

Office of the State
Long-Term Care
Ombudsman



Resident Advocate Volunteer Manual

Promoting the Rights of People
Living in Long Term Care Facilities

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Welcome!

You are starting a journey with a program that has a long tradition of helping others. Your involvement in the Resident Advocate Program will help promote quality of life for individuals who live in long-term care facilities. Welcome to the program!

Every licensed facility in Iowa is required by Code to have a Resident Advocate Committee (RAC). Currently there are over 3,200 volunteers across the state serving in nursing facilities and residential facilities. Administration of the program rests with the Iowa Department of Elder Affairs, with specific duties assigned to the State Resident Advocate/Long Term Care Ombudsman.

The Resident Advocate Program is unique to Iowa, even though all states under the Older Americans Act are required to have an office of the State Long-Term Care Ombudsman. The program has existed since 1971.

The Resident Advocate Committee functions as an autonomous group within the facility and represents every resident. It is an important role, especially for residents who do not have family or friends nearby and those who might be reluctant to bring concerns directly to the staff. Volunteers spend at least 3 hours per month in the facility talking with the residents to better understand the conditions at the facility from the residents' point of view. The Resident Advocate Committee convenes on a regular basis to share information gathered during the visits. Issues are then communicated with facility staff so they can work to correct problems or implement suggestions for improvement. Compliments should also be passed on to the facility staff. Concerns that you cannot resolve to the satisfaction of the resident may be sent to the Long Term Care Ombudsman or state regulatory agency.

Thank you for participating in the Resident Advocate Committee (RAC) program. This program cannot work without the many dedicated volunteers, like you, who commit so many hours to help residents in long-term care facilities. And YOU will make a difference for the residents living in long-term care facilities. I look forward to meeting you soon. The staff in the Office of the State Long-Term Care Ombudsman stands ready and willing to assist you in any way we can.

Jeanne Yordi
State Long-Term Care Ombudsman

GETTING STARTED

This resource will help you familiarize yourself with the role and responsibilities of a Resident Advocate as well as to supplement the orientation and further training. It is expected that you will attend continuing education classes that are offered once a year.

Resident Advocates are volunteers who help safeguard the rights and quality of life of people who reside in care facilities in Iowa. This is done by visiting the residents on a frequent basis to monitor daily life in the facility. Resident Advocates work to resolve resident and/or family concerns at the facility level.

You do not work alone. If you have any questions about the Resident Advocate Committee such as needing supplies for your meetings, recruiting new members, needing assistance with complaints, or to discuss situations in your facility, please call **toll free 1-800-532-3213**.

After you have participated in orientation please call your committee chair. He/she will give you facility specific information like how the committee chooses which residents to visit as well as the time, date and location of meetings.

You may ask the Chair or another committee member to go with you the first couple of times you visit the residents. Remember the visits will be made at your convenience and must be unannounced.

HISTORY

The Older Americans Act was enacted by the U.S. Congress in 1965 to help older citizens. The Office of the State Long-Term Care Program mandates are included in this Act.

When a person moves into a long-term care facility, they retain all constitutional and civil rights that any other citizen has. Long-term care facilities may be any of the following:

- Nursing Facilities (NF)
- Intermediate Care Facilities (ICF)
- Intermediate Care Facilities for Person with Mental Illness (ICF-PMI)
- Residential Care Facilities (RCF)
- Residential Care Facilities for the Mentally Retarded (RCF-MR)
- Residential Care Facilities for the Mentally Ill (RCF-MI)
- Elder Group Homes (EGH)

People who live in long-term care facilities are protected even further by state and federal laws and regulations created specifically for them.

Each person living in a long-term care facility has the right to a dignified existence including self-determination, communication and access to persons and services inside and outside the facility.

RESIDENT RIGHTS THE FOUNDATION OF RESIDENT ADVOCACY

When people move into a long-term care facility they are faced with many losses, but they do not lose their basic rights. In fact the federal government and the State of Iowa have provided care facility residents with additional rights.

“The facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life.”

A brief summary of Resident Rights includes, but is not limited to, the right to:

- Be informed of his/her own rights
- Be informed of all services and pertinent charges
- Be fully informed of his/her health and medical condition, and given the opportunity to participate in planning care and/or medical treatment
- Refuse medical treatment
- Not be involuntarily transferred or discharged from the facility except under specific circumstances
- Submit complaints or recommendations concerning the policies or services of the facility to any person or agency of the resident’s choice, and be free from restraint, interference, coercion, discrimination or reprisal
- Manage his/her own personal financial affairs
- Be free from abuse and restraints
- Be treated with consideration, respect and dignity
- Have privacy during treatment and care of personal needs, when visiting with spouse, guests or others
- Have records treated with confidentiality
- Share a room if both husband and wife are residents of the facility
- Not perform services for the facility
- Send and receive personal mail
- Make and receive personal phone calls
- Participate in social, religious, and community group activities or refuse to participate in any activities
- Choose his/her own physician and/or pharmacist
- Retain and use personal possessions and clothing as space permits

RESIDENT ADVOCATE POSITION DESCRIPTION

With minimum supervision advocates visit residents in facility, advocate for their needs, complete reports, and attend committee meetings. Resident advocates are also required to attend orientation and educational programs.

Desired Qualities

Kind and compassionate
Good listening skills
Ability to read, write and follow directions
Understand and abide by confidentiality policy
Non-judgmental regarding lifestyle choices of others
Ability to work with staff, residents, families, and administration
Respect the dignity and rights of all long-term care residents
Respect confidentiality

Job Duties

Visit residents at least 3 hours each month
Assist residents (and families) to understand and exercise their rights
Attend committee meetings
Work to find solutions and resolution to resident and/or family concerns
Respect and promote the resident's right to self-determination
Attend training once a year
Maintain notes on all resident visits
Give a complete report on resident visits at each quarterly meeting
Work as a team with residents, families, administrators and their staff
Maintain confidentiality

As an advocate for the resident you serve as a volunteer for the State of Iowa-The Office of the State Long-Term Care Ombudsman.

Your job is not to be a spokesperson for the facility.

COMMITTEE CHAIR AND SECRETARY POSITION DESCRIPTION

The Resident Advocate Committee Chair and Secretary continue to function as an advocate, but also have these additional responsibilities.

Job Duties for Chair

Leads group discussions
Presents views of group in clear and concise manner
Acquires list of current residents for the committee
Schedules and conducts meetings on at least a quarterly basis
Completes required paperwork in a timely manner
Helps to orient new committee members
Updates committee on new residents and facility information
Helps to recruit new committee members
Meets with facility staff to present concerns
Provides information to the Department of Inspection & Appeals when called
Visits residents on a regular basis

Job Duties for Secretary

Takes minutes and organizing material
Provides leadership if the Chair is unavailable
Records minutes of committee meetings
*Completes the Resident Advocate Committee Meeting Summary and Change of Status forms

*Send a copy of meeting minutes and change of status forms within 10 days of meeting to:

**State Long-Term Care Ombudsman
Iowa Department of Elder Affairs
510 E. 12th St
Jessie M. Parker Building, Suite 2
Des Moines, IA 50319**

**If you use the postage paid envelopes, the address is different but is correct.*

WHY DO RESIDENTS NEED A RESIDENT ADVOCATE VOLUNTEER?

There are four basic reasons why a resident may need help in resolving their own problems.

- Many residents are unaware of their rights or are unaware of what facilities are required to do.
- Institutional factors, such as isolation, lack of power, and resistance to change, make it difficult for a resident to resolve a problem without assistance.
- Physician and/or mental limitations or circumstances make it difficult for residents to work through the complexities of a problem-solving process
- The process of solving a problem may seem overwhelming.

BASIC RULES FOR RESIDENT ADVOCATE VOLUNTEERS

Be objective while visiting residents and identifying problems. If a concern is important enough for the resident to tell an advocate about, it is important enough for advocates to offer to try to fix. No concern is too trivial to be addressed.

Be calm, supportive and show interest in what the resident discusses with you.

Acknowledge that you heard the resident. Repeat the information back, using the same words.

Clarify what the resident wants you to do and be certain you understand how the resident wants this resolved. Ask: "How can I help?" or "Would you like me to check this out for you?" Respect the resident's right to refuse. If the resident asks you NOT to pursue this issue, you must honor that request.

If an advocate doesn't understand the concern, he/she should ask for clarification. If the resident cannot explain, offer comfort and try again.

Do not give advice. Offer suggestions on how the problem might be resolved. Don't be afraid to ask questions.

Listen. Listen with your ears, your eyes and your heart.

Be sure to identify yourself as a Resident Advocate when you are inquiring of others about problems or complaints. Remember that some information is confidential and cannot be shared.

As a volunteer for the State of Iowa Department of Elder Affairs/Office of the State Long-Term Care Ombudsman, you may not accept gifts from families, residents, or facility staff. This includes free meals on a routine basis.

Volunteers are not allowed to do any type of personal care for residents. This includes transferring a resident from one location to another such as from the bed to a chair or offering them a drink or snack. Find a staff person to assist the resident.

Be aware of odors: smoke, perfume, or strong food odors on your clothes can be upsetting for residents, or trigger allergic reactions.

Gather as much information as you can. Keep a journal. Document names, dates, and location in or outside the building and report resident concerns, both resolved and unresolved at unit meetings.

FRIEND VS. ADVOCATE

It is easy and natural to slip into ways of communicating that we use frequently. Visiting as a Resident Advocate is not necessarily the same as visiting with a friend or family member. You are there to listen and respond, not to share stories.

Active listening can alert you to clues that the resident is giving. Remember the resident is the focus of your attention. Acknowledge that you heard the resident. Repeat the information back using the same words.

Building trust and establishing relationships can take time. Don't assume that no complaints mean all is well. When a resident raises an issue or concern, remember to respond, not react. This will make all the difference in whether or not the resident will confide in you.

Here are some differences between a Resident Advocate and a friend:

FRIEND

The relationship is established through normal life experiences in the process of social or business contacts.

The relationship is highly subjective and based on mutual needs and attractions.

The relationship does not have any goal or purpose beyond mutual satisfaction.

The communication is equal. It is a give and take relationship.

ADVOCATE

The relationship is deliberately planned and promoted through the Resident Advocate Program for a specific purpose.

The relationship is very defined, objective, purposeful and controlled.

The relationship has a goal: to provide advocacy for residents living in long-term care.

Communication is not equal. The Advocate is encouraged to listen as the resident talks. The advocate shares as appropriate.

VISITING A RESIDENT

Knowing where to start is a good first step. Resident advocates perform three different kinds of visits: individual resident visits, visits to new residents, and general facility visits.

Visiting frequently with individual residents and learning to have conversations that will provide you with good information is key to the success of an advocate. Even though an advocate is NOT a friendly visitor, building trusting relationships with residents is a first step in helping each individual define and advocate for the daily life schedule that fits their needs.

It is also a good idea to visit a resident about 2-4 weeks after they move into the facility. Using the quality of life section in the observation list will help you identify possible needs that are not being met.

