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# Emotional Care in the Nursing home Setting

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# Emotional Care in the Nursing home Setting

Submitted by: Trista Pohlman B.A., LSW

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MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work

St. Catherine University and the University of St Thomas  
St. Paul, Minnesota

In partial fulfillment of the Requirements for the Degree of  
Master of Social Work

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The clinical research project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Internal Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's Thesis nor a dissertation

**Abstract**

This research project examines emotional care provided to nursing home residents, prior to them being hospice qualified. Hospice offers a continuum of care that has documented success. In review of the literature, it appears that the nursing home setting provides a set of standards for how needs are responded to that inhibit the type of care hospice is able to provide. By conducting qualitative semi-structured interviews of six employees working in the role of case management in a nursing home setting, an analysis by phenomenological method was done and several themes were found. The following themes emerged: The following themes were found: multiple roles of case managers with the subthemes; intake process and acclimation of new residents; ongoing care with the subthemes; social health, emotional health, medical health and spiritual health; residents with complex issues with the subtheme insurance frustrations. Following the findings, there is a discussion and implications for further study.

My deepest gratitude...

To my family, friends, coworkers and committee who believed in me and held me up  
with support and positivity, I will always remember.

To Mary and Linda who were wonderfully generous with their time and expertise.

To those who continue to use their gifts to enhance the lives of the elderly and push to do  
so in ways that honor the population they serve.

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## **Emotional Care in the Nursing Home Setting**

Hospice care provides a model of case management unmatched when compared with the current nursing home setting. Statistics imply an increasing need for services for our elderly in the nursing home setting that will exceed our current capabilities. According to the United States Census Bureau, the aging population is exploding. Currently thirteen percent of the U.S. population is over the age of 65 and that percentage is expected to rise to twenty percent by the year 2030. Today, half of the 1.5 million people living in nursing homes are over the age of 85. The U.S. Census Bureau reports that the total number of individuals over age 85, currently about 5 million people, will double by the year 2030 and increase even faster to about 20 million by 2050. Staggering numbers like these create an urgency compelling the examination of what is working well within our current practices in nursing home settings and within the specialized care programs currently available.

When an individual struggles with the provision of safe self-care in an independent living situation, alternative living arrangements need exploration. One possible type of care is a nursing home facility. Services provided in a nursing home setting are offered in accordance to individualized need and can involve minimal assistance, or up to several caregiver hours each day. A nursing home can accommodate short term surgical restorative care or long term care that follows the patients' needs to end of life.

End of life care is labeled hospice care. In order to receive the specialized services of a hospice program, the resident's physician places an order for hospice. The subsequent focus of the care plan, and those involved in it, is to bring comfort and quality of life to the patient, but without expectation of healing. The physician, the patient, and those caring for the patient,

coordinate to make the collaborative determination that life saving measures are no longer of benefit to the patients' health. At this time the patients anticipated life expectancy is six months or less.

Often times the terms palliative care and hospice are used interchangeably which leads to confusion over differentiation of definition. In an effort to distinguish one from the other the following explanation is offered. Palliative care is described as comprehensive care focused on preventing or relieving physical, emotional, psychological, and spiritual suffering in patients with life-threatening illnesses (Kwekkeboom 2005). Palliative care can be administered at any time during a serious illness when the patient expresses discomfort. Hospice care picks up when the physician ceases life saving measures and focuses on end of life measures. Hospice care involves a team of qualified providers engaged in holistic approach which encompasses the physical, emotional, social and spiritual needs of the patient. The demand for hospice and subsequent monetary commitment to hospice continues to increase dramatically. Hospice is the model of service delivery for end of life care.

Armed with the success of hospice, the question remains, if holistic case management practice is effective, what do nursing home facilities offer a patient that emulates the hospice success prior to being hospice qualified? Are the needs of patients whom are striving for curative measures empowered to receive the level of holistic case management that the hospice patient receives? If not, why? The monetary support of hospice and the financial commitment to provide services in a holistic approach create an atmosphere where hospice qualified residents can readily receive more intense services. It is in this researcher's opinion that further study to reveal barriers the nursing home faces in provision of emotional care prior to a hospice order is

valuable research as there appears to be a gap in care. This research project aims to answer the question, what barriers do nursing homes face as they provide emotional care to patients prior being hospice enrolled?

### **Review of Literature**

Replication of a process found to work well in case management, like hospice, gets its firm foundation from the understanding of its strengths as well as an acknowledgement of its history.

In 1963, a physician by the name of Dame Cicely Saunders, lectured at Yale on the work she had begun in London dating back to 1948. Her introduction to specialized care for the dying launched a series of events resulting in the evolution of the holistic hospice care we know today. She enthusiastically spoke to medical students, nurses, social workers and chaplains showing the dramatic before and after evidence of controlled symptom care for patients and their families.

The reviewed literature revealed hospice to be a volunteer movement in the United States who's footing in the hospital setting did not begin until the 1980's. Research tells us that Medicare Hospice Benefit was enacted in 1983 in the United States. By 1995, hospice was a 2.8 billion dollar business with 1.9 million coming from Medicare reimbursement.

Once an order for hospice is placed by the physician, an assessment of the patients physical and mental health needs is gathered for care plan creation. The interdisciplinary team that works on the patient care plan may consist of some or all of the following partners; the primary care physician, nurses, home health aides, social workers, clergy and or other counselors, trained volunteers, family, and speech, physical and occupational therapists as needed. Research "characterized agencies that provide formal or informal hospice care in the



United States according to four types of services considered important by caregivers: medications and treatments; rehabilitative care; emotional, social, and spiritual support; and practical support “(e.g., continuous home care) (Smith et al 2008).

Within 48 hours of the initial hospice referral, the process of gathering a patient’s information begins. The hospice interdisciplinary team creates a care plan that is very individualized and intimate in its provision of compassionate services. In each nursing home there are patients currently hospice enrolled. By comparing the emotional care practices prior to this enrollment with the holistic approach in hospice program, conversation on creating an environment where the continuity of quality care is documented for its success will hopefully one day lead the hospice model of case management to be the a nursing home standard.

For many patients the choice to receive Hospice is as much a family decision as it is a patient’s decision. Family involvement adds so much comfort and depth to a patient’s end of life journey, and research shows that it is important, whenever possible, that the hospice team includes family.

It is deeply emotional to “walk” with a loved one toward end of life. When family is an active participant in the hospice plan, “good counseling and supports are important to keep families engaged as they attend to their individual struggles with this challenging time as patient and family address the emotional, Psychological and spiritual aspects of dying” (nhpo.org).

A component of the hospice philosophy is an acknowledgement of meeting patients spiritual support needs. This can involve regular visits with a Chaplin, expression of desires for after death services and family counseling. In addition to spiritual supports, emotional health and wellness are assessed and incorporated in the care plan. In the nursing home setting hospice

is more and more prevalent. Today one in five hospice users live in a nursing home (Huskamp et al 2010).

Taking the dynamics of the hospice model as a standard for quality care and utilizing that lens in review of the literature with respect to emotional care in the nursing home setting, this researcher has revealed a potential gap in care between nursing home case management and the increased service of hospice care. This gap is worth further study.

Nursing homes offer a level of care available to people who do not require hospitalization, yet cannot care for themselves at home, says the National Institute on Aging. Nursing home care offers a service for aging individuals when quality of care is not met at home due to lack of support or high care needs beyond what the individual or family can provide. As a result of an ageing population, increasing numbers of people will die in long-term care facilities such as nursing or care homes.

