

## **The Role of the Physician in the Nursing Home Health Care Team**

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### **Introduction:**

The physician is often seen as a magician, someone with godlike power able to restore life to those even on the brink of death. Behind the magic, however, there is an entire team of nurses, consulting specialists, and many other personnel who are essential to the healing process. The doctor can only accomplish what he/she does with the help of his team. It is especially important that everyone communicate efficiently so that each member of this team can fully understand the patient and be able to treat him/her together. Such a group that works together to accomplish this goal is known as the interdisciplinary team (IDT).

At Terence Cardinal Cooke (TCC), alongside the traditional medical staff, there are many additional divisions of workers that have daily contact with the residents including social workers, dietary staff, physical/occupational therapy, recreational therapy, and many others. It becomes increasingly complicated for this staff to properly communicate with each other at all or effectively, and at times they seem to be doing completely differently tasks. The challenge of the IDT is for its members to work together and communicate with each other despite the complicated nature of its existence. This staff composition also complicates the relationship between the physician and the IDT.

### **Background:**

A once suggested model for the workplace environment was a well-oiled machine: If every part of the machine did its job, the machine would work successfully, and if one part was not working, it could easily be replaced by another similar part. A more recent analysis of the

healthcare system suggests that it is, in fact, more complicated: “A complex system is not constituted merely by the sum of its components, but also by the intricate relationships between these components. In ‘cutting up’ a system, the analytical method destroys what it seeks to understand” (Cilliers 1998). One may liken the healthcare organizational structure, not to a machine in which every part does its own job, but to an amoeba cell, a cell that must move and adapt quickly to its surroundings. Such adaptation occurs through constant and fluid communication between the many and necessary parts of the cell rather than a hierarchical structure (Anderson, 2005).

This understanding of a health care team working fluidly together fits O’Daniel’s definition of an IDT:

When considering a teamwork model in health care, an *interdisciplinary* approach should be applied. Unlike a *multidisciplinary* approach, in which each team member is responsible only for the activities related to his or her own discipline and formulates separate goals for the patient, an interdisciplinary approach coalesces a joint effort on behalf of the patient with a common goal from all disciplines involved in the care plan [italics added] (O’Daniel, 2008).

For this team to function properly, communication is key, so that each individual task works toward the same goal as everyone else’s tasks. The key factor of this team is also that work is done “on behalf of the patient” and that communication is directed toward the patient’s care. As Collucio writes: “to communicate and make decisions with the expressed goal of satisfying the needs of the patient while respecting the unique qualities and abilities of each healthcare provider” (Collucio, 1983).

Such communication is important not only because it maximizes efficiency in the work place, but also because it has been shown to improve health care. For example, one study asserted that with better communication between CNAs and co-workers, there is reported to be better EOL assessment and care delivery processes (Zheng, 2010). Another report quantitatively

linked work effectiveness to lower quality of life and quality of care deficiencies (Temkin-Greener, 2009). An additional source hypothesized that more open communication, more participation of nursing staff, more relationship-oriented leadership, and less formalization would “lower prevalence of resident behavior problems, restraint use, complications of immobility, and fractures.” The study found that, at least according to its methods, this was the case (Anderson, 2003).

### **The IDT at TCC:**

The TCC health care team embodies this notion of an IDT, of all of its units working together. Perhaps the best example of this communication is the care plan, or CCP, meetings. In these weekly meetings, the managing nurse, social worker, dietician, and other staff members sit together and discuss the welfare of residents on their unit quarterly, annually, and depending on residents’ needs and requests. At these meetings, the staff has time to properly discuss residents’ issues in one place together. These meetings are purposefully held away from the hustle and bustle of the floor, where it is often difficult to concentrate on anything.

I wondered why the physicians did not attend these meetings. They are clearly an integral part of the IDT, both in the sense that they have much to contribute to the discussion of the residents as well as the fact that they have much to gain from hearing about the residents’ conditions. They often claim that they are too busy with patient rounds and filling orders to stop by a meeting, and there is some truth to that statement. Most physicians cover several units at a time, often over one hundred residents, as opposed to other staff members who, at least for a certain point in time, only cover one floor or a few closely knit units. It sometimes seems that they barely have a second to stop and think. By the nature of them not going to the meetings,

however, I thought that there was a break in the connection between the physicians and the rest of the IDT.

During our work at TCC, we were assigned two cases that I believed symbolize the general communication issues within the facility. One case involved the MOLST (Medical Orders for Life Sustaining Treatment) documents. MOLST forms allow residents to elect directives such as Do Not Resuscitate (DNR), Do Not Intubate (DNI), and others in advance of these decisions becoming relevant. It is the policy of TCC that all residents complete a MOLST form, unless they refuse to complete one. The interns and I were assigned the task of auditing the MOLST forms of the building, making sure that the physician, witnesses, and the resident/health care proxy properly signed them, and all decisions were properly marked. We expected the assignment to be simple, to be merely scanning through completed documents and looking for slight mistakes, but after going through several floors of the forms, we realized that there were many incomplete forms with many different issues.

