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Hot Survey Topics



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Upon completion of this presentation, attendees should be able to:

1. Identify the top 10 tags most frequently cited
2. Describe steps that the facility leadership can take to review and revise each system
3. Verbalize audit methods leadership can complete for oversight of compliance

1. F-441: Infection Control
2. F-371: Sanitary Conditions
3. F-323: Accidents
4. F-309: Quality of Care
5. F-431: Labeling and Storage of Drugs & Biologicals
6. F-329: Unnecessary Drugs
7. F-279: Comprehensive Care Plans
8. F-241: Dignity
9. F-514: Clinical Records
10. F-282: Care in Accordance with Care Plan

1. F-323: Accidents
2. F-309: Quality of Care
3. F-225: Investigate Allegations of Abuse
4. F-226: Seven Components Abuse Policies
5. F-157: Notification of Changes of Condition
6. F-514: Clinical Records
7. F-441: Infection Control
8. F-279: Comprehensive Care Plans
9. F-314: Pressure Ulcers
10. F-281: Services that Meet Professional Standards
tied with F-312: A resident who is unable to carry out
ADL's receives necessary services



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F-441

Infection (Prevention) and Control

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- No evidence of real-time surveillance
 - Facility failed to keep an updated infection log to trend and map infections
- Facility failed to identify and report outbreak timely
- Disposable wash basin used for more than one resident
- Mouthwash and toothbrushes not labeled in shared bathrooms
- Staff unable to describe resident isolation and no signs present to direct visitors
- Monthly Infection Surveillance Reports incomplete
- Facility failed to monitor the use of antibiotics for residents who do not meet McGeers criteria
- Staff providing cares and not removing gloves and washing hands prior to touching items in room or obtaining clothes in closets/drawers

- Tracking of staff attendance when calling in (actually wanted a log of all call-ins and when they came back to work)
- Proper storage of items in the dietary refrigerators
- Bath towels on the toilet tank in tub room
- Red hazard bag on floor in hall
- Blood Glucose Meters not disinfected between each use. (Following manufacturer's recommendations)
- Catheter drainage bag on floor
- Dressing change technique

- Program Development and Oversight
- Policies and Procedures
- Infection Preventionist
- Surveillance
- Documentation
- Monitoring
- Data Analysis
- Communicable Disease Reporting
- Education
- Antibiotic Review and Stewardship



- **Process Surveillance**

- Compliance with best-practice, policy and procedure
- Early identification and risk assessment

- **Outcome Surveillance**

- Definitions for infections
- Identify and report evidence of infections and outbreaks
- Reporting to state health department as needed

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities

<https://federalregister.gov/d/2016-23503>



The facility must establish an infection prevention and control program (IPCP) that must include, **at a minimum**, the following elements:

- “A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;”

2. Written standards, policies and procedures to include:

- A system of surveillance designed to identify possible communicable diseases or infections before they can spread
- When and Whom possible incidents of communicable disease or infections should be reported



- (Continued) Policies and Procedures
 - Standard and transmission-based precautions
 - Type and duration of isolation
 - The isolation should be least restrictive possible for the resident under the circumstances
 - Circumstances when employees are prohibited to work with a communicable disease or infected skin lesions

(Continued) Policies and Procedures:

- Hand Hygiene for all staff involved in direct resident contact
- Antibiotic Stewardship Program (Phase 2-November, 2017)
 - Protocols
 - Monitoring
- A system for recording incidents identified under the facility's IPCP and corrective action taken

- Infection Preventionist
- Facility must designate one or more individuals responsible for the IPCP (Infection Prevention and Control Program)
 - Must have primary professional training in nursing, Med tech, microbiology, epidemiology or related field
 - Be qualified by education, training, experience or certification
 - Work at least part-time in the facility
 - Have completed specialized training in Infection Prevention and Control

- Infection Preventionist must participate/be a member of the facility's QAA Committee and report on the Infection Prevention and Control Program (IPCP) to the committee on a regular basis
- **Both the Infection Preventionist and the Infection Preventionist participation on QAA are **Phase 3: November, 2019.**

Influenza and pneumococcal immunizations:

- Policies and Procedures
- Prior to offering—must provide education to the resident or resident's representative on benefits and potential side effects
- Influenza: Offer between October 1-March 31 annually unless medically contraindicated or already immunized during time period
- The Resident or resident's representative has the opportunity to refuse

