U.S. Department of Veterans Affairs

Public Access Author manuscript

Res Gerontol Nurs. Author manuscript; available in PMC 2018 May 01.

Published in final edited form as:

Res Gerontol Nurs. 2017 May 01; 10(3): 129–138. doi:10.3928/19404921-20170411-01.

Developing the Supporting Choice Observational Tool (SCOT):

A Formative Assessment Tool to Assist Nursing Home Staff in Realizing Resident Choice

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Abstract

Quality of care in nursing homes has begun to address the importance of resident choice in daily life, yet there are no published tools to teach nursing home staff how to offer such choice. In the current study, a formative assessment tool was developed that can provide staff with detailed and concrete feedback on how to realize resident choice. The tool was created and refined through 22 hours of ethnographic observation in two Veterans Health Administration Community Living Centers (CLCs), 22 hours of developmental testing in two CLCs, review by a modified Delphi panel, and use of an algorithm to assess its logical structure. The resulting Supporting Choice Observational Tool (SCOT) documents how choice is or is not offered and is or is not enabled within a singular staff–resident interaction. SCOT findings could be used in clinical teaching, quality improvement, or research efforts intent on enhancing nursing home resident quality of life.

The culture change movement in U.S. nursing homes has made notable strides over the past two decades. Culture change promotes person-centered care, which is believed to improve quality of nursing home care and resident quality of life more than traditional medical models (Zimmerman, Shier, & Saliba, 2014). Resident choice in daily life is a key

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The authors have disclosed no potential conflicts of interest, financial or otherwise.

The NIH-NIA had no role in the design and conduct of the study, data collection, management, analysis, and interpretation of data, or in preparation, review, or approval of the manuscript.

component of person-centered care (Rahman & Schnelle, 2008; White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009).

The need to promote resident choice in daily life has gained increasing recognition within the field of nursing home quality of care. The Minimum Data Set (MDS) 3.0 requires documentation of residents' self-reported preferences regarding personal care, sleeping habits, meals/snacks, and recreational activities. If such preferences are rated as important by the resident, then whether they are met is also captured in the MDS (Centers for Medicare & Medicaid Services, 2015). However, the actual care processes used by staff to promote resident choice are not well-characterized or documented (Schnelle et al., 2009; Schnelle, Osterweil, & Simmons, 2005).

Schnelle et al. (2009) made strides toward documenting whether nursing home resident choice is being realized by developing a standardized observational protocol. Intended for researchers, this protocol assesses direct care staff behaviors related to resident choice during four activities of routine morning care (i.e., transition from bedtime, toileting, dressing, and breakfast). Two categories are documented: (a) choice being offered and (b) choice being honored. Choice being offered is reported as *active*, *passive*, or *none*, and choice being honored is reported as *yes*, *no*, *don't know*, or *not applicable*. Simmons et al. (2011) further revised the protocol for use by nursing home supervisors; the revised protocol serves to capture the absence or presence of staff offering choice. In application, both protocols act as summative assessment tools that calculate rates of whether the observed behaviors were enacted (Schnelle et al., 2009; Schnelle et al., 2013; Simmons et al., 2011).

What is lacking in the literature and in practice is a formative assessment tool of resident choice. In contrast to summative assessment, formative assessment answers how behaviors were enacted rather than quantifying whether the behavior occurred. The formative assessment approach is particularly noted for its promise in sustained clinical learning (Epstein, 2007; Kogan, Holmboe, & Hauer, 2009) and internal quality improvement efforts (Andersen, Jensen, Lippert, Østergaard, & Klausen, 2010; Elwyn et al., 2010; Handfield-Jones et al., 2002; Hess, Jonston, Iobst, & Lipner, 2013).

The current study's purpose was to develop a formative assessment tool of how nursing home staff can promote resident choice in daily life. The work was grounded in Self-Determination Theory (Deci & Ryan, 1990), which emphasizes autonomy as a universal human need. Resident choice was conceptualized as a subset of Self-Determination Theory's concept of autonomy. Consonant with Kasser and Ryan's (1999) extension of Self-Determination Theory, the current study's tool examines how observed staff behaviors affect resident choice in daily life (a) directly by providing proactive support and (b) indirectly by influencing a resident's ability to actualize her/his own choices. Ethnographic observation was used in two Veterans Health Administration (VHA) Community Living Centers (CLCs) (i.e., nursing homes) to create the tool, developmental testing of the tool was conducted in two VHA CLCs, a modified Delphi panel was consulted to ascertain the tool's face and content validity, and an algorithm was developed on which to base the tool's structure.

