

## **Reconnecting to Care: A Nursing Initiative at the Baycrest Geriatric Health System**

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*The moment one definitely commits oneself, then Providence moves too. All sorts of things occur to help one that otherwise would never have occurred.*

- Johann Wolfgang von Goethe

Why has Baycrest decided to get back to basics and reconnect to care? How has it begun to do this? Are there any lessons for others? This paper is an overview of the reasons for this initiative, a little of how it has been implemented so far, and some initial lessons for nursing leaders and others.

In the 20<sup>th</sup> Century it was not uncommon for people to enter “old folk’s homes” immediately upon retirement. The percentage of people over 65 who lived in institutional settings was very high in Canada. In provinces like Quebec almost 15% of seniors lived in such settings (Canadian Centre for Justice Profile Series 2001: 4). The threshold for admission was very low and residents’ capacity to care for themselves was very high. The institution provided meals and housekeeping services for a population that lived in boarding house- or hotel-like accommodations. Nursing services, if there were any, provided minor support such as insulin injection for diabetics, health monitoring, and health and nutritional advice. Baycrest was founded in the early 20<sup>th</sup> Century as such an old people’s home (Baycrest Centre for Geriatric Care 2002: 2).

As the population has aged, a lower proportion of seniors have come to live in long term care (LTC) and complex continuing care (CCC) settings. More older people live independently in their own homes, in communities dedicated to them and in a wide

variety of housing with differing levels of support for independent living. The institutional old folk's home has become a long term care facility and a provider of complex continuing care. The population in non-acute settings is now mostly over 80 years old with a much lower capacity to care for themselves and with many more needs for support than in the past (Baycrest 2002: 15). They typically require assistance with many aspects of daily living with increasingly heavy and complex continuing care needs. They can be differentiated to some extent between nursing home long term care patients and hospitalized complex continuing care patients. But both require increasing amounts of basic nursing care and can be linked for the purpose of our paper. Over the last decade in Ontario, 78% of LTC clients have been classified in the mid-to-heavy care categories; 63% possess some form of cognitive or psychiatric disorder (Alzheimer's disease, related dementias, psychoses and mental disorders); 72% are incontinent, up from 51% in 1992; 37% require constant encouragement or total feeding, up from 28% in 1992; and 72% require one or two staff to assist with toileting, up from 48% in 1992. In the Apotex Centre, which is Baycrest's nursing home, the residents are over 85 years of age on average and the vast majority requires continuing direct care on a daily basis for even the most basic life tasks (Baycrest 2002: 15). Baycrest also provides complex continuing care (CCC) to a similar but more clinically demanding population in its hospital units. For the purposes of this paper, we will consider the difficulties associated with long term care (LTC) and complex continuing care (CCC) together under the term Complex Continuing/Long term Care (CC/LTC).

Alongside these demographic and institutional changes, there has been an explosion of highly differentiated knowledge and skills to support this aging population (Long-Term Care Task Force 2000: 17). Research on aging has included everything from primary research on the aging brain to the sociological consequences of the proliferation of people over the age of 80 in the general population. There is a growing array of highly specific therapies and pharmaceuticals to deal with problems associated with aging, such as hypertension, diabetes, cancer, heart disease and even cognitive deterioration. Specialized interventions range from orthopedic surgery to replace aging joints, to recreation therapy, which enables older people to make good use of their restored limbs. People over 65 consume 40% of all pharmaceuticals, even though they constitute less than 20% of the population (Division of Aging and Seniors 1996: 3). As a result, intra-professional specialization has proliferated, for example, in clinical nurse specialists who offer support in such areas as incontinence, wound management, stroke treatment and others. At Baycrest there are more than 35 different types of specialized professionals who have direct contact with patients and provide highly differentiated support. They range from geriatric dentists to music therapists.

The extent of this differentiated specialization has tended at times to diminish the importance of the basic care requirements of people. Supports for daily living such as dressing, bathing, feeding and toileting have been devalued, and thus relegated to less skilled aides or other non-regulated support personnel. Such workers are rarely rewarded for their devotion to individual patients. In fact they are largely invisible and tend to be ignored within organizations. Typically they are left out of case conferences, even though

they have the most intimate and continuous knowledge of individual patients in the nursing home setting. Moreover, as the threshold for admission increases, and as those who live in nursing home and complex continuing care facilities generally require more support with care and activities of daily living, the workload of direct care workers significantly increases.

