BY MAURICE BROWNLEE, RN, BSM, MBA, LNHA, CPHRM

A guide for managing the 'second-tier' nursing home

Certain facilities are primarily responsible for nursing homes' bad reputation—here's how to change that

The long-term care industry has endured much bullying over the past decade, and the bullying tactics have taken many forms. One is represented by the recent flooding of our judicial system with frivolous liability lawsuits. Other tactics have included negative news media, which have gravitated to the smallest mishaps in nursing homes, and strident calls for stricter regulatory oversight.

The industry has been unable to erase a negative perception in the minds of many consumers and, in all honesty, the poor management of many nursing homes has ignited much of the bullying that the industry is experiencing today. As a result, in 2005 the long-term care industry is viewed as a two-tier system—specifically, a system in which the poor receive poor care in substandard (second-tier, or lower-tier) nursing homes.

Researchers at Brown University and Temple University found that 85% of the residents of the average second-tier nursing home (which represented approximately 15% of all non-hospital–based nursing homes during the 1990s) were Medicaid recipients.[1] Their research also revealed that such nursing homes are characterized by having fewer nurses, low occupancy rates, excess health-related deficiencies, relatively frequent termination from Medicaid/Medicare programs, and an increased likelihood of serving African-American residents, as well as being disproportionately located in the poorest counties (table).[1]

The researchers used data from the Online Survey, Certification and Reporting (OSCAR) data network, the Minimum Data Set (MDS), and the 2000 Area Resource File, which is a county-level collection of data drawn from the 2000 census. They also used information compiled from national surveys of health service resources. The researchers found that there are approximately 14,130 non-hospital–based Medicare- and Medicaid-certified nursing homes in the United States, of which 13% met the criteria of "second-tier" defined in the research.[1] Proprietary facilities accounted for nearly three-quarters of these lower-tier facilities. Throughout the country, approximately 9% of all white nursing homes residents were in lower-tier nursing homes, compared with 40% of African-Americans; in other words, African-American nursing home residents are approximately four times more likely to be in lower-tier nursing homes than their white counterparts.

At this point, it should be clear that individuals who work for or own second-tier nursing homes have a distinct set of challenges. Managing the facility's exposure to risk and liability, for example, becomes more difficult, particularly as states introduce their concepts of community-based care. Many second-tier nursing homes, particularly those located in inner cities and remote rural areas, will find themselves admitting sicker residents. Given the staffing issues and skill sets typical of nurses in second-tier nursing homes, this poses a new set of risk-liability challenges.

As nursing home litigation increases, a growing number of attorneys are forcing second-tier nursing homes into out-of-court settlements—often awarding a quick $40,000 to $50,000 to a family member who has, in fact, never even visited his or her loved one in the nursing home.

Another risk-liability challenge: Because second-tier nursing homes often can't afford to be meticulous regarding whom they admit, these facilities feel obligated to accept high-risk residents with multiple psychiatric diagnoses—residents who are susceptible to going into crisis and displaying disruptive behaviors. A recent report suggests that as many as 90% of dementia patients exhibit disruptive behaviors during the course of the disease, including verbal aggression, hitting, resisting care, sexual disinhibition, wandering, and property damage.[2] Addressing these behaviors not only leads to risk-liability exposure, but it also causes stress and staff burnout.

Still another challenge is the risk of increased workers' compensation claims in second-tier nursing homes. As already mentioned, the attributes of a second-tier nursing home include decreased staff and lack of resources. Staff members in these facilities are more likely to employ poor lifting techniques and injure themselves. Moreover, because of cost constraints, these facilities are less likely to invest in a mechanical lift program.

A Practical Care Model for Second-Tier Facilities

The key to successfully managing second-tier nursing homes is to adopt a care model that focuses on two basic concepts: (1) training/staff development, and (2) prioritizing quality in the delivery of care. In terms of priorities, how practical is it to expect a charge nurse who works an eight-hour shift to perform the following tasks?

1. Make CNA assignments and supervise CNAs.
2. Pass medications for two hours—twice in an eight-hour shift.
3. Document resident care.
4. Handle disgruntled family members and residents.
5. Assist in the dining room.
6. Handle incidents/accidents and call physicians/families when necessary.