(Influenza Immunization-continued)

- Documentation in the medical record must include:
 - Education provided to resident/representative on benefits & potential side effects
 - Administration of vaccine or if not received, the medical contraindication or refusal



- Pneumococcal Immunization:
 - Each resident is offered a pneumococcal immunization unless medically contraindicated or already immunized The Resident or resident's representative has the opportunity to refuse
- Documentation in the medical record must include:
 - Education provided to resident/representative on benefits & potential side effects
 - Administration of vaccine or if not received, the medical contraindication or refusal

- Other updates to Infection Control
 - Linens: Personnel must handle, store, process and transport linens so as to prevent the spread of infection
 - Annual Review: The facility will conduct an annual review of it's IPCP and update the program as necessary





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CDC

Centers for Disease Control and Prevention

The Core Elements of Antibiotic Stewardship for Nursing Homes

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- **Core Elements for Antibiotic Stewardship**

- Leadership Commitment
- Accountability
- Drug Expertise
- Action
- Tracking
- Reporting
- Education



<http://www.cdc.gov/media/releases/2015/p0915-nursing-home-antibiotics.html>



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AHRQ-Agency for Healthcare Research and Quality Nursing Home Antimicrobial Stewardship Guide

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Nursing Home Antimicrobial Stewardship Guide

- Provides toolkits to help nursing homes optimize the use of antibiotics
 - Start an Antimicrobial Stewardship Program tool kit (guide to establish a new program in a nursing home)
 - The Monitor and Sustain Stewardship Toolkit (guidance and tools for tracking progress toward meeting antimicrobial program goals and provides feedback to prescribing clinicians)

<http://www.ahrq.gov/nhguide/about/index.html>

Nursing Home Antimicrobial Stewardship Guide

- Toolkits to Determine Whether It is Necessary to Treat a Potential Infection With Antibiotics
 - Suspected UTI SBAR toolkit
 - Communicating and Decisionmaking for Four Infections toolkit
 - Minimum Criteria for Common Infections toolkit

<http://www.ahrq.gov/nhguide/about/index.html>

Nursing Home Antimicrobial Stewardship Guide

- Toolkits to Help Prescribing Clinicians Choose the Right Antibiotic for Treating an Infection
 - Working with a Lab to Improve Antibiotic Prescribing Toolkit
 - Concise Antibigram Toolkit
 - Comprehensive Antibigram Toolkit
- <http://www.ahrq.gov/nhguide/about/index.html>

Nursing Home Antimicrobial Stewardship Guide

- Toolkit to Education and Engage Residents and Family Members

“This section contains one toolkit that provides guidance and tools for educating residents and their family members about antibiotics and engaging them in health care decisions

<http://www.ahrq.gov/nhguide/about/index.html>

Orientation and Yearly

- Policies and Procedures
- Hand Hygiene (return demonstration)
- Personal Protective Equipment
- Transmission Based Precautions
- Standard Precautions
- Linen Handling
- Identification of signs/symptoms of infection
- Communicating, Documentation, Reporting
- Staff illness/signs and symptoms
- Infection Criteria



“On-The-Spot”

- When break in procedures/technique or practice is observed either through audit or observation
- When an infection (or infections) are identified and procedures/techniques need to be reinforced
- New information needs to be addressed



- Hand Hygiene Audits
- Food Preparation Audits
- Personal Protective Equipment Audits
- Water Pass Audits
- Med Pass Audits
- Catheter Care Audits
- Peri-Care Audits
- Room Sanitization Audits
- Environmental Audits
- Dining Room Audits
- Linen Handling Audits





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F371- Kitchen Sanitation

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- Staff member entered the kitchen without hairnet
- Dry storage container lid open
- Food items opened with no date when opened
- Kitchen floor not maintained in a sanitary condition
- Thawing of meat improperly
- Drain under the dish machine not clean
- Grout in kitchen floor had build up
- Light cover missing on florescent bulbs in the kitchen
- Not maintaining proper refrigerator temperatures
- Peeling paint on ceiling
- Dishwasher not at appropriate temperature
- Bare handed touching of food items
- Unacceptable food temps
- Stacking wet dishes/pans

Surveyors will be instructed to look for:

