



PASTORAL CARE IN A LONG-TERM CARE SETTING

In 1984 the Carmelite Sisters for the Aged and Infirm undertook to begin formal pastoral care departments in each of their 23 facilities. St. Joseph's Manor in Trumbull, CT, a 297-bed long-term care facility owned by the Diocese of Bridgeport and operated by the Carmelite Sisters, was one of the first to implement this community directive.

St. Joseph's has three levels of care: a home for the aged (23 beds), intermediate care (64 beds), and skilled nursing (210 beds). The average age of the residents is 87. An adult day care program has operated at St. Joseph's for the last seven years. On the same campus are 50 apartment units and 36 condominium units, also owned by the diocese but managed under separate contract. Many of the older people living in these units participate in the spiritual life of the Manor.

Before 1986, pastoral care at St. Joseph's was traditional. A priest celebrated Mass and the other sacraments with the Catholic residents, and Carmelite Sisters worked throughout the building, enhancing the spiritual atmosphere. The Sisters showed special care when residents were seriously ill or near death.

In 1986, St. Joseph's established a formal Pastoral Care Department, and I was hired as the director of pastoral care. The goal was to see spiritual care integrated with the good physical, emotional, and psychological care that was already

St. Joseph's

Manor

Exemplifies

a Strong

Commitment

to Serving

the Needs

of All

**BY KARIN "TEDDI"
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present to achieve the best possible quality and sanctity of life in its final stages.

BEGINNING THE PASTORAL CARE PROGRAM

Pastoral care begins with a personal relationship that enables a resident to discuss whatever gives life meaning, both now and in the past, as well as his or her relationships and feelings. Residents in a long-term care setting are often dealing with enormous loss. They may have lost their health, home, status, and family role, and often their spouses and other family members have died. Yet mentally alert residents often speak openly about death. They see it as a natural part of life, are generally realistic about its approach, and have definite ideas about the healthcare they desire at the end of their life.

After becoming acquainted with the residents, I identified the other initial tasks: to develop a policy and procedure manual, to teach staff how to use pastoral support, and to become part of the interdisciplinary care planning team. As a part of this team, it often fell to me, as pastoral care director, to ask the "why" questions: "Why would we suggest this medical procedure for a 97-year-old in the end stages of Alzheimer's?" "Whose need are we meeting in suggesting tube feeding—the resident's, the family's or, perhaps, the staff's?" One thing that became immediately apparent was the overemphasis on the "medical model" of healthcare. We did many things because we could and never stopped to ask if we should. This approach is understandable in light of the enormous burden of the regulatory process, and because most healthcare workers are trained in acute care settings. However, this approach does not always serve the long-term care resident best. What one is willing to endure in the short term because of acute illness becomes untenable as a daily existence. It was evident that



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one way pastoral care could benefit overall care would be through the introduction of an ethical evaluation of events and treatments. It would also benefit our residents to use a "hospice mentality" when making a diagnosis and/or projection of a terminal condition.

In 1988 St. Joseph's established an Ethics Committee, of which I was chairperson. The committee includes physicians, administrators, nurses, social service workers, members of the community and the diocese, and pastoral care workers. After we had conducted some self-education, one of our first major projects was to ask each resident (or his or her representative) to indicate a preference regarding cardiopulmonary resuscitation. The results of this survey demonstrated the importance of a living will, durable power of attorney, and appointment of a health-care agent. We began to offer education on this topic to residents, families, and staff as well as the community at large. We found that people who are beginning to experience memory or cognition problems are still able to understand and express opinions regarding the care they desire at the end of life, and these desires are usually closely aligned with their beliefs.

Knowing that faith informs this decision enables family members responsible for severely cognitively impaired residents to consider treatment options in light of the resident's faith history.

