be any person (18 years of age or older) who has shown care and concern for the resident's welfare and is familiar with the resident's activities, health, religious beliefs, and values. The close friend must present a signed, written statement (to be filed in the medical record) describing (with specific examples) that person's relationship

to and familiarity with the resident. Social Work Service, or other staff must verify, in a signed and dated progress note, that this requirement has been met.

5. PROGRAM ADMINISTRATION

a. Eligibility and Admission Guidelines

(1) Veterans are eligible to receive care in VA CLCs if they meet the current nursing home eligibility criteria, and if it is determined the veteran is in need of the level of care and services available in a particular VA CLC.

(2) CLC admission applications must be reviewed by a designated screening and admissions process composed of either a CLC interdisciplinary team or a designated CLC-based admission coordinator. The admission coordinator or team must be fully aware of the services offered and admit the veteran according to the veteran's needs for services and the CLC's ability to provide those services. The CLC medical director, in collaboration with nurse leader, is ultimately responsible for decisions regarding CLC admissions. Neither the medical director nor the nurse leader must attend admission meetings or make the initial admission decisions. However, both the medical director and nurse leader are critical to the admission process if questions arise and they provide oversight of the admission process.

(3) The need for placement into a VA CLC is based on an assessment of medical, nursing, and therapy needs; level of functional impairment; cognitive status; rehabilitation needs; and special emphasis care needs, such as spinal cord injury, polytrauma, or end of life care. Outcomes of admission deliberations are to be recorded and include the:

- (a) Anticipated length of stay, and
- (b) Assignment of a treating specialty code related to the reason for admission.

b. **Programs and Services.** A dynamic array of programs and services are available in VA CLCs although not all VA CLCs are able to provide every program or service. VA CLCs may provide specialty units or programs for groups of residents with special needs, such as: skilled nursing, rehabilitation, or care for residents with dementia. Development of specialty programs is based on local needs, resources and staff competencies. *NOTE: These specialty units and programs may incorporate additional standards of practice and tailor activities, such as therapeutic recreation, nutrition and other programs to meet the age and functional needs of program participants.*

c. **Standards of Care.** Provision of care is guided by the standards set forth in TJC's Long-term Care standards. Certain programs within the CLC may voluntarily seek accreditation or certification for specialized programs or services, such as hospice or rehabilitation. In addition, VA local, regional and national policy provides guidance for ensuring that the services provided in VA CLCs fully meet or exceed the expectations of accrediting or certifying agencies.

d. Leadership

(1) The VA facility Director has the responsibility of changing the official title from NHCU to CLC throughout the facility.

(2) Leadership must be committed to person-centered care and be actively engaged to unify the facility under the common mission. CLC leaders are encouraged to modify or add to current shifts, establish permanent assignments, explore the possibilities for merging traditional service roles, and incorporate resident-centered care planning models. CLC leaders are encouraged to make physical changes including: removing nurse stations, renovating the environment of care to increase lighting, creating living rooms, and personalizing resident doors and bedrooms. CLC leaders need to encourage all CLC staff, not just nursing staff, to assist with serving meals or assisting appropriate residents with eating. CLC leaders should empower direct care staff to be creative and innovative in personalizing the care of the resident and facilitating optimal clinical and quality of life outcomes from the resident's perspective.

(3) The organizational environment and leadership structure is designed to embrace and support an interdisciplinary approach to person-centered care. This structure empowers all CLC staff to share equal responsibility in the provision of care to meet the medical, psychosocial, and spiritual needs of the resident. This Handbook encourages the organization to explore innovative leadership, staffing, and care planning designs that foster unity and responsibility across disciplines. Although the CLC staff must include some traditional roles as identified by discipline, neighborhood or household leadership positions have the flexibility to be filled by any qualified staff member that allows for the formation of a diverse leadership.

6. VOLUNTEERS

Volunteers play a vital role in VA, especially in the CLC setting. Volunteers support program areas by providing assistance to residents, family and staff by leading planned or unplanned activities and by supporting opportunities for creative expression. Volunteers need to be involved in all aspects of culture transformation in the CLC. Volunteers offer the CLC a wealth of knowledge and resources that enhance the residents' quality of life and care in the CLC setting.

NOTE: The following paragraphs are preceded by a vignette from the residents' perspective.

