MAKING PATIENT SAFETY AND A "HOMELIKE" ENVIRONMENT COMPATIBLE: A CHALLENGE FOR LONG TERM CARE REGULATION

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The problem of compromises and impediments to patient safety within the American health care system,[1] as well as possible legal and voluntary initiatives to address this problem,[2] has attracted enormous professional and public attention over the past decade. The lion's share of this attention, as illustrated powerfully by the other contributions to this Symposium issue of the *Widener Law Review* and the voluminous sources cited therein, has been focused specifically on safety issues connected to medical care provided in the acute care hospital environment. Shortcomings in making acute care medicine safe for patients certainly still persist,[3] but commendable positive strides have been made.[4] By contrast, issues pertaining to the safety of recipients of long term care ("LTC") services have received considerably less study and discussion.[5]

This article examines the topic of resident[6] safety in long term care (distinguishing resident safety from Quality Assurance/Quality Improvement, which has been the subject of significant attention in LTC recently),[7] concentrating particularly on nursing facilities.[8] A panel convened by the

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1. INSTITUTE OF MEDICINE ("IOM"), TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000).

2. *See*, *e.g.*, Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501 (2004).

3. Drew E. Altman et al., *Improving Patient Safety—Five Years after the IOM Report*, 351 NEW ENG. J. MED. 2041 (2004); Laura Landro, *The Informed Patient: Hospitals Make Fewer Errors, But Fall Short on Safety Goals*, WALL ST. J., Nov. 17, 2004, at D5 (reporting on reports of the Leapfrog Group and the Institute for Safe Medication Practices); Paul Barach & Donald M. Berwick, *Patient Safety and the Reliability of Health Care Systems*, 138 ANNALS INTERNAL MED. 997 (2003).

4. Robert M. Wachter, *The End of the Beginning: Patient Safety Five Years After 'To Err Is Human,'* HEALTH AFF. (2004), http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.534v1.

5. *But see* Kathryn Hyer & Brenda Johnson, *Post-Acute and Long-Term Care*, *in* RISK MANAGEMENT HANDBOOK FOR HEALTH CARE ORGANIZATIONS 457 (Roberta Carroll ed., 4th ed. 2004) (discussing safety strategies in LTC); ANDREW D. WEINBERG, RISK MANAGEMENT IN LONG-TERM CARE (1997).

6. Because of its focus on LTC, and nursing facilities specifically, this article employs the term "resident" rather than "patient" to signify the consumer of services. *See* 42 C.F.R. § 483.10 (2004).

7. *See* Marshall B. Kapp, *Improving the Quality of Nursing Homes: Introduction to a Symposium on the Role of Regulation*, 26 J. LEGAL MED. 1 (2005); Steven H. Woolf, *Patient Safety Is Not Enough: Targeting Quality Improvements to Optimize the Health of the Population*, 140 ANNALS INTERNAL MED. 33 (2004).

8. "Nursing homes" are defined by the National Center for Health Statistics as "facilities

American Health Lawyers Association in 2003 "agreed that patient safety is an important public health issue that is applicable to all healthcare settings, including, but not limited to, hospital inpatient and outpatient settings and long-term care."[9] This article asserts that, although the LTC industry and its regulators[10] may learn much from hospitals' extensive experiences and efforts in the patient safety realm, these lessons are fundamentally limited because of an array of important relevant distinctions between acute care and LTC in the United States. These distinctions carry major implications for devising and implementing effective legal and non-legal strategies to achieve the highest degree of LTC resident safety consistent with all the other important social values we desire the LTC system to protect and promote.

I. LEARNING FROM HOSPITALS

As noted, the LTC industry and its regulators certainly may learn much from hospitals' extensive research, experience, and innovative efforts[11] in the patient safety realm. At least at a superficial level, there are a number of areas of pertinent commonality between hospitals and LTC providers. Both acute and LTC providers exist largely for the purpose of helping dependent persons with health-related problems and their families. Both kinds of providers attempt to accomplish this objective by employing or otherwise affiliating with professional staff members. For both hospitals and LTC providers, the provision of medical care is a primary product. Acute and LTC providers both operate within systems comprised of complex organizational structures and dynamics. Both are heavily influenced by financial environments characterized by finite resources. Moreover, both acute and LTC providers ordinarily carry out their work under tremendous, continual public scrutiny exerted by the media and legal actors with regulatory and judicial oversight powers over their activities.

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with three or more beds that routinely provide nursing care services." IOM, IMPROVING THE QUALITY OF LONG-TERM CARE 42 n.3 (Gooloo S. Wunderlich & Peter O. Kohler eds., 2001) [hereinafter IMPROVING].

9. Colloquium, *Minimizing Medical Errors: Legal Issues in the Debate on Improving Patient Safety*, AM. HEALTH L. ASS'N 25 (2003).

10. In addition to the relevant regulatory and other legal implications, the challenge of promoting patient safety also entails many ethical issues beyond the scope of this article. *See* Virginia A. Sharpe, *Promoting Patient Safety: An Ethical Basis for Policy Deliberation*, HASTINGS CENTER REP., July-Aug. 2003, at S2; Peter A. Clark, *Medication Errors in Family Practice, in Hospitals and after Discharge from the Hospital: An Ethical Analysis*, 32 J.L. MED. & ETHICS 349 (2004); Mark E. Meaney, *Error Reduction, Patient Safety and Institutional Ethics Committees*, 32 J.L. MED. & ETHICS 358 (2004).

11. *See*, *e.g.*, Lucian L. Leape et al., *What Practices Will Most Improve Safety?: Evidence-Based Medicine Meets Patient Safety*, 288 JAMA 501 (2002); Kaveh G. Shojania et al., *Safe but Sound: Patient Safety Meets Evidence-Based Medicine*, 288 JAMA 508 (2002).

II. ACUTE CARE/LTC DISTINCTIONS

Despite these areas of apparent commonality, most of the lessons derived from patient safety initiatives in the hospital context cannot as a general matter be transposed simply and easily to the protection of persons in LTC generally, or to nursing facility residents specifically. The acute and LTC arenas are distinct in significant enough respects to create different, special resident safety challenges in LTC that call for original responses. The most salient of these distinctions are outlined below.

A. LTC as a Constellation of Services

Most acute care rendered in hospitals is focused narrowly, indeed virtually exclusively, on the provision of medical interventions (chiefly the performance of technical procedures and the administration of medications) designed to manage or ameliorate discrete, immediate medical threats to patients as quickly and definitively as possible. The *raison d'etre* for acute care is to make the patient better, or at least to control the immediate medical crisis sufficiently so the patient can be discharged from the hospital.

By contrast, nursing facilities are expected to make available to their resident population a much broader constellation of services. Besides acute medical treatment for immediate physical ailments, particular residents also might require a variety of ongoing medical, nursing, social, psychological, rehabilitative, supportive, and spiritual services not commonly falling within the province of acute care. Engaging in these various kinds of LTC activities may present risks to resident safety different from the acute care medical error risks that hospitals have begun to learn how to handle effectively.

