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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.

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Why QAPI?

According to the Center for Medicare and Medicaid, QAPI is the "*Coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving.*"

Federal regulation 42 CFR, Part 483.75(o) describes the change as follows:

- QA is the specification of standards for quality of service and outcomes, and a process throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going, both anticipatory and retrospective, in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.

- PI (also called Quality Improvement - QI) is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

As a result, QAPI amounts to much more than a provision in federal statute or regulation; it represents an ongoing, organized method of doing business to achieve optimum results, involving all levels of an organization. The QA & A and PI processes are blended together by written and implemented policies and procedures that include systems for data collection, and monitoring for high risk, high volume, and problem-prone issues, which include adverse events. This change has made it essential that facilities systematically identify, report as appropriate, track, and investigate data and information related to adverse events with the aim of developing and implementing plans to prevent adverse events and ensure resident safety. Bottom line, it is the right care for every resident, every time.

We are all aware that healthcare is an ever-changing environment. But, it seems that the pace of change has components of urgency that is greater than in the past. This urgency is likely based on the rising cost and demand for healthcare now that the baby boomers have begun reaching Medicare age. The primary focus of the change is on improving the value delivered to residents and measuring this value in terms of resident outcomes that are achieved per dollar spent. This is a significant change for healthcare, including care being delivered in long-term care. One of our greatest challenges is not only to anticipate the future risks, but also to provide solutions around managing uncertainty. Leaders who embrace the changes and find solutions are likely to help their organizations not only thrive but gain, which is "Why QAPI."

Resources: Federal Register, CMS

Nursing Shortage Solutions in Long Term Care

A "long-standing" shortage of registered nurses in the U.S. is "expected to worsen" over the next seven years, according to recent reports. The U.S. Bureau of Labor Statistics stated that about 233,000 additional jobs for registered nurses opened each year through 2016, in addition to about 2.5 million existing positions. However, only about 200,000 candidates passed the registered nurse licensing exam last year, and thousands of nurses leave the profession each year.

Research explains that several factors contribute to the shortage, including a lack of qualified instructors, decreased funding for training programs, and difficult working conditions. In addition, some nursing positions—such as those in emergency departments or intensive care units and rehabilitation units in skilled nursing centers—require experience and expertise, preventing hospitals and nursing homes from hiring "newly minted" nurses for the positions.

According to industry experts, the nursing shortage has operated on an eight to ten year cycle since World War II. As the shortage reaches a critical level, the government has added funds, and hospitals and nursing homes have upgraded working conditions. However, as the shortage is alleviated, retention efforts are relaxed and working conditions become more difficult, often driving nurses into other less stressful professions.

The first solution is to create workplace environments so attractive to nurses that those who work there will not want to leave, and those who do not work there will want to join the staff. Recent research has provided some clues. One can start with research on Magnet hospitals in the early 2000s. The majority of nurses working in Magnet hospitals identified the following eight essential factors that attracted them to and retained them in the organization:

- Working with nurses who are clinically competent
- Good nurse-physician relationships and communication
- Nurse autonomy and accountability
- Supportive nurse manager or supervisor
- Control over nursing practice and practice environment
- Support during orientation and continuing education
- Adequate nurse and direct care staffing ratios to match resident acuity and behavior
- Concern for the resident is paramount

Dynamic, well-educated long-term care nurse leaders and managers can provide the vision and leadership to create practice environments that lead to Magnet long-term care facilities. All nurses in long-term care facilities should become familiar with the American Nurses Credentialing Center Magnet Nursing Recognition Program and use the Scope and Standards for Nurse Administrators (American Nurses Association, 1996) as a strategic plan to create a "magnet" workplace environment.

The second solution is to use the scarce nursing resources available in long-term care facilities effectively and efficiently. The statistics on the nursing workplace shortage indicate this is a long-term problem. This precious resource cannot be squandered through inefficiencies and inappropriate use of nursing staff.

Registered Nurses. The first area to examine is the role of the registered nurse. Registered nurses are accountable for the assessment, planning, implementation, and evaluation of nursing care for residents. Yet, safely fulfilling this essential responsibility is a challenge for most RNs in nursing facilities. Differentiating the roles and responsibilities of RNs and LP/VNs in nursing facilities is a good place to start. These roles are not interchangeable, but complementary.

Technology. The use of technology aids in minimizing wasted time spent on paperwork, data management, obtaining supplies, moving residents, locating staff for assistance, and communicating with others. This helps to focus the nurses' time on taking care of residents. Time is a valuable commodity and taking advantage of technological systems will provide immediate positive results for nursing facilities.

Continuity of Care. Organizing how nursing staff provide continuity of care for residents is a key component for effective use of staff. Continuity of care can be achieved when adequate and relevant information about the resident is available, used, and transferred among individuals involved in the care of residents (information continuity). It can also be achieved when there is a consistent nurse/STNA (CAN) coordinating and providing care to the resident (care provider continuity).

Nursing Staff. Finally, effective and efficient use of nursing staff requires active involvement of nursing staff in making decisions about their work and resident care. Staff involvement in decision-making was reported among the most significant variables in explaining job satisfaction and productivity in Magnet hospitals (Scott & Aiken, 1999). Autonomy in nursing practice was an important aspect of job satisfaction for nurses employed in long-term care facilities.