7. VETERAN CENTERED CARE

"You are the experts in providing care, but I am the expert on me. I am a 77-year old veteran who likes to stay up late and watch TV. My mornings begin around 8:30 with a cup of coffee and a newspaper. I like to tinker with wood projects. I have always taken showers and prefer to do so before bed. It is important that the people caring for me know these habits and traits that are unique to me. Whether I am here for a short stay or to live the remainder of my life, I want to build a relationship of trust and respect with my caregivers and to have my personal choices honored whenever possible."

a. **Provision of Care.** Care is provided in an environment where personal preferences are honored and a sense of family or community exists, regardless of the reason for admission or anticipated length of stay. The attitudes of all care providers center around a family approach to care where a mutually beneficial relationship exists between care providers and residents. Every resident must be treated with dignity and respect, and cared for in a manner that is clinically sound, safe, supportive, and person-centered. An interdisciplinary team of professionals assesses, plans, implements, and evaluates a plan of care that is individualized and outcome oriented. Involved staff, who feel valued and respected, provide the human touch, i.e., smiles, reassurance, and friendship. This care model fosters a warm relationship based on compassionate care while ensuring resident safety, maximizing the quality of life, and improving clinical outcomes.

b. **Care Planning**

(1) The care plan is the road map for the entire team to communicate an individualized, interdisciplinary plan to meet the physical, spiritual, and psychosocial needs of the resident. Goals are resident-centered and reflect the resident's preferences, needs, and habits. The resident is involved in care planning to the fullest extent possible. If the resident lacks decision-making capacity, care planning needs to involve the surrogate decision-maker authorized to make decisions on the resident's behalf (see VH Handbook 1004.1). If the resident desires, other family members and friends need to be involved. Residents, as well as surrogates, friends, and family, if appropriate, are encouraged to attend the Interdisciplinary Team Conference and are given the opportunity to help develop and make changes to the plan of care.

(2) The Resident Assessment Instrument (RAI) Minimum Data Set (MDS) process is the official methodology for assessment and treatment planning. The RAI MDS coordinator and the interdisciplinary team ensure that the care plan is an accurate guide for the resident's individualized care. Direct care providers must have input and access to the plan of care to ensure the plan is implemented and the resident's goals achieved. **NOTE:** *VA's implementation of the process is consistent with guidelines developed by the Centers for Medicare and Medicaid Services (CMS) and is consistent with timeframes and guidelines as outlined by TJC standards.*

c. **Interdisciplinary Team.** The interdisciplinary team is defined by local and national policy and TJC standards, as determined by the specific needs of the residents and the scope of services and programs available at each site.

(1) An effective interdisciplinary process is based on a cooperative willingness of all team members to share information and ideas and problem-solve together, so that services are coordinated and integrated. At a minimum, for an interdisciplinary team to meet for the purposes of care and treatment planning, the following staff must be in attendance: medical provider, nurse, dietitian, social worker, and therapeutic recreation member. Other staff (and disciplines) that know the resident well and may affect care decisions need to attend, as appropriate, including nursing assistants, environmental services, pharmacists and other members of the team that have been traditionally included in the interdisciplinary process.

(2) All CLC staff is responsible for meeting the needs of the resident and are an integral part to ensuring overall quality of life, physical functioning and social well-being of the resident.

Traditional service roles may merge in order to meet the needs of the resident. Active resident or surrogate involvement, and the involvement of family and friends if the resident desires, in the team decision-making process is central to creating a team that meets for the purposes of care and treatment planning.

8. ENVIRONMENT OF CARE

"For whatever time I am here, this is my home. I have my favorite chair by the window, pictures of my family on my bulletin board, and a quilt from home covering my bed. There are a variety of places available to me to spend my time and pursue my hobbies and interests. I can play the piano in the living room, enjoy gardening on the patio, enjoy woodworking in the activity room, or spend some quiet time reading in my room. My surroundings are pleasant and comfortable. They are accessible to me and help me feel welcomed. They bring vitality to my life."

a. Home-Like Environment

(1) The environment in a VA CLC fosters comfort and familiarity while stimulating a sense of purpose, comfort, and belonging. Architectural designs and furnishings need to consider the unique needs of the populations served, including age cohorts and the cultural, regional, physical, and psychosocial differences which may vary depending on the specialty programs and geographic location of the CLC. Residents and CLC staff need to be closely involved in the planning and design of the environment of care. Families need to be involved in the personalization of the residents' bedroom.

(2) Environmental enhancements which complement the physical design, can impact the overall feeling of an area. Distinctive décor, household or neighborhood "themes," and consistent staffing can be used to facilitate the concept of neighborhoods or households that promote individuality and foster a sense of belonging. Floating of staff and frequent assignment changes are discouraged.

