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QUALITY ASSURANCE FOR LONG-TERM CARE PROVIDERS

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INTRODUCTION

We have written this book for those of you who will be managing nursing homes in the 1990s. Yours is an industry that has been forever changed by a decade of study and policy-making. The passage of the Omnibus Budget Reconciliation Act of 1987 (OBRA87) resulted in a new playing field on which long-term care is to be delivered. This is a field where standards of quality constitute the rules of a new game where management skills count as never before.

Quality assurance is the key ingredient in the mix of skills needed for effective management under OBRA87. Unfortunately not all providers have the knowledge and skills needed to respond to the challenges in OBRA. We must accept the fact that as an industry we have not done an outstanding job of quality assurance in the past. Critics of long-term care providers cite instances of inadequate or unsafe care practices and less than acceptable living conditions for clients. These were the facts of life in long-term care as we came to understand it in the 1980s. But they are not, we believe, due to the venality of providers. Nor can they be traced to a lack of understanding of the care-giving process. Instead, shortcomings in quality mainly are the consequence of a regulatory system that has directed its attention to the wrong indicators of institutional life; a system that has focused management attention and initiatives on issues that have little or no bearing on the daily lives of nursing home residents.

AUTHOR'S NOTE: All quotations are taken from the following sources: Health Care Finance Administration, 1989, *State Operations Manual: Provider Certification*, (Publication No. 7), Washington, DC: Author; Omnibus Budget Reconciliation Act of 1987 P.L. 100-203; and *A Consumer Perspective on Quality Care* by Joy Spaulding, 1985, Washington, DC: National Citizens' Coalition for Nursing Home Reform.

In the pages that follow, we describe a new management focus on quality of care and quality of life. By putting the resident and his or her experiences at the center of a quality management system, we believe that we have given operational form to OBRA87. We have taken a set of regulations and translated them into a working system for nursing home administrators. This is a system that is "information driven." It directs providers to the specific kinds of information to collect and to the use of information to identify quality problems, and it suggest ways to involve staff and residents in quality assurance processes.

The ideas and practices described in the pages of this book have been tried and found to be useful in a variety of long-term care settings. We have organized them into a plan that providers can use to change the culture of nursing homes and their management styles. The plan helps providers build a *quality culture* that shapes the beliefs and actions of care givers through the use of a Quality Mangement Model that guides the use of quality assurance activities within their facilities. Our plan is based on some basic assumptions about the caring process that we call "Theory Q"—wherein "Q" means "quality." This is a new perspective on long-term care, one that enables the caring professions to deliver quality care and living experiences to residents. It is important to note that our plan is an outline for the work you will need to do in your own organization. The steps that make up our plan are stated in a form that can be modified to fit your organization, the competencies of your staff, and the special needs of your clients. You can think of it as a starting point for putting your own response to OBRA in place.

Ours is an ambitious plan and we recognize that it only can be presented in a general way in a book of this length. Consequently, we have developed a series of exercises whereby you can assess your own organization to help introduce the plan in an orderly manner. These exercises give staff members experience in applying Theory Q to quality of life and quality of care issues. They are designed to produce a shared perspective on quality and a common commitment to improving the life experiences of all residents.

Although many providers will use this book to cope with regulation, we have tried to focus it on elderly people living in nursing homes. The quality of services they receive ultimately is reflected in their experiences—their daily care and their feelings about their personal and social lives. The quality management systems we describe serve as mechanisms for providing better care and living environments for the elderly person. If our text can help providers look at their organizations through the eyes of their residents, it will have reached the goals we have set for ourselves as writers.

CONTENTS

Chapter 1

MANAGING LONG-TERM CARE IN THE 1990s

THE CHALLENGES OF THE 1990s

The decade of the 1990s will bring a whole new set of challenges to the desks of nursing home providers. Older, more severely disabled clients will be appearing at the doors of nursing homes. Shortages of skilled personnel will make recruitment and retention of staff a daily concern. Cost containment policies will limit the resources available to compensate employees and to address the needs of residents. Additionally, all of these developments will take place in a regulatory environment quite unlike that of the 1980s.

When the United States Congress enacted the Omnibus Budget Reconciliation Act of 1987 (OBRA87), it put a new "legal bedrock" in place on which long-term care is to be constructed in the 1990s. This foundation includes new standards for judging the quality of care received by nursing home residents along with specific guidelines for organizing the caring process. But, more importantly, OBRA87 is a statement of public policy that guarantees quality care and living experiences for nursing home residents.