- Documentation of internal and external temperature gauges
- Measure the temp of a PHF(Potentially Hazardous Food)/TCS (Time/Temperature Controlled for Safety) food that has a prolonged cooling time
- Check for potential cross-contamination
- Check the firmness of frozen food and inspect the wrapper to determine if it is intact enough to protect the food
- Interview food service personnel

- Food comes from approved sources
 - Final Rule provisions
- Proper sanitation and food handling
- Prevention of foodborne illness
- Food storage and labeling
- Safe food handling (including vendors)



- **A Culture of Safety!**
- Daily observation
 - Train staff for mystery auditor roles
- Food safety rounds
 - Walk around with your staff
- On-going education
- Competency Testing
- Quality improvement
 - Get staff involved
 - Value staff ideas
 - Make this a team sport

- Proper food storage
- Proper food labeling
- Proper food handling
- Hair nets- hair containment
- Hand hygiene and glove use
- Inspection of food from vendors and canned goods
- Sanitation and cleaning
- Food temps and logs
- Maintenance records
- Employee work policies – illness
- Quality improvement techniques
- Culture of safety



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F323 - Prevention of Accidents

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Do You Have a *CULTURE* of Safety?

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- Intent is that the facility provides an environment that is free from hazards over which the facility has control and
- Provides appropriate supervision to each resident to prevent avoidable accidents



This includes systems and processes to:

- **Identify** hazard(s) and risk(s);
- **Evaluate** and analyze hazard(s) and risk(s);
- **Implement** interventions to reduce hazard(s) and risk(s); and
- **Monitor** for effectiveness and modify approaches as indicated.
- Residents receive supervision and assistive devices to prevent avoidable accidents

- No emergency pull cord in resident bathroom
- Facility failed to ensure a floor mat was at the resident's bedside as ordered by MD
- Televisions too large for surface and not secured
- Facility failed to place call lights within reach to prevent recurrent fall and accidents
- Facility failed to develop/update care plan following a resident fall to prevent additional falls/accidents
- Facility staff failed to utilize mechanical lift as indicated on the care plan
- No evidence of fall risk assessment

- Failure to follow manufacture's guidelines for mechanical lifts
- Chemicals left unattended
- Failure to evaluate fall prevention devices
- Residents with falls or accidents without investigation and plan to prevent injury
- Staff not trained on use of resident devices or equipment
- After several falls- no emergency services



- An unexpected or unintentional incident that may result in injury or illness
- Does not include side effects or reactions relates to an adverse effect from a drug or treatment



“Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g. onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Falls are not a result of an overwhelming external force (e.g. a resident pushes another resident).

An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.”

-MDS 3.0 RAI Manual, Pg. J-27

Accident occurred when:

- Environmental hazards had been identified
- Resident risks were identified
- Hazards & risks were assessed
- Interventions were implemented to decrease hazards and risk
- Effectiveness of interventions were being monitored and modified as needed

Accident occurred related to **failure** to:

- Identify environmental hazard
- Identify individual resident risk factors
- Evaluate/analyze hazards & risks
- Implement interventions to reduce an accident
- Monitor and modify interventions as needed

-

- Hazards
 - Electrical cords
 - Beds by heat registers
 - Carpet condition
 - Handrails secure
 - Sharp edges on furniture
 - Chemicals secured
 - Sharps secured
 - Equipment working properly



- Updated Policies and Procedures for Accident Prevention
- Staff Education (examples)
 - Policies and Procedures
 - Culture of Safety, Prevention, Quality
 - Assessment Process
 - Hazard Identification
 - Equipment Use (Including updated Bed Rail information)
 - Consistent Implementation of Care Plan Interventions
 - Safe Lifting and Transfers
 - Investigation and Root Cause Analysis
 - Communication



Root Cause Analysis:

- **Does your staff understand how to immediately begin a RCA investigation with resultant pertinent interventions?**





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F309 - Quality of Care

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- “Facility ...must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.” CMS, 2015
- Key to compliance
 - Best practice, following standards
 - Evidence-Based and Person Centered
 - All around the best interdisciplinary care
 - Follow care plan, policy and procedures and all medical orders

- **Quality gauge for F309**
 - “The resident obtains improvement or does not deteriorate within the limits of a resident’s right to refuse treatment, and within the limits of recognized pathology and the normal aging process.”