(3) The presence of plants, pets, computer access, and children bring vitality to both public and private areas of a home-like CLC. These elements provide an opportunity for interaction and a chance for residents to provide rather than receive care. The use of music, art, natural lighting, a variety of colors and textures, the presence of personal belongings and access to the Internet and video games are other important considerations. It is important that residents and families have opportunities to display their creative works, like art work, on walls in general use and private space, as appropriate.

b. Facility Space. Staff workspace and medical equipment are a necessary reality in a CLC. These elements need not, however, be the focal point in the environment. Creative designs for equipment storage areas are an example of ways to de-institutionalize the facility space. Traditional nurse stations are discouraged or, if absolutely necessary, need to be unobtrusive in order to foster staff presence and facilitate interaction with residents. Hallways need to have adequate natural lighting, and to be clean and uncluttered. Unobtrusive and recognizable room identifiers can help orient residents through halls or to bedrooms promoting independence. It is important to recognize the need for a variety of personal and shared spaces to meet the physical and psychosocial needs of the residents. **NOTE:** *The Office of Facilities Management has*

released a *Nursing Home Design Guide* which reflects the best practices of care and supporting facility design concepts for creating functional, pleasing, nurturing, and efficient environments for those residents who reside in VA CLC's. " This is an internal VA link not available to the public. <http://vaww.va.gov/facmgt/standard/nursinghome.asp>

c. **Bedrooms and Bathrooms.** Bedrooms and bathrooms are personal spaces that need to reflect the individuality of the resident. The concept of bedroom limits the use of the bedroom to sleeping and personal care. The resident lives and spends the majority of time in other parts of the house or neighborhood. The presence of personal belongings in the bedroom is encouraged. To respect resident privacy, except in the case of an emergency, staff and visitors are asked to always announce their presence and request permission to enter, at least by knocking on the door before entering. Bedroom and bathroom space is not to be utilized for storage of facility equipment which is not being used. Allowances for residents personal choice in safe bedroom design is necessary to foster a sense of control and personal initiative. Facility design of the bedroom and bathing areas ensure safe functioning, personal comfort, and adequate space for the staff and equipment which may be needed to assist residents with personal care.

d. **Kitchen and Dining.** The kitchen and dining environment encourages socialization and enhances the dining experience, supporting the belief that meals are an activity or event rather than a task to be completed. Kitchen and snack areas are designed to ensure safe food storage and easy accessibility by residents. Kitchen and dining furniture are comfortable and typical of those found at home or in a restaurant. The dining room needs to have sufficient chairs so that staff may sit next to residents needing assistance with eating. Tables may be enhanced with the use of colorful tablecloths, place mats, or decorative centerpieces. Consideration needs to be given to residents' preferences regarding the use of age, generation, and interest for appropriate music during meals. Kitchen and dining areas are utilized for their intended purpose of cooking, eating, and socialization. Access to kitchen areas facilitates the concept of households. A variety of snacks needs to be available at all times. Local policy must ensure that medical equipment is not stored in these areas and that medical procedures (including blood pressures, treatments, and medication administration, etc.) are not completed during meals or in the dining environment. Small, intimate dining areas with the opportunity for a choice of meals are encouraged. Serving food family style and directly onto plates rather than trays offers residents the opportunity to interact appropriately and socialize at meals. Staff is encouraged to bring their own food and to dine in the dining area with residents.

e. **Social Areas.** The CLC environment provides a variety of comfortable areas for socialization and relaxation. These areas need to be small, resembling a living room. They need to be welcoming places designed with the primary consideration of resident preferences. Furniture needs to be comfortable, accessible, and appealing to the residents. Access to safe and usable outdoor areas is an important consideration. There needs to be opportunities to enjoy outdoor recreational activities, such as gardening, and sufficient space for events like barbecues with comfortable places to sit and relax.

9. NUTRITION AND FOOD SERVICES

"Breakfast is my favorite meal of the day, but I am not an early riser. I appreciate that the staff allow me to sleep in and eat breakfast when I wake up around 8:30am. I prefer to start my day

with something light – some coffee and a pastry – and then I select what I eat for lunch and supper from a couple of options. My snack tooth is satisfied between meals with more choices, which allow me the variety I really enjoy. Occasionally, when the weather is nice, I take my lunch or afternoon snack out on the patio overlooking the flower gardens. I am eating better and feeling stronger every day!"

a. **Nourishing Food.** Food is nourishing in many ways. Meals are important for adequate nutrition and creating opportunities for socialization and enjoyment. What a person chooses to eat, with whom, and where is highly individualized. Ultimately, food and beverage intake affects a person's state of physical, mental, emotional and spiritual health. Residents have the right to consume food in a safe, dignified, and respectful manner. The interdisciplinary team works together to prevent weight loss and negative sequelae from dysphagia and to provide adequate hydration. Meal time in the CLC needs to mirror that of home, enriching lives and nourishing souls, as well as providing the necessary daily requirements.

b. **Dining**

(1) Residents may desire to eat their meals in a variety of locations, including the house dining rooms, outside patios, community areas, or on rare occasions, their bedrooms. If a resident prefers to eat in their room, staff needs to determine why in order to ensure the decision actually represents resident preference and not an avoidance of a situation the resident deems undesirable. If reasonable, these choices need to be honored. The dining atmosphere is important to promoting good nutrition, as well as facilitating socialization during meals. Consideration for the resident's ease of use needs to be given to dinnerware, food packages, and condiments.

