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Featured Article

Understanding the relationship between nursing home quality initiatives and caregiving behaviors

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ABSTRACT

Background and Objectives: Qualitative research including frontline worker voices on nursing home quality is important but limited in the current available literature. This research aims to explore the perspectives of nursing home staff in relation to CMS quality initiatives and identify themes to better inform policymakers of the frontline worker experience.
Research Design and Methods: This qualitative study included 20 participants from four nursing homes in the Baltimore/Washington DC metropolitan area. Interviews were performed in person based on an open-ended questionnaire developed by the PI. Interviews were transcribed and audio recorded if consent was given. Themes were identified, extracted, and coded related to participant knowledge of CMS quality initiatives and their opinions on quality care.
Results: Findings suggest that participants have little knowledge of CMS quality initiatives, and their definitions of high-quality care do not align with metrics tracked by CMS.
Discussion and Implications: Policymakers must work to incorporate frontline worker views when defining and measuring quality care. Additionally, facility leaders may benefit from incorporating frontline worker input into quality improvement programming.
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Introduction

The nursing home industry is a highly regulated and complex system, monitored by a multi-tiered regulatory process stemming from the federal level down to state governments and local jurisdictions.[1,2] Nursing home regulations aim to ensure all facilities meet a minimum standard of quality reflected by health inspections and tracking of patient outcomes, yet reports have revealed widespread issues regarding successful implementation of nursing home regulatory policy on all levels. The Office of the Inspector General (OIG) and the National Academies of Sciences Engineering and Medicine (NASEM) have identified prevalent problems contributing to the ineffectiveness of regulation in this sector. From states performing CMS delegated annual surveys in an untimely manner to tools criticized for their inability to determine objective quality, nearly every aspect of the nursing home regulatory process has been scrutinized.[3,4]

Recent research reveals that components of quality consumers would find valuable in making informed choices for nursing home care are either misleading or absent, and scoring systems depicting quality ratings may not be an accurate representation of what one would consider high quality.[5–7] Research continues to explore how the nursing home regulatory system operates and relates to nursing home quality outcomes. Findings in this research show the system often falls short of ensuring minimum quality standards are met in facilities caring for the nursing home population, leaving residents vulnerable to abuse, neglect, and poor health outcomes.[4,8] Nursing home staffing is a contributing factor to these shortcomings, as burnout and high turnover within the sector, exacerbated by the COVID-19 pandemic, have been linked to low job satisfaction and decreased quality of life for nursing home residents.[9,10]

Qualitative interviewing can be an informative approach to understanding the experiences of workers in healthcare. Researchers have conducted qualitative interviews to identify trends in staff responses to regulation and its impact on work environment, however these studies make up a small portion of research in the recently published literature on nursing home quality, and interviews most often include managerial-level and supervisory staff.[11,12] Lacking in the literature is the input of frontline workers who perform hands-on care. As identified by Chung, Certified Nursing Assistants (CNAs) provide 80 % of the care to nursing home residents.[13] Yet, little is known about their opinions on the work duties they are assigned which

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have been implemented to meet expected quality standards.[13,14] The literature is also sparce in qualitative analysis of floor nurses and therapy staff who provide care that impacts quality such as medication administration, wound care, and prevention of functional decline. Noting the gaps in current literature regarding the important topic of nursing home quality, this research involves the lived experiences of direct caregiving providers within nursing homes in contrast to studies focusing on managerial perspectives.

As policymakers evaluate and update policy, it is vital they receive direct, detailed feedback from those performing a majority of the hands-on care in nursing facilities. Contributions can be made to the relevant literature base and policy can be adapted to reflect the input of those expected to comply with standards with input from those most entrenched in the field. The purpose of this research is to understand the perceptions of frontline nursing home workers in regard to their job duties and how those duties relate to nursing home quality as they define it and per CMS metrics.