Moreover, although this article concentrates on nursing facilities, it must be noted that nursing facilities do not by any means constitute the entirety of a LTC system. Instead, LTC is comprised of a rich (and still developing) continuum of formal settings and services[12] that are available to respond to the current individualized needs of particular consumers,[13] supplemented by an enormous

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12. Regarding LTC as a continuum of services, *see* William T. Smith, *The Nursing Home and the Continuum of Care*, *in* MULTIDISCIPLINARY PERSPECTIVES ON AGING 41-61 (Lynn M. Tepper & Thomas M. Cassidy eds., 2004); ROSALIE A. KANE ET AL., THE HEART OF LONG-TERM CARE 72-73 (1998); Nancy L. Wilson, *Long-Term Care in the United States: An Overview of the Current System*, *in* LONG-TERM CARE DECISIONS: ETHICAL AND CONCEPTUAL DIMENSIONS 35, 35-37 (Johns Hopkins Univ. Press 1995); HOUSE COMM. ON WAYS AND MEANS, 108TH CONG., 2004 GREEN BOOK app. B-24-32 (Comm. Print 108-6 (2004)) [hereinafter GREEN BOOK].

13. Among professionals in the aging field, "consumer" is the term most frequently selected to denote users of non-institutional LTC services. Unique safety issues for older persons arising from the emerging paradigm of consumer-centered and consumer-directed home and community-

amount of informal, unpaid home care provided by families and friends.[14] In fact, less than five percent of persons aged sixty-five and older receive care in nursing facilities.[15] Besides informal care provided by a person's family and friends, home and community-based alternatives to nursing facilities and assisted living facilities[16] include independent living aided by home care (which may encompass health, personal care, and/or homemaker services),[17] adult day care,[18] adult foster care,[19] and hospice care.[20] Various levels of LTC may be provided by a single agency or even on the same physical campus, as occurs in life care or continuing care retirement communities.[21] More commonly, though, the consumer and/or family are forced to cope with a frustratingly fragmented LTC marketplace.[22]

B. Patient/Resident Populations

"The living arrangements of America's older population are important indicators [of well-being] because they are linked to income, health status, and the availability of caregivers."[23] Differences in the prevailing demographic,

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based LTC are noteworthy but beyond the scope of this article. *See* Marshall B. Kapp, *Consumer Direction in Long-Term Care: A Taxonomy of Legal Issues*, 24 GENERATIONS 16 (2000) (discussing legal issues); Rosalie A. Kane & Carrie A. Levin, *Who's Safe? Who's Sorry? The Duty to Protect the Safety of Clients in Home- and Community-Based Care*, 22 GENERATIONS 76 (1998) (discussing ethical issues). For general background information on consumer-directed LTC, *see* National Association of State Units on Aging, Consumer Direction-2004 State of the States, http://www.nasua.org /consumerdirection.htm (last visited Dec. 30, 2005).

14. *See*, *e.g.*, LYNN FRISS FEINBERG ET AL., THE STATE OF THE STATES IN FAMILY CAREGIVER SUPPORT: A 50-STATE STUDY (2004); Marshall B. Kapp, *Family Caregivers' Legal Concerns*, 29 GENERATIONS 49 (2003-04).

15. GREEN BOOK, *supra* note 12, at B-25.

16. *See* Bernadette Wright, *An Overview of Assisted Living: 2004*, Pub. Pol'y Inst., Issue Brief No. 72 (2004); SHERYL ZIMMERMAN ET AL., ASSISTED LIVING: NEEDS, PRACTICES, AND POLICIES IN RESIDENTIAL CARE FOR THE ELDERLY (2001).

17. Regarding home care, *see generally* National Association for Home Care and Hospice, http://www.nahc.org (last visited Nov. 4, 2005).

18. Regarding adult day care, *see generally* National Adult Day Services Association, http://www.nadsa.org (last visited Nov. 4, 2005).

19. KANE ET AL., *supra* note 12, at 174-76.

20. Hospice care may be provided either in an institutional or a non-institutional setting. *See generally* The National Hospice and Palliative Care Organization, http://www.nhpco.org (last visited Nov. 4, 2005).

21. Regarding Continuing Care Retirement Communities ("CCRCs"), *see generally* LAWRENCE A. FROLIK & ALISON M. BARNES, ELDER LAW CASES AND MATERIALS 430-36 (3d ed. 2003).

22. IMPROVING, *supra* note 8, at 70.

23. FEDERAL INTERAGENCY FORUM ON AGING RELATED STATISTICS, OLDER AMERICANS 2004: KEY INDICATORS OF WELL-BEING 8 (2004), *available at* http://www.agingstats.gov/ chartbook2004/OA_2004.pdf. [hereinafter KEY INDICATORS].

functional, health, and social characteristics of the modern American nursing facility resident population compared with the prevailing characteristics of typical hospitalized patients arguably create relevant distinctions between the two settings in terms of types and degree of risk exposure and effective strategies both to avoid the materialization of those risks in the first place and to remedy them when they occur. These population differences are manifold.

One major demographic characteristic of the nursing facility population is old age. Over ninety percent of nursing facility residents are over age sixty-five and almost half are over eighty-five; the average age is more than eighty.[24] At age ninety-five, an individual has about an equal chance of being cared for in a nursing facility or in the community.[25] The geriatric population among hospital patients certainly is substantial, but not to the same extent present in nursing facilities. "It can be concluded that institutionalized homes for the elderly constitute age-differentiated settings by the very way in which they are defined and organized."[26]

Moreover, the percentage of nursing home residents with chronic, serious physical disabilities creating permanent dependence in terms of needing assistance with activities of daily living ("ADLs")[27] continues to escalate. In 1999, almost twenty percent of nursing facility residents needed assistance with one to three ADLs and more than seventy-seven percent required regular assistance with four to six ADLs.[28] Among nursing facility-dwelling Medicare recipients over age sixty-five, in 2002, almost sixty-five percent had functional limitations requiring assistance with three or more ADLs.[29]

> Although nursing home residents are not by definition passive, they are remarkably dependent. The ability to perform ADLs such as dressing, grooming, bathing, or eating cannot safely be assumed for these individuals. In fact, the job description of nurses' aides mainly involves assistance with the basic functions of daily living such as helping individuals get in and out of bed, giving baths, assisting elders in the toilet or in feeding.[30]

This development is attributable not only to the general aging of the population, but also to the constellation of private and public sector initiatives

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24. A. B. BERNSTEIN ET AL., HEALTH CARE IN AMERICA: TRENDS IN UTILIZATION 46-47 (2003).

25. GREEN BOOK, *supra* note 12, at B-26.

26. Monisha Pasupathi & Corinna E. Löckenhoff, *Ageist Behavior*, *in* AGEISM: STEREOTYPING AND PREJUDICE AGAINST OLDER PERSONS 201, 214 (Todd D. Nelson ed., 2002).

27. Activities of daily living ("ADLs") "are activities necessary to carry out basic human functions," and include bathing, dressing, eating, ambulating, toileting, and transferring from a bed to a chair. GREEN BOOK, *supra* note 12, at B-25.

28. KEY INDICATORS, *supra* note 23, at 111.

29. *Id.* at 112.

30. GEORGE J. AGICH, DEPENDENCE AND AUTONOMY IN OLD AGE: AN ETHICAL FRAMEWORK FOR LONG-TERM CARE 59 (2d. ed. Cambridge Univ. Press 2003).

