ACTION POINTS

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Note: The purpose of this page is to encourage dissemination of the findings in QSHC, particularly to managers. Please feel free to photocopy this page and pass it on.

Q. DO NURSING HOMES OFFER A SAFE ENVIRONMENT FOR ELDERLY PEOPLE?

The decision to move an elderly person into a nursing home is often made on the grounds that they will be safer there. But this assumption may be misplaced, according to the author of this paper. He reports that there are many unsafe situations in the 17 000 nursing homes in the US—including falls, adverse drug events, pressure ulcers, problems with tube feeding, and equipment breakdowns. Better reporting of errors would help, but this will be difficult to achieve in view of the "pervasively adversarial—bordering on poisonous—legal, economic, political and medical environment surrounding the US nursing home industry". The author advocates a range of changes, such as modified Medicaid and Medicare payments, better information, quality initiatives, more financial support, and better communication between residents, family, and staff. "To meet . . . expanded expectations and preferences will be a formidable task, calling for expansive thinking and ingenuity beyond simple compliance with the safety oriented boundaries established by command and control regulations".
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We need to do much more to make nursing homes safe and satisfying.

Q: ARE NURSING HOME RESIDENTS GETTING APPROPRIATE MEDICATION?

A panel of three physicians and a pharmacist reviewed the medication taken by 1354 residents in nursing homes in Bergen, Norway in 1997. The residents were physically disabled or psychogeriatric patents aged 65 and over. Out of a total of 7419 drug items, the panel identified 2445 drug related problems: 47% of these were safety issues, 44% involved using at least one inappropriate drug, and 25% had problems about effectiveness. The most frequent concerns were related to adverse drug reactions, inappropriate drug choice, and probable undertreatment. Psychoactive drugs accounted for most problems. The authors comment: "Although this study was performed in a nursing home setting, the identified medication problems may not be unique to nursing home residents but may be relevant for the frail elderly population in general".
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The medication given to nursing home patients should be regularly reviewed by a doctor and a pharmacist.

Q: ARE WE GETTING A REASONABLE PICTURE OF ADVERSE DRUG EVENTS?

"We need to do a better job of keeping track of potential side effects when designing randomised clinical trials (RCTs)", say the authors of this brief report from Case Western Reserve University, Cleveland, Ohio. They note that some side effects are anticipated and monitored (second order effects), while others (third order effects) are unexpected and therefore the data on them are not collected systematically. Collection systems do exist, but they rely on the judgement of individual practitioners and the advice to these practitioners is often inadequate. The authors looked at the guidelines issued by 20 US National Institutes of Health and by the World Health Organization, and concluded that much of the language was "broad and vague". They wrote: "We think there should be more clarity and uniformity in these guidelines and that all guidelines should be accessible through the Internet or some other form of common global communication to the scientific community".
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We need to press for clear guidelines on reporting adverse events, and ensure that they are widely disseminated.

Q. HOW CAN WE ENCOURAGE DOCTORS TO FOLLOW GUIDELINES?

This randomised control trial, which took place in the Netherlands between 1996 and 1998, looked at ways of encouraging GPs to comply with cardiovascular guidelines issued by the Dutch College of GPs. A group of physician assistants were trained as facilitators, and they took part in a programme of feedback and support. The investigators found a statistically significant improvement for five of the 12 indicators: two concerning assessment of risk factors, two concerning provision of information, and the fifth on checking heart failure patients for clinical signs of deterioration. There were no changes in prescribing, however. The authors conclude that the support programme did improve clinical decision making, particularly in single handed practices, non-training practices, and those with older GPs. "The effects on the clinical decision making were, however, small and the average cost per practice was 1500 Euros", they add.
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We still need to keep working on how to encourage doctors to follow guidelines.