



“Mine own countree”: quality of care in nursing homes

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And now, all in mine own countree,
I stood on the firm land!
— Samuel Taylor Coleridge,
The Rime of the Ancient Mariner

In this issue (page 1441) Gina Bravo and colleagues report on their study in which they assessed the quality of care provided to 301 impaired elderly residents in 88 unlicensed and licensed nursing homes in Quebec.¹ They used a standard tool to assess care processes in 6 dimensions of care (environmental, physical, medical management, psychosocial, human rights and financial). Overall, care processes were adequate in both types of facility; however, the unlicensed homes performed significantly worse than the licensed facilities in 2 areas: physical care and medical management. Deficiencies were found in other areas as well, but the differences between the 2 types of facility were nonsignificant. Overall, 25% of the facilities were found to provide inadequate care to at least one resident; this was especially true in homes with fewer than 40 residents, where up to 20% of the residents received inadequate care.

Bravo and colleagues are to be commended for their careful and painstaking work. But where do we go from here? It is clear from their study that quality of care in both the unlicensed and the licensed nursing homes was deficient, and it is unlikely that this situation is particular to Quebec. Quality of care should be measured in all facilities on an ongoing basis.

But what should be measured, and how? Waiting for a catastrophic event to occur, such as a patient wandering out of the nursing home unnoticed and dying of exposure, is not a good way to measure quality. Nor is mortality a relevant measure: annual mortality rates in nursing homes are about 20%, and some deaths are undoubtedly or exclusively due to natural processes that are irreversible. The real challenge is to devise ways of evaluating quality of care in a frail and medically precarious population. Bravo and colleagues used the QUALCARE scale.² This is useful for research, but because of its complexity and cost of administration it is not feasible for routine assessments.

There are important barriers to implementing a comprehensive program for monitoring and managing quality of care in nursing homes. Some of these difficulties are inherent in the complex organizational structures of residential care. For example, in Ontario chronic care hospitals and long-term care facilities are governed by different min-

istries. As some commentators have remarked, health care continues to be defined by reimbursement mechanism and not by patient need.³ The organizational problems that led to licensed and unlicensed nursing homes have been reviewed previously.⁴

The Minimum Data Set approach has been adopted in several countries as a basis for assessing quality of care in nursing homes, and for assisting in care planning.⁵ Use of this approach has led to improvements in at least some dimensions of care.⁵ The Minimum Data Set approach has also been proposed as a basis for funding, although it is not free from perverse incentives.⁵

The Minimum Data Set is a good first step, but it fails to link defined outcomes to specific processes of care. A sound approach would yield at least semiquantitative estimates of the impact of, say, skin care and nutritional support on the prevalence of bedsores. A methodological approach such as total quality management^{6,7} allows clinicians to be involved in determining just what processes need to be measured and what the appropriate, clinically valid outcomes are.

Medical directors of nursing homes should ensure that care protocols for managing common problems are available, understood, accepted and implemented. As a first step, the problems of falls, incontinence, inappropriate use of restraints, osteoporosis, immunization, dysphagia and common infections could be targeted.⁸ Individual care plans should be patient-centred and goal-oriented and include measurable outcomes. Medication reviews should be routine, at prespecified intervals; neuroleptic medication should be used only as a last resort and as part of a broader behaviour management plan with clearly defined target symptoms. Advance directives should be ascertained, preferably within the boundaries of defined levels of intervention, and be regularly reviewed.

Bravo and colleagues have done well by tugging this issue into the limelight. But further research is needed. Outdated and parochial policies that impede the delivery of good care to elderly people in nursing homes must be revisited. Inaction in this regard amounts to not-so-benign neglect. Until then, clinicians will probably feel a kindred sense with the Ancient Mariner, yearning to set their feet on firm ground.

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The evolving paradigm of health technology assessment: reflections for the millennium

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Thirty years ago an American congressman said, "Technical information needed by policy makers is frequently not available, or not in the right form. ... Technology assessment is a form of policy research. ... It identifies policy issues, assesses the impact of alternative courses of action, and presents findings."¹ Those words launched an explosion of activity in the field of technology assessment as decision-makers found assessment results increasingly important in managing the rapid technological change that has become the hallmark of the 20th century.²⁻⁴

In the specific area of health technology assessment, this exuberance shows little sign of abating. In Canada, bodies such as the Canadian Coordinating Office for Health Technology Assessment, Quebec's Conseil d'évaluation des technologies de la santé and British Columbia's Office for Health Technology Assessment are examples of this growth. These groups and others contribute to decision-making, not only at the health care system level, but also at the level of patient care by promoting the development of clinical practice guidelines and other methods for improving care. Thus, for decision-makers at all levels in rapidly changing health care systems, reflecting on the future of health technology assessment is critical in an environment that is increasingly dominated by cost-effectiveness, evidence-based medicine and changing ideas of accountability.

What is health technology assessment?

Technology assessment has been applied to many different health care technologies by a variety of organizations using many methods. Its expansion reflects a rising concern about the growth of health care systems. In many jurisdictions, including Canada, health care systems are being sub-

stantially restructured as a result of aging populations, rapidly developing new and often expensive medical technologies and increasing costs. In addition, some restructuring efforts are aimed at making delivery systems more responsive to patient needs.

Health technology assessment is not simply more research. Four key features, which are critical to its ongoing impact, distinguish it from research. The first is its policy orientation. Distinct from health-related research, health technology assessment seeks to produce and communicate information reflecting not the whims or interests of an individual scientist but the contribution of scientific inquiry to policy-making.

The second feature is interdisciplinary content and process. The character and strength of health technology assessment comes from integrating the efforts of multiple disciplines.

Third, health technology assessment accomplishes this integration by synthesizing information, examining databases and, at times, generating primary data. Choices among these methods are driven by the relevance of the results to improved decision-making.

Fourth, those engaged in health technology assessment recognize the importance of disseminating and communicating information. Research findings are often reported in publications where they may be read almost solely by like-minded people. In contrast, health technology assessment organizations must actively move assessment results into the decision-making process, often tailoring dissemination means and strategies to different target audiences.

In short, health technology assessment is a bridge between the world of research and the world of decision-making, particularly policy-making.⁵ Effectively bridging