Impact of legislation on nursing home care in the United States: lessons for the United Kingdom

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Despite the growing recognition that our ageing population represents a major challenge to the provision of health services,^{1 2} no major government policy initiative had focused on this topic until the recent establishment of a royal commission. The royal commission was asked to concentrate on funding, but it was also required to define and establish mechanisms to assure the quality of long term care for elderly people, and was instructed to consider "the expectations of elderly people for dignity and security in the way in which their long term needs are met."³

In the United States, where long term care has undergone dramatic changes in the past 10 years, the quality of care continues to be hotly debated. The impetus for changes in the long term care system includes legislation and regulation in the form of the Nursing Home Reform Act of 1987. One aspect of this legislation pertained to the appropriateness of prescribing. We summarise briefly the legislation in respect of prescribing, its implementation, and influence on nursing home care delivery and consider alternative approaches for the United Kingdom.

Prescribing practices in nursing homes

Before the Nursing Home Reform Act, psychotropic drugs were used widely in US nursing homes.⁴⁻⁶ These drugs were prescribed for 43%-55% of patients in homes, despite the lack of documentation justifying their use.⁵⁻⁷ This practice may have been part of an effort to economise on staff, as larger facilities that employed fewer direct care personnel per bed were more likely to have high rates of psychotropic drug use.⁴

In 1983, the US Congress asked the Institute of Medicine of the National Academy of Sciences to make recommendations for improving the quality of care in nursing homes.⁸ The 1986 report highlighted the substantial evidence of appalling care, including documentation of neglect and abuse that had led to premature death, permanent injury, and unnecessary fear and suffering.⁹ While recommending high quality care designed to improve wellbeing, the Institute of Medicine report recommended specifically that fewer psychotropic drugs should be used.

Omnibus Budget Reconciliation Act of 1987

The Nursing Home Reform Act, embedded in the Omnibus Budget Reconciliation Act of 1987 and implemented in October 1990, contained virtually all the Institute of Medicine's recommendations and included regulations pertaining to guidelines for drug treatment.^{8 10} These regulations require that extensive documentation justifying the prescription of psychotropic drugs is provided. They state that no resident's drug regimen should include drugs that are not medically necessary¹¹—defined as drugs used in excessive

Summary points

Excessive use of psychotropic medication was commonplace in nursing homes in the United States before the Nursing Home Reform Act 1987 was passed

After legislation, psychotropic drugs were used less and a more structured approach to care planning was observed

In the United Kingdom, policy relating to nursing home care is unclear and explicit criteria for quality prescribing have not been formulated

A combination of structured assessment and review of patients, concerted educational interventions, and greater multidisciplinary working may improve long term care in the United Kingdom

doses, for too long, without adequate indications, or in the face of adverse consequences indicating that the dose should be reduced or the drug stopped.¹²

Summary of medication use

The legislation on prescribing requires that medication use must be summarised in relation to the following elements^{13 14}:

- Number of drugs used in the previous seven days
- Whether new drugs had been started in the previous 90 days
- Number of days in the previous seven on which the resident had received injections of any kind
- Number of days in the previous seven on which antipsychotic, anxiolytic, antidepressant, hypnotic, or diuretic drugs had been given.

Assessment instrument

In response to the legislation and the associated Health Care and Financing Administration regulations,^{10 15 16} a resident assessment instrument was designed and tested in 1989. It was implemented nationally in 1990 to coincide with residents' rights regulations.¹⁷ Drug regimen reviews are conducted on a monthly or quarterly basis using this instrument. Consultant pharmacists evaluate the appropriateness of, and response to, each patient's drug therapy,¹² and report any irregularities to the attending doctor and director of nursing.¹¹ These pharmacists are usually employed by large pharmacy consulting or provider organisations which have a contract with nursing homes to deliver pharmaceutical services.

Inspection

Inspectors of homes follow guidelines. These list commonly used antipsychotic drugs covered by the regula-

tion (for example, chlorpromazine, thioridazine, and haloperidol) and their corresponding proper indications (for example, schizophrenia) and improper indications (for example, non-cooperation) for use. If the use is not justified and documented, the home may be subject to punitive actions.