Background

The major focus of nursing home quality research is the CMS Five-Star Rating. The Five-Star Rating is a ranking of one to five given to nursing homes throughout the United States, accessible on the government-run website Care Compare. It is calculated using data from health inspection surveys, Quality Measures (QMs), and staffing reports, with five stars being the highest of quality, three stars representing average quality, and one star being the lowest quality.[15] Nursing homes often aim to achieve higher CMS Five-Star Ratings than local counterparts in order to increase the potential for consumers to select their facility for care over others.[11]

Health inspection surveys are a comprehensive event, required to be performed in nursing homes every 12 to 15 months. The relevant state department of health will review medical records, operations logs, the physical presentation of a facility, ensuring facilities meet minimum standards of care provision to maintain their CMS certification.[1] Deficiencies, referred to as “F-tags” (Federal tags), are applied when issues are observed, and impact the overall CMS Five-Star Rating of a nursing home. The most severe F-tags are associated with civil monetary penalties (CMPs).[16] Prior to the expected survey window, many facility leaders spend time preparing the facility to be “survey ready” to avoid severe F-tags and the associated penalties, as well as poor outcomes that affect quality ratings.[17,18]

The purpose of regulation within the nursing home sector is to create guidelines to protect the vulnerable population that utilizes these services and ensure they are cared for at the highest practical level at all times.[16] However, those providing a majority of the care are often the least involved in learning about survey expectations or the purpose of performing duties as they relate to rules and regulations.[13] Voices of those who complete the daily duties that have the highest impact on nursing home residents and resulting survey outcomes are vital in understanding why some facilities may underperform during health inspections.

QMs are health outcomes that are aggregated to create care performance components that are tracked and analyzed by CMS to reveal trends in nursing home quality. If residents are being appropriately cared for, such cleaned, toileted, and provided therapy services, outcomes as tracked by the QMs are likely to reflect higher quality. Some QMs are utilized in the calculation of the overall CMS Five-Star Rating, and data on a majority of the QMs are accessible to the public. Research regarding frontline staff perceptions of the QMs is minimal, with frontline worker participants making up less than a quarter of those interviewed on the topic in some cases.[5,6]

Qualitative research provides an opportunity to explore phenomena and develop concepts that cannot be extracted numerically from other forms of data. To understand frontline worker experiences and determine a link between caregiving behaviors and quality outcomes, qualitative interviewing is the necessary route.

Framework

Donabedian’s framework is utilized by CMS in their quality measurement efforts and frames this research as well.[19] This framework includes how structure, process, and outcome impact quality of care. Structure refers to the organizational structure and policies of a healthcare setting, process is the delivery of care, and outcomes are the impacts and effects of the care.[20] Qualitative feedback from frontline workers provides insight as to how the structures and processes in the industry influence the care and health outcomes of nursing home residents.

Overlapping with Donabedian’s framework in the system of nursing home regulation is the principal agent theory. CMS acts as the main principal in the hierarchical structure of nursing home regulatory oversight, enlisting multiple agents such as state health departments, nursing home administrators, and frontline workers to ensure the goal of improved nursing home quality is achieved.[21] CMS outlines the objective of improving quality of care and quality of life, improving service delivery and patient safety, and improving professional standards in the nursing home industry through regulatory oversight.[1] Successful implementation of the principal-agent theory results in the achievement of the common goal of those involved, therefore it is necessary to understand the objectives of frontline workers to determine if both principal and agent are aligned. When the expectations and goals of CMS do not align with the expectations and goals of those providing care, adverse outcomes and unmet goals are anticipated.

This research presents a qualitative analysis that yields insight into the knowledge and opinions of nursing home staff who are providing a majority of the care that impacts quality as defined by CMS. Answers from frontline workers about their perceptions of their job roles and their resulting caregiving behaviors provide understanding into staff awareness of regulations and if behaviors are motivated by regulations or by other factors. If nursing home workers provide responses that reveal the caregiving methods (i.e., processes) are not informed by the policies and regulations governing nursing home institutions (i.e., structure), then it is possible that desired outcomes are not being achieved. Conversely, caregiving behaviors not informed by policies intended to reduce poor health outcomes and mortality could result in increased instances of illness and potential death.

