Family Council Interest Survey – Top 3 Priorities

Highlights of the Family Council Survey as we presented in the PowerPoint at the November 19 FC Meeting:

Highlights

- Compassionate and helpful staff. Continue to work on the resident centered care training and mindset.
- Overall positive COVID clinical and safety measures but, more must be done to consider family as essential caregivers
- Spend more time with residents
- Improve communication
- Clarify and improve end of life process to families
- Build on the virtual connection of residents with families

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Survey feedback - top 3 priorities*:

Priority 1	Priority 2	Priority 3
Resident Centered Communication - Prompt communication - Transparent - Technology – nurses station phone - Technology – virtual visits - End of Life Protocol (from admission through to end of life)	**Spending Time** - Social Interaction - Essential Caregiver status - Anticipate Resident needs - Personal care - Recreation	**Nutrition (Dining experience)** - Visual/ Smell/ Texture (Senses) - Décor (flowers) - Acknowledge Shabbat as a special meal day and other occasions…. - Supervision - Assistance - Marquis

* Priorities are <u>not in order of preference</u> but, rather, represent the general categories of hope, concern, and recommendation that families recommend SLT consider in their decision making, for improvement, of resident (and family) quality of life.

1. Resident Centered Communication:

- Physician & Staff to Family and vice versa (information, health and medication updates, concerns, etc. Consider an interactive digital bulletin board at each nurse's station and/or on the website.
This digital "blog" or "daily update" may offer everything from the daily/weekly menu rotation to activity calendar to

some funny daily puzzle or joke but it would remove some of the paper clutter from the lobby and elsewhere and families could access it online at any time.

- “phones at nurses’ stations MUST be updated to, at very least, include a busy signal when busy (it currently just rings)” and…” better pick up of calls from families to check on their loved one” – voicemail, set specific time of day for calls and man the phone with a person able to answer clinical questions”. Current situation is not working. Remote phone not being picked up”

- Family to Resident and vice versa (social, essential caregiving, supporting activities of daily living, effects of isolation)
Consider all families essential caregivers.
Create a permanent “policy and procedure” for all families which lays forth the clinical expectations from LBHH as to how they can protect themselves, staff and residents from infection on any level, at the same time, being able to visit 1-2 times/week. Consequences for not following P&P and enforcement also included.

- “More access for families who were doing care prior to COVID-19. Although the rules permitted it, that was not the way it was being enforced at Louis Brier. My family member died for lack of adequate care during COVID-19 restrictions”

COVID Visitation related
- “Visitation via I phone is not working. Too noisy inside.”

- “Virtual visits and window visits are usually at times that she is not in a great frame of mind. It's often times that she's sundowning.” / “Prefer to see her when she's alert.”

- “Used to access skype on the computer with my mother's companion. Skype is no longer available”

- “Appointments on zoom but the times were not convenient for me”

- “Perhaps there is a way to assist seniors on computers iPads, cell phone so they can communicate with family independently but need help getting started”

- Learn from COVID that virtual communication “can be” extremely helpful to bridge the communication gap for some seniors. Consider encouraging families, upon arrival, to have their loved one familiarized with some form of digital device for their own entertainment, communication, brain stimulation (reading), etc. Reading Kindle books, being able to do crosswords or puzzles, reading email, texting, and FaceTime can all provide the resident with stimulation, autonomy and entertainment.

- Learn from COVID that digital communication is, for some residents, an inappropriate choice as they may be become agitated, frustrated and unable to even master reasoning this effort. Individualize communication choices which will change as the resident physical/mental status also changes.