Impact of legislation on prescribing

Prescribing behaviour in US nursing homes has changed. In fact, changes were observed in anticipation of the formal implementation of the regulations. The prescribing of antipsychotic drugs decreased by about a third after the Nursing Home Reform Act.¹⁸⁻²⁰ It was not apparent that one psychotropic drug had been substituted for another, as the reductions in use were accompanied by a small increase in the prescribing of antidepressants and no increase in prescribing of sedative or hypnotic drugs.¹⁸ Patients whose documented symptoms before the legislation could be treated appropriately by antipsychotic drugs were less likely to have these drugs stopped.¹⁹ It seemed that the reductions resulted from a fall in new users of antipsychotic drugs.²⁰

Policy implications for the United Kingdom

In contrast to the United States, UK legislation pertaining to nursing homes does not contain explicit criteria in relation to the quality of care, the use of restraints, or the prescribing of psychoactive drugs. In terms of drug use, the regulations provide guidance only on the recording, safe keeping, handling, and disposal of drugs. However, some reports from UK nursing homes suggest that prescribing may not be optimal and that current practice in some homes would be considered to contravene the US legislation.²¹⁻²² It may seem that improvements in prescribing are needed, but legislation is only one impetus for change.

Introducing legislation to improve the quality of prescribing may be anathema to many doctors in the United Kingdom, who would consider it a challenge to clinical freedom. Though the Misuse of Drugs Act covers details on the prescription of controlled drugs,²³ the only legislative attempt aimed at changing prescribing behaviour in the United Kingdom was the limited list, which tried to counter rising drug costs but did not have a dramatic impact on patients and doctors' choice of drugs.²⁴⁻²⁵

Quality through education

The United Kingdom may be better suited to an approach that focuses on achieving quality prescribing through education,²⁶ as regulation to promote change does not necessarily promote quality. Inadequate training in geriatric pharmacotherapy may contribute to poor prescribing in nursing homes.⁸⁻²⁷⁻²⁸ Programmes tailored to the individual have proved to be successful in changing prescribing patterns and are familiar to doctors in the United Kingdom as medical and pharmaceutical advisers have used them to improve prescribing within general practice (the process of "academic detailing").²⁹⁻³⁰ The long term benefits of this approach for doctors, other healthcare professionals, and patients may be much greater.²⁹⁻³⁰

HILARY ROSEN

A structured approach in the United Kingdom

In its report *Medication for Older People*, the Royal College of Physicians has called for the development of national guidelines on the administration of drugs in nursing homes and the identification and publication of good clinical and caring practice.³¹ It has been reported that the quality and quantity of data on the healthcare needs of patients in long stay homes in the United Kingdom are poor.³² Thus, clear assessment and review of patients together with research into effective interventions should be considered as strategies for improving patient care in nursing homes.³² The resident assessment instrument, which is currently being evaluated for use in the United Kingdom, may be a way of structuring and standardising care, and it is hoped that it will improve outcomes.¹³ Clearly, this has resource implications in terms of training and implementation. However, combining structured assessment and review of patients, the introduction of concerted educational interventions, and greater interdisciplinary working may be the best way of improving pharmacotherapy in UK nursing homes.

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Commentary: A new script for nursing home care in the United Kingdom?

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There is precious little published evidence about the control and monitoring of medication prescribed for frail older residents in nursing homes in the United Kingdom. This is all the more worrying when set in the context of the general paucity of research on nursing home care for this vulnerable client group.¹ A recent national audit report illustrates that further research in this field is well overdue.² Hughes and colleagues argue that the United Kingdom can learn from experience of prescribing practice in nursing homes in the United States. The authors credit the legislation against over-utilisation of psychotropic drugs in American nursing homes with a reduction of a third in the prescription of antipsychotic drugs. However, reductions in the prescribing of psychoactive drugs are reported to have occurred before the legislation came into effect.³⁻⁴ Furthermore, the legislation was criticised for being restrictive without providing guidelines on alternative drug treatments and, possibly, for leading to negative prescribing habits that were detrimental to some older patients.⁵⁻⁶

Recommendations rather than legislation

Parallels with the position in the United Kingdom are tenuous. There is no systematic evidence documenting poor prescribing practice in nursing homes here. However, pockets of evidence indicate that prescribing is more common among older residents in nursing homes (compared with their peers who are not living in nursing homes), and that it is highly variable and often inappropriate.⁷⁻⁹ The impact of local variations in prescribing practice on the health and welfare of older residents is unknown. Certainly there is no British legislation to enforce any kind of national prescribing standards. The royal commission's recommendation that a national care commission should be established with wide ranging powers to monitor care, set assessment

and quality benchmarks, and encourage good practice and innovation in long term care settings for older people does provide some hope. However, the signs that the commission's recommendations are being "mothballed" by the government and are not being pursued by the opposition do not augur well.