We discovered that much of the error was due to the lack of a clear process of filling out the document. While MOLST is a medical form, at TCC, it is often the social workers who take charge in beginning the end of life (EOL) conversation and complete the form while the doctors have their own discussion later and sign the document, often after the social worker has marked the resident's decisions. This arrangement leaves room for errors. For example, the physician may sign the document assuming it will be completed, but the social worker may not fill it out; perhaps the social worker fills out the form, but the physician is unaware and does not sign it; or occasionally, the paper form of the MOLST, completed by social work, contradicted advance directives orders on Sigmacare, the health care database for TCC. This problem was rampant throughout the building.

A consultant was hired to lead in-services explaining the MOLST process to the staff. These in-services were given to physicians, social workers, and nurses. We sat in on each meeting, and although much of the same information was discussed at each occasion, there was a significant difference in attitude between physicians and social workers toward the MOLST in terms of its importance, and whose job it was to complete it. Physicians believed that the social workers should take care of it, and the physician would sign the form, while the social workers insisted that the doctors needed to pay more heed to the documents. Clearly, there was a misunderstanding as to how the physicians and social workers should correspond for the MOLST.

The second issue I noted that suggests miscommunication is the palliative care protocol report. This report is an excel sheet that tracks residents throughout the process of their being placed on palliative care. Each column highlights a period in the referral process such as the actual referral, consultations, meetings, and progress notes in the process, as well as the official placement on palliative care. This sheet is emailed to the staff daily so that everyone is up-to-date on who needs to be seen about palliative care. There was a lot of missing information in the charts, so the interns and I were assigned to recover these dates. We searched through Sigmacare in order to find this data. After going through months of patient progress notes, we discovered that many of the dates were not properly documented. The referral, for example, is an unofficial stage at which someone mentions that maybe the patient should be put on palliative care. This referral can take the form of anything from being mentioned in morning report, to a side conversation with the physician or nurse. Hence these referrals are often not documented, unless someone happens to hear about it in morning report. In addition, IDT meetings about palliative care are often only recorded in the resident's paper charts and not recorded on Sigma.

Additionally, there were gaps in between dates such as gaps in between referrals and when the residents were seen by the palliative care consultants, or gaps between consults and filling in orders. These gaps should not have been more than a few days, but they were commonly months long. There were also several residents missing some of the many parts of the palliative care procedure including the care plan, filled out by the nurse, and medical orders and alert, filled out by the physician. I initially believed that these spaces in the process were due to the complicated nature of the primary health care team at TCC and how difficult it is to fully communicate to every person on staff. If these communication gaps were not addressed, they might lead to gaps in the actual care of residents on palliative care. Perhaps some residents who should have been on palliative care would be forgotten, and their needs would not be properly addressed, simply because they were not documented properly.

**The Plan:**

I decided to further examine the relationship between these issues and IDT-physician communication in order to determine the root of the problem and attempt to improve upon methods of communication. I chose to examine several factors. Firstly, I wanted to examine the role of the physician in the IDT Team and what they perceived their role to be. It seemed to me that physicians considered themselves to be somewhat separate from the team, perhaps like medical consultants for the regular IDT. As opposed to taking charge of the situation, physicians seemed to come when they were needed.

Additionally, I wanted to look into the general communication between members of the IDT. While the CCP meetings are efficient means of communication, when the team was not all gathered together there, it seemed that not everyone was on the same page in regard to what was

happening with residents. Sigma, although a good backup place to keep notes, was not necessarily the best way to communicate, so if something was not recorded properly or was not recorded at all, it would not be properly communicated outside of the CCP meeting unless it was an emergency situation. If this general communication was not efficient, it would explain why physician-IDT communication may have issues.

Finally, I wanted to track the actual treatment of residents on palliative care. The palliative care protocol sheet and the notes, or lack thereof on Sigma, suggested that there were often discrepancies among different fields in regard to the proper care of residents.

For my data, I interviewed physicians, social workers, and nursing managers, three key positions in the IDT, from three floors of the hospital, one floor from each service line: discrete, geriatrics, and sub-acute. My questions focused on the nature of the CCP meeting, but they also focused on general communication. I wanted to determine whether or not the CCP meetings were indicative of general communication among team members. I expected to find that the attitude of TCC could be improved to promote better communication. I also asked about palliative care in order to understand the IDT's perspective on the subject.

