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Quality Clinical Care in Nursing Facilities

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A B S T R A C T

Despite improvements in selected nursing facility (NF) quality measures such as reduction in antipsychotic use; local, state, and national initiatives; and regulatory incentives, the quality of clinical care delivered in this setting remains inconsistent. Herein, recommendations for overcoming barriers to achieving consistent, high-quality clinical outcomes in long-term (LTC) and post-acute care are provided to address inadequate workforce, suboptimal culture and interprofessional teamwork, insufficiently evidence-based processes of care, and poor adoption and fidelity of technology and integrated clinical decision support. With high staff attrition rates in NFs, mechanisms to measure and close knowledge gaps as well as opportunities for practice simulations should be available to educate and ensure adoption of clinical quality standards on clinician hiring and on an ongoing basis. Multipronged, integrated approaches are needed to further the quest for sustainment of high clinical quality in NF care. In addition to setting a tone for attainment of clinical quality, leadership should champion adoption of practice standards, quality initiatives, and evidence-based guidelines. Maintaining an optimal ratio of hours per resident per day of nurses and nurse aides can improve quality outcomes and staff satisfaction. Clinicians must consistently and effectively apply care processes that include recognition, problem definition, diagnosis, goal identification, intervention, and monitoring resident progress. In order to do so they must have rapid, easy access to necessary tools, including evidence-based standards, algorithms, care plans, during the care delivery process. Embedding such tools into workflow of electronic health records has the potential to improve quality outcomes. On a national and international level, quality standards should be developed by interprofessional LTC experts committed to applying the highest levels of clinical evidence to improve the care of older persons. The standards should be realistic and practical, and basic principles of implementation science must be used to achieve the desired outcomes.

The Centers for Medicare & Medicaid Services (CMS) denote quality of clinical care as a fundamental principle that applies to all treatment and care provided to nursing facility (NF) residents.[1] However, attainment of quality clinical care in the NF environment remains elusive.[2]

The Institute of Medicine report on Nursing Home Quality indicated that high-quality NF care requires (1) a competently conducted, comprehensive assessment of each resident; (2) development of a treatment plan that integrates the contributions of all the relevant nursing home staff, based on the assessment findings; and (3) properly coordinated, competent, and conscientious execution of all aspects of the treatment plan.[2] Though we understand these components and strive to align with these principles, barriers to excellence exist and critical strategies are necessary to succeed.

Key principles enable NFs to deliver consistently safe, effective, efficient, high-quality, and person-centered care.[3] Care should be (1) based on sound clinical principles and reliable evidence; (2) delivered via proper care processes that reflect effective clinical problem solving and decision making; (3) provided by properly qualified individuals who perform their functions effectively and know their roles and their limits; (4) consistent with regulatory standards, but not focus

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primarily on, regulations; and (5) guided and supported by effective management.[3]

In order to achieve higher quality clinical care in NFs, multifaceted strategies must be developed to address 4 pillars that bolster the workforce, enhance interprofessional collaboration, optimize processes of care, and effectively use technology with integrated clinical decision support (CDS). Table 1 summarizes the challenges to clinical quality and calls to action.

Adequate Workforce

Issues

A barrier to high-quality NF care is the insufficient cadre of highly skilled professional staff such as therapists, pharmacists, and physicians with expertise in geriatric care. In addition to clinical skills needed to care effectively for older adults, clinicians must have knowledge of key clinical conditions.

A second workforce challenge is identifying and maintaining the ideal mix of registered nurses (RNs), licensed practical nurses (LPNs), and clinical nurse aides (CNAs). Although maintenance of RN positions with supplementation of CNAs has been shown to improve quality,[4] the issues go beyond the number of each type of staff. Knowledge, skills, experience, and commitment to the type of care provided in NFs play a critical role. Moreover, high attrition rates of NF staff impact quality of care as turnover requires that facilities spend time and resources to continuously train new staff to the culture, policies and procedures, clinical standards of practice, and care processes.

