The NJ SEED Project: Evaluation of an Innovative Initiative for Ethics Training in Nursing Homes


Objectives: This article reports the results of an evaluation of the New Jersey Stein Ethics Education and Development (NJ SEED) project—a statewide initiative to create, organize and educate a statewide network of regional long-term care ethics committees. The main focus of the evaluation was to measure utilization of the committees, describe how facilities have benefited from the project, and identify potential barriers to the use of this resource.

Methods: Based on administrative records from the NJ SEED project, 225 facilities were identified and asked to complete a facility survey. Ninety-three surveys were received, resulting in a 41% response rate. An additional survey of the regional ethics committees (RECs), as well as several focus groups and individual interviews were conducted to supplement the survey data.

Results: Fifty-eight percent of the facility respondents reported current participation in an NJ regional ethics committee. About one third (30%) of participating facilities had requested a formal case consultation (on at least one occasion) on behalf of a resident, but two thirds had consulted with their RECs on a more informal basis. Facilities that reported participating in the REC Network were more likely to have formally written policies than nonparticipants.

Conclusions: Many NJ nursing homes find the statewide REC Network to be an important resource; however continued efforts need to be expended for recruiting and training facilities that are not taking full advantage of this important source of peer support and professional expertise. (J Am Med Dir Assoc 2005; 6: 68–75)

Medical directors and others who provide care to nursing home residents are regularly challenged by a myriad of ethical and legal dilemmas. Ethical issues that arise regularly in nursing homes include issues surrounding informed consent, assessment of decision-making capacity, confidentiality of records, the role of surrogate decision makers, resident rights, risk management, advance care planning, and decisions regarding life-sustaining treatments (tube feeding, CPR, hospitalization, antibiotic therapy, surgery, etc.). Additional concerns include the quality of end-of-life care, inadequate pain and symptom management, inappropriate prolongation of the dying process, lack of provider attentiveness to diverse religious and cultural traditions, institutional, policy and regulatory barriers to resident-centered care, and infringement on patient care preferences.

The need for ethics committees in long-term care is evident. While the number of ethics committees in nursing homes has increased over the past several decades, the idea of establishing a statewide systematically educated long-term care regional ethics committee network is an innovative concept.

The following article reports the results of an evaluation of the New Jersey Stein Ethics Education and Development (NJ SEED) project—the first statewide initiative to create, organize and educate a statewide network of regional long-term care ethics committees to serve New Jersey’s nursing homes and assisted living residences. This project sought to improve the quality of care provided to NJ nursing home residents by providing facility staff with access to skilled mechanisms for resolving ethical dilemmas. To date, New Jersey is the only state to have such a statewide initiative in place.

THE HISTORY OF NJ SEED

Growing concern about the ethical climate for decision making in long-term care settings led to passage in 1992 of the New Jersey Advance Directives for Health Care Act. Under this legislation, nursing homes were called upon to confront issues related to autonomy, self-determination, and the complex role of a designated proxy in healthcare decision making.
Simultaneously, in 1992 the New Jersey Association of Health Care Facilities (NJAHCF) recognized the need for ethics education of its members and sponsored a pilot initiative to develop skilled ethics committees in nursing homes. The association (which is the primary representative of the “for profit” nursing home industry) recognized the need for intensive education regarding advance directives, their interpretation, and relevant case law. Balancing autonomy, justice, and beneficence (the art of bioethics) was problematic for many nursing homes that faced limited staff resources (including physicians), and in-house ethics expertise. Therefore, the NJAHCF funded the development of three pilot Regional Long-term Care Ethics Committees for purposes of peer support and education.

