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For a more human approach to long-term patient care

Nursing homes must change negative attitudes toward their patients and embrace a philosophy that motivates them to pride, status, dignity, and achievement.

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The World Health Organization defines health as a "state of complete physical, mental and social well being, not merely an absence of disease and infirmity."

There are, therefore, three distinct components of need: physical, mental and social. To date, we have failed our longterm patients in all three areas.

Generally, physical needs are adequately met by professional disciplines if the illness is clearly visible, if it has a known and speedy cure, and if it is housed in a young and productive person. It is then worthy of the time expended and cost has no bounds. Symptoms are examined, probed and tested—orders dispense drugs and skills. With a speedy recovery, all can share in an ego-enhancing experience.

But woe to the person who does not respond! From an interesting case, he falls into disfavor and becomes a chronic irritation, for whom the treatment tends to be avoidance. Avoidance leads to professional isolation, which in turn creates anxiety and stress.

Dr. Ewald W. Busse, a psychiatrist at Duke University Medical School, told the 52nd annual meeting of the American College of Physicians, at Denver, Colorado, recently that "the physician must realize the impact of social deprivation and isolation upon health and aging." He went on to say that "deprivation" can result in temporary or permanent disability. In theory, it is atrophy due to misuse and creates mental and physical impairment.

We repeat over and over again, "the patient comes first," as if repeating it will make it so. It does not. Marshall McLuhan is quoted in *Nursing Management* as saying that the hospital comes first and is, in fact, the patient. The patient's role only makes it all possible.

For example, in order to maintain a dry environment, the catheter is frequently used in preference to toilet training or scheduling. For staff convenience, we close our eyes to the many serious side effects of the catheter on the person's health and comfort, not to mention the cost. Toilet training and scheduling, when effectively applied, can also reduce laundry use from as high as 12-18 lbs. of linen p.p.d., in some extended care units, to approximately 5-6 lbs. where the person is given the dignity of bathroom privileges.

If we really believed that the patient comes first, we would not allow him to remain on the perimeter of the hospital environment vying with the hospital for the focus of attention. When he is denied his rightful place, his needs are not met and, slowly, we rob him of his ego strength.

We all have an inherent and insatiable desire to prove our worthiness to ourselves, and to the people around us. When the patient does not see this reflected in the eyes and actions of those who care for him, when the search for recognition is futile, patients frequently despair. An environment which does not provide an activation program becomes nothing more than monotonous hours of boredom from which there is no escape or relief. Finally, because his emotional and social needs are not met, the patient escapes into his own world of unreality.

Our nursing homes and extended care hospitals admit many pitiful cases. Physically, some arrive in fetal positions, unable to walk without the support of two nurses, and then only on their haunches. Yet, four months later, with a restorative program, these same patients are able to walk upright. Mental impairment is frequently relieved, and recoveries are many.

Accredited general hospitals can be as guilty as some nursing homes or private hospitals, in their neglect of patient needs. We can point a finger at all professional disciplines, including architects, for their role in aiding and abetting this deterioration. Collectively, we have often been the defeating mechanism which destroys a human being's dignity and worth.

There is not much point, however, in belaboring the past. What are we going to do in the future?

In assessing our patients, we must be able to recognize the mental and physical deterioration of vegetation—a degrading illness which replaces

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or superimposes itself on the or al infirmity. This illness is frequently mistaken for the inevitable process of aging. In such cases, pessimistic attitudes may consider this condition irreversible, as a result of which therapeutic measures are not initiated.

We should bear in mind that vegetation is created by the patient's environment, which is often too medical and not enough humane. We must, therefore, break with the traditional concepts of care. Change will come eventually, because the public is showing concern, but it will be slower if we have to wait for the initiative to come from those who must push upward.

Many of our accepted policies are outmoded and need to be revised. Consider for example, the use of uniforms. A white uniform portrays a sterile hospital environment, it becomes the backdrop which sets the stage for the person, in which he plays the sick role. We do not want to emulate a hospital environment, yet we find administrators who insist on uniforms (at hospital cost).

We must be concerned with the enrichment of human life just as much as we are in saving it. If, for example, we restrict visiting hours, we discourage a social milieu. The patient suffers from loneliness and boredom. She interprets the lack of visitors as a slight to her, so she loses her self esteem, she feels socially isolated and inadequate. Her self image is distorted, as respect for self declines.

Indifference finally leads to deteriorated habits and appearance. Slowly, she conforms and divorces herself from her family and friends. Emotionally, the deprivation shows itself in grief, anxiety, fear and guilt; eventually, the personality deteriorates and she reverts to infantile dependencies.

Soon, the condition of the mind reflects itself in some disease. Physical symptoms appear. What do we do? We treat each symptom, one by one, with a pill or a treatment, but all the pills in the world will not bring back self esteem or alleviate grief, anxiety, fear and guilt if negative attitudes remain.

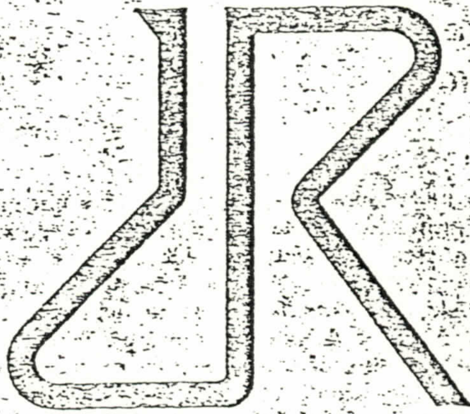
We must become convinced that we have a role to play in providing a beneficial social environment. We must open the door—welcome visitors, encourage volunteers, and participation with the community. The community will help us restore the patient to social health and the patient will lose her symptoms, one by one.

