

NURSING HOME CARE

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Nursing homes (NHs) are an integral component of a broad array of long-term care services for older, chronically ill, functionally disabled Americans. Despite the desire of most older people to remain in their own homes, and the development of community long-term care services and innovative specialized geriatric units that can prevent or delay NH admission, the need and demand for NH care is likely to increase during the next several decades.

More than 1.5 million Americans awaken every day in one of over 15,000 nursing homes. While some NHs provide high-quality care, the poor quality of care in many has been repeatedly documented in the medical literature, congressional testimony, and lay press for the last two decades. The medical profession must accept much of the responsibility for the poor quality of care in NHs. Most physicians do not care for NH residents, and many of those who do, provide substandard care. The visits of physicians are commonly brief and superficial; documentation in medical records is scanty; treatable conditions are underdiagnosed or misdiagnosed; and psychotropic drugs are often misused. Misuse of psychotropic drugs is also due in part to the absence of mental health interventions by appropriately trained professionals. Only recently has interest developed in the education of physicians, nurses, and other health professionals in long-term care and in basic biomedical, clinical, and health services research focusing on NHs and NH residents.

Despite the logistic, economic, and attitudinal barriers that can foster inadequate medical care in NHs, there are many principles and strategies that can lead to improvements in the quality of medical care provided to NH residents. Fundamental to achieving these improvements is a clear perspective on the goals of NH care, which are in many respects quite different from the goals of medical care in other settings and patient populations.

The objectives of this chapter are to briefly review some demographic aspects of NH care and then to focus in particular on the clinical care of NH residents and strategies to improve the care currently provided. While the focus of the chapter is on medical care, this by no means implies that other aspects of the care residents of NHs receive (such as nursing, psychosocial, rehabilitative) are not just as, if not more, important.

NURSING HOMES AND
NURSING HOME RESIDENTS

The increasing number of people ages 85 and older with functional disabilities; the predicted decrease in the availability of family caregivers (due to smaller, more geographically dispersed families and an increase in the number of working women), who currently provide most noninstitutional long-term-care services; and continued restrictive eligibility and reimbursement policies for community long-term-care services will all contribute to an increasing demand for institutional long-term care for the next several decades. Recent estimates suggest that the lifetime risk of entering a NH for the cohort of people who turned 65 in the year 1990 is 43 percent (about 50% in women and 33% in men). Although only about 5 percent of those ages 65 and older are in a NH at any one time, this proportion rises to nearly 25 percent for white women 85 and older.

Table 36-1 illustrates several characteristics of NHs and NH residents. Nearly two thirds of NHs have fewer than 100 beds, and almost three-quarters are run for profit. Many nonprofit, often religiously affiliated, institutions provide several different levels of care at the same site. These range from residential care through assisted living and skilled nursing care. In many states, the most rapidly growing segment of institutional long-term care is assisted living. These settings try to create a more homelike environment, provide needed support services, and yet avoid becoming a medicalized minihospital, as many NHs have. Many long-term care facilities are becoming "vertically integrated" with other geriatric health and social services through affiliations with acute care hospitals, health maintenance organizations, and life care communities in order to create a continuum of care. The National Chronic Care Consortium includes approximately 30 organizations throughout the United States that are attempting to create continuums of care for the frail geriatric population. A relatively small proportion of NHs have developed affiliations with academic medical centers and serve as important sites for medical and interdisciplinary training and research activities.

TABLE 36-1
Selected Characteristics of Nursing Homes and Nursing Home Residents

NURSING HOME CHARACTERISTICS	ALL CURRENT RESIDENTS	TOTAL (%)	AGE					SEX			RACE		
			LESS THAN 65 YEARS (%)	65-74 YEARS (%)	75-84 YEARS (%)	85 AND OVER (%)	MALE (%)	FEMALE (%)	WHITE (%)	BLACK (%)	OTHER (%)		
All nursing homes	1,548,600	100	11	16	38	36	28	72	88	10	11		
Ownership													
For-profit	989,700	64	12	16	38	34	28	72	87	10	12		
Not-for-profit	420,800	27	6	14	38	42	25	76	90	8	9		
Government and other	138,100	9	17	17	37	29	36	64	89	10	11		
Certification													
Medicare and Medicaid	1,213,700	78	10	16	38	36	27	73	88	10	12		
Medicare only	50,000	4	NA	13	38	44	27	73	96	-	-		
Medicaid only	240,600	15	16	16	37	32	31	69	87	10	13		
Not certified	443,000	3	9	11	40	40	33	67	94	4	6		
Bed Size													
Less than 50 beds	71,100	5	12	14	38	36	31	69	90	6	9		
50-99 beds	378,300	24	11	14	37	39	29	72	91	8	9		
100-199 beds	794,200	51	10	16	38	36	26	74	88	10	11		
200 beds or more	305,000	20	13	18	37	31	29	72	84	14	16		
Affiliation													
Chain	857,300	55	10	16	38	36	27	74	88	10	12		
Independent	689,100	45	12	15	37	36	29	71	88	10	11		

NA, not applicable.
SOURCE: National Center for Health Statistics—1995 National Nursing Home Survey as depicted by the American Health Care Association (1997).

Close to 90 percent of NH employees are nursing staff, predominantly nurses' aides, who provide more than 90 percent of hands-on patient care. These individuals often have a limited educational background, and in some areas of the country, their first language is not English. The turnover rate for these nurses' aides exceeds 50 percent per year. Less than 20 percent of physicians attend patients at NHs, and those who do, frequently make very brief visits. Most NHs have only part-time social workers and part-time contract physical, occupational, and recreational therapists. These work-force characteristics are clearly not optimal for providing high-quality medical care to a population that is becoming frailer and sicker.

The dynamics of NH populations have been the subject of several studies. At admission, NH residents appear equally distributed between short stayers (1 to 6 months) and long stayers (who may stay several years). At any one time, however, a cross-section of NH residents reveals a much higher proportion of long stayers. While most NH discharges occur within the first 3 to 6 months after admission, studies of NH admissions have revealed that only 28 percent of the residents were discharged to their own homes, and 33 percent were discharged dead. Moreover, 75 percent had died within 2 years. During the last several years, an increasing number of NHs have begun providing subacute care in Medicare skilled beds or "distinct-part" Medicare units. As this trend continues, the number of short-staying NH residents will increase, as will the proportion of discharges to home. The typical long-stay NH resident is an elderly, white, widowed, and functionally disabled woman. Nearly two thirds of NH residents are women. One-third are 85 or older; one-half have significant degrees of dementia, frequently with associated behavioral disorders; and more than one-half are incontinent. The majority are nonambulatory and require help in most basic activities of daily living.