Methods

This study collected information via qualitative interviewing with the aim of understanding the perceptions frontline nursing home staff members have about their duties that are governed by regulatory guidelines, and how those perceptions impact care delivery behaviors.

Research question

How do frontline workers perceive and respond to job duties related to nursing home quality initiatives and how does their perception impact caregiving behavior?

Recruitment

Six nursing home administrators (NHAs) known by the principal investigator (PI) through professional networks in the Baltimore, MD and Washington, DC metropolitan area were contacted to have their staff participate in the study. Four agreed to allow the PI to have staff

participate. The four facilities that were involved in the study were owned by three different companies, allowing for variation in responses. Each NHA who agreed to facility participation was asked to identify five workers to be interviewed for the study, resulting in 20 total participants. As themes emerged and were then repeated throughout the 20 interviews without new themes discussed, data saturation was evident, and it was determined that sufficient data were collected for the purposes of the study and further interviews were not necessary. Eligible participants included nursing assistants, floor nurses, and therapy staff; aged 18 years and older; English speaking; with various years of experience. Interviewees were provided with a description of the study and contact information of the PI, as well as a consent form if they agreed to have the interview recorded. The PI reviewed the recording consent form with each participant, reiterating that the interviews were anonymous and confidential, there was no risk associated with participation, and their participation was voluntary. Participant identifiers were not recorded for the study, rather each participant was assigned a three-digit number using a random number generator along with an alpha character correlating with the site. Each interviewee received instructions on how to redeem a $20 incentive of their choice at the conclusion of the interview, funded by the University of Maryland, Baltimore County (UMBC) Graduate Student Association. This study was granted an approval of exemption from the Institutional Review Board of UMBC, Kuali Protocol # 1320. All recordings and transcriptions were stored in a password protected file within the PI's UMBC Microsoft account, only accessible by the PI.

Interviewing procedures

Participants were asked basic descriptive information, followed by semi-structured open-ended questions as outlined in the interview guide in Appendix A. The interview guide was developed by the PI with input from collaborators familiar with qualitative interviewing of nursing home workers in an effort to develop a tool mitigating bias or assumptions during interviews. The guide and interview procedures were audited by the collaborators ensuring reflexivity of the research. Interviews ranged from 10 to 32 min. Each interview was completed in person, with nine agreeing to be audio recorded. The PI transcribed responses during all 20 interviews. Following the prompts in the interview guide, frontline worker knowledge of quality initiatives and opinions on defining high quality care was gauged by asking questions about job duties and subjective opinions regarding those duties.

Data analysis

A two-tiered coding scheme was developed to analyze responses via inductive thematic analysis informed by the work of Braun and Clarke.[22] Initially, responses were coded based on the interview guide and included descriptive information, worker perception of duties/roles, definition of nursing home quality, and inclusion of the Five-Star Rating, QMs, or survey in responses. Responses identifying any of these items were coded during each line of questioning, with the absence of these items identified as well. Questions that elicited a "yes" or "no" response were coded as such. The transcribed interviews were reviewed a second time for shared themes throughout the responses. Themes were considered significant and added to the coding scheme when overlapping sentiments were provided in multiple interviews. After the initial interviews, the transcribed interviews and recordings were reviewed on three separate occasions by the PI to ensure all relevant themes were captured and coded appropriately.

Results

Trends found from responses are discussed in relation to the research question. Themes included definitions of quality by participants that are not reflective of CMS quality measurement, limited knowledge regarding CMS quality initiatives, and goal displacement when comparing CMS goals regarding nursing home care to frontline worker perceptions and actions.