I outlined a basic questionnaire, but I changed my questioning format as I became more experienced with the interviews and depending on the conversation I was having. I have attached my notes on the interviews in the appendix. The data only covers a small percentage of the staff here at TCC, and there are differing numbers of physicians, social workers, and nurses interviewed. The data however, was not designed to collect quantitative data, but it was meant to analyze what I had observed about daily proceedings of social workers, physicians, and nursing staff.

**Results/The Interviews:**

In terms of physician-IDT relationship, I asked physicians if they saw TCC as a hierarchical structure or more as a fluid model, where everyone speaks to everyone in a freer and less formal environment. This question was based on a study that examined two nursing homes, one of which used a strict, hierarchical structure, while the other used a more fluid model (Colon-Emereic 2006). Most physicians answered that TCC was more of a fluid structure. Even those who claimed it was hierarchical explained that they do speak with all the members of the staff. These answers suggested that the physician was not the leader of the team, but he/she was a contributing member of the team as opposed to its boss. This model does not necessarily suggest worse communication or lesser care. It only means that the method of communication is different, not worse.

In terms of general communication outside of CCP meetings, as much as it seemed that they were always busy and did not have time for anything, the physicians explained that they were generally reachable. A few physicians stressed verbal communication, and that they were always talking to everyone on the floor. They stressed that they are available via text or calling their cellphones. The social workers and nurses also claimed that they were always speaking with each other. One nurse, when I asked her about the loss of information transferred over shifts, was adamant that no information gets lost on her unit, and when I mentioned general communication, she explained that they are always talking to each other. Most people agreed that CCP meetings are often more efficient than hallway conversations, but they still believed that they were able to be in constant contact, and therefore able to deal with issues as they came up as a team.



In terms of palliative care, there was near unanimous agreement, especially from the physicians, that each resident is treated individually, whether he/she is on palliative care or not. Palliative care, for the primary health care team, was generally assumed to be a function of the state of the residents. In other words, they are given better care, not because they are on palliative care, but they are on palliative care because they need better treatment and more attention.

Perhaps most importantly, many people interviewed expressed satisfaction and happiness at the communication. For the most part, they were happy with how communication was between physician and the rest of the team and how communication was among the team in general. Some people even suggested that it had improved since they arrived. For example, one social worker mentioned that morning report was a relatively new feature, and it was fantastic way for the administration to communicate with the primary health care staff. This satisfaction was not what I expected, at least not after many of my experiences.

### **What is the real problem?**

I initially hypothesized that the issues of communication concerning issues including MOLST and the palliative care protocol were due to physician-IDT miscommunications, but the general consensus of the people interviewed was that physician-IDT communication was overall satisfactory. There are a few reasons I may have been mistaken in my assumption. Firstly, I assumed that there was less communication occurring than there actually was. The staff was constantly moving around, so it was difficult to understand how anyone could effectively communicate with anyone else. Almost every time I interviewed someone, they were either in the middle of something or working on something else during the interview. A few times I even had to come back to speak with them later because they were so busy. This feeling of perpetual

busyness might have influenced my judgment of the facility and how much communication was actually occurring.

I was also mistaken about the quality of communication. An article on communication in regard to palliative care argues that communication is not an either/or phenomenon. It matters how things are said and the quality of speech (Doane, 2012). Perhaps I assumed that rushed discussions in the hallway or hasty phone calls were not effective in promoting communication, and only CCP meetings could be effective for communication. While hallway, informal discussions may have seemed inefficient, it is possible that the quality of these discussions allowed for efficient communication, despite the location of the talk.

Despite my findings that communication is generally effective, I would still suggest that all physicians to attend CCP meetings, even for a short period of time. The staff is generally pleased with overall communication, but they generally agree that CCP meetings are the most effective means of communicating. Although the physicians are very busy, to take the time to sit in on these meetings would promote better health care and save time of communication in the long run. Some physicians would argue that these meetings are actually inefficient. For example, one physician mentioned that he did not like to attend CCP meetings, and he would rather discuss the medical issue with the resident/family after or before the meeting. I would argue that spending more time in the meeting, even if no medical issues are discussed, will provide a better sense of the holistic condition of the resident and therefore allow the physician to provide better medical care.

Now that I determined the general success of IDT-physician communication, I believed that the issue at hand with the MOLST and the palliative care protocol report was related to a different qualitative issue. Analyzing these two cases, one can see that they both have to do with

protocol. The MOLST is an issue with planning a proper method for filling out the document, and the issues with palliative care protocol report are regarding lack of proper documentation. As interns, we were working from the perspective of the administration, from an outside perspective. We therefore assumed that since the procedure was not properly followed, there was an issue on the level of the care of the resident as well.