For the purpose of discussing clinical care in the NH, it is helpful to subdivide NH residents as depicted in Figure 36-1. The two basic types of NH residents, short stayers and long stayers, can be further subdivided. Short stayers include (1) patients recovering from medical and functional problems after an acute

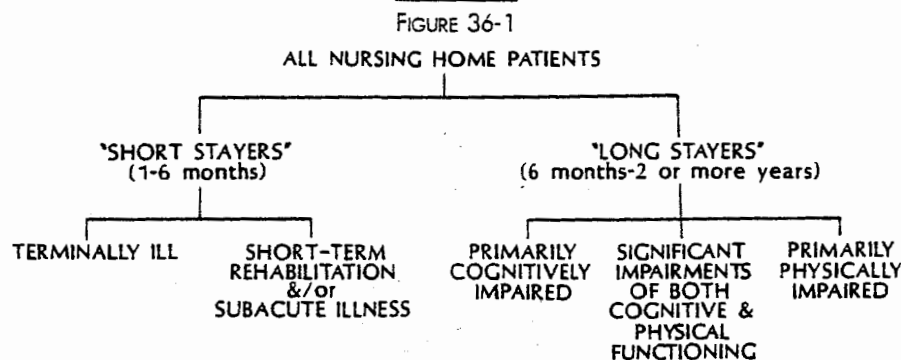
illness who have a reasonable expectation of discharge to a lower level of care (e.g., patients recovering from hip fracture, stroke, pneumonia, or decompensated congestive heart failure with prolonged bed rest) and (2) patients who have end-stage or terminal disease (e.g., cancer, severe brain injury, chronic lung disease, or heart failure) and are expected to die in days to weeks. Long stayers comprise patients with chronic disabilities involving impaired cognitive function (e.g., dementia) or impaired physical function (e.g., stroke, arthritis, multiple sclerosis), or both. The approaches to assessment, the goals for care, and the treatment process differ substantially between these different types of NH residents. The relative proportion of residents of each type can have important programmatic and financial implications for individual NHs as well as for NH chains.

THE GOALS OF NURSING HOME CARE

Fundamental to improving the care of NH residents is a clear conception of the goals of care. The key goals of NH care are listed in Table 36-2. While the prevention, identification, and treatment of chronic, subacute, and acute medical conditions are important, most of these goals focus on the functional independence, autonomy, quality of life, comfort, and dignity of the residents. Physicians who care for NH residents must keep these goals in perspective while addressing the more traditional goals of medical care.

The heterogeneity of the NH population must also be recognized in order to focus and individualize the goals of care. Nursing home residents can be subgrouped into five basic types, as depicted in Figure 36-1. The focus and goals of care for these five subgroups of NH residents are obviously very different.

Many NHs attempt to isolate these different types of residents geographically. This strategy has several advantages, including the specialized training of staff to care for residents with specific types of problems (e.g., rehabilitation, terminal illness) and the separation of



Different types of nursing home residents. After Ouslander et al: *Medical Care in the Nursing Home*, 2nd ed. New York, McGraw-Hill, 1996.

TABLE 36-2
Key Goals of Nursing Home Care

1. Provide a safe and supportive environment for chronically ill and dependent people
2. Restore and maintain the highest possible level of functional independence
3. Preserve individual autonomy
4. Maximize quality of life, perceived well being, and life satisfaction
5. Provide comfort and dignity for terminally ill patients and their loved ones
6. Stabilize and delay progression, whenever possible, of chronic medical conditions
7. Prevent acute medical and iatrogenic illnesses and identify and treat them rapidly when they do occur

SOURCE: From Ouslander J et al: *Medical Care in the Nursing Home*, 2d ed. New York, McGraw-Hill, 1996, with permission.

residents with severe dementia and behavioral disturbances from cognitively intact residents. The latter often find interactions with severely demented residents very distressing. Nursing homes that care for a large number of postacute patients on Medicare skilled nursing benefits generally create a geographically separate Medicare "distinct-part" unit. These units have a heavier concentration of licensed nursing staff and other members of the interdisciplinary care team (rehabilitation therapists, social workers/discharge planners).

Although it is not always possible to isolate different types of residents geographically and residents often overlap or change between the types described, conceptually subgrouping NH residents in this manner can help the physician and interdisciplinary team focus the care-planning process on the most critical and realistic goals for individual residents.

CLINICAL ASPECTS OF CARE FOR NURSING HOME RESIDENTS

In addition to the different goals for care in the NH, several factors make the assessment and treatment of NH residents different from those in other settings (Table 36-3). Many of these factors relate to the process of care and are discussed in the following section. A fundamental difference in the NH is that medical evaluation and treatment must be complemented by an assessment and care-planning process involving staff from multiple disciplines. Data on medical conditions

and their treatment are integrated with assessments of the functional, cognitive, affective, and behavioral status of the resident in order to develop a comprehensive database and individualized plan of care. The Minimum Data Set (MDS), mandated by the Omnibus Budget Reconciliation Act (OBRA) legislation implemented in 1991, is now the basis for this comprehensive assessment (see "Federal Rules and Regulations" for a discussion of OBRA).

Medical evaluation and clinical decision making for NH residents are complicated for several reasons. Unless the physician has cared for a resident before NH admission, it may be difficult to obtain a comprehensive medical database. Residents may be unable to relate accurately their medical history or describe their symptoms, and medical records are frequently unavailable or incomplete—especially for residents who have been transferred between NHs and acute-care hospitals. When acute changes in status occur, initial assessments are often performed by NH staff with limited skills and are transmitted to physicians by telephone. Even when the diagnoses are known or strongly suspected, many diagnostic and therapeutic procedures have an unacceptably high risk-to-benefit ratio among NH residents. For example, a barium enema may cause dehydration or severe fecal impaction; nitrates and other cardiovascular drugs may precipitate syncope or disabling falls in frail ambulatory residents with baseline postural hypotension; and adequate control of blood sugar may be extremely difficult to achieve without a high risk for hypoglycemia among residents with diabetes with marginal or fluctuating nutritional intake who may not recognize or complain of hypoglycemic symptoms.

Further compounding these difficulties is the inability of many NH residents to participate effectively in important decisions regarding their medical care. Their prior expressed wishes are often not known, and an appropriate or legal surrogate decision maker has often not been appointed. Several strategies described later in this chapter may help to overcome many of these difficulties.

Table 36-4 lists the most commonly encountered clinical disorders in the NH population. They represent a broad spectrum of chronic medical illnesses; neurologic, psychiatric, and behavioral disorders; and problems that are especially prevalent in the frail elderly, such as incontinence, falls, nutritional disorders, and chronic pain syndromes. Although the incidence of iatrogenic illnesses has not been systematically studied in NHs, it is likely to be as high as, if not higher, than in acute hospitals. The management of many of the conditions listed in Table 36-4 is discussed in some detail in other chapters of this text (see Contents and Index regarding specific conditions). Clinicians caring for NH residents should be especially well versed in the unique medical aspects of managing these conditions in the frail dependent elderly patient.

