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Training Manual for the Long Term Care Facility Quality Assessment and Assurance Committee

Kris S. King

TRAINING MANUAL FOR THE LONG TERM CARE FACILITY QUALITY ASSESSMENT AND ASSURANCE COMMITTEE

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An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Science in Health Management

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ABSTRACT

This thesis addresses the need for a training manual for the federally required long term care Quality Assessment and Assurance Committee. The training manual has been designed to provide guidance to the Committee members, recognizing that effective leadership is essential for a successful quality and compliance program in any facility.

There have been numerous publications devoted to quality assurance in the long term care setting; however, few provide simplistic and meaningful explanations for conducting quality assurance and improvement activities. This manual has adopted a unique approach by correlating federal requirements to specific quality assurance and improvement processes.

The training manual was evaluated by four long term care professionals, each with extensive experience and diverse backgrounds in the industry. It was the overwhelming opinion of the evaluators that the manual fills an obvious need within the long term care industry because of the simple writing style, the use of real world applications and

the practical integration of quality and federal compliance issues.

The evaluators suggested additional work in Section 6 of the training manual which is devoted to quality improvement applications. All evaluators expressed a desire for additional examples in identifying quality improvement issues that may exist beyond the realm of regulatory compliance.

It was the opinion of each of the evaluators that the training manual should be submitted for publication because of the unique approach and the simple writing style. The enthusiastic response of the evaluators underscores the need for this manual as well and the need for additional study in this area.

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Chapter I

INTRODUCTION

A Quality Assessment, Assurance and Improvement Training Manual for the Long Term Care Facility QA Committee

In spite of the resources that have been expended in its name, "quality" remains an elusive commodity in the American health care industry. The first documented initiative to assess quality in this country dates back to 1910 when William Flexner, M.D., evaluated the quality of our nation's medical schools (Harvey 16). His findings, while alarmingly negative, have been identified as the precursor for the industry's current accreditation and regulatory monitoring activities to ensure quality in the delivery of healthcare services.

There have been hundreds of research papers, books and periodicals devoted to an analysis of quality of care, but there is a glaring absence of material that can be used by the healthcare manager on a day-to-day basis (Berwick 11). Moreover, the majority of resource material directed toward

quality assurance has been designed for the acute care industry. Because of the different type of care provided by long term care facilities, as compared to that rendered in the average hospital, the focus of a quality assessment, assurance and improvement program would have distinct differences in a long term care facility (Institute of Medicine 24).

Although there has been much public outcry toward a need for improving quality in the nation's long term care industry, the approach toward achieving this improvement has been through an increase in regulatory involvement. In its report on the quality of care in nursing homes in 1986, the Institute of Medicine Committee on Nursing Home Regulation identified that poor quality homes outnumber the very good homes in spite of the intense regulatory atmosphere within the industry. It was also the conclusion of the Committee that while regulation was necessary in order to provide some assurance of the quality of care provided to the institutionalized elderly, regulation is not sufficient in guiding direct care workers to provide quality services on a daily basis (IOM 22).

As a result of the recommendations by the Institute of Medicine, legislative reform was instituted to upgrade the federal requirements governing long term care facilities. These requirements, known as OBRA '87, were not implemented until 1990 and outlined specific federal requirements for quality assessment and assurance in long term care (United States 48878). In addition, these revisions included a quality of care requirement which addresses separate care issues for compliance in the provision of services to the institutionalized elderly (United States 48873). These requirements are outcome oriented and provide indicators for evaluating the end result of resident care. For example, residents will not acquire pressure ulcers, will not acquire infections, will not lose range of motion in their extremities, etc. (United States 48873). For purposes of evaluating quality assurance compliance, these regulations can provide objective measurements and definitions to the term "quality" in the long term care environment. In other words, when these negative outcomes are identified within the resident population of a given facility, one would conclude that quality is either absent or compromised in the provision of care unless there are

documented clinical explanations. Although these requirements provide goals for a quality assurance program, a true quality initiative must also focus on preventing negative outcomes and improving performance through an evaluation of interdepartmental systems and processes. Therefore, establishing outcomes for the retrospective evaluation of care is only one facet of the quality improvement process.

Regulation is not the sole answer for either assuring or improving quality in healthcare, nor is it a tool for cost savings (Claybaker 103). Regulation will not help people to understand why processes and systems are important in a healthcare facility, nor will regulation facilitate an environment for continually improving these processes and systems.

The regulatory survey process in long term care, or in any industry, is merely an assessment of compliance at a given point in time; it is not the panacea for preventing or solving quality of care problems. Each department within a facility must understand what quality means in their own area as well as what it means for the facility as a whole; each worker must be able to interpret quality from "dysquality" on a daily

basis. Although regulation evaluates the outcome of systems and processes at a given point in time, regulation does not provide the direction as to how to achieve an acceptable outcome.

"Quality" is an intangible and not something that is immediately evident to all health care practitioners. Consequently, a practical tool is needed to tell the QA Committee what to look for, what data to collect, how to analyze the data once it has been collected, and how to proceed once the analysis of information has been completed. This translates into a need for a training manual that provides practical instruction to the long term care professional in the following categories:
l) the ability to assess quality within each area of the facility and within the facility as a whole, 2) the ability to develop quality assurance guidelines, parameters and monitoring tools for departments and the facility as a whole, and 3) the ability to identify continuous quality improvement methodologies that are applicable to the long term care facility environment.

Although a training manual will not assure that long term care facilities will adopt effective quality monitoring and

improvement programs, a manual will at least provide a mechanism for educating Committee members in the practical aspects of these programs. The difference between this training manual and existing published manuals for quality assurance in long term care is the explanation of the process and the rationale for implementing each assessment, monitoring and improvement component. This training manual will provide guidance to the Committee in establishing compliance standards and monitoring programs. In addition, the manual will include sample forms to promote interdisciplinary assessment and evaluation. This manual is also intended to serve as an educational tool for the working manager. Guidelines will be provided for each Committee member who also has responsibilities as a department manager in the nursing facility. The data collection instrument that is used as the primary Committee monitoring tool is cross referenced to federal regulation tag numbers to correlate the QA process with the federal long term care survey process.

The healthcare industry has moved from a traditional pattern of retrospective quality assurance programs and committees to an attempt to embody the principles of quality

improvement, the same principles that have been prevalent in the industrial world for the past twenty or more years. It is anticipated that the quality improvement methodology will assist healthcare professionals in resolving both the cost and quality problems that seem to be prevalent in our health care delivery system. The healthcare industry is moving slowly toward the adoption of quality management concepts. Presently, successes are being documented in numerous acute care institutions throughout the country. Nevertheless, many feel that continuous quality improvement and total quality management cannot work in and cannot be successfully applied to health care facilities. Certainly this prophecy will be a self-fulfilling one in healthcare facilities in which the educational process is not extended down through the organization to all levels of management and workers. The success of this initiative will largely rest on the abilities of the day-to-day managers and their workers; therefore, their educated involvement is crucial. As a result, the effectiveness of CQI in the healthcare industry can be tested fairly only in those organizations in which there has been a serious commitment to educating the workers and supporting them through the

learning curve.

In order to provide an opportunity for learning how these quality initiatives can be applied to daily practice, a training manual is essential to promote a successful transition from quality assurance to continuous quality improvement, regardless of the health care setting. This manual will provide an initial foundation for this learning process in long term care facilities.

In healthcare, continuous quality improvement represents a completely different way of thinking as compared to the traditional quality assurance programs (Leebov 11). Whereas quality assurance has been traditionally focused on regulatory and accreditation requirements and is practitioner focused, quality improvement focuses on continually improving systems and processes, addressing common and special causes and in preventing problems from occurring. Quality assurance has traditionally been departmentally focused. In comparison, quality improvement is more organizationally focused, evaluating interdepartmental relationships from a systems point of view, involving both clinical and non-clinical processes. The intent of this manual is to make this

relationship clear to the user in order that quality improvement can be seen as a circular rather than a linear process.

An effective healthcare quality improvement program must embody both quality assurance and quality improvement. There is a need to examine outcomes as well as to evaluate processes and determine areas where waste and inefficiency can be eliminated. Furthermore, because change is such an integral part of all healthcare environments, there is an ongoing need to examine internal systems, relationships with suppliers and methods for improving the way things are done. The key, however, is that everyone within the organization is provided a foundation for understanding these methodologies and how implementation can be applied to their individual work setting.

Although there are significantly more documented resources for quality assurance in the acute care setting as compared to the long term care setting, there is relatively little information available for any healthcare manager to translate quality improvement concepts into practical applications (Leebov xviii). In spite of the abundance of

literature on the subject of quality in health care, it is not written to be useful material for the middle level of management in health care facilities (Berwick 11). The need for a practical tool is more pronounced in the long term care industry because of the scarce resources, both in terms of number of dollars and number of staff to commit to a QA/QI program. As a result of this scarcity of resources, each long term care QA Committee is virtually "on their own" when it comes to understanding, implementing and monitoring a departmental quality assurance program. An effective manual must be written that can be understood by a variety of individuals representing all levels of education and experience. Furthermore, it must serve as a guide to explain why certain processes/outcomes are important, what can be done to assess individual and departmental performance in these areas and what should be done with the information once it has been collected.

In the typical long term care facility, there is no quality assurance or quality improvement department such as would be found in an acute care facility. The responsibility for implementing a quality monitoring program has traditionally rested with the administrator and/or director of

nursing and may or may not be an integrated program that involves key representatives from each area. In those facilities that are part of a corporate chain or group ownership, staff are often given a corporate quality assurance manual to follow in monitoring quality in their specific area. Typically these corporate programs are based upon regulatory standards, and the facility is evaluated by corporate consultants on a periodic basis for compliance with these standards.

Unfortunately, most corporate programs are lacking in providing employees with the rationale behind the quality assurance standards and the suggested means by which they can be achieved and/or improved. If situations of noncompliance are identified, the outcome is usually punitive rather than educational, and negative evaluations are directed toward a department or individual rather than to a process or a system. The focus is much the same as that of the traditional quality assurance programs that have been prevalent in the acute care industry until recent years. The effect on the facility, therefore, is many times demoralizing rather than promoting a positive atmosphere of continual improvement.

In place of the traditional practice of focusing on only what is wrong, today's quality assurance and improvement Committees should focus on what is right and on what can be done to improve those areas that are determined to be less than satisfactory. The QA Committee must serve as the leader for quality initiatives within the long term care facility. The Committee must be knowledgeable as to the process of assessing, assuring and improving quality to educate staff within the facility and reinforce initiatives for improving quality of care and quality of resident life. Because of the intense regulatory scrutiny and the limited resources within the facility, the long term care professional works under a tremendous degree of stress for comparatively low wages, as compared to other areas of the healthcare industry. There is also little financial or human resource commitment to the job orientation and training process. Consequently, the turnover in positions is generally high. Employees need reinforcement and support in learning how to meet and/or exceed job expectations. Employees and managers also need to know when their performance meets or exceeds quality standards in order to experience that sense of accomplishment that results from doing a job well.

The intent of this training manual is to provide Committee members with a general education and orientation to the broad areas of involvement of the federal survey process in the evaluation of facility quality. This training manual will merge federal regulatory compliance issues with quality assessment and improvement techniques for each department within the long term care facility. This will serve as a means of training staff in the pertinent details of the federal long term care survey requirements. Each departmental section of the QA Committee data collection instrument is designed to be used as a foundation for departmental quality assurance and improvement programs.

The manual will be organized to correlate federal requirements to the quality assessment process. Pertinent federal requirements will be listed as they relate to defining quality within each particular department. In addition, guidelines will be included for developing an ongoing facility monitoring program to evaluate actual performance against these standards.

Many of the professional staff of long term care facilities are independent contractors who spend a limited number of hours in the facility each month. Therefore, those persons

with the most knowledge regarding the facility systems, processes and internal procedures are rarely individuals with clinical background or experience in quality assurance or quality improvement programs. Yet these are the persons who comprise the QA committee membership and are held responsible for the ultimate quality performance of the facility. Often these individuals have neither any previous management or healthcare experience, and have never before worked in a long term care facility. This again supports the need for a documented training manual that answers the questions so often asked by long term care workers - "why am I doing this?", "what is it for?" and "what am I supposed to do with it?".

Long term care facilities cannot wait for the corporate quality assurance inspection or the next survey by a regulatory agency to evaluate their compliance and their quality of care. Effective quality assurance or improvement programs should not be isolated to conducting the same study each quarter, merely to comply with the corporate standards. To be effective, the quality assessment, assurance and improvement process must be inherent in the day to day operational functions as a part of each worker's

daily routine. This will not occur, however, if there is not a practical working guide for the QA Committee to follow to direct the transformation process and provide direction to facility managers with respect to their responsibilities.

As is true with the implementation of any new concept, there must be a resource for educating key managers regarding their responsibilities in the program. There must also be a guiding force that directs and evaluates key performance areas within the facility and key inter-departmental processes within the facility. The QA Committee must be educated in the concept of quality improvement in order to serve as a resource to the staff. Managers and their workers need to know the recipients of the products of their labor (their "customers") and what the downstream effect of their work is upon these individuals. This training manual will incorporate these continuous quality improvement concepts into the orientation for long term care QA Committee members. In order to demonstrate the application to the long term care facility, the manual will also provide examples of how these concepts can be utilized in the overall management of facility quality.

Chapter II

LITERATURE REVIEW

Since the 1990 Institute of Medicine (IOM) report entitled Medicare: A Strategy for Quality Assurance, the focus on patient outcomes in health care has intensified (Fleming 22). In this report, a definition for quality of care was identified as follows:

> Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge (Fleming 22-23).

As a result of the 1989 Omnibus Budget Reconciliation Act (OBRA), the federal government has defined "desired outcomes" for the institutionalized elderly. Furthermore, a regulatory definition for Quality of Care was incorporated into these requirements:

> CFR 483.25 Quality of Care: Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care (United States 48873).

In addition to this broad definition, the Quality of Care requirement identifies numerous subcategories of resident care that each facility must address for overall compliance:

a. Activities of Daily Living (bathe, dress and groom, transfer and ambulate, toilet, eat and use speech, language or other functional communication systems)
b. Vision and Hearing
c. Pressure Sores
d. Urinary Incontinence
e. Range of Motion
f. Mental and Psychosocial Functioning

g. Naso-gastric tubes

h. Accidents

i. Nutrition

j. Hydration

k. Special Needs (injections, parenteral and enteral fluids, colostomy, ureterostomy or ileostomy care, tracheal suctioning, respiratory care, foot care and prosthesis)

l. Unnecessary Drugs

m. Medication Errors
(United States 48873).

In each of these categories, quality of care is evaluated by comparing the assessed resident condition at the time of admission to the degree of improvement or decline identified at specific intervals throughout resident stay in the facility. The initial comprehensive assessment of the resident provides a baseline from which the quality of care provided by the facility is evaluated (United States 48873). If the level of functioning of the resident declines in any one or all of these specific categories, and there is no clinical explanation

for such decline, the resident is considered as having a "negative care outcome".

In Activities of Daily Living, the initial level of physical functioning that the resident demonstrates in performing his or her own personal care is evaluated on an ongoing basis (AHCA P-114). If the level of independence declines over that which was assessed on initial admission, the facility must demonstrate that all efforts have been exhausted to prevent such a decline. If there is clinical reason to believe that the resident could have improved his/her functioning, given the proper restorative or rehabilitative services, then this would also be regarded as a negative care outcome (United States 48873).

This same type of evaluation is done for evaluating pressure sores, range of motion, mental and psychosocial functioning, urinary incontinence, hydration, and nutrition (AHCA P-113). In other Quality of Care categories, the resident must receive the proper treatment and care for specified services, such as those listed under the category "Special Services" (AHCA P-136-139).

Given the broad spectrum of issues that are addressed in the Quality of Care requirement, an effective quality

assurance Committee must evaluate quality from multiple perspectives. Some quality of care areas require direct observation of the staff to determine whether the correct clinical procedure is being followed. By comparison, other evaluations of quality cannot be evaluated without a review of the resident's clinical record to compare current conditions to the resident's status at the time of admission. Yet other categories require an evaluation of aggregate data to identify trends such as a general increase in the use of chemical or physical restraints, an increase in the number of resident injuries, etc.

From a review of this aggregate data, a more focused review is required to determine causes and identify whether some aspect of corrective action should be taken within the facility. Finally, an ongoing evaluation is needed of processes affecting each of these quality of care indicators. This is the source of opportunities for improvement and the true essence of modern quality management.

In addition to addressing the provision of direct care in the long term care facility, the revised federal requirements also address Quality of Life (United States 48871). In their evaluation of care in nursing homes, the IOM recognized that

the nursing home is a "home" for many of its care recipients. Consequently, quality of everyday life within the institution has been identified as an essential ingredient for the overall well-being of the nursing facility resident (IOM 45).

The long term care facility is a unique health care setting in that it serves as both a clinical treatment and a living situation (IOM 47). This is most appropriately recognized by the federal Quality of Life requirement and the specific issues that it addresses:

> A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life:
>
> a. Dignity
> b. Self-determination and participation
> c. Participation in resident and family groups
> d. Participation in other activities
> e. Accommodation of needs
> f. Activities
> g. Social Services

h. Environment

(United States 48871)

In this particular quality evaluation, input from the resident or resident's legal representative is a key ingredient. The intent of this requirement is to assure that each resident is provided with a "home-like" environment, and the definition of "home-like" will vary from resident to resident. One resident may appreciate having a room filled with pictures, plants and momentos from the past while another resident may consider this environment too cluttered to enjoy. What one resident regards as a stimulating recreational activity may be a totally negative experience to another. Therefore, the definition of "quality of life" becomes very individualized. As a result, evaluating whether a facility meets the objectives of this requirement must involve the residents themselves. This represents a change in focus in long term care QA program needs when compared to traditional QA programs.

Quality of Life evaluations can be described as what one author identifies as Provider-Receiver (PR) Encounters (Omachonu 42). PR encounters are those points in the

health care process that will result in poor quality if they are unmanaged or are managed inadequately. Applying this concept specifically to the long term care industry, poorly managed PR encounters include a wide variety of possible abuse and neglect situations. Although these can occur in any type of health care institution, they are most often associated with care in nursing homes. These include intentional delays in answering call lights, removing trays from slow eaters before meals are finished, isolating patients in corridors for hours at a time, failing to assist non-ambulatory residents to activity programs (Omachonu 42). Because the nursing home patient is not always physically able to express input in these aspects of care, the quality assurance program must provide a mechanism for monitoring PR encounters on an ongoing basis.

A summary of these two requirements demonstrates that the federal government has clearly defined "quality" for long term care facilities to a degree that exists in no other health care regulatory environment. In spite of this elaborate definition of both quality of care and quality of life, the regulation alone will not provide the direction that a facility

QA Committee needs to properly evaluate and manage quality within the facility.

Utilizing the basic criteria for evaluating medical care, the IOM recommended that quality in long term care be evaluated according to structural, process and outcome components (IOM 53). Applying these components, a long term care facility quality assessment and improvement program should include some of the following issues related to structure, process and outcome:

Structure

Structure would relate to the basic characteristics of the nursing facility that enable the provision of quality services (IOM 53). This includes internal systems for hiring and training appropriately qualified personnel, providing sufficient numbers of staff to care for the type(s) of residents in the facility and providing adequate supplies and equipment for staff to perform their job adequately (IOM 53). Generally speaking, once this evaluation has been completed, there should be no need to repeat this review unless there are changes in policy or key personnel. Unfortunately, however, many long term care facility quality assurance programs are weighted down with countless

structural evaluations that offer little meaningful information.

Process

Process evaluation relates to the relationship between direct care services, how they are provided, and their impact on resident outcomes. In its evaluation of nursing homes, the IOM identified an historical inconsistency in correlating process evaluation results to resident outcomes (IOM 54). This is similar to the problem that results in relying on an annual nursing home survey to assure quality of care throughout the rest of the year. Although it is not the panacea for quality problems, process evaluation does contribute to the management of quality within a facility. Consequently, the IOM recommended that process criteria be included in the evaluation of nursing home care (IOM 54).

If process evaluation is continually revised to focus on the significant aspects of care within the ever-changing resident population, the results will be meaningful. Because of the diversity of resident care that is found in the majority of nursing homes, the quality assurance process should include ongoing monitoring of key processes that are directly related to quality. These include providing treatments and

personal care to residents, abiding by proper hand washing technique, providing incontinence care, range of motion, etc. In addition to these basic care processes, monitoring should also address handling of residents in isolation for infection and other special care issues which may not occur on a regular basis but do occur periodically. When approached in this manner, process evaluation becomes an integral part of the education and training programs within the facility.

In a study commissioned by the IOM, longitudinal data was collected and evaluated concerning residents in 107 nursing facilities in 11 states and the District of Columbia (IOM 47). The results of this study demonstrate the diverse care needs that typical long term care facility staff encounter (IOM 47). In these facilities, the majority of residents either expired or were discharged within 90 days of admission (IOM 47). Although smaller in number, the remaining population represented the vast majority of inpatient days of care. Within this population, the type of care required by the residents could be effectively categorized into three major groups, regardless of the type or location of the nursing facility (IOM 47). In this study, approximately 11% required light care or between 40 to 60 minutes per day;

approximately 49% required moderate care or between 61 to 134 minutes per day, and approximately 40% required "heavy" care, between 135 to 268 minutes per day (IOM 47).

Although not specifically addressed in this study, the constant change in a key portion of the resident population of most nursing facilities would require a greater emphasis on process evaluation than would perhaps be required in other health care facilities. Unlike acute care facilities, long term care facilities often do not have the capability to physically separate resident care areas by acuity and diagnosis. Therefore, it is not uncommon for staff to encounter a variety of resident types within a given clinical care assignment. Moreover, because of the frequent numbers of resident admissions, the resident population is constantly changing. These two factors affect the need for greater process evaluation over other health care institutions. Nevertheless, process evaluation alone will not assure quality, nor will it point to cost or quality issues which should be addressed because of their effect on other systems, processes or departments within the facility.

If health care is examined from a process point of view, three basic types of processes could be quickly identified in each health care setting:

l) patient flow processes that involve the movement of patients or people from place to place,

2) information flow processes that collect and transport data that is used in clinical and administrative decision-making, and

3) material flow processes that move equipment and supplies (Berwick 34).

In each of these processes, there are suppliers and customers, or people who do a particular job and people who receive the product of that job and depend upon it for their own area of work (Berwick 34). Because there are multiple customers in a work process environment, customer interests may sometimes appear to be in conflict (Berwick 35). A continuous quality improvement effort should focus on educating departments in the customer-supplier relationship as it applies to their organization. The greater the understanding of these concepts, the more likely it is that departments will attempt to meet the needs of their many diverse customers. When this union occurs, the

greater the opportunity for the organization to improve overall quality and productivity (Berwick 35).

Outcome

Outcomes provide a means of evaluating the effect of direct care and services on the resident's physical and psychosocial status (IOM 55). The final federal requirements that resulted from the IOM report focus heavily on resident outcomes as previously described in CFR 483.25 Quality of Care. The traditional long term care quality assurance manual incorporates outcome criteria that have been initiated in the acute care setting. Although these criteria may have some application to the long term care environment, generally this is not the case merely because of the key differences between the two types of facilities.

Acute care facilities are short-stay institutions, and evaluation of outcomes in the short-stay patient is much more easily defined and more meaningful in identifying shortcomings in quality of services. In that setting, care is directed toward a specific clinical diagnosis or reason for treatment. There is a specific outcome identified at the outset, and it is generally expected that this outcome will be

positive when compared to the reason for initial care and treatment.

In contrast, in the long term care setting, outcomes are evaluated on both a short and a long term basis. Outcomes are not always as clearly or easily defined in the long term care setting. Therefore, the federal requirements could be considered a sound basis for implementing the outcome-oriented quality assurance review. This would identify possible shortcomings with regard to individual quality of care issues such as residents not acquiring decubitus ulcers or contractures during their stay. These would indeed be regarded as negative resident outcomes.

Outcome evaluation would not, however, be sufficient in and of itself. In addition, data must be evaluated on an aggregate basis in order to truly assess quality of care. Although one acquired decubitus ulcer in a population of 120 may not be indicative of a facility-wide quality problem, a statistic of ten acquired ulcers involving a number of residents in a 120-bed facility in a given month would paint a different picture as to the quality of facility care. This type of aggregate data is invaluable in identifying general care trends and providing information as to the scope of these

trends within a long term care facility. Pointed analysis of aggregate data provides a direction for more intensive evaluation of both processes and short term outcomes.

In addition to addressing the basic structual, process and outcome issues, the long term care quality assurance program must also address the meaningful evaluation of pertinent and useful data. The traditional quality assurance manuals that have been published for long term care focus largely on paperwork compliance. These manuals typically include a wide assortment of forms that staff must complete in order to evaluate whether "quality" exists in their department. Generally, the focus is on generic processes and compliance with documentation requirements associated with these processes. Most often, however, these manuals do not offer any guidance or instruction in correlating these findings to pertinent resident outcomes. Nor do these manuals provide the Committee with guidance in evaluating the information that is collected once these worksheets have been completed. While quality assurance necessitates data collection and use of worksheets, both tasks should never proceed without the answer to a basic

question: What does this information tell us about quality in our department or in our organization?

For example, a recent 1993 update to Quality Assurance for Long Term Care by Aspen publishers includes numerous forms, policies and monitoring tools for evaluating physical restraint use in the nursing facility. This supplement devotes at least sixteen pages to this topic, yet the entire focus is on proper completion of forms and collection of data as to the numbers and types of restraints used in the facility. There is no emphasis on correlating these numbers to any specific trends of restraint use within the facility to determine if the number is increasing or decreasing. There is no mention of correlating findings of diminished functional status in residents who are physically restrained. Nor does the supplement provide any direction to the Committee or the user as to how the data should be evaluated, once it has been collected. All of this data is essentially useless without a rationale as to the reason for collecting the numbers and an explanation as to how this data can be used as a management tool. If the information does not provide the manager with a sense of focus as to areas in which quality

could or should be improved, data collection becomes a meaningless, paper compliance gesture.

The Quality Assurance Manual for Long-Term Care Facilities published by National Health Publishing offers excellent examples of individual departmental quality assurance standards. In addition, forms are provided for collecting standardized data in each nursing facility department such as overtime hours, pounds of dirty linen processed, number of work orders processed by maintenance, new hires within each department, etc. Although the worksheets and the statistical data can be useful management tools in evaluating trends and correlating work flow problems to quality issues, there is no explanation given as to why any of the information is relevant. The manual offers no guidance in selecting key departmental statistics and no explanation as to how the information should be evaluated once it is reported. Consequently, the impression is given that each department need only complete the monthly statistics and conduct the same audits each month or each quarter in order for "quality" to result.

The Internal Audit System is a quality assurance manual that is marketed heavily to long term care facilities. It provides an additional focus beyond the traditional sets of departmental audit worksheets. A numerical value is assigned to each of the quality assurance standards so that a total compliance score is calculated for each department at the conclusion of the audit process. After data is collected, each department receives a numerical score for measuring the quality of its performance against the standards.

Audit worksheets can be useful references; however, the QA process must not give the impression that a good compliance score on one or more worksheets would equate with a "quality" department. When this occurs, quality assurance or quality improvement becomes a score and does not reflect a process within the organization. If all departments had high compliance scores, would this then represent a "quality" facility? The impression that is given is "yes". Unfortunately, reality dictates that if the departmental quality standards are not constantly revised to reflect true processes and services relevant to the facility, the QA program will have no value. The "numbers" will look good, but they will have no meaning.

The use of these standardized worksheets has established a way of thinking about the quality assurance process that seems to have permeated throughout many health care facilities. Typically each department, or the Quality Assurance Coordinator, identifies specific quality assurance standards that should be monitored on a monthly or a quarterly basis. These standards may be structural, outcome or process-oriented but are generally restricted to paper compliance issues. The department is given the responsibility for conducting an evaluation of performance against these pre-defined standards on an ongoing basis. The results are then reported back to the QA Committee. If the department achieves a 100% compliance score, the department is praised, the standards are generally not revised, and a new date of review is scheduled to repeat the process. There is generally no discussion as to key processes that should be evaluated within the department or inter-departmentally within the facility. If compliance is less than 100% the department provides reasons that this occurred, and the cycle merely repeats itself.

It is this type of traditional quality review paradigm that continuous quality improvement seeks to revise. Individual

nursing facilities cannot be faulted for this type of quality program because all of the literature that is being marketed to the industry promotes the same type of robotic behavior: audit, collect numbers and prepare reports. A tremendous amount of data is collected, but very little information is received. There is little if any interdepartmental communication, and virtually no discussion of key processes that are inherent in an honest evaluation of quality. All too often, there is no involvement of the direct care staff who are the primary reasons why quality initiatives will fail or succeed within the facility.