PASTORAL CARE ACTIVITIES

The pastoral care staff increased from two to four to meet the growing demand for a pastoral presence and services. As we became familiar with residents' spiritual needs, we saw that religious services needed to be offered in a variety of ways and settings. Approximately 86 percent of the residents at St. Joseph's are Catholic. Mass is offered daily in the chapel and serves a good number of residents. However, many residents need specialized planning to allow them to participate as fully as possible. We now offer Mass on the nursing units once a month, using a dining room table as the altar. Residents sit in a semicircle no farther

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than 10 to 12 feet away. A resident who is a priest and who wishes to remain active in the ministry offers the Mass, assisted by a member of the pastoral staff. The congregation consists of 10 to 20 residents who are physically or cognitively unable to attend the chapel service.

We have found that the ability to participate at Mass persists well into the progression of dementia, if it was an important part of the resident's life before the onset of illness. Offering Mass in a setting with few distractions, where residents can sit within a few feet of the altar, enables them to recognize the visual cues of the cross, the candles, and the priest, and to hear and attend to the prayer. One male resident wandered the halls all day, shuffling about asking, "Where do I go?" "What do I do?" In the chapel he could not focus enough to know where he was. However, at Mass on the unit, he greeted the priest when he entered, answered every response to the Mass, and thanked the priest for coming.

Communion is also distributed privately daily to those who are unable to attend

Mass in the chapel. Once residents no longer recognize Mass or Communion, we try to meet their need for ritual through a special prayer service that is part of our dementia care program. This program is designed for patients in a specific stage of dementia who have been judged able to benefit from a structured group process. These residents are invited to join

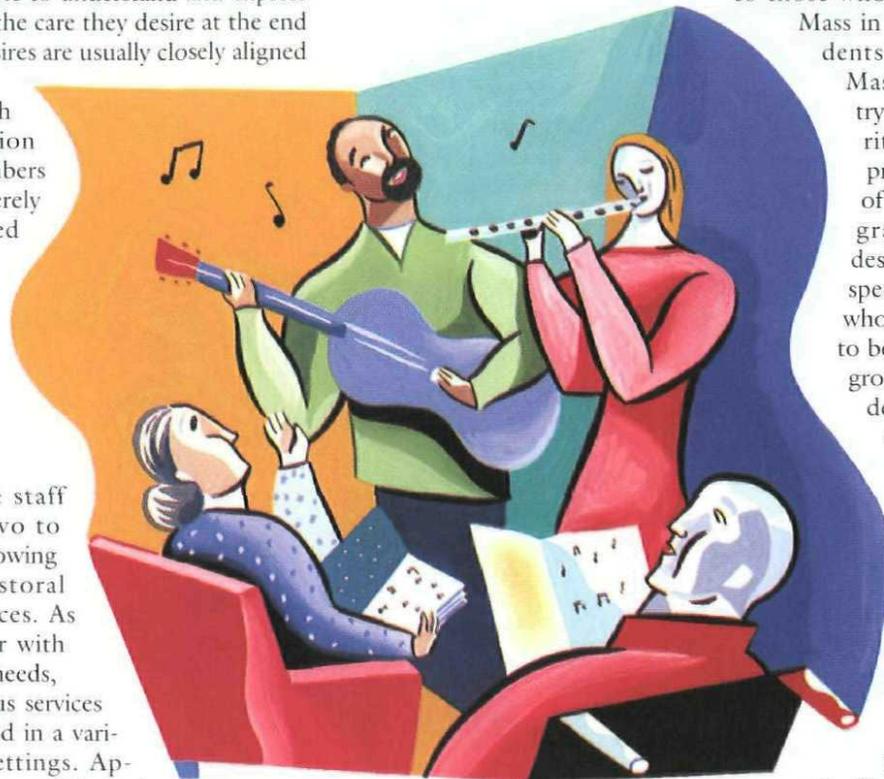
one of our three clubs: the Horizon Club, Rainbow Club, or Sunshine Club.

They spend most of each day together, taking part in a variety of activities. One of these is the prayer service, which takes about 15 minutes and consists of

familiar music and prayer. As

part of the service, each participant is addressed by name and asked what he or she wishes to pray for. One may pray for "my mother," while another "that my friends and I will have a good day."