In early 1995, leadership from two of the three original Regional Long-term Care Ethics Committees approached the Office of the Ombudsman for the Institutionalized Elderly. It was proposed that replicating this model statewide, would provide much needed education and peer support for front line nursing home staff who confront “everyday” as well as end-of-life ethical dilemmas in their facilities, and would provide an ongoing resource for case consultation to resolve ethical dilemmas at the bedside. Resident-centered decisions, it was reasoned, could be facilitated through a regional ethics committee prior to engaging a state agency or the courts for dispute resolution. This was a highly unusual request, as the State Ombudsman’s programs, which are partially funded by dispute resolution. This was a highly unusual request, as the State Ombudsman’s programs, which are partially funded by the federal Older American’s Act, have as their primary purpose, the investigation of nursing home resident’s complaints of abuse, neglect, and exploitation (physical, psychological, financial, etc.). However, the New Jersey Supreme Court, as early as 1987, had recommended that the Department of Health consider the development of regional ethics committees for nursing homes. The Ombudsman, at that point, assembled an Ethics Advisory Committee comprised of interested professionals from around the State, and undertook an initiative to promote the development and training of a statewide regional ethics committee network. In order to ensure that each long-term care ethics committee member had access to similar preparatory education, a statewide ethics education and skill development program was developed. The NJ SEED project—a partnership between the New Jersey Department of Health and Senior Services, The Office of the Ombudsman for the Institutionalized Elderly, and The Cooper Health System/University Medical Center in Camden, NJ—was the resulting statewide initiative to confront ethical issues in nursing homes.

**DESCRIPTION OF THE NJ SEED PROJECT**

The NJ SEED Ethics training program consisted of a five-module educational curriculum taught by nationally recognized bioethicists and palliative care specialists. Educational topics included principles of biomedical ethics, case consultation methods, the law and ethics, pain and palliation, advance directives, and the role of religion and culture in end-of-life care. The training materials (slides, print, and video) were given to program participants, so attendees could share learned course information with other staff members at their home institutions. Between 1998 and 2001, NJ SEED provided the curriculum to more than 700 professional staff members representing 250 of New Jersey’s 365 nursing homes and assisted living residences, and a smaller number of representatives from hospitals, government agencies and hospices.

In addition to its role in providing skilled training, the NJ SEED project helped to support the establishment and expansion of a statewide network of 15 skilled long-term care regional ethics committees (hereafter referred to as RECs) to serve the nursing homes and assisted living residences within their geographical region. The members on these committees are volunteers, and membership varies from committee to committee. A well functioning committee has members who have received training in the methods for conducting case consultation reviews, uses a systematic process, has a method of documentation, has regular ongoing training on diverse ethical topics, conducts regular outreach to staff members to accommodate staff turnover, and has multidisciplinary REC members (including administrators, activity therapists, consumers, doctors, nurses, social workers, chaplains, nutritionists, nurse aides, etc.). Many RECs charge dues ($100 or $150 per facility) which they use for continuing education purposes. The Ombudsman and a member of his staff meet bi-monthly with the RECs to provide educational support in a variety of areas. In this way, the REC Network serves as an educational pipeline for the dissemination of educational information to long-term care facilities in their geographical regions. As a result of the NJ SEED project, all of the nursing homes and assisted living residences within New Jersey’s 21 counties now have access to one of 15 geographically distributed committees.

**STUDY OBJECTIVES**

The objective of the present study was to evaluate the impact of NJ SEED on nursing homes in New Jersey whose staff attended the NJ SEED educational training program. Specific aims of the evaluation included the following: (1) to describe the extent to which facilities that participated in NJ SEED currently utilize RECs, (2) to identify the type of staff members that are members of the RECs, (3) to determine the number and type of case consultations that nursing homes bring to the RECs, (4) to determine the impact of NJ SEED on the development of ethics-related policies, procedures, and activities within participating facilities, (5) to examine the perceived benefits of the RECs, and (6) to identify barriers to use of the committees. The purpose of the study was to obtain a better understanding of the strengths and weaknesses of the program in order to determine how the NJ SEED project could be used as a model that could be adopted by other states.