METHOD

Institutional Review Board approval was obtained from VHA data collection sites and investigators' VHA affiliates and university affiliates as required. The project involved site visits to three nursing home facilities (i.e., CLC1, CLC2, and CLC3). CLC2 was visited twice whereas CLC1 and CLC3 were visited once, totaling four visits. Site visits lasted 5 days and were conducted over a period of 14 months. Researchers conducted ethnographic observation at CLC1's site visit and CLC2's first site visit, using the resulting data to iteratively derive and develop a preliminary draft of the tool. This tool went through developmental testing in CLC2's second site visit and CLC3's site visit—a process that has been performed in others' observational tool development (Daly et al., 2009). Modified Delphi panel consultation helped refine the tool and shed light on the instrument's face and content validity. An algorithm was then developed to finalize macro-level tool design (i.e., column structure and column sequencing).

Phase 1: Ethnographic Observations

Ethnographic observational data were gathered within one to two units at CLC1's site visit in July 2010 and CLC2's first site visit in January 2011. Facilities were chosen purposively as those in the process of planning or constructing homes based on the Green House Model, an innovative model of person-centered care in nursing homes. Based on an opportunistic sampling scheme, units that primarily served residents with dementia, short-stay and subacute care patients, and hospice patients were excluded. Observations were made in public areas of the chosen units; staff members of any occupation and residents in these areas were eligible for observation as long as their identity remained anonymous. However, most residents were male, as is characteristic of the Veterans Administration patient population.

Ethnographic observations primarily involved the first author (J.A.P.) observing activity opportunistically while standing in a stationary position. Observation occurred on weekdays, mostly during the day shift but also during evening and night shifts. Nursing home units were also sampled opportunistically, with the researcher shifting unit location based on activity level. Cursory research field notes were written immediately after each observation and subsequently updated in more detail.

Observations were structured using sensitizing concepts (i.e., concepts that help direct researchers' attention to emerging data relevant to their research questions) (Charmaz, 2006). These concepts were derived from other researchers' findings in qualitative work and survey. To identify areas of daily life, sensitizing concepts included the when, where, what, with whom, and how of (a) eating and drinking, (b) engaging in recreational activities, (c) socializing, (d) mobilizing (e.g., walking), and (e) receiving technical care (e.g., receiving medications) (Davies, Ellis, & Laker, 2000; Duncan-Myers & Huebner, 2000). To identify staff words and actions that promoted resident choice, sensitizing concepts included staff explaining reasoning for their decisions and soliciting feedback regarding their actions (Davies et al., 2000).

Field notes were reviewed iteratively using thematic coding; themes and recurring behavior patterns emerged inductively. This analytic process was conducted by the first author (i.e., the analyst) and facilitated by Microsoft Office Excel® software. The analyst wrote several analytic memos to clarify and focus the intent behind the coding. The coding process informed the researcher's subsequent drafting of a preliminary version of the observational tool and a basic codebook for tool use. Other team members (V.A.P., C.W.H.) reviewed the two drafted products and provided input to the analyst iteratively until consensus was reached.

Phase 2: Developmental Testing of the Preliminary Tool

The draft tool went through developmental testing at two sites: CLC2 during a second site visit (April 2011) and CLC3 (September 2011). The sampling method of nursing homes and their units replicated that of the ethnographic observation effort.

Phase 2's observation periods were sampled opportunistically, as in Phase 1. The researcher (J.A.P.) wrote summaries on the context of each observational period and on methodological questions that arose during or 2 to 3 days after the site visit. Coauthors (V.A.P., C.W.H.) reviewed the developmental testing results from this facility in iterative fashion and reached consensus on a new set of coding decision rules for the next developmental testing effort.

The research team analyzed field notes qualitatively in an iterative fashion. The analysis informed a set of decisions for the tool's conceptual development and a new version of the observational tool, based on those decisions, for modified Delphi panel review.