From the perspective of the physician, however, this is not necessarily the case. In general, physicians and the health care team itself were mostly concerned with speaking with each other, the type of communication that leads to dealing with issues with the resident. Computing into sigma does not necessarily fill that function. Even from the general perspective of the IDT, not recording CCP meetings in sigma, does not necessarily hinder resident health care. In fact, most of the IDT meeting slots are missing from the palliative care protocol sheet because they are simply not recorded.

Understanding this difference in perspective is important to understanding the issues regarding communication. In terms of the MOLST, the physicians were merely unaware of the proper procedure for filling them out, of knowing that they had to take charge. The administration was worried about the MOLST forms because they prioritized proper documentation, while the physician and IDT were focused on treating the residents, so a few errors or discrepancies may not have bothered them as much. After the in-service, however, when the importance of proper MOLST was explained to the physicians, they improved their work, at least according to one of the social workers interviewed. For a problem where the health care team is unfamiliar with or unaware of the protocol, there is a simple solution, and that is to educate the team about the proper procedure.

The palliative care protocol report sheet represents a more complicated issue. The overall process of the sheet is determined from an administrative point of view. For the administration, it is incredibly important that every step of the process for palliative care be documented, that every action taken or not be recorded. For the physician and IDT, however, what is important is the treatment of the resident. All the physicians asserted that palliative care orders are merely a formality, and they do not change the way they perceive or care for their residents. With this perspective in mind, not every single step in the care needs to be recorded because the steps are not relatively important in the overall scheme of the care. This issue should be addressed by promoting more discussion between the health care team and the administration in order for them to better understand each other. If the groups met more often to explain their processes, the administration would be able to better explain what they consider proper procedure to the primary health care staff. In return, the IDT could address their frustrations with the protocol and any suggestions they have to change it.

This communication here is already improving. Morning report, for example, is a relatively new procedure that involves both the primary care team and the administration, allowing inter-group communication. Unfortunately, physicians do not come. I would advise there to be a meeting, at least weekly between primary care staff members and certain administrative personnel in order to prevent these discrepancies from occurring in the future.

**Conclusion:**

This internship has exposed me to the frailty of human life juxtaposed with the vibrant souls of the residents of this facility. I sat with addicts as they shared their stories of triumph. I listened to the poetry of a bedridden man. I saw my first dead body. My perspective of what it

means to be a physician will never be the same. I now know what it means to heal someone, even if you cannot cure them.

On the other hand, I was also exposed to the complicated, and sometimes nasty, world of legal medicine and the politics involved. I began this report with a linear view of health care communication, but I now understand how complicated taking care of a resident can be and how difficult it is to properly communicate these ideas to the different members of the team. Alongside the complicated medicine procedures was the harsh reality of the protocol that comes with health care.

My interviews with the staff, however, did not simply reveal this complicated process of staff communication, but they also suggested a general positive attitude among many staff members toward the current proceedings. It is encouraging to see so many staff members working together to achieve this goal. Despite the discrepancies in communication, the facility has come so far and is still able to genuinely make its resident's lives better.

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## Appendix: Notes from Interviews

Note: Unless words are in quotation marks, these are not direct quotes from the people interviewed.

### Physician 1:

How do you practically communicate with your team (sigmacare, communication book, etc.)? What method is the most efficient? Which one is the most often used?

- I use sigmacare for my orders and labs
- My communication book is important for anything
- And we speak a lot during the daytime
- We also have meetings at the end of the week, all the physicians, to discuss possible issues with residents

Do you attend CCP meetings?

- Yes, but often I'll have to leave early

How do you generally find out what happens when you're *not* there?

- If I don't know, I will get the information myself

How often do you find yourself talking with the social worker?

- I find myself speaking with everyone regularly
- For example, if I'm going into a resident's room, I'll go in with the CNA and ask them about the resident's welfare

Does palliative care change anything for how you deal with residents?

- Palliative care is a process, and we discuss it throughout if we're going to put someone on palliative care or not
- We may also involve more people

If I were to categorize nursing homes in 2 extremes: one as a hierarchical structure, where they physician is the boss and there are clear chains-of-command underneath, or a very fluid model where everyone contributes equally, where would you put TCC?

- We are a very fluid model
- We generally have a close relationship among the staff
- Physicians used to not even be here every day, that's not true anymore

### Physician 2:

How do you practically communicate with your team (sigmacare, communication book, etc.)? What method is the most efficient? Which one is the most often used?

- It really depends. I use the communication book, but most of the time I text on my blackberry. Often I'm interrupted with calls.

How do you view the use of Sigma?



- Sigma is most often used just for formal requests, not for actual communication

Do you attend CCP meetings?

- Only if there's an acute issue. Usually, I don't like to wait until the meeting to tell the family, so I'll just call them.

How do you generally find out what happens when you're *not* there?

- The nurse manager tells me if there's a serious problem. I'm not necessarily told anything if the patient is stable.