(fueled in large part by legal requirements)[31] that have been markedly effective in helping even very frail and disabled older individuals to forestall nursing facility admission until an overwhelming degree of chronic disability has been reached. Because entry into a nursing facility rarely happens today unless and until reasonable, less drastic alternatives have been attempted and exhausted for an individual,[32] the illness and disability acuity level among nursing facility residents is substantially higher, more complex, and more resistant to improvement than was previously the situation in LTC settings.[33] Increasingly, when individuals finally are admitted to nursing facilities, often it is with the expectation and plan that they will die there.[34] This all carries potentially serious connotations for residents' vulnerabilities to risks of avoidable harm.[35]

Special safety concerns also may be implicated by the very significant prevalence of serious, chronic mental disabilities among nursing facility residents.[36] In many respects, "nursing homes have become the mental hospitals

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31. *E.g.*, Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581 (1999) (holding that Title II of the Americans with Disabilities Act requires governmental units to provide publicly financed services to disabled persons in the most integrated, i.e., least institutional, appropriate environment). *Cf.* MARSHALL B. KAPP, ETHICS, LAW, AND AGING REVIEW: DEINSTITUTIONALIZING LONG-TERM CARE: MAKING LEGAL STRIDES, AVOIDING POLICY ERRORS (Marshall B. Kapp ed. 2005) (examining the challenges entailed in substituting home- and community-based LTC services for nursing facility admission as long as possible for severely disabled elders).

32. Few individuals choose to enter a nursing facility if there are any other viable options. *See* J. Kevin Eckert et al., *Preferences for Receipt of Care Among Community-Dwelling Adults*, 16 J. AGING & SOC. POL'Y 49 (2004); Marshall B. Kapp, *The "Voluntary" Status of Nursing Facility Admissions: Legal, Practical, and Public Policy Implications*, 24 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 1, 3 (1998); Marshall B. Kapp, *"A Place Like That": Advance Directives and Nursing Home Admissions*, 4 PSYCHOL. PUB. POL'Y & L. 805 (1998).

33. "People admitted to nursing homes today require more care - and more-complex care - than just a decade ago . . . That is because older adults with relatively mild infirmities often are settling in assisted-living centers or opting for care at home." Glenn Ruffenach, *Nursing-Home Costs Jump 6.1%*, WALL ST. J., Sept. 28, 2004, at D8. *See also* AARP, BEYOND 50.03: A REPORT TO THE NATION ON INDEPENDENT LIVING AND DISABILITY 79, Figure 20 (2003) ("Today's Nursing Home Residents Have More Severe ADL Limitations Than in the Past"); Mark S. Lachs et al., *Adult Protective Service Use and Nursing Home Placement*, 42 GERONTOLOGIST 734, 735 (2002) (persons identified by Adult Protective Services as self-neglecting are at the highest risk of nursing facility placement).

34. *See* JOANNE LYNN, SICK TO DEATH AND NOT GOING TO TAKE IT ANYMORE! REFORMING HEALTH CARE FOR THE LAST YEARS OF LIFE 85 (2004).

35. *See*, *e.g.*, Marshall B. Kapp, *Legal Anxieties and End-of-Life Care in Nursing Homes*, 19 ISSUES L. & MED. 111, 112-113 (2003-2004) (discussing treatment harms to which nursing facility residents are exposed because of care providers' legal anxieties). Regarding the sources of those legal anxieties, *see infra* notes 93-96 and accompanying text.

36. *See generally* WILLIAM E. REICHMAN & PAUL R. KATZ, PSYCHIATRIC CARE IN THE NURSING HOME (1996). Although not to the extent found in nursing facilities, cognitive impairment also is increasingly prevalent among residents of assisted living facilities. *See* Homa

of our era."[37] Dementia is the most common negative health condition among nursing facility residents,[38] and the majority (66.9%) of dementia-related deaths in the United States occurred in nursing facilities in 2001.[39] The prevalence of mental disability, coupled with the unfortunate reality that proper treatment for mental illness frequently is lacking in nursing facilities,[40] constrains the ability of most nursing facility residents to oversee their own care and play much of a meaningful part in watching out for their own safety. By contrast, hospitalized and ambulatory patients have been advised to advocate for themselves in helping to prevent treatment errors.[41] Additionally, the prevalence of serious cognitive impairment among nursing facility residents largely moots the potential, which has been discussed extensively in the hospital context,[42] that communicating medical errors to patients can act as a useful component of a safety improvement strategy.

Much more so than their hospital counterparts, nursing facility residents are likely to be financially poor[43] and therefore dependent on public benefit programs, with the added vulnerabilities that such a condition entails. In 2002, more than forty-three percent of Medicare enrollees aged sixty-five and older who resided in nursing facilities had an annual income of less than $10,000 and one-third of persons in this group had an annual income between $10,000 and $20,000.[44] Most people tend not to leave their own homes or assisted living facilities to enter nursing facilities until they have run out of money.[45] They only reluctantly leave at that point because, in nursing facilities, "the impoverished, including middle-class men and women who have outlived their savings, are covered by Medicaid as they are not (except for a small percentage) in assisted

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Magsi & Timothy Malloy, *Underrecognition of Cognitive Impairment in Assisted Living Facilities*, 53 J. AM. GERIATRIC SOC'Y 295, 295 (2005) (finding more than half of the residents of seven ALFs studied had cognitive impairment).

37. STEVEN H. ZARIT & JUDY M. ZARIT, MENTAL DISORDERS IN OLDER ADULTS: FUNDAMENTALS OF ASSESSMENT AND TREATMENT 321 (1998).

38. NANCY A. KRAUSS & BARBARA M. ALTMAN, CHARACTERISTICS OF NURSING HOME RESIDENTS - 1996 (1998).

39. Susan L. Mitchell et al., *A National Study of the Location of Death for Older Persons with Dementia*, 53 J. AM. GERIATRIC SOC'Y 299, 300-301 (2005).

40. ZARIT & ZARIT, *supra* note 37, at 321.

41. JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, SPEAK UP: HELP PREVENT ERRORS IN YOUR CARE, *available at* http://www.jcaho.org/general+public/gp+speak+up/speakup.pdf (last visited Dec. 26, 2005).

42. Kathleen M. Mazor et al., *Communicating with Patients About Medical Errors: A Review of the Literature*, 164 ARCHIVES INTERNAL MED. 1690 (2004).

43. *See* GREEN BOOK, *supra* note 12, at A7 (finding that, in 2001, persons over age sixty-five who lived with their families were in poverty status only about one-fourth as often as those elderly who lived apart from their families).