- Care of a resident with dementia
- End of Life
- Diabetes
- Renal disease
- Fractures
- Congestive heart failure
- Non-pressure related skin ulcers
- Pain
- Fecal Impaction



- Failure to follow a MD order for medications, splints/devices, etc
- Failed to complete a preadmission assessment for resident with dementia to ensure appropriate plan for transition of care
- Facility failed to initiate CPR until EMS arrived
- Facility failed to document assessment of access site for dialysis resident
- Lack of documentation of pain management effectiveness
- Failed to obtain adequate communication post dialysis
- Resident with change of condition did not receive services to prevent dehydration

1. Definitions and overview
2. Therapeutic Interventions or Approaches
3. Medication Use
4. Resident and/or Family Involvement
5. Care Process
6. Staffing and Staff Training
7. Medical Team Involvement
8. Monitoring and Follow Up
9. Quality Assessment and Assurance

- Assessment and Management of Care at End of Life
- Advance Care Planning
- Collaboration with Hospice with Care Planning



- Screening to determine if the resident has been or is experiencing pain;
- Comprehensively assessing the pain;
- Identifying circumstances when pain can be anticipated; and



- Developing and implementing a plan, using pharmacologic and/or non-pharmacologic interventions to manage the pain and/or try to prevent the pain consistent with the resident's goals
- Monitor and evaluate outcomes





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F431- Labeling and Storage of Drugs and Biologicals

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- Drugs and Biologicals should be:
 - Labeled, including the expiration date
 - Stored in a locked compartment at the correct temperature
- Controlled drugs must have:
 - Licensed pharmacist oversight of system
 - Separately locked compartment (unless in single unit packaging distribution system)



- Who has access to your medication system (you may be surprised)
- Is there a double check system to ensure labels and expiration dates?
- Controlled drug system – where are the possible weaknesses
- Follow the paper trail for controlled substances





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F329 - Unnecessary Drugs

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- An unnecessary Drug is a drug that is used:
 - In excessive dose (including duplicate therapy)
 - For excessive duration
 - Without adequate monitoring
 - Without adequate indications for its use
 - In the presence of adverse consequences which indicate the dose should be reduced or discontinued

- Lack of documentation to show evidence that medication is given:
 - At proper dose (i.e. excessive doses of Acetaminophen)
 - Proper duration
 - With adequate monitoring
 - Indication for use is clearly documented
 - With no identification of adverse consequences
- No evidence of non-pharmacological interventions prior to and in conjunction with medication use
- Gradual Dose Reductions not attempted
- Plan of care did not mention types of behavior or specific monitoring interventions
- Lack of documentation of behaviors with antipsychotic use

- Staff education on medications
- Monitoring of newly prescribed medications
- Documentation
 - Non-pharmacological alternatives used
 - Medical indication for use
 - Adverse reactions and response
 - Tapering or discontinuing
 - Periodic review



- Monitoring
- Effectiveness
- Adverse Consequences
- Documentation





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F279 - Comprehensive Care Plans