Are you always aware of everything going on with the resident? Do you feel that you have to ask rather than be told?

- I'm usually told if there's something, but if there's no real issue, then I'm not

When you find something, how do you go about communicating it yourself?

- If there's a small issue, like an order, I'll just put it in and not tell anyone. Why would I bother someone with an order of X medicine or other?
- If there's a larger issue I speak with the nurse manager, the CNA, the entire staff, basically

How often do you find yourself talking with the social worker?

- For my long-term care residents, if they're stable, there's not much to discuss, so we don't talk that often.
- For the rehab/sub-acute patients, I speak with them relatively a lot. K is usually very available, so I'll speak with her the most. Other social workers aren't always as available. It really depends on how available the social workers are.

Does palliative care change anything for how you deal with residents?

- "Absolutely not."
- I'll fill an order if I see one, but that's about it
- I'll refer people for pal. Care consultants, maybe ~20% of the time. They're often good at getting through to the families
- I can often use them to help determine care

If I were to categorize nursing homes in 2 extremes: one as a hierarchical structure, where the physician is the boss and there are clear chains-of-command underneath, or a very fluid model where everyone contributes equally, where would you put TCC?

- Somewhere in between

For a follow-up question, how do you see your role as a physician, as the boss and leader of the team, or are you a contributing member who happens to be the medicine expert?

- I think just like everyone else. Everyone here has something to contribute.

Do you have a method for filling out a MOLST?

- Nope. That's something you should work on

### Physician 3:

How do you practically communicate with your team (sigmacare, communication book, etc.)?

What method is the most efficient? Which one is the most often used?

- My communication book

How do you view the use of Sigma?

- There is a messaging feature on sigma, but it's not really used

Do you attend CCP meetings?

- No. I don't find it productive to be at the meeting to discuss one or two medical issues

- If the family wants to discuss something, I'll meet with them separately

How do you generally find out what happens when you're *not* there?

- The charge nurse will usually update me, or I'll check on Sigma
- I talk to everyone, but it depends on the issue, so if a specific patient has an issue, I'll mention it to the CNA for that resident

Does palliative care change anything for how you deal with residents?

- That's a difficult question. Really, every resident is treated differently

How do you treat each unit differently (assuming they deal with different service lines)?

- Not really. They're all considered geriatrics, so I treat them the same

If I were to categorize nursing homes in 2 extremes: one as a hierarchical structure, where the physician is the boss and there are clear chains-of-command underneath, or a very fluid model where everyone contributes equally, where would you put TCC?

- It's generally a chain-of-command structure
- But I do talk to everyone

Do you have a method for filling out a MOLST?

- The social workers initiate them

Any recommendations to better communication?

- Nope

#### **Physician 4:**

How do you practically communicate with your team (sigmacare, communication book, etc.)?

What method is the most efficient? Which one is the most often used?

- It's best to personally call someone.
- I don't use email because I don't like it

Do you attend CCP meetings?

- No.

How do you generally find out what happens when you're *not* there?

- If there's something they want to tell me, they'll find a way to get in touch with me.

Are you always aware of everything going on with the resident? Do you feel that you have to ask rather than be told?

- Not always. I find I have to ask depending on the situation.
- I'll speak to the CNAs or whoever about what's important

How often do you find yourself talking with the social worker?

- On the sub-acute floors, more often. On the other floors, not as often.

Does palliative care change anything for how you deal with residents?

- That's a difficult question. It depends on the status of the patient, the reason for palliative care, and their general outcome
- It's a very individualized treatment, and it's not always easy
- It really depends on the situation
- For consultants, you ask if there's an issue with failure of the resident
  - o If they're not performing well, if they're deteriorating
- Right now there's no meeting to implement new palliative orders
  - o The orders will eventually be there, so they will get implemented,
  - o But there's not necessarily constant communication regarding pal. care

If I were to categorize nursing homes in 2 extremes: one as a hierarchical structure, where they physician is the boss and there are clear chains-of-command underneath, or a very fluid model where everyone contributes equally, where would you put TCC?

- This place is more fluid

For a follow-up question, how do you see your role as a physician, as the boss and leader of the team, or are you a contributing member who happens to be the medicine expert?

- The latter choice

How much do you “prepare” for meetings with family members/friends?

- I generally try to prepare with the team whenever we’re meeting with family

Do you have a method for filling out a MOLST?

- You know the answer to that question (laughing).

- No, there’s no practical official procedure as of now.

Any recommendations to better communication?

- It would help to get minutes from the morning report meeting

- Right now, I’m informed on an informal basis, if Dr. Lechich realizes something significant and important to tell me

### **Physician 5:**

How do you practically communicate with your team (sigmacare, communication book, etc.)?

What method is the most efficient? Which one is the most often used?