44. KEY INDICATORS, *supra* note 23, at 113.

45. Regarding the widespread antipathy toward entering a nursing facility, *see supra* note 32.

living."[46] In 2003, there were an estimated 1.6 million nursing home beds (out of a total of 1.8 million) certified to participate in the Medicaid program.[47]

C. Different Organizational Cultures

In many respects crucial to the issue of care recipient safety, the organizational culture of nursing homes diverges significantly from that permeating acute care generally, and hospitals particularly. For starters, although both acute and nursing facility providers are concerned about responding to both the care needs and the legal and ethical rights of their consumers, they generally are driven by different priorities. In acute care, a focus on the *needs* of the *patient* ordinarily clearly predominates, while the nursing facility culture for the most part revolves around the *rights* of *residents*.[48] This means that the fundamental goals of nursing facility care frequently may be multiple and internally inconsistent. As noted by one set of authors, "An overriding issue in quality assurance for long-term care is how to balance pursuit of safety versus respect for individual freedoms, and what to do with the bad results."[49]

In addition to pursuing health and safety for its residents (certainly the chief objective of hospitals and ambulatory care providers for their patients), nursing homes are concerned about maximizing respect for, and supporting the effectuation of, their residents' autonomous decision-making (including risk-taking) prerogatives. The impetus for moving conceptualization of the nursing facility's mission in this direction, and the potential philosophical and practical tensions between the goals of resident safety on one hand, and autonomy on the other,[50] is reflected in contemporary criticisms of nursing facilities that still supposedly foster dependency by keeping residents "well cared for, safe, and virtually powerless."[51] At best, the push for resident autonomy, both externally and internally generated, may act as a powerful source of distraction from, if not an outright enemy of, the nursing facility's attempt to assure resident safety. To afford residents more control over their own lives inevitably entails the possibility

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46. Jane Gross, *Under One Roof, Aging Together Yet Alone*, N.Y. TIMES, Jan. 30, 2005, at 1, 27.

47. GREEN BOOK, *supra* note 12, at B-35.

48. Regarding nursing facility residents' rights, *see*, *e.g.*, 42 C.F.R. § 483.10 (2004); IOM, REAL PEOPLE REAL PROBLEMS: AN EVALUATION OF THE LONG-TERM CARE OMBUDSMAN PROGRAMS OF THE OLDER AMERICANS ACT (1995), *available at* http://www.nap.edu/readingroom/books/rprp/contents.html [hereinafter OMBUDSMAN].

49. KANE ET AL., *supra* note 12, at 207.

50. *See*, *e.g.*, GEORGE J. AGICH, AUTONOMY AND LONG-TERM CARE (1993). Regarding the safety/autonomy tension, *see, e.g.*, MARSHALL B. KAPP, ETHICS, LAW, AND AGING REVIEW: DEINSTITUTIONALIZING LONG-TERM CARE: MAKING LEGAL STRIDES, AVOIDING POLICY ERRORS xi-39 (2005) (Marshall B. Kapp ed., 2003).

51. Charlene Boyd, *Residents First: A Long-Term Care Facility Introduces a Social Model That Puts Residents in Control*, HEALTH PROGRESS, Sept. 1994, at 34.

that they may make risky, even foolish, choices. It should not be surprising, therefore, that nursing facility providers often suffer from cognitive dissonance in trying to figure out how to behave.

Another mission-related cultural distinction pertains to the "homelike," or social environment that nursing facilities are expected to create and maintain, as compared to the more narrowly constrained institutional, medically-driven character of hospitals and ambulatory care centers. Most nursing facility residents remain nursing facility residents for a relatively long, indeterminate period of time; hence, the facility should mimic the individual, family, and social expectation of an emotionally warm environment and that of a happy personal home set in a friendly community, even while the facility is being regulated closely by government[52] as a health care institution.

As the Committee on Improving Quality in Long-Term Care of the Institute of Medicine noted:

> . . . long-term care is both a health program and a social program. For the health services component, judgments about quality emphasize medical and technical aspects of care, and such judgments are generally based on achieving desired health and functional outcomes and on adherence to correct processes of care. For the social services aspect, judgments about quality place more emphasis on the opinions and satisfaction of consumers (or their surrogate agents).[53]

The problem is the impossibility of maintaining the same level of safety against risks of harm in a homelike nursing facility environment, with the personal freedom of action for residents and families that such an environment encompasses, that ought to be reasonably achievable in an acute care environment. In the acute care setting, the provider retains the power to exercise control over virtually all foreseeable matters (down to limiting what items families can bring into the hospital and the coming and going of patients) that might endanger patients' safety. By contrast, the homelike environment imperative of nursing facilities, which recognizes ideal safety precautions are not always synonymous with residents' ideas about acceptable levels of quality of life,[54] restrains nursing facility providers much more in exercising control over risks.

As noted previously, essentially by definition, the respective time frames of acute and long term care are rather distinct. The longer time period during which residents remain within nursing facilities is relevant in terms of opportunities for

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52. Regarding the contribution of government regulation to the cultural atmosphere of nursing facility care, *see infra* notes 93-94 and accompanying text.

53. IMPROVING, *supra* note 8, at 5.

54. "Quality of life has an inevitable subjective component, necessitating direct input from the persons most concerned—the long-term care consumers—to provide feedback on quality of life domains and to suggest how they should be weighted." *Id.* at 84. *See also* AARP, *supra* note 33, at 81 ("What these reports [of the Centers for Medicare and Medicaid Services on the quality of care in nursing facilities] do not address is the quality of life in nursing homes.").

various risks of harm to develop and materialize. In order to achieve greater safety in nursing facilities, it is more important to concentrate on the general patterns of behavior a home follows to assure safety than it is to focus just on discrete problematic incidents as most homes do.

The legal and ethical doctrine of informed consent for specific medical interventions[55] notwithstanding, professional domination is the prevailing *modus operandi* in acute care settings. In the patient care sphere, the medical staff basically is in charge of pursuing the hospital's fundamental goal of making the patient well and achieving an expeditious discharge. In nursing facilities, by contrast, there usually is a much greater effort made to include the collective voice of the resident population in shaping many of the facility policies that affect the quality of residents' collective and individual lives. For example, residents' councils are common in nursing facilities as formal structures allowing residents to meet and air opinions about various aspects (for example, regarding food served or activities planned) of facility operations.[56] Facilitating opportunities for resident participation enhances resident autonomy but may result in facility situations that carry the seeds of peril to residents' safety.

In the hospital environment, families (defined broadly) often constitute an important part of the organizational culture in the sense of accompanying patients, visiting and running errands for them, advocating for them regarding specific medical treatments, acting as an intermediary between patient and health care providers, emotionally and spiritually supporting patients, overseeing insurance and other financial matters pertaining to the hospital stay, and helping to formulate and ultimately implement discharge plans for post-hospital care. In the nursing facility context, families are involved in the same way but often in a much more intense, often burdensome,[57] way and for a longer duration.[58] "Caregivers often become the 'hidden clients' of nursing homes."[59] Over time, continuing personal relationships often develop between a resident's family members and facility management and staff, other residents and/or their families, ombudsmen, and, sometimes, the agencies that regulate the nursing facility. Many nursing facilities establish formal family councils to give administration and staff input. Family members may take on particular tasks connected to the care of their loved ones, such as the adult child or spouse who always comes to the

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55. Regarding the informed consent doctrine, *see generally* RUTH R. FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT (1986).

56. Participation in resident councils is mentioned specifically as part of the resident's rights in federal law. 42 U.S.C.A. § 1396r(c)(1)(A)(vii) (West 2005); 42 U.S.C. § 1395i-3(c)(1)(A)(vii) (2000).