In addition to the numerous factors already mentioned that make the medical assessment and treatment of these conditions different, the process of care

TABLE 36-3

Factors that Make Assessment and Treatment in the Nursing Home Different from Those in Other Settings

1. The goals of care are often different (see Table 36-1).
2. Specific clinical disorders are prevalent among nursing home residents (see Table 36-3).
3. The approach to health maintenance and prevention differs (see Table 36-6).
4. Cognitive, affective and functional status are just as important as, if not more important than, medical status.
5. Assessment must be interdisciplinary, including:
 - Nursing
 - Psychosocial
 - Rehabilitation
 - Nutritional
 - Other (e.g., dental, pharmacy, podiatry, audiology, ophthalmology)
6. Sources of information are variable:
 - Residents often cannot give a precise history.
 - Family members and nurses' aides with limited assessment skills may provide the most important information.
 - Information is often obtained by telephone.
7. Administrative procedures for record keeping in both nursing homes and acute care hospitals can result in inadequate and disjointed information.
8. Clinical decision making is complicated for several reasons:
 - Many diagnostic and therapeutic procedures are expensive, unavailable, or difficult to obtain and involve higher risks of iatrogenic illness and discomfort than are warranted by the potential outcome.
 - The potential long-term benefits of "tight" control of certain chronic illnesses (e.g., diabetes mellitus, congestive heart failure, hypertension) may be outweighed by the risks of iatrogenic illnesses in many very old and functionally disabled residents.
 - Many residents are not capable (or are questionably capable) of participating in medical decision making, and their personal preferences based on previous decisions are often unknown (see Table 36-7).
9. The appropriate site for treatment and the level of intensity of such treatment are often difficult decisions that involve medical, emotional, ethical, and legal considerations that may be in conflict with one another in the nursing home setting.
10. Logistic considerations, resource constraints, and restrictive reimbursement policies may limit the ability of and incentives for physicians to carry out optimal medical care of nursing home residents.

SOURCE: From Kane RA et al: Everyday matters in the lives of nursing home residents: wish for and perception of choice and control. *J Am Geriatr Soc* 45:1086, 1997, with permission.

in NHs also differs substantially from that in acute hospitals, clinics, and home care settings.

PROCESS OF CARE IN THE NURSING HOME

The process of care in NHs is strongly influenced by numerous state and federal regulations, the highly in-

terdisciplinary nature of NH residents' problems, and the training and skills of the staff that delivers most of the hands-on care. New federal regulations that profoundly influence the process of NH care are discussed in a subsequent section of this chapter.

The involvement of the physician in NH care and the nature of the medical assessment and treatment offered to NH residents are often limited by logistical and economic factors. Few physicians have offices based either inside the NH or in close proximity to the

TABLE 36-4
Common Clinical Disorders in the Nursing Home Population

MEDICAL CONDITIONS	
Chronic medical illnesses	Skin (pressure sores, vascular ulcers)
Congestive heart failure	Conjunctivitis
Coronary artery disease	Gastroenteritis
Degenerative joint disease	Tuberculosis
Diabetes mellitus	Gastrointestinal disorders
Hypertension	Ulcers
Obstructive lung disease	Reflux esophagitis
Renal failure	Constipation
Infections	Diarrhea
Respiratory tract	Malignancies
Urinary tract	
NEUROPSYCHIATRIC CONDITIONS	
Dementia	Neurologic disorders other than dementia
Behavioral disorders associated with dementia	Stroke
Wandering	Parkinsonism
Agitation	Multiple sclerosis
Aggression	Brain or spinal cord injury
Depression	
FUNCTIONAL DISABILITIES REQUIRING REHABILITATION	
Stroke	Joint replacement
Hip fracture	Amputation
GERIATRIC PROBLEMS	
Delirium	Iatrogenic disorders
Incontinence	Adverse drug reactions
Gait disturbances, instability, falls	Falls
Malnutrition, feeding difficulties, dehydration	Nosocomial infections
Pressure sores	Induced disabilities—restraints and immobility, catheters, unnecessary help with basic activities of daily living
Insomnia	Death and dying
Chronic pain: musculoskeletal conditions, neuropathies, malignancy	

SOURCE: From Ouslander J et al: *Medical Care in the Nursing Home*, 2d ed. New York, McGraw-Hill, 1996, with permission.

facility. Many physicians who do visit NHs care for relatively small numbers of residents, often in several different facilities. Most NHs therefore have numerous physicians who make rounds once or twice per month. Although these physicians are not generally present to evaluate acute changes in the status of a resident, they nevertheless often attempt to assess these changes by telephone. Many NHs do not have the ready availability of laboratory, radiological, and pharmaceutical services with the capability of rapid response, which further compounds the logistics of evaluating and treating acute changes in medical status. Thus, NH residents are often sent to hospital emergency rooms, where they are evaluated by personnel who are generally not familiar with their baseline status and who frequently lack training and interest in the care of frail and dependent elderly patients.

Restrictive Medicare and Medicaid reimbursement policies may also dictate certain patterns of NH care. While physicians are required to visit NH residents only every 30 to 60 days, many residents require more frequent assessment and monitoring of treatment, especially those who have the shorter acute hospital stays brought about by the prospective payment system (diagnosis-related groups). Reimbursement for one routine visit is hardly adequate for the time that is required to provide good medical care in the NH, including travel to and from the facility, assessment and treatment planning for residents with multiple problems, communication with members of the interdisciplinary team and the resident's family, and proper documentation in the medical record. Activities that are often essential to good care in the NH, such as attendance at interdisciplinary conferences, family meetings, complex assessments of decision-making capacity, and counseling residents and surrogate decision makers on treatment plans in the event of terminal illness, are generally not reimbursable.

Amid these logistic and economic constraints, expectations for the care of NH residents are high. Table 36-5 outlines the various types of assessments that are generally recommended for the optimal care of NH residents. Physicians are responsible for completing an initial assessment within 48 to 72 hours of admission and for monthly or bimonthly visits thereafter. Licensed nurses assess new residents as soon as they are admitted and on a daily basis, and they generally summarize the status of each resident weekly. The extent of involvement of other disciplines in the assessment and care-planning process varies depending on the residents' problems, the availability of various professionals, and state and federal regulations.

Representatives from nursing, social service, dietary, recreational, and rehabilitation (physical and/or occupational) should participate in interdisciplinary care-planning meetings. Residents are generally discussed at this meeting within 2 weeks of admission and quarterly thereafter. The product of these meetings is an interdisciplinary care plan, which separately lists interdisciplinary problems (such as restricted mobility, incontinence, wandering, diminished food intake, and

poor social interaction), goals for the resident related to the problem, approaches to achieving these goals, target dates for achieving the goals, and assignment of responsibilities for working toward the goals among the various disciplines. The interdisciplinary care-planning process serves as a cornerstone for resident management in many facilities, but it is a difficult and time-consuming process, which requires leadership and tremendous interdisciplinary and interpersonal cooperation. Although physicians are usually not directly involved in the care-planning meetings in most facilities, they are generally required to review the care plan and may find the team's perspective very valuable in planning subsequent medical care.

The usefulness of the care planning process in shaping how NH care is delivered is limited by our lack of knowledge in at least two areas. First, we do not know what labor resources are required to implement many care plan recommendations. Second, we have not described systems to transfer written care plan recommendations into daily practice patterns. Both problems are particularly relevant when the importance of the nurses' aide job is considered. Because nurses' aides provide the majority of NH care, they also are responsible for implementing many aspects of the care plan. Management, communication, and training technologies for transferring care plan processes to nurses' aides have not been validated. Moreover, the high turnover rate of nurses' aides and the large number of aides involved in any one resident's care create formidable barriers to developing effective procedures to transfer care plans into daily practice. We lack even basic knowledge of what levels of care it is possible to achieve given the resident-to-aide ratios that exist in most NHs. This only increases the probability that care plan recommendations will be inconsistently implemented. Inconsistent implementation is particularly problematic for care processes that require consistent behavior from nurses' aides across multiple shifts or those that require significantly increased labor expenditures. For example, there is evidence that 2-hour repositioning and toileting recommendations in care plans are not consistently transferred into daily practice. We address these issues again later in this chapter when we discuss the effects of regulatory and practice guidelines on nursing home practice behavior.

