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Improving Interprofessional Value-Based Care for Residents in Skilled Nursing Facilities

by

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Dedication

This DNP project is dedicated to my grandparents, William & Mary Bobo, and Ted & Ann Mitchell, thank you for believing in me and inspiring me. I would also like to dedicate this to Zach Roethemeyer, this project would not have been possible without your constant love and support.

Acknowledgments

I want to acknowledge Dr. Candace Harrington and all the wisdom, guidance, and passion she put into this project. I feel privileged to have learned this process from her. I would also like to thank Dr. Mary Skinner for contributing her time, knowledge, and long-term care wisdom into this project. This scholarly work would not have been possible without you both.

Abstract

Background/Significance: Providers may unknowingly impede residents' equitable treatment without understanding ethnocultural diversity and values, thus preventing residents and their families from receiving care consistent with residents' values and beliefs.

Purpose: This project aimed to improve equitable healthcare with spiritual and ethnocultural congruence integrated into care processes and workflow in a skilled nursing facility.

Methods: The Institute of Healthcare Improvement model for improvement (MFI) and an adapted evidence-based practice guideline guided the quality improvement project, implemented in one section of a 60-bed long-term care unit at a skilled nursing facility.

Practice Change: Process and care delivery workflow changes included three aims: (1) resident and family members' satisfaction with value-based care processes, (2), staff and providers' acceptability and usability and (3) implementation compliance were analyzed and revised with three rapid quality improvement cycles.

Results: Aim one was exceeded with a 28.5% positive percentage of change in resident satisfaction with mental well-being assessment and consideration from baseline to week four and a 14.3% positive percentage of change in resident satisfaction with mental well-being assessment at week eight. Aim two, to exceed the 70% benchmark for acceptability and useability of the care process changes, was met (83%) at week eight. Aim three was exceeded with a 166.7% positive change noted in the provider administration of the adopted assessments at week eight.

Implications: The project leader demonstrated quality improvement for value-based resident-centered care processes and workflows is possible and improves equitable care in long-term care settings.

Improving Interprofessional Value-Based Care for Residents in Skilled Nursing Facilities

Background

The importance of spiritually and ethnocultural congruent care and how these beliefs and values influence residents' healthcare decision-making is often misunderstood or misinterpreted by skilled nursing facility staff and healthcare providers. Nursing facility staff and providers are vital in caring for multiethnic older individuals with chronic and complex illnesses to relieve suffering and promote quality of life (Bokberg et al., 2019).

Only 47% of adults in the United States reported consideration of their goals or concerns when discussing their treatment plan with their healthcare providers. Family members often feel providers are unaware of their loved one's end-of-life and symptom management wishes (Armstrong & Mullins, 2017; Gonella et al., 2020b). To promote resident-centered care in nursing facilities, residents require a holistic assessment of their spiritual, social, psychological, and physical needs (Bokberg et al., 2019). Only 3% of nursing home residents report discussions about spiritual concerns with providers (Gonella et al., 2019).

Long-term skilled care is skilled nursing facilities (SNF) and intermediate care facilities caring for residents with chronic or debilitating diseases requiring 24-hour care (Harrington et al., 2022; National Institute on Aging, 2023). Short-term care, also known as post-acute rehabilitation, typically lasts 25-30 days and provides care for residents expected to recover over a short period from surgery, illness, or other injury (National Institute on Aging, 2023). These residents receive rehabilitation to return home.

Palliative care is symptom management to maximize one’s quality of life, may be initiated at any point in health care, and is particularly beneficial for chronically ill residents (Gonella et al., 2019). Palliative care improves quality of life through physical symptom management, spiritual and mental support, cultural competency, and family support (Gonella et al., 2019). Palliative and end-of-life (EOL) care are often used interchangeably but have distinct differences and roles in resident care. EOL, or hospice care, is the last care provided for terminally ill individuals to relieve suffering and provide dignity throughout the dying process (Gonella et al., 2019). Providers communicating this vital distinction for residents and families promote palliation, symptom management, and quality of life without inciting anxiety in residents.

While symptom management through palliation allows providers to treat residents holistically and with dignity during their care, caregivers and loved ones of palliative care residents have reported the least satisfaction with care in nursing homes compared to other healthcare settings (Quigley et al., 2020). When culture-specific preferences and spiritual symptom management are implemented in resident care, residents and their families report increased satisfaction with care, improved quality of life, and decreased anxiety and fear (Dobrina et al., 2018; Rahemi & Williams, 2019; Smith et al., 2020). Resident-centered symptom management also improves staff teamwork and can reduce healthcare costs (Dobrina et al., 2018). Despite these known benefits, health care providers lack understanding and knowledge about the assessment and incorporation of cultural and spiritual values and preferences into resident care consistently (Gonella et al., 2020a; Pollock & Seymour, 2018; Rahemi & Williams, 2019; Semlali et al., 2020).

Literature Review

Research regarding symptom management and value-based care for nursing home residents reflects the importance of honoring ethical principles, understanding quality symptom management indicators, and varying tools and interventions to optimize value-based care discussions (Armstrong & Mullins, 2017; Bokberg et al., 2019; Boomer et al., 2019; Gomez-Virseda et al., 2020; Gonella et al., 2020a; Gonella et al., 2020b; Grobe et al., 2019; Harrington et al., 2022; Kataoka-Yahiro et al., 2017; Rahemi & Williams, 2019; Semlali et al., 2020; Smith et al., 2020; Pollock & Seymour, 2018; Towsley et al., 2020). Regarding resident care decisions, autonomy—the right of residents to make their own decisions—was recognized as the central guiding principle (Gomez-Virseda et al., 2020; Smith et al., 2020; Pollock & Seymour, 2018). Gomez-Virseda et al. (2020) posited that autonomy is more nuanced and relational than given credit by health professionals. Autonomous decisions often consider the opinions of others and evolve. They should be appreciated even if the individual has cognitive deficits. Providers must promote justice by respecting resident autonomy even if resident values and preferences conflict with a provider's beliefs, values, or cultural norms (Smith et al., 2020). Providers should acknowledge their personal implicit biases and values to avoid impeding ethnocultural value-based care and resident autonomy (Boomer et al., 2019; Pollock & Seymour, 2018).

Family members consistently reported better communication and involvement with care planning when the care plan was comfort-oriented, promoted family knowledge of prognosis, and incorporated shared decision-making (SDM) (Boomer et al., 2019; Gonella et al., 2020b; Quigley et al., 2020). Quigley et al. (2020) endorsed open communication was the number one contributing factor to highly rated symptom management, followed by respecting family members and providing emotional and spiritual support. Open communication was defined globally across the literature as communication that informed and involved all staff members about resident preferences, included them as active participants in the treatment plan, and fostered an environment whereby staff felt empowered to share their ideas for implementation freely (Boomer et al., 2019; Gonella et al., 2020a; Quigley et al., 2020). Inversely, residents and families have reported language barriers and differing backgrounds as contributors to perceived poor quality of care (Gonella et al., 2020b).

Without understanding cultural diversity and values, providers may unknowingly impede the possible transition to conservative treatment, thus preventing residents and their families from receiving care that is consistent with their values (Gonella et al., 2020a; Pollock & Seymour, 2018). Gonella et al. (2020a) found nurses identified multi-professional communication as a tool to improve resident and family communication, relationships, and interactions with the care team. Nurses also emphasized a need for advanced care planning and goals of care discussions to improve resident care (Gonella et al., 2020a). Nurses believed families were often unaware of resident preferences, which led to potentially unwanted aggressive interventions and slower transitions to end-of-life care (Gonella et al., 2020a). Dobrina et al. (2018) discovered that nurses were concerned for residents’ psychological and spiritual needs, whereby resident family members' exclusion in care planning led to miscommunication and unnecessary distress. Gonella et al. (2019) echoed the need for family involvement in care planning as family satisfaction with palliative care increased when they knew they were carrying out their loved one's wishes. Rahemi & Williams (2019) discovered family dynamics also impacted minority resident's symptom management and EOL care preferences; minority resident's religious beliefs, race/ethnicity, distrust of medical professionals, English proficiency, and acculturation impacted their care preferences; thus, they should be assessed for and included in care planning (Rahemi & Williams, 2019).

Education interventions to improve resident-centered symptom management demonstrated mixed results throughout the literature. Bokberg et al. (2019) found no statistically significant differences in nurse perception of resident-centeredness or care environment after resident-centered care education sessions (Bokberg et al., 2019). The researchers found staff recognized a connection between having a relationship with residents and understanding resident care preferences better to provide high-quality symptom management (Bokberg et al., 2019). Boomer et al. (2019) found practice development programs with education sessions improved staff confidence in delivering care, communicating with residents and families, knowledge, and skills. Kataoka-Yahiro et al. (2017) discovered training modules with emphasis on palliation, culture, and communication theories statistically significantly increased staff knowledge and confidence regarding palliative care training ($p < .05$) and increased satisfaction with managing resident symptoms, respect, dignity, decision-making discussions, and providing information to residents and families (Kataoka-Yahiro et al., 2017).

Armstrong & Mullins (2017) found that decision aids (DAs) allowed providers to distinguish residents' values, helped residents make informed decisions, and promoted shared decision-making. These researchers found a significant design flaw, whereby only 55% of decision aids that included value clarification sections came after providing healthcare options, which limited providers' ability to tailor information to resident values (Armstrong & Mullins, 2017). This finding emphasizes the importance of providers performing value assessments at initial encounters to individualize resident care plans (Armstrong & Mullins, 2017). Towsley et al. (2020) implemented a program that video-recorded residents discussing wishes regarding care preferences, advanced care planning, and EOL and shared the videos with the care team and resident families. Residents reported the videos allowed them to reflect on and clarify their preferences (Towsley et al., 2020). Staff and family members reported a subsequent need to clarify the residents' answers (Towsley et al., 2020). In addition, these videos were not conducive to capturing resident preference changes over time and could mislead the care team and families regarding changed resident preferences (Towsley et al., 2020). Residents' care preferences and values evolve and should be assessed regularly to capture their desires accurately (Gomez-Virseda et al., 2020; Towsley et al., 2020).

Staff utilization of standardized tools for resident preferences discussions was found to be universally beneficial across the literature for systematic assessment of values for all residents, personalized care, and family inclusion concerning care (Grobe et al., 2019; Harrington et al., 2022; Semlali et al., 2020). However, staff must use these tools to guide the discussion to understand residents' needs and values without confining their answers to preselected choices (Grobe et al., 2019). Semlali et al. (2020) research confirmed these findings as some experts in their study found tools and checklists to facilitate cultural preferences conversations were helpful, while others stated strong communication skills were more valuable to elicit resident preferences and less rigid than standardized forms.

The only published evidence-based clinical practice guideline supported resident-centered care and symptom management (Harrington et al., 2022). The guideline included seven assessments for ethnocentric value-based care: spirituality, mental wellbeing, pain for communicative and non-communicative residents, constipation, dyspnea, and congestion based on the most problematic and prevalent issues at EOL (Harrington et al., 2022). An expert panel established the face and content validity of the guideline, with an Appraisal of Guidelines Research and Evaluation (AGREE) II score of 87.2% (*n* = 5) and long-term care interprofessional evaluation (*n* = 22) indicating a 92.7% approval rating, confirming its evidence-based merit to guide clinical practice (Harrington et al., 2022). The guideline's primary limitation is the lack of implementation in a real-world setting.

This writer identified several themes from this literature review. The ethical considerations for resident-centered care revolve around supporting resident autonomy in their care decisions and considering how their spiritual and cultural background can impact their choices while providers advocate for their residents' preferences and deter their own biases from affecting resident care (Boomer et al., 2019; Grobe et al., 2019; Pollock & Seymour, 2018). Long-term care residents have diverse cognition and mental capacity; providers should seek insight into care preferences for residents who can speak to their values, even if they experience cognitive impairment. Open communication between providers, residents, and family members can provide insight into resident values and preferences as well as inspire trust between all involved persons (Dobrina et al., 2018; Gonella et al., 2019; Gonella et al., 2020a, 2020b; Quigley et al., 2020). Building rapport with nursing home residents and their families was instrumental in understanding residents' preferences and providing high-quality palliation (Boomer et al., 2019; Bokberg et al., 2019; Gonella et al., 2019; Gonella et al., 2020a; Grobe et al., 2019). Residents and family members may feel a lack of control regarding their state of health and care planning. Consistent discussions and open communication about prognosis and goals of care support residents' understanding of their condition and that their care team understands their values and ethnocentric wishes. Ultimately, this empowers residents to make decisions that align with their values and beliefs. Confounding evidence supporting educational interventions for staff was noted throughout the literature (Bokberg et al., 2019; Boomer et al., 2019; Kataoka-Yahiro et al., 2017).