Participants

The research participants included eight CNAs, nine therapy staff, and three nurses. Worker experience ranged from six months to 40 years. Three of the therapy participants were the director of their department or had prior experience as a director of a rehab department. All three nurses were licensed practical nurses, with one having prior experience in nurse management.

Duties

When asked to describe their duties, all participants discussed tasks that were related to at least one QM, although the term "quality measures" was not used. A majority of responses when describing main job duties (70 %) involved activities of daily living (ADLs) such as bathing or toileting a resident. Other common responses related to QMs included overall prevention of functional decline or promoting functional independence (60 %) and skin integrity/wound prevention (35 %).

A685: "Our goals around here are focused on, um a lot of it is endurance and strengthening, ADLs, transfers, balance. . .. To be able to stand longer periods of time during ADLs, to be able to walk longer periods of time, strength to maintain their standing. . .. So they continue at the level of performance they were at home. For [long term care patients] we're trying to prevent decline in their current status."

B474: "[Assessments] are head to toe. . ..You're looking for symptoms of anything that is not normal, something unusual, something that particular patient has never exhibited. You're looking for are they happy, has any condition changed, intestine, skin. They should be addressed if you find them."

D351 (paraphrased): Assisting patients young to old, grooming, feeding, transferring, talking to them, helping them do things they can't do for themselves.

No participants discussed preparing for health inspection surveys directly, however several discussed items that are commonly addressed during surveys, such as turning and repositioning regularly or timely medication administration (25 %). These responses indicate some overlap of workers' understanding of their duties aligning with CMS definitions of quality as defined by the QMs, but reveal a lack in comprehensive understanding of CMS quality initiatives.

High quality care

When asked to describe high quality care the most frequently discussed theme when describing high quality care was teamwork (75 %), followed by individualized care, i.e. care that is specific to an individual's needs versus a blanket approach to providing care (60 %) and adequate staffing (60 %). Empathy (55 %) and communication (55 %) were also common themes discussed when addressing high quality care.

A835: "Everybody has different needs. . . I think that we should be working as a team. I think that nursing staff, social work, dietary, therapy, um everybody should be communicating and as a team and providing services for our patients that they need."

B474: "Being empathetic, sympathetic, and uh, advocating. These are all things that is required in order to get the optimum care."

C513: "I think to provide high quality care to a patient you obviously have to look at that specific client's full picture, all of their needs, their cultural context, everything…. You need to have really good communication between all the disciplines."

Patient outcomes, such as a patient reaching their maximum potential or improving independence, were mentioned by six participants (30 %), and ensuring quarterly assessments were performed to "make sure no one falls through the cracks" (C775) was discussed once (5 %). Some participants also discussed items they would look for to determine whether a nursing home facility was of high quality in addition to care, including cleanliness and presentation of a building (35 %) and customer service (35 %). A majority of the themes identified are not reflective of items tracked through QM data collection or survey processes which CMS uses to define high quality care.

Knowledge of CMS quality initiatives

When participants were asked what they knew about how CMS measures nursing home quality, only one participant (5 %), who was also in a leadership position, named the Five-Star Rating without prompting by the interviewer. Once hearing the term from the interviewer, most participants stated they had heard of the Five-Star Rating but did not know the components or how it was calculated (65 %). Four participants had never heard the term Five-Star Rating (20 %). Several participants were able to identify some accurate details regarding the Five-Star Rating (15 %), but none were able to describe all of the relevant components of survey, QMs, and staffing.

A603 (paraphrased): They want less infections, less bad reviews…I know the state comes and does an inspection. They tell you what to do.

B361: "Recently I haven't looked at what CMS identifies as high quality care. But if I had to guess…making sure the patients are up to par. Making sure their nails are cut… making sure they are getting changed, making sure they are getting turned, I mean you could go on and on… I just know [Five Star Rating] exists and I realize most nursing homes want to be five stars."