According to the research, nursing home settings can vary greatly from a hospital model, with a nurse station on each floor, to a home style setting. In the hospital style setting, schedules are regimented and the medical model of care is adhered to. In a home style setting the décor is created to reflect a home atmosphere. Beyond décor, nursing homes also take on the feel of the administrative make up and philosophy of the care facility. When looking at scores for contented residents the research supports the home atmosphere. Research shows physical environment should be 'homely'; it should support patients' need for social interaction and privacy; it should support the caring activities of staff, family members and patients; and it should allow opportunities for spiritual expression (Rigby Payne and Froggatt 2010) resulting in optimal quality of life.

In recent years the culture of nursing homes has shifted. The closing of state institutions caused the nursing home population to greatly increase. As the demand for beds increased so did the funding source and ownership of many nursing homes.

“Nursing home care was once a mostly nonprofit enterprise administered by religious organizations and government-owned facilities, but in recent decades it has become a market-driven and highly competitive industry” (Kaffenburger 2011). With those changes came more government regulation and a call to watch over the vulnerable elderly population of our society in care facilities.

In accordance to regulation there are expectations, often tied to funding sources for reporting nursing home activity and resident satisfaction. Nursing homes are required to collect information about the health, physical functioning, mental status, and general well-being of residents, using a screening tool called the “Minimum Data Set” (or “MDS”). Nursing homes are required to complete the MDS on each nursing home resident upon admission and whenever the resident’s condition changes. The information from the MDS is collected electronically by the Center for Medicare and Medicaid Service (CMS) for each person living in a certified nursing home in the country. CMS uses some of the MDS information to measure the quality of certain aspects of nursing home care, such as whether residents have developed a pressure ulcer, are in pain, or are losing weight. These measures are called “quality measures.” (medicare.gov)

It is important to understand how nursing homes are utilizing this information. Is it solely reportable numeric or are the nursing homes taking the information and utilizing it to create best practice?

Moving to a nursing home is a difficult transition in an already challenging stage of life. The existing literature on transfer trauma and relocation stress suggests that even for relatively

healthy people it is deleterious to health and wellbeing to be transferred from one facility to another (Farhall, Trauer, Newton, & Cheung, 2003).

It is often the case that resident come to the nursing home with beliefs in their abilities that do not mirror the perceptions of the family and professionals closest to them. Although many residents do not have a recognizable terminal illness, psychological and spiritual distress can result from multiple health problems, loss of function and awareness (Hall et al 2012). It causes anxiety for the resident and caregivers as this transition to allowing a life of greater assistance is made. Transitions are difficult and loneliness is common as the resident struggles to make sense of their limitations and adjust to the many changes of the new living environment.

Weiss (1973, 1974) described two types of loneliness: emotional and social loneliness. Emotional loneliness results from the lack of close intimate attachment to another person. Individuals who have experienced the loss of significant others such as a spouse and friends may experience this form for loneliness. Social loneliness results from the lack of a network of social relationships where the individual is a part of group of friends sharing common interests. Individuals who have moved to a new social environment may experience this form of loneliness. To prevent depression symptoms and emotional and social loneliness, further research is needed to understand more deeply the significance and quality of the relationships between the residents and their significant others and how these affect depression symptoms and emotional and social loneliness (Drageset et.al 2011). It is the intent of this study to gather knowledge on how nursing homes currently address loneliness in the resident population.

Nursing home residents are at increased risk for depression due to physical and cognitive disability, disruption of regular routines, separation from familiar environments, potential loss of

support from friends and family, loss of control over daily activities and reduced opportunities for pleasurable activities. Yet, the mental health needs of nursing home residents have largely been neglected; in spite of the fact that epidemiological data suggests that mental health problems are prevalent in this population. Depression is secondary only to dementia in terms of prevalence. (Konnert et al 2009). Geriatric depression can be marked by cognitive impediments including executive decline, disorientation, short-term memory loss, impaired visual spatial skills and psychomotor functioning, reduced functional capacity, increased disability and use of aged-services. (Johnston et al 2007).

Usage of pharmacological interventions is related to less perceived barriers for providing medical versus psychotherapeutic interventions, to a shortage of mental health clinicians in certain areas (Molinari et al., 2007), and perhaps to a lack of available specialized programs that can be accessed in long-term care setting. In an effort to attend to the complex needs of the residents “Study findings confirm NHs’ utilization of psychopharmacological interventions over mental health services such as group counseling, substance abuse counseling or other specialized mental health programs because of their relative ease. These results are consistent with prior concerns about a shortage of well-trained geriatric mental health professionals in the workforce (Halpain, Harris, McClure, & Jeste, 1999; Jeste et al., 1999), and the documentation of continued greater usage of psychotropic medications in NHs relative to the implementation of behavior management programs (Hawes et al., 1997). In this study the availability of professionals trained to work with the geriatric population will be a point of inquiry.

### *Staffing*

In the nursing home setting, the staff is identified as the individuals that offer the services, support and spend the greatest number of hours in direct contact with the residents.

Despite the immeasurable importance of staff both in patient care and relationship, research has shown that staffing a nursing home poses challenges. Staffing levels likely only meet minimum requirements that don't allow for the addressing of emotional needs of clients. Federal law requires all Medicare and/or Medicaid-certified nursing homes employ enough staff to provide care for each resident based on their needs, but there is no current Federal standard for the best staffing levels. The Medicare and/or Medicaid-certified nursing homes must have at least one licensed Registered Nurse (RN) for at least 8 hours per day, 7 days a week, and other nursing staff, such as an RN or Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN), on duty 24 hours per day. Certain states may have additional staffing requirements. Certified Nursing Assistants (CNAs) are generally on staff 24 hours per day. They work under the supervision of a licensed nurse to help residents with daily activities, such as eating, bathing, and dressing. All CNAs must complete a competency evaluation program or a nurse assistant training within 4 months of their permanent employment. They must also take continuing education training each year.

Most people apply for caregiving positions with the intent to provide assistance to those they serve and to bond with the residents. There is compassion and drive to use ones time and talents to enhance the experience of a person in need. The jobs are known to be tough but thought to be worth the effort. Unfortunately, in some nursing home facilities, the experience of many staff is that the structure of the facility either in budgetary or philosophical ways does not allow the employees the time to make these connections with residents as desired. "Care workers in institutional settings such as nursing homes face a unique set of challenges. Their work lives are marked by routine acts of intimate care that are usually done alone in the privacy of home. In nursing homes, these everyday activities—bathing, dressing, and feeding—are transformed into

bits of labor to be carried out by low-paid paraprofessionals who often work under difficult conditions that prioritize profit over emotional care” (Rodriquez 2011).

Research suggests that nursing home staff is often overworked and unavailable to care for the emotional needs of the residents. If nursing home residents are to receive appropriate care for depression, it is essential that nursing assistants be able to: (1) recognize and report signs and symptoms of depression in older adults and (2) understand the fundamentals of aging, mental health, and depression and the appropriate responses (Glaister et.al 2008). The ability of nursing homes to employ enough staff so that the basic needs of the residents are met, while secondly allowing time to build relationships, is difficult due to monetary issues and program accountability requirements.

Research suggests that the nursing community also faces internal struggle with the demands of the work load and the desire to provide emotional support to residents. The International Code of ethics for nurses states that inherent in nursing is the respect for human rights, including the rights to life, to dignity and to be treated with respect (Franklin, Ternstedt & Nordfeldt 2006). Nurses need the time in their work day to do the work they came to the profession inspired to do. This includes time connecting with people they serve in the nursing home setting.

