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THE WAYS TO IMPROVE PHYSICIAN-NURSING RELATIONSHIPS IN LONG TERM CARE (LTC)

Overview

There are new specific points in resident care of Georgian Health Care system, where hospitals for long-term care of patients with chronic diseases and Nursing Homes for elderly develop. In that type of Health Care institutions the physician-nursing relationship is important and sometimes difficult. Nursing departments in long term care settings face a myriad of challenges to remain in compliance with long term care regulations. One component of these objectives involves physicians and the process of communication [1]. In long-term care nurses and physicians face many challenges including regulatory, legal, medication use, resident care, third party payor and ethical decisions. At the forefront is the challenge of accurately assessing and treating residents with many complex co-morbid medical and psycho-social conditions. Medical conditions once thought to be acute and terminal are developing into chronic conditions due to technological and medical advancements and radical changes in resident care guidelines.

In a long term care setting there are many regulations regarding physicians and their accountability to residents. These regulations include time frames for physician visits, end stage or terminal care, and medication review. One key to successfully navigating these regulations is a functional communication process between nursing staff and the physician. If the physician-nursing-resident team concept is proactive, resident care can be enhanced.

Key communication points:

- Timely, accurate communication
- Communication that is open and interactive
- Continuous feedback

Resident-physical relationship

The starting point is the resident-physician relationship at the time of admission [3]. At times due to facility location or physician time constraints, the resident's family physician is unable to continue to follow the resident in a long-term care setting. A physician search is initiated by the long term care facility and completed prior to admission of the resident. This resident-physician relationship is critical and in many instances is contracted sight unseen. The physician is unable to physically examine or interview the resident. Residents requiring admission to a long-term care setting have many complex medical issues. The basis of physician acceptance of a new resident is contingent on the documentation supplied by the facility's admission process. This information must be accurate, current and concise to ensure placement of the resident in the appropriate unit of the long term care facility. Communication must be clear and timely to allow for critical analyze of resident-family information on the part of the facility and the physician. A physician will usually not read through volumes of information or be on a telephone call for extended amounts of time. The

physician's main areas of concern are resident diagnosis, medications, treatments, payment source and family support. This information can be relayed through fax or telephone.

Long term care is a consumer driven market that is highly competitive. Admission decisions need to be quickly and accurately made. Hospitals wish to decrease their length of stay and long-term care facilities wish to maintain their census. At the same time long term care settings must select residents who are appropriate for the type of care provided by the facility. Facility that is unable to treat and care for a resident requiring ventilator care should not consider this type of resident during the admission review process. The nursing assessment at time of admission is important to appropriate resident care. Communication assessment information can enhance the initial treatment process. A pre-admission resident review by the nurse can facilitate the admission decision. It is useful to enhance communication processes.

Key communication points:

- Preadmission assessment
- Critical analysis of accurate resident-family information
- Timely decisions about admissions

Resident support system

Physicians also "inherit" the resident's support system. This support system can range from an overly involved family member to no involvement from the family. Family members may call a physician several times a day to discuss their loved one's health status, despite being updated by facility staff. Other family members may feel that their loved one's physician is remote from their care. The change in physician visit schedule from daily in the acute care setting to monthly in long term care is a dramatic change for the resident and their family. Other family members may never contact the physician or offer any assistance concerning history of the resident's medical condition, past behaviors, or resident coping mechanisms. Inactive, active family involvement may add to the challenge of caring for residents. The overly concerned family member may feel that the physician is not responding to their daily telephone calls (or more frequent inquiries) to the physician, especially if the physician is new to the resident and their family. Here again nursing is the liaison between resident/family and physician. Nurses must convey to the physician concise physical assessments and ensure the resident/family that the physician is aware of resident status and appropriate interventions have been implemented. Standard facility policies regarding skin care, nutrition, social activities and bowel protocol will assist the communication process. The physician needs to be familiar with routine interventions that will be implemented as part of their resident's care and then be able to order interventions to address resident care needs and standards. The nurse-physician communication system should be supportive of each other and more importantly the resident.