The lack of physicians trained in Geriatric Medicine is another major challenge to providing high-quality care in the NF setting. Almost half of fellowship positions in Geriatric Medicine go unfilled, and there are not enough fellowship-trained geriatricians to provide care for the NF population. In 2017, there were only 272 fellowship applicants nationwide.[5]

Examples of Solutions to Workforce Challenges in NFs

In response to the shortage of geriatricians in NF, the Society for Post-Acute and Long-Term Care Medicine (AMDA) has developed the Futures Program and an extensive core curriculum for certified medical directors.[6] The Futures Program is a one-day educational session that occurs in conjunction with the annual AMDA conference and provides residents, fellows, and other members of the interdisciplinary team with information about the roles and responsibilities of the different disciplines within post-acute and LTC medicine. In addition, AMDA has developed a core curriculum for attending physicians that may be helpful in providing practicing physicians, including hospitalists who are increasingly providing care in NFs, the basic knowledge to provide quality care in the NF setting. Centers such as the Peter Lamy Center on Drug Therapy and Aging, at the University of Maryland, provide interprofessional continuing education focused on enhancing assessment and care planning for older adults that can improve medication safety and increase pharmacotherapeutic knowledge of team members. CNAs, like other health professional groups, can benefit from additional training on management of residents with complex comorbidities. Specifically, there is evidence to support the value of extended training of CNAs to enhance their skills, boost their self-esteem, and reinforce the significance of their role in providing resident care.[7,8]

Recommendations

The presence of board-certified geriatric practitioners in the NF must be increased to bolster clinical quality. Physicians interested in working in the NF settings should be encouraged to become a certified medical director, and NF corporations should incentivize physicians to achieve this certification. Practicing internists, family physicians, and hospitalists should be encouraged to take the AMDA core curriculum for attending physicians. This curriculum can enhance the clinical skills and knowledge necessary to provide high quality clinical care. Pharmacy providers are encouraged to recruit and retain consultant pharmacists who are board-certified in geriatric pharmacy (BCGP). A particularly critical area of focus for improved NF care relates to excessive use (ie, misuse and overuse) of potentially unnecessary medications (ie, antipsychotics and others) that increase residents' risks of falls, mental status changes, urinary retention, cardiac arrhythmias, stroke, and death.[9]

Optimizing the RN time spent/resident/day from 16 minutes to 30-40 minutes has been shown to reduce pressure ulcer development, hospitalization, and UTIs.[10–12] Facilities with RN-supervised, well-trained CNAs, given autonomy to fulfill their responsibilities of resident care, perform well on quality indicators.[11,13,14] These CNAs also are more likely to be satisfied and remain in their positions, thereby reducing turnover.[11] Leaders need to relay to their administrators the business case for investing in education and training of CNAs and maintaining a ratio of hours per resident per day of 0.2 to 0.7 RN, 0.5 to 0.7 licensed practical nurse, and 1.95 to 3.4 CNA.[4,11] Leaders should also be encouraged to develop career ladders for CNAs that recognize their experience and additional training with both titles and salary increases.

Optimal Culture and Interprofessional Teamwork

Issues

Facility culture and attitude can be barriers to quality when they are not supportive of clinicians, residents, and their families.[15–17] A culture that is focused on cost reduction and task completion without a balance of passion for person-centered care of older adults can run counter to high-quality clinical care. NF for-profit status is associated with a significantly higher percentage of residents with pressure ulcers, significantly lower mean practice environment scores, higher use of antipsychotics, and more 30-day hospital readmissions.[18–20] NF with greater percentages of Medicaid residents tend to have a greater use of potentially harmful medications (eg, antipsychotics), consistent with poor clinical quality.[19]

Suboptimal interprofessional collaboration can be a barrier to medication safety within NFs.[21–24] For example, adverse drug events have been attributed to limited access to physicians and consultant pharmacists.[21,22,24] When clinical assessment and care planning is shared interprofessionally and communicated effectively, adherence to recommended practices, and patient functional status may be improved.[25,26]

Example Solutions for Improving Culture and Teamwork

A culture that supports a true team approach, the participation of nurses in organizational decisions, and adequate resources with optimal deployment of CNAs, has been associated with better outcomes, including a lower percentage of residents with pressure ulcers and fewer quality deficiencies.[14,18] For example, when pharmacists and physicians conduct medication reviews collaboratively, inappropriate medications can be discontinued successfully in NF residents.[27] Such interprofessional collaborations should be patient-centered, comprehensive, encourage continuous dialogue, support cohesive thinking, and develop consensus agreement on approaches to care.[28]

The THRIVE research collaborative initiated, disseminated, and studied the Green House Model of NF culture, which includes architectural and social changes with transformation of the NF's organizational culture.[29] On startup, Green House adopters receive