DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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TO: Dennis G. Smith, Director
Center for Medicaid & State Operations
Centers for Medicare & Medicaid Services

FROM: George Grob
Assistant Inspector General for Evaluation and Inspections

SUBJECT: Emerging Practices in Nursing Homes (OEI-01-04-00070)

Over the years, the Office of Inspector General (OIG) has undertaken an extensive body of work dealing with nursing homes in the areas of oversight, financing, and quality of care. We recently undertook a review to look at initiatives used by some in the nursing home community. We did not independently evaluate the initiatives, but we did look for and observe emerging practices related to improving staffing, improving quality of care, and enhancing residents' quality of life.

Methodology

We base this review on visits to 16 nursing homes, which we selected using a three-stage process: First, we analyzed results of the three most recent Medicare certification surveys for all nursing homes. We selected homes that had no deficiencies more serious than a scope and severity of "D" (defined by CMS as "minimal harm or potential for actual harm that is isolated to the fewest number of residents, staff, or occurrences"). From these homes, we included only homes that had no deficiencies worse than "D" from complaint investigations in the last 3 years. This analysis yielded 1,347 nursing homes.[1] We also asked national organizations for recommendations on homes to contact.[2]

Second, from this pool of 1,347 nursing homes, we selected homes with which to conduct telephone interviews in 9 States: California, Iowa, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island, South Carolina, and Texas. We chose these States to provide a geographic mix. Within States, we included homes that were not-for-profit and for-profit; rural, urban, and suburban; and large, medium, and small. We conducted telephone interviews with 61 homes. These interviews addressed practices related to improving staffing, quality of care, and quality of life. We typically interviewed the homes' administrator and director of nursing.

Third, we chose 16 homes for site visits, based on practices we learned about during the telephone interviews. Our selection also considered geographic diversity of the homes and

accessibility to traveling OIG staff. While on site, we met with the homes' management and staff to learn details about the practices they had described during the telephone interviews. At 14 of the homes, we also met with residents and/or their family members.

For our review, we looked for emerging practices that nursing home administrators believed had many of the following characteristics:

- address a specific problem that the home has identified
- tie into ongoing operations of the home
- have enough substance so that, according to the people we interviewed, the practices appear to make a significant contribution to high-quality care in the home
- have been in place for sufficient time to be considered a success by the nursing home administrators and seem likely to continue at the home
- have shown measurable results according to the home
- are replicable in other homes.

We recognize three limitations to this methodology:

1. We did not independently evaluate the effectiveness of practices reported by nursing homes. In particular, we do not claim a causal relationship between implementing these practices and achieving good results on the certification survey.
2. We present discrete practices in this report found at one or more nursing homes. Our selection of these practices does not ensure their successful implementation by other nursing homes.
3. We did not select a random sample of nursing homes to contact. Thus, what we learned is not generalizable statistically to the universe of nursing homes.

We conducted this review in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency.

IMPROVING STAFFING

Nursing homes operate in an environment of high staff turnover where it is difficult to attract, train, and retain an adequate workforce. Turnover among nurse aides, who provide most of the hands-on care in nursing homes, means that residents are constantly receiving care from new staff who often lack experience and knowledge of individual residents. Furthermore, research correlates staff shortages and insufficient training with substandard care.[3]

Mentoring Programs

On our site visits, we observed nurse aide mentoring programs in 11 nursing homes. Nurse aide mentors are experienced aides trained to provide peer leadership to newly hired aides. Mentors receive training in leadership, communication, teaching, and conflict resolution.

Typically a newly hired aide observes and learns from the mentor, gradually assuming more responsibilities and independence. The mentor consults with nursing home managers throughout this time regarding the new nurse aide's progress. The mentor evaluates and keeps track of the skills learned by the new aide. The mentor also helps the new aide acclimate to the nursing home. When the mentor and manager believe that the new aide is ready to work on his/her own, the mentoring period ends.

Mentors may take on tasks in addition to training new aides, depending on the home. On our visits we saw that mentors might:

- conduct in-service training for other staff
- help orient new employees from non-nursing units, such as dietary and housekeeping staff
- participate in the hiring process--for example, by touring the nursing home with prospective employees

Establishing a mentor program requires a commitment of time and money. Mentors spend time away from resident care when they are in training for their role, or they may care for fewer residents. This means that nursing homes must bring on additional staff to care for those residents. Mentors also may be paid more than other nurse aides, typically 50 cents or $1 more per hour while serving as mentors.