These regulations also are "rock" side of the "rock and hard place" position in which long-term care providers find themselves today. The "hard place" side grows out of a mixture of major demographic changes in the elderly population and widely held beliefs about the outcomes of care and their costs. The operating space between the "rock and hard place" is narrowing as we enter the 1990s and face up to the new emphasis on quality in long-term care. This is a crunch that puts a high premium on understanding the vision put forth by OBRA87 and requires that we manage proactively in order to meet its demands.

As the population of the United States ages, the challenge of providing quality health care and supportive services to the elderly will become more pronounced. Although many older persons will continue to become independent, an increasing number will turn to long-term care providers for services. These will be the "old-old," the most rapidly growing segment of our population, who are frail and in need of a wide range of health care services and assistance in the activities of daily living. These clients will require a complex set of services that will need constant adaptation to emerging problems and needs.

The operating room between the "rock and hard place" is further restricted by the way long-term care is viewed in our culture. Most people believe that everyone who is not fully functional will "get better" with proper care. This expectation means that every treatment or intervention offered to residents must result in improved health and/or increased capacity for independent living. Further, no matter how complex the problems of the elderly client, society assumes that they can be resolved without increasing economic and/or social costs.

Despite the unrealistic nature of these expectations, they are important concerns for long-term care providers. These are the beliefs that give rise to policies concerning funding and regulation. Simply put, providers are expected to deliver care that "works" for the resident, in a setting that will preserve the quality of his or her life, with an expenditure of a minimum amount of money. These are the challenges that providers must cope with in the upcoming decade. They can be captured in a statement, offered by the National Coalition on Nursing Home Reform: *Nursing home staff and managers should treat residents the same way that they would like to be cared for if they were residents.*

In other words, providers should place themselves in their client's shoes and treat every decision they make as though it had a direct impact on their own lives. This is a shift of focus from the organizational aspects of care to the client and the outcome of the services he or she receives. It is also a change that will require major modifications in the ways providers deliver and manage care.

A FRAMEWORK FOR LONG-TERM CARE MANAGEMENT

The best way for providers to respond to the challenges of the 1990s is to create a *quality culture* in their facilities. This culture comprises some basic beliefs about quality of care and quality of life that are shared by all employees, supervisors, and managers. These beliefs lead to actions that add up to the kinds of client outcomes spelled out in

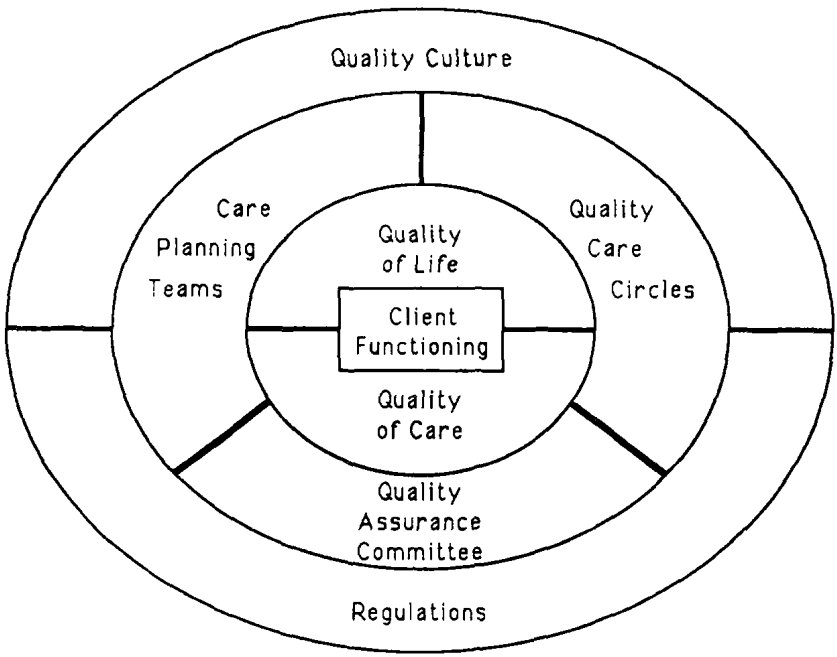

Figure 1.1 Focus on Quality

OBRA. They are an integral part of the management systems needed to make quality assurance the business of every person working in the facility.