Respect the resident's right to privacy by always knocking and waiting for an invitation to enter the room. The resident's room is his or her home. If there is no answer, announce yourself, and ask for permission to enter.

Always introduce yourself and explain your position as Resident Advocate. Don't assume the resident remembers you or what you do. Ask if he or she would be willing to talk with you, and where he or she would be most comfortable. The law requires that you have privacy during your visits with residents. Residents need to feel free to express their concerns. Accept their right to refuse to visit with you.

Address the resident formally with Mr. or Mrs. until asked to do otherwise. Do not use pet names such as "Honey" or "Sweetie".

Eye contact is important during conversation, so try to visit at eye level, facing the resident. Do not tower over the resident, especially when the resident is lying down or is in a wheelchair. It psychologically puts the resident at a disadvantage. Remember to be careful not to intrude their personal space.

Sometimes space is limited in a resident's room, and there may be no place for you to sit. You may need to go in search of a chair. Do not sit on the bed without permission. Always ask permission before sitting down. "Where would you like me to sit?"

Make resident visits relaxed and informal.

Be objective while visiting residents and identifying problems. If it is important enough for the resident to tell you about, it is important enough for you to offer the resident assistance in finding a solution.

Different problems call for different strategies to resolve them. Depending on the seriousness of the concern, the committee may choose to monitor the situation temporarily before deciding how to proceed.

It is easy to startle people when you approach from behind so it is best if you approach directly from front.

Introduce yourself each time you visit a resident and let them know you are a volunteer.

If the resident is willing, you may want to find a quiet place to visit to help eliminate distracting sights and sounds. However, a resident may be hesitant since you are a stranger. Follow their lead and eliminate any distractions that you can.

Do not assume a resident has a communication deficit because they live in a long-term care facility. Speak as you normally would, however if a resident does not seem to understand you, simplify your language.

People will have a better chance of understanding you if you learn to speak in a low tone, slow down your rate of speech and be clear and concise. This can be challenging! However, talking slower than normal, lowering your pitch and choosing your words carefully can make a big difference in communication.

Allow the resident time to formulate a response and do not interrupt the silence. It may take some residents up to 45 seconds to process your words. Wait patiently and you will be surprised how often you get a response.

Quizzing people simply reminds them what they don't know. "Where is your room?" "What did you have for lunch?" These questions do not benefit anyone. "Let's go for a walk and you can show me your room" is better because you can help her find her room.

It's okay to take brief notes. Just make sure you focus on the resident and not on your writing.

We all have good days and bad days, sometimes we have good hours and bad hours. Some days, a resident may carry on a long, in-depth conversation and other days you may not even be able to get their attention. Still, treating everyone with the same courtesy and respect will show everyone that you care.

VISITING THE FACILITY

The facility staff must, to a certain extent, protect the residents who live there. That makes it important that someone be aware of visitors in the facility. Resident Advocate visits should always be unannounced, but once you arrive at the facility, it is courteous to let someone in charge know you are in the building.

Remember that a facility may temporarily experience problems that normally do not occur. That is why it is important to visit frequently – it helps you understand which incidents are isolated and which are on-going, or system-wide problems.

If making a general facility visit seems overwhelming to you, consider visiting during a meal. You can observe many routines in a short time span.

An example of facility visit would include:

- Arriving 90 minutes prior to the start of the meal or plan to stay approximately 90 minutes after the end of the meal.
- As you enter the facility look to see if residents are already seated in the dining room.
- Residents may eat in their room if they desire. Some staff members should remain to answer call lights and assist those eating in their rooms. All other staff members should be in the dining room.

Choose a section of a hallway to observe and follow those residents throughout the meal. Use the sections of the observation list that show what to look for in the dining room and during the meal. Also, watch for the following

- Staff should assist the resident with personal needs prior to taking him/her to the dining room? (Change incontinent brief, assist to the bathroom)
- A resident should be asked if they would like to be taken to the dining room.
- Residents should have time to wash their face and hands prior to each meal.
- Is the dining room open for an extended period so each resident can eat at a preferred time?
- Once seated in the dining room the staff should take a minute to make the resident comfortable.
- Does the nurse pass supplemental liquids prior to a meal? If so, is the resident too full to eat?
- Staff should always double check to make certain every resident is in the dining room and no one is forgotten
- Clothing with food spills should be replaced (exception: a person with dementia or a person in severe pain may be better left alone)
- Residents should receive assistance with personal needs following the meal.

- Residents should be allowed enough time to eat, and should not be rushed from the dining room, nor should a resident be left for long periods of time following the meal.
- Residents should not be lined up in a hallway waiting for assistance.
- Staff members who feed a resident should identify foods and beverages before placing it in the resident's mouth.

Keep this thought in mind: Is this a routine I would be comfortable with and is this a meal I would be excited to eat?

In this single 2 hour visit, an advocate can observe multiple routines in the daily life of the facility. The advocate can observe many different staff and many different residents at the same time. A facility should promote a dining experience and not "feeding time." Conversations should be encouraged between residents and between residents and staff to promote a normalcy in the life of the resident.

Changing the dining experience can be a first step in promoting person-directed care.

NON-VERBAL COMMUNICATION

Non-verbal cue	Supportive	Non-supportive
Touching	Occasional touching; soft touching, may “ground” the person to your presence	No contact; sharp, abrupt touch
Eye contact	Maintains good eye contact	Does not look into person’s eyes; looks elsewhere
Gestures	Nodding agreement; friendly gestures	Distracting movements; irrelevant pointing
Posture	Relaxed caring pose toward other	Tense, rigid, leaning pose; leaning away
Distance	Close proximity, be aware of personal space	Sitting while the person stands; standing while the person sits; far away
Facial expressions	Frequent smiling; animated face; interested expression	Frowning; straight face, scowling; yawning
Voice volume & tone	Soft and caring, speak low, slow, clear, concise	Too loud; too fast; unpleasant tone

Studies indicate that

- **65% of what we hear is related to tone of voice**
- **28% of what we hear is related to body language and facial expression,**
- **7% of our understanding comes from the actual words spoken.**

SAMPLE INTERACTIONS AND CASES

When you encounter a resident who you suspect has Alzheimer's or dementia, you may need to look at concerns in a different way. In many cases, you will need to contact the Ombudsman's office for assistance. Resolving issues for people with dementia can be very unique and may require a more in-depth review that you can provide. Sample cases follow:

EXAMPLE

RAC: "You look nice today. Did you just get your hair done?"

RESIDENT: "They never wash my hair. I haven't had a shower since I came here."

***REMEMBER:** The resident may not understand your question. You might ask: Have you had a bath?

Good Response: "Let's go ask what we can do about this."

Poor Response: "Your hair was just done and you look clean. I think you just forgot."

Action Plan:

Investigate:

- With the permission of the resident, tell staff the resident is concerned he/she didn't get a shower.
- Ask the staff if they can tell you which days this resident is scheduled for a shower.

Resolve:

- If you determine that showers are being given on a regular basis, talk with the staff about how to change the resident's perception that he/she did not get a shower. Find a solution to change the resident's *perception* of the problem. Would a calendar in the room help?

EXAMPLE

RAC: "How was lunch today?"

RESIDENT: "I didn't get any."

***REMEMBER:** The resident may not understand your question. You might check out the menu and then ask specifically, "did you enjoy the meatloaf?" Also, people with Alzheimer's or dementia have short term memory loss, so it is not unusual for him/her to forget that a meal was just completed.

GOOD RESPONSE: “Are you hungry now?”

POOR RESPONSE: “Look at this menu. It shows you had meatloaf. It’s 1:30, so I know you already ate.”

Action Plan:

Investigate:

- Was the resident sleeping and missed lunch? Did the resident continually wander away and didn’t eat much? Did he/she not like what was served?
- If you were not there during the meal, you may ask the staff: “This resident complains of being hungry. Can you tell me how much he ate at lunch?”

Resolve:

- Ask the staff “Can we get him a snack?”
- Any time a resident complains of being hungry, a snack and beverage should be offered.

EXAMPLE

RAC: “You sure have a nice room.”

RESIDENT: “It’s okay except for the man that lives above me. He’s really noisy and then he comes into my room at night.”

***REMEMBER:** A person with Alzheimer’s or dementia may have hallucinations or delusions. Many times, though, staff does not take the time to search and find a sight or sound that a resident doesn’t understand, which leads us to believe he or she is hallucinating or delusional.

GOOD RESPONSE: “That is terrible. I will make sure that does not happen again.”

POOR RESPONSE: “This is a one story building. There isn’t anyone upstairs—this building doesn’t have an upstairs and no one comes in your room at night except the staff.”

Action Plan:

Investigate:

- Start with the resident. Ask her to show you where the noise comes from. Ask her how the man gets down into her room. Pay close attention and observe the area. You know this facility is only one story. What could this resident possibly be hearing to make her think a man lives upstairs. If you can’t figure it out, and the staff has no ideas, ask them to listen carefully each time they enter the room, to see if perhaps water pipes, the heat, an oxygen tank may be making noises that this resident misinterprets.
- You ask about the night staff, and discover the night nurse is male.

Resolve:

- You ask that the night nurse be notified of this resident's delusion and that he introduce himself and be extra cautious with this resident.

EXAMPLE

Resident: "I'm sick. I need to see my doctor."

Good response: "I'll check with your doctor and see what I can do." "Can you tell me where it hurts?" "Can I help?"

Poor response "There is NOTHING wrong with you."

EXAMPLE

Resident: *"I had \$100 in my purse and someone stole it."*

Good response: "That's a scary thought." "I'll make sure they don't do that again." "Let's walk down to your room and see what we can find."

Poor response "You never had \$100 in your purse."

EXAMPLE

Resident: *"Nobody's going to make decisions for me. You can go now...and don't come back!"*

Good response: "I'm sorry this is a tough time." *"It was nice to meet you."*

Poor response "I'm not going anywhere and you can't remember enough to make your own decisions."

EXAMPLE

Resident: "My son just dumped me here."

Good response: "Tell me about your son, Joe. Where does he live?" "Let's walk to the staff desk and ask the person if you can call Joe"

Poor response "The staff told me Joe called yesterday and you talked for 15 minutes. And, he comes to see you almost every day after work."

CONNECTING WITH FAMILIES

Families are able to provide information about residents who may not be able to speak for themselves. Once families have an understanding of what Resident Advocates do, and what rights the resident has, it becomes easier for the Resident Advocates to fulfill their role.

Regulations require Resident Advocates be given the names, phone numbers and addresses of each resident's family members unless the family member has stated in writing that he or she does not want such information released. The administrator will provide you with this information upon request.

Contact the families and encourage them to share information about the resident. If the resident is cognizant **YOU CAN ONLY** share information about the resident with the resident's permission. If the resident is uncommunicative then you need to tell the family what your concerns are and ask the family member, or the resident's power of attorney, if they will give you permission to talk to the staff. Let them know that you are someone they can turn to for help, and encourage them to help you in your role.

