

Quality Improvement in Long-term Care

Back to the Fundamentals of Care

A Roadmap to Improve Nursing Home Care Quality

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WHERE do you start when nursing home staff decide to undertake quality improvement projects? A recently completed research project has some important findings that can provide much-needed direction for nursing home staff. Funded by the National Institute for Nursing Research, researchers examined resident outcomes in facilities in Missouri and randomly selected 90 facilities representing a range of quality of care. Nurses who were “blinded” to each facility’s resident outcomes (predominately good, average, or poor) watched the staff while they delivered care to examine care delivery processes for clues about how some facilities achieve good resident outcomes while others struggle to get average or poor outcomes for their residents.^{1,2}

What they found is remarkable! In facilities where resident outcomes were predomi-

nately good (such outcomes as very low rates of pressure ulcers, weight loss, incontinence, fecal impaction, dehydration, falls, behavioral symptoms, symptoms of depression, urinary tract infections, decline in activities of daily living, antipsychotic drug use, physical restraint use, bedfast, and little or no activity), the staff were busy with residents doing the fundamentals of care. Staff were helping residents walk as much as possible and were helping restore the ability to walk when needed. Assessing for fall risk was common, and staff developed plans to help residents at risk for falling. Restraint assessments were done *before* the use of a physical restraint, and alternatives to restraints were commonly used: activity involvement, social spaces in the environment to encourage socialization, understanding the source of behaviors, and safe spaces for walking and enjoying the outdoors.

Nutrition and hydration were a major focus for the staff in facilities achieving good resident outcomes. The food was appealing and served attractively so that people wanted to eat! Nutritional supplements were not the norm, but tasty food and encouraging the residents to eat the food was the norm. Meals were mostly served restaurant-style (not cafeteria on a tray), and choices were common. Residents could readily reach their food and

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drinks (tables and chairs were of the correct height), and adaptive equipment such as plate guards and adapted utensils or cups were common so that residents could feed themselves. For those who could not, staff helped just 1 or 2 residents at a time, not several (as many as 8-10 in the facilities with poor resident outcomes). When a resident had a problem with weight loss, a registered nurse followed up to see that the resident was assessed. Then nursing actions were taken to determine why the resident was experiencing a loss of weight, and interventions such as helping get favorite foods were implemented.

Toileting was a key fundamental activity for the staff in facilities achieving good resident outcomes. While staff in all the facilities in the study could tell the research nurse the appropriate toileting plans for residents (such as every 2-3 hours or before and after meals), only in facilities achieving good outcomes were staff observed *actually doing toileting* with residents. In the other facilities, the practice was checking and changing incontinence products, not actually toileting residents. It was common in facilities achieving good outcomes, but not in the other facilities, for a resident with incontinence to be assessed for the causes of incontinence and a program to be developed to address the cause. Fecal impactions and foley catheters were rare in facilities with good resident outcomes. Whereas all facilities had monitoring programs for bowel regimes, facilities with poor resident outcomes often had residents with impactions and with foley catheters.

Attention to skin condition was common in facilities with good resident outcomes, resulting in very few facility-acquired pressure ulcers. Assessment for skin breakdown risk was common on admission and routinely in the course of care. Unfortunately, in facilities with poor resident outcomes, facility-acquired pressure ulcers were common and risk assessment rarely completed. It is likely that focusing on encouraging ambulation, nutrition, and hydration, and toileting residents

results in facility-acquired pressure ulcers being a rare event in facilities with good resident outcomes.

Another important fundamental of care that was attended to in facilities with good resident outcomes was managing pain. Assessing for pain and treating pain was rarely done in the other facilities. Perhaps better management of pain helped residents walk more and eat more, contributing to the better outcomes of care.

So, advice to staff in nursing homes embarking on quality improvement programs: start with the fundamentals of care. First, observe your own care delivery processes to learn what is really being done for the residents. You may be in a facility that has a "disconnect" between what is really done and what is talked about being done. We discovered many facilities with average or poor resident outcomes where the administrative staff and the nurses would claim that residents were toileted while the nursing assistants were actually doing "check and change," not toileting.

After observing the care, start with focusing on improving the walking ability of your residents. Start a walk-to-dine program where resident are encouraged to walk to the dining room rather than get there by using wheelchairs and make helping residents walk in the hall an expectation each shift for staff. Measure your progress with helping residents to walk, counting the number of residents who actually walk in the hall on a given day. Once progress is made in improving walking and you are sure the care delivery process will stay active on each unit, focus on the dining experience. Again, begin with observation: Are residents being helped? Can they reach their food and drinks? Do table heights need changing? Should residents be seated in dining room chairs rather than their wheelchairs for meals? Are condiments accessible? Identify key people in the food preparation and delivery process and develop a team to observe, and then problem solve improvements. Monitor weights and see if efforts are paying off in improved nutritional status. Develop a fluid

program around the clock and see that residents not only have access to fluids they like but are encouraged to drink them.

Tackle the toileting process after successes with walking, nutrition, and hydration. Staff will be able to toilet residents who have better walking ability without lifting to the commode or excessive assistance. Staff will need to learn that it really does not save time to “check and change” and that the expectation

of leadership is that toileting is not just talked about but actually done.

Quality improvement projects can have a real impact on the residents and their clinical outcomes. Focusing on the fundamentals of care in nursing homes is key to quality. The fundamentals of care may not be “high tech,” but the benefits of focusing on them and getting them done are definitely worth the effort.

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