Despite these costs, managers at nursing homes we visited attributed improvement in staff retention to the use of mentors. Managers felt that improvements in retention can lead to an increase in quality and continuity of care. The administrator at one of these homes typified these comments when she credited mentoring with a decrease of almost 50 percent in nurse aide turnover.

Involving Staff in Decisionmaking

Two nursing homes we visited train staff to participate in quality improvement programs. At one of these homes, managers, dietary staff, nurses, and housekeepers receive classroom training on data analysis and critical thinking skills. The class members then apply these skills to a specific project identified by management. Staff who complete the course are empowered to solve problems close to the resident level and are considered "floor leaders."

At the second home, ad-hoc teams, comprising staff from different disciplines, conduct quality improvement projects. Managers charge teams with improving a specific area of the home's operations, and the teams disband after completing their task.

At three other homes, we observed involvement of staff from multiple disciplines on operational committees. For example, nurse aides, dietary staff, and activities staff participate in the quality improvement, safety, restraint reduction, and wound care committees.

Managers at these homes told us that staff participation in committees and quality improvement projects takes staff away from resident care duties, placing an additional burden on other staff to take over their duties while they engage in these projects. However, these managers also felt that drawing on the knowledge and experience of these staff can help improve quality of care and quality of life for the residents. In addition, they felt that participating in projects and committees can increase job satisfaction and staff retention because staff have input into the nursing home's operations.

Maintaining Flexible Work Schedules

Seven nursing homes we visited offer flexible or nontraditional schedules to their employees. Such schedules provide a way for staff to attend to personal matters. Two of these seven homes also offer flexible schedules to staff who are pursuing advanced degrees, such as in registered nurse programs.

For example, one nursing home we visited operates two 12-hour shifts for the nursing staff, instead of the typical three 8-hour shifts; the shifts run from 7 a.m. to 7 p.m. or 7 p.m. to 7 a.m. Another home we visited allows employees to work two 16-hour shifts on the weekend and be paid for a full 40-hour week.

Managers at the homes that have implemented these changes told us they have found that the scheduling can meet both the needs of the home and the needs of staff, thus contributing to staff satisfaction and retention. Aides told us they were pleased with flexible or nontraditional schedules, because they are able to take time off if needed.

At the home operating 12-hour shifts, family members told us that they like having only two nurse aides care for the residents, rather than three, because it improves continuity of care. Aides who work the day shift at this home told us that this schedule gives them time to spend visiting with and getting to know residents in the afternoon because they spend the earlier part of their shift providing more hands-on caregiving.

IMPROVING QUALITY OF CARE

Most nursing home residents are frail physically, and many have conditions such as dementia that place them in need of intensive health services. As a result, residents are susceptible to adverse events, such as falls, pressure sores, and weight loss. Many residents take multiple medications to address these and other medical conditions; as a result, they face further complications from interactions among medications. Monitoring, preventing, and treating these conditions are significant components of the care that residents require.

Using Data for Decisionmaking on Resident Care

Five nursing homes we visited make a concerted effort to incorporate routine analysis of data into decisionmaking about resident care. These nursing homes draw on data that staff collect on residents' weight loss or gain, skin conditions, and falls. The homes have formalized their ongoing observation and assessment of residents to identify those at high risk for adverse events. At weekly meetings, interdisciplinary teams identify and discuss interventions to treat and prevent adverse events.

One nursing home we visited instituted a committee that meets every week. The committee reviews any resident who is in hospice care; who has skin problems, such as pressure sores or skin tears; who has gained or lost weight; or who has been involved in a fall or other incident. The committee also reviews Quality Indicators for each resident every 3 months.[4]

Another nursing home we visited uses data from the Quality Indicators to focus on two residents each week. Nurse managers prepare case studies on the selected residents. For that week's residents, the committee looks at any Quality Indicators that raised concern, and the group assesses why the problems arose and what types of intervention are needed to correct them.

Routine collection and review of these data require a substantial and ongoing time commitment. Reviewing these data also requires training staff in how to use them for analytical purposes. Through meetings such as these, the staff at the homes believe they can arrive at the root cause of an adverse event and that reducing these events leads to improvement in the health status of residents.