The morale and attitudes of these direct care workers have been well documented in the literature, and their difficulties have been starkly contrasted with the more positive attitudes of more highly educated and specialized clinicians and administrators who are generally higher on the institutional “pecking order.” Direct care workers are frequently cynical about the institution, bored by the repetitive and routine nature of their work, and distressed by the deterioration of those in their care. Often they feel under-appreciated for their capacity to cope with the difficulties of their work. At times they become overwhelmed and exhausted by it.

At the professional and institutional level there is a similar “pecking order.” Nurses in long term care and complex continuing care facilities are considered to be less skilled and motivated, and of a lower professional status than those who work in acute care settings. It may be that this is one of the factors that leads to the fragmentation and neglect of direct care in acute care settings as well. This professional and institutional status hierarchy follows general social values, which emphasize and value heroic acute interventions and avoid, ignore or even denigrate the institution and workers who provide CC/LTC. This kind of care is not heroic. Rather, it is a support for the day to day lives of

people. They have an everyday life that requires getting up, dressing, cleaning themselves, eating and going to the bathroom. If these quite necessary aspects of daily life are not recognized as fundamental, then we have a hard time recognizing the value of those who provide support for them.

Over the years, the necessary nature of direct care, the fact that it is repetitive, difficult and of relatively low status has led to two contrasting responses to the difficulties associated with direct care: the industrialization of the processes of care; and the obscuring of the real nature of these processes of care by creating euphemisms to describe them. The first was a kind of industrialization of the tasks associated with it. The terminology associated with these tasks carried a mechanical, routinized character. For example, patients who needed a great deal of care were categorized as “heavy cases;” and, the flow of work involving the feeding of patients at meal time began to be seen as the “bottleneck” of work processes in the long term care setting. Reducing direct care to mechanical tasks converted the long term care setting into a kind of industrial machine, such as the machine-like institution satirized in *One Flew Over the Cuckoo’s Nest*. Work loads assigned by the number of measurable tasks became the rule. As a result the “caring” aspects of direct care became even less valued.

A contrasting, but no less damaging way of dealing with the difficulties of direct care has been to obscure how hard the work is by stressing its social, psychological and even spiritual aspects. The reality of cleaning the excrement of incontinent patients can be ignored and even hidden beneath such euphemisms as “nurturing the interactive

experience of patient care.” The dependent and needy nature of the people who live in long term care facilities is often lost when they become “clients,” “residents,” or even “tenants.”

Rarely is excellent direct care recognized and rewarded. The dedicated and devoted direct care nurse in non-acute settings is hardly ever singled out. The chronic long term nature of the work offers few chances for heroic interventions. Excellent care can comfort and support, but it cannot cure, and it only rarely dramatically improves the condition of patients. The chronic nature of patient conditions and the inevitable deterioration over the long term does not speak to the constant requirement of the system to seek positive outcomes. This can make it difficult for a system focused on cure and such outcomes to reward the direct care worker.

The end result is that professional and non-professional direct care workers come to the notice of senior staff in all settings only when things go wrong; and they can go wrong in a variety of ways. Complaints about staff attitudes and practices from patients and families can increase, more staff will leave as they become more and more dissatisfied, and adverse incidents such as unfed patients, bed sores, falls and drug errors can become more common. More severe consequences can also occur. Poor toileting has at times resulted in ignoring severe constipation or other gastrointestinal issues with consequences ranging from malnutrition, impacted stool, and all too often, death. Poor bathing has resulted in skin disorders ranging from dermatitis to severe bed sores. Poor feeding has resulted in malnutrition, severe weight loss and even nutritional dementia.

The recognition of these and similar issues about the nature and especially the relative significance of direct care in a more client-centred environment has led Baycrest to initiate a series of interconnected efforts. It formed a multi-disciplinary committee to reframe the Baycrest model of care. Its membership includes people who live at Baycrest, family members, bedside nursing staff, and a wide range of professionals and administrators. The views of the people who call Baycrest “home” were given a special prominence in order to allow the group to frame its mandate, identify client perspectives on issues and begin to address concerns. Not surprisingly, the issues that residents and their families identified had to do with lapses of day-to-day care – such concerns as increased number of baths, telling families about cancelled medical appointments, the availability of drinking water during the night, responsiveness to call bells and making sure that patients are kept dry.