Educational interventions help increase symptom management knowledge and skill but assessing resident care preferences is not consistently improved through these interventions. While we may enhance knowledge about assessing resident preferences, the acquired knowledge must be applied through interventions in resident care before becoming measurable. Providers found assessment tools helpful in determining resident care preferences, especially those that utilized open-ended questions (Grobe et al., 2019; Harrington et al., 2022; Semlali et al., 2020). Tools using open-ended discussion allow residents to expound on the intricacies of their beliefs, values, or culture that generic, preordained answers cannot surmise. This approach supports healthcare professionals' holistic understanding of resident preferences to better inform further discussions or treatment decisions. These themes pointed to the need for evidenced-based, resident-centered, open discussion tools to regulate and facilitate an understanding of the psychosocial and cultural aspects of resident care to personalize symptom management to resident needs.

Limitations throughout the research included limited settings for research studies, infrequent timing of value-based interventions, and lack of resident input on value-based care interventions. Many reviewed studies were conducted in inpatient hospices or facilities with access to external hospice resources. Hospices and hospice services provide specialized training for staff to improve symptom management and resident experiences, limiting the transferability of findings. Other studies described their research settings as nursing facilities without specifying the level of care provided at these facilities, such as assisted living, memory care, or long-term care. Distinguishing the level of care is imperative to understanding the complexity of care required and the likelihood of residents' ability to engage in value-based assessments. Researchers who implemented assessments or interventions for residents' value-based care once during their study missed opportunities for equitable improvement. Evaluation of resident values cannot be limited to one interaction, as resident values are dynamic and may change depending on several factors, including their health, lived experiences, or time and reflection. Researchers often focused on exploring providers' feelings towards using assessment tools to facilitate value-based discussions. While it is essential to understand the providers' perspective, residents cannot be excluded from these discussions as they are the focus of the value-based discussions. Health care professionals cannot appreciate resident-based care processes' impact without resident input.

Intervention/Practice Change Rationale

During a needs assessment with the director of nursing (DON) at a long-term care facility, they reported spiritual and cultural symptoms of residents were not evaluated effectively, were considered a gap in the current care processes, and requested this quality improvement (QI) project for practice change. The DON reported multifactorial reasoning for the omission of spiritual and ethnocultural value-based care, including time constraints, being unfamiliar with resources, and having no consistent way to evaluate these needs for residents.

To better serve residents’ mental, spiritual, and cultural needs in long-term care, the Faith, Belief, or Meaning, Importance and Influence, Community, and Address/Action in Care (FICA) and the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) assessment tools from the evidence-based clinical guideline *An Interprofessional Approach to Holistic End-of-Life Care in Long Term Care Facilities* were implemented at a long-term care facility in Kentucky (Harrington et al., 2022; Puchalski & Romer, 2000; Tennant et al., 2007; Appendix A, Appendix B). The project leader piloted this QI project on one 22-bed section of the facility before the subsequent integration across the facility. Implementing assessments for spirituality and wellbeing created a reliable and time-effective solution for staff to better understand resident symptom management needs. The intervention was also feasible as the assessments were incorporated into the current care processes to promote process efficiency.

Purpose & Specific Aims

This project aimed to improve equitable healthcare with spiritual and ethnocultural congruence integrated into care processes and workflow in a skilled nursing facility. This initiative provided means for improved resident and family satisfaction with their care and increased provider proficiency in assessing long-term care residents' mental, spiritual, and cultural needs. This quality improvement aimed to improve resident-centered care for residents of all backgrounds and cultures and improve value-based interprofessional ethnoculturally and spiritually congruent care processes by eliminating waste and allowing providers to focus on culturally appropriate aspects of resident care and decrease inappropriate cultural or spiritual interventions. Acceptability, useability, and compliance were set as outcomes for the QI project.

Specific, Measurable, Achievable, Relevant, and Timely (SMART) Goals

The project leader (a Doctor of Nursing Practice student) set three SMART goals for this QI project.

1. Residents and their designated families will report improved perceived value-based care by 10% within eight weeks or upon discharge. Family was defined in two ways: 1) a group related by blood, marriage, or adoption with a common ancestral relationship based on commitment or obligation, and 2) a voluntarily committed bond of mutual support and love in a relationship, friendship, kinship, or companionship with one or several others (Laderer, 2022).
2. Facility interprofessional staff will rate the acceptability and useability of the spiritual and mental wellbeing assessments at or greater than 80% within eight weeks.

3. Based on chart audits, the facility will integrate the spiritual and mental wellbeing assessments into their workflows with 10% compliance at four weeks and 30% at eight weeks.

Method

Quality Improvement Model

The project leader used the Institute for Healthcare Improvement (IHI) model for improvement (MFI) for three rapid plan, do, study, act (PDSA) cycles to guide quality improvement (Institute for Healthcare Improvement [IHI], 2023). The IHI MFI is a cyclical model allowing for adjustment and change throughout a QI project (IHI, 2023). The project leader utilized the IHI MFI framework by developing a team, creating an aim statement, establishing measures, identifying changes the project could make, and making a PDSA cycle (IHI, 2023). This project team comprised of the DNP student as the project leader, the DON of long-term care, an assistant DON, bedside care staff, a social worker, a geriatrician, a geriatrician fellow, and an APRN.

The "plan" portion of the PDSA cycle assessed the skilled nursing facility's value-based care workflow, current ethnocultural-centric care processes, and the acceptability and useability of the FICA and SWEMWBS assessments as components of routine care (IHI, 2023; Puchalski & Romer, 2000; Tennant et al., 2007). The project leader and staff nurse educators conducted in-services for the providers, the social worker, and the bedside care staff on the practice change processes, the initial plan for implementation, and the chosen spirituality and mental wellbeing assessments. The project leader evaluated residents' and family members' satisfaction with value-based care processes during each cycle using the resident and family satisfaction survey (Appendix C). The project leader evaluated the acceptability and useability of the value-based care processes using an 12-question modified practitioner feedback questionnaire (MPFQ) for all interprofessional disciplines involved in care provision at the beginning of each cycle (Hansen, 2019; Appendix D). During the “do” phase, the chosen FICA and SWEMWBS ethnocultural-centric measures were initiated and implemented into routine care processes and workflow (IHI, 2023; Puchalski & Romer, 2000; Tennant et al., 2007). During each cycle's “study” phase, resident and family members' satisfaction, staff acceptance and useability, and care process implementation were analyzed (IHI, 2023). During each cycle’s “act” phase, the value-based care process and workflow were adjusted for optimal resident outcomes based on data analysis and feedback from the project stakeholders (IHI, 2023). Three PDSA cycles were needed to achieve the project's outcome goals allowing the team to adapt for project success (IHI, 2023).

Setting/Environment

The location of this intervention was a skilled nursing facility in Kentucky, in their long-term care unit. The long-term care unit had 60 beds and served residents requiring long-term skilled care and short-term rehabilitation. The DON selected a designated hallway (hereafter, the pilot section) for the project implementation. The pilot section had 22 beds in which only long-term care residents lived in this hall; no short-term rehabilitation residents were admitted to this section during the project.

Sample

Any resident in the pilot section who agreed to participate was included in data collection if they could speak to their care preferences. The project leader excluded non-communicatory residents or those with disease processes made expressing their preferences difficult. All residents in the pilot section could opt out of the data collection but received the quality improvement measures and process changes. Staff participants included all the unit's nursing aides (NAs), licensed practical nurses (LPNs), registered nurses (RNs), geriatricians, APRNs, and the social worker.

Stakeholders

The key stakeholders of this project were the DON, the assistant DON, geriatricians, an APRN, a social worker, residents, and their designated families. Stakeholders considered aging well, a high-quality continuum of care, and symptom management imperative to meet the facility's mission and values. This project supported the facility's mission and values.

Needs Assessment

The project leader completed a needs assessment discussed previously for the long-term care unit and discovered that residents' spiritual, mental, and cultural needs were inadequately assessed using the current care processes, potentially decreasing the perceived value-based care quality.

Facilitators and Barriers

Facilitators for project implementation at the facility included good relationships between residents and staff and organizational support of the project. Barriers were time constraints for providers and the social worker, facility culture perpetuating resistance to practice change, residents' and families' willingness to participate, and residents' ability to respond to surveys.

Ethical Considerations/Permissions

The University of Louisville Institutional Review Board (IRB) approved this project proposal as a quality improvement before implementation (22.1007; Appendix E). The DON for the long-term care unit provided written support for the project (Appendix F). All data collected throughout the project were de-identified to protect resident anonymity.

Budget

Financial requirements for this project were minimal, as the assessments were incorporated into pre-existing staff processes. The education session occurred during the designated staff meeting time. The paper handouts for the educational evaluation and bulletin boards and printed surveys with envelopes were approximately $43. The nursing facility covered the cost of staff education related to the project with an estimated $231. The project leader's time for the educational meeting, chart audits, survey collection, and data analysis cost an estimated $250. Future savings from improved quality ratings may be realized one year after implementation. Resident-centered care and symptom management may decrease cost of care for facilities and reduced hospital readmission penalties (Dobrina et al., 2018).

Measures

Instruments

The FICA and SWEMWBS guide the collection of pertinent resident care information, detailing mental wellbeing and spiritual values so resident care plans can reflect these (Puchalski & Romer, 2000; Tennant et al., 2007). The FICA tool is a qualitative questionnaire with four domains consisting of 11 open-ended questions to facilitate cultural and spiritual discussions with residents and assess the importance of faith in their life (Borneman, 2018). The FICA tool has no associated scale or rating, thus allowing providers to evaluate resident faith and spirituality conversationally to guide care interventions (Puchalski & Romer, 2000). The FICA's four subscales ($\alpha = 0.77$-0.89) and overall ($\alpha = 0.93$) internal consistency indicated its value for inclusion in the project (Borneman et al., 2010). Borneman et al. (2018) demonstrated FICA's transferability as a reliable spiritual assessment tool for multiple care settings (Borneman et al., 2018).

The SWEMWBS was developed as a condensed version of the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) to assess mental wellbeing through seven questions about a person's emotionality and functionality (Fat et al., 2017). The SWEMWBS utilizes a five-point Likert scale to assess each question (none of the time, rarely, some of the time, often, and all the time) and is scored from seven to 35; higher scores indicate positive mental wellbeing (Harrington et al., 2022). Researchers demonstrated the SWEMWBS had internal reliability (α = 0.84), showing that SWEMWBS would assess residents' mental wellbeing as intended (Fat et al., 2017).

Process Measures

Measured outcomes of this project included improved perceived symptom management based on resident and family perceptions, which were assessed with a resident and family satisfaction survey during each cycle. No short-term rehabilitation residents were discharged during the project, so no data were lost due to resident retention. Survey data included nominal and summative data. Staff aggregate acceptability and useability percentages were measured using the MPFQ during each cycle (Hansen, 2019). Staff demographic data were collected as a part of the MPFQ survey (Hansen, 2019). Central tendencies were calculated based on data measurement. The percentage of change for provider implementation of the care process was assessed during cycles two and three through resident chart review because the measures in cycle one equaled zero.

Outcome Measures

Resident and family satisfaction with value-based care was measured utilizing a resident and family survey developed by the project leader and distributed at the beginning of each cycle.

The acceptability and useability of the new care process were measured through the MPFQ, distributed at the beginning of each cycle (Hansen, 2019). Compliance with the updated care process was measured through chart audits at the end of cycles two and three.

Procedure/Intervention Implementation

Phase One

The procedure involved three-phase IHI Quality Improvement Plan-Do-Study-Act cycles (Appendix G.1; Appendix G.2; Appendix G.3; IHI, 2023).