STRATEGIES TO IMPROVE MEDICAL CARE IN NURSING HOMES

Several strategies might improve the process of medical care delivered to NH residents. Detailed descriptions of these strategies, as well as the management of common clinical conditions in the NH, can be found in a 1996 textbook on NH care by Ouslander et al. Several strategies will be described briefly including the use of a comprehensive documentation standards;

TABLE 36-5
Important Aspects of Various Types of Assessments in the Nursing Home*

TYPES OF ASSESSMENTS	TIMING	MAJOR OBJECTIVES	IMPORTANT ASPECTS
Medical			
Initial	Within 48 hours of admission	<p>Verify medical diagnoses</p> <p>Document baseline physical findings, mental and functional status, vital signs, and skin condition</p> <p>Attempt to identify potential remediable, previously unrecognized medical conditions</p> <p>Get to know the resident and family (if this is a new resident)</p> <p>Establish goals for the admission and a medical treatment plan</p>	<p>Physical examination and a thorough review of medical records are necessary.</p> <p>Relevant medical diagnoses and baseline findings should be clearly and concisely documented in the patient's record.</p> <p>Medication lists should be carefully reviewed and only essential medications continued.</p> <p>Requests for specific types of assessments and inputs from other disciplines should be made.</p> <p>An initial medical problem list should be established.</p>
Periodic	Usually monthly	<p>Monitor progress of active medical conditions</p> <p>Update medical orders</p> <p>Communicate with patient and nursing home staff</p>	<p>Progress notes should include clinical data relevant to active medical conditions and focus on changes in status.</p> <p>Unnecessary medications, orders for care, and laboratory tests should be discontinued.</p> <p>Mental, functional, and psychosocial status should be reviewed with nursing home staff, and changes from baseline noted.</p> <p>The medical problem list should be updated.</p>

the use of nurse practitioners or physicians' assistants; and a systematic approach to screening, health maintenance, and preventive practices for the dependent NH population. In addition to these strategies, the strong leadership of a medical director who is appropriately trained and dedicated to improving the facility's quality of medical care is essential to develop, implement, and monitor policies and procedures for medical services. He or she should set standards for medical care and serve as an example to the medical staff by caring for some of the residents in the facility. The medical director should also be involved in various committees (e.g., the pharmacy, infection control, quality assurance) and should involve interested med-

ical staff in these committees as well as educational efforts through formal in-service presentations, teaching rounds, and appropriate documentation procedures.

One of the fundamental problems with the medical care delivered to NH residents is documentation. Nursing home residents often have multiple coexisting medical problems and long past medical histories. Residents often cannot relate their medical history, and their previous medical records are frequently unavailable or incomplete. Thus, it is difficult, and sometimes impossible, to obtain a comprehensive medical database. Critical aspects of the medical database should be recorded systematically on the medical record. An example of such documentation is shown in Figure

TABLE 36-5
Important Aspects of Various Types of Assessments in the Nursing Home* (continued)

TYPES OF ASSESSMENTS	TIMING	MAJOR OBJECTIVES	IMPORTANT ASPECTS
As needed	When acute changes in status occur	Identify and treat causes of acute changes	<p>On-site clinical assessment by the physician (or nurse practitioner or physicians' assistant), as opposed to telephone consultation, will result in more accurate diagnoses, more appropriate treatment, and fewer unnecessary emergency room visits and hospitalization.</p> <p>Vital signs, food and fluid intake, and mental status often provide essential information.</p> <p>Infection, dehydration, and adverse drug effects should be at the top of the differential diagnosis for acute changes in status.</p>
Nursing	Within hours of admission, and then routinely with monitoring of daily and weekly progress	<p>Identify biopsychosocial and functional status strengths and weaknesses</p> <p>Develop an individualized care plan</p> <p>Document baseline data for ongoing assessments</p>	<p>Particular attention should be given to emotional state, personal preferences, and sensory function.</p> <p>Careful observation during the first few days of admission is important to detect effects of relocation.</p> <p>Potential problems related to other disciplines should be recorded and communicated to appropriate members of interdisciplinary care team.</p>
Psychosocial	Within 1-2 weeks of admission and as needed thereafter	<p>Identify any potentially serious psychological signs or symptoms and refer to mental health professional, if appropriate</p> <p>Determine past social history, family relationships, and social resources</p> <p>Become familiar with personal preferences regarding living arrangement</p>	<p>Getting to know family members and their preferences and concerns are critical to good nursing home care.</p> <p>Relevant psychosocial data should be communicated to the interdisciplinary team.</p>

36-2. Documentation should also contain information about the resident's treatment status in the event of acute illness (see the next section). These are data essential to the care of the resident and should be readily available in one place in the record so that when emergencies arise, when medical consultants see the resident, or when members of the interdisciplinary team

need an overall perspective, they are easy to locate. This documentation should be copied and sent to the hospital or other health care facilities to which the resident might be transferred. Time and effort will be required to keep this documentation updated. For facilities with access to computers and/or word processing, incorporating this information into a database should

TABLE 36-5
Important Aspects of Various Types of Assessments in the Nursing Home* (continued)

TYPES OF ASSESSMENTS	TIMING	MAJOR OBJECTIVES	IMPORTANT ASPECTS
Rehabilitation (physical and occupational therapy)	Within days of admission and daily or weekly thereafter (depending on the rehabilitation program)	<p>Determine functional status as it relates to basic activities of daily living</p> <p>Identify specific goals and time frame for improving specific areas of function</p> <p>Monitor progress toward goals</p> <p>Assess progress in relation to potential for discharge</p>	<p>Small gains in functional status can improve chances for discharges as well as quality of life.</p> <p>Not all residents have areas in which they can reasonably be expected to improve; strategies to maintain function should be developed for these residents.</p> <p>Assessment of, and recommendations for, modifying the environment can be critically important for improving function and discharge planning.</p>
Nutritional	Within days of admission and then periodically thereafter	<p>Determine nutritional status and needs</p> <p>Identify dietary preferences</p> <p>Plan an appropriate diet</p>	<p>Restrictive diets may not be medically necessary and can be unappetizing</p> <p>Weight loss should be identified and reported to nursing and medical staff.</p>
Interdisciplinary care plan	Within 1-2 weeks of admission and every 3-4 months thereafter	<p>Identify interdisciplinary problems</p> <p>Establish goals and treatment plans</p> <p>Determine when maximum progress toward goals has been reached</p>	Each discipline should prepare specific plans for communication to other team members based on their own assessment.
Capacity for medical decisions	Within days of admission and then whenever changes in status occur	<p>Determine which types of medical decisions the resident is capable of participating in</p> <p>If resident still is capable, encourage him or her to identify a surrogate decision maker in the event he or she becomes incapable of participation in medical decision making</p> <p>If the resident lacks capacity for many or all decisions, identify appropriate surrogate decision makers (if not already done)</p>	<p>Residents with varying degrees of dementia may still be capable of participating in many decisions regarding their medical care.</p> <p>Attention should be given to potentially reversible factors that can interfere with decision-making capacity (e.g., depression, fear, delirium, metabolic, and drug effects).</p> <p>Family and health professional concerns should be considered, but the resident's desires should be paramount.</p> <p>The resident's capacity may fluctuate over time because of physical and emotional conditions.</p>

TABLE 36-5
Important Aspects of Various Types of Assessments in the Nursing Home* (continued)

TYPES OF ASSESSMENTS	TIMING	MAJOR OBJECTIVES	IMPORTANT ASPECTS
Preferences regarding treatment intensity and nursing home routines	Within days of admission and periodically thereafter	Determine resident's wishes as to the intensity of treatment he or she would want in the event of acute or chronic progressive illness	<p>Specificity is important (i.e., "No heroic measures" is ambiguous).</p> <p>An attempt to identify the specific procedures the resident would or would not want should be made.</p> <p>This assessment is often made by ascertaining the resident's prior expressed wishes (if known), or through surrogate decision makers (legal guardian, durable power of attorney for health care, family).</p>

Federal rules now mandate the use of the Minimum Data Set as a component of the assessment of nursing home residents (see the text). See Table 32-8; these issues are also discussed in more detail in the text.

