The Basis for Improving and Reforming Long-Term Care. Part 3: Essential Elements for Quality Care

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There is a pervasive effort to reform nursing homes and improve the care they provide. Many people are trying to educate and inform nursing homes and their staff, practitioners, and management about what to do and not do, and how to do it. But only some of that advice is sound.

After more than 3 decades of such efforts, and despite evidence of improvement in many facets of care, there are still many issues. Despite improvements, the overall public, political, and health professional perception of nursing homes is often still negative.

To date, no tactic or approach has succeeded nationwide in consistently facilitating good performance or correcting poor performance. Only some of the current efforts to try to improve nursing home quality and to measure it are on target. Many of the measures used to assess the quality of performance have limited value in guiding overall quality improvement.

Before we can reform nursing homes, we must understand what needs to be reformed. This series of articles has focused on what is needed for safe, effective, efficient, and person-centered care. Ultimately, all efforts to improve nursing home care quality must be matched against the critical elements needed to provide desirable care.

Based on the discussions in the previous 2 articles, this third article in this 4-part series considers 5 key elements of care processes and practices that can help attain multiple desirable quality objectives. (J Am Med Dir Assoc 2009; 10: 597–606)

Keywords: Nursing homes; reform; quality of care; evidence-based care; quality improvement

According to the Institute of Medicine (IOM), high-quality care is safe, effective, efficient, available, timely, and equitable. Therefore, a nursing home’s care could be considered to be of high quality if it consistently meets these criteria.

In assessing the current status of long-term care, we cannot lump all nursing homes together. They vary substantially in their competence, their clinical performance, and the overall quality of their care and services. For various reasons, competence and performance may or may not correlate well with regulatory compliance or a facility’s performance under some widely used quality measures. Furthermore, aggregate outcomes (eg, measures developed for the Centers for Medicare and Medicaid Services [CMS] related to nursing home quality measurement) do not readily permit an accurate determination of the quality of care given to individuals.

In short, capable facilities provide care that is safe, effective, efficient, and person-centered. They are competent in most or all aspects of care that they provide. They generally obtain good results, often prevent potential complications, and commonly detect and correct the consequences of inadequate care that was rendered elsewhere.

Some nursing homes provide competent care in some aspects, but not in others. And, still other, problematic facilities provide marginal or poor care in most or all care aspects. Problematic facilities, and facilities that have some problematic aspects of care, may fail to identify or correct their problems. They are often surprised and upset when surveyors or others identify those problems, and they may try to blame those others for not confirming the facility’s misconceptions about their care quality.

Even in facilities with a generally good record overall, some aspects of care may be handled ineffectively. Many common practices in long-term care are still inconsistent with evidence; for example, approaches to delirium and problematic behavior, pain, hydration issues, swallowing, bacteriuria, weight loss and anorexia, medication use, thyroid disease, and other diverse medical issues.
There are many efforts to review care and assess results in nursing home residents/patients, ranging from the Omnibus Budget Reconciliation Act (OBRA) survey to quality measures and indicators.\textsuperscript{18} Quality measures and reviews assess some combination of structure, process, and results (outcomes). Much of the effort to improve nursing homes focuses on assessing outcomes and then trying to improve the results by promoting various practices and processes.

Ultimately, all efforts to improve nursing home care quality must be matched against the critical elements needed to provide desirable care. We cannot just assume that these improvement and reform efforts are on target, or that their failure to have an enduring impact on quality is simply the fault of the target audience (eg, nursing home staff, management, and practitioners). These improvement initiatives may be only partially relevant, they may give incorrect advice, or they may fail to cover some essential issues.

How do we know when a nursing home’s care meets these criteria for high quality? The same factors that affect individual patient outcomes are also relevant to using outcomes to try to measure quality. In the short- and long-stay populations characteristic of nursing homes, outcomes are heavily influenced by the total burden of illness, overall physical stability, and the links between causes and consequences.\textsuperscript{19}

In considering both processes and results, there are four ways in which something may be done\textsuperscript{20}: the right thing may be done correctly or incorrectly, or the wrong thing may be done correctly or incorrectly. Since many diverse factors (eg, preexisting illnesses and impairments) can affect results, it is possible to do the right thing correctly but not always obtain the best outcomes. It is also possible to do the wrong thing, or the right thing in the wrong way, and obtain desired results eventually (eg, despite causing avoidable complications such as delirium, weight loss, or falling resulting in hospitalization, while trying to treat pain or depression).

Therefore, to evaluate quality of care, we must know how a facility attains its outcomes, not just those results.\textsuperscript{21} For example, the use of quality measures and indicators must be sensitive to the links among many quality goals (related to links among causes and consequences in residents and patients, as discussed in this series) and the possibility of interim complications or collateral damage as a result of efforts to attain certain quality goals.

