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SURVEY survival

BY RETA A. UNDERWOOD, ADC

Time for a year-end review

This year it's been difficult to find a magazine, association, or government agency that hasn't been talking up long-term care quality—although the nursing home industry continues to fall out of survey compliance in large numbers. The fault seems to cut two ways. In a July 9, 2004 letter to CMS Administrator Mark McClellan, MD, PhD, Sen. Charles E. Grassley of Iowa outlined several survey and enforcement concerns, including the integrity and effectiveness of the system. "Unfortunately, these qualities of care concerns are not new," he said, citing Government Accountability Office reports of continuing problems.

The good news is that the industry and its experts acknowledge the need for improvement. This, in itself, is the first step toward improvement. Now all we have to do is change. How? you ask. It surely isn't by reinventing the wheel. Rather, think of it as fixing a flat tire.

First, we need to know which tire is flat so we can change it—i.e., where the most positive change is needed. This is not accomplished by undertaking years of research. To improve the quality in each nursing home across the country, we need to start by taking a good in-depth look at our own individual facilities—to take a step back and see what is good and what is bad. "Start with nursing care, the quality of food served, and the activity program," recommends Sukhen Dey, PhD, founder and CEO of Deyta, Inc., a company that specializes in LTC quality assurance. Other important areas for in-depth analysis should at a minimum include resident stability and satisfaction, the facility's performance on quality indicators (QIs), and the status of facility staff.

Resident instability is a cue to providers, just like a loud noise is when your tire blows out. It is an indicator of how well services are being provided. Residents who are not stable because of infections, fractures, weight issues, behaviors, or depression are indicators that services are not adequate to create and sustain health. Furthermore, true resident and family satisfaction comes only after a period of time during which residents get what they need on a regular basis. "Normally there is a common threshold rating of 80% representing good-to-excellent scores that indicate an average functioning facility," explains Dr. Dey. "Once data are collected and areas needing improvement are identified, facilities need to keep in mind that there are many different approaches to correction, depending on local conditions.

Questions to focus upon when reviewing for resident stability and satisfaction include:

- How many urinary tract infections occurred in our facility this year?
- How many fractures did residents experience this year?
- How many residents lost significant weight or gained more they should have?
- How many residents have undesirable behaviors?

- What are these behaviors and what is being done about them?
- What is the rate of antidepressive medication use?
- Is the rate high enough based on our resident-with-depression QI?

Other ways to uncover important information include outsourcing to a mystery shopping company, who will include a survey of your residents and their family members; and using rating scales, although, Dr. Dey notes, "In long-term care, the return of paper surveys is low, and providers may want to consider other, more untraditional methods, including taste testers to assess the quality of food served and telephone interviews to ask focused questions of responsible parties." A simple rating scale is best. Choices of excellent, good, fair, or poor will suffice. Add a comment section for more detailed feedback. It is important that anonymity is allowed. Areas explored would include resident care, environment, food (quality, taste, and variety), staff (attitude, competence, response patterns), activities (variety, whether they are resident-directed), social services, housekeeping services, etc.

Consumers are becoming savvy about the information available, putting greater emphasis and accountability on facilities to know their care-rating percentages and QI data. Reviewing the 11 domains and 24 focus areas within the QIs, as well as the 11 quality measures (QMs), can be a daunting task—much like rotating your tires to prevent wear—but, similarly, it should be performed regularly. Using a variance graph will give you an easy, at-a-glance review of the peaks and valleys that have occurred within your facility during a given period of time.

Keeping Data Accurate
In order for improvement to occur, however, your data must be accurate, so the first thing to do is to review for data accuracy (like using an air gauge). To complete this review, you will need access to the resident's medical record, various facility reports such as the pharmacy audit and its monthly recommendations, and a copy of the most recent Resident Level Quality Indicator Summary that includes the data from the last MDS transmission. Questions to address include:

- Are the quality indicator data on accidents, which include new fractures and falls information, reflective of the facility documentation on file. If not, why?
- Is the fracture or fall documented completely in the resident record?
- Is the resident's plan of care updated?
- Have the causal factors regarding the fall been addressed and documented in the record?
- Is the resident stable?
- Is the record appropriately cross-referenced? (If a resident is documented as bedfast or restrained and has suffered a fall, something is terribly out of sequence, and further investigation is needed.)