(2) Appropriate numbers of staff need to be assigned to the dining room to provide assistance and ensure resident safety. It is expected that all members of the interdisciplinary team and facility staff participate in serving meals to ensure that every resident is assisted. Meals are to be served to the resident at the proper temperatures. When a resident is unable to feed themselves, appropriately-trained staff provides that service, as needed. When a resident requires assistance with eating, the staff provides the assistance in a respectful manner, actively engaging the resident to the extent possible. The goal is to provide residents with the assistance needed, encouraging the resident to be as involved as possible in the dining experience based on an interdisciplinary team assessment, such as assisting the resident cut food, while allowing the resident enough time to feed themselves. Residents with feeding tubes can be invited to the table and be given opportunities for "tasting," a program that allows the resident to participate in meal times by experiencing the aroma of food and light brushing of food items on the lips and tongue. **NOTE:** *It should be recognized that oral intake may be improved when residents are given the choice of where to eat.*

(3) Times at which residents choose to eat may vary based on their preferred routines, especially the morning meal. Flexible or extended meal times allow for accommodation of residents' personal preferences. For example, extended breakfast service times or continental breakfasts may allow a resident to sleep later and may result in better nutrition.

c. **Diet Orders and Restrictions.** Residents are to be given choices of food preferences at meal times. Entrée options and alternatives need to be available. Evidence shows the elderly consume more adequate nutrition with fewer restrictions to their diet, therefore VHA encourages the liberalization of diets in the CLC environment. When medically necessary, therapeutic diets must be available and served to the resident. Finger foods need to be readily available for those who have difficulty with utensils, for example residents suffering from dementia. Adaptive devices must be readily available for those who have difficulty handling regular utensils. It is important that all who assist the resident with meals recognize the importance of the adaptive equipment and ensure such equipment is properly cleaned and stored.

d. **Snacks and Supplements**

(1) Snacks are to be readily available to CLC residents between meal times, 24-hours a day. Staff needs to be available to assist those who are unable to obtain their own snacks or who may need guidance on making better snack choices. The variety of snacks needs to be extensive enough to meet all residents' needs.

(2) Food supplements and fortified foods need to be the first choice when additional calories or supplementation is necessary. Prescribed medical nutritional products may be available, but an effort needs to be made to identify why a resident is not receiving adequate nutrition prior to their initiation. For example many residents find ice cream more palatable and preferable to medical nutritional products and would consume this snack if offered. Feeding abilities, dentition issues, food preferences, and medications need to be evaluated as possible causes for inadequate intake. The use of a fortified beverage supplement program is often successful when given with medications. This approach provides residents with a small amount of supplemental beverage each time their medications are given, resulting in consumption of extra calories by the end of the day, with less impact on their appetite at meal time. Additionally, interdisciplinary team awareness of a resident's nutrition and hydration needs is critical so that team members are able to actively offer residents' their favorite foods and beverages throughout the day.

e. **Hydration.** Beverages of various consistencies need to be readily available and offered to the resident throughout the day. Staff needs to be available to help those unable to obtain beverages on their own. Since there is a reduced sense of thirst in the elderly, it is critical for all CLC staff to ensure that residents are reminded and encouraged to consume adequate fluids daily.

f. **Other Considerations.** Quality of life is improved when residents are offered food choices and are able to enjoy home style meals. Within safety standards, efforts must be made to allow for the enjoyment of all foods. Not all residents are able to consume recreational foods prepared outside the facility. In these cases, Nutrition and Food Service provides alternative home style choices to the resident, reflective of the dietary orders. Examples of outside foods include, but are not limited to: favorite foods brought in by family, holiday treats shared by friends, or party foods provided by volunteer groups. Facility-sponsored cooking groups are a great opportunity for residents to participate in the preparation and consumption of home style foods. Alcohol consumption by residents while at the CLC must be guided by local policy in coordination with the medical staff and is allowable when appropriate. A hot beverage available in the kitchen, dining area, or other common area is a nice way to encourage socialization among

the CLC residents. Access to ice cream dispensers, toasters, bread machines, and other such appliances for resident use may help stimulate socialization, independent living skills, and appetite.

10. ACTIVITIES OF DAILY LIVING

"You understand my functional abilities and are ready to assist me in the performance of my self-care activities. My therapists and nurses have provided me with techniques and equipment to complete these activities as independently as I am able. I appreciate that you have the patience to assist me in these activities rather than complete them for me and that you respect my personal choices as to what time I get up, what clothes I choose to wear, and how and when I prefer to bathe. I like to look and feel my best each day so that I am ready to participate in the activities offered and to visit with friends and family."

a. Daily Functioning

(1) There are two necessary components for normal daily functioning: Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).