Phase One "Plan"

Following IRB approval, the staff geriatricians, APRN, bedside care staff, and the social worker were educated about the care process change at two educational sessions during staff meetings. The sessions lasted approximately 15 minutes to discuss the components of the assessments with handouts of the tools and a description of the care process changes. Educational handouts from the meetings were posted on bulletin boards throughout the unit to remind of the process change. The APRN led daily huddles to keep the team motivated for the care process change when the project leader was not at the facility. The social worker was appointed to collect resident and family satisfaction surveys if a resident was being discharged and the team leader was absent. No residents who resided in the pilot section of the facility were discharged during the implementation of this project, but some residents were lost to follow-up due to health decline or death.

The project leader educated residents about the intervention and asked residents if they would like to participate in the QI project: residents were informed that their participation was voluntary, and they could opt out. A handout was given to new residents as a part of their admission packet to accommodate residents admitted to the facility's pilot section during the project. During this time, the project leader also educated residents’ family about the project when present.

Phase One "Do"

To assess baseline satisfaction with symptom management for spiritual, mental, and cultural needs, the project leader gave satisfaction surveys to residents and their families. The project leader recorded responses for residents who wished to participate and could answer the survey themselves but could not write their responses. No personal identifying characteristics were reported to protect resident anonymity. During this data collection, no resident family members were present at the bedside to answer family satisfaction surveys. Satisfaction surveys were left at the resident bedside for one week to allow family members time to respond. Family inclusion continued when seen at the facility.

Before project initiation, all staff engaged in resident care were asked to complete the MPFQ via a text message link sent to them from the DON, as she preferred since there was no organization email system. Informed consent was not applicable in this QI project. The data were collected through MS Forms and downloaded into Excel for analysis. After the education sessions, the providers were asked to perform the FICA and SWEMWBS assessments on residents residing in the pilot section throughout cycle one (Puchalski & Romer, 2000; Tennant et al., 2007). The providers administered the assessments on admission or with acute visits. The secretarial staff scanned the assessments into the electronic chart.

Phase One “Study” (Data Analysis)

The project leader analyzed cycle one responses to the MPFQ using summative value percentages to assess pre and post-intervention responses (Hansen, 2019). The questionnaires were anonymous and personal identifiers were not recorded. The MPFQ is 12 questions with a five-point Likert scale with response options of “strongly disagree”, “disagree”, “agree”, “strongly agree”, or “neither agree nor disagree” (Hansen, 2019). The first question of the survey asked about the participants role on the unit. This question was assigned a nominal value for each role. For statistical analysis, each Likert scale response was assigned a numerical value as follows: “strongly disagree” is scored at 1, “disagree” is scored at 2, “neither agree nor disagree” is scored 3, “agree” is scored at 4, and “strongly agree” is scored at 5. With this scoring system, the total scores ranged from 11-55/55. Percentages of acceptability and useability were calculated by dividing the numerator by the denominator and multiplying by 100. The individual respondent’s percentages were added, divided by the total number of respondents, then multiplied by 100. The summative value used the baseline 70% from AGREE II (Agreetrust, 2017).

Eight out of 38 staff members who provided direct care completed the MPFQ questionnaire for cycle one, with a response rate of 21.1% (Hansen, 2019). Nurses (LPNs and RNs) were 50% (*n* = 4) of respondents. Geriatricians represented 25% (*n* = 2) of the response group. The other participants were an APRN (*n* = 1) and social worker (*n* = 1), each comprising 12.5% of the respondents.

Staff were asked to respond to the statement, “*There is a need for assessments on this topic.*” In response, 62.5% (*n* = 5) selected “strongly agree,” 25% (*n* = 2) selected “agree,” and 12.5% (*n* = 1) responded “strongly disagree” (*M* 4.25/5.0, *SD* 1.3887). For the second statement, “*The assessments recommendations are clear,*” 62.5% (*n* = 5) of respondents selected “strongly agree,” 25% (*n* = 2) selected “agree,” and 12.5% (*n* = 1) selected “neither agree nor disagree” (*M* 4.5/5.0, *SD* 0.7559). Then participants answered the third statement, “*The assessments are suitable for the residents for whom they are intended”*. In response, 37.5% (*n* = 3) of respondents selected “strongly agree,” 50% (*n* = 4) selected “agree,” and 12.5% (*n* = 1) selected “disagree” (*M* 4.125/5.0, *SD* 0.99*)*. The fourth statement read, “*The assessments apply to individual residents,*” 50% (*n* = 4) of participants selected “strongly agree,” and 50% (*n* = 4) selected “agree” (*M* 4.5/5.0, *S*D 0.53). The fifth statement read, “*When applied, the assessments will produce more benefits for residents than harm,*” 37.5% (*n* = 3) of respondents selected “strongly agree,” 50% (*n* = 4) selected “agree,” and 12.5% (*n* = 1) responded “neither agree nor disagree” (*M* 4.25/5.0, *SD* 0.707).

The sixth statement inquired, “*The assessments present options that will be acceptable to residents,*” 37.5% (*n* = 3) of respondents selected “strongly agree,” 50% (*n* = 4) selected “agree,” and 12.5% (*n* = 1) selected “strongly disagree” (*M* 4.0/5.0, *SD* 1.309), indicating the widest variation in opinions of all questions. The seventh statement questioned, “*Application of the assessments will require reorganization of services/care in my practice setting,*” 12.5% (*n* = 1) of respondents selected “strongly agree,” 37.5% (*n* = 3) selected “agree,” 25% (*n* = 2) selected “neither agree nor disagree,” and 25% (*n* = 2) selected “disagree” (*M* 3.375/5.0, *SD* 1.06). The eighth statement participants evaluated, “*The assessments are feasible in the long-term care environment,*” 37.5% (*n* = 3) respondents selected “strongly agree,” 50% (*n* = 4) selected “agree,” and 12.5% (*n* = 1) selected “neither agree nor disagree” (*M* 4.25/5.0, *SD* 0.707). The ninth statement read, “*The assessments are likely to be supported by a majority of my colleagues,*” 12.5% (*n* = 1) of respondents selected “strongly agree,” 50% (*n* = 4) selected “agree,” and 37.5% (*n* = 3) selected “neither agree nor disagree” (*M* 3.75/5.0, *SD* 0.707). The tenth statement considered, “*If I follow the assessment recommendations, the expected effects on resident outcomes will be obvious,*” 25% (*n* = 2) of respondents selected “strongly agree,” 62.5% (*n* = 5) selected “agree,” and 12.5% (*n* = 1) selected “neither agree nor disagree” (*M* 4.125/5.0, *SD* 0.64). The final statement inquired, "*The assessments reflect a more effective approach for improving resident outcomes than is current usual practice (If they are the same as current practice, please check N/A),*" 12.5% (*n* = 1) of respondents responded, "strongly agree," 50% (*n* = 4) selected "agree," 25% (*n* = 2) selected "neither agree nor disagree," and 12.5% (*n* = 1) selected "disagree" (*M* 3.625/5.0, *SD* 0.916).

Descriptive analysis of staff demographic information was performed. Demographic data were collected with the Likert data to assess how each staff role rated acceptability and useability throughout the project (Hansen, 2019; see Table 1). Nurses (LPNs and RNs) average survey total was 46.5/55 (84.6%). The geriatrician's average survey score was 48/55 (87.3%) and the APRNs score was 47/55 (85.5%). Lastly, the social workers score was 29/55 (53%). The cycle one summative percentage of acceptability and usability of the new care process for all respondents, regardless of profession, was 81.4%. Data analysis would have been more transparent with the delineation of roles since the responsibilities of RNs and LPNs vary in long-term care settings.

Table 1

Cycle One Aggregate MPFQ Scores Per Discipline

Discipline	*n*	M	%
Geriatricians	2	48/55	87.2%
APRN	1	47/55	85.5%
Nurses (RN, LPN)	6	46.5/55	84.6%
Social worker	1	29/55	53%

The project leader assessed resident and family satisfaction surveys for rate of resident satisfaction with the facility's current care practices for evaluating spirituality, culture, and mental wellbeing. The dichotomous answers (yes [1] and no [0]) were used to evaluate resident satisfaction. The value-based satisfaction rate was calculated by dividing the numerator (yes [1]) by the denominator, or total surveys collected, and multiplying by 100. The summative data from open survey responses were analyzed for nuances not captured in the other questions.

Fifteen residents from the pilot section were surveyed for baseline data before the care process change was implemented. Family responses to the satisfaction survey was low, with only one family member completing a survey, thus data analysis was not warranted for family responses. Upon further inquiry, the project leader learned many of the residents were wards of the state or had no family members to act as advocates, which increased the project's value further. Rate of satisfaction with value-based care was calculated for cycle one. Residents were asked to respond to two questions: "*Do you believe your healthcare team assesses for and considers your culture and spirituality during your care?*". Five residents, (33.3%) reported being satisfied with the facility's current care process for culture and spirituality evaluation and thought these topics were considered in their care plan. In contrast, 66.7% (*n* = 10) of residents reported these topics were not assessed or considered. Next, residents were asked to respond to, "*Do you believe your healthcare team assesses for and considers your mental wellbeing during your care?*". In response, 46.7% (*n* = 7) of residents reported being satisfied and that staff do assess and consider their mental wellbeing. However, 53.3% (*n* = 8) of residents were dissatisfied and did not feel that staff assessed for mental wellbeing. Thus, the QI project was justified and continued without modifications.

Residents responded to open answers on the resident satisfaction survey and expanded upon their perception of the value-based care process. Several topics were uncovered from their comments. Multiple residents stated some staff were better at assessing these topics than others and that assessments for these topics were done sporadically. Residents also reported staff were caring, but perceived as too busy to discuss value-based topics with them; residents perceived staff only assessed their physical needs due to time constraints.

The geriatricians and APRN reported no hindrances or issues with the workflow and care process change. The APRN reported the language of the SWEMWBS focused on geriatric populations and was relevant for the intended audience (Tennant et al., 2007).

Phase One "Act"

Stakeholder feedback, resident and family feedback, and MPFQ data were evaluated by the project leader for care process modifications with changes in workflow and care processes (Hansen, 2019). The social worker felt that the FICA assessment was not an efficient use of their time and believed it overlapped with other assessments completed upon resident admission (Puchalski & Romer, 2000). The social worker reported issues with the necessity to keep residents focused and clarifying questions for understanding (Puchalski & Romer, 2000). Based on stakeholder feedback and team agreement, the FICA assessment was eliminated for the remaining cycles (Puchalski & Romer, 2000). The project leader planned to print MPFQs for cycle two rather than send out electronic versions for better congruence with facility practices (Hansen, 2019). The project leader planned to contact resident families during scheduled care plan meeting days and provide families with resident and family satisfaction surveys with the expectation of improving cycle two response rates.

Phase Two

The project leader used the second cycle to refine the workflow, care processes, and procedure variances noted during the first cycle (Appendix G.2; IHI, 2023).

Phase Two "Plan"

Based on the feedback from residents, families, providers, the social worker, and bedside staff, the project's process was improved to make the assessments and care process more suitable for the facility. The project leader adapted the care process based on the previous PDSA cycle and included only the SWEMWBS to increase project feasibility and acceptance of the practice change (Tennant et al., 2007). Due to low response rates from staff, the project leader transitioned the MPFQs to paper handouts and distributed the questionnaires to staff through their mailboxes on the unit (Hansen, 2019). The care team could return their questionnaires to the project leader or APRN based on their preference (Hansen, 2019). A change in the approach to increase family participations was enacted for this cycle.

Phase Two "Do"

During unit rounding, the project leader prompted staff to complete the MPFQ and submit their responses (Hansen, 2019). Families were contacted on the day of their quarterly care plan meetings by the project leader or APRN, reminded about the QI project, and asked to complete the resident and family satisfaction survey.

The project continued with the process improvements of only administering the SWEMWBS, printing MPFQ's, and contacting resident families on their care plan dates (Hansen, 2019; Tennant et al., 2007). The project leader distributed and/or administered the MPFQ, resident and family satisfaction surveys, and chart audits during cycle two (Hansen, 2019). The project leader continued to distribute the resident satisfaction surveys and recorded survey responses when residents were unable to write their responses. No identifiable information was gathered to protect resident anonymity.