“Reconnecting to Care” (RTC) is a response by nursing at Baycrest that began in 2004. The RTC initiative is comprised of changes in the organization and delivery of care that will be addressed throughout Baycrest over the next few years. Central to it is the recognition that the basic business of long term and continuing complex care facilities, especially those dedicated to care for the elderly, is to provide direct support for clients who are no longer capable of caring for themselves. A major objective of RTC was to address both sides of the issue: how to improve the daily care of residents of Baycrest, while at the same time improving the working lives of the providers of care. Senior management recognized the need for an intervention and also was prepared to support it

financially and organizationally. The initial financial support came from several donors; one who funded the physical renovation of the unit and another who contributed to the educational program itself. Baycrest provided added funding for the educational program.

At the same time as it was becoming clear that a deep change initiative was needed, several areas at Baycrest became obvious candidates for intervention. They had clear personnel problems including high turnovers of care staff as well as managers. There was a relatively high level of client and family dissatisfaction with direct care services. These provided multiple base lines for improvement. Though many of them were not easily measurable and it would be difficult to attribute causality to particular interventions, it would be relatively easy to recognize change when it occurred and change was the objective.

As a result, the intervention itself could now become the subject of detailed planning. It was decided to begin by temporarily closing one nursing unit so that it could be physically renovated while all day-evening and night nursing would come together in a three week intensive program. Inter-professional staff would join them for part of the program. All participants in the program would be evaluated before it began and again after the unit reopened. The process was called “The Reconnecting to Care Renewal Program.”

This initiative has been a change management program. It was not and could not be planned as a controlled experiment largely because there are so many uncontrolled



variables. For example, it could not be known in advance if the staff, or the patients, would remain constant - indeed it was expected that they would change as the renewal project proceeded. As a result the program did not have clear measurable baselines or outcomes. Moreover the interventions were constantly being adjusted as the program progressed so that they did not remain constant even through a single iteration of the renewal project. What did remain constant were its objectives - the focus on basic care and the decision to increase the capacity of staff to provide it in an intelligent, humane, ongoing way. The results of the change project have been largely positive and are described below.

The first of six units was closed on October 18, 2004 and the staff program ran over a four week period. It began with an orientation to the entire RTC program so that participants could understand the reasons for it, its objectives and the changes that were expected in staff. There were observers who watched the process and gauged participant reactions and reflective journaling to monitor changes in critical thinking attributes. The renewal program proceeded largely according to plan and its first cohort returned to work on November 5, 2004.

Outcomes of the first cycle of renewal were positive. There was a measurable reduction in staff turnover, a significantly easier time for recruiting new staff to the unit and a measurable reduction in complaints about staff by families and residents.

External observers of the organization also noticed the change. Baycrest was accredited after the RTC program had begun and the accreditation report of July 2005 declared that

“The most significant quality improvement initiative is the Renewal Project which is also an excellent example of risk management”. “The Renewal process has been excellent in breaking down silos and allowing different levels of staff to work together”.

A group of students from the University of Toronto were also asked to observe a number of units at Baycrest. These students noticed and documented a marked difference between the unit that had been renewed and others that had not. They found that staff members were more responsive, more alert, and more dedicated to their work than those on the other units. The observable changes in the mood of the unit, and in the attitudes of staff were mirrored in comments recorded by both Baycrest residents and families. Some thought that the changes were “nothing short of a miracle.” They declared that “staff are more proactive and responsive” to residents needs.

Staff surveys showed that staff had a bigger picture of their roles, as well as more awareness of system and process issues. They knew each other across the different shifts and had developed a better understanding that they were part of a team. They were clearer about what they were expected to do and were given feedback on how they performed.

Since the decision was made to continue with the program, five other cycles of the renewal program have occurred in 2005. Feedback from participants and observers of each cycle was used to improve the subsequent iterations. Recently data was gathered about the changes that were instituted and the consequences to patients. These included

the standard of nursing, and a series of quality indicators. They show marked improvement despite an increase in patient acuity in all units. They are detailed below.

In the five units on complex continuing care the case mix index which measures the acuity of patients conditions has increased. See Table 1.

<b>UNIT</b>	<b>Pre-Renewal</b>	<b>Post- Renewal</b>
<b>5E</b>	1.20	1.26
<b>5W</b>	1.27	1.28
<b>6E</b>	1.18	1.25
<b>7E</b>	1.19	1.24
<b>7W</b>	1.20	1.24

Table 1: Changes in Case Mix Index

There has been a marked improvement in the degree to which nursing staff met preset standards – based on training, skill sets, attitude to patient care and aptitude for working with patients and for critical thinking. Both Registered Nurses (RNs) and Registered Practical Nurses (RPNs) have been upgraded. See Table 2.