Phase 3: Modified Delphi Panel

A modified Delphi panel was implemented from October 2012 through March 2013 to solicit expert feedback in a methodical and consensus-building fashion. Use of the Delphi technique spans over 50 years of research (Donohoe & Needham, 2009). The approach has several key characteristics: panel members are consulted iteratively, panel members' responses are anonymous after each iterative round, the panel coordinator provides streamlined feedback on group responses to panel members, and the panel coordinator calculates the quantitative results of the amassed responses at the end of the full process (Landeta, 2006). The third step of the approach was modified for the current study to share feedback on group responses at one point in time only (i.e., in time for a panelist conference call meeting).

The targeted panel size was 10 members (Table 1). Panelist selection was designed to encapsulate breadth of expertise to maximize the synergistic effect of the combined panelists' opinions (Donohoe & Needham, 2009). Potential panelists met at least two of four non-mutually exclusive criteria related to areas of professional expertise (i.e., culture change or resident choice [$n = 6$], nursing home clinical work/caregiving [$n = 5$], staff training [$n = 4$], and nursing home observational tool development [$n = 3$]) were invited via e-mail. Panelists represented a variety of professions, including interdisciplinary clinical roles (i.e., nursing, dietary, and recreational therapy) and non-clinical roles (i.e., foundation director, surveyor, and training consultant). One half of panelists had professional affiliation with the VHA.

Gathering panelist feedback involved three online rating surveys and a conference call meeting. Researchers designed the rating surveys after multiple iterations of review. This survey design was based on a modified approach of the RAND/UCLA Appropriateness Method (Fitch et al., 2001), a standardized technique for measuring and amalgamating expert opinion. The first rating survey asked panelists to rate, along three separate 9-point Likert scales, the extent to which each category was *important*, *relevant*, or *usable* for training staff about supporting resident choice. The second rating survey asked panelists to score the response options for each category on how clear the response options were and whether the response options were comprehensive and distinct from one another. A 9-point Likert scale was used for the clarity criterion. A binary *yes/no* selection was requested for the comprehensive and distinct criteria. One researcher (J.A.P.) led a 2-hour modified Delphi panel meeting via phone after the second rating survey. Seven of 10 panelists were present. Prior to the meeting, panelists received information containing their own and other panelists' aggregated responses from the first two rating surveys. A third rating survey asked panelists to respond to the same questions posed in the second rating survey, but for only those categories and response options revised during the panelist meeting.

The RAND/UCLA Appropriateness Method (Fitch et al., 2001) was remodeled again to analyze rating survey data. The median value of panelists' aggregated responses in the first two rating surveys, combined with the dispersion of these responses, determined what would be done with each survey item. The binary *yes/no* questions in the second and third rating surveys were also assessed. Response options from the second rating survey were discussed during the panelist meeting and re-assessed in the third rating survey if <80% of panelists ranked the item as comprehensive or distinct and/or substantive comments, questions, or suggestions were raised in the openended comment sections. Table 2 presents the key changes to the tool that resulted from panelist input. Decisions were made on how to resolve any remaining concerns (after completion of the third rating survey) based on using an algorithmic decision tool or research team judgment.

Phase 4: Algorithm

Algorithms are used frequently in medical decision making. This methodology often uses flowcharts to guide binary decisions throughout the decision-making process. An algorithm was developed for the current study to serve two purposes. First, it was applied iteratively after the modified Delphi panel process to assist in final stages of tool development. This effort provided insight into the tool's structural consistencies and inconsistencies as well as its structural parallelisms or lack thereof, thus informing additional SCOT revisions. Second, the algorithm was intended to serve as a training aid for those first using the SCOT. The algorithm can assist novice readers in understanding the pathways that an unfolding choice situation between a staff member and resident may take.

RESULTS

After the SCOT's creation through ethnographic observation and developmental testing, a modified Delphi panel of 10 members, as well as an algorithm, served instrumentally in tool refinement. A visual image of the algorithm is available upon request of the current authors.

