International Association of Gerontology and Geriatrics: A Global Agenda for Clinical Research and Quality of Care in Nursing Homes

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A workshop charged with identifying the main clinical concerns and quality of care issues within nursing homes was convened by the International Association of Gerontology and Geriatrics, with input from the World Health Organization. The workshop met in Toulouse, France, during June 2010. Drawing on the latest evidence and mindful of the international development agenda and specific regional challenges, consensus was sought on priority actions and future research. The impetus for this work was the known variation in the quality of nursing home care experiences of older people around the world. The resulting Task Force recommendations include instigation of sustainable strategies designed to enhance confidence among older people and their relatives that the care provided within nursing homes is safe, mindful of their preferences, clinically appropriate, and delivered with respect and compassion by appropriately prepared expert doctors, registered nurses, administrators, and other staff. The proposals extend across 4 domains (Reputational Enhancement and Leadership, Clinical Essentials and Care Quality Indicators, Practitioner Education, and Research) that, in concert, will enhance the reputation and status of nursing home careers among practitioners, promote effective evidence-informed quality improvements, and develop practice leadership and research capabilities. **(J Am Med Dir Assoc 2011; 12: 184–189)**

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In 2008, more than half a billion people were older than 65 years of age (www.census.gov/prod/2009pubs/p95–09–1.pdf). It is estimated that by 2040 this number will be at least 1.3 billion. In 2008, 313 million (62%) of the older population lived in developing countries; more than half of this population lives in China and India and by 2040, there will be more than 500 million older persons in these countries alone. In view of the rapid increase of the aging population in developing countries, there is a need to develop programs that have a special focus on quality long-term care in these countries as well as strengthening the care offered in developed countries.

The fastest growing group of the older population is the oldest old, that is, people 80 years or older. Globally in 2000, the oldest old numbered 70 million and their numbers are projected to increase to more than 5 times that over the next 50 years.[1] Adding years to life is a great achievement when this is accompanied by a good level of health and well-being and independence. Unfortunately for many

people longevity brings with it an array of challenges that reduce functional independence and concurrently increase dependency on others. Some of these are age related, and others are condition specific. Support for older people who lose independence through disability, illness, and age-related frailty or poverty takes many forms ranging from family-based community models to long-term care within institutions such as hospitals and nursing homes. The current global drive to deliver health and social care in alignment with the 5 principles for the care of older persons set out by the United Nations in 1991[2,3] provides the moral foundation of the development agenda for nursing homes. This is coupled with the spirit of the evidence-based practice movement, which we interpret within this context to be the right of older people who reside in nursing homes to receive care that is informed by the best available international evidence. Care should be person centered and promote autonomy. In addition, we believe that care should be delivered with cultural sensitivity in ways that are mindful of an individual's preferences. It follows that every older care home (nursing home) resident has the right to take part in clinical and other research studies that help to produce the evidence base for their care.

Although it is out of the remit of our Task Force on Nursing Homes to make recommendations beyond the nursing home, it is important to recognize the need for a range of specialized housing options for this population, and to maximize opportunities for older people to age in place in their own home. In addition, systems that allow seamless movement through home care, day care, respite programs, assisted living, group housing, palliative and hospice care, and nursing homes may be advantageous.[4] Although, in some regions, nursing home provision is the major component of long-term care services, it is recognized that many other alternative community models are evolving. One example is the foster care program developed for aging veterans in the United States. Thus, although this consensus statement focuses on improving the quality of care in nursing homes, we embrace the development of novel approaches to long-term care that take into account elders' preferences. Irrespective of the particular care model that is adopted to achieve a good quality of life and optimize experiences of care, attention must be afforded to the development of shared decision-making processes with older people and a program of effective transitions.[5–7] Determination of the best setting for any individual will ideally involve their personal choices, a focus on their functional abilities, physical and mental health, views of family carers, religious and cultural considerations, available programs, and fiscal resources.[8]

At this time, there is a global opportunity to consider the adequacy and quality of the social and health care provisions made to support those for whom self-care is a diminishing or an unobtainable option.