With so many variables and challenges, what is the best way to achieve consistently high-quality care? From one viewpoint, attaining each of these quality attributes requires distinct approaches for each aspect of care and facility operations. This article will discuss how a few basic common approaches, based primarily on correct clinical problem solving and decision making, can attain multiple desirable quality objectives.

FIVE KEY ELEMENTS

Consistently safe, effective, efficient, and person-centered care results when facilities and practitioners do the basics correctly and consistently. Conversely, problematic nursing homes and practitioners fail largely because they do not do the basics properly. Table 1 summarizes these differences, as discussed herein.

In nursing homes, the “right thing in the right way” refers to care that:

1. is based on sound clinical principles and reliable evidence;
2. is delivered via a proper care process that reflects effective clinical problem solving and decision making;
3. accommodates, but does not focus primarily on regulations;
4. is provided by properly qualified individuals who perform their functions effectively and know their roles and their limits; and
5. is guided and supported by effective management.

Thus, nursing homes can be improved by ensuring that they do the basics properly and consistently. Desirable efforts to improve and reform long-term care must be consistent with these principles.

CONSISTENT APPLICATION OF EVIDENCE-BASED CARE

Capable nursing homes and practitioners consistently provide care that meets desired quality attributes and is consistent with key philosophical, biological, and medical principles. The first 2 articles in this series discussed these concepts, including the meaning of “evidence-based” care. The 2 key components of evidence-based care include (1) scientific evidence about the evaluation and management of illness and impairment and (2) detailed evidence about the patient (eg, symptoms, results of physical assessment, past history).\textsuperscript{22,23}

Sound evidence-based care requires testing hypotheses by collecting and examining evidence about the patient (eg, a detailed chronology of symptoms and condition changes, a sufficiently detailed physical examination); and avoiding diagnostic (cause identification) fallacies. For example, symptoms have causes, and causes and consequences occur in various relationships. Effective, safe, efficient, and person-centered care requires identifying those exact relationships in each resident/patient, not just care-planning symptoms and problems in isolation.\textsuperscript{24} Generalities about diagnosing and treating illnesses and impairments must be tailored to each individual situation.

Clinical Problem Solving and Decision Making

For complex matters such as postacute and long-term care, empirical approaches to problem solving and cause identification are superior to others, including guesswork and rote protocols. Both clinicians and nonclinicians can apply these methods, even though they may not be equally skilled at performing specific steps such as cause identification.

Competent clinical problem solving and decision making in long-term care requires critical skills related to observation, defining problems, identifying causes, and making decisions.\textsuperscript{22} Capable facilities and practitioners use these proven clinical problem-solving and decision-making approaches to implement evidence-based care.\textsuperscript{25} They can provide valid evidence to support their conclusions and interventions,
Table 1. Comparing Characteristics of Capable and Problematic Facilities Relative to Delivering Quality Care