The literature points to a changing system for nursing home care. The increase in managed funding sources has created competition within a system that was largely private. Quality measures aim to ensure a level of services for residents that is consistent and of high standard yet the measures tie to budget and budget ties to staffing hours. The result is basic care has improved yet staff are unable to have the extra time needed to connect with residents. There is a need to train staff to recognize emotional care concerns with the residents. With the

anticipated rise in the elderly population, nursing home services will continue to be in demand. The research is timely and valuable to a population of people who do not have a voice to advocate for themselves.

### *Conceptual Framework*

The following lenses termed theoretical, professional and personal are each incorporated in this research design to offer a comprehensive view when addressing the research question “What barriers do nursing homes face as they approach providing emotional care to residents prior to a hospice order?”

### *Theoretical Lens*

The social work profession operates within a variety of theories to gain understanding of issues. Using the Systems Theory this researcher will look at the current systems in place in the nursing home. System Theory aims to identify how systems relate to and work with one another in continuance of care. A system is a set of components that interact with each other and collectively form a whole. System thinking is the use of thought to create combinations of ideas, looking at patterns and cohesion to give understanding of the whole. A social system is a combination of co-occurring or mutually influencing activities that together constitute an entity. There must be a level of organization in social system because without organization there can be multiple events going on but a system fails to form. There are boundaries to a system and certain things are found inside and outside of those boundaries. The measure of effectiveness of organization is reflected in the system creation and attainment of goal fulfillment. Internal and



external forces can affect a systems creation and ongoing survival. (Greene 1991) In this study the nursing home setting in its current operational state will be examined.

Through several interviews involving differing rural nursing home facilities, system consistencies will be reviewed. The intent is to gather insight into what nursing home staff identifies as strengths and barriers to the work they strive to achieve in addressing emotional health with the residents prior to a hospice order in the nursing home setting. Any study highlights issues, with high numbers of nursing home residents experiencing depression; reviewing identified barriers to providing emotional care prior to a hospice order can have a direct impact on nursing home service delivery and future planning.

### *Professional Lens*

The profession of social work is driven by the NASW Code of Ethics, within which the following ethical principles bear relevance in this research study. The following statements are guiding principles within the NASW Code of Ethics. 1. Social worker's primary goal is to help people in need and to address social problems. 2. Social workers challenge social injustice. 3. Social workers respect the inherent dignity and worth of the person. 4. Social workers recognize the central importance of human relationships.

It is within our guiding principles to engage in constant assessment of systems that serve populations of people who are unable to represent themselves. The elderly population within the nursing home setting is largely without a voice. They are vulnerable. The imminent increase of elderly in our country coupled with the data suggesting that this population struggles with mental health concerns directly related to the aging process makes this research study of value to the

population researched and to the social work profession. The elderly in the nursing home setting need the support of outside voices to empower them.

### *Personal Lens*

Most of this researcher's professional experience in social work has been working in case management with youth and families, mental health and community collaborative. Though not utilizing my social work licensure in my currently held position as a patient services assistant, the position provides exposure to a cross section of the rural community. As members of the elderly population reach out for services, identified observations, coupled with professional experience create this researcher's base and filter. The relationship between the nursing home and our community resources fueled this researcher's ultimate interest in further discovery of barriers in emotional care for nursing home residents. The aging population will be dramatically increasing in coming years. It is our professional responsibility to create systems of care that empower and care for the aging as they live the final years of life. Identifying the barriers that currently exist can open dialogue about changes necessary to improve systems of care. This researcher's interest in this topic has been an evolution. Influences include; social work education, philosophical beliefs, working in a capacity where connections to the elderly have been established and nourished, having aging relatives and a quote that weighs heavily on the heart "We are all here just walking each other home". It is this researcher's belief that we bare responsibility to one another. Lack of experience and knowledge with this population is not an excuse but a driving force. This researcher's inexperience can offer objectivity channeled toward a greater learning experience. It results lead to a more mindful and impactful personal and professional practice as a social worker. Introspective research of the nursing home

functionality in relation to emotional care of residents prior to being hospice enrolled, and its subsequent identified strengths and barriers will add insight to conversation on this important topic area.

### **Methodology**

The method used to look at the material collected in this study is Phenomenology. A very simplistic explanation of phenomenology is the study of documented firsthand experience, analyzed to provide insight to an area of interest.

“Phenomenologists distinguish phenomena (the perceptions or appearances from the point of view of a human) from noumena (what things really are) (Willis, 2007, p. 53).

“Phenomenology (is) focused on the subjectivity of reality, continually pointing out the need to understand how humans view themselves and the world around them”(Willis, 2007, p. 53)

Within a system such as the nursing home, phenomenology can be used to look at structure of experience. Phenomenology is the study of structures of consciousness as experienced from the first-person point of view. The central structure of an experience is its intentionality, its being directed toward something, as it is an experience of or about some object. An experience is directed toward an object by virtue of its content or meaning (which represents the object) together with appropriate enabling conditions (Smith et. all, 2011).

By speaking with case managers in a semi structured interview process the perspective of employees with first hand intimate knowledge of services provided in the nursing home experience can be explored. As the individual in the care coordination role, the case manager is present for admission and continues with the resident for the duration of the residents stay at the

nursing home facility. Case managers coordinate information and services from the physicians, direct care staff, families and support staff which provides a continuous charted narrative to how the resident is functioning and the needs presented. Case managers are often the individuals that administer the tools that measure resident quality and experience. Within this study's data collection Phenomenology is a useful theoretical framework to gain understanding of the current structure and experience of nursing home residents when examining multiple interviews and coding for themes as experienced by the case managers.

This research project aims to examine what barriers nursing homes face as they provide emotional care to residents prior to a hospice order. Phenomenology utilized as a qualitative research method that researches the essence of an experience for research participants, specifically seeking to understand the essence of the nursing home experience through the eyes of the case managers. "The focus is thus on understanding from the perspective of the person or persons being studied."(Willis, 2007, p. 107). Horizontal and structural analysis will be performed on the data. This analysis protocol is consistent with phenomenological methods.

### *Respondent*

The interviews for this qualitative research study employ the expertise of case workers from separate nursing home settings. The interviewees have varied levels of experience but all work to coordinate care and advocate services for the residents in a nursing home setting. The respondent was informed that the interview will be destroyed upon completion of the classroom project which includes transcribing. The data analysis and written report will be placed in academic archives. The informed consent was approved by the University of Saint Thomas Institutional Review Board (IRB) for exempt level review and the final version, which included

the questions to be asked in the interview was approved by Dr. Felicia Sy, professor and IRB designee, the Research project committee and IRB.

The following strategy for recruitment was utilized to obtain a sample of case managers to interview for the study. Project explanation and participation requests were administered by this researcher through telephone contact to the administration of each nursing home facility within 100 miles of Ely, MN.

When approaching the nursing home administrator the following information was provided; I introduced myself as a graduate student at St. Thomas University, studying for my master's degree in social work. It was explained that as a component of the master's program we are required to do a research project. My research project looks at the barriers nursing homes face as they provide emotional care to residents prior to a being hospice enrolled. It is my goal to interview 8-10 case managers from varied nursing home facilities. The interviews will take approximately 30-45 minutes. None of the nursing homes or case managers is named in the final research project. Would you be willing to approach your staff about a potential interview? I am available to answer any questions you have about the project and or its process.

The interested administrators were given opportunity to discuss the scope and intent of the project. Verbal permission was requested for an interview of a case manager within the facility. Those case managers expressing interest in an interview were offered additional information on the scope and intent of the project as well as contact information to this researcher for questions about the project prior to their agreement to interview. Upon receipt of verbal agreement by the administration, a request of letter of intent to participate with the

research project, on agency letterhead was requested. The project application with all appropriate attachments was sent to the IRB for approval.