- Emails and texting

- I go on rounds every day, so that’s how I know

Do you attend CCP meetings?

- If they need me, they’ll call me, but if I’m not, they won’t

If I were to categorize nursing homes in 2 extremes: one as a hierarchical structure, where they physician is the boss and there are clear chains-of-command underneath, or a very fluid model where everyone contributes equally, where would you put TCC?

- We work as a team, and we all treat each other well

- Sometimes people want the doctor because they assume the MD knows everything

Do you have a method for filling out a MOLST?

- Social worker fills out the MOLST

- But I am involved in the conversation

Any recommendations to better communication?

- Backup communication

o Email, for example

- There should also be a better example to tell others if the resident wants to see them

### **Social Worker 1**

How do you practically communicate with your team (sigmacare, communication book, etc.)?

What method is the most efficient? Which one is the most often used?

- It depends on the person. Some people are really good with email and are by their email the whole day

- Some people just don’t

- IDT meetings *should* be a way to communicate with everyone, but realistically, not everyone goes

Do you attend CCP meetings?

- Social workers *have* to go. They're the ones leading the meetings. Other people usually, but not always, go to the meetings, and some staff just never show up

How do you generally find out what happens when you're *not* there?

- Always at CCP meetings, but let's say I'm not at morning report. I usually get that information in an email, or the nurses will inform me about what's going on.

When you find something, how do you go about communicating it yourself?

- See previous answers: email or in person. CCP if they attend

Does palliative care change anything for how you deal with residents?

- Every resident is different. Palliative care means that we deal with them a certain way, but even then, each person's palliative care is different
- For example: I once sent someone home who was on Calvary hospice care

Do you always feel empowered to tell what you've seen? Do you always give over what you've seen?

- I'm not always necessarily on the same level as others. I can try to talk to people about stuff, but often my position as social worker hinders me.
- For example: If I'm talking to a family about advanced directives, the best response I'll get from them is "you don't know what you're talking about." The worst response could be "that's the guy who tried to kill my family."
  - o You really need a doctor to convey this stuff to families
- In addition, if you're not in a meeting, it's very hard to get any information across
  - o You need a doc's attention to get them to do something
  - o But if they're busy with something else, they'll say "OK" and then keep doing the other thing they're doing
  - o Palliative care, for example, has to do with getting someone's attention. I can tell the doc, someone should be on pal. care, but if they're busy with something, they won't deal with it then, and maybe not even later

Physicians?

- There are 2 ways of looking at an IDT meeting: either the meeting is efficient and useful, or it's a waste of time. If it's good, you'll come to the meeting. If it's a waste of time, you won't
- Dr. 1 comes to all of the IDT meetings. Maybe he'll leave early, but he *will* be there. As for the rest of the staff (shrugs his shoulders)...
  - o If they're free, and if they aren't with other residents, I'll be there

Do you have a method for filling out a MOLST?

- MOLST is similar to other methods of communication. It matters that we communicate
  - o I'll run in there when someone's admitted and talk about MOLST. Often the resident will say something like "Oh, I'm going home in 2 weeks. Doctor said. I'm fine!" So we'll just do full code
  - o Then the doctor will actually have seen that he's not fine, and he'll put him on DNR
  - o That's where dueling MOLSTs come into play

- People get asked the same EOL questions over and over again. That's where confusion comes in
- If the doctor came to the CCP meeting and explained to the resident their condition, or explained their condition to me, it would be much easier to deal with the problem
- Now, if you put stuff in the doc's book of communication, it will get done almost 100% of the time, unless there's a reason not to do it, something the doc may have already dealt with

Any recommendations to better communication?

- It would be nice if technology here was updated to the year 2008
- There's this new device that came out recently, I don't know if you heard about it. It's called the Blackberry, and you can text from it and send emails on it!
- Everyone here should have a working email address and a working phone that does email
- The system is just too slow

## **Social Worker 2:**

How do you practically communicate with your team (sigmacare, communication book, etc.)?

What method is the most efficient? Which one is the most often used?

- It depends on what I need to communicate. There's an assessment upon admission and every few months when I have to ask if the resident has considered harming themselves or committing suicide. If they answer yes, I tell the nurse and physician immediately in person, or I call them. They're usually responsible. I also email so that there's documentation of the communication.
- Morning report is fantastic. It's new, and it's really great that administration is there to help us with our issues.
- The email system has really been improved

Do you attend CCP meetings?

- The social worker is the communicator between the team and the physician if a decision is made, at least for discrete
  - For example, sending emails to the physicians about passes

How do you generally find out what happens when you're *not* there?

- Email. Aside from what I'm told, I'll communicate with the staff about what should be done in my position when I'm not there
- It's important to recognize that it's documentation proof
- Physicians are generally responsive to this stuff

Does palliative care change anything for how you deal with residents?