Phase Two "Study" (Data Analysis)

During cycle two, the project leader analyzed the MPFQs as described previously in the phase one study portion (Hansen, 2019). For cycle two, 16 of 38 (42.1%) staff members completed the printed MPFQ; However, one respondent failed to report their profession and another respondent did not respond to a statement on the questionnaire (Hansen, 2019). These two responses were omitted from data analysis due to missing data. Of the remaining 14 respondents, 42.9% (*n* = 6) were nurses (LPNs and RNs). Nursing assistants made up 28.6% (*n* = 4) of the survey takers and 14.3% (*n* = 2) of participants were geriatricians. The social worker (*n* = 1) and APRN (*n* = 1) made up 7.1% of the respondents, respectively.

The staff responded to the same 11 questions of the MPFQ referenced in cycle one analysis to assess staff perception of the new care process (Hansen, 2019; Appendix H). In response to the need for the assessment, 28.6% (*n* = 4) of respondents selected "strongly agree," 64.3% (*n* = 9) selected "agree," and 7.1% (*n* = 1) responded "strongly disagree" (*M* 4.07/5.0, *SD* 0.997). For the second statement about the clarity of recommendations, 28.6% (*n* = 4) of respondents selected "strongly agree," 50% (*n* = 7) selected "agree," and 21.4% (*n* = 3) selected "neither agree nor disagree" (*M* 4.07/5.0, *SD* 0.73). In response to the third statement about the suitability of the assessment, 35.7% (*n* = 5) of respondents selected "strongly agree," 42.9% (*n* = 6) selected "agree," 14.3% (*n* = 2) selected "neither agree nor disagree," and 7.1% (*n* = 1) selected "disagree" (*M* 4.07/5.0, *SD* 0.92*)*. The fourth statement about applicability to individual residents resulted in 28.6% (*n* = 4) of participants selecting "strongly agree," 50% (*n* = 7) selecting "agree," and 21.4% (*n* = 3) selecting "neither agree nor disagree" (*M* 4.07/5.0, *S*D

0.73). The fifth statement about more benefit than harm for residents resulted in 28.6% (*n* = 4) of respondents selecting “strongly agree,” 42.9% (*n* = 6) selecting “agree,” and 28.6% (*n* = 4) responding “neither agree nor disagree” (*M* 4/5.0, *SD* 0.78).

The sixth statement inquiring about the acceptability of the assessments’ options resulted in 42.9% (*n* = 6) of respondents selecting “strongly agree,” 42.9% (*n* = 6) selecting “agree,” 7.1% (*n* = 1) selecting “neither agree nor disagree,” and 7.1% (*n* = 1) selecting “strongly disagree” (*M* 4.14/5.0, *SD* 1.099). The seventh statement questioned about the work burden in their organization, 21.4% (*n* = 3) of respondents selected “strongly agree,” 42.9% (*n* = 6) selected “agree,” 28.6% (*n* = 4) selected “neither agree nor disagree,” and 7.1% (*n* = 1) selected “disagree” (*M* 3.7857/5.0, *SD* 0.89). For the eighth statement regarding feasibility in the long-term care setting, 21.4% (*n* = 3) respondents selected “strongly agree,” 64.3% (*n* = 9) selected “agree,” 7.1% (*n* = 1) selected “neither agree nor disagree,” and 7.1% (*n* = 1) selected “disagree” (*M* 4/5.0, *SD* 0.78). The ninth statement about colleague support resulted in, 28.6% (*n* = 4) of respondents selecting “strongly agree,” 35.7% (*n* = 5) selecting “agree,” 28.6% (*n* = 4) selecting “neither agree nor disagree,” and 7.1% (*n* = 1) selecting “disagree” (*M* 3.857/5.0, *SD* 0.949). The tenth statement considered the expected effects on outcomes with 21.4% (*n* = 3) of respondents selecting “strongly agree,” 42.9% (*n* = 6) selecting “agree,” and 35.7% (*n* = 5) selecting “neither agree nor disagree” (*M* 3.857/5.0, *SD* 0.77). The eleventh statement inquired about the effectiveness of the new approach and 21.4% (*n* = 3) of respondents selected “strongly agree,” 35.7% (*n* = 5) selected “agree,” 28.6% (*n* = 4) selected “neither agree nor disagree,” and 14.3% (*n* = 2) selected “disagree” (*M* 3.64/5.0, *SD* 1.008). The project leader independently chose for “neither agree nor disagree” to be a response to the MPFQ (Hansen, 2019). To gain understanding of staff responses the project leader asked staff if they had selected “neither agree nor disagree” and if so to qualify that answer. Many nurses and nursing assistants stated they were unsure of the previous process in place to assess resident spirituality and mental wellbeing and therefore could not speak to if the new care process was more effective. The social worker reported the new care process seemed inefficient given that mental wellbeing and spirituality were assessed prior to the updated care process.

The project leader assessed the MPFQ further and analyzed survey responses by profession (Hansen, 2019; see Table 2). Nurses (LPNs and RNs) average survey total was 41.6/55 (75.6%). The nursing assistants average survey total was 45/55 (82%). The geriatrician’s average survey score was 47.5/55 (86.5%) and the APRNs score was 43/55 (78%). The social workers score was 29/55 (53%). The cycle two summative percentage of acceptability and usability of the new care process for all respondents was 79.3%.

Table 2

Cycle Two Aggregate MPFQ Scores Per Discipline

Discipline	*n*	M	%
Geriatricians	2	47.5/55	86.5%
APRN	1	43/55	78%
Nurses (RN, LPN)	6	41.6/55	75.6%
Nursing assistants	4	45/55	82%
Social worker	1	29/55	53%

The project leader calculated the cycle two rate of resident satisfaction with value-based care as previously described in cycle one data analysis. For cycle two, 13 residents were able to complete the resident and family satisfaction survey. In response to, “*Do you believe your healthcare team assesses for and considers your culture and spirituality during your care?*”

38.5% (*n* = 5) of residents reported being satisfied with the assessment process for culture and spirituality evaluations. In contrast, 61.5% (*n* = 8) of residents reported being dissatisfied with their cultural and spirituality assessment. Next, residents were asked to respond to, "*Do you believe your healthcare team assesses for and considers your mental wellbeing during your care?*". In response, 69.2% (*n* = 9) of residents reported being satisfied and that staff do assess and consider their mental wellbeing. However, 30.8% (*n* = 4) of residents were dissatisfied and did not feel that staff assessed for mental wellbeing.

In addition, percentage of change for resident satisfaction with value-based care assessments between cycle one and cycle two was calculated; The dichotomous answers ([0 for not satisfied] and [1 for satisfied]) in resident satisfaction surveys were used for percentage of change calculations (new number minus base number divided by base number which was then multiplied by 100 for the percentage of practice change). There was a 28.5% positive percentage of change in resident satisfaction with mental wellbeing assessment and consideration between cycle one and two, thus exceeding the SMART goal set a priori. Percentage of change in resident satisfaction with culture and spirituality assessment and consideration was not calculated as the FICA was dropped from the care process change (Puchalski & Romer, 2000).

The project leader reviewed open responses on the cycle two resident and family satisfaction surveys, the answers contained similar open response topics to cycle one. Residents continued to report certain staff members were better at assessing value-based needs and that these assessments were done intermittently. In addition, some residents reported a desire to discuss their mental wellbeing but felt like there was not an opportunity to do so.

Reviewing the family satisfaction data, response rates remained low (*n* = 2) even after the modification of contacting resident families on days of their care plan meetings. Due to low rates of family responses to the resident and family satisfaction survey, data analysis could not be performed. Considering the low rates of family member responses to the resident and family satisfaction survey, the team collaborated about ways to improve family’s responsiveness.

Rate of implementation was calculated for cycle two through chart audits. The dichotomous answers ([0 for not present] and [1 for present]) in chart reviews were used for practice change calculations (present [1] divided by total number of residents which was then multiplied by 100). Out of 20 residents, 15% (*n* = 3) had been administered the FICA by the social worker (Puchalski & Romer, 2000). Providers had administered the SWEMWBS to 15% (*n* = 3) of residents as well (Tennant et al., 2007).

The project leader met with the providers to discuss their experience with the SWEMWBS throughout cycle two and discussed if modifications were needed for the care process (Tennant et al., 2007). The providers were satisfied with the practice change and no modifications were required for the care process. Feedback regarding the SWEMWBS tool included that was comprehensive and allowed providers to have open communication with residents regarding their mental health (Tennant et al., 2007).

Phase Two "Act"

Based on stakeholder feedback, chart audits, and resident and family value-based care satisfaction surveys, the process was changed once more to increase family satisfaction survey responses.

Phase Three

The project leader refined the assessment process to improve the family response rates to the satisfaction survey in PDSA cycle three (IHI, 2023; Appendix G.3).

Phase Three "Plan"

The plan modification necessary based on phase two was a modification for improving family involvement. This modification required the project leader to call resident family members and record their answers to the resident and family satisfaction survey.

The project leader asked the APRN to help facilitate communications with the resident family members. The APRN selected five families of residents in the pilot section for the project leader to call.

Phase Three "Do"

During cycle three, the project leader collected printed MPFQs, resident satisfaction surveys, performed chart audits, and called resident family members to administer the resident and family satisfaction survey (Hansen, 2019). The project leader recorded the family responses (*n* = 2) to the value-based satisfaction survey, no identifiable information was collected.

Phase Three "Study" (Data Analysis)

Cycle three MPFQs were analyzed as described previously in the phase one and two data analysis portions (Hansen, 2019). During cycle three, 14 of 38 (36.8%) staff members responded to the MPFQ (Hansen, 2019). Nurses (LPNs and RNs) comprised 50% (*n* = 7) of the respondent pool. Nursing assistants made up 21.4% (*n* = 3) of the survey takers and 14.2% (*n* = 2) of participants were geriatricians. Lastly, the social worker (*n* = 1) and APRN (*n* = 1) made up 7.1% of the respondents, respectively.

The staff responded to the same 11 MPFQ questions referenced in the previous cycles to assess staff perception of the updated care process (Hansen 2019; Appendix H). In response to the need for the assessment, 42.9% (*n* = 6) of respondents selected "strongly agree," 35.7% (*n* = 5) selected "agree," 14.3% (*n* = 2) selected "neither agree nor disagree," and 7.1% (*n* = 1) responded "disagree" (*M* 4.14/5.0, *SD* 0.949). For the second statement about the clarity of recommendations, 28.6% (*n* = 4) of respondents selected "strongly agree," 64.3% (*n* = 9) selected "agree," and 7.1% (*n* = 1) selected "disagree" (*M* 4.14/5.0, *SD* 0.77). In response to the third statement about the suitability of the assessment, 42.9% (*n* = 6) of respondents selected "strongly agree," 50% (*n* = 7) selected "agree," and 7.1% (*n* = 1) selected "disagree" (*M* 4.21/5.0, *SD* 1.05*)*.

The fourth statement about applicability to individual residents resulted in 42.9% (*n* = 6) of participants selecting "strongly agree," 50% (*n* = 7) selecting "agree," and 7.1% (*n* = 1) selecting "neither agree nor disagree" (*M* 4.357/5.0, *S*D 0.63). The fifth statement about more benefit than harm for residents resulted in 50% (*n* = 7) of respondents selecting "strongly agree," 42.9% (*n* = 6) selecting "agree," and 7.1% (*n* = 1) selecting "neither agree nor disagree" (*M* 4.428/5.0, *SD* 0.646). The sixth statement inquiring about the acceptability of the assessments' options resulted in 28.6% (*n* = 4) of respondents selecting "strongly agree," 57.1% (*n* = 8) selecting "agree," 7.1% (*n* = 1) selecting "neither agree nor disagree," and 7.1% (*n* = 1) selecting "strongly disagree" (*M* 4.0/5.0, *SD* 1.037). The seventh statement questioned about the work burden in their organization, 21.4% (*n* = 3) of respondents selected "strongly agree," 50% (*n* = 7) selected “agree,” 21.4% (*n* = 3) selected “neither agree nor disagree,” and 7.1% (*n* = 1) selected “disagree” (*M* 3.857/5.0, *SD* 0.86). For the eighth statement regarding feasibility in the long-term care setting, 35.7% (*n* = 5) respondents selected “strongly agree,” 50% (*n* = 7) selected “agree,” 7.1% (*n* = 1) selected “neither agree nor disagree,” and 7.1% (*n* = 1) selected “disagree” (*M* 4.14/5.0, *SD* 0.86).