For those case managers in agreement with being interviewed, a second consent form was signed. Two signed consents will be returned to this researcher, one from administration and one from the interviewee prior to an interview being scheduled. Once the signed consent form and letter on agency letterhead were received, a telephone interview with a case manager was scheduled. This project aimed to obtain 8-10 interviews with nursing home case managers.

#### *Data Collection*

Data was collected in a single episode, semi-structured telephone interview lasting 30-45 minutes in length. The respondent was able to review the questions to be asked of them prior to the interview onset. The questionnaire was developed in response to articles reviewed and formulated in effort to acquire detailed description of the many facets of nursing home life and care priorities.

Upon completion of each interview the researcher obtained a transcription the interaction. Themes were pulled from the data collected and attributed to the research done. The anonymity of each respondent was protected through the omission of names, locations or specifics of the associated facility. There is minimal risk to the respondent and no direct benefit to the participation in this research study. Each signed document of consent and agency letter is in a locked file cabinet at my place of employment where only this researcher has the key.

Each interview was recorded on freeconferencecall.com. Every interview had its own access code which was provided to the specific interviewee. All access codes were listed on this researchers private password protected computer.

Transcriptions of all interviews were held on this researcher personal access locked computer. Recorded interviews were kept until transcription was complete and then they were destroyed. Transcriptions were kept until the final paper is submitted to St. Thomas University and presentation of the project are complete. Upon submission of the final research project, the transcriptions were deleted from the locked computer where they were securely held. Anticipated date of deletion is May 19th, 2014 after the presentation is made.

### *Interview Questions*

The following list of questions will serve as the guide for our interview. Feel free to contact me with questions or concerns about any interest area listed below. During the interview process you may opt out of any question you do not wish to answer.

Facility Questions –Geared toward establishing size and function of the facility

1. How many individuals reside here when this nursing home is at full capacity?
2. How many residents do you currently have?
3. What percentage of the residents are short term stays of 6 months or less?
4. What percentage of the residents are long term stays?
5. What tools does the facility use that result in care plan creation?

6. What is the ratio of staff to resident?
7. In your opinion is the rate of staff turnover high or low at this care facility?

Case Management- This set of questions is intended to guide the interviewee through job process and provide insight into the emotional care delivery to residents within the nursing home setting.

8. What is your position in this facility?
9. What duties are included in your job description?
10. How do you work with residents with mental health issues at this care facility?
11. What measures are in place to transition a new resident to the new environment?
12. What are the services available to provide care for residents in the following areas; social, emotional, physical, spiritual? Address each individually.
13. What components are involved in a residents care plan? Who is a part of the care plan?
14. How often are the care plans reviewed?
15. In your opinion what factors affect the emotional health of a resident?
16. What tools are required in a residents file?
17. How do mandated requirements enhance care?
18. How do mandated requirements inhibit care?
19. Do funding reimbursements create opportunities for service delivery or make barriers in service delivery? How?



20. Do you feel the increase in assisted living facilities has resulted in nursing home residents have greater or fewer issues at admission?
21. What are the external influences that enhance provision of emotional care to residents?
22. What are the internal influences that enhance provision of emotional care to residents?
23. What are the external influences that inhibit provision of emotional care to residents?
24. What are the internal influences that inhibit provision of emotional care to residents?

### **Data Analysis**

This research project aims to examine what barriers nursing homes face as they provide emotional care to residents prior to being hospice enrolled. This researcher conducted interviews of case managers in several nursing home settings.

Phenomenology is a qualitative research method that researches the essence of an experience for research participants. Specifically in this study the researcher sought to understand the essence of the nursing home experience through the eyes of the case managers for improved residential care. Data was collected through semi structured interview with case managers. Horizontal and structural analysis was performed on the data. This analysis protocol was consistent with phenomenological methods.

### *Setting*

The interviews took place over the phone from the nursing homes within which the interviewee is employed. The space for the researcher and interviewee was private with no threat of interruption or ability to be overheard.

*Risks and Benefits*

This research project bears minimal risk and minimal benefit. Those facilities and individuals giving consent to participate, did from a place of informed knowledge. Project intent and design was discussed and a standing invitation to bring forth additional questions was conveyed. There was participant ability to withdraw involvement at any time should discomfort or conflict arise. Participants had minimal risk but may experience emotional distress as discussion of work process and/or memories of relevant associated events are recalled. Given the professional training of all participants as case managers it was expected that the training and experience of the professional is a skill set that prepared them for an interview of this nature. None of the facilities in agreed participation were named in the text of the research paper. No interviewee was named or described in the text of the research paper.

**Findings**

This study includes six interviews of case managers employed in nursing home facilities located in Northern Minnesota communities. These nursing homes offer services to patients qualified to receive short or long term nursing home care. The smallest three of the six nursing homes in this research study had occupancy of fewer than 30. The remainder of the participating facilities had occupancies of between 70 and 100 residents. The six interviewees were from individual facilities; each owned separately and located in separate communities within a 100 mile radius.

All interviewed participants were female and had been employed at the facility for longer than one year. The interviews took place utilizing a service called freeconferencecall.com, a tool which allowed both the researcher and interviewee to call in a private meeting code, with the subsequent interview recorded. All six recorded interviews were transcribed. The transcriptions were coded using open coding methods. Evolving from close examination of the transcriptions commonalities emerged and placed into themes and subthemes. The following themes were found: multiple roles of case managers with the subthemes; intake process and acclimation of new residents; ongoing care with the subthemes; social health, emotional health, medical health and spiritual health; residents with complex issues with the subtheme insurance frustrations.

#### *Multiple roles of case managers*

The role of case manager was identified as a title held by each of the interviewees, however many interviewees had other assigned duties in addition to their case management role. This dynamic creates conflict for the case managers as they strive to meet job expectations and manage time well. These multiple roles also take the case manager away from one on one contact with the residents. For example, one interviewee holds the title of the director of nursing and has a nursing degree.

“I am the director of nurses. So I do assume, you know, the 24 hour responsibility for the nursing home. But I also work with admissions and discharges. I am part of our interdisciplinary team.”

Several case managers reported being titled as the social services director or social worker and one identified herself as a clinical manager of the facility.

“The only thing I don’t do is the nursing assessments and the financial piece.”

“I do quality management. I do vulnerable adults. I do admissions. I do care conferences. I do initials. I do discharge.”

In all of the interviews conducted, one person filled the case management role regardless of other duties and titles held. Only one nursing home with a larger population of residents employed three case managers. All case managers complete the intake process with new residents.

For each case manager, the intake process requires high organization and coordination of paperwork and resources. This collaboration of documentation provides the both the case manager and other staff working with the resident, the information necessary to create an accurate and empowering care plan for the resident. Once created, this plan must be coordinated and monitored throughout the residents stay at the nursing home. The collaboration of services and subsequent meeting planning and execution are the responsibility of the case manager.

Each case manager coordinates quarterly meetings to review the status of the resident. At the meeting the patients plan is reviewed with each service area represented in the ongoing case documentation. As a result of the meeting, the addition or subtraction of care hours is adapted based on resident progress or decline.

Present at quarterly case management meetings are members of the team that provide professional service, as well as the resident and the resident's family. Meetings can be called at greater frequency if there is cause for concern, such as a medical complication, noted decline or improvement in patient ability or an expressed dissatisfaction by the resident with an aspect of their care.

The case managers were consistent in their message that communication is essential to successful case management. Some facilities hold daily or weekly team meetings to go over resident needs, review recent events and address concerns in any of the areas of need; physical, emotional, social, or medical.