Most families will welcome the opportunity for you to assist them in advocating for their loved ones.

It is important to remember that if a family does contact you with a concern, but the resident does not want you to pursue it, you must honor the wishes of the resident.

RESIDENT INTERVIEWS & DOCUMENTATION

It is suggested that each Resident Advocate keep a journal of resident interviews. Advocates can use a tablet, spiral notebook, 3-ring notebook, or whatever will work for you.

Taking notes while interviewing a resident is okay, but ask permission first. “Do you mind if I write down a few notes so I can remember the details of what you told me?” Focus on the resident, not on your note taking. Just jot down key words, dates and times and fill in the details later.

Then during the committee meeting each RAC member should give a complete report of all the residents that they were able to visit. Remember to include any concerns or suggestions that were resolved during the quarter. It is important that all this information is put in the minute summary report.

The documentation that you keep when you make your rounds can be a revealing account of ongoing changes in the residents’ conditions and life in the facility.

Remember to document as much information as you can. Good documentation will help you present your case in the future.

RESPONDING TO RESIDENT CONCERNS

If a concern is identified during a resident interview, the next step is to decide how to handle it. Resident Advocates are expected to maintain resident confidentiality, including the source of a complaint, information about a resident's medical condition, financial status, and psychosocial concerns, *unless the resident gives you permission to discuss his or her status with others.*

Residents may need your help to define the true problem. For example, if a resident is unhappy because his family moved him into the facility against his will, he may find fault with everything. However, the true problem may be his anger at his family and grief over the loss of his former home. It takes practice to learn how to ask questions that can help the resident sort out his or her feelings and concerns.

Find out what has already been done to resolve the problem. Who has the resident talked to about this? What was the person's response? Clarify what the resident wants you to do. Ask: "How can I help?" or "Would you like me to check this out for you?" If the resident has not discussed the situation with anyone and/or does not want your assistance, this may be a clue to another issue.

If the resident would like your assistance, it is up to you to develop an action plan with the resident. Asking the resident, "How can I help you with this?" "Would you like me to explain this to your family?" "Do I have your permission to use your name and the information you have given me?" gives you clear direction on how the resident wishes to proceed.

If a resident insists that nothing be done or said about a concern expressed, you must respect this wish. You might explore reasons why the resident chooses not to have this problem corrected and perhaps you can help with those issues. When you are dependent on another person for your most basic needs, the fear or neglect or retaliation can be very real.

RESIDENT ADVOCATE VOLUNTEER OBSERVATION LIST

This observation includes items you may choose to review during your visits. Your committee may choose to select one or two areas to focus on during visits to the facility between committee meetings, or you may choose to use the entire list. It is not required that volunteers use this list, nor is it required that it be completed and submitted to anyone. We hope you find this as a useful reminder on how to help the residents define their quality of life.

ENTERING THE FACILITY

- Facility grounds are free of litter and weeds
- Lawn and landscaping are neatly trimmed
- Sidewalks and driveway are free of big cracks
- Ashtrays in smoking area are kept empty
- Facility appears clean
- Facility is odor free
- Windows are clean
- Hallways are clear of obstructions (one side of the hall should be free from obstructions or barriers)
- Floors are clean and not sticky, dirty, or slippery

Notes:

ENTRY WAY (PROMINENT PLACE)

- Facility license is posted in a public area
- Telephone number for the Ombudsman, DIA, police, Medicare fraud posted in conspicuous places in the facility
- Resident's Rights clearly posted
- Text of 135C is posted
- Last survey prominently posted
- Current list of the Resident Advocate volunteers is clearly posted

Notes:

LIVING ENVIRONMENT

- There is an area where residents can visit with friends or family
- Furniture in public areas free of food spills and odors
- There are signs to clearly direct residents or visitors to their destination

Notes:

RESIDENT'S ROOMS

- Call lights are within reach
- Call lights are answered within 15 minutes
- Resident rooms are clean, attractive, personalized and pleasant
- Bedside tables are clean
- Each resident's room has adequate light
- Lighting can adjusted by each individual resident
- Adequate closet and storage space is available for personal items
- Seating is available for visitors
- Fresh water available and within reach

Notes:

BATHROOMS

- Bathrooms are clean and well maintained
- Bathrooms have adequate lighting
- Grab bars are installed in each bathroom
- Soap dispenser is full
- Paper towels and toilet paper are stocked
- Gloves are available for staff

Notes:

QUALITY OF LIFE

- Residents are not left sitting unattended in common areas for a long periods of time
- Residents in wheelchairs located so they can request assistance
- There is a system in place for residents sitting in common areas to call staff
- Cushions are used to help residents sit/lay comfortably
- Residents report being active and involved in the daily life of the facility
- Adaptive equipment is conveniently located, clean and appears to be in good condition
- Temperature is comfortable for each individual resident
- Residents are well groomed, shaved, hair is combed, eyeglasses are clean and appear to fit comfortably
- Teeth and dentures appear clean and comfortable
- Residents clothing is clean, dry and appropriate
- Residents appear calm, content and comfortable in their surroundings
- Residents receive personal mail unopened
- Residents have access to a telephone where they can have private conversations
- Residents report that individual spiritual, emotional, social needs are met
- Individual TVs and radios are tuned to the resident's choice of stations
- TVs and radios in common areas are tuned to stations suitable for residents
- Visiting hours are not restricted on a routine basis
- Visitors are welcomed

Notes:

ACTIVITIES

- Activity program meets the needs of the residents
- Activity calendar is clearly posted in the facility and is kept up to date
- Staff reminds residents of activities and participation is encouraged
- Staff prepares each resident for activities by helping with proper clothing, grooming and personal needs
- Activities include individual one-on-one activities, small and large group activities, community outings, promote conversation and social interaction
- Activities are individualized to promote a sense of normalcy and well-being
- Families are invited and encouraged to participate in activities
- Activities are adapted for different levels of ability and mental status
- Snacks and beverages are offered at each activity

Notes:

STAFF

- Staff appears clean, neat and odor free
- Residents report that staff is kind and gentle
- Staff appears comfortable with residents, and converses easily with them
- Staff members can identify individual residents
- Staff is visible and available
- Staff can be easily identified by their uniforms
- Staff wears name tags or identifying information
- Staff appears happy and friendly
- Staff is respectful to residents, visitors and co-workers

Notes:

DIETARY

- Each meal is pleasing to the eye
- Hot food is hot and cold food is cold
- Residents report being satisfied following the meal
- Selections of beverages made available
- Assistance is provided immediately as needed
- Alternate choices and substitute menu items are always available upon request and are offered to those not eating the meal items served
- Menus are clearly posted and are up to date
- Meals and snacks are served at the times posted
- Snacks are available upon resident request

Notes:

DINING ROOM

- Dining room is clean and attractive
- Dining room furnishings are clean and odor free
- Dining room chairs are clean (including under the arms)
- Tables are wheelchair accessible (the arms of the wheelchair fit under the table)
- Residents report adequate staff is available to assist during meal times
- Arrangements are made when a resident has special visitors for a meal

Notes:

ADMINISTRATIVE STAFF

- The following people are available to meet with residents, RAC members, family members, or visitors upon request.

Administrator	Director of Nurses (DON)
Social Worker	Activity Director
Dietary Supervisor/Dietician	Laundry
Environmental/Maintenance	

- The administrative team (listed above) treats all residents with dignity and respect
- The administrative team listens to concerns, works to resolve these concerns and reports back to the complainant in a timely manner

Notes:

RESIDENT/FAMILY COUNCILS

- Resident council meets regularly in a private location and residents are offered a private place to meet without facility staff present
- Family council meets regularly
- Resident Advocate Volunteers meet with the chair of each group to learn of concerns or compliments

Notes:

CCDI/SPECIAL CARE UNITS

- A variety of activities are offered frequently throughout the day and evening
- Residents with dementia receive individual assistance when participating in activities
- There is a system in place to assess residents with dementia (since they may not remember to use a call light or get a drink of water)
- Beverages and snacks are offered frequently throughout the day and evening
- Residents rooms are individualized and personal
- A variety of signage is used to help residents find their way around the unit
- Residents are encouraged to participate in facility activities
- Staff have a variety of techniques to assist residents with dementia
- The unit is quiet without unnecessary traffic or noise
- Staff is easily identified
- Residents are treated with dignity, courtesy and respect
- Prompting and cueing is done quietly and discreetly
- Residents are encouraged to participate in frequent social activities
- Meals are served according to each individual needs (each food in a separate bowl, plates are a contrasting color, choices are offered, finger food provided to those who cannot sit long enough to eat)
- Staff is available to assist individual residents with meal time challenges
- Residents are encouraged to eat

FACILITY STAFF

Without staff, a long term care facility is merely a building. It is the staff that makes or breaks the reputation of a facility. It is the staff that can make a facility a home. Before an advocate can resolve a concern identified by a resident, the advocate must know which staff may be able to help.

ADMINISTRATOR

The administrator is the chief operating staff member. In the State of Iowa, it takes a 4 year college degree and a state license to be an administrator of an intermediate care facility. Your relationship with the administrator is crucial to solving problems for residents.

DIRECTOR OF NURSING

Usually called D-O-N, this person is in charge of all nursing care and supervision of nursing staff within the facility.

ASSISTANT DIRECTOR OF NURSING

The A-D-O-N handles part of the nursing care supervision and duties. Each facility divides the duties between the DON and ADON differently. A small or medium sized facility may not have an assistant DON.

CHARGE NURSE

Some facilities split into different areas of care, and establish a charge nurse to supervise each area. A charge nurse can be a Register Nurse or a Licensed Practical Nurse.

REGISTERED NURSE

RN's may have either a 2 year or 4 year nursing degree.

LICENSED PRACTICAL NURSE

LPN's have less schooling than RNs. They may be charge nurses if they have taken a supervisory course. LPN's are limited in assessments and evaluations, which must be done under the supervision of an RN.

CERTIFIED NURSING ASSISTANTS

Commonly called C-N-A's, must be listed on the state registry to work in the State of Iowa. CNA's must take a 75 hour course and pass both a written and skills test. CNAs perform the daily personal care for each resident, and assist with the activities of daily living.

SOCIAL WORKER

The social worker must have a college degree, and concentrates on quality of life for the residents. He/she spends time with each resident and/or family, and can assist with the transition to life in a facility. He/she can also assist the family with

outside resources, such as applying for Medicaid. In smaller facilities, a social worker designee may be appointed. This person is not a licensed or degreed social worker, but has experience helping residents and families.

ACTIVITIES DIRECTOR

Activity Directors must attend a community college class and pass a state exam to be certified as an activity director. An Activity director works to create a full and rich life each day for residents. Both group and individual activities are offered to meet the needs of the residents.

DIETARY/FOOD SERVICE

A dietician must be engaged to supervise menu planning. Under the direction of a dietary manager, the dietary staff prepare and often serve meals and snacks.