Corporate long term care quality assurance and improvement programs suffer from the same lack of focus. The 1992 corporate Quality Assurance manual developed by the largest management corporation for long term care facilities, Beverly Enterprises, is merely a repetition of the federal long term care requirements. Each department is expected to comply with the federal requirements for which they are assigned responsibility. With this expectation, however, there is no instruction as to the means by which each manager and the QA Committee should evaluate departmental compliance. There is no integration of

departmental processes, services, and performance with other key departments within the facility. Compliance is strictly in a linear direction for each individual department. Furthermore, if compliance is not met, there is no information provided to guide staff through the analysis of the identified problem and what might factors might be related to solving or improving the situation.

Examples of the difficulties that typically arise from the linear, departmental approaches to quality are demonstrated in the following scenarios. The dietary department may achieve a 100% compliance with the dietary quality assurance standards, and consequently receive much praise by the QA evaluator. However, the impact that the dietary department may have on nursing is not necessarily evaluated in this process. If there is poor cooperation on the part of the dietary staff in providing a resident with substitutes for a refused or poorly eaten meal, total quality has not been achieved.

If the laundry department passes its quality assurance inspection but consistently fails to provide sufficient linen to the nursing staff at the beginning of each day shift, total quality has not been achieved. In actuality, when this type

of false signal is sent to a department regarding its "total quality performance", the result is generally more negative than positive because less than optimal behavior has been reinforced. There is no stimulus to change or improve. There is merely a reinforcement for a department to continue to function in an isolated, compartmentalized manner.

This type of quality assurance program not only reinforces solitary thinking on the part of individual departments, but it can also result in poor morale in neighboring departments. A classic example of two departments often in conflict in the long term care environment are the nursing and housekeeping departments. It is not uncommon for a housekeeping employee to view nursing responsible (not housekeeping) for cleaning resident "accidents" on floors that have already been cleaned once by the housekeeping staff. The nursing staff, on the other hand, views their primary responsibility as direct patient care. From the nursing perspective, housekeeping staff are in the facility to assure general cleanliness on an ongoing basis.

In the traditional linear QA process, the issue of cleaning up "accidents" would remain unaddressed because neither

department would see this as their responsibility. If this issue were not noticed in a typical quality assurance evaluation, there would be no quality problem because the quarterly QA review resulted in a high rate of compliance for both departments.

In a process-oriented quality review, both departments would collaborate to identify the best solution for addressing these types of issues on an ongoing basis. The priority would be to find a system solution to the problem that jointly affects both departments and the facility as a whole. The goal would be to improve overall performance as opposed to "blaming" a department or an employee for an identified quality problem.

If departmental interdependence and a need for collaborative work processes is not emphasized in the quality assurance program, negative feelings will likely be harbored. This will be magnified if one department receives recognition for having a better quality performance than the other, in spite of these continual episodes of inter-departmental "dysquality". When this occurs, quality assurance becomes a de-motivating force rather than a motivating force within

the facility. As a result, the quality assurance program begins to work at cross purposes with its own objectives.

Successful health care quality programs must replace the traditional quality assurance methods which reinforce independence of departmental functions rather than the inter-dependence that is required for continuous quality improvement (Ferguson 5). When workers are motivated to only perform well within their own department, independent to the needs of the rest of the facility, "dysquality" is almost a natural result. Quality assurance programs that foster these types of mindsets can wreak havoc in any organization, and their impact is more greatly magnified in the long term care facility (Ferguson 5).

Long term care facilities typically have a comparatively small number of employees in each department. Consequently, the need for effective inter-relationships and a general appreciation for departmental interdependence cannot be emphasized too greatly. The facility QA Committee should nurture effective interdependence and stimulate a "group think" atmosphere in which continual improvement is the central focus.

The focus on health care providers to meet low cost and high quality demands is destined to continue in our country. Successes in these areas are not achieved overnight, nor are they achieved without an integrated quality management approach (Roth 8). This reinforces the need to provide the QA Committee members with a useful, easily understood resource for evaluating cost and quality in key operational areas. Moreover, this resource should also provide general guidance for continuously improving the product of each department's work to internal and external customers. This includes the residents as direct care recipients and actual care-givers and workers within the facility.

Rather than focusing solely on thresholds, standards, inspections and surveys, modern quality initiatives must direct energies toward a continuous search for small opportunities to reduce rework and waste (Berwick 14). Modern QA Committees must abandon the notion of identifying people as the source of quality problems and embrace the concept of examining processes as the source of flaws and quality problems (Berwick 36).

This harmony cannot be achieved, however, without an individual employee understanding of the impact of his/her

work product on his department's performance and the impact of his department's work on the rest of the organization. This focus is notably absent from current quality assurance and improvement programs and manuals for long term care facilities. It falls within the jurisdiction of the facility QA Committee to promote an ongoing evaluation of key processes within the facility. However, without the resource to demonstrate the need and to point the long term care professional into the direction for continued learning, this will not systematically occur.

There is a need within the long term care industry for a training manual that provides the QA Committee with detailed instructions in assessing and monitoring quality as a simultaneous byproduct of federal regulatory compliance. Furthermore, there is a need for basic instruction in long term care regarding the concepts of continuous quality improvement which relate to key departmental processes and customer-supplier relationships.

Chapter III

METHODS AND EVALUATION

This Quality Assessment and Assurance Committee Training Manual has been prepared utilizing the current federal requirements for long term care facilities as a foundation. The manual focuses on the inter-relationship between federal regulatory compliance and basic quality assessment and assurance processes. In addition, a basic overview is provided regarding the regulatory responsibilities of the facility Quality Assessment and Assurance Committee. Emphasis is directed toward strategic information gathering and how the Committee should evaluate this information on an ongoing basis.

In researching this topic, the author examined numerous published resources concerning quality assurance which are available to the long term care professional. Based upon this evaluation and ongoing dialogue with professionals in the long term care industry on a local and national basis, the author identified a need for a different approach from the traditional quality assurance publications. Furthermore, to address the increasing emphasis on continuous quality

improvement applications within the health care industry, the author incorporated basic information on key processes and customer-supplier relationships unique to the long term care facility.

As a result of over twelve years of long term care consulting experience, the author has recognized that long term care administrators and facility department managers often lack experience in the regulatory survey process. To address this need, key federal requirements have been quoted in the training manual as they relate to the provision of quality of care and quality of life within the facility.

The manual is intended to provide instruction to the long term care Quality Assessment and Assurance Committee regarding basic quality management concepts and processes. Therefore, the manual will serve a multitude of purposes. The first purpose is to provide a general orientation to the federal requirements that pertain to each departmental unit in order to emphasize that regulatory compliance and quality assurance/improvement should not be regarded as separate functions.

The second purpose is to provide orientation and useful instruction to Committee members in the process of

evaluating quality as it applies to each facility department and to the facility as a whole. Recognized quality "gurus" are consistent in their belief that truly effective quality management and improvement programs will not exist without a commitment from the top. In the long term care facility, this commitment must come through both executive management as well as the QA&A Committee. Unlike acute care, financial resources are scarce in long term care. There is no designated department which functions solely to educate staff, monitor quality of care and staff performance, and energize quality efforts. Consequently, the significance of the Committee is much greater in long term care than that which may be found in other health care settings.

The third purpose is to provide QA&A Committee members with a basic understanding of the concepts of continuous quality improvement and the applicability to the long term care setting. A portion of each departmental section is devoted to defining key processes and customer-supplier relationships that apply to that department. It is hoped that each Committee member will then be able to work with other individual department managers to translate a definition of quality to his or her workers. The goal should

be that all employees will understand what quality means in their department and in their respective jobs.

This manual stresses the interdependent relationship of departments within the organization and the need for continual focus on processes that result in rework, redundancy and quality problems. Furthermore, the manual focuses on two key issues, cost and quality, as focal points for a facility quality improvement program.

In addition to referencing federal requirements applicable to key nursing facility departments, basic concepts for monitoring significant health care processes and events are included in the data collection and data analysis sections. Sample monitoring tools are provided as samples for the Committee to reference in addressing key structural, process and outcome issues. Included with these sample monitoring tools and forms are individualized instructions as to how each and why each form should be used.

In the review of existing published industry literature, the author identified a lack of explanation concerning the reason that specific information was collected or audited in the quality assurance monitoring process. There was also a lack of explanation concerning how the information should be

evaluated once it had been collected. As a result, this manual includes instructions for use of worksheets and forms, the reason for collecting information, the significance of the data to the departmental quality review process, and how to evaluate whether action should be taken once the information has been collected.

SUBJECTS

Four evaluators have been selected to critique the training manual, each of whom has an impressive professional background in long term care. Evaluators were selected not only for their professional experience but also for their differences in viewpoint in terms of their professional capacity in the long term care industry. Two of the evaluators have a clinical nursing background with one having additional experience as a nursing home administrator. The other two evaluators have strictly a consulting and/or administrative background. Therefore the results of these evaluations will provide a balance between clinical and non-clinical points of view in evaluating and improving facility quality.

Evaluator A has been a consultant to long term care facilities on matters of health information services and quality assurance for the past seventeen years. She has been actively involved in quality assurance and improvement activities in the facilities for which she regularly consults. She has been a guest lecturer to professional organizations at the state and national level concerning topics of interest in long term care. She has been recognized by a national professional association for her literary contributions to the profession and has served as a contributing editor for a national professional journal.

Evaluator B has had a wide variety of experiences during the seventeen years he has been a licensed nursing home administrator. He has been the administrator for two 180-bed skilled nursing facilities with one of these positions also including responsibility for 272 independent living units. He also has experience as a District Director for one of the largest nursing home management corporations in the country. In this position he was responsible for the operational oversight of five skilled nursing facilities in the midwest region. He has been actively involved in the long term care industry's professional organizations and has

served as state president for one such organization. Currently he is president of a management and consulting firm which services long term care facilities and assisted living centers.

Evaluator C is a registered nurse who also serves as the executive director of a skilled and residential care facility. She has served in this capacity for more than three years and has been instrumental in creating a facility reputation for quality that is well known throughout the midwest. Her expertise in the clinical nursing area and in the administrative operations of a skilled nursing facility will provide a valuable contribution. In addition to her Bachelors Degree in Nursing, Evaluator C also has a Master of Arts degree.

Evaluator D has worked in the long term care industry in various capacities since 1982. She has former experience as a nursing supervisor and as a nurse consultant for long term care facilities. For the past seven years she has worked as a long term care facility Director of Nursing in large facilities with greater than 150 beds.

In addition to her clinical experience, Evaluator D has achieved other professional milestones in her career. She is

one of a very few certified Directors of Nursing Administration in the state of Missouri. She has been active in state and national associations for long term care directors of nursing and has also been recognized by a major university for her professional nursing accomplishments.

INSTRUMENT

The training manual will be evaluated utilizing several different techniques. At the outset, the evaluators were individually consulted to assure their level of interest in participating in the project. During this discussion a brief overview of the nature of the project was discussed, as well as the role that each would play in the process.

An introductory letter was prepared for distribution with the training manual to explain in greater detail the proposed objectives of the project and to provide general instruction as to the role of the evaluator. (See Appendix A.) In addition to the introductory letter, a questionnaire was developed to facilitate gathering information regarding each evaluator's assessment of the training manual. (See Appendix B.) The questionnaire was designed to elicit specific opinions from each evaluator as to the following key areas:

l) value of the manual in training long term care QA&A Committee members regarding pertinent federal regulations that affect a facility quality assessment and improvement program,

2) effectiveness of the manual in training QA&A Committee members as to methods that can be used for monitoring facility quality,

3) effectiveness of the manual in demonstrating the relationship between quality surveillance and federal regulatory compliance in the long term care setting,

4) value of the manual in providing introductory exposure to the concepts and applications of quality improvement to the long term care setting,

5) recommendations for improvement in the content or presentation of the training manual.

A personal conference or telephone interview was also conducted with each evaluator following the completion of their evaluation to discuss any other items of concern or suggestions for improvement that may not have been specifically addressed in the questionnaire.

MATERIALS

The training manual incorporates federal regulations for quality of care and quality of life as these apply to long term care facilities participating in the Title XVIII (Medicare) and/or Title XIX (Medicaid) programs.

The manual begins with an introduction which describes the basic purpose of the training manual and the reason that it has been developed. Following the introduction, a table of contents is provided which describes the individual sections and the page number where each is located. Following the table of contents, a section is included to describe general instructions for using the manual. This section provides explanation as to the general format and content of the manual and the individuals who would be considered its primary and secondary users.

At the beginning of each section a detailed listing is provided as to the specific contents of that section. Learning objectives are also identified for each section in relation to the information discussed in that portion of the manual. A separate section is devoted to quality improvement. This section provides general information concerning key customer-supplier relationships in the facility and key

processes which affect the provision of quality services in departments and within the facility as a whole.

A glossary of general terms is included at the end of the manual in addition to a suggested bibliography for continued professional development in the area of quality improvement.

PROCEDURE

Each evaluator will be given an Introductory Letter with a copy of the training manual and a questionnaire. The questionnaire includes an evaluation of each chapter in the manual as well as a general assessment regarding the effectiveness of the manual in meeting the stated objectives. The questionnaire will be given to the evaluators to be completed at their leisure in conjunction with their individual review of the training manual. Evaluators will be given approximately three weeks to review the manual and complete the questionnaire. Once an evaluator has completed the questionnaire, individual discussion will be held with the author, either in person or by telephone. The purpose of this discussion is to summarize findings and elicit additional feedback regarding the effectiveness of the manual and individual suggestions for improvement.

TRAINING MANUAL FOR THE
LONG TERM CARE
QUALITY ASSESSMENT AND ASSURANCE
COMMITTEE

Table of Contents

For a detailed listing of section contents, please see the first page of each section.

TRAINING MANUAL FOR THE LONG TERM CARE FACILITY QUALITY ASSESSMENT AND ASSURANCE COMMITTEE

Introduction and Statement of Purpose

Why Was This Manual Developed?

This training manual is intended to challenge the traditional long term care quality assurance thought process and routine. The author has consulted with numerous long term care professionals since the implementation of the 1990 federal long term care requirement for Quality Assessment and Assurance (QA&A). Based upon these discussions and upon personal observations, it is apparent that many long term care professionals are not pleased with the effectiveness of their internal quality assurance programs.

Often the QA program is viewed as additional paperwork that serves little or no purpose beyond documenting quarterly minutes at a required Committee meeting. The program often consumes tremendous staff time without providing meaningful and usable information for the Committee.

This manual is an effort to move beyond the traditional studies which create mounds of paperwork...

to a Committee process focused on meaningful activities for measuring and improving compliance and quality throughout the facility.

In many long term care facilities, administrators and department managers have no prior experience with either the federal long term care survey process or healthcare quality management. Therefore, this manual has been developed with three primary purposes in mind: l) to orient Committee members who may be newcomers to the long term care federal survey process 2) to assist new and experienced Committee members in seriously evaluating the effectiveness of their existing quality management program and 3) to introduce the long term care professional to basic concepts of continuous quality improvement that can be applied to all facilities.

Most quality "gurus" are consistent in their belief that truly effective quality management and improvement programs will not exist without a commitment from the top. In the long term care facility, this commitment must come through both executive management as well as the Quality Assessment and Assurance (QA&A) Committee. Unlike acute care and other health care settings, long term care facilities have no formal Quality Department to educate staff, monitor quality of care and staff performance, and energize quality efforts. This makes the role of the Committee extremely critical in the long term care facility. The

Committee sets the pace and provides the leadership that will ultimately guide the success or failure of the facility quality management program.

Although it is easy to describe the problem with quality management in long term care, the solution often becomes much more complicated. How do we make quality management a dynamic process in the facility? Can we merge regulatory compliance with quality assurance activities and successfully educate staff as to the importance and similarities of these processes? How do we motivate people to become more involved in efforts to improve quality in the facility?

This manual is intended to provide answers to these questions by providing guidance to the Committee members as the leaders of the quality and compliance initiatives within the long term care facility. The author has attempted to reinforce the necessity for Committee members to seriously evaluate data collection and auditing in terms of its value in describing quality in their facility. Much of the literature being distributed to the industry promotes the same type of robotic behavior: audit, collect numbers, prepare reports, review the reports, file the reports. A tremendous amount of data are collected, but very little information is received. Recognizing this pattern, the author has attempted to provide users with answers to critical questions in the evaluation of data: "why are we doing what we are doing?", "what do we do with the information once we have collected it"?, "what processes should we work to improve in order to make our work easier, improve quality and reduce cost?"

Unlike many quality assurance manuals for long term care, this manual includes instructions for completing each sample monitoring tool. In addition to providing a rationale for the use of each form, a description is included as to how the information should be evaluated by the Committee on an aggregate basis. Although forms are not the answer for assuring quality, they do provide the structure that many professionals need to organize their evaluation.

This or any other manual should not represent the end evaluation of a facility's quality assurance and improvement program. Rather, this manual should be the beginning of an endless examination of current methods to determine overall effectiveness and usefulness of the program within a facility. A quality management program must be a living entity that changes its emphasis and focus as the resident population and the educational level of the employees changes. Furthermore, the program must constantly seek new and improved ways of providing services, reducing costs and improving customer satisfaction.

We are beginning to see a paradigm shift in terms of the manner in which quality is both defined and compared in health care facilities. Unlike the historical past, health care experts predict that consumers will become increasingly more selective in choosing their health care providers (Mozena xix). Although cost will always be a consideration, the trend is to compare cost with quality in the evaluation of health care facilities and providers. Industry leaders are predicting that the successful health care institution of the future will be characterized by continual improvement of the quality of its care and services (Mozena xix). Consequently, the goal of constant improvement must be assumed by all

employees within the organization and not just the facility administrator or board of directors.

Recognizing the continuing emphasis upon formal quality improvement efforts in health care, this manual has included basic information for the QA&A Committee to apply this concept to long term care. The intent of the quality improvement section is to introduce simple and practical applications, recognizing that the majority of long term care facilities do not have the luxury of multiple full-time employees devoted to QA and QI. Consequently, this manual has been developed keeping in mind the financial and human resource constraints of the typical long term care facility. It is hoped that this document will serve as a useful resource and an initial stepping stone to continued learning for the long term care professional.

Quality is not a department responsibility.
Quality is everyone and everything within an organization.

Harold A. McAlindon

Section 1 Content: Organization and Focus of the Manual

Subsection 1.0 What You'll Learn From This Section:

- **The intended primary and secondary users of the manual.**
- **The organization and general content of the manual.**
- **The learning objectives for users of this manual.**

Subsection 1.1: Who Should Use the Manual

Users of this manual can be separated into two groups: 1) primary users and 2) secondary users.

Primary users are the QA&A Committee members or those with an identified responsibility for assessing, managing, and improving quality of care and quality of life within the long term care facility. Although all employees have a responsibility for quality within the scope of their job, the Committee members have the organizational authority to take action on matters pertaining to quality. These include but are not limited to the following:

Members of the Governing Body
Administrators
Medical Directors
Directors of Nursing
Department Managers and Supervisors
Quality Assurance/Improvement Coordinators
Quality Assessment & Assurance Committee Members
Staff Development Coordinators

Secondary users are those individuals who are involved but have no ultimate management authority in the work processes that comprise quality of care and quality of life within a long term care facility. In actuality, all employees within the facility should be secondary users of this manual.

In order for the QA/QI program to have meaning, each department worker should understand the impact of his/her

department on quality of care and quality of life within the facility. Moreover, each departmental worker should be actively involved in the quality assessment, assurance and improvement program. The business of quality is not a one-person job. Unfortunately, the general employee often has absolutely no input or involvement in the QA/QI program unless it is to be told that he or she has performed below acceptable standards.

The mission of upper management should be to involve *all* employees in the use of those portions of this manual that relate to their job responsibilities. A QA/QI program should be all inclusive and never exclusive in its involvement of the facility staff.

Subsection 1.2: Description of Manual Content

As described in the preceding section, this manual is intended for use by the described primary users. The manual uses a "how to" approach for discussing the functions of quality assessment, assurance and improvement from the viewpoint of the QA&A Committee. Basically these functions can be generally described as performing **quality management** for the facility. In the context of this training manual, the term "quality management" will be used to describe this global Committee function.

Primary Users

If you are an administrator, medical director or any of the other primary users, refer to Section 2 for a general discussion of the federal regulations and interpretive guidelines concerning the committee roles and responsibilities. This chapter includes general comments regarding the responsibilities, selection and function of the QA&A Committee. Section 6 addresses the basic concept of continuous quality improvement (CQI) and provides general direction to the Committee in its implementation within the facility.

If you are a department manager or supervisor who is not a member of the facility QA&A Committee, read and have a general working knowledge of Section 2. Understanding the federal regulation and the responsibilities of the QA&A program will help you to see how your departmental program relates to the global picture.

Format of the Manual

The manual is comprised of six sections. Each of these sections is divided into subsections which relate to the general topic described in the section title. A complete description of the section contents is provided at the beginning of each section. Following the description of the section contents, each section contains a summary of learning objectives for that portion of the manual.

Definition of Terms

Section 7 is a glossary of QA/QI terms and serves as a general reference for all facility staff. In addition, the glossary includes quality improvement terminology that may be new to many long term care professionals. While these terms are not necessary for understanding regulatory compliance, they are considered worthwhile for professional development in the health care industry.

Suggested Reading

Section 8 is a bibliography of suggested reading concerning quality improvement applications in health care. Although additional reading is not essential from a survey compliance point of view, it is a necessary component of individual professional enhancement. Because of the increasing focus on CQI and statistical process control in health care, this bibliography will require constant updating.

As a healthcare professional, consider it your personal obligation to continue your education in all aspects of quality management. This includes ongoing reading, attending seminars concerning quality enhancement and discussing and applying new concepts within your work place.

Subsection 1.3: Goals for Users of the Manual

At the end of studying this manual, you should gain the following insight as to the role and function of the long term care Quality Assessment and Assurance Committee:

1) Understand the information that should be evaluated in each department in terms of general compliance and quality performance.
2) Understand how to develop and evaluate quality indicators for key departments within the facility.
3) Understand the inter-relationship between the federal long term care survey process and your facility QA/QI program.
4) Be familiar with one approach for assessing the effectiveness of your facility QA/QI program.
5) Understand why focused data collection is significant in the quality assessment and assurance process.
6) Understand the impact of federal regulations on the provision of quality services by key departments or areas of service.
7) Understand many factors long term care surveyors are instructed to evaluate during the certification survey process in key areas of service.
8) Understand how QA/QI information should be evaluated by the Committee once it has been collected.
9) Understand the basic difference between QA and QI and have a working knowledge of QI applications in the long term care setting.

If the lowest person in your organization cannot tell you what the facility quality mission is, you do not have a quality mission.

Kris King

Section 2 Content: Overview of the QA&A Committee Role & Responsibilities

Subsection 2.0 What You'll Learn in This Section:

- **The federal requirement, interpretive guidelines and survey procedures and probes for the QA&A Committee.**
- **The duties and leadership role of the Committee members.**
- **The purpose, content and disclosure guidelines for Committee minutes.**
- **The importance of incorporating input from all levels of the facility staff in assessing the effectiveness of the program.**

Subsection 2.1
The Federal Regulation for the QA&A Committee

Read and be familiar with the federal requirement, interpretive guidelines and survey procedures and probes for the QA&A Committee.

The federal requirement: 483.75 (0) [This is the actual law as it is written.]

(1) A facility must maintain a quality assessment and assurance committee consisting of:
(i) The director of nursing services;
(ii) A physician designated by the facility staff; and
(iii) At least 3 other members of the facility's staff

(2) The quality assessment and assurance committee:
(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and
(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies

(3) A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section (AHCA P-215).

Interpretive Guidelines: [This is the interpretation provided to the reader by the Health Care Financing Administration, also known as HCFA.]

The quality assessment and assurance committee is responsible for identifying issues that necessitate action of the committee, such as issues which negatively affect quality of care and services provided to residents. In addition, the committee develops and implements plans of action to correct identified quality deficiencies, in areas such as pharmaceutical services and infection control. Do not routinely review the specific actions or reports of the

committee during the course of the Standard Survey. However, if you identify facility problems in which committee action is or should be relevant, then review those documents that are necessary to evaluate committee actions pertaining to identification of, and correction of, quality deficiencies (AHCA P-215).

Survey Procedures and Probes: **[These are the procedures and investigative instructions given to surveyors to evaluate compliance with this requirement.]**

→ When this requirement is reviewed, it is intended that you look at the function of the Quality Assessment Committee.

→ Do not cite deficiencies based on the substantive content of the quality assurance records. However, you may cite quality deficiencies if the quality problem was identified independent of the investigation of the Quality Assessment Committee, or the action of the committee is insufficient to resolve this problem (AHCA P-215).

Subsection 2.2
Duties of the QA&A Committee Members

Do not evaluate the scope of responsibility of the QA&A Committee based upon the length of the federal requirement. Although the text is relatively brief, the scope of the responsibilities that are described are quite broad. Keep in mind the following four basic Committee duties in reference to meeting the responsibilities identified in the federal regulation.

Duty #1: Quality Surveillance

From a survey perspective, it is important to be able to track that the Quality Assessment and Assurance Committee identified the problem(s) and continually addressed correction of the problem(s) until the situation was satisfactorily resolved.

How can this be done? As a Committee, in cooperation with the facility management team, you must develop an information system that collects strategic data on an ongoing basis. These data will serve as a map for directing you to those areas that deserve priority attention and corrective action. This data go beyond routine monthly statistics. These data will include an overview of strategic operational issues that describe the successes and possible shortcomings of key processes within the facility. From a review of this information, you will develop a plan for prioritizing issues which need corrective action and for directing departmental managers in further investigation of problem causes and solutions.

As a group, you must be proactive as well as reactive in your activities. In other words, you must be able to identify trends and read into key statistical information that could represent potential care problems as well as respond to actual problems as they occur.

Duty #2) Appropriate and Timely Action

You must demonstrate timely action in reference to significant issues that affect quality in the facility. Although the minimum required frequency for Committee meetings is quarterly, it is implied that the Committee would meet as often as necessary to address and resolve continued quality problems that negatively impact upon care.

For example, if the facility continued to routinely report an increase in the number and severity of acquired decubitus ulcers, this would be a known factor that negatively impacts upon resident well-being. Therefore, it would seem prudent for the QA&A Committee to immediately become involved in resolving this problem, whether or not there had recently been a quarterly Committee meeting.

This does not necessarily mean that all members of the Committee must be present in order to discuss and evaluate an immediate plan of action. Perhaps the Administrator and Director of Nursing could discuss and evaluate possible causes and review findings and recommendations with the Medical Director by teleconference. The important issue would be that the facility/Committee was able to demonstrate the following significant facts:

a) knowledge of the problem as a result of routine surveillance of potential quality of care issues

b) action taken once the problem was identified

c) development of an ***effective*** plan of correction to address and resolve the problem in a timely manner.

d) follow-up on the problem situation until it has been satisfactorily corrected.

Duty #3: Maintaining Committee Minutes

Minutes of your meetings should be strategically and succinctly recorded with the primary goal of providing a trail of Committee actions. Do ***not*** disclose minutes to surveyors unless the management of a specific quality of care problem is being questioned during the survey. Should this occur, copies of the minutes should be provided only in reference to tracking the specific problem being evaluated by the surveyor.

A sample format for documenting QA&A Committee minutes is provided on the following page.

Quality Assessment and Assurance Committee
Sample Minutes Format

Opening: Date and time meeting was held.

Members Present: List names and titles of Committee members in attendance.

Members Absent: Identify names and titles of Committee members not in attendance.

Guests in Attendance: List those non-members who are present such as consultants or department representatives who may not be Committee members.

Old Business:

In order to demonstrate continuity in reference to the problem-solving process, it is suggested that this section be devoted to a status report regarding any issues pending from the previous meeting such as a follow-up report on any corrective action plan that was recommended for any unresolved issues, concerns or problems.

Committee Reports:

Because the QA and A Committee now incorporates the previous responsibilities of the Infection Control, Pharmacy, Utilization Review, and Safety Committees, it is suggested that each meeting address pertinent statistics and review key indicator data with a brief statement as to the general results and pertinent recommendations.

Examples:

Infection Control data for the previous month (or previous quarter) was reviewed with all statistics identified as being within acceptable performance ranges. No recommendations for corrective action or improvement were indicated.

Utilization Review statistics for the month of ____ are as follows:

Medicaid Admissions: 4 All were evaluated for level of care and all exceeded 36 points..

Medicare Report: 5 Admissions Certified for Part A
4 Residents Approved for Continued Stay
1 Continued Stay Denial: Benefits Exhausted

The Pharmacy report identified an increase in medication errors, and a plan for focused monitoring on Division 2 was discussed and approved. A follow-up report will be presented to the Committee at the next meeting which has been scheduled for next month.

New Business:

Generally each department is scheduled for presentation of a monitoring report or QA evaluation of their department. There is no "right" or "wrong" way in which to format these reviews; however, it is common for 1 or 2 reports to be presented at each scheduled meeting throughout the year. This would be an appropriate time to review a summary of findings and discuss appropriate follow-up reviews as may be necessary.

Rather than focusing on the use of "problems", it is advisable to describe findings and recommendations as opportunities for quality "improvement".