ENHANCING NURSING HOME PRACTICE AND LEADERSHIP

Workforce issues, including shortages of doctors and nurses, are a global concern and all administrations should plan to achieve an adequate supply of doctors and nurses and other professionals equipped to meet the demands of its citizens.[9] In simple terms, health workforce planning for population aging requires an appropriate supply of able nursing home practitioners and leaders. A consequence of history, including underinvestment and piecemeal regulatory responses to substandard practices, has meant that working within care homes has been afforded a low status, giving rise to recruitment and retention challenges and workforce instability. Although numerous different approaches to nursing home and long-term care exist, it is almost universal that health care workers involved in this industry have a relatively low status compared with health care workers in other environments. This applies to nursing staff, administrators, and physicians working in nursing homes. Coupled with low status, as might be expected, are much lower and often inadequate salaries. This has resulted in an inadequate critical mass of professionals with expert knowledge and skills central to the achievement of excellence and advancing nursing home care for and with older people.

There is growing recognition of the urgent need for culture change and investment in nursing home careers with pay and reward packages comparable to practitioners working in other traditionally higher valued care settings, such as acute hospitals. Furthermore, systems to recognize and endorse nursing home practice knowledge are essential. In addition, practitioners need access to continuing professional development opportunities that will equip them with the confidence, knowledge, and skills to perform at their best,[2] as well as enable the ambitious and most able to develop as leaders. This area of need will be further explored later in the article.[10]

Improving quality in nursing homes cannot be divorced from taking steps toward wider cultural reform and greater valuing of the expert professional knowledge and skills central to achievement of excellence and advancing nursing home care for older persons.

In many countries, neither general nor specialist physicians provide clinical leadership within nursing home care. We believe that such a lack of expert clinical involvement has 2 major effects. First, it leads to inferior medical care within institutions, both because of the lack of a physician overseeing the direct medical care of the patient, but also because of the lack of physician input into the administrative structure. Second, involvement of recognized expert physicians within the nursing home tends to increase the prestige of the institutions. It is recognized that a shortage of geriatricians/physicians will make this difficult in many countries, especially in developing countries. However, this is a long-term goal that we believe will enhance quality of care in nursing homes.

In the absence of confirmed geriatricians, medical schools should propose accelerated programs of theoretical and practical training for general practitioners who are involved in the medical coordination and/or direction of nursing homes. The International Association of Gerontology and Geriatrics could also propose educational programs and provide training certificates for general practitioners.

The Task Force therefore recommends the following:

Recommendation 1. Effective leadership structures are established that where possible, include an expert physician (medical director), an expert registered nurse (nursing director), and skilled administrator.

Recommendation 2. An international alliance is formed to develop nursing home leadership capacity and capabilities.

Recommendation 3. Showcase international exemplars of excellence in nursing home practice to raise awareness of the demonstrable benefits for older people and high standards achieved through expert practice.

Recommendation 4. Create positive working conditions for nursing home practitioners with attractive career development opportunities, recognition, and similar rewards enjoyed by health care workers in comparable roles within the acute care services.

CLINICAL INDICATORS AND QUALITY INDICATORS FOR NURSING HOME CARE

Functional decline, disability, and frailty associated with geriatric syndromes[11] are prevalent in the nursing home population. These common conditions have major implications for functional independence and represent major determinants of quality of life. The interplay of comorbidity with later life conditions reduces resilience and recovery capacity and compounds the disablement process. Hence, all older people admitted to nursing homes have complex clinical and care needs that require expert management in addition to their psychosocial needs that include provision of a quality living environment, meaningful activities, and social contact.

Quality of care is a multidimensional concept and for the sake of brevity we highlight only a few of the important considerations. At a most basic level, we wish to draw attention to the vulnerability of older people who require long-term care and the importance of ensuring that their basic human rights, as described earlier, are met. We also emphasize the importance of maintaining the links and engagement of nursing home residents to the broader community.