HOUSEKEEPING

In charge of cleaning common areas, halls, dining areas and resident rooms and bathrooms.

LAUNDRY

Washes, dries, folds/hangs clothes and redistributes to residents. Also takes care of sheets, linens, and towels.

ENVIRONMENTAL

In charge of HVAC, building and grounds.

APPROACHING FACILITY STAFF

Know what procedure the administrator wants you to use when attempting to address a concern. At some facilities, the administrator may prefer to handle all Resident Advocate issues directly. In others, the administrator may want the committee to speak first to a department head, and then to the administrator only if the issue is unresolved.

Before approaching the administrator or designated staff person to request a meeting to discuss resident concerns, organize your plan of action by preparing a list of the concerns, questions and points which your committee would like to address. Know what you want to have happen during the meeting.

Determine who can fix the problem. Don't blame a nurse aide (CNA) for a facility policy or procedure established by administrative staff or by the corporate office. An aide may be close to the problem, but not have the power to solve it.

Set a specific time with the person to address the issues. Avoid stopping the administrator or the designated staff person in the hall and expecting to receive their full attention. Set an appointment.

Talk with the appropriate staff person in private.

Pass along compliments. Use staff names and specific incidents when possible.

Don't let complaints accumulate: doing so runs the risk of you becoming so frustrated that you will be unable to state your concerns objectively.

Speak calmly and directly.

State the problem clearly and concisely without laying blame. Be very specific and descriptive as possible. The better your facts, the greater your position.

Do not speak in generalities such as, "The food is terrible," or "The meat is impossible to eat." It makes it very difficult to determine how to fix problems.

Stick to the facts. Don't exaggerate. This only weakens your credibility and you may find yourself defending the exaggeration.

Having more than one Resident Advocate attend the meeting with the facility provides support and witness to the proceedings.

Do not define the solution to a problem before gathering all relevant information from all of the parties involved. *Remember the solution must be to the satisfaction of the resident, not the facility, family or you.*

During the meeting with the facility, listen to what they have to say, but don't forget that it is your role to protect the residents' well being and quality of life. Try to remain objective, but see the problem through the eyes of the resident.

Responses such as "We'll look into it," or "We will take care of that," are too vague. Ask the facility to specify what exact steps will be taken to resolve the issue. Good documentation can clear expectations before ending the meeting with the facility, so each party involved understands the issues and the timeline for resolution.

Avoid rehashing old issues. Unless a pattern is developing that you need to discuss, avoid bringing up the past.

Let the facility representative know that you will be following up with them.

Be persistent.

If the problem re-occurs, or the agreed upon solution was not put into effect, meet with the facility again and try to determine what went wrong. Perhaps a new strategy needs to be produced. Remember the Ombudsmen are here to assist you.

Remember to keep the resident or complainant informed as to what is being done about the problem.

Keep in mind that every time you speak up for an individual resident, or advocate for residents, *there is value in your efforts*. Residents are counting on you to do the best that you can!

If a concern is brought up during the committee meetings the chairpersons, and perhaps one or two designated members, usually make an appointment after the meeting to visit with the administrator to discuss concerns and their resolutions. Sometimes committees invite the administrator or his/her representative to the latter portion of committee meetings to accomplish this as a matter of convenience and timeliness for both parties.

Resident Advocates should revisit the resident when the time has elapsed for resolution to determine if the concern has been handled sufficiently. Advocates should also keep in touch with the administrator to keep him or her abreast of how things are proceeding.

WORKING AS A COMMITTEE

It is important that resident advocates attend the committee meetings. Only resident advocates should attend the portion of the meeting when concerns are first being discussed. It is appropriate to invite guests to a portion of your meeting: residents, family members, the administrator, or staff members. However, during the time when others are present, confidentiality measures must be observed as appropriate. If advocates are not able to attend the meeting they should make sure their information is shared with the Resident Advocate Committee Chair. This ensures their issues/concerns are discussed by the committee.

Committee meetings are meant to be an opportunity for advocates to discuss issues or concerns in a private and confidential atmosphere. During the part of the meeting that information is shared about the visits with residents committee members should look for patterns that may show up from the various comments and concerns of the residents. When comparing notes and sharing information it can be surprising what emerges. The group decides on a plan of action for addressing and resolving system-wide issues. This is also a time when advocates should share resolved situations.

Having discussed the findings, the committee should decide what concerns are presented to the administrator for resolution, and determine an appropriate time line and response for each to be completed. Resident Advocate Committee Volunteers are strongly encouraged to work to resolve concerns as they arise. All concerns should be recorded and shared at the committee meeting, even if they have been resolved.

Committees usually choose to meet at the facility. However, any location is appropriate as long as it is convenient to members and the committee is able to meet in private. Committees must meet at least quarterly. Many committees find that meeting monthly instead of quarterly helps the committee to stay current and aware of facility activity. It also signals to residents and families that concerns are addressed in a timely manner, as well as providing greater unity and support for the members.

Remember The Office of the State Long Term Care Ombudsman is available to help with the following items:

- Clarifying State and Federal Rules and Regulations
- Talking through situations
- Investigating complaints
- Resolving committee challenges

RESIDENT ADVOCATE COMMITTEE (RAC) “SAMPLE MEETING AGENDA”

- I. Read minutes of last meeting
- II. Review committee membership
 - A. Changes in officers, address, phone numbers--complete change of status form
 - B. Need for new members-include note on your meeting minutes summary
 - C. Review assignment of RAC members to residents
- III. Review previous months' concerns that are still pending
- IV. Discuss facility visits
 - A. Review positive findings and observations
 - B. Review resident concern/complaints and discuss resolution (What did the resident ask you to do? How did you resolve the concern for the resident? Who did you talk to? How did they resolve it?)
 - C. If necessary, make referrals for any unresolved concerns (Ombudsman, DIA)
- V. Discuss new resident/new family interviews
 - A. Discuss positive/negative comments and resolution
 - B. If necessary, make referrals for any unresolved concerns (Ombudsman, DIA)
- VI. Discuss DIA survey and complaint visits and the facility plan of correction
- VII. Miscellaneous items to discuss
- VIII. Share information with facility administrator or designee
 - A. Receive facility update
 - B. Report positive findings
 - C. Report new concerns/complaints and develop a timeline for resolution and response
- IX. Date of next meeting
- X. Distribute copies of meeting minutes summary to administrator and the Office of the State Long-Term Care Ombudsman
- XI. Adjourn

ACCOUNTABILITY MEASURES

In 2000, the Department of Human Services changed how nursing facilities are reimbursed under the Medicaid program. There was an opportunity to include an allowance that would financially recognize good providers. This allowance is called Accountability Measures.

There are ten possible points a provider can earn. These include staffing, occupancy rate, percentage of Medicaid recipients, deficiency free surveys or being in substantial compliance during a survey. The last measure is **“Sixty percent or more of the issues identified by the Resident Advocate Committee are resolved by the facility.”**

The Resident Advocate Meeting Minutes Summary is a very important form that we use in the calculation of this point. Information on these reports will not be a black mark against the facility. In fact, facility-specific items listed will not be reported or acted upon by a state agency. For the purposes of the accountability measures, only the number of issues identified and the number of issues resolved will be calculated as a percent and sent to the Department of Human Services.

It is important that each resident advocate volunteer keep a journal of any issues identified and the resolution. These should be shared during the committee meetings, and the secretary will complete the form and mail it to us. A part of each committee meeting should always be review of issues from previous months to record resolution. If concerns linger and are not resolved, it is always a good idea to call the Ombudsman's office to discuss the situation.

Remember, the Accountability Measure program is to reward providers who respond to resident concerns. The philosophy of the Resident Advocate program supports this. The goal is not to seek out complaints. The goal is to identify issues or concerns that residents bring to your attention and help get it resolved to the satisfaction of the resident. By bringing these issues and concerns to the attention of the facility staff, most issues can be resolved immediately. The continuous improvement of quality of life issues is vital to the success of any nursing home.

Earning Accountability Measure points translates into extra income for the facility. Here is an example: A 60 bed facility that has 25 Medicaid residents, and earns 3 Accountability Measure points, would earn an estimated extra \$75 each day or \$27,375 per year!

If you have any questions about the Accountability Measures or would like more in-depth information, please call Jeanne Yordi, State Long-Term Care Ombudsman 800-532-3213.

RESIDENT ADVOCATE COMMITTEE MEETING MINUTES/REPORT INSTRUCTIONS

The Committee Meeting Minutes/Report form must be submitted to the facility administrator and to Jeanne Yordi, State Long-Term Care Ombudsman, 510 E. 12th Street, Jessie Parker Building Suite 2, Des Moines Iowa 50319. (Postage paid envelopes will be provided to you at no charge. Call 800-532-3213 to request a supply.) PLEASE SUBMIT WITHIN 10 DAYS OF YOUR MEETING.

FRONT OF MEETING MINUTES REPORT

1. **Facility, City, Date:** It is very important that you include this information. There are several facilities in the state that have the same name or very similar names. This helps us make sure we record the information for the correct facility.
2. **Date of Next Meeting:** Make certain all members are aware of the next meeting date. If you want to reserve a private space at the facility, please let the administrator or designee know in advance.
3. **Number of Volunteer Hours:** Please record the total number of hours the volunteers logged in the previous month or quarter. This should include hours spent visiting with residents, observing routines in the facility, documentation, attending committee meetings and requesting assistance from another agency.
4. **RAC Members in Attendance:** List RAC members in attendance. There are individual lines for the chair and secretary.
5. **RAC Members Absent:** List RAC members absent, even if they are "excused."
6. **Facility Staff in Attendance:** List all facility staff in attendance.
7. **# of Issues/Concerns from previous months now resolved:** Review previous meeting minutes and indicate any issues/concerns now resolved. The Ombudsman's new tracking/report system requires this information so that resolution data can be recorded. THIS STEP IS VITAL FOR THE ACCOUNTABILITY MEASURES POINT. (See the page on accountability measure information.)

Use the "comment" section to record any positive or negative general comments, to ask questions you would like the ombudsman to answer, or to request information or assistance.

BACK OF MEETING MINUTES FORM

8. **Item #:** Begin each month with the number of the month, and then use the alphabet to identify each complaint. (Example: for the April meeting, items would be numbered (4a, 4b, 4c,4d, for October, 10a, 10b, etc.)
9. **Positive/Negative Comments from Residents:** List all comments from residents, whether positive or negative. Resident names should NOT be included on this form, but should be kept in individual RAC member journal notes. These comments will help everyone involved get a clear picture of how residents view life at this facility. These comments will be very helpful as the facility continually tries to improve both quality of life and quality of care for residents. Resident names can be released only with permission from the resident. This permission should be documented in your notes.

If a negative issue/concern is raised, make notes regarding what you did to attempt to resolve this situation. A concern is considered resolved when the RESIDENT is happy with the outcome.