The SCOT guides observations of singular staff–resident interactions that involve daily life choices (Figure A, available in the online version of this article). It focuses on the following features of choice: in the moment, observable, frequent, and present or absent. In the moment choice about daily living constitutes choice about issues that are modifiable in the moment, such as with whom to have a meal that day; in contrast, it is not about choices that are long-term decisions, such as roommate selection. Observable choice about daily living entails staff and resident behaviors surrounding choice that can be described by an outside observer; the SCOT cannot and does not try to determine the internal motivations or feelings of the staff member being observed. Frequent choice refers to the likelihood that a particular area of choice would arise on a daily basis (e.g., when to eat could potentially occur a few times per day, whereas whether to go on an outing to the mall would not). Choice does not necessarily have to be present to be documented. The SCOT also documents the absence of choice when choice could have been offered or enabled but was not.

The SCOT

The SCOT comprises nine categories. Each category exists within a column, and each column is labeled with a letter proceeding in alphabetical order from left to right. The categories also precede from left to right in the temporal order of how they are observed. Column A *Area of Daily Life* with Column B *Type of Choice* as combined represent the choice situation. Columns C through E are grouped under the heading *Staff Offers a Choice?* Column F presents the *Resident Accepts Offering of Choice?* within the choice situation. The last three columns, G through I, fall under the heading *Staff Enables the Choice or Request?*

Choice Situation (Columns A & B)—The choice situation represents the SCOT’s unit of analysis, which is discerned by pairing a response option from Column A with a response option from Column B. For example, a choice situation could concern the “where” (a type of choice) of “meal/snacks/drinks” (an area of daily life) (i.e., where does the resident want to eat his/her breakfast?). Another example of a choice situation would be “how much” (a type of choice) seasoning the resident wants on his/her omelet (related to the “meals/snacks/drinks” area of daily life).

Column A presents those areas of daily life that allow for in the moment, observable, and frequent choice situations, and comprise “bathing/showering,” “connections/contacts to those outside the facility,” “grooming/dressing/toileting,” “health care,” “moving around the facility/positioning,” “meals/snacks/drinks,” “recreational activities/entertainment,” “sleeping habits,” and “temperature/noise/light.”

Column B narrows the choice situation by specifying its context. Does the area of daily life being observed relate to the “with whom,” “what,” “when,” “where,” “how,” “how much,” “how long,” “how often,” “whether or not,” or “which” of the choice being offered or enabled?

Staff Offers a Choice? (Columns C, D, and E)—This heading’s three columns describe staff behaviors when choice is or is not offered to residents. Column C, *Type of Communication*, delineates the communication type staff used in the choice situation (i.e.,

verbal communication such as declarative statements [e.g., “It’s time to have a shower.”], commands [e.g., “Come with me to have a shower now.”], questions [e.g., “Would you like to have a shower this morning or this evening?”], or non-verbal communication [e.g., beckoning to a resident to come to the shower room]). Any of these communication types can or cannot facilitate the offering of choice; the eventuality varies on the context and communicator’s intent. As a generality, some communication types can be more authentic in their offering of choice than others (e.g., open-ended questions versus commands).

Column D, *YES, Staff Offers a Choice*, highlights means by which a staff member may offer choice. First, there is the construct of “[the staff member] creates the possibility for choice?” Here the SCOT depicts to what extent the staff member initiated the choice situation independently or reacted to a pre-existing choice situation. The column then captures the order by which asking for a choice versus acting on the choice occurs (i.e., “asks once, acts after,” “asks repeatedly, acts after,” and “asks while already acting”).

The third column of this set, Column E (i.e., *NO, Staff Does Not Offer a Choice*), portrays staff behaviors associated with not offering a choice. These behaviors again include the ordering of asking about versus acting on a choice (i.e., “asks first, but acts before getting a response,” “acts first, asks after,” and “acts without ever asking”).

Resident Accepts Offering of Choice? (Column F)—This column reflects a juncture in the SCOT where the tool transitions from documenting a staff member offering choice to documenting a resident’s actions. Staff enabling choice follows temporally; it is predicated on the resident’s behavior. The resident’s behavior may be in response to the staff member’s initial offering of choice or to some other internal or external stimulus. The SCOT’s first two Column F options assume the resident is or is not responding to the staff member’s offering. Thus, Column F’s first three response options include: “resident accepts offering of choice,” “resident rejects offering of choice,” and “resident does not respond to offering of choice.” Alternatively, the resident’s behavior may be independent from staff behavior in that it is self-initiated, hence the existence of Column F’s fourth response option, “resident makes his/her own request without staff offering a choice.” Importantly, the remaining columns (G, H, and I) each have response options that could logically follow from any of the four potential resident roles in column F.