Other items which could apply to the area of New Business would be as follows:

a. Recent survey findings
b. Any significant areas of concern identified by the staff (whether or not a formal review has been done or a documented problem has been identified.
c. Any significant areas of improvement or achievement accomplished (whether or not a formal review has been done)
d. Reports on improvements in care statistics (decrease in acquired pressure ulcers, decrease in number of Foley catheters, decrease in acquired infections, etc.)
e. Results of satisfaction questionnaires/surveys
f. Feedback from families/residents via Resident Council
g. Feedback from employee groups such as employee retention committees
h. Discussion of facility and/or departmental quality improvement projects.

Next Scheduled Meeting Date: Note the date/time of the next QA and A Meeting.

Adjournment: Time the meeting concluded.

Prepared By: Reviewed By:

_____ _____

Quality Assurance Coordinator Administrator

_____

Medical Director

Duty #4: Quality Education and Leadership Within the Facility

As a group and as individuals, you serve as the quality ***leaders*** in the facility. This encompasses several key activities:

a. You set the pace at which action is taken and prioritize quality issues that should be addressed within the facility.

b. You work with administration to assure that staff are provided with proper education and resources to actively participate in the quality activities being conducted within the facility.

c. You involve employees at all levels in quality measurement and improvement activities and reinforce a commitment to quality of care and quality of resident life.

d. You work with administration to effectively coordinate quality assessment, assurance and improvement activities within the facility, assuring that all departmental efforts are harmoniously integrated.

Effective leadership is essential to the success of quality within the organization. While it is necessary to have a strong commitment from the Board of Directors and the facility administrator, the QA&A Committee serves as the

internal leader in this process. Consequently, you can be both the reason for success and for the failure of quality initiatives (Scherkenbach 154).

A definition of a leader described by Lao-tsu is referenced in the management methods described by Dr. W. Edwards Deming (Scherkenbach 155). This definition may be helpful in demonstrating the leadership role that the Committee should strive to emulate (Scherkenbach 155):

> A leader is best
> When people barely know that he exists,
> Not so good when people obey and acclaim him,
> Worst when they despise him,
> "Fail to honor people, They fail to honor you;"
> But of a good leader, who talks little,
> When his work is done, his aim fulfilled,
> They will all say, "We did this ourselves."

From another perspective, adopt the five Committee "C's" as essential action steps for each and every facility quality initiative:

Commit to the concept of quality as a priority within the organization. Be an example to your employees. You should be the cheerleaders for the quality efforts in the facility.

Coach the staff in the methods of assessing and improving quality in their areas of service.

Communicate continuously the goals and the results of quality improvement projects to all workers and customers in the process.

Coordinate the efforts of the staff to assure that everyone is working together toward a common goal.

Care about the people who work for and within your organization equally as much as you do the residents who live in your facility. Your employees, consultants and suppliers are your most important resources for providing quality services.

Source: King Healthcare Enterprises, Inc.

Subsection 2.3: Assessing and Improving The Facility QA Program

In this subsection, you will learn one method of evaluating your QA program as it is now and where you, as a Committee, think it should be. This assessment process is based upon two major operating goals for the Committee. The first is that the QA program works in unison with internal processes for monitoring regulatory compliance. The second is that a successful QA program involves and recognizes input from all levels of staff in the facility.

This manual uses the term "QA/QI program" to describe facility quality programs. Whether the program addresses only quality assurance or also encompasses quality improvement concepts, the self-assessment process has universal application. This terminology for the internal facility program does not affect the name of the actual Committee. The name, Quality Assessment and Assurance (QA&A) Committee, is derived from the long term care federal requirement.

The self-assessment process consists of the following steps using the self-assessment tools on pages 84 and 85:

a) **Complete the Committee QA/QI Self-Assessment form displayed on page 84.**

b) Obtain input from each of the facility department managers and supervisors using the self-assessment form.

c) Obtain input from employees in each department using the employee QA/QI assessment form.

d) Review the results. Focus on all "NO" answers on both sets of assessment forms.

e) Decide where you, as a Committee, think you should make modifications in the QA program to change all "NO" answers to "YES".

f) Assist departments in reducing unnecessary paperwork and "studies" that do not contribute to a meaningful quality or regulatory compliance assessment.

g) Work with departments to modify their programs to include indicators and performance measurements pertinent to the Quality of Care and Quality of Life regulatory issues.

SELF-ASSESSMENT OF YOUR FACILITY'S QA/QI PROGRAM

Complete the following questions regarding your feelings about your department and/or facility QA/QI program.

1. Does the program give managers beneficial information to evaluate the performance of their department?____ the facility as a whole?___

2. Does the program assist departments and their staff in preparing for survey compliance? _____

3. Do all staff have an active role in the quality assurance or quality improvement process? _____

4. Could your employees answer this question: what does "quality" mean in reference to your job? ____

5. Could your employees recite the facility mission statement? ____

6. Are staff encouraged to openly discuss problem issues in reference to their department or in reference to problems they encounter with other departments? ____

7. Is there an atmosphere of cooperation in the facility for resolving interdepartmental quality issues? _____

8. Does the information collected in the quality assurance program allow you to detect trends such as areas of improvement and areas of decline in key processes within the facility? _____

9. Are you including cost effectiveness in your quality assessments?___

10. Are staff development/inservice education programs designed to incorporate quality assessment and assurance findings? _____

11. Once a change has been implemented in the facility as a result of a quality assurance or improvement issue, is there an ongoing program of monitoring to evaluate the effectiveness and appropriateness of the change? _____

12. Do all quality assurance studies or reports have a useful purpose? _____

List any studies or reports which do not seem to have a specific purpose and identify the reason they are being done.

SOURCE: King Healthcare Enterprises, Inc. 4/93

Employee QA/QI Program Assessment

1. Do you know what represents "quality" in your daily work? In other words, do you know what must occur in order for you to do an outstanding job? ___

2. Do you know what the quality mission or quality goals are for your department?

3. Do you know if the department has a Quality Assurance or Quality Improvement program?

   If "Yes", are you involved in it?

4. Are you involved in the facility's Quality Assurance or Quality Improvement program?

5. Do you know who is on the facility QA Committee?

6. Have you been asked to give suggestions on improving quality in your department?
   - ω on reducing costs in the facility?
   - ω on improving system breakdowns with other departments?

Source: King Healthcare Enterprises, Inc.

Discussion

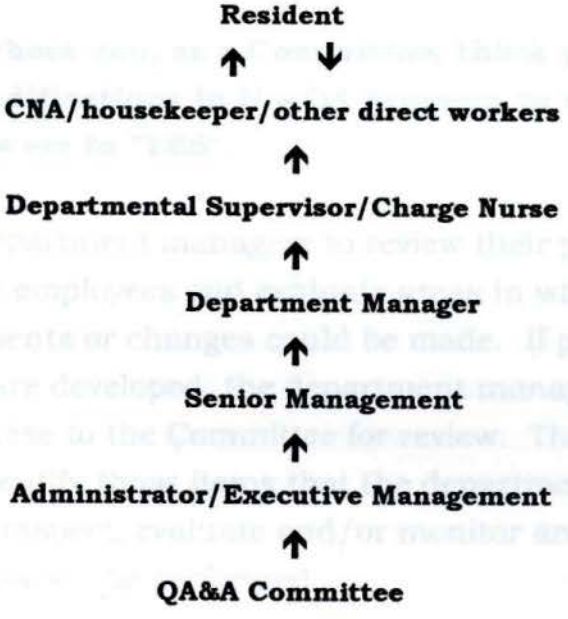
a) Completing the Committee QA/QI Self-Assessment.
The purpose of completing the self-assessment is to critically evaluate whether the present program is adding value to the Committee's quality surveillance responsibilities or is merely adding more work for the staff. The self-assessment should be done periodically and not just on a one-time basis.

b) Obtain input from each of the facility department managers and supervisors using the self-assessment form.
Successful QA/QI is a "group think" process. Therefore, the Committee must involve input from all department managers on an ongoing basis.

You may decide that this can be done more effectively by merely having a group meeting to review the questions and ask for feedback. An alternative would be to ask managers and supervisors to complete and return the form as a type of internal survey. The Committee would then evaluate the completed self-assessment forms.

c) Ask employees from each department to complete the employee QA/QI assessment form.
Employees are usually the most closely involved with the resident and are ultimately where quality of care and quality of life will be realized in the facility. There is a strong need, therefore, to get them involved in the QA/QI process. Their input is essential to the success of the

program. Their active involvement will often lead to improved employee morale and worthwhile suggestions for cost and quality improvements. As a Committee, steer department managers toward greater employee involvement in the entire process. Review the following diagram which illustrates the relationship between the resident and the QA&A Committee.



Notice how far removed the Committee members are from the actual resident encounters that represent "moments of truth" in quality of life and quality of care. Extremely large organizations with 200 or more beds may have even more "layers" between the resident and the quality leaders. This is why involvement of all staff at every level is critical to the success of quality initiatives.

d) **Review the results. Focus on all "NO" answers.** "NO" answers provide you with targets for beginning the improvement process. If you, as a Committee, have answered "YES" to all assessment questions, but there are different opinions by department managers and/or employees, then the Committee should focus on these different opinions. Solicit more input as may be necessary.

e) **Decide where you, as a Committee, think you should make modifications in the QA program to change all "NO" answers to "YES".**

Ask all department managers to review their present plan with their employees and evaluate areas in which improvements or changes could be made. If proposed changes are developed, the department manager should submit these to the Committee for review. The plan should identify those items that the department will routinely inspect, evaluate and/or monitor and how often the process will be performed.

f) **Assist departments in reducing unnecessary paperwork and "studies" that do not contribute to a meaningful quality or regulatory compliance assessment.**

g) **Work with departments to modify their programs to include indicators and performance measurements pertinent to the Quality of Care and Quality of Life regulatory issues.**

As a Committee member, think of yourself as an internal consultant for quality surveillance for each department. Help departments to work with their employees in developing meaningful measures of quality within their area of service.

The overall objectives of the quality management program in each department and within the facility as a whole should be to:

1. establish the quality mission or objectives of each area of service;
2. determine the present level of performance against that desired in the quality mission;
3. work together to develop a plan for improving performance where improvement is needed, and
4. constantly re-evaluate performance to determine if the corrective action plans have been effective. Modify the plan as necessary.

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.

Will A. Foster

Section 3 Content: Incorporating Regulatory Compliance into the QA/QI Program

Subsection 3.0 What You'll Learn In This Section

- **The basic surveillance issues included in the Quality of Care and Quality of Life federal requirements.**
- **The role of quality indicators and significant statistics in the surveillance of key processes and outcomes in the facility.**
- **The importance of a dynamic QA/QI program that incorporates useful information from all resources in the facility.**

Overview

After assessing your program, you may have identified a need to increase the evaluation of key regulatory compliance issues into the Committee surveillance. This Section is designed to assist you in that process.

To a large extent, the federal requirements for long term care facilities have given you specific definitions for both quality of care and resident quality of life. These are the cornerstones of the federal long term care survey process. Therefore, the Committee must incorporate these elements into the facility quality assessment and assurance program. (Refer to the federal guidelines for a detailed description of each of the broad categories listed in the following subsections.)

Subsection 3.1 Quality of Care Federal Requirement

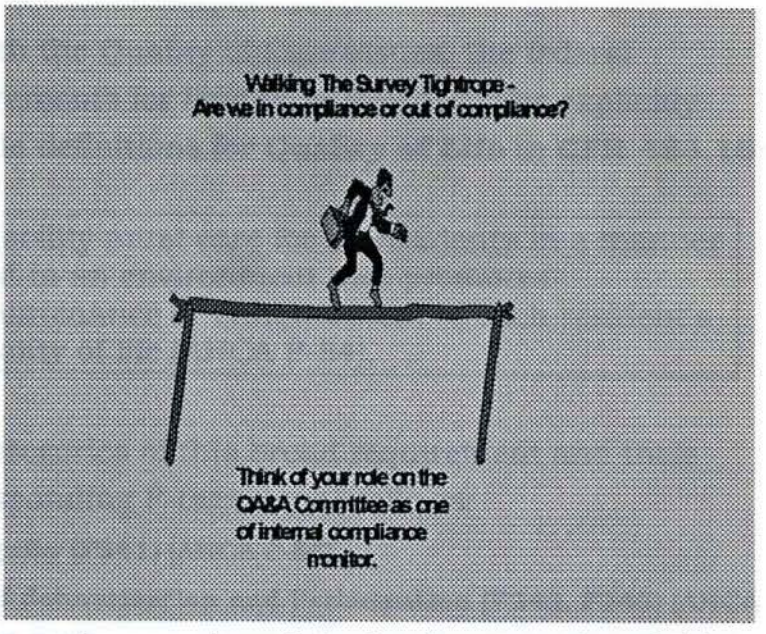
Quality of Care (CFR 483.25)
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care (AHCA P-113).

Subcategories of this requirement include individual reference to each of the following quality of care issues and their corresponding F-tags:

- **Activities of Daily Living (F 310 through F315)**
  Bathe, dress, and groom;
  Transfer and ambulate;
  Toilet;
  Eat; and
  Use speech, language or other functional communication system (AHCA P-113-P-120).
- **Vision and Hearing (F318)** (AHCA P-121).
- **Pressure Sores (F319, F320)** (AHCA P-122-P-124).
- **Urinary Incontinence (F321, F322)** (AHCA P-124-P-126).
- **Range of Motion (F323, F324)** (AHCA P-126, P-127).
- **Mental and Psychosocial Functioning (F325, F326)** (AHCA P-129, P-130).
- **Naso-gastric tubes (F327, F328)** (AHCA P-130).
- **Accidents (F329, F330)** (AHCA P-131, P-132).
- **Nutrition (F331, F332)** (AHCA P-132-P-134).
- **Hydration (F333)** (AHCA P-333).

- **Special Needs (F334 through F-341)** (AHCA P-136-P-139)
  (Injections; Parenteral and enteral fluids; Colostomy, ureterostomy or ileostomy care; Tracheostomy Care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses)
- **Unnecessary Drugs (F342 through F347)** (AHCA P-139 - P-150)
  (Includes general medication use and specific guidelines for antipsychotic drug usage).
- **Medication Errors (F350, F351)** (AHCA P-150-P-156).

Committee Focus



Now that you have reviewed the basic categories of this requirement, evaluate how well your own QA program monitors essential regulatory compliance for Quality of Care outcomes:

1. Look at the present system for evaluating Quality of Care requirements.

2. Assess whether the present system includes a means of evaluating each of the resident outcomes in the Quality of Care Requirements.

3. Regard the QA program as an opportunity for ongoing self-appraisal of the facility's compliance with regulatory requirements. If the QA program is effective, compliance will be a natural byproduct.

Subsection 3.2 Quality of Life Federal Requirement

As with the Quality of Care issues, the federal requirements for long term care facilities explicitly include definitions for **Quality of Life** in **CFR 483.15:**

> A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life (AHCA P-84).

Subcategories of this broad requirement and their corresponding F-tags are as follows:

- **Dignity (F241)** (AHCA P-84).
- **Self-determination and Participation (F242, F243)** (AHCA P-85-P-86).
- **Participation in resident and family groups (F246 through F251)** (AHCA P-86, P-87).
- **Participation in other activities (F252)** (AHCA P-87).
- **Accommodation of needs (P253, P254)** (AHCA P-86, P-87).
- **Activities (F255, F256)** (AHCA P-89-P-91).
- **Social Services (F257, F258, F259)** (AHCA P-91 - P-94).
- **Environment (F260 through F265)** (AHCA P-94 - P-99).

Committee Focus

Evaluate how well your program monitors compliance with Quality of Life requirements.

1. Look at the present methods for monitoring Quality of Life issues as they relate to each department's care activities. Include onsite monitoring for observance of Residents' Rights in all areas of care.

2. Look at the present methods for monitoring how well the facility adapts the physical environment to meet the particular needs of each resident. Incorporate an ongoing evaluation of environmental issues into the program.

3. Incorporate Resident Council issues and concerns into the QA program on an ongoing basis.

4. Incorporate feedback from the facility ombudsman regarding perceptions of staff - resident encounters and other Quality of Life issues.

Subsection 3.3 Additional Federal Requirements Relating to Quality Surveillance

Refer to the following additional federal requirements and F-tags for related quality of care and quality of life regulations that the Committee should include in its surveillance:

- **Resident Assessment (F270-A through F294)(F301 through F303)**
- **Comprehensive Care Plans (F295 through F300)**
- **Nursing Service (F353-A through F359)**
- **Dietary Service (F360-A through F378)**
- **Physician Services (F385-A through F397)**
- **Specialized Rehabilitative Services (F405-A through F407)**
- **Dental Services (F-410-A through F-417)**
- **Pharmacy Services (F-425-A through F-434)**
- **Infection Control (F-440-A through F-447)**
- **Physical Environment (F-454-A through F-483)**
- **Administration (F-490-A) which includes a minimum of these areas:**

  CNA training, education and proficiency (F496-F502); use of qualified staff and outside resources (F503-F507); medical director (F508-F510); laboratory services (F511-F519); radiology services (F520-F526); clinical records (F527-F531); disaster preparedness (F532-F535).

Committee Focus

1. Look at the present methods for monitoring specific departmental performance requirements in each of the F-tags identified on the preceding page.

2. Incorporate methods for evaluating compliance with staff training, education and proficiency into each departmental program and/or in the facility-wide staff development program.

"Don't measure yourself by what you have accomplished, but by what you should have accomplished with your ability."

Author Unknown

Section 4 Content:
Using Indicators and Statistics to Monitor Quality and Regulatory Compliance

Subsection 4.0 What You'll Learn In This Section

- **The role of quality indicators in monitoring care and regulatory compliance.**
- **The way in which significant facility statistics can be used to identify key areas of concern in quality of care and quality of life issues.**
- **The importance of distinguishing useful information in the data that is reported to the Committee.**
- **The value of tracking significant information about the facility patterns of care over time.**

Subsection 4.1 Developing Quality Indicators

Quality indicators are one method of evaluating and comparing performance against established measures. This allows the Committee and individual departments to objectively evaluate their performance in a given period as well as to track performance over time. This information will also provide a means of assessing internal regulatory compliance if indicators are established using the federal requirements.

Step 1:
Identify care issues that can be measured and which reflect regulatory compliance.
You must decide upon key quality indicators that compare actual performance against pre-established standards. By starting with those areas that you know are a part of the survey process, you will successfully merge the two into a uniform and ongoing evaluation.

For example, each of the following care issues are components of the federal Quality of Care and Quality of Life requirements for which quality indicators can be easily adopted:

Aspect of Care	Sample Indicators
➢ Resident Nutrition (Quality of Care) **F331, F332**	⇨ % of residents with 5% weight loss in the previous 30 days
" **F327, F328**	⇨ % of residents on tube feedings
(Quality of Care) **F327, F328**	⇨ % of residents weaned from tube feeding to an oral diet
(Quality of Care) **F331, F332**	⇨ Number of residents hospitalized for a diagnosis of malnutrition
➢ Resident hydration (Quality of Care) **F333**	⇨ % of residents hospitalized with a diagnosis of dehydration
➢ Resident skin integrity (Quality of Care) **F319**	⇨ % of residents with acquired pressure ulcers since admission
➢ Resident mobility	⇨ % of residents with orders for routine physical restraint use
	⇨ % of bedfast residents

- **Resident incontinence management (Quality of Care) F321, F322**
  - ⇨ % of residents with urinary incontinence
  - ⇨ % of residents with an indwelling catheter
- **Provision of meaningful activities for all residents (Quality of Life) F252, F255, F256**
  - ⇨ % of residents participating in group activities
  - ⇨ Average number of activities offered per day
  - ⇨ % of residents requiring one-on-one activities
  - ⇨ % of interviewable residents indicating satisfaction with facility activities (per survey)
- **Meeting the social and emotional needs of all residents**
  Quality of Life **F257, F258, F259**
  Quality of Care **F325, F326**
  - ⇨ % of residents with assessed emotional/behavioral problems
  - ⇨ % of residents for whom a behavioral management program is documented

This is not an exhaustive list but is merely an example of using key regulatory compliance issues as quality indicators.

Step 2:
Review the subsections of the Quality of Care federal requirements and compare the categories to existing departmental quality indicators.

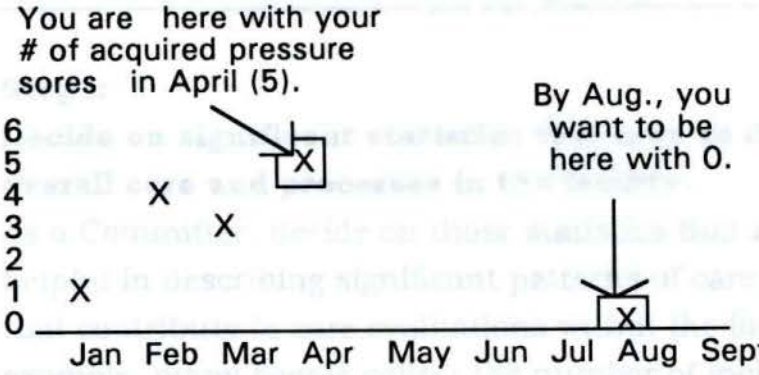
Are all of the categories in the Quality of Care requirements presently being reported to the Committee as some type of indicator?

If not, make a list of areas which need to be incorporated into each departmental monitoring program. Refer this list to the department manager and work with that manager to develop an indicator program which mirrors the regulatory requirements.

Ask each department to determine what data are useful for evaluating quality/compliance in their area. Review their input, and suggest changes where you feel appropriate in either gaining more useful information or eliminating collection of non-useful information. You may need to add additional indicators and statistics after comparing the target areas in the federal requirements.

Useful data tell you where you are now so that you can decide whether changes need to be made to get where you want to be. Maybe changes that have been made in the past resulted in improvements; maybe things got worse rather than improving. You will never know without collecting ***useful*** information.

EXAMPLE



Unless you routinely track information for compliance between the months of April and August, you will not know whether the plan of action started in April is effective or if the problem is actually getting worse.

Step 3:
Review the subsections of the Quality of Life federal requirements and compare the categories to existing departmental quality indicators.

Are all of the categories in the Quality of Life requirements presently being evaluated and reported to the Committee as some type of indicator?

If not, make a list of areas which need to be incorporated into each departmental monitoring program. Refer this list to the department manager and work with that manager to develop an indicator program which mirrors the regulatory requirements.

Subsection 4.2 Significant Statistics That Help to Describe Facility Quality

Step 1:

Decide on significant statistics that help to describe overall care and processes in the facility.

As a Committee, decide on those statistics that are helpful in describing significant patterns of care or factors that contribute to care evaluations within the facility. For example, many people collect the number of incident reports completed every month. Does this number alone tell you anything useful? Not really. With only a number, you only can say whether more or less reports were completed compared to the previous month.

Step 2:

Distinguish between useful reporting statistics and statistics that provide no value to the Committee.

Using the example with incident reports described in Step 1, useful information is gained from the analysis of the content of the reports: number of residents with unexplained injuries, number of falls, number of skin tears, number of residents with three or more injuries in the current month, etc. Furthermore, even these data will give you more usable information if it were reported according to nursing division and shift of occurrence.

Examples of such statistics and their value to the Committee include some of the following:

(1) Nosocomial infections each month by type and nursing division

Rationale: Tracking the acquired infections by type and by nursing division will give you an indication of where possible infection control problems are occurring. For example, if all of the urinary tract infections are occurring on a particular division, and the majority involve residents with Foley catheters, it would be reasonable to evaluate catheter care and staff technique on that particular division.

The need to track this information is also included in the federal requirements for Infection Control, CFR 483.65 (F-tags F440-A, F441, F442, F443) (AHCA P-185).

(2) Inhouse resident injuries each month

a. minor injuries
b. fractures

Rationale: Tracking resident injuries such as skin tears, bruising and other minor injuries by type of injury, location of resident and shift of occurrence can provide useful information for reducing or preventing these types of occurrences.

For example, if skin tears are occurring primarily during the transport of residents to the shower room or during personal care, then it would be pertinent for the Committee to evaluate the cause. Is it because

staff need additional training? Is it because the shower schedule is loaded down with too many difficult resident transfers on the same day? Can an increase in resident skin tears be correlated with an increase in new nursing assistants?

If there are patterns with respect to individual residents, could this be prevented by applying protective padding to wheelchairs and siderails?

With respect to more serious injuries such as fractures, it would be wise to track and evaluate each of these occurrences on an ongoing basis to determine if there were a preventable cause of the accident which resulted in the resident fracture. Furthermore, if there is a pattern with respect to the staff members or types of falls that resulted in fractures, this pattern should be further investigated by the Committee.

The need to track and investigate preventable causes of accidents that result in resident injury is also addressed in the federal requirement for Quality of Care, 483.25 (h) Accidents (F-tags F329 and F330) (AHCA P-131).

(3) Resident elopements each month

Rationale: If residents are getting out of the facility unattended and unnoticed, there is a need to evaluate the security systems in place in the facility to prevent such occurrences. This again relates to the federal

requirement for Quality of Care, 483.25 (h) Accidents as noted in #2 above.

If there are resident elopements, and your facility has a security system on the outside doors, then staff are either disarming the system or are ignoring the alarm when it is triggered. In either case, this would signal a need for attention to the matter of resident elopement.

(4) Discharges to home each month

Rationale: This is a statistic that reflects positively on the rehabilitation focus of the facility in caring for residents. Therefore, this is not only a positive marketing tool, but it also reflects compliance with the federal requirement for appropriately assessing each resident's rehabilitation potential (federal requirement 483.20(b)(xi) (AHCA P-102).

(5) Number of residents with contractures

a. residents with facility-acquired contractures
b. residents admitted with contractures

Without knowing the number of residents admitted with contractures as compared to the current number inhouse, the Committee cannot evaluate the effectiveness of the resident assessment program for identifying residents at risk for developing contractures.

Evaluating this number also detects whether staff are appropriately documenting the presence of resident contractures at the time of admission or readmission to the facility. Without proper documentation in the initial assessment, contractures will be facility acquired unless otherwise identified.

This information also relates to compliance with the Quality of Care Requirement 483.25 (e) Range of Motion (F-tags F323 and F324) (AHCA P-127).

(6) Number of residents requiring assistance during meals

Monitoring this number is intended to provide management with an indication of the need to evaluate staffing during meal hours. An increase in the number of residents who require staff assistance during meals, i.e., those who must be fed by the staff, represents a potential problem for the facility if not addressed. There must be sufficient, *available* staff to assist residents in all areas of the facility where meals are served. Staff assistance must also be provided in as timely a manner as is possible. Therefore, shifts in the number of residents requiring staff assistance need to be monitored closely in comparison with staff availability during meal service times.

(7) Turnover rate for the nursing assistants each month and patterns in nursing division and shift

Rationale: Turnover in any work setting creates the potential for problems in quality, and this is enhanced in the long term care environment where the nursing assistant is so critical to the success of both quality of care and quality of life. Knowing this number is helpful for comparison with other trends and patterns in the facility.

From a management perspective, it is helpful to understand any patterns that may be detected with respect to turnover, and if possible, to elicit feedback from nursing assistants as to the reason for leaving. Although salary as compared to work responsibilities is often the cause, improvement in working conditions and a spirit of teamwork can often result in dramatic reduction in turnover.

(8) Turnover rate for the licensed nursing staff each month

Rationale: When the turnover rate for the licensed staff is also high, the ability of the facility to provide quality and continuity in resident care is extremely compromised. Consequently, there is a need for the Committee to be aware of the turnover in each of these key resident care areas in relation to care outcomes.

(9) Number of new admissions and readmissions each month and causes for hospitalization

Rationale: Admissions and readmissions create significant work for the direct care staff in particular. Furthermore, from an administrative standpoint, hospitalizations create potential census problems. Therefore, tracking patterns in causes of resident hospitalization is beneficial for determining if the need for hospitalization could have been prevented with more proactive management of care.

(10) Number of internal transfers for the month

Rationale: Internal transfers or room moves also represent significant work for the direct care staff and can also be traumatic for the residents. This number should be evaluated to determine if internal transfers can be reduced. Possibly there should be greater assessment of each resident's room assignment in the preadmission process in order to eliminate subsequent changes for incompatibility. If internal transfers are due to discharges from a Part A designated area, it may be advantageous to consider holding vacancies for potential inhouse transfers from this area.

Summary

These are merely suggestions as to how key statistics may tell you significant information about quality of care and other important activities within the facility. You, as a Committee, must determine what indicators and statistics

are important in describing key events in your own facility.

You may find it necessary to revise statistics as the resident population and type of care changes in your facility. The important point to remember is that the data must be selected with a purpose in mind. You should be able to describe a rationale for each statistic that you collect. The more you are able to merge quality surveillance with compliance monitoring, the greater your ability to determine your survey outcome on an ongoing basis.

Subsection 4.3 Collecting and Reporting Information

Once you have determined which indicators and statistics should be reported, then identify:

1) the frequency for reporting the information

AND

2) the method for collecting and reporting the data to the Committee.

Reporting Frequency

In order to detect trends and patterns of care, you will want to track most indicators and statistics on a monthly basis, regardless of whether the QA&A Committee meets monthly or quarterly.