The ninth statement about colleague support resulted in, 35.7% (*n* = 5) of respondents selecting “strongly agree,” 42.9% (*n* = 6) selecting “agree,” 14.3% (*n* = 2) selecting “neither agree nor disagree,” and 7.1% (*n* = 1) selecting “strongly disagree” (*M* 4.0/5.0, *SD* 1.109). The tenth statement considered the expected effects on outcomes, 28.6% (*n* = 4) of respondents selected “strongly agree,” 64.3% (*n* = 9) selected “agree,” and 7.1% (*n* = 1) selected “neither agree nor disagree” (*M* 4.2/5.0, *SD* 0.5789). The eleventh statement inquired about the effectiveness of the new approach with 21.4% (*n* = 3) of respondents responding “strongly agree,” 64.3% (*n* = 9) selecting “agree,” 7.1% (*n* = 1) selecting “neither agree nor disagree,” and 7.1% (*n* = 1) selecting “disagree” (*M* 4.0/5.0, *SD* 0.78). The project leader independently chose for “neither agree nor disagree” to be a response to the MPFQ (Hansen, 2019). To gain understanding of staff responses the project leader asked staff if they had selected “neither agree nor disagree” and if so to qualify that answer. Many nurses and nursing assistants stated they were unsure of the previous process in place to assess resident spirituality and mental wellbeing and therefore could not speak to if the new care process was more effective.

To distinguish variances in responses, the project leader further assessed the MPFQ by organizing survey responses by profession (Hansen, 2019; see Table 3). Nurses (LPNs and RNs) average survey score was 46.57/55 (84.7%). Nursing assistants survey mean was 48.7/55 (88.5%). The geriatrician’s average survey score was 47/55 (85.5%) and the APRNs score was

45/55 (81.8%). Lastly, the social workers score was 26/55 (47.3%). The cycle three summative percentage of usability of the new care process for all respondents was 82.7%, meeting and surpassing the established SMART goal of staff rating acceptability and useability of the care process at 80% by cycle three.

Table 3

Cycle Three Aggregate MPFQ Scores Per Discipline

Discipline	*n*	M	%
Geriatricians	2	47/55	85.5%
APRN	1	45/55	81.8%
Nurses (RN, LPN)	7	46.6/55	84.7%
Nursing assistants	3	48.6/55	88.5%
Social worker	1	26/55	47.3%

Rate of satisfaction with value-based care was calculated as previously described in cycle one and two data analysis sections. During cycle three, 11 residents were able to complete the resident and family satisfaction survey. In response to, "*Do you believe your healthcare team assesses for and considers your culture and spirituality during your care?*" 36.4% (*n* = 4) of residents reported being satisfied that their culture and spirituality was evaluated. In opposition, 63.6% (*n* = 7) of residents reported being dissatisfied with their cultural and spirituality assessment. Next residents were asked to respond to, "*Do you believe your healthcare team assesses for and considers your mental wellbeing during your care?*". In response, 72.7% (*n* = 8) of residents reported being satisfied with the assessment and consideration of their mental wellbeing. However, 27.3% (*n* = 3) of residents were dissatisfied with the assessment and consideration of their mental wellbeing.

Percentage of change in resident satisfaction with mental wellbeing assessment was calculated between cycle one and cycle three. There was a 14.3% positive percentage of change in resident satisfaction with mental wellbeing assessment and consideration from cycle one to cycle three. Once again, this exceeded the SMART goal of having 10% positive percentage of change in resident satisfaction with value assessment and consideration by cycle three.

Open responses to the cycle three resident and family satisfaction survey were assessed. Cycle three responses contained similar open response topics to the previous two cycles: some staff members were better at assessing value-based needs than others and staff did not always provide time to discuss these topics. One resident reported that they felt mental wellbeing assessments had improved in the last few weeks.

With the modification of the project leader calling resident family members, the response rate for cycle three remained the same as cycle two (*n* = 2). Given the low response rate, analysis was not warranted and was omitted.

Rate of provider implementation of the care process change was calculated for cycle three as previously described in cycle two data analysis. Out of 18 residents in the pilot section, 44.4% (*n* = 8) had been administered the SWEMWBS by providers (Tennant et al., 2007). The implementing team members exceeded the SMART goal of performing the care process change with 30% of residents in the pilot section by cycle three. In addition to previous analysis, the percent of change for provider implementation of the practice change between cycle two and three was analyzed. The dichotomous answers ([0 for not present] and [1 for present]) in chart reviews were used for percentage of change calculations (new number minus base number divided by base number which was then multiplied by 100 for the percentage of practice change). Between cycle two and three, providers demonstrated a 166.7% positive percentage of change in administration of the care process change.

For cycle three, providers were asked to provide feedback regarding the care process change. The geriatricians and APRN did not see any necessary changes to the care process. The provides reiterated positive feedback regarding the SWEMWBS, including that it was comprehensive and easy to use (Tennant, 2007).

Phase Three "Act"

The facility adopted the practice change, utilizing the SWEMWBS to assess resident mental wellbeing upon admission and as needed (Tennant et al., 2007). Meeting with families on care plan meeting days and calling family members produced the same number of family member responses to the resident and family satisfaction survey. The project leader recommended the facility continue discussing family satisfaction with culturally congruent care on the day of, or during, care plan meetings as this provided the most contact with families throughout the project. For the purposes of this project, satisfaction surveys were printed and distributed to families. Moving forward, feedback regarding value-based care could be conversation based instead of families needing to return a physical survey. The facility can perform further PDSA cycles to maintain this care process improvement.

Global Analysis/Discussion

The project leader conducted the data analysis using Excel. MPFQ forms for the first cycle were collected using Microsoft Forms and exported to Excel while paper MPFQ surveys from cycles two and three were manually entered into Excel (Hansen, 2019).

The SMART goal that resident’s and their designated families would report improved perceived value-based care by 10% by eight weeks or upon discharge was met and surpassed. Cycle two demonstrated a 28.5% percent of positive change in resident satisfaction from cycle one, while cycle three demonstrated a 14.3% positive percentage of change in resident satisfaction from cycle one. The percentage of change between cycle one and three was still acceptable, but it was a significant decrease compared to the percentage of change seen between cycle one and two. Residents were lost to follow up in cycles two and three and the sample size was reduced from cycle one (*n* = 15) to cycle three (*n* = 11). The percentage of change variance was not due to the care process change but rather the reduction in resident sample size: this could not be prevented, over the course of the QI project seven residents declined or died and only two residents that were able to participate in the project were admitted. Along with resident satisfaction, the project attempted to assess resident family satisfaction perceived symptom management through value-based assessments. However, this skilled nursing facility is similar to others in that family engagement is limited until there is a crisis, given that there were no crises throughout this project family involvement was minimal. In addition, family involvement was not possible for all residents as many residents reported having no family and others were wards of the state.

Staff feedback throughout the cycles utilizing the MPFQ was critical to the integration of the new care process (Hansen, 2019). The SMART goal that facility interprofessional staff would rate acceptability and useability of the care process change at or greater than 80% within eight weeks was surpassed: Cycle one 81.4%, cycle two 79.3%, and cycle three 82.7% respectively. Staff response to the care process change was positive and exceeded the AGREE II benchmark of 70%, indicating the change was not only practical for the facility's workflow, but the staff also perceived it as valuable for resident-centered care (Agreetrust, 2017).

Despite the high acceptability and useability from staff, the project leader independently chose to provide a "neither agree nor disagree" option to statements on the MPFQ (Hansen, 2019). This limited the project leader's interpretation of staff perceptions regarding the care process. To better understand responses, staff were asked if they had used that response on the questionnaire and to qualify that response. Many nurses and nursing assistants reported they concurred with to the new care process and their ambiguous answers were related to lack of understanding of the previous care process used by the providers to assess resident culture, spirituality, and mental wellbeing. The APRN and social worker reported all implementing providers may not accept the assessments due to time constraints and resistance to change. An example of resistance to change was seen when the social worker reported the FICA was a duplication of work and took too long to administer (Puchalski & Romer, 2000). The social worker was initially engaged in the project, but when residents began expanding upon their answers to the FICA, the social worker reported that information gathering was inefficient. The social workers admission assessments inquire if residents are religious and, if so, what religion they observe. The assessments do not assess culture or give open response space to capture nuisances in resident beliefs not encapsulated solely through religious faith. The FICA accounts for resident culture and allows the resident to describe spiritual values in their own words (Puchalski & Romer, 2000). Allowing residents to speak freely through open-ended questions facilitates value-based care discussions and allows residents to expand upon the unique facets of their beliefs and values, as culture and spirituality cannot be standardized. It was unfortunate that the social worker felt time constraints related to the residents sharing their values, however resident mental wellbeing assessments were accepted and were adopted. Time constraints and resistance to change are global problems seen in health care settings; the project leader demonstrated the facility’s ability to successfully implement the SWEMWBS care process change through formal adoption into their existing workflow. In addition, this updated care process optimized the providers workflow intent.

The final SMART goal was that the providers would integrate the care process change into their workflows with 10% compliance by cycle two and 30% compliance at cycle three. Providers surpassed this goal as the rate of administration of the SWEMWBS was 15% ($n = 3$) for cycle two and 44.4% ($n = 8$) at cycle three (Tennant et al., 2007). In addition, positive percentage of change in provider administration of the SWEMWBS was 166.7% between cycle two and three (Tennant et al., 2007). Surpassing the implementation rate goals, providers established the SWEMWBS is feasible for mental wellbeing assessments in the long-term care setting (Tennant et al., 2007). Throughout the cycles, the providers reported several positive comments about the SWEMWBS: it was comprehensive, the language of the tool seemed geared towards geriatric populations—the questions were digestible and relevant for the intended audience—and the tool opened genuine conversation with residents (Tennant et al., 2007). These statements promote that the SWEMWBS was conducive to the providers standard of care and promoted well rounded value-based discussions.

Facilitators for Data Analysis

The primary facilitator identified for data analysis was utilizing Microsoft Forms and its ability to interface with Excel, allowing for continuity. The project leader learned how to write formulas in Excel for all the data results calculations with the project chair’s guidance, which will be more valuable and feasible in future practice and QI projects.

Barriers to Data Analysis

Low response rates to the family satisfaction survey were observed throughout the cycles, therefore analysis could not be performed. When staff members were asked to report their profession, at times RN's and LPN's would simply write in "nurse". This prevented the two professions from being analyzed separately when their distinctly different roles and education would permit separate analysis. LPNs are trained to be task oriented, and their education enables them to carry out provider orders to meet resident needs (National Council of State Boards of Nursing [NCSBN], 2023). This differs from the conceptual and critical thinking education RNs receive, enabling them to provide comprehensive care in addition to performing resident care tasks (NCSBN, 2023). Lastly, by providing the option "neither agree nor disagree" for MPFQ surveys, staff members were not made to pick a stance on the statements, but rather they could be ambiguous and noncommittal (Hansen, 2019). This led to the project leader seeking staff input through summative comments to better understand their rational for selecting "neither agree nor disagree".

Interpretation of Findings

This quality improvement project fulfilled residents' expressed need for their health care providers to know and understand their beliefs, values, and cultural preferences with incorporation into an individualized care plan. This project also flipped the script for residents that were wards of state and unaccustomed to having a say in their care by giving them space and time to discuss their value-based needs. Throughout this project, residents expressed the desire to communicate their personal values with staff, wanted the staff to give the time and opportunity to make their values known and did not want to feel rushed in this process. These statements highlight current evidence that open communication between providers and residents provides insight into resident values as well as inspire a trust between both parties (Dobrina et al., 2018; Gonella et al., 2019; Gonella et al., 2020a, 2020b; Quigley et al., 2020). The SWEMWBS helped accomplish this by providing space for resident mental wellbeing discussions and giving residents time to be reflective and open with the care team at their discretion (Tennant et al., 2007).

