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## The 7 Reasons Why Most F-Tags are Cited Part III & Part IV

In this new series, we have discussed that, while it is true that each F-tag has content specific requirements and/or implementation nuances, the underlying reasons why facilities receive survey deficiencies actually transcend F-tag boundaries. It doesn't matter which F-tag is involved, i.e. F323 Falls, F314 Pressure Sores, F315 Continence Management, F309 Pain, F325 Weight Loss, F-ETC... *The reason your facility got an F323 deficiency may be the same reason your facility received an F324 tag!* This series continues to explore the **7 reasons** why most F-tags are cited AND the **7 corresponding solutions** to prevent survey deficiencies.

### **Reason #3: The Care Plan... Monitoring & Modification:**

The Care Plan is the core document that determines and directs the care, treatment, and services provided to the resident. Interventions are developed and implemented to prevent and/or minimize the impact of the resident's potential or actual risk factors. Typical 'guidance to surveyor' language regarding review and revision of the care plan appearing in the investigative protocol section of the various guidance identifies the following benchmarks:

- Resident condition and effectiveness of interventions have been monitored; care plan revisions made based upon:
  - Outcome/effects of goals and interventions.
  - Decline or lack of improvement.
  - Complications associated with the respective intervention.
  - Resident failure to comply with programming; level of participation, response.
  - Change in condition, cognition, etc.
  - Resident input.

In a nutshell, if a resident is at risk for a negative outcome, have the care plan interventions been successful in preventing the risk from being actualized? If the resident has experienced a negative outcome, has the facility evaluated the contributing factors and revised the care plan interventions accordingly?

Survey deficiencies related to the Care Plan specifically in the area of monitoring and modification of interventions, *regardless of the F-tag involved*, typically include reference to the following:

- The facility knew that an intervention wasn't effective but did not modify the intervention timely to prevent a negative outcome.

- Staff knows that the resident repeatedly removes the personal alarm and stands up from the wheelchair; staff repeatedly replaces the personal alarm; no change in fall prevention strategy until resident falls and sustains injury.
- Staff knows that the resident refuses the 2PM nutritional supplement every day; no change in weight-gain interventions; resident continues gradual weight loss trend until next quarterly care plan review.
- Resident refuses to lie down in bed or recliner periodically throughout the day to provide pressure relief to coccyx. No change in pressure sore prevention strategy; resident develops Stage II pressure sore.
- The facility did not modify an intervention following a negative outcome.
  - Resident continues attempts to self-transfer from bed after sustaining deep laceration to forehead from previous fall; facility believes they had implemented everything they can to prevent falls; no additional changes to the fall prevention interventions.
  - Resident with significant weight loss; already receiving nutritional supplements, etc.; facility believes they have already implemented everything to prevent further weight loss; no additional changes to the weight gain interventions.
  - Resident develops Stage II to coccyx; Care Plan updated to reflect treatments in progress; no changes to the pressure sore prevention interventions.

#### Solutions:

All staff need to be educated to the fact that care plan intervention monitoring and modification is a 365-day a year process. Staff need to be aware of what 'ineffective' means, i.e. if a resident can remove a personal alarm and stand up, then the alarm or its placement is ineffective in preventing a fall; if the resident is not consuming a supplement then it is not currently effective in reversing the weight loss trend, etc. Next, staff need to be made aware of the necessity/their responsibility to communicate their observations of intervention ineffectiveness right away! Care plan intervention changes are not reserved for quarterly care plan review day only. If an intervention is not effective or the resident is refusing the intervention, the intervention needs to be changed promptly... hopefully before the resident experiences a negative outcome or more negative affects. When a resident experiences a negative outcome, an investigation into the causal and/or contributing factors is essential including:

- A documented re-assessment of the resident's respective risk factors.
  - Example: after a fall incident, re-do the resident's fall risk assessment to identify potential/actual change in risk factors.
  - Example: after an occurrence of skin breakdown, re-do the resident's skin risk assessment to identify potential/actual change in risk factors.
- Review the existing care plan interventions:
  - Were existing care plan interventions consistently implemented? If not, why not?
    - Is it a question of staff performance?
    - Is it a question of resident non-compliance and/or preference?
  - In light of the risk reassessment, what additions/modifications are indicated?

Based upon the outcome of the above review process, related actions need to be taken, i.e. staff re-education, increased staff supervision to ensure consistent implementation of care plan interventions, implementation of new or additional interventions... and ongoing monitoring of effectiveness with prompt modification if/when needed.