Quality measures

None of the participants independently identified QMs as a metric that CMS uses to evaluate quality, and 65 % of the participants had never heard the term "quality measures". Almost half of the participants (45 %) discussed individual QM items such as wounds or falls as metrics CMS uses to measure quality but had not heard them called referred to as "quality measures". Seven of the participants stated they had heard the term once prompted by the PI but did not know any other details of the QMs (35 %).

B573: "Honestly, in all the facilities I have worked in, it's rare you hear them say 'this is because of quality measures'".

C775: "[Department heads] meet once a month…. to make sure infections are down and staffing is up…. If people have falls we go over falls…. I assume we are doing all that because of the CMS guidelines."

D937 (paraphrased): I know they use the MDS, gather that data… they probably have to report skin breakdowns.

Survey

Most participants had heard of the survey and had some understanding of expectations for performing well on surveys (75 %). Two participants stated they knew of the survey but did not know details (10 %) and one participant, who had worked in their role for two years, had never heard of the survey (5 %). Two participants did not provide conclusive statements regarding their knowledge or lack of knowledge on the survey (10 %).

A603 (paraphrased): Sometimes the state is called, the survey will give you tags and you have to work on those tags.

B763: "[Survey] doesn't get me in a frenzy. Because if you're always doing what you are supposed to do you don't have to worry about being in trouble when they come."

C513: "I know what they are looking for when they come for survey…..they're definitely kind of digging around… are things safe and hygienic, do the patients have access to things they need."

In discussing surveys, 45 % of participants mentioned workers acting differently during a survey, following protocols more strictly to avoid getting in trouble while under inspection.

A423 (paraphrased): There's more teamwork when the state is here. They don't want to get tagged.

C775: "Why does the state have to be here to make it right?… I just think it's human nature. Honestly, I think that everybody's life is imperfect… and then the state comes in they are expecting perfection, and I think that's very hard to maintain anyway…. There's a very high standard."

These answers again reveal a disconnect between staff knowledge and understanding of their role in nursing home quality when compared to CMS quality initiatives. Staff knew slightly more about the survey process than QMs, but the responses lacked details that would demonstrate sufficient understanding of the survey process and how it relates to nursing home quality as defined by CMS.

Monitoring and behavior

Over half of the participants knew that CMS monitored patient outcomes or individual QMs occurred in some fashion (65 %), while 35 % of participants did not know about monitoring or tracking of quality items by CMS. When asked if knowing that these outcomes were being monitored changed how they thought about performing their job duties, 80 % of participants stated no, including sentiments about doing their best no matter who is watching or what is being tracked. However, 70 % of participants thought other workers may perform their job duties differently if they were aware CMS was tracking and monitoring patient outcomes. Of the 20 participants, 19 (95 %) stated they saw a link between their job and the quality of care in nursing homes. One respondent did not answer the question on linking their job to nursing home quality directly.

A423 (paraphrased): It doesn't change how I look at my job. I try to do my all. I might be in a nursing home down the line.

B763: "No, 'cause I would like to say that I do my very best…. I go above and beyond for each patient… I know how I would have wanted [my grandmother] cared for… so I do the same with everybody. I believe that if [others] knew they was tracked and things like that their job performance would be better… the care that you give, your name goes back."

When discussing how monitoring may impact worker behavior, 20 % of participants stated enforcement of consequences was necessary to elicit compliance, and that knowledge of monitoring is not effective if there is no penalty for poor performance.

C513: "If we had that kind of environment where you knew you could be replaced for not performing your job correctly yeah I think it would make people want to do the right thing more often, but here there's no consequence."

D351 (paraphrased): People don't really take their job seriously if they are not held accountable.

Despite general awareness of patient outcomes being tracked or monitored by CMS, workers do not identify this as a motivator in their job performance.

Additional themes

Throughout the interviews, several additional topics arose by participants repetitively which may be of interest for future research on nursing home quality.