Over the past decade there has been increasing evidence that physical exercise programs can reduce falls[12,13] and improve function.[14,15] More recently, physical exercise has been demonstrated to enhance mental function, slow the rate of deterioration in persons with dementia, and modulate challenging behaviors.[16,17] Mental exercise programs also improve ongoing function and may enhance quality of life.[18] Within these approaches, nursing homes should be open to society with free flow of the community into the nursing home and residents' involvement in the community.

Pain is often poorly assessed and undertreated in nursing homes.[19,20] Appropriate end-of-life care can improve quality of life and may even extend life span.[21–23] Polypharmacy (especially the use of psychoactive drugs) and unexpected reactions to medications is extremely common in nursing home residents.[24–26] When new drugs are approved for use, they have rarely been tested in nursing home residents, and yet this population and frail older persons are the most likely to receive these drugs and to have adverse reactions.

It has been clearly established that physical restraints, and in some cases chemical restraints, are ineffective, unsafe, and violate human rights.[27,28] It is recognized that occasionally a physical restraint represents an enabling device to allow improved function and under those circumstances should not be considered a physical restraint.

As long-term care systems develop, it is essential that they develop sustainable systems that allow them to deliver quality care. Since Deming involved the modern approach to continuous quality improvement, it has been demonstrated that this approach can markedly improve quality in a variety of industries, including the nursing home industry.[29] A monthly review of quality indicators by the nursing home leadership and workforce and empowerment of staff to remedy major problems has become a clear instrument of quality improvement. Public reporting of quality indicators appears to further improve quality.[30] Finally, we wish to note that the voices of nursing home residents themselves and their family carers should be heard in discussions about quality, and for many the evidence suggests that this is associated with positive staff attitude, staff knowledge, and good communication. The Task Force therefore recommends the following:

Recommendation 5. That nursing home quality indicators are developed that are sensitive to clinical and care needs and the right of older people to care that is dignified and respectful.

Recommendation 6. The use of physical and chemical restraints should be reduced to those that are absolutely indispensable.

Recommendations 7. That "meaningful activities" be offered to residents to provide physical and mental exercise and opportunities to participate within the nursing home and in community life, enhancing personal autonomy, social relationships (including intergenerational relationships), and social support.

Recommendation 8. That evidence-informed pain assessment and management programs are introduced into all nursing homes

Recommendation 9. That evidence-informed end-of-life and palliative care programs are introduced into all nursing homes.

Recommendation 10. That national drug approval agencies consider requiring drug trials that are age appropriate and inclusive of nursing home residents before they are approved.

EDUCATION TO CHANGE BEHAVIOR OF STAFF, IMPROVE CARE, AND INCREASE PRESTIGE

Given the small number of health professionals with expertise in nursing home care, it is essential that an international group of educators are developed. In the United States, the

physicians who obtained a certificate of medical direction from the American Medical Directors Association were found to have better quality outcomes than those who were not certified.[31,32] Certification in a specialized field tends to increase the reputation of health care professionals in that field.

Although education often has short-term effects, its long-term sustainability is often questionable.[33]

Locating collaborative models that pool and deploy nursing home expertise and leadership (nationally or internationally) offer the most affordable routes to advancing evidence-informed practice.[34] Communities of practice provide an efficient approach to developing sustainable collaborative capacities for evidence-informed practice.[35]

A promising community of practice model for use in nursing homes was developed in the United Kingdom.[36,37] The learning is situated in the workplace and practitioners work collaboratively to find implementation solutions to driving up standards through the implementation of evidence-based care guidance such as pain management. Community of practice membership is drawn from across a number of facilities and, dependent on geographical proximity, members can work and learn together through real-time meetings, over the Internet, or use a blended approach to suit circumstances. The group develops a sense of ownership of the evidence-based guidance by interpreting it through the lens of an agreed value base. In this way, cultural differences can be accommodated with the proviso that dignity and respectful care is in the foreground.[38,39] The learning journey builds confidence and competence to drive local improvements, and there is flexibility to use a range of brief or more involved improvement methods during the action phases. The use of Internet-mediated learning opens up possibilities for developing an international alliance of nursing home communities of practice to efficiently cascade expertise where it is needed.