*The basis of nursing home assessment is the Resident Assessment Instrument, which includes the Minimum Data Set and Resident Assessment Protocols.

SOURCE: From Ouslander J et al: *Medical Care in the Nursing Home*, 2d ed. New York, McGraw-Hill, 1996, with permission.

be relatively easy and will facilitate its rapid completion and periodic updating.

Medical documentation in progress notes for routine visits and assessments of acute changes is frequently scanty and/or illegible. "Stable" or "No change" are sometimes the only documentation for routine visits. Even though time constraints may preclude extensive notes, certain standard information should be documented. The SOAP (subjective, objective, assessment, plan) format for charting routine notes is especially appropriate for NH residents (Table 36-6). Adequate documentation of the level of service provided is also necessary to meet guidelines for reimbursement. These guidelines take into account the extent of the medical history and physical examination performed by the provider, as well as the complexity of medical decision making. Simple databases with word-processing capabilities can be used to enable physicians to efficiently produce legible, concise, yet comprehensive, progress notes.

Another area in which medical documentation is often inadequate relates to the residents' decision-making capacity and treatment preferences. These issues are discussed briefly at the end of this chapter as well as in Chapter 40. In addition to documenting critical information in the record (e.g., identifying residents on "No CPR Status" on the front and/or spine of the medical record), physicians must thoroughly and legibly document all discussions they have had with the resident, family, legal guardians, and/or durable power of attorney for health care about these issues. Failure to do so may result not only in poor communication and inappropriate treatment, but in substan-

tial legal liability. Notes about these issues should not be thinned from the medical record and are probably best kept on a separate page behind the face sheet.

A second approach to improving medical care in NHs is the development and implementation of selected screening, health maintenance, and preventive practices. Table 36-7 lists examples of such practices. With few exceptions, the efficacy of these practices has not been well studied in the NH setting. In addition, not all the practices listed are relevant for every NH resident. For example, some of the annual screening examinations are not appropriate for short stayers or for many long-staying residents with end-stage dementia (Fig. 36-1). Thus, the practices outlined in Table 36-7 must be tailored to the specific NH population as well as to the individual resident and must be creatively incorporated into routine care procedures as much as possible in order to be time-efficient, cost-effective, and reimbursable by Medicare.

All long-staying residents should have some type of comprehensive medical reevaluation yearly. The efficacy of a routine standard annual history and physical examination and large panels of laboratory tests has been questioned. A targeted physical examination and functional assessment and selected laboratory tests are probably beneficial. Because reactivated tuberculosis is relatively common among chronically ill elderly patients, all NH residents should have a skin test on admission and yearly (unless they have a known prior positive test). Testing for the "booster phenomenon" has been recommended 10 to 14 days after an initial negative test because there is some incidence (probably in the range of 5% to 15%) of conversion to a

FIGURE 36-2

Example of a comprehensive data base for nursing home medical record documentation.

Wesley Woods Center Long Term Care

PAST HISTORY, FUNCTIONAL/PSYCHOSOCIAL DATA BASE

I. Past Medical History

A. Major Acute Hospitalizations (Diagnosis/Year)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

II. Major Surgical Procedures (Procedure/Year)

1. _____
2. _____
3. _____
4. _____

III. Antimicrobial Prophylaxis required: Yes No

Reason: _____

IV. Last PPD: Neg Pos (Date ___/___/___)

V. Neuropsychiatric Status

- ##### A. Cognitive Impairment None Yes
- Dementia (by DSM criteria) present:
 Alzheimer's Mixed
 Multi-infarct Uncertain/other

B. Psychiatric/Behavioral Disorders

1. _____
2. _____

C. Usual Mental Status

- Oriented, follows simple instructions
 Disoriented, but CAN follow simple instructions
 Disoriented, CANNOT follow simple instructions
 Not alert (lethargic, comatose)

D. Most Recent Mental Status Score MMSE ___/30 (date ___/___/___)

VI. Functional Status

A. Ambulation

- Unassisted With cane/walker
 Transfer: Ind Dep Wheelchair

B. Continence Cont Inc

- Urine _____ _____
 Stool _____ _____

Chronic catheter: Yes No

If yes:

- Reason: skin condition
 comfort/preference
 urinary retention (PVR = _____)
 Due to: weak bladder
 obstruction
 uncertain

C. Basic ADL Ind Dep

- Bathing
 Dressing
 Grooming
 Feeding
 Tube Feeding: Yes No

If yes: Date placed: ___/___/___

- Reason: swallowing dysfunction
 poor nutrition other _____

D. Vision: Glasses Yes No

- Adequate for regular print
 Impaired - can read large print
 Moderately impaired - cannot read/identifies objects
 Highly impaired - eyes track objects
 Severely impaired - eyes do not track objects

E. Hearing Aid Yes No

- Adequate Minimal difficulty
 Hears only when speaker adjusts
 Highly impaired (no useful hearing)

Last Update of this Form:

Date	Initials
___/___/___	_____
___/___/___	_____
___/___/___	_____
___/___/___	_____

positive response. Many NH residents are anergic, which can create difficulty in detecting active cases.

Because most NH residents have chronic medical conditions that are being actively treated, monitoring these conditions and their treatment becomes an im-

portant aspect of medical care. Several examples of such monitoring are presented in Table 36-7. It is extremely important to assess vital signs and weight accurately on a routine basis so that when changes occur, they can be compared with the resident's baseline.

TABLE 36-6
SOAP Format for Medical Progress Notes on Nursing
Home Residents

Subjective	New complaints
	Symptoms related to active medical conditions
	Reports from nursing staff
	Progress in rehabilitative therapy
Objective	Reports of other interdisciplinary team members
	General appearance
	Weight
	Vital signs
	Physical findings relevant to new complaints and active medical conditions
Assessment	Laboratory data
	Consultant reports
Assessment	Presumptive diagnosis(es) for new complaints or changes in status
	Stability of active medical conditions
Plans	Changes in medications or diet
	Nursing interventions (e.g., monitoring or vital signs, skin care, etc.)
	Assessments by other disciplines
	Consultants
	Laboratory studies
	Discharge planning (if relevant)

SOURCE: After Ouslander J et al: *Medical Care in the Nursing Home*, 2d ed. New York, McGraw-Hill, 1996, with permission.