These ingredients come together in a "focus on quality" like that shown in Figure 1.1.

The outer ring of the drawing in Figure 1.1 is meant to suggest that the quality culture is the provider's response to regulations. This culture is the source of the beliefs and patterns of behavior of staff and managers, which are organized into three quality assurance groups: *care planning teams* (CPTs), *quality care circles* (QCCs), and the *quality assurance committee* (QAC). These groups make decisions about facility policy and individual care plans to influence the quality of life and quality of care experienced by the resident. These qualities, in turn, affect client functioning so that residents can live as independently as their condition permits.

Consider each of the elements in Figure 1.1 in more detail. This will help you see how the attitudes and actions of your staff will need to be changed to make the quality culture a reality in your facility.

BELIEFS ABOUT QUALITY: THEORY Q

The center of Figure 1.1 pictures an assumption that underlies much of the thinking in OBRA. That is, quality makes a difference in the functional behavior of the client. We call this assumption "Theory Q" because it contains two fundamental ideas about cause and effect in long-term care. These are: (a) the higher the quality of care received by the resident, the higher his or her level of functioning, and (b) the higher the quality of life experienced by the resident, the higher his or her level of functioning. It follows that providers should be able to make adjustments in the quality of care he or she receives by altering his or her living experiences.

If the quality culture is to take root in a facility, staff members and managers will need to "buy off" on the assumptions of Theory Q. They will need to accept the notion that quality can be managed and that it has a direct impact on the outcomes of care. In effect, every one of the functional problems of the client can be related to the quality of services he or she receives or to the quality of his or her social and personal life.

Theory Q rationalizes the care-giving process by putting client functioning at its center. It makes sure that every client experience is evaluated according to its functional outcome(s) and that all care-related decisions are made using objective information about the client. This leads to a definition of quality that captures the use of information for care planning and service delivery. Quality resident care and living experiences

(a) are based on objective and up-to-date assessment of resident condition;
(b) are provided in accordance with a plan of care that is based on assessed need; and
(c) result in promoting functioning at the optimal level possible given resident condition.

These three dimensions—assessment, care planning, and functional development—represent an operational definition of Theory Q. They can be viewed as a series of steps whereby individual resident care is planned and delivered. This gives us a way to translate the Theory into a Management Model.

THE QUALITY MANAGEMENT MODEL

Once the above steps are put in order, we are able to show how they can be managed to attain the client outcomes specified in OBRA. The

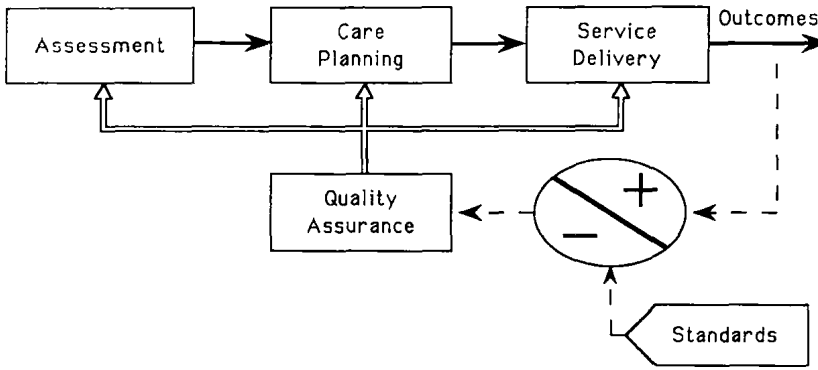

Figure 1.2 The Quality Management Model

drawing in Figure 1.2 locates the components of the above definition in a Quality Management Model so you can see how information is used for quality assurance.

These three steps result in functional outcomes that can be observed by care givers and managers. Outcome information is then "fed back" and compared with standards. This is represented by the above circles where the plus (+) sign indicates that outcomes might exceed standards and the minus (−) sign that outcomes might fall short of standards.

If outcomes fail to "measure up" to standards, quality assurance activities are initiated. These result in changes in one or more of the steps to better fit care plans and services to resident needs. If, however, resident outcomes show that standards are met or exceeded, quality assurance can reallocate organization resources to new resident goals or to services delivered to other clients.

The Quality Management Model emphasizes resident individuality and sets a process in motion to ensure that the care delivered is appropriate and based on assessment of resident strengths and weaknesses. The model also recognizes that resident conditions are dynamic and that care plans must be updated periodically to reflect new problems and needs. The emphasis on adaptation of care involves all members of the care-giving team and helps each care giver take responsibility for the quality of client experience. Finally, aggregated information about resident responses to service delivery can be reviewed to help providers correct care practices and facility living conditions.