57. Jane B. Tornatore & Leslie A. Grant, *Burden Among Family Caregivers of Persons with Alzheimer's Disease in Nursing Homes*, 42 GERONTOLOGIST 497 (2002).

58. PETER S. SILIN, NURSING HOMES: THE FAMILY'S JOURNEY (2001).

59. Alan Pearson, *Nursing Home Admission*, *in* THE ENCYCLOPEDIA OF ELDER CARE: THE COMPREHENSIVE RESOURCE ON GERIATRIC AND SOCIAL CARE 450, 451 (Mathy D. Mezey et al. eds., 2001) (citation omitted).

facility at mealtime to help feed the resident. Additionally, families ordinarily are closely involved in the initial decision to admit a loved one to the nursing facility and in the process of selecting a particular facility.[60]

Another cultural aspect of family involvement in nursing facilities with implications for the effective pursuit of resident safety is the personal guilt many relatives experience, because they blame themselves for not being able to continue caring for their older loved one in a private home or community setting. Family members thus may feel they have abandoned their loved one to a nursing facility.[61] "Relatives' guilt and grief are often manifested as anger directed at nursing home staff. [Additionally,] [o]ther attitudinal barriers can obstruct good communication between relatives and nursing home staff."[62]

The cultural atmosphere of nursing facilities within which resident safety initiatives must be pursued also is influenced heavily by continuing negative public perceptions about, and attitudes towards, nursing facilities generically. For the most part, the nursing facility industry still carries a terrible public reputation, fueled by a constant stampede of adverse publicity about scandalously inadequate care appearing regularly in the popular media. The dominance of proprietary ownership, including a number of for-profit chains with extended corporate structures, also contributes to the industry's negative public image (although not-for-profit facilities usually are held in low regard too).[63] Because of negative public perceptions and attitudes, sincerely motivated safety initiatives often are greeted with skepticism and are not enthusiastically supported. This problem, and the resulting dampening of enthusiasm for bold and needed systemic improvements in nursing facilities, is exacerbated by a generally hostile political climate, in which holders and seekers of public office understand the significant political advantage of being portrayed in the media as "tough" on nursing homes.

D. Staffing Differences

Staffing patterns are important to the issue of patient safety, as "modern healthcare delivery is carried out by a complex web of participants. . ."[64] In

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60. SILIN, *supra* note 58, at 59-99.

61. *Id.* at 37-51.

62. Pearson, *supra* note 59, at 451. *See also* Nancy Foner, *Relatives as Trouble: Nursing Home Aides and Patients' Families*, *in* THE CULTURE OF LONG TERM CARE: NURSING HOME ETHNOGRAPHY 165 (J. Neil Henderson & Maria D. Vesperi eds, 1995).

63. Regarding the difficulties of not-for-profit nursing facilities, *see generally* Marshall B. Kapp, *The Nursing Home Crisis: Views From a Trustee in the Nonprofit Sector*, 4 J. HEALTH CARE L. & POL'Y 308 (2001). *Cf.* Anup Malani & Albert Choi, *Are Non-Profit Firms Simply For- Profits in Disguise? Evidence from Executive Compensation in the Nursing Home Industry*, U. VA. PROGRAM L.& ECON. WORKING PAPER SERIES (2004).

64. Bryan A. Liang, *A Policy of System Safety: Shifting the Medical and Legal Paradigms to Effectively Address Error in Medicine*, 5 HARV. HEALTH POL'Y REV. 6, 8 (2004).

hospitals, the vast majority of direct patient care is provided by registered and licensed practical nurses. Nurses are the central building block of nursing facility staffs. However, in nursing facilities, RNs and LPNs frequently function in supervisory, rather than direct care, positions. In nursing facilities, unlike hospitals, the bulk of hands-on resident care depends on certified nurse assistants ("CNAs"), who lack degrees and are poorly paid at or near the minimum wage. In addition to the difference in educational qualification levels between hospital and nursing facility direct care staff, nursing facilities, as a group, overwhelmingly experience more chronic and severe staffing shortages and more extensive staff turnover at all levels than generally would be observed in hospitals.[65]

The difference in staffing mix between hospitals and nursing facilities is understood further by considering the role of physicians in each care setting. The physician's presence in most nursing facilities is considerably less robust than that ordinarily evident in hospitals.[66] According to the American Geriatrics Society, "[P]hysicians still do not spend significant amounts of time caring for nursing home residents."[67] Each Medicare and Medicaid-certified nursing facility must contract with a licensed physician to serve as the facility medical director,[68] with administrative responsibility regarding the quality of medical care provided therein,[69] but the medical director is allowed to (and in all but the largest facilities does) function in this role on a less than full-time basis. Federal regulations mandate each nursing facility admission be approved in writing by a physician

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65. AARP, *supra* note 33, at 82-83. Regarding the negative impact on quality of care and resident safety in nursing facilities owing to staffing that is inadequate in training, quantity, and consistency, *see* Donna R. Lenhoff, *LTC Regulation and Enforcement: An Overview from the Perspective of Residents and Their Families*, 26 J. LEGAL MED. 9, 14-23 (2005); John F. Schnelle, *Determining the Relationship Between Staffing and Quality*, 44 GERONTOLOGIST 10 (2004); Xinzhi Zhang & David C. Grabowski, *Nursing Home Staffing and Quality Under the Nursing Home Reform Act*, 44 GERONTOLOGIST 13 (2004); Marilyn J. Rantz et al., *Nursing Home Quality, Cost, Staffing, and Staff Mix*, 44 GERONTOLOGIST 24 (2004); Jeffrey M. Levine, *Understaffing in Nursing Homes: Causes, Consequences and Cures*, *in* MEDICAL-LEGAL ASPECTS OF LONG-TERM CARE 65, 65-85 (Jeffrey M. Levine ed., 2003).

66. Paul R. Katz et al., *Medical Practice with Nursing Home Residents: Results from the National Physician Professional Activities Census*, 45 J. AM. GERIATRICS SOC'Y 911 (1997); Richard H. Fortinsky & Lauren Raff, *The Changing Role of Physicians in Nursing Homes*, GENERATIONS, Winter 1995-96, at 30.

67. American Geriatrics Society Clinical Practice Committee, *Regulation and Quality of Care Standards in Nursing Facilities*, 48 J. AM. GERIATRICS SOC'Y 1519, 1519 (2000).

68. 42 C.F.R. § 483.75(i) (2004). The American Medical Directors Association offers a program through which a physician may obtain a CMD (Certified Medical Director) designation. *See* American Medical Directors Certification Program, Certified Medical Director (AMDA CMD) Application Kit Order Form, http://www.amda.com/cmd/kit.html (last visited Nov. 4, 2005).

69. *See generally* Joseph G. Ouslander & Eric G. Tangelos, *Medical Direction in Long-Term Care*, 11 CLINICS GERIATRIC MED. 331 (1995).

and every nursing facility resident remain under a physician's care.[70] Otherwise, physician contact with nursing facility residents usually takes the form of issuing telephone orders and/or sending the resident to the hospital emergency department in response to a nurse's phone call reporting a problem, or treating a resident who has been brought to the physician's private office. Moreover, few nursing facilities are affiliated with medical schools; hence medical students and post-graduate medical trainees (residents and fellows) rarely are available to contribute to resident care. The very limited physician involvement as an integral part of a nursing facility's daily life poses obvious problems for conducting effective resident safety improvement projects in nursing facilities.

