

"Betrayal: The Quality of Care in California Nursing Homes"
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Hearing Testimony
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We reviewed the quality of care in two California nursing homes during February 1998 at the same time as the state nursing home survey was conducted. Our review approach is based on recommendations of the 1986 Institute of Medicine report¹ and has been used in over 100 nursing homes in three different national evaluations of nursing home survey activities funded by HCFA.^{2,3,4}

The findings were unquestionable; we found important, facility-wide quality of care problems in both nursing homes. As illustrated in Exhibit 1, these included avoidable hospitalizations due to insufficient monitoring in one facility, and one death in each facility in which the response to the resident's deteriorating status was too little and too late. Care was appropriate, however, in association with deaths of six other residents, many of whom required comfort care only. Falls with fractures that were not well documented or may have been prevented occurred in one facility. In the other facility, a highly restrictive restraint was used without documented need. Both facilities had high rates of residents dressed in hospital gowns late in the day and one facility had a high rate of residents who were unclean.

Nutritional problems were found in both facilities with low weight residents not receiving food supplements and continuing to lose weight; and inadequate nutrition even when a resident was tube-fed in one facility. A high skin infection rate was found in one nursing home, accompanied by poor infection control precautions. In both facilities, there was a high rate of bed sores among residents who were not mobile, and not kept dry nor repositioned.

While no quality assessment approach is perfect, the medical literature, as well as common sense, provide support for these quality standards. From two nursing homes, we cannot generalize about the quality of nursing home care throughout California. Nevertheless, the state nursing home survey should detect these quality problems. But we have found similar problems with the survey in other states as well.

How did we find these problems?

We used a two-staged review conducted by two nurses with extensive experience in long-term care and quality assessment, who used laptop computers. In the first stage, we collected information on more than 80 residents. Residents were selected based on two objectives: 1) to focus on the residents most vulnerable to quality problems such as new admissions and those at risk for bed sores; and 2) to obtain a random sample of current residents that could be used to generalize results to the whole facility.

We collected uniform information from four different sources: resident observation/interview, the nursing home chart, the nursing home staff, and the Minimum Data Set (MDS) in order to assess 75 different quality standards. We compared each facility's rate of poor outcomes with a norm from a group of more than 60 facilities. Where the facility had a higher rate than the norm, we conducted a second stage: a more detailed review of selected residents.

Exhibits 2 and 3 provide an illustration of one quality standard (or indicator). For the 40 long-stay

residents in our sample, we determined whether the Body Mass Index, the ratio of weight and height, was less than 22 kilograms per meter squared: a standard set by the Nutritional Screening Initiative in 1992 and which research has shown is associated with a 30%-60% increase in mortality.^{5,6} We determined whether these residents were receiving some type of high protein or high calorie supplements to improve their nutritional status.^{7,8} After excluding residents with terminal illness or who refused to eat, we determined the percentage of residents in the facility who were both low weight and not receiving supplements. For this facility the rate was 29% compared with the national norm of 18%; this quality standard required further review.

In the second stage (Exhibit 3), we reviewed selected cases looking for evidence of continued weight loss, problems such as bed sores that require adequate nutrition to prevent or treat, the presence of a dietary assessment, and follow through on dietary plans. We recorded the findings for each case, determining whether the low Body Mass Index was justified, because the facility did all that could be done for that resident, or potential or actual harm occurred due to inadequate care. We found two cases that were justified, but six cases of either actual or potential harm.

What could HCFA do to improve the survey process?

I suggest the following five changes to the nursing home survey (Exhibit 4):

- (1) Examine larger resident samples including both a random sample to determine general rates of poor outcomes and focused samples of vulnerable populations.
- (2) Review quality of care for new admissions, one of the most vulnerable populations. Because of declining hospital lengths of stay, nursing homes are confronted by new admissions with greater acute care needs, which they are not always prepared to treat.
- (3) Collect uniform quality of care data using a structured protocol at each facility. Multiple sources of information should be used, including: resident observation/interview, chart review and staff interview. The MDS is a resident assessment instrument, but not a quality assessment instrument. It is completed by the facility staff and does not measure many important outcomes.
- (4) Target areas for further review based on facility-wide outcomes of care. We will never have the resources to review every resident in every nursing home, so we need to choose the facilities and areas to review based upon comparison with national norms.
- (5) Recognizing that both measuring and assuring quality is a very difficult job, we need to work together to make the most appropriate use of the latest knowledge and technology. That is the reason why I am here today. Thank you for this opportunity.

References

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