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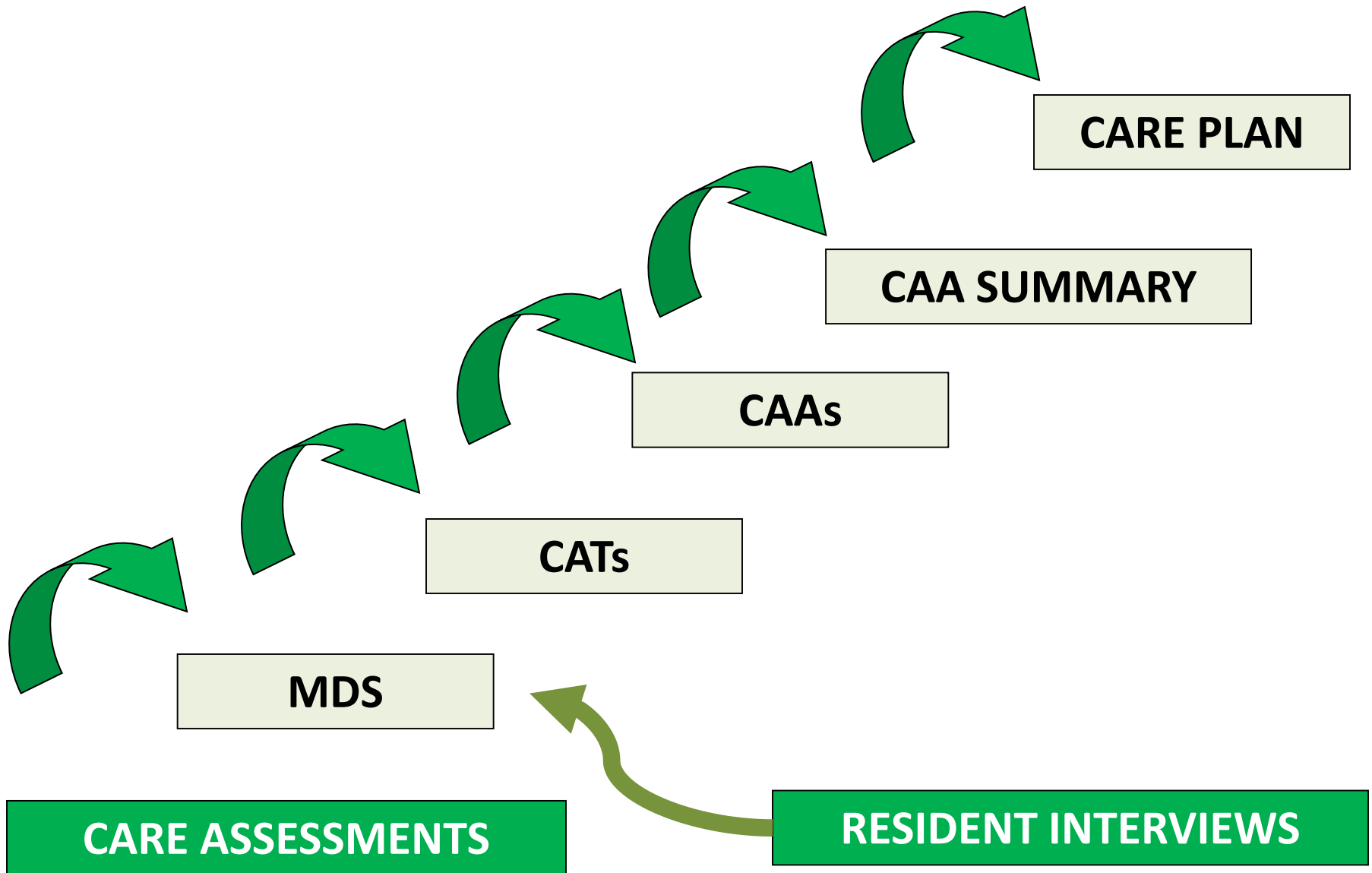
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- The facility must develop and implement a comprehensive, person-centered Care Plan for each resident that is consistent with the resident rights:
 - Measureable objectives and time frames
 - Addresses services to maintain resident's highest level of functioning
 - Services required but not provided due to resident right to refuse
 - Specialized services or specialized rehabilitative services as a result of PASARR recommendations
 - Residents goals for admission, preferences and potential for discharge and discharge plans

RAI PROCESS

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F-241 Dignity

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“A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident’s individuality. The facility must protect and promote the rights of the resident”

- Grooming
- Clothing
- Activities of choice



- Nurse calling a resident “Honey”
- C.N.A. telling a resident it’s time to change their diaper
- Not shaving female facial hair
- All residents wearing “bibs” rather than using napkins for those residents appropriate
- C.N.A. wheeling resident from tub room with bath blanket not covering – exposing resident in hallway



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F514 - Medical Records

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- “In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are”:
 - Complete
 - Accurately documented
 - Readily accessible
 - Systematically organized



- Need to be able to provide records that show:
 - Sufficient information for resident identification
 - Resident assessments
 - The comprehensive care plan
 - Services provided
 - Preadmission screening and resident review evaluations and determinations conducted by the State
 - Progress notes (Physician, nurses, other licensed professionals progress notes)
 - Lab, radiology and other diagnostic reports



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F282: Services Provided By Qualified Persons in Accordance with Plan of Care

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- “If you find problems with quality of care, quality of life, or resident rights, are these problems attributable to the qualifications of the facility staff, or lack of, inadequate or incorrect implementation of the care plan?” CMS State Operations Manual
 - Do your colleagues:
 - Know the plan of care?
 - Know what outcomes are expected?
 - Know what treatments other therapists are providing?