7. Perform treatments.
8. Be off the clock on time.

It is nearly impossible to complete all of these tasks with accuracy and proficiency. For the sake of this care model, practical means *basic.*

An approach to fulfilling people's basic needs is nothing new—witness psychologist Abraham Maslow's famous Hierarchy of Needs theory (the author owes his insight on Maslow's theory to the graduate work of George Boeree[3]). Early in his career, Maslow noticed in experiments involving monkeys that some needs took precedence over others. For example, if one is hungry and thirsty, one tries to take care of the thirst first; after all, a human being can do without food for weeks but can only do without water for a couple of days. Likewise, if you are very thirsty but someone has put a choke hold on you and you cannot breathe, the need to breathe is more important than your thirst.

These same principles can be applied to the second-tier care model: If the basics of delivering care are achieved, quality care is sure to follow. When a facility delivers quality care, the likelihood for errors and omissions is decreased drastically. Moreover, decreased errors and the delivery of quality care create happier family members and residents. If family members and residents are happier, your staff is likely to be happier, as well.

Let's apply this assumption to the following case study:

Ms. JW is a resident of Otto Nursing Home. She is a 78-year-old, nonambulatory resident with the following diagnoses: osteoporosis, old stroke with left-side paralysis, incontinent of bowel/bladder, and multiple decubiti on her coccyx.

The staff got Ms. JW up at 5:30 a.m., and she now sits patiently in the dining room waiting for her breakfast. Meanwhile, Nurse BB reports to work at 7:00 a.m. and starts her daily routine. Ms. JW has now been waiting for her breakfast for an hour and a half. Nurse BB rushes to get her report from the nurse on the previous shift. Nurse BB remembers that her DON warned her she could not have her medication cart in the dining room because of a new regulation. She rushes to start her medication pass and begins at precisely 7:30 a.m. Ms. JW has now been waiting patiently for two hours. Nurse BB prepares and administers Ms. JW's eight medications, and Ms. JW takes them without a fight.

Finally, at 8:00 a.m., Ms. JW's tray arrives. A staff member places the tray on the table and summons someone to assist her, but unfortunately for Ms. JW, someone has called off this morning, so she will have to wait until the attendant finishes at the next table. At 8:30 a.m., the attendant sits down to feed Ms. JW, who eats 10% of her cold meal and begs to go back to bed.

Applying the principles of Maslow's Hierarchy of Needs to the above case study would improve this facility's level of care and significantly decrease its exposure to liability. This case study is frightening, but it is witnessed daily in nursing homes across the United States.

There are two dilemmas involved, both related to care and training. First, the care dilemma: The staff got Ms. JW up at 5:30 a.m. and left her sitting in the same position for three hours, with no attempt to reposition her. Additionally, it is likely that the wound dressing on her coccyx was soiled and needed to be changed and, with multiple decubiti already appearing on her coccyx, the wound was bound to worsen. But Nurse BB had reported to work with only one concern in mind (task-driven)—passing her medications in a timely manner. Nurse BB administered Ms. JW's eight medications on an empty stomach. Finally, Ms. JW's tray was placed in front of her and, when the staff finally attempted to assist her, they gave her cold food.

Now the training dilemma: The lack of training turned this situation from bad to worse. The DON has apparently misinterpreted the Dining and Food Service Investigative Protocol in the Long-Term Care Survey Manual, which reads in part that the administration of medications during meal service is not prohibited (1) for medications that need to be given at meals or (2) for those residents who are accustomed to taking their medications with meals.[4]

Further, the attendants should be instructed that it is important to leave the resident's tray in the warmer until she is ready to be helped. Nurse BB needs training in several areas, including the importance of making rounds before accepting the keys to the medication cart, medication administration, and nursing management 101.

Following Maslow's line of thought, Ms. JW's need to eat and drink should have taken precedence. However, the likelihood of Ms. JW's wanting to eat at her full potential after sitting for three hours on her sore coccyx was slim, at best. The proposed second-tier care model would have required the nurse to stop and prioritize, to ensure that Ms. JW's basic needs were met first, rather than pumping eight pills down her throat on an empty stomach. This second-tier care model also would have required the nurse to park the medication cart and assist when she saw that there was a staff shortage in the dining room.

The second-tier care model is simple: It forces staff members to consider residents' basic needs first.

The second-tier care model is simple: It forces staff members to consider residents' basic needs first. Think about it: What sense does it make to send staff to perform range-of-motion exercises on a resident if the resident is exhausted from thirst or is in pain?

The Practical Approach

Second-tier nursing homes need to understand that their service quality is not about the size of the nursing home, how the nursing home looks, or even its locale. Rather, the most practical approach to running a successful second-tier facility is to: (1) provide residents with a clean,

safe environment, (2) serve good food, and (3) provide courteous service. These three elements do not require an increase in FTEs. They simply require additional training and commitment.