<table>
<thead>
<tr>
<th>Capable Facilities</th>
<th>Problematic Facilities</th>
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<tr>
<td>- Are competent in most or all aspects of care that they provide</td>
<td>- Provide marginal or poor care in most or all care aspects</td>
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<td>- Provide true evidence-based care and use systematic approaches to clinical</td>
<td>- Provide care that is not truly evidence based and does not follow key clinical</td>
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<td>problem solving and decision making</td>
<td>problem-solving and decision-making approaches</td>
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<td>- Use empirical methods to seek, interpret, and act upon evidence</td>
<td>- Use haphazard approaches, including guesswork and treatment by rote</td>
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<td>- Can readily identify links between causes, consequences, and interventions</td>
<td>- Cannot or do not consistently connect causes, consequences, and interventions correctly</td>
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<td>- Strive to ensure that adequate information is collected</td>
<td>- Often, draw conclusions and render care based on inadequate information gathering or</td>
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<td>to facilitate proper management of all conditions and situations</td>
<td>failure to consider available, relevant information</td>
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<td>- Try to maximize diagnostic accuracy and minimize diagnostic fallacies</td>
<td>- Commonly fail to avoid diagnostic fallacies and errors</td>
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<td>- Can identify a pertinent rationale for diagnoses and interventions, whether</td>
<td>- Tend to lack or misunderstand the basis for diagnoses and nonmedical causes of</td>
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<td>medical or nonmedical</td>
<td>patient symptoms and problems</td>
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<td>- Often do not know or cannot explain why specific treatments are right for a given</td>
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<td>patient</td>
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<td>- Tend to justify treatments by authority (ie, someone told them it was the right thing</td>
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<td>- Often fail to individualize care; only consider some relevant issues</td>
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<td>- Tend to treat by rote and to give medical care out of context</td>
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<td>- Are excessively preoccupied with “medical” and “social” models of care</td>
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<td>- Mistakenly view care based on primary diagnosis, payer source, or alleged reason for</td>
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<td>admission</td>
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<td>- Care is often incompatible with relevant geriatrics principles and practices</td>
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<td>- Care is often unsafe, ineffective, inefficient, and not truly person-centered</td>
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<td>- Results are variable or problematic</td>
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<td>- Often cause preventable complications</td>
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<td>- Often fail to seek, identify, and correct consequences of inadequate care rendered</td>
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<td>- Often use diagnostic tests and consultations as an inadequate substitute for basic</td>
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<td>assessment of symptoms and problems</td>
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<td>- Tend to use claims of “clinical judgment” to rationalize inadequate clinical problem</td>
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<td>- Are excessively preoccupied with regulatory compliance as the basis for delivering</td>
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<td>- View survey-related materials as the primary or sole basis for adequate care</td>
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<td>- Have inadequate and/or inaccurate clinical protocols and procedures</td>
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<td>- Exercise little or no meaningful control over who is allowed to make clinical</td>
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<td>recommendations and decisions</td>
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<td>- Management does not promote facility commitment to evidence-based care and clinical</td>
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<td>problem solving and decision making</td>
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<td>- Management is largely or totally removed from oversight of or involvement in care</td>
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<td>delivery process</td>
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<td>- Tend to view service utilization decisions separately from full care delivery</td>
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<td>process (eg, have separate “utilization review” meetings), and from narrow</td>
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including how they identified links between causes, consequences, and interventions. For example, they can show how they decided that one person with a fall risk needed a medication adjustment while another needed more assistance with toileting, or exactly how and why they determined the cause of weight loss or increasing lethargy and confusion.
A properly trained, objective observer can readily validate the basis for their actions.

When there are multiple causes of a symptom or a common cause (e.g., a cerebrovascular accident) of multiple symptoms, capable facilities can show how interventions are targeted to underlying causes or explain why it was not possible or appropriate to do so. They recognize that just rendering treatment by rote (e.g., automatically treating symptoms, ordering tests) by itself does not constitute effective care.

Capable facilities and practitioners adapt testing and treatment recommendations from protocols and guidelines, to individual circumstances. For example, while considering general recommendations in various guidelines about pain management, they do not just give opioids to everyone with severe pain, but they also identify the details of pain because, depending on circumstances, there may be a readily treatable cause and other interventions may be more appropriate.

Capable facilities and practitioners give medical treatment in the proper context, always considering its purpose for the patient (phronesis), not just its pertinence to disease or organ system function. They consider each person's physical, functional, and psychosocial dimensions, including how medical care impacts function and quality of life. They seek input from the residents/patients (or a substitute decision maker), and they adapt care to changing goals and objectives for each person. Interventions are consistent with the evidence about effectiveness and risks. And, they can explain the clinical and ethical basis for decisions to intervene or to withhold or withdraw care.

Capable facilities and practitioners adhere to geriatrics principles and practices that reflect evidence-based care delivered via a sound care-delivery process. Of all medical disciplines, geriatrics focuses prominently on this balanced approach and on avoiding harm while trying to do good. “Geriatrics is more process than content, more how than what. The approach we learn calls for flexibility, comprehensiveness, and sensitivity.”

**False “Medical” and “Social” Model Dichotomy**

Most nursing home patients and residents have some significant acute and/or chronic medical conditions underlying their impaired function. A focus on identifying and treating these conditions is often called the “medical model.” This use of term is often pejorative, as it appears to downplay or disdain anything clinical and medical and often equates it with excessive and problematic medical care.

Regardless of the setting or level of care, true “person-centered” care requires attention to all 3 dimensions (physical, functional, and psychosocial). Whereas the “social model” is often portrayed as more “humane” and “person-centered” than the “medical model,” this is a false dichotomy.

Appropriate medical interventions can have many positive effects on function and quality of life, while inappropriate interventions are often inhumane and have a negative effect on these things. Medical treatment that is more intrusive than helpful, or that it is not germane to improving people’s function or quality of life, typically reflects a failure of effective clinical problem solving and decision making. True reform of long-term care must correct the bad practices that underlie inappropriate care, not disdain good medicine because bad practices are common.

**Problematic Facilities**

In contrast to capable facilities and practitioners, problematic ones often do not follow systematic care processes or have a clinically pertinent rationale for their decisions and actions. They often test and treat by rote, and thus fail to individualize their care. However, it does not require any particular clinical skill to do things by rote; eg, give the same test or treatment routinely for everyone, based on lists or protocols.