Key communication points:

- Standards of medical and nursing practice that are current
- Routinely update resident's family about a change of resident status
- Share essential information with a physician

Physician-nursing relationship

Changes in physician visiting schedule dose do not imply that the physician is not updated on the status of his/her residents. Nursing staff is still the liaison between the family and the physician. At this crucial step in the communication process the physician may inform the nursing staff of his/her preferences and standing orders. Nursing staff need to understand the individual physician's behaviors and methods of medical practice. These preferences can include, but not be limited to, time frames for non-emergent phone calls from the nursing department, scheduling for routine diagnostic studies such as blood work being drawn on a specific day of the week to ensure notification of diagnostic/clinical investigations and abnormal reports. In these instances, the communication process between nursing and the resident's physician is extremely important since residents in a long term care setting exhibit symptoms of a disease process that is not always typical in nature. A resident who is unable to verbally communicate or is confused does not demonstrate typical medical signs of a change in the condition. Since some residents are unable to verbalize their complaints of illness, a nurse must have excellent assessment skills and be able to verbalize these assessment findings to a physician. For example, in a long term care setting a resident's elevated temperature of two point four degrees (2.4 degrees F) above their baseline range could be an elevated temperature at ninety-nine degrees. A resident's first sign of a urinary tract infection may be confusion, not pain or grimacing on urination or foul smelling urine. The nurse must clearly explain these changes in resident status so that the physician can determine the next step in the treatment. A nurse must clearly indicate the resident's usual behavior, vital signs, eating habits, social activities, etc. so that the physician can make a sound qualified decision for the treatment.

Key communication points:

- Good assessment skills on part of the nurse
- Changes in resident health
- Timely and accurate physician notification

Physician visits

Once the physician has accepted the resident, long-term care regulations require a specified time frame for physician visit's to be in compliance. Federal regulations require monthly visits for the first three months, then visits every sixty days. No more than ten days time lapse between required visits is allowed. Physician visits include documentation in the resident's medical record, reviewing the resident's individual care needs and plan of care, including but not limited to medications, treatments and individualized resident care issues. Nursing Unit Managers can monitor their unit's physician visit schedule and inform the Director of Nursing of any problems. Prior to being out of compliance, the Director of Nursing will notify the resident's primary physician by a telephone call and a letter of the need to visit. Again communication must be timely and accurate. If this is not effective, the facility's Medical Director must be notified to ensure the physician visit is completed in a timely fashion. At times physician to physician communication will be more effective. If the resident's primary physician does not visit timely, it may necessitate that the Medical

Director visits the physician's residents and complete the resident assessments and other required forms.

Key communication points:

- Accurate monitoring of physician's visit schedule
- Notification to a physician for need to visit prior to regulatory deadline
- Medical Director active participation with nursing and medical staff

Medicare certification

Medicare certification forms must be completed in a timely fashion to ensure facility receives accurate payment for services rendered to the resident [3]. A good monitoring of this system includes the Registered Nurse Assessment Coordinator (RNAC) monitoring Medicare certification forms completion. Nursing staff will send these forms to the physician and inform the Director of Nursing in a timely fashion of any concerns prior to the situation becoming problematic. Again timely and concise communication with the primary physician will allow timely form completion.

Key communication points:

- RNAC vigilant monitoring of form completion
- Timeliness of form being sent to physician
- Physician compliance

Terminal/end stage care

Despite the most professional and qualified nursing and physician care rendered to residents in a long term care setting, end of life decisions need to be made. End of life discussions are usually not easy for the resident, the resident's family, nursing staff or the physician. This is a very emotional time for all involved. If the resident has completed a living will or advanced directive it may make the decision process easier but this is reliant on the fact that all involved in resident care recognize that the disease process is now end stage or in a terminal phase. If the resident has no written indication of the end life wishes, the discussion becomes harder. Based on the ethical practices of the physician and of the facility, certain documentation needs to occur. The facility's medical ethics committee may need to meet with the resident and/or resident's family to discuss care options. Nursing and physicians must remain objective during this phase of resident care. Dying does not indicate nursing or physician failure. Support needs to be given to the resident, their family and the team caring for the resident.

Key communication points:

- Upon admission determine a resident's end of life decisions
- Update a resident's family upon decline in resident status
- Update facility's ethical committee with decline in resident status