Much of this starts with the administrator. A recent study examining the influence of administrators' membership in professional organizations revealed that, after controlling for available resources, leadership and innovation were independently associated with nursing home quality.[5] Admittedly, second-tier nursing homes will confront a great challenge in recruiting qualified candidates. They may have to literally "grow" their own leaders. Companies may wish to implement Administrator in Training (AIT) and DON training programs to meet this need. This process will require companies to strategize and identify leaders early.

Another solution includes offering seasoned leaders incentives to work in these facilities. Long-term care companies will also have to be proactive and invest in the DON position to ensure that DONs receive adequate training. The traditional on-the-job approach will not be enough. DONs must be trained in such areas as healthcare law, diversity management, conflict resolution, and human resources management.

Another strategy that companies can consider is to offer "mental health days" for both the DON and the administrator. These individuals are likely to be more stressed in second-tier nursing homes, which will accelerate burnout. Companies can also consider mandating that DONs and administrators use vacation days every six months to prevent burnout. Finally, companies should ensure that corporate support is extremely visible in their facilities during the DON's and administrator's first year.

What about the residents of these facilities and their families? It is important to note that happy family members rarely attempt to sue facilities they like. Educating families and keeping them abreast of events can make or break a second-tier nursing home. Many facilities have adopted the Expectation Management System and have found that failure to properly train staff in explaining realistic expectations places many family members in the position of constantly finding fault. Employees also must be educated on how to respond to disgruntled family members.

What about the role of medical directors? As long-term care operates in two-tier fashion, much needs to be done to educate medical directors on how to care for low-income residents. Residents of second-tier nursing homes are more likely to have multiple health issues. The American Medical Directors Association (AMDA) has suggested there is a dearth of evidence-based outcome data on the care of frail elders and has taken the lead in developing a series of evidence-based clinical practice guidelines for long-term care. A partial list includes guidelines for managing osteoporosis, pain, depression, falls, medications, chronic obstructive pulmonary disease, and acute change of condition. Administrators, DONs, and staff working in second-tier facilities need to be taught these guidelines and adhere to them.

Another plausible solution would be for facilities to lobby attending physicians to employ physician assistants and nurse practitioners, who are much more likely to establish an on-premises presence than the physicians.

Educating families and keeping them abreast of events can make or break a second-tier nursing home.

Conclusion

The future of second-tier nursing homes is uncertain. Nevertheless, nursing homes that might be considered to be in this category should not allow the two-tier stigma to define the care they deliver. Rather, second-tier nursing homes need to be *proactive* and get started in their quest to deliver quality care. Quality care is achieved by employing some of the simple techniques offered in this article. The first step requires a commitment to meet each resident's basic needs. The second step requires a commitment to train and develop staff at all levels. These are simple but vital steps toward ensuring the delivery of quality care, even in this resource-challenged setting. ■

Table. Attributes of second-tier nursing homes[1]

- 85% or more of residents supported by Medicaid
- Less than 10% of residents supported by private payers
- Less than 8% of residents supported by Medicare
- Located in poor urban or rural communities
- High percentage found in the Deep South (e.g., Louisiana, Mississippi, and Georgia)
- Employ fewer RNs
- More likely to have a change in ownership and even termination from Medicaid/Medicare programs
- Have significantly more deficiencies—specifically, health-related deficiencies
- More likely to serve residents who have a psychiatric or mental retardation diagnosis
- Lack community resources
- Unable to attract quality facility leaders

Maurice Brownlee, RN, BSM, MBA, LNHA, CPHRM, is owner of Brownlee and Associates, LLC, a long-term care clinical compliance/risk management service, and founder of the Director of Nursing Training Institute. For more information, phone (404) 914-6212 or visit www.brownleeandassociates.com.
To send your comments to the author and editors, e-mail brownlee0406@nursinghomesmagazine.com.

References

1. Mor V, Zinn J, Angelelli J, et al. Driven to tiers: Socioeconomic and racial disparities in the quality of nursing home care. The Milbank Quarterly 2004;82(2):227-56.
2. Braun U, Kunik M. Behavioral disturbances in dementia: Finding the cause. Geriatrics 2004;59(12):32,34.
3. Boeree G. Personality Theories of Abraham Maslow. Unpublished manuscript, Shippensburg University of Pennsylvania, 2004.
4. The American Healthcare Association. Long-Term Care Survey Manual. Washington, D.C., December 2002.
5. Castle NG, Fogel BS. Professional association membership by nursing facility administrators and quality of care. Health Care Management Review 2002 Spring;27(2):7-17.