The new care process change was accepted by the skilled nursing facility staff (82.7%) and exceeded the AGREE II established benchmark (70%; AgreeTrust, 2017). By integrating a standardized, evidence-based assessment tool into care processes, the interprofessional team better met all residents’ value-based needs, inclusive of mental wellbeing needs. This project is sustainable for providers as it was incorporated into their existing workflow to streamline their care and reduce wasteful care interventions not in alignment with resident needs.

Implications for Practice

This project demonstrated that the SWEMWBS assessment improved resident satisfaction with perceived value-based symptom management (Tennant et al., 2007). The SWEMWBS also met the providers need for a consistent tool to assess resident mental wellbeing to promote value-based care (Tennant et al., 2007). This project would easily be implemented in any size long-term care facility to improve resident-centered care. Long-term care staff are crucial in engaging residents in discussions about their values and beliefs. This quality improvement project demonstrated that ethnocentric and spirituality-based conversations respect residents’ needs, honor their autonomy, and increase their perceived quality of life and palliative care.

Limitations

Staff response rate to the feedback questionnaire increased throughout the cycles: however, sample sizes remained relatively small based on the size of the chosen pilot facility section (cycle one *n* = 8, cycle two *n* = 14, cycle three *n* = 14). The project leader did not request nurses to identify themselves as LPNs or RNs, thus limiting understanding of the individual profession's responses. A decrease was seen in the number of residents able to participate in the satisfaction surveys throughout the eight weeks (cycle one *n* = 15, cycle two *n* = 13, cycle three *n* = 11). This could not be helped, as residents' health declined, or they died they were lost to follow up in cycles two and three; the reduction of sample size did impact the percentage of change evaluations. Although this project had positive outcomes, project implementation in this facility, and future facilities, will consistently see engrained culture as a barrier. The project leader had to adjust the care process to adapt to care team resistance. In future projects, the project leader should assess the care facility's culture and goals to inform the project's implementation.

Suggested Next Steps

The suggested next steps include the care facility continuing to administer the SWEMWBS as well as other care facilities utilizing this assessment for improved resident perception of value-based care (Tennant et al., 2007). This project was presented at the Southern Ohio Northern Kentucky (SONK) Consortium to disseminate its findings. Following the completion and presentation of this project's manuscript, this work will be submitted to a scholarly journal for publication and further dissemination of this work in collaboration with the project committee.

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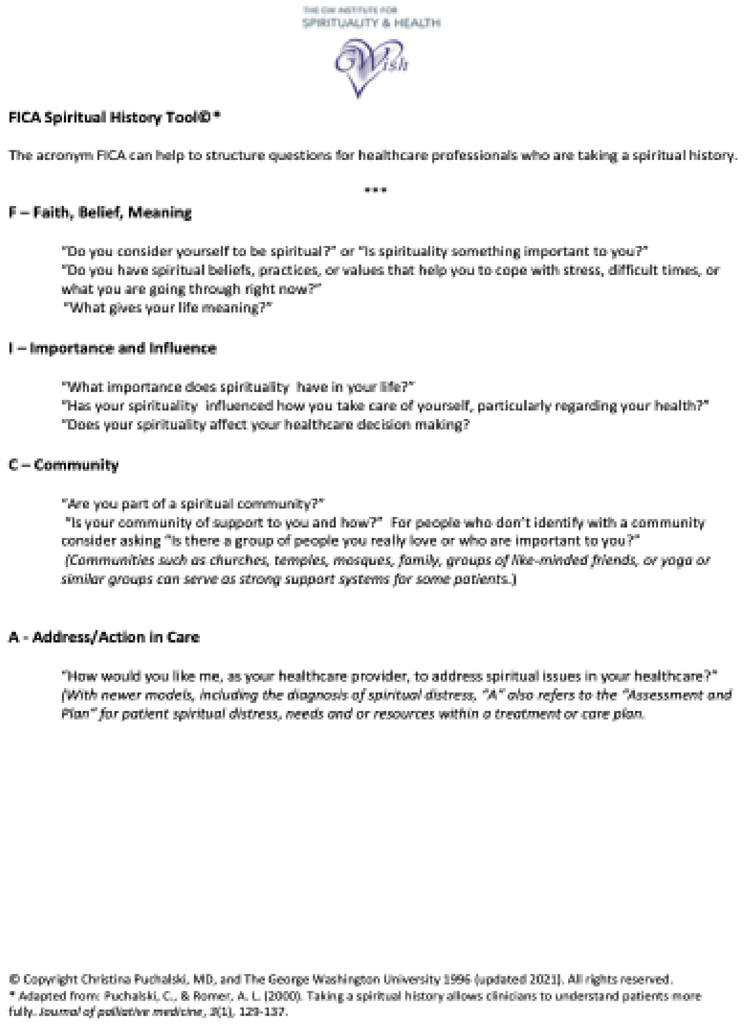
Appendix A

FICA Spiritual History Tool



THE GW INSTITUTE FOR SPIRITUALITY & HEALTH

GWish

FICA Spiritual History Tool© *

The acronym FICA can help to structure questions for healthcare professionals who are taking a spiritual history.

***

F – Faith, Belief, Meaning

"Do you consider yourself to be spiritual?" or "Is spirituality something important to you?"
"Do you have spiritual beliefs, practices, or values that help you to cope with stress, difficult times, or what you are going through right now?"
"What gives your life meaning?"

I – Importance and Influence

"What importance does spirituality have in your life?"
"Has your spirituality influenced how you take care of yourself, particularly regarding your health?"
"Does your spirituality affect your healthcare decision making?

C – Community

"Are you part of a spiritual community?"
"Is your community of support to you and how?" For people who don't identify with a community consider asking "Is there a group of people you really love or who are important to you?"
(Communities such as churches, temples, mosques, family, groups of like-minded friends, or yoga or similar groups can serve as strong support systems for some patients.)

A - Address/Action in Care

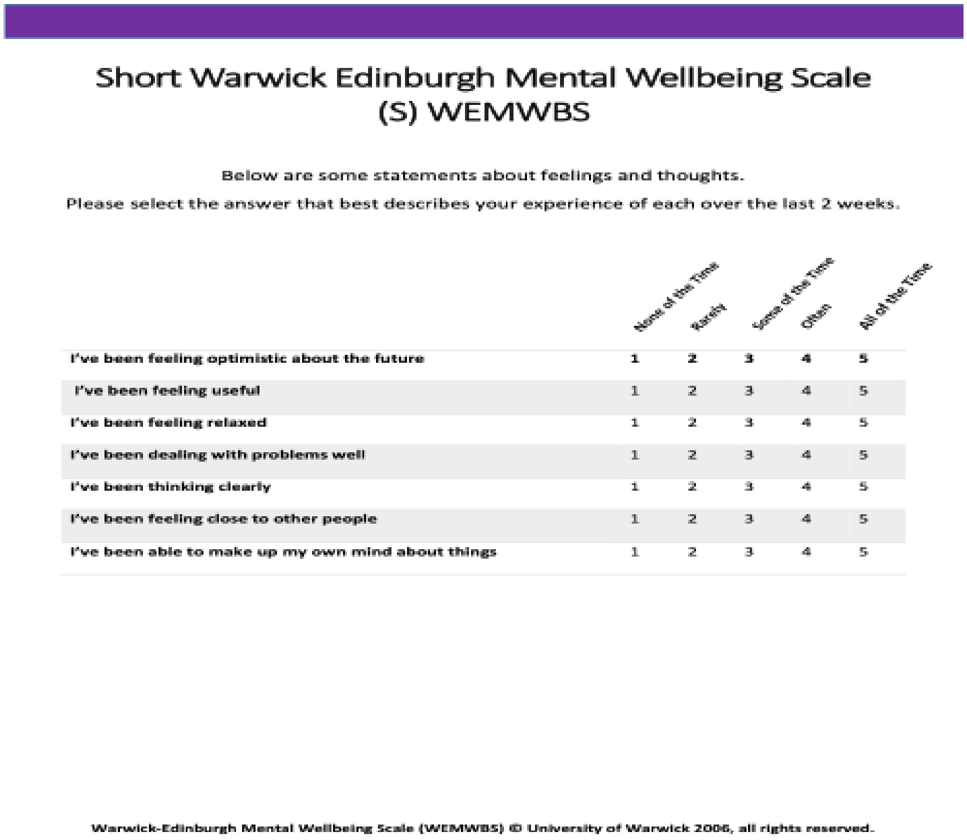
"How would you like me, as your healthcare provider, to address spiritual issues in your healthcare?"
(With newer models, including the diagnosis of spiritual distress, "A" also refers to the "Assessment and Plan" for patient spiritual distress, needs and or resources within a treatment or care plan.

* Adapted from: Puchalski, C., & Romer, A. L. (2000). Taking a spiritual history allows clinicians to understand patients more fully. *Journal of palliative medicine*, *3*(1), 129-137.

The FICA Spiritual History Tool is composed of 11 questions spread over four domains to address multiple facets of spirituality. This tool guides the health care teams understanding of resident culture and spirituality; the FICA Spiritual Assessment Tool should be administered to residents during admission or during follow-up visits, as appropriate. After administering the FICA Spiritual Assessment Tool, health care providers can identify spiritual issues and make appropriate referrals spiritual care providers (Harrington et al., 2023; Puchalski & Romer, 2000).

Appendix B

Short Warwick-Edinburgh Mental Wellbeing Scale



Short Warwick Edinburgh Mental Wellbeing Scale
(S) WEMWBS

Below are some statements about feelings and thoughts.
Please select the answer that best describes your experience of each over the last 2 weeks.

	None of the Time	Rarely	Some of the Time	Often	All of the Time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

The SWEMWBS is a shortened mental wellbeing assessment utilizing a seven-item scale adapted from the original, 14-item mental wellbeing scale. The SWEMWBS should be performed upon admission and as needed to guide the healthcare team in determining the resident's current state of mental health (Harrington et al., 2023). Score ranges and classification are as follows: 17 or less indicates probable depression or anxiety, 18-20 suggests possible depression or anxiety, 21-27 advises average mental wellbeing, and 28 and above supports high mental wellbeing (Fat et al., 2016). Based upon identified needs, appropriate referrals should be made to support services that promote resident mental wellbeing including but not limited to social services, therapists, financial resources, and spiritual advisors (Fat et al., 2016; Harrington et al., 2023).

Appendix C

Resident and Family Satisfaction Survey

Resident and Family Satisfaction Survey

1. Do you believe your healthcare team assesses for and considers your spirituality and culture during your care? Explain:

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2. Do you believe your healthcare team assesses for and considers your mental wellbeing during your care? Explain:

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Appendix D

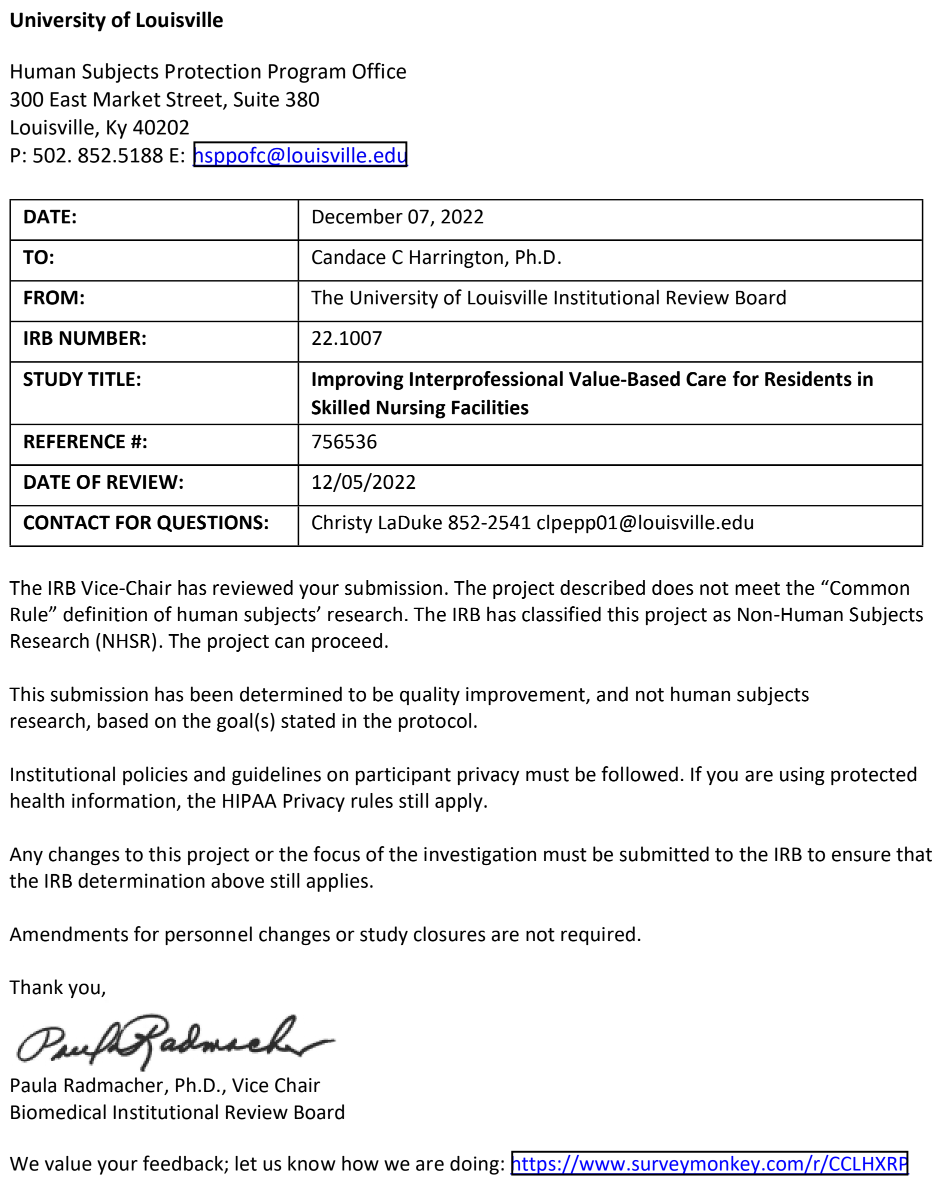
Modified Practitioner Feedback Questionnaire

Modified Practitioner Feedback Questionnaire

Questions	Neither Agree nor Disagree	Strongly Agree	Agree	Disagree	Strongly Disagree
What is your role at the nursing facility?					
There is a need for assessments on this topic.					
The assessment's recommendations are clear.					
The assessments are suitable for the residents for whom they are intended.					
The assessments apply to individual residents.					
When applied, the assessments will produce more benefits for residents than harm.					
The assessments present options that will be acceptable to residents.					
Application of the assessments will require reorganization of services/care in my practice setting.					
The assessments are feasible in the long-term care environment.					
The assessments are likely to be supported by a majority of my colleagues.					
If I follow the assessment recommendations, the expected effects on resident outcomes will be obvious					
The assessments reflect a more effective approach for improving resident outcomes than is current usual practice. (If they are the same as current practice, please check N/A)					

Appendix E

IRB Approval Letter



University of Louisville

Human Subjects Protection Program Office
300 East Market Street, Suite 380
Louisville, Ky 40202
P: 502. 852.5188 E: hsppofc@louisville.edu

DATE:	December 07, 2022
TO:	Candace C Harrington, Ph.D.
FROM:	The University of Louisville Institutional Review Board
IRB NUMBER:	22.1007
STUDY TITLE:	**Improving Interprofessional Value-Based Care for Residents in Skilled Nursing Facilities**
REFERENCE #:	756536
DATE OF REVIEW:	12/05/2022
CONTACT FOR QUESTIONS:	Christy LaDuke 852-2541 clpepp01@louisville.edu

The IRB Vice-Chair has reviewed your submission. The project described does not meet the “Common Rule” definition of human subjects’ research. The IRB has classified this project as Non-Human Subjects Research (NHSR). The project can proceed.

This submission has been determined to be quality improvement, and not human subjects research, based on the goal(s) stated in the protocol.

Institutional policies and guidelines on participant privacy must be followed. If you are using protected health information, the HIPAA Privacy rules still apply.

Any changes to this project or the focus of the investigation must be submitted to the IRB to ensure that the IRB determination above still applies.

Amendments for personnel changes or study closures are not required.

Thank you,

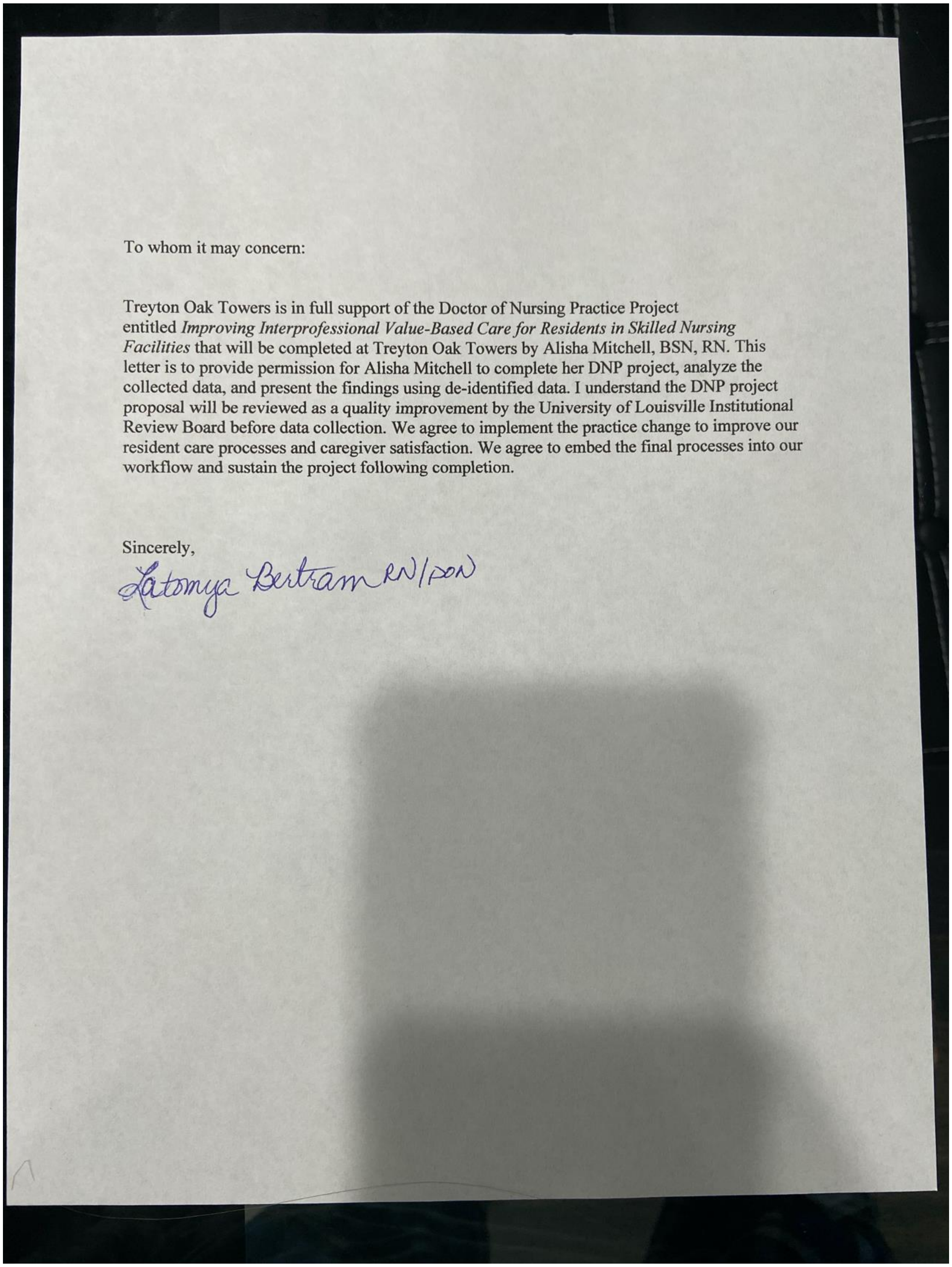
Paula Radmacher

Paula Radmacher, Ph.D., Vice Chair
Biomedical Institutional Review Board

We value your feedback; let us know how we are doing: https://www.surveymonkey.com/r/CCLHXRP

Appendix F

Letter of Support



To whom it may concern:

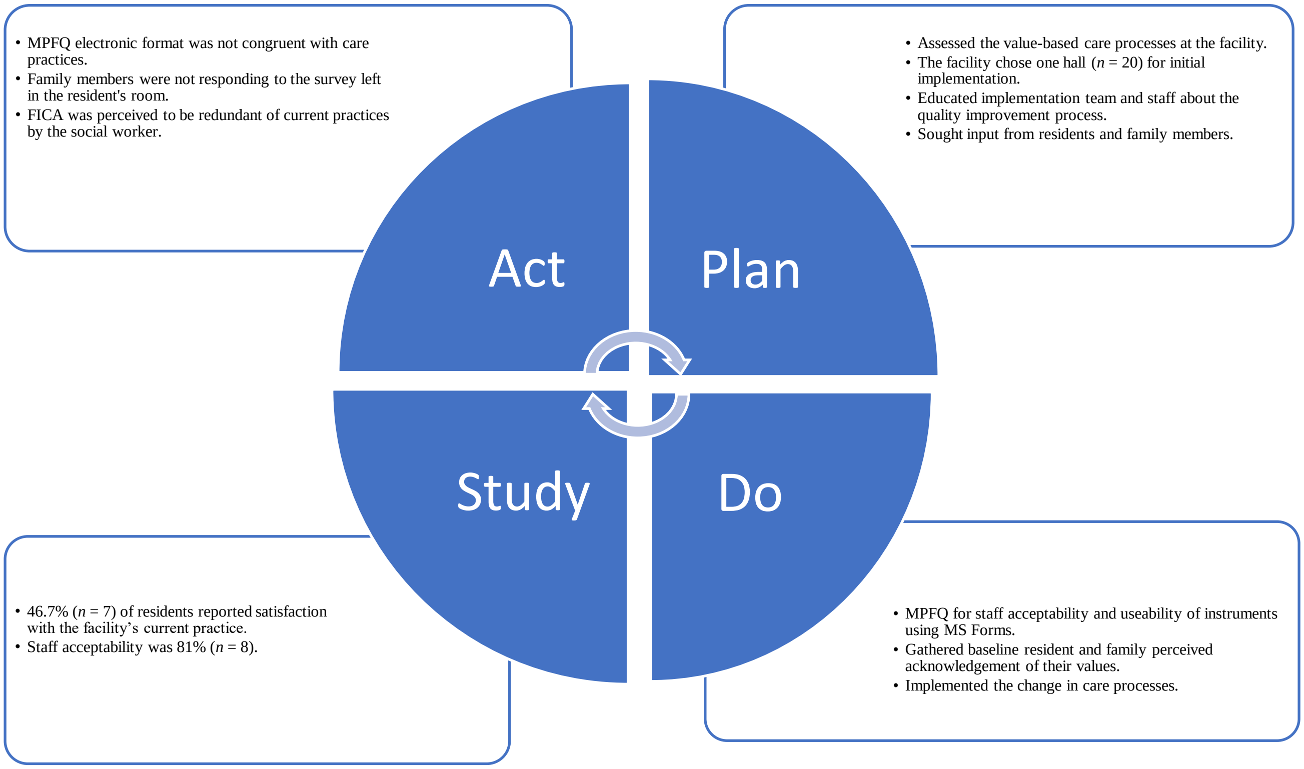
Treyton Oak Towers is in full support of the Doctor of Nursing Practice Project entitled *Improving Interprofessional Value-Based Care for Residents in Skilled Nursing Facilities* that will be completed at Treyton Oak Towers by Alisha Mitchell, BSN, RN. This letter is to provide permission for Alisha Mitchell to complete her DNP project, analyze the collected data, and present the findings using de-identified data. I understand the DNP project proposal will be reviewed as a quality improvement by the University of Louisville Institutional Review Board before data collection. We agree to implement the practice change to improve our resident care processes and caregiver satisfaction. We agree to embed the final processes into our workflow and sustain the project following completion.

Sincerely,

Latonya Bertram RN/DON

Appendix G.1

PDSA Cycle One



- MPFQ electronic format was not congruent with care practices.
- Family members were not responding to the survey left in the resident's room.
- FICA was perceived to be redundant of current practices by the social worker.

