RESIDENT-CENTERED CARE

Teresian House Takes a Team-Based Approach to Care of the Elderly

BY MARIANNE OSBORN GOULD, RN, BSN

The concept of resident-centered care is rooted in the philosophy of the Carmelite Sisters for the Aged and Infirm, founded by Mother Angeline Teresa McCrory in 1929, who said,

> At the time I was called a revolutionary, but I went ahead with my plans for creating new, home-like residences for the elderly, where they would have full freedom and privacy and would be encouraged to retain their independence. It would provide living quarters for elderly couples and recreational facilities, as well as medical care.[1]

As stated by Mother Angeline, the philosophy and mission of the Carmelite Sisters for the Aged and Infirm has always centered on the individuality of the resident. The Carmelite order has also always recognized the individuality of caregivers. Like the women who first worked with Mother Angeline, the Carmelite Sisters for the Aged and Infirm of today represent myriad professions and talents. In addition to administrators and nurses, Carmelites also include social workers, chaplains, dietitians, nurses' aides, musicians, housekeepers, and accountants. Because of the interdisciplinary composition of the order, the Carmelites are particularly well suited to a team-based approach to care of the elderly that draws on the different strengths, talents, training, and expertise of its members.

Ms. Gould is coordinator of health services, Teresian House, Albany, NY.

A History of Care

The first Carmelite home for the elderly, St. Patrick's, opened in Bronx, NY, in 1931. In 1974, the Carmelite Sisters for the Aged and Infirm opened Teresian House, a 300-bed facility located in Albany, NY. In the years since 1974, Teresian House has embarked on a journey through physical, organizational, psychological, social, and spiritual changes. This article will highlight only a few of the challenges encountered during the journey that ultimately shaped the Teresian House of today.

As originally built, the structure of Teresian House featured hospital-like corridors of private and semiprivate rooms. The nurses' station, a separate room, was located in the center of the building and was always the center of activity. Places where residents could gather, such as the chapel, therapy rooms, beauty parlor, and the "country store," were located on the first floor—far from the actual living areas.

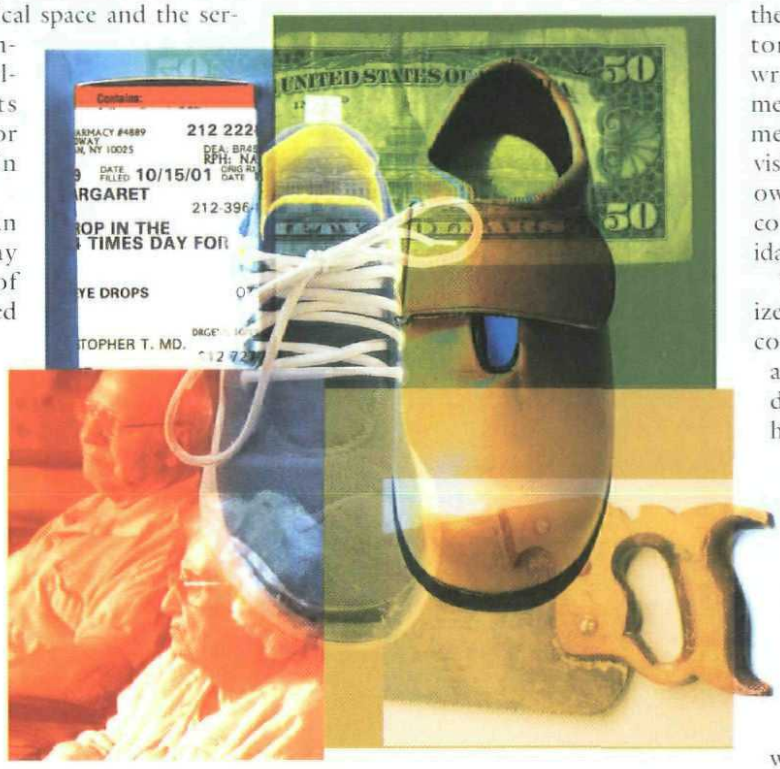
Limitations included a very small chapel, with fixed pews seating about 50 people and little room for wheelchairs. To accommodate more residents, Sunday Mass was said in St. Joseph's Hall, the official community gathering space. Although pleasant enough, that room was not conducive to contemplation. Meals were served in the main dining room, also located on the first floor.