E. Differences in Kinds of Safety Concerns

In hospitals, iatrogenic and nosocomial dangers ordinarily are connected to botched medical procedures, medication errors, and infections. Hospital safety strategies largely are efforts to respond to those specific dangers.

Nursing facilities share hospitals' concern about medication errors.[71] A substantial amount of prescription and over-the-counter drugs are ordered and dispensed every day in the nursing facility setting, presenting abundant opportunities for medication errors to take place. There is a high incidence of serious and often preventable adverse drug events ("ADEs") emanating from medication use in nursing facilities. Even worse, published studies actually may, if anything, underestimate the real extent of ADEs in nursing facilities.[72] When an ADE occurs in a nursing facility, the risk of harm, or even fatality, to the resident is substantial.[73]

Among the identified causes of medication errors in nursing facilities are the following: faulty communications when a person is transferred from a hospital to the nursing facility; excess dosage; drug interactions; mistaken drug selection; failures in baseline or continuing monitoring; not acting in response to relevant information; contraindicated drug use; confusing abbreviations; sound-alike and look-alike drugs; and sloppy order-writing.[74] The Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") lists among its 2005 Long Term Care National Patient Safety Goals the following: "Improve the safety of

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70. 42 C.F.R. § 483.40 (2004).

71. Angela C. Cafiero, *Reducing Medication Errors in a Long-Term Care Setting*, ANNALS LONG-TERM CARE, Feb. 2003, at 29.

72. Gerson T. Lesser et al., *Underestimation of Adverse Drug Events in Nursing Home Residents*, 162 ARCHIVES INTERNAL MED. 609 (2002).

73. Diana Reese, *One Pill Too Many*, CONTEMP. LONG-TERM CARE, Nov. 1997, at 65.

74. William N. Kelly, *First Do No Harm: Reducing Medication Errors in Long-Term Care*, ANNALS LONG-TERM CARE, Apr. 2002, at 49.

using medications"[75] and "[a]ccurately and completely reconcile medications across the continuum of care."[76]

In nursing facilities, the most prevalent safety concerns other than medication errors tend to revolve around dangers different than those that predominate in hospitals (although all of these dangers certainly exist in hospitals). The situation necessitates the implementation of more specific nursing facility-oriented safety interventions. An especially prevalent and severe problem in the care of nursing facility residents is the development of pressure ulcers, also known as pressure sores, bedsores, and decubitus ulcers.[77] These are localized areas of skin tissue damage or necrosis that develop because of sustained pressure over a bony protrusion such as the hips, buttocks, elbow, or heel. Major risk factors include immobility, friction, shear, incontinence, and poor nutritional status, all dangers to which nursing facility residents are exposed disproportionately.[78] Potential morbid complications of untreated pressure ulcers are cellulitis, osteomyelitis, and sepsis (infection). Extreme cases can be fatal.

There is professional debate about whether pressure ulcers are totally avoidable for non-ambulatory individuals.[79] Some take the negative position, pointing to the recent death of actor Christopher Reeves due to a pressure ulcer-caused infection despite impeccable personal nursing attention.[80] Nonetheless, there is a strong consensus among professional experts in the aging arena that severe pressure ulcers should rarely, if ever, materialize in nursing facility residents who have been afforded competent, attentive medical and nursing

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75. To pursue this safety goal, each nursing facility is supposed to, among other things, "[i]dentify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs." JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, 2005 LONG TERM CARE NATIONAL PATIENT SAFETY GOALS (2004), *available at* http://www.jcaho.org/accredited+organizations/long+term+care/npsg/05_npsg_ltc.htm (last visited Dec. 30, 2005).

76. *Id.* To pursue this safety goal, nursing facilities are instructed:

> [To] . . . develop a process for obtaining and documenting a complete list of the resident's current medications upon the resident's admission to the organization and with the involvement of the resident. This process includes a comparison of the medications the organization provides to those on the list.
>
> A complete list of the resident's medications is communicated to the next provider of service when it refers or transfers a resident to another setting, service, practitioner or level of care within or outside the organization.

77. Eric A. Coleman et al., *Pressure Ulcer Prevalence in Long-Term Nursing Home Residents Since the Implementation of OBRA '87*, 50 J. AM. GERIATRICS SOC'Y 728, 730 (2002).

78. Gary H. Brandeis et al., *A Longitudinal Study of Risk Factors Associated with the Formation of Pressure Ulcers in Nursing Homes*, 42 J. AM. GERIATRICS SOC'Y 388 (1994).

79. *See* Richard G. Bennett et al., *The Increasing Medical Malpractice Risk Related to Pressure Ulcers in the United States*, 48 J. AM. GERIATRICS SOC'Y 73 (2000).

80. John Schwartz, *With Paralysis, Challenge Goes Beyond Walking*, N.Y. TIMES, Oct. 12, 2004, at F5.

preventive care. Such care would include regular turning and/or repositioning, skin inspection, assuring adequate nutritional intake, and the use of pressure-relief surfaces where possible. From this perspective, the occurrence of pressure ulcers in a nursing facility resident indicates the presence of errors or inexcusable shortcomings in delivering quality care.[81] Thus, a virtual mantra among plaintiffs' attorneys is: "In cases of preventable pressure sores occurring in nursing homes, neglect should always be considered as a possible cause."[82]

Pressure ulcers are one indicator of safe, quality care measured by nursing facilities as part of the mandatory Minimum Data Set ("MDS").[83] The MDS is required for participation in the Medicare and Medicaid programs. Part of the MDS evaluation includes the required Resident Assessment Instrument ("RAI"),[84] which is useful as a comprehensive guide to assess all facets of resident care, including pressure ulcers.

Another significant safety concern in nursing facilities is the prevalence and severity of resident falls. A fall is defined as "unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of syncope or overwhelming external force."[85] Approximately half of all nursing facility residents fall at least annually, with serious (sometimes even fatal) injury occurring in about ten percent of residents.[86] Complications may include bone fractures, injury to the soft tissues, increasing functional dependence, and the fear of falling again—which itself can be debilitating.[87] Falls among hospitalized

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81. *See* Dana B. Mukamel & Christine A. Brower, *The Influence of Risk Adjustment Methods on Conclusions About Quality of Care in Nursing Homes Based on Outcome Measures*, 38 GERONTOLOGIST 695 (1998); David R. Zimmerman et al., *Development and Testing of Nursing Home Quality Indicators*, 16 HEALTH CARE FIN. REV. 107 (1995).

82. Lesley Ann Clement, *Litigating the Pressure Sore Case Against a Nursing Home*, NAELA Q., Fall 1999, at 10, *available at* http://www.naela.com/PDFFiles/QuarterlyFall99.pdf.