Monday through Friday we meet with all of the department heads and it is our nursing staff, so , we have two nurses stationed, so its each of our charge nurses, director of nurses, MDF coordinators, activities, dietary maintenance, therapy, both occupational and physical therapy, our business office, myself, the administrator if he is available. Full group of people. So then what we do is review any skin alterations, bruises, falls. And then we determine how that might have happened and what the plan of action will be. And then I review my incident reports so if anything might have happened out of the ordinary. The staff have these reports to fill out that Ill review. Each of the nurses will go over each of their residents on the hallways and give an update on how things have been going for them.

Case management, through coordinated document gathering and ongoing communication creates flow to each facet of the nursing home process from intake, through ongoing care, in discharge, and in aftercare.

### *Intake process*

Case managers spoke intently in relation to the number of documents required to do an effective intake of a new resident. Some documents are internal creations, such as a social history form which details the likes and dislikes of the resident. Other documents are those set forth by the government and insurance companies. It is the responsibility of the case manager to be certain that the files are complete in preparation of the admissions conference. A few standard informational pieces which are essential for intake include: a demographics page, medical report, the insurance information and preadmission screening.

According to the case managers interviewed, the preadmission screening is required to accurately determine a residents' qualification to an assigned level of care. This service had historically been done by the nursing home but the preadmission responsibilities have shifted to the hospital discharge planners and insurance companies.

The preadmission screening has changed just recently as a part of the law. The preadmission screening has been something that we have always had to have completed; however now they have shifted the responsibility onto the hospital discharge planners. Sometimes depending on the insurance provider, they might have their own preadmission screener too, so that in essence somebody might get two preadmission screenings.

In addition to preadmission documents the hospital and or clinic provide medical documentation. Medical documents detail both health history and the current strengths and weaknesses of the resident. There are recommendations for ongoing medical care, which can include written orders for skilled services such as physical, occupational therapy, and dietitian support and medication management.

Upon admission the details of these collected documents are reviewed with the resident and the residents' family. Greater detail is collected during the in person intake which allows the facility to get to know the resident. Social preferences, meal preferences, cultural and religious traditions are documented as well as family dynamics and supports. Once the intake and admission has taken place, the resident faces the task of adjusting to a new environment.

*Acclimation of New Residents*

In the interview the case manager was asked to reflect on how the nursing home handles acclimation of a resident to the new environment of the nursing home. Each of the interviewees spoke of verbally welcoming the resident as a standard of introduction. It was reiterated across interviews that it is important to take time for introductions to staff and offer a tour of the facility.

Upon admit we take them to their room and show them around their room. Orientate them to their room and the call light. Stuff like that. Bring them throughout the nursing home, the day room, the dining room, the bathroom, stuff like that.

One case manager detailed the repair and refreshing of the space that the nursing home places as priority so that the resident feels they are moving into a space that is cared for.

What happens is after a resident leaves our facility, the discharge maintenance department goes through the room. They paint areas, like if there are scuff marks where someone accidentally bumped something into the wall. They'll remove hooks. From the beds, to wax on the floor if it needs to be done. And then if someone is getting admitted to our facility prior to them entering, we have a checklist that we use for our nursing assistants to go through the room. And make sure that the privacy curtain is clean, that they have a bulletin board, hangers in the closet and their name is on the door.

Several case managers stated that they personally make an effort to check in on new residents and ask them how they are doing. This is done at greater frequency in the first few weeks of placement. There is concern among the case managers that the amount of time they would prefer to spend with residents is not available to them because of other job responsibilities. Case managers must fit the needs of the new residents in with the ongoing care of current residents.

### *Ongoing Care*

Soon after admission a case plan is created utilizing all internal and external documentation. This case plan gives direction to resources that best enhance the residents' quality of life. The goal is to maintain or improve functioning while in care. Often times the needs are great and not all goals can be simultaneously achieved. It is reported by the case managers that knowing what goals to place as highest priority when creating an individualized plan is where the team approach is highly beneficial.

It's really figuring out what is appropriate to go in. I don't know if that makes any sense or not. But some things can be an issue initially and so you put it in the care plan and then pretty soon you find your plan of care just becomes routine. So it's not that you stop doing that but you might need to change your plan of care because it has become the normal pattern.

The utility of each team member is crucial in gaining an overall picture of resident health. Resident health is referenced by the areas of social, emotional, medical and spiritual health. Each of these categories is a subtheme to ongoing care and discussed in the subsequent text social beginning with social health.

### *Social Health*

Social health refers to resident relationships and interaction with the world around them. Each of the interviewees spoke of social programming offered on site. The idea that social activity is healthy for the residents in nursing homes is widely accepted across the interviewed sites. All of the nursing homes have at least one activity director whose role is to provide entertainment and social engagement that encompasses resident ability levels. Those residents able to travel off site are encouraged to do so.



We have our own bus, and so at least once a week, weather permitting, the residents that are able, go on an outing.

Nursing homes post activity schedules weekly or monthly so that the residents can reference the option to attend. The activities board is seen as an instrument of value by the case managers who can utilize this tool for conversation and to encourage excitement about the coming day.

Sure, from the social part, we have activities three times a day. They also have an exercise program each morning, and then they also do one for the cognitively impaired. They may go to their rooms and do hand massage.

Provision of social activity options for each resident, geared toward all ability levels was stressed by the case managers. A resident's ongoing interest and involvement in activities provide insight to overall health that is then shared at team meetings according to the case managers.

Another interviewee spoke of both group and individual activities. Many residents enjoy reminiscing together. This activity was seen in as a social activity. Reminiscing can both assist the residents in feeling a sense of community but also allow the staff to get to know the resident and that fosters growth in relationships. A connection with the people in daily contact with the residents is valuable to the emotional health of the residents.

### *Emotional Health*

Emotional health is monitored and attended to in a variety of ways. Interviewees spoke of relationships with family as significant to the resident's emotional well-being. The ability of the resident to maintain contact to family through visits, phone calls and letters is impactful to the residents' emotional health.

Many facilities try to extend family and friend visiting hours. It is another way they can deliver the message to the resident, family and the community, that the facility is open, welcoming and that interactions are healthy for the resident.

The family decision to utilize a nursing home is a difficult one for many families. Supporting the connection with family includes tending to the family understanding of the changes in their loved one and what that means to the family dynamic.

We need to include the family and then what we also need to do is provide education and support to the family because what their loved one is going through, they are not used to either. They need to learn along with us.

It can be uncomfortable during family visits when there has been little education as to what expectations are reasonable and expected. Some facilities offer groups which families can attend. Those groups offer education, support and can be a safe place for the family to begin to honor the emotion of the residents increasing deficits.

“They don’t understand why mom or dad is acting like this because they never did before.”

Sometimes a sudden or gradual change in a resident can lead to questions about the residents mental health in the nursing home setting. All interviewees spoke of “behaviors”. Residents experience varied behaviors attributed to their emotional well-being. Being attentive to when these behaviors occur and/or the triggers that create behavioral challenges for the residents is a focus addressed in the case plan. Change is emotionally challenging for residents. The move to the facility is a large change. Often time residents are sharing a room with another resident who is a stranger to them. The loss of privacy can be difficult, as can a completely new routine or routine where there was no routine before.

The adjustment to a facility, especially for people coming in who have never been to a nursing home. Some people having to adjust also to a roommate. We do have many single and private rooms that we have developed through our course. Sometimes it can be a transition for the person as well as having a different routine.

Some residents arrive at the nursing home having an established relationship with a mental health professional. It is important to maintain the relationships the resident has with providers who know the resident. The familiarity of the established relationship offers a healthy connection the life they had before entering the nursing home. The insight can also be deeply valuable in evaluating emotional and physical health as the resident remains in the new setting.