- "Doesn't change a thing for me"
  - They're not necessarily EOL
  - Maybe involve the family more
  - No one gets treated differently here, even in terms of Medicaid/medicare and private payment
- We're more conscious of EOL care – funeral advance planning

Do you always feel empowered to tell what you've seen? Do you always give over what you've seen?

- This staff is especially receptive. I'll report any medical issues residents report to me to the staff, and it'll usually be acted upon.

Physicians?

- Dr. 1 has been here a long time and sees the relevance of the CCP meetings. Drs. 2 and 3 don't. Once they've been here a little longer, they might realize the value
  - o It's tricky to communicate with docs 2 and 3 because they're not even on the same floor all the time. Time is wasted just getting to them, or trying to find them
  - o If a family requests a doctor though, they'll be there in a heartbeat
  - o So right now, they come on an as-needed basis
- Were fortunate to have docs on the floor from 9-5, so we're really in communication a lot

Do you have a method for filling out a MOLST?

- It's supposed to be an MD decision
  - o Here, Social workers end up doing it
  - o I'll start the MOLST when the resident comes in
- The thing is, you can't make anyone do a MOLST if they don't want to have one

Any recommendations to better communication?

- I don't have a beeper or a cellphone. I think it's being worked on, but right now, if I'm not in my office, I can't be easily reached. If there's an emergency while I'm out for lunch, there's no way to get in touch with me
- Coming to CCP meetings on time. If you don't, it's a sign of disrespect, and it's very frustrating

### **Social Worker 3:**

How do you practically communicate with your team (sigmacare, communication book, etc.)?

What method is the most efficient? Which one is the most often used?

- Have to go to unit to communicate directly
- Some people respond very well with email
- I always try to call the doctor
- In general, it's helpful to go to the floor to talk to them
  - o It doesn't work all the time, but that's ideal communication
- Sometimes you tell them something, so you have to keep reminding them
- That's why email's a good idea, so you have documentation that you told them something

How do you view the use of Sigma?

- Sigma is used like a chart
- It's not really for team communication

How do you generally find out what happens when you're *not* there?

- I have to seek out the info.
- I tell them, but no one tells me unless something is going on

When you find something, how do you go about communicating it yourself?

- I'll immediately go to the nurse and tell them
- I'll get in touch with the doctor if I'm particularly worried

If I were to categorize nursing homes in 2 extremes: one as a hierarchical structure, where the physician is the boss and there are clear chains-of-command underneath, or a very fluid model where everyone contributes equally, where would you put TCC?

- Generally fluid atmosphere
- I find myself sometimes reporting directly to Dr. Lechich

How much do you “prepare” for meetings with family members/friends?

- We generally don’t unless there’s a special/complex situation

Do you have any suggestions as to how to improve interdisciplinary communication?

- Some people don’t say anything until later
  - o Example: therapy who sees residents 1-on-1 should really report what they see

Do you have a method for filling out a MOLST?

- Have to pull in the physicians
- It used to be that we would do everything, but after the education, physicians play a role
- Still, I call the family and take the initial steps

#### **Social Worker 4 and Nurse 1 together (same unit):**

How do you practically communicate with your team (sigmacare, communication book, etc.)?

What method is the most efficient? Which one is the most often used?

- Emails “all the time”
- We’re always communicating
- CCP meetings every week
- Everything works, but it depends on severity
  - o For doctors, texting is good because they’ll deal with it as soon as they have a chance to check their texts

How do you view the use of Sigma?

- Definitely can help people in terms of progress notes – fixing issues and realizing problems
- Makes sure that everyone has the same story

Do you attend CCP meetings? How do you generally find out what happens when you’re *not* there?

- Yes. If I can’t make it on a certain day, they’re often rescheduled so that everyone can attend
- It’s important that representatives from each department show up at the meetings for legal reasons
- But it’s also significant who specifically is there
  - o The people working in Huntington’s *know* the residents really, really well

Are you always aware of everything going on with the resident? Do you feel that you have to ask rather than be told?

- Nope. Basically perpetual communication

When you find something, how do you go about communicating it yourself?

- A lot can change in status, really anything can
  - o Certain residents are just always moaning, but sometimes that moaning may be due to a new problem, even though it’s the same symptom

- Really need someone to check in every day, ideally a full-time physician and full-time NP

How does communication work when changing shifts? How do you prevent loss of information?

- Sigma notes clarify. Documentation is very important
- It's also important to rely on "grapevine communication" and then to follow that informal discussion with formal follow-up
- Certain CNAs and other staff members get upset when certain people do things differently, even if it's an OK way to do it

Does palliative care change anything for how you deal with residents?