Monthly tracking will achieve the following minimum objectives:

1) monitor patient care outcomes and key processes within each area of service;

2) evaluate changes in resident population;

3) evaluate staffing needs;

4) develop marketing information regarding positive outcomes; and

5) establish benchmarks or standards of performance from which comparisons can be drawn on a current basis as well as over a period of time.

An annual overview of monthly tracking of sample indicators and statistics is displayed below.

QUALITY INDICATOR TRACKING FORM

INDICATOR	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
% Residents with acquired pressure sores	3	4	5	3	10	12	11	13	15			
% Residents treated for UTI	2	1	0	1	2	3	4	7	10			
% Residents with Foley catheter	0	1	1	3	5	6	7	8	7			
% Residents with acquired contractures	0	0	0	0	5	5	5	7	7			
Reported medication errors	2	1	0	1	3	5	4	6	4			
% Residents with significant, unplanned weight loss	0	0	.5	2	2	5						
# of Residents total assist in feeding	12	12	13	13	20	22						
Number of tube feeders	2	7	10	11	11	10	11	10	3			
# Residents hospitalized for: dehydration	0	0	0	2	0	0	1	3	7			
decubitus ulcer	0	0	0	0	0	0	0	1	3			
fracture	0	0	0	0	0	0	0	0	1			
sepsis/UTI	1	0	1	0	0	1	3	2	5			
# Residents discharged home	-	-	-	-	-	-	-	-	-			
# of reported on-the-job injuries	1	0	2	3	1	4	8	7	6			
# reported incidents involving resident skin tears/bruising on: 7-3 shift	7	3	10	13	12	24	21	23	25			
3-11	1	2	1	5	6	5	3	4	6			
11-7	0	0	0	0	0	3	2	2	2			
Turnover percentage for nursing assistants	75	50	65	60	120	145	163	150	200			

Source: King Healthcare Enterprises, Inc.

Notice how you can paint a picture of overall facility care patterns and quality progress with the tracking of significant information over time.

In the above example, it is obvious that something significant happened between the months of April and May to cause such a drastic increase in the turnover of nursing assistants. At this same time, the percentage of residents with acquired decubitus ulcers more than doubled. Other significant areas of care showed similar decline with a serious number of hospitalizations for negative outcomes in the month of September.

By reviewing the aggregate data shown on the tracking form, it appears that the facility may have admitted a number of heavy care residents in February and March as the number of tube feeders increased from two in January to seven in February and 10 in March. If these were not new admissions, such an increase would lead you to question the reason for so many residents being placed on tube feedings at one time.

Note that the number of residents requiring staff assistance with feeding also showed an increase around this period of time and was not reported for the last several months of the period. This would indicate that possibly no one knows how many residents are in this category, and this would also be an area of concern.

Displaying aggregate data on a master tracking form such as this one allows the Committee to identify possible

relationships between outcomes in one area and significant occurrences in another.

Reporting Method

Once you have decided on the information that you believe the Committee should be evaluating in each department and area of service, you must determine a method for collecting the information. This is referred to as a QA Information System, and a sample process for developing such a system is discussed in Section 5.

In God we trust. All others must use data.

W. Edwards Deming

Section 5 Content:
Developing a QA Information System

Subsection 5.0 What You'll Learn In This Section

- **Understand the need for an effective QA Information System.**
- **Understand the purpose of using a Quality Management Report for Committee quality surveillance and department compliance monitoring.**
- **Understand how to analyze the Quality Management Report data and develop a plan of action.**

Subsection 5.1: The Importance of an Effective QA Information System

☆ You will only be as good as the information you receive. Therefore, you must develop a system for collecting accurate and meaningful information concerning compliance and quality issues.

WHY?

Review these key points by Mikael Sallmander of Meta Health Technology, Inc. which reinforce the need for a good QA information system in any health care setting:

> ***If you can't collect, you can't measure.***
> ***If you can't measure, you can't manage.***
> ***If you can't manage, you can't improve.***
> ***If you can't improve, you can't compete.***

Your Committee QA Information System should provide a means for:

> **MEASURING** performance/compliance in key areas so that the Committee can provide guidance to departments in **MANAGING** and **IMPROVING** quality of care and resident life in the facility.

These are your goals. Now let's examine how you can meet these information needs.

Subsection 5.2 Key Steps to Developing a QA Information System

Step 1:

Evaluate current information sources to determine if they are being utilized effectively.

a. Look at what is already being done in the facility in terms of monitoring and reporting on significant quality and compliance issues:

* consultant reports
* departmental QA reports
* complaint investigations
* resident and resident family satisfaction surveys; Resident Council feedback
* safety and disaster preparedness evaluations
* observation of key processes and procedures (walking rounds, med pass & treatment observations)
* evaluation of aggregate clinical data (# of pressure ulcers, acquired infections, injuries, etc.)
* evaluation of medical records and incident reports
* evaluation of medication error reports and other administrative and clinical resource documents

b. Now consider how much of this information is being utilized by you, as a Committee, on an ongoing basis to make quality assessments.

Ask yourself the following questions:

- ✓ How much information is being reported to the Committee from these traditional sources?

  If the Committee is not receiving summary data from each of these sources, a complete assessment of facility performance is not being provided.

- ✓ Is there sufficient feedback from each of these sources to the QA&A Committee?

  Summary data from each of these sources should be a part of the total quality management improvement.

- ✓ Is the Committee using the present information that it receives?

  Once information is received by the Committee, there should be an evaluation as to whether it is useful in the facility quality surveillance program.

- ✓ Of the information that is presently being collected and reviewed by the Committee, which adds actual ***value*** to the quality management process as opposed to adding only ***work***?

  If particular processes and reporting procedures are not adding value, the Committee should evaluate their elimination. If additional information should be collected which would provide value to the

overall quality management program, then a system should be instituted which accomplishes this objective.

- ✓ Is the Committee acting upon valid information rather than assumptions and feelings?

You must evaluate quality on the basis of information. Without actual "numbers", you have no means of objectively judging performance. Quality measurement cannot be based on emotional reactions. Furthermore, tracking of significant care issues can provide invaluable information to challenge a premature surveyor judgment regarding duration, scope and severity of key findings in a survey.

Step 2:

Compare what you are presently collecting and evaluating to the quality indicators and statistics you developed in Section 4.

Ideally your QA&A program will incorporate an overview of actual practice and performance in these key quality of care and quality of life areas.

Step 3:

Establish a system for routine data collection and reporting to the Committee.

The Quality Assurance Management Report and Quality Management Issue Reporting forms shown on the

following pages are sample Committee data collection instruments. Using these as examples, a suggested procedure is included in this section for establishing a routine data collection and reporting system from departments to the QA Coordinator and/or QA&A Committee.

This procedure is merely a tool for demonstrating how a QA information system could be developed. Regard this system merely as an example, and make modifications to suit your needs as Committee members and the needs of your department managers. You will want to develop a system that involves all departments and is meaningful for activities and staff in your own facility.

Section 5.3: Using a Quality Management Report

Purpose for Using the Quality Management Report and Quality Management Issue Reporting Form

There are several purposes for using a specific reporting form such as the Quality Management Report:

1. To pull together a wide scope of general quality and compliance information for review by the QA&A Committee;

2. To summarize the results of internal monitoring in each department or area of service and provide a means of accountability for key compliance issues on an ongoing basis;

3. To orient and to remind departments of the federal requirements with the use of F-tags in each applicable area of the report; and

4. To solicit involvement and input by all departments in the QA process.

The purpose for the separate Issue Reporting Form is to initiate an analysis and dialogue regarding areas of concern identified in the general report as an initial means of preparing a plan for corrective action. The

intent is to motivate staff to think about the cause(s) for specific problems areas and possible solutions.

NOTE: You will notice that two separate formats are included for the general report form. The first is subdivided into separate reporting departments with individual places for the reporting individual(s) to sign the form. The intention here is not to create more paper but to encourage more direct involvement from the people responsible for these areas. People are inclined to take issues more seriously if they are directly involved and if they are actually signing their name as verification of the accuracy of the information being reported.

The second form is a general form completed by only one individual, generally the QA Coordinator. There is no "right" or "wrong" way for facilities to document their reporting information. These are merely examples.

Suggested Procedure for Using the Quality Management Report and Quality Management Issue Reporting Forms

1) Distribute the sample reporting forms to those persons responsible for the particular area of service that is identified.
2) Supply each person with a copy of the Quality Assurance Issue Reporting form. One issue reporting form will be completed for all "NO" answers to the QA Report questions.
3) Explain to all reporters that the answers to these questions must be supported by internal monitoring programs. Answers cannot be "best guesses", assumptions or merely what people want to hear.
4) Collect all QA reporting data and Issue Reporting forms at the beginning of each month as they apply to data collected for the previous month.
5) Distribute copies of all Issue Reporting forms to Committee members at least one week prior to the next scheduled Committee meeting. Distribute copies of the completed QA report at the Committee meeting.
6) Discuss as a group all QA Issue Reporting Forms and develop and record a plan for correcting/improving each issue.
7) Record key quality indicator data on the Committee tracking form for the current reporting period and identify any patterns of improvement or decline in performance from the previous period. Discuss those areas in which a possible plan of improvement should be addressed.

8) Collect all extra copies of the QA report form at the end of the meeting and destroy them.
9) Record Committee minutes and a list of areas to be followed up at the next meeting. Note the names of the individuals who have been assigned responsibility for reporting on each item at the next meeting.

Collecting data to complete forms is not quality management. You must be cautious that you collect usable information and not just data. You must focus on what you *do* with the information. Effective quality management results from the action that you take in response to the information that you collect and evaluate.

QUALITY MANAGEMENT REPORT

(Cross-referenced to related federal requirements as noted by F-tags.)

Part I Reporting Department: NURSING SERVICE
Direct Care Areas

Reporting Period: _____ to _____ 19__

1. DECUBITUS ULCERS (F319, F320)
   Total Patients with Pressure Ulcers at end of this reporting period: ____
   Categorization of pressure ulcers according to stage and when acquired:

	Admitted	Acquired	Total
Stage I	____	____	____
Stage II	____	____	____
Stage III	____	____	____
Stage IV	____	____	____
Grand Totals:	____	____	____

2. FOLEY CATHETERS (F321)
   Number of Patients with Catheters: _____ All medically justified? Yes No

3. BOWEL AND BLADDER TRAINING (F322)
   How many patients currently in a program? ____
   # of successes this period: _____ Total incontinent residents: ____

4. RESTRAINTS (Subcategory of **Level A F220-A,** Resident Behavior & Facility Practices)
   PHYSICAL RESTRAINTS (F211)
   a. Current # of patients with routine physical restraint use: ____
   b. Current # patients in restraint release/reduction program: ___
   c. # of restraints successfully discontinued in this reporting period: ____
   d. # of restrained residents with assessed decline in mobility (F312, F221): ____
   CHEMICAL RESTRAINTS (F222, F342 through F346, F348, F349)
   a. Current # of patients on Antipsychotics/Antidepressants: ___
   b. Current # of patients on dosage reduction: (F346, F349) ___
   c. Current # of residents with **documented** clinical contraindications for dosage reduction: ____

5. Consultants: (podiatrist, psychiatrist, dentist, etc.) (F410-A, F411-F417, F340, F505)
   Necessary services available for residents as needed? ___Yes___No

6. Pharmacy

Timely availability of meds? (F425-A)	___Yes ___No
Drug regimen reviews done in a timely manner? (F430)	___Yes ___No
All recommendations acted upon and/or addressed? (F431)	___Yes ___No
All drugs and biologicals stored in a proper manner (F433)	___Yes ___No
Med passes monitored for proper administration technique? (F350)	___Yes___No
monitoring identified no significant med errors? (F351)	___Yes___No
Medication/treatment carts kept locked when unattended?	___Yes___No

Review of Medication Error Reports (F350, F351)

Total Reported Errors for Month: ____
a. Medication Administered After DC Date: ____
b. Medication Administered at Wrong Frequency: ____
c. Wrong Medication Administered: ____
d. Correct Medication Administered at Wrong Dose: ____

e. Omitted Dose(s): ____

7. **Laboratory/Radiology Services: (F511, F520)**

a. Are lab results received in a timely manner? ___Yes ___No

b. Are x-ray reports timely? ___Yes ___No

c. Physician notified of significant abnormals in 24 hrs.? **(F164)** ___Yes ___No

d. Stat lab service prompt? ___Yes ___No Stat x-ray prompt? ___Yes___ No

Completed by: _____ **Title:**_____
Signature

Date: _____

Attach a completed Quality Management Issue Reporting Form for each "NO" answer recorded in this section.

QUALITY MANAGEMENT REPORT

Part II Reporting Department: NURSING SERVICE
Infection Control

Reporting Period: _____to_____19__

8. **UTI's (F322)**
Number of patients currently receiving treatment for a UTI: _____
Of these, how many have a Foley catheter?: _____
How many are symptomatic? ____ asymptomatic?: _____
Number of patients with UTI for the reporting period: _____
Number which were symptomatic: ____ asymptomatic: _____
C&S Results: (Fill in number reported for each category.)
___1 organism isolated ___2 organisms isolated
___3 organisms isolated ___More than 3 organisms

9. **ANTIMICROBIAL DRUGS (F440-A, F441, F443)**
Number of patients placed on antimicromobial drugs this period:____
TYPES OF INFECTIONS
Type: _____ Number: _____
Type: _____ Number: _____
Type: _____ Number: _____
Type: _____ Number: _____

10. **ISOLATIONS (F440-A, F442)**
If any residents were placed in isolation during this period, complete the following:

Reason for Isolation :	# Patients :
_____	___
_____	___
_____	___
_____	___

Staff monitored for following proper procedure? ___ Yes ___No
All staff followed proper procedure during monitoring? ___ Yes ___No

Completed by: _____Title: _____
Signature

Date: _____

Attach a completed Quality Management Issue Reporting Form for all "NO" answers in this report.

QUALITY MANAGEMENT REPORT

Part III Reporting Department: NURSING SERVICE
Staff Development

Reporting Period: _____ to _____ 19__

11. **Staff Development:**

a.	Required inservices held according to schedule? **(F501, F502)**	__Yes__No
b.	Followup assessments are conducted to determine effectiveness of educational programs?	__Yes__No
c.	All uncertified nursing assistants completed training within required time frames? **(F496, F498)**	__Yes__No
d.	Uncertified nursing assistants always assigned to work with certified assistants?	__Yes__No
e.	Staff development programs planned in conjunction with QA findings? **(F501)**	__Yes__No

Completed by: _____ Title: _____
Signature

Date: _____

Attach a completed Quality Management Issue Reporting Form for all "NO" answers in this report.

QUALITY MANAGEMENT REPORT

PART IV Reporting Department: NURSING SERVICE Central Supply

12. Central Supply:

a.	Adequate inventory of supplies for each nursing station?	___Yes___No
b.	Supply inventories maintained with minimum emergency orders?	___Yes___No
c.	Supplies used are charged to the proper resident or stock account?	___Yes___No
d.	Supply storage area orderly?	___Yes ___No
e.	All supplies stored off the floor?	___Yes___No

Completed by: _____ Title: _____
Signature

Date: _____

Attach a completed Quality Management Issue Reporting Form for all "NO" answers to this report.

QUALITY MANAGEMENT REPORT

PART V Reporting Department: REHABILITATION SERVICES

Reporting Period: _____to_____19__

13. CONTRACTURES (F323, F324)
Patients admitted with contractures: _____
Patients with contractures acquired inhouse: ____
Number of Patients in Restorative ROM Program: _____ Of these, answer the following:
Improving: _____ # Remaining Same: _____ # Regressing: _____

14. RESTORATIVE REHABILITATION PROGRAM
# of patients discharged from skilled therapy to a restorative program this period:__
Number of residents currently in a restorative PT program: _____
Number of residents currently in a restorative OT program: _____
Number of residents currently in a restorative Speech program: ____

Completed by: _____Title: _____
Signature

Date: _____

QUALITY MANAGEMENT REPORT

PART VI Reporting Department: MEDICAL RECORDS

Reporting Period: _____to_____19__

15. Attending Physicians:

a. Admission physicals being done in a timely manner? ___Yes ___No
b. All physicians seeing patients in a timely manner? **(F391)** ___Yes ___No
c. All residents seen every 30 days for first 90 days of stay?**(F391)** ___Yes ___No
and at least every 60 days thereafter by physician or alternate?**(F391)** ___Yes___No
d. All physicians have a designated alternate to assume responsibility
for care of their residents during periods of unavailability?**(F387)** ___Yes ___No
e. All physicians completing required documentation
in a timely manner? **(F389, F390)** ___Yes ___No

16. PT/OT/Speech:

a. Are all admissions screened for rehab needs? **(F406)** ___Yes ___No
b. Are the therapists meeting the facility's schedule for visits? ___Yes ___No
c. Documentation of services provided to the facility
within 7 days of completion? ___Yes___No
d. Therapists involved in physical restraint assessments? **(F221)** ___Yes___No

17. Weights:

a. Admission weights done on day of admission? ___ Yes ___No
b. Monthly weights timely? ___ Yes ___No
c. Re-weights done for residents with 5% loss/gain in 30 days?**(F331)** ___ Yes ___No
d. # of residents with significant, unplanned weight loss for the period: ____
If a significant # of re-weights, are scales accurate? ___Yes ___No
e. Significant, unplanned weight changes reported:
to the physician? **(F164)** ___Yes ___No
to the dietitian? **(F332)** ___Yes ___No
to RN Coordinator for possible re-assessment (new MDS)?**(F287)** ___Yes ___No

18. Other Documentation Issues:

a. Physicians completing closed records in a timely manner? ___Yes___No
b. Documentation of treatments being done in a timely manner? ___Yes___No
c. Documentation of medication administration complete/timely? ___Yes___No
d. Comprehensive assessments (MDS) completed in 14 days of adm.?**(F286)** ___Yes___No
within 14 days of significant change in condition? **(F287)** ___Yes___No
e. Are care plans completed within 7 days of the MDS? **(F296)** ___Yes___No
f. Are quarterly MDS and care plan reviews timely? **(F289)** ___Yes___No
g. Care plans correspond with resident assessments and reflect appropriate
reference to Resident Assessment Protocols? **(F290, F295)** ___Yes___No
h. Progress toward care plan goals reflected in routine charting by
all disciplines? **(F531)** ___Yes___No
i. Discharge summary completed to accompany all ***anticipated***
discharges from the facility? **(F302, F303)** ___Yes___No

19. **Hospital Admissions:** (Relates to Task 5C of Survey Procedures - examining Quality of Care provided prior to resident's death and/or transfer to a hospital.) **(F308-A, F309)**
Number of Hospitalizations for this Reporting Period: _____

Of these, how many were for the following diagnoses/conditions?

a. Diagnosis of Fracture: _____
b. Other Trauma: _____
c. Impaction & Ileus: ____
d. Status Epilepticus/Seizures: ____
e. Insulin Shock: _____
f. Debridement of Decubitus Ulcer(s): ___
g. UTI: ____
h. Pneumonia: ___
i. Dehydration: ___
j. Malnutrition: _____
k. Drug Toxicity: ____

20. **Number of Deaths:**
Number in last 30-day period from_____to _____:____

21. **Other Discharges:**
Number of Residents Discharged Home in Previous Month: _____

Number of Residents Transferred to Other Facilities in Previous Month: _____
Reason(s) for Transfers:
Financial Reasons: _____
Unhappy with Current Placement: _____
Transfer Destination Closer to Family: _____

Completed by: _____Title: _____
Signature

Date: _____

Attach a completed Quality Management Issue Reporting Form for all "NO" answers to this report.

QUALITY MANAGEMENT REPORT

PART VII Reporting Department: ADMINISTRATION

Reporting Period: _____to_____19__

22. HOT LINE CALLS FOR 30-DAY PERIOD (F223, F228, F230)
Total number of calls investigated: _____
Number of complaints unsubstantiated: ____
Number of complaints substantiated: ____ (F228)
Of substantiated complaints, indicate classification:
Patient Care: ___ Abuse: _____ Misappropriation of Resident Property: _____
All suspected abuse cases investigated inhouse and reported as required? (F228, F229, F230) __Yes ___No

23. FINANCIAL
Disposition of decedent personal funds completed within 30 days of death?(F170) __Yes__No

24. RESIDENT COMPLAINTS/GRIEVANCES (F177, F178)
Summarize resident complaints/grievances for this period:

Nature of Problem/# of Occurrences	New or Old Problem?
_____	_____
_____	_____
_____	_____

Do Resident Council minutes reflect that all problems or resident complaints have been followed up by staff? (F178) ___Yes ___No

25. Safety:
a. Resident incidents evaluated for patterns in falls/resident injuries on each shift? (F223, F330) ___Yes ___No
b. Patterns involving recurring incidents for the same resident are evaluated for to determine possible preventive measures? (F330) ___Yes __No
c. Number of employees with on-the-job injuries for current period: _____
How many involved lifting/turning of residents? _____ Needlesticks? _____
d. # of resident elopements: ____ Noted patterns as to resident, time of day, etc. were assessed for possible preventive measures? (F330)___Yes___No
e. # of reported resident injuries of unknown origin: _____(F223, F228)

Completed by: _____Title: _____
Signature

Date: _____

Attach a completed Quality Management Reporting Form for all "NO" answers in this report.

QUALITY MANAGEMENT REPORT

PART VIII Reporting Department: DIETARY

Reporting Period: _____to_____19__

26. Dietary:

a. Food leaves kitchen and is served to residents in scheduled time frames? **(F362)** ___Yes___No

b. Food temperatures within acceptable parameters in all areas of tray service? **(F367, F377)** ___Yes___No

c. Food served as planned on the menu? **(F365)** ___Yes___No

d. All residents provided necessary assistance during meals? **(F368)** ___Yes___No

e. Food served conforms to documented physician diet orders? **(F332)** ___Yes___No

f. How many residents are being served trays in their rooms?___
Of these, how many require staff assistance?_____**(F314)**

g. Dietitian assessing tube feeders for complications?**(F328)** ___Yes___No

h. Dietitian assessing residents with decubitus ulcers? **(F332)** ___Yes___No

i. Dishwasher temps in compliance with required ranges? **(F377)** ___Yes___No

j. Refrigerator temps monitored and kept below 45F degrees? **(F377)**
Freezer temps kept below 0 F? **(F377)** ___Yes___No

Completed by: _____Title: _____
Signature

Date: _____

Attach a completed Quality Management Issue Reporting Form for each "NO" answer in this report.

QUALITY MANAGEMENT REPORT

PART XIX Reporting Department: SOCIAL SERVICES

27. Social Services:

a. Resident/family complaints acted upon and documented?**(F257)** ___Yes___No

b. Internal transfers done with prior notification of resident/family?**(F254)**__Yes__No

c. Residents have adequate supply of clothing? **(F257)** ___Yes___No
 # reports of lost/misplaced clothing for the period:_____

d. Social Services notified of all behavioral/emotional problems? **(F257)**___Yes ___No

e. Social Services involved in assessing residents with agitation and/or increased use of /psychotropic meds? **(F257)** ___Yes___No

f. Social Services has specific interventions in care plans for residents with automatic triggers in Section H of MDS? **(F257)** ___Yes___No

g. Post discharge plan of care completed for all ***anticipated*** discharges? **(F303)** ___Yes___No

Completed by: _____Title: _____
Signature

Date: _____

Attach a completed Quality Management Issue Reporting Form for all "NO" answers in this report.

QUALITY MANAGEMENT REPORT

PART X Reporting Department: HOUSEKEEPING

Reporting Period: _____to _____19__

28. **Housekeeping:**
    a. Toxic chemicals properly stored in the facility/on cleaning carts? **(F260)**__Yes__No
    b. Soap and paper towels always available in staff bathrooms?**(F441, F446)**__Yes__No
    c. Resident overbed tables, wheelchairs kept clean? **(F261)** ___Yes __No
    d. Facility and resident rooms clean and odor free? **(F260, F261)** ___Yes___No
    d. Caution signs routinely used when floors are wet? **(F479)** ___Yes___No

Completed by: _____Title: _____
Signature

Date Completed: _____

Attach a completed Quality Management Issue Reporting Form for all "NO" answers in this report.

QUALITY MANAGEMENT REPORT

PART XI Reporting Department: LAUNDRY

Reporting Period: _____to _____19__

29. **Laundry:**

a. Is adequate linen available to each nursing station at the beginning and throughout each shift? ___Yes___No

b. Are all resident rooms provided with sufficient towels/face cloths in good condition ? **(F262)** ___Yes___No

c. Is linen in good repair without holes/stains? **(F262)** ___Yes___No

d. Staff follow proper procedure in handling soiled linens? **(F447)** ___Yes___No

e. Dirty linen sent to laundry in a timely and acceptable manner? **(F447)** ___Yes___No

f. Water temperatures within proper ranges? ___Yes___No

Completed by: _____Title: _____
Signature

Date: _____

Attach a completed Quality Management Issue Reporting Form for all "NO" answers in this report.

QUALITY MANAGEMENT REPORT

PART XII Reporting Department: ACTIVITIES

Reporting Period: _____to _____19__

30. Activities:

a. Residents getting to/from activities with timely staff assistance? ___Yes ___No
b. Current # residents physically unable to attend activities: ___
c. Current # residents who consistently refuse to attend activities: ___
d. Small group programs regularly held for the severely confused?**(F255)**__Yes__No
e. How many small group activities were conducted this month?:_____
f. Sufficient activities on weekends to meet resident preferences? **(F255)**__Yes __No
g. Sufficient activities on evenings to meet resident preferences? **(F255)** __Yes __No
h. Does activity calendar reflect a variety of activities to meet needs/preferences of all residents? **(F242, F255, F282)** ___Yes___No
h. Activities held as posted on the calendar? **(F255)** ___Yes___No

Completed by: _____Title: _____
Signature

Date: _____

Attach a completed Quality Management Issue Reporting Form for all "NO" answers in this report.

QUALITY MANAGEMENT REPORT

PART XIII Reporting Department: MAINTENANCE

31. Maintenance:

a.	Are work orders processed in a timely manner? **(F479)**	___Yes___No
b.	All resident furniture and resident equipment in good repair? **(F329)**	___Yes___No
c.	Resident rooms without peeling paint, broken tile? **(F261)**	___Yes___No
d.	All bathing areas equipped with non-skid surface? **(F329)**	___Yes___No
e.	All call lights in working order? **(F472, F473)**	___Yes___No
f.	Lighting adequate in all resident areas/all light bulbs working? **(F263)**	___Yes___No
g.	Handrails secure and in good repair? **(F329, F482)**	___Yes___No
h.	Safety checks completed on all essential mechanical, electrical and patient care equipment? **(F459)**	___Yes___No
i.	All routine maintenance schedules current?	___Yes___No
j.	Facility free of pests and rodents? **(F483)**	___Yes___No
k.	Are water temperatures monitored on a regular basis? **(F329)**	___Yes___No
l.	Are water temps. in acceptable ranges throughout the day? **(F329)**	___Yes___No
m.	Room temperatures in comfortable and acceptable ranges? **(F481)**	___Yes___No
n.	Outside grounds free of debris; grass and shrubs maintained?	___Yes___No
o.	Emergency drills conducted in accordance with required schedules? **(F535)**	___Yes___No
p.	Staff are routinely informed of and demonstrate knowledge of fire/evacuation procedures? **(F533, F534, F535)**	___Yes___No

Completed by: _____ Title: _____
Signature

Date: _____

Attach a completed Quality Management Issue Reporting Form for all "NO" answers in this report.

Source: King Healthcare Enterprises, Inc. Revised 9/93

QUALITY ASSURANCE ISSUE REPORTING FORM

Dept./Area of Service : _____Date: _____

Describe the issue that was identified as an area of concern on the Quality Assurance Report:

In your opinion, what is the reason for the problem? (Be specific in your answer. Examples might include equipment failure or shortage, lack of proper communication between departments, staff failed to follow proper procedure, etc.)

List possible suggestions for correcting the situation.

Is there a need to change the standard of performance or the quality assurance monitoring procedure? If "YES", explain why.

Submitted by: _____Title:_____

Source: King Healthcare Enterprises, Inc.

QUALITY MANAGEMENT REPORT

(Cross-referenced to related federal requirements as noted by F-tags.)

