Dear Dr. Jeff

By Jeff Nichols, MD, CMD

Fixing Potholes in the Road to Better Communication

Dear Dr. Jeff:
You recently responded to the issue of homes troubled by a single disruptive family member creating turmoil. Our problem is different. We have a hundred families, each seemingly reasonable, who exhaust our staff with minor complaints and questions. It feels as though we hardly have time to actually care for the residents. Yet the residents themselves appear happy. Any suggestions?

Dr. Jeff responds:
In the classic movie *Cool Hand Luke,* the warden responds to each conflict with the hero-convict Paul Newman, before punishing him, saying, "What we've got here is a failure to communicate." But sometimes the problem really is a communications failure, particularly when the care is competent and compassionate, but the families are still unhappy. Although some LTC professionals dream of a facility caring only for childless orphans, the reality is that chronic disease in our society generally plays out in the context of the family, and excellent care requires that family anxieties be addressed as well. When the families and the nursing home work together as a team, the work is easier and more satisfying.

Communication with families begins at the time of admission. Thirty years ago, families and often prospective residents routinely visited and toured the facility prior to admission. Sometimes they selected the floor or room they preferred, met relevant staff and reviewed facility practices. Admissions were arranged for the morning and often lunch had been ordered in advance. Although occasional family tours still occur at some facilities, they are generally in the context of an anticipated hospital discharge the following day.

More often, new residents come directly from the hospital barely knowing to which facility they are being discharged, or where it is located, before being hustled into an ambulance or ambulette. A common question on admission is: "Does my family know I'm here?" Often families insist that discharges be delayed until after working hours so that they may accompany a loved one during the transfer for reassurance or even simply to find out where they are going. Whether for hospital or family convenience, admissions now generally occur in the late afternoon or evening, long after the day shift has left. Indeed, many facilities will still accept a new resident until 11:59 p.m. to get credit for another filled bed for the day. Anxious residents and staff arrive when the facility is typically less staffed. Senior administrative, rehabilitation, dietary, and social work personnel have usually already gone home. Frequently, there is no physician or nurse practitioner there.

Families, already suspicious of the quality of nursing home care, are unlikely to be reassured by this scenario. So, even if everything the first night and following morning proceeds relatively smoothly, the facility is already working to catch up from a poor initial impression.

Shouldering Blame

Unfortunately, the first night rarely goes smoothly. Perhaps the admissions department has failed to alert the unit of the anticipated arrival of the resident or their variety of special needs. Transfer documentation may have been misplaced. Medication lists and discharge summaries are often inaccurate, inconsistent, or simply missing. Cognitively intact patients and involved family caregivers may not be adequately informed about the major diagnoses for which patients have been treated, much less the results of significant tests or the anticipated prognosis. Weight-bearing status may be unspecified or unclear, complex diets inappropriate for long-term care may be requested, and braces or other supportive equipment may be in place without instructions regarding their use or permission for their removal at night.

Often the floor staff, whether directly or nonverbally, conveys the message that they weren't prepared for the resident and wish the new arrival hadn't come. Unprepared rooms and unmade beds, prolonged pharmacy delays, missing meals, lack of required translators, and a general air of confusion reinforce a negative first impression that may take weeks or months to overcome, if at all. Once a family has been persuaded that the facility is disorganized and disinterested, they will understandably be vigilant in protecting their loved one from our mistakes and ignorance.

Even if we blame many of these problems on the hospitals, evil insurance plans regulating lengths of stay, or the chaotic medical system that creates silos and inadequately funds long-term care (indeed, all of them deserve some of the blame), the families will ultimately blame us. Complainers, even chronic complainers, are not always wrong. And, after all, we are providers presenting ourselves as caring for the old and frail. Facilities that fail to create an orderly and welcoming transfer process invite family conflict.

Family perceptions of disrespect and disinterest typically lead to demands to speak with the medical director, whom they incorrectly assume runs the facility. A brief exploration of their questions and concerns is advisable. Time will ultimately be saved if the relevant disciplines are also present, particularly the unit nurse manager or the director of nursing.

In the Know

Federal law requires facilities participating in Medicare and Medicaid to collect significant information regarding every resident's prior history and preferences, complete an elaborate assessment process (the MDS [Minimum Data Set]), create a care plan based on all the information obtained, and deliver care based on the combination of all that data and the written orders of a licensed physician. Everyone working in skilled nursing facilities knows this, but virtually no one outside of our world knows it.

For example, many New York nursing homes have been meeting regularly with networks of local hospitals to improve care coordination and assist in a statewide process attempting to integrate physical and behavioral health. As part of that process, facilities were asked what percentages of new admissions are screened for depression or dementia using validated measures, and whether these screens are ever repeated. The hospital representatives were totally shocked to learn that the number for every nursing home was 100%, and that periodic reevaluations are standard practice. If major teaching hospitals with sophisticated case management departments don't know about the MDS and that it embeds the PHQ-9 (Patient Health Questionnaire) and BIMS (Brief Interview for Mental Status) screening tests, why would we expect families to know anything about it?

When the family is oriented to this process, their anxiety is relieved, opening the door to better communication. They should be informed that we will be reaching out to them with important information regarding their loved one's habits and preferences. Families are generally amazed at the comprehensiveness and resident-focused nature of this process. Next, families should be instructed that the designated representative will be invited to a care planning meeting where they will be fully informed of the results of all assessments and will be encouraged to participate in the creation of the care plan. When informed about the process, few families will barrage every department requesting information or making suggestions.

Caregivers should also be told about ways they may be able to improve their loved one's stay. These ways include locating or supplying appropriate clothing and shoes for a post-acute stay and bringing dentures, eyeglasses, or hearing aids, which may have been left at home or taken home from the hospital for safety. Other personal items such as reading materials, puzzles, photographs, comforters, and a device to listen to favorite music may also make the nursing home experience more enjoyable and home-like.

Making Allies

The care planning meeting is another opportunity to make the family into an ally. Unrealistic expectations can be addressed while priority areas can be incorporated into the care plan. Unfortunately, since the family's presence often necessitates extra time in an otherwise time-consuming process, many facilities discourage family participation. Those meetings are scheduled during work hours, often in locations without adequate telephone or Skype connections to allow outside participation. Times are rarely adjusted for family convenience but may be shifted at the last minute to meet staff needs.

If timing conflicts do not allow family participation, arrangements should be made for the family to meet with one of the team members who can summarize the findings from each of the disciplines and fully inform the family about the care plan and all medications. That individual, who may be a nurse, social worker, or rehabilitation therapist, should be prepared to resolve any outstanding concerns for the family.

Many professionals try to minimize the severity of resident disabilities in an attempt to reassure families. We may describe a resident who is continent and ambulatory, but forgetful, disoriented to time, and having a tendency to wander off at night as having "early Alzheimer's." But from the family's perspective, these are devastating changes. Failure to clarify functional deficits can produce false expectations regarding the trajectory of recovery. Of course, miracles do happen, but false hope only produces poor decisions and ongoing recriminations. Ironically, family guilt is allayed when the facility demonstrates exactly why nursing home placement is absolutely necessary.

Families who feel welcomed, listened to, and informed are unlikely to be suspicious, demanding, or obstructive. Communication is a sign of respect. In order to get respect, we must demonstrate respect.

Dr. Nichols *is president of the New York Medical Directors Association and a member of the* Caring for the Ages *Editorial Advisory Board.*