In problematic facilities, the staff and practitioners tend to rely heavily on authority and personal relationships to determine appropriate care. Their rationale for doing something is often that someone or something (e.g., a consultant, the director of nursing, the facility’s risk manager or attorney, a surveyor) told them it was the right thing to do. But they often cannot describe the reasoning behind their conclusions and actions. They typically do not try to validate adequately or challenge whether they were told the right things, the qualifications of those telling them what to do, or why a recommendation or choice is relevant to a specific patient or a situation.

Capable facilities use consultations judiciously and scrutinize consultative recommendations for their clinical rationale. The staff and practitioners freely challenge the pertinence of suggested tests and treatments that lack a plausible rationale.

In contrast, problematic facilities tend to divide up patients by organ systems and problems, and they allow those of various disciplines to have jurisdiction over that aspect of care. For example, in many facilities every behavior problem automatically gets a psychiatric consult, any swallowing problem a speech therapy referral, and every weight loss is turned over to a dietician. Often, the person assigned to these problems has only limited ability to perform a differential diagnosis of underlying causes. And yet, staff and practitioners may be advised or pressured to follow, and not to challenge, such recommendations, regardless of their accuracy or relevance.

In fact, many current practices in long-term care are not compatible with applicable evidence, some of which has existed for several decades. For example, years of intensive efforts to limit restraint use have been based on the premise that it is important to balance concerns about risks with the recognition of the greater benefits of liberalized approaches. And yet, ironically, many nursing homes are obsessed with trying to prevent aspiration as an end in itself, rather than in the context of the whole patient picture.

Thus, unwarranted use in both hospitals and nursing homes of modified texture diets and feeding tubes due to excessive preoccupation with even minor swallowing abnormalities has deprived untold numbers of nursing home residents of the simple human pleasure to eat and drink as they wish, despite a manageable risk. Inexplicably, there are few publicly stated concerns about the fact that most nursing homes have adopted related policies that disregard evidence and
phronesis. In addition, there is often a vigorous outcry against even reasonable attempts to point out these excesses and misconceptions.36

Do Challenges Justify Shortchanging Process?

Over time, nursing homes have had many challenges in getting enough knowledgeable, skilled practitioners and staff to perform care-related functions and tasks consistently and correctly.37 Thus, some might argue that circumstances have made it necessary for nursing homes to rely on consultants, guesswork, and rote approaches in order to provide care. Furthermore, compared with the past, care overall has improved.38 So, perhaps approaches other than the empirical method, including guesswork, are better than nothing, as they sometimes work.

The problem is, these other approaches have gone about as far as they can go in improving care. By the law of averages, doing things by rote will work sometimes. For example, a guess that any change in behavior or mental function is caused by a urinary tract infection, or concluding that “aggressive” individuals with dementia are just being “assertive”30 will sometimes be correct, and often incorrect.

If nursing homes did surgery, it would never be acceptable to have partially competent surgery done by individuals with limited knowledge and skills, who made guesses based on reading an article, attending meetings, or listening to their supervisor. And, it would be unacceptable to justify it by noting a shortage of properly trained surgeons.

There should be comparable respect for competent medical practice. Given the realities discussed earlier in this series (Parts 1 and 2),22,24 including the complexities involved with multiple simultaneous causes and consequences, guesswork and rote approaches are often both wrong and hazardous. They commonly result in collateral damage and complications (eg, colitis caused by unnecessary antibiotics and avoidable hospitalization caused by missed diagnoses) that are not detected by the usual quality measurement approaches.

Health care reform generally, and nursing home reform in particular, requires as much respect for competent clinical problem solving and decision making activities as there is for competent surgical technique. Therefore, nursing home reform must improve the caliber of performance across the board, by licensed health care practitioners and by others who are not practitioners. Desirable reform efforts must support a proper, not superficial, evidence-based approach to clinical problem solving and decision making. Quality evaluation efforts must cover not just results but how those results were attained, and whether there was any collateral damage while trying to attain them.39

APPROPRIATE CARE DELIVERY PROCESS

Need for Effective Care Delivery Process

As discussed previously in this series,22 the care delivery process is the means of applying effective clinical problem-solving and decision-making methods and evidence-based care. Adherence to the full care delivery process is essential to provide high-quality care in every setting, regardless of the disciplines or specialties that are involved. All of the steps of the care delivery process are relevant—not just those identified or emphasized in nursing home regulations and related guidance and materials.