(a) ADLs include: grooming, bathing, dressing, personal hygiene, toileting, eating, mobility, and transfers from one location to another (moving in bed, sitting, and standing).

(b) IADLs encompass most household and community type activities, such as: cooking, laundry, shopping, management of finances, making and keeping appointments, answering the telephone, and planning activities.

(2) When a resident suffers an event that impairs function in these areas, particularly the ADLs, they may require some level of assistance in order to maintain function at the highest level possible. To best understand the level of functional support needed in the context of the resident's daily life, the interdisciplinary team addresses each of these areas through individualized interviews and assessments. Plans of care are developed and implemented with the resident as the center of the plan. Personal preferences, physical and cognitive abilities, values, and cultural differences need to be integrated into all ADL goals and plans of care. A variety of approaches and programs, including skilled rehabilitative treatment and restorative programs may be available to achieve and maintain performance of self-care activities. Once a resident is discharged from those services, encouragement and facilitation of learned skills needs to continue for the length of stay in the supportive environment of the CLC.

b. Activities of Daily Living (ADLs)

(1) **Eating**

(a) A variety of plates, utensils, foods, and seating options need to be available to meet the needs of the residents. Efforts need to be made to encourage independence while providing assistance and support, as needed, in order to foster personal autonomy. Meals need to be an unhurried, enjoyable activity in which the resident actively participates. To the extent possible

meals need to be served in a way to resemble a home-like setting or dining room rather than a large institutional gathering space.

(b) An interdisciplinary approach to meeting the resident's needs is essential. Occupational Therapy needs to be consulted for recommendations and provision of appropriate adaptive equipment and positioning devices. Speech Therapy needs to work with veterans who have dysphagia and swallowing disorders. Recreation Therapy might assist in achieving an appropriate milieu during mealtimes. **NOTE:** *All facility staff from all disciplines are encouraged to share mealtimes with residents to provide assistance, model appropriate behaviors and promote socialization and companionship. Physical Therapy should provide recommendations for residents who can participate in a formalized walk-to-dine or similar program.*

(2) **Grooming.** For residents with limitations in strength and coordination, adaptive equipment can be beneficial in encouraging active participation and independence with grooming activities. The adaptive equipment includes items, such as, but not limited to: light weight items, built-up handles, cuffs, electric, and dycem. It is highly recommended that residents and families are offered the opportunity to bring their own personal grooming supplies and that appropriate space is given for storage of these products.

(3) **Bathing.** A resident may experience difficulty with bathing due to decreased endurance, poor balance, flaccid or weak upper or lower extremities, or cognitive issues. The resident needs to be provided with the appropriate adaptive equipment, as needed, to promote independence, such as: tub benches, long-handled sponges, or wash mitts. It is important to identify the resident's preferences (shower or bath) and prior routines (frequency and time of day) when establishing bathing schedules. The environment needs to be safe, barrier free, comfortable, and private. The resident's sleep-wake cycle must be respected to promote maximum active participation during bathing.

(4) **Dressing.** Dressing is an activity that requires time, a sequence of events and an appropriate environment. This activity also requires: balance, strength, coordination, initiation, and problem solving; the resident may require assistance in one or more of these areas. Adaptive equipment is available to promote independence such as dressing sticks, reachers, sock aids, shoe horns and button hooks. The resident may complete this activity either in bed, wheelchair or regular chair dependent on the level of support needed and personal preference. The resident needs to be offered the option of selecting their personal clothing each day and night. Appropriate bed attire is to be used for sleep and appropriate clean clothes need to be worn daily. **NOTE:** *Although on occasion a resident may prefer to remain in pajamas during the waking hours, staff is to offer encouragement and needed assistance so that the resident can be dressed in their street clothes during the day.*

(5) **Sleep.** The resident's preference for waking and bed times needs to be part of the plan of care. It is important to provide the opportunity to take a nap during the day, as long as it does not interfere with the sleeping routine. Educating the resident and collaborating in the development of the best schedule is a priority. The resident needs to be positioned in bed according to the needs of the resident to promote maximum functioning, comfort, and safety. The facility's nighttime environment needs to be conducive to resident sleep and restfulness;

noise and lighting needs to be reduced to prevent any disturbance in the resident's sleep or rest. Waking residents early in the morning for bathing and breakfast out of sync with their personal rhythms contributes to agitation, irritation, and lack of cooperation during bathing and other routines. Resident choice is a critical component of care.