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F-225 and F-226 Abuse

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- Prevention
 - Do not hire people found guilty of abuse, mistreatment or misappropriation
- Response
 - All employees responsible to report suspected abuse, mistreatment, neglect, misappropriation and injuries of unknown origin

- Review Policy and Procedure to ensure all 7 steps are present:
 - Screening
 - Training
 - Prevention
 - Identification
 - Investigation
 - Protection
 - Reporting and Responding



- Discuss stressors that can lead to abuse.
 - Culture of safety
 - Address stressors before abuse takes place
 - Open conversations about frustrations and how to obtain support
 - Time out: peer support





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What is Your Next Step?

Tools for Compliance

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CDC Resource: Infection Control Assessment Tool for Long-term Care Facilities

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<https://www.cdc.gov/infectioncontrol/pdf/ICAR/LTCF.pdf>

Infection Control Assessment Tool for Long-term Care Facilities

This tool is intended to assist in the assessment of infection control programs and practices in nursing homes and other long-term care facilities. If feasible, direct observations of infection control practices are encouraged. To facilitate the assessment, health departments are encouraged to share this tool with facilities in advance of their visit.

Overview

Section 1: Facility Demographics

Section 2: Infection Control Program and Infrastructure

Section 3: Direct Observation of Facility Practices (optional)

Section 4: Infection Control Guidelines and Other Resources

Infection Control Domains for Gap Assessment

- I. Infection Control Program and Infrastructure
- II. Healthcare Personnel and Resident Safety
- III. Surveillance and Disease Reporting
- IV. Hand Hygiene
- V. Personal Protective Equipment (PPE)
- VI. Respiratory/ Cough Etiquette
- VII. Antibiotic Stewardship
- VIII. Injection safety and Point of Care Testing
- IX. Environmental Cleaning

Section 1: Facility Demographics	
Facility Name (for health department use only)	
NHSN Facility Organization ID (for health department use only)	
State-assigned Unique ID	
Date of Assessment	
Type of Assessment	<input type="checkbox"/> On-site <input type="checkbox"/> Other (specify):
Rationale for Assessment (Select all that apply)	<input type="checkbox"/> Outbreak <input type="checkbox"/> Input from accrediting organization or state survey agency <input type="checkbox"/> NHSN data (if available) <input type="checkbox"/> Collaborative (specify partner(s):) <input type="checkbox"/> Other (specify):
Is the facility licensed by the state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the facility certified by the Centers for Medicare & Medicaid Services (CMS)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Facility type	<input type="checkbox"/> Nursing home <input type="checkbox"/> Intermediate care facility <input type="checkbox"/> Assisted living facility <input type="checkbox"/> Other (specify):
Number of licensed beds	
Total staff hours per week dedicated to infection prevention and control activities	
Is the facility affiliated with a hospital?	<input type="checkbox"/> Yes (specify – for health department use only): <input type="checkbox"/> No

Section 2: Infection Control Program and Infrastructure

I. Infection Control Program and Infrastructure		
Elements to be assessed	Assessment	Notes/Areas for improvement
A. The facility has specified a person (e.g., staff, consultant) who is responsible for coordinating the IC program.	<input type="radio"/> Yes <input type="radio"/> No	
B. The person responsible for coordinating the infection prevention program has received training in IC. <i>Examples of training may include: Successful completion of initial and/or recertification exams developed by the Certification Board for Infection Control & Epidemiology; Participation in infection control courses organized by the state or recognized professional societies (e.g., APIC, SHEA).</i>	<input type="radio"/> Yes <input type="radio"/> No	
C. The facility has a process for reviewing infection surveillance data and infection prevention activities (e.g., presentation at QA committee).	<input type="radio"/> Yes <input type="radio"/> No	
D. Written infection control policies and procedures are available and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations (F-441), or standards. <i>Note: Policies and procedures should be tailored to the facility and extend beyond OSHA Bloodborne pathogen training or the CMS State Operations Manual</i>	<input type="radio"/> Yes <input type="radio"/> No	
E. Written infection control policies and procedures are reviewed at least annually or according to state or federal requirements, and updated if appropriate.	<input type="radio"/> Yes <input type="radio"/> No	
F. The facility has a written plan for emergency preparedness (e.g., pandemic influenza or natural disaster).	<input type="radio"/> Yes <input type="radio"/> No	

II. Healthcare Personnel and Resident Safety		
Elements to be assessed	Assessment	Notes/Areas for improvement
Healthcare Personnel		
A. The facility has work-exclusion policies concerning avoiding		

F323: Accident Prevention Audit Tool

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Area of Review	YES	NO	Recommended Action	Staff Responsible/ Date
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Hazards Observation

- Are chemicals accessible to residents?
- Are staff promptly responding to alarms?
- Is the environment safe for residents?