Unfortunately keeping the resident connected with services sometimes poses challenges. When a resident enters the nursing home and has an ongoing relationship with a therapist the resident must travel off site to retain the services.

If a resident has not had mental health care but it is determined that there are mental health concerns, a referral can be placed for evaluation or therapeutic services. It is however reported by the interviewees that the common amount of time for a resident referred for mental health intervention involves a one and a half to two month wait. The reason for this according to the case managers is the incredibly low population of professional trained in geriatric mental health.

They would have to go off site. You know, you can have somebody that you think is in crisis, and they'll say, Well I'm sorry we can get that man out about two and a half months from now.

The biggest challenge we have in our area is no psychiatrists. We have to send people down to Duluth. Luckily we have not had any issues with the individuals we have currently, but sometimes it can take, you know, weeks before they can get in. Even like a month and some people don't want to go that far. It is very sad and we definitely do have a need.

None of the interviewees reported any mental health practitioners that come on site. One facility does contract with a service called telehealth. This service had the benefit of ongoing care without long wait times. A wait time of less than one week is seen by the case managers as useful when responding to medication monitoring or treatment of mental health concerns.

Other factors reported by the case managers as impactful on the residents' emotional health include; the resident relationship with the staff, involvement in activities and being active.

Forming relationships not only supports the resident emotional health according to the case managers, the relationships with the staff allow for identification of resident improvement or decline. The daily work in the nursing home setting is intensely personal and details of the resident emotional health can be charted in the residents file.

### *Medical Health*

Residents arrive in the nursing home with medical documentation that supports the appropriateness of a nursing home placement. Most ongoing medical care is received through off site visits to the clinic. One nursing home is attached to the hospital making the facility very accessible to physician care.

Medically I think we do a fantastic job. Being that we are attached to a hospital there is a physician that is on call 24 hours a day and available to come over. We rarely put our residents in the hospital if we can help it, unless they are very sick. We treat them medically in their home then and the doctors come over and see them and do rounds and we do our IVs, everything right here. We have lab and x-ray right on sight. The doctors come over at least once a month and do physical round on each of the residents.

For medical we have physicians that make rounds every 30 days and then if there is something transpiring the nurses will either fax or phone the doctor or make appointments as needed for them.

A physician comes once a month. And that is what is required in at least the first 90 days; they have to be seen once a month. After that it can be 60 days.

There are a variety of nursing and assistants that attend to the daily medication, health and physical needs of the residents. There is one LPN nurse to every 8 residents with an RN on staff to administer medications. In addition to caring for the physical body, it is also important to care for the spirit.

### *Spiritual Health*

All interviewees reported that multiple denominations are welcomed into the nursing home setting. Regular visits by clergy are both group oriented and individual in nature. It is seen by case managers as important to demonstrate openness to all religious beliefs and make accommodations to a resident's faith whenever feasible. Many churches will keep the nursing homes updated on their schedules to let the home know in advance when there is a holiday or special service. On call services are also offered participating area churches. The case managers find that the churches are supportive and available when a need arises regardless of time, day or night.

Yeah, spiritually we have churches that come to the facility at least once a week for different services. We have the Catholic Church, the Lutheran Church, and the Baptist Church. We invite all the different churches so that we meet all the resident's needs. We have some clergy that come on other days. Just come in. On off days if there is someone that is, seems to appear in distress, you know, seems to be end of life, we do call their clergymen. And you know we have some Native American residents too that when they have been ill or end of life we allow their families to come in to do rituals as well.

For many residents in nursing home care, the loss of their church family is another source of disconnect. Having faith based support is helpful to the resident but loss of ones church, like so many aspects of the nursing home transition, can pose challenges to the adjusting resident.

### *Residents Complex Issues*

The case managers were asked what they have witnessed as a result of assisted living facilities and adult foster care as options for the elderly.

All but one case manager felt that the growth of adult foster care and assisted living facilities has impacted type of nursing home resident that is being admitted today. There was significant focus directed at on the lack of regulation and requirements that assisted living facilities are held accountable to.

This lack of accountability creates an interesting new dynamic. New nursing home admits are arriving from assisted living facilities with complex needs that would have been addressed in a nursing home setting had they made the move sooner.

It was articulated by more than one case manager that the residents are coming from the assisted living facilities later than would be recommended. The level of skilled care offered in the assisted living is inadequate leading to resident decline in health. By the time the resident arrives in the nursing home, recovery is difficult and at times unattainable.

Secondly, one interviewee shared a perception that the culture of the nursing home reputation remains as one of negativity. Assisted living and adult foster care sound more dignified to the family of the resident and therefore families are placing loved ones in assisted living. Assisted living facilities are not anxious to have vacancies. The case managers theorize

that this may also impact the decision of the assisted living and the resident's family, to move the resident to more specialized care.

Checks and balances that they have at assisted living facilities because when new individuals are coming to our facility after leaving assisted living, the families are kind of frustrated that they were there much longer than they probably should have. They didn't realize until they came to the nursing home, how much care they would receive.

### *Insurance Frustrations*

The goal at the nursing home is for a client to maintain their highest level of independence. The case managers interviewed discussed how insurance companies can create barriers for residents. One way barriers are created is by not supporting connections to the home environment.

“There is always a fear that somebody's gonna lose their bed. It shouldn't be that way but there are only so many days on medical assistance and then we have to discharge them unless they are willing to pay out of pocket.”

Having the insurance company direct the case plan through threat of monetary reimbursement can be counterproductive to the resident personal goals. Money is a topic that elicits anxiety for the resident and the threat the loss of their living space when away from the nursing home for too many days creates unfortunate circumstances where residents are not encouraged to stay with friends or family without the threat of nonpayment by medical assistance programs.

Get them back to your facility in 16 days or less because by day 18, that's it for medical assistance. The rush is on and they begin calling on days 14, 15, 16, 17 to get the resident status of stay at the nursing home put together and if they are not willing to hold the bed with their own funds, they definitely want them out, which is sometimes hard for some of these people.

When asked if funding requirements create opportunities or barriers for services the interviewee responded “It can be either or. You know, like you know, somebody who wants to go home every night and then is here on a Medicare stay can't do that”

“Our veterans who are here on a veteran contract can only go home for two days a month”

Insurance companies, who attempt to monitor and orchestrate organization within the nursing home setting, create barriers for the nursing home looking for the least restrictive life experience for each resident.

### **Discussion**

The intent of this study is to examine barriers encountered by case managers, when addressing the emotional care provided to nursing home residents prior to being hospice qualified. It was hypothesized that the level of services provided to a hospice qualified nursing home resident exceeds that of a nursing home resident in the area of emotional health. It was further hypothesized that barriers to the provision of emotional care in the nursing home setting have internal and external influences that contribute to the current systems in nursing homes today.

The majority of the findings support the research with a few additional findings of interest. Upon reviewing the findings using the phenomenological lens, the collective perspective of current case managers was analyzed against the literature reviewed. The interviewees offer insight on issues faced by the geriatric population in the nursing home setting, the structure of the nursing home standards of care and level of service the facility is able to provide.

An interesting occurrence emerged from the themes and subthemes found in the interviewees transcriptions. The issues that presented as themes fall into a number of categories that when put in a systems theory dynamic speak to the Macro, Mezzo and Micro levels of practice in social work within the geriatric population in the nursing home setting. Macro level



social work is intervention large in scale that affects entire systems of care. Mezzo social work is seen at the midlevel, involving institutions or other smaller groups. Micro social work practice happens directly with an individual or family. Some factors found through the interviews are strength based and others create barriers to emotional health of the nursing home population.