10. Indicate whether or not the issue/concern was resolved this month. Use this column in upcoming months to identify issues/concerns that still need to be addressed. **You must put a yes or no in this column.**
11. Use the “notes” section and additional pages if needed to record special notes you want to remember.

RESIDENT ADVOCATE COMMITTEE MEETING MINUTES/REPORT

Please submit minutes of RAC meetings to the facility administrator and to Jeanne Yordi, State Long-Term Care Ombudsman, 510 E. 12th Street, Jessie Parker Building Suite 2, Des Moines, IA 50319, send via e-mail to Jeanne.Yordi@iowa.gov or request self-addressed postage paid envelopes by calling 800-532-3213 You can also call this number to ask for information or assistance.

FACILITY _____ CITY _____ DATE _____

Date and time of Next Meeting _____

Total Number of Volunteer Hours _____ This number is for the previous Month _____ Quarter _____

RAC Members in Attendance Chair _____ Secretary _____

Members Present

Members Absent

Facility Staff in Attendance

of Issues/Concerns from previous months now resolved:

Month _____ Item # (s) _____

Month _____ Items # (s) _____

Month _____ Item # (s) _____

Month _____ Items # (s) _____

COMMENTS:

FACILITY NAME _____ CITY _____

Month and item #	POSITIVE/NEGATIVE COMMENTS FROM RESIDENTS	IF NEGATIVE COMMENT, WHAT HAS BEEN DONE TO RESOLVE THIS ISSUE	RESOLVED? YES OR NO	<u>NOTES</u>

CULTURAL DIVERSITY

Cultural diversity is the acceptance and promotion of the variety of human cultures and their different value systems in a given society. Cultural diversity recognizes the importance of native languages, dress, traditions, and beliefs that govern self-identity. The loss of cultural identity through assimilation and acculturation is the main concern among proponents of cultural diversity to maintain diversity of human experience.

People should be sensitive to the possibility that cultural diversity may affect their relations with individual patients and families. It may also affect residents' willingness or ability to understand, accept, and adhere to prescribed regimens.

- Consider each person as an individual, as well as a product of their religion, ethnic background, language and family system.
- Do not place everyone in a particular ethnic group into the same category, assuming that there is one approach for every person in the group.
- Examine the role cultural values help define and give meaning to all residents living in long-term care facilities.
- Regard the faith community for various cultures as a critical support system.
- Understand that families from different cultures consider and use alternatives to Western healthcare philosophy and practice.
- Consider the culture's typical perception of aging, caring for elderly family members and memory impairment.

Remember that when you are dealing with people, many facets are involved in their lives that help shape personality. Becoming aware of this information will help you as you work with all people living and working in long-term care facilities. It can also help when a resident has a bias or prejudice against staff or another resident of another race or lifestyle. Points to consider include:

- *Cohort* (persons born at about the same time)
- *Income* (size and sources of personal finances)
- *Social roles* (parent, widow, retiree)
- *Gender* (based on gender, people may learn to perceive the world differently and be perceived differently)
- *Sexual orientation* (heterosexual, bisexual, homosexual)
- *Ethnicity* (a shared sense of identity that includes a set of cultural meanings based on national origin, religion, language, and/or race)
- *Race* (a social construct that people may use to categorize themselves or others)
- *Cultural identification* (values or behaviors shared with a group based on national origin, language, religion, or occupation)
- *Friendship patterns* (persons with whom people choose to socialize and the frequency of the interactions)
- *Religion, spirituality* (practice of an organized religion or a personal set of spiritual values)
- *Value system* (belief system regarding behavior and life goals)
- *Language* (spoken at home and in the community)
- *Community* (size, region)
- *Occupation* (present or former)
- *Family composition* (marital status, children)
- *Formal education* (years of schooling, diplomas, degrees)
- *Health status* (healthy, frail, disabilities, chronic illnesses)
- *Functional independence* (degree of ability to take care of personal needs, presence of cognitive or physical disabilities)
- *Generation as an American* (first generation, etc.)
- *Personal interests* (preferred activities, hobbies, attitudes)
- *Personality* (temperament, characteristic style of adaptation, patterns of relation to others)
- *Dietary practices* (preferred foods)

Adapted from: Aging and diversity: An Active Learning experience (Tried and Mehrotra, 1998)

RESIDENTS WITH COMMUNICATION CHALLENGES

(Please Note: People living in Intermediate Care Facilities for Person with Mental Illness (ICF-PMI), Residential Care Facilities for the Mentally Retarded (RCF-MR), or Residential Care Facilities for the Mentally Ill (RCF-MI) and Elder Group Homes (EGH) are usually referred to as "Clients", however in this manual everyone living in any long-term care facility is called a resident.)

- Remember to give the resident adequate time to respond
- For those who are difficult to understand, try to catch one word as a clue to what they are saying then use that word in your response
- If you need to, ask the resident to repeat what they just said or with the resident's permission, ask a staff person to help you understand what the resident is saying
- Also, remember that just because a person has difficulty speaking doesn't mean they are hard of hearing, so try not to speak any louder than you would normally speak
- Some residents may need to use signs and/or gestures to communicate.
- Listening is as important in good communication as talking. Use your eyes to observe, your ears to hear, your mind to reflect and your heart to feel what the client is communicating
- Be aware of nonverbal communication, e.g. clenched fists, frightened expression, flushed face
- Be non-threatening
- Approach cautiously
- Basic self-care is important as it helps with self-esteem
- The activity program should meet the needs of the residents and offer both large and small group activities, social events, community outings and one to one time
- Remember the feelings a resident has are real-they are neither good nor bad

There are many reasons residents may be unable to communicate. Perhaps they have had a stroke, have a disease that makes speech difficult to understand, or have dementia. If the resident can understand but not respond in words, it is appropriate to ask the staff the best way to communicate. Many times the resident can blink their eyes or squeeze your hand to respond to yes or no questions. If the resident has dementia, it will take extra time and effort on your part to help him or her understand your questions.

Remember to talk with residents as if they can communicate with you. This will help restore a sense of normalcy to their lives and maintains dignity. Sometimes a simple way of letting the resident know who you are works best. For example you may say, "I am a volunteer who will be visiting you from time to time to see how things are going for you."

Maintain eye contact. Watch for signs of recognition. Remember words that spark a reaction.

Saying complimentary things about the resident or their room in a sincere tone is a good way to set the mood. Show that you care.

Use short, simple adult sentences. Speak in a low tone, slowly, clearly and concisely. As we age, our ability to hear higher pitched sounds diminishes. Unlike with other residents, questions should mainly be those that are easily answered with yes, no or gestures.

Take cues for communicating by the phrases and mannerisms that the resident frequently uses. That is to say, when you respond to things the resident is saying, use some of the words that he or she has used.

Listen. If nothing else, just listen. Ask, "What would you like to tell me?" or "Is there something you'd like me to know?" And then attentively, patiently, listen to the answer. Do not expect a quick response. It may take 30 to 45 seconds for the resident to formulate a response. Do not assume the resident does not understand or lacks insight until they have been given several chances to respond.

There may be times when it will be impossible to converse with a resident. Then you must rely on your intuition and your skills of observation to assess how life is for the resident. Contact family members whenever possible.

RESIDENTS WITH DEMENTIA

Dementia is an umbrella term for several symptoms related to a decline in thinking skills. Common symptoms include a gradual loss of memory, problems with reasoning or judgment, disorientation, difficulty in learning, loss of language skills, and decline in the ability to perform routine tasks.

People with dementia also experience changes in their personalities and behavioral problems, such as agitation, anxiety, delusions (believing in a reality that does not exist), and hallucinations (seeing things that do not exist).

Alzheimer's disease (pronounced *AHLZ-hi-merz*) is one of several disorders that cause the gradual loss of brain cells. The disease was first described in 1906 by German physician Dr. Alois Alzheimer. Although the disease was once considered rare, research has shown that it is the leading cause of dementia.

Several disorders that are similar to Alzheimer's disease can cause dementia. These include front-temporal dementia, dementia with Lewy bodies, Parkinson's disease, Creutzfeldt-Jakob disease, and Huntington's disease. All of these disorders involve disease processes that destroy brain cells. Vascular dementia is a disorder caused by the disruption of blood flow to the brain. This may be the result of a massive stroke or several tiny strokes. Some treatable conditions — such as depression, drug interactions, and thyroid problems — can cause dementia. If treated early enough, this dementia may be effectively treated and even reversed.

**50-70% of residents in nursing home
have some type of dementia**

STAGES OF ALZHEIMER'S (simplified)

Early Stages

- The person may appear to be depressed - may refuse treatment
- The person may begin to experience conflict with others (marital conflict, problems with staff)
- You may notice increased frustration or anger at not being able to remember or to complete simple tasks

Middle Stages

- Familiar tasks may seem to complicated to complete
- The person may begin to show lapses in judgment and rational thought
- Social participation may change due to occasional confusion about people, place and time
- The person may begin to withdraw due to the inability to understand directions or an attention span deficit

Late Middle Stages

- The person has a need for increased assistance and/or cueing with ADL's—bathing, dressing, grooming
- Challenging behaviors may become more frequent as the person loses the ability to understand, but pacing and wandering are very normal at this stage
- The person may occasionally not recognize family or friends
- The person may experience difficulty recognizing familiar objects, pictures, television, self in mirror
- The person may show a decreased awareness of the surroundings
- It may appear that the person cannot see or hear, but they simply don't understand
- The person may exhibit repetitive behaviors
- The person experiences a decline in language ability

Late Stages

- The person probably no longer meets the criteria for a CCDI unit
- The person is probably incontinent
- The person may lose the ability to walk, may shuffle their feet, may experience falls
- The person will have difficulty manipulating silverware or toothbrush
- At this stage the person will need extensive assistance with all ADL's
- Eventually, the person will no longer have the ability to move about purposefully
- The person will probably not recognize familiar faces
- The person may experience medical complications like weight loss, repeated infections, difficulty swallowing, aspiration, falls or seizures
- In the final stage, primitive reflexes return

With Alzheimer's disease, memory is impaired, and judgment, logic and reasoning are all affected. This usually means the person undergoes a personality change. Some people may become very meek and mild, while others may yell and become combative. People with Alzheimer's do not become mean and combative without reason. When confronted with a situation that confuses or frightens them, they may lash out with their arms simply because they don't have the words to express their feelings.

Residents may pace, wander or elope. To pace means walking back and forth in a fairly small area. The resident seems to have to no real purpose except to walk. Pacing is a repetitive motion. A resident begins walking, and seems unable to stop. They walk as far as they can in one direction, turn and go as far as possible in the opposite direction. They do not deviate from the path and do not seem to be in search of anything or anyone. It is very difficult to distract a person when they are pacing, and they may become frustrated if you try.

A resident may "wander" in and out of other residents' rooms or may wander throughout the facility, stopping to look at people or objects. They may appear to be lost or looking for something or someone. Are they looking for a way out? Looking for their children? Parents? Their room? A wandering resident usually starts out with a thought to find something or someone, but after a few steps loses that thought, yet continues the wandering. These residents may be redirected with the promise of an immediate activity, snack, drink, or something more interesting to do.