The behavioral domain allows us to see those residents who have an identified behavior with or without depression, with treatment or without. Compare the current physician orders with this information, taking into account the use of other psychopharmacologic medications to determine whether these treatments are being received and, if not, document why. Nine or more medications in a given day sound like a lot, unless you consider that we care for the chronically ill elderly, who are plagued by some complicated debilitating conditions. Resources for reviewing this area should include your monthly pharmacy review and the BEERS list, a precautionary list of medications found to be potentially harmful to seniors. According to a recent study in the *Archives of Internal Medicine*, researchers analyzed more than 750,000 outpatient prescription claims from 1999 and found that more than 20% involved a prescription for drugs on the BEERS list, 41% of which were prescriptions for a psychotropic drug, most commonly an antidepressant.

For cognitive impairment, review the plan of care for appropriate interventions such

as cueing, task segmentation, use of adaptive devices, and special programming.

Reviewing the elimination/continence domain discloses the facility's overall approach to preventive treatment, and should be deemed of great importance. Generally, if someone has the ability to transfer independently and sit on the toilet or is considered a low risk for incontinence, he/she should be placed on an established prompted voiding program to maintain the highest practicable level of function. For those residents triggered to have an indwelling catheter, check to see if there is a proper diagnosis or an assessment that contains physician documentation to support its continued use. Incidence of urinary tract infections should be viewed with a critical eye: Is there a trend in your facility?

Too much weight loss or weight gain can be detrimental to anyone, but especially to those residents whose disease and diagnosis status depend on their intake. Therefore, nutritional status must be reviewed, with consideration given to the registered dietitian's plan of care, along with a regular review of residents' actual intake.

Review of physical function can trigger ancillary care items. Someone who is bedfast can easily become isolated, suffer from depression, or have poor self-esteem. Those residents who are in a comatose state with a total dependence on staff require a plan of care reflecting interventions from all departments relative to their area of expertise. The physician should have a written diagnosis to support a bedfast status, otherwise we should be getting residents out of bed. A decline in ADLs indicates that the resident's condition has changed for the worse—but was this significant change of status identified and care-planned? If a decline in range of motion has developed, was further screening or assessment conducted by therapy?

When someone is on an antipsychotic medication but has no diagnosis for its use, you are not only out of compliance, but you are billing for an unnecessary medication, which constitutes misuse of medication and fraud. Cross-reference your antianxiety medication users with those who have behavior symptoms or depression, as well; look for any inconsistency and act immediately to correct this out-of-compliance status.

A resident's quality of life depends on having alternatives and options in spending free time every day. Residents who are triggered as having little activity are either miscoded on the MDS, isolating themselves from day-to-day life, or unable to make their desires known to staff. Determine which it is and put a care plan in action.

Skin care problems that have resulted in pressure ulcers need to be corrected quickly. Use the resident's treatment records to determine that the physician's orders are being followed and progress is being made in healing the wound. If healing is not being recorded, someone must determine why. However, applying a corrective measure prior to occurrence—i.e., prevention—is best. For example, all mattresses should have pressure-relieving qualities, turning and repositioning of residents should occur as scheduled, moisture barriers should be applied after each incontinence episode, etc. Should skin breakdown occur, institute an "all hands on deck" approach to intervention.

Benchmarking

Once all areas have been reviewed, you will want to compare your percentages with those of surrounding facilities, as well as state and national averages. These statistics are easily obtained on the Nursing Home Compare Web site at www.medicare.gov/NHCompare/home.asp. For those areas of your facility that are not up to par, you have at least made the first step toward improving them. You have found the flat tire, and chances are you know how to repair it. Let's get started now.■

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