**METHODS**

The data collection consisted of four components: a survey of all facilities that participated in the NJ SEED training program; a brief survey of one chair from each REC; two focus groups; and interviews with the Office of the Ombudsman and a regional ethics committee chair. Each of these is discussed in turn.
Facility Survey

Every long-term care facility in New Jersey that had at least one staff member who participated in the NJ SEED Ethics Education Training Program—at any point—was targeted to receive a Facility Survey. This list was generated from records of participants kept by the NJ SEED program. The tool was first pilot tested with several NJ SEED participants, and revised based on their feedback. The survey was mounted on the Internet using a Web-based survey portal called SurveyMonkey.com. Initially, all potential survey participants were sent a letter explaining the purpose of the survey. This letter provided participants with a link to the Web site, and explained how to access the survey online via the Internet, as well as how to request a printed copy of the survey tool. Since the initial response was low, a hard copy (printed version) of the survey and a reminder letter were mailed to all nonrespondents 2 weeks later.

Regional Ethics Committee Survey

The chairperson from each of the 15 RECs was contacted and asked to complete a brief survey. Each chair was initially sent a letter, which was followed up by a phone call. As with the Facility Survey, chairs were given the option of completing the survey either online, or by completing it on paper and returning the survey by mail or fax.

Focus Groups

Two focus groups were held. The first focus group consisted of members of the regional ethics committees. The second group consisted of former participants in the NJ SEED program. Several of these individuals were also members of an REC.

Interviews

An interview was held with the leadership of the Office of the Ombudsman for the Institutionalized Elderly in order to gain a perspective about the impact of the REC Network on NJ long-term care facilities. Another interview was held with a chair of one of the RECs to capture information about the referral process and the types of cases that are referred.

All study procedures were reviewed and approved by the Thomas Jefferson University Institutional Review Board.

RESULTS

Respondent and Facility Characteristics

Survey Response Rate

Two hundred twenty-five long-term care facilities were identified as eligible to participate. We received a total of 93 completed surveys, resulting in a 41% response rate. About one third of the surveys were completed online (35%), and the remaining surveys were completed via a written version of the survey (65%). Facilities from all but one county in New Jersey were represented in the sample.

Respondent Characteristics

Most surveys were completed by the facility’s director of social services (87%), although some administrators (8%), and directors of nursing (4%) completed the survey. Respondents reported being employed at their current facility for less than a year (12%), 1 to 2 years (23%), 3 to 5 years (25%), 6 to 9 years (15%), and 10 or more years (24%). About half (54%) of the respondents said that they had been participants in the NJ SEED ethics training program. Of those who attended the training, 33.3% attended in 2001, 35.4% attended in 2000, 16.7% attended in 1999, and 14.6% attended in 1998.

Facility Characteristics

Over half of the facilities were for-profit corporations (59%), a third were not-for-profit (33%), and 7% were government facilities. Most facilities accepted Medicaid (91.1%), Medicare (95.6%), and private insurance (83.3%). One third of the facilities reported being certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (32%).

Presence of Ethical Dilemmas in Nursing Homes

Survey respondents were provided with a list of eight common types of ethical dilemmas that caregivers in long-term care settings often face, and were requested to indicate whether each of the issues had arisen within their respective facility. Each issue and the percent of respondents indicating that the issue had presented itself as an ethical dilemma at their facilities are found in Table 1.

Participation in the Regional Ethics Committees

Of particular interest to this study was the extent to which facilities utilize the resources of the NJ REC Network. According to the facility survey, 53 of the 93 facilities (58%) who responded to the survey are members of the NJ REC Network; 10% said that they were members of the NJ REC Network in the past, but are not currently; 25% said they do not participate in the NJ REC Network at all; and 8% stated they were “not sure.” Of those who participate in an REC, most attend educational programs sponsored by the committee (86%); two thirds participate in case consultations (67%), and a smaller number receive aid with policy development (43%).