Part I	**Reporting Department: NURSING SERVICE** **Direct Care Areas**

Reporting Period: _____ to _____
19__

1. **DECUBITUS ULCERS (F319, F320)**
   Total Patients with Pressure Ulcers at end of this reporting period:_____
   Categorization of pressure ulcers according to stage and when acquired:

	Admitted	Acquired	Total
Stage I	_____	_____	_____
Stage II	_____	_____	_____
Stage III	_____	_____	_____
Stage IV	_____	_____	_____
Grand Totals:	_____	_____	_____

2. **FOLEY CATHETERS (F321)**
   Number of Patients with Catheters: _____All medically justified? ___ Yes ___No

3. **BOWEL AND BLADDER TRAINING (F322)**
   How many patients currently in a program? _____
   # of successes this period: _____ Total incontinent residents: _____

4. **RESTRAINTS** (Subcategory of **Level A F220-A,** Resident Behavior & Facility Practices)
   PHYSICAL RESTRAINTS (F211)
   a. Current # of patients with routine physical restraint use: ____
   b. Current # patients in restraint release/reduction program: ___
   c. # of restraints successfully discontinued in this reporting period: ____
   d. # of restrained residents with assessed decline in mobility **(F312, F221)**: ____

   CHEMICAL RESTRAINTS (F222, F342 through F346, F348, F349)
   a. Current # of patients on Antipsychotics/Antidepressants: ___
   b. Current # of patients on dosage reduction: **(F346, F349)** ___
   c. Current # of residents with **documented** clinical contraindications for dosage reduction: _____

5. **CONSULTANTS: (podiatrist, psychiatrist, dentist, etc.) (F410-A, F411-F417, F340, F505)**
   Necessary services available for residents as needed? ___Yes___No

6. **PHARMACY**
   Timely availability of meds? **(F425-A)** ___Yes ___No
   Drug regimen reviews done in a timely manner? **(F430)** ___Yes ___No
   All recommendations acted upon and/or addressed? **(F431)** ___Yes ___No
   All drugs and biologicals stored in a proper manner **(F433)** ___Yes ___No
   Med passes monitored for proper administration technique? **(F350)** ___Yes___No
   monitoring identified no significant med errors? **(F351)** ___Yes___No
   Medication/treatment carts kept locked when unattended? ___Yes___No

Review of Medication Error Reports **(F350, F351)**

Total Reported Errors for Month: ____

a. Medication Administered After DC Date: _____
b. Medication Administered at Wrong Frequency:____
c. Wrong Medication Administered: _____
d. Correct Medication Administered at Wrong Dose: ____
e. Omitted Dose(s): ____

7. LABORATORY/RADIOLOGY (F511, F520)

a. Are lab results received in a timely manner? ___Yes ___No
b. Are x-ray reports timely? ___Yes ___No
c. Physician notified of significant abnormals in 24 hrs.? **(F164)** ___Yes ___No
d. Stat lab service prompt? ___Yes ___No
e. Stat x-ray prompt? ___Yes___ No

Part II Reporting Department: NURSING SERVICE
Infection Control

8. UTI's (F322)

Number of patients currently receiving treatment for a UTI: _____
Of these, how many have a Foley catheter?: _____
How many are symptomatic? ____ asymptomatic?: _____
Number of patients with UTI for the reporting period: _____
Number which were symptomatic: ____ asymptomatic: _____
C&S Results: (Fill in number reported for each category.)
___I organism isolated ___2 organisms isolated
___3 organisms isolated ___More than 3 organisms

9. ANTIMICROBIAL DRUGS (F440-A, F441, F443)

Number of patients placed on antimicromobial drugs this period:____

TYPES OF INFECTIONS

Type: _____ Number: _____

Type: _____ Number: _____

Type: _____ Number: _____

Type: _____ Number: _____

10. ISOLATIONS (F440-A, F442)

If any residents were placed in isolation during this period, complete following:
If Yes, complete the following:

Reason for Isolation :	# Patients :
_____	____
_____	____
_____	____
_____	____

Staff monitored for following proper procedure? ___ Yes ___No
All staff followed proper procedure during monitoring? ___ Yes ___No

Part III Reporting Department: NURSING SERVICE
Staff Development

11. STAFF DEVELOPMENT:

a. Required inservices held according to schedule?**(F501, F502)** ___Yes___No
b. Followup assessments are conducted to determine effectiveness of educational programs? ___Yes___No
c. All uncertified nursing assistants complete training within required time frames? **(F496, F498)** ___Yes___No
d. Uncertified nursing assistants always assigned to work with certified assistants? ___Yes___No
e. Staff development programs planned in conjunction with QA findings? **(F501)** ___Yes___No

Part IV Reporting Department: NURSING SERVICE
Central Supply

12. CENTRAL SUPPLY:

a. Adequate inventory of supplies for each nursing station? ___Yes___No
b. Supply inventories maintained with minimum emergency orders? ___Yes___No
c. Supplies used are charged to the proper resident or stock account? ___Yes___No
d. Supply storage area orderly; nothing stored on the floor? ___Yes___No

Part V Reporting Department: REHABILITATION SERVICES

13. CONTRACTURES (F323, F324)

Patients admitted with contractures: _____
Patients with contractures acquired inhouse: _____
Number of Patients in Restorative ROM Program: _____ Of these, answer the following:
Improving: _____ # Remaining Same: _____ # Regressing: _____

14. RESTORATIVE REHABILITATION PROGRAM:

a. # of patients discharged from skilled therapy to a restorative program this period:__
b. # of patients currently in a restorative rehabilitation program: ____
c. # of patients currently in a restorative OT program: _____
d. # of patients currently in a restorative Speech program: ____

Part VI Reporting Department: MEDICAL RECORDS

15. ATTENDING PHYSICIANS:

a. Admission physicals being done in a timely manner? ___Yes ___No
b. All physicians seeing patients in a timely manner? **(F391)** ___Yes ___No
c. All residents seen every 30 days for first 90 days of stay?**(F391)** ___Yes ___No
and at least every 60 days thereafter by physician or alternate?**(F391)** ___Yes___No
d. All physicians have a designated alternate to assume responsibility for care of their residents during periods of unavailability?**(F387)** ___Yes ___No
e. All physicians completing required documentation in a timely manner? **(F389, F390)** ___Yes ___No

16. PT/OT/SPEECH:

a. Are all admissions screened for rehab needs? **(F406)** ___Yes ___No
b. Are the therapists meeting the facility's schedule for visits? ___Yes ___No
c. Documentation of services provided to the facility within 7 days of completion? ___Yes___No
d. Therapists involved in physical restraint assessments? **(F221)** ___Yes___No

17. WEIGHTS:

a. Admission weights done on day of admission? ___ Yes __No
b. Monthly weights timely? ___ Yes __No
c. Re-weights done for residents with 5% loss/gain in 30 days?**(F331)** ___ Yes __No
d. # of residents with significant, unplanned weight loss for the period: ____
If a significant # of re-weights, are scales accurate? ___Yes ___No
e. Significant, unplanned weight changes reported:
to the physician? **(F164)** ___Yes ___No to the dietitian? **(F332)** ___Yes ___No
to RN Coordinator for possible re-assessment (new MDS)?**(F287)** ___Yes ___No

18. OTHER DOCUMENTATION ISSUES:

a. Physicians completing closed records in a timely manner? ___Yes___No
b. Documentation of treatments being done in a timely manner? ___Yes___No
c. Documentation of medication administration complete/timely? ___Yes___No
d. Comprehensive assessments (MDS) completed in 14 days of adm.?**(F286)**__Yes__No
within 14 days of significant change in condition? **(F287)** ___Yes___No
e. Are care plans completed within 7 days of the MDS? **(F296)** ___Yes___No
f. Are quarterly MDS and care plan reviews timely? **(F289)** ___Yes___No
g. Care plans correspond with resident assessments and reflect appropriate reference to Resident Assessment Protocols? **(F290, F295)** ___Yes___No
h. Progress toward care plan goals reflected in routine charting by all disciplines? **(F531)** ___Yes___No
i. Discharge summary completed to accompany all ***anticipated*** discharges from the facility? **(F302, F303)** ___Yes___No

19. HOSPITAL ADMISSIONS: (Relates to Task 5C of Survey Procedures - examining Quality of Care provided prior to resident's death and/or transfer to a hospital.) **(F308-A, F309)**

Number of Hospitalizations for this Reporting Period: _____

Of these, how many were for the following diagnoses/conditions?

a. Diagnosis of Fracture: _____
b. Other Trauma: _____
c. Impaction & Ileus: ____
d. Status Epilepticus/Seizures: ____
e. Insulin Shock: _____
f. Debridement of Decubitus Ulcer(s): ___
g. UTI: ____
h. Pneumonia: ___
i. Dehydration: ___
j. Malnutrition: _____
k. Drug Toxicity: ____

20. NUMBER OF DEATHS:

Number in last 30-day period from_____to _____:____

21. OTHER DISCHARGES:

Number of Residents Discharged Home in Previous Month: _____

Number of Residents Transferred to Other Facilities in Previous Month: _____

Reason(s) for Transfers:

Financial Reasons: _____
Unhappy with Current Placement: _____
Transfer Destination Closer to Family: _____

Part VII Reporting Department: ADMINISTRATION

22. HOT LINE CALLS FOR 30-DAY PERIOD (F223, F228, F230)

Total number of calls investigated: _____
Number of complaints unsubstantiated: ____
Number of complaints substantiated: ____ **(F228)**
Of substantiated complaints, indicate classification:
Patient Care: ___ Abuse: _____ Misappropriation of Resident Property: _____
All suspected abuse cases investigated inhouse and reported as required? **(F228, F229, F230)** ___Yes ___No

23. FINANCIAL

Disposition of decedent personal funds completed within 30 days of death?**(F170)**__Yes__No

24. RESIDENT COMPLAINTS/GRIEVANCES (F177, F178)

Summarize resident complaints/grievances for this period:

Nature of Problem/# of Occurrences	New or Old Problem?
_____	_____
_____	_____
_____	_____

Do Resident Council minutes reflect that all problems or resident complaints have been followed up by staff? **(F178)** ___Yes ___No

25. **SAFETY:**
    a. Resident incidents evaluated for patterns in falls/resident injuries on each shift? **(F223, F330)** ___Yes ___No
    b. Patterns involving recurring incidents for the same resident are evaluated for to determine possible preventive measures? **(F330)** ___Yes __No
    c. Number of employees with on-the-job injuries for current period: _____ How many involved lifting/turning of residents? _____ Needlesticks? _____
    d. # of resident elopements: ____ Noted patterns as to resident, time of day, etc. were assessed for possible preventive measures? **(F330)**___Yes___No
    e. # of reported resident injuries of unknown origin: _____**(F223, F228)**

Part VIII Reporting Department: DIETARY

26. **DIETARY:**
    a. Food leaves kitchen and is served to residents in scheduled time frames? **(F362)** ___Yes___No
    b. Food temperatures within acceptable parameters in all areas of tray service? **(F367, F377)** ___Yes___No
    c. Food served as planned on the menu? **(F365)** ___Yes___No
    d. All residents provided necessary assistance during meals? **(F368)** ___Yes___No
    e. Food served conforms to documented physician diet orders? **(F332)** ___Yes___No
    f. How many residents are being served trays in their rooms?___ Of these, how many require staff assistance?_____**(F314)**
    g. Dietitian assessing tube feeders for complications?**(F328)** ___Yes___No
    h. Dietitian assessing residents with decubitus ulcers? **(F332)** ___Yes___No
    i. Dishwasher temps in compliance with required ranges? **(F377)** ___Yes___No
    j. Refrigerator temps monitored and kept below 45F degrees? **(F377)** Freezer temps kept below 0 F? **(F377)** ___Yes___No

Part XIX Reporting Department: SOCIAL SERVICES

27. **SOCIAL SERVICES:**
    a. Resident/family complaints acted upon and documented?**(F257)** ___Yes___No
    b. Internal transfers done with prior notification of resident/family?**(F254)**__Yes__No
    c. Residents have adequate supply of clothing? **(F257)** ___Yes___No # reports of lost/misplaced clothing for the period:_____
    d. Social Services notified of all behavioral/emotional problems? **(F257)**___Yes ___No
    e. Social Services involved in assessing residents with agitation and/or increased use of /psychotropic meds? **(F257)** ___Yes___No
    f. Social Services has specific interventions in care plans for residents with automatic triggers in Section H of MDS? **(F257)** ___Yes___No
    g. Post discharge plan of care completed for all ***anticipated*** discharges? **(F303)** ___Yes___No

Part X Reporting Department: HOUSEKEEPING

28. **HOUSEKEEPING:**
    a. Toxic chemicals properly stored in the facility/on cleaning carts? **(F260)** __Yes__No
    b. Soap and paper towels always available in staff bathrooms?**(F441, F446)**__Yes__No
    c. Resident overbed tables, wheelchairs kept clean? **(F261)** ___Yes __No
    d. Facility and resident rooms clean and odor free? **(F260, F261)** ___Yes___No
    e. Caution signs routinely used when floors are wet? **(F479)** ___Yes___No

Part XI Reporting Department: LAUNDRY

29. Laundry:

a. Is adequate linen available to each nursing station at the beginning and throughout each shift? ___Yes___No

b. Are all resident rooms provided with sufficient towels/face cloths in good condition ? **(F262)** ___Yes___No

c. Is linen in good repair without holes/stains? **(F262)** ___Yes___No

d. Staff follow proper procedure in handling soiled linens? **(F447)** ___Yes___No

e. Dirty linen sent to laundry in a timely and acceptable manner? **(F447)** ___Yes___No

f. Water temperatures within proper ranges? ___Yes___No

Part XII Reporting Department: ACTIVITIES

30. Activities:

a. Residents getting to/from activities with timely staff assistance? ___Yes ___No

b. Current # residents physically unable to attend activities: ___

c. Current # residents who consistently refuse to attend activities: ___

d. Small group programs regularly held for the severely confused?**(F255)** ___Yes___No

e. How many small group activities were conducted this month?:_____

f. Sufficient activities on weekends to meet resident preferences? **(F255)** ___Yes___No

g. Sufficient activities on evenings to meet resident preferences? **(F255)** ___Yes___No

h. Does activity calendar reflect a variety of activities to meet needs/preferences of all residents? **(F242, F255, F282)** ___Yes___No

i. Activities held as posted on the calendar? **(F255)** ___Yes___No

Part XIII Reporting Department: MAINTENANCE

31. Maintenance:

a. Are work orders processed in a timely manner? **(F479)** ___Yes___No

b. All resident furniture and resident equipment in good repair? **(F329)** ___Yes___No

c. Resident rooms without peeling paint, broken tile? **(F261)** ___Yes___No

d. All bathing areas equipped with non-skid surface? **(F329)** ___Yes___No

e. All call lights in working order? **(F472, F473)** ___Yes___No

f. Lighting adequate in all resident areas/all light bulbs working?**(F263)** ___Yes___No

g. Handrails secure and in good repair? **(F329, F482)** ___Yes___No

h. Safety checks completed on all essential mechanical, electrical and patient care equipment? **(F459)** ___Yes___No

i. All routine maintenance schedules current? ___Yes___No

j. Facility free of pests and rodents? **(F483)** ___Yes___No

k. Are water temperatures monitored on a regular basis? **(F329)** ___Yes___No

l. Are water temps. in acceptable ranges throughout the day? **(F329)** ___Yes___No

m. Room temperatures in comfortable and acceptable ranges? **(F481)** ___Yes___No

n. Outside grounds free of debris; grass and shrubs maintained? ___Yes___No

o. Emergency drills conducted in accordance with required schedules? **(F535)** ___Yes___No

p. Staff are routinely informed of and demonstrate knowledge of fire/evacuation procedures? **(F533, F534, F535)** ___Yes___No

Completed by:

_____**Title:**_____

Date: _____

Subsection 5.4 Analyzing the Quality Management Report Information

A. Refer to the information provided in this section as a rationale for collecting and evaluating each of the categories of information in the Quality Management Report. Categories are cross-referenced with applicable federal requirements for long term care in order to orient staff to the relationship between compliance and the information that is being reported.

Each section of the report is described in this section to include the following:

1) regulatory cross-references;
2) rationale for including the information in a monthly report; and
3) suggestions for analyzing the information and evaluating the need for Committee action.

B. Read the rationale for including each of the items in the monthly report. You may wish to delete or add to these items depending upon the levels and types of care provided in your facility.

C. Review the information in each category for the current period and compare it to the information reported from the previous period to identify improvements and changes in practice patterns.

D. Reporting categories are phrased such that all "NO" answers represent issues and practice patterns that you should review and discuss at the QA&A Committee meeting.

Ask the person responsible for completing each "NO" answer attend the Committee meeting and participate in the discussion. All Issue Summary forms should be discussed as a group in a positive and solution-oriented manner.

E. Evaluate all categories that are reported as "numbers" of occurrences in comparison with the results of the previous month and for the year-to-date.

Focus on increases in patterns of care that represent negative outcomes, analyze the reason for the problem, and develop a specific corrective action plan.

Also focus on increases/decreases that represent a positive outcome. Document these improvements and recognize those departments and individuals who are responsible for the achievement.

Analyzing the Information by Individual Category

Section 1: Decubitus Ulcers

1. DECUBITUS ULCERS
Total patients with pressure ulcers at the end of this reporting period:____
Categorization of pressure ulcers according to stage and when acquired:

	Admitted	Acquired	Total
Stage I	____	____	____
Stage II	____	____	____
Stage III	____	____	____
Stage IV	____	____	____
Grand Totals:	____	____	____

Cross Reference to Federal Requirements:

F319: Pressure Sores: Residents who enter the facility without pressures will not develop pressure sores unless there is evidence to support that it was clinically unavoidable. (AHCA P-122)

F320: Pressure Sores: Residents with pressure sores receive the necessary care and treatment to promote healing, prevent infection and prevent the development of new pressure sores (AHCA P-124).

Rationale for Reporting: The number and severity of decubitus ulcers in the facility is a critical care indicator. The number of acquired decubitus ulcers is indicative of the quality of nursing management from a variety of different perspectives. The number of decubitus ulcers involving newly admitted or readmitted residents is useful in describing the types of residents that the facility is accepting or the numbers of decubitus ulcers being acquired by residents as a result of hospitalization. Accuracy in distinguishing these two types of pressure sores is essential as this is one of the items to be reported to surveyors at the beginning of the survey process.

Analyzing the Information: Look for 2 basic changes in the reporting information.

1) Increase in the number of acquired decubitus ulcers.
2) Increase in the severity of decubitus ulcers in general.

A change in either of these numbers should lead to further examination as to the cause. Possible reasons might include:

1) staff not performing treatments as ordered

2) residents not being turned and repositioned
3) residents restrained in chairs/wheelchairs are not provided with pressure-relieving devices
4) restrained residents are not being released from restraints and toileted on an every 2-hour basis
5) poor nutritional status of residents with decubitus ulcers.
6) staff are not providing proper peri-care for incontinent residents.

These are some of the reasons for the problem; possible causes should then be investigated such as:

l) lack of supervision of nursing assistants by licensed personnel
2) disproportionate staffing ratios for heavy care residents
3) lack of sufficient pressure-relieving devices
4) scheduling, availability and capability of staff to perform treatments
5) availability of treatment supplies
6) need for increased nutritional intake and focused assessment by the registered dietitian
7) timely contact with and followup by the attending physician regarding all treatment sites that are not responding to treatment.

Based upon the results of the investigation of the cause(s), a plan of correction should be implemented and the effectiveness of this plan should be reviewed within 30 days.

If there is an increase in either number or severity, a weekly decubitus ulcer assessment and reporting system should be in place to monitor progress or lack of progress on a more timely basis than is reflected in the facility-wide QA report.

Section 2: Foley Catheters

2.	FOLEY CATHETERS (F321) Number of Patients with Catheters: _____All medically justified? Yes No (Circle one - If no, explain)_____

Cross Reference to Federal Requirements:

F321: A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that the catheter was necessary (AHCA P-125).

Rationale for Reporting: The Committee should not only monitor the number of residents with catheters but should also assure that each of these cases is assessed for documentation of a clinical diagnosis to justify the catheter. Often this is assumed and not specifically or individually evaluated.
The interpretive guidelines for **F321** are specific in identifying that chronic, indwelling catheters should be used only after a restorative program to improve bladder function has been attempted and/or there has been an attempt to manage incontinence (prompted voiding program, use of adult sanitary padding, external catheter, etc.)(AHCA P-125). In this case, documentation of key information regarding incontinence management is as important as the number of residents with catheters.

Analyzing the Information: If this number is increasing, the reason needs to be evaluated. Possible causes might be:

1) Increase in number of hospital transfers with indwelling catheters
2) Increase in number and/or severity of incontinent residents with skin breakdown for which a catheter was ordered to promote healing.

Issues to consider in these instances include:

1) Are all new admissions/readmissions with an indwelling catheter assessed for bladder retraining potential?
2) Could any of the existing catheter patients be managed with a 2-hour toileting program or some other type of incontinence management?
3) If catheter use has increased as a result of decubitus care, does the general decubitus care prevention program need to be evaluated? Refer back to the information reported in Section 1 and the previous monthly statistics for supportive data.
4) Does clinical record documentation support that use of all indwelling catheters meets the interpretive guidelines?

If the number reflects an increase without sufficient information to provide a sound reason, consider a focused review of all residents with an indwelling catheter. A target date for completing the audit and reporting findings to Executive Management would be 30 days from the date of this report. A followup assessment as to the results of any corrective action would be appropriate for discussion at the next Committee meeting.

Section 3 : Bowel and Bladder Training

3. BOWEL AND BLADDER TRAINING F322)
How many patients currently in a program? ____
# of successes this period: _____ Total incontinent residents: ____

Cross Reference to Federal Requirements

F322: Urinary Incontinence: Incontinent residents receive appropriate treatment and services to **prevent urinary tract infection** and to **restore as much normal bladder function as possible.**

Rationale for Reporting: Based upon the comprehensive assessment, the facility should evaluate incontinent residents to determine the degree to which incontinence can either be eliminated or more appropriately managed. Therefore, all incontinent residents should be assessed in terms of their ability to participate in a bowel and/or bladder retraining program.

Section 4: Restraints

7. RESTRAINTS (Subcategory of **Level A F220-A,** Resident Behavior & Facility Practices)
PHYSICAL RESTRAINTS (F211)
a. Current # of patients with routine physical restraint use: ____
b. Current # patients in restraint release/reduction program: ___
c. # of restraints successfully discontinued in this reporting period: ____
d. # restrained residents with assessed decline in mobility **(F312, F221):** ____
CHEMICAL RESTRAINTS (F222, F342 through F346, F348, F349)
a. Current # of patients on Antipsychotics/Antidepressants: ___
b. Current # of patients on dosage reduction: **(F346, F349)** ___
c. Current # of residents with **documented** clinical contraindications for dosage reduction: ____

Cross Reference to Federal Requirements:

F221: This requirement refers to the resident's right to be free from physical restraint imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

F222: This requirement relates to the use of chemical restraints under the same guideline as described above.

F312: This requirement is a Subcategory of Quality of Care and relates to maintaining and/or improving the resident's mobility and other capabilities to perform activities of daily living independently.

F342 through F346, F348, F349: These requirements pertain to the use of unnecessary drugs and antipsychotic drugs. In

F342 through **F347**, guidelines are provided for assuring that drugs are given for a proper diagnosis and are not given in excess quantities or for an excessive duration. This includes antipsychotics as well as drugs used for sleep induction, anxiolytic/sedative drugs and hypnotics.

F348 specifically defines the conditions for which antipsychotic drugs may or may not be used, either as a routinely ordered medication or as a P.R.N. medication. **F349** specifies that residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions unless there are clinical contraindications for reducing or discontinuing the drugs. The guidelines for defining clinical contraindications and the justification that would be required for use of a drug outside the guidelines are found in **F349.**

Rationale for Reporting: Numbers regarding the use of physical and chemical restraints often change from month to month depending upon changes in nursing staff, how staff evaluate resident behavior and safety needs, how this information is reported to the attending physician and the philosophy of the attending physician in using physical or chemical restraints. Therefore, use of either and/or both needs to be monitored on a monthly basis to determine whether actual practice is conforming to documented guidelines.

Quite often, dosage reduction is identified by an attending physician or consulting psychiatrist to be clinically contraindicated for particular residents. Therefore, the number of these residents should be evaluated in comparison to the total number of residents on antipsychotic medication and the current number in a dosage reduction program. It is not uncommon for surveyors and other individuals external to the facility to make a judgment that the number of residents on antipsychotic drugs is "too high". Therefore, you should be prepared to explain exactly what that number means and what it includes.

Analyzing the Information: Look for increases in use of either physical or chemical restraints as well as for decreases. If you are successfully reducing the use of physical and chemical restraints, this is a positive accomplishment and one that should be tracked to demonstrate this ongoing effort. If you have a small number of physical or chemical restraints, you should still track the number merely to document and demonstrate such a positive facility characteristic. This can be a valuable marketing tool as well as being a positive survey finding.

If restraint use is increasing and there are no residents in either a physical reduction or release program, this would be an indication to evaluate the source of the increase - new admissions, changes in resident condition, etc.

Consider a Committee recommendation for a focused review of the restraint assessments for residents with new orders for physical restraints.

If chemical restraint use is increasing, the Committee should evaluate the reason for chemical restraints being ordered and determine that documentation supports appropriate use of behavioral interventions and environmental accommodations such that chemical restraint use is the choice of last resort rather than the first alternative.

Section 5: Consultants

Consultants: (podiatrist, psychiatrist, dentist, etc.) (F410-A, F411- F417, F340, F503, F505)
Necessary services available for residents as needed? ___Yes___No

Cross Reference to Federal Requirements:

F410-A through F417: This encompasses the responsibility of skilled nursing facilities (F411 through F413) and nursing facilities (F413 through F417) to provide routine and emergency dental services for the resident (AHCA P-180, P-181). Included in this is the responsibility to provide prompt referral for residents with lost or damaged dentures (AHCA P-180).

F340: This requirement is a part of the global requirement for a comprehensive assessment of the resident, making specific reference to foot care (AHCA P-139). Specifically, the care of diabetic residents and residents with circulatory disorders is identified.

F503, F505: These requirements address the responsibility of the facility to provide professional services necessary to fulfill the entire scope of care promulgated in the federal requirements and that these be either through employment or through outside arrangements (AHCA P-205, P-206).

Rationale for Reporting: Often difficulties in obtaining timely consultation with specialists are not brought to the attention of the QA Committee. Including this information in the routine report provides an opportunity for discussion by all affected departments.

Analyzing the Information: Although the information is easily analyzed at face value, there may be a need to correlate this answer with information reported under Section 10, Resident Complaints. If there is no reported problem with consultants, yet there are multiple complaints from residents regarding untimely repair of dentures, eyeglasses, etc., then there would be a need to examine this area further.

1) Are residents being referred to specialists in a timely manner?
2) Are consultants responsive to the facility in scheduling their visits?

Section 6: Pharmacy

Pharmacy

Timely availability of meds? **(F425-A, F426)** ___Yes ___No
Drug regimen reviews done in a timely manner? **(F430)** ___Yes ___No
All recommendations acted upon and/or addressed? **(F431)** ___Yes ___No
All drugs and biologicals stored in a proper manner **(F433)** ___Yes ___No
Med passes monitored for proper administration technique? **(F350)** ___Yes___No
monitoring identified no significant med errors? **(F351)** ___Yes___No
Medication/treatment carts kept locked when unattended? ___Yes___No

Review of Medication Error Reports **(F350, F351)**

Total Reported Errors for Month: ____ This includes:

a. Medication Administered After DC Date: _____
b. Medication Administered at Wrong Frequency:____
c. Wrong Medication Administered: _____
d. Correct Medication Administered at Wrong Dose: ____
e. Omitted Dose(s): ____

Cross Reference to Federal Requirements:

F425-A, F426: This is the level A requirement pertaining to the pharmacy service and its responsibility to provide routine and emergency drugs to meet the needs of each resident (AHCA P-182)..

F430: This requirement refers to the need for the pharmacist to review the drug regimen or each resident on at least a monthly basis (AHCA P-183)..

F431: The pharmacist must report any irregularities identified in the drug regimen review to the attending physician and the director of nursing, and these reports must be acted upon (AHCA P-183).

F433: All drugs and biologicals must be stored in locked compartments under proper temperature controls with only authorized personnel having access to the keys (AHCA P-184).

F350: Under the general category of Quality of Care, this requirement specifically relates to medication errors in that the facility must be free of medication error rates of 5% or greater (AHCA P-150).

F351: This requirements states that residents will be free of significant medication errors (AHCA P-150).

Rationale for Reporting: Often facilities do not regard it as their direct responsibility to address whether the pharmacy service and/or the Pharmacy Consultant are meeting compliance requirements. This is, however, a function of the QA Committee, and the facility must take an

active role in assuring that the quality of their service meets federal requirements.

Analyzing the Information: The administration of medications should be evaluated by direct observation of the staff technique and procedure as well as by analyzing trends and patterns that are detected through review of medication error reports. These are two different sources of medication errors, both of which impact on quality of care and regulatory compliance.

The objective for reviewing this information is to identify:

a) any particular problems with technique in those individuals who administer medications
b) any problems with labeling of medications that is at the source of medication errors
c) any problems with correct transcription of orders that results in a medication error.

Once these compliance areas have been monitored, any compliance problems should be addressed at the QA Committee meeting in order that a plan can be developed to demonstrate improvement and/or correction of the situation.

Section 7: Laboratory/Radiology

Laboratory/Radiology:	
a. Are lab results received in a timely manner? **(F511)**	___Yes ___No
b. Are x-ray reports timely?	___Yes ___No
c. Physician notified of significant abnormals in 24 hrs.? **(F164)** ___Yes ___No	
d. Stat lab service prompt? **(F511)**	___Yes ___No
e. Stat x-ray prompt?	___Yes___ No

Cross Reference to Federal Requirements:

F511: Within the requirements for Administration **(483.75)** is this separate requirement for Laboratory Services. This requirement places the facility responsible for the timeliness and quality of the laboratory services (AHCA P-207).