Staff Enables the Choice or Request? (Columns G, H, & I)—All of these columns represent a later set of staff behaviors in a choice situation: whether a staff member’s offered choice or a resident’s self-expressed request was enabled. Column G, *Type of Communication/Actions*, characterizes the manner in which the choice or request was or was not addressed (i.e., [staff member] “uses words only,” “uses actions only,” “uses both words and actions,” or “maintains the status quo”).

Column H, *YES, Staff Enables the Choice or Request*, underscores the means by which a staff member enables a choice or request. Does the staff member “act independently,” “coordinate with another staff member,” or “facilitate a resident’s own actions” by assisting the resident or not preventing the resident from acting?

The last column, Column I (i.e., *NO, Staff Does Not Enable the Choice or Request*), lists the behavioral markers present when a staff member does not enable a resident's choice or request. These markers comprise "explains why the choice or request is not enabled" (which a staff member may initiate or explain in response to the resident inquiring), "says the choice or request may not be enabled but does not explain why not," and "does not comment on the lack of enabling the choice or request."

DISCUSSION

To the current authors' knowledge, the SCOT is the first inductively derived tool for understanding staff behavior during resident choice opportunities. In use, the tool would be applied to observe staff-resident interactions opportunistically. The finalized SCOT documents how choice is or is not offered and enabled within a particular daily life area. The SCOT offers a potential teaching and quality improvement tool for VHA-specific nursing homes by sensitizing staff and leadership as to how to promote resident choice in daily life.

A number of valid and reliable person-centered care observational tools exist that, although not specifically designed to promote resident choice in daily life, may help promote resident choice indirectly. For example, the CARES Observational Tool (Gaugler, Hobday, & Savik, 2013) assesses the person-centeredness of staff interactions with residents with dementia. Relevant staff interactions include efforts to engage residents in their own care, ask how residents are doing, and explain ongoing activities or care (Gaugler et al., 2013). Dementia Care Mapping also uses observation to track behavioral indicators of person-centered care in individuals with dementia (e.g., behaviors indicating well-being or ill-being) and their formal caregivers (e.g., personal detractions) (Bradford Dementia Group, 1997). The Resident-Centered Assessment of Interactions with Staff and Engagement Tool also observes resident and staff behaviors, but for a more generalized population (i.e., residents who do not necessarily have dementia). Observations try to identify the quality and quantity of staff-resident interaction and resident engagement in meaningful activity (Snow et al., in press).

Like the SCOT, one set of pre-existing standardized observational protocols examines nursing home staff behaviors that promote resident choice in daily life in particular and does not focus on the dementia population (Schnelle et al., 2009; Simmons et al., 2011). However, the SCOT's development and purpose differ from this set of protocols. The developmental methodology used to design the set of protocols is not delineated in detail. Inductive research methods were used to develop the SCOT and these allowed measurable constructs to emerge directly from the collected ethnographic data. Inductive research methods led to pinpointing rich or deep measurable constructs. For example, Column A's "sleeping habits" was identified. Sleeping habits related to resident choice regarding when to wake up or go to bed, when to nap or doze, and whether to sleep with the lights or TV on or after a snack. As conceptualized, this choice domain has more depth than the typically conceived activity of bedtime (i.e., time of waking up or going to bed). The tool also assumes a different assessment methodology from Schnelle et al.'s (2009) and Simmons et al.'s (2011) set of protocols. The SCOT is a formative assessment tool that provides qualitative feedback to staff rather than a summative tool that provides scores.

The SCOT's formative approach offers a number of promising applications, including use as a tool for clinical teaching, quality improvement, or research. The formative educational approach has been mentioned in the literature only recently as being used with nursing home staff (Krichbaum, Kaas, Wyman, & Van Son, 2015). Its potential for encouraging deep and sustained learning lies in how it provides constructive input on the details of staff actions (the "how") (DiVall et al., 2014; Hettema et al., 2012). Accordingly, the SCOT operationalizes staff behaviors related to choice in-depth and identifies where breakdowns in promoting choice occur. The intent is to provide information to staff for awareness building and skill development, which could be achieved by a pair of clinical team members observing each other over several occasions and reviewing the findings in facilitated peer discussions or one-on-one consultations. The shared SCOT findings might illustrate to an observed staff member how he/she tends to use declarative statements in choice situations or comment on the lack of enabling a choice or request. The findings could also be used to engage a staff member in considering what has been learned about a resident's preferences by applying alternative choice-related practices.

