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HOSPICE AND PALLIATIVE CARE PRACTICE GROUP

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EMERGING PRACTICES IN NURSING HOMES: LESSONS FOR HOSPICES

March, 2005

Recently the Office of the Inspector General issued a report regarding Emerging Practices in Nursing Homes related to quality of care, improved staffing and the enhancement of the quality of life of the residents. While there is only minimal mention of the hospice relationship, the report provides valuable insights regarding emerging practices. Likewise, it can provide an important tool for hospices in contracting with nursing homes for patient care.

The report was based on visits to 16 nursing homes. The OIG analyzed Medicare certification surveys for all nursing homes and chose homes that had no deficiencies more serious than a scope and severity of "D" which CMS defines as "minimal harm or potential for actual harm that is isolated to the fewest number of residents, staff or occurrences." Using this initial group, the OIG selected homes for telephone interviews in California, Iowa, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island, South Carolina and Texas. The OIG chose states to provide a certain mix with regard to geography, size and rural/urban mix. Out of the 61 facilities participating in telephone interviews, 16 were chosen for site visits based on the information gathered during the phone interviews. The OIG recognized certain limitations in its report and the methodology it used. For example, it did not independently evaluate the effectiveness of the practices that the nursing homes reported, and it did not select a random sample of nursing facilities. Nevertheless, the report provides important information regarding what the OIG may consider to be best practices. The report covered staffing improvements, quality of care improvements and quality of life enhancements.

I. IMPROVING STAFFING.

The report acknowledged the problems of high staff turnover especially of nurse aides. The report stated that research finds a correlation between insufficient staff training and staff shortages with less than standard care.

A. Mentoring Programs.

The report stated that of the facilities visited, most had nurse aide mentoring programs and acknowledged that such programs require time and money. When mentors are being trained, this time takes them away from resident care and mentors may also be compensated at a higher level than other nurse aides. However, the report indicated that managers found an improvement in retention of staff as a result of using such mentors and that such staff retention could also increase continuity and quality of care.

B. Involving Staff in Decision-Making.

Involving staff in quality improvement projects and committees, while costly to facilities appeared to improve quality of care and quality of life. There also was a sense among administrators that such involvement added to staff satisfaction and retention.

C. Maintaining Flexible Work Schedules.

Some of the facilities that were visited provided flexible schedules to staff who were engaged in educational pursuits or who needed flexibility for other personal reasons. The feedback not only from staff but also from family members was that this flexibility could allow staff, particularly nurse aides, to get to know the residents better.

II. IMPROVING QUALITY OF CARE.

A. Using Data for Decision-making on Resident Care.

The report indicated that some of the facilities visited were including data to formally observe and assess residents identified as high risk. One of the facilities had a formal committee that met weekly to review any resident who was receiving hospice care. Also

the committee reviewed residents with skin problems, those who had either gained or lost significant amount of weight or had been involved in a fall. Another facility used data from the Quality Indicators and focused on case studies of two separate residents each week. This was a mechanism for assessing the reason for problems and the types of interventions that would be most useful in addressing them. Once again it was found that this collection and review of data took a significant amount of time but that it was a means to improve health care of the residents.

B. Including the Family in Resident Care.

The report indicated that on admission, two of the facilities visited had specific means whereby families' concerns would be raised at the time of admission, perhaps with a formal meeting. Also, family members were involved in risk management and care planning. For example, in the event of a fall, the family members were not only informed of the fall but involved in finding ways to prevent future falls. In a number of the facilities visited, family members were a significant part of efforts to minimize the use of restraints.

III. ENHANCING QUALITY OF LIFE.

The report pointed out that many nursing home residents have led very independent active lives with significant control over their own daily activities prior to entering the nursing home and suggested several important strategies.

A. Maintaining a Home-Like Environment.

In some of the facilities, waking hours were flexible and the hours for breakfast were likewise flexible. Expansion of meal entrées was also found to add to the feeling of independence of the residents. In some of the facilities visited, there were also special efforts made to improve the physical environment. Some facilities had aviaries or atriums. There was specific mention of respect for residents after death with one nursing facility holding memorial services for those residents who had died. One facility allowed families to have resident funerals or visitations within the facility.

B. Seeking Resident Input on Nursing Home Operations.

The report mentioned the importance of resident councils and indicated that one facility had a specific resident committee to address quality improvement. It was felt that this provides an early warning system for any emerging problems.

The entire report is found at http://www.oig.hhs.gov/oei/ntor.html. This report may provide an important mechanism for discussion between hospices and nursing facilities regarding the collaboration and coordination of care for hospice patients residing in nursing homes.

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