

The Changing World of Long-term Care in RI: One Nurse's Journey

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ABSTRACT

This paper presents a personal look at the changing world of long-term nursing care in one facility over the course of a 38-year nursing career. The paper reviews the ways the role of "nurse" has evolved and expanded due to changes in patient populations, industry standards, and technology advancement. Though the job has changed dramatically over the decades, the most integral parts of successful nursing remain the same: Connection to patients and their families, and a commitment to quality care and patient well-being.

KEYWORDS: Nursing care, long term care evolution, nurse case management

In 1976, I finished my freshman year of college and decided not to return to school. At my father's urging, I went on my first job interview for a nurse's aide position. There was no certification required to be a nurse's aide. The entire training consisted of watching procedural film strips followed by ten days of training with an experienced nursing assistant. After working as an aide for one year, my father encouraged me to attend nursing school. I enrolled in Rhode Island Junior College and graduated in 1979, while working part time as a third shift nurse's aide.

I got my first job as a licensed nurse at the same facility where I worked as an aide. I did not realize at the time that I would spend my career in that very building. In the years since, I've worked in many positions ranging from charge nurse to infection control nurse.

At that time, working in a nursing home meant taking care of frail elders exclusively. Generally, patients resided at the facility for end-of-life care. Typically a licensed nurse's day would involve medication administration, turning and repositioning, simple wound care, nutrition via gastric tube, nasal gastric tube, or hand feeding. Anything beyond the scope of nursing would be handled by contracted professionals. In the 1970s, patients conformed to the schedules of the facility. We didn't take into account their personal preferences and habits from their daily lives before they were admitted. Patients were bathed, dressed, and groomed according to set daily schedules. At the time, we thought it was best for patients at risk for falls to be restrained. There was little flexibility. Visiting hours were scheduled, nurses wore starched white uniforms, white hose and caps. I could

never have anticipated the changes that would come in the world of long-term care.

Although the way we cared for patients was rigid, I always felt personally connected to them, especially the first patients I ever cared for. Stanley was one of the patients I became fond of. Many staff would bring their children in for visits. I still have a photo of Stanley holding my daughter during a visit. He never had children of his own, but all of the nurses sensed that our children were treated as grandchildren by the patients. Today this is called intergenerational programming. At that time, we just knew our children brought such joy to the elderly.

Over the years, reimbursement changes, Medicare regulation, and evolving patient demographics have dramatically altered nursing and long-term care. The once privately owned facility where I work was purchased by a corporation. It has since been sold three more times to even larger corporations.

The nursing facility itself has also dramatically changed. In the early 1990s, we opened one of the first secured dementia specialty units in the state specializing in individualized care and a habilitation approach to dementia care. Culture change, a homelike environment, consistent assignments an extensive activity program, and a holistic focus on patients' prior lifestyles were integral to the success of the unit. Restraints became a thing of the past. Multiple industry studies revealed restraining patients actually caused more serious injury and were not effective in the prevention of falls. Staff became adept at developing creative solutions for falls prevention. The Activity Department had a vital role in developing interventions as well.

We tried to make life on the unit reminiscent of residents' prior lives. I will always remember the day we enacted a wedding ceremony for them. A nurse's aide wore her wedding gown, there were flowers donated by a local florist, music, wedding cake and dancing. And, of course, with lots of reminiscing and tears, residents were encouraged to share their words of wisdom. This was one of the most challenging yet rewarding positions I have held. I learned about behavior management, validation therapy and therapeutic activities, and these became tools in our toolbox of dementia care.

Not all of the changes we made were as lasting. There are many factors that have an impact on change. One of those factors is finances. At the same time we opened the dementia unit, we opened a Joint Commission accredited sub-acute

unit to care for short-term, medically complex patients. Initially the sub-acute unit cared for ventilator dependent patients with 24/7 respiratory therapists on staff. Changes in reimbursement later in the '90s made continuation of ventilator care unprofitable. Care for ventilator-dependent patients was discontinued, but the sub-acute unit is still thriving today. All these units required nurses to expand their areas of expertise.