Although most respondents stated their job performance is not impacted by knowing that outcomes are monitored, 65 % said having increased knowledge about how quality is measured in nursing homes helps them better understand their role and their job duties as they relate to the nursing home system overall.

B474: "Now that I know how these agencies do utilize the care we give to do what they do. . ..it just gives me more sense on how they use it."

D357 (paraphrased): Knowing these items helps to understand why certain things are asked of me.

Discussion

Based on the responses by frontline caregivers in nursing homes, it appears that caregiving processes are not informed by current structures, and the goals of caregivers do not directly align with CMS. The goal of CMS outlined in the federal regulatory guidelines for nursing homes is to improve the quality of life of nursing home residents by improving care quality, resident safety, and the logical flow of regulations.[1] By way of the Donabedian framework, the structures of regulation attempt to improve the outcome of nursing home quality: health inspection surveys, tracking and monitoring of QMs, and assignment of overall quality rankings via the Five-Star Rating. Responses given in this research do not reflect a properly functioning system informed by the Donabedian framework. In the context of the principal-agent theory, caregiving behaviors aligned to the goals set forth by CMS are needed to achieve the outcome of improved quality. Although frontline workers identify high quality care as an important objective, their tools to define high-quality care do not reflect the measurements used by CMS.

Frontline workers possess little knowledge of the structures CMS has created to improve the quality of nursing homes. Many participants stated they had only heard of the Five-Star Rating or related concepts, with no insight regarding their purpose or significance. Although terminology is recognizable, the relevance of the Five-Star Rating or QM tracking to the day-to-day concerns of caregivers is miniscule. Frontline workers who participated in this study defined high quality care as involving empathy, communication, teamwork, individualized care, and adequate staffing. While CMS guidelines include requirements for individualized care plans, and staffing is an ongoing focus for policymakers, the concepts of empathy, communication, and teamwork are not transparent in QMs or survey results.[1] Most participants did not indicate that they would alter their caregiving behaviors because of the survey, QM tracking, or the concept of being monitored. The current quality tracking systems do not resonate with the workers whose jobs have the greatest impact on quality as measured by CMS. Their focus is primarily on humanistic attributes of care, not calculable numeric metrics, a finding consistent with other research in this field.[14]

The differences in caregiver perception of high-quality care in comparison to CMS expectations is a phenomenon known as goal displacement, where the original goals set forth by an organization or governing body are not reflected in the daily practices of the workers.[23] CMS is striving to achieve outcomes driven by the Five Star Rating, surveys, and QMs, while those responsible for implementing processes, i.e. caregivers, are driven by reciprocity and compassion. The findings in this research reveal this disconnect. With the misalignment of goals between the principal and agent, the ability to achieve desired outcomes is hindered, and those receiving care suffer the consequences of a disjointed care delivery system. The results support findings that are critical of the Five Star Rating system and its ability to truly represent quality as it is defined by consumers and caregivers.[24] Bridging the institutional regulatory practices to care delivery is a solution that, while challenging, could benefit the industry greatly.[25]

Nearly every participant of this study acknowledged a link between their job and the level of quality in a nursing home. A majority of participants also mentioned job responsibilities directly related to QMs and items that are reviewed during surveys, although they had not heard of the QMs or were only vaguely familiar with the terminology. Participants noted that education and understanding the "why" behind job tasks and how the system works was helpful. The survey and QM items may be more likely identified by frontline staff as quality-based goals to improve upon if they were provided with the education and support to understand the system. Job duties discussed by participants were related to QMs, but the motivation behind performing tasks were described in emotional sentiments. To build upon that motivation with education on how the care translates into a higher QM score or better survey outcomes could translate into successful quality improvement, as evidenced by similar initiatives.[12,26]