## **Part IV**

In this new series, we have discussed that, while it is true that each F-tag has content specific requirements and/or implementation nuances, the underlying reasons why facilities receive survey deficiencies actually transcend F-tag boundaries. It doesn't matter which F-tag is involved, i.e. F323 Falls, F314 Pressure Sores, F315 Continence Management, F309 Pain, F325

Weight Loss, F-ETC... *The reason your facility got an F323 deficiency may be the same reason your facility received an F324 tag!* This series continues to explore the **7 reasons** why most F-tags are cited AND the **7 corresponding solutions** to prevent survey deficiencies.

#### **Reason #4: Actual Practice**

‘Actual Practice’ in the context of this article refers to what surveyors actually observe staff doing/doing incorrectly or not doing. The surveyor compares these observations to the resident’s care plan, the physician order sheets, facility policies, and/or current practice standards. Examples are many: care plan refers to TED hose during the day/TED hose not on; nurse uses incorrect technique when administering medications through a G-tube; care plan indicates resident to have bed alarm/alarm not turned on; resident with swallow precautions including supervision at all meals/observed eating alone in room; staff observed to enter room of resident on Contact Precautions, touching environmental surfaces without gloves; care plan indicates resident requires 2 assist with transfer/CNA observed transferring resident alone; resident to have heel protectors on at all times when in bed/heel protectors not on or not positioned correctly; residents not repositioned at designated intervals; ETC ETC ETC...

Are some of you going “Well, Duh!” right about now?

Then ask yourself “How likely is it that *the one and only time* the staff member did it incorrectly or didn’t do it at all was when the surveyor happened to observe it?”

It is certainly unlikely that all the actual practice deficiencies cited every day are caused by staff’s ‘survey jitters.’ What is more likely is that issues, like the ones in the example above, occur every day and all too easily become ‘routine practice.’

#### **Solutions:**

- Make sure that staff know what they are supposed to do and how they are supposed to do it.
  - Does the facility make it easy for CNAs to know the way care is supposed to be provided to a specific resident? Is there a written document always readily available (and always accurate!) that the CNA can refer to during the shift?
  - Does the facility ensure that skills are verified and skill deficits are identified during orientation?
  - Does the facility routinely verify ongoing skills competence at least annually?
- Make sure that staff with accountability for the performance of others (not limited necessarily to those with ‘supervisor’ in their job title) know that they are accountable for the performance of others; are supervisors supervising?
  - In order to be effective and impactful, **Supervision** must be immediate, individualized, constant and ongoing. Supervision is oriented in real time and is generally multi-layered within a department or a facility. *Walking by an actual practice issue without addressing the problem will reinforce the practice.* It may not be feasible for the supervisor/department head/administrator to fully address the issue at the time, but pointing it out and then setting a later time to complete the discussion is advisable.
    - Does the unit nurse walk by a resident without addressing the absence of TED Hose? Does the unit nurse check the bed alarm when in the

- resident's room administering medications? Does the nurse bring these issues to the respective CNA's attention?
- Does the supervisor immediately intervene when the CNA is working in a Contact Precautions room without gloves – and then share the observation with the nurse to ensure better on-unit supervision in the future?
  - Does the Administrator mention to the DON that the residents in the Dining Room haven't been repositioned since breakfast – and now it's almost lunchtime?
- Quality Assurance monitoring, on the other hand, may be retrospective and/or conducted to identify aggregate trends and patterns, not individual staff's performance. There are several types of QA audits that can impact actual practice issues:
    - Verification Audits:
      - Represent a snapshot in time.
      - Determines whether care or a service was delivered by observing for evidence of the care or service.
      - Example: The resident has heel protectors on at the time of the Verification Audit observation. We don't know if the heel protectors were put on as soon as the resident was put in bed but they are on now.
      - Verification Audits can serve as a 'screening' audit. If problems are identified through the Verification Audit process, then you know you have issues that need to be evaluated further. Good results on the Verification Audit don't guarantee that care was timely or performed correctly but it can help the facility prioritize which actual care areas need attention first.
    - Process of Care Audits:
      - Require direct observation of the care being delivered.
      - Answers the questions 'Is it happening? Is it happening timely? Is it happening correctly?'
      - Similar to what surveyors do when conducting their observations during the survey.

We need to nip 'routine practice' problems in the bud with effective supervision and monitoring in order to reduce the potential for and incidence of 'actual practice' deficiencies.

*Next Time: Reason #5... Nursing Documentation*

#### **About the Author:**

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*For questions about the contents of this newsletter, contact Jacque Thornton, at the Aging Services of Georgia office at 404-872-9191.*