Including the Family in Resident Care

<u>At admission.</u> Two nursing homes we visited directly address families' concerns about nursing home care at the time of a resident's admission. Both homes developed these practices when families raised questions soon after the residents' admission. Many of the concerns arose because of families' unfamiliarity with nursing home care. Families had expected nursing home care to be similar to hospital care, with daily involvement of physicians and with licensed nursing staff handling most aspects of care.

One of these nursing homes convenes a half-hour meeting with the family members of a new resident a week after admission. During this meeting, the director of social services and nursing unit manager explain the resident's condition, diagnoses, medications, treatments, diet, insurance, and advance directives. Family members take home information on these topics, as well as a sheet with telephone numbers of the home's staff and managers.

In the other nursing home, the medical director sends a letter to the resident's family outlining how the home will care for the resident. This practice began after the home's family satisfaction survey showed that many families were disturbed that they did not hear regularly from physicians. The letter to families informs them that physicians will call whenever the resident is evaluated or hospitalized. The medical director also emphasizes that family members should call him if they have any concerns.

To curtail adverse events. One nursing home we visited has a policy of not only informing families when a resident has fallen, but involving family members in preventing future falls. As an example, staff at this home told us about talking with family members of a resident who fell several times in the middle of the night. The staff learned from family members that the resident often got up during those hours to pray. Staff likely would not have gained that knowledge without discussing the situation with the resident's family, and this information helped them accommodate the resident's needs.

Six nursing homes we visited described their efforts to educate families as a key strategy in reducing the use of restraints. The manager at one of these homes commented that families often want restraints used at all times to prevent falls. At another of these homes, the director of nursing told us that "We try to be open with families about the pros and cons of restraints and have found that families generally do not want to restrain residents." Strategies for informing families about restraints focus on telling them about the risks of falling and the preventive measures that the home uses to minimize those risks, such as using low beds and placing safety mats by beds. One nursing home uses its newsletter for families as an educational vehicle for restraint reduction.

Although friction can occur when family members of residents disagree with each other on courses of treatment, one nursing home manager told us that sharing information with families on anticipated concerns has helped lower the number of calls from families. Contacting the families keeps them informed about issues developing with the resident.

ENHANCING QUALITY OF LIFE

Prior to moving to the nursing home, many residents led active, independent lives in which they exercised control over their own environment and daily activities. Once inside the nursing home, that home provides both for residents' health care needs and their social

needs. Residents often lack decisionmaking authority over basic aspects of day-to-day life, such as their choice of food and control over their daily schedules and activities.

Maintaining a Home-Like Environment

Flexible waking hours. Two nursing homes we visited allow residents to wake on their own schedule. At one of the homes, coffee, rolls, and cereal are available at 6 a.m. for early risers, and the home offers a hot breakfast from 8 to 10 a.m. At the other home, breakfast is served from 6:30 to 9 a.m.

Implementing this practice requires some flexibility on the part of the food service system and the nursing staff. The staff at one home told us they initially thought it would take all day to feed the residents. But after trying the practice, as a nurse there told us, "it was just a matter of getting these changes into our routine." An aide at that home told us that she likes this approach, because it gives her greater flexibility in helping residents wake up. Overall, staff felt that this practice appears to give residents a greater sense of control over their own lives.

Expanding dining choices. Three nursing homes we visited offer residents choices of two or more entrees at each meal. One of these homes provides a buffet-style serving line for residents who can serve themselves. Residents go through the line and select their food; staff carry the trays to the table for the residents. One home sets dining tables with linens and allows residents to choose daily with whom they would like to dine.

Preparing a range of meal options can be costly, and nursing home managers told us it demands organizational flexibility. However, because meals are an important social event in the daily lives of residents, the managers reported that making the dining experience as pleasant as possible can enhance residents' sense of well-being.

Physical environment. Five nursing homes we visited had made special efforts to make their interiors appear more like a home than an institution. Two nursing homes redecorated shower rooms to make them appear more like a bathroom in one's own home. One home even turned bathroom painting and redecoration into a contest with competing teams made up of staff and residents.

We also observed three nursing homes that revamped their common areas with the specific goal of making them more home-like. For example, one home furnished an atrium with comfortable seating and an aviary to create a common area that encourages gatherings by residents and their families.