Despite the old age and prevalence of chronic medical conditions and functional disabilities among the NH population, several preventive health practices may be effective. Most of these are related to infectious diseases (Table 36-7). One important exception relates to body positioning and range of motion for immobile residents, with the hope of preventing pressure sores, contractures, and aspiration pneumonia. The efficacy of endurance and strengthening exercise in improving or preserving functional status and preventing complications among frail NH residents is currently under investigation. In addition to preventive practices for NH residents, prevention is also relevant for the entire NH staff. All NH staff who have close contact with res-

idents should be vaccinated against influenza annually. The NH staff must also be intensively educated about infection control procedures such as hand washing, wound care, and catheter care.

The facility should have sound policies and procedures for infection control and should monitor patterns of infection and antimicrobial susceptibility carefully. Because of the prevalent and often inappropriate use of antimicrobials, resistant organisms and *Clostridia difficile* diarrhea have become important problems in NHs. Another example of facility-wide prevention relates to environmental safety. Recommendations for assessing and altering the home environment to prevent falls are also relevant to NHs. Facilities should monitor falls and other accidents and make routine "environmental rounds" to identify potential hazards.

Another strategy that may help improve medical care in NHs is the use of nurse practitioners and physicians' assistants. These health professionals may be especially helpful in carrying out specific functions in the NH setting. Although there is substantial overlap in training and skills, nurse practitioners may have a helpful perspective in interacting with nursing staff about the nonmedical aspects of NH resident care. On the other hand, both nurse practitioners and physicians' assistants may be especially helpful in facilities in which there is a high concentration of subacutely ill patients who require frequent medical assessment and intervention. Both can be very helpful in implementing some of the screening, monitoring, and preventive practices outlined in Table 36-7 and in communicating with interdisciplinary staff, families, and residents at times when the physician is not in the facility. One of the most appropriate roles for nurse practitioners and physicians' assistants is in the initial assessment of acute or subacute changes in the status of the resident. They can perform a focused history and physical examination and can order appropriate diagnostic studies. Several algorithms have been developed for this purpose, one of which is shown in Figure 36-3. This strategy enables the on-site assessment of acute change, the detection and treatment of new problems early in their course, more appropriate utilization of acute care hospital emergency rooms, and the rapid identification of residents who need to be hospitalized.

FEDERAL RULES AND REGULATIONS

In 1987, OBRA contained a comprehensive set of new rules and regulations for NH care. These regulations are largely based on the recommendations made in the Institute of Medicine report on quality of care in NHs. The intent of the new regulations is to improve the quality of care provided in NHs. The rules and regulations cover a broad range of administrative and clinical issues, and many specific guidelines are set forth relating to clinical care for such conditions as pressure sores, incontinence and catheter use, malnutrition,

TABLE 36-7

Screening, Health Maintenance, and Preventive Practices in the Nursing Home

PRACTICE	MINIMUM-RECOMMENDED FREQUENCY*	COMMENTS
Screening		
History and physical examination	Yearly	The yield of routine annual history and physical is debated. Focused examination probably beneficial, including rectal, breast, and in some women pelvic examination.
Weight	Monthly	Persistent weight loss should prompt a search for treatable medical, psychiatric, and functional conditions.
Functional status assessment, including gait and mental status testing	Yearly	Functional status assessed periodically by physicians. Systematic global functional assessment should be done at least yearly in order to detect potentially treatable conditions or prevent complications such as early dementia, gait disturbances, urinary incontinence.
Visual screening	Yearly	Assess acuity and identify correctable problems
Auditory	Yearly	Identify correctable problems
Dental	Yearly	Assess status of any remaining teeth and fit of dentures
Podiatry	Yearly	More frequently in diabetics and residents with peripheral vascular disease
Tuberculosis	On admission and yearly	Test all residents and staff Control skin tests and booster testing are generally recommended for nursing home residents (see the text).
Laboratory tests	Yearly	These may have reasonable yield in selected long-stay residents.
Stool for occult blood		
Complete blood count		
Fasting glucose		
Electrolytes		
Renal function		
Albumin, calcium, phosphorus		

TABLE 36-7

Screening, Health Maintenance, and Preventive Practices in the Nursing Home (continued)

PRACTICE	MINIMUM RECOMMENDED FREQUENCY*	COMMENTS
Thyroid function [including thyroid-stimulating hormone (TSH) level]		
Monitoring in selected residents		
All residents	Monthly	More often if unstable or subacutely ill
Vital signs, including weight		
Diabetic residents	Must be individualized	Fingerstick tests may also be useful if staff can perform reliably.
Fasting and postprandial glucose, glycosylated hemoglobin		
Residents on diuretics or with renal insufficiency (residents with creatinine level >2, or BUN >35)	Every 2-3 months	Nursing home residents are more prone to dehydration, azotemia, hyponatremia, and hypokalemia.
Electrolytes, BUN, creatinine		
Anemic residents who are on iron replacement or who have hemoglobin lower than 10	Monthly until stable, then every 2-3 months	Iron replacement should be discontinued once hemoglobin value stabilizes.
Hemoglobin-hematocrit		
Residents on specific drugs (e.g., digoxin, phenytoin, procainamide, theophylline, nortriptyline)	Every 3-6 months	More frequently if drug treatment has just been initiated
Blood level of drug		
Prevention		
Influenza		
Vaccine	Yearly	All residents and staff with close resident contact should be vaccinated.
Amantadine	Within 24-48 hours of outbreak of suspected influenza type A	Dose should be reduced to 100 mg/d in elderly; further reduction if renal failure present. Unvaccinated residents and staff should be treated throughout outbreak; those vaccinated can be treated until their symptoms resolve.
Pneumococcal pneumonia bacteremia		
Pneumococcal vaccine	Once	Vaccine should be given if vaccine history is uncertain.

TABLE 36-7

Screening, Health Maintenance, and Preventive Practices in the Nursing Home (continued)

PRACTICE	MINIMUM RECOMMENDED FREQUENCY*	COMMENTS
Tetanus		
Booster	Every 10 years; every 5 years with tetanus-prone wounds	Many elderly people have not received primary vaccinations; they require tetanus toxoid, 250-500 U of tetanus immunoglobulin, and completion of the immunization series with toxoid injection 4-6 weeks later and then 6-12 months after the second injection.
Tuberculosis		
Isoniazid 300 mg/d for 1 year	Skin test conversion in selected residents	Residents with abnormal chest x-ray film (more than granuloma), diabetes, end-stage renal disease, hematologic malignancies, steroid or immunosuppressive therapy, malnutrition should be treated.
Other Infections		
Antimicrobial prophylaxis for residents at risk	Generally recommended for dental procedures, genitourinary procedures, and most operative procedures	Chronically catheterized residents should not be treated with continuous prophylaxis
Immobility		
Body positioning, range of motion, and exercise for immobile residents	Ongoing	Frequent turning of very immobile residents is necessary to prevent pressure sores. Semiupright position is necessary for residents with swallowing disorders or enteral feeding to help prevent aspiration. Range of motion to immobile limbs and joints is necessary to prevent contractures.
Infection control procedures and surveillance	Ongoing	Policies and protocols should be in effect in all nursing homes. Surveillance of all infections should be continuous to identify outbreaks and resistance patterns.

behavioral disorders associated with dementia, and drug therapy.