A Protestant service is offered weekly in the chapel for those who are not Roman Catholic. Ecumenical and paraliturgical services are offered





several times a year, and special events such as May Crowning are a regular part of Manor life. All services that take place in the chapel are televised on our in-house television channel, enabling residents to take part from their own rooms or in the large sitting room areas.

In addition to the priest resident who says Mass, volunteers, both residents and from the community, help with a variety of duties. Some assist with sacristan duties, distribute Communion, or lead meditation or the Legion of Mary. Others visit individual residents.

SUCCESSFUL INTEGRATION OF PASTORAL CARE

In 1993 my duties expanded to include mission effectiveness for the facility. I work with a committee of 16 employees to plan in-service sessions and events designed to expand employees' understanding of mission. One successful project has been Mission Day. Each month up to 24 employees take part in a day-long seminar that focuses on understanding ourselves as people who have the same needs as our residents do. We reflect on our values, memories, beliefs, and gifts. Using experiential techniques, we feel what it is like to use a wheelchair, to suffer from hearing or vision loss, or to adjust to the effects of a stroke. After two years of these Mission Days, employees from every department reported an increased understanding of and patience for our residents. They also reported increased respect and appreciation for the work of other departments.

The pastoral care team expanded in 1996 to six members. It includes four who are certified by the National Association of Catholic Chaplains, one priest, and one pastoral assistant. Three members are lay, two are Carmelite Sisters, and the priest is a diocesan priest assigned by the diocese. As the director, my responsibilities include department administration as well as a floor assignment. Each certified pastoral care team member has primary responsibility for one nursing unit, and each meets regularly with each resident on the unit in order to participate with the

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care planning team. They are also responsible for charting on each resident at least quarterly, as federal regulations require. We cover the units seven days a week, from 8 am to 5:30 pm, and to 8 pm three days a week for family ministry.

The priest's duties revolve around the liturgical and sacramental elements of ministry. He sees every new Catholic resident and usually administers the Sacrament of the Sick. This sacrament is also offered biannually in a communal service, and individually whenever someone's condition warrants it. Our pastoral assistant takes care of the chapel and assists me on my assigned unit when there is a conflict in my schedule. The priest and the two religious sisters live on the premises and are available 24 hours a day for any true emergency. However, with advance planning, these situations are rare in long-term care.

After 12 years, pastoral care givers at St. Joseph's function as an integral part of the healthcare team. If I were to advise someone just beginning this process, I would emphasize several areas. The first is education. Residents, family members, staff members, and administrators often need clarification about the nature of pastoral care. Issues of spirituality must be defined and distinguished from issues of religion. High-quality pastoral care should be available to all.

Second, the Pastoral Care Department can be no different from any other department. If all the others have policy and procedure manuals that are cross-referenced to other disciplines, the Pastoral Care Department must do the same. If all departments are running a continuous quality improvement monitor, the Pastoral Care Department must also do so. Concrete measuring tools used in other aspects of long-term care must be adapted for the Pastoral Care Department. This enables other disciplines to understand the role of pastoral care, and helps the Pastoral Care Department define itself and clearly see its relationship to the other members of the healthcare team.

Finally, pastoral care professionals must learn to speak a variety of languages, including those of medical practitioners, administrators, rehabilitators, dieticians, and social workers. When the healthcare team, the resident, and the family are working in concert, it is often the pastoral care professional who reminds all of their common humanity. It is pastoral care's role to see that the meaning of events is understood from the resident's perspective and through his or her faith. Otherwise, pastoral care will continue to be seen as operating on the fringes of healthcare rather than as an integrated partner. □

CARMELITE MISSION AND PHILOSOPHY OF CARE STATEMENT

"Our belief is that we have an opportunity and a responsibility to provide pastoral care for all persons associated with our health care facilities—residents, families and staff. In the spirit of ecumenism, we respect the religious beliefs of those with whom and to whom we minister, however we uphold our philosophy and mission." 1984

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