Based on the responses of participants in this study, dedicated professionals who can bridge the gaps between CMS requirements and daily operations and care would mitigate goal displacement and improve the potential for the structures in place to result in processes that achieve outcomes. Involvement of frontline workers and non-managerial staff in quality improvement process would improve the potential to align goals of the agents in this sector with the principal (CMS), leading to higher probability of improved quality.[12,26] This has been observed in several European countries that have integrated healthcare professionals into the regulatory process, effectively improving patient experiences and quality of care delivery.[27]

Several topics of discussion that emerged in this study either aligned with existing literature or indicated topics of interest for future research regarding nursing home quality. Participants identified that surveys do not accurately portray a facility's normal state of operation, which aligns with findings by other researchers in the field.[13,16] This supports initiatives geared toward adapting the surveys to be less predictable with findings more representative of the day-to-day state of facilities.[4] A concern voiced by participants was the absence of consequences for poor performance. This is reminiscent of findings in the literature regarding the lack of application of CMPs to deficient nursing homes, as well as the backlog of surveys throughout the country reducing pressure felt by facilities to comply with regulations.[3,28,29] As attempts are made to reduce this backlog in surveys, ongoing research should evaluate the outcomes of these surveys and any changes regarding CMPs that may impact nursing home quality and the perceptions workers have on the effectiveness of increased regulatory enforcement.

Adequate staffing was a topic discussed by most participants in this study, the only component of the CMS Five-Star Rating that was acknowledged consistently during interviews. With upcoming adjustments to minimum staffing requirements in nursing homes, feedback from staff members regarding their experiences with new staffing rules will be important in determining the impact of these rules.[30]

Limitations

Responses in this study may have been limited by participant fear of consequence or retaliation from their employer, although the PI explained no risk was associated with participation and their answers were anonymous. This may have impacted the level of honesty or completeness of some answers. Participants were not asked to identify if they were full-time, part-time, per-diem, or agency/contract

staff, which may have been useful in understanding the knowledge or perceptions of some workers. NHAs and other leaders in the facilities selected study participants, potentially skewing the data with responses from workers who were identified to participate due to their passion for their role and performance as an employee. This study was limited to four sites within a close geographic, mostly urban region and may not be generalizable to the broader population of nursing home workers in other states or more rural areas.

Conclusion

Findings in this study revealed common themes in the perceptions of frontline nursing home workers relating to their roles and nursing home quality. These workers identified their roles as directly linked to quality, however their definitions of quality and priorities in providing high quality care did not align with the metrics used by CMS to define and measure quality. The Five-Star Rating, surveys, and QMs were not identified by frontline workers as motivators in their provisions of care, rather emotional motivators such as empathy. Altering QMs and survey items or implementing additional metrics to reflect quality from a humanistic approach may provide a more relatable goal for nursing home workers to align with in efforts to improve nursing home quality. Additionally, enhancing quality improvement programming such as ongoing staff education may be useful to effectively implement policies aimed at improving nursing home quality.

This study supports existing literature recommending adaptations to current nursing home regulatory policy in order to improve nursing home quality in the United States, while filling the gap of frontline worker perceptions on the topic. Concepts such as communication and teamwork were consistently discussed by participants in this study, with little concern voiced regarding the regulatory efforts in place by CMS. To align CMS goals with frontline worker goals and achieve improved quality in US nursing homes, emphasis should be placed on education of current systems to frontline workers and integrating caregiver voices into regulatory oversight to achieve improved quality outcomes.

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Declaration of competing interest

All authors declare they have no conflicts of interest.

CRediT authorship contribution statement

Stephanie Weston: Writing – review & editing, Writing – original draft, Visualization, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Nancy Kusmaul:** Writing – review & editing, Methodology, Conceptualization. **Nancy Miller:** Writing – review & editing, Methodology, Conceptualization. **Zoë McLaren:** Writing – review & editing. **H. Wayne Nelson:** Writing – review & editing.

Supplementary materials

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.gerinurse.2025.103673.

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