At the Macro level of service there are a number of barriers that create challenge to the provision of emotional care to a nursing home resident prior to being hospice qualified. A predominant theme shared by all case managers is the use of the required Minimum Data Set (MDS). The MDS is a tool used to track changes in levels of functioning in nursing home residents. A baseline measurement is created for each resident using the minimum data set at admission and those results are recorded in the patient chart. As the resident becomes acclimated to his/her surroundings and builds relationships with staff, the MDS tool is re-administered on a minimum of quarterly basis. This tool, in conjunction with staff charting and feedback to the case manager serve to provide a picture of how the resident is meeting their goals. The positive use of the MDS is that the case managers see the MDS tool as consistent. The same tool is used in repetition. The MDS asks the same questions of each resident, and is thorough in its repetition which can show trends and change in the individual residents.

As stated in the literature provided by Medicare, documents such as the MDS, aide in monitoring the status of resident health. The information is used to report the functionality of the individual resident and is a quality and performance measure of the nursing home facility itself. The difficulty comes with administration in a timely fashion and the reality that online reporting requirements can be daunting. Furthermore, MDS completion within set guidelines of time results in incentives as well as punishments for the nursing home facility.

Paperwork with the budget attached creates anxiety for the employee who then needs adequate time to administer and enter the information. Data entry removes staff from direct patient care. With research supporting emotional health through connection to staff, this MDS practice creates a barrier. This barrier is not present in the hospice model where there is additional staffing and time given to staff to create a personal relationship with the residents served.

Insurance companies create a conflict in interest within the nursing home mission. The timelines that the insurance companies place on the nursing homes with regard to number of days that the resident occupies a nursing home bed can create a barrier to emotional health in the nursing home resident. If a resident has the opportunity for example, to visit a relative, or say they have a rare opportunity to spend time at home because there is temporary live in care, the nursing home is forced by the insurance company to discharge the resident or they must begin making the resident pay out of pocket. The nursing home goal to create a care plan in which the resident is the most independent and in which the highest priority is resident satisfaction cannot possibly be met in this restrictive rule driven reimbursement plan. The example of a veteran being allowed only a couple days a month at home is extremely limiting. In a population where depression is second only to dementia it is interesting to consider the care practice that the insurance companies force upon nursing home residents. In the hospice model there is flexibility allowed in planning as the goals are often created with familial involvement and the threats of out of pocket expenses are decreased.

When many nursing homes made the transition from church and government run, to a profit run system, a competition was created, as stated in Kaffenburger 2011. Much of a nursing homes budget is tied to the accountability through reporting of numbers in numerical and informational nature. Even in this competitive reimbursement environment, the level of reimbursement does not create a budget surplus in the nursing home. Budgets are tight and expenses are closely monitored.

At the Mezzo level of nursing home function, as reflected through interview coding, there are several issues that are valuable to consider when looking at the barriers in nursing homes when attempting creation of the holistic approach prior to being hospice qualified. Nursing homes continue to work to improve their public image and create change in perception in a culture that looks to their services with a critical eye. Hospice does not bear the burden of recovering from a bad public view.

The accurate and timely reporting of required information is not only internally valuable but needed for public rapport and can assist in building public confidence in nursing home care. The public is allowed to monitor the satisfaction of the residents, the experiences reported and the quality of care that both the resident and the family feel is provided. With this accountability the nursing home staff feels that they are held to a high standard which can serve to keep quality resident care as a top priority. At the same time continuous reporting can create anxiety for the staff who feel they are constantly critiqued. When attempting to make certain that all tasks have been completed, the human connection to residents can take a second position which creates decreased job satisfaction for the staff. Hospice staff has paperwork as well, however patient time is prioritized.

Weekly, or as in one nursing home, daily, staff meetings where resident needs are reviewed creates open dialogue that a case manager finds highly beneficial when addressing changes in the resident. When the dialogue has been continuous, the changes that emerge can lead to early case review and adjustment to patient care can be detailed in the case modification. The discussion should encompass all reports of professionals working with the resident so that an informed conversation can be held. This conversation may include a change in the residents mental health state, medical changes, a personal concern such as a disconnect with a member of one's family, adjustment issues to the nursing home itself or role changes in the residents life. Appropriate responses can be informed changes made by those working closest with that resident. It is this researchers feeling that case managers strive to create the holistic care plan in the nursing home setting but the previously mentioned barriers make its application difficult.

The concern over appropriate amounts of time for staff to create and maintain charting and documentation comes in direct conflict with a nursing homes ability to provide personalized care to its residents. Just as in the literature reviewed, so much time is demanded in information gathering, that the human aspect of the nursing home job description has been negatively impacted. Yet charting is necessary for continuity of care, as one interviewee stated, "if it is not written down it is as if it did not happen".

When assessing the transcribed and coded data utilizing the Micro social work lens within the systems theory perspective, the information coded from the interviews is supported in literature reviewed. The relationships with staff are greatly important to the residents in the nursing home setting. These internal relationships are those individuals with whom the resident now places his or her trust and where the resident gets care needs met.

Case managers feel ongoing communication is imperative to good quality care of the residents. It serves the resident and team well to constantly evaluate process within the facility and the internal monitoring of resident satisfaction gives support to strong case plan creation. When a resident has an incident, the paperwork is filed, and there is a meeting which serves as an opportunity to improve quality of life for the resident through modifications as well as serving to direct future care to prevent reoccurrence.

The research acknowledged the difficult time a transition to a nursing home facility can create for an individual and their family. Helping the family understand what is happening to their loved one, what to expect and how to meet the challenges of a family member who no longer acts as they have for years.

Many nursing home facilities attempt to create a continuum of care as seen in hospice. The difference between hospice and nursing home care comes down to time. The time allowed by insurance companies who reimburse the professionals that care for the residents. In nursing home care the physical, emotional, spiritual and social needs of the resident are valued, however the time allotted to move beyond basic care is limited. Once hospice qualified a resident has additional staff to attend to their needs.

Nurses enter the profession to connect with people and often feel a frustration when the work does not allow time for that connection as stated in the literature by Franklin, Ternstedt and Nordfelt 2006. When that staff is unable to connect on a personal level the result can be a contribution to loneliness for the resident as discussed in the literature by Weiss (1973, 1974).

As noted in literature by Rodreges the staff provides intimate acts of care and consistent interaction with the residents. This can be both nurturing when the relationships are positive and a stressor if the staff person holds a negative attitude toward a resident.

A major theme repeated in each interview and stated as a major concern in the literature reviewed was the challenge facilities faces due to lack of geriatric knowledgeable mental health professionals in this part of the state. In Konnert et al 2009, geriatric depression is noted as second only to dementia. Yet if a resident is in a mental health crisis it is standard to have to send the resident a couple hours away for stabilization and proper treatment. If there is concern that the residents would benefit from therapeutic mental health services and a referral is placed, the wait times are often up to two months. There is a large deficit in geriatric qualified therapists which can be considered both mezzo and micro in its complicated effect on resident mental health. There need to be qualified therapists available for the trained staff to recognize signs of geriatric mental health and obtain those appropriate services as needed. In the hospice model there are professionals contracted to attend to mental health needs of the hospice enrolled individual.

The human need for food and shelter, physical care are all met in the nursing home. The attention to the emotional journey of the patient and exploration with the patient as to what a nursing home move means to them is not current practice. Transition into the new surroundings, written in the research by Farhall, Trauer, Newton and Cheung, 2003, is documented as a challenging time for residents. How the nursing home handles this transition is articulated by the workers as introductions, facility tours, making certain the new living space is well prepared and clean. There was attention to checking in with the resident more frequently in the beginning

weeks of arrival. There needs to be more than a clean living space. There are many factors to aging that could be sensitively addressed with all residents. Role changes, body changes, family, and the loss of home, name a few areas relevant to the nursing home resident. The support needs to exist for the nursing home to move deeper and walk with the resident through the last years of their lives. Time to grieve with the resident, time to reminisce and reflect over the life the resident has lived can create a more holistic approach to end of life care.

