



A SNOW STORM STORY

It was November 16, 1987 and the Chicago suburbs were having an early snowfall. It snowed all one day and throughout the next. In all, 16 inches fell in 24 hours. This created a nightmare for getting anywhere, let alone to and from a nursing home in Elgin, Illinois.

I, being the Administrator, got a call from my new ADON, the morning of the 16th, saying that the staff was not showing up as scheduled. The DON, also, had yet to arrive. Consequently, she did not show up for three days and shortly thereafter became the former DON. My ADON was quite concerned and wanted to know what to do. We talked for a while and decided on a different staffing approach that day. I asked her to list the critical tasks, by patient, and assign them to specific staff. I instructed her to organize the staff into teams that would deliver the priorities, such as food, medications and clothing.

When I arrived at the facility, it looked different; it had new life. There was activity, and “ALL” was focused on the patients. As the day progressed there were no meetings, no breaks, and no complaints. No time was wasted, and everything felt great. With my ADON and another RN in charge of the teams, the critical things were under control. They were no longer racing around trying to get staff to show up. Instead, they were directing the teams to deal with individual patient needs such as laundry, transportation to meals and notification of families to assure them that all was well.

The attitude of the staff was the best it had ever been. They were on a mission, and they were not going to be deterred. While dealing with this crisis there was no turnover, no call-ins, no insubordination, no finger pointing and no excuses; just performance and the satisfaction of jobs getting done.

72 hours later the same staff was still on the job. Sleep was done in shifts as the teams organized and executed the important work. No one was allowed to push themselves beyond the breaking point, and everyone was focused on the patient. You could detect that this was important to both the staff and the resident. In that 3-day period, more was accomplished with half the staff than had ever been accomplished in the past, using my entire workforce.

In introspect I made a decision never to go back to the former departmental structure. The new culture would be without the autocratic departmental territorial limitations. We had discovered a new way of functioning better than ever before. I call it functional management, because problem solvers are assigned the responsibility for every “priority function” in the facility. For every problem we had a function; for every function we had a team member covering that function; for every function we assigned an “F” tag survey

responsibility. This became our new regimen of compliance, not just a snow-screen to impress surveyors.

An example of change:

- To eliminate lost, stolen and misplaced clothing, we assigned a clothing Aide whose only job was to keep track of the clothing between the resident, the laundry department and the family.
- We assigned a treatment nurse for each shift to help ensure that all appropriate treatments were completed every day.
- To eliminate room odors, we had a room care aide assigned to rooms that has developed odors, saving the CNA's time so they could serve the resident.
- Decreased Resident weights and low meal consumption had become an obvious problem. To help resolve this, we had Restaurant Waiters assigned to specific tables so the residents got what they wanted and were assisted if needed, to ensure increased satisfaction and meal consumption.
- We assigned restorative aides to exercise and stimulate the resident two shifts per day to eliminate the lack of exercise and strengthening the residents were previously receiving.
- Formerly, cognition exercises and interaction of dementia residents with the other more functional residents had almost ceased to exist. To resolve this problem, we developed psychosocial clubs organized around medical diagnoses that allowed for the interaction of the functional residents with the low functioning residents. If they had common problems they could interact in a group therapy session very effectively.

Patient Problems became the driving force for our treatment regimens and the additional Programs resulted in better and more meaningful outcomes. Care plan assignment sheets were generated for each staff function, making the staff directly accountable for patient improvement. Staff was required to sign off when the task was performed. Estimated performance times were used to create a more productive and efficient workday. For the first time, staff had the authority to carry out their day-to-day responsibilities without much supervision. Now they were more satisfied with their work, and in the process, were restoring the patients.

EPILOGUE:

From my prospective as the Administrator, we had redefined the service model for a nursing home. We had realigned the work and reorganized the pecking order into teams. From that, we built a system of procedures, policies and forms to support this new culture. The system eventually grew into what we now refer to as the Caregiver Management System. It starts with the Assessment of each resident's condition and

results in a care plan of standardized programs that are designed to result in better outcomes.

These programs are assigned to specialists who are specifically trained to solve or alleviate that resident's specific problems. This gives the team leaders something to measure; first being accountability, second performance and third effectiveness. This process also leads to efficiency because the work is better organized and focused on outcomes. It becomes a form of self-management, because the staff is empowered to get their job done and use a system to document their successes. Authority to get the job done is embodied in their work assignments.