Record review:

- Resident is assessed for unsafe wandering and/or elopement
- Risk of falls is assessed and care plan is individualized

Following a Fall/Accident

- The incident/accident was investigated (Root cause analysis)
- Interventions were put into place based on investigation and are individualized
- The Plan of Care was promptly updated
- Hazards and risks were identified
- Staff consistently implement new care plan interventions

F271: Kitchen Sanitation Audit Tool

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Area of Review	YES	NO	Recommended Action	Staff Responsible/ Date
Are all foods in the refrigerators and freezers covered, labeled and dated? -Are the refrigerators/freezers clean? -Are thermometers in the refrigerators and freezers?				
Is the interior of the refrigerator fan clean and free of dust?				
Are food bins clean and labeled with no scoops inside?				
Are thermometers for food properly sanitized before using?				
Are food temperature logs being completed?				
Are hair restraints worn by food service staff?				

F309: Quality of Life Audit Tool

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Area of Review	YES	NO	Recommended Action	Staff Responsible/ Date
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The resident's prognosis for end of life with supporting documentation is identified

Is there a pain assessment in the medical record?

Is there a care plan addressing both pharmacological and non-pharmacological interventions?

Do the nurses document the pain intensity with the pain scale and location with prn administration?

Is there documentation of effectiveness of prn pain medication?

When the resident is approaching the end of life, if the resident is not already receiving palliative care, documentation includes discussion and education to the resident/responsible party, about palliative care options, including hospice

F329: Unnecessary Drugs Audit Tool

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Area of Review	YES	NO	Recommended Action	Staff Responsible/ Date
Documentation is present in the resident record, of attempts to manage behaviors with non-pharmacological interventions for residents using antipsychotic medications prior to the use of medications?				
Gradual dose reductions are attempted for residents in accordance with F329				
Antibiotics are used for confirmed or suspected bacterial infection				
Medications are used within the manufacturer's recommended timeframes, stop date or duration (unless documentation exists for clinical justification for continued use)				
There is documentation of evidence for monitoring for effectiveness and adverse consequences				

Area of Review	YES	NO	Recommended Action	Staff Responsible/ Date
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Review of Care Plan:

- 1. Evidence that care plan is based on comprehensive assessment
- 2. Updated with resident changes
- 3. Individualized
- 4. Measureable and realistic goals
- 5. Individualized Interventions
- 6. Addresses all identified care needs of the resident
- 7. Directions for staff on proper monitoring
- 8. How to handle refusals of care

There is evidence of resident and/or legal decision maker involvement in then plan of care

- System Audits
 - Choose a few charts per week
 - Review Care Plan Interventions
 - Observe Staff
 - Interview Staff
 - Use this information for updating the care plan and Staff education!
 - Get direct care staff involved in doing the audits/peer observation



“Well-trained and dedicated employees are the only sustainable source of competitive strength.”

-Robert Reich



- Medicare.gov/Nursing Home Compare
 - <http://www.medicare.gov/nursinghomecompare/search.html>
- State Operations Manual, Appendix PP
 - <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R167SOMA.pdf>
- Nursing Home Inspect:
 - <http://projects.propublica.org/nursing-homes/>

CDC: The Core Elements of Antibiotic Stewardship for Nursing Homes

[http://www.cdc.gov/longtermcare/
prevention/antibiotic-
stewardship.html](http://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html)

- U.S. Department of Health & Human Services: AHRQ: Nursing Home Antimicrobial Stewardship

<http://www.ahrq.gov/nhguide/index.html>

- Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria (SHEA/CDC Position Paper)
 - <http://www.jstor.org/stable/10.1086/667743>
- APIC (Association for Professionals in Infection Control and Epidemiology):
 - <http://www.apic.org/>
- Centers for Disease Control and Prevent
 - <http://www.cdc.gov/>

Thank You!

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