For several reasons, adherence to the care delivery process is especially vital for both long-term and short-stay nursing home residents/patients. Although many individuals are involved in providing care, only some of them have the required expertise for effective clinical decision making.22 Health care practitioners usually are present only intermittently, patients often cannot give a detailed symptom history, and relatively few diagnostic tests are readily available. The care issues are often complex. Many different medical conditions tend to present with a few common or nonspecific symptoms and findings. Treatment is only sometimes relevant to function and quality of life, and often causes symptoms that are hard to distinguish from those attributable to disease. The relevance of treatments must be reconsidered frequently. Ethical issues are prominent. Patient goals and wishes must be considered.

Effective care requires knowing the basis for decisions and treatment selection, not just the selected treatments or the results. Interventions need a rationale based in the care delivery process and outcomes must be correlated with underlying processes and other outcomes. Excessive attention to interventions and outcomes—either while delivering care or trying to assess care quality—reflects a misunderstanding of the evidence.

Care Delivery Process Components

As discussed in the second article in this series,22 a fully functioning care delivery process has key components (eg, gathering information, defining problems, identifying causes). Clinical problem solving requires being able to evaluate an individual and describe and define the issues correctly and completely, distinguish clinically significant from incidental findings, and determine appropriate interventions. For example, abdominal pain allegedly a result of constipation could actually be a result of medication side effects.40 Just treating the symptoms with laxatives or analgesics could easily exacerbate the problem.

Thus, a detailed chronological history of symptoms and condition changes (eg, onset, duration, and the course over time) is essential to caring for all short-stay patients and long-term residents. Additionally, the patient history has been identified as providing the most useful information (compared with the physical examination or lab tests) to help make a diagnosis.41,42 Under the challenging circumstances found in the nursing home, the history generally must be supplemented by some physical assessment to provide enough additional information to permit effective clinical decision making.

For example, the OBRA interpretive guidelines on nutrition (F325) emphasize weight loss percentage as a trigger for surveyor review and, by extension, facility interventions.43 However, identifying the pattern of weight loss and the presence and causes of anorexia are much more meaningful than the percentage of weight loss alone. Depending on the pattern, the same percentage of weight loss can have
very different underlying causes and clinical implications. Therefore, it is critical to know all relevant details about weight loss and anorexia. Unfortunately, such information may be overlooked in the haste to intervene to try to ensure regulatory compliance.

**Variable Adherence to the Care Delivery Process**

Ironically, the care delivery process is often shortchanged in a setting where it is especially crucial. Although every nursing facility has some form of an interdisciplinary care process (ICP), only some of what passes for the ICP actually follows the care delivery process faithfully.

Capable facilities and practitioners promote and implement the full care delivery process, consistently and correctly. They have competent clinical problem-solving and decision-making activities, and they strive to minimize diagnostic failings and to correct inappropriate clinical decision making. They use diagnostic tests and consultants appropriately to supplement—not replace—detailed assessment and effective diagnosis or cause identification by primary care practitioners and staff. They do not just treat symptoms indiscriminately, regardless of context or causes. They recognize that the pertinence of interventions is more important than the quantity or which disciplines are involved in the care.

Capable facilities do not just treat patients based on their primary diagnosis or reason for admission. They gather enough details about all situations (eg, behavioral issues, falls, pain, anemia, anorexia and weight loss) to allow appropriate individuals to distinguish the significance and causes of abnormalities, symptoms, and risks, so that appropriate interventions are more likely to be effective and not harmful. They know that superficial symptom reports (eg, someone “seems depressed” or is “agitated,” “combative,” “losing weight,” or “having pain”) alone do not provide a clinically meaningful basis for diagnostic or treatment decisions.

Capable facilities expect an actual physical assessment (eg, by touching and moving an area of the body to gauge the degree of pain) by a nurse to supplement any symptom history. They use tests (eg, serum albumin, chest x-Rays, or urine cultures) judiciously, not as a substitute for clinical problem solving including differential diagnostic efforts. They routinely consider complications of current treatments (primarily, medications) as potential causes of any changes of condition or symptoms. They have meaningful dialogue with practitioners about patient issues, to enable appropriate clinical problem solving and decision making.

Capable facilities try to identify interventions that balance evidence-based care with the rights of individuals to request or decline specific treatment. But they do not succumb to the pressure to accede to patient and family wishes, regardless of clinical relevance or risk.

For example, capable facilities will ask residents details about their pain, including treatments that may have been helpful in the past. But, they do not just routinely accept what they are told at face value and then obtain medication or treatment orders. Instead, they attempt to validate that current pain is similar to past pain, to do a physical assessment to verify what they are told about the pain, and to consider the pertinence of any specific treatment requests from the patient or family.