In this environment low moral was no longer an issue. The main issue evolved into problem solving for the resident. Problem solvers were now organized into specialty teams with specialty programs designed to respond to the assessment. We set up a computerized library of blue print templates for each available program standardizing as much of the process as possible. This way we could get consistency and the staff could get the restorative and psycho/social programs done.

Immediately, the staff and patient morale rose, absenteeism subsided and the rampant turnover went away. Why? Again, from my perspective, it was due to an actual feeling of making a difference in the patient's condition. We stressed a philosophy of getting all the patients better. If we could get a reputation in the community, of being problem solvers, we would receive more referrals. This is, in fact, exactly what happened. In those "Pre-Team" days, occupancy had declined to 169 patients in our 207-bed facility. After the institution of teams, our occupancy rose to an average of 199. The Medicare census, which started at 4 patients, skyrocketed to 34 within 6 months of converting to specialty units. The specialty units were created as distinct parts on the first and second floor. We had 36 Medicare beds, 100 chronic care beds, 50 dementia/confused/alzheimers beds and 21 respiratory/pulmonary beds.

When I first became the Administrator, the facility was decertified, disorganized and was issued a conditional license due to a drowning in the whirlpool that occurred when a therapist left a patient unattended. We were getting pressure from the State to close down, or turn the facility back over to the original owners. At that point the facility was not profitable and could not pay its' bills. Within three months of the conversion to this type of organizational structure, the license and certification were reinstated. The facility had now become rated as one of the best in the region, receiving five of the six stars of quality, along with a deficiency free survey.

After the snowstorm incident, due to an enhanced Medicare program and better services to the Medicaid program, the facility was now showing record profits and stable cash flow. The increase in census was a major factor in making such profits because the excess capacity costs were now eliminated. Costly turnover and call-ins were gone and the risk of injury to staff and residents diminished to zero. What was once a group of twelve middle managers running departments, was now a small group of three Case Manager's running teams that were assigned to specialty units, according to functions needed to solve resident's problems. This, alone, eliminated \$200,000 in middle management costs.

Our facility now had hospitality aides supporting the Case Management teams with room care, restaurant services, clothing care and basic entertainment. The unit-care CNA's

served the dependent patients. The restorative aides provided the restorative programs while the rehab aides were assigned to the rehab cases, and the therapists and nurses specialized in treating certain diseases and nursing diagnoses. All of this stemmed from an assessment of each patient's physical, social, psychological and spiritual problems within a blueprinted and programmatic format created from a computerized library. This library was set up to standardize the response to the assessment triggered so the programs could be based on the patient's individualized problems.

From this ending came a beginning of my functional management system design including the realignment of workflow and reorganization of the service product, so the market for long term care can be better served and the investors in this process are better rewarded. These management methods have since been organized and computerized to re-engineer the operational forms and procedures into efficient electronic tools. In the vernacular of other industries we instituted a quality improvement system that controlled the problems using the functional management teams, case management and computerized care models.

Most people, when told this story respond the following way. "Sure... you can do it on adrenalin but it will wear off and slide back into the abyss." However, this was not my experience. The staff informed me that they knew how to do this all along but no one would ever let them. I tend to believe my staff because they were the ones who made it work.

"The Unfortunate Truth"

Following our three-day snowstorm lesson, the facility was completely reinstated, but unfortunately, due to its' new appearance and overall value, sold 6 months later. This fresh and exciting facility that had been re-born over a 3-day period was, once again acquired by what I refer to as, "a Warehouse". All that had been redone was undone as the facility was quickly turned back into the typical nursing home that I had walked into on day one.

"What next?"

As for myself, I moved on to another waiting warehouse, but this time I knew the formula. It took me 22 months to fix this one, just so it could be sold... same as the last. At this point in my career, I was sick of fixing them up, only to see everything I'd worked for sold out from underneath me, so I resurrected my consulting business and began perfecting this infrastructure for a broader purpose.

"What about now?"

Since that time my son and my wife have helped me computerize and perfect the entire process and we have successfully implemented the functional management process in over 100 nursing homes. Although these methods we have implemented, have never failed to work, the continuing battle against old methods along with the ineffectiveness of absentee ownership has forced us to look in a new directions still. We have decided that the only way to do it right is to do it ourselves.