<b>Category</b>	<b>Pre-Renewal</b>	<b>Post- Renewal</b>
<b>RN below</b>	34%	15.6%
<b>RPN below</b>	31%	15.2%
<b>RN at standard</b>	22%	21.5%
<b>RPN at standard</b>	22%	23%
<b>RN above</b>	14.5%	45%
<b>RPN above</b>	15.2%	44%

Table 2 Changes in Meeting Nursing Standards

The consequences to patient quality indicators have in general been positive. Nurses have become more proactive. For example, they have questioned the need for excessive bed rest, as well as the need for tracheostomies and feeding tubes. A good example is the change on the 7<sup>th</sup> floor CCC units. Before renewal these units had discharged only to external hospitals or upon the death of the patient. Since renewal two patients have progressed towards discharge back to their own homes. Two have gone from CCC to a Long term care facility and six more are improving. Seven patients who had been bed-bound are now up: some are now pivoting out of bed on their own while others are walking. Six patients have had their tracheostomy tubes corked in preparation for removal. Two patients who had been fed by tube are now eating orally.

The changes in clinical quality indicators are similarly noteworthy. See Table 3 below

UNIT	Bedfast Pts		Restraints		Falls		Urinary TIs	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
<b>3E</b>	44%	0.0%	0.0%	0.0%	11.1%	0.0%	33.3%	33.3%
<b>5E</b>	26.1%	15.4%	13.0%	0.0%	7.7%	0.0%	4.4%	7.7%
<b>5W</b>	0.0%	13%	3.4%	0.0%	3.9%	0.0%	11.5%	3.2%
<b>6E</b>	4.0%	0.0%	0.0%	0.0%	4.0%	0.0%	20.0%	0.0%
<b>7E</b>	0.0%	0.0%	3.1%	4.2%	0.0%	0.0%	3.1%	0.0%
<b>7W</b>	12.2%	8.0%	0.0%	0.0%	3.0%	16.0%	3.0%	0.0%

Table 3: Changes in Quality Indicators

Overall response by patients and families remains positive. There are few, if any complaints brought forward to the Senior nursing or Senior administrative level. This means that concerns are addressed at the unit level – where care should be the focus.

Minutes of Family Council and Family Advisory groups do not report the same degree of dissatisfaction as was evident before Renewal.

At each stage of the renewal process the feedback from participants, patients and family has been used to strengthen the process. Some of the changes have been to make the process more transparent to all those involved. Others have been to improve the classroom training. For next iterations we will increase the involvement of non-nursing staff. This would allow more staff to join in the new ways of relating to each other and to patients and their families.

One of the many paradoxes in health care is that improved services which produce healthier patients also increase demand. This has been true in the overall health field, where every improvement whether in accessibility, through public funding, or in innovation through new technology or drugs, has resulted not only in healthier populations, but also in an increase in the demand for health services. This was no less true at Baycrest where this change initiative provided more direct nursing care and nursing became more focused on that care. The expectations of patients and their families were raised and there has been an increased demand for nursing services and also for the services of other disciplines. The training of nursing staff prepared them for this new level of service delivery, and they have been largely able to meet these demands.

However this was not the case for some of the other disciplines. Many staff members found it difficult to adjust to new nursing attitudes, and found it difficult when they were

also faced with more demanding patients and families. These demands were harder to fulfill and there was too little planning for this consequence.

At times the relation between nurses and other professionals was disrupted by the change in attitude and work orientation of the nursing staff. Along with the clients and their families, nurses became more demanding of the other professions. They now had the expectation that other professions would be able to follow up on their increased and more fundamental efforts. Unfortunately other staff often did not have the resources to do this. And tensions between professions increased as a result.

Coming to recognize this state of affairs was somewhat difficult for the nursing directors. They were not immune to the go-it-alone tendency that is a deep part of nursing culture. (A good example is the idea that nurses, especially in long term and complex care facilities, do everything that all the other professions do between five in the afternoon and nine in the morning.) In this case nursing was not able to meet the growing demand for social work, occupational therapy and so on. It became necessary to recognize not only what other professions contribute, but also to reach out for their help.

In recent months there have been a series of meetings precisely to ask for that help and to begin to assimilate the perspectives of other professions on the ideas of reconnecting to the care of patients and families. These meetings have allowed nursing directors to form fresh relationships with professional leaders and to request their help in the next stages of the Baycrest renewal project. So far this has opened up a richer understanding of the

similarities and differences of the different approaches to care and a careful and somewhat tentative negotiation of ways forward toward a more comprehensive set of standards and a richer model of care. What the next obstacles will be, await the results of the next rounds of renewal.

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