In contrast, problematic facilities may advise their staff just to do what the patients, families, or practitioners tell them, or they may not be told when they should challenge unfounded or inappropriate recommendations and orders. For example, they will tell staff to get the practitioner to order whatever a patient requests for pain, even if there has been no additional assessment to validate that the request is appropriate.

Problematic facilities and practitioners commonly omit critical parts of the care delivery process. For example, information exchange among staff and between staff and practitioners regarding symptoms such as altered mental status and fever commonly lacks enough detail—including a chronology of symptoms and condition changes—to enable any meaningful clinical decision making by a practitioner. Conversely, practitioners may make clinical decisions in nursing homes without requesting enough details. They may fail to seek or recognize important causes; eg, adverse consequences related to current medications or diarrhea attributable to something other than *Clostridium difficile*.46

Although they profess to individualize care, problematic facilities often use the same rote approaches for everyone, regardless of their relevance. They fail to effectively tailor general knowledge to specific situations. Whereas capable facilities use consultants judiciously, problematic ones use them as an inadequate substitute for performing the basic care delivery process steps. However, careful scrutiny of consultant recommendations is often essential because many consultants do not understand or incorporate the necessary comprehensive view of the patient (eg, that symptoms can have multiple or remote causes), or they fail to perform an adequate differential diagnosis.47

**Inadequate Justifications for Shortchanging the Care Delivery Process**

Nursing homes may offer reasons for not following the care delivery process consistently. For example, some facilities claim that they only have to do the assessment required under the OBRA regulations. Many nursing homes claim that they are handicapped because so many of their nurses lack “clinical judgment.” They may claim that nurses who are not Registered Nurses (eg, licensed practical or vocational nurses) are not allowed by law to perform an assessment. However, because even a layman can give a doctor a detailed history of an illness and perform a rudimentary physical assessment, these arguments are implausible.

Many nursing homes defer to risk management and other consultants who advise them against having detailed clinical policies and procedures. However, their rationalization for this is generally suspect. For example, they may argue that no one approach works for all patients because all individuals are unique. Or, they may advise that facilities that do not have clinical policies cannot be held accountable for failure to follow them. However, it is feasible to implement clinical practice guidelines and other protocols successfully in nursing homes.49
Capable facilities promote proper exercise of "clinical judgment." As noted earlier in this series, valid clinical judgment is exercised by drawing conclusions while performing appropriate clinical problem solving and decision making via the care delivery process. Capable facilities do not confuse unsubstantiated guesswork resulting from shortchanging the care delivery process with valid clinical judgment. In contrast, problematic facilities and practitioners tend to use the notion of "exercising clinical judgment" to rationalize conclusions and interventions that lack a clinically pertinent basis, or are accompanied by failure to investigate root causes of symptoms.

However, for better or worse, all aspects of the care delivery process—not just assessment or treatment selection—involves some clinical judgment. For example, nurses are exercising judgment, however inadequate, whenever they decide to accept whatever a resident or patient tells them without performing a further assessment, to only provide certain information about a patient to other staff or to a practitioner, or to request a physician to order a specific treatment, test, or consultation. Problematic facilities, and even many capable facilities with some problematic care, often allow staff and consultants to write "phantom" verbal orders (ie, alleged verbal orders that are not based on a written protocol or a discussion with the practitioner) for tests and treatments (eg, lab work and specific nonmedication interventions).

For example, nursing staff may be encouraged to automatically order psychiatric consultations or urine cultures for behavior issues, or dietary consults for any kind of appetite or weight problem. If this is done without any meaningful medical and nursing assessment, the patient is likely to suffer because important causes of symptoms may be missed or inappropriate interventions instituted.

For all of the aforementioned reasons, efforts to reform nursing homes must promote consistent adherence to the entire care delivery process (incorporating sound clinical problem-solving and decision-making activities) as the preferred route to high-quality care. Any "reform" initiatives that do not do this, or that promote shortchanging the care delivery process or effective clinical problem solving and decision making, are impeding—not supporting—essential reform.

A BALANCED APPROACH TO REGULATORY COMPLIANCE

Many state and federal laws and regulations exist to try to raise the quality of care in nursing homes. Such efforts often include tools for facilities (eg, the Minimum Data Set [MDS] and related interpretive tools including Resident Assessment Protocols) and for surveyors (eg, interpretive guidelines and investigative protocols). Many "reformers" have tried to use the survey process and regulations to influence performance and drive interpretations of care quality.

All nursing homes must comply with at least some state and/or federal regulatory requirements to keep their licenses and their reimbursement. For various reasons, including the importance of regulatory compliance to nursing homes, many of them have tried to use survey-related materials as their primary route to providing care. However, this is misguided. Only some facilities and surveyors (including survey agencies) appear to understand the purpose and limitations of the survey process, and act accordingly.

