Issue 3 * Volume V * Q3 2018

Solutions for Risk Management

Issues directly or indirectly affecting the senior living industry can change overnight. *Solutions for Risk Management* provides the latest news, updates, trends and risk management tips.

RMS RISK MANAGEMENT SOLUTIONS

Are You and Your Residents Being Tripped Up by Falls?

Resident falls remains one of the most frequent challenges confronting the senior living industry. The Agency for Healthcare Research and Quality (AHRQ) has stated that three out of every four nursing center residents fall each year, and the average resident has two to three falls per year. Most nursing centers have more than 100 falls per year.

In addition to posing a significant risk to resident safety, facilities are also at increased risk for negative regulatory outcomes. F689 (Free of Accident Hazards/Supervision/Devices) is now the second most-commonly cited F-tag in the long-term care survey process. In addition to being frequently cited, F689 often comes with a high severity level. F689 ranks as the number one cited tag with a severity level of J, K, or L (immediate jeopardy) and as the second most-cited F-tag with a severity level of F or above, according to the July data available in QCOR, the Quality, Certification, and Oversight Reports site of the Centers for Medicare & Medicaid Services.

The problem of falls in nursing facilities is multifaceted and can be difficult to resolve. In order to effectively manage residents, individual fall risk it is necessary to understand existing risk factors that contributes to the high number of falls in elderly adults. Numerous potential contributing factors are related to falls including, but not limited to, gait and balance disturbances, neurological disorders, musculoskeletal disorders, psychoactive medication use, cognitive impairment and hearing and/or visual impairment. Environmental risk factors also play a significant role in a resident's risk for falls, including inaccessible call buttons, inadequate lighting, and uneven, wet, or slippery floors. Lack of space leads to overcrowded rooms which can be difficult to navigate. Malfunctioning equipment or incorrect use of equipment may also contribute to falls.

The cause of falls can be related to intrinsic, extrinsic or systemic factors. Intrinsic factors are resident-related conditions, i.e., acute infection, pain, orthostatic hypotension, sleep pattern disturbances, a desire to move, hunger or behaviors. Extrinsic factors are related to the resident's physical environment, i.e., wet floors, crowded environment, poor seating, excessive noise, or poor lighting. Systemic factors are those concerns that may affect a larger percentage of residents and include things like staffing-related concerns (i.e., insufficient staff, inconsistent staff assignments), employee breaks (i.e., staff taking lunch or breaks at the same time), or resident boredom (i.e., lack of activities).

The facility should evaluate current practice to ensure a proactive team approach exists for falls management in order to promote a safe environment of care.

1) Resident Assessment and Reassessment
    a. Risk assessment tool of choice: standardized and empirically tested
    b. Pre-admission screening
    c. Review of intrinsic risk factors
    d. Review of extrinsic risk factors

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e. Pre-fall assessment: admission and re-admission
f. Post-fall assessment
g. Quarterly
h. Significant change in condition

2) Interventions
   a. Pre-fall assessment interventions
      i. Pre-admission screening for fall risk
      ii. Daily admission team review: during the daily clinical team meeting
      iii. Changes in the medication regimen, mental (emotional) status, or physical status
   b. Post-fall interventions
      i. Immediate medical needs management
      ii. Post-fall medical needs management
         1. Comprehensive physical assessment performed by a licensed nurse every shift for 72-hours, to include vital signs, blood glucose testing, if hypoglycemia is suspected, neurological assessment for 72-hours post-fall
            i) When the resident is not a reliable historian, unobserved falls should be treated as head injuries
            ii) It is recommended that neurological assessments be completed for seven days post-fall for residents receiving anticoagulant therapy
         2. Documentation of fall
      iii. Immediate keep-safe plan until new interventions are in place
      iv. New intervention
   c. Intervention list available for reference
   d. Availability and access to equipment and supplies
      i. New technology
      ii. 24-hour availability to equipment and supplies
   e. 24-hour management support
   f. Root cause analysis

3) Plan of Care Development
   a. Immediate and comprehensive care plan development
   b. Interdisciplinary team participation
   c. Health care provider input
   d. Family input
   e. As appropriate, non-compliance/resident choice plan of care
4) Notification and Communication
   a. Staff: Daily clinical meeting, 24-hour report, verbal report, nurse aide care plans communication system, visual cues, and documentation in medical record of family and/or resident education
   b. Resident, family, and health care provider: Resident, if competent; family and health care provider notification within 12 hours (depending on extent of injury, if any), to include notification of immediate or new interventions; and documentation in the medical record.
5) Education: During orientation and at periodic intervals, to include facility-specific program or protocol
6) Equipment Management
   a. Monthly inspections of resident transfer, movement, and lift equipment, i.e., mechanical lifts, van lifts, wheelchairs, geriatric chairs, shower chairs or gurneys, bed locks, and side rails
   b. Laundering and care of lift pads
   c. Documented routine battery changes in accordance with the manufacturer's recommendations for alarms and motion detectors
   d. Documented sensor pad replacement in accordance with the manufacturer's recommendations
7) Review and Follow-Up
   a. Daily during clinical team meeting, or
   b. Weekly (Falls Committee structure)
   c. Monthly Incident and Accident Tracking and Analysis
   d. Monthly (Quality Assurance/Performance Improvement Committee structure), or
   e. Quarterly Quality Assurance Committee review

Medication and Drug Regimen Review

In 2009, the Institute for Safe Medication Practices analyzed over 116,000 serious, disabling, and fatal adverse drug events reported to the FDA. The prevalence of potential and actual medication adverse consequences and errors are significant in health care settings and most often occur during transitions in care. These consequences affect the resident's health, safety and quality of life. As health care providers, we must due diligence for our residents to minimize the occurrence of adverse drug events. One important way is to ensure systems are in place for drug regimen review.

