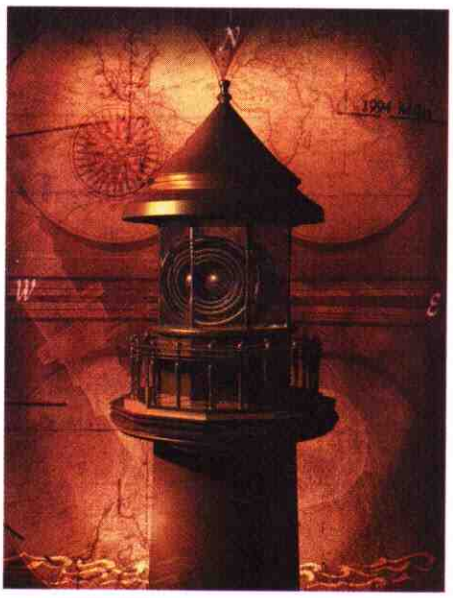
GUEST **editorial** BY DENNIS HAYES

Changing nursing homes: A new perspective



While I commend the thrust of Paul Willging's December 2003 column ("Quality Management Isn't as Tough as It Looks," p. 13), I respectfully disagree on two issues.

The first is his use of the term *multidisciplinary* in lieu of the more appropriate term, *interdisciplinary*. In practice, multidisciplinary approaches are inherently *not team* processes. Rather, they represent the many disciplines approaching the resident (patient) from distinct and separate disciplinary orientations. An example of this is the hospital system, the traditional "medical model," in which all the varied disciplines do their own thing, quite independently from each other. Witness, for example, the departmental reports that come from x-ray, lab, radiology, physical therapy, internal medicine, or any other discipline. One need only look to the discipline or departmental reports included in a typical hospital discharge packet to see the duplication and lack of coordination among the many disciplines participating in the care of a hospitalized patient. There is no *interdisciplinary communication*. Each practitioner or technician records the same background, presenting problem, reason for admission, and current status and then goes on to say what his/her discipline did without regard to what the other disciplines did or, indeed, without even seeing the other disciplines' work! They all write from their own points of view, not benefiting from the views of their colleagues in other disciplines.

In a properly operating nursing home, the MDS and/or the care plan should be the product of coequal teammates' input. That assessment/plan should come from a consensus/discussion approach, rather than from several different and often (if not routinely) conflicting approaches, as seen in the multidisciplinary model. This interdisciplinary approach still does not occur in most nursing homes, but the method is potentially available and the approach possible.

My second concern with Dr. Willging's otherwise excellent column has to do with failure to consider the most fundamental defect in the nursing home's operating model: It is essentially a *nursing* model. Absent a true effort to eliminate this defect, it is doubtful that any appreciable improvement in nursing homes will occur. Without sounding "antinurse" (in fact, my wife is a nurse)—something I have been accused of when someone has been unprepared to fully hear me out on the matter—I contend that the problem in nursing homes is a problem with a system that has elevated nurses' importance beyond reason.

As important as nurses are, they predominate everything in the nursing home, just as doctors predominate everything in the hospital (which isn't working terribly well, either). Quite frankly, nurses have been made to believe that they run the facility. They tell laundry and housekeeping what to do. They also tell social workers, dietitians, and activities directors what to do even though they might know little about any of these professionals' areas.

This "nursing model" might be even more problematic than the multidisciplinary approach because, in fact, it often is a *monodisciplinary* approach! Therefore, if we ever hope to achieve high quality of care and, hence, customer satisfaction, we have to do the following:

1. Equalize both pay and status for all disciplines. Why is a high school grad with some 15 additional months of training (an LPN) worth $20 per hour or more? Why, especially, is that so when a 150-bed facility might have as many as 20 of these LPN positions? At the same time, this same facility might have a single MSW, perhaps with one assistant (BSW), and they are being paid $15 and $12 per hour, respectively. And consider that these many high-paid LPNs are regularly asking the MSW to serve as a clothing clerk, an eyeglass fixer, or a doctor's appointment maker.

Similarly, activities professionals are paid $15 per hour, even though they might have master's degrees. But they are told to transport residents, go on clinic appointments, and clean up after meals. It begs the question: From whom will quality of care more likely come? From the nurse who passes pills and seldom is really able to even speak to residents, or from the activities director who provides age-appropriate activities and strives to eliminate boredom for those confined to a "home" they never bought or wanted? Or from the social worker who helps elderly residents cope with sexuality urges, grief, and their struggle to exercise any remaining independence? Or is it the from dietitian who struggles to balance eating and nutritional issues for the medically fragile client?