The SCOT could help target areas for quality improvement. A debriefing guide would be a beneficial complement to the instrument toward such an aim. The guide would provide topics and methods for managers and staff to examine SCOT patterns and trends in their unit at large. Reviewing the guide could facilitate discussion and problem solving among team members. A guide could outline subjective issues surrounding the promotion of resident choice that are important but that cannot be documented with a structured observational protocol. With results in hand, staff could discuss when and how competing demands (e.g., already knowing resident preferences, medical care needs, staff convenience, and other residents' needs) influence the SCOT's findings; how optimal choice promotion varies with resident mix (e.g., for patients with dementia); how gender-based, generational, and cultural differences between staff and residents can affect choice promotion; and how to manage communication failures regarding choice between a staff member and resident.

Researchers, in turn, could use the SCOT to gain insight on patterns of choice-promoting behaviors by time and location. Studies using the SCOT could also lead to developing a typology of staff choice-promoting profiles, which could then be examined in light of such variables as staff position and job tenure or type of communication typically used.

LIMITATIONS

The current study's scope centered on the SCOT's development. Future work must test the psychometric properties of this tool within the VHA population and beyond. Assessing intra- and interrater reliability would mark an initial step in achieving this aim. It also cannot be claimed that the SCOT meets the needs of promoting choice for a varied resident mix. Validating the tool with different resident populations, such as with residents with moderate to severe dementia, is necessary to address this concern of generalizability.

The modified Delphi panelists also mentioned the need to meet a wide range of staff educational and literacy levels. Currently, the SCOT has not been assessed as to whether it is staff-friendly (i.e., understandable and usable by a variety of staff members). The tool could

benefit from review by end users via cognitive testing and field testing by nursing home staff members (U.S. Department of Veterans Affairs, 2014).

The current study's tool development process might have benefitted from ordering steps differently. An algorithm was used to structure the tool after the first two rating surveys and panelist conference call, and again after the third rating survey. Thus, some final decisions on tool content relied solely on the research team's judgment. For example, an overhaul of Columns H and I appeared necessary on using the algorithm, yet these final changes did not undergo modified Delphi panel review.

CONCLUSION

The SCOT was developed to serve as a formative assessment tool that uses structured observation. Its method of development highlights the strengths of inductive research, and its content and function resonate with culture change; its use would constitute ground-up versus top-down staff learning and internal quality improvement. On validation in VHA and non-VHA settings, the SCOT may prove an important tool for nursing home staff learning, quality improvement, and research initiatives that promote resident choice in daily life and thus quality of life.

Acknowledgments

This study was supported by U.S. Department of Veterans Affairs (VA) Health Services Research & Development Grant PPO #09-266. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the VA or U.S. Government. Dr. Mitchell is supported by NIH-NIA K24AG033640 and Dr. Palmer is supported by NIH-NIA T32AG023480.

The authors thank the modified Delphi panelists who served a critical role in this study's instrument development: Carolyn Blanks; Carmen Bowman, MHS, BSW; Linda Bump, RDLD, LNHA; Christine Chhor, LPN; Monika Fletcher, CNA; Sonne Lemke, PhD; Susan Misorski, BSN; Judy Skilton, ACC, CDP; Lynn Snow, PhD; and one other panelist whom could not be reached to obtain the permission to include his/her name in this publication.