The Resident Assessment Instrument User's Manual has been updated to Version 1.16 and will begin implementation on October 1, 2018. We now have the intent, rationale, steps for assessment, coding instructions, and tips for new questions in Section N – Medications.

The intention of a drug regimen review is to improve resident safety by identifying and addressing potential and actual clinically significant medication issues at the time of a resident's admission (start of SNF PPS stay) and throughout the resident's stay (through Part A PPS discharge).

The intent of the drug regimen review items (N2001, N2003 and N2005) is to document whether a drug regimen review was conducted upon the resident's admission (start of SNF PPS stay), throughout the resident's stay (through Part A PPS discharge), and whether any clinically significant issues were addressed in a timely manner.

The MDS manual indicates that a drug regimen review includes medication reconciliation, review of all medications the resident is currently using, review of the drug regimen to identify, and, if possible, prevent potential clinically significant medication adverse consequences.

Key Steps in the Assessment Process:

1. Complete DRR upon admission, or as close to admission as possible, to identify any potential or actual clinically significant medication issue(s).
2. DRR to include review and comparison of acute care hospital setting discharge medication orders with physician admission medication orders, collaboration with pharmacist, and interview with the resident or resident's representative.
3. If a potential or actual clinically significant medication issue is identified, communicate with the physician and implement all physician-prescribed or recommended actions by midnight of the next calendar day.

Important to Note:

1. The drug regimen review includes all prescribed medications, over-the-counter medications, nutritional supplements, and vitamins, as well as homeopathic and herbal products, administered by any route. It also includes total parental nutrition and oxygen.
2. A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician communication.
3. "Clinically significant" means effects, results, or consequences that materially affect, or are likely to affect, an individual's mental, physical, or psychosocial well-being, either positively, by preventing a condition or reducing a risk, or negatively, by exacerbating, causing, or contributing to a symptom, illness, or decline in status. Examples of clinically significant issues include, but are not limited to the following:
   a. Medication prescribed despite allergy or prior adverse reaction
   b. Excessive or inadequate dose
   c. Drug interaction
   d. Duplicate therapy
   e. Use of medication without evidence of adequate indications for us
   f. Presence of a medical condition that may warrant medication therapy

Recommendations:

- Ensure that nursing staff are clinically competent in standards of medication administration practices.
- Educate the nursing staff about medication indications and monitoring of adverse effects.
- Implement a system to ensure each resident's medication usage is evaluated upon admission and routinely thereafter.
- Educate the nursing staff on the significance of reporting clinically significant medication issues in a timely manner.

New Patient Driven Payment Model Coming Next Year

In twelve months, skilled nursing facilities are going to have to make another transition. Beginning October 1, 2019, the Patient Driven Payment Model will be replacing the RUG-IV payment system.

In August 2018, CMS finalized plans to move from the Prospective Payment System to a patient characteristics-based payment system, known as Patient-Driven Payment Model (PDPM). This represents the most significant change in Medicare reimbursement methodology in over 20 years. Therefore, providers need to begin preparations now if they want to be successful under the new system.

The PDPM is designed to eliminate payments according to services delivered and focuses payment on resident classifications and anticipated resources needed during the course of the residents stay. The primary goal is providing resident-centered care that treats the needs of the whole person instead of incentivizing delivery of an ultra-high volume of services.

The Case-Mix components are moving from Nursing and Therapy case mix in RUG-IV to PDPM components of Nursing, Non-Therapy Ancillary, Physical Therapy, Occupational Therapy and Speech Therapy. PDPM will establish a rate on the five-day MDS for the entire stay by combining five different case-mix components with the non-case-mix component. The rate could change by completing an Interim Payment Assessment (IPA) for substantial changes

CMS contends that the calibration of the new model will be budget neutral across all providers while individual facilities project possible dramatic changes in their annual Medicare revenue as a result of this new system.

Preparations:

- Communicate with hospitals regarding the ability to provide clinically complex care and specialized services to residents.
- Negotiate with therapy providers regarding the changes in reimbursement. Therapy providers will need to carefully manage how they deliver services in order to provide just the right level of care for each resident and achieve the desired functional outcome.
- Ensure facility staff are educated and competent in the clinical conditions being accepted.

Key points of PDPM:

- It will classify residents into one of ten primary classifications used as a component in calculating case-mix indexed component. These rates are combined with a non-indexed component to derive the daily rate.
- The therapy minutes delivered will have no impact on reimbursement.
- There could be a reduction in the number of assessments completed since PDPM requires one scheduled assessment (five day) and two unscheduled (PPS Discharge and Interim Payment Assessment).

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