Medicare review

Numerous long term care regulations are involved in the medication regime of each resident. Pharmacy consultants review each resident's medical record to ensure that each medication is ordered and administered according to appropriate nursing and medical standards, including long term care standards. In this area of the regulatory process the physician

needs to document clearly medical reasoning for a specific pharmaceutical regime. Not only is the facility's pharmacy formulary utilized including cost of the drug and drug-to-drug interactions, but the physician also needs to consider long term regulations for ordering medication. Regulations include review for un-necessary or duplicate drug therapy, psychoactive medications and indications for same, and drug reductions. Physicians may feel that they are loosing some of their ability and power to assess and treat residents entrusted in their care, but nursing must again be the liaison between the pharmacy consultant and the physician. Although physicians may be knowledgeable of some of the long term care regulations regarding medications, nursing must review with the physician some of the regulations. This review must be completed in a non-threatening method, but factual manner. The nurse must state the reason for the regulatory concern clearly and concisely, and give options to the physician to ensure that appropriate medical care is administered to the resident. The nurse also has the option to have the physician speak directly to the pharmacy consultants. Physicians actively attending the quality assurance/performance improvement committee of the facility would have met the pharmacy consultant during these meetings and have an opportunity to speak with them directly. Due to physician time constraints this may not occur.

Key communication points:

- Nursing awareness of pharmacy consultant review
- Nursing awareness of pharmacy regulations in LTC
- Facilitate communication between nursing-physician-pharmacist

Physician notification regarding change in resident status

Residents in the long term care setting fall and/or develop alterations in their skin integrity due to various causes. Resident assessment and treatment is of prime importance. Many times the injury does not necessitate an emergency room visit or physician urgent notification. Facility's standards of nursing care can allow for treatment while the resident remains at the facility. Standards of nursing for routine and urgent care are to be developed in conjunction with the facility's medical director. Nursing assessment must be accurate. Nursing to physician notification must be timely and encompass a review of the resident's medical status, behavior, medication regime and family support system. Nursing standards must include protocols for urgent and non-urgent emergencies, as well as a time frame for physician response before nursing involves the facility's medical director or the community's emergency management team in resident's treatment.

Key communication points:

- Standards of resident care developed to guide nursing staff
- Clear protocols for routine and urgent resident care and physician notification
- Active involvement of the facility's medical director

Residents with impaired cognition

At times due to disease or medical conditions residents in a long term care setting may seem cognitively impaired. A resident's cognitive impairment may be seen during the admission process or during their stay in the long term care setting. One of the best indicators to

determine resident capability is to administer to the resident a mini-mental test. Results of this test will determine the resident's level of cognition, including the degree of impairment. Based on the result of this test and the outcomes of a resident's normal decision processes, capability can be determined. Nursing staff must accurately and timely notify the resident's physician of both the test results and the resident's decision process outcomes. Once the physician has determined the resident is cognitively impaired, the resident's family needs to be notified. At this point a strong nursing-physician relationship will ease family awareness of this change. A change in resident capability status, indicating impairment, has a domino effect on resident care. There now needs to be in place a process that determines who will make decisions for this resident. This process may require judicial assistance if the resident has no documentation to indicate who they had chosen for their decision process. Nursing-physician must have strong communication to analyze assessment and treatment modalities, and new patterns of communication.

Key communication points:

- Administer mini-mental examine to determine resident cognition
- Critically analyze results of mini-mental examination and resident behavior
- Accurate communication between nursing-physician regarding resident decision outcomes

Conclusion

LTC is a highly regulated industry. Regulatory processes for long term care are complicated and difficult. Many times these regulations cause the long term care industry to be under a microscope. Bad publicity, warranted or not, increases the severity of the regulatory process. Nurses and physicians are the guardians for appropriate care of residents in long term care settings. Communication between physicians and nursing is vital. Communication techniques and processes must be open, clear, and concise so that the nurse and the physician have as their main focus the best interest of the resident and his/her family. Communication is the key that will facilitate proper professional care in the long term setting, and solidify the nurse-physician-resident-family team approach to total resident care.

Figure 1

Long-term stay Hospital (Nursing and Elderly home) beds per 100000			
Countries	2000	2005	2010
Armenia	21.07	31.39	33.48
Azerbaijan	20.09	19.27	17.86

Belarus	169.02	170.29	187.67
Belgium	1203.84	1194.92	1227.87
Bulgaria	57.84	55.97	60.66
Czech Republic	633.75	673.11	660.33
Denmark	863.09	817.58	844.69
Estonia	440.74	502.86	631.19
Finland	660.04	817.43	1087.79
France	762.73	793.41	906.83
Georgia	...	...	...
Hungary	646.27	752.32	825.51
Iceland	587.93	691.53	697.16
Ireland	424.27	472.53	585
Israel	213.1	223.6	228.5
Italy	221.12	289.77	352.34
Kazakhstan	104.94	120.55	...
Kyrgyzstan	47.67	54.34	46.44
Latvia	219.09	231.08	275.17
Lithuania	523.87	539.55	566.54
Netherlands	1060.23	1044.58	1036.51
Norway	...	943.61	891.92
Poland	...	232.62	232.83
Sweden	1701.24	1521.35	1423.01
Switzerland	1169.66	1167.09	1172.93
United Kingdom	...	882.03	870.04