Nurses in skilled nursing facilities are today caring for patients who once remained in the acute care setting for extended periods of time. They are administering intravenous (IV) meds, total parenteral nutrition (TPN), and doing advanced wound care; they are taking care of patients with new tracheostomies, patients with multidrug resistant strains of infections requiring contact precautions, poly trauma patients, and surgical patients. Consequently, units have become very fast-paced. It is not unusual to have 35-45 admissions and discharges per month. Gone are the days of the sleepy nursing home. Today's nurses are in scrubs and running shoes tending to beeping IV pumps, answering call lights, rounding with physicians, passing medications, and doing treatments.

Staff is no longer limited to nurses and outside contractors. Now, skilled nursing facilities have large complements of physical therapists, occupational therapists, speech therapists, and respiratory therapists. Nurses have more technology at their disposal: electrocardiogram (EKG) machines, automated external defibrillators (AEDs), pulse oximeters, crash carts, bladder scans, not to mention the recent requirement of electronic medical records. The clinical and technical expertise of nurses has greatly expanded. Nurses, particularly older career nurses like myself, have had to adapt from a setting that once cared for frail elders to the high-tech, medically complex nursing of today.

To meet the needs of the patients we now care for, many consultants have become a crucial part of the care team. These include palliative care nurses, hospice care clinicians, psychiatric consultants, and wound consultants. All of these changes created a need for nurse case managers to coordinate the delivery of care.

In 2010, I accepted the role of nurse case manager, a position which is becoming more popular in nursing facilities to manage the care and reimbursement for Medicare patients, managed care patients and insurance patients. Case managers act as a patient advocate and liaison with physicians and insurers. We do concurrent reviews for insurance companies to ensure timely care and proper reimbursement, and obtain prior authorizations. It is very rewarding to meet with patients and families, and work closely with the interdisciplinary team to coordinate care and set goals to ensure good outcomes and safe transitions home.

Today, performance is measured in outcomes. José (not his real name) was a patient who came to our facility from Boston following an extended and complicated hospital stay for a hip fracture, myocardial infarction (MI), and respiratory

failure. On admission, he had a tracheostomy tube and was unable to speak, a percutaneous endoscopic gastrostomy (PEG) tube for nutrition, and a peripherally inserted central catheter (PICC) line for IV antibiotics. Over time, through the collaborative effort of speech therapy and respiratory therapy, José began speaking with a passey miur valve, had a blue dye test and modified barium swallow test to assess abilities. He progressed from a puréed diet with nectar liquids to a regular diet with thin liquids. He was decannulated and the PEG tube was discontinued prior to discharge. José was able to return home at his prior level of function. I felt gratified to see this once debilitated person return for a visit with his wife carrying an enormous tray of homemade goodies.

I have always treasured the connection with patients and families. Receiving a Christmas card or a random phone call from a former patient just to say "hello" are the greatest rewards. I still meet with former patients' family members, and we have built lasting friendships.

As I near retirement, it is with great satisfaction and fulfillment that after 38 years, I still come to work in the same facility. Though the entryway has changed after several renovations and expansions, it's still comforting to come back to this place and try to make a difference every day.

As I was gathering my thoughts for this article, I realized the place my nursing career was born at the urging of my father was the same place where his life would end. Three years ago, I found myself on the other side, as a family member sitting at my father's bedside in the same room where I had cared for many patients. Now I was there as a daughter with my daughters and my mother telling stories about my dad's life. We sat for 2 days with dad until he passed away. Along with it being such an emotional time, the experience gave me a different perspective on what so many patients' family members go through. I have sat with families as their loved ones were dying, thinking I was saying just the right thing. Sometimes there are just no words.

Disclaimer

The views expressed herein are those of the author and do not necessarily reflect the views of Oak Hill Nursing and Rehabilitation Center.

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Disclosures

The author has no financial disclosures to report.

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