To be sure, we need licensed nurses, but the fact is that these individuals have few assessment skills and do little actual assessment and even less care planning. They are, for all intents and purposes, little more than dispensers of medications and treatments. Never-

theless, they're more highly paid than the people who have more training and more interaction with the residents.

How does this inequity in both status and pay contribute to a sense of team? How does it contribute to a quality organization? The old nursing model, in which nurses predominate over other team members, is no longer (if it ever was) appropriate.

2. Come up with a truly participative and equal-input model of facility operations. If the disproportionate influence of the nursing discipline in nursing homes is allowed to continue, a truly collegial model will never be achieved. Achieving the highest levels of quality service and customer satisfaction hinges, in my considered opinion, on a system that allows coequal status and pay. No nursing home provides this.

I have argued for years that nursing homes must break the mold and try another way. I have always aspired to a model wherein a supervisor who is not a nurse, and who hasn't been tainted by the nursing or nursing home model, would be appointed the shift supervisor. This person would be charged with overseeing the whole building each and every shift, each and every day. He or she would not need to be clinically trained but, instead, would merely need to be able to distinguish clean from dirty, good smells from bad, smiles from frowns, cries from laughter, and hot from cold. Only these simple basics would be required. This person would supervise everyone, including the nurses, in all operational and nonclinical matters.

This shift supervisor would not tell a nurse how to pass a pill or how to determine whether the pill should be passed, but would say, "It is 10:00 a.m. Aren't you supposed to be passing the ten o'clock meds?" Or, "This person seems to be grimacing in pain. What can we do for her?" Or, "There is a foul odor emanating from the vicinity of this resident. Can you please find out why?" In short, this supervisor would be a time-and-motion person, a schedule monitor. If a shower were due, they would see that it got done.

Nurses don't do this. They don't like that part of their job. Typically, they do not follow up and do not communicate all that well with their supposed charges, the CNAs. They do not follow up on what they expect to take place because, frankly, they do not seem to view follow-up and supervision as part of their job. They are more likely to say, "I have my job to do," despite the "charge nurse" or "nurse supervisor" title by which they go. Never mind the fact that they are compensated for supervisory, as well as clinical, responsibilities.

We need to quit fooling ourselves. Nurses don't want to supervise; they never have and never will. Ask one. Most will confirm this. So why do we insist on vesting them with this responsibility? I have been an administrator for 23 years, and this is probably more exasperating than the regulatory climate we face.

I enjoy Dr. Willging's column, but as one who has been in the "trenches," somewhere Paul has not been, I felt compelled to comment. I would love to hear his reaction. ■

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Paul Willging Responds

In reality, we are in total agreement on your first point, and our agreement on point number one pretty much moots point number two. While perhaps not that obvious in my December column, my views have always been highly supportive of the twin concepts of interdisciplinary and multidisciplinary assessment and care. Our customer, the geriatric resident, deserves no less. In fact, I wrote in another publication just last year (*Caring for the Ages*): "Since the customer presents, therefore, an interrelated mélange of care issues, since the service package must be equally comprehensive in addressing those issues, so too must the effort to measure and improve care be based on the concept of inter- and multi-disciplinary teamwork." Note: "inter" precedes "multi."

As for point number two, let me quote that oft-used admonition: "There is no "I" in "team." As you indicate in your editorial, "...the care plan should be the product of coequal teammates' input." In other words, if we take a truly interdisciplinary team approach to assessment and care, there is no "number one"—not the doctor, not the nurse.

Although someone needs to coordinate assessment and care-planning meetings, that task should not elevate the coordinator to a superior role as to contribution and authority. Actually, I would go so far as to suggest that a facility that doesn't "get it," that is still debating the relative value of the various disciplines within the community, has a long way to go in buying into the concepts underlying successful quality management. If the facility's culture has, indeed, changed (a necessary prerequisite for successful QM), then there is no place for such a dispute.

Finally, on your observations regarding compensation and its relation to value, be it for nurses or any other discipline: In our economic system, prices are established by the relationship between supply and demand—not necessarily by the value of one's contribution to the care delivered. Just one example: Therapists' salaries in long-term care are not today what they were before the Omnibus Budget Reconciliation Act of 1997. Why? Because the prospective reimbursement mandated for Medicare SNFs by that legislation reduced the industry's demand for therapists and, absent a commensurate reduction in supply, the "price of" (i.e., salaries for) therapists went down. Did that reflect any decrease in their value to patient care? Of course not. But it did reflect a different intersection point on the supply/demand curve.