QUALITY ASSURANCE SYSTEMS

The Quality Management Model is put into operation by the three quality assurance groups shown in Figure 1.1. Each of these groups has a share of the total facility responsibility for quality assurance and they make up a quality assurance system whereby providers respond to the specific mandates of OBRA.

• *Care planning teams (CPTs).* These groups already are in place in most facilities. They are responsible for reviewing assessments and for making sure that resident care and treatment is based on current condition and needs. The CPTs also are required to monitor the outcomes of care in order to tailor the care plan to changes in resident condition and/or functioning.

The CPT is the "front line" of provider response to OBRA. Accordingly, it bears the most direct responsibility for compliance with regulation. It also is the mechanism whereby care givers share their expertise and insights as to resident need and programmatic response. By standardizing the approach of CPTs and directing their attention to quality of care and quality of life issues, providers will have created the *key* ingredient of the quality assurance system.

• *Quality care circles (QCCs).* Quality concerns are more than a matter of individual resident treatment and outcomes. They also are found in the aggregate experiences of clients and in the overall approach to care found on a particular floor or unit in a facility. These more general quality issues require another quality assurance response—one that will enlist the contributions of all care givers.

Quality problem solving at the floor or unit level is the responsibility of the quality care circle. This is a group of concerned care givers who come together to address specific quality issues affecting the clients under their care. Their problem solutions take the form of changes in care practices and adaptation of client social and personal life. QCCs are the most revolutionary component of the quality culture. They validate the notion that every care giver has a contribution to make to the quality of services offered by the facility. They also mobilize facility resources at appropriate levels in the organization so that problems can be quickly identified and resolved. If QCCs are given a full measure of management support, they can make significant strides in bringing the facility into conformity with the demands of OBRA.

• *Quality assurance committee (QAC).* This committee is specifically mandated by OBRA. Its function is to review assessment and care-planning practices and monitor certain problem areas such as infection

control. As we see it, the QAC helps providers identify the policy changes needed to respond to regulatory requirements.

The work of the QAC is facilitated by a quality assurance coordinator. This is a new management role in most provider organizations. The coordinator not only assists the QAC in raising and resolving policy issues but also collects the documentation required by OBRA and acts as the "point person" for reviews and surveys.

RESPONDING TO THE CHALLENGES OF THE 1990s

Putting the quality culture in place is not an easy task. It involves changing the values of many employees and the emphases they place on quality of resident care and life. It also implies some fundamental changes in management practice in order to involve residents and employees in quality problem solving. This requires a broad commitment to quality shared by everyone in the facility, a commitment that is operationalized in the three quality assurance groups and nurtured by supervisors and managers.

If supervisors, department heads, and administrators can all "sign off" on the commitment to build a quality culture, it is possible to begin to do so in a systematic way. These individuals can come together as a management team to plan the development of the culture so that it draws on the strengths of staff members while taking facility characteristics and resource limitations into account.

To help with the change process, we have identified a series of steps that can move a facility toward the quality culture. Each of the steps draws on the content of one of the chapters in this book. At the end of each chapter, you will find an exercise or activity that you and your staff can complete. These add up to a facility-wide focus on quality like that shown in Figure 1.1—an approach to care that will work for care providers in the 1990s.

Step 1: Test your beliefs concerning quality and get employees to start thinking about the quality of care and life in your facility. (Exercise 1, Chapter 1)

This exercise gives staff members the opportunity to focus on quality by asking them to put themselves in the resident's shoes. By rating the quality of life and care offered by the facility, they begin to define quality in terms of their work and the interactions they have with residents.

Step 2: Conduct a simple quality audit of your facility to determine its position with regard to standards. (Exercise 2, Chapter 2)

This is not the same as an external audit. It is an opportunity for staff to examine recent regulatory experience of the facility and to begin to identify problem areas. It also gives managers an opening to communicate expectations regarding care practices to their employees and to identify barriers to good practice. This begins to establish an open problem-solving environment, which is an essential attribute of the quality culture.