Figure 2

% of Physicians working in Hospitals			
Countries	2000	2010	2011
Armenia	38.05	42.69	42.73
Austria	56.56	55.87	...
Azerbaijan	45.43	41.24	39.66
Belarus	...	98.67	91.94
Belgium	...	...	...
Bulgaria	...	52.93	...
Czech Republic	...	57.22	...
Denmark	67.38	...	...
Georgia	49.51	46.11	43.24
Germany	48.89	51.79	...
Norway	...	58.49	...
Poland	...	51.82	...
Portugal	62.51	54.12	...
Republic of Moldova	50.51	32.47	32.67
Romania	45.52	50.32	...
Turkey	74.44	77.03	

Figure 3

% of Nurses working in Hospitals			
Countries	2000	2010	2011
Denmark	59	...	...
Estonia	...	72.59	...
Finland	52.72	...	...
France	72.37	66.43	...
Georgia	...	...	...
Germany	66.79	58.55	...
Israel	71.75	69.93	68.21
Kazakhstan	63.8	...	...
Kyrgyzstan	62	...	...
Latvia	77.65	63.85	...
Lithuania	63.02	64.13	...
Norway	...	57.38	...
Portugal	...	59.26	...
Romania	...	51.28	...
Russian Federation	65.5	...	...
Spain	70.49	64.02	...
Switzerland	...	47.58	...

Figure 4

Total inpatient expenditure as % of total health expenditure			
Countries	2000	2010	2011

Austria	39.08	39.9	...
Azerbaijan	61.8	...	...
Belarus	60	44	43
Belgium	...	28.8	...
Czech Republic	26.58	32.27	...
Denmark	...	38.15	...
Estonia	35.34	32.42	32.23
Finland	38.79	35.54	...
France	38.35	36.8	...
Georgia	...	17.1	...
Germany	35.25	34.48	...
Hungary	29.32	27.03	...
Iceland	56.16	43.72	...
Israel	35.4	...	...
Italy	43.22	46.26	46.61
Netherlands	36.49	50.18	...
Norway	42.8	44.69	45.36
Poland	...	32.56	...
Portugal	23.89	19.55	...
Republic of Moldova	...	30.1	29.2
Serbia	29.25	31.1	...
Slovakia	...	20.11	...
Slovenia	...	34.76	...

Spain	28.16	...	...
Sweden	4.59	28.52	...
Switzerland	46.18	45.42	...

Figure 5

Expenditure on inpatient care, PPP$ per capita			
Countries	2000	2010	2011
Czech Republic	260.95	607.75	...
Denmark	...	1702.82	...
Estonia	184.76	419.48	...
Finland	718.98	1155.41	...
France	975.84	1462.35	...
Germany	944.02	1495.7	...
Hungary	250.09	432.6	...
Iceland	1539.09	1447	...
Israel	621.92	...	...
Italy	...	1371.02	...
Netherlands	853.9	2537.33	...
Norway	1302.62	2407.53	2375.02
Poland	...	452.21	...
Portugal	395.33	533.4	...
Slovakia	...	421.37	...
Slovenia	...	844.17	...

Spain	433.1	...	...
Sweden	104.97	1071.54	...
Switzerland	1487.85	2393.21	...

Figure 6

Public inpatient expenditure as % of total inpatient expenditure			
Countries	2000	2010	2011
Austria	82.79	84.93	...
Azerbaijan	46.4	...	...
Belarus	...	98.5	97
Belgium	...	79.24	...
Czech Republic	98.47	96.13	...
Denmark	93.8	94.39	...
Estonia	...	93.5	92.96
Finland	84.23	86.46	...
France	94.37	93.27	...
Georgia	...	31.3	...
Germany	86.64	83.99	...
Greece	...	...	...
Hungary	88.62	86.98	...
Iceland	99.21	99.27	...
Italy	89.9	93.69	...
Kyrgyzstan	70	...	...
Lithuania	...	96.04	...

Luxembourg	93.9	...	...
Netherlands	80.9	...	...
Norway	92.1	94	94
Republic of Moldova	81	83.8	90.3
Serbia	...	91.2	...
Turkey	85.1	...	

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