F520: Also within the requirements for Administration **(483.75)** is this separate requirement for Radiology and other diagnostic services. This requirement places the facility responsible for the timeliness and quality of the laboratory services (AHCA P-209).

F164: This requirement states that the resident's attending physician will be notified immediately of a significant change in resident status (AHCA P-51). As described in the interpretive guidelines, this includes any condition that would require a new form of treatment or therapy, and these often relate to findings from laboratory and x-ray reports (AHCA P-209).

Rationale for Reporting: The survey procedures and probes for both of these requirements instruct the surveyor to evaluate whether a lack of delays in performing tests, in providing interpretations or a lack of prompt notification of the physician of test results contributed to delays in changing resident care plans or in changing treatment (AHCA P-208, P-209). Therefore, the QA Committee should have a mechanism for evaluating these processes in their routine monitoring program.

Analyzing the Information: If there are any "NO" answers to this section of the report, a specific evaluation should be conducted to determine the cause. It should not be immediately concluded that the cause is the laboratory or radiology service without a review of the process by which services are ordered or requested and by which results are received. Issues which the Committee may wish to consider are the following:

l) Is there a monitoring procedure in place to verify that a report is received for all requisitioned services such as maintaining a copy of the requisition in a pending file?
2) Have any incident reports been generated regarding a failure of the lab or x-ray to notify the facility/physician immediately of any significant abnormals? If so, additional information from these reports would be useful in describing the scope of the problem.
3) Is there an effective internal procedure for receiving, filing and communicating report results to the attending physician? This process also needs to be discussed and evaluated before a conclusion can be reached as to the reason for the problem.

Section 8: UTI's

UTI's (F322)
Number of patients currently receiving treatment for a UTI: _____
Of these, how many have a Foley catheter?: _____
How many are symptomatic? ____ asymptomatic?: _____
Number of patients with UTI for the previous 30-day period: _____
Number which were symptomatic: ____ asymptomatic: _____
C&S Results: (Fill in number reported for each category.)

___1 organism isolated ___2 organisms isolated ___3 organisms isolated

___More than 3 organisms

Cross Reference to Federal Requirements

F322: Urinary Incontinence: Incontinent residents receive appropriate treatment and services to **prevent urinary tract infection** and to **restore as much normal bladder function as possible.**

Rationale for Reporting: The surveyor procedures and probes for this requirement are specific in directing that the number of

Sections 9 and 10 Antimicrobial Drugs and Isolations

ANTIMICROBIAL DRUGS (f440-a, f441, f443)

Number of patients placed on antimicromobial drugs this period:____

TYPES OF INFECTIONS

Type: _____ Number: _____

Type: _____ Number: _____

Type: _____ Number: _____

Type: _____ Number: _____

ISOLATIONS (F440-A, F442)

Complete the following regarding any isolations during this period:

Reason for Isolation :	# Patients :
_____	___
_____	___

Staff monitored for following proper procedure? ___Yes___ No

All staff followed proper procedure during monitoring? ___Yes___ No

Cross Reference to Federal Requirements:

F440-A: This is a **Level A** requirement and therefore a significant compliance issue. This requirement addresses the broad scope of infection control within the facility to include the ability to provide a proper environment to prevent spread of disease as well as the ability to analyze significant increases in numbers and types of infections (AHCA P-185).

F441: This requirement refers to the need to demonstrate that infections are investigated, controlled and prevented within the facility. Included is the guideline for maintaining a separate infection control log which provides for individual evaluation of resident infection data as to site, causative agent, and related precautions taken to prevent spread within the facility (AHCA P-185).

F442: This requirement stipulates that the facility infection control program will dictate what procedures, such as isolation, should be applied to individual residents in the event of infection. Interpretive guidelines include reference to monitoring staff for proper adherence to infection control procedures.

F443: This requirement refers to the need to maintain records pertaining to the incidence of infection and corrective actions taken (AHCA P-185). The function of the formerly required Infection

Control Committee is considered to be a responsibility of the QA Committee.

Rationale for Reporting: This synopsis of infection data is intended to provide information to the Committee regarding infection trends within the facility. With the addition of the QA&A requirement, the function of the former Infection Control Committee is regarded as one of the responsibilities of the QA&A Committee.

Use the section relating to isolation to monitor general compliance with facility policies/procedures regarding isolation and clinical reason for isolation. Monitoring staff at any time that isolation occurs provides reinforcement of proper procedure and technique. If problems are identified with regard to staff technique, this should be documented on the Quality Assurance Issue Form and reported as an item of discussion at the Committee meeting.

Analyzing the Information: Look for increases in numbers over the previous reporting period or over that which is considered the average infection rate for the facility. Identified increases should then be evaluated for any patterns or trends such as location of involved residents, common diagnoses, or recent hospitalization at the same hospital.

Section 11: Staff Development

Staff Development:		
a.	Required and problem-oriented inservices held according to schedule?**(F501, F502)**	___Yes___No
b.	All uncertified nursing assistants complete training within required time frames? **(F496, F498)**	___Yes___No
c.	Uncertified nursing assistants always assigned to work with certified assistants?	___Yes___No
d.	Staff development programs planned in conjunction with QA findings? **(F501)**	___Yes___No

Cross Reference to Federal Requirements:

F496: Under the Level-A requirement for Administration, 483.75, this F-tag refers to the requirement for all nursing assistants working in the facility full-time for more than 4 months to have completed a training and competency evaluation program (AHCA P-201). If individual state requirements are more stringent, then the specific required time frame should be noted to correspond with that period.

F498: This requirement specifically describes the definition of "competency" with respect to the nurse aide (AHCA P-202).

F501: This requirement identifies the need for the facility to complete a performance review of every nurse aide at least once every 12 months and to provide regular in-service education based on the outcome and areas of weakness of these reviews (AHCA P-204). In addition, the requirement specifies that nurse aides providing care to the cognitively impaired should be provided with training to address the care of the cognitively impaired (AHCA P-204).

F502: This requirement refers specifically to the proficiency of nurse aides and the responsibility of the facility to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the care plan (AHCA P-204). Survey procedures and probes direct the surveyor to observe staff skills and techniques in communication, personal skills, basic nursing skills, basic restorative services, resident rights and mental health and social service needs (AHCA P-204).

Rationale for Reporting: The need to report this information to the Committee is to provide a means of monitoring that the inservice education program is truly a "staff development" program. In other words, there should be a direct correlation with the number and types of education and training programs offered in the facility and the quality assessment and quality of care observations and reports from all resources.

Analyzing the Information:

If there are continuing problems with regard to a specific area of nursing care, the QA Committee should focus on the type of education and training being offered in the area of Staff Development. Possible areas of discussion regarding this information include the following:

a) What is the attendance at staff education and training programs? Are all staff attending? Should attendance be mandatory? If attendance is mandatory and staff are not complying, is any action taken to address unexcused absences?

b) Are education and training sessions offered on all three shifts when possible?

c) Are education and training programs supplemented with a followup monitoring to determine effectiveness?

d) Is the inservice and training schedule developed based upon constant dialogue and feedback from the Director of Nursing, the charge nurses and other department managers within the facility?

Section 12: Central Supply

Central Supply:		
a.	Adequate inventory of supplies for each nursing station?	___Yes___No
b.	Supply inventories maintained with minimum emergency orders?	___Yes___No
c.	Supplies used are charged to the proper resident or stock account?	___Yes ___No
d.	Supply storage area orderly; nothing stored on the floor?	___Yes ___No

There are no specific cross references to central supply; however, the issue of timely ordering and receipt, availability and organization of supplies is important to the overall management of the facility. In addition, improper management of inventory and an ineffective charging system can result in excessive cost to the facility. Therefore, these items are considered important in the overall quality monitoring in the facility.

Section 13: Contractures

8. CONTRACTURES (F323, F324)
Patients admitted with contractures: _____
Patients with contractures acquired inhouse: _____
Number of Patients in Restorative Program: _____ Of these, answer the following:
Number of Patients Improving: _____ Number Remaining Same: _____ Number Regressing: ___

Cross Reference to Federal Requirements:

F323: Range of Motion: Residents who enter the facility without a limited range of motion do not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable (AHCA P-127)

F324: Range of Motion: Residents with a limited range of motion receive the appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion (AHCA P-127).

Rationale for Reporting: In order to assure that residents are being properly assessed for the potential for contractures, information regarding residents who acquire contractures within the facility is needed. This information is also useful in evaluating staffing needs and staffing capabilities in areas of the facility where residents acquire contractures or are at high risk for developing contractures.

In order to assess the effectiveness of contracture care within the facility, data are needed regarding the progress of individual residents.

Analyzing the Information: An increase in acquired contractures leads to a further analysis as to the cause. Any one of the following should be pursued as possible reasons:

l) increase in residents who are at high risk for developing contractures (bedfast, multiple sclerosis, strokes, cerebral palsy, etc.)
2) need for additional staff to accommodate preventive ROM for all residents assessed as being at risk
3) need for increased supervision of staff to assure that appropriate technique is being followed and that services are being provided in accordance with care planning objectives

Section 14: Restorative/Rehabilitation Program:

Restorative/Rehabilitation Program:

a. # of patients discharged from skilled therapy to a restorative program this period:___
b. # of patients currently in a restorative rehabilitation program: ____
c. # of patients currently in a restorative OT program: _____
d. # of patients currently in a restorative Speech program: ____

There are no specific F-tags listed for this category as this is merely for informational purposes to monitor the staffing of the restorative program and the effectiveness of communication between skilled therapy and restorative programs. Reporting the number of patients being discharged from the skilled rehab program as compared to those currently in the restorative program is useful in evaluating staffing needs.

Section 15: Attending Physicians

Attending Physicians:

a. Admission physicals being done in a timely manner? ___Yes ___No
b. All physicians seeing patients in a timely manner? **(F391)** ___Yes ___No
c. All residents seen every 30 days for first 90 days of stay? **(F391)** ___Yes ___No
and at least every 60 days thereafter by physician or alternate? **(F391)** ___Yes ___No
d. All physicians have a designated alternate to assume responsibility for care of their residents during periods of unavailability? **(F387)** ___Yes ___No
e. All physicians completing required documentation in a timely manner? **(F389, F390)** ___Yes ___No

Cross Reference to Federal Requirements:

F387: All of these requirements are subcategories of the general Physician Services requirements which can result in a Level A violation depending upon the types of violations identified during the survey. This particular requirement addresses the issue that every attending physician must have another physician to supervise the medical care of residents when he/she is unavailable (AHCA P-171).

F389, F390: These requirements address the need for the physician to write, sign and date progress notes at each visit **(F389)** and to sign and date all orders **(F390)**.

F391: This requirement establishes the minimum frequency for physician visits: at least once every 30 days for the first 90 days and at least once every 60 days thereafter (AHCA P-173).

Rationale for Reporting: Including this information in the routine QA reporting merely provides a means for monitoring the process and bringing any physician compliance problems directly to the attention of the Medical Director who is responsible for supervising medical care in the facility.

Analyzing the Information: Should there be a problem with physician availability, physician compliance with scheduled visits to residents and/or with documentation requirements, refer to the Medical Director. The responsibility for the Medical Director to coordinate medical care in the facility is specified in **F510** (AHCA P-206).

Section 16: PT/OT/Speech

a.	Are all admissions screened for rehab needs? **(F406, F311-F315)**	___Yes ___No
b.	Are the therapists meeting the facility's schedule for visits?	___Yes ___No
c.	Documentation of services provided to the facility within 7 days of completion?	___Yes___No
d.	Therapists involved in physical restraint assessments? **(F221)**	___Yes___No

Cross Reference to Federal Requirements:

Although F406 refers to specific specialized rehabilitation services, the additional F-tags are indirect references to the participation of Physical, Occupational and Speech Therapists as a part of the overall program of services provided to residents. While many restorative services are assessed and supervised by the nursing staff, restorative rehab programs established by the licensed therapist should be included in the facility evaluation of restorative services.

F406: This is under the general Level A requirement for specialized rehabilitative services **483.45, F405-A** (AHCA P-176). This requirement stipulates that residents who require specialized rehabilitation services shall receive these services (AHCA P-176). Although the requirement does not specifically state that all admissions will be screened for rehabilitation needs, this is generally the most effective method for assuring that all resident needs are met.

F311-F315: These requirements refer to the specific components of the comprehensive assessment process as they relate to the provision of quality of care (AHCA P-113-P-120). The facility must assure that the resident's functional status does not decline unless there is adequate clinical justification for such decline (AHCA P-113). The assessment process must include development of an appropriate plan to maintain and/or improve the resident's abilities in the following categories: bathing, dressing and grooming; transfer and ambulation; toileting; eating; and use of speech, language or other functional communication system.

F221: This requirement refers to the proper use of physical restraints (AHCA P-76). Included in the interpretive guideline is reference to the need to consult with occupational or physical therapists to consider the use of less restrictive therapeutic interventions (AHCA P-76).

F283: This requirement is a component requirement of the comprehensive resident assessment referring to Rehabilitation Potential (P-102). This relates to the ability to improve independence in functional status through restorative care programs. This requirement has been included in the cross reference because of the need for a close referral relationship between skilled rehabilitation services and restorative services that are needed to maintain the level of functioning achieved at time of discharge from a skilled program.

Rationale for Reporting: In addition to monitoring compliance with regulation, the information reported in this section also relates to the internal communication process between the therapists and the rest of the facility staff. If the facility does not employ therapists but uses an outside agency, there is a need to assure that therapists meet their required schedule in order that all residents receive treatments in the required frequency.

If therapists do not provide ongoing communication with the nursing staff as to resident progress, communication with families can be adversely affected regarding residents' rehabilitation status. Thus, the need to receive timely documentation of services.

Analyzing the Information: Any items answered with a "NO" should be evaluated directly with the therapists to determine ways of improving the process. For example, if all admissions are not being screened for rehabilitation needs, it may be due to the therapists not receiving admission and readmission notices. If documentation of services is not

present in the medical record in a timely manner, it may be due to either untimely charting by the therapy staff or untimely filing by therapy or the clerical staff in the facility.

The number of patients in the restorative ambulation program should be evaluated on an ongoing basis to evaluate staffing needs against the types of resident care in the facility. This should also be evaluated against the number of residents assessed as having a decline in mobility from an evaluation of the comprehensive resident assessment data. This provides a source for evaluating whether residents are being properly assessed for restorative rehabilitative needs and whether their level of function is maintained following discharge from the restorative program.

Section 17: WEIGHTS

Weights:

a.	Admission weights done on day of admission?	___Yes ___No
b.	Monthly weights timely?	___Yes ___No
c.	Re-weights done for residents with 5% loss/gain in 30 days?**(F331)**	___Yes ___No
d.	# of residents with significant, unplanned weight loss for the period: ____	
	If a significant # of re-weights, are scales accurate?	___Yes ___No
e.	Significant, unplanned weight changes reported to the	
	physician?**(F164)**	___Yes ___No
	to the dietitian? **(F332)**	___Yes ___No
	to RN Coordinator for possible re-assessment (new MDS)?**(F287)**	___Yes ___No

Cross Reference to Regulatory Requirements:

F331: This requirement addresses the need for the resident to maintain acceptable parameters of nutritional status such as body weight and protein levels unless his/her clinical condition is such that this is not possible (AHCA P-132). This requirement is included in the general Quality of Care requirements as they relate to the resident comprehensive assessment (AHCA P-132).

F332: This requirement stipulates that the resident will receive a therapeutic diet when there is a nutritional problem (AHCA P-132). Therefore, if a resident has a significant, unplanned weight loss, referral to the dietitian would be appropriate to evaluate a possible diet change.

F287: The comprehensive assessment must be conducted promptly after a significant change in resident condition (AHCA P-103). A significant, unplanned weight loss of 5% in 30 days or 10% in 180 days is identified as one of the reasons for conducting a new assessment for a significant change in resident condition (AHCA P-104).

F164: This requirement states that the resident's attending physician will be notified immediately of a significant change in resident status (AHCA P-51). As described in the interpretive guidelines, this includes any condition that would require a new form of treatment or therapy, and this often relates to significant, unplanned weight loss (AHCA P-209).

Rationale for Reporting: Weight is a significant care issue in the institutionalized elderly, and it impacts on several compliance issues. Generally, a timely admission weight is that which is taken on the day of admission, although this is not a specific federal requirement. A timely monthly weight would be that which is taken on a regular schedule in order that changes in readings can be evaluated in a meaningful manner. Therefore, the facility should establish a schedule for taking routine weights. The QA program should include a monitoring system to assure that the schedule is maintained. If there are problems with obtaining accurate and timely resident weights and reporting this information to the correct individuals, this should be discussed at the QA Committee meeting.

Analyzing the Information: This reporting data apply to several compliance issues:

a) obtaining timely weights
b) obtaining accurate weights
c) conducting proper follow-up on weights that represent a significant change in resident condition.

If the number of residents with significant, unplanned weight loss for the period is greater than 5% of the resident population, this should be evaluated more closely. Consider what the causes may be:

a) recent episode of flu or other short term illness;
b) recent change in the menu resulting in a decreased pattern of meal consumption;
c) increase in the number of residents requiring staff assistance during mealtime pointing to a possible need for evaluating staff to resident ratios during meals;
d) possible problem with accuracy of the scales causing fluctuation in weights and false weight loss.

Since significant, unplanned weight loss is one of the criteria for identifying a significant change in resident condition and conducting a new resident assessment, there should be a system in place for reporting both 5% weight losses in the previous 30 days as well as 10% weight loss in the previous 180 days.

Section 18: Other Documentation Issues

Medical Records:

a. Physicians completing closed records in a timely manner? ___Yes___No
b. Documentation of treatments being done in a timely manner? ___Yes___No
c. Documentation of medication administration complete/timely? ___Yes___No
d. Comprehensive assessments (MDS) completed in 14 days of adm.?**(F286)** ___Yes___No
within 14 days of significant change in condition? **(F287)** ___Yes___No
annually? **(F288)** ___Yes___No
e. Are care plans completed within 7 days of the MDS? **(F296)** ___Yes___No
f. Are quarterly MDS and care plan reviews timely? **(F289)** ___Yes___No
g. Care plans correspond with resident assessments and reflect appropriate reference to Resident Assessment Protocols? **(F290, F295)** ___Yes___No
h. Progress toward care plan goals reflected in routine charting by all disciplines? **(F531)** ___Yes___No
i. Discharge summary completed to accompany all ***anticipated*** discharges from the facility? **(F302, F303)** ___Yes___No

e. Are all admissions/readmissions screened for restorative needs? **(F283)** ___Yes___No
f. # of residents discharged from skilled therapy to a restorative program this period: ____

Cross Reference to Federal Requirements:

F286: This requirement specifies the frequency at which comprehensive and quarterly assessments should be done (AHCA P-103). The initial resident assessment should always be completed within the first 14 days after admission to the facility (AHCA P-103).

F287: This requirement specifies that a new assessment shall be completed promptly after a noted significant change in resident condition (AHCA P-103). The interpretive guidelines also identify specific criteria for the facility to follow in determining when a significant change in condition has occurred (AHCA P-104).

F288: This requirement specifies the need for a new assessment to be completed no less often than every 12 months (AHCA P-103).

F289: This requirement specifies the need for a quarterly review of the comprehensive assessment (AHCA P-105).

F290: This requirement refers to the need to use the comprehensive assessment in the development, review and revision of the comprehensive plan of care (AHCA P-106).

F295: This requirement addresses the need for a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment (AHCA P-107). Survey procedures and probes focus on use of the assessment (including the RAPS) in addressing strengths and

preferences, preventing declines, and managing risk factors (AHCA P-107).

F302: Under the category of Discharge Summary, 483.20(e), this F-tag describes the specific circumstances under which a discharge summary should be completed and also describes its content (AHCA P-110).

F303: This F-tag refers to the need for documentation of a post-discharge plan of care for all anticipated discharges which will assist the resident to adjust to his or her new environment (AHCA P-110).

F531: This F-tag describes the content of clinical records (AHCA P-211). Survey procedures and probes direct surveyors to evaluate whether there is enough record documentation for staff to conduct care programs and to revise the program, as necessary, to respond to the changing status of the resident as a result of interventions (AHCA P-211). Interpretive guidelines state the record must contain adequate information to show that the facility knows the status of the individual, has adequate plans of care and provides sufficient evidence of the effects of the care provided (AHCA P-211).

Rationale for Reporting: Although there are no specific cross references for timely documentation of medication and treatment administration, these areas which should be monitored merely for compliance with professional standards of practice.

There is a need for the facility not only to report the results of monitoring for timely completion of required documentation but also to report the results of a content evaluation of interdisciplinary documentation. In the evaluation of quality of care, the focus will be on the comparison of the resident's present status to that which was assessed at the time of admission. If documentation does not support that the facility adequately assessed and managed risk factors and responded to resident change in condition, any identified resident deterioration may be attributed to a quality of care problem. While documentation will not be the sole criterion for a quality of care evaluation, it will be a contributing source of information in making this evaluation.

Analyzing the Information: Any problems with specific documentation patterns should be addressed by the Committee in terms of the scope of the problem, the degree to which the problem has already been addressed with the involved and methods which have been instituted to correct the situation. If these problems continue to be reported to the

Committee, a recommendation for individual practitioner counseling may be appropriate.

If there is a problem with timely completion of assessments and care plans, the process for completing assessments and scheduling care plans should be evaluated by the RN Coordinator and reported to the Committee by the RN Coordinator.

Medical record content evaluations should be a part of the ongoing quality assessment, assurance and improvement evaluations conducted in Medical Records. Furthermore, if there are problems in these areas, the Committee should evaluate to what extent these findings have been incorporated in the facility staff development program.

Section 19: Hospital Admissions

Hospital Admissions: (Relates to Task 5C of Survey Procedures - examining Quality of Care provided prior to resident's death and/or transfer to a hospital.) **(F308-A, F309)**

Number of Hospitalizations for this Reporting Period: _____

Of these, how many were for the following diagnoses/conditions?

a. Diagnosis of Fracture: _____
b. Other Trauma: _____
c. Impaction & Ileus: ____
d. Status Epilepticus/Seizures: ____
e. Insulin Shock: _____
f. Debridement of Decubitus Ulcer(s): ___
g. UTI: ____
h. Pneumonia: ___
i. Dehydration: ___
j. Malnutrition: _____
k. Drug Toxicity: ____

Cross Reference to Federal Requirements:

F308-A, F309: These are the F-tags for the Quality of Care requirements (AHCA P-113). Refer to Task 5C in the long term care survey procedures for a description of the manner in which findings from the closed record review portion of the survey can be correlated back to Quality of Care findings in the actual survey (AHCA P-21).

F170: This is a part of the Resident Rights section stipulating that the facility must convey within 30 days of a resident's death a final accounting of personal funds deposited with the facility (AHCA P-55).

Rationale for Reporting: Reason for resident hospitalization should be evaluated on an ongoing basis to identify any patterns and trends that may relate to quality of care. A part of the ongoing analysis of the quality of medical record documentation should include a review of all hospitalizations to assure that the record reflects timely assessment and followup of noted changes in condition leading to resident hospitalization. This is important

for internal reasons as well as for potential liability and compliance concerns.

Information regarding other types and reasons for resident discharge is also important from a management and marketing point of view. The facility should regard its discharges to home and/or a more independent living environment as very positive reflections on the quality of care and rehabilitative services provided.

If residents are leaving the facility for reasons of dissatisfaction, this is an important issue to the QA Committee as well as to the executive management of the facility. It is suggested that a focused review of all cases in this category be conducted, summarized and reported back to the Committee for review and possible integration with Committee findings in related areas.

Analyzing the Information: An increase in hospitalizations in any of the categories should be analyzed in comparison to current statistics in those same areas. For example, if there is a high number and/or an increase in hospitalizations for UTI, refer back to the current reporting information on UTI's. Chances are that there will be a relationship between the two figures, and in either case, a focused review should be conducted on these cases, where the residents were located, the relationship to catheter care, hydration practices and procedures on the unit, etc.

Each of these categories of care should be evaluated from a retrospective review to determine if any aspect of care could or should have been initiated that was not, or if documentation of staff interventions and actions could be improved to support the assessment and followup processes.

Section 20: Number of Deaths

Number of Deaths:
Number in last 30-day period from_____to _____:___

Section 21: Other Discharges

Number of Residents Discharged Home in Previous Month: _____

Number of Residents Transferred to Other Facilities in Previous Month: _____
Reason(s) for Transfers:
Financial Reasons: _____
Unhappy with Current Placement: _____
Transfer Destination Closer to Family: _____

Section 22: Hot Line Calls for the Period

HOT LINE CALLS FOR 30-DAY PERIOD (F223, F228, F229, F230)
Total number of calls investigated: ____
Number of complaints unsubstantiated: ____
Number of complaints substantiated: ____
Of substantiated complaints, indicate classification:
Patient Care: ___ Abuse: _____ Misappropriation of Resident Property: _____
All suspected abuse cases investigated inhouse and reported as required? (F228, F229, F230) ___Yes ___No

Cross Reference to Federal Requirements:

F223: This requirement relates to the resident's right to be free from abuse (AHCA P-79). Survey procedures and probes direct the surveyor to evaluate your complaint record and to evaluate any predisposing factors to abuse or neglect (AHCA P-79). In addition, the surveyor is instructed to ask for copies of incident reports in the 3 to 6 months prior to the survey. The surveyor should also evaluate the facility's investigation of potential abuse matters to determine if they are comprehensive and responsive (AHCA P-80).

F228, F229, F230: This requirement outlines specific procedures for the facility to follow in reporting all alleged violations involving mistreatment, neglect or abuse including injuries of unknown origin and misappropriation of resident property (AHCA P-82, P-83). The facility should report the results of the investigation to the administrator within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken (AHCA P-83).

Section 23: Financial

Disposition of decedent personal funds completed within 30 days of death?(F170)__Yes__No

Section 24: Resident Complaints/Grievances

RESIDENT COMPLAINTS/GRIEVANCES (F177, F178)
Summarize information of resident complaints/grievances for this period:

NATURE OF PROBLEM	NEW OR OLD PROBLEM?

Do Resident Council minutes reflect that all problems or resident complaints have been followed up by staff? (F178) ___Yes ___No

Cross Reference to Federal Requirements:

F177: This requirement refers to the right of the resident to voice grievances without discrimination or reprisal. This includes grievances with respect to treatment which has been given as well as that which has not been given (AHCA P-59).

F178: This is a followup to F177 which addresses the obligation of the facility to provide prompt efforts to resolve grievances that a resident may have, including those with respect to the behavior of other residents (AHCA P-59).

Rationale for Reporting: Areas of resident grievance or complaint represent areas for possible quality improvement. These issues will also likely be addressed when the surveyors meet privately with the Resident Council. Therefore, it is prudent that the facility maintain a constant awareness of the status of these complaints and issues.

Analyzing the Information: Look for recurrent or unresolved problems. These need to be treated as a priority by the QA Committee. If problems have been addressed and resolved, it is important that the person responsible for documenting the Resident Council minutes include accurate status reports regarding problem followup as this will likely be evaluated by surveyors to determine facility response to resident complaints.

Section 25: SAFETY

Safety:

a. Resident incidents evaluated for patterns in falls/resident injuries on each shift? **(F223, F330)** ___Yes ___No

b. Patterns involving recurring incidents for the same resident are evaluated for to determine possible preventive measures? **(F330)** ___Yes ___No

c. Number of employees with on-the-job injuries for current period: _____ How many involved lifting/turning of residents? _____ Needlesticks? _____

d. # of resident elopements: ____ Noted patterns as to resident, time of day, etc. were assessed for possible preventive measures? **(F330)**___Yes___No

e. # of reported resident injuries of unknown origin: _____**(F223, F228)**

Cross Reference to Federal Requirements:

F223: This requirement refers to the resident's right to be free from abuse (AHCA P-79). In the interpretive guidelines for this definition, abuse includes treatment by facility staff as well as by other residents, family members or legal guardians, friends or other individuals (AHCA P-79).

F228: In relation to resident safety, this requirement identifies the need for proper reporting and investigating of injuries of unknown origin (AHCA P-82).

F330: As a part of the general Quality of Care requirement, 483.25, this F-tag relates to the specific issue of Accidents (AHCA P-132). This requirement refers to each resident receiving adequate supervision and assistance devices to prevent accidents (AHCA P-132). Survey procedures and probes make specific reference to a review and evaluation of patterns in incident reports (AHCA P-132).

Rationale for Reporting: Although the number of actual incident reports is not always either a positive or a negative indication of resident safety, it does provide information regarding general trends in the facility. The number could increase after a strong program to encourage documentation of all residents and therefore would not necessarily mean a change in resident or facility practices. Therefore, the information reported to the Committee should reflect an analysis to detect specific patterns, trends and possible preventive measures that should be implemented either within the facility as a whole or with respect to individual residents.

Information regarding employee incidents is reported as a general issue of concern to management from a worker safety point of view.