83. 42 U.S.C. § 1396-r2 (2000) requires that States keep a comprehensive information reporting system that includes details of formal proceedings against health care entities. *See also* Mukamel & Brower, *supra* note 81. Social Security Act sections 1819(f)(6) and 1919(f)(6) require that the Secretary of the Department of Health and Human Services specify a minimum data set core of elements and common definitions for use in conducting comprehensive assessments of residents residing in nursing facilities. Centers for Medicare and Medicaid Services, State Operations Manual, App. R - *Resident Assessment Instrument for Long-Term Care Facilities*, http://cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp (last visited Nov. 4, 2005).

84. Centers for Medicare and Medicaid Services, *supra* note 83.

85. Joseph V. Agostini et al., *Prevention of Falls in Hospitalized and Institutionalized Older People, in* MAKING HEALTH CARE SAFER: A CRITICAL ANALYSIS OF PATIENT SAFETY PRACTICES 291 (Kaveh G. Shojania et al. eds., 2001).

86. Agostini et al., *supra* note 85.

87. *Id.*; Beverly L. Roberts, *Falls: What a Tangled Web*, 43 GERONTOLOGIST 598, 598 (2003) ("The fear of falling often leads older adults to restrict their activities, which can contribute to deconditioning, an increased risk for falls, and dependency.").

patients also are a persistent problem,[88] but the old age and frailty profile of nursing facility residents makes them especially vulnerable to serious injury when falls occur.

The 2005 Long Term Care National Patient Safety Goals of the JCAHO include "Reduce the risk of resident harm resulting from falls." Specifically, this document directs nursing facilities to:

- Assess and periodically reassess each resident's risk for falling, including the potential risk associated with the resident's medication regimen, and take action to address any identified risks.
- Implement a fall reduction program, including a transfer protocol, and evaluate the effectiveness of the program.[89]

Despite the fact that much can be done in the realm of effective prevention,[90] some resident falls in nursing facilities may be inevitable. Certainly, enhancing resident freedom of choice and movement carries the possibility of increased risk. Accepting a certain risk of falls is preferable to continuing the practice, commonplace in the industry before Congressional enactment of the Nursing Home Reform Act in 1987,[91] of continuously physically and/or chemically restraining large numbers of residents, purportedly to prevent falls.[92] Although there still is work to be done in this arena, significant progress has been achieved over the past two decades in reducing the routine use of restraints in nursing facilities, with corresponding benefits to residents' sense of autonomy.

Another risk area that may be affected by an enhanced institutional respect for resident autonomy involves the constellation of potential harms that may happen to a cognitively impaired resident who physically wanders away from the nursing facility. Most of the strategies available to nursing facilities to deal effectively and proactively with this common problem entail some degree of intrusion on residents' freedom of movement, and consequently, conflict with a culture that puts a premium on maximizing the homelike nature of the residents' long term living environment.

An extremely important risk area affecting nursing facility residents with dismaying frequency,[93] but ordinarily affecting hospital patients only very rarely,

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88. Eileen B. Hitcho et al., *Characteristics and Circumstances of Falls in a Hospital Setting: A Prospective Analysis*, 19 J. GEN. INTERNAL MED. 732, 737 (2004).

89. JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, *supra* note 75.

90. American Geriatrics Society et al., *Guideline for the Prevention of Falls in Older Persons*, 49 J. AM. GERIATRICS SOC'Y 664 (2001).

91. This legislation was part of the Omnibus Budget Reconciliation Act of 1987 ("OBRA"), Pub. L. No. 100-203, 101 Stat. 1330 (1987), based largely on policy recommendations contained in IOM, IMPROVING THE QUALITY OF CARE IN NURSING HOMES (1986).

92. *See* Marshall B. Kapp, *Nursing Home Restraints and Legal Liability: Merging the Standard of Care and Industry Practice*, 13 J. LEGAL MED. 1 (1992).

93. *See* Lenhoff, *supra* note 65, at 10-13.

concerns patterns of neglect or, in extreme cases, abuse. Neglect and abuse may take a variety of forms and almost always emanate from a pattern of systemic, as opposed to individual, errors and omissions unfolding without correction over a sustained period of time and requiring systemic remedial and preventive strategies different than those usually developed and implemented in hospitals to address their own, different kinds of safety shortcomings.

E. Legal Environment

Hospitals are subject to extensive legal and quasi-legal (for instance, voluntary accreditation-related) regulation designed to assure the quality and safety of medical care rendered to patients.[94] Compared to nursing facilities, though, hospital regulation may seem almost minimal. The extent to which nursing facility personnel in the United States today function within a cultural environment constantly threatening them with external, punitive oversight and intervention is a distinguishing feature of institutional LTC that carries substantial implications for attempts to implement effective resident safety strategies.

Negative media coverage of the nursing facility industry and high malpractice insurance premiums, or difficulty in obtaining malpractice insurance at all, create to some degree the providers' aura of apprehension. Such media coverage includes provocative advertisements to potential plaintiffs by personal injury attorneys, advertisements sent to nursing facility personnel for risk management products portrayed as desperately needed, discouraging messages about colleagues' conflicts with regulators or the courts transmitted through the professional "grapevines" and "rumor mills," and adverse personal experiences in dealing with the regulatory or judicial systems.[95]

The regulatory environment engulfing contemporary nursing facility operations includes, among other components,[96] provider anxieties about Medicaid certification and state licensure surveys, criminal prosecutions initiated by local prosecutors and state Attorneys General charging facility ownership and staff with abuse and neglect of residents (and, in the case of dead residents, homicide), criminal prosecutions brought by the United States Attorney's Office and the federal Department of Health and Human Services' Office of Inspector General ("OIG") on Medicare/Medicaid program fraud and abuse theories for billing the government for inadequate care, and criminal prosecutions and/or

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94. *See, e.g.*, 42 C.F.R. § 488.10 (2005). For an example of a state hospital licensure statute, *see* 210 Ill. Comp. Stat. 85/1-16 (2005).

95. Kapp, *supra* note 35, at 115.

96. Regarding other components of the regulatory environment affecting nursing facilities, *see, e.g.*, regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) ("HIPAA") concerning the confidentiality of medical information, 42 C.F.R. pt. 164, and the Occupational Safety and Health Standards Act ("OSHA") regarding the working conditions of employees, 29 C.F.R. § 1910 (2005).

professional disciplinary actions for overuse or improper use of controlled substances.[97] Government regulators are aided in their enforcement activities by state long-term care ombudsman programs, whose representatives enjoy the legal power to enter a nursing home at any time to investigate complaints or otherwise communicate with residents.[98] Besides being subject to mandatory government standards of behavior, an increasing percentage of nursing facilities are being economically forced by the pressures of a competitive marketplace to participate in private, theoretically voluntary accreditation programs administered by bodies such as the JCAHO,[99] whose Long-Term Care National Patient Safety Goals have been alluded to above.[100]

All of this contributes to an intrusive regulatory climate. This climate fosters an aura of apprehension among nursing facility administrators and staff that intensely discourages active, open, enthusiastic cooperation in identifying and ameliorating safety problems, when the safety shortcomings identified and addressed may turn out to be discoverable and admissible in legal proceedings as evidence to support adverse actions taken against safety-seeking facilities and individual staff members.