Medical directors, administrators, and directors of nursing should be intimately familiar with the law itself

(as implemented in 1991), as well as with the detailed interpretive guidelines promulgated by the Health Care Financing Administration. Three areas of these regulations critical importance to clinicians are briefly

TABLE 36-7

Screening, Health Maintenance, and Preventive Practices in the Nursing Home (continued)

PRACTICE	MINIMUM RECOMMENDED FREQUENCY*	COMMENTS
Environmental safety	Ongoing	Appropriate lighting and colors, and the removal of hazards for falling, are essential in order to prevent accidents. Routine monitoring of potential safety hazards and accidents may lead to alterations that may prevent further accidents.

*Need for selected diagnostic tests and their frequency may vary depending on resident's condition.

SOURCE: After Ouslander J et al: *Medical Care in the Nursing Home*, 2d ed. New York, McGraw-Hill, 1996, with permission.

reviewed herein: residents' rights, resident assessment, and chemical and physical restraints.

The rules and interpretive guidelines repeatedly emphasize that NH residents have the right to care directed at restoring and maintaining the highest practicable level of functioning. Thus, the traditional "custodial care" approach is no longer appropriate. Potentially remediable clinical conditions and functional deficits should be regularly sought and addressed with

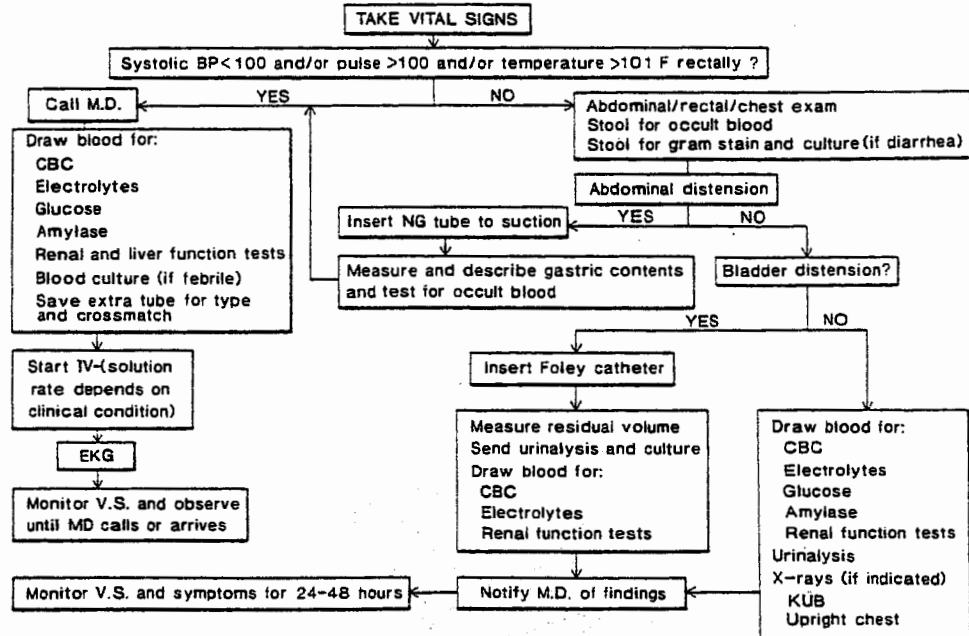
this goal in mind. The focus on residents' rights also relates to the issue of decision making and informed consent. The regulations emphasize the right of NH residents to participate in decisions about their care and mandate a clear approach to assessing decision-making capacity, proxy decision makers, and informed consent.

New guidelines for resident assessment are a cornerstone of the clinical aspects of the regulations. The

FIGURE 36-3

ACUTE ABDOMINAL PAIN

Symptoms: Sudden onset of diffuse or localized pain with or without nausea, vomiting, diarrhea



Example of an algorithm for use by nurse practitioners and physicians' assistants.

d
h
e
l
y

mandated assessment includes three key components: the MDS, triggers, and resident assessment protocols (RAPs). The MDS is a comprehensive assessment that covers key clinical areas. It must be completed within 14 days of admission, and most of the assessment must be reviewed and updated quarterly. The MDS protocol identifies multiple "triggers" for the assessment of a variety of conditions using the RAPs. The RAPs are detailed assessment protocols that address 18 clinical areas, including cognitive loss, mood disorders, falls, nutritional status, and incontinence. Although the MDS, triggers, and RAPs outline a high level of clinical assessment and care for NH residents, many typical NHs have neither the resources nor the personnel to make full use of them. In addition to its potential use in the care of individual NH residents, the MDS will be used in the future as a tool for prospectively reimbursing NH care based on resident characteristics, as well as for identifying quality-of-care issues in specific NHs.

Omnibus Budget Reconciliation Act's regulations on chemical and physical restraints have been the most contentious among clinicians, probably in large part because they begin to impinge on the practice of medicine and nursing. The regulations define both physical and chemical restraints broadly. Much has been written about untying NH residents and "restraint-free" NH environments, but too few data are available on the impact of such environments on quality of life and safety to make specific recommendations. The regulations mandate that physical restraints be used only after a multidisciplinary assessment documents that less restrictive alternatives are not effective; and that when restraints are used a rehabilitative plan of care, including releasing and repositioning the resident every 2 hours, be implemented. Antipsychotics can only be prescribed for specific conditions identified in the interpretive guidelines. The regulations on antipsychotics use, similar to those for physical restraints, mandate that there be ongoing documentation of an attempt at behavioral interventions or other alternatives to drug use and that drug therapy be monitored closely with appropriate dosage reductions and trials off therapy, when appropriate, based on the response of target symptoms.

The MDS/RAP system largely emphasizes assessment and does not make specific recommendations about interventions for most care areas. Practice guidelines, however, are more specific in their treatment recommendations, and the recent development of multiple guidelines for long-term care could potentially lead to improvement in NH care. The intent of practice guidelines is to provide advice on how to best approach assessment and treatment of a clinical problem. Practice guideline advice is based on a summary of state-of-the-art knowledge about best practices in a clinical area. Guidelines generally take the form of an algorithm that lists assessment steps with a corresponding treatment option suggested from the assessment data. The guidelines are based on review of the clinical literature, which it is hoped provides sci-

entific evidence about the efficacy of the treatments recommended. In many cases, however, critical decision points have not been rigorously studied; thus, the algorithm recommendations are based on expert consensus. Whether they are based on expert consensus or scientific evidence, guidelines are useful in that they consolidate in a single format current knowledge about the treatment of complex conditions. Unfortunately, there is little or no evidence that they can be effectively implemented in NHs given existing resource limitations (see "Process of Care in the Nursing Home") or whether they are effective when used under even well-controlled conditions. For the guideline concept to change NH practice patterns successfully, it must be extended to also consider issues that influence how guidelines can be implemented in daily NH practice. We believe that all guidelines should be tested under realistic NH conditions before disseminating them to NHs. These field tests should address such key implementation issues as the following: (1) Does the guideline include a procedure for targeting residents who are likely to be responsive to treatment? (2) What is the provider's cost of the intervention and how does this compare to usual care costs? (3) What quality control and training technologies are effective in maintaining the consistent implementation of the interventions described in the practice guidelines? Currently, no guidelines in OBRA regulation have addressed these implementation issues.