This physical environment worked well at the time because most of the residents were what was then considered the "well elderly," and services provided followed a social model. As the residents became more frail over the years, two of the five floors were certified as skilled nursing units. Residents with more complex medical needs were housed on those floors. Staffing levels were adjusted according to the residents' care needs. Having different levels of care within the same

facility allowed changes in staffing to improve flexibility.

The shift away from a social model was gradual. As the residents continued to need more assistance with activities of daily living (such as bathing, eating, and transferring from chair to bed), each succeeding sister administrator did her part to improve the physical space and the services offered. In this manner, Teresian House developed and maintained its reputation as a model for care of the elderly in Albany.

By the 1980s, Teresian House had shifted away from the social model of services and was considered a medical model. As in other "good" nursing homes, some residents were restrained (according to New York State Health Department guidelines), feeding tubes were inserted in some critically ill patients (after ethics committee meetings and recommendations), and residents' lives were governed by what physicians ordered and by established routines of the nursing home. The organizational structure at that time was traditional in nature, with top-down decision making. Nursing unit managers directed the care on each floor.



Movement Toward Fundamental Change

In 1991, Teresian House undertook a detailed study of its strategic plan. The study outlined Teresian House's strengths, weaknesses, opportunities, and threats. The areas examined included:

- Physical and architectural features
- Policies and programs
- Residents and staff
- Social and environmental features
- Priority setting and planning

Teresian House surveyed residents, families, and staff to determine their opinions of the facility and its services. Results showed the need for work in several areas. First and foremost, a resident satisfaction survey indicated that residents wanted more control over their care. Surveys concerning the physical environment revealed the lack of adequate space in both resident rooms and offices. Additionally, total quality improvement teams had made several suggestions for changing our approach to care, but the physical environment at the time hampered the implementation of these suggestions.

Teresian House made all levels of staff aware of the findings. Our administrator, Sr. Pauline Brecanier, wrote her own vision statement and challenged all staff members to write their own vision statements and set their own goals. Leadership then convened meetings to consolidate and prioritize goals.

The formation of a specialized, interdisciplinary steering committee to study the care and treatment of our residents with dementia was high on the priority list. The purpose of this steering committee was threefold:

- To address the needs of residents with early dementia
- To demonstrate the feasibility of providing specialized dementia care in an existing unit without disturbing the organization and placement of residents
- To demonstrate whether progression of dementia can be stabilized or slowed

Over the course of the next several years, the Dementia Program Project was implemented. The first challenge was to create separate, smaller dining areas where residents with dementia could eat in a pleasant environment with minimal distractions. A third-floor lounge was considered suitable because an adjoining closet could be modified to serve as a kitchen serving area, and restrooms were nearby. We also decided to serve the residents with dementia one course at a time. (This deceptively simple approach was immediately successful. Rather than being distracted by the soup and salad available at the same time and eating neither one, the residents in the special dining program began to eat or drink all their soup before approaching the next course!)

Although our emphasis was on the dining experience, we also planned to train staff to interact with residents with dementia around the clock and in all situations. To provide continuity of

approaches, profiles were completed for each resident accepted into the special program unit. These profiles listed the physical needs of the residents as well as descriptions of their interests and individualized hints for staff on how to avoid confrontations, which, in those with dementia, are so often merely the result of an inappropriate approach.

Because our plan included specialized training of staff to conduct programs, we posted notices asking for a show of interest. Twenty-six aides representing all three shifts applied for the course. After being interviewed and ranked, 12 applicants were selected for the 12-hour course. An interdisciplinary team consisting of the administration, nursing services, social services, activities, occupational therapy, and staff development departments developed and taught the curriculum.