Regulations and surveyor guidance were meant to provide a broad foundation of expectations and to guide interpretation of care reviews. All of these sources contain only the rudiments of a care delivery process and a few elementary tools. They lack enough meaningful guidance about vital care process steps such as how to define a problem correctly, identify links between causes and consequences, or select the right interventions.

No laws, regulations, or related tools contain adequately detailed guidance for effective clinical problem solving and decision making. Ironically, excessive attention to the regulatory and survey emphasis on assessment and care planning may have contributed to downplaying some of the most important care delivery process components; eg, careful problem definition, cause identification, treatment selection in context, and effective monitoring with rational adjustment of interventions.

For example, the MDS was meant to be a basic tool to consistently document key information, mostly about the consequences—not the causes—of impairment and disability. It is mostly descriptive and only modestly detailed. It is very inadequate regarding medical illness, and it does not help link causes and impairments in specific patients. In other words, it is a weak tool for clinical problem solving and decision making. Despite this, many facilities use it to plan care directly with little or no additional adherence to the care delivery process or additional efforts at clinical problem solving.

Capable facilities recognize that the route to regulatory compliance always lies in effective clinical problem solving and decision making. They ensure that the entire care delivery process is done correctly, and do not just focus obsessively on major regulatory expectations such as assessment and care planning.

Problematic facilities use regulations and related content as their primary or sole approach to making care decisions and providing care. They overemphasize compliance-related assessment and care planning, and thus tend to shortchange other key steps such as problem definition and cause identification, which the OBRA-related materials do not cover in enough detail.

Some facilities are preoccupied with surveys and surveyors’ opinions about the facility’s conclusions and interventions. They may ask individual surveyors or state agencies what they should have done, or done differently, related to a survey deficiency or to avoid one. Yet surveyors—like anyone else—would have to follow the care delivery process, assess a patient in depth, and go through the clinical problem-solving and decision-making process before they could advise adequately on proper diagnosis and treatment. However, they are not authorized by law or regulation to do that.

Instead, the OBRA survey process requires facilities to show surveyors the basis for what they have done and how they have reached various conclusions. Surveyors are supposed to determine whether facilities complied with process expectations relative to resident/patient outcomes.
Ironically, some surveyors and facilities focus excessively on whether the “right” interventions were made and how quickly they were implemented. Because facilities may not have or understand the basis for their decisions and actions, they may be unable to provide it. Conversely some surveyors may not understand valid explanations or challenge invalid ones.

Thus, true nursing home reform requires a much better understanding universally of the attributes and limitations of surveys, regulatory processes, and regulation-related quality measurements, in overseeing and evaluating quality of care. None of these include or promote all of the critical elements of clinical problem solving and decision making that are needed to provide or evaluate high-quality care.

CARE PROVIDED BY PROPERLY QUALIFIED INDIVIDUALS

An effective care delivery process requires various individuals to perform diverse functions, including observation, data collection, documentation, reporting, analyzing information, making treatment decisions, and delivering treatments. These functions require relevant knowledge and skills.

For example, assessment and monitoring require the ability to observe, document, and report information. Physicians and nurse practitioners function as information analysts and treatment decision makers, but may not deliver much treatment.

For various reasons, there is a shortage of adequately trained and skilled individuals, including Level 1 (highly capable) and Level 2 (moderately capable) clinicians to perform these required tasks consistently and correctly. This deficit is likely to remain for some time.

One way to improve long-term care is to find and train additional qualified practitioners. Another route to improving care is to strengthen the performance of everyone who is involved in direct care, including existing staff and practitioners. The same relative handful of symptoms and underlying causes (eg, dementia, medication-related adverse consequences, and pneumonia) recur repeatedly. The underlying principles and approaches are enduring and universal.

As noted, the art of cause identification is based on principles and processes that even nonclinicians can apply. Staff may not know all of the relevant possible causes of symptoms, but they should know how to gather information to help others identify the cause(s) from among various possibilities. They can understand how to avoid diagnostic fallacies; for example, by not jumping to premature conclusions based on limited knowledge of a patient or limited ability to interpret information. As discussed in the next section, facility management can establish systems and processes to promote an effective care delivery process.

Capable facilities have a culture that focuses on the care delivery process and evidence-based care. They try to ensure that diagnostic conclusions and treatment decisions are made by qualified individuals with relevant skills in clinical problem solving and decision making. For example, they either improve the skills of individuals who are primarily trained to function as data collectors and treatment deliverers or they keep such individuals from requesting treatment orders based on drawing inadequate conclusions about causes of symptoms. They try to compensate for problematic individual performance by reviewing care decisions and challenging questionable conclusions and interventions. In problematic facilities, and when problems occur in capable facilities, the staff and practitioners may be expected or allowed to perform functions that are beyond the scope of their knowledge, training, and skills.