Elope is the word used when a resident leaves a secure area without supervision. When a resident elopes from a special care unit or from a general nursing home it is important to consider where they think they are going. For example: was she just wandering and encountered the door and exited, or did she decide to leave and go home. Did someone or something frighten her to the extent she felt she needed to "escape?"

Residents who have short term memory loss have trouble concentrating. Asking short, simple questions, and keeping time spent attempting to engage them in conversation will be beneficial. Short activities should be planned on a frequent basis throughout the day.

A resident may ask you over and over who you are, or "where should I go?" "What should I do now?" "Is it time for breakfast. I'm hungry." Showing frustration will usually only make the situation worse. Simply answering the question as clearly and concisely will help. Redirection may also help the resident focus on something else.

As a resident with Alzheimer's disease begins to lose his or her ability to find the right words to say, they may simply make a noise.

It is not unusual for a person with Alzheimer's to get their days and nights reversed, or to just take short frequent rests throughout a 24 hour period. This is an expected behavior, and does not necessarily require medication to make them sleep. If a

resident is awake at unusual hours, the staff should offer beverages and a snack, and engage them in some simple activities. A resident should NOT be forced to sleep simply because the night time staff chooses not to care for them.

There comes a time in the life of each person with Alzheimer's disease when the brain can no longer control the bladder and the resident becomes incontinent. Some residents can continue to remain continent if the staff works hard to tune into the resident and can encourage them to go into the bathroom prior to the resident being incontinent.

A person with dementia may have hallucinations or delusions. When a person has a hallucination, they see or hear people or objects that don't really exist. A delusion is a thought about a situation that does not really exist.

Do not discredit comments made by a person with Alzheimer's disease by saying "they are just hallucinating or having delusions." There is almost always some truth in what the resident is telling you. Perhaps when she was taking her shower, the staff put her dirty clothing in the dirty clothes bin, and she thinks they were stolen. Unless the hallucination or delusion is frightening or depressing to the resident, one should usually agree with their comments.

COMMUNICATION AND ALZHEIMER'S DISEASE

There are four main areas of communication affected by Alzheimer's disease:

Memory--The resident probably has a limited attention span, which makes it difficult to follow lengthy conversations. He or she may struggle with losing their train of thought when listening or talking.

Comprehension—When we hear a sound, a signal must travel to the brain to interpret that sound. Because the brains of people with Alzheimer's disease have difficulty transmitting signals, the brain cannot sort out what is being heard, so the resident may appear to not understand.

Language Skills—It is not uncommon for people with Alzheimer's to have difficulty finding the right words to say. However, if you listen to them long enough, you can usually detect the feelings that they are trying to convey. Is she frustrated? Is she excited? Is she scared? Addressing the feelings is important when you cannot address the thoughts.

Social Communication—Many times people with Alzheimer's disease have difficulty filtering out background distractions that seem to compete for attention, such as a TV or radio, telephone ringing, overhead intercom or conversations of others.

People with Alzheimer's disease many times have difficulty understanding ordinary conversation and the meaning of words. This can sometimes lead to combative behavior—he is simply responding to a situation in which he feels uncomfortable, but can't find the words to describe.

Residents are easily distracted. Do not be offended if a resident wanders away during a conversation.

Residents in the middle to late stages of Alzheimer's disease have trouble learning new things, including meeting new people. You may introduce yourself to a resident, only to have them ask who you are 5 minutes later. A simple, short answer is always appropriate. "I'm Mary. What's your name?" "Hello Esther. I'm Mary."

Residents may focus on one person or one idea and repeat it continuously. "Where do I go now?" "When is my husband coming?" "I'm really hungry!" Listening to the question and attempting to find an answer that will soothe the resident is essential. "You can just walk around here for awhile," or "I'll walk with you to your room;" "Your husband will be here anytime now;" or "Let's go get a snack" would all be good answers to the questions.

When encountering residents who may have either dementia or Alzheimer's disease, non-verbal communication is just as important, and maybe more important, than verbal communication. In other words, how you say something is just as important as what you say. Because residents with dementia or Alzheimer's do not always understand the words, they rely heavily on understanding what you say by your tone of voice, body language, facial expressions, and gestures. .

When speaking with a resident who has dementia or Alzheimer's, it is important to slow down your rate of speech. Speaking low, slow, clear and concise will help the resident understand. Be patient, and wait up to 45 seconds for a response.

THINGS TO CONSIDER

We all have good days and bad days. Residents with Alzheimer's or dementia may have good hours and bad hours. Yet, sometimes it is something simple that has caused a problem for the resident.

However, these are not excuses to be used by staff. If an item on this list seems to be a problem, then it is up to you to encourage the staff to fix it. Once again, the Ombudsman's office is available to assist you.

Fatigue. It takes a lot of energy for people with Alzheimer's to function. If they struggle with repetitive motions, they may be extra tired. Sitting in a chair with their feet up for a short nap is helpful.

Impaired vision or hearing. Do they need glasses or a hearing aid? Are they wearing them? Glasses can disappear if a resident tends to wander and lay items down around the facility. It is important that all eye glasses are marked with the resident's name, and that the facility has a written description of them. Hearing aids can be a challenge and may become uncomfortable or not adjusted appropriately. The resident may throw a hearing aid away, flush it down toilet or wash it down the drain.

Acute or chronic illness or physical discomfort. Sometimes we attribute everything that happens with a resident with Alzheimer's disease "is because he/she has Alzheimer's." However we need to remember to look beyond the disease. Not eating may be a sign of a toothache or upset stomach. Crying may be due to a headache or a pain elsewhere in their body. Being combative may be a sign that arthritis is painful and not being treated.

No orientation information or cues. Residents need markers, or cues, to let them know where they are. Signs to the dining room or activity room should be throughout the facility. The resident with Alzheimer's should have special identification on their room to help them find it alone. Bathrooms must be clearly marked.

Unstructured environment. Residents with Alzheimer's disease do not have the ability to entertain themselves. Frequent, short activities should be scheduled for the waking hours, with frequent drinks and snacks offered. A good schedule is that each hour has 15 minutes of exercise or an active game, 15 minutes of singing or laughter or brain teasers, 15 minutes of a quiet activity or craft, and 15 minutes of rest or free time.

Environment too large/small/cluttered. Residents with Alzheimer's disease usually feel more secure in smaller environments. For many of us, it may be

uncomfortable to be in the short hallway with the doors closed at both ends, but this tends to make the resident feel more secure. The resident's room should be decorated with familiar, comfortable items. Old pictures tend to work better than more recent ones, since they may have access to their long-term memory. Holiday decorations may be too distracting and confusing for residents, though bright colors make the area feel vibrant.

Dehydration. A resident with Alzheimer's disease will not think to go to their room to look for a pitcher of water if they are thirsty. Water should be offered at least hourly throughout the day.

Stimulation: Too much/not enough. Once again, residents with Alzheimer's disease do not have the ability to entertain themselves. Finding the right balance between activities and free time is a challenge for the staff, and it may change daily depending on the moods of the residents.

Tasks too complicated or unfamiliar. Familiar daily tasks become a huge chore for residents with dementia. Brushing their teeth, getting dressed, or even turning on TV may become tasks that are too complicated. The resident usually can do these tasks, however, if staff will take the time to give one direction at a time. Instead of "Here, put on your shirt," it must be broken down: "Lift your left arm. Put your hand through the hole. Pull it over to your right arm. Put your hand through the hole. Can you feel the button? Can you put the button through this hole?" It takes a very long time to care for residents in this way, and many times, the staff simply carries out the task to speed up the process.

Unfamiliar environment. Residents with Alzheimer's tend to like the security of always staying in the same place, and not having rooms or furniture shuffled around.

OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN

Some of the ways the Ombudsman's Office can help include:

As a "reality check." If you encounter a situation in which the facility is telling you something but you just don't know if the response is legitimate or appropriate, the Ombudsman can serve as an information resource on standard practices within the industry.

To confirm rules and guidelines governing facilities. An administrator may tell you that the "state won't allow us to do that." A telephone call to the Ombudsman can clarify guidelines regarding a particular issue.

To obtain assistance in investigating an individual concern when information is not accessible to you. You may have done everything you feel you can do, but you still have concerns about a situation. The Ombudsman can investigate further for you.

To refer a complaint. If your committee encounters a problem that is beyond the scope of the volunteer protocol, the Ombudsman can begin a more in-depth investigation.

Resources. To obtain information on other agencies that may be able to offer assistance or information for you, the resident, family or facility.

Technical support--supplying your committee with materials such as forms, manuals, brochures, press releases, videos, etc.

Training--orientation, annual training and continuing education.

Recruitment--providing application packets to prospective members. You can help recruit local volunteers for your committee by providing names of prospective recruits from your area or giving them an application and encouraging them to send it to the address listed on the bottom of the application.

Emotional Support--call the Ombudsman office to talk through issues arising in your facility.

You can reach the Ombudsman's Office through the hotline number:

**Toll Free 1-800-532-3213 or
Emergency pager 1-877-999-8674**

DEPARTMENT OF INSPECTIONS & APPEALS

Through your individual resident interviews and committee meetings, you may determine the facility has a system-wide problem that is affecting the lives of several residents. You may choose to contact the Department of Inspections & Appeals (DIA) to file a formal complaint. The Department of Inspections & Appeals (DIA) will help resolve concerns for a particular resident. Their role as the regulatory agency allows investigators to survey the practices of the facility to make certain state and federal regulations are being followed.

You may either call or write the Department of Inspections & Appeals. Before calling the Department of Inspections & Appeals (DIA), it is a good idea to write down all the information that you want to cover during the call. This will help organize your thinking and may remind you of details that you want to provide. If you choose to put your complaint in writing, send it to:

**Iowa Department of Inspections & Appeals
Division of Health Facilities
Lucas Building
321 E 12th Street
Des Moines IA 50319
877-686-0027 (toll free)**

DEPARTMENT OF INSPECTIONS AND APPEALS SURVEY & COMPLAINT INVESTIGATION PROCESS

Frequency and duration

The Iowa Department of Inspections & Appeals (DIA) conducts annual surveys of all long-term care facilities in the state. The surveys in nursing facilities are conducted at least every 15 months with some facilities being inspected as frequently as nine months. The duration of the survey is usually four to five days.

Deficiencies

A deficiency is what DIA calls a regulatory requirement that is not being met by the facility. When the survey team reaches agreement on what requirements are not being met, they then determine the level of deficiency severity and the scope of the problem.

Posting the survey results

When the facility has received a copy of the "Statement of Deficiencies," and completed an acceptable "Plan of Correction," the survey must be posted in the facility, in a place where residents and families can find it. It must be displayed for easy examination by the public.

Revisits

DIA conducts a "revisit" usually between 30-45 days after the survey. The focus is on those problems previously identified to determine if they have been resolved or continue to exist.