A primary care problem

Hughes and colleagues do not elaborate on the reasons for poor prescribing in US nursing homes, but perverse incentives may have operated in the insurance driven system of that country. In the United Kingdom, the burden of responsibility for prescribing rests with general practitioners—a group that was never consulted about adopting responsibility for nursing home residents. Frail older patients were systematically removed from the care of consultant geriatricians and gravitated on to general practitioners' lists as the number of long stay beds in hospitals withered in the wake of burgeoning development of private sector nursing homes. Overworked, undertrained, and sometimes unenthusiastic general practitioners have tried to pick up the pieces ever since.¹⁰ Older patients in nursing homes often need intense specialist care that general practitioners are often poorly equipped and inadequately remunerated to provide. Not surprisingly, the rearguard action of general practitioners to provide medical support to nursing homes is under increasing strain, culminating in growing calls to exclude nursing home patients from the terms of their contract to provide general medical services.¹¹

Ways to improvement

The investment of skill and time to remedy healthcare problems in UK nursing homes—whether through pre-

vention, assessment, treatment, or rehabilitation—cannot be left to beleaguered general practitioners. In the United States, drug treatment in nursing homes can be monitored through the expert support of consultant pharmacists, often contracted to support homes. Alongside pharmacists, specialist nurses and rehabilitation therapists have been put forward as able to offer a similar service in the United Kingdom, thus easing the burden placed on primary healthcare teams.¹² In addition, simple guidelines on the effective management of common conditions known to trouble older residents in nursing home are long overdue and would help nursing home staff maintain and improve health status.¹³ These kinds of recommendations were made in a recent report on prescribing practice in primary care.¹⁴

The refocusing of nursing home regulation and inspection systems to monitor more useful indicators of high quality health care in homes is another obvious pathway to improvement. The expected plans to create independent (joint health and social care) home regulation authorities may provide opportunities for this to be explored.¹⁵ Perhaps even more straightforward, developing public and professional awareness of the impact of drugs on frail older people through clear labelling and advice leaflets may reduce the morbidity associated with these agents.¹⁶

What is the road to recovery for UK nursing homes? The script has not yet been written. When it is, let us hope that it is not “too little, too late.” Whatever the price of any effective remedy, the most vulnerable members of society cannot be expected to continue to bear the cost of maintaining the current *laissez faire* attitude to improving health care in nursing homes. The present residents of our nursing homes are the very people who fervently supported the NHS from its

cradle ... and believed it would care for them to the grave. They deserve better treatment than that currently meted out in NHS long term care.

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The hospital of the future

Is bigger better? Concentration in the provision of secondary care

John Posnett

A close observer of the NHS over the past 10 years might be forgiven for thinking that the debate about the concentration of acute hospital services has been driven more by the needs of NHS managers and the medical professions than by the needs of the local populations that they are supposed to serve. Managers have faced pressures to reduce unit costs and, in particular, the “wasteful” costs of management itself. The medical professions, through their respective royal colleges, have encouraged the closure or rationalisation of smaller units through pressures for greater specialisation.

The result has been pressure for further concentration in the provision of hospital services through rationalisation and trust mergers. The logic is inescapable: larger units reduce average costs through the operation of economies of scale and larger units improve patient outcomes by increasing average volumes of activity by clinicians. Unfortunately, this logic is not supported by the evidence.

Summary points

NHS managers have been subject in recent years to considerable pressure to increase concentration and trust mergers

This pressure has been justified by a belief that larger hospitals lead to lower average costs and better clinical outcomes

Evidence from research does not support any general presumption that larger hospitals benefit from economies of scale or that service concentration leads to improved outcomes for patients

Service planners would do well to give more prominence to the importance of ensuring that hospital services are local and easily accessible

This is the third in a series of seven articles

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