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The Supporting Choice Observational Tool (SCOT)

[illegible]

FIGURE A. The Supporting Choice Observational Tool (SCOT)

Columns A & B = Choice Situation (i.e., the unit of analysis which is defined by the area of daily life and type of choice being observed)

Columns C & D & E = Staff Offers A Choice? (i.e., the staff member's behavior when choice is or is not offered to the resident)

Column F = Resident Accepts Offering Of Choice? (i.e., the resident's behavior in response to the staff member's initial offering of choice or in response to some other internal or external stimulus)

Columns G & H & I = Staff Enables The Choice Or Request? (i.e., the staff member's behavior when the offered choice or the resident's self-expressed request was or was not enabled)

TABLE 1Modified Delphi Panelists' Characteristics ($N = 10$)

Variable	<i>n</i>
Supporting Choice Observational Tool relevant expertise ^a	
Culture change or resident choice	6
Nursing home clinical work/caregiving	5
Staff training	4
Nursing home observational tool development	3
Nursing home–related professional experience	
Dietician	1
Foundation director	1
Nursing assistant	2
Licensed practical nurse	1
Recreational therapist	1
Research psychologist	2
Surveyor	1
Training consultant	1
Veterans Health Administration affiliation	
Yes	5
No	5

^aPanelist count does not total 10 because areas of expertise were not mutually exclusive.

TABLE 2

Key Changes to the Supporting Choice Observational Tool (SCOT) Based on Advisory Panel Input

Domain/Response Option	How Domain/Response Option was Changed	Rationale for Change
Area of Daily Life (domain)	Renamed (previously “Daily Living”)	Previous name did not refer clearly to the underlying construct.
Connections/Contacts (outside facility) (response option in the Area of Daily Life domain)	Added to the domain’s list of response options	Domain should incorporate this daily living component to support content validity.
Moving Around Facility/Positioning (response option in the Area of Daily Life domain)	“Facility” was added to the response option	Previous wording was unclear.
Health Care (nursing, medical, therapies) (response option in the Area of Daily Life domain)	Renamed (previously “Medical Care”)	Previous name did not capture treatment conducted by the full range of health care providers.
Type of Communication (domain)	Renamed (previously “Who, What, When, Where, How, etc.”)	Previous name did not refer clearly to the underlying construct.
Uses a Declarative Statement (response option in the Type of Communication domain)	“Declarative” was added to the response option	Previous response option was not clearly distinguishable from another response option named “Uses a Command.”
Uses a Question (“tag,” yes/no, and/or with two or more responses, open ended) (response option in the Type of Communication domain)	Reorganized to have sub-parts (previously each subpart was its own response option)	Reorganizing was needed to provide clearer organization of the different types of communication.
Yes, Staff Offers a Choice (domain)	Renamed (previously “Staff Behavior When Choice is Offered”)	“Behavior” was removed because it can connote negative judgment.
Asks in Anticipation of Events and Asks in Reaction to Events (two response options in the Yes, Staff Offers a Choice domain)	Removed from the domain’s list of response options	This set of contrasting response options is conceptually unclear and requires strong English literacy.
Asks for Active Choice and Asks for Passive Choice (two response options in the Yes, Staff Offers a Choice domain)	Removed from the domain’s list of response options	This set of contrasting response options can be construed as being value-laden and can already be captured by the “Type of Communication” response options.
No, Staff Does Not Offer a Choice (domain)	Renamed (previously “Staff Behavior When Choice is NOT Offered”)	“Behavior” was removed because it can connote negative judgment.
Suggests What to Do (response option in the No, Staff Does Not Offer a Choice domain)	Removed from the domain’s list of response options	The response option may overlap with other response options in this domain.
Tells What to Do (response option in the No, Staff Does Not Offer a Choice domain)	Removed from the domain’s list of response options	The response option may overlap with other response options in this domain.
Yes, Staff Does Enable the Choice or Request (domain)	Renamed (previously “Staff Behavior When There is Follow-Through on Choice”)	“Behavior” was removed because it can connote negative judgment.
Follows Through in the Moment (response option in the Yes, Staff Does Enable the Choice or Request)	Removed from the domain’s list of response options	The response option addressed events in the future, which are not observable in real-time.
Follows Through at a Later Time (response option in the Yes, Staff Does Enable the Choice or Request)	Removed from the domain’s list of response options	The response option addressed events in the future, which are not observable in real-time.
Follow-Through is Promised but Not Observed (response option in the Yes, Staff Does Enable the Choice or Request)	Removed from the domain’s list of response options	The response option addressed events in the future, which are not observable in real-time.
No, Staff Does Not Enable the Choice or Request (domain)	Renamed (previously “Staff Behavior When There is NO Follow-Through on Choice”)	“Behavior” was removed because it can connote negative judgment.