Analyzing the Information: Safety information reported to the Committee should be compared in relation to other activities within the facility such as:

1) number of new nursing assistants on each shift and the relationship to the types of unknown injuries reported for the same period

2) number of resident falls involving residents in a restraint release/reduction program

3) number of worker's compensation claims for back injuries

4) number of residents that require 2 or more staff for lifting/turning and transfer and whether staffing is adequate where these residents reside

5) date of last staff training session on proper lifting technique and the degree to which staff has turned over since that session

6) do the medical records of residents with recurring injuries reflect an assessment of the problem and a plan to prevent recurrence?

Section 26: DIETARY

Dietary:		
a.	Food leaves kitchen and is served to residents in scheduled time frames? **(F362)**	___Yes___No
b.	Food temperatures within acceptable parameters in all areas of tray service? **(F367, F377)**	___Yes___No
c.	Food served as planned on the menu? **(F365)**	___Yes___No
d.	All residents provided necessary assistance during meals? **(F368)**	___Yes___No
e.	Food served conforms to documented physician diet orders? **(F332)**	___Yes___No
f.	How many residents are being served trays in their rooms?___ Of these, how many require staff assistance?_____**(F314)**	
g.	Dietitian assessing tube feeders for complications?**(F328)**	___Yes___No
h.	Dietitian assessing residents with decubitus ulcers? **(F332)**	___Yes___No
i.	Dishwasher temps in compliance with required ranges? **(F377)**	___Yes___No
j.	Refrigerator temps monitored and kept below 45 F? **(F377)**	___Yes___No
k.	Freezer temps kept below 0 F? **(F377)**	___Yes___No

Cross Reference to Federal Requirements:

F314: This requirement is a part of the comprehensive resident assessment and refers to the resident's eating and eating abilities (AHCA P-118). In this category, survey procedures and probes specifically direct the surveyor to evaluate if there is sufficient staff time and assistance provided to maintain each resident's eating abilities (AHCA P-118).

F328: This requirement is a part of the comprehensive resident assessment and pertains specifically to residents who are fed by nasogastric tubes (AHCA P-130). This requirement addresses the need for appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, and other complications associated with tube-feeding (AHCA P-130).

F319 and F320: These requirements relate to adequate measures being taken to prevent pressures from occurring and for providing the necessary treatment and services to promote healing for those residents identified as having pressure sores (AHCA P-124). Nutritional status is considered one of the risk factors for poor healing, and survey procedures and probes direct attention to both aggressive preventive measures and care (AHCA P-124).

F365: This falls under the broad federal requirement for Dietary Services, **483.35**, which is a Level A requirement. F365 refers specifically to menus being followed, i.e., food is served as planned (AHCA P-164).

F367: This also falls under the broad federal requirement for Dietary Services, **483.35. F367** refers specifically to food being palatable, attractive and at the proper temperature (AHCA P-164).

F368: This also falls under the broad federal requirement for Dietary Services, **483.35. F368** requires that food be prepared in a form designed to meet individual needs, e.g., is cut, chopped or ground for individual's needs (AHCA P-165).

F377: This also falls under the broad federal requirement for Dietary Services, **483.35. F377** requires that the facility must store, prepare, distribute and serve food under sanitary conditions (AHCA P-167). Specific reference is made to required temperatures for refrigerator and freezer storage (AHCA P-166).

Rationale for Reporting: These data reporting items focus on three basic categories of information which should be a part of the routine monitoring and inspection procedures within the dietary department and within the service of food on the nursing units:

a) Food is stored and served to residents in conformance with the requirements.
b) Residents are given adequate assistance to maintain as much independence eating as possible.
c) The nutritional and clinical needs of tube-fed residents and residents with pressure ulcers are a part of the assessment and care planning process.

These key processes should be a part of the routine management of the dietary and food services departments. The outcome of these evaluations should then be reported to the QA Committee to provide a general overview of areas which directly affect quality of care, resident satisfaction of food and regulatory compliance.

Analyzing the Information: Any "NO" answer should be evaluated in terms of the process or equipment that is involved. For example, if food temperatures are not within acceptable range for tray service on the nursing units, then the food carts and the method of actual tray service on the units needs to be evaluated.

If there is an increase in the number of residents being served in their rooms, there should be a corresponding evaluation of how many of these residents require staff assistance as this will directly affect the demands placed upon the nursing staff in these areas. If a significant number of these residents require staff assistance or supervision, this will also impact upon the staffing on the units.

If there are problems with temperatures of the refrigerator and/or freezer, then the equipment itself should be evaluated. Monitoring of dishwasher temperatures is generally a good idea to assure that hot water usage in the kitchen is not being affected by use in other parts of the facility. If the kitchen is on a separate hot water system, then this category may not require as frequent monitoring as would be required otherwise.

Section 27: SOCIAL SERVICES

Social Services:

a. Resident/family complaints acted upon and documented? **(F257)** ___Yes___No
b. Internal transfers done with prior notification of resident/family?**(F254)**__Yes__No
c. Residents have adequate supply of clothing? **(F257)** ___Yes___No
   # reports of lost/misplaced clothing for the period:_____
d. Social Services notified of all behavioral/emotional problems? **(F257)**___Yes ___No
e. Social Services involved in assessing residents with agitation/psychotropic meds? **(F257)** ___Yes___No
f. Social Services has specific interventions in care plans for residents with automatic triggers in Section H of MDS? **(F257)** ___Yes___No
g. Post discharge plan of care completed for all ***anticipated*** discharges? **(F303)** ___Yes___No

Cross Reference to Federal Regulations:

F254: Under the broad requirement concerning Resident Behavior and Facility Practices (483.13), this F-tag stipulates that the resident must receive notice before the resident's room or roommate in the facility is changed.

F257: This is the specific requirement for Social Services that identifies that the facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident (AHCA 91). The interpretive guidelines enumerate specific examples of what these services might include (AHCA P-91, P-92).

F303: In the case of anticipated discharges, the facility will provide a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment (AHCA P-110).

Rationale for Reporting: The evaluation of compliance with the federal requirements concerning Social Services is a very subjective one. Responding to residents' social and emotional needs is an intangible; therefore, this section includes only basic evaluation items relating to processes within the Social Services area.

Analyzing the Information: In this section, look for evidence that Social Services is not receiving information regarding changes in resident behavior and/or situations in which there should be social services involvement. There should be a system of timely referral between nursing and social services regarding changes in the resident's mood and behavior. The documentation by social services in the progress notes should also be consistent with the assessment of the resident as reflected in Section H of the comprehensive assessment (MDS). Evaluation of this section will also relate to the information reported in the Medical Records section of the QA report.

One or more "NO" answers in this section should trigger a more indepth evaluation as to the cause such as:

a) Is the present staffing in the Social Services department adequate to meet the needs of the facility residents?
b) Is the communication system between nursing and other departments to Social Services timely and effective as it relates to significant social and emotional factors in each resident's life?
c) Is the documentation process within the Social Services department adequate to meet the requirements for assessment, care planning, documenting resident progress and planning for post-discharge care?

Section 28: HOUSEKEEPING

Housekeeping:

a. Toxic chemicals properly stored in the facility/on cleaning carts? **(F260)**__Yes__No
b. Soap and paper towels always available in staff bathrooms?**(F441,F446)**__Yes__No
c. Resident overbed tables, wheelchairs kept clean? **(F261)** __Yes __No
d. Facility and resident rooms/bathrooms clean and odor free?**(F260, F261)**__Yes __No
e. Caution signs routinely used when floors are wet? **(F479)** ___Yes ___No

Cross Reference to Federal Requirements

F260: This requirement falls under the general Level A category of Quality of Life, **483.15**. The individual requirement at **F260** stipulates that the facility must provide a safe, clean, comfortable and homelike environment (AHCA P-94). Within the interpretive guidelines and the survey procedures and probes, reference is made to evaluating cleanliness of room and the general environment and odors (AHCA P-94).

F261: Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior (AHCA P-96).

F441: This requirement falls under the broad Level-A requirement for Infection Control, 493.65 (AHCA P-185). Within the requirements for infection control, F441 stipulates that the facility investigate, control and

prevent infections in the facility. Specific reference to housekeeping relates to the need for adequate provisions for staff to abide by proper handwashing technique.

F446: Also in relation to Infection Control, this relates to the specific requirement that staff wash their hands after each direct resident contact for which handwashing is indicated and that the facilities for handwashing exist and are available to the staff (AHCA P-186). With respect to housekeeping, this would pertain to the need for maintaining soap and towels for staff use in all care areas.

F479: Under the broad Level-A requirement for Physical Environment, **483.70, F479** relates to the need to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public (AHCA P-197)

Rationale for Reporting: The information included in the Housekeeping section provides an overview of general departmental management issues. Review of this information at the QA Committee level would provide for a means of discussing not only how the department rates itself but also how other staff members rate cleanliness and availability of soap and towels within the facility.

Analyzing the Information:. If there are any "NO" answers in this section either by the department's analysis of its own performance or by way of feedback from other staff, the QA Committee should consider:

a) Does the housekeeping department have specific cleaning schedules for resident rooms, floors and general living areas?

   If so, are these schedules being followed? Who is responsible for monitoring compliance with the schedules?

b) Is there a daily schedule for checking and replenishing soap and towel dispensers within resident care areas and in staff and general public toilet facilities?

   If so, are these schedules being followed? Who is responsible for monitoring compliance with the schedules?

c) If there have been numerous falls on wet floors, consider specific discussion as to whether caution signs are being properly used by staff.

Section 29: Laundry

Laundry:		
a.	Is adequate linen available to each nursing station at the beginning and throughout each shift?	___Yes___No
b.	Are all resident rooms provided with sufficient towels/face cloths in good condition ? **(F262)**	___Yes___No
c.	Is linen in good repair without holes/stains? **(F262)**	___Yes___No
d.	Staff follow proper procedure in handling soiled linens? **(F447)**	___Yes___No
e.	Dirty linen sent to laundry in a timely and acceptable manner? **(F447)**	___Yes___No
f.	Water temperatures within proper ranges?	___Yes___No

Cross Reference to Federal Requirements

F262: As a part of the general Level-A requirement, Quality of Life, F262 requires that each resident room be provided with clean bed and bath linens that are in good condition (AHCA P-97).

F447: This requirement concerns general prevention of the spread of infection as a part of the facility's infection control program (AHCA P-187). The facility personnel must handle, store, process, and transport linens so as to prevent the spread of infection (AHCA P-187).

Rationale for Reporting: Although item a. of this section does not correlate directly with a federal requirement, it represents an essential item of service that impacts directly upon the nursing staff and their ability to provide optimal care to the residents. Often this information is best provided by both representatives of the nursing staff as well as the housekeeping staff. Although linen may be delivered to the nursing units throughout the day, the key issue is whether there is adequate linen to meet the needs of the staff throughout each shift.

Other reporting items in this section relate to the summary of general monitoring systems that should be in place to evaluate the actual quality of the linen in the facility as well as the manner in which it is provided to the staff and handled in processing.

Analyzing the Information: Any "NO" answer should be evaluated from a process point of view. For example, if there is not adequate linen available throughout the course of each shift, the reason needs to be identified. It could be the result of insufficient quantities of linen in the facility or it could be the result of a need for more frequent processing of laundry by the laundry staff. Therefore, consider the following in relation to any "NO" answers:

a) How do laundry personnel determine the quantity of linen that should be distributed to each nursing station at the beginning of each shift and

throughout the day? Is this quantity re-evaluated as the number of incontinent residents changes within the facility?

b) Is the present supply of linen and towels in good condition? When was the last replacement of linen or towels? Is the linen of a durable quality or is it less expensive at time of purchase but requires frequent replacement?

c) Is there a common source of stains on linen? If so, is there an alternate for this item that would be less damaging to the linen or is there a way to protect linen from this stain source?

d) What is the staff of the laundry department? Is it scheduled on only the day shift or is there an evening shift for washing and drying linen?

e) Is the storage of dirty linen on the nursing units causing odor problems in the facility? Is there a schedule for retrieving dirty linen and is it being followed?

f) Is the temperature of the water monitored in the laundry area to assure that water is warm enough to promote proper cleaning?

Section 30: ACTIVITIES

Activities:		
a.	Residents getting to/from activities with timely staff assistance?	___Yes ___No
b.	Current # residents physically unable to attend activities: ___	
c.	Current # residents who consistently refuse to attend activities: ___	
d.	Small group programs regularly held for the severely confused?**(F255)**	___Yes___No
e.	How many small group activities were conducted this month?:_____	
f.	Sufficient activities on weekends to meet resident preferences? **(F255)**	___Yes___No
g.	Sufficient activities on evenings to meet resident preferences? **(F255)**	___Yes ___No
h.	Does activity calendar reflect a variety of activities to meet needs/preferences of all residents? **(F242, F255, F282)**	___Yes___No
i.	Activities held as posted on the calendar? **(F255)**	___Yes___No

Cross Reference to Federal Requirements:

F242: This F-tag corresponds to the individual federal requirement for resident self-determination and participation (ACHA P-85). In the context of this requirement, specific reference is made to the resident's right to choose activities, schedules and health care consistent with his or her interests, assessments, and plans of care.

F255: This F-tag corresponds to the individual federal requirement for Activities and falls within the broad Level-A requirement for Quality of Life (ACHA P-89). Survey procedures and probes include instructions for the surveyor to observe residents for their specific involvement in individual and/or group activities and to question residents as to their satisfaction with the facility activity program (AHCA P-89). Surveyors are also instructed to compare residents' activities to the information recorded in the resident comprehensive assessment concerning resident interests (AHCA P-90).

F282: This F-tag corresponds to one of the individual comprehensive assessment categories, that of Activities Potential of the resident (AHCA P-102). This requirement refers to the need to assess the resident's ability and desire to take part in activities which maintain or improve, physical, mental and psychosocial well-being (AHCA P-102). Reference is also made to the fact that the assessment should consider the resident's normal everyday routines and lifetime preferences.

Rationale for Reporting: Although item a. in the report does not correspond to a specific federal requirement, this category of information provides a means of assuring that the number of residents requiring staff assistance is being evaluated. The same holds true for items b. and c. As these numbers increase, there should be a corresponding re-evaluation of the overall activity program and its effectiveness in meeting individual resident needs and preferences. The remaining categories in the Activities section refer to general compliance issues that should be included in the general departmental quality assessment and assurance program.

Analyzing the Information: Analysis of the facility Activity program should be done not only by the Activities staff but also by the residents and the other members of the facility staff. This is recommended because of the very subjective nature of a quality evaluation in this area and the need to include as many different viewpoints and perspectives as possible. Residents who are interviewable can provide individual input as to their satisfaction with the facility activities. However, those residents who are not interviewable must be assessed by the entire interdisciplinary team. Therefore, the QA Committee must solicit input from all departments in reviewing the adequacy of the program to meet the changing needs of the resident population. This evaluation cannot be done by merely reviewing the activity calendar but must also include a comparative evaluation of the calendar to the specific resident population.

If the number of residents requiring staff assistance is increasing, there may be a need to evaluate the manner in which Activities informs nursing as to specific activity schedules of residents.

If the number of residents physically unable to attend activities is increasing, there may be a need to evaluate volunteer staffing in Activities to provide additional time for Activities employees to perform one-on-one activities in resident rooms.

A review of the number of residents refusing to attend activities is useful for a number of reasons. Activities should be evaluating each of these residents on an ongoing basis to determine the reason for the refusal. Although residents have a right not to participate in planned facility activities, each

case needs to be evaluated in comparison to the resident assessment information and to the resident's activity needs. If many of the residents who refuse to attend activities are those with an Alzheimer's-type dementia, possibly the staff approach for inviting and/or encouraging attendance needs to be evaluated. At the Committee level, review of these numbers is merely a point of reference for asking for a more detailed analysis from the Activities department.

Section 31: MAINTENANCE

Maintenance:

a.	Are work orders processed in a timely manner? **(F479)**	___Yes___No
b.	All resident furniture and resident equipment in good repair?**(F329)**	___Yes___No
c.	Resident rooms without peeling paint, broken tile? **(F261)**	___Yes___No
d.	All bathing areas equipped with non-skid surface? **(F329)**	___Yes___No
e.	All call lights in working order? **(F472, F473)**	___Yes___No
f.	Lighting adequate in all resident areas/all light bulbs working?**(F263)**	___Yes___No
g.	Handrails secure and in good repair? **(F329, F482)**	___Yes___No
h.	Safety checks completed on all essential mechanical, electrical and patient care equipment? **(F459)**	___Yes___No
i.	All routine maintenance schedules current?	___Yes___No
j.	Facility free of pests and rodents? **(F483)**	___Yes___No
k.	Are water temperatures monitored on a regular basis? **(F329)**	___Yes___No
l.	Are water temps. in acceptable ranges throughout the day? **(F329)**	___Yes___No
m.	Room temperatures in comfortable and acceptable ranges? **(F481)**	___Yes___No
n.	Outside grounds free of debris; grass and shrubs maintained?	___Yes___No
o.	Emergency drills conducted in accordance with required schedules? **(F535)**	___Yes___No
p.	Staff are routinely informed of and demonstrate knowledge of fire/evacuation procedures? **(F533, F534, F535)**	___Yes___No

Cross Reference to Federal Requirements:

F261: This F-tag falls under the general Level-A requirement, Quality of Life and refers to the provision of housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior (AHCA P-96). With respect to maintenance, interpretive guidelines identify that resident areas will be well-kept without peeling paint, visible water leaks and plumbing problems (AHCA P-96).

F263: This F-tag specifically refers to the need for residents to have adequate and comfortable lighting levels in all areas (AHCA P-97).

F329: This F-tag relates to the resident environment being free of accident hazards and identifies specific examples concerning resident handrails and resident care equipment such as wheelchairs and walkers (AHCA P-132).

F459: F459 through F483 of this section are all included in the broad Level-A requirement **483.70**, Physical Environment (AHCA P-188). F459 is the specific requirement for maintaining all essential mechanical, electrical and patient care equipment in safe operating condition (AHCA P-191).

F472, F473: These F-tags relate to the proper functioning of resident communication (call) systems in resident rooms and toilet and bathing facilities (AHCA P-195).

F479: This F-tag is referenced as a part of the facility's responsibility to maintain a safe, functional, sanitary, and comfortable environment for residents, staff and the public (AHCA P-197). If maintenance work orders are not processed in a timely manner, the overall safety of residents and visitors could be affected.

F481: This requirement refers to resident rooms having adequate outside ventilation by means of windows or mechanical ventilation, or a combination of the two (AHCA P-198). Survey procedures and probes point to the specific evaluation of temperature, humidity and odor levels being within acceptable levels (AHCA P-198).

F482: This requirement states that corridors be equipped with firmly secured handrails on each side (AHCA P-198).

F483: This requirement refers to the need for an effective pest control program so that the facility is free of pests and rodents (AHCA P-198).

F533, F534, F535: These requirements refer to the facility's responsibility to train all employees in emergency procedures when they begin to work, to periodically review the procedures with the staff, and carry out unannounced staff drills using those procedures (AHCA P-213). In addition, survey procedures and probes direct surveyors to specifically question two staff persons separately what their duties are in the event of a fire, how to use the fire extinguishers and what to do in the event of a missing resident (AHCA 213).

Unless you try to do something beyond what you have already mastered, you will never grow.

Ronald E. Osborn

Section 6 Content: Quality Improvement Applications in Long Term Care Facilities

Subsection 6.0: What You'll Learn In This Section

- **General differences between traditional quality assurance and quality improvement.**
- **The basic concepts of quality improvement that are customer and process driven.**
- **Simple applications of the quality improvement concepts to the long term care setting.**

Subsection 6.1
Why Quality Improvement? What's In It For Me?

You may be asking yourself, "why bother with quality improvement when I can barely deal with all of the day-to-day problems now?" This is precisely the reason to concern yourself and your employees with the systematic methods for improving quality that are inherent in quality improvement. Your approach need not be elaborate, but you should at least foster an environment where improvement is the central focus and employees are encouraged to openly communicate and be innovative in solving work problems.

Many long term care professionals spend their entire day putting out fires, functioning in a crisis mode on an ongoing basis. This represents a vast expenditure of negative energy for the facility. Consider what the outcomes are of this management style. Invariably employee turnover, low morale, decrease in quality, decrease in census and ultimately poor survey results accompany this style of management. These are all of the outcomes that facility management wishes to avoid. Therefore, use that same energy for putting out fires to systematically examine critical processes that represent problems for the facility.

Most long term care professionals agree that merely reducing the employee turnover rate could have a drastic impact on improving overall quality in the facility, not to mention reducing the expenditure for constantly hiring and training staff that come through the "revolving door" of the

employment office. Can quality improvement help you in this struggle? Yes. Will it be easy? No. A commitment to quality improvement is hard work for everyone, but the long term benefits will result in something positive for everyone.

Consider the human side of quality in any work environment. Most employees would like to enjoy their job and would like to feel good about the work that they do. Every employee has at least one aspect of his/her job that creates frustration and makes quality of performance more difficult. Quality improvement provides an opportunity for addressing these issues and taking advantage of a group think environment to solve problems in a systematic manner. You must think of the quality improvement process as a management tool for improving the working environment, reducing unnecessary costs and increasing the quality of services. This will create a win-win situation for everyone, the residents and the staff.

Subsection 6.2 Overview of QA Versus QI

The term "quality of care" is often overused in health care. On paper, every healthcare facility adopts a mission of providing quality care to its patients. The tendency, however, is for a healthcare facility to measure its performance or quality against that of other facilities rather than against itself. Traditional quality assurance methods have tended to reinforce this pattern of thinking. In other words, as long as "we're no worse" than anyone else, there is no need to be overly concerned about quality (Spath 35).

In the long term care industry, the tendency is to measure quality against the outcome of the facility inspection or survey. All too frequently, there is not a desire or motivation to improve within the facility unless a problem or deficiency is cited by a surveyor.

This **We're No Worse** philosophy is demonstrated by a story told by Tom Peters in his book, A Passion for Excellence. During the course of a series of seminars with managers of a major retail chain, Tom began expressing his dissatisfaction with the generally poor quality of service in the retailing industry. In the middle of this portion of the presentation, an executive vice president stood up and interrupted him by saying: "Tom, sit down and calm down. Or get off our case. It's a changing and complex and highly competitive world. *We are no worse than anybody else."* (Spath 35).

Those of you who have experience in a long term care facility can translate this "We're No Worse" attitude to "This Is Not a Quality Issue Because....."(Spath 35). How this attitude can dictate the effectiveness of the facility's quality assurance and improvement activities is demonstrated by the following examples:

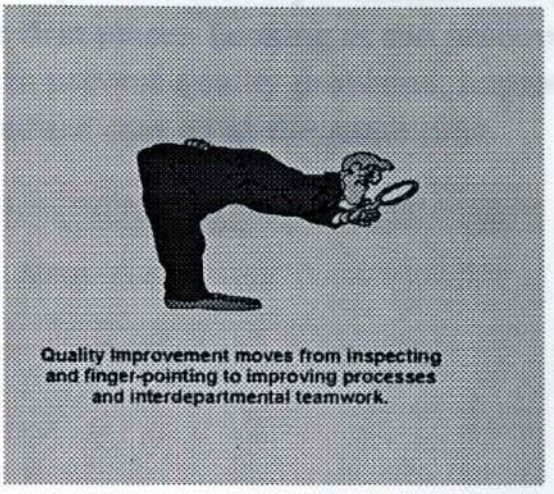
Finding	This Is Not a Quality Issue Because....
1. Increase in skin breakdown	The state surveyor said our decubitus ulcer care was better than other facilities in the area.
2. We had 15 residents with skin tears last month.	Considering the turnover in staff we had that month, that's not bad at all!
3. A resident got out of the building unattended and was found by the police off the facility grounds.	Everyone has a resident get out of the building unnoticed. As long as there was no serious injury, there's not much that we can do to stop these occurrences.
4. There has been an increase in staff and family complaints regarding dirty floors and resident rooms.	Everything will be clean by the time of the survey.
5. Our medication error rate was 4.75% on Division A and under 2% on the other divisions during a routine audit of medication passes.	As long as our rate is less than 5%, we won't be cited during the survey.
6. Signing admission paperwork takes over 30 minutes. Families are complaining and it's creating a bottleneck in the front office.	That's the way we've always done it.

Quality improvement directly challenges the "**We're No Worse**" philosophy. Rather than emphasize compliance with a designated standard of performance, quality improvement focuses on key processes that are involved in each department which affect the overall provision of quality in each department of the facility. While each department has a need to monitor and implement its own quality evaluation, this effort can become counterproductive if there are problems with key processes that affect the performance of other departments.

For example, the dietary department may have an excellent quality assessment and assurance monitoring program for determining compliance with departmental standards. This would include accuracy in meal preparation as compared to diet orders, staff compliance with infection control and sanitation standards in meal preparation, etc. However, if the dietary department interacts negatively with the nursing staff in serving meals, providing room trays and responding to requests for dietary substitutions, there is a need to evaluate these processes and the points of interaction between these departments and the resident.

Once the process is evaluated as one that is jointly owned by both nursing and dietary, the groundwork is laid for initiating quality improvement.

How is QI Different from QA?



Traditional quality assurance focuses on retrospective audits and inspections or looking at things "after-the-fact". The focus is typically to find "the bad apples" or those individuals who failed to meet a desired level of performance. Consequently, it is not hard to understand how quality assurance often has a negative image in the minds of employees. While this type of evaluation still has a significant role in a total quality program, the information should be regarded as but one set of findings that represent an opportunity for improvement of the process that led to the quality finding.

The cartoon on the following page is a good illustration of the reason why focus on process is so important to any quality improvement program.

If you continually look at quality problems as something that can be "fixed" with the band-aid approach, you will miss the opportunity to prevent the very reason for the problem occurring in the first place. Looking at the process provides an opportunity to prevent quality problems, improve efficiency and reduce cost all at the same time.

Source: The Team Handbook

Traditional quality assurance focuses on only those areas that fall within certain departmental boundaries. In this type of quality focus, each department becomes its own "chimney" of excellence with no one focusing on those areas in which departments interact together to provide a service to the resident. These "gaps" in the quality focus are traditionally where the true problems occur and where the opportunities for improvement are most plentiful.

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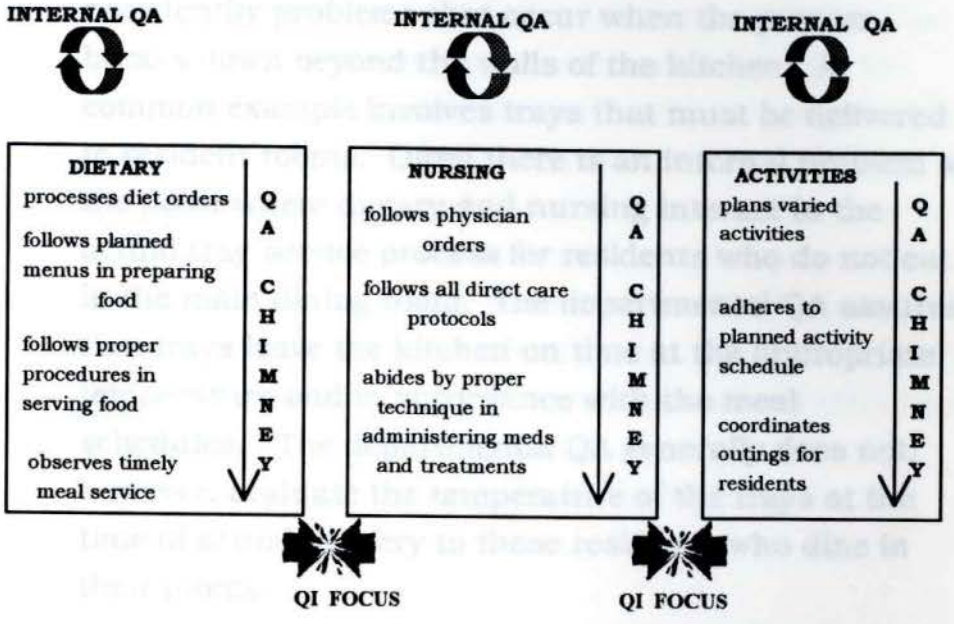
Graphically, this type of "quality" program can be displayed as follows:



Quality improvement recognizes that the opportunities for improving quality generally occur in those areas where two or more departments interact in a process. These are also the points where the resident is most affected by failures in the process. A traditional quality assurance approach to resolving a problem that results from a failed process would be to focus on a person or department as being responsible for failing to meet a standard. Quality improvement, on the other hand, would focus on bringing the owners of the process together to evaluate methods for improving the system.

EXAMPLES

1) The dietary department may have an excellent internal review in terms of meeting departmental quality AND compliance standards, **BUT** this type of compliance does not identify problems that occur when the process breaks down beyond the walls of the kitchen. A common example involves trays that must be delivered to resident rooms. Often there is an internal problem at the point where dietary and nursing interact in the actual tray service process for residents who do not eat in the main dining room. The departmental QA assures that trays leave the kitchen on time at the appropriate temperature and in accordance with the meal schedules. The departmental QA generally does not, however, evaluate the temperature of the trays at the time of actual delivery to those residents who dine in their rooms.