Complaint Investigations

Formal complaints filed with DIA must be investigated within 20 working days of receipt. Complaints can be either written (including e-mail or fax) or oral, both have the same investigation requirements.

An inspection following a complaint is usually conducted by one surveyor instead of a team, but the format is similar to that of an annual survey.

THE ROLE OF THE RESIDENT ADVOCATE IN THE SURVEY PROCESS

Contacting the Chair

The survey teams, made up of two to three members, typically Registered Nurses, contact the Resident Advocate chair upon arrival in the facility. (We encourage the chairperson to call the other RAC members and let them know the survey team is there, so they may share any concerns that they might have.) If the chair is not available, the team should attempt to reach an alternate member. Committees should check the posted information regarding the Resident Advocate committee to make sure that it is current so the surveyors will call the correct person.

Furnish information at beginning of survey

The surveyors look to the Resident Advocates to furnish them with any information the committee feels they should know: any care concerns, privacy or rights issues, unresolved complaints, ongoing problems or situations, or individual residents about whom the Resident Advocates have concerns. Resident Advocates are encouraged to share meeting minute's information with the surveyors. Remember that resident's names can only be released if you have their permission.

Complaint Investigations

The chair will also be notified when a complaint investigation is taking place, and the surveyor will want to get any information from the committee regarding the specific nature of the complaint. Resident Advocate input is critical at this time because the investigation occurs in such a short time – usually 1-2 days.

Exit Conference

The chair is also notified of the anticipated time and date of the exit conference, during which the facility is made aware of the survey findings. Resident Advocates are encouraged to attend the exit conference in order to understand the results of the investigation. It is up to the chair to inform the other Resident Advocates about both the entrance of the survey team and the exit conference.

HELPFUL ABBREVIATIONS

AC	before meals
ADL	activities of daily living, such as bathing, eating, or walking
ADON	assistant director of nursing
ADR	adverse drug reaction
AMA	against medical advice
AMI	acute myocardial infarction (heart attack)
AoA	Administration on Aging
BID	twice a day
BIN	twice a night
BS	blood sugar
BP	blood pressure
CA	cardiac arrest (or cancer)
CBC	complete blood count
CHF	congestive heart failure
CNA	certified nurse aide
CNS	central nervous system
COPD	chronic obstructive pulmonary disease
CPR	cardiopulmonary resuscitation
CVA	cerebrovascular accident (stroke)
CVD	cardiovascular disease
DC'd	discontinued
D/S	discharge summary
DEA	Department of Elder Affairs
DHS	Department of Human Services
DIA	Department of Inspections and Appeals
DON	director of nursing
DRGs	diagnosis related groupings
DX	diagnosis
FBS	fasting blood sugar
Fx	fracture
GI	gastro-intestinal
HBP	high blood pressure
hs	hour of sleep
Hx	history
I4A	Iowa Association of Area Agencies on Aging
ICF	intermediate care facility
IDDM	insulin dependent diabetes mellitus
IFMC	Iowa Foundation for Medical Care
ii	two [tablets]
IM	intramuscular
IV	intravenous
LNHA	licensed nursing home administrator
LOC	loss of consciousness

LPN	licensed practical nurse
LTC	long-term care
MDS	minimum data set (assessment form)
MI	mental illness
MR	mentally retardation
NPO	nothing by mouth
NH	nursing home
NIDDM	non-insulin dependent diabetes mellitus
NVD	nausea, vomiting, diarrhea
NWB	no weight bearing (no walking permitted)
OAA	Older Americans Act
OBRA	Omnibus Reconciliation Act (nursing home reform legislation)
OBS	organic brain syndrome
OT	occupational therapy
oz	ounce
pc	after meals
PO	post operative/phone order/by mouth
p.r.n	as required, as need arises
PT	physical therapy
qh	every hour
QID (q.i.d.)	four times a day
RA	Resident Advocate
RCF	residential care facility
RN	registered nurse
R/O	rule out
ROM	range of motion (of a joint)
Rx	treatment (prescription)
SNF	skilled nursing facility
SOS	may give (a drug) if needed
s	without
SOB	shortness of breath
Stat	immediately
Sx	symptoms
Temp	temperature
TID	three times a day
Title XIX	Medicaid
TPR	temperature, pulse, respiration
Tx	treatment
URD	upper respiratory disease
URI	upper respiratory infection
UTI	urinary tract infection
VS	vital signs
WBC	white blood count
WNL	within normal limits

CHAPTER 9 RESIDENT ADVOCATE COMMITTEES

321—9.1(231) Resident advocate committees established.

9.1(1) *Committee for each licensed facility.* A resident advocate committee shall be established for each licensed health care facility as defined in Iowa Code section 135C.1, in accordance with Iowa Code section 135C.25 and chapter 231, and shall operate within the scope of these rules.

9.1(2) *Committee membership.* The committee shall consist of at least two members or a number sufficient to meet the needs of the residents except in facilities licensed to serve fewer than 15 residents.

In such facilities, the minimum number of members shall be one.

9.1(3) *Committee member residence.* Members shall reside within the service area of the facility.

321—9.2(231) Application for committee membership. Any individual may apply to the department for membership. AAAs and other organizations are encouraged to recommend names of potential volunteers for resident advocate committee membership to the department.

9.2(1) *Application forms.* Application forms may be obtained from any AAA, the department address in rule 321—2.1(231), or other organizations designated by the department.

9.2(2) *Submission of forms.* Each applicant shall complete and submit an application for membership to the department address in rule 321—2.1(231).

9.2(3) *Membership restriction.* Applications for membership on resident advocate committees will not be accepted if the applicant has an ownership interest in a facility; or is employed by the facility or a competing facility; or has been employed by the facility within the past three years; or is related to an employee, board member, or licensee of the facility; or is a public employee involved with the sponsoring or placement of residents in the facility; or is an administrator of a long-term care facility; or is a professional consultant to the facility. Relatives shall be defined as any one of the following: father, mother, son, daughter, brother, sister, aunt, uncle, first cousin, nephew, niece, wife, husband, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepparent, stepbrother, stepchild, stepsister, half sister, half brother, grandparent or grandchild.

9.2(4) *Waiver of membership restriction.* The waiver of membership restriction for relatives in subrule 9.2(3) may be reviewed and approved by the executive director and granted, if it can be documented to the department that efforts have been made individually or jointly by the resident advocate committee or the department to contact and recruit alternative applicants.

9.2(5) *Committee membership for facilities for mentally ill, mentally retarded, or developmentally disabled.* Applications for resident advocate committee membership for any facility caring primarily for persons who are mentally ill, mentally retarded, or developmentally disabled shall be accepted only after

consultation with the director of the division of mental health, mental retardation and developmental disabilities of the Iowa department of human services. The applications shall be considered acceptable if the director of the division of mental health, mental retardation and developmental disabilities of the Iowa department of human services institutes no disqualifying action within ten days of notification of the proposed appointments.

321—9.3(231) Appointment to resident advocate committees.

9.3(1) Notification. Members of the resident advocate committee shall be appointed from individuals whose applications for membership have been accepted according to this rule. Appointments shall be made by letter within 45 days of receipt of applications by the executive director or designee. Appropriate facilities shall be notified of the appointments.

9.3(2) Traits or skills. Appointment of resident advocate committee members may be made from accepted applicants who may, but are not required to, possess a combination of the following traits or skills: knowledge of the long-term care system; understanding of the aging process; training in the human services field; experience in complaint identification, processing, and documentation; a commitment to the welfare and rights of residents; and understanding of the types and needs of clients served by the facility.

9.3(3) Preference. Preference for membership on resident advocate committees may be given to applicants with backgrounds and expertise that differ from existing members of the same committee.

321—9.4(231) Cancellation of appointments to resident advocate committees.

9.4(1) Reasons for cancellation. A resident advocate committee member's appointment may be canceled by the executive director for any of the following reasons: falsification of information on the application for membership form, acting as a member without appointment, attending less than one half of the meetings convened each year by the resident advocate committee chairperson, voluntary resignation, and actions which are found by the executive director to violate these rules or the intent of the ombudsman program.

9.4(2) Filing an objection. A facility administrator who objects to the membership of the resident advocate committee for that facility may file a written objection with the executive director. The objection shall be considered and investigated as a confidential complaint.

9.4(3) Notification of cancellation. The executive director shall notify, in writing, the remaining committee members and the facility of the cancellation of resident advocate committee members' appointments.

321—9.5(231) Request for reconsideration of appointment or cancellation of appointment.

9.5(1) Time of request. A request for reconsideration concerning the appointment or cancellation of the appointment of a resident advocate committee member may be made in writing to the department within 30 days of the written notice of the appointment or cancellation.

9.5(2) *Time for response.* The executive director shall consider the request and notify the requesting party of the director's decision regarding the request within 30 days of receiving written notice of the request.

321—9.6(231) Resident advocate committee structure and meetings.

9.6(1) *Structure.* Every committee shall have a chairperson and secretary selected by the membership. The chairperson shall coordinate the activities of the committee. The secretary shall record minutes of each meeting and prepare reports as necessary.

9.6(2) *Meetings.* The committee shall meet at least quarterly and on other occasions as required to accomplish its responsibilities. The chairperson shall notify all members of the time and place of each meeting.

a. The administrator or staff of the facility shall not attend committee meetings except upon request of the committee.

b. Confidential information shall not be discussed during meetings when members of the general public are present.

c. The secretary shall complete a report on the committee meeting on the report form designated by the department. Copies of the report shall be submitted to the administrator and the office of long-term care resident advocate/ombudsman.

d. Committee minutes shall be retained by the facility for a period of at least two years and shall be available to the department of inspections and appeals and the department of elder affairs upon request.

321—9.7(231) Responsibilities of the committee.

9.7(1) *Duties.* The committee shall represent and advocate for the rights of residents of the facility.

9.7(2) The committee or individual members shall:

a. Conduct ongoing reviews of each resident according to the procedures identified in rule 9.10(231);

b. Investigate complaints and grievances according to the procedures established in rule 9.11(231); and

c. Participate in a training session approved by the department at least once per year.

321—9.8(231) Committee access and assistance.

9.8(1) *Access.* The committee shall have access to the facility and private access to the residents.

9.8(2) *Assistance to the committee.* The committee may request information, advice and counsel from the facility administrator, medical or health professionals or specialists, the department or from other state and local agencies. Upon contacting anyone on behalf of residents in the performance of duties, the resident advocate committee member shall clearly be identified as a resident advocate committee member who is a volunteer advocate and shall clearly state the purpose and justification for this contact.

321—9.9(231) Confidentiality.

9.9(1) *Restriction on access.* Resident advocate committee members shall not have access to the following unless access is granted by the resident or resident's responsible party:

- a. Medical, financial or personal records of the residents; or
- b. Records of the social services department of the facility.

9.9(2) *Nondisclosure of information.* The committee shall not disclose information concerning the residents or the operation of the facility in a manner that will identify individuals or the facility, except to the ombudsman program or as requested in proceedings involving the investigation of a facility by the department of inspections and appeals.