References: Journal of Gerontological Nursing and Advanced Healthcare Network

The Pros and Cons of Advanced Directive

The law has long been clear that an adult who is able to give informed consent to medical treatment—who understands her or his condition, treatment options, intended effects, and possible side effect of these choices—has the sole right and authority to make those decisions. Residency in a nursing home does not affect this right. In fact, nursing home staff have the responsibility to provide to residents with education about advance directives which must include: 1) written information about the individual's rights under state law to make decisions about their medical care, including the right to accept or refuse medical or surgical treatment and the right to make advance directives; and 2) the healthcare provider must have written policies respecting the implementation of these rights.

The healthcare provider's written policies and procedures must include the following requirements:

- to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;
- not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
- to comply with state law respecting advance directives; and
- to provide (individually or with others) education for both staff and the community covering issues about advance directives.

An advanced directive (also called a living will) is a legal document that gives instructions to physicians. It takes effect when it has been medically determined that an individual is either physically or mentally incapacitated beyond the ability to express his or her wishes in terms of medical treatment. Typically, it is utilized when an individual is in a vegetative state and needs life support to be kept alive. An advanced medical directive lets health care providers know the sort of treatments and medications the individual has approved. A living will tells which treatment is desired when life is threatened, including dialysis, breathing machines, resuscitation (if you breathing or the heart stops), tube feeding, organ or tissue donation after death, refusal of over-sedation, or toleration of some discomfort in order to be able to maintain awareness and/or retain some contact with family and friends.

The most important benefit of an advanced directive is to allow a person to express choices and wishes to healthcare providers. This strongly asserts the person's choice into what treatments or procedures will be used in an emergency and end of life experience. It provides peace of mind by answering the matter of whether or not life support should be used. An advanced directive by the individual reduces the responsibility and often guilt of loved ones who are otherwise asked to make the decision. An advanced directive is much more than CPR, a subpart of the directive.

Another benefit of an advanced directive is to prevent any unnecessary delay in administering medical treatments that require consent. Without an explicit statement, precious time could be lost in determining who has the legal authority to act on behalf of a critical patient. Medical options might be lost with the passage of mere minutes.

Making informed decisions on a living will/advanced directive requires some research into exactly what sort of medications and treatments should be administered in an emergency or if any action should be taken other than comfort. Thus, one of the collateral benefits of preparing an advanced directive is that it gets people thinking about their opinion on life support and can get them talking to their doctors about exactly what specific procedures entail.

The major drawback to an advanced directive is that it is a piece of paper. A doctor might not know of its existence or it might not be produced in time to be of much use. Also, it can possibly not be honored if it is from another state, if the family insists on treatment despite what the directive says, or the resident finds the communication uncomfortable. In the nursing home setting, the nurse may send the resident to an ER for treatment during a serious condition change without looking at the advanced direction information before contacting the proxy. This is why the individual with an advanced directive should also name a healthcare proxy to communicate the validity of the directive after speaking privately with the resident.

However, according to MDS outcome documentation by CMS, almost one-third of residents in nursing homes have not completed an advanced directive or named a proxy. As a result, much more work needs to be done. The facility's Quality Assessment and Assurance Committee may want to form a performance improvement team with a benchmark goal to improve this outcome of following resident self-determination.

References: CMS.gov, Ohio Bar, State of New Jersey Department of Health, Ohio Department of Health

Emergency Action Plans and Fire Response

Nobody expects an emergency – yet the simple truth is emergencies and disasters can strike any business, anytime, anywhere. Few people can think clearly and logically in a crisis, so it is important to plan in advance and conduct practice drills.

What is an Emergency Action Plan?

An emergency action plan covers the designated actions employers and employees must take to ensure personnel safety from fires and other emergencies. Emphasis is placed on the protection of lives and property, in that order. Typically, the issue of how to respond to a fire is a primary component of an emergency action plan in most facilities.

What is covered in an Emergency Action Plan?

- Preferred method of reporting fires and other emergencies
- Evacuation policies and procedures
- Diagrams of the floor plan showing escape routes, extinguishers, assembly, and shelter areas
- Description of the various alarm systems or specific equipment shut-down procedures (if applicable.)

Fire Protection

When a fire starts, think first of your safety, then the safety of others around you. Sound the alarm and alert the fire department. Never attempt to use a fire extinguisher unless you have been trained to use it, and the fire is small enough to be tamed with the equipment on hand.

Fire Extinguisher Basics

Extinguishers are classified by the type of fire they can put out. Some extinguishers are combination type; these can be used on several different types of fires. Extinguishers are designed to fight fires in the incipient stages only. All fire extinguishers should have an inspection tag, a trigger seal, and a pin. They should be mounted off the ground, ready for easy access.

If the facility's fire prevention policy provides for use of fire extinguishers, the following guideline should be used:

- Stand six to eight feet away from fire, pull the pin, aim at the base of the fire, squeeze the handle, and sweep side to side
- Never let a fire come between you and a speedy exit
- After use, do not return the extinguisher to its original mounting – it must first be refilled

If you need assistance with developing, enhancing, or updating your facility's emergency action plan, contact an RMS Consultant today!

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