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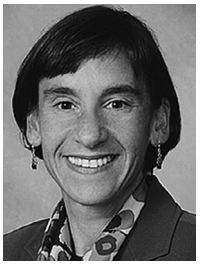
From the Editor



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The wonderful world of long term care

Despite claims on the part of regulators in long term care that facilities be "home-like" and that care be individualized, it is challenging to allow this to happen. A room set up by a resident and his or her family so that the bed is pushed up against a wall so there is more open space in the room, for example, can be seen as a restraint. Situations in which we are asked to follow a pharmacist recommendation to decrease a medication that might be providing symptom relief but is considered risky due to dosage or renal or liver impact becomes a damned if you do and damned if you don't situation. A facility may get a deficiency for giving a medication 30 min late because the medication nurse sat and talked with a resident who was doing life review about her time working as a nurse prior to getting married. Yet there is no evidence of harm to individuals based on the timing of most daily medications and a bed placed against a wall may be a personal preference. Unfortunately it is adherence to these still confining and sometimes inappropriate regulations that continue to drive the industry and caregiving.

When surveyors are in the building we all dread the day, try to avoid interactions, feel like criminals and simply wait with dread about what concerns will be raised that were not in any way intended to cause harm to anyone of our residents. It is this, and the unrealistic expectations for those of us in the industry that we can never err in any way, that makes so many want to and/or actually leave the wonderful world of long term care.

Section 6102(c) of the Affordable Care Act required that all skilled nursing centers develop Quality Assurance and Performance Improvement (QAPI) programs. The stated purpose and intent of the QAPI regulations is to develop, implement, and maintain an effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care, and quality of life. QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving. The QAPI rule requires that all nursing homes establish and implement effective, comprehensive, data-driven QAPI programs that focus on systems of care, including indicators of outcomes of care, quality of life, and resident and staff satisfaction. While this is absolutely terrific in theory we need to gather data to demonstrate the value of this requirement. As someone who does behavior change and implementation research, outcomes in these areas are very hard to achieve.

The way it could be

Personally I dream about the way it could be. I am not against regulations as policy can change behavior and assure that high quality care is provided. The regulations, however, should be based on strong evidence (or at least some evidence!). Timing of when a medication is given, for example, is not important in the majority of situations. What is important is that there is evidence, either empirical or clinical for the individual patient, that the medication given is helping the problem it is indicated for. I dream of the day when the team, including behavioral health consultants, pharmacy consultants, primary care providers, nurses and direct care workers, and residents/families work together on the use of medications, pain management, on the ways to optimize quality of life of residents and on nutritional intake among other problems we encounter. I know this is the intention in care planning and other types of team meetings but I am not convinced that the team is all that coordinated. The teams in long term care still function very much like multidisciplinary teams (i.e., a group of health care workers who are members of different disciplines each providing specific services to the resident) versus interdisciplinary teams (i.e., a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the resident). Coordination of visit times, or a coordinated call about the resident might be ways to improve the team approach. I believe with more use of technology we will achieve that goal.

My dream for the future is that the survey process would result in a care goals for the facility rather than a plan of corrections focused only on deficiencies. This might even replace the QAPI requirement. The care goals would be developed with input from the surveyors as

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well as the team and consider the deficiencies but move beyond them. Once goals are developed for the subsequent year, I dream of a time when the team would do a brainstorming session to facilitate the best way to achieve their goals. Brainstorming is an individual or group method for generating ideas or finding solutions to problems. It involves the identification and delineation of the current status of the care issue (e.g., infection control, fall prevention) and what optimal care might be and what prevents it from happening. The group is then asked to generate solutions to the problem with no criticism or attempts to limit the type or number of ideas. Brainstorming ideas are then placed into themes identified, which is referred to as affinity diagramming. An Interrelationship Diagraph is then developed to determine which of the identified themes is the best or strongest driver. Participants are asked to consider how each theme is connected to the other themes. For example, does staffing influence the use of behavioral approaches; does staffing influence resources; etc. Once all the relevant connections between themes have been drawn, the theme with the most arrows going out of it or away from it, is referred to as the "driver" or root cause. This then becomes the focus of the goal for the facility. For example, it might be identified that family concerns are driving what happens in terms of fall prevention and preventing the staff from engaging residents in physical activity. The facility may want to do some focused education of family, address this issue in care plan meetings, etc.

The whole issue of resident safety and fall prevention continues to be particularly upsetting to me in that we defy what is known and continue to implement inappropriate “safety” interventions. The need for de-implementation of harmful care interventions that are not considered problematic on the part of the surveyors, families, administrators or some caregivers is greatly needed. Recently I saw a resident who is able to ambulate independently without an assistive device, albeit with a gait pattern that is consistent with cognitive impairment (i.e., slow, wide based, unsteady and tentative), being pushed in a wheelchair. When I asked the direct care worker why the individual was in a wheelchair she informed me that the family insisted that he not walk to prevent a fall given his recent history of several falls. This scenario is not uncommon. After a fall, residents are encouraged to use a wheelchair and to ambulate only with physical therapy. There is no evidence to support this response to falls. In fact there is increasing evidence that exercise and engaging in regular physical activity is the best way to prevent falls.[1,2] In this situation we spoke with the family and removed the wheelchair and began some training with him to use a walker.

Lastly, my dream is that we would work with residents, particularly, those who are short stay, to practice taking their own medications and performing other care related interventions if appropriate. How can we expect individuals to be able to perform safe self-care if they do not have the opportunity to learn the techniques prior to discharge. I appreciate the need for safety of all the residents and medications will need to be locked and kept out of reach of other residents. Practice makes perfect, however, and supervised practice might help to prevent future medication errors and omissions following discharge.

I have been working in long term care now for 46 years and I continue to believe that we want to provide the best possible care to individuals living in these settings. There are many care challenges. We are dealing with people who bring their own beliefs, behaviors, and goals, and we are trying to manage individuals within regulations that are developed to broadly address safety and quality. Further we as health care providers are human and may unintentionally forget to call a family, forget to change an order based on a given recommendation, or decide to take a resident outside for a few minutes to see the flowers blooming while another resident has to wait for care to be received. I dream of a future when there will be more focus on the wonderful things we do every day and less on the human errors that are not intended, particularly those that have not resulted in any known harm.

References

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