321—9.10(231) Committee procedures.

9.10(1) *Resident reviews.* To evaluate the degree of satisfaction that residents have with the quality of life experienced in the facility in which they reside, resident reviews shall be recorded, including responses to questions asked of residents or their representatives.

9.10(2) *Review visits.* Committee members shall make some visits to observe residents at different times of the day.

9.10(3) *Review reports.* The report of each resident review shall be discussed with the committee as appropriate. Reports shall be retained by the committee chairperson for a period of at least two years. The report shall be available to the department of inspections and appeals and department of elder affairs upon request.

9.10(4) *Complaints and grievances during reviews.* Complaints and grievances identified by the resident during resident reviews shall be handled according to subrule 9.11(2) and shall not be recorded with resident reviews.

321—9.11(231) Committee response to complaints and grievances.

9.11(1) *General rule.* Throughout the investigation of all complaints and grievances, the committee shall maintain objectivity and act as advocates for residents without being adversaries of the facility.

a. The dignity and privacy of residents will be maintained by all persons involved in a complaint or grievance investigation.

b. The committee may receive and investigate complaints or grievances regarding the rights and welfare of residents of a facility using the procedures appropriate to the source of the complaint, either from an individual or the department of inspections and appeals.

c. The committee shall solicit the input of the complainant or resident regarding the complainant's or resident's wishes on action to be pursued by the committee.

d. The purpose of the committee response to complaints or grievances is to seek the resolution of problems and prevent unnecessary recourse to regulatory action against a facility. This purpose shall not, however, prevent such regulatory action when necessary to protect or achieve the rights of residents.

9.11(2) *Action upon receipt of a complaint or grievance.* Upon receipt of a complaint or grievance, the committee will contact the facility administrator to discuss the allegations only if the contact does not violate confidentiality.

a. Information which may identify the complainant or resident shall be confidential unless the complainant or resident has given written permission to the resident advocate committee for the disclosure of the identity.

b. Rescinded IAB 2/4/04, effective 3/10/04.

- c. The investigating resident advocate committee member shall make an unannounced visit to the facility.
- d. The committee member investigating the complaint or grievance will, to the extent possible, ascertain the facts of the situation by talking with residents, staff, and others who might have information regarding the matter under investigation and through personal observations of conditions and activities in the facility.
- e. If a resolution has not been reached, the committee may contact the ombudsman program for follow-up action as appropriate.
- f. The committee members are responsible for keeping the complainants informed of progress of the complaint.

321—9.12(231) Complaints referred from the department of inspections and appeals. The following procedures shall apply to complaints referred by the department of inspections and appeals to the department of elder affairs:

9.12(1) Referral process. Complaints or grievances received or initiated by the department of inspections and appeals may be referred for investigation to the resident advocate committee by transmittal to the ombudsman program at the department address in subrule 321—2.1(2).

9.12(2) Confidentiality. Information that may identify the complainant or resident shall be confidential.

9.12(3) Notification. The ombudsman program will provide adequate information within three days to a member of the appropriate resident advocate committee. Written notification will be provided within seven days.

9.12(4) Investigation. A committee member will investigate the complaint or grievance in accordance with rule 9.11(231).

321—9.13(231) Role of the AAAs. Rescinded IAB 2/4/04, effective 3/10/04.

321—9.14(231) Approval of training for committees in nursing facilities and residential care facilities.

Rescinded IAB 2/4/04, effective 3/10/04.

321—9.15(231) Accountability measures.

9.15(1) The department shall develop a standardized report form to be used by resident advocate committee secretaries. The form shall specify issues and concerns identified by the committee, the facility's response, and whether the issue or concern was resolved.

9.15(2) An issue or concern shall be designated as resolved when both the committee and the facility agree that the issue or concern has been resolved. If the facility disagrees with the committee's determination that an issue or concern has not been resolved, the aggrieved party may request a review by the office of the long-term care resident advocate/ombudsman by submitting a written request within 20 calendar days of the issuance of the form described in 9.6(2) "c."

9.15(3) Upon receipt of a request, the office of the long-term care resident advocate/ombudsman shall contact the facility administrator and the chairperson of the resident advocate committee to discuss the request. The office of the long-term care resident advocate/ombudsman shall have the discretion to uphold the committee's determination that the issue or concern is unresolved, designate the

issue or concern as resolved, or redefine the issue or concern as a means to negotiate a compromise.

9.15(4) The decision of the office of the long-term care resident advocate/ombudsman shall be made within 20 calendar days of the receipt of a request for review. Additional time may be allowed upon agreement by the resident advocate committee and the facility administrator.

9.15(5) An aggrieved party has 30 calendar days from the receipt of written notice of the decision of the office of the long-term care resident advocate/ombudsman to request a hearing. The department shall transmit the request to the department of inspections and appeals pursuant to 481 IAC 10.4(10A).

9.15(6) The hearing shall be conducted by the department of inspections and appeals pursuant to 481 IAC 10.1(10A) to 10.24(10A,17A).

9.15(7) All appeals shall be conducted pursuant to 321 IAC 2.7(4).

9.15(8) Judicial review. Procedures for judicial review shall be conducted pursuant to 321 IAC 2.7(6).

9.15(9) For each committee, the office of the long-term care resident advocate/ombudsman shall record the number of issues and concerns listed on the form designated under 9.6(2) "c" and the number resolved. Once a year, the office of the long-term care resident advocate/ombudsman shall calculate the percentage of issues and concerns identified by the committee that are resolved based on the total number of issues and concerns identified during the reporting period.

9.15(10) By May 1, 2002, the office of the long-term care resident advocate/ombudsman shall report to the department of human services the resolution rate of each facility based on resident advocate committee reports generated between October 1, 2001, and March 31, 2002.

9.15(11) By May 1 of each subsequent year, the office of the long-term care resident advocate/ ombudsman shall report to the department of human services the resolution rate of each facility based on resident advocate committee reports generated between January 1 and December 31 of the preceding year.

These rules are intended to implement Iowa Code chapter 231.

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*Effective date of Ch 9 delayed by Administrative Rules Review Committee.

IAC 2/4/04

**Resident Advocate Volunteer Application
Office of the Iowa Long Term Care Ombudsman Program**

Name: _____

Date of Birth _____

Address: _____

City: _____ Zip: _____

Home Phone _____

For Office Use Only:

Letter/Manual Mailed	Facility #
Screening Call	Approved
Packet Mailed	Facility #
Orientation	Entered

Work Phone* _____ email address _____

***If selected as a Resident Advocate, can we post your work phone number? Circle Yes No**

Occupation/Former Occupation _____

Name and city of Nursing Home where you would like to serve as a Resident Advocate

How did you learn about this volunteer opportunity? _____

What skills or strengths do you have that would be valuable as a Resident Advocate?

Please describe your past and present work experiences.

Please describe your past and present volunteer experiences.

Do you have a financial interest in this facility/facilities? Yes No

Are you a member of the Board of Directors of this facility? Yes No

Do you now, or have you ever worked in a facility? Yes No
If yes, please name the facility, job title(s) and dates employed.

Are you related to an employee, owner or licensee of the facility where you wish to volunteer?
Yes No If yes, please explain.

REFERENCES. Please list two people we may call as a reference.

Name _____ Daytime Phone _____

Name _____ Daytime Phone _____

Have you ever been convicted of a criminal offense? Yes No

If yes, please list conviction and date of conviction.

RESPONSIBILITIES

- ✓ I understand that I am applying to be a Resident Advocate Committee Volunteer for the State of Iowa/Office of the State Long-Term Care Ombudsman.
- ✓ My volunteer work will be conducted in a long-term care facility of my choice, but I understand that I am NOT a volunteer for the facility.
- ✓ I understand that if my application is accepted, I promise to participate in orientation prior to the beginning my volunteer duties and to read the volunteer manual.
- ✓ I promise to spend a minimum of 3 hours each month in the facility visiting assigned residents, keeping a journal of resident visits, concerns identified and resolution data.
- ✓ I will attend additional training programs.
- ✓ I will attend Resident Advocate Committee Meetings.
- ✓ I will contact the State Long-Term Care Ombudsman if I need any assistance, or if I believe further investigation of any problem is needed.
- ✓ I understand that failure to fulfill these responsibilities may result in termination of volunteer duties.

CONFIDENTIALITY

- ✓ Resident Advocate Volunteers will NOT discuss any resident without permission from the resident. Protecting the privacy and confidentiality of each resident must be treated with the utmost caution.
- ✓ Discussion regarding a resident should involve ONLY persons authorized by the resident such as nursing assistants, directors of nursing, administrators, the Office of the State Long-Term Care Ombudsman or the Department of Inspections and appeals.
- ✓ Resident Advocate Committee members will NOT discuss any information regarding the facility or any resident with unauthorized individuals or the general public, whether inside or outside of the facility.
- ✓ Discussion of concerns regarding the facility, a specific resident or residents in general shall be conducted in a private place.
- ✓ Breach of this confidentiality policy may result in termination of volunteer duties.

By signing this application, I verify that all information is true and correct. I understand the responsibilities and confidentiality rules associated with this volunteer position and I agree to abide by these terms.

Signature _____ Date _____

Mail completed application to: Office of the State Long-Term Care Ombudsman, 510 E. 12th Street, Jessie Parker Building, Suite 2, Des Moines, Iowa 50319. If you have any questions, please call 800-532-3213.

RESIDENT ADVOCATE COMMITTEE MEETING MINUTES/REPORT

Please submit minutes of RAC meetings to the facility administrator and to Jeanne Yordi, State Long-Term Care Ombudsman, 510 E. 12th Street, Jessie Parker Building Suite 2, Des Moines, IA 50319, send via e-mail to Jeanne.Yordi@iowa.gov or request self-addressed postage paid envelopes by calling 800-532-3213 You can also call this number to ask for information or assistance.

FACILITY _____ CITY _____ DATE _____

Date and time of Next Meeting _____

Total Number of Volunteer Hours _____ This number is for the previous Month _____ Quarter _____

RAC Members in Attendance Chair _____ Secretary _____

Members Present

Members Absent

Facility Staff in Attendance

of Issues/Concerns from previous months now resolved:

Month _____ Item # (s) _____

Month _____ Items # (s) _____

Month _____ Item # (s) _____

Month _____ Items # (s) _____

COMMENTS:

Change of Status

Facility_____

County_____

Address_____

City, State, Zip_____

Date_____

Member Information

New Address	New Position (list position)	Resigned Position (list position)	Resigned from committee	Other (Please specify)

Name_____

Address_____

Phone_____

Member Information

New Address	New Position (list position)	Resigned Position (list position)	Resigned from committee	Other (Please specify)

Name_____

Address_____

Phone_____

Member Information

New Address	New Position (list position)	Resigned Position (list position)	Resigned from committee	Other (Please specify)

Name_____

Address_____

Phone_____

Notes