### **Implications**

With the impending increase in this countries geriatric population, it is imperative that current means of providing care in the final years of life is closely examined. The historical poor treatment of our elderly has led to strict regulation with the intention of holding nursing homes accountable to a level of care. The required information gathered and reported is useful to the nursing homes, however gathering that information is time consuming. The reimbursable staff hours are out of sync with the need of residents when so much time is required for documentation and charting. The human connection takes time and resources. It is through these connections that the research showed the highest resident satisfaction. And in hospice care the ratio of human time to resident is greatly increased.

There needs to be more education. Dementia and depression are complex issues that can create many behaviors. It is important that the staff be well versed in identification of warning signs of mental illness. There needs to be training on caring for residents with dementia and mental health issues and education provided to the families walk with the staff in journey of understanding the disease process.

It is also important to give the residents voice and vocabulary to assert their needs. Empowerment of individuals gives meaning and purpose. In whatever way possible residents should be empowered and feel they are treated with dignity.

As additional resources become available, such as assisted living and adult foster care, it is important to seek what has gone well in nursing homes, where gaps in care are present and where hospice has found success. Looking at the success of hospice can also offer insight. Collectively each level of eldercare has strengths and weaknesses that can ultimately offer broad programming change to maximize benefit to the residents served.

In the profession of social work, where we strive to advocate for those who are voiceless, there is a need to extend the field of geriatric study. When educating ourselves on the strengths, challenges and deficits in the current nursing home care system, we can educate our families and communities. It is through education and realistic expectation that we can begin to elicit culture change. Our culture has largely viewed our elderly with diminished value and therefore once placed in a long term care setting, the population fades from priority. The utilization of programs like hospice and the success found in the holistic approach to human health draw new light on the positive impact of a continuum of care.

This study has identified a great need for professionals trained to the specifics of geriatric care. It is a disservice to our elderly, who have spent their lives maintaining and creating a future for younger generations, not understand and put priority to what it means to be aging in our country. We must continue to strive to understand what it means to live in a culture that devalues personhood based on inability to contribute at levels achievable in youth.



The addition of assisted living and adult foster homes shows there is a growing need for safe levels of care prior to nursing home eligibility. There is attention and conversation beginning with regard to the safety and security for our elderly.

Additional considerations include acknowledgement that our cultures values are in a shift which has resulted in many families putting off retirement for years due to financial necessity. With the lack of retirement come decreased resources for families to care for loved ones. It is also worth consideration that our improved medical care has created longer life expectancy yet living longer lives has created elderly with complicated care issues that are not manageable in the home setting. The exploding geriatric population with so few trained in geriatric mental health care creates an urgency for further study, recruitment to the field of geriatric study and a need for the country to plan for our collective future.

This study finds strength in its firsthand account of the nursing home experience through the lens of case managers. It is a weakness that there were only six interviews conducted. There is a definite need to continue this research.

## References

Bartels, S.J., Moak, G.S., & Dums, A.R. (2002). Mental health services in nursing homes: Models of mental health services in nursing homes: A review of the literature. *Psychiatric Services*, 3, 1390–1396.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., Erbaugh, J., 1961. An inventory for measuring depression. *Arch. Gen. Psychiatry* 4, 561–571.

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Dale, O., Smith, R., Norlin, J.M., & Chess, W. (2006) *Human Behavior and the Social Environment: Social Systems Theory* (5th ed.). Boston, MA: Allyn & Bacon

Farhall, J., Trauer, T., Newton, R., & Cheung, P. (2003). Minimizing adverse effects on patients of involuntary relocation from long-stay wards to community residences. *Psychiatric Services*, 54, 1022–1027.

Franklin, L., Ternstedt, B., & Nordenfeldt, L., (2006). Views on Dignity of Elderly Nursing Home Residents.

Greene, R. R. (1991). General systems theory. In R. R. Greene & P. H. Ephross, *Human behavior theory and social work practice* (pp. 227-259). New York: Aldine de Gruyter. *Ethics* 13(2).

Hall, S., Goddard, C., Speck, P., & Higginson (2012). It makes me feel that I'm still relevant: A qualitative study of the views of nursing home residents on dignity therapy & taking part in a phase II randomized controlled trial of Palliative Care Psychotherapy. *Palliative Medicine*. 27(4) 358-366 DOI:10.1177/0269216312449272.

Halpain, M.C., Harris, M.J., McClure, F.S., & Jeste, D.(1999). Training in geriatric mental health: Needs and strategies. *Psychiatric Services*, 50(9), 1205–1208.

Hawes, C., Mor, V., Phillips, C.D., Fries, B.E., Morris, J.N., Steele-Friedlob, E., et al. (1997). The OBRA-87 nursing home regulations and implementation of the Resident Assessment Instrument: Effects on process quality. *Journal of the American Geriatrics Society*, 45(8), 977–985.

Kaffenberger, K. R. 2001. “Nursing Home Ownership—An Historical Analysis,” *Journal of Aging & Social Policy* 12: 35–48.

Medicare.gov

Molinari, V., Christman, L., Hyer, K., Polivka-West, L.M., & Brown, L. (2007). A survey of the use of psychological services in long term care settings. *Psychologists in Long Term Care Newsletter*, 21(1), 3–4.

Monette, D., Sullivan, T., & DeJong, C., (2011). Applied Social Research A tool for the Human Services.

Murty, S. A., Gilmore, K. K., Richards, K. A., & Altilio, T. T. (2012). Using a LISTSERV to develop a community of practice in end-of-life, hospice, and palliative care social work. *Journal Of Social Work In End-Of-Life & Palliative Care*, 8(1), 77-101.

Normann, H.K., Asplund, K. & Norberg, A. (1998). Episodes of lucidity in people with severe dementia as narrated by formal carers. *Journal of Advanced Nursing*, 28, 1295–1300.

Rigby, J., Payne, S., & Froggart, K., (2010). What Evidence is there about specific environmental Needs of older people who are near the end of life and are cared for in hospices or similar institutions: A literature review. *Palliative Medicine* 24(2) 268-285.

Rodriquez, J., (2011). “It’s a dignity thing”: Nursing Home Care Worker Use of Emotions. *Sociological Forum*. Vol. 26, No. 2. DOI:10.1111/1573-7861.2001.01240.x

Smith, M. A., Seplaki, C. C., Biagtan, M. M., DuPreez, A. A., & Cleary, J. J. (2008). Characterizing hospice services in the United States. *The Gerontologist*, 48(1), 25-31.

Smith, David Woodruff, "Phenomenology", *The Stanford Encyclopedia of Philosophy* (Fall 2011 Edition), Edward N. Zalta (ed.), URL <<http://plato.stanford.edu/archives/fall2011/entries/phenomenology/>>.

Weiss RS (1973) *Loneliness. The Experience of Emotional and Social Isolation*. MIT Press, Cambridge, MA.

Weiss RS (1974) The provisions of social relationships. In *Doing Unto Others* (Rubin Z ed.). Prentice-Hall, Englewood, NJ, pp. 17–26.

Willis, J. (2007). *Foundations of Qualitative Research: Interpretive and Critical Approaches*. Thousand Oaks: Sage Publications.

US Census Bureau. <http://www.census.gov/>.

Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M., Leirer, V.O., 1983. Development and validation of a geriatric depression scale: a preliminary report. *J. Psychiatr. Res.* 17, 37–49.