The Dementia Program Project was successful on a number of levels:

- We developed criteria for identifying needs in a population incapable of communicating in "ordinary" ways.
- By recognizing the individuality of *caregivers*, and matching their strengths to the needs of residents with dementia, we proved that a team pulling together can accomplish more than any individual could, no matter how highly motivated.
- The project forced us to consider unconventional approaches, not only toward dementia, but also toward all behavioral challenges.
- We broke down virtually all care practices into their smallest delivery unit. This "cluster concept" became the cornerstone of care delivery at Teresian House.

The Dementia Program Project and its individualized approach to environmental, organizational, psychological, social, and spiritual concerns fundamentally altered the methods of care delivery at Teresian House and reinforced our belief in the benefits of resident-centered care.

Current Environment

By the late 1990s, administration and staff realized that even specialized programs could not meet all the residents' needs given the existing physical structure. With a renewed awareness of the resident-centered model of care, the entire facility embarked on a series of changes in all the environments.

We held regular meetings with residents, families, and physicians to keep them updated on the developing changes. Weekly meetings for all staff in all departments, and on all three shifts, resulted in many innovative ideas as well as a sense of everyone being involved in the decision-making process.

Teresian House underwent physical changes both in its original facility and in the newly constructed, adjoining facility. Resident-centered care was a key design feature in the Bishop Howard H. Hubbard Pavilion, our new building. A team of architects specializing in long-term care designed this two-story addition. Its configuration of two squares joined in a "bow-tie" shape allowed for clusters of 12 or 13 resident rooms arranged around two courtyards.

The upper floor, named Mount Carmel, is home for residents who are still quite independent and alert. The lower floor, Carmel Garden, is our dementia unit, where the practices of the Dementia Program Project continue in a structurally enhanced environment. Because it surrounds two courtyards, the lower floor provides protected walking paths both inside and outside the unit. Both these floors have four small dining areas, one on each side of two kitchens. Many recreational spaces are available on both floors, such as living rooms, garden rooms, and game rooms. All Pavilion resident rooms have dutch doors (divided horizontally so that either the top or bottom can be closed), allowing the residents different degrees of privacy.

> To keep the staff involved and physically present in the activities of the residents, their work spaces were incorporated into the living areas of the unit.

One hundred residents transferred to the new facility. Fifty independent residents moved to Mount Carmel, and 50 residents with middle-stage dementia moved to Carmel Garden. Major renovations then began in the old building. The cluster concept, as developed in the Dementia Program Project, was evident in the physical changes made to the old building. These changes consisted of converting all residents' rooms to private rooms with private baths, reducing the number of residents cared for on each floor from 60 to 40, and constructing kitchen/dining areas (serving 20 residents) in each wing. Staff refer to each wing as a "neighborhood."

A large living/family room is central to each neighborhood and furnished much as any private residence would be, with comfortable, upholstered furniture as well as televisions, videocassette recorders, and pianos or organs. Bathing and showering rooms were enlarged, and washers and dryers (for personal clothes) are available on each floor.

Planners carefully considered the use and placement of nurses' stations in both the new and old buildings. To keep the staff involved and physically present in the activities of the residents, their work spaces were incorporated into the living areas of the units. In the Pavilion, cabinets adja-

Continued on page 72

REFLECTIONS

Continued from page 8

deserve particular emphasis. Research on diseases that particularly affect the elderly, such as Alzheimer's, must be a priority. The research agenda, however, should not be limited to specific diseases. For instance, we need to learn more about how to adjust the home environment of elderly persons to help them avoid dependency-creating events such as falls. Research and development of new technologies may extend the period in which the elderly can live independently.

Finally, prevention both in terms of research and application should also be prominent on the public agenda. We recognize that, with aging, limitations on life and activity increase for most people. This recognition, however, should not imply a passive acceptance of conditions that preventive measures could address.

Advocacy is an essential function for improving our ability to serve aging and chronically ill persons.