Apart from the use of the RECs, some facilities reported

### Table 1. Percentage of Respondents Reporting That Ethical Dilemmas With Respect to the Following Issues Occur at Their Facilities (N = 93)

<table>
<thead>
<tr>
<th>Issues</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing residents’ decision-making capacity</td>
<td>71 (79)</td>
</tr>
<tr>
<td>Do not resuscitate decisions</td>
<td>70 (78)</td>
</tr>
<tr>
<td>Do not hospitalize decisions</td>
<td>70 (77)</td>
</tr>
<tr>
<td>Tube feeding issues</td>
<td>67 (74)</td>
</tr>
<tr>
<td>Implementing advance directives</td>
<td>63 (70)</td>
</tr>
<tr>
<td>Ascertaining resident health care preferences</td>
<td>60 (68)</td>
</tr>
<tr>
<td>Identifying surrogate decision-makers</td>
<td>53 (59)</td>
</tr>
<tr>
<td>Withholding/withdrawing life sustaining treatments</td>
<td>44 (48)</td>
</tr>
</tbody>
</table>
having their own in-house (institutional) ethics committee (27%), or sharing an in-house (institutional) committee with one or more facilities (13%). Others reported using the services of a hospital (28%) or corporation-wide ethics committee (11%) on an occasional basis; however, very few facilities reported using hospital or corporate ethics committees on a regular basis.

In order to examine the association between having an in-house ethics committee and participating in the REC Network, we conducted a chi-square test of independence. The results indicated the following: Among those who reported having an in-house ethics committee (n = 37), 28 or 76% of these facilities reported belonging to an REC, compared with 9 (24%) who did not. These results suggest that nursing homes with their own in-house ethics committee are more, not less, likely to belong to an REC.

Survey respondents were also asked to indicate which members of their staff, in particular, participate in their local REC. Information regarding the position of staff members who are members of an REC, and the type of activities that those staff members participate in, are presented in Table 2. Also shown in Table 2, is the number of times that facilities made a request to the REC for a formal case consultation. Of the 53 facilities that reported being members of an REC, about half said that they have never requested a formal case consultation from the REC and 30% requested at least one or more; the remaining 20% were not sure how often their facility had requested a case consultation. Among those who did request a case consultation, 85% described the opportunity to have access to expertise in this arena as either “extremely” or “highly” valuable. It is important to note that it was more common for facilities to approach the RECs on an informal basis. About two thirds of the facilities (65%) had utilized the services of the RECs to informally discuss a case on at least one occasion.

**Impact on Policy and Procedure Development**

Respondents were asked to report whether their facility had a formally written policy regarding 10 different ethics-related issues. In addition to looking at the results for all facilities together, we hypothesized that facilities that reported active participation in the REC Network would be more likely to have formally written policies than facilities that are not active participants in the REC Network. The results for all facilities, as well as for these two groups separately is presented in Table 3. The results demonstrate that facilities that reported participation in the REC network are more likely to have formally written policies than facilities that do not participate in the REC network (however, only one of these differences reached statistical significance). Most notably, 96% of facilities that participate in an REC have a formally written policy regarding the implementation of advance directives compared to 76% of facilities that do not participate in an REC. Facilities that participate in an REC are also more likely to have a formal policy regarding identifying surrogate decision-makers, ascertaining resident healthcare preferences, and withholding or withdrawing life sustaining treatments compared with facilities that do not participate in an REC.

**Perception of the Impact of NJ SEED**

One of the aims of this project was to evaluate the extent to which participants in the NJ SEED program felt that this program influenced the way their facilities approach ethical decision-making. Respondents who reported that they had attended the NJ SEED training program (n = 48) were asked whether they felt that their facility was influenced by this initiative in any of nine different ways. Table 4 shows the percent of respondents who answered affirmatively to these questions.