Additionally, nursing facility care providers are legitimately concerned about potential civil malpractice lawsuits being brought against them by, or on behalf of (usually by family members), injured residents. For most of these providers, litigation-related fears mainly revolve around the hassle, emotional trauma, and damage to professional reputation associated with being sued.[101] The ultimate winning or losing disposition of a lawsuit is almost irrelevant, especially in light of the financially insulating effect of liability insurance. Rather, provider anxieties grow out of the media feeding frenzy that invariably accompanies litigation against nursing facilities alleging transgressions in resident care quality and safety. Apprehension that preventive or remedial safety initiatives may be interpreted by the fact-finder in a subsequent litigation context as an admission of legal fault provides further disincentives to nursing facility administrators and staff from acting expeditiously and effectively when safety problems become apparent.[102]

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97. Marshall B. Kapp, *Resident Safety and Medical Errors in Nursing Homes: Reporting and Disclosure in a Culture of Mutual Distrust*, 24 J. LEGAL MED. 51, 63-66 (2003).

98. *See* OMBUDSMAN, *supra* note 48; Carroll L. Estes et al., *State Long Term Care Ombudsman Programs: Factors Associated With Perceived Effectiveness*, 44 GERONTOLOGIST 104 (2004).

99. *See* JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, 2004-2005 COMPREHENSIVE ACCREDITATION MANUAL FOR LONG TERM CARE (2005); JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, THE COMPLETE GUIDE TO THE 2004-2005 SURVEY PROCESS: LONG TERM CARE AND SUBACUTE PROGRAMS (2005).

100. *See supra* notes 75 and 76 and accompanying text.

101. Kapp, *supra* note 35, at 115.

102. Kapp, *supra* note 97, at 68.

III. ADDRESSING THE RESIDENT SAFETY IMPERATIVE

This article has enumerated some of the particular challenges entailed in attempting to improve the resident safety situation in long-term care, and most specifically in nursing facilities. Reasons have been cited to show why recent patient safety lessons generated in the hospital context, although valuable, cannot automatically be transposed successfully to the nursing facility sphere. Instead, more particularized, targeted strategies that focus on nursing facilities' unique resident population, cultural context, and types of risks involved must be developed and implemented. These strategies must include, among other things, much more research on the extent, nature, and causes of threats to resident safety particular to nursing facilities, funded demonstration projects testing targeted safety interventions, and the appropriation of adequate public and private resources to properly address the challenges, for example, by significantly increasing the wages of the CNAs who provide the bulk of direct care to nursing facility residents.[103] Developing an improved working climate for CNAs will also be essential to reducing staff turnover and the safety concerns accompanying lack of stability in the workforce.[104]

Part of any effective resident safety strategy must address head-on the powerful and counterproductive disincentives to cooperation now fostered by what is perceived by the nursing facility industry to be an adversarial, antagonistic legal environment.[105] In a development creating hope in this regard, the regulatory paradigm for nursing facilities is beginning to shift away from primary reliance on a rigid command and control approach, at least at the federal level.[106] Although aggressive command and control regulation still retains some vigorous proponents, questioning of the continued value of a police model built on

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103. Susan C. Eaton, *Frontline Caregivers in Nursing Facilities: Can Policy Help in Recruitment and Retention Crisis?*, PUB. POL'Y & AGING REP., Spring 2003, at 8.

104. Ruth A. Anderson et al., *Complexity Science and the Dynamics of Climate and Communication: Reducing Nursing Home Turnover*, 44 GERONTOLOGIST 378 (2004); Dale E. Yeatts et al., *Self-Managed Work Teams in Nursing Homes: Implementing and Empowering Nurse Aide Teams*, 44 GERONTOLOGIST 256, 257 (2004).

105. *See, e.g.*, David M. Studdert & David G. Stevenson, *Nursing Home Litigation and Tort Reform: A Case for Exceptionalism*, 44 GERONTOLOGIST 588 (2004). *But see* Eric M. Carlson, *Siege Mentality: How the Defensive Attitude of the Long-Term Care Industry Is Perpetuating Poor Care and an Even Poorer Public Image*, 31 MCGEORGE L. REV. 749 (2000) (arguing in favor of even more directive and more punitive command and control regulation of every facet of nursing facility operations); Kieran Walshe & Charlene Harrington, *Regulation of Nursing Facilities in the United States: An Analysis of Resources and Performance of State Survey Agencies*, 42 GERONTOLOGIST 475 (2002) (advocating the devotion of even more resources to the survey system assigned to enforce command and control regulations).

106. Jennifer L. Hilliard, *The Nursing Home Quality Initiative: Shift in Policy, Shift in Paradigm*, 26 J. LEGAL MED. 41 (2005); Susan Nedza, *Driving Improvement in Long-Term Care: Enforcement and Quality Initiatives*, 26 J. LEGAL MED. 61 (2005).

apprehending and penalizing offenders has grown more vocal. Hence, in large measure the LTC policy energy has turned away from blaming and shaming miscreants toward coming up with workable legal and non-legal strategies (for example, behavioral incentives supplied by a competitive economic marketplace) to supplement or replace the heretofore prevailing regulatory and litigation approaches to assuring and improving both quality and safety.

One important example of the shifting nursing facility paradigm with some promise[107] for effectively and efficiently enhancing the accountability of nursing facilities regarding resident safety (and quality of care) is the Nursing Home Quality Initiative ("NHQI"). NHQI is an ambitious endeavor which began in 2002 for the purpose of bringing together, in a concerted effort to improve the quality and safety of nursing facility care, several different components: the regulatory structure responsible for setting and enforcing nursing facility standards; new and enhanced sources of information for consumers to use in making intelligent choices in a competitive marketplace for LTC services;[108] community-based quality improvement programs; and public/private partnerships and collaborations.[109]

IV. CONCLUSION

In sum, by concentrating on the factors specially shaping the provision of nursing facility care in the United States at this time, we may create and/or take advantage of valuable opportunities to improve the safety of nursing facility residents. We must work diligently to make the most of these opportunities. At the same time, however, the unique characteristics of American nursing facilities call for a heavy dose of realism in the expectations of residents, families, the public, the media, and—perhaps most importantly—the legal system, concerning not only the possibilities but also the limits of resident safety strategies. "In general, nursing homes are not insurers of safety for their residents."[110] Ultimately, the goal of resident safety must be continually balanced in practical ways against competing social objectives such as enhancing resident autonomy. Acceptable compromises reflecting differing values may need to be made. Guaranteeing the absence of resident injuries may well turn out to be partially

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107. Alice Dembner, *U.S. to Push for Better Nursing Home Care*, BOSTON GLOBE, Dec. 23, 2004, at A3.

108. Regarding such information sources, *see, e.g.*, Robert L. Kane et al., *Using Resident Reports of Quality of Life to Distinguish Among Nursing Homes*, 44 GERONTOLOGIST 624 (2004); Timothy J. Lowe et al., *Consumer Satisfaction in Long-Term Care: State Initiatives in Nursing Homes and Assisted Living Facilities*, 43 GERONTOLOGIST 883 (2003).

109. Regarding the NHQI, *see generally* Hilliard, *supra* note 106; Nedza, *supra* note 106.

110. FROLIK & BARNES, *supra* note 21.

incompatible with the full fostering and flourishing of a homelike living environment for the frailest and most dependent of our fellow citizens.