- It has to do with family acceptance
  - o Often families just don't want to think about things right then
  - o Often they'll merely mention the conversation and have the family agree to full code
    - It's usually OK with early residents, and then it's legal and good with the state
  - o Because Pal. Care assumes more care, families are frustrated when assuming that not Pal. Care means less care
  - o It's also important to mention that you can revise Pal. Care, it's not a final decision
- We don't really deal with them differently
  - o Everyone should technically be on Pal. Care
  - o We treat them all the same, it's just a matter of being in a different stage of the disease

Any recommendations to better communication?

- Get a full time doctor/NP

How much do you "prepare" for meetings with family members/friends?

- Ideally have a meeting 10-15 minutes before each family meeting, just so that everyone's on the same page. It doesn't always work out that way

How does your unit work so cohesively? What methods of communication do you use?

- It has to do with the people working
  - o It's important for there to be perpetual talking
- It's important to address the issues, not just the people
  - o "Minute-by-minute basis"
  - o It's hard to get info if only one person on the team is interested/invested in the case
- Nurse: I've worked with many members from other units who just don't care. Here, they all really do
  - o This unit is a utopia, while other units do close-to-expected work

How often do acute problems come up? Considering that Huntington's is a long-term disease, how often do you deal with practically medical issues aside from the progression of the disease?

- Disease generally progresses really slowly
  - o There aren't as many discharges/admissions
- The staff has been here forever, *really* familiar with the disease, with the residents
- Also, family's are really involved. They often call the meetings and know as much as what's going on as the staff does



What is the physician-IDT relationship? How often do they come by? How much does their input matter?

- There really should be a permanent doctor and permanent NP for the floor (see other questions for details)

Do you have a method for filling out a MOLST?

- Nurse starts right away with family and with MOLST
  - o Similar to Pal. Care, family often doesn't want to talk about it
  - o Often they'll merely mention the conversation and have the family agree to full code
    - It's usually OK with early residents, and then it's legal and good with the state
  - o Just important to think about and begin mentioning the conversation
- Doctors *should* be a part of the discussion because they can really answer the medical issues of resuscitation and other issues
- Important to recognize that everyone works really hard

## Nurse 2:

How do you practically communicate with your team (sigmacare, communication book, etc.)?

What method is the most efficient? Which one is the most often used?

- It depends on the situation. We use a combination of methods
- Often you have to multitask
- To get in touch with the physician
  - o There are times when you know where they'll be such as wound rounds, certain conferences, etc.
  - o For general information about residents, they have their communication books
- We keep each other informed

How do you view the use of Sigma?

- It's not really used for communication

Do you attend CCP meetings?

- CCP meetings are generally effective
- The physician comes if there's a medical issue

How do you generally find out what happens when you're *not* there? Are you always aware of everything going on with the resident? Do you feel that you have to ask rather than be told?

When you find something, how do you go about communicating it yourself?

- We keep each other informed

How does communication work when changing shifts? How do you prevent loss of information?

- Nothing gets lost around here
- We have shift reports in between shifts
- The CNAs report to the other CNAs
- Everyone is together formally

Does palliative care change anything for how you deal with residents?

- "Don't know nothin' about Palliative Care"

If I were to categorize nursing homes in 2 extremes: one as a hierarchical structure, where they physician is the boss and there are clear chains-of-command underneath, or a very fluid model where everyone contributes equally, where would you put TCC?

- It's generally a chain-of-command situation
- But it's really a day-to-day situation
  - o You base it on what's going on
  - o Sometimes standardizing doesn't work

Do you have a method for filling out a MOLST?

- That's more the social worker and physician. I can be a witness though.

### **Nurse 3:**

How do you practically communicate with your team (sigmacare, communication book, etc.)? What method is the most efficient? Which one is the most often used?

- Everyone is into emails (not me)
- I'd rather call or talk face-to-face, but I'll go with the flow

How do you view the use of Sigma?

- You can use it, but meetings are more effective

Do you attend CCP meetings?

- Generally, everyone is there for the CCP meetings
- Doctor is there if we need him for certain issues
- If the patient is stable and there are no issues, they will not be there

How do you generally find out what happens when you're *not* there?

- Generally the staff comes to her and tells her

If I were to categorize nursing homes in 2 extremes: one as a hierarchical structure, where they physician is the boss and there are clear chains-of-command underneath, or a very fluid model where everyone contributes equally, where would you put TCC?

- The doctor is on top because of the orders
- But not for running the unit

How much do you "prepare" for meetings with family members/friends?

- Usually have a pre-meeting where the team discusses the issue
- But if the family just wants to talk, no problem

Do you have any suggestions as to how to improve interdisciplinary communication?

- People should pick up the phone sometimes to confirm

Do you have a method for filling out a MOLST?

- That's more the social worker and physician. I can be a witness though