- Staff to Resident and vice versa (more time required by staff if no family allowed, improve attention to detail on ADL; improve call bell response time)

- Resident to Resident (losing the community feel as programming languishes, new residents and no community identity, lacking social interaction)

2. Spending Time:

- Care aid and resident:

- Challenge of allowable time per resident does not preclude quality of time spent with resident – improve ADL details and training of care aid to target anything that gives the resident a feeling of self worth:

Examples:

- Better assistance with basic daily preparedness: ensures hearing aids are in and secure, dentures are clean, in and secure; phone is charged, connected with the resident; ensure their book and glasses are within reach; hair brush and/or shaver; remote control working and within reach…whatever it is which enables the resident to help themselves to activity they can do and enjoy.

- Physician and Resident

- Challenge of allowable time per resident does not preclude quality of time spent with resident – document physician visits and resident communication. Ensure family communique/debrief afterwards (email, text messenger etc.).
- "Communicate ANY change is physical, mental or emotional health status promptly"

- Recreations and Resident

- "Split a 1 hour event into 12 - 5 minute resident visits, just to say hello or deliver a colourful card"
- "Ensure outdoor trips to the gardens for everyone when weather supports it." (use volunteers, family and companions)
- "Ensure an activity at some level (even social interaction) is provided to each resident daily"
- "Individual music therapy that targets/ triggers the memory is most effective for all especially for Alzheimer sufferers."
- - "Provide individual music therapy that reflects a resident's specific past music interest, experience; E.g., use information acquired during intake/admission and ongoing interaction with individual residents"

- Companion and Resident

– do a better job of zeroing in on residents who have no family; ensure a minimum visitation via companion program. Contact families or representative to ask if they can afford to support their loved one with a companion. Zero in on the Companion Advisory Committee to provide regular 360 feedback to continuously enhance and expand the program. Finalize a fee structure that is attractive to most all families and residents. Define the task that care aids perform which are daily activity supports and companions "could do". Have the companion Advisory Committee look into training and development of companions for continuous improvement of companions.

- Family Member and Resident

– Bottom line, "consider all families as essential visitors". Just as companions have a list of things they can/cannot do for residents, so can families adhere to particulars of support for daily care activities.
- Here is the big bang for the buck FREE, loving, caring, daily activity and social/emotional support for the resident as long as family adhere to any and all visitation protocol in place at the moment.

3. Nutrition (Dining Experience)

- Improved focus on the mealtime experience

Before each meal:
Some residents are wheeled to the bistro or sit outside the 1st floor dining hall over 1 hour in advance of their meal and left to sleep and stare into nothingness. It is degrading, uncomfortable and unnecessary that there should be no music,

no person walking around to chat, no help to wipe a runny nose or even provide water.

Suggestion: FC suggestion for playing soothing music at each nursing station and before mealtime was effective for those sitting in hallways; Appropriate choice of music has a calming effect on the residents. Highlight any/all Jewish special traditions at mealtime (Shabbat – weekly??).

During the meal:

Move hallway resident dining into Dining Rooms. If one companion or care has more than one resident to feed, ensure proximity so each can be attended to with attention and consideration. “Dignity in Dining”

Marquis – where is the feedback process? Oversight? Management taste testing? Supervision?
Consider random meal testing for all sensory grading (sight, smell, texture, taste, temperature, consistency) of a meal, more than once, to ensure consistent preparation

- Hydration and nutrition intake: (family concern)..” that breakfast was not the only meal that resident fully ate that day.” And lack of hydration causing listlessness, confusion and UTI

After the meal:

- “Check trays for waste and personal items”
- “Ask how they liked/enjoyed their meal “(feedback if possible)
- “Consider music or brief 30 minute music video, book reading, faith based lesson/reading or something calming and interesting”

The survey responses included positive feedback on what is going well. The purpose of highlighting this is to encourage LBHH to <u>do more</u> of what is working well.

Some examples of what LBHH could do more of:
- Some individuals treat residents like their own family member
- Some individuals show compassion, respect, kindness, empathy
- Playing specific music to please and calm residents
- Programming shows and video loops of soothing, heartfelt, colourful, historical, calming content
- Rachels’ home baked treats
- Anticipating resident personal needs