(6) **Transfers and Mobility.** Although there may be times when a resident's clinical status warrants bed rest, or a particular occasion when a resident prefers to remain in bed or stay in their bedroom for the day, in most cases staff is to encourage and assist residents to be out of bed and out of their bedrooms for at least short periods of time daily. The physical and psychosocial needs of the resident determine mobility and the method of transfer. A resident needs to receive education and assistance regarding the mobility plan, based on the level of the resident's functional capacity. Residents need to be encouraged to actively participate in mobility training and transfer to the greatest extent possible. Appropriate safe use of mobility and transfer equipment and techniques are imperative to the safety of both the resident and staff. A home-like setting where the resident is encouraged to participate in normal household routines enhances a resident's rehabilitation and fosters independence.

c. **Instrumental Activities of Daily Living (IADL's).** IADLs include tasks such as cooking, laundry, shopping, management of finances, answering the telephone, making and keeping appointments, planning activities, safety and emergency procedures and self-administration of medications. An opportunity to practice and participate in these types of activities needs to be individualized to the needs of the resident and to prepare the resident for discharge into the community once goals of care have been achieved. In short-stay skilled nursing or rehabilitation focused settings, performance of these activities is critical to the discharge planning process. In long-stay settings participation to the level of a resident's maximal ability is an important aspect in quality of life, meaningful use of time, determining need for skilled rehabilitation services, and planning recreational activities.

11. LIFE ENHANCEMENT

"I need time to think, to socialize, to create and to remember. I don't want to be 'kept busy.' Rather, I would like to use my time participating in those things that are meaningful to me. I have enjoyed many activities in my life that have contributed to my sense of purpose and personal satisfaction. These activities include my spiritual and cultural customs, as well as my recreational, social and leisure pursuits. It is important for you to know all about me and the things that I enjoy. It is important for me to have the opportunity to do the things I have always liked to do and to try new things that stimulate my interest, challenge my mind and add meaning to days. Most of all, I do not want to be bored or lonely."

a. **Quality of Life.** Quality of life is the essence of the CLC environment whether the resident is in the CLC for short or long-stay care. Resident preference is the key to enhancing the quality of that life. The things we choose to do, the people we choose to do them with, and the way in which we do them are what make each person unique. Personal preference, active participation, and meaningful activity are essential to the happiness and well-being of residents. All members of the CLC share the responsibility of supporting life enhancement activities to meet the individual needs of residents and to promote a strong sense of personal satisfaction and community within the CLC.

b. **Customs and Rituals.** Customs and rituals are regular, patterned, learned and traditional ways of appearing or behaving. Customs and rituals may be reflected in language, communication, religion, and celebrations, as well as routines such as those upon rising and personal care. The opportunity for residents to continue practicing their customs and rituals is extremely important because it is part of who they are. Examples of customs include: having particular foods during a celebration, participating in religious services or rituals, playing video games, or listening to a particular type of music. Examples of daily rituals include bathing and personal hygiene habits.

c. **Culture.** Culture is the way that people live in accordance with their history, language, and beliefs. Culture imposes expectations for behavior. Cultural traits can be learned from one's community or passed down from generation to generation and may include components of age, gender, ethnicity, race, and religion. Culture can include technology, art, and sciences. It is important to recognize and celebrate the cultural differences within the CLC. The cultural interests of the resident must be supported and respected. Interests can be brought to the CLC, explored and pursued in the community, or the residents can teach others about their interests and knowledge. In addition, the culture within the CLC itself imposes expectations for behavior and personal comfort for the resident. It is important that the culture within the CLC is one that advocates resident autonomy, choice, a sense of well-being, a sense of belonging and importance within the community. The culture imposes expectations for staff behaviors with and among residents. The creation of a new culture in the CLC is meant to facilitate innovation and staff and resident empowerment. This culture transformation reflects well-being and defines the quality of care and quality of life that are the expected outcomes.

d. **Spirituality.** Spirituality is a sense of connection to something greater than self, including an emotional experience, religious awe, or personal experience. The key is an individual's concept of spirituality; it is the active and vital connection to a force, spirit, or sense of deep self. It is a vital part of an individual's holistic health and well-being. Residents must be able to practice their own components of spirituality. For example, quiet areas for meditation, guided imagery, and chanting need to be available to the residents. The resident, family, and friends must be allowed access to religious services and personal contact with members of chaplain service or other religious and spiritual leaders from the community.

e. **Community**

(1) Community life is an important consideration in the residents' quality of life. It includes the CLC environment, as well as the community in which the CLC is geographically located. Integration or reintegration into both spectrums is vital to the sense of belonging. Residents need to have a variety of opportunities to explore the community during group and individual outings. Residents may choose to maintain affiliations and memberships with organizations in the community.

