CREATIVE LONG-TERM CARE ADMINISTRATION

Fourth Edition

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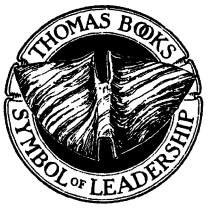

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We dedicate this book with fond memories and highest regards to the more than three decades of students who have become our esteemed colleagues.

PREFACE

During the last 30 years, we have had the privilege of having long-term care administrators from all over the United States study with us at the University of Minnesota. These men and women have been creative, perceptive, and often quite adroit in applying academic knowledge to their administrative practice. They have also been generous in teaching us to understand which areas of practice might need and benefit from academic inquiry. This reciprocal teaching-learning relationship has always guided the selection and development of content for this book.

Prior editions of *Creative Long-Term Care Administration* (1983, 1988, and 1994) have been used as textbooks for both undergraduate and graduate courses. They have also been popular as a basic resource for an array of other long-term care practitioners and professions, as well as housing managers, board members, and owners.

This, the fourth edition, has been revised extensively. There is, for example, the fundamental updating throughout to reflect structural and regulatory changes which have been occurring in the field as well as the introduction of recent research findings, evolving ideas, and new practices. In addition, there are new perspectives introduced by nine new chapter authors plus three entirely new chapters: monitoring clinical outcomes, spiritual care, and using information technology. Finally, we particularly welcome the seasoned scholarship and visionary leadership provided by Dr. Leslie Grant as third editor of this fourth edition.

George Kenneth Gordon
Ruth Stryker

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Chapter 1

THE HISTORY OF CARE OF THE AGED

RUTH STRYKER

Every society develops ways of dealing with its marginal citizens–those who consume more than they produce and who, to that extent, are dependent upon society for support. They are usually referred to as "the poor" or "those on welfare." Historically, the poor included the chemically dependent (inebriates), the developmentally disabled (imbeciles), the mentally ill (lunatics), the disabled (cripples), criminals and the aged. The labels used to identify these groups in the past (as indicated in parentheses) contrast with those used today and reflect gradual social and attitudinal changes which have mainly taken place during the past three decades.

Cultural attitudes, expediency and both the capability and willingness of a society dictate how it will deal with its unproductive members. Nomadic tribes often left them behind to die, and Eskimos commonly put them on an ice floe. During the Greco-Roman era, medical attention was given only to those who could be cured, thus abandoning the disabled and aged to prevent a drain on resources. European societies tended to group "all of the poor" by isolating them in some kind of spartan housing arrangement. Primary, financial responsibility, while always mixed, has shifted across the centuries from the family to the church and philanthropy and, more recently, to the public through taxes with attempts to increase family responsibility.

Cultural attitudes toward nonproductive members of society have also varied. Helper motivations differ. For example, the Roman privileged class cared for "unfortunates" in order to achieve a sense of individual virtue. In contrast, Maimonides, the twelfth century Jewish physician and philosopher, declared that a recipient of benefactions should be spared a sense of shame and that assistance should enable persons to help themselves–a modern day rehabilitation philosophy! The contrast in motivation of the "helper" is startling–one for the benefit of the benefactor, the other for the benefit of the recipient. One

might note that human nature does not seem to change; both the self-righteous and the altruist are among us today.

In addition, there is often conflict between individual and collective willingness to help the poor. While some families are willing and able to care for one another, others cannot or will not. Because some children feel it is their right to inherit family money, they accept annual parental gifts without any expectation of using them to postpone welfare eligibility for their parents. Others feel no right to spend money they themselves did not earn and will use it for their parents. Some taxpayers are concerned about welfare cheats while others are concerned about the needy. Nursing home residents, their families, our employees and the taxpayers of this country hold these views also. In long-term care, we deal with value systems and motivations that differ from our own on a daily basis. You might say, "so does everyone else." True, but compared to business and other health care settings, it has a far greater impact on the financial structure, the community image, staff morale and self-esteem of residents. These almost schizophrenic aspects of modern society challenge the development of more progressive methods of caring for the aged.

HISTORY OF NURSING HOMES

Saint Helena (250–330 AD) established what is probably one of the first homes for the aged (gerokomion). She was a wealthy, intelligent, Christian convert and mother of Constantine the Great. Like other early Christian "nurses" who devoted their lives to the sick and needy, she gave direct care herself. For many centuries, individual benefactors, benevolence societies, and religious groups remained responsible for care of the poor and led the development of early hospitals. Indeed, early English law prohibited government sponsored help because it "encouraged idleness."

Major changes occurred during the Renaissance (1500–1700 AD) throughout Europe. Books became more available to universities, Da Vinci made his anatomical drawings, Leewenhoek invented the microscope, and medical, pharmacy, and nursing schools were established.

During the Reformation, the British Parliament attempted to suppress the influence of the church through dissolution of monasteries and hospitals run by the church. As a result, "low" women took over the care of the sick in hospitals, bringing a dark period of history for health care. It was at this time that care of the poor became a societal rather than a religious responsibility. The English Poor Law of 1601 explicated how this would be done. If possible, parents, grandparents, and children of "every poor, old, blind, lame, and impo-

tent person or other person not able to work" were required to support such relatives. An overseer set able-bodied paupers to work and provided relief for those without relatives and unable to work. This system of "relief" was brought to New England by the colonists.

In America, some paupers were auctioned off to families either for care or work. This inhumane practice declined after the revolution and was replaced by contracting with one person to care for all the poor in one town. Because these privately owned almshouses made a profit (usually from the work of the "inmates," as they were known), towns frequently decided to run their own almshouses, which were sometimes called poorhouses, poor farms or work houses. Poverty and illness were viewed as signs of a character defect, moral weakness or punishment for sin. Therefore, some minimal gratitude for care was expected. Inmates were thus expected to contribute to their keep through work. Quarters were spartan and were expected to cost as little as possible. Privileges for leaving the premises were directly related to "good" behavior and the number of years of residence in a particular area.

During the early 1900s, privately owned "boarding homes" became available to the more affluent aged, and church-sponsored homes for the aged emerged. A certain number of deserving citizens who had fallen on hard times were often allowed to "spend their last days" at many of these homes through the donations of benefactors. A few institutions introduced a nurse to care for the bodily needs of those who required it, but only personal and custodial care were envisioned.

At the same time, able bodied workers were drawn from the poor houses. Convicts were sent to prisons. Orphanages were built to prevent exploitation of children without parents. Hospitals were established for the mentally ill and mentally retarded. Special homes were built for the blind and the deaf. Gradually, only the poor aged remained in the poor houses.

When the first Social Security Act was passed in 1935, conditions in county poor farms had become deplorable. The Act specifically denied anyone living in a public institution from receiving assistance payments. While the intent of this regulation was to force closure of county poor houses, it did not work out that way in many instances. Some counties leased the poor farm to a private individual, thus, it was no longer a public institution technically, so "inmates" could stay and still receive their payments. Residents who feared they could not find a better situation stayed where they were, but others left and found a private boarding house. Indeed, this exit to the community enabled some owners to maintain large homes by taking in "paid guests" during the depression. Ultimately it also gave impetus to the start of many proprietary nursing homes.

Throughout the next 30 years, the number of aged continued to increase and many homes for the aged became nursing homes. The latter increased