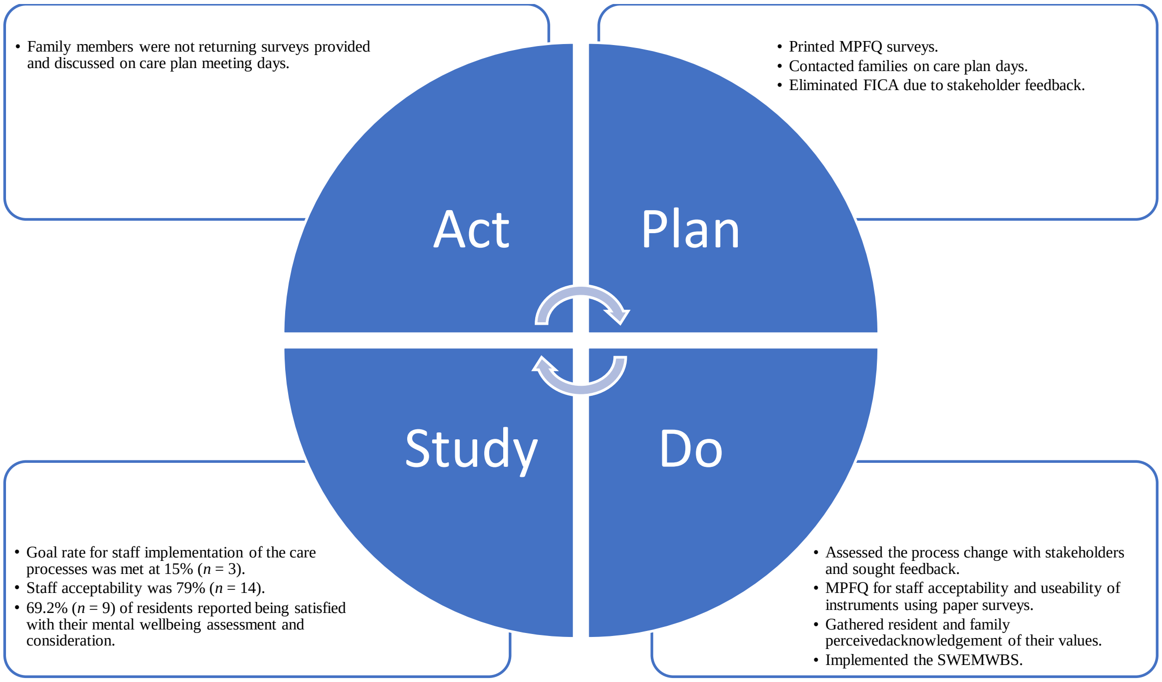
- Assessed the value-based care processes at the facility.
- The facility chose one hall (*n* = 20) for initial implementation.
- Educated implementation team and staff about the quality improvement process.
- Sought input from residents and family members.

- 46.7% (*n* = 7) of residents reported satisfaction with the facility's current practice.
- Staff acceptability was 81% (*n* = 8).

- MPFQ for staff acceptability and useability of instruments using MS Forms.
- Gathered baseline resident and family perceived acknowledgement of their values.
- Implemented the change in care processes.

Appendix G.2

PDSA Cycle Two



- Family members were not returning surveys provided and discussed on care plan meeting days.

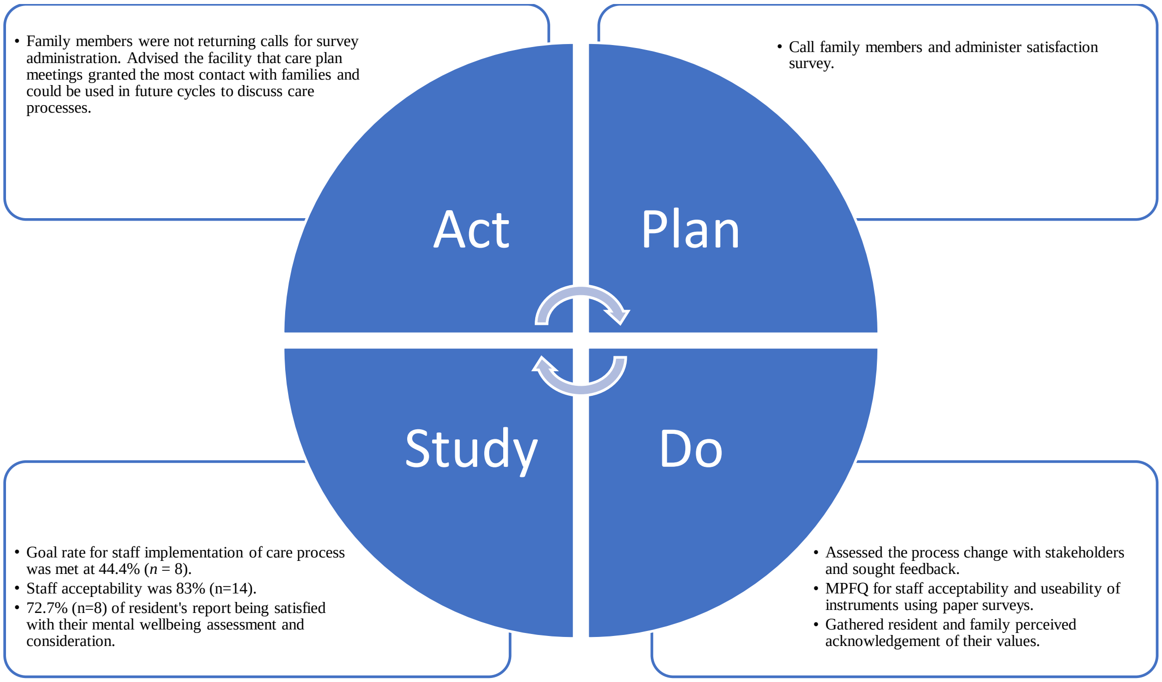
- Printed MPFQ surveys.
- Contacted families on care plan days.
- Eliminated FICA due to stakeholder feedback.

- Goal rate for staff implementation of the care processes was met at 15% (*n* = 3).
- Staff acceptability was 79% (*n* = 14).
- 69.2% (*n* = 9) of residents reported being satisfied with their mental wellbeing assessment and consideration.

- Assessed the process change with stakeholders and sought feedback.
- MPFQ for staff acceptability and useability of instruments using paper surveys.
- Gathered resident and family perceivedacknowledgement of their values.
- Implemented the SWEMWBS.

Appendix G.3

PDSA Cycle Three



- Family members were not returning calls for survey administration. Advised the facility that care plan meetings granted the most contact with families and could be used in future cycles to discuss care processes.

- Call family members and administer satisfaction survey.

- Goal rate for staff implementation of care process was met at 44.4% (*n* = 8).
- Staff acceptability was 83% (n=14).
- 72.7% (n=8) of resident's report being satisfied with their mental wellbeing assessment and consideration.

- Assessed the process change with stakeholders and sought feedback.
- MPFQ for staff acceptability and useability of instruments using paper surveys.
- Gathered resident and family perceived acknowledgement of their values.

Appendix H

MPFQ Response By Discipline

Cycle One Mean Scores Per Discipline

Statements	**Geriatricians (*n* = 2)**	**APRN (*n* = 1)**	**Nurses (*n* = 4)**	**Social Worker (*n* = 1)**
There is a need for assessments on this topic	5/5	5/5	4.5/5	1/5
The assessments recommendations are clear	5/5	5/5	4.25/5	4/5
The assessments are suitable for the residents for whom they are intended	4/5	5/5	4.25/5	2/5
The assessments apply to individual residents	4/5	5/5	4.5/5	4/5
When applied, the assessments will produce more benefits for residents than harm	4/5	5/5	4.25/5	3/5
The assessments present options that will be acceptable to residents	4/5	5/5	4.25/5	1/5
Application of the assessments will require reorganization of services/care in my practice setting	4/5	3/5	4/5	2/5
The assessments are feasible in the long-term care environment	4/5	4/5	4.25/5	4/5
The assessments are likely to be supported by a majority of my colleagues	4/5	3/5	4/5	3/5
If I follow the assessment recommendations, the expected effects on resident outcomes will be obvious	4/5	4/5	4.25/5	3/5
The assessments reflect a more effective approach for improving resident outcomes than is current usual practice (If they are the same as current practice, please check N/A)	3/5	3/5	4/5	2/5
Total Score	48/55 (87.2%)	47/55 (85.5%)	46.5/55 (84.6%)	29/55 (53%)

Strongly Agree (5), Agree (4), Neither Agree nor Disagree (3), Disagree (2) Strongly Disagree (1)

Cycle Two Mean Scores Per Discipline

Statements	**Geriatricians (*n* = 2)**	**APRN (*n* = 1)**	**Nurses (*n* = 6)**	**Nursing Assistants (*n* = 4)**	**Social Worker (*n* = 1)**
There is a need for assessments on this topic	4.5/5	4/5	4.2/5	4.25/5	1/5
The assessments recommendations are clear	4.5/5	4/5	3.8/5	4/5	4/5
The assessments are suitable for the residents for whom they are intended	4.5/5	4/5	3.8/5	4.5/5	2/5
The assessments apply to individual residents	4.5/5	4/5	3.6/5	4.25/5	4/5
When applied, the assessments will produce more benefits for residents than harm	4.5/5	5/5	3.6/5	4/5	3/5
The assessments present options that will be acceptable to residents	4.5/5	5/5	4/5	4.5/5	1/5
Application of the assessments will require reorganization of services/care in my practice setting	3.5/5	3/5	4/5	4/5	2/5
The assessments are feasible in the long-term care environment	4.5/5	4/5	3.4/5	4.25/5	4/5
The assessments are likely to be supported by a majority of my colleagues	4.5/5	3/5	3.8/5	3.75/5	3/5
If I follow the assessment recommendations, the expected effects on resident outcomes will be obvious	4.5/5	4/5	3.4/5	4/5	3/5
The assessments reflect a more effective approach for improving resident outcomes than is current usual practice (If they are the same as current practice, please check N/A)	3.5/5	3/5	4/5	3.5/5	2/5
Total Score	47.5/55 (86.5%)	43/55 (78%)	41.6/55 (75.6%)	45/55 (82%)	29/55 (53%)

Strongly Agree (5), Agree (4), Neither Agree nor Disagree (3), Disagree (2) Strongly Disagree (1)

Cycle Three Mean Scores Per Discipline

Statements	**Geriatricians (*n* = 2)**	**APRN (*n* = 1)**	**Nurses (*n* = 7)**	**Nursing Assistants (*n* = 3)**	**Social Worker (*n* = 1)**
There is a need for assessments on this topic	4.5/5	4/5	4.4/5	3.3/5	4/5
The assessments recommendations are clear	4.5/5	4/5	4.3/5	4.3/5	2/5
The assessments are suitable for the residents for whom they are intended	4.5/5	5/5	4.3/5	4.6/5	1/5
The assessments apply to individual residents	4.5/5	5/5	4.3/5	4.6/5	3/5
When applied, the assessments will produce more benefits for residents than harm	4.5/5	5/5	4.3/5	4.6/5	4/5
The assessments present options that will be acceptable to residents	4.5/5	4/5	4/5	4.6/5	1/5
Application of the assessments will require reorganization of services/care in my practice setting	3.5/5	3/5	4.1/5	4/5	3/5
The assessments are feasible in the long-term care environment	4.5/5	4/5	4.1/5	4.6/5	2/5
The assessments are likely to be supported by a majority of my colleagues	4/5	3/5	4.3/5	4.6/5	1/5
If I follow the assessment recommendations, the expected effects on resident outcomes will be obvious	4/5	4/5	4.3/5	4.6/5	3/5
The assessments reflect a more effective approach for improving resident outcomes than is current usual practice (If they are the same as current practice, please check N/A)	4/5	4/5	4.1/5	4.3/5	2/5
Total Score	47/55 (85.5%)	45/55 (81.8%)	46.6/55 (84.7%)	48.6/55 (88.5%)	26/55 (47.3%)

Strongly Agree (5), Agree (4), Neither Agree nor Disagree (3), Disagree (2), Strongly Disagree (1)