**Nature of Case Consultations**

The chairperson of each of the 15 regional ethics committees was mailed a brief questionnaire asking them to describe the nature of the types of cases referred to their committee for consultation review. Nine of the twelve respondents reported initiation and/or withdrawal of tube feedings as a frequently occurring reason for case consultation requests. Case consultation requests were also received involving the withholding of other treatments (eg, pacemakers, dialysis, and hospitalization). Other matters frequently mentioned included patients’ rights and the determination of decision-making.
making capacity. Respondents also reported issues and conflicts between patient, family, and provider preferences. Other diverse issues included resident or family requests for discharge to unsafe living conditions, or family requests for withholding needed pain medications. The final common theme pertained to issues surrounding advance directives, that is, a lack of advance directives, conflict regarding the designation of a proxy decision-maker, or conflict between family and staff regarding the implementation of advance directives. When the REC chairs were asked to describe the content of any education programs they had offered in the past 2 years, pain management and palliative care were the most common topics, mentioned by five of the eight respondents who had offered educational programs.

Focus Group and Interview Findings

Two focus groups were held with various staff members of long-term care facilities across the state of New Jersey. Participants were asked questions regarding: (1) their perceptions of the benefits of the NJ SEED program to long-term care facilities in NJ, (2) their experience of what the REC Network have to offer long-term care facilities, and (3) their ideas regarding what factors may explain why some facilities participate in the REC Network and other do not. For a summary of the themes that arose in response to these questions see Appendix I.

An interview was also conducted with the Ombudsman to gain an understanding of the specific advantages of this kind of REC Network. According to the Ombudsman, the regional ethics committee network makes ethics education more accessible to facility staff by: (1) bringing educational programs closer to the location of the long term care facilities, (2) lowering the cost, (3) providing the opportunity for shorter, but more frequent meetings, and (4) enabling the RECs to be responsive to the particular concerns of their member facilities.

Table 4. Number of NJ SEED Participants Who Answered “Yes” to the Following Question: “According to your perception, did the NJ SEED Project impact your facility in any of the following ways?” (N = 48)

| By helping your facility to identify and resolve ethical dilemmas? | 91% |
| By linking your facility to a regional ethics committee? | 63% |
| By improving your facility’s relationship with the Office of the Ombudsman? | 70% |
| By increasing your understanding and confidence with the Office of the Ombudsman’s guidelines for handling end-of-life ethical dilemmas? | 89% |
| By fostering improved pain management policies and protocols? | 68% |
| By fostering an understanding of the interface between law and ethics? | 83% |
| By fostering an increased understanding of the roles culture and religion play in the provision of compassionate care? | 78% |
| By fostering an understanding of the major ethical principles of significance to providers of long-term care services? | 86% |
| By promoting a more moral community at your facility? | 73% |

DISCUSSION

According to the results of the facility survey, over half of the facilities surveyed reported being members of the statewide REC Network. Information obtained from the surveys, focus groups, and interviews suggests that utilizing the RECs to discuss cases on an informal basis may be a more popular use of the regional ethics committees than utilizing them to conduct formal case consultations. While less than one third of facilities have requested a formal case consultation, two thirds of the facilities have engaged an REC to informally discuss a specific case.

Among potential barriers to widespread utilization of the REC Network, one key factor may be lack of awareness. Our survey provides evidence that some facilities are not fully aware of the existence of the RECs, or of how to go about accessing them. Seven (8%) of the respondents were not even sure whether their facility participates in an REC. Among those who reported participating in an REC, 13 (or 26%) did not know when their facility had first become a member of an REC, and a substantial number (20%) were not able to say how often their facility has requested a case consultation from an REC or engaged in informal dialogue about specific cases.
The main reason for the lack of awareness of the RECs is most likely due to high staff turnover. Within the focus group discussions and interviews, the high turnover rate among long-term care facility staff was cited repeatedly. While many of the individuals who originally took part in the NJ SEED training may still be working in the long-term care field, there are also many new faces. Veterans of SEED have been educated about the importance of ethics, and are aware of the RECs as a resource to turn to for support in addressing ethical issues that arise in their facilities; but new staff may be unaware of the availability, and the workings, of the REC Network. If a nursing home loses its SEED-educated staff members, and the new staff is unaware of the REC Network, it is possible that that facility will no longer be connected with an REC. This possibility underscores the need for a system that can provide continuous education and support.

