The study by Lapane and Quilliam published in this issue of Journal of the American Medical Directors Association explores an important issue in social science methodology, namely, how to distribute resident safety perception questionnaires among nursing home employees in a manner that will yield the highest response rate (and presumably the most reliable data). From a social policy and clinical practice perspective, however, we might vigorously inquire about this research, “So what?” Does it matter what workers perceive about nursing home safety and, even more fundamentally, does the nursing home safety situation itself really matter? As to the latter question at least, we would all respond resoundingly in the affirmative: nursing home safety is an incontrovertibly significant concern indeed. However, getting a firm analytic handle on that concern and, more significantly, actually doing something positive about it is an exceedingly difficult task.

Making the care of nursing home residents safer is, first and foremost, an ethical imperative. It is driven by the fundamental moral precepts of beneficence (helping or doing good for others) and nonmaleficence (preventing harm) and the nursing home’s fiduciary responsibility to protect the welfare of vulnerable, dependent individuals who have placed their trust in the facility’s promise to care for them safely. Moreover, achieving a safe environment for residents, staff, and visitors is an important and necessary component of a nursing home’s overall legal and financial risk management strategy in a contemporary climate of escalating professional negligence and workers’ compensation litigation being brought against the nursing home industry; in the absence of personal injury, there is no basis for litigation or liability. In addition, an effective safety program can help facilities avoid administrative sanctions for being out of compliance with applicable regulatory requirements.

Finally, there is a viable business case for improving safety in nursing homes (just as there is for error prevention in the hospital and medical office settings). In the modern long-term care marketplace, nursing homes now have to compete vigorously for customers and qualified employees, and one criterion that both potential nursing home residents’ families and potential job applicants may carefully scrutinize with a comparing eye is the safety record of any particular facility. Thus, a successful, public culture of safety can act as a powerful marketing tool for nursing homes working hard to maintain full censuses and adequate staffing patterns.

Although the safety climate within nursing homes has vital ethical, legal, and financial implications, this subject has received much less serious and sustained attention than has been devoted to hospital and medical office safety in the American health policy and practice arenas. By way of illustration, my Google search conducted on May 2, 2007, retrieved 7.3 million items for the phrase “Hospital Patient Safety,” but only 1.3 million (mostly dealing with fire and life safety code provisions), 1.4 million, and 1.2 million items for, respectively, “Nursing Home Patient Safety,” “Nursing Home Resident Safety,” and “Assisted Living Facilities Safety.” For the latter three phrases, there was a substantial overlap of retrieved items.

The commendable successes in safety enhancement achieved in hospitals and other acute care spheres over the past decade provide only limited lessons for the nursing home world. In a number of relevant respects, the acute care and nursing home environments differ significantly in ways that prevent an easy interpolation of safety-oriented techniques and strategies from the former to the latter. For a variety of reasons, accomplishing the goal of improved safety presents unique challenges for nursing homes and their clinical, administrative, and governance leaders.

Nursing home residents often deviate from typical hospital populations in terms of age, chronic disability levels and long-term prognoses, mental capacity, financial and insurance circumstances, and extent and type of family involvement. Each of these aggregate resident characteristics may substantially impact the risk profile within nursing homes as compared to hospitals and therefore call for different prophylactic and remedial responses.

Further, the culture of nursing homes as special institutions or organizations within American society raises distinct questions with interesting safety control considerations. In the hospital, immediate patient needs (as determined by medical professionals) take precedence; in the nursing home, though, resident rights, including the right to take on certain risks (for
example, the right of a hypertensive resident to choose to eat salt-laden foods), are accorded a preferred status in developing the resident’s care plan. The nursing home is supposed to foster resident autonomy, independence, self-sufficiency, and a self-perception of resident control, values that usually receive short shrift in a hospital environment focused more narrowly on immediate health and safety. While hospitals are clearly medical institutions, nursing homes are expected to be not only health care providers, but also facilitators of a homelike environment with a social orientation. This schizophrenia of public expectations and attitudes exacts a cost in terms of a necessary acknowledgment that quality of care (including a maximization of safety from harm) is not necessarily synonymous with quality of life for residents.

Inconsistent, often conflicting expectations regarding the proper medical versus social function of nursing homes in American society are reflected in media and political attacks on facilities for being too regimented but simultaneously failing to protect residents from all possible harms. The extensive external regulatory apparatus that suffocates nursing homes under a pervasive aura of deep distrust, on one hand, while at the same time penalizes them for maintaining an institutional rather than a friendly, informal ambiance, on the other, similarly illustrates the cognitive dissonance and be-all-things-to-all-people fantasy prevalent among public policy makers when nursing homes are involved.

Staffing is one of the most important determinants of risk and safety in health care facilities, and here as elsewhere there are major distinctions between hospitals and nursing homes. Dangers to resident and staff safety unique to the nursing home setting emerge from distinguishing characteristics such as a facility’s specific staff size, mix (entailing the presence, visibility, and respective responsibilities of different professionals including physicians), and turnover rates, as well as limitations of the local labor pool (including the availability of suitable medical director candidates).

A comprehensive safety program concentrating on injury prevention and error reduction and correction ought to be an essential component of every nursing home’s quality improvement and quality assurance efforts. Such a program should be concerned with the well-being not only of residents, but of staff and visitors as well. However, the successful design and implementation of nursing home safety programs face special challenges of the types described above, and must take into account the distinguishing aspects of nursing home care. Addressing those challenges and others will require the full collaboration of all levels and categories of facility staff. Consequently, staff perceptions of a facility’s safety situation are important, and the Journal of the American Medical Directors Association’s published study by Lapane and Quilliam regarding methodological issues in measuring those perceptions is an important contribution to the safety endeavor.

REFERENCES
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