EFFECTIVE MANAGEMENT OVERSIGHT

As noted, nursing homes are challenged to have a functioning system that consistently provides high-quality care to ill and impaired individuals, amidst very high public expectations. The degree of successful oversight and coordination of a facility’s care processes and practices heavily influences the attainment of safe, effective, efficient, and person-centered care.

In many nursing homes, the administrator remains largely aloof from direct care, and instead lets the director of nursing spearhead that care. However, whereas the nursing department provides most direct care, the administrator must ultimately ensure that the whole care delivery system works properly.

Although they do not provide direct care, facility management nonetheless has a crucial role in overseeing its provision. They must understand what they are overseeing. Even if they are not health professionals, they should be able to comprehend the concepts and issues covered in this series of articles; eg, because all symptoms and problems (eg, skin breakdown, dizziness, and behavioral issues) have causes, the staff and practitioners should be expected to seek and address underlying causes of symptoms in a coordinated fashion. They should promote integration and coordination of care from diverse sources because each person’s physical, functional, and psychosocial dimensions are all intertwined.

Facility management plays a critical role in ensuring effective participation of direct care staff and practitioners. Evidence from the neurosciences shows that there is wide variation in how individuals solve problems and make decisions. Because the human brain may be wired more to promote social relationships and self-preservation, people are often inclined to make decisions, and to try to justify them, based more on emotional impact and personal experience than on deliberating objective evidence.

Therefore, management in long-term care facilities must take these human factors into account. By virtue of having oversight over all departments and disciplines, a facility’s administrator is in the best position to coordinate these diverse perspectives. A facility cannot assume that anyone with a license knows what they are doing, or that all those involved in direct care can somehow coordinate their beliefs and approaches without some guidance. Unguided clinical decision-making and care processes can easily become based more on personal opinions, relationships, and on political considerations (eg, who knows and agrees with whom) than on effective clinical decision-making principles.
Effective management supports and oversees the facility's entire care delivery system. Management must ensure that a proper care delivery process occurs consistently, and that all departments and disciplines know their roles and perform their functions effectively. They commit the facility and its staff and practitioners to effective care processes and evidence-based care as the main route to all desirable outcomes, including financial results, regulatory compliance, and resident and staff satisfaction. They promote respect for the value of good detective work, problem solving, data gathering, and cause identification, as being key to providing compassionate, respectful, safe, and individualized care. They spearhead a broad facility commitment to coordinated clinical decision making and evidence-based care, and a resistance to tradition-, habit-, and myth-based care.\(^1\)\(^7\),\(^5\)\(^7\) And, they encourage staff and practitioners to question and challenge situations that appear to contradict desirable clinical decision-making approaches.

Effective management steers the facility away from excessive preoccupation with “medical” and “social” models of care. It suppresses approaches to care based on labeling; eg, “the patient is just here for rehabilitation” (or “wound care” or “IV therapy”). Instead, it promotes a comprehensive view, as discussed in this series of articles, including treatment in the proper context.

Effective management promotes sound clinical problem solving and decision making as the foundation for service utilization. Recognizing that utilization decisions are always the end point of patient assessment and clinical decision making, it does not allow any one discipline (eg, therapists or nurses) to dominate the care process or clinical decision making by virtue of having excessive influence over discharge decisions.

Effective management implements systems and processes (eg, quality assurance and performance improvement activities) to oversee and influence the performance and practices of the diverse individuals who work and practice there. In contrast, management in problematic facilities tends to let care processes and practices run on politics and relationships, more than on critical scrutiny. Administrators may not know the right way to do things or be able to assess whether their staff are acting appropriately. Instead, they may wait for others (eg, state surveyors) to evaluate the care and identify remediable problems for them.

Therefore, meaningful nursing home reform requires support for developing management who can effectively oversee the care delivery process and who promote it as the preferred way to desired outcomes based on effective clinical problem solving and decision making.

**SUMMARY**

High-quality nursing home care results from competent performance of key functions and tasks, based on applying clinical problem-solving and decision-making principles via the care delivery process. In contrast, problematic care results from failures of related knowledge, skill, processes, and oversight. Capable facilities tend to do the right things in the right way, whereas problematic ones tend to do the wrong things or to do the right things incorrectly.

Therefore, meaningful nursing home reform must support—as well as not inhibit—the 5 key elements of competent care systems, as discussed in this article. The final article in this series will examine current initiatives that are trying to improve nursing home care quality, and the extent to which they promote or inhibit these essential approaches.

**REFERENCES**