(2) The opportunity to formally meet as a community, neighborhood or household to discuss issues that arise, plan activities, and conduct learning circles needs to be available at a minimum of twice monthly.

(a) The residents and their agenda are the focus of the meetings. CLC staff, volunteers and, if appropriate and consistent with resident preferences, family need to be invited to attend these community meetings so the resident knows their voiced concerns and preferences are heard.

(b) A monthly community meeting (formerly known as Resident Council) brings all of the neighborhoods or households together to discuss issues, provide education, and voice ideas. These meetings need to include CLC residents, staff, volunteers, and, if appropriate, family. All concerns, issues, ideas, suggestions, and preferences need to be addressed at this time. When this not feasible, action needs to be taken and reports generated to ensure follow-up.

f. **Activities**

(1) An activities assessment for each resident needs to be completed upon admission and at regularly-scheduled intervals, as defined by local policy.

(a) This assessment is used to assist the CLC staff, volunteers, and family members to ensure meaningful use of leisure time for the resident. The assessment needs to include the following information:

1. Leisure interests,
2. Functional levels,
3. Adaptations needed for leisure functioning, and
4. Past and present patterns of leisure participation.

(b) In addition to leisure activities, it is important to understand how the resident normally spends their day. Elements of a meaningful day may include formal group activities, such as games, outings, and celebrations. The goal of the assessment is to determine what, in the course of a usual day, is meaningful for the resident as well as what else the resident might enjoy.

(2) The activities program needs to reflect the interests, needs, and preferences of the residents. A variety of activities need to be available throughout the day to meet the needs of residents of all ages in the context of physical and cognitive functioning. Activities can be self-directed, or directed by someone in the community. Activities can be planned, unplanned, group, or individual. They need to promote spontaneity, respect the need for quiet and down time, and provide opportunities for both active and passive participation. If the resident is not able to actively participate in planned activities or to pursue self-directed activities, then time must be afforded to provide appropriate activity on an individual basis. Scheduled programming for the day may be of benefit to residents who are not able to make choices about how to spend their time on their own. Activities should be age, gender and culturally driven, and as much as possible, reflect lifelong preferences to ensure quality use of leisure time.

(3) Creative expression is the ability to utilize different mediums as forms of self-expression and to convey meaning in life. For some this is a natural talent while others have a desire to learn. It can encompass music, writing, dance, drama, art, or design. The CLC staff and

environment need to support creative expression and provide opportunities to participate and explore new interests. Residents need to be encouraged to display or showcase their art within the CLC. Given the importance of meaningful use of time for residents in CLCs, it is expected that meaningful activities are available on all shifts including weekends and evenings.

(4) When the need for skilled recreation therapy is identified, the recreation therapist or Creative Arts Therapist (CAT) requests a physician's order for evaluation and treatment. An individualized, time-limited, goal-oriented plan of care must be implemented utilizing specified treatment modalities during scheduled therapy sessions to achieve the veteran's maximum level of function.

g. Family Involvement

(1) A resident's family is an integral part of the CLC and needs to be closely involved in all activities and planning to the extent appropriate, feasible, and consistent with resident preferences. Family is defined by the resident and CLC staff needs to honor the resident's choice. Some people do not consider blood relatives as family. For example, a resident may not have had contact with the only surviving sibling for 20 years, but has a friend or neighbor they have known for 30 years. The resident considers the friend or neighbor to be their family. In addition, given that CLC services may be utilized by a younger cohort of residents, it is important to make provision for active participation of friends, spouses, and children if the resident so desires.

(2) The CLC must develop a family council and hold regular meetings in accordance with local policy. The meetings may serve a number of purposes, including: information sharing, education, opportunities for support, discussion among family members, and family involvement in social and or recreational activities with the resident, volunteers, and staff. Family council meetings can be held in connection with other programs that are occurring in the CLC, such as picnics, holiday celebrations, and special meal occasions.

h. Considerations for Care

(1) Include family and significant others in the resident's life if the resident so desires.

(2) Ensure religious and spiritual needs are met to the extent possible and appropriate.

(3) Identify and honor important cultural rituals.

(4) Provide symptom management and relief of pain.

(5) Institute restorative nursing programs to improve functional capacity.

(6) Provide alternative behavior management strategies; massage, aromatherapy, music, visualization, and Snoezelen therapy are examples of proven strategies.

(7) Find creative ways to collaborate with Nutrition and Food Services to provide alternative meal choices.

(8) For residents who are communicative, but lack decision-making capacity, create opportunities for them to express preferences about their daily care and honor those preferences to the extent possible. When necessary, adaptation of a resident's lifelong preferences is a meaningful way to encourage the resident to participate in an activity.

(9) Provide consistency of caregivers to the extent possible.