Once we truly understand and become convinced of this, we can intelligently approach our long-term patients and involve them in living experiences rather than in dying ones.

The family unit has to be considered. Sometimes, reconciliation is necessary, or communications have long ceased and therefore the visiting relative might be uncomfortable. We find that by involving them in our activities, the members of the family begin to enjoy themselves and look forward to coming. Often, they too benefit from the encounter.

Spouses, especially, require attention. At the Priory Hospital, they are made most welcome. The coffee pot is always on and we encourage them to feel at home. Should they have a wedding anniversary, dinner is served at a secluded table.

We carry this a step further: the husbands aid us in our therapy. A few weeks ago, we admitted a 65-year old lady, a graduate nurse, who showed severe regression. Her only sign of emotion was a faint smile. Her husband is very devoted and, naturally, felt depressed over his wife's condition. We encouraged him to



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come often and take his wife out. This surprised him because this had not been the case at the former agency.

We later explained reality orientation to him and requested him to assist us. He was delighted. Now, when he takes his wife car riding, he tells her the time, date, and discusses the weather. He explains the headlines to her and discusses current events. He told me he has even started singing. This man now has a spring in his step and looks happy. He told me he had lost the ability to talk to his wife. Now, his visits have purpose. The last time they left for an outing his wife acted like a young girl; she was laughing and her eyes all but spoke. Our staff is waiting for the next step when she begins to talk. The husbands, therefore, become our most valued therapists.

Pride in self encouraged

At the Priory, pride in self is encouraged, the patient is dressed in becoming attire and is expected to play the well role. We assume all have a potential for some recovery; we build on strengths. Our gains vary from a sweet smile to independence, and we delight in both. When a patient is admitted she is again embraced by her children and grandchildren; even pets are included. She is in the midst of community involvement. Many events in the community are brought to the Priory.

To instill pride, we have hair-dressers, wig and make-up demonstrators introduce the latest styles and trends. It is all in fun—you should hear the giggling that goes on when one of the husbands joins the demonstration. Children bring their pets and show them off and are delighted with the "ohs" and "ahs!" We see puppies, chicks, bunnies, kittens and we have our own canary.

This past summer again saw the Priory stampede. Performing horses are brought right on to the grounds. You should hear the ladies: "I like the bucking one" or "Just like Calgary." Our staff lent the proper environment by coming in western attire.

A Mutt Show has also been a lot of fun. Children from miles around bring their dogs, all receive prizes—and can you imagine the pleasure of our ladies when *they* are the judges and *they* dole out the prizes!

Our ladies have their own kitchenette. Often, with the help of volunteers, they make sandwiches and cookies for festive occasions; they can smell cooking again—talk about stimulating the senses! We have wine and cheese parties and gambling at the casino. Incidentally, introducing vices is a great stimulator.

Our care is built on creativity and innovation. I could list many more activities, but space does not permit. Suffice it to say, we do enjoy our work.

With more and more hospitals extending their facilities to include long-term patients, we do not have adequate experienced staff to assume strong leadership roles. Education is desperately needed by all disciplines. This education must come from dedicated faculty who have been actively involved in extended care, so that they can initiate the desired program.

Once exposed to the system of an acute care centre it is very difficult to participate in psycho-social involvement with a patient. When, for example, a new registered nurse comes to an extended care unit she has to be retrained to a new philosophy, yet, in most cases, while this is happening, this nurse tries to superimpose her ideas, which she believes correct. She still hasn't the ability to judge, because she does not comprehend the full scope of restorative care for the long-term patient, so, we have conflict. In this see-saw, extended care finds it difficult to maintain its identity.

Having been exposed to extended care prepares a person for acute care and enriches the experience, but in reverse it can have a destructive influence. You can see the results of this as you walk through some long-term facilities. Nurses and doctors in these institutions have tended to model them after hospitals based on their acute care philosophies.

We must recognize that the two are not compatible. It isn't a traditional hospital we want, it is a home, yet one which still can maintain accreditation standards.

Change will come about only when disciplines become aware that energies expended on the aged are fruitful and rewarding. In the past, procedures we thought were futile, because of age, are now being carried out, thereby rewarding the patients with years of meaningful living. Yet we still find pessimistic attitudes in all disciplines, people who do not understand the restorative potential as it relates to the aged.

Sometimes, far-reaching policies and decisions are made for extended care by people with acute care oriented disciplines who do not have a full understanding of the real problems and issues.

One example is in the design of long-term hospitals. Acute care hospitals are designed for the staff and hospital convenience, which is most ntial, and beds become the focus of planning. In extended care, this cannot be allowed to happen—the patient must become the focus of prime importance. Yet, we find planners using the ideas of acute care hospital oriented disciplines and applying them to extended care standards.

Nurses are rarely consulted when plans are developed, even though nursing care is a most critical component. Planners of nursing homes and extended care facilities should make use of persons who have been actively involved in such working situations long enough to be able to make valid assessments and meaningful decisions, yet all too often they do not do so. So we continue to have modified types of acute care hospitals manned by acute hospital-oriented personnel.

Long-term care is still in its infancy. A confrontation is urgently needed. We must change the negative attitudes regarding the established patient role and embrace a philosophy which conveys expectations. This will motivate our patients to pride, status, dignity and achievement. It can be accomplished in a stimulating environment by a highly motivated, intelligent and perceptive staff, who truly focus on the needs of the aged. Their work, however, should not be impeded by anti-therapeutic policies, which continue to place hospital and professional interests above the needs of the patients. •