An important theme that arose throughout the focus groups and interviews was the fact that relationships are a key factor to the successful functioning of the RECs. One member of an REC astutely noted that case consultations can only be conducted if that call is made by the facility to the REC, and that call is often only made if there is a personal connection between the staff at the facility and the members of the REC. While RECs may try to reach out to facilities, the choice to seek the support of the committee may be dependent on whether or not a staff member feels comfortable doing so. Some committee members believe it is the personal connection with someone at an REC that often determines this level of comfort.

Additional reasons for possible underutilization of the RECs were brought up in both the focus groups and the interviews. One committee member felt that facilities are reluctant to get outsiders involved with their business; their preference is to try to resolve their problems in-house without getting the ethics committees involved. While contacting the REC for assistance with an ethical dilemma may be perfectly comfortable for some facilities, it may feel like “airing dirty laundry” to others. Another concern may be the fear of contacting a governmental agency, such as the Ombudsman, about facility concerns. A facility’s level of comfort with contacting their REC may also be influenced in great part by the attitudes of the leadership of the facility. If a facility feels positive about utilizing the expertise of the REC and is open to their input, they are more likely to call upon them when they are in need.

When asked whether the NJ SEED project had impacted their facility, the majority of former NJ SEED participants said that it had. From all indications, it appears that the NJ SEED training has had an important impact on the culture surrounding ethics in long-term care facilities in New Jersey. Information obtained from the focus groups revealed that the inception of SEED led to a broad scale consciousness-raising about the importance of ethics in long-term care. It empowered long-term care professionals to come together and air their concerns and it fostered the development of relationships between facilities.

Most importantly, it may have motivated facilities to review and refine their policies. Our results suggest that in many cases, facilities that are members of an REC are more likely to have formally written policies with an ethical emphasis than facilities that are not members of an REC. However, we cannot infer that belonging to an REC causes facilities to change or alter their policies and procedures for several reasons: First, because staff who are motivated to review and change their policies in light of ethical considerations may be more likely to seek out opportunities for ethics education. Second, because there may have been other educational opportunities and programs that facility staff have been exposed to besides the NJ SEED program. Therefore, any impact on policy and procedure development cannot be attributed solely to the NJ SEED training. Nevertheless, it is still important to note this association because it may suggest that participating in an REC, and its associated offerings, may impact facilities in ways that foster the development of ethically based policies.

Finally, a significant number of facilities surveyed (between half and three-quarters) reported the common occurrence of a variety of ethical dilemmas within their facilities. One of the major goals of the NJ SEED program was to emphasize that ethical dilemmas will, and do occur, as a natural process of providing care in the long-term care environment. The REC Network was developed specifically to provide the support and expertise that facilities need to make the most responsible, sensitive, and ethically sound decisions possible. The NJ SEED project and REC Network have strived to provide a common language and formal methodological approach to discussing and confronting ethical dilemmas that are vital to achieving this end.

This evaluation was not completed until several years after the project was first implemented. While the NJ SEED project was implemented between 1998 and 2001, this evaluation was not begun until the beginning of 2003. Assuming that the program may have had its strongest impact when it was fresh in people’s minds and they were still highly motivated to apply what they had learned, the effect of conducting the evaluation several years later, may actually have led to an underestimation of the impact of the program on facilities. When considering the time lapse between the project implementation and its evaluation, some of the findings of this study are quite remarkable.

The greatest weakness of the NJ SEED project is that the structure of the initiative has relied completely on grants, which provide funds for a finite period of time; yet the continued success of a project of this kind relies on continuous education and support. Despite a limited availability of funds, a complete statewide retraining of the NJ SEED project, in which all members of the RECs were invited to attend, was offered in December of 2003 (beyond the point of when this evaluation was conducted). Additionally, since the conclusion of the NJ SEED grant period, the Robert Wood Johnson Foundation NJ Health Initiatives has provided funding to provide pain management education to long-term care facilities within the state utilizing the REC Network. NJ SEED is also currently providing continuing education on the topic of ethical issues.
surrounding the care of the individual with developmental disabilities.