12. END OF LIFE ISSUES

"When I am nearing the end of my life, I want my provider and family to be honest and open with me in determining the best place for me to spend my last days. The care that I receive fosters hope, dignity, peace of mind, comfort, relief from pain, symptom management, and the ability to make personal choices about my care. My surroundings look and feel like home, providing a comfortable environment which supports the presence of friends and family at all times. During these precious days, quality of life and meaningful use of time take on a new level of importance as I seek peace and closure in my life. The care provided now is for both me and my family. It includes spiritual and emotional support, privacy to be alone with friends and family when needed, and respect for the choices I have made about my care. The memory wall in the hallway, the memorial services provided by the chaplain, and the end of life rituals completed by staff assure me that I will be respected and remembered when I am gone."

a. **Care Planning.** A diverse population of residents, both short-stay and long-stay may reside in the CLC environment. When cure is no longer possible, the focus of care often shifts from curative and rehabilitative to that which emphasizes comfort, relief from pain, symptom management, and quality of life. The goals of care at the end of life need to reflect the preferences of the resident. Optimally, the resident or authorized surrogate and the health care team establish these goals as part of a shared decision-making process. The resident's goals of care may encompass a range of appropriate preferences, including the option to forgo all curative care, or alternately, to include both curative and palliative treatments in the care.

(1) End of life care is to be offered in the setting that is most desirable to the resident.

(2) The plan of care emphasizes the comprehensive management of the physical, psychological, social, cultural, spiritual, and emotional needs of the resident.

(3) If the resident desires, the needs of the family need to be honored to extent feasible and appropriate.

(4) Accommodations need to be available for family and friends whom the resident wishes to have present during their final days.

(5) Bereavement activities need to be available for residents, families and staff. **NOTE:** *Practicing end of life rituals at the CLC can provide a supportive environment for the dying residents by putting things in order and resolving issues as well as assisting staff and others with their grief.*

b. **Hospice and Palliative Care (HPC)**. When end of life is imminent, a resident's plan of care may include the provision of HPC services where the primary goal of treatment is comfort rather than cure. HPC collectively represents a continuum of comfort-oriented and supportive services provided in the VA CLC for the resident in the advanced stages of incurable disease. This includes bereavement care for the resident's family. When the resident reaches the point where they choose HPC, the care is provided in the setting choice of the resident. HPC is provided by an interdisciplinary team demonstrating competencies to plan, direct, and provide HPC. Current VHA policy mandates each facility establish a Palliative Care Consult Team (PCCT).

c. **Considerations for End of Life Care**

- (1) Identify cultural rituals for end of life and time of death care and honor them to the fullest extent possible.
- (2) Ensure religious last rites are honored.
- (3) Include family and significant others in the resident's life as much as the resident desires.
- (4) Provide consistency of caregivers.
- (5) Support the strength and courage of the dying resident.
- (6) Consistently speak to residents in a comatose state.
- (7) Ensure a well-managed medical program for symptoms and pain management.
- (8) Provide support groups for residents and families.
- (9) Facilitate spiritual talking circles for residents, family, and staff.
- (10) Offer alternative therapies, such as massage, music, visualization, etc. for symptom and pain management.
- (11) Provide facility rituals that allow the resident to be supported through the end of life and recognized at the resident's death, as:
 - (a) Wakes to provide other residents and family the opportunity to view the body.
 - (b) Funeral processions through the facility that leave using the front door.
 - (c) Assisting residents in the facility with transportation to the formal wake or burial ceremony.
 - (e) Facility memorial services to recognize the lives of those or have died.

(f) A process to create a permanent remembrance of those who have died, such as Remembrance Walls, Living Trees and Memory Plaques.

(g) Playing taps or the resident's favorite music as the resident leaves the facility for the last time.

(12) Provide loved ones, staff and other residents the opportunity to mourn and participate in the bereavement process.

(13) Consider a formal program that provides assistance to the resident in writing or recording the resident's life story, which can be passed on to the family or left at the facility after death.

(14) Encourage families to share fond memories and life events that describe the value the resident has had in the lives of others. Bring mementos and cherished possessions, including pets, to the resident's bedroom.

COMMUNITY LIVING CENTERS SERVICES

Community Living Centers provide the following services:

1. Short Stay

- a. Rehabilitation.
- b. Skilled nursing care.
- c. Restorative care.
- d. Maintenance care for those awaiting alternative placement.
- e. Psychiatric care.
- f. Dementia care.
- g. Geriatric Evaluation and Management (GEM).
- h. Hospice (may exceed 90 days).
- i. Respite care.

2. Long Stay

- a. Dementia care.
- b. Skilled nursing care.
- c. Maintenance care.
- d. Psychiatric care or chronically mentally ill care.
- e. Spinal Cord Injury and Disorders.