Step 3: Identify current quality control and assurance systems in your facility and the changes needed to implement the Quality Management Model. (Exercise 3, Chapter 3)

All facilities have provisions for quality control and assurance already in place. Examples of these include pharmacy control, infection control, and medical care advisory and utilization review committees. The task of this exercise is to bring these activities under the control of the new quality assurance committee. It also begins to define the role of the quality assurance coordinator and the information needed to monitor all aspects of the service delivery process.

Step 4: Activate the quality care circles in the facility by listening to their stories and examining care-giving rituals. (Exercise 4, Chapter 4)

As noted previously, the quality culture may require changes in the beliefs of many employees. By directing staff attention to the stories they tell about themselves and residents, and their rituals of care, managers can gain important insights into the existing value system. The exercise also points to beliefs and behaviors that will need to be changed as the facility becomes more deeply committed to quality.

Step 5: Train quality care circle members in the techniques of quality management. (Exercise 5, Chapter 5)

Fortunately, there are a number of tested techniques for managing quality. These involve the collection and analysis of information about residents and care practices. Training of QCC members in these techniques gives the organization the capacity to identify and respond to quality problems.

Step 6: Develop a set of policies, procedures, and performance indicators for the management of quality of care. (Exercise 6, Chapter 6)

Although regulations set the standards for long-term care providers, they are rarely stated in ways that help staff and managers in their daily work. Accordingly, each regulatory requirement must be translated into facility policies and procedures that will guide the activities of care givers. In addition, each standard must be linked to an indicator that can be monitored to ensure compliance. This exercise takes the quality of care mandates in OBRA and helps providers work through the translation process with their employees.

Step 7: Organize quality assurance groups and assign responsibilities for monitoring the quality of care in your facility. (Exercise 7, Chapter 7)

This step creates the formal lines of authority and responsibility needed to assure quality care. It involves examining the policies, procedures, and indicators created in Step 6 and assigning responsibilities to care planning teams, quality care circles, and the quality assurance committee. As a part of this exercise, providers will need to make formal changes in current management responsibilities and practices. By planning these changes carefully, providers can realize the benefits of a "bottom up" approach to quality assurance.

Step 8: Develop a set of policies, procedures, and performance indicators for the management of quality of life. (Exercise 8, Chapter 8)

This step parallels Step 6. Members of the three quality assurance groups examine OBRA quality of life standards and develop approaches whereby the facility can meet these expectations. Since the quality of life standards are "new," they will require a substantial revision of facility policies and procedures. These revisions will involve new language and new indicators of performance. In total, the changes brought about in this step give all employees a new perspective on the living experience of clients.

Step 9: Organize quality assurance groups and assign responsibilities for managing quality of life in your facility. (Exercise 9, Chapter 9)

Quality of life mandates in OBRA require a management response like that developed for quality of care in Step 7. The three quality assurance groups (CPTs, QCCs, QAC) need to review the policies,

procedures, and indicators developed in Exercise 8 to determine the appropriate division of quality assurance responsibility. Because many of the quality of life mandates are new, this exercise requires new sets of responses and more careful management supervision than other regulatory responses.

TAKING THE FIRST STEP

We have found that the best way to begin the development of a quality culture is to sensitize staff members as to the quality of client experiences. This can be done by asking each employee to respond to a simple questionnaire. This gives employees something concrete to talk about as they think about quality and it gives managers an overview of the current perceptions of quality in the facility. This is Step 1.

Step 1: Test your beliefs concerning quality and get employees to start thinking about the quality of care and life in your facility.

The questionnaire in Exercise 1 is drawn from the quality challenge we offered earlier in this chapter: *Nursing home staff and managers should treat residents the same way that they would like to be cared for if they were residents.*

Prior to the administration of the questionnaire, a meeting of all supervisory personnel should be held. The purpose of this meeting is to sensitize supervisors to the importance of the client's view of life. At the meeting, each item on the questionnaire should be discussed and the group should try to agree on the answer that best reflects life in the facility. This discussion will give supervisors some clues as to the kinds of reactions they might expect from staff members as they are working through their questionnaires.

UTILIZING THE RESULTS

This is not a quality of life survey. It only opens the door to staff thinking about the kind of environment your facility provides for residents. To get a sense of where you are, collect the questionnaires and tabulate the numbers of [Y] and [N] answers on a master sheet, and note areas of strength and weakness. Then make a list of the comments and suggestions made under each heading. Save these for later exercises where you will be working with your quality assurance groups.

This exercise also gives you and your supervisory staff the opportunity to identify employees who show a strong interest in quality