There are some limitations to this study that should be mentioned. This study like many program evaluations is purely observational. Therefore, we cannot draw absolute cause and effect conclusions about the impact of the NJ SEED project on nursing homes in New Jersey. Only those facilities with staff that were trained through the NJ SEED project were requested to participate in the study. Without a true comparison group, we cannot compare the impact of the NJ SEED project on facilities in New Jersey with facilities that have not been exposed to this project. Furthermore, we can not completely isolate the effects of the NJ SEED program on facilities, because there are other educational programs and opportunities that staff may have attended other than programs offered through NJ SEED project.

While our response rate was limited to 41%, it is important to note this is a very good response rate for a mailed survey, especially to professionals in the nursing home industry who are notoriously overworked, and for whom completing this survey was probably not a priority. We randomly called some nonresponders to remind them about the survey and most of them said that they really wanted to complete it; but that it was buried in a pile on their desk and they had just not found the time yet. We have no reason to believe that facility respondents were different in any systematic way than facility nonrespondents. In fact, we were reassured to find that the proportion of surveys returned to us from each county was practically identical to the proportion of surveys sent out to each county. This finding indicated that there was no systematic bias in terms of geographical region.

CONCLUSION

Through educating, empowering, and supporting a network of RECs, the NJ SEED project has had a positive impact on many long-term care facilities in the state of NJ. While many facilities are members of the RECs and participate in case reviews and education programs, there appear to be other facilities that are not taking full advantage of this important source of support and expertise. The continued success of this project will depend on the extent to which facilities are encouraged to utilize the RECs to the fullest extent.

Note to readers:

The intended purpose of this article is to inform medical directors and other long-term care professionals that this type of statewide model for providing ethics education, not only exists, but has been shown to be a viable method for providing support and expertise to nursing homes. A methodological guide for implementing or replicating a similar model goes beyond the scope of this article. Information of this type can be obtained from the corresponding author who is in the process of assisting other geographical regions in developing similar initiatives.

ACKNOWLEDGMENTS

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REFERENCES


APPENDIX 1

Benefits to facilities resulting from the NJ SEED program:

- Helped to establish relationships and networking opportunities for LTC professionals
- Responsible for increasing dialogue and fostering trust between facilities
- Led to a consciousness-raising about the importance of ethics in long-term care
- Led to major cultural change regarding ethical issues and residents’ rights
- Provided a standardized methodology and process for conducting case consultations
- Ombudsman seen as supportive rather than threatening
- Empowered staff to take a proactive approach to ascertaining and implementing residents’ wishes
- It gave credence to resident and family choices
- Fostered awareness of new areas (pain management, palliative care, etc.)
- An ability to sit down with the important parties and discuss the issues
- Staff feeling more comfortable with managing issues on their own

What do the RECs have to offer to facilities?

- Support when facilities need help making a decision
- Offer help in focusing the issues

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- An ability to sit down with the important parties and discuss the issues
- Staff feeling more comfortable with managing issues on their own
- When they want another level of deliberation
- A resource to talk to, not only for case consultation
- The RECs help to resolve a lot of cases before consultation is needed
- Empowers staff; provides reassurance
- Provides a safety net; breeds comfort levels
- Provides facilities with information to share with families

How have the RECs helped residents and their families?

- Greater dialogue with families from the outset
- Education and support is given to families to help them make difficult decisions
- The dying process is respected more
- Family more involved in final hours

Potential Factors Related to Utilization of the REC Network

- Whether the facility has their own (in-house) ethics committee
- High turnover of staff leads to lack of awareness of the REC as a resource
- Comfort in calling the REC and familiarity with the process
- Whether they have a personal connection with a member of the REC
- The facility's attitude toward bringing in an outside resource