Dear Dr. Jeff:

I am a new medical director. My contract says that, among other things, I am expected to provide consultation regarding resident-care policies and procedures, but after 3 months, no one has asked me anything. Should I be delighted that everything is running smoothly or worried that I am not carrying out my responsibilities?

Dr. Jeff responds: Both you and the facility should be worried. Federal regulations, technically 42 CFR 483.75(i), require that the facility have a medical director who is responsible not only to assist in the formulation of resident-care policies, but also their implementation.

Resident-care policies, according to the Centers for Medicare & Medicaid Services—issued guidance for surveyors (F-tag 501 within the State Operations Manual), include a long list of obligations beyond monitoring the performance and privileges of practitioners. They’re well worth reviewing in detail.

Included is oversight of the nursing facility’s policies and procedures governing the work of nonphysician health care workers such as nurses, rehabilitation therapists, and dieticians. The medical director is also responsible for resident assessments, care planning, medication use, infection control, physical restraint use, radiology, pharmacy, and (lest anything was left off the list) “overall quality of care.”

If your facility is failing to involve you in this process, it is at risk for a significant deficiency under this section of the code. The deficiency citation is for the facility, not for you, as it is responsible for involving you in the process. At least as important, if a medical director’s expertise is going to waste, the facility and its residents are losing the opportunity to have a knowledgeable physician improve its practices and quality of resident care.

Many physicians are confused by the distinction between policies and procedures. Policies are the overarching principles by which we practice, while procedures are the detailed mechanisms by which these policies are carried out. For example, it might be the policy of the facility that every new resident receives a comprehensive assessment of care needs and an interdisciplinary care plan, and that these be updated as the resident’s needs change. Since this is required by law, it seems like an uncontroversial policy.

Federal law mandates the completion of a Minimum Data Set, Version 3.0 (MDS 3.0) form upon every new admission. But which staff members collect various portions of the required information and what additional information they collect varies from facility to facility. These are procedures. Since, as we have all come to learn, the devil is in the details, it is vital that the medical director review care procedures as well as the care policies.

AMDA has identified this process as a key function of the medical director. Indeed, in the association’s 2011 white paper on the functions and responsibilities of the nursing home medical director (White Paper A11), creating, periodically reviewing, and updating policies and procedures is literally first on the list. Most facilities maintain a policy and procedure manual and revise it annually. Given its size, it is advisable to divide a typical manual into sections for scheduled, periodic reviews. If nothing else, this can avoid the nontrivial problem of marathon meetings.

During the review process, one key question to ask is whether what is written is what the facility actually does. In many nursing homes, the policy and procedure manual is a large volume kept in the administrator’s office, unknown to most of the staff and ignored by others. Listed procedures may describe outdated pieces of equipment or assign tasks to individuals with job titles that no longer exist. Changed circumstances may, of necessity, change actual practice while leaving the manual untouched.

For example, the Patient Self-Determination Act of 1990 required nursing homes to notify new residents of their right to execute advance directives at the time of their admission. In a calmer era, many facilities regarded a social worker as the most appropriate professional to initiate that discussion. However, many facilities now accept new admissions to subacute units on Friday nights and weekends without increasing social work staffing to address this technical requirement, potentially leaving the facility noncompliant with the legal requirement that the notification occur within 48 hours of admission.

Clearly, medically unstable populations may be the residents who most need formally documented advance directives. As a practical matter, this task might properly fall to an admitting nurse, the nursing supervisor, or (under ideal circumstances) to an admitting physician. However, without an updated procedure, there is a significant risk that it becomes no one’s responsibility and is occasionally forgotten.

By Jeffrey Nichols, MD

Understanding Policy Is the Medical Director’s Best Practice

Good P&Ps, Best Practices

Well-crafted policies allow facilities to improve their care. A medical director can enhance or retard that process. For example, the responsibility for oversight of dietary-service policies does not mean that the medical director should be involved in creating menus, selecting ingredients, or reviewing recipes. But at a time when registered-dietician organizations have been moving away from the ever more detailed American Diabetes Association regimens to more liberalized diets for nursing home residents, these changes should be reflected in a facility’s dietary manual.

The diets offered in a facility constitute a resident-care policy. If the medical director supports the change away from a starchy diabetes diet to a simpler nonconcentrated-sweet diet, the residents’ quality of life will benefit. Attending physicians can order only those diets that are offered by the facility, so such a move will inevitably change care practices. This is an example of how the administration and leadership function of the medical director can improve the care of dozens or even hundreds of residents.

There is a natural desire to have policies and procedures reflect best practices. But they should not be a “wish list” of desired practices and unobtainable goals. Your policy should not be “All our residents will be free of pressure ulcers,” but rather “Our residents will be free of unavoidable new pressure ulcers acquired in the facility and all those with pressure ulcers, whether acquired outside the facility or in house, will have appropriate measures taken to facilitate healing.” This policy should then lead to procedures such as identifying and assessing skin integrity upon admission, determining how often thereafter the risk of skin breakdown will be assessed, deciding what measures will be taken to protect residents, and what care your facility will give when a wound erupts.

Thus, reviewing the procedures in place allows for the identification of potential gaps in prevention and care and the implementation of improved procedures. But even the best procedures do not guarantee that every outcome will be perfect, nor do they guarantee that residents won’t refuse elements of ideal care. Remember that attorneys and the state survey agency hold us accountable both to state and federal regulations and to our own policies and procedures. If a bad outcome does occur, we will be considered responsible for it if we failed to follow our own preventive procedures, even if we complied with all legal requirements.

For example, it might be a best practice for every ambulatory resident to have his or her gait reassessed by a physical therapist monthly. However, given the short- age of physical therapists in long-term care and the demand for their services in rehabilitation, this is probably not an efficient use of their time or an attainable goal within your facility. However, if facility policy states that monthly assessments will occur and an unassessed resident does fall—regardless of whether the fall was actually preventable—the facility might be found negligent.

Procedures must reflect what we actually do. Honesty really is the best policy.

Most nursing homes have both a quality-improvement committee and a policies and procedures committee. The medical director should serve on both. For most physicians, quality improvement sounds like an exciting challenge while policy and procedures sound like the ultimate in boring paper pushing. But a meaningful quality-improvement process consists of more than simply monitoring statistics or assigning praise and blame.

Changing will only occur with changes in the care process. Poor outcomes are generally not the result of bad apples but rather of bad systems. As AMDA Vice President Dr. Len Gelman, CMD, is fond of saying, “Every system is perfectly designed to produce the outcome it produces.” In short, the problems that are identified in the quality-improvement process should be addressed through the policy and procedure process. Only if we change the way we deliver care can we hope to improve the care we deliver.

Don’t be shy about asserting your need to be involved in the review of resident care procedures. Ask to see the policy and procedure manual. Ask the administrator and director of nursing when these policies are reviewed and how. Compare what you see in the manual with what you see actually occurring in the facility and with what you know to represent good care. By doing so, you have the opportunity to improve the lives of all the residents in the nursing home.

Dr. Nichols is the medical director of Our Lady of Consolation and Good Samaritan Nursing Homes in Suffolk County, N.Y., and senior vice president for clinical effectiveness of the Catholic Health Care System of Long Island. He invites your questions for column inclusion in this column, to caring@elsevier.com. You can also comment on this and other columns at www.caringfortheages.com, under “Views.”