Such an effort would be independent of, but would ultimately complement, our ongoing advocacy for accessible and affordable health care coverage for all. We recognize that, even with universal health care, many of the housing, day care, and social services that are essential parts of the care continuum would still not be addressed. □

The preceding is adapted from "The Graying of America: Ethical and Policy Implications for the Church and Nation," the Hillenmeyer Lecture that Fr. Place delivered at Thomas More College on April 23, 2001. The full text is available at www.chausa.org/prespage/hillenmeyer.asp or by contacting CHA order processing at 314-253-3458.

NOTES

1. C. Evashwick and T. J. Holt, *Integrating Long-Term Care, Acute Care, and Housing*, The Catholic Health Association, St. Louis, 2000.
2. The Catholic Health Association, *Profile of a Community Partner: Building Networks with Catholic Charities*, St. Louis, November 1996.
3. C.J. Fahey, *The Policy Agenda for Long-Term Care*, Draft 3, November 12, 1999, at http://www.fordham.edu/thirdage/ethics001.htm.

RESIDENT-CENTERED CARE

Continued from page 58

cent to the residents' family rooms function as staff workstations. In the old building, the old nurses' station was eliminated and cabinets in each family room now function as staff work space.

Surprisingly, constructing the new building was the easy part of the renovation. The real challenge for Teresian House staff was adjusting to their new work space amid the residents as well as to their place in the new organizational structure, which now centers on a team-based approach.

The concept of a leader directing a team of staff representing all departments replaced the idea of an RN manager of a floor with supplemental help from various departments. In keeping with our vision, this leader is called the resident-centered care coordinator (RCC). He or she is trained as a mini-administrator and has overall responsibility for a 40- to 50-resident unit. The RCC leads a team consisting of an RN, an LPN, nurses' aides, resident assistants, a social worker, an activities coordinator, and housekeepers. This team performs all the tasks necessary to address resident needs on an assigned floor.

Each team reviews all the tasks performed for residents and collaborates on a list of global duties, defined as tasks that can be performed by any team member as long as the task does not exceed the scope of his or her job description. The scenario of a resident turning on a call light is a good example of these global duties. Any member of the unit team can *answer* a call light. The person answering the light may not be qualified to bring the resident to the bathroom or to administer medication, but that person may move a box of tissues closer, pull a shade down, or alert the nurse to a request for pain medication. In addition to lowering the noise level on the floor, the prompt answering of call lights illustrates one advantage of the team approach, which is quick and efficient response to resident requests.

To prepare the team to care for individual resident needs, a preadmission assessment form is used. Completed by the resident and family before admission, this form lists items such as medications the prospective resident receives, preferences for meal and bath times, placement of bed, and interest in church and other outside activities. By reviewing the information on this assessment, the unit team can form a picture of the resident's life in the community and use it as a basis for an individualized care plan.

The preadmission assessment form also reflects our shift in focus from the medical model—requiring the resident to fit into the established routines of the facility—to a focus on the facility accommodating, as much as possible, the routines of the resident.

The physical and organizational changes implemented by Teresian House have resulted in profound psychological, social, and spiritual benefits for the residents. The cluster concept enables the different personalities and interests of each resident to blossom. Large parties and gatherings still happen occasionally, but the day-to-day activities center in a homelike group. With few exceptions, residents are now allowed to age in one place, eliminating the fear of being sent to another floor when physical capabilities diminish. Replacing the institutional aura with the more homelike environment allows for more family-oriented gatherings. Residents are now more relaxed and interact more with staff and other residents. Each floor can cite numerous anecdotes of the positive effects of this new environment.

Of course, not every change was met with wholehearted enthusiasm, and not every change succeeded. Some staff members left because they did not agree with performing global duties that they believed were beneath their educational level. In some instances, prepared budget line items (especially food) went beyond set parameters and had to be brought back in line by careful monitoring. Nevertheless, our fundamental belief that benefits for the residents would result from the practice of resident-centered care was a beacon for our journey and remains our hope for the future. □

NOTES

1. Lorretta Pastva, *The Carmelite Sisters for the Aged and Infirm*, Editions du Signe, Strasbourg, France, 2000, p. 4.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, November-December 2001