Making changes to the physical plant can be expensive; even redecorating rooms can be costly. However, a home-like environment provides residents with a living situation that is

less institutional and more like a residence. These changes also can improve the overall physical appearance of the nursing home.

Community ties. Many nursing homes we visited had undertaken initiatives that made them part of the communities in which they are located. In one home, residents work with Meals-on-Wheels, packaging condiments for other elders in the area. Another home's residents hold fundraisers for the town's education programs. In a third home, residents hold an annual baby shower for residents of a nearby shelter. In yet another home, local schoolchildren teach computer skills to residents. Finally, one home we visited operates a day-care center for children, and another home operates an adult day-care program.

One nursing home we visited has a community center and offers weekly public seminars on a variety of topics. Community members may use the home's learning center and library. Another home offers activities for residents that are also open to the community, such as a pep rally the home held for a local football team bound for the Super Bowl. Staff from the home often attend these events with their families.

To people in the local community, a nursing home may seem an isolated, distant place. According to the nursing home managers we interviewed, involving the home and its residents in the larger community reinforces relationships that many residents already had prior to moving to the home. In addition, nursing home managers told us that these practices open the home to the local community, increasing its visibility and support there.

Respect for residents after death. One nursing home we visited holds memorial services for deceased residents. These services take place shortly after the resident dies, and the home invites the resident's family to attend. Because the deceased resident had been part of the life of other residents and staff at the home, these services provide residents and staff a time to grieve together. One home we visited allows residents to have their funerals and/or wakes onsite.

Seeking Resident Input on Nursing Home Operations

All nursing homes we visited had resident councils that meet periodically.

One home we visited has a resident committee on continuous quality improvement. This committee comprises a group of residents who meet weekly with the administrator to provide an early warning on any emerging problems. An example of resident input was evident in one nursing home that changed its arrangement for meals. Residents expressed concerns, and as a result the home revised its meal service. When another nursing home was ready to purchase new furniture for resident rooms, its managers asked the residents what would work best and made purchase decisions based on that input.

Finally, the administrator of one nursing home told us that residents may be reluctant to raise their concerns to management; in that home, residents wear "Speak Up" buttons to encourage all residents to voice their opinions. When residents provide her with their preferences, the administrator told us that the home can better meet their needs beyond those related to health care.

We hope you find this information useful to CMS in its ongoing efforts to improve care in nursing homes. It is not necessary for you to submit formal comments on this report. However, if you wish to provide comments, we would welcome them. If you have any questions about this report, please do not hesitate to call me, or one of your staff may contact Tricia Davis, Director, Medicare and Medicaid Branch, at 410-786-3143 or through e-mail [Tricia.Davis@oig.hhs.gov]. To facilitate identification, please refer to report number OEI-01-04-00070 in all correspondence.

cc: Carmen Keller, Deputy Director
Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services

Sean Tunis, M.D., Director & Chief Clinical Officer
Office of Clinical Standards and Quality
Centers for Medicare & Medicaid Services

ENDNOTES

[1] The 1,347 nursing homes are a subset of 13,961 homes that were active providers with all three certification surveys in CMS's Online Survey and Certification Reporting System.

[2] These organizations included the National Citizens' Coalition for Nursing Home Reform, the American Health Care Association, the American Association of Homes and Services for the Aging, the American Medical Directors' Association, and the American College of Health Care Administrators. For homes recommended by national associations, we broadened our criteria. Two homes each had one deficiency with a scope and severity of "F" (defined by CMS as minimal harm or potential for actual harm that includes many residents, staff, or occurrences). While these homes fell outside of our initial criteria, we felt it was important to observe approaches in homes that national organizations recommended.

[3] Centers for Medicare & Medicaid Services, "Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report," December 2001, pp. ES-1, 1-7.

Institute of Medicine, Committee on Improving Quality in Long Term Care, Division of Health Services, "Improving the Quality of Long-Term Care, 2001." Ed. G.S. Wunderlich and P. Kohler, Washington D.C., National Academy Press, p. 129.

[4] Quality Indicators are measures derived from the Minimum Data Set, which comprises assessments that nursing homes complete on admission for every resident and update on a regular basis. They can be used to identify problem areas, such as a high number of medications, significant weight loss, use of restraints, or incontinence. Residents are assessed within 14 days of admission; then annually; and also within 14 days of a significant change in condition. A subset of Minimum Data Set items is collected quarterly.