2) The activities department meets all of the internal quality requirements in terms of providing varied and appropriate activities for residents, **BUT** the process breaks down with residents who need physical assistance to and from activities. Because of a lack of appropriate communication between activities and nursing, residents requiring assistance do not get to activities on time and are returned to their floor by activities staff and left to congregate near the elevators. Activities is "doing their job", and nursing is taking care of the residents needs; however, nursing is unaware of each residents' specific activity schedule. The result is a

lack of coordination in the two areas in order to focus on improving the process for the resident.

A QI approach to these situations would be for representatives of each area involved in the process to meet and work as a team to analyze how the process could be improved. This team would not necessarily be comprised of managers from each of the areas but would involve people who actually do the work and can speak to reasons that the process is or is not effective. In these examples, nursing assistants would be regarded as essential individuals to involve in improving the process. On the contrary, however, nursing assistants are rarely involved in most long term care facility QA/QI programs. This is the major difference between traditional quality assurance and quality improvement.

Traditional quality assurance programs focus on communication only with the managers of departments. Because the focus is on "problem people", the manager is looked upon as the solution for solving a quality problem. In contrast, in a quality improvement environment, the process is viewed as the quality problem. Therefore, the solution is to involve all of the people who are directly involved in the process. Because the people in the process are the true "experts" on describing and understanding why the process does or does not work, these are the people who should be involved in the improvement program efforts.

In a continuous quality improvement environment, employees are encouraged to ask "why do we do this?" with

respect to every task in the process. In evaluating why things are done a particular way and how they can be improved upon, employees and management focus on adding services that "add value" and removing those areas of work that add no value. No process or system is regarded as sacred or untouchable in a continuous quality improvement environment.

Subsection 6.3
The Customer and Process Drive Behind QI

Quality improvement is driven by customer expectations and is focused on key processes that affect and/or involve those customers.

Who is a customer?

In a long term care facility, your first thought will likely be that the resident or the resident's family is "the customer". While this is true in many instances, the resident is but one of many "customers" within the long term care facility. There are both **internal customers**, those who are employed by the facility, and **external customers**, or those who make the choice to reside in or do business with your facility (Leebov 35). The processes or interactions between customers and suppliers are the areas in which quality improvement can be most beneficial.

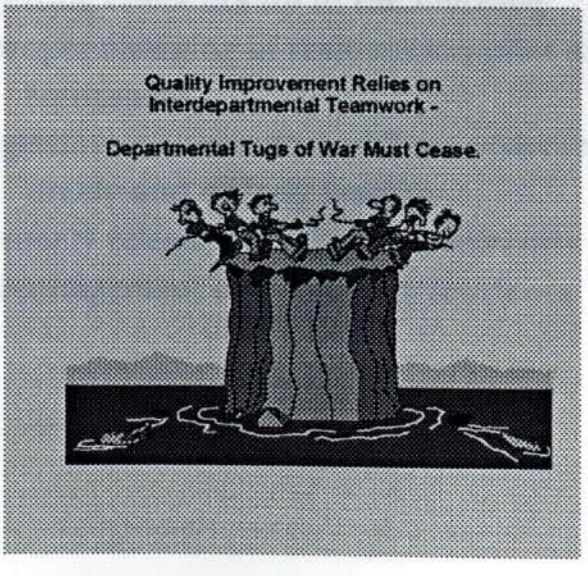
For example, in the nursing department, nursing is the supplier of many direct care services to the resident. Therefore, in those patient care processes, the resident is the customer. Listed below are other examples of key customer-supplier relationships in the typical long term care facility:

Department (supplier)	**Process** (work that is done; product that is made)	**Customer(s)** (person(s) receiving the product or work)
Dietary	Menu Development	Resident
Laundry	Providing Clean Clothes and Linens	1) Resident 2) Nursing staff
Nursing	Treatments	Resident
Social Services	Admitting a New Resident	1) Resident 2) Resident's Family 3) Nursing Staff 4) Dietary 5) Housekeeping 6) Medical Records 7) Business Office 8) Rehab Services 9) Physician

The last example involving Social Services concerns direct, immediate customers, such as the resident and/or the resident's family. In addition, several indirect customers are identified who are affected by the process if it is not performed correctly. This is known as the "downstream effect" of a process (Leebov 39).

For example, if Social Services fails to obtain all necessary information regarding the resident at the time of

admission, a multitude of process problems can occur. If the attending physician's telephone number and complete name are not recorded at the time of admission, this directly affects the nursing staff. If incorrect or incomplete insurance or payment information is received, the business office will either be unable to process the resident's bill or will experience a delay in payment and the resident's family will likely be billed incorrectly. If the Medical Record Department is not informed of the admission prior to the resident's arrival, the chart will not be made up in advance, and both Medical Records and Nursing will be affected by this failure of the process. If the Rehab Department is not informed of the new admission, then the resident will not be screened in a timely manner for a possible need for rehabilitation services that may not have been ordered on admission. If the Pharmacy service is not given the correct insurance and payment information, the resident or resident's family will be billed incorrectly.



Subsection 6.4 Examining Key Processes

What are Key Processes?

In evaluating processes that could be improved, focus on those areas that impact most directly on quality of care, quality of life and cost issues. Processes that typically are at the core of many problems in a long term care facility include some of the following:

- ⇨ proper and timely identification of personal belongings
- ⇨ return of resident belongings from the laundry
- ⇨ the admission process
- ⇨ food service in the dining room and in residents' rooms
- ⇨ hydration of residents
- ⇨ transporting residents to and from activities
- ⇨ determining need for internal transfers
- ⇨ getting residents up in the morning
- ⇨ proper charging of resident supplies and equipment
- ⇨ getting residents to and from activities in a timely and orderly fashion
- ⇨ timely release of residents' restraints
- ⇨ management of wandering residents

Subsection 6.4
Examining Key Processes in Long Term Care

Processes that Relate to Cost

As a Committee, assist departments in looking at processes that relate to significant cost issues within the facility. Consider some of the following:

$ Overtime costs in any department

a. Identify why there is a need for overtime. Gather specific information as to the reason such as call-ins or completion of paperwork.

b. Is there a pattern as to the degree with which it occurs?

c. Truly analyze the reasons for the overtime and whether there are alternative solutions. Can these reasons be eliminated or reduced?

d. Work as a group to outline alternative solutions.

e. Determine which solution(s) can be realistically implemented on a trial basis.

f. Implement the proposed solution.

g. Monitor the action taken to determine if the solution was effective.

h. Finalize the implementation and continue to evaluate the process.

Other areas which can be evaluated in terms of cost related to product use are:

$ **Cost of Employee Turnover**

Have we truly evaluated why employees are leaving by conducting exit interviews?

How much overtime is involved in staffing due to vacancies and employee "no-shows"?

How much is presently being spent on training new employees to replace old employees?

How much is being spent on agency help to fill needed vacancies?

$ **Cost of Laundry Chemicals/Cost of Incontinent Care Products**

Why are we using the products we are using?

Are the present products effective?

Are there alternative products that achieve the same or better service at a lesser cost?

Can we reduce cost by evaluating our present purchasing practices?

Processes that Relate to Quality

* providing timely staff assistance to residents during meals

* taking accurate and timely resident weights

* communicating significant changes in resident condition to all necessary parties

* hydration of residents who are unable to maintain proper fluid intake independently

Use the following guidelines to identify those processes that the Committee should regard as priorities:

1) Identify all areas of non-compliance or substandard performance in the Quality Management Report.

2) Evaluate which area(s) represent the most significant impact on quality of care or quality of resident life. Any item that represents a potential negative finding in a Quality of Care requirement or a Quality of Life requirement should be regarded as a priority and evaluated in terms of the involved process(es).

Subsection 6.5 Key Steps to Quality Improvement

The Quality Assurance Section of the American Health Information Management Association has identified the following basic steps for process improvement:

Step One:

List and prioritize improvement opportunities.

Step Two:

Define the improvement project that you select and appoint a QI team to study the process.

Step Three:

As a team, analyze the process problems.

Step Four:

Speculate causes of problems based on each team member's experience with them.

Step Five:

Test assumptions by gathering data in the areas that are believed to be the cause of the process problem.

Step Six:

Identify root causes to the problem.

Step Seven:

Consider alternative solutions to the problem.

Step Eight:

Design solutions and control measures to monitor the effectiveness of the solutions.

Step Nine:

Address resistance to change.

Step Ten:

Implement solutions and control measures.

Step Eleven:

Check performance to evaluate the effectiveness of the solutions.

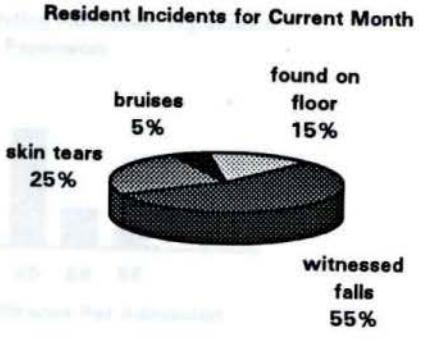
Quality Improvement Tools

In order to support each of the above steps, there are basic techniques that are used to systematically analyze processes and address possible solutions. These methods utilize data to drive the decision-making and assist in the problem-solving process.

It is not the intent of this manual to educate you in the statistical methods of quality improvement but merely to expose you to the terms and their general application. References are included in the bibliography for additional study in these tools and their direct application.

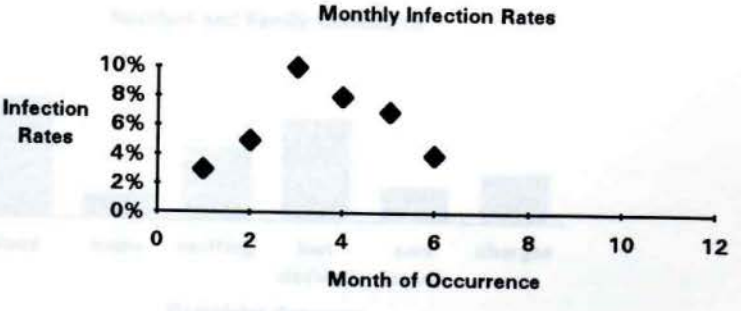
1. Pie Chart

A pie chart is used to graphically display data when the entire circle represents 100% of the category.



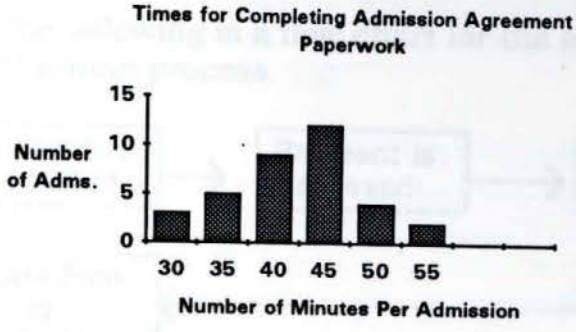
2. Run Chart

A run chart is a linear graph that is used to track occurrences over a period of time in order to identify patterns and trends.



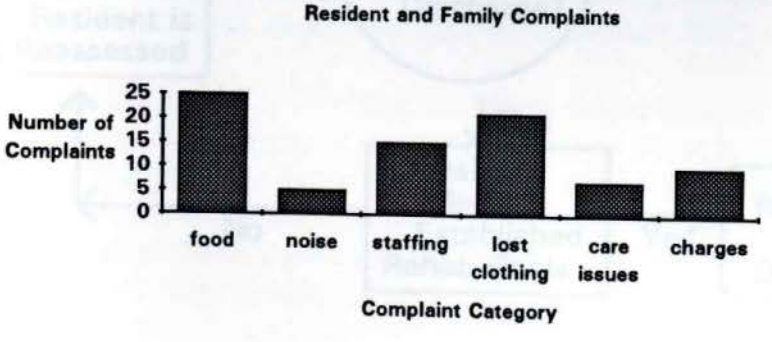
3. Histogram

A histogram is used to emphasize how frequently an event occurs. Histograms are popular because they are easy to interpret and are not difficult to make.



4. Pareto Diagram

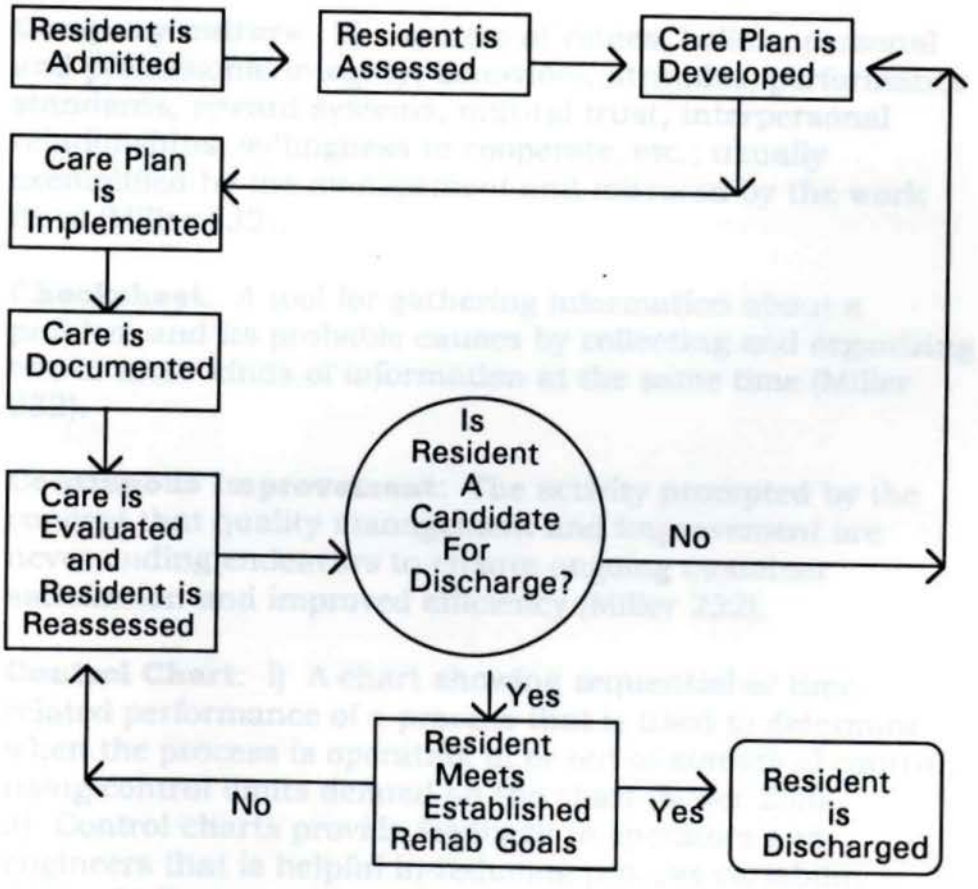
The Pareto diagram is a type of histogram that is used to describe the attributes of particular data. This is particularly useful in demonstrating the degree to which particular problems are occurring in a process.



5. Flow Chart

Flow charts are used to display all aspects of a process in a graphic format. It is most useful in quality improvement in identifying duplication of work or areas in which customer needs are not being met.

The following is a flow chart for the assessment and care planning process.



Section 7 - Glossary of Terms

Benchmark: 1) The standard or point of reference in measuring or judging quality, value, etc. Compare with baseline (Miller 230). 2) The process of comparing the best products or processes that will lead to superior performance of a company (Miller 230).

Company culture: The system of values, beliefs, personal and professional integrity, behaviors, attitudes, performance standards, reward systems, mutual trust, interpersonal relationships, willingness to cooperate, etc.; usually exemplified by the management and mirrored by the work force (Miller 232).

Checksheet: A tool for gathering information about a problem and its probable causes by collecting and organizing two or more kinds of information at the same time (Miller 232).

Continuous Improvement: The activity prompted by the concept that quality management and improvement are never-ending endeavors to ensure ongoing customer satisfaction and improved efficiency (Miller 232).

Control Chart: 1) A chart showing sequential or time-related performance of a process that is used to determine when the process is operating in or out of statistical control, using control limits defined on the chart (Miller 233). 2) Control charts provide feedback to operators and engineers that is helpful in reducing process variability (Miller 233).

Cost of (poor) quality: This represents the internal losses that a company experiences due to poor quality (Miller 233).

Customer: A customer is someone who depends on the process for a product, service, or information (Mozena 4).

Data collection: The systematic gathering of sufficient meaningful and related data relevant to a specific goal (Miller 234).

Flow Chart: A "map" of a process, used to detect the need for some obvious changes (Miller 236).

External Customer: External customer refers to anyone outside your organization (Mozena 4).

Internal Customer: Internal customer refers to anyone within your organization (Mozena 4).

Paradigm shift: The advent and acceptance of a totally new model that is theory-shattering and displaces and discredits older theories and models (Miller 239).

Process - In a quality improvement project, all work (each task or duty) is viewed as a process. (Mozena 4).

Quality:

a. The totality of features and characteristics of a product or service that bear on its ability to satisfy a given need (Miller 241).

b. Meeting or exceeding customer expectations at a cost that represents value to them (Miller 242)

Quality Improvement Council: A quality improvement council is a selected group of senior management members who work together to represent the organization's best interests regarding quality efforts. They oversee, select, support, provide resources, resolve organizational barriers, and make recommendations concerning the quality improvement projects (Mozena 4).

Quality Improvement Project: A QIP is a management-approved, time-limited activity, with assigned project team members who have specific responsibilities and authorities

and approved resources to perform analysis on, and make recommendations or changes regarding, a defined work process (Mozena 3).

Supplier - A supplier provides the process with materials, information, and objects (Mozena 4).

Total Quality Management: The integration of quality and management methods, practices, concepts and beliefs into the culture of the organization to bring about continuous improvement (Cassidy).

Value-added service: Providing enhancements to a product or to a service that are not specifically requested by the customer; exceeding customer expectations (Cassidy).

Waste: The difference between the way things are now and the way they could or should be if there were no errors, troubles, problems or complexities (if everything were "right" and optimized) (Miller 247).

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Chapter V

SUMMARY

Four evaluators completed the training manual evaluation form identified as Appendix B. In addition, I conducted personal interviews with each evaluator upon completion of the evaluation form to elicit additional feedback. The general opinion of the evaluators was that the manual provides an excellent resource for the long term care industry regarding both federal compliance and quality assurance and improvement. Each evaluator stated that the manual fills a void in the published literature presently available to the long term care industry. It was personally gratifying that all four individuals stated that the manual should be submitted for publication.

The specific evaluation responses from the four evaluators are summarized as follows with 5 being rated as highly effective and 1 being rated as highly ineffective.

Question #1:

How would you rate the format and organization of the manual as a training tool for the long term care Quality Assessment and Assurance Committee?

All four evaluators submitted a rating of 5 for this category.

Question #2:

How effective is the manual in educating QA&A Committee members regarding their responsibilities for quality surveillance?

Three evaluators submitted a rating of 5 for this category. One evaluator submitted a rating of 4 for this category.

Question #3:

How effective is the manual in educating Committee members concerning the long term care federal requirements which relate to Quality Assessment and Assurance?

Three evaluators submitted a rating of 5 for this category. One evaluator submitted a rating of 4 for this category.

Question #4:

How effective is the manual in teaching the relationship between federal regulatory compliance and the facility QA/QI program?

Two evaluators submitted a rating of 5 for this category. Two evaluators submitted a rating of 4 for this category.

Question #5:

How effective is the manual in teaching Committee members how to select meaningful data for the job of quality surveillance?

Two evaluators submitted a rating of 5 for this category. One evaluator submitted a rating of 4, and one evaluator submitted a rating of 3 for this category. In the latter case, the evaluator commented that additional information would have been helpful in demonstrating how to identify quality issues that are not specifically addressed in federal regulatory compliance.

Question #6:

How effective is the manual in training Committee members to analyze information for determining a plan of action?

Two evaluators submitted a rating of 5, and two evaluators submitted a rating of 4 for this category.

Question #7:

How effective is the Quality Improvement section for explaining the difference between QA and QI?

Two evaluators submitted a rating of 5, and two evaluators submitted a rating of 4 for this category.

Question #8:

How effective is the manual in demonstrating how quality improvement can be applied to the long term care setting?

Two evaluators submitted a rating of 5, and two evaluators submitted a rating of 4 for this category.

I was pleased that all four evaluators found the manual to be user friendly. Each of them commented on the fact that the manual was written in a simple and easy to understand manner. In addition, all evaluators felt that the manual would serve as an excellent resource for the experienced as well as the untrained long term care worker and/or the healthcare professional with no previous long term care experience.

All evaluators felt that the manual addresses regulatory compliance, quality assurance and quality improvement in a manner not found in any available published resource. All found the merging and cross referencing of quality issues with federal compliance to be extremely valuable. In addition, there was a universal appreciation for the forms, reporting mechanisms, the use of "real world" examples in evaluating data, the use of sample Committee minutes and the detailed rationale in Section 5 for collecting specific

information and developing a plan of action. One evaluator referred to this section as the "meat and potatoes - the good stuff".

There was also universal appreciation for the focus on collecting *useful* information and the need to involve individuals in all departments and at all levels within the facility. Three of the evaluators made specific mention that they liked the quotations at the beginning of each section as this set the tone and prepared the reader for the specific learning objectives of each section. I was pleased to hear this unsolicited feedback as each quotation was used with this goal in mind.

Each of the evaluators submitted pertinent and worthwhile suggestions for improving the manual. All four felt that the section on quality improvement could be expanded to include additional examples and applications, and I agree with this assessment. It was also unanimously suggested that additional explanation be provided concerning how to identify quality improvement issues beyond regulatory compliance. In other words, specific examples would be helpful in directing the reader to identify and prioritize opportunities for improving quality. One

evaluator added that additional information on establishing benchmarks or standards/norms would be helpful.

Two evaluators suggested additional explanation be provided as to the reason for separate quality management reporting forms. Since both of these evaluators were unclear as to the reason for having different versions of the same form, I need to clarify the rationale for the separate forms. One evaluator was unsure as to the use of the Quality Management Issue Reporting form, so additional explanation needs to be provided.

One evaluator suggested that all questions on the Quality Management Reporting form refer to only one issue. For example, each question should ask a "yes" or "no" answer to only one item rather than to several related items. This eliminates possible confusion from the person being asked to complete the form or answer the question.

One evaluator suggested additional explanation at the beginning of the manual concerning the use of the various terms pertaining to quality, i.e., quality improvement, quality assurance, and quality management. An additional suggestion was made to consider incorporating other federal regulatory requirements that impact on long term care

facility quality such as the Medical Safety Device Reporting Act, OSHA, CLIA, etc.

In general, the evaluators expressed appreciation and enthusiasm for the training manual. Regardless of their individual line of work within the industry, each evaluator found the manual a useful reference. It was personally gratifying that each evaluator also expressed that he/she learned something new or found a useful application or tool as a result of reading the manual.

I developed this training manual because I felt there was a need for explaining how federal regulatory compliance and quality can be merged into one program within a long term care facility. In addition, I felt a need to develop a useful educational resource for individuals who serve on a long term care Quality Assessment and Assurance Committee. Based upon the written and verbal feedback from my evaluators, I feel that this training manual has successfully addressed this need.

Because my evaluators represent different professional perspectives within the long term care industry, I feel that their assessments provide a good cross section in terms of reaffirming the need for and assessing the value of the

manual. Two evaluators are registered nurses, one being a Director of Nursing and one being an Executive Director in large, progressive nursing facilities. The other two evaluators are non-nursing professionals with extensive background in long term care. One is a healthcare consultant with over twenty years of experience in both acute and long term care. One is a licensed nursing home administrator with a background as both an administrator and as a regional manager for a large national corporation.

The diversity of the evaluator backgrounds provides a well-rounded perspective as to the usefulness of the manual to a long term care facility Quality Assessment and Assurance Committee. Moreover, because of the high degree of professional respect I have for each of the evaluators, their assessment carries great value. Each of the evaluators is well known for their professional abilities and accomplishments in the long term care industry. Consequently, I feel that their universal praise is an endorsement that the manual serves the intended purpose of providing a valuable quality and compliance tool for the long term care industry.

The enthusiasm that all evaluators expressed for the development of this manual underscores the need for further work in this area.

APPENDIX A

INTRODUCTORY LETTER TO AUDITORS

You have been selected to participate in this graduate research project because of your expertise and recognized professional accomplishments in the long term care industry. Your role in this project is to serve as one of four evaluators who have been selected to review and critique the enclosed Training Manual for the Long Term Care Quality Assessment and Assurance Committee. A questionnaire has been enclosed for documentation of your comments and suggestions, and a followup meeting will be held either in person or by telephone to finalize your evaluation. Your participation will remain anonymous in this project as your identity will be known only to me, the primary investigator.

The purpose of this project is to develop a training manual that merges quality surveillance and regulatory compliance for the QA&A Committee. This manual has been developed to address a perceived need for usable training material for long term care facility QA&A Committee members and workers in the area of quality assessment, assurance and improvement.

Although numerous manuals have been published on the topic of Quality Assurance in Long Term Care, this project addresses the need for a simplified approach to an integrated program of federal regulatory compliance combined with quality of care and service indicators for monitoring quality at the Committee level. In the experience of the author, the success or effectiveness of a facility quality assurance or quality improvement program is directly related to the commitment and participation of the leadership. Therefore, this manual is an attempt to provide guidance to Committee members in the process of quality assurance and improvement as well as to introduce unfamiliar Committee members to pertinent regulatory and survey issues.

It is the opinion of this author that present day quality assurance/improvement publications dwell mostly on collecting statistics and other practice data without focusing on why specific data is being collected and what action, if any, should follow the data collection process. This manual has attempted to address the issue of collecting strategic information that provides value rather than merely representing work for the Committee and facility workers.

With the increased focus on continuous quality improvement (CQI) in the health care setting, the manual also incorporates basic CQI concepts that apply to all long term care facilities. For reasons of simplicity, the manual has focused on two central themes in the quality improvement process, these being cost and quality. In addition, a general discussion is provided concerning key processes that affect cost and quality within the long term care setting. Moreover, a review is included of basic customer/supplier relationships that is inherent in the total quality management and continuous quality improvement philosophies. This section of the manual is intended to provide a superficial explanation of the QI philosophy with an appendix of suggested reading on the subject.

Recognizing that all long term care facilities function with scarce financial and human resources, this manual has been written to emphasize the practical value of the quality assurance and improvement process as a management and survey compliance tool. It has also been intended to serve as a basic instructional tool for the inexperienced worker, realizing that managers in long term care facilities are often inexperienced in management, quality assurance and the long term care process. The overriding goal of this manual is to merge necessary components in all three of these categories to emphasize that regulatory compliance and quality of long term care services should be a product of the same process.

This manual is not intended to be a sophisticated or burdensome program that is not easily understood by the average long term care manager. It is also not intended to be so resource consumptive that it becomes financially inefficient and ineffective for use in a long term care facility.

Your honesty and thoroughness in completing the questionnaire is most appreciated as is your time and voluntary participation in evaluating the manual itself. In appreciation for your participation, you will receive a copy of the final results of the project. Please do not hesitate to attach additional comments to the questionnaire, should that be necessary.

I will be contacting you in the next few weeks to schedule a personal interview to discuss your findings, opinions and solicit additional feedback. If you could complete your review of the manual by December 1, 1993, it would be most appreciated. A self-addressed and stamped envelope has been provided for returning your evaluation to me.

Again, thank you for your time and cooperation in participating in this project.

Sincerely,

Kris King

APPENDIX B

TRAINING MANUAL EVALUATION FORM

Please critique the manual in each of the categories listed below. Feel free to add comments concerning any revisions or additions which you feel would improve the quality of the manual.

Circle the number which best describes your feeling regarding each assessment factor according to a scale with 5=Highly Effective and 1=Highly Ineffective. If you rate an area with a 3, 2 or 1, please provide a general statement as to what should be done to make this item more effective.

1. How would you rate the format and organization of the manual as a training tool for the long term care Quality Assessment & Assurance Committee? 5 4 3 2 1

   Comments:_____

2. How effective is the manual in educating QA&A Committee members regarding their responsibilities for quality surveillance? 5 4 3 2 1

   Comments:

3. How effective is the manual in educating Committee members concerning the long term care federal requirements which relate to Quality Assessment and Assurance? 5 4 3 2 1

   Comments:
   _____
   _____
   _____

4. How effective is the manual in teaching the relationship between federal regulatory compliance and the facility QA/QI program? 5 4 3 2 1

   Comments:
   _____
   _____
   _____

5. How effective is the manual in teaching Committee members how to select meaningful data for the job of quality surveillance? 5 4 3 2 1

   Comments:
   _____
   _____
   _____

6. How effective is the manual in training Committee members to analyze information for determining a plan of action? 5 4 3 2 1

   Comments:
   _____
   _____
   _____

7. How effective is the Quality Improvement section for explaining the difference between QA and QI? 5 4 3 2 1

Comments:

8. How effective is the manual in demonstrating how quality improvement can be applied to the long term care setting? 5 4 3 2 1

Comments:

Please note any suggestions for improving the training manual which may not have been addressed in the preceding questions.

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