In sum, OBRA 1987 and the new practice guidelines set high standards for NH care. If implemented as intended and monitored appropriately by state and federal agencies, they are likely to improve care. Early data suggest that this is the case in at least some care areas. There is a possibility, however, that efforts to regulate care by enforcing regulations and practice guidelines that have not been tested in actual practice might also produce barriers to improvement. The current survey-based regulatory system evaluates NHs under the assumption that they have the resources and ability to comply with ambitious regulations and that written care plans provide an accurate description of the care provided. For example, if a problem is identified by the MDS, then there should be a care plan to reflect a further assessment or a treatment strategy. Practice guidelines offer advice about what these assessments and treatments should be and how they should be implemented. However, if NH staff do not have the resources to actually implement these recommended strategies, then the best they can do is emphasize paper compliance or care planning. The penalty for not describing appropriate levels of care in written materials is a survey deficiency. Excellent documentation of care on paper may effectively prevent survey deficiencies but does not necessarily reflect the true quality of care. Furthermore, efforts spent on paper compliance and the illusionary high quality of care produced on paper may distract providers from solving important staff and resource issues that can limit the implementation of effective interventions.

THE NURSING HOME—ACUTE CARE HOSPITAL INTERFACE

Nursing home residents are frequently transferred back and forth between the NH and one or more acute care hospitals. The major reasons for transfer include infection and the need for parenteral antimicrobials and hydration, acute cardiovascular conditions, and hip fractures. Transfer to an acute care hospital is often a very disruptive process for a chronically ill NH resident. In addition to the effects of the acute illness, NH residents are subject to acute changes in mental status and a myriad of potential iatrogenic problems. Probably the most prevalent of these iatrogenic problems are related to immobility, including deconditioning and difficulty regaining ambulation and/or transfer capabilities, and the development of pressure sores.

Because of the risks of acute hospitalization, those making the decision to hospitalize a NH resident must carefully weigh a number of factors. A variety of medical, administrative, logistic, economic, and ethical issues can influence decisions to hospitalize NH residents. Very often when NH residents become acutely ill, they simply need a few days of close observation with intravenous antimicrobials and hydration, such as for a lower respiratory or urinary tract infection. Decisions about hospitalization in these situations boil down to the capabilities of the physician and NH staff in providing these services in the NH; the preferences of the resident and the family; and the logistic, reimbursement, and administrative arrangements for acute hospital care. If, for example, the NH staff has been trained and has the personnel to institute intravenous therapy without detracting from the care of the other residents, and if there is a nurse practitioner or a physician's assistant to perform follow-up assessments, the resident with an acute infection who is otherwise medically stable may best be managed in the NH. Increasingly, NHs with Medicare skilled and subacute care units are caring for sicker patients, especially under capitated care arrangements. Many facilities, however, have limited nursing staff; they do not run continuous intravenous infusions, and they do not have nurse practitioners or physicians' assistants and are therefore not capable of managing these situations adequately.

One of the biggest difficulties arising from the frequent transfer of NH residents to acute care hospitals is the disruption in the continuity of medical records at a time when major changes in the residents' status are occurring. Hospitals often receive inadequate information from the NH records upon transfer, and vice versa when the resident is transferred back to the NH. Most NHs begin an entirely new medical record after a resident has been readmitted from an acute care hospital, which further compounds the difficulty in obtaining an adequate medical database. Using standard documentation similar to that depicted in Figure 36-2 helps provide hospital personnel and physicians

(who may be covering the primary physician) with critical data and helps update these data when the face sheet is completed at the NH on readmission. The physician's hospital discharge summaries are rarely available within 24 to 48 hours of the resident's NH admission, and standard intrafacility transfer forms often contain incomplete or ambiguous information. The development of a standard discharge summary and NH readmission order forms with data tailored to the needs of the NH greatly improves the transfer of information and the assessment process.

ETHICAL ISSUES IN NURSING HOME CARE

Ethical issues arise as much, if not more often, in the day-to-day care of NH residents than in the care of patients in any other setting. Because these issues are discussed at length in Chapter 40, they are only briefly mentioned here. Several of the most common ethical dilemmas that occur in the NH are outlined in Table 36-8. Nursing homes care for an extraordinarily high concentration of individuals who are unable or questionably capable of participating in decisions about their current and future health care. It is among these same individuals that severe functional disabilities and terminal illness are prevalent. Thus, questions about individual autonomy, decision-making capacity, surrogate decision makers, and the intensity of treatment that should be given at end of life arise on a daily basis. These questions are both troublesome and complex but must be dealt with in a straightforward and systematic manner in order to provide optimal medical care to NH residents within the context of ethical principles and state and federal laws. Ethics committees have been established in some NHs, and all NHs should be encouraged either to establish such a committee or to become affiliated with an institution that has one that can serve the NH.

In addition to medical care decisions, ethical considerations also involve evaluating NH residents' satisfaction with their daily care and quality of life. Although there is growing interest in measuring resident satisfaction, there also is concern that conventional methodologies used to measure satisfaction may produce misleading information, sometimes inflating satisfaction levels. Commonly used direct questions about satisfaction (e.g., "Are you satisfied with how often someone helps you to use the toilet?" or "Would you like someone to help you use the toilet more often?") often produce data indicating that residents are highly satisfied. Our research has shown, however, that these high satisfaction reports occur even when the actual frequency of the care activity (e.g., toileting assistance) occurs at very low levels. For example, in a recent study, 80 percent of the residents surveyed reported that they were satisfied with their incontinence care even though, according to research staff observations

TABLE 36-8
Common Ethical Issues in the Nursing Home

ETHICAL ISSUES	EXAMPLES
Preservation of autonomy	Choices in many areas are limited to most nursing homes (e.g., meal times, sleeping hours) Families, physicians, and nursing home staff tend to become paternalistic.
Decision-making capacity	Many nursing home residents are incapable, or questionably capable, of participating in decisions about their care There are no standard methods of assessing decision-making capacity in this population.
Surrogate decision making	Many nursing home residents have not clearly stated their preferences or appointed a surrogate before becoming unable to decide for themselves. Family members may be in conflict, have hidden agendas, or be incapable of making decisions or unwilling to make them.
Quality of life	This concept is often entered into decision making, but it is difficult to measure, especially among those with dementia. Ageist biases can influence perceptions of nursing home residents' quality of life.
Intensity of treatment	A range of options must be considered, including cardiopulmonary resuscitation and mechanical ventilation, hospitalization, treatment of specific conditions (e.g., infection) in the nursing home without hospitalization, enteral feeding, comfort, or supportive care only.

SOURCE: After Ouslander J et al: *Medical Care in the Nursing Home*, 2d ed. New York, McGraw-Hill, 1996, with permission.

the actual frequency of incontinence care was insufficient to maintain dryness. In some cases, toileting assistance was not provided at all. Some investigators have reported that low expectations and/or fear of reprisal may act to inflate the satisfaction reports of many NH residents. Nursing home administrators, survey staff, ethics and quality committees, and physicians may be misled into believing that inflated satisfaction reports reflect good care practices and quality of life. Assessing residents' care preferences and then comparing these preferences to the care actually provided may produce data that are more useful for evaluating and improving NH residents' quality of life. We still have much to learn about how to measure residents' preferences and how to use the results to enhance quality of life of the growing frail population who may require NH care.

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