The Task Force recommends the following:

RESEARCH AGENDA

Recommendation 11. That the International Association of Gerontology and Geriatrics develop international certification courses for nursing (care) home health professionals.

Recommendation 12. Pilot the use of "Community of Practice Models" as a practice improvement method for nursing homes, using both face-to-face interdisciplinary training and virtual team support.

To achieve safe and effective nursing home practice that is informed and improved through research, it is imperative that nursing home residents are included within clinical research studies. The exclusion of dependent older people who reside in care homes, which is common, weakens the evidence base for practice and limits opportunity to produce robust care guidance. Failure to include older nursing home residents in research to evaluate risks for age-related diseases and functional decline, develop therapeutic agents to treat disease, manage symptoms, and alleviate later life conditions is an unacceptable inequality. Slowing the loss of ability to perform activities of daily living has received inadequate focus, despite these being a key component in the life of older nursing home residents. For these reasons, it is timely to challenge and address the lack of investment in research to develop interventions that slow the loss of functional abilities. These are a major determinant of a person's quality of life and increase risk of premature death. It is a concern that most of the current clinical evidence and care guidelines may not be extrapolated to nursing homes. Many nursing home residents are either frail or disabled. Frail persons represent an ideal population in which interventions can slow the trajectory to or prevent disability.[40–42] Although there are some cross-cultural studies comparing function in developing countries, there is a shortage of nursing home research in developing countries.[42] This has been slightly remedied with a recent increase of nursing home research in China.[43–46] There is little information on the trajectory of functional decline across nations. In addition, little is known concerning which care models cross-culturally improve outcomes.

There are a number of syndromes in nursing homes that often lead to deterioration in function. These include weight loss,[47–49] falls and hip fractures,[50,51] behavioral management,[52,53] dementia,[54–57] depression,[58,59] pressure ulcers,[60] pain management,[61,62] sarcopenia,[63,64] and incontinence.[65] Studies of these conditions in nursing homes come mainly from Europe and North America. This research needs international replications together with health economic outcomes. Among the recognized challenges to rigorous research within nursing homes are difficulties in instituting randomized controlled trials, undervaluing of the contribution of qualitative studies, the existence of multiple confounders such as polypharmacy and comorbidities, and problems consenting individuals with cognitive impairment. Limited access to technologies and research able practitioners further constrains the performance of care home research. It is essential that we address these challenges and advance research that will allow the development of policies to shape high-quality nursing home care.

An added value of such research is its potential to enhance daily practice, improve education, and create positive working conditions and career development opportunities.

Although there has been much standardization of the ethical requirements to undertake research, there still remain culturally different approaches throughout the world. Nursing home residents represent a highly vulnerable group.

To realize this research vision, the Task Force recommends the following:

Recommendation 13. A universal ethical approach to obtaining informed consent and monitoring the appropriateness of research is developed.

Recommendation 14. Develop nursing home research capacity in developing nations.

Recommendation 15. An investment is made in research priorities that address major public health problems and inequalities that affect older people receiving

long-term care. Research priorities for which a high need is recognized include the following:

1) A worldwide survey of different models of care, nursing home structure, and issues in improving quality of care is undertaken.
2) A worldwide survey of older persons and their families is undertaken to determine their preferences for long-term care.
3) A cross-national, prospective epidemiological study measuring function and quality of life in nursing homes is undertaken.
4) Culturally appropriate standardized assessment instruments are developed including those involving social participatory methods.
5) A function-focused approach of the prevalence of geriatric syndromes, their impact on function, and development of strategies to improve care for these syndromes needs to be developed.
6) Research that evaluates the impact of different models of care against trajectories of physical and cognitive function is undertaken.

CONCLUSION

The Global Agenda developed by the Task Force on Nursing Homes represents a framework to enhance the quality of nursing home care. The Task Force will introduce some pilot projects to test the efficacy of these recommendations. It is hoped that these recommendations will stimulate others, including governmental and nongovernmental organizations, to focus on the needs of residents in nursing homes throughout the world.

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